No. 18-35846

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ANDREA SCHMITT and ELIZABETH MOHUNDRO,

Plaintiffs and Appellants,

v.

KAISER FOUNDATION HEALTH PLAN OF WASHINGTON, KAISER FOUNDATION HEALTH PLAN OF WASHINGTON OPTIONS, INC., KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, and KAISER FOUNDATION HEALTH PLAN, INC.

Defendants and Appellees.

On Appeal from the United States District Court
for the Western District of Washington
No. 2:17-cv-01611-RSL, Hon. Robert S. Lasnik

BRIEF OF AMICI CURIAE IN SUPPORT OF APPELLEES' PETITION FOR REHEARING EN BANC FILED WITH CONSENT OF ALL PARTIES (Cir. R. 29-2(a))

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CORPORATE DISCLOSURE STATEMENT (FRAP 26.1(a))

The following information is provided under Federal Rule of Appellate Procedure 26.1:

Association of California Life and Health Insurance Companies is a nonprofit association and not a corporation.

California Association of Health Plans is a California nonprofit corporation. It has no parent corporation, and no publicly held corporation owns any of its stock.

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I. INTEREST OF AMICI

Under Federal Rule of Appellate Procedure 29(b) and Circuit Rule 29-2(a), Association of California Life and Health Insurance Companies (ACLHIC) and California Association of Health Plans (CAHP) file this amici curiae brief in support of Appellees' petition for rehearing en banc with the consent of all parties.[1]

ACLHIC is a nonprofit association whose members include 49 life and health insurance companies in California. ACLHIC's members represent an industry that provides more than $2 trillion of insurance coverage to Californians and has invested more than $400 billion in California's economy. Since 1962, ACLHIC has been the insurance industry's primary voice in Sacramento. Its main goals are to advance the interests of the life and health insurance industry before legislative and administrative bodies.

CAHP is a California nonprofit corporation whose members include 45 public and private health care service plans—including Appellee Kaiser Foundation Health Plan, Inc.—that collectively provide health care coverage to more than 28 million Californians. CAHP represents its constituent plans with respect to, among other things, legislative and regulatory issues affecting both the healthcare and health coverage industries.

[1] No party, party's counsel, or person other than amici, their members, and their counsel has authored the brief in whole or in part or contributed money that was intended to fund preparing or submitting the brief.

II. INTRODUCTION

The opinion holds that a court can find actionable disability discrimination under the Patient Protection and Affordable Care Act (ACA) based on any coverage exclusion for a medical service or device that an individual with a disability might seek—which, because disabled individuals may seek all types of healthcare services, could include virtually every coverage exclusion in every health plan and insurance policy throughout the United States. The opinion, if allowed to stand, could be interpreted to radically expand the scope of the ACA's antidiscrimination rules. It also could be interpreted to vest in individual courts the power to determine what benefits a plan must cover for disabled individuals, leading to ad hoc benefit mandates that vary by jurisdiction, by contract, and even by litigant. This would create vast uncertainty and make it extremely difficult, if not impossible, for health plans and insurers[2] to predict the scope of coverage required, craft affordable benefit plans, and price them properly.

This decision would also undermine the careful division of responsibility that Congress enshrined in the ACA and other federal laws. Under that division of

[2] In California (where amici's members do business), regulation of health coverage is split between two state agencies: the Department of Managed Health Care, which regulates "health care service plans" (Cal. Health & Safety Code §§ 1341, 1345(f)), and the California Department of Insurance, which regulates, among others, health insurers (Cal. Ins. Code § 106). The federal Public Health Service Act ("PHS Act") Act and the ACA refer to both types of entities as "health insurance issuers." PHS Act § 2791(b)(2), 42 U.S.C. § 300gg-91(b)(2); ACA § 1301(b)(2), 42 U.S.C. § 18021(b)(2).

responsibility, which Supreme Court decisions have ratified, state and federal *regulators* oversee the requirements for which healthcare benefits must be offered by health plans and insurers, while federal *courts* ensure *those benefits* are made available in a nondiscriminatory manner consistent with civil rights laws.

The opinion erased that division of responsibility when it misinterpreted and misapplied the ACA and, in doing so, reached a conclusion at direct odds with the Supreme Court's interpretation. The ACA's antidiscrimination provision, Section 1557 (42 U.S.C. § 18116), says that "an individual shall not, on the ground prohibited under … section 504 of the Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance." Section 504 in turn prohibits a federally funded program from discriminating against an individual "solely by reason of her or his disability." 29 U.S.C. § 794(a). In interpreting Section 504, the Supreme Court has explained that a limitation on health benefits that is "neutral on its face, is not alleged to rest on a discriminatory motive, and does not deny the handicapped access to or exclude them from the particular package" of benefits offered by a federally funded health program or activity does not violate the statute. *Alexander v. Choate*, 469 U.S. 287, 309 (1985). Under *Alexander*, alleged discrimination in benefit design, such as Appellants' allegation that a health plan has excluded

benefits for hearing loss other than for cochlear implants, does not violate Section 504—as the opinion correctly notes. That should have been the end of the Panel's analysis, because if there is no violation of Section 504, there is no disability discrimination claim under ACA Section 1557.

The opinion, however, went on to hold that *Alexander* does not govern disability discrimination claims under Section 1557 because—as the Panel erroneously concluded—Section 1557 must be read to incorporate an entirely unrelated provision of the ACA: Section 1302, 42 U.S.C. § 18022.[3] By reading requirements of Section 1302 into Section 1557, the opinion substantially and impermissibly broadens the scope of Section 1557 to encompass allegedly discriminatory benefit design. This is wrong for two reasons.

First, Section 1302 has no application whatsoever to large group plans such as those at issue in this case. Section 1302 imposes certain coverage requirements only on health coverage sold directly to *individuals* and to *small groups*. *See* 42 U.S.C. § 300gg-6(a). The Panel incorrectly assumed that the requirements of Section 1302 also apply to the *large group* coverage at issue in this case. The operative Second Amended Complaint does not allege that either Appellant is enrolled in health coverage sold to an individual or small group subject to Section

[3] The opinion refers to Section 1302 only by its U.S. Code citation, 42 U.S.C. § 18022. For ease of reference, we refer to Section 1302.

1302. So there is no allegation from which the Court could infer that Section 1302 applies to, or is otherwise relevant to, the coverage at issue. Indeed, the undisputed record in the district court shows that Appellants are enrolled in *large group* coverage. (ER 301.)

Second, even for coverage to which Section 1302 applies, the Panel incorrectly imported that section into the unrelated antidiscrimination provision. The disconnect between the scope of Section 1302 (which identifies factors that the Secretary of Health and Human Services must consider when defining benefits that must be offered to individuals and small groups) and the scope of Section 1557 (which prohibits discrimination in federally funded health programs and activities) demonstrates the fallacy of the Panel's analysis. These two provisions of the ACA regulate different subjects, have different purposes, and have different enforcement mechanisms. They even appear in different subtitles of the ACA, more than 100 pages apart in its official compilation.

There is simply no reason to conclude that Congress, when prohibiting disability discrimination in all federally funded coverage under Section 1557, intended to bury within Section 1302—which pertains only to certain coverage not at issue here—additional requirements that would radically transform federal antidiscrimination law and yet neglected to even reference that provision in Section 1557 itself.

The likely result of the Panel's misconstruction of the statute is that district courts will police benefit design, a subject that the ACA specifically left up to the regulatory agencies. This could wreak havoc on the operation of those plans, as it will make it difficult, if not impossible, to predict what benefits must be covered to avoid discrimination and to price coverage effectively and affordably. The opinion should be vacated en banc, and the district court decision affirmed.

III. THE CONSEQUENCES OF THE PANEL DECISION ARE OF EXCEPTIONAL IMPORTANCE

As the Supreme Court has repeatedly held, Section 504 requires covered entities to provide meaningful access to benefits to people with disabilities and make reasonable accommodations to achieve this. Section 504 does *not* require fundamental changes to the benefits offered. In the context of health coverage, this has meant that individuals with disabilities must not be prevented from accessing covered items and services because of their disabilities. When the covered items and services are defined in facially neutral terms and not designed with a discriminatory intent, Section 504 does not require federally funded health programs to expand the covered benefits to include additional items or services.

The opinion upends these long-settled expectations. If left intact, it could be interpreted to require health plans and insurers to cover virtually limitless items and services. Section 504 as applied in *Alexander*, and by extension Section 1557 (which incorporates the standards of Section 504), require health plans and insurers

to make only those accommodations necessary for a person with a disability to access meaningfully the covered benefits. For example, as HHS explained, a plan could not permissibly offer coverage for medically necessary bariatric surgery but deny coverage for that surgery for individuals with developmental disabilities. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376, 31429 (May 18, 2016). In addition, a plan may be required to provide coverage for auxiliary services, such as a sign language interpreter, to allow an individual with a disability to meaningfully access healthcare services under the plan. *See* Nondiscrimination in Health and Health Education Programs or Activities, 85 Fed. Reg. 37160, 37246 (June 19, 2020) (to be codified at 45 C.F.R. § 92.102); *see also* 45 C.F.R. § 92.202 (2019). The opinion would untether this analysis from the covered benefits under the contract, and would require health plans and insurers to cover additional healthcare for people with disabilities, with no discernible standards to apply when evaluating whether a particular item or service is needed by a person with a disability or to define the limits of this court-created requirement.

Plans and insurers, like other entities subject to Section 504, recognize they have an obligation to provide meaningful access to their services to people with disabilities, and they embrace doing so as a core part of their mission. But Sections 504 and 1557 require only that covered entities achieve this through reasonable

accommodations—not through fundamental alterations to their operations. *See Mark H. v. Lemahieu*, 513 F.3d 922, 937 (9th Cir. 2008). Facially neutral health coverage is the fundamental product that is purchased from health plans and insurers, and permitting enrollees to retroactively question the scope of the benefits purchased in their coverage contract would amount to a fundamental alteration to the health coverage product.

In modern health coverage, whether sold directly to individuals or through employer groups, a health plan or insurer agrees to pay a portion of incurred expenses for healthcare services covered under the plan or policy in exchange for a monthly premium payment. The benefits and premiums are generally reviewed and approved in advance by state or federal regulators. Issuers then reduce costs to the plans, enrollees, and the healthcare system as a whole by negotiating lower reimbursement rates with contracted "network" providers, and by managing their enrollees' utilization through various mechanisms such as prior approval of services for medical necessity, or creating cost-sharing incentives to direct enrollees to higher-value, lower-cost providers or treatment settings. *See, e.g.*, Peter D. Fox & Peter R. Kongstvedt, *A History of Managed Health Care and Health Insurance in the United States*, THE ESSENTIALS OF MANAGED HEALTH CARE (6th ed. 2013).

The opinion upsets each aspect of this business. Health plans and insurers would need to reconsider their premium rate-setting methodology because they would not know in advance which disabilities their enrollees might have and therefore what additional benefits they would necessarily need to cover. Rates to all insureds would likely have to increase to reflect the extra benefits, plus a risk premium to account for the uncertainty about the potential costs of these benefits across the entire population. Because these additional benefits would not be part of the state or federal regulatory requirements, it would be unclear what provider reimbursement and enrollee cost-sharing obligations apply to these ad hoc court-determined benefit mandates. Further, because these coverage obligations could arise retrospectively based on a court's findings in particular litigation alleging that a plan or insurer impermissibly discriminated, health plans and insurers would not have the opportunity to negotiate favorable reimbursement arrangements with providers or to manage utilization by incentivizing enrollees to use lower-cost providers or service settings. Issuers' utilization review and clinical staff would need to consider a broader, potentially limitless, range of factors in evaluating whether a claim for a particular item or service is covered, without the framework of the schedule of benefits in the plan or policy.

All of this describes a fundamental alteration to health coverage that, as discussed below, Section 1557 does not require.

IV. REHEARING EN BANC IS NECESSARY BECAUSE THIS PROBLEM OF EXCEPTIONAL IMPORTANCE WAS CREATED BY AN ERROR OF LAW

A. *Alexander* compels affirmance of the district court's judgment.

The district court's opinion and the Panel's decision itself (Op. p. 18) correctly conclude that under *Alexander*'s interpretation of Section 504, which is incorporated into Section 1557, Appellants cannot state a claim for disability discrimination based on an allegation that a health plan uniformly excludes benefits for hearing loss other than for cochlear implants. Section 504, as applied in *Alexander*, does not "require that substantively different services be provided to the disabled, no matter how great their need for the services may be." *Wright v. Giuliani*, 230 F.3d 543, 548 (2d Cir. 2000). Section 504 requires "only that covered entities make 'reasonable accommodations' to enable 'meaningful access' to such services as may be provided, whether such services are adequate or not." *Id.*; *Modderno v. King*, 82 F.3d 1059, 1062 (D.C. Cir. 1996).

The district court correctly concluded that under the binding Supreme Court precedent of *Alexander*, Appellants had failed to state a claim under Section 1557. The Panel correctly agreed with this portion of the district court's order (Op. p. 18), and the district court's judgment should have been affirmed in full on this basis. The Panel, however, reached the contrary and erroneous conclusion that an

entirely unrelated provision of the ACA, Section 1302, has some bearing on the interpretation of Section 1557.

B. Section 1302 is irrelevant to the interpretation of Section 1557.

The premise underlying the Panel's opinion is that Sections 1302 and 1557 should be read together because they regulate the same health coverage. That premise is incorrect for several reasons, discussed below.

1. Section 1302 does not apply to the large group coverage at issue in this case.

A provision of the ACA, codified in PHS Act § 2707(a), 42 U.S.C. § 300gg-6(a), requires health plans and insurers to provide coverage for an "essential health benefits package" in health coverage issued to *individuals* and *small groups*. Section 1302 identifies criteria that the Secretary is required to consider when defining the term "essential health benefits package." Thus, by the ACA's plain terms, Section 1302 applies to coverage issued to individuals and small groups but *not* to large groups.[4] PHS Act § 2707(a), 42 U.S.C. § 300gg-6(a); *see also Florida ex rel. Attorney Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1252 (11th Cir. 2011) (ACA does not impose essential health benefits requirement

[4] "Individual" is the market for coverage sold to individuals, not employers. "Small group" is the market for health coverage sold to small employers; "large group" is the market for health coverage sold to large employers. *See* PHS Act § 2791(e), 42 U.S.C. § 300gg-91(e).

on large employer coverage), *rev'd on other grounds sub nom. Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012).

Thus, to plausibly allege that Section 1302 is relevant to this case, Appellants would have had to allege that their employment-based health coverage was sold to a small employer. The Second Amended Complaint does not do so. To the contrary, the undisputed record in the district court shows that Appellants are enrolled in *large group* health insurance coverage (ER 301), which is not governed by Section 1302.

2. Sections 1302 and 1557 regulate different subjects.

Granting Appellants leave to amend their complaint a third time would be futile because even if they could plausibly allege that they are enrolled in a type of coverage that is required to provide the essential health benefits described in Section 1302, the limited overlap in subjects addressed by Sections 1302 and 1557 reinforces the district court's conclusion that a coverage exclusion for hearing loss benefits other than for cochlear implants does not give rise to a Section 1557 discrimination claim.

The central objective of the ACA is to expand access to affordable health coverage to the uninsured. *See generally King v. Burwell*, 576 U.S. 988 (2015). Section 1302 is a key component of Congress's effort to achieve this objective, which Congress furthered in several ways. The ACA expanded eligibility for

federally subsidized coverage provided through individual health insurance and Medicaid. *See* Internal Revenue Code § 36B; ACA § 2001. It requires Americans to maintain minimum essential coverage. *See* Internal Revenue Code § 5000A. It requires health plans and insurers to extend coverage to nearly anyone who applies, without charging more based on the applicant's health status and without imposing exclusions on preexisting conditions. *See* PHS Act §§ 2701-2705, 42 U.S.C. §§ 300gg - 300gg-4. It eliminates lifetime or annual dollar benefit limits, ensuring coverage is available for catastrophic losses. PHS Act § 2711, 42 U.S.C. § 300gg-11. And, so that the guarantee of affordable and accessible coverage is not illusory, the ACA requires that the newly available federally subsidized Medicaid and individual health coverage provide a comprehensive benefit package defined by the Secretary under Section 1302. *Id*. § 2707, 42 U.S.C. § 300gg-6; 42 U.S.C. § 1396u-7(b)(5). [5]

Yet these provisions cover only a few of the hundreds of pages of statutes that constitute the ACA, which Congress also used as an opportunity to address a wide variety of *other* health policy objectives. Among those additional provisions is Section 1557, which applies to all federally funded health programs and activities; it is not limited to health *coverage*, which is the focus of Section 1302

[5] The ACA amended or added each provision of the PHS Act and Internal Revenue Code cited in this paragraph.

and the related provisions just described. And even within the realm of federally funded health coverage, Section 1557 has a wider application than the individual, small group, and Medicaid coverage to which Section 1302 applies. For example, Section 1302 does not apply to Medicare. *See, e.g.*, *Libby v. Price*, 689 F. App'x 659, 660 (2d Cir. 2017). Yet Medicare health plans are covered entities for purposes of Section 1557's antidiscrimination provision. Similarly, state Medicaid programs are required to provide essential health benefits coverage only to the population that was made newly eligible for coverage under the ACA, *see* 42 U.S.C. § 1396u-7(b)(5), while Section 1557 applies to *all* Medicaid-covered populations.

The disconnect between the two universes of programs covered by Sections 1302 and 1557 demonstrates the error of using Section 1302 as a guide to interpret the meaning of Section 1557.

3. Sections 1302 and 1557 differ in structure and function.

The different structures and functions of Sections 1302 and 1557 further demonstrate that there is no reason to believe Congress intended Section 1302 to expand the scope of what constitutes actionable discrimination under Section 1557.

Recognizing the difficulty of defining a mandatory comprehensive benefit package that would achieve its various policy objectives, Congress left that task

largely to the Secretary. In doing so, Congress identified, in Section 1302, ten *categories* of benefits to include in the package, as well as several factors the Secretary should consider in defining the package. The requirement that issuers of health coverage in the individual and small group markets cover the Secretary-defined essential health benefits package, like all the other PHS Act requirements described above, is enforced administratively by state insurance regulators or, if they fail to do so, by the Secretary directly. *See* PHS Act § 2723, 42 U.S.C. § 300gg-22. Under state laws, states may impose corrective action plans, levy fines and restitution, or suspend licenses to do insurance business for violations of the PHS Act.[6] If a state fails to enforce these federal requirements, the Secretary may impose civil monetary penalties directly on noncompliant entities. *See* PHS Act § 2723, 42 U.S.C. § 300gg-22; 45 C.F.R. pt. 150.

As regulators evaluate whether plans and insurers are providing a comprehensive benefit package, the ACA instructs them to also evaluate whether plans and insurers are proposing reasonable premium rates in light of the benefits offered. PHS Act § 2794, 42 U.S.C. § 300gg-94. Thus, Congress has assigned to

[6] *See*, *e.g.*, Wash. Admin. Code §§ 284-43-5642(11) (requiring insurers to comply with federal law regarding coverage of essential health benefits), 284-43-0140 (obliging insurers to comply with federal law); Wash. Rev. Code §§ 48.05.140 (authorizing insurance commissioner to suspend an insurer's license for failure to comply with insurance regulations), 48.05.185 (authorizing fine of up to $10,000 in addition to or in lieu of license suspension or revocation).

federal and state regulators oversight of each of the relevant aspects of health plans' and insurers' operations: regulators must define the benefits that must be offered, enforce compliance with those benefit mandates, review premium rates, and police additional protections designed to prevent discrimination against individuals based on health status and to promote access to health coverage.

In an appropriate Administrative Procedure Act case, a party may be able to challenge *the Secretary's* determinations under Section 1302 as to what constitutes essential health benefits. *See* 5 U.S.C. § 706. But the ACA creates no private right of action to challenge *regulated plans' or insurers' implementation* of the essential health benefit package requirement. *See* Christine H. Monahan, *Private Enforcement of the Affordable Care Act*, 126 YALE L.J. 1118, 1123 (2017). This reflects Congress's concern that deference be given to the primary enforcement authority of regulators, who are charged with balancing the interests of consumers and all other stakeholders in this comprehensively regulated industry. This comprehensive regulatory system—with Congress at every turn deferring to regulators both to define and to enforce the required benefits—makes it entirely implausible that Congress, when it incorporated the existing Section 504 right of action for disability discrimination into Section 1557, intended to expand the activities that could be challenged in court as disability discrimination in reliance on Section 1302. *See Middlesex County Sewerage Auth. v. National Sea Clammers*

Ass'n, 453 U.S. 1, 14 (1981) (holding that in light of "elaborate enforcement provisions" in a federal statute, "it cannot be assumed that Congress intended to authorize by implication additional judicial remedies for private citizens" suing under the same statute).

The opinion's discussion of its consequences (Op. pp. 22-23) further shows the error of the Panel's approach. First, the opinion quotes a portion of the Secretary's regulation on essential health benefits (Op. p. 22 (quoting 45 C.F.R. § 156.125)), which, as discussed, is irrelevant to this case. The opinion then quotes a portion of the preamble to the Section 1557 regulation but not the Secretary's interpretation that, consistent with *Alexander*, Section 1557 means "that covered entities have discretion in developing benefit designs and determining what specific health services will be covered in their health insurance coverage or other health coverage." 81 Fed. Reg. at 31434. The Secretary concludes that Section 1557 prohibits covered entities only from maintaining health coverage that "operate[s] in a discriminatory manner." *Id.* In contrast, the opinion suggests that a broader range of limitations and exclusions could be prohibited under Section 1557 than would be prohibited under *Alexander*. (Op. pp. 22-23.)

Finally, Appellants' rhetoric that affirming the district court's judgment would "eviscerate[]" the ACA's "key reforms" ignores the ACA's actual comprehensive reforms and enforcement scheme just described, which operate

entirely apart from Section 1557. (Appellants' Opening Br. p. 5.) As described above, the ACA dramatically reshaped health coverage in the United States through reforms that are codified in the PHS Act and Internal Revenue Code, and that are enforced robustly by state regulators and the federal government. Section 1557—which incorporates existing civil rights laws, and which the Secretary acknowledged imposes no major new substantive obligations on covered entities with respect to disability discrimination, 81 Fed. Reg. at 31446—plays no role in the enforcement of these reforms, which Congress clearly delineated. There is absolutely nothing to indicate that Congress intended the ACA to substantially expand the existing scope of federal antidiscrimination law and the private right to enforce it. Congress said nothing about that expansion in Section 1557, and instead buried the supposedly operative language more than 100 pages away in another ACA provision applicable only to a narrow set of plans and enforced solely by regulators.

In sum, there is no reason to conclude that Section 1302 or any other aspect of the ACA compels Section 1557 to be read any way other than literally—that it prohibits discrimination "on the ground prohibited under" Section 504.

V. CONCLUSION

The en banc Court should vacate the opinion and affirm the district court's judgment.

Dated: August 7, 2020

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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This brief contains 4,173 words, excluding the items exempted by Fed. R. App. P. 32(f). The brief's type size and typeface comply with Fed. R. App. P. 32(a)(5) and (6).

I certify that this brief is an amicus brief and complies with the word limit of Cir. R. 29-2(c)(2).

Signature s/ Joseph E. Laska **Date** 8/7/20