Nos. 18-35846

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ANDREA SCHMITT and ELIZABETH MOHONDRO,
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 Judge
(Seattle, No. 2:17-cv-01611-RSL)

REPLY BRIEF OF APPELLANTS ANDREA SCHMITT AND ELIZABETH MOHONDRO

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I. INTRODUCTION

In *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104 (9th Cir. 2000), this Court held that the Americans with Disabilities Act ("ADA") does not prohibit benefit design discrimination by an employer in its long-term disability plan. *See id.*, at 1115-1117. The Court's decision to exempt benefit design discrimination in that context was based on the lack of clarity from Congress: "[H]ad Congress intended to control which coverages had to be offered by employers, it would have spoken more plainly because of the well-established marketing process to the contrary." *Id.* at 1116.

Congress has now spoken more plainly. In Section 1557 of the Affordable Care Act ("ACA") Congress explicitly prohibited discrimination in "contracts of insurance" issued by health insurers that receive Federal financial assistance:

> [A]n individual shall not, ***on the ground prohibited under*** … ***section 504*** of the Rehabilitation Act of 1973 (29 U.S.C. §794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, ***including credits, subsidies, or contracts of insurance***…. The enforcement mechanisms provided for and available under … section 504 … shall apply for purposes of violations of this subsection.

42 U.S.C. §18116(a) (emphasis added). As the Department of Health and Human Services ("DHHS") explained, Congress meant what it said: "A covered entity ***shall not, in providing or administering*** health-related insurance or other health related

coverage … ***have benefit designs that discriminate*** on the basis of … disability." 45 C.F.R. §92.207(b)(2) (emphasis added).

Appellants Andrea Schmitt and Elizabeth Mohundro have been denied coverage for medically necessary outpatient office visits and durable medical equipment based solely upon their disability and the benefit design of their health plans. Their health insurance through Kaiser Health Plan of Washington ("Kaiser") covers outpatient office visits and durable medical equipment when medically necessary. ER 74, 187, 205. These services would be covered, but for the design of Kaiser's plans, specifically the application of Kaiser's Hearing Loss Exclusion. ER 194. As a result, Appellants do not receive the full coverage of outpatient office visits and durable medical equipment that other non-disabled insureds receive. This disability-based exclusion is illegal under the ACA's Section 1557. *Cf., Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669, 683, 103 S. Ct. 2622 (1983) (pregnancy exclusion in a health plan violated Title VII of the Civil Rights Act).

Kaiser argues that the Hearing Loss Exclusion is not prohibited by Section 1557 because the Exclusion eliminates coverage of a special benefit called "hearing loss treatment," whether or not the insured is disabled. Kaiser Opposition brief ("Opp."), p. 3. Kaiser claims that this conclusion is driven by Section 1557's incorporation of ***all*** of Section 504 of the Rehabilitation Act ("Section 504"), which

in turn incorporates the ADA, and the pre-ACA cases interpreting the two Acts. *Id.*, p. 2. Kaiser additionally argues that since "hearing loss" is not always a disability under Section 504, the Hearing Loss Exclusion cannot be discrimination. *Id.*, p. 1.

Kaiser is wrong on every count. ***First,*** Congress did not incorporate all of Section 504 or the ADA into Section 1557. The plain language of Section 1557 shows that only the "ground" of and "enforcement mechanisms" from Section 504 of the Rehabilitation Act were incorporated. *See* 42 U.S.C. §18116(a). Congress knew how to refer to the rest of Section 504 and did so in the following subsection. *See* 42 U.S.C. §18116(b) (preserving Section 504's "rights, remedies, procedures, or legal standards" despite passage of Section 1557). Congress's choice of words is presumed to be deliberate. *United States v. Motamedi*, 767 F.2d 1403, 1406 (9th Cir. 1985).

Second, the limited incorporation of Section 504 into Section 1557 is consistent with the legislative purpose of the ACA and DHHS's administrative interpretation. One of the main goals of the ACA was to ensure that all Americans, even those with disabilities, have access to comprehensive coverage to meet their health care needs. That goal would be undermined if this Court were to conclude that Section 1557 allows health insurers to arbitrarily exclude all medically necessary coverage for hearing loss, or other disabling conditions like AIDS, autism, and cancer.

Third, Kaiser relies on outdated cases for its claim that since some people with hearing loss are not disabled, the Hearing Loss Exclusion cannot be facial discrimination. In 2008, the Section 504 definition of "disability" was amended so that it must be broadly construed in favor of coverage. *See* 29 U.S.C. §705(9), *incorporating* 42 U.S.C. §12102(4)(A); 29 C.F.R. §1630.2(1)(i). All insureds who are prescribed medically necessary treatment for hearing loss likely are "disabled." Even if the Hearing Loss Exclusion captures some non-disabled insureds in its net, it is still a form of either facial/proxy or disparate impact discrimination. *See Pac. Shores Props., Ltd. Liab. Co. v. City of Newport Beach* ("*Pacific Shores"),* 730 F.3d 1142, 1160, n.23 (9th Cir. 2013).

Congress intended that people with disabilities have access to comprehensive, non-discriminatory health benefits when it enacted the ACA. Arbitrary, disability-based exclusions in ACA-regulated plans are no longer permissible. The Court should conclude that Appellants adequately alleged a claim of disability discrimination under Section 1557 and remand the case for further proceedings.

II. ARGUMENT

A. SECTION 1557 PROHIBITS DISABILITY DISCRIMINATION IN BENEFIT DESIGN.

Kaiser argues that this Court should apply certain pre-ACA caselaw interpreting Section 504 and the ADA to conclude that its Hearing Loss Exclusion is permissible. *See* Opp. pp. 1-3. This Court should reject Kaiser's argument. ***First,***

the plain language of Section 1557 reveals that only limited portions of Section 504 and none of the ADA are incorporated. ***Second,*** Section 1557 must be interpreted within the context of the ACA's legislative history and remedial purpose. ***Third,*** DHHS also concludes that Section 1557 applies to categorical exclusions of treatment for a disabling health condition.

1. Section 1557 Only Incorporates the "Ground" of and "Enforcement Mechanisms" of Section 504.

When Congress enacted Section 1557, it included insurance contracts within the definition of "federal financial assistance." *See* 42 U.S.C. §18116(a) ("[A]n individual shall not, ***on the ground prohibited under … section 504 of the Rehabilitation Act of 1973*** (29 U.S.C. §794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, ***including*** credits, subsidies, or ***contracts of insurance***") (emphasis added); 45 C.F.R. §92.4; 81 Fed. Reg. 31383. For the first time, ACA-regulated health insurers are subject to federal anti-discrimination law.

Under Section 504, the definition of "federal financial assistance" ***excludes*** contracts of insurance.[1] *See* 45 C.F.R. §84.3(h) ("Federal financial assistance means any grant, loan, contract (***other than*** … ***a contract of insurance***") (emphasis added). Nor are "contracts of insurance" generally subject to the Title I of the ADA. *See* 42 U.S.C. §12111(2). And, in most Circuits, private insurance contracts are not "places of public accommodation" under the ADA's Title III. *See, e.g., Weyer,* 198 F.3d at 1113, 1115. Congress' expansion of anti-discrimination law to ACA-regulated health insurance contracts was deliberate and groundbreaking.

Congress chose not to amend either Section 504 or the ADA to include ACA-regulated health insurers. Congress could have, but did not, expand the definition of "federal financial assistance" under Section 504 to include "contracts of health insurance." Nor did Congress adopt all of Section 504 when drafting Section 1557. Congress only referenced the "ground" of and "enforcement mechanisms" of Section 504 in 42 U.S.C. §18116(a). Tellingly, in the next subsection, Congress referred to Section 504's "rights, remedies, procedures, or legal standards" to ensure

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[1] Kaiser erroneously claims that "decades of jurisprudence" shows that Section 504 applies to contracts of insurance and "plan benefit design." Opp. pp. 17, 26; *compare* 45 C.F.R. §84.3. ***None of the Section 504 cases cited by Kaiser involve private insurance***. *See id*. Section 504 does not apply to insurance contracts (excluding Medicaid and Medicare programs). *See Jacobson v. Delta Airlines,* 742 F.2d 1202, 1210 (9th Cir. 1984); *United States v. Baylor Univ. Med. Ctr.,* 736 F.2d 1039 (5th Cir. 1984).

that existing anti-discrimination law, (*e.g.*, in employment, places of public accommodation, other state services), would not be invalidated or limited. 42 U.S.C. §18116(b) ("Nothing in this title … shall be construed to invalidate or limit the ***rights, remedies, procedures, or legal standards*** available to individuals aggrieved under … section 504") (emphasis added). This Court must presume that Congress intended the different words in subsections (a) and (b) to mean different things. *Motamedi*, 767 F.2d at 1406.

This Court should conclude that Congress drafted Section 1557 to borrow only the "ground" and the "enforcement mechanisms" from Section 504. *See York v. Wellmark, Inc.*, 2017 U.S. Dist. LEXIS 199888, at *52 (S.D. Iowa Sep. 6, 2017) ("The plain meaning of these two sentences combined is clear and unambiguous – claims for discrimination are available on the grounds prohibited in the four listed federal civil rights statutes, and are to be addressed under the … corresponding enforcement mechanisms of the four statutes"). The elements borrowed from Section 504 are limited to just the ground and enforcement mechanisms. "Section 1557 of the ACA ***extends*** the protections of Section 504 of the Rehabilitation Act … ***in the context of the ACA.***" *Huffman v. Univ. Med. Ctr. Mgmt. Corp.*, 2017 U.S. Dist. LEXIS 180999, at *5-*6 (E.D. La. Oct. 31, 2017) (emphasis added).

Kaiser argues that Congress incorporated into Section 1557 ***all*** of Section 504, and, by way of 29 U.S.C. §794(d), ***all*** of the ADA (including the ADA's insurance

safe harbor) into Section 1557.[2] Opp. pp. 17, 25, 30. Yet there is no evidence that Congress intended to incorporate the ADA or other aspects of Section 504 aside from the ground or enforcement mechanisms. *See id.* Congress made a specific choice to reference only the "ground" of and enforcement mechanisms from Section 504, and not the ADA, perhaps recognizing that the ADA's insurance safe harbor would undermine the ACA's anti-discrimination efforts.[3] *See* Blake, Valarie K., *An Opening for Civil Rights in Health Insurance After the Affordable Care Act,* 36 B.C. J.L. & SOC. JUST. 235, 279 (June 2016) (hereinafter, "Blake").

2. Section 1557 Must Be Interpreted In Light of the ACA's Purpose and Context.

This Court must consider the ACA as a whole when interpreting Section 1557. "A fair reading of legislation demands a fair understanding of the legislative plan." *King v. Burwell,* __ U.S. __, 135 S. Ct. 2480, 2496 (2015); *see also id.,* at 2493 ("We cannot interpret federal statutes to negate their own stated purposes"). Congressional

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[2] The ADA's insurance safe harbor does not apply to Section 1557 (*see* Opp. p. 25): ***First,*** the insurance safe harbor does not apply to Section 504, since Section 504 does not regulate private insurance contracts. Therefore, it is not a Section 504 "ground" or "enforcement mechanism" imported into Section 1557. ***Second,*** the insurance safe harbor would render Section 1557 meaningless, since insurers could claim that any benefit design was a form of "underwriting risk." *See Weyer,* 198 F.3d at 1118.

[3] While Section 504 and ADA caselaw may be helpful when interpreting Section 1557, such caselaw may not undo Congress's deliberate expansion of anti-discrimination law to reach the benefit design of ACA-regulated health plans.

intent must also be determined in light of the ACA's remedial nature. Comprehensive remedial statutes are accorded "a sweep as broad as their language." *Griffin v. Breckenridge*, 403 U.S. 88, 97, 91 S. Ct. 1790 (1971).

"In the Affordable Care Act, Congress addressed the problem of those who cannot obtain insurance coverage because of pre-existing conditions or other health issues." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 547, 132 S. Ct. 2566 (2012). Members of Congress intended that the legislation end unfair discrimination on the basis of disability and other serious health conditions. *See* ***Addenda C-E***, 81 Fed. Reg. 31379.

The ACA is one of the most significant anti-discrimination laws passed by Congress. *See* Blake, p. 237. In addition to Section 1557, the ACA prohibits insurers from discrimination based upon health conditions in enrollment and re-enrollment. *See* 42 U.S.C. §§300gg-1; 300gg-2; 300gg-4. It ends the use of discriminatory pre-existing condition limitations in ACA-regulated health insurance. 42 U.S.C. §300gg-3. It prohibits insurers from using disability, health status and medical conditions as a basis of denying eligibility for coverage. 42 U.S.C. §300gg-4(a). It restricts insurers from discriminating against people with health conditions when it comes to paying for premiums. *See* 42 U.S.C. §300gg.

Congress not only intended to make it easier for people with disabilities and health conditions to purchase health coverage, it also intended to end disability

discrimination in the type of benefits offered. Without this protection, insurers could simply re-write illegal pre-existing condition limitations as benefit exclusions. *See* Blake, p. 257. ACA-regulated health plans must offer comprehensive health benefits in ten broad categories of coverage, known as Essential Health Benefits ("EHB"). 42 U.S.C. §18022(b)(1). The ten categories of EHB includes durable medical devices, hospitalization and outpatient office visits. *See* 42 U.S.C. §§18022(b)(1)(A), (C), (G). Coverage of "habilitative services and devices" must include "devices that help a person keep, learn, or improve skills and functioning for daily living … ***for people with disabilities in a variety of inpatient and/or outpatient settings***." 45 C.F.R. §156.115(a)(5) (emphasis added).

Offering some coverage within the ten categories of benefits, standing alone, is not enough to comply with the ACA. Insurers must ensure that the benefits are offered ***in a non-discriminatory manner***. *See* 42 U.S.C. §§300gg-6; 18022(b)(4)(B); 18116(a); 45 C.F.R. §§156.110(d); 156.125(a); 92.207(2). The ACA specifically targeted a few of the most pernicious forms of benefit design discrimination including lifetime and annual dollar caps on benefits and exclusions of mental health and substance use treatment. *See, e.g.*, 42 U.S.C. §§300gg-11; 18022(b)(1)(E); 45 C.F.R. §156.115(a)(3). With Section 1557, Congress included, for the first time, a general prohibition of other forms of disability discrimination that occur in the design of health insurance benefits. *See* 42 U.S.C. §18116(a).

3. Federal Regulators Confirmed that Section 1557 Prohibits Disability Discrimination Based on Benefit Design.

The Court should also consider the administrative interpretation of Section 1557 by DHHS. Kaiser concedes as much. *See* Opp. pp. 32-37. The Section 1557 rules generally prohibit disability discrimination by health insurers and specifically prohibit the "benefit designs that discriminate on the basis of … disability in a health-related insurance plan or policy." 45 C.F.R. §§92.207(a), (b)(2).

DHHS found that "categorical exclusions of all coverage related to certain conditions could raise significant compliance concerns under Section 1557." 81 Fed. Reg. 31433. Such exclusions may only be based upon scientific or medical reasons.[4] *See* 81 Fed. Reg. 31405 ("Scientific or medical reasons can justify distinctions based on the grounds enumerated in Section 1557"). Arbitrary exclusions based upon protected traits, including disabilities, are prohibited. 81 Fed. Reg. 31408; 31434. "[P]roffered justifications cannot rely on overbroad generalizations and cannot be hypothesized or invented *post hoc* in response to litigation." 81 Fed. Reg. 31409. While DHHS did not specify that any particular

[4] This standard is derived from Section 504 caselaw. *See, e.g., Woolfolk v. Duncan*, 872 F. Supp. 1381, 1389 (E.D. Pa. 1995) (Under Section 504, a provider may only withhold treatment based upon a "bona fide medical reason"); *Glanz v. Vernick*, 750 F. Supp. 39, 46 (D. Mass. 1990) (same). Similar standards are required under the ADA. *See Bragdon v. Abbott*, 524 U.S. 624, 649, 118 S. Ct. 2196 (1998).

service must be covered to avoid discrimination, it concluded that ACA-regulated health plans could not ***arbitrarily*** exclude treatment for a particular condition:

> [I]f a plan limits or denies coverage for certain services or treatment for a specific condition, [DHHS] ***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.

81 Fed. Reg. 31433 (emphasis added). *See also* 81 Fed. Reg. 31434 (a fact specific inquiry is required to determine if a benefit design is discriminatory).

Kaiser argues that Section 1557 rulemaking only changed anti-discrimination law related to "gender transition."[5] Opp. p. 33. The DHHS rules and commentary indicate otherwise. While some of the Section 1557 regulations call out specific discriminatory practices related to gender transition, others are generally applicable to all protected classes. *See* 45 C.F.R. §§92.207(a), (b)(1), (2). *See also* 45 C.F.R. §92.207(c) (the specific regulations under 92.207 do not limit the effect of the other more general regulations). DHHS confirmed this approach in its rulemaking

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[5] Kaiser points to DHHS commentary that the Section 1557 requirements were not new to many (***but not all***) covered entities. Opp. p. 35, *citing* 81 Fed. Reg. 31446, 31378. While health providers receiving federal financial assistance were already subject to Section 504, ***contracts of insurance were not.*** DHHS anticipated that insurers might have to change benefit restrictions and exclusions to comply with Section 1557. *See* 81 Fed. Reg. 31430.

commentary. *See* 81 Fed. Reg. 31429 (DHHS applied "basic nondiscrimination principles" to all protected traits), 31433 (DHHS's "approach … in the proposed rule under §92.207(b)(5) relating to … gender transition is the same general approach that [DHHS] will take when evaluating denials or limitations of coverage for other types of health services."). Examples of other kinds of discriminatory benefit design appear throughout the DHHS commentary. *See, e.g.,* 81 Fed. Reg. 31429 (a blanket exclusion of a surgical procedure for insureds with developmental disabilities is discrimination); 81 Fed. Reg. 31434, n. 258 (prior authorization or step therapy for anti-HIV protease inhibitors likely discriminatory).

Kaiser argues that one example of disability discrimination provided by DHHS – that it would be discrimination for a plan to exclude a type of surgery for adults with developmental disabilities, while covering the surgery for other adults – was "on all fours with the standards for discrimination under [Section] 504 and the ADA." Opp. p. 33, *citing to* 81 Fed. Reg. 31429. Unfortunately, no such claim for discrimination in private health insurance could have succeeded under either Section 504 or, in this Circuit, under the ADA. Yet, Kaiser's arguments beg the question: if, as Kaiser suggests, Section 1557 does nothing new, then how does Section 1557 protect against disability discrimination in benefit design discrimination? *See* 45 C.F.R. §92.207(b)(2). Kaiser offers a curious response:

> For example, a hearing aid exclusion that only applied to insureds with significant limitations in hearing but did not apply to insureds who had minor non-disabling hearing loss, could be a *prima facie* violation.

Opp. p. 34. In Kaiser's example, there is unequal treatment between disabled and non-disabled insureds when it comes to a particular benefit – hearing aid coverage. ***Similar unequal treatment results from the actual Hearing Loss Exclusion***. Under the Hearing Loss Exclusion, insureds without disabling hearing loss receive full coverage of inpatient hospitalization, outpatient office visits and durable medical equipment to treat their health conditions. Their medically necessary health care needs are fully met. Meanwhile, insureds with disabling hearing loss are denied the inpatient hospitalization, outpatient office visits and durable medical equipment to treat their condition. Those disabled insureds do not have all of their medically necessary health care needs met. ***The only difference between Kaiser's hypothetical and this case is how the disputed benefit is classified***.

To avoid allegations of discrimination, Kaiser bundles together hospitalization, outpatient office visits, and durable medical equipment when provided to treat hearing loss into a special kind of medical service – "Hearing Loss Treatment" – so it can claim that it excludes all insureds from coverage of this benefit. *See* Opp. p. 4, *citing to* ER 11 ("The benefits plaintiffs seek are not part of the plan in which they participate."). Yet Kaiser's internal policy on hearing coverage reveals that devices to treat hearing loss are a form of durable medical

equipment. *See* ER 234 (For cochlear implants to be covered, "the member must have a durable medical or cochlear implant benefit"); *see also, id.* (In some plans, a bone anchored hearing aid is covered under the "medical benefit" and "prosthetic device benefit"). When devices and services to treat hearing loss are covered, Kaiser often classifies them under the generic benefits of durable medical equipment, prosthetic devices, outpatient office visits, etc. ***Kaiser may classify "Hearing Loss Treatment" as a special benefit only to exclude it.***

In anti-discrimination law, classification matters. Arbitrary classifications, whether motivated by animus or unconscious prejudice, can result in discrimination. *See Crowder v. Kitigawa*, 81 F.3d 1480, 1484 (9th Cir. 1996). A bus company cannot classify the seating in a bus based upon race in order to declare that it still offers the same bus service to white and black riders, while excluding black riders from the better seats. *See, e.g., Browder v. Gayle*, 142 F. Supp. 707, 717 (M.D. Ala. 1956). A college cannot classify hockey teams as men's and women's teams, so that it can claim that allows all to play in a nondiscriminatory fashion, while giving the best equipment, funding and practice times to men's team. *See, e.g., Cook v. Colgate Univ.*, 802 F. Supp. 737 (N.D.N.Y. 1992) *vacated as moot*, 992 F.2d 17 (2d Cir. 1993). A health insurer cannot classify otherwise covered speech, occupational and physical therapies as "neurodevelopmental therapies" when those services are used to treat developmentally disabled insureds, just so that the services can be excluded

from coverage. *See, e.g., Z.D. v. Grp. Health Coop.*, 2012 U.S. Dist. LEXIS 76503, at *33 (W.D. Wash. June 1, 2012).[6] Similarly, Kaiser cannot classify otherwise covered services as special treatment for a disability, just to exclude it.

B. APPELLANTS' ADEQUATELY PLED A PRIMA FACIE CLAIM OF DISABILITY DISCRIMINATION.

Kaiser argues that Appellants failed to adequately plead a claim of facial or disparate impact disability discrimination. *See* Opp. p. 37. This Court, however, has held that the distinction between "facial" and "disparate impact" discrimination is not useful when addressing disability discrimination. *Crowder*, 81 F.3d at 1484. "[I]t is more useful to assess whether disabled persons were denied 'meaningful access' to state-provided services." *Id.* *See also Mark H. v. Lemahieu*, 513 F.3d 922, 937 (9th Cir. 2008); *McGary v. City of Portland*, 386 F.3d 1259, 1266-67 (9th Cir. 2004). Nonetheless, Kaiser's objections based upon facial and disparate impact discrimination are addressed below.

1. The Hearing Loss Exclusion is facially discriminatory.

Kaiser maintains that its Hearing Loss Exclusion is not a form of facial discrimination because not all "hearing loss" is disabling under Section 504. *See* Opp. p. 38-39. Kaiser is wrong for at least three reasons. ***First,*** Kaiser relies on

[6] *Z.D.* was based on the Washington Mental Health Parity Act, not the ADA, so it was not constrained by *Weyer*. *See Z.D.*, 2012 U.S. Dist. LEXIS 76503, at *33.

outdated cases based on a more restrictive definition of "disability" than currently in place.[7] *See Tabb v. Quinn*, 2007 U.S. Dist. LEXIS 98989, at *16 (W.D. Wash. Apr. 12, 2007). The definition of "disability" in both laws was expanded in 2008 with the Americans with Disabilities Act Amendments Act ("ADAAA"). *See* 29 U.S.C. §705(9), *incorporating* 42 U.S.C. §12102. Post-ADAAA, the definition of disability under Section 504 must be "construed in favor of broad coverage." 42 U.S.C. §12102(4)(A); 29 C.F.R. §1630.2(1)(i). "The primary purpose of the ADAAA is to make it easier for people with disabilities to obtain protection under the ADA." 29 C.F.R. §1630.1(c)(4). "The primary object of attention … should be whether covered entities have complied with their obligations and whether discrimination has occurred, not whether the individual meets the definition of disability." *Id.* Under this standard, all insureds who are prescribed medically necessary treatment for hearing loss are likely "disabled."

Second, only insureds with disabling hearing loss will meet Kaiser's "medical necessity" standard for coverage. *See* ER 228 ("Medically Necessary" is treatment that is consistent with the standard of care and ***that may not be omitted without adversely affecting the insured's condition***). A non-disabled insured whose need

[7] *Kulas v. Roberson*, 1999 U.S. App. LEXIS 30588, at *5 n.6 (9th Cir. Nov. 19, 1999) should be disregarded, as it is improperly cited by Kaiser pursuant to FRAP 36-3(c)(iii).

for hearing treatment does not rise to the level of "medical necessity" is ineligible for coverage even without the Exclusion. Insureds who meet Kaiser's medical necessity requirement (*i.e.*, they need hearing treatment to avoid an "adverse effect" to their health) are very likely to be disabled. It is likely that only disabled insureds are denied coverage due ***solely*** to Kaiser's Hearing Loss Exclusion.

Third, even if this Court were to accept Kaiser's premise that its Hearing Loss Exclusion is applied to some non-disabled insureds with hearing loss, Kaiser's "over-discrimination" does not excuse its practice. This is the "grotesque scenario" for covert disability discrimination that this Court warned against in *Pacific Shores*. The fact that Kaiser, in theory, may apply the Exclusion to some non-disabled insureds does not "cleanse the taint of discrimination."[8] *Id.* Ultimately, it is irrelevant whether the "Hearing Loss Exclusion" applies solely to disabled insureds or it captures some non-disabled insureds in its net. The Exclusion is a form of actual or "constructive" disparate treatment. *See McWright v. Alexander*, 982 F.2d 222, 228 (7th Cir. 1992).

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[8] Kaiser argues that Appellants' discussion of proxy discrimination is a "new legal theory" first raised on appeal. *See* Opp. p. 41. Both facial and disparate impact discrimination were briefed and argued before the trial court. ER 50-52, 126-131. Kaiser concedes that "proxy discrimination" is a form of disability discrimination, whether it is characterized as facial or disparate impact discrimination. *See* Opp. p. 41-42. It is not a new legal theory, but if it were, the Court should still consider it. *See Dream Palace v. Cty. of Maricopa*, 384 F.3d 990, 1005 (9th Cir. 2004).

a. Facial Discrimination is Properly Alleged When an ACA-Regulated Health Insurer Excludes Treatment for a Disability.

The crux of Kaiser's argument is that Section 1557 disability discrimination can only be found when an insurer entirely excludes ***a class of disabled people***, and that no discrimination occurs when ***a class of treatments or services*** that those disabled people need is excluded. *See* Opp. p. 43 ("[Kaiser] 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").

Kaiser's claim is contrary to existing anti-discrimination principles. In *Newport News*, the Supreme Court held that a health plan discriminates when it offers disparate coverage of health services needed by a protected class. Discrimination in the provision of health benefits is not limited to exclusions of an entire class of people:

> [I]f a private employer were to provide complete health insurance coverage for the dependents of its female employees, and no coverage at all for the dependents of its male employees, it would violate Title VII…. ***The same result would be reached even if the magnitude of the discrimination were smaller***. For example, a plan that provided complete hospitalization coverage for the spouses of female employees but did not cover spouses of male employees when they had broken bones would violate Title VII by discriminating against male employees.
>
> Petitioner's practice is just as unlawful. ***Its plan provides limited pregnancy-related benefits for employees' wives, and affords more extensive coverage for employees' spouses for all other medical conditions requiring hospitalization.***

Id., 462 U.S. at 683 (emphasis added).

The history behind *Newport News* is instructive. In an earlier case, *General Elec. Co. v. Gilbert*, 429 U.S. 125, 97 S. Ct. 401 (1976), the Supreme Court found that an employer's plan did not discriminate on the basis of gender when it offered the same disability policy to both male and female employees, even though the policy excluded all coverage related to pregnancy. In response, Congress passed legislation to expand Title VII to address discrimination "on the basis of pregnancy, childbirth or related medical conditions" in the "receipt of benefits." *See* 42 U.S.C. §2000e(k). After the amendment was effective, in *Newport News*, the Supreme Court found that Congress intended to broaden existing anti-discrimination principles to ensure that "it is discriminatory to treat pregnancy-related conditions less favorably than other medical conditions." *Id.*, 462 U.S. at 684. Reversing *Gilbert*, the Supreme Court held that a health plan facially discriminates when it offers a package of benefits that excludes coverage for pregnancy-related treatment. *Id.* at 685.

This case is similar. Despite *Weyer* and other cases cited by Kaiser, this Court should conclude that, with Section 1557, Congress has acted to expand anti-discrimination principles to apply to a narrow new area, the benefits in ACA-regulated health insurance. As a result of Section 1557, it is certainly discriminatory to exclude deaf people from all hospitalization coverage. *See* Opp. pp. 42-43. That

is the "simple test" of disability discrimination under Section 1557. *See Newport News,* 462 U.S. at 683. But Section 1557 goes further to reach exclusions of medical services that treat protected traits, even though those exclusions may be of "smaller magnitude." *See id.* Like the pregnancy exclusion in *Newport News,* Kaiser's Hearing Loss Exclusion is facial discrimination.

DHHS reached the same conclusion about Section 1557's reach. "[A]rbitrary age, visit, or coverage limitations could constitute discrimination." 81 Fed. Reg. 31408. "[I]f a plan limits or denies coverage for certain services or treatment for a specific condition, [DHHS] 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." 81 Fed. Reg. 31433. "[C]overed entities must use neutral, nondiscriminatory criteria in making decisions as to which benefits and services to cover, and their health coverage cannot operate in a discriminatory manner." ***Addendum F,*** FAQ No. 45. So did multiple state insurance commissioners. *See, e.g.,* ***Addendum H*** ("[T]he Department will consider an exclusion of treatments for autism spectrum disorder as discriminatory and prohibited"); ***Addendum K*** ("Potentially Discriminatory Benefit Design Example: Bone marrow transplants are excluded from transplant coverage regardless of medical necessity"); ***Addendum J***

(Washington Insurance Commissioner settlement with ***Kaiser*** to remove a blanket exclusion of gender transition procedure).

b. Alexander v. Choate Supports A Finding of Facial Discrimination.

Alexander v. Choate, 469 U.S. 287, 105 S. Ct. 712 (1985), supports Appellants' claims, not Kaiser's. *See* Opp. p. 18. ***First,*** *Choate* held that a Medicaid benefit exclusion based upon a protected trait could "effectively den[y] otherwise qualified handicapped individuals the meaningful access to which they are entitled." *Id*. at 301. ***Second,*** the Supreme Court confirmed that an exclusion that applied only to disabling conditions or that prevented disabled individuals from receiving needed, covered treatment could violate Section 504 by denying "meaningful access" to Medicaid benefits. *Id.* at 302. ***Third,*** *Choate* made clear that "meaningful access" must be defined in relation to the purpose of the statute at issue. *Id.* at 303. *Choate* involved the Medicaid Act, the purposes of which did not include providing "adequate health care." *Id.* Here, the ACA was enacted with an express anti-discrimination purpose: to ensure that all Americans, including people with disabilities, have meaningful access to coverage for the health care they need.

Under the principles in *Choate,* Appellants have alleged a *prima facie* case of disability discrimination. Kaiser's exclusion is based upon a disabling trait. Appellants have alleged that Kaiser denies coverage of hospitalization, outpatient office visits and durable medical equipment when those benefits are needed to treat

their disabling hearing loss, denying them meaningful access to otherwise covered benefits. And, unlike the Medicaid Act, the ACA requires regulated health insurers to offer an appropriate, comprehensive range of benefits without discrimination based upon disability or pre-existing health condition. *See Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 596; 42 U.S.C. §§18022(b)(4)(B), (D); 45 C.F.R. §156.125(a); 78 Fed. Reg. 12842 (A benchmark plan must provide EHBs ***and*** meet non-discrimination requirements).

Kaiser ignores *Choate's* foundational principles, instead referring to certain ADA and Section 504 cases that followed. *See* Opp. pp. 19-25, *citing Weyer* among others. Kaiser's cases do not represent an unquestioned or unanimous line of judicial decisions. A minority of courts have held that the ADA may prohibit insurers and employers from offering benefits that discriminate based on disability. *See, e.g., Tompkins v. United Health Care of New England*, 203 F.3d 90, 95 n.4 (1st Cir. 2000) (health insurers are subject to Title III of the ADA); *Carparts Distribution Ctr. v. Auto. Wholesaler's Ass'n*, 37 F.3d 12, 19 (1st Cir. 1994) (same).

The ADA cases relied upon by Kaiser suffer from some significant weaknesses. *See Sirva Relocation, LLC v. Richie*, 794 F.3d 185, 199 (1st Cir. 2015). ***First,*** "[t]he Supreme Court has never considered whether the ADA forbids [a Title I or Title III entity] from offering disparate benefits to different classes of the disabled." *Id.* ***Second,*** some of Kaiser's cases "were made over strong dissents."

Id. ***Third****,* many of the cases were decided before *Olmstead v. L.C.,* 527 U.S. 581, 119 S. Ct. 2176 (1999), which broadened the concept of disability discrimination. *See id.* The First Circuit concluded:

> Given this littered legal landscape, it cannot be said that there is no room for principled disagreement about the viability of differential-benefits claims under the ADA.

Id., at 200. Into this "littered landscape," Congress took action to require ACA-regulated health insurers to end arbitrary disparate benefits based upon disabling conditions.[9]

c. Olmstead v. L.C. Also Supports Appellants' Claims.

Kaiser claims that *Olmstead* should not be considered because it was a "reasonable accommodation" case. *See* Opp. p. 46. Kaiser conflates the ***remedy*** of "reasonable accommodation" in *Olmstead,* with the ***legal violation*** of disability discrimination that was found by the Supreme Court. *See Olmstead,* 527 U.S. at 601 ("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."). In *Olmstead,*

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[9] Kaiser argues that Congress must be presumed to be aware of past judicial interpretations of the ADA. *See* Opp. pp. 29-30. This argument favors Appellants. Congress knew of the ADA decisions and made a deliberate choice ***not*** to incorporate the ADA into Section 1557.

the Supreme Court rejected the concept in *Choate*, and the other cases cited by Kaiser that disability discrimination can only be found where there is a "comparison class" of non-disabled persons that received preferential treatment. *Id.*, 527 U.S. at 598. "Congress had a more comprehensive view of the concept of discrimination advanced in the ADA." *Id.*

After *Olmstead*, the "comparative approach" to disability discrimination under Kaiser's earlier ADA cases is no longer required.[10] *McGary*, 386 F.3d at 1266. Consistent with both *Choate* and *Olmstead*, disability discrimination occurs when meaningful access to services and benefits is not provided. *See id.* at 1266-1267, *citing Crowder* and *Bay Area Addiction Research and Treatment, Inc. v. City of Antioch*, 179 F.3d 725, 733-35 (9th Cir. 1999). This broader approach is designed "to guard against the façade of equal treatment" when more is needed to actually redress discriminatory wrongs. *McGary*, 386 F.3d at 1267. It targets both intentional discrimination and exclusions that result from inaction, thoughtlessness, or other indifference. "Facially neutral policies may be, in fact, discriminatory if their effect is to keep persons with disabilities from enjoying the benefits of services

[10] The Rehabilitation Act as amended in 1992, reflects this expansive view of disability discrimination. The 1992 Amendments recognized that persons with disabilities have the right to "enjoy full inclusion and integration in the economic, political, social, cultural and educational mainstream of American society." 29 U.S.C. §701(a)(3), as amended.

that, by law, must be available to them." *Presta v. Peninsula Corridor Joint Powers Bd.*, 16 F. Supp. 2d 1134, 1136 (N.D. Cal. 1998). Disability discrimination principles, as they have evolved from *Choate* to *Olmstead*, and when they are applied in the context of the ACA, compel a finding that the Hearing Loss Exclusion is a *prima facie* form of facial discrimination.

2. Alternatively, the Hearing Loss Exclusion is a form of Disparate Impact Discrimination. [11]

Alternatively, the Hearing Loss Exclusion results in disparate impact discrimination because it disproportionately burdens insureds with disabling hearing loss by denying them "meaningful access" to otherwise covered, medically necessary benefits to treat their disability, as well as the legally mandated external review. *See Crowder*, 81 F.3d at 1484; *Cal. Found. for Indep. Living Ctrs. v. Cty. of Sacramento*, 142 F. Supp. 3d 1035, 1063-64 (E.D. Cal. 2015); *see also* 45 C.F.R. §92.101(b)(2)(i) (incorporating 45 C.F.R. §84.4(b)(1)(iii), prohibiting insurers from providing a "benefit or service that is not as effective as that provided to others").

---

[11] The Ninth Circuit recognizes disparate impact discrimination under Section 504, concluding that a denial of "meaningful access" to benefits encompasses both disparate treatment and disparate impact. *Crowder*, 81 F.3d at 1484; *Mark H.*, 513 F.3d. at 937; *see* Opp. p. 43. DHHS confirmed that Section 1557 includes disparate impact claims. 81 Fed. Reg. 31440.

To distinguish *Crowder,* Kaiser argues that no case has applied the "meaningful access" standard to insurance benefit design. Opp. p. 44. This is unsurprising, since neither Section 504 nor the ADA, at least in this Circuit, apply to private insurance benefits. *See* §II.A.1, *supra.* Kaiser also claims that *Crowder* was an "access" case and therefore different from this case.[12] *See* Opp. p. 44. In *Crowder,* visually impaired travelers were denied meaningful access to benefits **(**state services, programs and activities) enjoyed by other non-disabled people, while their guide dogs were subject to quarantine. *Id.,* 81 F.3d at 1484. This case can be described similarly as an "access to benefits" case: Kaiser's Exclusion eliminates meaningful access to the full benefits (hospitalization, outpatient office visits, durable medical equipment) that Kaiser offers to other insureds.

Kaiser also argues that Appellants must show "statistical evidence" of a "significant adverse or disproportionate impact" on the proposed class to avoid dismissal under Rule 12(b)(6). Opp. pp. 44-45, *citing to John Doe One v. CVS Pharmacy, Inc.,* 348 F. Supp. 3d 967, 983-84 (N.D. Cal. 2018). It is true that on ***summary judgment***, such statistical evidence is required in disparate impact claims related to employment. *See Rose v. Wells Fargo & Co.*, 902 F.2d 1417, 1424 (9th

[12] As Amici DREDF *et al.,* explain, the distinction between "access" and "content" based discrimination claims is flawed and unsupported by *Choate.* *See* Dkt. No. 16-1, pp. 9-13.

Cir. 1990). Even if statistical evidence is required to prove a Section 1557 claim, evidence of how Kaiser applies the Hearing Loss Exclusion is only available as a result of discovery. At the Rule 12(b)(6) stage, it is certainly plausible that the Hearing Loss Exclusion is applied by Kaiser exclusively, or to a substantial degree, on insureds with hearing disabilities resulting in disparate impact.

Finally, Kaiser claims that the over-discrimination cases cited by Appellants (*see* Opening Brief, pp. 38-40) are distinguishable because "they all involved differential treatment of disabled individuals compared to others outside the protected class." Opp. p. 42. This is just a re-hash of Kaiser's argument that since all insureds get the same package of benefits, there is no discrimination. This is the quintessential disparate impact case: Kaiser's Exclusion applies nearly exclusively to disabled insureds, denying them access to the full benefits that all other insureds receive.

C. KAISER'S FINANCIAL CLAIMS ARE UNSUPPORTED BY THE RECORD.

Finally, Kaiser argues that, should Plaintiff prevail, the financial impact on health insurers would be "enormous" and unintended by Congress. *See* Opp. p. 53.

First, Congress was significantly concerned about the financial impact of the ACA on ***health consumers***, not insurers. The ACA, including Section 1557, was designed to ***reduce*** the economic cost of uncovered health benefits for consumers. *See* 42 U.S.C. §18091(2)(E) (The "economy loses up to $207,000,000,000 a year

because of poorer health and shorter lifespan of the uninsured"); 42 U.S.C. §18091(2)(G) (Reducing medical expenses owed out-of-pocket would improve financial security for health consumers).

Second, any negative financial impact imposed on insurers by the ACA and Section 1557 is mitigated by significant financial subsidies received and the expansion of the ACA-regulated insurance market. *See Molina Healthcare of Cal., Inc. v. United States*, 133 Fed. Cl. 14, 19 (August 4, 2017); 42 U.S.C. §§18061-18063.

Third, the cost of removing the Exclusion is likely small, since Kaiser covers the most expensive hearing treatment - cochlear implants. ER 194. In 2018, Washington's Medicaid program added coverage of hearing aids for adults. *See* ***Addendum N***.[13] Adding the benefit for nearly 1 million enrollees was approximately $4 million annually, or just ***$0.33 per person per month***. *Id.*

Fourth, and finally, Kaiser's unsubstantiated claims of "enormous" financial impact evokes the historic stigma that kept people with disabilities locked out of health coverage before the ACA. When such claims are offered without evidence, they may "perpetuate[ ] unwarranted assumptions" that disabled people are unable

[13] Washington Health Care Authority Fiscal Note for House Bill No. 1264 (2018), at https://fortress.wa.gov/FNSPublicSearch/GetPDF?packageID=47296 (last visited May 6, 2019).

to benefit from treatment or are unworthy of the cost involved. *Cf. Olmstead*, 527 U.S. at 600. Anti-discrimination laws are meant to "replace such reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically sound judgments." *Sch. Bd. of Nassau Cty. v. Arline*, 480 U.S. 273, 284-85, 107 S. Ct. 1123 (1987).

III. CONCLUSION

Appellants pled a plausible claim of disability discrimination under Section 1557 alleging that Kaiser's Hearing Loss Exclusion discriminates on the basis of disability. The trial court's decision should be reversed, and this case remanded for further proceedings.

RESPECTFULLY SUBMITTED this 13th day of May, 2019.

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Form 8. Certificate of Compliance Pursuant to 9th Circuit Rules 28.1-1(f), 29-2(c)(2) and (3), 32-1, 32-2 or 32-4 for Case Number 18-35846

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DATED: May 13, 2019.

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CERTIFICATE OF SERVICE

I hereby certify on May 13, 2019, I electronically filed this REPLY BRIEF OF APPELLANTS ANDREA SCHMITT AND ELIZABETH MOHONDRO with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF System. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

DATED: May 13, 2019, at Seattle, Washington.

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ADDENDUM N

Individual State Agency Fiscal Note

Revised

Bill Number: 1264 HB	Title: Hearing devices for adults	Agency: 107-Washington State Health Care Authority

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

ACCOUNT		FY 2018	FY 2019	2017-19	2019-21	2021-23
General Fund-Federal	001-2	1,667,000	3,320,000	4,987,000	6,610,000	6,610,000
	Total $	1,667,000	3,320,000	4,987,000	6,610,000	6,610,000

Estimated Expenditures from:

		FY 2018	FY 2019	2017-19	2019-21	2021-23
Account						
General Fund-State	001-1	535,000	1,084,000	1,619,000	2,198,000	2,198,000
General Fund-Federal	001-2	1,667,000	3,320,000	4,987,000	6,610,000	6,610,000
	Total $	2,202,000	4,404,000	6,606,000	8,808,000	8,808,000

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☒ Requires new rule making, complete Part V.

Legislative Contact:	Chris Blake	Phone: 360-786-7392	Date: 01/18/2017
Agency Preparation:	Michael Grund	Phone: 360-725-1949	Date: 02/13/2017
Agency Approval:	Carl Yanagida	Phone: 360-725-1033	Date: 02/13/2017
OFM Review:	Robyn Williams	Phone: (360) 902-0575	Date: 02/13/2017

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Briefly describe by section number, the significant provisions of the bill, and any related workload or policy assumptions, that have revenue or expenditure impact on the responding agency.

See attached narrative.

II. B - Cash receipts Impact

Briefly describe and quantify the cash receipts impact of the legislation on the responding agency, identifying the cash receipts provisions by section number and when appropriate the detail of the revenue sources. Briefly describe the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explain how workload assumptions translate into estimates. Distinguish between one time and ongoing functions.

See attached narrative.

II. C - Expenditures

Briefly describe the agency expenditures necessary to implement this legislation (or savings resulting from this legislation), identifying by section number the provisions of the legislation that result in the expenditures (or savings). Briefly describe the factual basis of the assumptions and the method by which the expenditure impact is derived. Explain how workload assumptions translate into cost estimates. Distinguish between one time and ongoing functions.

See attached narrative.

Part III: Expenditure Detail

III. A - Expenditures by Object Or Purpose

	FY 2018	FY 2019	2017-19	2019-21	2021-23
FTE Staff Years					
A-Salaries and Wages					
B-Employee Benefits					
C-Professional Service Contracts					
E-Goods and Other Services					
G-Travel					
J-Capital Outlays					
M-Inter Agency/Fund Transfers					
N-Grants, Benefits & Client Services	2,202,000	4,404,000	6,606,000	8,808,000	8,808,000
P-Debt Service					
S-Interagency Reimbursements					
T-Intra-Agency Reimbursements					
9-					
Total:	$2,202,000	$4,404,000	$6,606,000	$8,808,000	$8,808,000

III. C - Expenditures By Program (optional)

Program	FY 2018	FY 2019	2017-19	2019-21	2021-23
HCA Other (200)	2,202,000	4,404,000	6,606,000	8,808,000	8,808,000
Total $	2,202,000	4,404,000	6,606,000	8,808,000	8,808,000

Part IV: Capital Budget Impact

None.

Part V: New Rule Making Required

Identify provisions of the measure that require the agency to adopt new administrative rules or repeal/revise existing rules.

See attached narrative.

HCA Fiscal Note

Bill Number: 1264 HB HCA Request #: 17-09

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

This bill directs the Health Care Authority (HCA) to require medical assistance coverage for hearing devices for adults (age 21 and older) effective January 1, 2018.

Medical assistance coverage shall include the purchase of 1 or 2 new hearing aids every 5 years, depending on hearing loss assessments, including the ear molds or other earpieces and the connecting tubing or wire and including a prefitting evaluation and follow-up appointments. Also included is the replacement, repair, reprogramming, and rental of hearing aids that are lost, damaged, or need maintenance, and the replacement of ear molds, ear pieces and tubing or wire that no longer fit properly or are worn out.

Medical assistance coverage shall also include the repair, maintenance, and replacement parts for cochlear implant devices and bone conduction devices.

Bill Details

Section (9)(a) - For enrollees who have an average decibel loss of 45 or greater in the enrollee's better ear, medical assistance includes the purchase of 1 new hearing aid every 5 years.

Section (9)(b) - For enrollees who have an average decibel loss of 56 or greater in each ear, medical assistance includes the purchase of 2 new hearing aids every 5 years.

Section (9)(c) - For enrollees who have tried to adapt with 1 hearing aid for a period of 6 months and who have an average decibel loss of 45 or greater in both ears, medical assistance includes the purchase of 2 new hearing aids every 5 years.

Section (9)(d) - Medical assistance includes repair, maintenance, and replacement parts for cochlear implant devices and bone conduction devices.

II. B - Cash Receipts Impact

Cash Receipts			FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
001	GF-Federal Medicaid Title XIX	C	1,667,000	3,320,000	3,305,000	3,305,000	3,305,000	3,305,000
Total			**1,667,000**	**3,320,000**	**3,305,000**	**3,305,000**	**3,305,000**	**3,305,000**
Biennial total				**4,987,000**		**6,610,000**		**6,610,000**

The HCA anticipates that the services provided as a result of this bill will be eligible for a weighted average Federal Medical Assistance Percentage (FMAP) of 75.71% in FY 2018, 75.38% in FY 2019, and 75.05% in FY 2020 and forward, based on the October 2016 Forecast.

II. C - Expenditures

Expenditures			FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
001	GF-State	1	535,000	1,084,000	1,099,000	1,099,000	1,099,000	1,099,000
001	GF-Federal Medicaid Title XIX	C	1,667,000	3,320,000	3,305,000	3,305,000	3,305,000	3,305,000
Total			**2,202,000**	**4,404,000**	**4,404,000**	**4,404,000**	**4,404,000**	**4,404,000**
Biennial Total				**6,606,000**		**8,808,000**		**8,808,000**

Medicaid

Hearing Aid and Hardware Repair

Medicaid currently covers hardware for children (age 20 and younger), but not for adults (age 21 and over). The last fiscal year in which hearing aid hardware was covered for adults was fiscal year 2010. During the year, 0.6 percent of eligible adults utilized this benefit at a cost of $471.74 per client. Utilizing the same utilization and costs from 2010, the HCA projects that 0.6 percent of eligible clients will utilize the benefit. Furthermore, the HCA assumes that in each year, half of the projected clients will utilize the benefit for one hearing aid at a per client cost of $471.74, and the other half will utilize the benefit for two hearing aids at a per client cost of $943.48.

	One Hearing Aid	Two Hearing Aids	Total
Total Eligible Clients	964,756	964,756	
Estimated Utilization	0.30%	0.30%	
Potential Users	2,894	2,894	
Cost per Client	$ 471.74	$ 943.48	
Total Expenditures	$ 1,365,216	$ 2,730,431	$ 4,095,647

Cochlear Implant Devices and Bone Conduction Devices

The HCA does not currently provide coverage for adults who need cochlear implant devices or bone conduction devices. The HCA projects that approximately 0.012 percent of eligible clients will utilize the benefit at a per client cost of approximately $2,658.80 for repair, maintenance, and replacement parts.

	Cochlear Implant / Bone Conduction
Total Eligible Clients	964,756
Estimated Utilization	0.012%
Potential Users	116
Cost per Client	$ 2,658.80
Total Expenditures	$ 308,421

Testing

Medicaid currently covers hearing tests for all clients.

Part IV: Capital Budget Impact

None

Part V: New Rule Making Required

WAC policies and state plan would need to be updated.