No. 18-35846

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ANDREA SCHMITT and ELIZABETH MOHUNDRO,
each on their own behalf, and on behalf of all similarly situated individuals,

Plaintiffs/Appellants,

v.

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

Defendants/Appellees.

On Appeal from the United States District Court for the
Western District of Washington
The Honorable Robert S. Lasnik, U.S. District Court Judge
(Seattle, Case No. 2:17-cv-01611-RSL)

APPELLEES' BRIEF

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rules of Appellate Procedure 26.1, the undersigned attorney of record for 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., certifies as follows:

Kaiser Foundation Health Plan of Washington Options, Inc. ("KFHPWO") is a Washington for profit stock corporation organized under 23B RCW. Kaiser Foundation Health Plan of Washington ("KFHPW") is the sole shareholder of KFHPWO. There are no publicly-held companies that own 10% or more of KFHPWO's stock.

Kaiser Foundation Health Plan, Inc., does not have a parent corporation. Kaiser Foundation Health Plan, Inc., is a non-profit corporation that does not issue stock, therefore no publicly held corporation owns 10% or more of Kaiser Foundation Health Plan, Inc.'s stock.

Kaiser Foundation Health Plan of the Northwest states that it is an Oregon tax exempt nonprofit corporation. Kaiser Foundation Health Plan of the Northwest is an affiliate of Kaiser Foundation Health Plan, Inc., and has no stock.

s/ Medora A. Marisseau
Medora A. Marisseau, WSBA #23114

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I. INTRODUCTION

Appellants' claim, based on the faulty premise that Congress changed the longstanding definition of "disability discrimination" when it enacted Section 1557 of the Patient Protection and Affordable Care Act, codified at 42 U.S.C. § 18116 ("ACA § 1557"), is that all covered health plans are now mandated to provide coverage for all types of hearing aids and related services, even though such services are not Essential Health Benefits. *See* 42 U.S.C. § 18022(b)(1)(G); WAC 284-43-5640(7)(c)(4).

Andrea Schmitt and Elizabeth Mohundro ("Appellants") allege they are hearing-disabled participants under their employers' health plans ("Plans") administered by Kaiser Foundation Health Plan of Washington, as to Schmitt, and Kaiser Foundation Health Plan of Washington Options, Inc., as to Mohundro (collectively "Kaiser"). ER 67–68. Appellants alleged "intentional discrimination" as the sole basis for their ACA discrimination claim, which in turn is based entirely on their Plans' exclusion of coverage for some hearing aids and certain services relating to hearing loss. ER 69, 76. Appellants' argument is premised on the legally unsupportable assertion that all hearing loss is a "disability" under 42 U.S.C. § 12102(1)–(2) (a condition is a disability only if it "substantially limit[s]" an individual's hearing or other major life activity).

ACA § 1557 is modeled after and expressly incorporates the test for "disability discrimination" under Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 ("RA § 504"). If Congress had intended the ACA to create an entirely new standard for disability discrimination in plan benefit design, it could have done so explicitly, but it did not. The District Court correctly applied decades of established law interpreting RA § 504 and Title II of the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12131, *et seq*., in the context of health benefit plan design claims, when it ruled that the exclusion at issue here "is not designed with reference to a disability and applies to both disabled and non-disabled plan participants, does not discriminate on the basis of disability." ER 11. As noted by the District Court, this result is supported not only by ACA § 1557 itself, but also the implementing regulations and the agencies' comments:

> [W]e 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 in 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 on disability.
>
> 81 Fed. Reg. 31375-1, 31429 (May 18, 2016). See also Id. at 31434 (DHHS 'recognizes that covered entities have discretion in developing benefit designs and determining what specific health services will be covered . . .' and declines to prohibit

> 'categorical exclusions of all coverage related to certain conditions' other than gender transition.)"

ER 20.

The Plans *cover* some hearing aids and devices such as cochlear implants, which treat more serious hearing loss that may be disabling, as well as bone anchored hearing aids. ER 194, 233-35. In contrast, the exclusion applies to certain types of hearing aids, such as those allegedly used by Appellants, that can improve hearing loss and benefit the non-disabled and disabled alike. Importantly, the exclusion applies equally to all plan participants.

Appellants appear to concede that the exclusion would not be discriminatory under RA § 504 or ADA standards. The Plans limit coverage based not on a disability, but on specific devices and services for a medical condition – hearing loss – which affects both the disabled and the non-disabled. Applying the well-settled "discrimination" standards of RA § 504 as developed through decades of case law, the District Court correctly dismissed Appellants' Second Amended Complaint for failure to state a cognizable claim under ACA § 1557. ER 22-23. This Court should affirm.

II. STATEMENT OF THE ISSUE PRESENTED FOR REVIEW

Did the District Court correctly dismiss Appellants' Second Amended Complaint under Fed. R. Civ. P. 12(b)(6) for failure to state a claim for disability discrimination under ACA § 1557?

III. STATEMENT OF THE CASE

A. Appellants' Allegations and the Plans.

In their Second Amended Complaint, Appellants alleged they have been diagnosed with hearing loss, and are enrolled in employer-sponsored health insurance plans administered by Kaiser. ER 67–68, ¶¶ 1-2. They have different employers and different plans; however, the exclusion at issue is essentially the same. ER 69. They further alleged they are "qualified individual[s] with a disability" under ACA § 1557, and require outpatient office visits and hearing aids to treat their hearing loss. ER 71–72, ¶¶ 14-15.

Because Kaiser receives federal financial assistance and its health plans are a "health program or activity," Kaiser is subject to the anti-discrimination provisions of ACA § 1557(a). ER 74, ¶ 23. The Plans generally provide coverage for medically necessary outpatient services and certain durable medical equipment like wheelchairs and prosthetic legs, which can benefit those suffering from disabilities, but exclude coverage for certain hearing aids and related services. ER 187, 194, 205. The Plans cover 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. *See* ER 194, 233–35.

As the District Court noted: "The benefits plaintiffs seek are not part of the plan in which they participate[.]" ER 11. Instead, the Plans provide the same

coverage to all participants, whether disabled or not. Appellants not only have equal access to all Plan benefits, but also have coverage for hearing exams, cochlear implants and bone anchored hearing aids on the same terms as all other Plan participants. The Plans do not exclude coverage for the hearing disabled, while providing such coverage for the non-hearing disabled. The Plans do not even exclude all health services or devices relating to hearing loss.

B. The District Court's Ruling.

The District Court granted Kaiser's motion to dismiss for failure to state a claim under Fed. R. Civ. P. 12(b)(6). ER 16-24. Relying on the U.S. Supreme Court's definition of disability discrimination under RA § 504 in *Alexander v. Choate*, 469 U.S. 287, 299–304 (1985), and the applicable statutes and regulations, the court noted that a health program or activity cannot be designed in a way that "effectively denies disabled individuals meaningful access to the program or benefit[.]" ER 18:2–3. The court found "hearing loss" does not necessarily equate to a "disability" because to qualify as a disability, the ability to hear must be "substantially limited," and that the Plans treat the disabled "no differently than persons who have but are not disabled by their hearing loss." ER 23:1–7.

The district court further ruled that in enacting the ACA, Congress "did not compel insurers to cover all medical conditions or to provide all types of medical services/treatments in every policy." ER 19:18–20. Instead, where Congress

determined that a type of service or treatment was "essential," it included those services in the ACA's list of ten essential health benefits ("EHBs") in 42 U.S.C. § 18022(b)(1), leaving it undisputed that hearing aids and most hearing-loss services are not EHBs. ER 19:20 to 20:1.

Citing Department of Health and Human Services ("DHHS") regulations, the court also ruled that health plans are not required to cover any particular benefit or service, and that the ACA does not prohibit "categorical exclusions of all coverage related to certain conditions" other than gender transition. ER 20:6–20. Thus, "Section 1557 generally requires only that if a plan covers inpatient treatment for a particular disorder, it must make the services available to everyone who has that disorder regardless of their race, color, national origin, sex, age, or disability." ER 21:3-5 (emphasis in original).

Contrary to Appellants' assertion, the district court did not determine ACA § 1557 is inapplicable unless the services involve EHBs (Appellant's Brief, pp. 12-13, 47-49). The district court correctly noted Washington law does not require coverage of hearing aids (except for cochlear implants) as EHBs, and observed "Plaintiffs are not arguing that defendants violated the ACA by failing to cover an EHB." ER 20, n.5.[1] However, the district court continued with its analysis whether

[1] Appellants attempt to contest this assertion by citing an argument by defense counsel. *See* ER 64, lines 5-16.

Appellants were subjected to disability discrimination in a health plan under ACA § 1557. It ruled that nothing in ACA § 1557 "mandates a particular scope of benefits in every healthcare plan (other than the inclusion of the EHBs) or precludes distinctions on the basis of the patient's condition, disease or illness (other than gender transition)" which is a form of sex discrimination. ER 21. The district court then applied the longstanding meaning of "discrimination" developed under Section 504 of the Rehabilitation Act, concluding that the exclusion was not "discrimination" because it was not designed with reference to a disability and applies equally to both the disabled and non-disabled. ER 22.

Rejecting Appellants' argument that they were denied coverage for otherwise available outpatient services and durable medical equipment solely because they were related to hearing loss, the district court stated:

> The argument is attractive in its simplicity: plaintiffs' claims for healthcare benefits were denied and/or limitations of coverage were imposed because of the nature of the disability for which they sought treatment, so they must be the victim of disability discrimination. The argument proves too much, however. Taken to its logical conclusion, it would compel an insurer that covers a treatment or service in a particular circumstance, such as prenatal doctor's visits or prosthetic limbs, to cover every doctor's appointment or durable medical device for every kind of condition, disorder, or illness. Under plaintiffs' theory, the ACA automatically converted every healthcare policy into the top-end, gold-level plan.[2] The structure and language of the law

[2] Appellants characterize this as an improper concern about cost. (App Brief, pp. 13, 46). Rather, the district court was simply observing that Appellants' interpretation would convert the anti-discrimination provisions of Section 1557 into

> cannot support such an interpretation." ER 19

ER 19:9–17. The court concluded:

> The benefits plaintiffs seek are not part of the plan in which they participate: the allegations of the complaint do not, therefore, give rise to a plausible inference that they were excluded from participation in or denied the benefits of their health plan under section 504 of the Rehabilitation Act or the ACA. The question, then, is whether plaintiffs were subjected to disability discrimination in a health program. For the reasons discussed below, the Court finds that the hearing loss exclusion, which is not designed with reference to a disability and applies to both disabled and non-disabled participants, does not discriminate on the basis of disability. . . .
>
> While the Court accepts as true plaintiffs' allegation that they are disabled by their hearing loss, the policy at issue treats them no differently than persons who have but are not disabled by their hearing loss. Neither the disabled nor the non-disabled patient with hearing loss has coverage for most hearing care. To confuse matters even more, defendants' policy covers cochlear implants, a treatment that is medically appropriate only when the hearing loss is significant and therefore disabling. *Thus, the policy at issue provides a specified hearing service for disabled participants while excluding coverage for other hearing services regardless of whether the participant is disabled or not-disabled by their hearing loss.* In these circumstances, plaintiffs have failed to raise a plausible inference that the benefit design or coverage denial was motivated by their disability.

ER 22: 18–25; ER 23: 5–14 (emphasis added). Citing *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 677–78 (8th Cir. 1996), the District Court held that it is not discrimination to exclude coverage for some hearing loss services and devices so

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a sweeping benefit mandate for every condition and service, something expressly rejected by case law and DHHS.

long as disabled and non-disabled plan participants are treated the same. ER 23, n.4.

IV. SUMMARY OF THE ARGUMENT

ACA § 1557 prohibits disability discrimination by expressly incorporating RA § 504, and using language identical to both RA § 504 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. Appellants were neither excluded from participation in, nor denied the benefits of, the Plans. Applying the long-established test for disability discrimination in health plans, the Plans' exclusion did not subject Appellants or any hearing disabled persons to "discrimination" because the exclusion of coverage for some hearing aids and related services is evenhandedly and equally applied to all participants, including the disabled and non-disabled alike. Insurers are not required to cover all treatments and devices that might benefit disabled persons. The Plans are neither facially discriminatory, nor do they disparately impact the hearing disabled by denying meaningful access to the offered benefits. Because the ACA did not alter the established disability discrimination standards, the District Court properly dismissed Appellants' Second Amended Complaint for failure to state a cognizable ACA § 1557 claim.

V. ARGUMENT

A. Standard of Review

This Court reviews a dismissal under Fed. R. Civ. P. 12(b)(6) *de novo*. To

survive dismissal, a complaint must allege sufficient facts to state a "plausible" ground for relief. *Bell Atl. Corp. v. Twombly,* 550 U.S. 544, 570 (2007). "Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements" are not sufficient to state a claim. *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009); *Twombly*, 550 U.S. at 555. "Sufficient factual matter" necessary to avoid dismissal does not include allegations that are conclusory or speculative or that require the Court to draw unreasonable or unwarranted factual inferences. *See Manufactured Home Communities., Inc. v. City of San Jose*, 420 F.3d 1022, 1035 (9th Cir. 2005). When a complaint fails to adequately state a claim, such deficiency should be "exposed at the point of minimum expenditure of time and money by the parties and the court." *Twombly*, 550 U.S. at 558. A complaint may be lacking for: (i) absence of a cognizable legal theory, or (ii) insufficient facts under a cognizable legal claim. *See Robertson v. Dean Witter Reynolds, Inc.*, 749 F.2d 530, 534 (9th Cir. 1984).

B. The ACA's Mandate for Coverage of Essential Health Benefits Does Not Include Coverage for Hearing Aids.

Congress enacted the ACA in 2010 to comprehensively reform the nation's health care system and provide affordable, universal health care for every American. It bars health insurers from imposing annual or lifetime coverage caps, and requires 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 DHHS to conduct a survey of health plans, and ensure the scope of EHBs "is equal to the scope of benefits provided under a typical employer plan[.]" 42 U.S.C. § 18022(b)(2)(A). 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. WAC § 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 EHB. Appellants acknowledge that only 25 states include coverage for some hearing aid treatment in their benchmark plans. Appellants' Appellants' Brief, p. 7, n.2. In its motion to dismiss, Kaiser summarized the states' coverage for hearing aids in approved EHB benchmark plans as follows:

> • 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.

ER 245.[3]

The District Court correctly noted it is "undisputed that hearing aids and most hearing loss services are not included in the list of EHBs" and Appellants "are not arguing that [Kaiser] violated the ACA by failing to cover an EHB." ER 20-21 n.2. Appellants instead argue that the Plans' exclusion of some hearing aids and related services is prohibited by ACA § 1557 because it singles out the hearing disabled and subjects them to discrimination. Contrary to Appellants' assertion, there is no dispute that devices and treatments must be covered in a non-discriminatory manner, even if they are not EHBs. The crucial inquiry in this case is what disability "discrimination" means under the ACA.

C. ACA § 1557's Prohibited Acts.

ACA § 1557 extends the pre-existing anti-discrimination laws of four specific civil rights statutes to federally funded health programs:

> 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

[3] *See* Essential Health Benefits: Benchmark Plan Comparison, at https://www.cigna.com/assets/docs/about-cigna/informed-on-reform/top-11-ehb-by-state-2017.pdf. *See* attached Addendum C.

> 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). ACA § 1557 prohibits discrimination on the basis of disability by incorporating RA § 504, which contains identical language of the three prohibited acts:

> 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). 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, or to "be subjected to discrimination[.]" 42 U.S.C. § 12132.

To state a claim for disability discrimination under ACA § 1557, a plaintiff must allege: (1) he or 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 solely by reason of a disability. 42 U.S.C. 18116(a); 29 U.S.C. § 794; *SEPTA v. Gilead Sciences, Inc.*, 102 F. Supp. 3d 688, 699 (E.D. Pa. 2015); *Doe v. BlueCross BlueShield of Tennessee*, 2018 U.S. Dist. LEXIS 126845 (W.D. Tenn. July 30, 2018) (ACA § 1557 incorporates RA § 504's requirement that discrimination be "solely" because of disability).

Appellants have not, and cannot, allege that they were "excluded from participation in" Kaiser's Plans. At oral argument, their counsel "agree[d] that our clients have access" to the Plans, so the parties agree Appellants were not denied "participation in" the Plans. ER 54:6-7. Though they sometimes argue they were "denied the benefits of" the Plans, the District Court correctly disagreed because the "benefits plaintiffs seek are not part of the plan in which they participate: the allegations of the complaint do not, therefore, give rise to a plausible inference that they were excluded from participation in or denied the benefits of their health plan[.]" ER 22:19–21. Any claim that Appellants were "excluded from participation in" or "denied the benefits of" the Plans fails as a matter of law.

Appellants' case therefore, depends on the theory they were "subjected to discrimination" solely by reason of a disability. The District Court found that the Kaiser Plans' exclusion, "which is not designed with reference to a disability and applies to both disabled and non-disabled plan participants, does not discriminate on the basis of a disability." ER 22:23-26. This is consistent with applicable case law.

See, e.g., *Choate*, 469 U.S. at 302; *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 608 (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"); *Krauel*, 95 F.3d at 678 (excluding one disability from coverage does not violate ADA if exclusion applies equally to all individuals).

D. ACA § 1557's Prohibition Against "Discrimination" Expressly References and Incorporates the Same Standards as Existing Civil Rights Laws.

ACA § 1557's discrimination standards vary depending on the type of discrimination alleged — race, color, national origin, sex, age, or disability. *See* 42 U.S.C. 18116(a) ("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 . . ., title IX of the Education Amendments of 1972 . . ., the Age Discrimination Act of 1975 . . ., or section 504 of the Rehabilitation Act of 1973. . ., be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance"). Claims under section 1557 follow the substance and enforcement mechanisms specific to RA § 504 and/or other related federal civil rights statutes, depending on the protected status involved. *See, e.g.*, *Huffman v. Univ. Med. Ctr. Mgmt. Corp.*, 2017 U.S. Dist. LEXIS 180999, *5–6

(E.D. La., Oct. 31, 2017) (ACA § 1557 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); *Briscoe v. Health Care Serv. Corp.*, No. 16-CV-10294, 2017 WL 5989727, at *9–10 (N.D. Ill. Dec. 4, 2017); *Doe v. Blue Cross Blue Shield of Tennessee, Inc.*, 2018 U.S. Dist. LEXIS 126845 (W.D. Tenn. July 30, 2018); *John Doe One v. CVS Pharm., Inc.*, 348 F. Supp. 967, 981 (N.D. Cal. 2018); *E.S. v. Regence BlueShield*, 2018 U.S. Dist. LEXIS 163287, *10 (W.D. Wash. Sept. 24, 2018); *SEPTA, supra,* 102 F. Supp. 3d at 697-699 (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); *Cummings v. Premier Rehab., PLLC,* 2019 U.S. Dist. LEXIS 7587 (N.D. Tex. Jan. 16, 2019) (emotional distress damages are unrecoverable under RA § 504, and "[a]ccordingly, they are also not available in actions brought under Section 1557 of the ACA").

By expressly incorporating the grounds and enforcement mechanisms of RA § 504, Congress clearly intended to apply the existing discrimination standards of that statute to disability discrimination claims under ACA § 1557. The preamble to the final rule implementing Section 1557 makes this point explicitly: "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[.]" 81 Fed. Reg. 31376.[4] The District Court correctly ruled that ACA § 1557 incorporated the definition of disability discrimination embodied in RA § 504. ER 17.

E. Disability Discrimination in Benefit Design under the Rehabilitation Act and the ADA.

Appellants mistakenly contend that disability discrimination under RA §504 has not applied to plan benefit designs. As set forth below, cases interpreting RA § 504 and the ADA[5] have uniformly held that plan benefit designs that exclude specific treatments, services or devices, are not "discriminatory" as long as the 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.

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[4] Copies of the relevant Federal Register pages quoted herein are attached as Addendum A.

[5] The Ninth Circuit has held that Title II of the ADA and RA § 504 are substantially similar and Title II "extends the anti-discrimination prohibition embodied in section 504 [of the Rehabilitation Act] 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). Thus, "[t]here 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); *see also Weinreich v. L.A. County Metro. Transp. Auth.*, 114 F.3d 976, 978 (9th Cir. 1997) .

The genesis of this rule is the U.S. Supreme Court's opinion in *Choate*, *supra*, 469 U.S. 287. There, Medicaid recipients claimed that Tennessee's proposed restriction of inpatient treatment coverage 14 days a year violated RA §504 because it discriminated against the disabled who would need longer periods of treatment.

The Court rejected the argument noting 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[,]" and ruling the policy did not amount to discrimination. *Choate.* 469 U.S. at 302. The Court explained:

> To the extent respondents further suggest that their greater need for prolonged inpatient care means that, to provide meaningful access to Medicaid services, Tennessee must single out the handicapped for more than 14 days of coverage, the suggestion is simply unsound. At base, such a suggestion must rest on the notion that the benefit provided through state Medicaid programs is the amorphous objective of "adequate health care." *But Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs*. Instead, the benefit provided through Medicaid is a particular package of health care services, such as 14 days of inpatient coverage. That package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered-not "adequate health care."

Id. at 302–03 (emphasis added). The Rehabilitation Act does not require a health plan to single out the disabled for special treatment, and covered entities are free to define the benefits they will provide, so long as they are equally accessible to both the disabled and the non-disabled. *Id.* at 308–09.

The Supreme Court later clarified that it is not discriminatory 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 (1988). These Rehabilitation Act cases reject Appellants' assertion it is discriminatory to offer coverage for certain medical devices (such a prosthetic legs) that may benefit those who have a mobility disability, while denying certain hearing aids for persons with hearing loss (some of whom may be disabled and some of whom may not). That is not "discrimination."

The rule requiring only equal access and evenhanded treatment also applies to benefit plans under the ADA. It is enough that all insureds are given equal access to plan benefits, and it is irrelevant that a plan might treat some forms of disability more favorably than others. *See Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006, 1015–16 (6th Cir. 1997). "The ADA simply does not mandate equality between individuals with different disabilities." *Id.* 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*, *supra*, 145 F.3d 601 ("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*, *supra*, 95 F.3d 674, the plaintiff claimed her health care plan's exclusion of infertility treatments constituted disability discrimination under the ADA. The Eighth Circuit confirmed 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." *Id.* at 678. In so ruling, the court quoted the following passage from an EEOC enforcement guide:

> [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, <u>are not distinctions based on disability</u>. 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. 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:

> [T]he 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.

Id. 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 (prior to the enactment of the Mental Health Parity Act), one district 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). The court noted that the same result would apply under RA § 504. *Id.* at 96, *citing Traynor*, *supra*, 485 U.S. 535, 549.

The concurring opinion in *Modderno*, cited in *Wilson*, in interpreting RA § 504, 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 [RA] §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 … (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).

These cases all stand for the proposition that exclusions or limitations of certain conditions in health benefit plan 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.

Appellants' specific claim — that exclusion of coverage for hearing aids and related services 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 but covered "virtually every other type of durable medical equipment, such as crutches, prostheses, and glasses." *Id.* at *4. 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. But the court went on to explain why the plaintiffs had failed to state a claim for discrimination under the ADA, relying on *Doe v. Mutual of Omaha,* 179 F.3d 557, 560 (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 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, but provided a higher cap for other conditions. 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 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 this reasoning to Titles I and II of the ADA:

> 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 16263 at *22–26.

Appellants attempt to distinguish *Micek, Krauel*, and *Doe* (Appellants' Brief, p. 19, n.3), asserting those cases relied on the ADA's "safe harbor" provision, which provides that the ADA shall not be construed to prohibit or restrict insurers from underwriting risks that are based on or consistent with state laws but shall not be used as a "subterfuge" for discrimination. 42 U.S.C. § 12201(c). This argument is unavailing because these cases do not rely on this safe harbor provision in their analysis that the exclusion of a service in does not "discriminate" under the ADA if it applies equally to all. Moreover, ACA § 1557 incorporates RA § 504, which in turn expressly incorporates the ADA's safe harbor provision. *See* 29 U.S.C. § 794(d). The ADA's safe harbor provision provides no basis to distinguish the cases interpreting the discrimination standards under the ADA.

The caselaw firmly establishes that it is not "discrimination" under RA § 504 or the ADA for health care plans to exclude coverage for any particular treatment or device, so long as the exclusion is equally applied to all.

F. The ACA Did Not Establish a New Standard for Disability Discrimination in Benefit Design.

Appellants' claim relies entirely on the erroneous argument that ACA § 1557 created a drastically new standard for discrimination in "benefit design." They rely on ACA § 1557's reference to "contracts of insurance" and posit that anti-discrimination principles were extended for the first time to health insurance plans.

This is a misreading of the statute, which references "contracts of insurance" merely as an example of a *form of financial assistance* that an entity may receive to subject it to the statute:

> an individual shall not . . . 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[.]

ACA § 1557(a) (emphasis added). The statutory language provides no support for Appellants' proposition. Contracts of insurance are not a new program or activity subject to discrimination prohibitions; rather, they are listed as an example of federal funding sources that would bring recipients under the ACA's ambit.

Appellants' contention - that the ACA subjected contracts of insurance to antidiscrimination laws for the first time – also ignores decades of jurisprudence interpreting and applying disability discrimination claims under RA § 504.[6] As discussed above, at least eight federal appellate courts have applied RA § 504 and the ADA to claims based on "benefit design," including exclusions or limitations in insurance contracts. (*See* the cases discussed above in section V.E.)

[6] See also ADA's legislative history: "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, . . . 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. S. Rep. No. 101-116, at 29 (1989).

None of these cases found RA § 504 or the ADA inapplicable because of an allegation that the disability discrimination claim was based on plan benefit design or an insurance contract.[7] *See, e.g.*, *Choate*, 469 U.S. 287 (Medicare benefit design does not deny meaningful access); *Parker*, 121 F.3d at 1015 (benefit plan not discriminatory under the ADA because it is equally applied to all); *Krauel*, 95 F.3d at 678; *Doe*, 179 F.3d at 558; *Modderno*, *supra*, 82 F.3d at 1061. Nor does Kaiser dispute that ACA § 1557 applies to benefit design. Disability discrimination claims under ACA § 1557 extend to benefit design and the content of insurance contracts in the same way and to the same extent as such claims under RA § 504.

The critical question is not whether the application of discrimination prohibitions to contracts of insurance is new (it is not), but whether the ACA's test for disability "discrimination" is new. Nothing in the ACA changed the test for disability "discrimination" in the context of health insurance. In one of the few cases addressing ACA § 1557 disability discrimination, the court in *SEPTA v. Gilead Sciences, Inc.*, *supra*, followed the identical logic expressed in the RA § 504/ADA cases discussed above. In *SEPTA*, a plaintiff diagnosed with Hepatitis C alleged that defendant drug manufacturer violated ACA § 1557 by charging an unreasonably

[7] Appellants suggest that Kaiser believes ACA § 1557 does not extend to benefit design. This is wrong. Disability discrimination claims under ACA § 1557 extend to benefit design and the content of insurance contracts in the same way and to the same extent as such claims under RA § 504.

excessive price for Hepatitis C treatment. 102 F. Supp. 3d 688 at 694–95. The Court dismissed the claim under Fed. R. Civ. P. 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.

Id. at 700.

ACA § 1557's prohibition of discrimination in the content, or benefit design, of health benefits is nothing new. 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 Appellants assert in this case. *See Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842–44 (1984). By expressly incorporating RA § 504 and using identical language to describe the prohibited discriminatory acts, ACA § 1557 unambiguously adopts the same test for discrimination in RA § 504. *Accord, Puerner v. Spine*, 2018 U.S. Dist. LEXIS 147276, *8 (S.D.N.Y. Aug. 28, 2018) ("Since Plaintiff states a claim under the RA,

she also states a claim under the ACA"); *Wood v. Jackson Hospital*, 2018 U.S. Dist. LEXIS 144499 (M.D. Ala. Aug. 23, 2018) (ACA § 1557 embodies the same disability discrimination standards as the Rehabilitation Act). "[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 (2012)); *quoting Smith v. City of Jackson*, 544 U.S. 228, 233 (2005) (plurality opinion). Further, "[w]hen . . . 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 administrative and judicial interpretations as well." *Bragdon v. Abbott*, 524 U.S. 624, 645 (1998).

While ACA § 1557 does not define "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) (finding 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 (1988); *see also Lorillard v. Pons*, 434 U.S. 575, 580 (1978) ("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"). Where, as here, the congressional intent is clear from the statute itself, that ends the matter — "for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron,* 467 U.S. at 842–43.

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 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) (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 sex discrimination); *see also SEPTA*, *supra*, 102 F. Supp. 3d at 697–699 (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 at issue).

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 intend to incorporate the principles announced in *Choate* and the other cases discussed in section V.E. above, it would have used language to differentiate ACA § 1557's definition of "discrimination" from the well-settled judicial interpretations of RA § 504 and the ADA. It did not.

Because Kaiser's exclusion of coverage for some hearing aids and related services is evenhandedly applied to the disabled and non-disabled alike, the District Court correctly ruled it does not "discriminate" against the disabled as that term is defined in RA § 504, the ADA, or ACA § 1557. Based on the holdings in *Choate* and the other cases discussed above, the District Court correctly ruled that ACA § 1557 "generally requires only that if a plan covers inpatient treatment for a particular disorder, it must make the services available to everyone who has that disorder regardless of their race, color, national origin, sex, age or disability." ER 21:3-5.

G. DHHS Implementing Regulations Confirm That, Except for Discrimination Based on Sex, ACA § 1557 Applies Pre-Existing Definitions of "Discrimination."

With no evidence that Congress intended to change the definition of disability discrimination in the ACA's statutory text, Appellants turn to DHHS's regulations and comments. Their arguments focus on a misreading of the regulation titled "Nondiscrimination on health-related insurance and other health-related coverage[,]" which provides as follows:

> **(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). Contrary to Appellants' arguments, the applicability of antidiscrimination laws to "benefit design" is nothing new, and as the District Court ruled, the DHHS prohibitions against categorical coverage exclusions of health services are limited to those related only to "gender transition" under sex discrimination (Title IX) standards. ER 21:6-17.

In addressing the above regulation, DHHS provided an example of a discriminatory benefit design that 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. DHHS's interpretation of ACA § 1557 expressly did not change the meaning or scope of "discrimination" as that term has been interpreted and

understood in existing law, particularly with respect to its interpretation within health plans under RA § 504 and the ADA:

> 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.

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

This provision and DHHS's responses to comments are entirely consistent with the non-discrimination standards under RA § 504 and the ADA as defined in long-established case law, as DHHS's bariatric surgery example illustrates. 81 Fed. Reg. 31429. Benefit designs that deny coverage of a service to persons who have a disabling condition, but at the same time grant coverage for the same service to those who do not have a disabling condition, could be prohibited as discrimination under ACA § 1557, as well as under RA § 504 and the ADA. For example, a hearing aid exclusion that 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. Under DHHS's interpretation, outside the context of gender transition services, benefit

designs may exclude coverage for services to treat specific conditions, so long those without the condition are not entitled to the same service, e.g. evenhanded treatment:

> [I]f a plan limits or denies coverage for certain services or treatment of a specific condition, [DHHS] will evaluate whether coverage for the same or similar service or treatment is available to individuals outside of that protected class or those with different health conditions and will evaluate the reasons for any differences in coverage.

81 Fed. Reg. 31433. DHHS thus confirms that the ACA generally adopted the pre-existing definition of disability discrimination in benefit design.

The only area where DHHS saw a change to pre-existing laws is the scope of sex discrimination, based on its interpretation that ACA § 1557 prohibits categorical exclusions of treatment for gender transition, which is a form of sex discrimination and under the ACA must be determined with reference to Title IX. 20 U.S.C. § 1681. DHHS 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[.]

81 Fed. Reg. at 31446 (emphasis added); *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").

Appellants rely exclusively on sex discrimination cases involving transgender individuals to support their argument that categorical exclusions of a service for a particular condition may be discriminatory. *See* Appellants' Brief, pp. 25–26. DHHS and the District Court recognized a distinction between transgender (sex) discrimination and other types of discrimination. The sex discrimination cases Appellants cite are instructive on the difference. For example, in *Boyden v. Conlin*, 341 F. Supp. 3d 979 (W.D. Wisc. 2018), the court ruled that a health plan's exclusion of "gender reassignment" procedures amounted to sex discrimination under the ACA. But the decision was based on the fact that the very procedures excluded for gender reassignment purposes, such as mastectomies, breast reconstruction, hysterectomies, and removal of fallopian tubes, ovaries and testes, *were covered* for treatment of medical conditions other than gender dysphoria. *Id.* at 989. The court noted that "a natal female born without a vagina qualifies for coverage of a vaginoplasty, but not the plaintiffs here because their natal sex is male . . . . a straightforward case of sex discrimination." *Id*. at 995.

Kaiser's Plans, by contrast, equally exclude certain hearing aid coverage for all plan participants, not just for hearing-disabled participants. The exclusion of transgender people from coverage is different than excluding all people from certain treatments. Sex discrimination cases, including those involving gender transition issues, cannot be blindly applied to disability discrimination claims. They involve

application of Title IX, which has a different standard of "discrimination" that is inapplicable to the concept of disability discrimination under RA § 504 as incorporated by ACA § 1557.

H. Appellants Failed to State a Claim for Disability Discrimination under ACA § 1557.

Appellants pled only intentional (disparate treatment) discrimination. ER 76:14-15. The claim fails because the Plans do not discriminate on their face. Appellants also argue, but did not plead, disparate impact discrimination and that argument should not be entertained in this appeal. Even if considered, it also fails.

1. Appellants Failed to State a Claim for Facial Discrimination or Disparate Treatment.

Appellants' sole cause of action for violation of ACA § 1557 is based on the allegation that Kaiser "intentionally discriminated" against persons with hearing loss. ER 76:14–15. Appellants have never claimed or argued that Kaiser designed its' Plans with any actual, subjective discriminatory intent.[8] Rather, their disparate treatment claim is based solely on the argument that the language of the exclusion

[8] The District Court correctly ruled that Appellants "failed to raise a plausible inference that the benefit design or coverage denial was motivated by their disability." ER 23:13–14. Their Second Amended Complaint contains only threadbare allegations and a formulaic recitation of discriminatory intent, falling short of the pleading requirements of *Iqbal* and *Twombly*. Appellants appear to accept this, and do not argue that Kaiser designed its Plan with any animus towards the disabled or actual intent to discriminate.

of certain hearing aids and related services discriminates against the hearing disabled is "facial disability discrimination." Their argument fails.

a. Hearing Loss is Not a *Per Se* Disability.

Appellants claim Kaiser's exclusion of coverage for some hearing aids and related services discriminates on its face because it is based upon the presence of a "disabling condition, hearing loss." Appellants' Brief, p. 3. But as the District Court correctly noted, the "fact that a plan participant has 'hearing loss' or is in need of 'hearing care' does not necessarily mean that he or she is disabled." ER 23:1-2.

Hearing loss is not a disability *per se*. 29 CFR 1630.2(j) ("[N]ot every impairment will constitute a disability within the meaning of this section," *i.e.* the regulations under the Americans with Disabilities Act); *Fraser v. Goodale*, 342 F.3d 1032, 1039 (9th Cir. 2003) ("We do not decide whether every diabetic is disabled, and we do not decide whether every severely obese person is not disabled. Instead, whether a person is disabled under the ADA is an individualized inquiry"); *Kulas v. Roberson*, 1999 U.S. App. Lexis 30588, *4-5 and n.6 (9th Cir. 1999)[9] (prisoner with hearing loss denied request for prescribed second hearing aid was not disabled under the ADA); *Tabb v. Quinn*, 2007 U.S. Dist. Lexis 98989, *16 (W.D. Wash. 2007) (60% loss of hearing in one ear was not "disability" under the ADA). *See also*

[9] Cited pursuant to FRAP 36-3(c)(iii).

Questions and Answers about Deafness and Hearing Impairments in the Workplace and the Americans with Disabilities Act.[10]

To be considered a disability, the hearing impairment must "substantially limit" an individual's hearing or other major life activity. 42 U.S.C. §12102(1)–(2). Whether hearing loss is a disability depends on its severity. *See*, *e.g.*, *Ayotte v. McPeek*, 2011 U.S. Dist. LEXIS 67913, *19 (D. Colo. 2011) ("Plaintiff's hearing impairment does not rise to the level of a disability under the Rehabilitation Act"); *Santiago Clemente v. Executive Airlines, Inc.*, 213 F.3d 23 (1st Cir. 2000) (rejecting claim that certain level of hearing loss constitutes a disability); *E.S.*, *supra*, 2018 U.S. Dist. LEXIS at *8 ("Courts have acknowledged that people can suffer from, and receive treatment for, temporary or mild forms of hearing loss at a level that does not substantially limit a major life activity and does not qualify as a disability under section 504").

Having a potentially disabling condition does not mean a person is disabled. Just as vision impairments that require glasses do not necessarily make one disabled, hearing loss is not a disability *per se*. People may have hearing loss, but not be disabled if the hearing loss is not substantially limited or even if it is substantial but only in one ear.

[10] https://www.eeoc.gov/eeoc/publications/qa_deafness.cfm. *See* Addendum B.

Kaiser's exclusion of coverage for some hearing aids and related services thus does not draw any disability-based distinction: it applies equally to the disabled and the non-disabled and is therefore not discriminatory on its face. "A facially discriminatory policy is one which on its face applies less favorably to a protected group." *Community House, Inc. v. City of Boise*, 490 F.3d 1041, 1048 (9th Cir. 2007) (city's men-only policy at homeless shelter violates Fair Housing Act). The District Court accepted Appellants' allegation that they are disabled by their hearing loss, but correctly ruled that the "policy at issue treats them no differently than persons who have but are not disabled by their hearing loss." ER 23:5-7. This Court should similarly hold that the Kaiser Plans' exclusion of certain hearing aids and services is facially neutral.

b. The Exclusion Does Not Treat the Disabled any Differently than Other Plan Participants.

Appellants argue disability discrimination does not require that a "non-disabled comparison group" be treated better, but that principle is limited to the context of claims that a defendant's policy or program was motivated by actual discriminatory intent. *See, e.g.*, *Pacific Shores Properties, LLC v. City of Newport Beach*, 730 F.3d 1142 (9th Cir. 2013) (under Fair Housing Act and ADA, evidence that city's sole purpose in enacting an ordinance was to discriminate against the disabled precluded summary judgment dismissal). Appellants' entire claim is based on the argument that the hearing disabled are treated differently than others under

Kaiser's Plans. The argument fails under the plain language of the Kaiser Plans. Nobody, whether disabled or not, has coverage for hearing aids, except those who need cochlear implants.

c. This is Not a Case of "Proxy Discrimination."

Appellants' argue for the first time on appeal that the Kaiser Plans' exclusion of coverage for certain hearing aids and services constitutes "proxy discrimination."[11] Appellants quote *McWright v. Alexander*, 982 F.2d 222 (7th Cir. 1992), for its "example of using gray hair as a proxy for age: there are young people with gray hair (a few), but the 'fit' between age and gray hair is sufficiently close that they would form the same basis for invidious classification." *Id*. at 228.

Appellants discuss proxy discrimination in the context of their disparate impact arguments. But as the cases Appellants rely upon illustrate, proxy discrimination is in fact "a form of facial discrimination [and] arises when the defendant enacts a law or policy that treats individuals differently on the basis of seemingly neutral criteria that are so closely associated with the disfavored group

[11] A party must generally present legal theories to the trial court to preserve them for appeal, as this "prevents the district judge from having to somehow divine on his own whether the complaint could conceivably be amended to state a claim" and obviates the need for the appellate court in the first instance to decide whether the new theory would survive a motion to dismiss. *See Vincent v. Trend Western Tech. Corp.*, 828 F.2d 563, 570 (9th Cir. 1987); *Yee v. Hughes Aircraft Co.*, 1996 U.S. App. LEXIS 18540, *4 (9th Cir. July 22, 1996) ("Generally, we will not consider an issue raised for the first time on appeal).

that discrimination on the basis of such criteria is, constructively, facial discrimination." *Pacific Shores*, 730 F.3d at 1160 n.23.

The proxy discrimination cases cited by Appellants are all distinguishable, and inapplicable, because they all involved differential treatment of disabled individuals compared to others outside the protected class. *See McWright*, 982 F.2d at 227 (sterile plaintiff stated a claim for disability discrimination because defendant denied her child-care leave for an adopted child "while routinely granting such leave to biological mothers"); *Children's Alliance v. City of Bellevue*, 950 F. Supp. 1491, 1495 (W.D. Wash. 1997) (seemingly neutral ordinance "expressly treats members of a protected class group differently than others who are similarly situated"); *Pacific Shores*, 730 F.3d at 1158–64 (ordinance was discriminatory because group homes for recovering alcoholics and drug users, compared to vacation homes and other facilities, were subjected to a more restrictive zoning scheme). Kaiser's exclusion of coverage for certain hearing aids and services, by contrast, applies evenhandedly and equally to all plan participants. It does not treat any non-disabled person, even those outside the scope of the alleged proxy, any differently.

d. The Exclusion of Coverage for Some Hearing Aid Devices and Related Treatment is Not a Disability-Based Distinction.

Another reason Appellants' claim fails is that facially discriminatory policies call out a specific disability, not a treatment or service from which the disabled may benefit. The cases cited by Appellants illustrate the point. *See, e.g., Lovell v. Chandler*, 303 F.3d 1039, 1052 (9th Cir. 2002) (Medicaid program was discriminatory on its face because it generally offered coverage for a surgical

procedure, but expressly and categorically excluded such coverage for "[p]ersons who are blind or disabled"). The Kaiser Plans are fundamentally different than the facially discriminatory plan in *Lovell*. It does not exclude only "deaf" or "disabled" persons from coverage for an otherwise covered service. Instead, it excludes certain hearing loss services and devices for all plan participants. Equating "hearing loss" or the ability to benefit from hearing aids with "disability" is the central fallacy of Appellants' argument, because not all people who could benefit from a hearing aid are disabled.

Kaiser's coverage exclusion does not treat the hearing disabled any differently than the non-disabled. On its face, it applies equally to all plan participants. It is facially neutral, and the District Court correctly ruled that Appellants failed to state disparate treatment claim.

2. Appellants Failed to State a Claim for Disparate Impact.

Appellants did not plead a cause of action for disparate impact. The argument fails because the Plans' exclusion did not deny the hearing disabled "meaningful access" to any plan benefits that are available to anyone else.

a. Disparate Impact Discrimination Requires a Denial of "Meaningful Access."

The courts do not agree whether RA § 504, and thus ACA § 1557 in the context of disability discrimination, even allows for disparate impact claims. *See Doe v. BlueCross*, *supra*, 2018 U.S. Dist. LEXIS 126845 at *12-*24. In *Choate*, the Supreme Court assumed without deciding that the Rehabilitation Act reaches some conduct that disparately impacts the disabled but expressed doubts because the disabled "typically are not similarly situated" to the non-disabled and allowing disparate impact claims under RA § 504 could prove unmanageable. *Choate*, 469

U.S. at 298-99.

This Court has held that the ADA encompasses some claims of disparate impact, but only in the context of claims involving the denial of "meaningful access" by the disabled to services that are made available to the non-disabled. *Crowder v. Kitagawa*, 81 F.3d 1480 (9th Cir. 1996); *see also Ruskai v. Pistole*, 775 F.3d 61, 78 (1st Cir. 2014) (when the Supreme Court in *Choate* assumed that a disparate impact theory could apply under RA § 504 in some situations, "the situation it identified was a case in which persons with disabilities were denied meaningful access to a government program or benefit"). *Choate* and *Crowder* were both "access" cases, and there is no case that has applied the "meaningful access" standard to claims for discrimination in insurance benefit design.

One district court, in dismissing an ACA § 1557 disability discrimination claim, ruled that in order "to state a § 504 disparate impact claim [under ACA § 1557], Plaintiffs must allege they were "disparately impacted by the Program's restrictions relative to other enrollees" and "treated differently" than the non-disabled because of a disability. *John Doe One*, *supra*, 348 F. Supp. at 982-83. Appellants attempt to distinguish this case because it did not involve a categorical exclusion (Appellants' Brief, p. 26, n.6), but the benefit design disparate impact analysis does not depend on exclusions being "categorical." Moreover, like Appellants, the plaintiffs in *John Doe One* failed to state a disparate impact claim

because they "alleged no statistical evidence sufficient to show that Defendant's Program has a 'significantly adverse or disproportionate impact' on [plaintiff's class]." *Id*. at 983-84.

b. Benefit Designs Must Give the Disabled Meaningful Access Only to Benefits that are Available to Others.

No case has held that disabled persons can state a claim for disparate impact under RA § 504 or ACA § 1557 in the context of allegedly discriminatory benefit design because such claims do not involve the denial of "access" to the benefits that the defendant "has chosen to provide." *Choate*, 469 U.S. at 302. In rejecting a claim that an exclusion of coverage for hearing aids violated ACA § 1557, the lower court in another, related case reasoned that the exclusion "does not then deny meaningful access to services that are easily accessible by others." *E.S.*, *supra*, 2018 U.S. Dist. LEXIS AT *7. Even if Appellants could assert a disparate impact claim despite no denial of access to Kaiser's Plans, their allegations do not give rise to a valid disparate impact claim.

The critical inquiry in any claim of unlawful disability discrimination is whether a challenged policy treats disabled persons differently because of their disability. *See United States v. Virginia*, 518 U.S. 515, 116 S. Ct. 2264 (1996); *Choate*, 469 U.S. at 299–302. The U.S. Supreme Court in *Choate* made it clear that RA § 504 (and thus ACA § 1557) guarantees equal access to, and even-handed treatment under, health plans. It does not mandate coverage for every impairment

that may afflict the disabled:

> 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.

Choate, 469 U.S. at 303–04 (citations omitted). The central purpose of RA § 504 "is to assure that handicapped individuals receive 'evenhanded treatment' in relation to nonhandicapped individuals." *Traynor*, *supra*, 485 U.S. at 548–49.

c. Equal Access Remains the Standard for Benefit Designs.

Appellants argue *Olmstead v. L.C. by Zimring*, 527 U.S. 581 (1999), changed the law announced in *Choate* and *Traynor* such that a disability discrimination plaintiff need no longer show that a policy is applied differently to people with disabilities and those without disabilities. Appellants' Brief, pp. 28–32. In *Olmstead*, the Supreme Court held that health care officials may violate the ADA's integration mandate by institutionalizing and segregating mentally disabled persons who qualified for community-based treatment, even though the plaintiffs had not identified a "comparison class" of similarly situated individuals who were treated more favorably.

But *Olmstead* (as well as all the other cases cited in Appellants' Brief at pp. 28–29) involved a claim for reasonable accommodation — not disparate impact — and a different analysis. A "plaintiff need not allege either disparate treatment or disparate impact in order to state a reasonable accommodation claim." *McGary v.*

City of Portland, 386 F.3d 1259, 1266 (9th Cir. 2004) (citing *Henrietta D. v. Bloomberg*, 331 F.3d 261, 276–77 (2d Cir. 2003). Appellants have not yet suggested ACA § 1557 mandates health plans to accommodate disabilities by eliminating all coverage limitations. The *Olmstead* court did in fact rely on "differential treatment" between the mentally disabled and the non-disabled. *See Olmstead*, 527 U.S. at 601 ("Dissimilar treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice).

Post-*Olmstead*. this Court has affirmed the disability discrimination tests under *Choate* and *Traynor*. *See Weyer*, 198 F.3d at 1117. *Weyer* held "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*. at 1116. The Court reasoned that *Olmstead's* reasonable accommodation analysis did not apply to claims of disability discrimination in insurance benefit design. "Applying *Olmstead* to insurance classifications would conflict with the Court's decisions in *Alexander v. Choate* and *Traynor v. Turnage*, which both endorse distinctions between types of disabilities". *Id.* at 1117–18.

DHHS confirms that under the ACA discrimination occurs only when the disabled are treated differently than the nondisabled:

> [I]f a plan limits or denies coverage for certain services or treatment of a specific condition, [DHHS] will evaluate whether coverage for the same or similar service or treatment is available to individuals *outside of that protected class or those with different health conditions* and will evaluate the reasons for any *difference* in coverage.

81 Fed. Reg. 31433 (emphasis added).

d. The Exclusion of Coverage for Some Hearing Aids and Related Services is not a Disability-Based Distinction.

The fact that Kaiser's Plans cover medical/surgical office visits, exams, surgeries and equipment, and cochlear implants, but not specified services for hearing loss, is not a "disability"-based distinction and therefore not "discrimination." *Accord v. Boyd Gaming Corp.*, 1999 U.S. App. LEXIS 40612, *3 (5th Cir. June 2, 1999) (plan's exclusion of weight loss treatment is not a disability-based distinction under the ADA because it applies equally to all insureds). Appellants, along with *all other disabled and non-disabled persons* in their Plans, have coverage for the enumerated non-hearing related services, but not certain services for hearing loss. Appellants do not allege they were denied any covered services, or that they received fewer benefits than those available to everyone else, *because of* a disability.

Krauel is especially instructive. It held that a health plan's exclusion of

coverage for infertility treatments was not discrimination based on disability, despite the greater impact it may have on the disabled. The court reasoned that "the Plan's infertility exclusion does not single out a particular group of disabilities," for example infertility due to cancer, while allowing coverage for infertility problems which are not disabilities, such as infertility due to age. *Krauel*, 95 F.3d at 678. Therefore, the court concluded that because the exclusion applied equally to all insureds, "in that no one participating in the Plan receives coverage for treatment of infertility problems[,]" the plaintiff's discrimination claim was properly dismissed as a matter of law. *Id.* The same analysis applies to the exclusion of some hearing aids and related services at issue here.

Appellants' attempts to distinguish *Krauel* are not availing. Neither *Olmstead* nor the plain language of ACA § 1557 altered the pre-existing law under RA §504 that even-handed insurance benefit designs do not discriminate if they are equally applied to a particular group of disabled persons and others, even if the disabled group is disparately impacted because of their unique needs. Nor is the medical condition of infertility, at issue in *Krauel*, substantively different than "hearing loss" because people with either condition may or may not be disabled. Finally, contrary to Appellants' argument, the *Krauel* decision's reference to the ADA's "safe harbor" was not part of and did not alter its analysis of what constitutes disability "discrimination." *See Esparza v. University Med. Ctr. Mgmt. Corp.*, 2017 U.S. Dist.

LEXIS 142944, *21 (E.D. La. Sept. 5, 2017) ("jurisprudence interpreting either [ADA] Title II or [RA] 504 is applicable to *both* Title II and 504") (emphasis in original), *citing Hainze v. Richards*, 207 F.3d 795, 799 (5th Cir. 2000).

The Ninth Circuit expressly adopted the reasoning of *Choate* and *Krauel* in a post-*Olmstead* case holding 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." *See Weyer*, *supra*, 198 F.3d at 1116–18; *Doe*, *supra*, 179 F.3d 557 (refusing to cover person with AIDS for a broken leg is discriminatory, while offering insurance policies that contain caps for various diseases some of which may also be disabilities with the meaning of the ADA is not). Consistent with *Choate* and its progeny, ACA §1557 does not mandate coverage for services just because they could have a disproportionate impact on individuals with a particular disability, as long as the service is excluded for all. *See SEPTA*, 102 F. Supp. 3d at 700.

e. ACA § 1557 Does Not Mandate that Insurers Guarantee Equal Results for Disabled Persons.

Relying on *Choate*, this Court has held that Title II of the ADA covers discrimination as a result of facially neutral state laws that deny disabled persons "meaningful access" to state services. *Crowder v. Kitagawa*, 81 F.3d 1480, 1483-85 (9th Cir. 1996) (State of Hawaii's requirement that carnivorous animals entering the state be quarantined for 120 days discriminated against visually impaired people

who rely on guide dogs, in violation of the ADA). The Court adopted *Choate*'s "meaningful access" standard, and held that the state's quarantine requirement discriminated against disabled persons who needed guide dogs because it denied them meaningful access to *other* state services, programs and activities *that the state provides to everyone*. *Crowder*, 81 F.3d at 1485. Specifically, the Court reasoned that without their guide dogs, the plaintiffs were effectively precluded from using "a variety of public services, such as public transportation, public parks, government buildings and facilities, and tourist attractions[.]" *Id.*

Crowder does not support Appellants. The underlying premise of *Crowder* is that discrimination was present because the state's services and programs were available to the non-disabled while effectively not available to the blind whose guide dogs are quarantined. No logical comparison can be made to the instant case since none of the benefits Appellants desire are available to the non-disabled. Appellants do not seek removal of a barrier in order to partake of the benefits offered by the Plans. Rather, they seek "health care precisely tailored to [a disabled person's] particular needs," something the Supreme Court expressly held is not required. *See Choate*, 469 U.S. at 302. Under RA § 504 and ACA§ 1557, the disabled are entitled to meaningful access only to a "benefit that the grantee offers." *Choate*, 469 U.S. at 301; *In re Express Scripts/Anthem ERISA Litig.*, 285 F. Supp. 3d 655, 687 (S.D.N.Y. 2018). Further, Appellants have medical needs other than hearing loss services and

have full access to all plan benefits for those services just like everyone else, in contrast to *Crowder*, where taking away a blind person's guide dog effectively denies them all access.

Under long-standing discrimination principles, insurers are required only to make the programs or services that they choose to offer equally available to the disabled and non-disabled alike. *Id*. That is exactly what the Kaiser Plans do. Appellants are covered for the same inpatient treatments, durable medical equipment, and other services as everyone else under the Plans. There is no authority to support Appellants' underlying belief that the disabled are entitled to coverage for every treatment or service to make insurance "equally effective" for everyone. Appellants' Brief, p. 37.

Appellants apparently concede, as they must, that the Kaiser Plans would not be considered "discriminatory" under RA § 504 or the ADA. Nothing in the language of the ACA, its implementing regulations, or any other authority supports the dramatic change in discrimination law that Appellants seek. This Court should affirm the District Court's ruling that Appellants failed to state a cognizable disparate impact claim.

I. Appellants' Theory Would Have an Enormous Impact on the Health Insurance Industry that Congress Did Not Intend.

Appellants argue that because hearing aids are a device that could benefit the hearing disabled, the ACA requires the device and related services to be covered. If

adopted, Appellants' proposed new legal standard for disability discrimination would have a significant and far-reaching impact on the nation's health insurance industry. According to the Center for Hearing and Communications, 48 million Americans have significant hearing loss. ER 245:21–22.[12] Even though the ACA does NOT require hearing aids to be covered as Essential Health Benefits under health plans, every federally-funded health insurer would need to immediately amend its health plans and policies to cover hearing aids and related services, and by extension, all other services and equipment that might treat any other potentially disabling conditions. The financial impact would be enormous, a result that DHHS expressly never envisioned:

> 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 . . . .**
>
> For the most part, because this regulation is consistent with existing standards applicable to the covered entities, the new burdens created by its issuance are minimal. . . . **The final rule does not include broad expansions of existing civil rights requirements on covered entities,** and therefore minimizes the imposition of new burdens.

[12] *See* http://chchearing.org/facts-about-hearing-loss.

81 Fed. Reg. at 31446, 31464 (emphasis added).

Appellants' theory, if adopted, would apply not only to all hearing aids and related services, but all medical treatments and services that could benefit people with any disability. As a court in a similar ACA § 1557 case explained:

> Plaintiffs' definition of these services is overly broad, and in turn, would require insurers to offer coverage for all doctor's appointments or all durable medical devices regardless of the health condition, injury or illness. This result would not be the type of "reasonable modification" contemplated by *Alexander* and there is nothing in the statute or its legislative history to suggest that this type of expansion was Congress' intent when enacting the ACA.

E.S., *supra*, 2018 U.S. Dist. LEXIS at *7.

If Congress had intended such a radical expansion of benefit mandates under the guise of "new" disability discrimination protections, it would have drafted the ACA to distinguish the well-established limits of discrimination under RA § 504 and the ACA. The expansion of discrimination standards would also have been the subject of vigorous national debate for years. Instead, the statute, the regulations and the caselaw are consistent: ACA § 1557 simply incorporates RA § 504 and exactly mimics its discrimination prohibitions.

VI. CONCLUSION

Appellants are not treated differently than any other Kaiser Plan participants because of their alleged disabilities. The benefits that the Kaiser Plans cover are equally applied to all, regardless of any disability. Under the case law interpreting

RA § 504 and the ADA, which existed when the ACA was enacted, the Kaiser Plans' exclusion is not discriminatory. There is nothing in the ACA, the regulations, or case law to support Appellants' claim that ACA § 1557 adopted a radical, new standard for disability discrimination in contracts of insurance. The district court's decision to dismiss Appellants' Second Amended Complaint for failure to state a claim under Fed. R. Civ. P. 12(b)(6) should be affirmed.

Respectfully submitted this 21st day of March, 2019.

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FOR THE NINTH CIRCUIT

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CERTIFICATE OF SERVICE

I, Medora A. Marisseau, 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 electronically filed the foregoing Appellees' Brief with the Clerk of the Court and caused it to be served upon the below counsel of record using the CM/ECF system.

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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.

Dated this 21st day of March, 2019, at Seattle, Washington.

/s/ Medora A. Marisseau
Medora A. Marisseau, WSBA #23114

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ADDENDUM A

FEDERAL REGISTER

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Part IV

Department of Health and Human Services

Office of the Secretary

45 CFR Part 92

Nondiscrimination in Health Programs and Activities; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

45 CFR Part 92

RIN 0945–AA02

Nondiscrimination in Health Programs and Activities

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 discrimination on the basis of sex in health programs other than those provided by educational institutions and the prohibition of various forms of discrimination in health programs administered by the Department of Health and Human Services (HHS or the Department) and entities established under Title I of the ACA. In addition, the Secretary is authorized to prescribe the Department's governance, conduct, and performance of its business, including, here, how HHS will apply the standards of Section 1557 to HHS-administered health programs and activities.

DATES: *Effective Date:* This rule is effective July 18, 2016.

Applicability Dates: The provisions of this rule are generally applicable on the date the rule is effective, except 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.

FOR FURTHER INFORMATION CONTACT: Eileen Hanrahan at (800) 368–1019 or (800) 537–7697 (TDD).

SUPPLEMENTARY INFORMATION:

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This **Federal Register** document is also available from the **Federal Register** online database through *Federal Digital System (FDsys),* a service of the U.S. Government Printing Office. This database can be accessed via the Internet at *http://www.gpo.gov/fdsys.*

I. Background

Section 1557 of the ACA provides that an individual shall not, on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (Title VI), 42 U.S.C. 2000d *et seq.* (race, color, national origin), Title IX of the Education Amendments of 1972 (Title IX), 20 U.S.C. 1681 *et seq.* (sex), the Age Discrimination Act of 1975 (Age Act), 42 U.S.C. 6101 *et seq.* (age), or Section 504 of the Rehabilitation Act of 1973 (Section 504), 29 U.S.C. 794 (disability), 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, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the Act or its amendments. Section 1557 states that the enforcement mechanisms provided for and available under Title VI, Title IX, Section 504, or the Age Act shall apply for purposes of addressing violations of Section 1557.

Section 1557(c) of the ACA authorizes the Secretary of the Department to promulgate regulations to implement the nondiscrimination requirements of Section 1557. In addition, the Secretary is authorized to prescribe regulations for the Department's governance, conduct, and performance of its business, including how HHS applies the standards of Section 1557 to HHS-administered health programs and activities.[1]

A. Regulatory History

On August 1, 2013, the Office for Civil Rights of the Department (OCR) published a Request for Information (RFI) in the **Federal Register** to solicit information on issues arising under Section 1557. OCR received 402 comments; one-quarter (99) were from organizational commenters, with the remainder from individuals.

On September 8, 2015, OCR issued a proposed rule, "Nondiscrimination in Health Programs and Activities," in the **Federal Register**, and invited comment on the proposed rule by all interested parties.[2] The comment period ended on November 9, 2015. In total, we received approximately 24,875 comments on the proposed rule. Comments came from a wide variety of stakeholders, including, but not limited to: Civil rights/advocacy groups, including language access organizations, disability rights organizations, women's organizations, and organizations serving lesbian, gay, bisexual, or transgender (LGBT) individuals; health care providers; consumer groups; religious organizations; academic and research institutions; reproductive health organizations; health plan organizations; health insurance issuers; State and local agencies; and tribal organizations. Of the total comments, 23,344 comments were from individuals. The great majority of those comments were letters from individuals that were part of mass mail campaigns organized by civil rights/advocacy groups.

B. Overview of the Final Rule

This final rule adopts the same structure and framework as the proposed rule: Subpart A sets forth the rule's general provisions; Subpart B contains the rule's nondiscrimination provisions; Subpart C describes specific applications of the prohibition on discrimination to health programs and activities; and Subpart D describes the procedures that apply to enforcement of the rule.

OCR has made some changes to the proposed rule's provisions, based on the comments we received. Among the significant changes are the following.

Section 92.4 now provides a definition of the term "national origin."

OCR decided against including a blanket religious exemption in the final rule; however, the final rule includes a provision noting that insofar as application of any requirement under the rule would violate applicable Federal statutory protections for religious freedom and conscience, such application would not be required.

OCR has modified the notice requirement in § 92.8 to exclude publications and significant communications that are small in size from the requirement to post all of the content specified in § 92.8; instead, covered entities will be required to post only a shorter nondiscrimination statement in such communications and publications, along with a limited number of taglines. OCR also is translating a sample nondiscrimination statement that covered entities may use in fulfilling this obligation. It will be available by the effective date of this rule.

In addition, with respect to the obligation in § 92.8 to post taglines in at least the top 15 languages spoken nationally by persons with limited English proficiency, OCR has replaced the national threshold with a threshold

[1] 5 U.S.C. 301.

[2] 80 FR 54172 (Sept. 8, 2015).

is inappropriate to define requirements under Federal law based on what could be the varying, and potentially changing, requirements of different States' approaches. As to other Federal laws, OCR will give consideration to an entity's compliance with the requirements of other Federal laws where those requirements overlap with Section 1557. In such cases, OCR will work closely with covered entities where compliance with this final rule requires additional steps. But in the final analysis, OCR must, in its capacity as the lead enforcement agency for Section 1557, maintain the discretion to evaluate an entity's compliance with the standards set by the final rule. This is consistent with the approach taken by other agencies to civil rights obligations, in which compliance with one set of requirements, adopted under different laws or for different purposes, is not considered automatic compliance with civil rights obligations.

Subpart A—General Provisions

Purpose and Effective Date (§ 92.1)

In § 92.1, we proposed that the purpose of this part is to implement Section 1557 of the ACA, which prohibits discrimination in certain health programs and activities on the grounds prohibited under Title VI, Title IX, the Age Act, and Section 504, which together prohibit discrimination on the basis of race, color, national 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.

In paragraph (b)(1), we proposed to incorporate the exclusions found in the Age Act, such that the provisions of the proposed rule would not apply to any age distinction contained in that part of a Federal, State, or local statute or ordinance adopted by an elected, general purpose legislative body which provides any benefits or assistance to persons based on age, establishes criteria for participation in age-related terms, or describes intended beneficiaries to target groups in age-related terms.[4] We requested comment on whether the exemptions found in Title IX and its implementing regulation should be incorporated into the final rule. We noted that unlike the Age Act, Section 504, and Title VI, which apply to all programs and activities that receive Federal financial assistance (including health programs and activities), Title IX applies only in the context of education programs and not to the majority of the health programs and activities subject to the proposed rule. In addition, we noted that many of Title IX's limitations and exceptions do not readily apply in a context that is grounded in health care, rather than education.

We invited comment on whether the regulation should include any specific exemptions for health service providers, health plans, or other covered entities with respect to requirements of the proposed rule related to sex discrimination. We stated that we wanted to ensure that the proposed rule had the proper scope and appropriately protected sincerely held religious beliefs to the extent that those beliefs may conflict with provisions of the proposed regulation. We noted that certain protections already exist with respect to religious beliefs, particularly with respect to the provision of certain health-related services; for example, we noted that the proposed rule would not displace the protections afforded by provider conscience laws,[5] the Religious Freedom Restoration Act (RFRA),[6] provisions in the ACA related to abortion services,[7] or regulations issued

[4] *See* 42 U.S.C. 6103(b).

[5] *See, e.g.*, 42 U.S.C. 300a–7; 42 U.S.C. 238n; Consolidated and Further Continuing Appropriations Act 2015, Public Law 114–53, Div. G, § 507(d) (Dec. 16, 2015).

[6] 42 U.S.C. 2000bb–1.

[7] *See, e.g.*, 42 U.S.C. 18023.

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.

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 and conditions under the plan or coverage for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender.

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.[228] However, such across-the-board categorization is now recognized as outdated and not based on current standards of care.[229]

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.

Moreover, we proposed in § 92.207(b)(5) to bar a covered entity from denying or limiting coverage, or denying a claim for coverage, for specific health services related to gender transition where such a denial or limitation results in discrimination against a transgender individual. In evaluating whether it is discriminatory to deny or limit a request for coverage for a particular service for an individual seeking the service as part of transition-related care, we provided that OCR will start by inquiring whether and to what extent coverage is available when the same service is not related to gender transition. If, for example, an issuer or State Medicaid agency denies a claim for coverage for a hysterectomy that a patient's provider says is medically necessary to treat gender dysphoria, OCR will evaluate the extent of the covered entity's coverage policy for hysterectomies under other circumstances. We noted that OCR will also carefully scrutinize whether the covered entity's explanation for the denial or limitation of coverage for transition-related care is legitimate and not a pretext for discrimination.

We noted that these provisions do not, however, affirmatively require covered entities to cover any particular procedure or treatment for transition-related care; nor do they preclude a covered entity from applying neutral standards that govern the circumstances in which it will offer coverage to all its enrollees in a nondiscriminatory manner.

We invited comment as to whether the approach of § 92.207(b)(1)–(5) is over- or underinclusive of the types of potentially discriminatory claims denials experienced by transgender individuals in their attempts to access coverage and care, as well as on how nondiscrimination principles apply in this context.

Paragraph (c) of § 92.207 of the proposed rule provided that 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. Paragraph (d) of the proposed rule provided that nothing in § 92.207 is intended to determine, or restrict a covered entity from determining, whether a particular health care service is medically necessary or otherwise meets applicable coverage requirements in any individual case.

The comments and our responses regarding § 92.207 are set forth below.

Comment: Numerous commenters requested clarification regarding the rule's applicability to various health programs or activities that are regulated under other Federal requirements and recommended that OCR deem health programs and activities that comply with existing Federal regulations as in compliance with, or exempt from, Section 1557. For example, commenters requested that compliance with CMS regulations pertaining to qualified health plans or insurance benefit design, such as prescription drug formularies designed by a pharmacy and therapeutics committee,[230] be deemed compliance with the final rule. Numerous commenters also requested that OCR harmonize its language access requirements with existing CMS regulations. This is addressed in the discussion of § 92.201.

In addition, other commenters sought clarification as to the applicability of the rule to wellness programs[231] and value-based insurance designs[232] that are regulated by other Federal departments and agencies, and similarly requested that compliance with other Federal laws regarding these programs be deemed compliance with this final rule. Conversely, regarding employer

[227] We note that under § 92.207(a), a covered entity would be barred from denying coverage of any claim (not just sex-specific surgeries) on the basis that the enrollee is a transgender individual.

[228] Liza Khan, *Transgender Health at the Crossroads,* 11 Yale J. Health Pol'y L. & Ethics 375, 393 (2011).

[229] *See infra* note 263. *See also* discussion in the proposed rule at 80 FR at 54189–90.

[230] 45 CFR 156.122(a)(3) (for plan years beginning on or after Jan. 1, 2017).

[231] U.S. Dep't of the Treasury, U.S. Dep't of Labor, and U.S. Dep't of Health & Human Servs., Incentives for Nondiscriminatory Wellness Programs in Group Health Plans (Final Rule), 78 FR 33158 (June 3, 2013).

[232] For a discussion of Value-Based Insurance Design, see Affordable Care Act Implementation FAQs Set 5, Q1, *http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html* (last visited May 4, 2016); U.S. Dep't of the Treasury, Dep't of Labor, and U.S. Dep't of Health & Human Servs., Coverage of Certain Preventive Services Under the Affordable Care Act, Final Rule, 80 FR 41318, 41321 (July 1, 2015); and U.S. Dep't of Health & Human Servs., Center for Medicare & Medicaid Servs., Medicare Advantage Value-Based Insurance Design Model (Sept. 1, 2015), *https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-01.html.*

Federal statute [251] with offering FEHB plans as a fringe benefit of Federal employment and, in that role, approves benefit designs and premium rates, sets rules generally applicable to FEHB carriers, adjudicates and orders payment of disputed health claims, and adjusts policies as necessary to ensure compliance with nondiscrimination standards. As a result, OCR will refer to OPM complaints that allege discrimination in the FEHB Program where OPM is the entity with decision-making authority over the challenged action; OPM will treat these claims as complaints filed against OPM and will seek relief comparable to that available were these claims to be processed by OCR under Section 1557.

In response to the comments requesting additional clarification on footnote 73 in the proposed rule, we reiterate that we will engage in a case-by-case inquiry to evaluate whether a third party administrator is appropriately subject to Section 1557 as a recipient in situations in which the third party administrator is legally separate from an issuer that receives Federal financial assistance for its insurance plans. This analysis will rely on principles developed in longstanding civil rights case law, such as the degree of common ownership and control between the two entities,[252] and will also examine whether the purpose of the legal separation is a subterfuge for discrimination—that is, intended to allow the entity to continue to administer discriminatory health-related insurance or other health-related coverage.[253] But we note that a third party administrator is unlikely to be covered by this final rule where it is a legal entity that is truly independent of an issuer's other, federally funded, activities.

Comment: Commenters requested clarification on OCR's approach when evaluating whether a prohibited discriminatory action occurred under § 92.207(b).

Response: We clarify that OCR's approach in applying basic nondiscrimination principles, as discussed in the proposed rule under § 92.207(b)(5) [254] relating to coverage for specific health services related to gender transition, is the same general approach that OCR will take when evaluating denials or limitations of coverage for other types of health services. In other words, OCR will evaluate whether a covered entity utilized, in a nondiscriminatory manner, a neutral rule or principle when deciding to adopt the design feature or take the challenged action or whether the reason for its coverage decision is a pretext for discrimination. For example, if a plan limits or denies coverage for certain services or treatment for a specific condition, OCR will evaluate whether coverage for the same or a similar service or treatment is available to individuals outside of that protected class or those with different health conditions and will evaluate the reasons for any differences in coverage. Covered entities will be expected to provide a neutral, nondiscriminatory reason for the denial or limitation that is not a pretext for discrimination.

Comment: One commenter asked OCR to clarify that targeted marketing practices designed to reach certain populations to increase enrollment, such as specific segments of those who are uninsured or underserved, are not considered discriminatory. This commenter pointed out that some issuers sometimes launch targeted campaigns to reach a high number of uninsured in their service areas. In so doing, issuers may study the profile of uninsured populations, and based on the results of that study, may concentrate their marketing efforts on certain demographic groups that are disproportionately uninsured or underserved. The commenter cited a Gallup Poll that indicated that roughly one-third of Hispanics remain uninsured, which the commenter stated creates a particular need for issuers to help educate and expand coverage for this community. The commenter sought reassurance that OCR will not consider it discriminatory to target enrollment efforts where they will make the most difference.

Response: Congress intended the ACA to help uninsured and underserved populations gain access to care. Nothing in this regulation is intended to limit targeted outreach efforts to reach underserved racial or ethnic populations or other underserved populations. Indeed, it is OCR's intention that this regulation will increase access for uninsured and underserved populations, much as other Departmental regulations implementing the ACA have strived to do.[255]

Comment: Several commenters recommended that we define "marketing practices" in the regulatory text of § 92.207(b)(2). These commenters suggested that the inclusion of a precise definition for "marketing practices" would serve to clarify the scope of § 92.207(b)(2).

Response: We decline to define "marketing practices" in the final rule because to do so would be overly prescriptive. We emphasize, however, that we intend to interpret the term "marketing practices" broadly; such practices would include, for example, any activity of a covered entity that is designed to encourage individuals to participate or enroll in the covered entity's programs or services or to discourage them from doing so, and activities that steer or attempt to steer individuals towards or away from a particular plan or certain types of plans. We remind covered entities that other Departmental regulations address marketing practices,[256] and covered entities are obligated to comply with all applicable Federal and State laws regarding such practices.

Comment: Many commenters recommended that we define "benefit design" in the regulatory text of the final rule. These commenters suggested that the inclusion of a precise definition of "benefit design" would serve to clarify the scope of § 92.207(b)(2). In addition, numerous commenters requested that we codify or provide examples of benefit designs that discriminate on the basis of race, color, national origin, sex, age, or disability. A number of commenters urged OCR to consider specific types of benefit designs as constituting per se discrimination under § 92.207(b)(2) of the final rule.

Response: We appreciate commenters' requests for guidance and clarification regarding potentially discriminatory benefit designs and suggestions for scenarios that constitute per se discrimination. However, we decline to

[251] 5 U.S.C. 8901 *et seq.*

[252] *See, e.g., Papa* v. *Katy Indus., Inc.*, 166 F.3d 937, 939 (7th Cir. 1999), *cert. denied*, 528 U.S. 1019 (1999) (ADA, ADEA); *Arrowsmith* v. *Shelbourne, Inc.*, 69 F.3d 1235, 1240–42 (2d Cir. 1995) (Title VII).

[253] *Papa* v. *Katy Indus., Inc.*, 166 F.3d at 941.

[254] 80 FR at 54190.

[255] *See, e.g.*, 45 CFR 155.210(b)(2)(i) (requiring Exchanges to develop and publically disseminate Navigator training standards that ensures expertise in the needs of underserved and vulnerable populations); 81 FR 12204, 12338 (Mar. 8, 2016) (establishing new requirement at 45 CFR 155.210(e)(8) to require Navigators to provide targeted assistance to serve underserved or vulnerable populations).

[256] 45 CFR 156.225(b) (prohibiting qualified health plans from employing marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs); 45 CFR 147.104(e) (prohibiting a health insurance issuer from employing marketing practices or benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions); 42 CFR 422.2260–422.2615 (establishing Part D marketing requirements).

define "benefit design" in the final rule because to do so would be overly prescriptive.[257] We also decline to codify examples of discriminatory benefit designs because determining whether a particular benefit design results in discrimination will be a fact-specific inquiry that OCR will conduct through its enforcement of Section 1557. For the same reason, we avoid characterizing specific benefit design practices as per se discriminatory in the final rule.[258]

OCR will analyze whether a design feature is discriminatory on a case-by-case basis using the framework discussed above. We reiterate that our determination of whether a practice constitutes discrimination will depend on our careful analysis of the facts and circumstances of a given scenario. 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.

Comment: We received a number of comments requesting that OCR add language to § 92.207(b) clarifying that categorical exclusions of certain conditions, such as coverage related to developmental disabilities or maternity care, are prohibited.

Response: While categorical exclusions of all coverage related to certain conditions could raise significant compliance concerns under Section 1557, OCR believes that existing regulatory language is sufficient to address this scenario. For example, the law has long recognized that discrimination based on pregnancy is a form of sex discrimination,[259] and OCR has interpreted Section 1557 in the same manner by defining the term "on the basis of sex" in this regulation to include "discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions." As a result, it is unnecessary to add language in response to commenters' concerns.

We note that some products known as excepted benefits, which are subject to this final rule as discussed *supra,* provide limited scope benefits or coverage only for a specified disease or illness.[260] It would not be discriminatory for such products to include exclusions of coverage for conditions that are outside the scope of the benefits provided in those products. Accordingly, the purpose and scope of the coverage provided under health-related insurance or health-related coverage are factors that OCR will consider in determining whether an exclusion of all coverage for a certain condition is discriminatory under this final rule.

Comment: In light of OCR's statement in the preamble to the proposed rule that "[t]he proposed rule does not require plans to cover any particular benefit or service, but a covered entity cannot have a coverage policy that operates in a discriminatory manner," [261] a few commenters asked OCR to clarify that the solution to a potentially discriminatory benefit design could be addition of coverage for a benefit or service.

Response: OCR agrees that the solution to a potentially discriminatory benefit design could be coverage, or added coverage, of a benefit or service.

Comment: The proposed rule invited comment as to whether the approach of § 92.207(b)(1)–(5) is over- or under-inclusive of the types of potentially discriminatory claim denials experienced by transgender individuals in their attempts to access coverage and care, as well as on how nondiscrimination principles apply in this context.[262] Many commenters supported OCR's approach in prohibiting a range of practices that discriminate against transgender individuals by denying or limiting coverage for medically necessary and medically appropriate health services. Numerous commenters asserted that the protections at § 92.207(b)(3)–(5) are vital to ensuring that transgender individuals are able to access the health coverage and care they need and urged OCR to preserve these provisions in the final rule.

For instance, many commenters strongly supported the proposed rule's prohibition against categorical or automatic exclusions of coverage for all health services related to gender transition. These commenters further supported the proposed rule's prohibition against otherwise denying or limiting coverage, or denying a claim, for health services related to gender transition if such a denial or limitation results in discrimination against a transgender individual. These commenters expressed hope that these prohibitions will serve to eliminate the significant barriers that transgender individuals have faced in accessing coverage for transition-related care, such as counseling, hormone therapy, and surgical procedures that they said had previously been denied to them because they have been viewed as cosmetic or experimental. Many commenters also favored the prohibition against denying, limiting, or otherwise restricting coverage for health services that are ordinarily or exclusively available to individuals of one sex based on an individual's gender identity. Commenters indicated that the proposed rule's protections will help to resolve various health care disparities suffered by transgender individuals.

Several commenters, however, opposed the protections that the proposed rule affords to transgender individuals. Some commenters suggested that covered entities should

[257] We note that "benefit design" is a term of art used in other Departmental and Federal regulations governing the private health insurance industry. *See e.g.,* 42 CFR 422.100(f)(3); 45 CFR 156.225(b); 45 CFR 147.104(e); 29 CFR 2510.3–40(c)(1)(iv)(A).

[258] CMS has identified benefit design features that might be discriminatory. For example, placing most or all prescription medications that are used to treat a specific condition on the highest cost formulary tiers (U.S. Dep't of Health & Human Servs., Centers for Medicare & Medicare Servs., Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters Rule, (Final Rule), 80 FR 10750, 10822 (Feb. 27, 2015); U.S. Dep't of Health & Human Servs., Centers for Medicare and Medicaid Servs., Final 2016 Letter to Issuers in the Federally-facilitated Marketplace, 37 (Feb. 20, 2015)); applying age limits to services that have been found clinically effective at all ages (80 FR at 10822 (Feb. 27, 2015); Final 2016 Letter to Issuers in the Federally-facilitated Marketplace, 36–37 (Feb. 20, 2015)); and requiring prior authorization and/or step therapy for most or all medications in drug classes such as anti-HIV protease inhibitors, and/or immune suppressants regardless of medical evidence (Centers for Medicare and Medicaid Servs., Qualified Health Plan Master Review Tool, Non-Discrimination in Benefit Design (2017), *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Master-Review-Tool_v1-1_03302016.zip* (open "Master Review Tool_2017v1.0.xlsm" document; then open "Non-Discrimination Guidance" tab)).

[259] Title VII prohibits discrimination in employment practices "because of sex," 42 U.S.C. 2000e–2(a), which is defined to include "because of or on the basis of pregnancy, childbirth, or related medical conditions. . . ." 42 U.S.C. 2000e(k); *Newport News Shipbuilding & Dry Dock Co.* v. *EEOC,* 462 U.S. 669, 684 (1983) ("discrimination based on a woman's pregnancy is, on its face, discrimination because of her sex.").

[260] 42 U.S.C. 300gg–91(c).

[261] 80 FR at 54189.

[262] 80 FR at 54191.

be permitted to categorically exclude coverage for transition-related health services based on moral or religious convictions that an individual's biological sex, or sex assigned at birth, should not be altered. Other commenters suggested that OCR is exceeding its legal authority by addressing covered entities' provision of coverage to transgender individuals 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 medically necessary or appropriate, it must apply the same standards to its coverage of comparable procedures related to gender transition. As a result, we decline to limit application of the rule by specifying that coverage for the health services addressed in § 92.207(b)(3)–(5) must be provided *only* when the services are medically necessary or medically appropriate.

With regard to § 92.207(b)(3), we recognize that not every health service that is typically or exclusively provided to individuals of one sex will be a health service that is appropriately provided to a transgender individual. Nothing in the rule would, for example, require an issuer to cover a traditional prostate exam for an individual who does not have a prostate, regardless of that individual's gender identity. However, the issuer must cover the health services that are appropriately provided to an individual by applying the same terms and conditions, regardless of an individual's sex assigned at birth, gender identity, or recorded gender.

We also clarify that the prohibition in § 92.207(b)(4) on categorically limiting coverage for all health services related to gender transition is intended to prevent issuers from placing categorical, arbitrary limitations or restrictions on coverage for all gender transition-related services, such as by singling out services related to gender transition for higher co-pays; it is not intended to prevent issuers from placing nondiscriminatory limitations or restrictions on coverage under the plan. We have revised the language of the provision to clarify that intent.

Comment: Some commenters requested that the final rule define "health services related to gender transition."

Response: We decline to include a definition of "health services related to gender transition." OCR intends to interpret these services broadly and recognizes that health services related to gender transition may change as standards of medical care continue to evolve.

The range of transition-related services, which includes treatment for gender dysphoria, is not limited to surgical treatments and may include, but is not limited to, services such as

[263] 80 FR at 54189 *See e.g.*, World Professional Association for Transgender Health (WPATH), *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (7th ed. 2011), *http://www.wpath.org/uploaded_files/140/files/* Standards Of Care, V7 Full Book.pdf; Institute of Medicine of the National Academies, *The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding (2011); www.nationalacademies.org/hmd/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx. See also* U.S. Dep't of Health & Human Servs., Departmental Appeals Bd., Appellate Division NCD 140.3, Docket No. A–13–87, Decision No. 2576, 22–24 (May 30, 2014), *http://www.hhs.gov/dab/decisions/dabdecisions/dab2576.pdf.*

[264] *See supra* discussion of the definition "on the basis of sex" under § 92.4.

[265] *See supra* discussion on including a religious exemption under § 92.2.

agencies that fund a variety of health programs in which physicians participate and thus come under Section 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, gender identity, sexual orientation, age, or disability. Thus, we note that the impact of Section 1557 on these entities is limited.

We received a few comments that indicated that the costs of compliance may be more than anticipated in the proposed rule. We have revised the analysis in this final rule based upon the comments and upon an updated statistical review of the health programs and activities.

The following regulatory analysis examines the costs and benefits that are attributable to this regulation only.

We first analyze the costs we expect the final rule to create for covered entities. We anticipate that the final rule will place costs on the covered entities in the areas of: (1) Training and familiarization, (2) enforcement, (3) posting of the nondiscrimination notice and taglines, and (4) revisions in policies and procedures, and may place costs on covered entities in the voluntary area of development of a language access plan. Then we examine the potential benefits the rule is likely to produce. In the subsequent analyses of costs in this RIA and the Regulatory Flexibility Act (RFA), we use data sets from the Census Bureau[314] and BLS[315] for estimating burdens.

A. Assumptions

In the proposed rule, we made the following cost assessment based on certain key assumptions, which include: (1) We assume that promulgation of this regulation will trigger voluntary activity on the part of covered entities that would not have occurred absent the promulgation of the regulation—which generates both costs and corresponding benefits; (2) to the extent that certain actions are required under the final rule where the same actions are already required by prior existing civil rights regulations, we assume that the actions are already taking place and thus that they are not a burden imposed by the rule; (3) although the regulation does not require training at any specific time, we assume that covered entities may voluntarily provide one-time training to some employees on the requirements of the regulation at the time that the regulation is published; and (4) we assume that employers are most likely to train employees who interact with the public and will therefore likely train between 40% and 60% of their employees, as the percentage of employees that interact with patients and the public varies by covered entity. For purposes of the analysis, we assume that 50% of the covered entity's staff will receive one-time training on the requirements of the regulation. We use the 50% estimate as a proxy, given the lack of certain information as described below. For the purposes of the analysis, we do not distinguish between employees whom covered entities will train and those who obtain training independently of a covered entity.

B. Training and Familiarization

In the proposed rule, we counted the cost of training on all aspects of the

[313] The Area Health Resource File itself double counts physicians who are licensed in more than one state. *See infra* discussion below at II.C.1.a.

[314] U.S. Census Bureau, Statistics of U.S. Businesses, *http://www.census.gov/econ/susb/* (last visited May 3, 2016).

[315] U.S. Dep't of Labor, Bureau of Labor Statistics, May 2015 National Occupational Employment and Wage Estimates, *http://www.bls.gov/oes/2014/may/oes_nat.htm (last visited May 3, 2016).*

Unfortunately, we cannot use the Census revenue data for estimating the number of small health insurance issuers because the Census data combines life and health insurance. Substituting costs for revenues allows us to obtain a rough estimate of the number of large insurance issuers, realizing that cost will probably be less than revenues, thus giving us a lower count of large issuers. Using the National Health Expenditure for 2013, net cost of health insurance equaled $173.6 billion. However, the 2012 Census data report a total of 815 health insurance issuers. Dividing the $174 billion in costs by the number of insurance issuers reported in the census tables yields average costs of over $213 million, which means that average annual revenues per issuer exceeds $213 million. We concluded, therefore, that there are almost no small insurance issuers. The above analysis comports with the conclusion CMS published in the Health Insurance Web Portal Requirements.[387]

4. Local Government Entities

We also excluded local governmental entities from our count of small entities because we lack the data to classify them by populations of fewer than 50,000. The following table shows the number of small covered entities we estimated could be affected by the proposed rule.

TABLE 6—SMALL COVERED ENTITIES

NAIC	Entity type	Number of firms
62142	Outpatient mental health and substance abuse centers	4,987
62141	HMO medical centers	104
62142	Kidney dialysis centers	492
62143	Freestanding ambulatory surgical and emergency centers	4,121
621498	All other outpatient care centers	5,399
6215	Medical and diagnostic laboratories	7,958
6216	Home health care services	21,668
6219	All other ambulatory health care services	6,956
62321	Residential mental retardation facilities	6,225
62199	General medical and surgical hospitals	3,067
621991	Psychiatric and substance abuse hospitals	411
6221	Specialty (except psychiatric and substance abuse) hospitals	373
6231	Nursing care facilities (skilled nursing facilities)	8,623
44611	Pharmacies and drug stores	16,520
6211	Offices of physicians	167,814
	Navigator grantees	100
	Total small entities	254,998

B. Whether the Rule Will Have a Significant Economic Impact on Covered Small Entities

Total undiscounted costs associated with the final rule are an average of $189 million per year over a five year period. If all of those costs are borne by small entities, this amounts to an average of $739 each year over that five year period. As a result, we believe that fewer than 5% of all small entities will experience a burden of greater than 3% of their revenues. Ambulatory health care services facilities (North American Industry Classification System 621), for example, are small entities with an average of 13 employees and revenue of $1.7 million based on 2012 reported data for employees of 6.4 million and total revenues of $825.7 million for 485,235 firms.[388] In addition, the majority of the costs associated with this final rule are proportional to the size of entities, meaning that even the smallest of the affected entities are unlikely to face a substantial impact. Thus, we would not consider this regulation a significant burden on a substantial number of small entities, and, therefore, the Secretary certifies that the final rule will not have a significant impact on a substantial number of small entities.

VIII. Conclusion

For the most part, because this regulation is consistent with existing standards applicable to the covered entities, the new burdens created by its issuance are minimal. The major impacts are in the areas of voluntary training, posting of notices, enforcement (where increased caseloads pose incremental costs on covered entities), voluntary development of language access plans, and revisions or development of new policies and procedures. The final rule does not include broad expansions of existing civil rights requirements on covered entities, and therefore minimizes the imposition of new burdens. Nevertheless, it is still a major rule with economically significant costs. The annualized cost of this rule over the first five years following its publication is $192.5 million using a discount rate of 3%, and $197.8 million using a discount rate of 7%. This RIA was organized and designed to explain the origin of these cost impacts and to incorporate relevant public comments.

[387] 75 CFR 24481, May 5, 2010.

[388] U.S. Dep't of Labor, Bureau of Labor Statistics, Industries at a Glance, *http://www.bls.gov/iag/tgs/iag621.htm* (last visited Mar. 26, 2016).

face and the participating individual's face regardless of the individual's body position;

(3) A clear, audible transmission of voices; and

(4) Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting.

(g) *Acceptance of language assistance services is not required.* Nothing in this section shall be construed to require an individual with limited English proficiency to accept language assistance services.

§ 92.202 Effective communication for individuals with disabilities.

(a) A covered entity shall take appropriate steps to ensure that communications with individuals with disabilities are as effective as communications with others in health programs and activities, in accordance with the standards found at 28 CFR 35.160 through 35.164. Where the regulatory provisions referenced in this section use the term "public entity," the term "covered entity" shall apply in its place.

(b) A recipient or State-based Marketplace℠ shall provide appropriate auxiliary aids and services to persons with impaired sensory, manual, or speaking skills, where necessary to afford such persons an equal opportunity to benefit from the service in question.

§ 92.203 Accessibility standards for buildings and facilities.

(a) Each facility or part of a facility in which health programs or activities are conducted that is constructed or altered by or on behalf of, or for the use of, a recipient or State-based Marketplace℠ shall comply with the 2010 Standards as defined in § 92.4, if the construction or alteration was commenced on or after July 18, 2016, except that if a facility or part of a facility in which health programs or activities are conducted that is constructed or altered by or on behalf of, or for the use of, a recipient or State-based Marketplace℠, was not covered by the 2010 Standards prior to July 18, 2016, such facility or part of a facility shall comply with the 2010 Standards, as defined in § 92.4, if the construction was commenced after January 18, 2018. Departures from particular technical and scoping requirements by the use of other methods are permitted where substantially equivalent or greater access to and usability of the facility is provided. All newly constructed or altered buildings or facilities subject to this section shall comply with the requirements for a "public building or facility" as defined in Section 106.5 of the 2010 Standards.

(b) Each facility or part of a facility in which health programs or activities are conducted that is constructed or altered by or on behalf of, or for the use of, a recipient or State-based Marketplace℠ in conformance with the 1991 Standards or the 2010 Standards as defined in § 92.4 shall be deemed to comply with the requirements of this section and with 45 CFR 84.23(a) and (b), cross-referenced in § 92.101(b)(2)(i) with respect to those facilities, if the construction or alteration was commenced on or before July 18, 2016. Each facility or part of a facility in which health programs or activities are conducted that is constructed or altered by or on behalf of, or for the use of, a recipient or State-based Marketplace℠ in conformance with the Uniform Federal Accessibility Standards as defined in § 92.4, shall be deemed to comply with the requirements of this section and with 45 CFR 84.23(a) and (b), cross-referenced in § 92.101(b)(2)(i) with respect to those facilities, if the construction was commenced before July 18, 2016 and such facility was not covered by the 1991 Standards or 2010 Standards.

§ 92.204 Accessibility of electronic and information technology.

(a) Covered entities shall ensure that their health programs or activities provided through electronic and information technology are accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burdens or a fundamental alteration in the nature of the health programs or activities. When undue financial and administrative burdens or a fundamental alteration exist, the covered entity shall provide information in a format other than an electronic format that would not result in such undue financial and administrative burdens or a fundamental alteration but would ensure, to the maximum extent possible, that individuals with disabilities receive the benefits or services of the health program or activity that are provided through electronic and information technology.

(b) Recipients and State-based Marketplaces shall ensure that their health programs and activities provided through Web sites comply with the requirements of Title II of the ADA.

§ 92.205 Requirement to make reasonable modifications.

A covered entity shall make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination on the basis of disability, unless the covered entity can demonstrate that making the modifications would fundamentally alter the nature of the health program or activity. For the purposes of this section, the term "reasonable modifications" shall be interpreted in a manner consistent with the term as set forth in the ADA Title II regulation at 28 CFR 35.130(b)(7).

§ 92.206 Equal program access on the basis of sex.

A covered entity shall provide individuals equal access to its health programs or activities without discrimination on the basis of sex; and a covered entity shall treat individuals consistent with their gender identity, except that a covered entity may not deny or limit health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the 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.

§ 92.207 Nondiscrimination in health-related insurance and other health-related coverage.

(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.

(d) Nothing in this section is intended to determine, or restrict a covered entity from determining, whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case.

§ 92.208 Employer liability for discrimination in employee health benefit programs.

A covered entity that provides an employee health benefit program to its employees and/or their dependents shall be liable for violations of this part in that employee health benefit program only when:

(a) The entity is principally engaged in providing or administering health services, health insurance coverage, or other health coverage;

(b) The entity receives Federal financial assistance a primary objective of which is to fund the entity's employee health benefit program; or

(c) The entity is not principally engaged in providing or administering health services, health insurance coverage, or other health coverage, but operates a health program or activity, which is not an employee health benefit program, that receives Federal financial assistance; except that the entity is liable under this part with regard to the provision or administration of employee health benefits only with respect to the employees in that health program or activity.

§ 92.209 Nondiscrimination on the basis of association.

A covered entity shall not exclude from participation in, deny the benefits of, or otherwise discriminate against an individual or entity in its health programs or activities on the basis of the race, color, national origin, sex, age, or disability of an individual with whom the individual or entity is known or believed to have a relationship or association.

Subpart D—Procedures

§ 92.301 Enforcement mechanisms.

(a) The enforcement mechanisms available for and provided under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, or the Age Discrimination Act of 1975 shall apply for purposes of Section 1557 as implemented by this part.

(b) Compensatory damages for violations of Section 1557 are available in appropriate administrative and judicial actions brought under this rule.

§ 92.302 Procedures for health programs and activities conducted by recipients and State-based Marketplaces.

(a) The procedural provisions applicable to Title VI apply with respect to administrative enforcement actions concerning discrimination on the basis of race, color, national, origin, sex, and disability discrimination under Section 1557 or this part. These procedures are found at §§ 80.6 through 80.11 of this subchapter and part 81 of this subchapter.

(b) The procedural provisions applicable to the Age Act apply with respect to enforcement actions concerning age discrimination under Section 1557 or this part. These procedures are found at §§ 91.41 through 91.50 of this subchapter.

(c) When a recipient fails to provide OCR with requested information in a timely, complete, and accurate manner, OCR may find noncompliance with Section 1557 and initiate appropriate enforcement procedures, including beginning the process for fund suspension or termination and taking other action authorized by law.

(d) An individual or entity may bring a civil action to challenge a violation of Section 1557 or this part in a United States District Court in which the recipient or State-based Marketplace SM is found or transacts business.

§ 92.303 Procedures for health programs and activities administered by the Department.

(a) This section applies to discrimination on the basis of race, color, national origin, sex, age, or disability in health programs or activities administered by the Department, including the Federally-facilitated Marketplaces.

(b) The procedural provisions applicable to Section 504 at §§ 85.61 through 85.62 of this subchapter shall apply with respect to enforcement actions against the Department concerning discrimination on the basis of race, color, national origin, sex, age, or disability under Section 1557 or this part. Where this section cross-references regulatory provisions that use the term "handicap," the term "race, color, national origin, sex, age, or disability" shall apply in its place.

(c) The Department shall permit access by OCR to its books, records, accounts, other sources of information, and facilities as may be pertinent to ascertain compliance with Section 1557 or this part. Where any information required of the Department is in the exclusive possession of any other agency, institution or individual, and the other agency, institution or individual shall fail or refuse to furnish this information, the Department shall so certify and shall set forth what efforts it has made to obtain the information. Asserted considerations of privacy or confidentiality may not operate to bar OCR from evaluating or seeking to enforce compliance with Section 1557 or this part. Information of a confidential nature obtained in connection with compliance evaluation or enforcement shall not be disclosed except where necessary under the law.

(d) The Department shall not intimidate, threaten, coerce, or discriminate against any individual for the purpose of interfering with any right or privilege secured by Section 1557 or this part, or because such individual has made a complaint, testified, assisted, or participated in any manner in an investigation, proceeding or hearing under Section 1557 or this part. The identity of complainants shall be kept confidential by OCR, except to the extent necessary to carry out the purposes of Section 1557 or this part.

Appendix A to Part 92—Sample Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Sample Nondiscrimination Statement: Discrimination is Against the Law

[Name of covered entity] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. [Name of covered entity] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

[Name of covered entity]:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:

ADDENDUM B

Questions and Answers about Deafness and Hearing Impairments in the Workplace and the Americans with Disabilities Act

INTRODUCTION

The Americans with Disabilities Act (ADA), which was amended by the Americans with Disabilities Act Amendments Act of 2008 ("Amendments Act" or "ADAAA"), is a federal law that prohibits discrimination against qualified individuals with disabilities. Individuals with disabilities include those who have impairments that substantially limit a major life activity, have a record (or history) of a substantially limiting impairment, or are regarded as having a disability.[1]

Title I of the ADA covers employment by private employers with 15 or more employees as well as state and local government employers. Section 501 of the Rehabilitation Act provides similar protections related to federal employment. In addition, most states have their own laws prohibiting employment discrimination on the basis of disability. Some of these state laws may apply to smaller employers and may provide protections in addition to those available under the ADA.[2]

The U.S. Equal Employment Opportunity Commission (EEOC) enforces the employment provisions of the ADA. This document, which is one of a series of question-and-answer documents addressing particular disabilities in the workplace,[3] explains how the ADA applies to job applicants and employees with hearing impairments. In particular, this document explains:

- when an employer may ask an applicant or employee questions about his hearing impairment and how it should treat voluntary disclosures;
- what types of reasonable accommodations employees with hearing disabilities may need;
- how an employer should handle safety concerns about applicants and employees with hearing disabilities; and
- how an employer can ensure that no employee is harassed because of a hearing disability or any other disability.

GENERAL INFORMATION ABOUT HEARING IMPAIRMENTS

In 2011, a study led by researchers from Johns Hopkins reported that nearly 20% of Americans 12 and older have hearing loss so severe that it may make communication difficult.[4] The study also found that 30 million Americans (12.7% of the population) had hearing loss

in both ears while 48 million Americans (20.3% of the population) had hearing loss in one ear.[5] According to 2010 data from the National Institute on Deafness and Other Communication Disorders (NIDCD), approximately 17% of American adults (36 million people) report some degree of hearing loss.[6] Of this group, 18% of American adults between the ages of 45 and 64 have experienced some degree of hearing loss.[7] NIDCD estimates that approximately 15% of Americans between the ages of 20 and 69 (26 million people) have high frequency hearing loss due to exposure to loud sounds or noise at work or in leisure activities.[8]

The Centers for Disease Control and Prevention (CDC) refer to hearing impairments as conditions that affect the frequency and/or intensity of one's hearing.[9] Although the term "deaf" is often mistakenly used to refer to all individuals with hearing difficulties, it actually describes a more limited group. According to the CDC, "deaf" individuals do not hear well enough to rely on their hearing to process speech and language. Individuals with mild to moderate hearing impairments may be "hard of hearing," but are not "deaf." These individuals differ from deaf individuals in that they use their hearing to assist in communication with others.[10] As discussed below, people who are deaf and those who are hard of hearing can be individuals with disabilities within the meaning of the ADA.

A hearing impairment can be caused by many physical conditions (for example, childhood illnesses, pregnancy-related illnesses, injury, heredity, age, excessive or prolonged exposure to noise), and result in varying degrees of hearing loss.[11] Generally, hearing impairments are categorized as mild, moderate, severe, or profound.[12] An individual with a moderate hearing impairment may be able to hear sound, but have difficulty distinguishing specific speech patterns in a conversation. Individuals with a profound hearing impairment may not be able to hear sounds at all. Hearing impairments that occur in both ears are described as "bilateral," and those that occur in one ear are referred to as "unilateral."[13]

The many different circumstances under which individuals develop hearing impairments can affect the way they experience sound, communicate with others, and view their hearing impairments.[14] For example, some individuals who develop hearing losses later in life find it difficult both to adjust to a world with limited sound, and to adopt new behaviors that compensate for their hearing loss. As a result, they may not use American Sign Language (ASL) or other communication methods at all, or as proficiently as individuals who experienced hearing loss at birth or at a very young age.

Individuals with hearing impairments can perform successfully on the job and should not be denied opportunities because of stereotypical assumptions about hearing loss. Some employers assume incorrectly that workers with hearing impairments will cause safety hazards, increase employment costs, or have difficulty communicating in fast-paced environments. In reality, with or without reasonable accommodation, individuals with hearing impairments can be effective and safe workers. (For information on Reasonable Accommodation, see Questions 9 - 14, below.)

1. When does someone with a hearing impairment have a disability within the meaning of the ADA?

As a result of changes made by the ADAAA, people who are deaf should easily be found to have a disability within the meaning of the first part of the ADA's definition of disability because they are substantially limited in the major life activity of hearing.[15] Individuals with a hearing impairment other than deafness will meet the first part of the ADA's definition of disability if they can show that they are substantially limited in hearing or another major life activity (e.g., the major bodily function of special sense organs).[16] A determination of disability must ignore the positive effects of any mitigating measure that is used. For example, a mitigating measure may include the use of a hearing aid or cochlear implant.[17]

Individuals with a history of a hearing impairment will be covered under the second part of the definition of disability if they have a record of an impairment that substantially limited a major life activity in the past.[18] Although this definition of disability does not apply frequently to individuals with hearing impairments, examples of when it might apply would include situations in which someone's hearing has been corrected surgically (not including surgery to put in a cochlear implant, a mitigating measure). Finally, an individual is covered under the third ("regarded as") prong of the definition of disability if an employer takes a prohibited action (for example, refuses to hire or terminates the individual) because of a hearing impairment or because the employer believes the individual has a hearing impairment, other than an impairment that lasts fewer than six months and is minor.

OBTAINING, USING, AND DISCLOSING MEDICAL INFORMATION

Title I of the ADA limits an employer's ability to ask questions related to hearing and other disabilities and to conduct medical examinations at three stages: pre-offer, post-offer, and during employment.

Job Applicants

Before an Offer of Employment Is Made

2. May an employer ask a job applicant whether he has or had a hearing impairment or about his treatment related to any hearing impairment prior to making a job offer?

No. An employer may not ask questions about an applicant's medical condition[19] or require an applicant to have a medical examination before it makes a conditional job offer. This means that an employer *cannot* legally ask an applicant such questions as:

- whether she has ever had any medical procedures related to her hearing (for example, whether the applicant has a cochlear implant);
- whether she uses a hearing aid; or
- whether she has any condition that may have caused hearing impairment.

Of course, an employer may ask questions pertaining to the applicant's ability to perform the essential functions of the position, with or without reasonable accommodation, such as:

- whether the applicant can respond quickly to instructions in a noisy, fast-paced work environment
- whether the applicant has good communication skills
- whether the applicant can meet legally mandated safety standards required to perform a job.

3. Does the ADA require an applicant to disclose that she has or had a hearing impairment or some other disability before accepting a job offer?

No. The ADA does not require applicants to disclose that they have or had a hearing impairment or another disability *unless* they will need a reasonable accommodation for the application process (for example, a sign language interpreter). Some individuals with a hearing impairment, however, choose to disclose or discuss their condition to dispel myths about hearing loss or to ensure that employers do not assume that the impairment means the person is unable to do the job.

Sometimes, the decision to disclose depends on whether an individual will need a reasonable accommodation to perform the job (for example, specialized equipment, removal of a marginal function, or another type of job restructuring). A person with a hearing impairment, however, may request an accommodation after becoming an employee even if she did not do so when applying for the job or after receiving the job offer.

4. May an employer ask questions about an obvious hearing impairment, or ask follow-up questions if an applicant discloses a non-obvious hearing impairment?

No. An employer generally may not ask an applicant about obvious impairments. Nor may an employer ask an applicant who has voluntarily disclosed that he has a hearing impairment any questions about the nature of the impairment, when it began, or how the individual copes with the impairment. However, if an applicant has an obvious impairment or has voluntarily disclosed the existence of a hearing impairment **and the employer reasonably believes that he will require an accommodation to perform the job because of the impairment**, the employer may ask whether the applicant will need an accommodation and what type. The employer must keep any information an applicant discloses about his medical condition confidential. (*See* "Keeping Medical Information Confidential.")

> **Example 1:** Julie has a severe hearing impairment in her right ear and is applying to the telephone sales department of a large clothing company. Julie tells the employer of her hearing impairment during the interview. The employer's sales associates currently wear headsets with earpieces for the right ear. The employer may ask Julie during her interview if she would need a left-sided headset as an accommodation.

After an Offer of Employment Is Made

After making a job offer, an employer may ask questions about the applicant's health (including questions about the applicant's disability) and may require a medical examination, as long as all applicants for the same type of job are treated equally (that is, all applicants are asked the same questions and are required to take the same examination). After an employer has obtained basic medical information from all individuals who have received job offers, it may ask specific individuals for more medical information if the request is medically related to the previously obtained medical information. For example, if an employer asks all applicants post-offer about their general physical and mental health, it can ask individuals who disclose a particular illness, disease, or impairment for medical information or require them to have a medical examination related to the condition disclosed.

5. What may an employer do when it learns that an applicant has or had a hearing impairment after she has been offered a job but before she starts working?

When an applicant discloses after receiving a conditional job offer that she has or had a hearing impairment, an employer may ask the applicant additional questions, such as how long she has had the hearing impairment; what, if any, hearing the applicant has; what specific hearing limitations the individual experiences; and what, if any, reasonable accommodations the applicant may need to perform the job. The employer also may send the applicant for a follow-up hearing or medical examination or ask her to submit documentation from her doctor answering questions specifically designed to assess her ability to perform the job's functions safely. Permissible follow-up questions at this stage differ from those at the pre-offer stage when an employer may only ask an applicant who voluntarily discloses a disability or whose disability is obvious whether she needs an accommodation to perform the job and what type.

An employer may not withdraw an offer from an applicant with a hearing impairment if the applicant is able to perform the essential functions of a job, with or without reasonable

accommodation, without posing a direct threat (that is, a significant risk of substantial harm) to the health or safety of himself or others that cannot be eliminated or reduced through reasonable accommodation. ("Reasonable accommodation" is discussed in Questions 9 through 14. "Direct threat" is discussed in Question 15.)

Example 2: Lydia applies for a position as an aircraft mechanic. After receiving a job offer, she is given a physical examination. The examination reveals that she has a slight hearing loss in her left ear. Although Lydia worked as an aircraft mechanic in noisy environment with the same level of hearing while she was a member of the military, the employer is concerned that Lydia will pose a risk to herself or others because she will not be able to hear sounds that might alert her to dangers in the work area such as the presence of moving aircraft or other moving vehicles. The employer may not withdraw the job offer simply because it believes Lydia cannot work safely in a high-noise environment. It must determine whether Lydia's hearing impairment would result in a direct threat (that is, a significant risk of substantial harm to Lydia or to others in the workplace). The employer may obtain additional information about Lydia's hearing impairment, including how her hearing impairment affected her past work experience, to make this determination.

Employees

The ADA strictly limits the circumstances under which an employer may ask questions about an employee's medical condition or require the employee to have a medical examination. Once an employee is on the job, his actual performance is the best measure of ability to do the job.

6. When may an employer ask an employee if a hearing impairment, or some other medical condition, may be causing her performance problems?

Generally, an employer may ask disability-related questions or require an employee to have a medical examination when it knows about a particular employee's medical condition, has observed performance problems, and reasonably believes that the problems are related to a medical condition. At other times, an employer may ask for medical information when it has observed symptoms, such as difficulties hearing, or has received reliable information from someone else (for example, a family member or co-worker) indicating that the employee may have a medical condition that is causing performance problems. Often, however, poor job performance is unrelated to a medical condition and generally should be handled in accordance with an employer's existing policies concerning performance.[20]

Example 3: Rupa wears a hearing aid to improve her bilateral, moderate hearing impairment. She was recently promoted from an administrative position to sales associate for a cable company. The new position requires significantly more time on the phone interacting with customers. Although Rupa has received excellent reviews in the past, her latest review was unsatisfactory citing many mistakes in the customer orders she records over the phone. The employer may lawfully ask Rupa if she has any difficulty hearing customers and, if so, whether she would benefit from an accommodation. A possible accommodation could be a captioned telephone that would allow Rupa to communicate verbally while receiving an almost real-time text relay of the conversation.

Example 4: An employee with a profound hearing impairment has received below average evaluations for six months. The employee's poor performance began when she was not selected for a vacant supervisory position. Moreover, the kinds of performance problems the employee is having - a significant increase in the number of late arrivals and typographical errors in written reports the employee routinely produces - cannot reasonably be attributed to a problem with the employee's hearing. The employer may not ask for medical information about the employee's hearing impairment, but instead should

counsel the employee about the performance problems or otherwise proceed as appropriate in accordance with its policies applicable to employee performance.

7. Are there any other instances when an employer may ask an employee with a hearing impairment about her condition?

Yes. An employer also may ask an employee about a hearing impairment when it has a reasonable belief that the employee will be unable to safely perform the essential functions of her job because of the hearing impairment. In addition, an employer may ask an employee about her hearing impairment to the extent the information is necessary:

- to support the employee's request for a reasonable accommodation needed because of her hearing impairment;
- to verify the employee's use of sick leave related to her hearing impairment if the employer requires all employees to submit a doctor's note to justify their use of sick leave;[21] or
- to enable the employee to participate in a voluntary wellness program.[22]

Example 5: An employer maintains a leave policy requiring all employees who use sick leave for a medical appointment to submit a doctor's note upon returning to work. Mark, an employee, uses sick leave to attend an audiologist appointment to adjust his hearing aids. In accordance with its policy, the employer can require Mark to submit a doctor's note for his absence; however, it may not require the note to include any information beyond that which is needed to verify that Mark used his sick leave properly (such as, the degree of Mark's hearing loss, the strength of his hearing aids, or the results of the adjustment).

KEEPING MEDICAL INFORMATION CONFIDENTIAL

With limited exceptions, an employer must keep confidential any medical information it learns about an applicant or employee. Under the following circumstances, however, an employer may disclose that an employee has a hearing impairment:

- to supervisors and managers, if necessary to provide a reasonable accommodation or meet an employee's work restrictions;
- to first aid and safety personnel if an employee may need emergency treatment or require some other assistance at work;
- to individuals investigating compliance with the ADA and similar state and local laws; and
- where needed for workers' compensation or insurance purposes (for example, to process a claim).

8. May an employer tell employees who ask why their co-worker is allowed to do something that generally is not permitted (such as working at home or working a modified schedule) that she is receiving a reasonable accommodation?

No. Telling coworkers that an employee is receiving a reasonable accommodation amounts to a disclosure that the employee has a disability. Rather than disclosing that the employee is receiving a reasonable accommodation, the employer should focus on the importance of maintaining the privacy of all employees and emphasize that its policy is to refrain from discussing the work situation of any employee with co-workers. Employers may be able to avoid many of these kinds of questions by training all employees on the requirements of equal employment laws, including the ADA.

Additionally, an employer will benefit from providing information about reasonable accommodation to all of its employees. This can be done in a number of ways, such as

through written reasonable accommodation procedures, employee handbooks, staff meetings, and periodic training. This kind of proactive approach may lead to fewer questions from employees who misperceive co-worker accommodations as "special treatment."

> **Example 6:** A large store does not provide its sales employees with smartphones. However, the employer does provide a deaf employee with one, as a reasonable accommodation, so that he can receive text messages instead of the numerous communications made over the public address system that he cannot hear, such as requests for sales representatives to report to different parts of the store to assist customers. If other employees ask why he has a smartphone and they do not, the employer may not divulge any information about the impairment, including the fact that the smartphone is a reasonable accommodation.

ACCOMMODATING EMPLOYEES WITH HEARING DISABILITIES

The ADA requires employers to provide adjustments or modifications - called reasonable accommodations - to enable applicants and employees with disabilities to enjoy equal employment opportunities unless doing so would be an undue hardship (that is, a significant difficulty or expense). Accommodations vary depending on the needs of the individual with a disability. Not all employees with a hearing disability will need an accommodation or require the same accommodations.

9. What type of reasonable accommodations may employees with hearing disabilities need?

Some employees may need one or more of the following accommodations:

- a sign language interpreter

  > **Example 7:** Simon has a hearing disability and works as a project manager for a regional telephone company. Simon is usually able to use his lip reading ability to communicate individually with his co-workers. However, Simon occasionally requests a sign language interpreter for large-group conferences and meetings, because it is not possible for him to use lip-reading when people who are not in his line of sight are speaking. Simon's employer would have to provide the sign language interpreter as a reasonable accommodation, absent undue hardship. (For more information about "undue hardship," see Question 12, below.)

- assistive technology, including:
  - a TTY, text telephone, voice carry-over telephone, or captioned telephone[23]
  - a video relay service
  - a telephone headset
  - appropriate emergency notification systems (for example, strobe lighting on fire alarms or vibrating pagers)
  - assistive computer software (for example, net meetings, voice recognition software)

    > **Example 8:** Allen, who has a hearing disability, works as an information technology (IT) specialist with a small, Internet-advertising firm. The IT specialist position requires frequent one-on-one meetings with the firm's president. Because it will not cause an undue hardship, the firm accommodates Allen by acquiring voice recognition software for him to use in his meetings with the president. The software is programmed to translate the president's spoken word into written electronic text.

  - assistive listening devices (ALDs)

Example 9: An employer has an annual all-employee meeting for more than 200 employees. Thelma, who has a severe hearing impairment, requests the use of an ALD in the form of a personal FM system. Speakers would wear small microphones that would transmit amplified sounds directly to a receiver in Thelma's ear. The employer determines that an ALD is a reasonable accommodation that will allow Thelma to participate in the meeting without causing an undue hardship.

- augmentative communication devices that allow users to communicate orally by typing words that are then translated to sign language or a simulated voice
- communication access real-time translation (CART), which translates voice into text at real-time speeds

Example 10: Kendall works as an associate for an international consulting firm. Kendall has a hearing disability for which he uses a hearing aid and lip reading. His company sometimes conducts video-conferencing meetings with clients in other countries. During these meetings, Kendall finds it difficult to participate because some of the clients speak with foreign accents and the video feedback is not continuous. Kendall requests the use of remote CART services to accommodate his hearing disability during international client meetings. The requested accommodation would translate the client's spoken word on Kendall's notebook computer monitor at an almost real-time speed. This accommodation would allow Kendall to participate fully in the meetings and should be provided, absent undue hardship.

- appropriate written memos and notes (especially used for brief, simple, or routine communications)
- work area adjustments (for example, a desk away from a noisy area or near an emergency alarm with strobe lighting)

Example 11: Ann works as an accountant in a large firm located in a high-rise building in the city. Ann has a large window in her office that faces the street-side of the building. She wears a hearing aid to mitigate her severe hearing impairment. Throughout the workday many exterior noises (for example, police sirens, car horns, and street musicians) are amplified by Ann's hearing aid and interfere with her ability to hear people speaking in her office. Ann requests, and her employer agrees, that moving her to a vacant interior office is a reasonable accommodation without causing an undue hardship.

- time off in the form of accrued paid leave or unpaid leave if paid leave has been exhausted or is unavailable.[24]

Example 12: Beth is deaf and requests leave as a reasonable accommodation to train a new hearing dog. Hearing dogs assist deaf and hard of hearing individuals by alerting them to a variety of household and workplace sounds such as a telephone ring, door knock or doorbell, alarm clock, buzzer, name call, speaker announcement, and smoke or fire alarm. A hearing dog is trained to make physical contact and direct a person to the source of the sound. Under her employer's leave policy, Beth does not have enough annual or sick leave to cover her requested absence. The employer must provide additional unpaid leave as a reasonable accommodation, absent undue hardship.

- altering an employee's marginal (i.e., non-essential) job functions

Example 13: Maria, a librarian, is primarily responsible for cataloguing books, writing book summaries, and scheduling book tours. Recently, Maria has had to fill in as a desk librarian since the regular librarian is on vacation. Maria has a severe hearing disability and uses a hearing aid. She finds it difficult to hear patrons if there is any background noise. She asks to switch her front desk duties with another librarian who processes book orders transmitted over the phone or Internet. Since working at the front desk is a minor function of Maria's job, the employer should accommodate the change in job duties, absent undue hardship.

- reassignment to a vacant position

  Example 14: Sonny, a stocking clerk on the floor of a large grocery store, develops Ménière's disease, which produces a loud roaring noise in his ears for long periods of time. It is difficult for him to hear customers and co-workers on the floor because of music and frequent announcements played over the store's public address system and background noise in the store, particularly during busy periods. The store manager tried several unsuccessful accommodations. Upon request, the employer should reassign the employee to a vacant position as a stocking clerk in the warehouse at the same location, absent undue hardship. The employee is qualified for the reassignment position and the warehouse is a quieter environment with fewer background sounds.

- other modifications or adjustments that allow a qualified applicant or employee with a hearing disability to enjoy equal employment opportunities

  Example 15: Manny is hired as a chemist for a pharmaceutical company. He has a hearing disability and communicates primarily through sign language and lip reading. Shortly after he is hired, he is required to attend a two-hour orientation meeting. The meeting includes a brief lecture session followed by a series of video vignettes to illustrate key concepts. To accommodate his hearing disability, Manny requests a seat near the trainer, closed captioning during the video segments, and adequate lighting to allow him to read lips throughout the meeting. Since there is no undue hardship, the employer grants these reasonable accommodations to allow Manny to participate fully during the orientation session.

Although these are some examples of the types of accommodations commonly requested by employees with hearing disabilities, other employees may need different changes or adjustments.[25] Employers should ask the particular employee requesting an accommodation what he needs that will help him do his job. There also are extensive public and private resources to help employers identify reasonable accommodations. For example, the website for the Job Accommodation Network (JAN) (http://askjan.org) provides information about many types of accommodations for employees with hearing disabilities.

10. How does an employee with a hearing disability request a reasonable accommodation?

There are no "magic words" that a person has to use when requesting a reasonable accommodation. A person simply has to tell the employer that she needs an adjustment or change at work because of her hearing impairment. A request for reasonable accommodation also can come from a family member, friend, health professional, or other representative on behalf of a person with a hearing disability. If an employer requires more information about the disability and why an accommodation is needed, it should engage in an "interactive process" -- a dialogue with the employee -- to obtain information that will help the employer in handling the request.

Example 16: Lionel has a hearing disability and is employed as an electrician. As a team leader, Lionel is responsible for receiving his team's list of daily work sites and any accompanying special instructions, traveling to the sites with his team, and directing the day's work at each site. Lionel receives the list of assignments and accompanying special instructions from the company owner during daily morning meetings attended by all of the team leaders. The special instructions are given orally. One morning, at the conclusion of a team leader meeting, Lionel passes a note to the owner reminding him of his hearing impairment and requesting that all special instructions for the team's assignments be written down because he is having difficulty hearing them. Lionel has requested a reasonable accommodation.

11. May an employer request documentation when an employee who has a hearing disability requests a reasonable accommodation?

Sometimes. When a person's hearing impairment is not obvious, the employer may ask the person to provide reasonable documentation about how the condition limits major life activities (that is, whether the person has a disability) and why a reasonable accommodation is needed. An employer, however, is entitled only to documentation sufficient to establish that the employee has a hearing disability and to explain why an accommodation is needed. A request for an employee's entire medical record, for example, would be inappropriate, as it likely would include information about conditions other than the employee's hearing disability.[26]

Example 17: Luíz, who has a hearing disability and communicates primarily through lip reading and speech, works as a programmer for an Internet security firm. The firm acquires a new client and promotes Luíz to be the senior programmer responsible for all consultations regarding the Internet security system design for the new client. Luíz's new assignment requires frequent phone conversations and teleconference meetings that do not allow for the use of Luíz's lip reading skills to aid in his verbal comprehension. As a result, Luíz's audiologist recommends, and Luiz requests, the use of a voice carry-over phone, which would provide an almost real-time text relay of the client's speech and also allow the client to hear Luíz. Because Luiz's hearing impairment is not an obvious disability, his employer may lawfully request medical documentation to verify his disability.

12. Does an employer have to grant every request for a reasonable accommodation?

No. An employer does not have to provide an accommodation if doing so would be an undue hardship. Undue hardship means that providing the reasonable accommodation will result in significant difficulty or expense. An employer also does not have to eliminate an essential function of a job as a reasonable accommodation, tolerate performance that does not meet its standards, or excuse violations of conduct rules that are job-related and consistent with business necessity and that the employer applies consistently to all employees (such as rules prohibiting violence, threatening behavior, theft, or destruction of property). Nor do employers have to provide employees with personal use items, such as hearing aids or other devices that are used both on and off the job.

If more than one accommodation would be effective, the employee's preference should be given primary consideration, although the employer is not required to provide the employee's first choice of reasonable accommodation. If a requested accommodation is too difficult or expensive, an employer may choose to provide an easier or less costly accommodation as long as it is effective in meeting the employee's needs.

Example 18: An employee with a bilateral hearing disability requests use of communication access real-time translation (CART) for an upcoming training. In place of the CART device, the employer suggests an assistive listening device (ALD) because it is

less expensive than CART. Twelve managers and supervisors are scheduled to take the training in a conference room at the employer's offices. Much of the information will be presented in a lecture format, accompanied by slides with printed information. The size of the room, the number of participants in the training, and the format of the training make it possible for the employee to use a portable assistive listening system effectively. The employer may, therefore, provide an ALD instead of CART under these circumstances.

Example 19: A deaf employee requests a sign language interpreter for regular staff meetings. The employer suggests that a co-worker could take notes and share them with the deaf employee or that a summary of the meeting could be prepared. These alternatives are not effective because they do not allow the deaf employee to ask questions and participate in discussions during the meetings as other employees do. Absent undue hardship, the employer must provide a sign language interpreter for the meetings.

13. May an employer be required to provide more than one accommodation for the same employee with a hearing disability?

Yes. The duty to provide a reasonable accommodation is an ongoing one. Although some employees with hearing disabilities may require only one reasonable accommodation, others may need more than one. An employer must consider each request for a reasonable accommodation and determine whether it would be effective and whether providing it would pose an undue hardship.

Example 20: A deaf employee can communicate effectively with her supervisor by lip-reading and with written notes. The employee wants to attend a three-day training program that will involve extensive communication between participants and the instructor and among participants themselves. The employee requests CART - communication access real-time translation - for the training. The employer may explore whether another form of reasonable accommodation - for example, a sign language interpreter - would be effective. But, the employer must provide the CART service or another effective form of reasonable accommodation, absent undue hardship, since lip-reading and exchanging occasional notes will not enable the employee to participate fully in the training.

14. What kinds of reasonable accommodations are related to the benefits and privileges of employment?

Reasonable accommodations related to the benefits and privileges of employment include accommodations that are necessary to provide individuals with disabilities access to facilities or portions of facilities to which all employees are granted access (for example, employee break rooms and cafeterias), access to information communicated in the workplace, and the opportunity to participate in employer-sponsored training and social events.

Example 21: Karin, who is deaf, works as an associate in a large investment firm. Every December, the partner in charge of the team for which Karin works holds a party at his residence for all of the team's members and a number of the firm's clients. Upon Karin's request, her employer provides her a sign language interpreter to allow Karin to fully participate in the social event.

An employer will not be excused from providing an employee with a hearing disability with a necessary accommodation because the employer has contracted with another entity to conduct the event.

Example 22: An employer offers its employees a training course on organization and time management provided by a local company with which the employer has contracted. An

employee who is deaf wants to take the course and asks for CART services or a sign language interpreter. The employer claims that the company conducting the training is responsible for providing what the deaf employee needs, but the company responds that the responsibility is the employer's. Even if the company conducting the training has an obligation, under Title III of the ADA,[27] to provide "auxiliary aids and services," which would include CART services and sign language interpreters, this fact does not alter the employer's obligation to provide the employee with a reasonable accommodation for the training.[28]

CONCERNS ABOUT SAFETY

When it comes to safety concerns, an employer should be careful not to act on the basis of myths, fears, or stereotypes about hearing impairments. Instead, the employer should evaluate each individual on her skills, knowledge, experience, and how the hearing disability affects her.

15. When may an employer refuse to hire, terminate, or temporarily restrict the duties of a person who has or had a hearing impairment because of safety concerns?

An employer only may exclude an individual with a hearing impairment from a job for safety reasons when the individual poses a direct threat. A "direct threat" is a significant risk of substantial harm to the individual or others that cannot be eliminated or reduced through reasonable accommodation.[29] This determination must be based on objective, factual evidence, including the best recent medical evidence.

In making a direct threat assessment, the employer must evaluate the individual's present ability to safely perform the job. The employer also must consider:

(1) the duration of the risk;

(2) the nature and severity of the potential harm;

(3) the likelihood that the potential harm will occur; and

(4) the imminence of the potential harm.[30]

The harm must be serious and likely to occur, not remote or speculative. Finally, the employer must determine whether any reasonable accommodation would reduce or eliminate the risk.[31]

Example 23: A school district denies an applicant with a hearing disability a job as a school bus driver for elementary school students, believing that she will not be able to drive safely and will not be able to monitor students, especially in the event of a medical or other emergency. The applicant has a clean driving record and has previously performed jobs transporting elderly patients by van to doctor's appointments and social events. Based on past experiences with accommodations, the applicant could monitor students effectively - and without compromising her driving - if an additional mirror highlighting the rear of the bus were installed. The mirror, placed above the driver, would allow her to better monitor students whose conversations she may not be able to hear or understand as well as those students located in the front of the bus. Under these circumstances, the school district cannot demonstrate that this applicant would pose a direct threat to the safety of others, and its refusal to hire her would violate the ADA.[32]

Example 24: An employee with a hearing disability requests training to operate a forklift machine at a large hardware store. For safety reasons, the employer requires that forklift operators be able to communicate with a spotter employee while operating the machine.

The employee suggests that he wear a vibrating bracelet to allow him to communicate with the spotter. The employer has attempted to use vibrating bracelets in the past without success because users cannot distinguish the vibrations between the forklift and the bracelet. The employee tries to use the vibrating bracelet, but experiences the same problem. Assuming no other accommodations are available, the employer may deny the employee training on a forklift.[33]

16. What should an employer do when another federal law prohibits it from hiring anyone with a hearing impairment?

If a federal law prohibits an employer from hiring a person with a hearing impairment, the employer is not liable under the ADA. The employer should be certain, however, that compliance with the law actually is required, not voluntary. The employer also should be sure that the law does not contain any exceptions or waivers.

Example 25: Terry has a severe hearing impairment that is slightly improved by her cochlear implant. She applies for a position driving large trucks. These positions are subject to hearing requirements and other standards enforced by the Department of Transportation (DOT). The employer may rely on DOT's hearing requirement in denying Terry employment. However, the employer may not rely on the DOT hearing requirement to exclude Terry from a position driving smaller trucks which are not subject to DOT's standards. Instead, the employer would have to establish that Terry would pose a direct threat, within the meaning of the ADA, if it denied her a position driving smaller trucks because of her hearing disability.

HARASSMENT

The ADA prohibits harassment, or offensive conduct, based on disability just as other federal laws prohibit harassment based on race, sex, color, national origin, religion, age, and genetic information. Offensive conduct may include, but is not limited to, offensive jokes, slur, epithets or name calling, physical assaults or threats, intimidation, ridicule or mockery, insults or put-downs, offensive objects or pictures, and interference with work performance. Although the law does not prohibit simple teasing, offhand comments, or isolated incidents that are not very serious, harassment is illegal when it is so frequent or severe that it creates a hostile or offensive work environment or when it results in an adverse employment decision (such as the victim being fired or demoted).

Example 26: Leonard works as a stocker at a local electronics store. Leonard lost his hearing two years ago as the result of a rare and debilitating illness. Since Leonard's recovery and return to work, his co-workers have constantly taunted him about his hearing impairment and recklessly driven the forklift near him while yelling for him to move. The employees know that Leonard cannot hear their warnings and often laugh at Leonard's startled reaction when he sees the forklift approaching him. Leonard complains to his supervisor in accordance with his employer's anti-harassment policy. The employer must promptly investigate and address the harassing behavior.

17. What should employers do to prevent and correct harassment?

Employers should make clear that they will not tolerate harassment based on disability or on any other basis. This can be done in a number of ways, such as through a written policy, employee handbooks, staff meetings, and periodic training. The employer should emphasize that harassment is prohibited and that employees should promptly report such conduct to a manager. Finally, the employer should immediately conduct a thorough investigation of any report of harassment and take swift and appropriate corrective action. For more information on

the standards governing harassment under all of the EEO laws, see http://www.eeoc.gov/policy/docs/harassment.html.

RETALIATION

The ADA prohibits retaliation by an employer against someone who opposes discriminatory employment practices, files a charge of employment discrimination, or testifies or participates in any way in an investigation, proceeding, or litigation related to a charge of employment discrimination. It is also unlawful for an employer to retaliate against someone for requesting a reasonable accommodation. Persons who believe that they have been retaliated against may file a charge of retaliation as described below.

HOW TO FILE A CHARGE OF EMPLOYMENT DISCRIMINATION

Against Private Employers and State/Local Governments

Any person who believes that his or her employment rights have been violated on the basis of disability and wants to make a claim against an employer must file a charge of discrimination with the EEOC. A third party may also file a charge on behalf of another person who believes he or she experienced discrimination. For example, a family member, social worker, or other representative can file a charge on behalf of someone with a hearing impairment. The charge must be filed by mail or in person with the local EEOC office within 180 days from the date of the alleged violation. The 180-day filing deadline is extended to 300 days if a state or local anti-discrimination agency has the authority to grant or seek relief as to the challenged unlawful employment practice.[34]

The EEOC will send the parties a copy of the charge and may ask for responses and supporting information. Before formal investigation, the EEOC may select the charge for EEOC's mediation program. Both parties have to agree to mediation, which may prevent a time consuming investigation of the charge. Participation in mediation is free, voluntary, and confidential.

If the mediation is unsuccessful, the EEOC investigates the charge to determine if there is "reasonable cause" to believe discrimination has occurred. If reasonable cause is found, the EEOC will then try to resolve the charge with the employer. In some cases, where the charge cannot be resolved, the EEOC will file a court action. If the EEOC finds no discrimination, or if an attempt to resolve the charge fails and the EEOC decides not to file suit, it will issue a notice of a "right to sue," which gives the charging party 90 days to file a court action. A charging party can also request a notice of a "right to sue" from the EEOC 180 days after the charge was first filed with the Commission, and may then bring suit within 90 days after receiving the notice. For a detailed description of the process, you can visit our website at http://www.eeoc.gov/employees/charge.cfm.

Against the Federal Government

If you are a federal employee or job applicant and you believe that a federal agency has discriminated against you, you have a right to file a complaint. Each agency is required to post information about how to contact the agency's EEO Office. You can contact an EEO Counselor by calling the office responsible for the agency's EEO complaints program. Generally, you must contact the EEO Counselor within 45 days from the day the discrimination occurred. In most cases the EEO Counselor will give you the choice of participating either in EEO counseling or in an alternative dispute resolution (ADR) program, such as a mediation program.

If you do not settle the dispute during counseling or though ADR, you can file a formal discrimination complaint against the agency with the agency's EEO Office. You must file within

15 days from the day you receive notice from your EEO Counselor about how to file.

Once you have filed a formal complaint, the agency will review the complaint and decide whether or not the case should be dismissed for a procedural reason (for example, your claim was filed too late). If the agency doesn't dismiss the complaint, it will conduct an investigation. The agency has 180 days from the day you filed your complaint to finish the investigation. When the investigation is finished, the agency will issue a notice giving you two choices: either request a hearing before an EEOC Administrative Judge or ask the agency to issue a decision as to whether the discrimination occurred. For a detailed description of the process, you can visit our website at http://www.eeoc.gov/eeoc/publications/fs-fed.cfm.

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[1] *See* 42 U.S.C. §12102(2); 29 C.F.R. §1630.2(g).

[2] For example, disability laws in California, Pennsylvania, New Jersey, and New York apply to employers with fewer than 15 employees.

[3] *See* "The Questions and Answers Series" under "Available Resources" on EEOC's website at www.eeoc.gov/laws/types/disability.cfm.

[4] *See* www.hopkinsmedicine.org/news/media/releases/one_in_five_americans_has_hearing_loss.

[5] *See* id.

[6] *See* www.nidcd.nih.gov/health/statistics/Pages/quick.aspx.

[7] *See* id.

[8] *See* id.

[9] CDC, National Center on Birth Defects and Developmental Disabilities (NCBDDD), http://www.cdc.gov/ncbddd/dd/ddhi.htm.

[10] Id.

[11] National Association of the Deaf, The Difference between Deaf and Hard of Hearing, http://www.nad.org/.

[12] CDC, National Center on Birth Defects and Developmental Disabilities (NCBDDD), http://www.cdc.gov/ncbddd/dd/ddhi.htm.

[13] In addition, there are four types of hearing loss that generally describe the origin of the hearing loss within the ear. Sensorineural hearing losses are the most common and primarily involve damage to the nerve fibers in the inner ear. These nerve fibers transmit the signals that the brain interprets as patterns of sound. Some types of sensorineural hearing loss can be improved through hearing aids or cochlear implants. Conductive hearing loss is often a treatable disorder involving a blockage in the outer or middle ear that impedes the transmission of sound energy to the brain. Mixed hearing loss is any combination of sensorineural and conductive hearing loss caused by related or isolated conditions. Finally, some sources recognize a fourth type of hearing loss. Central hearing loss primarily involves a permanent condition where the pathway from the inner ear to the brain is damaged. *See* Id.

[14] National Association of the Deaf, The Difference between Deaf and Hard of Hearing, http://www.nad.org/site.

[15] 29 C.F.R. §1630.2(j)(3)(iii).

[16] *See* 29 C.F.R. §1630.2(i)(1)(ii).

[17] 29 C.F.R. §1630.2(j)(5)(i).

[18] 29 C.F.R. §1630.2(k).

[19] Federal contractors are required under 41 C.F.R. § 60-741.42, a regulation issued by the Office of Federal Contract Compliance Programs (OFCCP), to invite applicants to voluntarily self-identify as persons with disabilities for affirmative action purposes. The ADA prohibition on asking applicants about medical conditions at the pre-offer stage does not prevent federal contractors from complying with the OFCCP's regulation. *See* Letter from Peggy R. Mastroianni, EEOC Legal Counsel, to Patricia A. Shiu, Director of OFCCP, www.dol.gov/ofccp/regs/compliance/section503.htm#bottom.

[20] An employer also may ask an employee about his hearing impairment or send the employee for a medical examination when it reasonably believes the employee may pose a direct threat because of his impairment. *See* "Concerns About Safety."

[21] An employer also may ask an employee for periodic updates on her condition if the employee has taken leave and has not provided an exact or fairly specific date of return or has requested leave in addition to that already granted. Of course, an employer may call employees on extended leave to check on their progress or to express concern for their health without violating the ADA.

[22] The ADA allows employers to conduct voluntary medical examinations and activities, including obtaining voluntary medical histories, which are part of an employee wellness program (such as a smoking cessation program), as long as any medical records (including, for example, the results of any diagnostic tests) acquired as part of the program are kept confidential. *See* Question 22 in EEOC Enforcement Guidance on Disability-Related Inquiries and Medical Examinations of Employees Under the ADA, http://www.eeoc.gov/policy/docs/guidance-inquiries.html.

[23] A text telephone or teletypewriter (TTY) allows a telephone user to send typed messages to another caller and to receive typewritten messages from the caller either directly (if the caller is also using a TTY) or through a telephone relay service (TRS) operator. A voice carry-over telephone allows someone with a hearing impairment to communicate orally over the telephone and to receive text communications from the other caller that are transcribed by a TRS operator. A captioned telephone allows users with hearing impairments to receive communications over the telephone orally while receiving an almost simultaneous text translation.

[24] For more information regarding an employer's responsibility to provide leave for covered individuals, see the Family and Medical Leave Act, the Americans with Disabilities Act, and Title VII of the Civil Rights Act of 1964 (November 1995), http://www.eeoc.gov/policy/docs/fmlaada.html, and Reasonable Accommodation and Undue Hardship Under the Americans with Disabilities Act at Questions 22 and 23 (October 17, 2002), http://www.eeoc.gov/policy/docs/accommodation.html.

[25] *See* the Job Accommodation Network's Searchable Online Accommodation Resource (SOAR), http://www.jan.wvu.edu/soar/vision.html.

[26] Requests for documentation to support a request for accommodation may violate Title II of the Genetic Information Nondiscrimination Act (GINA) where they are likely to result in the acquisition of genetic information, including family medical history. 29 C.F.R. §1635.8(a). For this reason, employers may want to include a warning in the request for documentation that the employee or the employee's doctor should not provide genetic information. Id. at 1635.8(b)(1)(i)(B).

[27] In an effort to eliminate discrimination against individuals with disabilities, Title III of the Americans with Disabilities Act requires businesses and non-profit organizations that are public accommodations to comply with basic nondiscrimination and building accessibility requirements, provide reasonable modifications to policies and practices, and supply auxiliary aids (for example, assistive listening devices, note takers, written materials, taped texts, and qualified readers) to ensure effective communication with persons with disabilities. For more information on the requirements of Title III of the ADA, visit the website for the U.S. Department of Justice, Civil Rights Division, Disability Rights Section, available at http://www.justice.gov/crt/about/drs/.

[28] An employer should include, as part of any contract with an entity that conducts training, provisions that allocate responsibility for providing reasonable accommodations. This can help to avoid conflicts or confusion that could arise and result in an employee being denied a training opportunity. An employer should also remember, however, that it remains responsible for providing a reasonable accommodation that an employee needs to take advantage of a training opportunity, regardless of how that responsibility has been allocated in the contract.

[29] 29 C.F.R. § 1630.2(r).

[30] Id.

[31] Id.

[32] *See* Rizzo v. Children's World Learning Center, 213 F.3d 209 (5th Cir. 2000).

[33] *See* Nix v. Home Depot USA, Inc., No. 1:02-CV2292MHS, 2003 WL 22477865 (N.D. Ga. Oct. 16, 2003).

[34] Many states and localities have disability anti-discrimination laws and agencies responsible for enforcing those laws. The EEOC refers to these agencies as "Fair Employment Practices Agencies (FEPAs)." Individuals may file a charge with either the EEOC or a FEPA. If a charge filed with a FEPA is also covered under the ADA, the FEPA will "dual file" the charge with the EEOC but usually will retain the charge for investigation. If an ADA charge filed with the EEOC is also covered by a state or local disability discrimination law, the EEOC will "dual file" the charge with the FEPA but usually will retain the charge for investigation.

ADDENDUM C

ESSENTIAL HEALTH BENEFITS: BENCHMARK PLAN COMPARISON 2017 AND LATER

INFORMED ON REFORM

Each State has had the option to select a new benchmark plan for plan years on and after 1/1/2017, and all benefits included in the benchmark plan are considered to be an Essential Health Benefit (EHB). Benefits that are considered to be EHB cannot include annual and/or lifetime dollar maximums. Large group clients do not have to cover any benefits defined as EHB, but if they do, they cannot impose annual and/or lifetime dollar limits. Additionally, effective on or after 1/1/2017, for ***any plan*** that covers an EHB service *both* in-network and out-of-network, the annual/lifetime dollar limits are prohibited on that EHB service *both* in-network and out-of-network. Depending on which State a client has selected as their EHB State, annual and/or lifetime dollar limits may need to be removed for any benefit defined as EHB for that State.

- Self-funded group clients can choose which state to use as their EHB State.
- Insured-group clients' EHB State must be the same as the clients' contract/situs State, except for HMO plans which must follow the HMO plan state.

The following chart compares the benchmark plans of each State for the top 11 benefits that most commonly include annual or lifetime dollar limits. This chart is not all inclusive. Additional benefits are considered EHB in each state. The below information is based on the new 2017 benchmark plan documents as well as state mandates enacted prior to 1/1/2012.

Top 11 EHB Benefits by State – 2017 and Later											
State	**Acupuncture**	**Autism***	**Bariatric surgery**	**Chiropractic care**	**Durable medical equipment**	**Hearing aids**	**Infertility**	**Routine foot care**	**TMJ**	**Transplants and travel**	**Wigs**
AL	No	Yes	No	Yes	Yes	No	No	No	No	Transplant – Yes Travel – No	No
AK	Yes	Yes	No	Yes	Yes	No	No	No	No	Transplant – Yes Travel – Yes	No
AZ	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	Yes	Yes	No	Yes	Transplant – Yes Travel – Yes	Yes
AR	No	Yes (includes ABA Therapy)	No	Yes	Yes	Yes (Includes Cochlear Implants)	Yes	No	Yes	Transplant – Yes Travel – No	No
CA	Yes	Yes (includes ABA Therapy)	Yes	No	Yes	Cochlear Implant – Yes Other – No	No	No	Yes	Transplant – Yes Travel – No	No
CO	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	Yes (under Age 18)	Yes	No	Yes	Transplant – Yes Travel – Yes	No

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EHB benchmark plan comparison – 2017 and later

Top 11 EHB Benefits by State – 2017 and Later											
State	Acupuncture	Autism*	Bariatric surgery	Chiropractic care	Durable medical equipment	Hearing aids	Infertility	Routine foot care	TMJ	Transplants and travel	Wigs
CT	No	Yes (includes ABA Therapy)	No	Yes	Yes	Yes (through Age 12)	Yes	No	Yes	Transplant – Yes Travel – Yes	Yes
DC	No	Yes	No	Yes	Yes	No	Yes	No	Yes	Transplant – Yes Travel – Yes	Yes
DE	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	Yes (under Age 24)	No	No	Yes	Transplant – Yes Travel – Yes	Yes
FL	No	Yes (includes ABA Therapy)**	No	Yes	Yes	No	No	No	Yes	Transplant – Yes Travel – No	No
GA	No	Yes	No	Yes	Yes	Cochlear Implant – Yes Other – No	Yes	No	Yes	Transplant – Yes Travel – Yes	No
HI	No	Yes	Yes	No	Yes	Yes	Yes	No	No	Transplant – Yes Travel – No	No
ID	No	No	No	Yes	Yes	No	No	No	No	Transplant – Yes Travel – Yes	No
IL	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	Bone Anchored – Yes Other – Yes (under age 18)	Yes	No	Yes	Transplant – Yes Travel – Yes	No
IN	No	Yes (includes ABA Therapy)	No	Yes	Yes	No	No	No	Yes	Transplant – Yes Travel – Yes	Yes
IA	No	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Transplant – Yes Travel – No	No
KS	No	No	No	Yes	Yes	Bone Anchored – Yes Other – No	Yes	No	Yes	Transplant – Yes Travel – No	No
KY	No	Yes (includes ABA Therapy)	No	Yes	Yes	Cochlear Implant – Yes Yes (under Age 18)	No	No	Yes	Transplant – Yes Travel – No	Yes
LA	No	Yes (includes ABA Therapy)	No	Yes	Yes	Yes (through Age 17)	No	No	No	Transplant – Yes Travel – No	No
ME	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	Yes (through Age 18)	No	No	No	Transplant – Yes Travel – No	No
MD	Yes	Yes	Yes	Yes	Yes	Cochlear Implant – Yes Yes (under Age 18)	Yes	No	Yes	Transplant – Yes Travel – Yes	Yes
MA	No	Yes (includes ABA Therapy)	No	Yes	Yes	Yes (through Age 21)	Yes	No	Yes	Transplant – Yes Travel – No	Yes

EHB benchmark plan comparison – 2017 and later

Top 11 EHB Benefits by State – 2017 and Later											
State	Acupuncture	Autism*	Bariatric surgery	Chiropractic care	Durable medical equipment	Hearing aids	Infertility	Routine foot care	TMJ	Transplants and travel	Wigs
MI	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Transplant – Yes Travel – No	No
MN	No	No	No	Yes	Yes	Yes (through Age 18) (includes Bone Anchored)	Yes	No	Yes	Transplant – Yes Travel – No	Yes
MS	No	No	No	Yes	Yes	No	No	No	Yes	Transplant – Yes Travel – Yes	No
MO	No	Yes (includes ABA Therapy)	No	Yes	Yes	Cochlear Implant – Yes Other – Yes for Newborns Only	Yes	No	Yes	Transplant – Yes Travel – Yes	Yes
MT	No	Yes (includes ABA Therapy)	No	Yes	Yes	No	Yes	No	Yes	Transplant – Yes Travel – Yes	No
NE	No	No	No	Yes	Yes	Cochlear Implant – Yes Other - No	No	No	Yes	Transplant – Yes Travel – No	No
NV	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	Yes	Yes	No	Yes	Transplant – Yes Travel – Yes	No
NH	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	Yes	Yes	No	Yes	Transplant – Yes Travel – No	Yes
NJ	Yes	Yes (includes ABA Therapy)	No	Yes	Yes	Yes (through Age 15) (includes Bone Anchored)	Yes	No	Yes	Transplant – Yes Travel – No	No
NM	Yes	Yes (includes ABA Therapy)	Yes	Yes	Yes	Yes (through Age 21)	No	No	Yes	Transplant – Yes Travel – Yes	No
NY	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	Yes (Includes bone anchored)	Yes	No	No	Transplant – Yes Travel – No	Yes
NC	No	No	Yes	Yes	Yes	Yes (through Age 22)	Yes	No	Yes	Transplant – Yes Travel – Yes	No
ND	No	No	Yes	Yes	Yes	No	No	No	Yes	Transplant – Yes Travel – No	No
OH	No	No	No	Yes	Yes	Cochlear Implant – Yes Other – No	No	No	Yes	Transplant – Yes Travel – Yes	Yes
OK	No	Yes	No	No	Yes	Yes (under Age 19)	No	No	No	Transplant – Yes Travel – No	Yes
OR	No	Yes (includes ABA Therapy)	No	No	Yes	Yes (under Age 18) (18+ if enrolled in School)	No	No	No	Transplant – Yes Travel – Yes	Yes
PA	No	Yes (includes ABA Therapy)	No	Yes	Yes	No	Yes	No	No	Transplant – Yes Travel – Yes	No

EHB benchmark plan comparison – 2017 and later

Top 11 EHB Benefits by State – 2017 and Later											
State	Acupuncture	Autism*	Bariatric surgery	Chiropractic care	Durable medical equipment	Hearing aids	Infertility	Routine foot care	TMJ	Transplants and travel	Wigs
PR**	No	Yes	Yes	Yes	Yes	No	No	Yes	No	Transplant – Yes Travel – No	No
RI	No	No	Yes	Yes	Yes	Yes (under age 19)	Yes	No	No	Transplant – Yes Travel – No	Yes
SC	No	Yes (includes ABA Therapy)	No	Yes	Yes	Yes – Cleft Lip/Palate Only No – Other Diagnoses	No	No	No	Transplant – Yes Travel – No	No
SD	No	No	Yes	Yes	Yes	No	No	No	Yes	Transplant – Yes Travel – No	No
TN	No	Yes	No	Yes	Yes	Yes (under Age 18)	Yes	No	Yes	Transplant – Yes Travel – Yes	No
TX	No	Yes (includes ABA Therapy)	No	Yes	Yes	Yes	No	No	Yes	Transplant – Yes Travel – No	No
UT	No	No	No	No	Yes	No	No	No	No	Transplant – Yes Travel – No	No
VT	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	No	Yes	No	Yes	Transplant – Yes Travel – Yes	Yes
VI***	Yes	No	Yes	Yes	Yes	Yes (includes Bone Anchored)	Yes	Yes	Yes	Transplant – Yes Travel – No	Yes
VA	No	No	No	Yes	Yes	Cochlear Implant – Yes Other – No	Yes	No	Yes	Transplant – Yes Travel – Yes	Yes
WA	Yes	No	No	Yes	Yes	Cochlear Implant – Yes Other – No	No	No	Yes	Transplant – Yes Travel – No	No
WV	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	No	No	No	Yes	Transplant – Yes Travel – Yes	No
WI	No	Yes (includes ABA Therapy)	No	Yes	Yes	Yes (under Age 18) (includes Bone Anchored)	Yes	No	Yes	Transplant – Yes Travel – No	No
WY	No	No	Yes	Yes	Yes	No	No	No	No	Transplant – Yes Travel – No	No

* Autism - Since ABA Therapy is a behavioral service, Federal Mental Health Parity regulations prohibit age limits, visit limits or annual/lifetime dollar limits for ABA Therapy even when it is not considered an EHB service.

** For Individual Family Plans business in Florida, ABA therapy will not be treated as EHB. Coverage of some short term rehabilitation services for autism (e.g. physical therapy, speech therapy, occupational therapy) may continue to be required in accordance with federal mental health and substance use disorder parity.

*** Initial guidance stated that EHB no longer applies to Puerto Rico and the Virgin Islands. However, it has since been determined that EHB does apply. Because there are no new benchmark plans for these territories, Cigna will continue to use the 2014 benchmark plans to identify benefits as EHB until HHS releases further guidance.