The Honorable Robert S. Lasnik

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

| | |
|---|---|
| ANDREA SCHMITT, on behalf of herself, and on behalf of all similarly situated individuals,<br><br>Plaintiff,<br><br>v.<br><br>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.,<br><br>Defendants. | CASE NO. 2:17-cv-1611<br><br>DEFENDANTS' MOTION TO DISMISS<br><br>NOTE ON MOTION CALENDAR: FRIDAY, FEBRUARY 9, 2018<br><br>ORAL ARGUMENT REQUESTED |



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Defendants ("Kaiser") respectfully move this Court for an order dismissing Plaintiff Andrea Schmitt's claim for disability discrimination pursuant to the Patient Protection and Affordable Care Act §1557, codified at 42 U.S.C. §18116 ("ACA §1557"). Plaintiff fails to state a claim under Fed. R. Civ. P. 12(b)(6). Her claim rests on the theory that because the Kaiser group health benefit plan selected by her employer (hereafter, the "Plan") excludes coverage for certain hearing aids[1] and related services, Kaiser has unlawfully discriminated against Plaintiff and a proposed class of other hearing-impaired individuals. ACA §1557 is modeled after and incorporates the test for discrimination under Section 504 of the Rehabilitation Act ("RA §504") and Title II of the Americans with Disabilities Act ("ADA"). Because the plain language of the Plan's hearing aid exclusion does not discriminate between the disabled and non-disabled and applies equally to all Plan participants, it is not "discriminatory" under established law interpreting RA §504 and ADA health insurance claims. Accordingly, Plaintiff fails to state a claim for disability discrimination under ACA §1557.

Plaintiff contends that the regulation implementing ACA §1557 with respect to non-discrimination in health–related insurance and health related coverage,[2] requires health plans to cover all medically necessary treatments and devices for hearing loss. Am. Comp. ¶7. In response to comments to the Final Rule promulgating the regulation, the U.S. Health and Human Services Department (HHS) expressly rejected this contention:

> As noted in the preamble to the proposed rule, we will evaluate whether a particular exclusion is discriminatory based on the application of longstanding nondiscrimination principles to the

[1] The Plan in fact covers hearing exams, cochlear implants (indicated for individuals with severe to profound hearing loss) and Bone Anchored Hearing Aids, which treat middle ear problems or assist individuals with no hearing in one ear. *See* the Group Medical Coverage Agreement, p. 23, and the Health Plan Policy for Cochlear Implants/Hearing Devices, attached as Exhibits 1 and 2 to the Declaration of Medora Marisseau, filed herewith.

[2] 45 C.F.R. §92.207.



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> facts of the particular plan or coverage. Under these principles, issuers are not required to cover all medically necessary services. Moreover, we do not affirmatively require covered entities to cover any particular treatment, as long as the basis for exclusion is evidence-based and nondiscriminatory.

81 Fed. Reg. 31435 (May 18, 2016)[3] (emphasis added).

Because the coverage exclusion in the Plan of some types of hearing aids complies with longstanding non-discrimination principles under RA §504 and the ADA, Plaintiff fails to state a claim for disability discrimination under ACA §1557. The Amended Complaint should be dismissed with prejudice.

Plaintiff's Amended Complaint should also be dismissed because she lacks constitutional standing. She admittedly never submitted a claim for hearing aid coverage under a Kaiser insured plan and has suffered no injury in fact. *Compare* Complaint ¶¶13&30 with Amended Complaint ¶¶13&30. Moreover, although Kaiser offers a hearing aid coverage rider, Plaintiff's employer elected not to select that coverage so that Plaintiff's claim can only be redressed by her employer. For all these reasons, Plaintiff's Amended Complaint should be dismissed.

## I. BACKGROUND OF THE AFFORDABLE CARE ACT AND HEARING AID COVERAGE IN HEALTH INSURANCE.

Congress enacted the ACA in 2010 in an effort to comprehensively reform the nation's health care system and provide affordable, universal healthcare for every American. It includes a provision barring health insurers from imposing annual or lifetime caps, and for individual and small group plans to cover ten categories of essential health benefits ("EHBs"), including "[r]ehabilitative and habilitative services and devices." *See* 42 U.S.C. §18022(b)(1)(G). Congress directed the Secretary of HHS to conduct a survey of health plans, and ensure that the scope of EHBs "is equal to the scope of benefits provided under a typical employer plan[.]" 42

[3] Relevant pages of the cited Federal Register are attached for the court's convenience.



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U.S.C. §18022(b)(2)(A). After a long and complicated process, the Secretary left it to each state to articulate the scope of essential health benefits in that state, through the adoption of a "benchmark" plan.

Washington's EHB benchmark plan covers cochlear implants but not hearing aids. W.A.C. §284-43-5640(7)(b)(1)&(c)(4). 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.*

The ACA did not include hearing aids or services as an essential health benefit, and most states' approved EHB benchmark plans exclude or limit coverage for hearing aids:

- The benchmark plan offers no coverage for hearing aids in Alabama, Alaska, California, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Michigan, 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 Colorado, Connecticut, Delaware, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, Tennessee, and Wisconsin.

Essential Health Benefits: Benchmark Plan Comparison, https://www.cigna.com/assets/docs/about-cigna/informed-on-reform/top-11-ehb-by-state-2017.pdf. According to the Center for Hearing and Communications, 48 million Americans have significant hearing loss. *See* http://chchearing.org/facts-about-hearing-loss.

## II. COVERAGE FOR HEARING LOSS UNDER THE PLAN

The Plan[4] provides coverage for Hearing Examinations and Hearing Aids as follows:

[4] On a motion to dismiss under Fed. R. Civ. P. 12(b)(6), the court may consider documents relied upon or referenced in the Complaint. The Plan therefore may be properly considered in this motion to dismiss. *See Parrino v. FHP, Inc.*, 146 F.3d 699, 706 (9th Cir. 1998). *See* Amended Complaint ¶6 (partially quoting from the Plan).



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> Cochlear implants when in accordance with Group Health clinical criteria.
>
> Covered services for cochlear implants include implant surgery, pre-implant testing, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).
>
> Hearing exams for hearing loss and evaluation and diagnostic testing for cochlear implants.
>
> [Not Covered are] Hearing aids including hearing aid examinations.
>
> Exclusions: Programs or treatments for hearing loss or hearing care including, but not limited to, externally worn hearing aids or surgically implanted hearing aids and the surgery and services necessary to implant them other than for cochlear implants; hearing screening tests required under Preventive Services.

Marisseau Dec., Exh. 1, p. 23. The Plan further provides "Group Health[5] may adopt reasonable policies and procedures to administer the Benefits Booklet. This may include, but is not limited to, policies or procedures pertaining to benefit entitlement and coverage determinations." *Id*., p.8, ¶B. Pursuant to this provision and incorporated into the Plan is the Health Plan Policy for Kaiser Foundation Health Plan of Washington Options, which states: "For most plans, Bone Anchored Hearing Aids, including testing, surgery, fitting, follow-up, speech therapy and programming are covered at the medical benefit when Clinical Criteria is met." Marisseau Dec., Exh. 2, p. 2.

The FDA, which regulates products and devices to improve hearing, defines a hearing aid as a "wearable sound amplifying device" and distinguishes between air-conduction hearing aids (Class I) and bone-anchored hearing aids (Class II). *See* 21 C.F.R. §874.3300. Cochlear implants are not technically hearing aids, but are electronic devices surgically placed under the

[5] Group Health Options Inc. is now known as Kaiser Foundation Health Plan of Washington Options. Marisseau Dec., ¶ 2.



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skin to stimulate nerve endings in the cochlea. The FDA defines cochlear implants as Class III devices that treat the severe to profound hearing loss. *See https://www.ftc.gov/system/files/documents/public_events/1022593/mann.pdf*, at p. 8.

The Plan selected by Plaintiff's employer, Columbia Legal Services,[6] follows the Washington benchmark plan in covering cochlear implants, and also offers additional base benefits such as hearing examinations and coverage for Bone Anchored Hearing Aids. The Plan is designed to cover treatments and services for hearing loss (such as cochlear implants) at an affordable price. This basic plan excludes coverage for (Class 1) hearing aids, as well as prosthetics, dental services, and glasses, among other things.

## III. PLAINTIFF HAS FAILED TO STATE A CLAIM OF DISABILITY "DISCRIMINATION" UNDER ACA §1557

To survive a motion to dismiss for failure to state a claim upon which relief can be granted, 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)). This requirement is met where the complaint "pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id*. The complaint must have "more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." *Twombly*, 550 U.S. at 555.

Plaintiff's allegation of "intentional discrimination" is based entirely on the Plan's exclusion of hearing aids. Am. Comp. ¶37. Because the Plan exclusion does not violate ACA §1557 as a matter of law, Plaintiff fails to state a claim for insurance disability discrimination.

[6] *See* Amended Complaint, ¶1.



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A. **Disability "Discrimination" Under ACA §1557 is Co-Extensive with Rehabilitation Act §504 and Title II of the ADA.**

The ACA is a relatively new law, and ACA §1557 applies Title VI, Title IX, the Age Discrimination Act, and the Rehabilitation Act protections to health care entities that receive federal financial assistance, and thus prohibits discrimination in healthcare on the basis of race, color, national origin, sex, age and disability. It expressly references and incorporates the four civil rights statutes covering various protected classes. As pertains to disability discrimination, ACA §1557 provides:

> an individual shall not, on the ground prohibited under . . . section 794 of title 29 [Rehabilitation Act §504], 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 . . . . The enforcement mechanisms provided for and available under such . . . section 794 . . . shall apply for purposes of violations of this subsection.

ACA §1557(a) (emphasis added).

This language of prohibited discriminatory acts is identical to that found in RA §504, which prohibits discrimination by federally-funded programs:

> 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

29 U.S.C. §794 (emphasis added).[7] Title II of the ADA similarly prohibits public entities from causing people with disabilities to "be excluded from participation in or be denied the benefits of" any services, programs or activities. 42 U.S.C. §12132.

The Ninth Circuit has explained that Title II of the ADA and RA §504 are substantially

[7] Section 705(20) defines disability as an impairment that "substantially limits" a "major life activity" such as "hearing." Plaintiff alleges she is so disabled, although not all hearing impairments are "disabilities." *See* https://www.eeoc.gov/eeoc/publications/qa_deafness.cfm



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similar, and Title II "extends the anti-discrimination prohibition embodied in section 504 [of the Rehabilitation Act of 1973] to all actions of state and local governments[.]" *City of L.A. v. AECOM Servs.*, 854 F.3d 1149, 1153-54 (9th Cir. 2017), *quoting* H.R. Rep. No. 101-485(II), at 84 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 367. "There is no significant difference in analysis of the rights and obligations created by the ADA and the Rehabilitation Act." *Zukle v. Regents of Univ. of Cal.*, 166 F.3d 1041, 1045 n.11 (9th Cir. 1999) (listing cases); *see also Weinreich v. L.A. Cty. Metro. Transp. Auth.*, 114 F.3d 976, 978 (9th Cir. 1997).

The preamble to the Final Rule implementing ACA §1557 expressly states that, except for the prohibition on discrimination on the basis of sex in health programs,[8] the Final Rule applies pre-existing requirements in Federal civil rights laws, such as the RA § 504 and ADA:

> It is important to note 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 . . . .

81 Fed. Reg. at 31446; *see also* 81 Fed. Reg. at 31378 ("Most of the requirements of Section 1557 are not new to covered entities, and 60 days should be sufficient to come into compliance with any new requirements").

ACA §1557(a) not only adopts the non-discrimination standards on the grounds prohibited in the four civil rights statutes it references, it also expressly incorporates the enforcement provisions of those statutes. "The enforcement mechanisms provided for and

[8] The regulation expanded the existing concepts of "sex" to include gender identity and termination of pregnancy. The regulation's prohibition against discrimination on these grounds were enjoined on a nationwide basis in *Franciscan Alliance, Inc. v. Burwell*, 227 F. Supp.3d 660 (N.D. Tex. 2016), on the basis that plaintiffs were likely to succeed on the merits of their claim that HHS exceeded its statutory authority and violated the Administrative Procedures Act (APA) in including these as "sex" discrimination.



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available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection." 42 U.S.C. §18116(a). By using this language, which does not appear to have been used in any other legislation, Congress clearly intended that claims of disability discrimination under ACA §1557 follow the substance and enforcement mechanisms of RA §504. *Accord, Huffman v. Univ. Med. Ctr. Mgmt. Corp.*, 2017 U.S. Dist. LEXIS 180999, *5-*6 (E.D. La., Oct. 31, 2017)(finding Section 1557 of the ACA has the same meaning and same protections as RA §504 and the ADA, with respect to disability discrimination); *York v. Wellmark, Inc.*, 2017 U.S. Dist. LEXIS 199888, *52-*53 (S.D. Iowa, Sept. 6, 2017) (because Title IX does not allow for disparate impact claims, neither does ACA §1557 for claims of discrimination on the basis of sex); *see also SEPTA v. Gilead Sciences, Inc.*, 102 F. Supp. 3d 688, 697-670 (E.D. Pa. 2015) (ACA §1557 manifests an intent to import the various standards and burdens of proof of the four referenced civil rights statutes, depending upon the protected class as issue).

There is nothing in ACA §1557 to indicate that Congress intended to change the scope of disability "discrimination" in any way. The statute expressly references RA §504 with respect to ACA §1557 disability discrimination and uses the identical language of RA §504 to describe the prohibited acts as discriminatory. "[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." *E.g., United States v. Kimsey*, 668 F.3d 691, 702 (9th Cir. 2012); *citing Cooper v. FAA*, 622 F.3d 1016, 1032 (9th Cir. 2010) (*rev'd on other grounds in FAA v. Cooper*, 566 U.S. 284, 132 S. Ct, 1441, 182 L. Ed.2d 497 (2012)), *quoting Smith v. City of Jackson*, 544 U.S. 228, 233, 125 S. Ct. 1536, 161 L. Ed.2d 410 (2005) (plurality opinion).

Further, "[w]hen . . . judicial interpretations have settled the meaning of an existing



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statutory provision, repetition of the same language in a new statute indicates, as a general matter, the intent to incorporate its administrative and judicial interpretations as well." *Bragdon v. Abbott*, 524 U.S. 624, 645, 118 S. Ct. 2196, 141 L. Ed. 2d 540 (1998). While ACA §1557 does not define the terms "denied the benefits" or "subjected to discrimination," Congress is presumed to know how those terms have been interpreted under the Rehabilitation Act and the ADA. *See Prince v. Jacoby*, 303 F.3d 1074, 1080 (9th Cir. 2002) (although the Equal Access Act did not define "equal access" or "discriminate against," Congress did not need to do so, as courts presume it was "aware of settled judicial construction of these phrases"). Courts "generally presume that Congress is knowledgeable about existing law pertinent to the legislation it enacts." *Goodyear Atomic Corp. v. Miller*, 486 U.S. 174, 184-85, 108 S. Ct. 1704, 100 L. Ed.2d 158 (1988); *see also Lorillard v. Pons*, 434 U.S. 575, 580, 98 S. Ct. 866, 55 L. Ed.2d 40 (1978) (*superseded by statute on other grounds as stated in Watson v. TVA*, 867 F. Supp.2d 1215, 1223 n.6 (N.D. Ala. 2012)) ("Congress is presumed to be aware of a . . . judicial interpretation of a statute and to adopt that interpretation when it re-enacts a statute without change").

To erase any doubt that ACA §1557 was not creating new discrimination standards for disability discrimination in health plans, HHS unequivocally stated that, with the exception of sex discrimination, the same pre-existing requirements existent under the enumerated civil rights laws, including RA §504 for disability discrimination in health plans, apply to ACA §1557. 81 Fed. Reg. 31446.

Plaintiff's claim that the scope of disability discrimination under the ACA §1557 is different than the well-established disability discrimination standards in health plans under RA §504 and the ADA, depends on a re-write of the regulation. Plaintiff's Amended Complaint purports to quote 45 C.F.R. §92.207(4) for the proposition that "an explicit, categorical (or



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automatic) exclusion or limitation of coverage for all health services related to [race, gender, age or disability] is unlawful on its face." Amended Complaint, ¶7, *citing* 81 Fed. Reg. 31429. In fact, that provision of the regulation applies only to "all health related services related to gender transition," a form of sex discrimination – the only type of discrimination for which a new standard was adopted in the regulation. *See* 81 Fed. Reg. 31429 (emphasis added).

The regulation governing non-discrimination in health insurance and health plans, promulgated pursuant to the Final Rule, states in its entirety:

> **(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;
>
> **(3)** Deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available;
>
> **(4)** Have or implement a categorical coverage exclusion or limitation for all health services related to gender transition; or
>
> **(5)** Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.
>
> **(c)** The enumeration of specific forms of discrimination in paragraph (b) does not limit the general applicability of the prohibition in paragraph (a) of this section.

45 C.F.R. §92.207 (emphasis added). Plaintiff's proposed re-write of the regulation cannot



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support her claim.

The elements of an ACA §1557 claim are identical to those for RA §504 claims. To state a claim for relief under the Rehabilitation Act §504, Plaintiff must allege that: (1) she is a qualified individual with a disability; (2) who was excluded from participation in, denied the benefits of, or subjected to discrimination under a health program or activity that receives federal funds; and (3) such exclusion, denial of benefits or discrimination was by reason of a disability. *Robertson v. Las Animas County Sheriff's Dept.*, 500 F.3d 1185, 1193 (10th Cir. 2007). This test is also used to determine whether there has been a violation of ACA §1557. *SEPTA v. Gilead Sciences, Inc.*, 102 F. Supp. 3d 688, 699 (E.D. Pa. 2015) (*citing Calloway v. Boro of Glassboro Dept. of Police*, 89 F. Supp.2d 543, 551 (D. N.J. 2000). Plaintiff does not, and cannot, allege that she was either "excluded from participation in" or "denied the benefits of" the Plan, so her case depends on establishing that she was "subjected to discrimination," which she cannot do.

B. **RA §504 and the ADA Do Not Prohibit Healthcare Coverage Exclusions that Disproportionately Impact Persons with a Particular Disability, So Long as They Are Equally Applied to All.**

Cases interpreting RA §504 and the ADA have uniformly held that plan benefit designs that exclude specific treatments, services or devices, are not discriminatory as long as the chosen benefit package is equally accessible to both disabled and non-disabled persons, even though a particular exclusion may disproportionately affect individuals with a particular disability.

The genesis of the rule is the U.S. Supreme Court's opinion in *Alexander v. Choate*, 469 U.S. 287, 302, 105 S. Ct. 712, 83 L. Ed.2d 661 (1985) (*superseded by statute on other grounds as stated in Prakel v. Indiana*, 100 F. Supp.3d 661, 683 n.17 (S.D. Ind. 2015). There, Medicaid recipients claimed that Tennessee's proposed restriction of inpatient treatment coverage to 14 days would have a disparate impact on the disabled in violation of RA §504. The Court assumed, without deciding, that RA §504 prohibits not only intentional, disparate treatment



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claims, but also "reaches at least some conduct that has an unjustifiable disparate impact upon the handicapped." *Choate*, 469 U.S. at 299. But the Court stressed that not all disparate impacts are actionable; a federal grantee "need not be required to make 'fundamental' or 'substantial' modifications to accommodate the handicapped, [though] it may be required to make 'reasonable' ones." *Choate*, 287 U.S. at 300, *citing Southeastern Community College v. Davis*, 442 U.S. 397, 99 S. Ct. 2361, 60 L. Ed.2d 980 (1979). RA §504 requires that disabled persons have "meaningful access" to benefits, and since the 14-day coverage limitation "does not exclude the handicapped from or deny them the benefits of the 14 days of care the State has chosen to provide[,]" the Court held the policy did not amount to discrimination. *Choate*, 469 U.S. at 302. The Rehabilitation Act does not guarantee "adequate health care," and covered entities are free to define the benefits they will provide, so long as the limits are not based on a discriminatory motive and are equally accessible to both the disabled and the non-disabled. *Choate*, 308-09.

In a subsequent case, the Supreme Court further clarified that is it not discrimination to offer differing benefits to persons with different disabilities. The central purpose of RA § 504 is to assure that disabled individuals receive "evenhanded treatment" in relation to non-disabled individuals, and there "is nothing in the Rehabilitation Act that requires that any benefit extended to one category of handicapped person also be extended to all other categories of handicapped persons." *Traynor v. Turnage*, 485 U.S. 535, 548-49, 108 S. Ct. 1372, 99 L. Ed.2d 618 (1988), *superseded by statute on other grounds as stated in Martin v. McDonald*, 761 F.3d 1366, 1371 n.3 (Fed. Cir. 2014). These Rehabilitation Act cases preclude Plaintiff's assertion[9] that by offering coverage for certain other medical devices, the exclusion of certain hearing aids is "discrimination."

[9] Am. Comp. ¶6.



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The same rule applies to benefit plans under the ADA. The ADA does not mandate equality among persons with different disabilities. *See Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006, 105-16 (6th Cir. 1997). It is enough that all insureds are given equal access to a policy, and it is irrelevant that a plan might treat some forms of disability more favorably than others. *Id.* "The ADA 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." *Id.* at 1009. "A contrary rule would destabilize the insurance industry, something which Congress could not have intended." *Conway v. Standard Ins. Co.*, 23 F. Supp. 2d 1199, 1202 (E.D. Wash. 1998), *citing Ford v. Schering-Plough Corp.*, 145 F.3d 601 (3d Cir. 1998) ("So long as every employee is offered the same plan regardless of that employee's contemporary or future disability status, then no discrimination has occurred even if the plan offers different coverage for various disabilities").

In *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674 (8th Cir. 1996), the plaintiff claimed her health care plan's exclusion of treatments for infertility constituted disability discrimination under the ADA. The court held that "[i]nsurance 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." *Krauel*, 95 F.3d at 678. The court quoted the following passage from an EEOC enforcement guide for ADA claims:

> [S]ome 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.

*Krauel*, 95 F.3d at 678, *quoting* EEOC: Interim Enforcement Guidance on Application of ADA to Health Insurance (June 8, 1993), at 405:7118 (emphasis added). The court concluded:



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> the Plan's infertility exclusion 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, the Plan's infertility exclusion applies equally to all individuals, in that no one participating in the Plan receives coverage for treatment of infertility problems.

*Krauel*, 95 F.3d at 678.

Other courts agree that the ADA does not require equal benefits for all disabilities. In rejecting an ADA discrimination claim against a disability plan that provided different levels of benefits for mental and physical disabilities, one court noted:

> A plethora of rulings on the subject all reach the same conclusion the ADA does not require equal benefits for different disabilities. *See Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1116-18 (9th Cir. 2000) (holding plan administrator's decision to classify mental-illness risks differently than physical disabilities is permissible); *EEOC v. Staten Island Savings Bank*, 207 F.3d 144, 148-53 (2d Cir. 2000) (holding ADA does not require parity between mental and physical disabilities); *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1101-02 (10th Cir. 1999) ("ADA does not prohibit an employer from operating a long-term disability benefits plan which distinguishes between . . . disabilities."); *Lewis v. Kmart Corp.*, 180 F.3d 166, 170 (4th Cir. 1999) (noting that disability plan need not provide same benefits for all disabilities); *Ford v. Schering-Plough*, 145 F.3d 601 at 608 ("The ADA does not require coverage for every type of disability."); *Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006, 1015-19 (6th Cir. 1997) (en banc) ("The disparity in benefits [is permitted] by the ADA because the ADA does not mandate equality. . ."); *EEOC v. CNA Ins. Co.*, 96 F.3d 1039, 1044-45 (7th Cir. 1996) (upholding plan that promised physical-disability benefits until age 65, but mental-disability benefits only for two years); *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 678 (8th Cir. 1996) (ruling that excluding one disability from coverage does not violate ADA if exclusion applies to all individuals); *see also Modderno v. King*, 317 U.S. App. D.C. 255, 82 F.3d 1059, 1061 (D.C. Cir. 1996) (holding §504 of the Rehabilitation Act does not require equivalent benefits for different disabilities).

*Wilson v. Globe Specialty Prods.*, 117 F. Supp.2d 92, 95-96 (D. Mass. 2000). That court noted that the same result would apply under RA §504. *Wilson*, 117 S. Supp.2d at 96, *citing Traynor v. Turnage*, 485 U.S. 535, 108 S. Ct. 1372, 99 L. Ed.2d 618 (1988) ("there is nothing in the Rehabilitation Act that any benefit extended to one category of handicapped persons also be



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extended to all other categories of handicapped persons").

The concurring opinion in the *Modderno* case, cited in *Wilson*, aptly explains the concept as follows:

> only by providing less coverage to some or all of the persons who are currently disabled does an insurance plan contravene [the Rehabilitation Act] §504 . . . . In this case the same insurance coverage was made available to all regardless of handicap; there is no indication and no claim that the benefits were only formally but not meaningfully available to the handicapped. *See Alexander v. Choate*, 469 U.S. 287, 302, 83 L. Ed. 2d 661, 105 S. Ct. 712 (1985) (disabled must "benefit meaningfully from the coverage they will receive"). Unless some coverage is denied to persons who currently have a disabling condition while at the same time granted to those who do not currently have a disabling condition, or denied to persons with a particular disability but not to persons with a different disability, there is no discrimination on account of disability. Equal coverage for all is non-discriminatory.

*Modderno v. King*, 82 F.3d 1059, 1065-66 (D.C. Cir. 1996) (Ginsberg, J., concurring).

In one of the few cases addressing ACA §1557 disability discrimination, the court in *SEPTA v. Gilead Sciences, Inc.*, 102 F. Supp. 3d 688 (E.D. Pa. 2015), followed the identical logic expressed in the above RA §504/ADA disability discrimination cases. There, a plaintiff diagnosed with Hepatitis C alleged that the defendant drug manufacturer violated ACA §1557 by charging an unreasonably excessive price for Hepatitis C treatment. *Id.* at 694-95. The Court dismissed the claim under FRCP 12(b)(6), explaining:

> None of the plaintiffs' theories connecting the high price of Gilead's drugs to Jane Doe and John Doe's inability to obtain those drugs states a viable claim under either the Rehabilitation Act or the Affordable Care Act. There are no allegations that Gilead changes the prices of its drugs depending upon whether the potential customer has Hepatitis C. While obviously only patients with a Hepatitis C diagnosis would try to acquire these drugs in the first place, that type of obvious barrier is an example of the Supreme Court's concern in *Alexander v. Choate* about interpreting Section 504 so as to reach all claims of disparate impact discrimination.

*Gilead*, 102 F. Supp.2d at 700.

These cases all stand for the proposition that health insurance coverage exclusions in a



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plan or policy are not discriminatory if they are applied equally to all beneficiaries, even if the exclusion will disproportionately affect individuals with a particular disability or provides different coverages for different disabilities. Yet, this is precisely what Plaintiff alleges is the basis for her claim.

In fact, Plaintiff's specific claim - that exclusion of coverage for hearing aids constitutes discrimination - was rejected, albeit in dicta, in *Micek v. City of Chicago*, 1999 U.S. Dist. LEXIS 16263 (N.D. Ill. 1999). There, the plaintiff's employer offered a health plan that excluded hearing aids from coverage but covered "virtually every other type of durable medical equipment, such as crutches, prostheses, and glasses." *Id.* at *4. On behalf of a purported class of plan beneficiaries who require hearing aids, the plaintiffs claimed the hearing aid exclusion was discriminatory under the ADA and the Rehabilitation Act. *Id.* at *4-*5. The court granted the defendant's motion to dismiss the Rehabilitation Act claims because the defendant city was not a covered entity, and dismissed the ADA and other claims because the plaintiffs lacked standing. The court then explained why the plaintiffs had failed to state a claim for discrimination under the ADA, relying on the case of *Doe v. Mutual of Omaha*, 179 F.3d 557 (7th Cir. 1999), in which Judge Posner used the analogy that a "camera store may not refuse to sell cameras to a disabled person, but it is not required to stock cameras specially designed for such persons." *Doe v. Mutual of Omaha*, 179 F.3d 557, 560 (7th Cir. 1999).

*Doe* involved a case brought under Title III of the ADA, in which the plaintiffs challenged the provisions of two health insurance policies that capped lifetime benefits for AIDS and AIDS-related conditions ("ARC") at $25,000 and $100,000, respectively, but provided a $1 million cap for other conditions. *Doe*, 179 F.3d at 558. Although the Seventh Circuit acknowledged that the caps rendered the policies of "less value to persons with AIDS than they



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would have to persons with other, equally expensive diseases or disabilities," the Court found no disability discrimination claim, noting:

> There is, as we have pointed out, a difference between refusing to sell a health-insurance policy at all to a person with AIDS, or charging him a higher price for such a policy, or attaching a condition obviously designed to deter people with AIDS from buying the policy (such as refusing to cover such a person for a broken leg), on the one hand, and, on the other, offering insurance policies that contain caps for various diseases some of which may also be disabilities within the meaning of the Americans with Disabilities Act.
>
> * * *
>
> We conclude that section 302(a) does not require a seller to alter his product to make it equally valuable to the disabled and the nondisabled, even if the product is insurance.

*Id.* at 563. The *Micek* court applied the reasoning of *Doe* to Titles I and II of the ADA, noting:

> as in *Doe*, plaintiffs in this case do not assert that the City denies policy access or coverage to disabled persons generally or to persons with significant hearing loss in particular, nor do they assert that the City charges disabled persons higher rates or structures the plans so as to deter disabled persons from seeking or maintaining employment with the City. Finally, plaintiffs receive exactly the same coverage that other City employees receive, regardless of disability. No person covered by a City policy is entitled to a hearing aid . . . .
>
> Plaintiffs complain, in effect, about an adverse impact on their family because it contains disabled members who cannot, under the terms of the City's policies, receive the treatment and equipment they desire . . . . Even though plaintiffs' policy has less value to them, in practice, than to other covered persons, "this does not make the offer . . . illusory," for plaintiffs have medical needs unrelated to their disability, "and the policies give [them] as much coverage for those needs as the policies give people" without their disability. *Id.* at 559. Accordingly, the court believes that even if plaintiffs had standing to sue, their complaint would fail to state a claim.

*Micek*, 1999 U.S. Dist. LEXIS at *22-*26.

C. **The Plan's Hearing Aid Exclusion Does Not Violate ACA §1557.**

Here, the Plan's hearing aid exclusion is equally applied to all insureds and Plaintiff



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makes no allegations to the contrary. The hearing disabled are not barred from coverage, but are provided the same coverage as everyone else in the Plan. They not only have equal access to all the other Plan benefits, but also have coverage for hearing exams, cochlear implants and bone anchored hearing aids—services that treat significant hearing loss—on the same terms as all other Plan participants. The fact that the Plan covers specified durable medical equipment and devices for other disabilities, but not (Class 1) hearing aids, is not a distinction between the disabled and the non-disabled, and therefore not "discrimination" under ACA §1557. The Plan does not exclude coverage for the disabled, while providing coverage for the non-disabled. The Plan does not even exclude all health services relating to hearing loss. Under the long-established case law outlined above, the hearing aid exclusion is not disability "discrimination" under RA §504 or the ADA. Because Plaintiff could not state a claim for disability discrimination in health insurance under RA §504 or the ADA, she fares no better under ACA §1557 which applies the same standard for "being subjected to discrimination" under a disability claim. The Amended Complaint should be dismissed.

D. **The Regulation Implementing ACA §1557 Does Not Expand Disability Discrimination to Prohibit Health Insurance Exclusions that are Equally Applied to All.**

As discussed above, the plain language of the statute directly addresses the precise question before this Court: whether ACA §1557 disability "discrimination" adopted the substance of and enforcement mechanisms for disability "discrimination" in health plans under RA §504 and the ADA, which preclude the claim Plaintiff asserts here. *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-44, 104 S. Ct. 2778, 81 L. Ed.2d 694 (1984). By expressly incorporating RA §504 and using identical language as to the discrimination it prohibits, ACA §1557 unambiguously adopts the same test for discrimination. Where, as here, the congressional intent is clear from the statute itself, that ends the matter "for



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the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron*, 467 U.S. at 842-43.

Plaintiff alleges a provision of the regulation nevertheless expanded the scope of disability discrimination under ACA §1557. Am. Comp. ¶7, *citing* 45 C.F.R. §92.207(b)(2). That section of the regulation provides that a covered entity "shall not, in providing or administering health-related insurance or other health-related coverage . . . [h]ave or implement . . . benefit designs that discriminate on the basis of . . . disability in a health-related insurance plan or policy, or other health-related coverage[.]" *Id.*

In addressing this regulation, HHS provided an example of a discriminatory benefit design which is on all fours with the standards for disability discrimination under RA §504 and the ADA:

> 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, . . . 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.

81 Fed. Reg. 31429. HHS's interpretation of ACA §1557, as discussed in the preamble and the regulation itself, expressly did not change the meaning or scope of "discrimination" as it has been interpreted and understood in existing law interpreting "discrimination" in health plans under RA §504 and the ADA.

The above regulatory provision and HHS's preamble and responses to comments is entirely consistent with the non-discrimination standards under RA §504 and the ADA as defined in long established case law, as HHS's bariatric surgery example illustrates. Benefit designs which deny coverage to persons who currently have a disabling condition which at the



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same time grant coverage to those who do not currently have a disabling condition could be prohibited ACA §1557 disability discrimination, as well as prohibited under RA 504 and the ADA. For example, a hearing aid exclusion which only applied to insureds who had significant limitations in hearing, but did not apply to insureds who had minor non-disabling hearing loss, could be a prima facie violation. Likewise, denial of the same service to persons with a particular disability but not to persons with a different disability could be a violation, such as denying transplant coverage for blind persons only.

Had Congress intended for ACA §1557 to create a new standard for discrimination based on a health plan's equally applied exclusion, it could have easily done so. It did not. If Congress did not seek to incorporate the principles announced in *Choate* and the other cases discussed in section B above, it would have used language to differentiate ACA §1557's definition of "discrimination" from that of the RA §504 and the ADA. It did not.

In sum, ACA §1557 expressly incorporates RA §504, and uses language identical to both the Rehabilitation Act and the ADA that disabled persons cannot "be excluded from participation in, be denied the benefits of, or be subjected to discrimination under" a health care program. Applying the long established test for disability "discrimination" in health plans, the hearing aid exclusion at issue here is not prohibited "discrimination." There is no ACA §1557 discrimination as a matter of law.[10]

[10] Plaintiff's Amended Complaint includes a conclusory allegation that Kaiser has "intentionally discriminated" on the basis of disability in excluding health care benefits related to hearing loss (Amended Complaint, ¶37). If Plaintiff ultimately establishes a *prima facie* case for intentional discrimination, Kaiser submits that the burden-shifting scheme set forth in *McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 93 S. Ct. 1817, 36 L. Ed. 2d 668 (1973) should apply, as it does to claims of discrimination on account of a disability under the Rehabilitation Act. *See Kim v. Potter*, 474 F. Supp.2d 1175 (D. Haw. 2007); *see also Raytheon Co. v. Hernandez*, 540 U.S. 44, 124 S. Ct. 513, 157 L. Ed. 2d 357 (2003) . If Plaintiff sets forth a *prima facie* disability discrimination claim under the ACA, Kaiser would be permitted to come forward with a legitimate, nondiscriminatory reason for its actions. *See Smith v. Barton*, 914 F.2d 1330, 1340 (9th Cir. 1990); *Lucero v. Hart*, 915 F.2d 1367, 1371 (9th Cir. 1990). If Kaiser does so, the burden shifts back to Plaintiff, who must demonstrate that the Kaiser's proffered



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## IV. THE AMENDED COMPLAINT SHOULD BE DISMISSED BECAUSE PLAINTIFF LACKS STANDING.

Plaintiff's claim should be dismissed because she lacks standing. Article III of the Constitution limits the "judicial power" of the United States to the resolution of "cases" and "controversies." A litigant must have "standing" to challenge the action at issue in the lawsuit. *See Valley Forge Christian College v. Americans United for Separation of Church & State Inc.*, 454 U.S. 464, 471, 70 L. Ed. 2d 700, 102 S. Ct. 752 (1982). The requirements of Article III standing are well settled: a plaintiff must show "(1) an injury in fact, (2) a sufficient causal connection between the injury and the conduct complained of, and (3) a likelihood that the injury will be redressed by a favorable decision." *Susan B. Anthony List v. Driehaus*, ___ U.S. ___, 134 S. Ct. 2334, 2341, 189 L. Ed. 2d 246 (2014) (internal quotation marks and alterations omitted). This test has been applied to Rehabilitation Act §504 claims. *See Le Strange v. Conrail*, 687 F.2d 767, 769 (3d Cir. 1982), *aff'd by Conrail v. Darrone*, 465 U.S. 624, 104 S. Ct. 1248, 79 L. Ed.2d 568 (1984), *superseded by statute on other grounds as stated in Leake v. L.I. Jewish Med. Ctr.*, 869 F.2d 130, 131 (2d Cir. 1989) ("We see no reason to formulate any test for standing for §504 actions other than that promulgated by the Supreme Court for general application"). The test should also apply to ACA §1557 claims.

The Supreme Court has defined an injury-in-fact as "an invasion of a legally protected interest [that] is (a) concrete and particularized, . . . and (b) actual and imminent, not conjectural or hypothetical." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560, 112 S. Ct. 2130, 119 L. Ed. 2d 351 (1992).

Here, Plaintiff's Amended Complaint deleted any reference or suggestion that Plaintiff

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reasons are pretextual or "encompassed unjustified consideration" of Plaintiff's disability. *Kim*, 474 F. Supp.2d at 1186; *Smith*, 914 F.2d at 1340. Plaintiff fails to make out a *prima facie* claim.



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has ever made a claim under a Kaiser insured plan for hearing aids or related treatment. As such, she fails to state any concrete, particularized, or actual injury whereby she was "subjected to discrimination." The Ninth Circuit explained the requirement for plaintiffs in discrimination cases to actually apply for a benefit in *Madsen v. Boise State Univ.*, 976 F.2d 1219 (9th Cir. 1992). The court found the failure of a disabled plaintiff to apply for the benefit at issue in the lawsuit was a prerequisite in order to have standing to challenge the policy:

> Like the OCR before us, we are confronted with the fact that Madsen never actually applied for a handicap parking permit. His lawsuit is based on the University's policy in the abstract. There is a long line of cases, however, which hold that a plaintiff lacks standing to challenge a rule or policy to which he has not submitted himself by actually applying for the desired benefit.

*Madsen*, 976 F.2d at 1220-21 (citations omitted).

Plaintiff summarily alleges that any effort to obtain a claim denial and appeal "would have been futile." Amended Complaint, ¶30. The conclusory allegation of futility is not sufficient to survive a motion to dismiss. *See Twombly*, 550 U.S. at 555 (The complaint must have "more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do").

Moreover, Plaintiff has been insured under the Plan since February 1, 2017. She obtained hearing aids two months *before* she was covered under the Plan. (Marisseau Dec. and Ex. 3 thereto) Plaintiff filed this action without ever having requested hearing aid coverage or any other hearing related coverage claim under the Plan, and without any "actual and imminent" need for hearing aid coverage. Plaintiff has no injury in fact and therefore no standing.

Plaintiff also cannot establish the third element for standing, which requires "it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision." *Lujan*, 504 U.S. at 561. Kaiser offers coverage riders for hearing aids, but Plaintiff's



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employer chose not to purchase it. Declaration of Natalie Bell. Thus, her alleged injury arises out of the employer's decision not to include the hearing aid coverage that Plaintiff desires. That injury cannot be redressed by any decision against Kaiser. The Amended Complaint should be dismissed for lack of standing.

## V. CONCLUSION

The Plan's hearing aid exclusion, the sole basis for Plaintiff's ACA §1557 claim, applies equally to the disabled and the non-disabled. The Plan includes coverage for certain types of hearing aids that treat significant hearing loss (cochlear implants and bone anchored hearing aids) and the hearing disabled have the same benefits under the Plan as everyone else. Because ACA §1557 applies the same standard for disability discrimination as is applied under RA §504 and the ADA, the exclusion is not "discrimination" and Plaintiff fails to state a claim upon which relief can be granted.

Plaintiff also lacks standing because she suffered no injury in fact. For the compelling reasons set forth above, Plaintiff's Amended Complaint should be dismissed.

Dated this 5th day of January, 2018.

**KARR TUTTLE CAMPBELL**

*/s/ Medora A. Marisseau*
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**CERTIFICATE OF SERVICE**

I, Kami Mejia, affirm and state that I am employed by Karr Tuttle Campbell in King County, in the State of Washington. I am over the age of 18 and not a party to this action. My business address is: 701 Fifth Avenue, Suite 3300, Seattle, Washington 98104.

On this day, I caused the foregoing DEFENDANTS' MOTION TO DISMISS to be served on the parties listed below in the manner indicated.

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☐ Via U.S. Mail
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☒ CM/ECF via court's website

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct, to the best of my knowledge.

Executed on this 5th day of January, 2018, at Seattle, Washington.

*/s/ Kami R. Mejia*
Kami R. Mejia
Litigation Legal Assistant



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# ATTACHMENT 1

# EXCERPTS FROM FED. REG. 3137 ET SEQ. (May 18, 2016)

LEGAL STATUS

LEGAL STATUS

# Nondiscrimination in Health Programs and Activities

A Rule by the Health and Human Services Department on 05/18/2016

DOCUMENT DETAILS

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DOCUMENT DETAILS

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## AGENCY:

Office for Civil Rights (OCR), Office of the Secretary, HHS.

## ACTION:

Final rule.

## SUMMARY:

This final rule implements Section 1557 of the Affordable Care Act (ACA) (Section 1557). Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. The final rule clarifies and codifies existing nondiscrimination requirements and sets forth new standards to implement Section 1557, particularly with respect to the prohibition of

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origin, sex, age, or disability.

We also proposed that the effective date of the Section 1557 implementing regulation shall be 60 days after the publication of the final rule in the **Federal Register**.

The comments and our responses regarding the proposed effective date are set forth below.

*Comment:* Some commenters asserted that 60 days after publication of the final rule did not allow sufficient time for entities to come into compliance with Section 1557 and requested that the effective date be one year after publication of the final rule. Similarly, one commenter stated that State agencies covered by Section 1557 need at least 150 days to come into compliance with Section 1557. The commenter stated that State agencies need additional time to assess the impacts, align nondiscrimination requirements from multiple Federal agencies, and make the required policy, operational, and system changes.

*Response:* OCR does not believe that extending the effective date beyond 60 days is warranted, except with regard to specific provisions for which there is a later applicability date, as set forth below. Most of the requirements of Section 1557 are not new to covered entities, and 60 days should be sufficient to come into compliance with any new requirements.

### SUMMARY OF REGULATORY CHANGES

For the reasons set forth in the proposed rule and considering the comments received, we are finalizing the provisions as proposed in § 92.1 with one modification. We recognize that some covered entities will have to make changes to their health insurance coverage or other health coverage to bring that coverage into compliance with this final rule. We are sensitive to the difficulties that making changes in the middle of a plan year could pose for some covered entities and are committed to working with covered entities to ensure that they can comply with the final rule without causing excessive disruption for the current plan year. Consequently, to the extent that provisions of this rule require changes to health insurance or group health plan benefit design (including covered benefits, benefits limitations or restrictions, and cost-sharing mechanisms, such as coinsurance, copayments, and deductibles), such provisions, as they apply to health insurance or group health plan benefit design, have an applicability date of the first day of the first plan year (in the individual market, policy year) beginning on or after January 1, 2017.

### APPLICATION (§ 92.2)

Section 92.2 of the proposed rule stated that Section 1557 applies to all health programs and activities, any part of which receives Federal financial assistance from any Federal agency. It also stated that Section 1557 applies to all programs and activities that are administered by an Executive Agency or any entity established under Title I of the ACA.

In paragraph (a), we proposed to apply the proposed rule, except as otherwise provided in § 92.2, to: (1) All health programs and activities, any part of which receives Federal financial assistance administered by HHS; (2) health programs and activities administered by the Department, including the Federally-facilitated Marketplaces; and (3) health programs and activities administered by entities established under Title I of the ACA, including the State-based Marketplaces.

In paragraph (b), we proposed limitations to the application of the final rule. We proposed the adoption of the existing limitations and exceptions that already, under the statutes referenced in Section 1557, govern the health programs and activities subject to Section 1557. We noted that these limitations and exceptions are found in the Age Act and in the regulations implementing the Age Act, Section 504, and Title VI, which apply to all programs and activities that receive Federal financial assistance.

**SUMMARY OF REGULATORY CHANGES**

For the reasons set forth in the proposed rule and considering the comments received, we are finalizing the provision as proposed in § 92.206 with technical revisions to clarify our intent and ensure consistency with other parts of the final rule.

**NONDISCRIMINATION IN HEALTH-RELATED INSURANCE AND OTHER HEALTH-RELATED COVERAGE (§ 92.207)**

In § 92.207 of the proposed rule, we provided specific details regarding the prohibition of discrimination on the basis of race, color, national origin, sex, age, or disability in the provision and administration of health-related insurance or other health-related coverage. We proposed that this prohibition applies to all covered entities that provide or administer health-related insurance or other health-related coverage, including health insurance issuers and group health plans that are recipients of Federal financial assistance and the Department in the administration of its health-related coverage programs. We noted that this section is independent of, but complements, the nondiscrimination provisions that apply to the Health Insurance Marketplaces [223] and to issuers of qualified health plans [224] under other Departmental regulations, and that entities covered under those provisions and Section 1557 are obligated to comply with both sets of requirements.

Based on the longstanding civil rights principles discussed in connection with the definition of "health program or activity" in § 92.4, we proposed to apply this part to all of the coverage and services of issuers that receive Federal financial assistance, whether those issuers' coverage is offered through the Marketplace [SM], outside the Marketplace [SM], in the individual or group health insurance markets, or as an employee health benefit program through an employer-sponsored group health plan.[225] We provided an example illustrating that an issuer participating in the Marketplace [SM], and thereby receiving Federal financial assistance, that also offers plans outside the Marketplace [SM] would be covered by the regulation for all of its health plans, as well as when it acts as a third party administrator for an employer-sponsored group health plan.[226]

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.

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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.

In paragraphs (b)(3) through (5) of the proposed rule, we proposed to address discrimination faced by transgender individuals in accessing coverage of health services. We proposed in paragraph (b)(3) that to deny or limit coverage, deny a claim, or impose additional cost sharing or other limitations or restrictions on coverage of any health service is impermissible discrimination when the denial or limitation is due to the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded by the plan or issuer is different from the one to which such services are ordinarily or exclusively available.[227] Under the proposed rule, coverage for medically appropriate health services must be made available on the same terms

because discrimination based on gender identity should not be recognized as a form of sex discrimination.

*Response:* We agree with the commenters who expressed their general support of the protections for transgender individuals afforded by the provisions at § 92.207(b)(3)-(5), and therefore we are keeping the provisions as proposed. We believe that it is important to ensure that civil rights protections are extended to transgender individuals to afford them equal access to health coverage, including for health services related to gender transition. As we stated in the preamble to the proposed rule, the across-the-board categorization of all transition-related treatment, for example as experimental, is outdated and not based on current standards of care.[263]

Further, we disagree with commenters who asserted that sex-based discrimination does not include discrimination based on gender identity. As discussed previously,[264] OCR's definition of discrimination "on the basis of sex" is consistent with the well-accepted interpretations of other Federal agencies and courts. Further, as previously noted in this preamble,[265] we decline to adopt a blanket religious exemption in the final rule as any religious concerns are appropriately addressed pursuant to pre-existing laws such as RFRA and provider conscience laws.

*Comment:* A significant number of commenters recommended that OCR revise the language in § 92.207(b)(4) that prohibits categorical exclusions or limitations of "all health services related to gender transition" to remove the word "all," and proposed modifications to § 92.207(b)(3)-(5) relating to the medical necessity or medical appropriateness of coverage for health services related to gender transition and sex-specific services. Other commenters, concerned that the rule may be too broadly interpreted, requested clarification as to when gender transition services or sex-specific services must be provided and recommended that the rule specify that such health services are to be provided only when medically necessary or medically appropriate. These commenters also requested that OCR clarify that the rule's intent is not to require covered entities to cover elective services or mandate that it cover certain services. Conversely, other commenters specifically requested that the rule clarify that covered entities cannot deny medically necessary services for gender transition-related care because such treatment is medically necessary for transgender individuals. Further, some commenters suggested that covered entities must provide coverage for procedures or services to treat gender dysphoria or associated with gender transition when substantially similar procedures or services are covered for other conditions. For example, commenters observed that a hysterectomy to treat gender dysphoria is substantially similar to a hysterectomy performed for cancer treatment or prevention in a cisgender woman (*i.e.,* a woman whose gender identity is consistent with her sex assigned at birth).

*Response:* OCR appreciates the array of comments provided but does not believe it is necessary to revise the regulatory text. As noted in the preamble to the proposed rule, we will evaluate whether a particular exclusion is discriminatory based on the application of longstanding nondiscrimination principles to the facts of the particular plan or coverage. Under these principles, issuers are not required to cover all medically necessary services. Moreover, we do not affirmatively require covered entities to cover any particular treatment, as long as the basis for exclusion is evidence-based and nondiscriminatory.

Thus, we reject commenters' suggestion that the rule require covered entities to provide coverage for all medically necessary health services related to gender transition regardless of the scope of their coverage for other conditions.

At the same time, the rule does require that a covered entity apply the same neutral, nondiscriminatory criteria that it uses for other conditions when the coverage determination is related to gender transition. Thus, if a covered entity covers certain types of elective procedures that are beyond those strictly identified as

1557, such as the National Health Service Corps, HRSA-funded community health centers, programs receiving National Institutes of Health (NIH) research grants, and SAMHSA-funded programs. In the proposed rule, we noted that physicians participating in a CMS gain-sharing demonstration project who receive gain-sharing payments would be covered under Section 1557 even if they did not participate in Medicare and Medicaid or any other health program or activity that receives Federal financial assistance. We also noted that there will be duplication and overlap with physicians who accept Medicaid or Medicare meaningful use payments, or other payments apart from Medicare Part B payments. Nevertheless, we noted that at least some of these physicians add to the total number of physicians reached under Section 1557 because some of them are not duplicates and do not accept Medicaid or Medicare meaningful use payments. We noted that although we do not have an exact number, adding these physicians may bring the total participating in Federal programs other than Medicare Part B to over 900,000.

In the proposed rule, when we compared the upper bound estimated number of physicians participating in Federal programs other than Medicare Part B (over 900,000) to the number of licensed physicians counted in HRSA's Area Health Resource File (approximately 890,000), we concluded that almost all practicing physicians in the United States are reached by Section 1557 because they accept some form of Federal remuneration or reimbursement apart from Medicare Part B.[313]

We invited the public to submit information regarding physician participation in health programs and activities that receive Federal financial assistance. We received no comments that would change the estimates that we provided; thus, the analysis in this final rule includes the same numbers of physicians as in the proposed rule.

#### 2. EXAMPLES OF HEALTH PROGRAMS OR ACTIVITIES CONDUCTED BY THE DEPARTMENT

This final rule applies to the Department's health programs and activities, such as those administered by CMS, HRSA, CDC, Indian Health Service (IHS), and SAMHSA. Examples include the IHS tribal hospitals and clinics operated by the Department and the National Health Service Corps.

#### 3. EXAMPLES OF ENTITIES ESTABLISHED UNDER TITLE I OF THE ACA

This final rule applies to entities established under Title I of the ACA. According to the CMS Center for Consumer Information and Insurance Oversight (CCIIO), there are Health Insurance Marketplaces covering 51 jurisdictions: (17 State-based-Marketplaces and 34 Federally-facilitated Marketplaces). The final rule covers these Health Insurance Marketplaces.

## II. Costs

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

Section 1557 applies to the Health Insurance Marketplaces. We note that these entities, along with the qualified health plan issuers participating in the Health Insurance Marketplaces, are already covered by regulations issued by CMS that prohibit discrimination on the basis of race, color, national origin, sex,