THE HONORABLE RICHARD A. JONES

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

E.S., by and through her parents, R.S. and J.S., and JODI STERNOFF, both on their own behalf, and on behalf of all similarly situated individuals,

Plaintiffs,

v.

REGENCE BLUESHIELD; and CAMBIA HEALTH SOLUTIONS, INC., f/k/a THE REGENCE GROUP,

Defendants.

No. 2:17-cv-01609-RAJ

DEFENDANTS' MOTION TO DISMISS

NOTE ON MOTION CALENDAR:
March 2, 2018

Oral Argument Requested

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I. MOTION

Defendants Regence BlueShield ("Regence") and Cambia Health Solutions, Inc. ("Cambia," collectively "Defendants") respectfully move the Court for an order dismissing Plaintiffs' Complaint pursuant to Fed. R. Civ. P. 12(b)(6) on the grounds that it fails to state a claim for relief.

II. INTRODUCTION

In 2010, Congress passed the Patient Protection and Affordable Care Act ("ACA"), which included the following provision:

> Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), 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, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

42 U.S.C. § 18116(a) ("Section 1557").

Plaintiffs are insureds under a Regence BlueShield health plan who allege that they have been diagnosed with hearing loss that allegedly qualifies them as disabled under regulations implementing Section 1557. Plaintiffs claim that they are subject to discrimination on the basis of disability under the ACA because their insurance plan excludes coverage for all treatment for hearing loss except cochlear implants. It is undisputed, however, that the hearing coverage exclusion applies to *all insureds*, disabled and non-disabled alike. Plaintiffs do not allege that they have been treated any differently than any other insured, nor do they allege that the

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exclusion applies only to hearing loss that qualifies as a disability. Instead, their theory is that Defendants' choice not to cover treatment related to actual or potential hearing loss—whether disabling or non-disabling—for *every* insured nonetheless constitutes discrimination on the basis of disability.

For over 30 years, courts (including the Ninth Circuit) have squarely and repeatedly addressed and rejected Plaintiffs' theory, as should this Court. For disability discrimination claims, Section 1557 expressly incorporates the enforcement mechanism of Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and is therefore subject to the same standards and limitations as claims brought under that statute. Authorities construing Section 504—and an analogous provision in the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12101, *et seq.*—are clear that insurance coverage limitations that do not single out disabilities and that apply equally to all insureds are not discriminatory. Here, on its face, the exclusion in Plaintiffs' plan is not targeted at persons who suffer hearing loss that constitutes a disability. Rather, it applies across the board to all members of the plan, whether disabled or not. Nothing in Section 1557 or discrimination law requires insurers to offer any particular coverage, or prohibits them from applying such a blanket exclusion.

The reason for that result is plain. Although insurers must provide equal access to the benefits or services that they choose to provide, neither Section 1557 nor the laws incorporated in that statute require insurers to alter their policies to offer coverage specifically designed for disabled persons, or to offer equivalent coverage for all diseases or conditions, whether disabling or not disabling. The contrary view would have vast and unforeseen consequences for insurers and federal courts, which would be tasked with managing the content of individual insurance policies, limitations, and exclusions to ensure that coverage was provided for any disability and on equivalent terms. If Congress intended to take that radical approach—which, as stated above, would contravene decades of precedent—Section 1557 would have expressly stated as much and provided standards for doing so. It does not.

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Plaintiffs' claim does not withstand either legal or logical scrutiny. For the reasons outlined below, Plaintiffs have not stated a claim for disability discrimination under the ACA, and their Complaint should be dismissed.

III. BACKGROUND

A. The ACA

Congress enacted the ACA in 2010 in an effort to comprehensively reform the nation's health care system. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 590, 132 S. Ct. 2566, 183 L. Ed. 2d 450 (2012) (Ginsburg, J., dissenting in part). The ACA is a sprawling and complicated piece of legislation comprising 10 titles and spanning over 900 pages with hundreds of provisions. *Id*. at 538-39. As relevant here, the ACA generally barred insurers from imposing annual or lifetime limits on anything that is an "essential health benefit." "Essential health benefit" is a term of art under the ACA that Congress left to the Secretary of the Department of Health and Human Services ("HHS") to define. 42 U.S.C. § 18022(b). Congress, however, did direct the Secretary to ensure that essential health benefits include "[r]ehabilitative and habilitative services and devices." 42 U.S.C. § 18022(b)(1)(G). Congress further stated that "[t]he Secretary shall ensure that the scope of the essential health benefits . . . is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary." 42 U.S.C. § 18022(b)(2)(A). To enable the Secretary to assess what sorts of benefits were typical in employer plans, Congress required the Secretary of Labor to conduct a survey of employer plans. *Id*. After an extensive process, the Secretary left it to each state to articulate the scope of essential health benefits in that state. States did so through the adoption of a "benchmark plan."

Washington's benchmark plan covers cochlear implants but not hearing aids. WAC 284-43-5640(7)(b)(i) & (c)(iv). Washington Insurance Commissioner regulations provide that a health benefit plan must include cochlear implants as rehabilitative services, and may, but is not required to, include hearing aids other than cochlear implants. *Id*.

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The ACA did not include hearing aids or services as an essential health benefit, and most states' approved benchmark plans exclude or limit coverage for hearing aids. The benchmark plan offers no coverage for non-cochlear hearing aids in the following states: Alabama, Alaska, California, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Mississippi, Montana, Nebraska, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington State, Washington DC, West Virginia, and Wyoming. The benchmark plan covers hearing aids only for children, while denying coverage for adults in the following states: Colorado, Connecticut, Delaware, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, Tennessee, and Wisconsin. Cigna, Essential Health Benefits: Benchmark Plan Comparison, https://www.cigna.com/assets/docs/ about-cigna/informed-on-reform/top-11-ehb-by-state-2017.pdf (last visited Jan. 18, 2018).

B. Plaintiffs' Allegations

Plaintiff E.S. is the six-year-old daughter and dependent of R.S. and J.S. She is insured under a Regence BlueShield insured health plan. Compl. ¶ 1. Plaintiff Jodi Sternoff is an adult who is also insured under a Regence BlueShield insured health plan. *Id.* ¶ 2. Plaintiffs allege that they and other members of the class "have been diagnosed with Hearing Loss," that "limits a major life activity so substantially as to require medical treatment." *Id.* ¶ 22. Plaintiffs allege that they require and/or will require medical treatment for their hearing loss, excluding treatment with cochlear implants. *Id.* ¶ 23. Plaintiffs also allege that they have paid out-of-pocket for medically-necessary treatment for their hearing loss, including audiology examinations and hearing aids. *Id.* ¶ 31.[1]

[1] Plaintiffs' counsel has brought similar claims on behalf of a different plaintiff against several entities affiliated with Kaiser Permanente. *See Schmitt v. Kaiser Found. Health Plan of Wash.*, No. 2:17-cv-01611 (W.D. Wash. Oct. 30, 2017). Kaiser responded by filing a Motion to Dismiss raising many of the same arguments presented herein. *Id.*, Dkt. 17.

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Defendant Regence BlueShield is an authorized health carrier based in King County and is engaged in the business of insurance in the State of Washington, including King County. *Id.* ¶ 3. Cambia Health Solutions, Inc., f/k/a The Regence Group ("Cambia"), is the nonprofit sole member and corporate owner of Regence BlueShield. *Id.* ¶ 4.

Regence's insured health plans in Washington contain the following benefit exclusion:

> We do not cover routine hearing examinations, programs or treatment for hearing loss, including but not limited to noncochlear hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them.

Id. ¶ 9 (quoting Plaintiffs' Regence Policy, Group No. 10018298).[2] Referred to in the Complaint as a "blanket" Hearing Loss Exclusion (*id.* ¶ 12), on its face this policy provision applies to all insureds under the plans at issue. Thus, a non-disabled person will not have coverage for a routine hearing examination, just as a disabled person would not have coverage for the same examination. Plaintiffs do not allege otherwise.

IV. STANDARD OF REVIEW

"To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678, 129 S. Ct. 1937, 173 L. Ed. 2d 868 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570, 127 S. Ct. 1955, 167 L. Ed. 2d 929 (2007)). A claim is facially plausible "when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* "[D]ismissal for failure to state a claim under [Rule] 12(b)(6) is proper if there is a 'lack of a cognizable legal theory or the

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[2] *See* Declaration of Brady Cass in Support of Defendants' Motion to Dismiss, Exs. 1-2. In ruling on a Rule 12(b)(6) motion, a court may consider the allegations contained in the pleadings, exhibits attached to the complaint, and matters properly subject to judicial notice. *Outdoor Media Grp., Inc. v. City of Beaumont*, 506 F.3d 895, 899-900 (9th Cir. 2007). A court may also consider a writing referenced in the complaint, but not explicitly incorporated therein, if the complaint relies on the document and its authenticity is unquestioned. *Swartz v. KPMG, LLP*, 476 F.3d 756, 763 (9th Cir. 2007).

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absence of sufficient facts alleged under a cognizable legal theory.'" *Conservation Force v. Salazar*, 646 F.3d 1240, 1242 (9th Cir. 2011) (quoting *Balistreri v. Pacifica Police Dep't*, 901 F.2d 696, 699 (9th Cir. 1988)).

V. ARGUMENT

A. Section 1557 Incorporates the Enforcement Mechanism and Standards Applicable to Section 504 of the Rehabilitation Act.

1. Congress' Express Incorporation of Section 504 Shows an Intent to Adopt Existing Understandings of Discrimination.

The text and structure of Section 1557 indicate that Congress intended to apply longstanding discrimination principles when evaluating whether health programs and activities discriminate on the basis of disability. As an initial matter, the text of Section 1557 is clear. Subsection (a) prohibits discrimination on certain grounds and establishes discrimination claim procedures. The first sentence reads in pertinent part: "[A]n individual shall not, on the ground prohibited under . . . section 504 of the Rehabilitation Act . . . , be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity . . . ." 42 U.S.C. § 18116(a). The next sentence then states "[t]he enforcement mechanisms provided for and available under such . . . section 504 . . . shall apply for purposes of violations of this subsection." *Id*. Read together, these sentences are clear and unambiguous—claims for discrimination are available on the grounds prohibited in Section 504, and are to be addressed under the available corresponding enforcement mechanisms of Section 504.

In addition, in defining the scope of the discrimination prohibition in Section 1557, Congress used the same language that it did in Section 504. Section 1557 provides that a qualified individual shall not, on the basis of disability, "be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity" that receives federal funding. 42 U.S.C. § 18116(a). Section 504 likewise provides that a disabled individual shall not, on the basis of disability, "be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving

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Federal financial assistance." 29 U.S.C. § 794(a). Congress' word-for-word inclusion of the prohibition of Section 504 demonstrates its intent to incorporate the standards and judicial constructions of that statute as well. If Congress had intended only to specify the grounds upon which ACA discrimination claims could be brought, it could have simply prohibited discrimination based on race, color, national origin, sex, disability, and age. Instead, its explicit use of Section 504's language and incorporation of the claims available to Section 504 plaintiffs underscores Congress' intent to subject disability claims under Section 1557 to the same standards as claims under Section 504.

Interpretive principles also support that view. "[W]hen Congress uses the same language in two statutes having similar purposes, . . . it is appropriate to presume that Congress intended that text to have the same meaning in both statutes." *Smith v. City of Jackson, Miss.*, 544 U.S. 228, 233, 125 S. Ct. 1536, 161 L. Ed. 2d 410 (2005). Furthermore, as the Supreme Court has explained:

> Congress is presumed to be aware of an administrative or judicial interpretation of a statute and to adopt that interpretation when it re-enacts a statute without change…. So too, where, as here, Congress adopts a new law incorporating sections of a prior law, Congress normally can be presumed to have had knowledge of the interpretation given to the incorporated law, at least insofar as it affects the new statute.

Lorillard v. Pons, 434 U.S. 575, 580-81, 98 S. Ct. 866, 55 L. Ed. 2d 40 (1978) (citations omitted); *see also Goodyear Atomic Corp. v. Miller*, 486 U.S. 174, 184-85, 108 S. Ct. 1704, 100 L. Ed. 2d 158 (1988) (Courts "generally presume that Congress is knowledgeable about existing law pertinent to the legislation it enacts."). And when Congress incorporates an old provision into a new statutory scheme, the re-enacted provision is generally assumed to retain its judicially-created gloss, unless otherwise specified. *See Bragdon v. Abbott*, 524 U.S. 624, 645, 118 S. Ct. 2196, 141 L. Ed. 2d 540 (1998) ("When . . . judicial interpretations have settled the meaning of an existing statutory provision, repetition of the same language in a new statute indicates, as a general matter, the intent to incorporate its . . . judicial interpretations as well.").

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Each of these principles indicate that, rather than depart from an understanding of what it means to be "subject to discrimination" under Section 504 (and its companion statute, the ADA), Congress intended the scope of disability discrimination under Section 1557 to be coextensive with disability discrimination under Section 504.

2. Federal Courts Have Repeatedly Held That Section 1557 Does Not Supersede Existing Standards Applicable to Discrimination Claims.

Multiple federal district courts have reached the same conclusion, holding that Section 1557's express incorporation of "[t]he enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act," demonstrates a clear intent not only to limit ACA discrimination claims to the grounds covered by the incorporated statutes—race/color/national origin, sex, disability, and age, respectively—but also to incorporate the standards applicable to each referenced statute, depending on the protected class of the plaintiff. *See Se. Pa. Transp. Auth. v. Gilead Scis., Inc.*, 102 F. Supp. 3d 688, 698-99 (E.D. Pa. 2015); *Briscoe v. Health Care Serv. Corp.*, No. 16-CV-10294, 2017 WL 5989727, at *9-10 (N.D. Ill. Dec. 4, 2017); *York v. Wellmark, Inc.*, No. 4:16-cv-00627-RGE-CFB, slip op. at 28-35 (S.D. Iowa Sept. 6, 2017).

In *Gilead*, the plaintiff transportation authority sued the defendant drug manufacturer for discrimination on the basis of disability due to the defendant's pricing of its Hepatitis C drugs. *Gilead*, 102 F. Supp. 3d at 696. In analyzing whether Section 1557 creates a private right of action, the court found that "Section 1557 cross-references these four federal civil rights statutes to provide the classes of those protected by the statute's non-discrimination provision." *Id.* at 698. It further noted that Section 1557 incorporates those statutes' "enforcement mechanisms," indicating that Section 1557 claims should be evaluated by the same standards as claims under the civil rights law applicable to the plaintiff's protected class:

> Congress's express incorporation of the enforcement mechanisms from those four federal civil rights statutes, as well as its decision to define the protected classes by reference thereto, manifests an

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> intent to import the various different standards and burdens of proof into a Section 1557 claim, depending upon the protected class at issue.

Id. at 698-99.

Likewise, in *Briscoe*, the plaintiffs sued the defendant health insurer, alleging that it "discriminated against them on the basis of their sex in violation of § 1557 of the ACA by providing disparate levels of health benefits, and specifically ACA mandated preventive services, for breastfeeding and lactating women." 2017 WL 5989727, at *8 (internal quotation marks and citation omitted). In determining the appropriate standard to apply to a sex-discrimination claim under Section 1557, the court looked to the language of the statute, which it found to be "plain and unambiguous." *Id.* at *9. Based on the reference to the civil rights statutes and the express incorporation of their enforcement mechanisms, the court held that Congress intended also to incorporate the standards applicable to each statute. *Id.* (citing *Gilead*, 102 F. Supp. 3d at 698-99).

The only court to reach a contrary conclusion is the District of Minnesota in *Rumble v. Fairview Health Services*, No. 14-CV-2037 SRN/FLN, 2015 WL 1197415 (D. Minn. Mar. 16, 2015). The court in *Rumble* decided that the statutes referenced in Section 1557 merely supplied the "grounds" upon which a plaintiff could sue but that "Congress . . . likely intended that the same standard and burden of proof to apply to a Section 1557 plaintiff, regardless of the plaintiff's protected class status." *Id.* at *12. The court found that "[r]eading Section 1557 otherwise would lead to an illogical result, as different enforcement mechanisms and standards would apply to a Section 1557 plaintiff depending on whether the plaintiff's claim is based on her race, sex, age, or disability." *Id.* at *11. The court, however, expressly declined to specify the uniform standard that purportedly applies to all Section 1557 claims. *Id.* at *12. Nor has any other court held that a single standard applies, much less identified what that standard is.

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Every other court to consider the issue has explicitly rejected the reasoning of *Rumble*, finding nothing "absurd" about applying different standards to different protected classes, just as the referenced civil rights laws do. *Gilead*, 102 F. Supp. 3d at 699 n.3 ("Had Congress intended, as the district court in *Rumble* suggests, 'that the same standard and burden of proof apply to a Section 1557 plaintiff, regardless of the plaintiff's protected class status,' Congress could have listed the six protected classes without reference to those statutes and expressly provided for a single enforcement mechanism instead of incorporating mechanisms from all four statutes." (citation omitted)); *Briscoe*, 2017 WL 5989727, at *9 ("If Congress intended for a single standard to apply to all § 1557 discrimination claims, repeating the references to the civil-rights statutes and expressly incorporating their distinct enforcement mechanisms would have been a pointless (and confusing) exercise."); *York*, slip op. at 35 ("It would be superfluous to repeat the four statutes if Congress meant to use the statutes solely to identify the grounds protected from discrimination.").

This Court should join the weight of authority and hold that Congress expressly incorporated the standards applicable to the referenced civil rights statutes and that Plaintiffs' disability discrimination claim under Section 1557 is limited to that which is "available under . . . section 504" of the Rehabilitation Act.

B. Defendants' Policy Is Not Discriminatory Because It Treats Disabled and Non-Disabled Insureds the Same.

Section 504 provides, in relevant part:

> No otherwise qualified individual with a disability in the United States, as defined in section 705(20) of this title, shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service.

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29 U.S.C. § 794(a). In analyzing claims under this section, courts in the Ninth Circuit "examine cases construing claims under the ADA, as well as section 504 of the Rehabilitation Act, because there is no significant difference in the analysis of rights and obligations created by the two Acts." *Vinson v. Thomas*, 288 F.3d 1145, 1152 n.7 (9th Cir. 2002) (citing *Zukle v. Regents of the Univ. of Cal.*, 166 F.3d 1041, 1045 n.11 (9th Cir. 1999)).

The critical inquiry in any claim of unlawful discrimination is whether the challenged policy treats individuals in the protected class differently "because of" their membership in that protected class. *See United States v. Virginia*, 518 U.S. 515, 116 S. Ct. 2264, 135 L. Ed. 2d 735 (1996); *Alexander v. Choate*, 469 U.S. 287, 299-302, 105 S. Ct. 712, 83 L. Ed. 2d 661 (1985). Plaintiffs fail to state a claim under Section 504—and by extension, Section 1557—for one basic reason: they fail to allege that Defendants provide different hearing loss coverage for disabled and non-disabled customers. *Every* insured under the plans at issue—whether they suffer from disabling hearing loss or any hearing loss at all—receives the same treatment. *See Santiago Clemente v. Exec. Airlines, Inc.*, 213 F.3d 25 (1st Cir. 2000) (rejecting claim that certain level of hearing loss constitutes a disability). As outlined below, such insurance coverage limitations or exclusions that are not explicitly classified by disability and that apply uniformly to all insureds are not discriminatory.

1. Courts Construing Section 504 and the ADA Have Uniformly Rejected Plaintiffs' Theory.

In *Alexander v. Choate*, the United States Supreme Court unanimously held that a state Medicaid program's reduction of covered days for inpatient hospital stays did not state a claim under Section 504 despite the plaintiffs' allegation that it would disproportionately impact disabled customers. 469 U.S. at 289. Assuming without deciding that Section 504 "reaches at least some conduct that has an unjustifiable disparate impact upon the handicapped," the Court held that the across-the-board reduction in coverage "does not invoke criteria that have a particular exclusionary effect on the handicapped" and "does not distinguish between those

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whose coverage will be reduced and those whose coverage will not on the basis of any test, judgment, or trait that the handicapped as a class are less capable of meeting or less likely of having." *Id.* at 299-302.

Explaining its reasoning, the Court noted that Section 504 guarantees equal access to health plans but does not guarantee coverage of every ailment that may afflict the disabled:

> Section 504 does not require the State to alter this definition of the benefit being offered simply to meet the reality that the handicapped have greater medical needs. To conclude otherwise would be to find that the Rehabilitation Act requires States to view certain illnesses, i.e., those particularly affecting the handicapped, as more important than others and more worthy of cure through government subsidization. Nothing in the legislative history of the Act supports such a conclusion. Section 504 seeks to assure evenhanded treatment and the opportunity for handicapped individuals to participate in and benefit from programs receiving federal assistance. The Act does not, however, guarantee the handicapped equal results from the provision of state Medicaid, even assuming some measure of equality of health could be constructed.

Id. at 303-04 (citing *Se. Cmty. Coll. v. Davis*, 442 U.S. 397, 99 S. Ct. 2361, 60 L. Ed. 2d 980 (1979)).

The Court then held that, whatever the merits of disparate impact claims under Section 504 may be generally, they are not viable where uniform coverage limitation may result in a greater impact on some disabled people:

> The 14-day rule challenged in this case 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 Medicaid services Tennessee has chosen to provide. The State has made the same benefit—14 days of coverage—equally accessible to both handicapped and nonhandicapped persons, and the State is not required to assure the handicapped "adequate health care" by providing them with more coverage than the nonhandicapped. In addition, the State is not obligated to modify its Medicaid program by abandoning reliance on annual durational limitations on inpatient coverage. Assuming, then, that § 504 or its implementing regulations reach some claims of disparate-impact discrimination, the effect of Tennessee's reduction in annual inpatient coverage is not among them.

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Id. at 309.

Traynor v. Turnage, 485 U.S. 535, 108 S. Ct. 1372, 99 L. Ed. 2d 618 (1988), is consistent with *Alexander*. In *Traynor*, certain veterans who alleged that they were disabled by alcoholism sued under Section 504 to require the Veterans Administration to extend the 10-year period for use of certain educational benefits. *Id.* at 538. A statute allowed an extension if use of the benefits was prevented by a physical or mental disorder not caused by the veteran's own "willful misconduct." *Id.* Regulations defined willful misconduct to include "primary alcoholism." *Id.* at 555 n.2. The Court concluded that Section 504 does not require equal benefits for all categories of handicapped persons: "There is nothing in the Rehabilitation Act that requires that any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons." *Id.* at 549. The Court emphasized that "the central purpose of § 504 . . . is to assure that handicapped individuals receive 'evenhanded treatment' in relation to nonhandicapped individuals." *Id.* at 548 (citations omitted).

Since the Supreme Court's rulings in *Alexander* and *Traynor*, at least eight federal Courts of Appeals have applied the ruling to situations in which an exclusion or limitation on insurance coverage for a particular type of treatment is alleged to disproportionately harm disabled customers or not to allow treatment for a certain disability in comparison to other disabilities. *See, e.g.*, *Modderno v. King*, 82 F.3d 1059, 1061 (D.C. Cir. 1996) (limitation on coverage for mental but not physical illness does not discriminate against mentally disabled under Section 504); *Rogers v. Dep't of Health & Envtl. Control*, 174 F.3d 431 (4th Cir. 1999) (same issue under ADA); *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1019 (6th Cir. 1997) (same issue under ADA); *Rodriguez v. City of New York*, 197 F.3d 611, 618 (2d Cir. 1999) ("New York cannot have unlawfully discriminated against appellees by denying a benefit that it provides to no one."); *P.C. v. McLaughlin*, 913 F.2d 1033, 1041 (2d Cir. 1990) ("[T]he law governing § 504 did not clearly establish an obligation to meet [the plaintiff's] particular needs vis-a-vis the needs of other handicapped individuals, but mandated only that the services provided to non-

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handicapped individuals not be denied [the plaintiff] because he is handicapped."); *Ford v. Schering-Plough Corp*., 145 F.3d 601, 608 (3d Cir. 1998) (holding that "[t]he ADA does not require equal coverage for every type of disability"); *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1101-02 (10th Cir. 1999) (limitation on mental illness does not violate ADA); *Cohon ex rel. Bass v. N.M. Dep't of Health*, 646 F.3d 717, 729 (10th Cir. 2011) (limitations on home-based care do not discriminate against the disabled under ADA).

Of *Alexander*'s progeny, the case perhaps most on point is the Eighth Circuit's ruling in *Krauel v. Iowa Methodist Medical Center*, 95 F.3d 674 (8th Cir. 1996). In *Krauel*, the plaintiff sued her employer for, *inter alia*, disability discrimination under the ADA because the plan failed to cover treatment for infertility. *Id.* at 675-76. The district court granted summary judgment for the defendant, and on appeal, the Eighth Circuit held that such a coverage limitation did not constitute a disability-based distinction. *Id.* at 675. Quoting with approval from enforcement guidance issued by the Equal Employment Opportunity Commission ("EEOC"), the Court noted that "'[a] term or provision is "disability-based" if it singles out a particular disability (*e.g.*, deafness, AIDS, schizophrenia), a discrete group of disabilities (*e.g.*, cancers, muscular dystrophies, kidney diseases), or disability in general (*e.g.*, non-coverage of all conditions that substantially limit a major life activity).'" *Id.* at 677 (quoting EEOC: Interim Enforcement Guidance on Application of ADA to Health Insurance (June 8, 1993), *reprinted in* Fair Emp't Practice Manual (BNA) 405:7115, 7118 ("EEOC Guidance"). "***Insurance distinctions that apply equally to all insured employees, that is, to individuals with disabilities and to those who are not disabled, do not discriminate on the basis of disability.***" *Id.* at 678 (emphasis added) (quoting EEOC Guidance at 405:7117).

The Eighth Circuit went on to quote other specific examples of non-discriminatory coverage limitations cited by the EEOC:

> "For example, a feature of some employer provided health insurance plans is a distinction between the benefits provided for the treatment of physical conditions on the one hand, and the

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> benefits provided for the treatment of 'mental/nervous' conditions on the other. Typically, a lower level of benefits is provided for the treatment of mental/nervous conditions than is provided for the treatment of physical conditions. Similarly, some health insurance plans provide fewer benefits for 'eye care' than for other physical conditions. Such broad distinctions which apply to the treatment of a multitude of dissimilar conditions and which constrain individuals both with and without disabilities, are not distinctions based on disability. Consequently, although such distinctions may have a greater impact on certain individuals with disabilities, they do not intentionally discriminate on the basis of disability and do not violate the ADA."

Id. (quoting EEOC Guidance at 405:7118). The Court held that the exclusion of infertility treatment did not discriminate on the basis of disability because it "does not single out a particular group of disabilities, allowing coverage for some individuals with infertility problems, while denying coverage to other individuals with infertility problems. Rather, [it] applies equally to all individuals, in that no one participating in the Plan receives coverage for treatment of infertility problems." *Id.*

The Ninth Circuit expressly adopted the reasoning of *Alexander* and *Krauel* in *Weyer v. Twentieth Century Fox Film Corp.*, another case involving limitations on coverage for mental but not physical health. 198 F.3d 1104, 1116 (9th Cir. 2000). Citing *Krauel*, the Court held that "there is no discrimination under the [ADA] where disabled individuals are given the same opportunity as everyone else, so insurance distinctions that apply equally to all employees cannot be discriminatory." *Id.* (citing *Krauel*, 95 F.3d at 678).[3]

[3] The one case addressing the exclusion of hearing loss treatment from insurer plans is consistent with those authorities. *Micek v. City of Chicago*, No. 98 C 6757, 1999 WL 966970 (N.D. Ill. Oct. 4, 1999). In *Micek*, the plaintiffs alleged that insurance policies discriminated against the disabled because they excluded hearing aids from coverage—even though the policies cover virtually every other type of durable medical equipment, such as crutches, prostheses, and glasses. *Id*. at *2. In an alternative holding, the court concluded that the hearing aid exclusion did not violate the ADA. *Id*. at *6. The court explained that the ADA was not intended to regulate the content of insurance policies, and, given that plaintiffs received the same coverage as all other employees, there was no discrimination.

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Here, Plaintiffs' claim falls squarely within *Alexander* and its progeny and is barred by the Ninth Circuit's decision in *Weyer*. Plaintiffs do not claim that they, or any other allegedly-disabled person, were treated any differently than any of Defendants' other insureds. Instead, they received the same coverage options that were offered to everyone else. Such across-the-board insurance limitations "cannot be discriminatory." *Id*. To the extent Plaintiffs argue that Defendants are discriminating because the policies treat hearing loss differently than other health conditions (*see* Compl. ¶ 9), that claim is exactly the type of claim that has been repeatedly rejected by the Supreme Court and the other courts cited above.

Furthermore, the exclusion of treatment for hearing loss is not a disability-based classification because it does not single out a particular disability, group of disabilities, or disability in general. *See Krauel*, 95 F.3d at 677. Instead, just like the limitations on mental health or eye care referenced in *Weyer* and *Krauel*, hearing loss affects the disabled and non-disabled alike. "The ADA [and by extension, Section 504 and Section 1557] simply does not mandate equality between individuals with different disabilities. Rather, the ADA, like the Rehabilitation Act, prohibits discrimination between the disabled and the non-disabled." *Parker*, 121 F.3d at 1019.

Nothing in the text of Section 1557 suggests that Congress intended to adopt a radically different and contrary approach. Congress prohibited discrimination by certain health programs or activities by incorporating, *inter alia*, Section 504. In addition, Congress expressly stated that "[t]he enforcement mechanisms provided for and available under . . . section 504 . . . *shall apply* for purposes of violations of this subsection." (Emphasis added.) Thus, rather than evince an intent to overturn years of precedent in this area with respect to health insurers' benefit designs, Section 1557 indicates that Congress not only was aware of how courts had interpreted Section 504 and its enforcement, but intended to *require* courts to apply those precedents to claims under Section 1557. And, as illustrated above, those precedents uniformly reject Plaintiffs' theory.

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2. Cases Construing Section 1557 Demonstrate Why Plaintiffs' Theory Fails.

Cases addressing claims under Section 1557 illustrate what conduct does or does not constitute unlawful discrimination in violation of that statute and demonstrates why Plaintiffs' claim fails. In *Gilead*, the Eastern District of Pennsylvania granted a Hepatitis C drug manufacturer's motion to dismiss a claim alleging discrimination in violation of Section 1557. 102 F. Supp. 3d at 702. The court concluded that even if plaintiffs were considered to be disabled, they failed to show that the drug manufacturer's actions discriminated on the basis of disability: "[t]here are no allegations that [the manufacturer] changes the prices of its drugs depending upon whether the potential consumer has Hepatitis C." *Id*. at 700.

Gilead stands in contrast to circumstances where a covered entity plausibly engaged in actual discrimination under the ACA. In *Callum v. CVS Health Corp*., for example, the court held that the plaintiff, a black male who had PTSD, alleged a plausible claim for discrimination under Section 1557 against a pharmacy. 137 F. Supp. 3d 817 (D.S.C. 2015). The pharmacy appeared to harass plaintiff and denied his request to shop after hours (something within its power to allow), but allowed a while female customer to do so. *Id*. at 830-31. The court concluded that CVS was a covered entity under Section 1557, and that the plaintiff had stated a plausible claim for race and disability discrimination precisely because of such differential treatment as a result of the plaintiff's race and disability.

Thus, the plaintiff in *Callum* specifically alleged that he was treated differently from others *because of* his protected status—the key question in every discrimination case. That causal link is absent here, where the hearing loss exclusion applies to all insureds, whether or not they are disabled or, indeed, suffer any hearing loss at all. Under the plain terms of the policies, the non-disabled person seeking coverage for a routine hearing check is treated exactly the same as a person who suffers from some degree of hearing loss. That type of coverage exclusion does not violate any of the anti-discrimination statutes cited in Section 1557.

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3. Courts' Rejection of Plaintiffs' Theory Is Consistent with Legislative History.

Courts' interpretation of Section 504, the ADA, and Section 1557 in the health insurance context is consistent with how both Congress and the executive have interpreted the ADA, the only meaningful legislative history to discuss this issue.[4] When Congress passed the ADA, for example, each House and Senate committee explicitly adopted the Supreme Court's interpretation of the Rehabilitation Act, that is, that benefit programs are not required to provide particular benefits or treat all classes of disabled persons equally:

> [T]he Committee also wishes to clarify that in its view, as is stated by the U.S. Supreme Court in *Alexander v. Choate* . . . employee benefits plans should not be found to be in violation of this legislation under impact analysis simply because they do not address the special needs of every person with a disability, e.g., additional sick leave or medical coverage.

S. Rep. No. 101-116, at 78 (1989); H.R. Rep. No. 101-485, at 137 (1990), *reprinted in* 1990 U.S.C.C.A.N. 267, 420. Likewise, the Senate Labor and Human Resources Committee report explains that, while coverage cannot be denied or limited "based on" a person's disability, neutral limitations or exclusions applicable to all persons are permitted:

> In addition, employers may not deny health insurance coverage completely to an individual based on the person's diagnosis or disability. For example, while it is permissible for an employer to offer insurance policies that limit coverage for certain procedures or treatments, e.g., only a specified amount per year for mental health coverage, a person who has a mental health condition may not be denied coverage for other conditions such as for a broken leg or for heart surgery because of the existence of the mental health condition. A limitation may be placed on reimbursements for a procedure or the types of drugs or procedures covered[,] e.g., a limit on the number of x-rays or non-coverage of experimental drugs or procedures; but, that limitation must apply to persons with or without disabilities. All people with disabilities must have equal access to the health insurance coverage that is provided by the employer to all employees.

S. Rep. No. 101-116, at 29.

[4] There was no specific discussion of Section 1557 during the extensive deliberations on the ACA.

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Furthermore, as the court explained in *Krauel*, the EEOC Guidance on the application of the ADA to health insurance expressly rejects the notion that "broad distinctions which apply to the treatment of a multitude of dissimilar conditions and which constrain individuals both with and without disabilities, are not distinctions based on disability." 95 F.3d at 678 (internal quotation marks and citation omitted).

4. Adopting Plaintiffs' Theory Would Have Profound Effects on the Insurance Markets That Congress Did Not Intend.

Plaintiffs' theory portends a significant, indeed radical, shift in the application of anti-discrimination law to the health insurance markets. In Plaintiffs' view, health plans would not only be required to offer specific coverage that persons with disabilities require, but they apparently would have to do so on the same terms and conditions applicable to all other physical conditions—a strict parity requirement that would apply to any number of potentially disabling conditions: eyesight, hearing, other physical limitations, and mental health. The result would be to rewrite the policies and award benefits to insureds that were specifically excluded from the contract, and for which those insureds never paid a premium. Any conditions, limitations, or exclusions would be open to judicially-mandated changes in benefits after the insurance contract had been agreed upon and rates had been set.

Under these circumstances, imposing liability on insurers for declining to offer certain benefits to all their insureds, or requiring insurers to treat all conditions equally, would alter the insurance markets in a way that Congress never intended or, if Congress did so intend, would require much more specificity than exists in Section 1557. As the Seventh Circuit explained when faced with a similar claim:

> However this is dressed up, it is really a claim that benefit plans themselves may not treat mental health conditions less favorably than they treat physical health conditions. Without far stronger language in the ADA supporting this result, we are loathe to read into it a rule that has been the subject of vigorous, sometimes contentious, national debate for the last several years.

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EEOC v. CNA Ins. Cos., 96 F.3d 1039, 1044 (7th Cir. 1996); *see Ford*, 145 F.3d at 608 ("The ADA does not require equal coverage for every type of disability; such a requirement, if it existed, would destabilize the insurance industry in a manner definitely not intended by Congress when passing the ADA.").

The Court should be similarly reluctant to accept an interpretation of Section 1557 that no court has adopted, that contradicts precedents dating back to 1985, and that does not find support in the text, structure, or legislative history of Section 1557 or any other statute.

C. Regulations Implementing Section 1557 Do Not Support Plaintiffs' Claim.

Lacking any support for their claim in the statute itself or the case law, Plaintiffs appear to rely on the regulations interpreting Section 1557 and statements by the Department of Health and Human Services Office of Civil Rights ("OCR") regarding Section 1557. There are myriad problems with this approach.

First, the regulations do not support Plaintiffs' view that Section 1557 alters existing law and requires insurers to offer specific coverage or to treat all conditions equally. The final rule provides in relevant part:

> (a) General. A covered entity shall not, in providing or administering health-related insurance or other health-related coverage, discriminate on the basis of race, color, national origin, sex, age, or disability.
>
> (b) Discriminatory actions prohibited. A covered entity shall not, in providing or administering health-related insurance or other health-related coverage:
>
> (1) Deny, cancel, limit, or refuse to issue or renew a health-related insurance plan or policy or other health-related coverage, or deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, or disability;
>
> (2) Have or implement marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, age, or disability in a health-related insurance plan or policy, or other health-related coverage[.]

45 C.F.R. § 92.207.

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By its terms, subsection (a) simply repeats the anti-discrimination mandate of Section 1557. Subsection (b) prohibits specific forms of discrimination, including in "benefit design[]," but does not change the fundamental requirement that the discrimination must be "on the basis" of disability. As courts have repeatedly concluded, a benefit design that treats all insureds equally is not discriminatory on the basis of any protected status.

OCR's explanation of these regulations is consistent with that view. On September 8, 2015, OCR published proposed rules for Section 1557 for notice and comment. HHS, Nondiscrimination in Health Programs and Activities, Proposed Rule, 80 Fed. Reg. 54,172 (Sept. 8, 2015). On May 18, 2016, OCR issued the final rule implementing Section 1557 and responded to numerous comments related to the rule. HHS, Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376-01 (May 18, 2016). In both instances, OCR explained:

> Paragraph (a) proposed a general nondiscrimination requirement, and paragraph (b) provided specific examples of prohibited actions. Paragraphs (b)(1) and (2) proposed to address the prohibition on denying, cancelling, limiting, or refusing to issue or renew a health-related insurance plan or policy or other health-related coverage, denying or limiting coverage of a claim, or imposing additional cost sharing or other limitations or restrictions, on the basis of an enrollee's or prospective enrollee's race, color, national origin, sex, age, or disability, and the use of marketing practices or benefit designs that discriminate on these bases.
>
> *In the proposed rule, we did not propose to require plans to cover any particular benefit or service,* but we provided that a covered entity cannot have coverage that operates in a discriminatory manner. For example, the preamble stated that a plan that covers inpatient treatment for eating disorders in men but not women would not be in compliance with the prohibition of discrimination based on sex. Similarly, a plan that covers bariatric surgery in adults but excludes such coverage for adults with particular developmental disabilities would not be in compliance with the prohibition on discrimination based on disability.

Id. at 31,429 (emphasis added).

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OCR's explanation makes clear that plans are *not* required to cover any particular benefit or service in order to comply with the regulations. Rather, once insurers do choose to offer a benefit, they must do so on a non-discriminatory basis. In this respect, the examples provided by OCR are illustrative. Insurers are free to choose what benefits or services to offer. A potential violation of Section 1557 occurs only when insurers discriminate between protected and non-protected classes when allowing access to those services. This understanding is entirely consistent with longstanding discrimination principles and existing law.

Additional guidance from OCR also supports Defendants' argument. Addressing the specific reference to "benefit design," OCR explained:

> OCR recognizes 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. *The final rule does not prevent covered entities from utilizing reasonable medical management techniques; nor does it require covered entities to cover any particular procedure or treatment. It also does not preclude a covered entity from applying neutral, nondiscriminatory standards that govern the circumstances in which it will offer coverage to all its enrollees in a nondiscriminatory manner*. The rule prohibits a covered entity from employing benefit design or program administration practices that operate in a discriminatory manner.

Id. at 31,434 (emphasis added).

When addressing the potential costs of compliance with the final regulation, OCR further stated:

> It is important to recognize that this final rule, except in the area of sex discrimination, applies pre-existing requirements in Federal civil rights laws to various entities, the great majority of which have been covered by these requirements for years. Because Section 1557 restates existing requirements, we do not anticipate that covered entities will undertake new actions or bear any additional costs in response to the issuance of the regulation with respect to the prohibition of race, color, national origin, age, or disability discrimination, except with respect to the voluntary development of a language access plan. However, we also note that the prohibition of sex discrimination is new for many covered entities, and we anticipate that the enactment of the regulation will result in changes in action and behavior by covered entities to

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> comply with this new prohibition. We note that some of these actions will impose costs and others will not.

Id. at 31,446.

Thus, OCR recognized that the final rule only changed the law with respect to one issue: sex discrimination as it applied to benefits related to gender dysphoria and transgender individuals. *See* 45 C.F.R. § 92.207(b)(3)-(5). In all other areas, OCR indicated that the rule "applies pre-existing requirements in Federal civil rights laws," and OCR did not anticipate new and costly changes in response to those requirements. That understanding is directly contrary to Plaintiffs' position, pursuant to which health insurers would be required to begin covering a vast array of potentially disabling conditions on equivalent bases in order to comply with Section 1557.

Plaintiffs appear to rely on certain of OCR's statements regarding categorical exclusions to support their claim. Compl. ¶ 7 ("As federal regulators state, 'an explicit, categorical (or automatic) exclusion or limitation of coverage for all health services related to [race, gender, age or disability] is unlawful on its face.[']") (quoting 81 Fed. Reg. 31,429). Plaintiffs are attempting to mislead the Court by inserting provisions in brackets that do not appear in the quoted text and that change its meaning entirely.

In fact, the OCR comment was specifically directed toward a specific situation: exclusions applicable to individuals with gender dysphoria or seeking gender transition-related services, an area that everyone understood was a potential change in current law. Quoted in full and in context, OCR makes this clear:

> In addition, we noted that many health-related insurance plans or other health-related coverage, including Medicaid programs, currently have explicit exclusions of coverage for all care related to gender dysphoria or associated with gender transition. Historically, covered entities have justified these blanket exclusions by categorizing all transition-related treatment as cosmetic or experimental. However, such across-the-board categorization is now recognized as outdated and not based on current standards of care.

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> OCR proposed to apply basic nondiscrimination principles in evaluating whether a covered entity's denial of a claim for coverage for transition-related care is the product of discrimination. We noted that based on these principles, an explicit, categorical (or automatic) exclusion or limitation of coverage for all health services related to ***gender transition*** is unlawful on its face under paragraph (b)(4); in singling out the entire category of gender transition services, such an exclusion or limitation systematically denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex.

81 Fed. Reg. 31,429 (emphasis added).

By deleting "gender transition" and inserting "[race, gender, age or disability]" Plaintiffs are attempting to manufacture some authority for their position. Plaintiffs' misquotation of the OCR commentary demonstrates how little support exists for their claim.

VI. CONCLUSION

Plaintiffs' claim finds no support in the text of the statute, case law, legislative history, regulations, or interpretive guidance. For the reasons above, Defendants respectfully request that the Court grant their Motion to Dismiss.

DATED: January 19, 2018.

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CERTIFICATE OF SERVICE

I hereby certify that I filed the foregoing with the Clerk of the Court using the CM/ECF system which will send notice of such filing to the following counsel of record:

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Executed on January 19, 2018, at Portland, Oregon.

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THE HONORABLE RICHARD A. JONES

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

E.S., by and through her parents, R.S. and J.S., and JODI STERNOFF, both on their own behalf, and on behalf of all similarly situated individuals,

Plaintiffs,

v.

REGENCE BLUESHIELD; and CAMBIA HEALTH SOLUTIONS, INC., f/k/a THE REGENCE GROUP,

Defendants.

No. 2:17-cv-01609-RAJ

ORDER GRANTING DEFENDANTS' MOTION TO DISMISS

This matter came before the Court on the Motion to Dismiss filed by defendants Regence BlueShield and Cambia Health Solutions, Inc. (collectively, "Defendants"). The Court has reviewed the Motion, papers filed in response and in support thereof, and the records and files herein. Being fully informed, the Court hereby ORDERS that:

1. Defendants' Motion to Dismiss is GRANTED in its entirety for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6).

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2. Plaintiffs' Complaint and all claims therein are DISMISSED with prejudice.

IT IS SO ORDERED.

Dated this __ day of _____, 2018.

THE HONORABLE RICHARD A. JONES
UNITED STATES DISTRICT JUDGE

Presented By:

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