No. 19-15074

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

JOHN DOE, ET AL., APPELLANTS

v.

CVS PHARMACY, INC., ET AL.,
APPELLEES

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
(THE HON. EDWARD M. CHEN)

BRIEF OF APPELLEES CVS PHARMACY, INC., CAREMARK, L.L.C., AND CAREMARK CALIFORNIA SPECIALTY PHARMACY, L.L.C.

Enu Mainigi
Grant A. Geyerman
Sarah Lochner O'Connor
WILLIAMS & CONNOLLY LLP
725 Twelfth Street, N.W.
Washington, DC 20005
(202) 434-5000

Tami S. Smason
FOLEY & LARDNER LLP
555 S. Flower Street
Suite 3300
Los Angeles, CA 90071
(213) 972-4500

Counsel for Appellees
CVS Pharmacy, Inc., Caremark, L.L.C., and Caremark California Specialty Pharmacy, L.L.C.

CORPORATE DISCLOSURE STATEMENT

Appellee CVS Pharmacy, Inc. is a wholly owned subsidiary of CVS Health Corporation. Appellees Caremark, L.L.C. and Caremark California Specialty Pharmacy, L.L.C. are wholly owned indirect subsidiaries of CVS Health Corporation.

CVS Health Corporation is a publicly traded company, but no publicly traded corporation owns 10% or more of its stock. CVS Health Corporation is the only publicly traded corporation that owns (directly or indirect) a 10% or more interest in Appellees CVS Pharmacy, Inc., Caremark, L.L.C., or Caremark California Specialty Pharmacy, L.L.C.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

FEDERAL CASES

STATE CASES

OTHER AUTHORITIES

INTRODUCTION

Appellants John Does I–V ("Does I–V") wish to rewrite the terms of their prescription drug insurance coverage. The prescription plans offered by their employers—like most health plans everywhere—provide lower prices on prescriptions filled at "in-network" pharmacies but lesser-to-no coverage at "out-of-network" pharmacies. In healthcare, this principle is commonplace and essential. For example, a Health Maintenance Organization ("HMO") plan typically limits coverage to care from physicians and facilities that contract with the HMO and does not cover "out-of-network" care except in an emergency. Under a Preferred Provider Organization ("PPO") plan, members pay less if they use providers in the plan's network but can obtain services from out-of-network providers for additional costs. Managed care plans like HMOs and PPOs are a widely used means of reducing healthcare costs, including premiums and deductibles paid by members.

Does I–V, who have HIV/AIDS, are subject to the same terms of coverage as all other enrollees in their employers' prescription plans. For any "specialty medication," their plans provide in-network pricing only when a designated specialty pharmacy fills the prescription and delivers the medicine through the mail or to a CVS retail pharmacy for pick-up. Does I–V call this plan design the "Program." The Program's specialty formulary includes more than 300 drugs

ranging from contraceptive devices to treatments for life-changing diseases like HIV/AIDS and cancer to medications for more common conditions like psoriasis, osteoporosis, arthritis, and asthma. *See* ER-48 n.6; *accord* ER-48–49, 51–52, 65, 66, 68.[1]

Does I–V do not dispute that they received the exact prescription benefits offered by their plans. Rather, they dislike having to receive specialty medicines through the mail or at CVS pharmacies to receive in-network prices; they would prefer to purchase their HIV/AIDS medicines at out-of-network "community pharmacies" without giving up in-network prices. They claim the Program discriminates against them on the basis of their HIV/AIDS, and through this suit, they seek "continued access to community pharmacies as an 'in-network' benefit." ER-96 (¶ 201). As the District Court correctly noted, "[t]he logical extension of Plaintiffs' discrimination challenge could threaten the basic structure of [HMOs and PPOs]." ER-192.

After this case was dismissed, the Sixth Circuit decided *Doe v. BlueCross BlueShield of Tennessee, Inc.*, 926 F.3d 235 (6th Cir. 2019). *BlueCross* held, as this Court should, that an HIV/AIDS patient's functionally identical allegations

[1] This brief uses the abbreviation "ER" for Appellants' excerpts of record; "SER" for Appellees' joint supplemental excerpts of record; "Br." for Appellants' brief; and "ECF" for docket entries in the District Court.

were not actionable under the Affordable Care Act ("ACA") or the Americans with Disabilities Act ("ADA") because neither statute recognizes a disparate impact claim premised on the terms of an insurance policy. Although aspects of the Sixth Circuit's cogent reasoning are new and were not the basis for the District Court's dismissal in this case, this Court may affirm on any ground supported by the record—and it should do so here.

Furthermore, even if the ACA did recognize disparate impact claims in disability cases, as the District Court presumed, Does I–V failed to sufficiently allege the ***disproportionate*** harm to HIV/AIDS patients and deprivation of "meaningful access" to a ***prescription benefit their employers offer*** necessary to state such a claim. As the District Court correctly held, whatever the Program's allegedly unpleasant impacts, they are not the result of Does I–V having HIV/AIDS. Rather, they are the result of purchasing a specialty medication, and they are experienced by any member of Does I–V's plans who purchases a specialty medicine. The ADA claim fails for the additional reason that, under controlling precedent, the terms of an insurance policy are not a "place of public accommodation," as the statute requires. Does I–V's claims under two California statutes and ERISA likewise fail for the reasons discussed herein, including because many of the arguments they now make on appeal were not pled in the Complaint or otherwise preserved below.

JURISDICTIONAL STATEMENT

The CVS Appellees agree with Appellants' jurisdictional statement.

ISSUES PRESENTED

1. Whether the Complaint fails to state an ACA claim, considering disparate impact is not a cognizable theory of disability discrimination under the ACA pursuant to *Doe v. BlueCross BlueShield of Tennessee, Inc.*, and even if it were, the Complaint does not allege effects disproportionately experienced by HIV/AIDS patients compared with other individuals purchasing specialty medications, impacts resulting from Does I–V's disability rather than the type of medication purchased, or any deprivation of any coverage benefit guaranteed by their prescription plans.

2. Whether the Complaint fails to state an ADA claim, considering Circuit precedent forecloses such claims where, as here, the alleged discrimination arises from the facially-neutral terms of an insurance policy.

3. Whether the Complaint fails to state a claim under California's Unruh Civil Rights Act, considering Does I–V do not allege intentional discrimination or a viable ADA claim to serve as the predicate for an Unruh Act violation.

4. Whether the Complaint fails to state a claim for denial of benefits under ERISA, considering Does I–V's prescription plans do not entitle them to purchase specialty medicines at in-network prices except through the Program.

5. Whether the Complaint fails to state a claim under California's Unfair Competition Law, considering the Program does not violate any law and is not "unfair" for purposes of the statute.

6. Whether Does I–V may pursue a cause of action for declaratory relief, considering declaratory relief is not an independent cause of action and, in any event, Appellants' Brief failed to properly appeal the issue.

STATEMENT OF THE CASE

Appellants Does I–V are five anonymous individuals who take HIV/AIDS medicines. ER-22–23, ER-25, ER-29, ER-32, ER-34 (¶¶ 20, 31, 43, 50, 58).

Appellees include CVS Pharmacy, Inc. (primarily a retail pharmacy company), Caremark, L.L.C. (a pharmacy benefits manager), and Caremark California Specialty Pharmacy, L.L.C. (a specialty pharmacy) (collectively, "CVS" or the "CVS Appellees"), which all are affiliates of the non-party CVS Health Corporation. Appellees Lowe's Companies, Inc., Time Warner, Inc. ("Warner"), and the National Railroad Passenger Co., ("Amtrak") (collectively, "the Employers") are three employers who allegedly provided prescription benefits to one or more of Does I–V. ER-21–22 (¶¶ 15–17). The Employers contracted with an affiliate of Caremark, L.L.C. to administer their employees' prescription plans.[2]

[2] That affiliate, CaremarkPCS Health, L.L.C., is not a party in the case. ER-205–06.

The CVS Appellees do not themselves provide prescription drug coverage to Does I–V.

A. "The Program" for Specialty Medications

Employers typically make changes to the terms and conditions of their health plans annually. For those offering HMOs, PPOs, or other managed care plans, which rely upon "networks" in order to control costs for plans and their members, those changes may include modifying the network of providers (e.g., doctors, hospitals, pharmacies) from which products and services can be obtained at the lowest cost.[3]

Specialty medicines generally are expensive drugs that require special handling (e.g., refrigeration) or administration (e.g., injections) and/or treat complex conditions. ER-48. In administering the Program, Caremark Specialty fills the patient's prescription and mails it to an address of his choice or a CVS retail pharmacy for pick-up. ER-16–17 (¶ 1). The Complaint labels this plan design "the Program." ER-17 (¶ 1).

[3] *See, e.g.*, U.S. Nat'l Library of Medicine, "Managed Care," https://medlineplus.gov/managedcare.html (last visited Aug. 6, 2019) (describing HMOs, PPOs, and other managed care plans); *accord, e.g.*, Health insurance plan & network types: HMOs, PPOs, and more, https://www.healthcare.gov/choose-a-plan/plan-types/ (last visited Aug. 6, 2019).

The Program applies to ***all*** specialty medications, including some that treat HIV/AIDS and many that do not. *See, e.g.*, ER-39, 48 & n.6, 48–71 (¶¶ 70, 94) (listing drugs like contraceptives, growth hormones, fertility treatments, and medicines for treating psoriasis, arthritis, and osteoporosis); *accord* SER-428–37. The Program formulary cited in the Complaint lists more than 300 medications. ER-48 & n.6. Anyone purchasing any one of these medications, whether an HIV/AIDS patient or not, is subject to the Program, as Does I–V acknowledge. ER-48, 76 (¶¶ 94, 120). The Program does not apply to non-specialty drugs. ER-39 (¶ 70) (distinguishing rules for "regular medications" from the "separate program for specialty medications").

Does I–V dislike the Program's pricing and service. As to price, Does I–V contend the Program "transform[s] drug purchase at community pharmacies from an 'in-network' covered benefit to an 'out-of-network' payment" such that "patients using a non-CVS community pharmacy will be considered going 'out-of-network' and will be subject to increased 'out-of-network' charges or may not have these medications covered at all." ER-38 (¶ 68). In other words, filling a specialty prescription except through Caremark Specialty costs Does I–V more out of pocket. *Id.* The Program places no physical barriers on Does I–V's ability to shop at community pharmacies or anywhere else.

As to service, Does I–V say their now out-of-network community pharmacists "with specific training in HIV/AIDS Medications" are "best positioned" to provide "advice and counseling" to them through "face-to-face interactions"; detect "adverse drug interactions" given their knowledge of Does I–V's "medical history"; and "immediately provide new drug regimens as their disease progresses." ER-38–39 (¶ 70). Does I–V also complain that, under the Program, Caremark Specialty's pharmacists are available only for phone consultations.[4] ER-46 (¶ 91). In addition, Does I–V claim that prescriptions sent by mail risk getting "lost or stolen" and raise "privacy and personal liberty concerns." ER-41 (¶ 74). Doe I alleges his medication once was left "baking in the afternoon sun," although there is no allegation the medicine's efficacy was affected. ER-23 (¶ 24).

Does I–V allege a disparate impact theory of discrimination, claiming "patients with HIV and AIDS are disproportionately impacted by the Program compared to other patients." ER-47 (¶ 92); *see also id.* ("HIV/AIDS patients are particularly hard hit."); ER-76–77 (¶ 120) ("predominantly impacts . . . persons

[4] Plan documents on which the Complaint relies—and which Does I–V agreed were properly considered when deciding Defendants' motions to dismiss, ER-161—clarify that Caremark Specialty's services include "[a]ccess to . . . support from a clinician-led care team to . . . manage your condition" and "[a]ccess to pharmacists available for emergency consultations 24 hours a day, 365 days a year." SER-145; *see also* SER-518.

with HIV-AIDS."); ER-74 (¶ 108) ("Enrollees with HIV/AIDS . . . are . . . disproportionately impacted by the Program"), ER-83 (¶ 145) (Class Members "disproportionately impacted"). The Complaint does not allege CVS designed the Program to discriminate intentionally against HIV/AIDS patients.

B. Does I–V's Prescription Plans

Employers are not required to offer employees welfare benefit plans and thus they have broad discretion in designing or selecting the benefits they offer. Once a benefit plan is in place, employers are free to amend, reduce or even eliminate their benefits packages at will, *see, e.g.*, SER-83–84, 99, assuming proper notice is provided. Although the Complaint relies upon the Employers' plans, it does not attach documentation explaining them or make allegations concerning the process by which the Employers incorporated the Program into their health plans in 2015 or 2016. Nor does the Complaint allege the terms of Does I–V's prescription plans, except to say (correctly) that specialty medications are no longer available at in-network prices unless obtained through the Program. *See* ER-17, 38 (¶¶ 1, 68).

C. The District Court Proceedings

In February 2018, Does I–V filed this lawsuit as a putative class action on behalf of individuals subject to the Program who purchased HIV/AIDS medicines. ER-1. After CVS moved to dismiss the original complaint, ER-6, Does I–V filed

an amended complaint asserting causes of action against CVS under five statutes: the Affordable Care Act ("ACA"), 42 U.S.C. § 18116; the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12182(a); the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), (a)(3); California's Unruh Civil Rights Act ("Unruh Act"), Cal. Civ. Code § 51(b); and California's Unfair Competition Law ("UCL"), Cal. Bus. & Prof. Code §§ 17200-17210. Does I–V sought a "declaration of rights" in a separate cause of action. ER-101–02. Only the ERISA and declaratory relief counts were pleaded against the Employers.

In July 2018, CVS moved to dismiss all counts in the Complaint, asserting the same grounds for dismissal as presented in its original motion. In September 2018, the District Court (Hon. Edward Chen) heard extensive argument on the motion, and in December 2018 it granted the motion in full, dismissed all claims with prejudice, and entered judgment for CVS and the Employers. ER-106–178, 179–218.

In its 40-page opinion, the District Court explained why Does I–V have failed to state a claim upon which relief may be granted against CVS. On the discrimination claims, it found Does I–V could not "allege that they were treated differently on the basis of their HIV/AIDS status" because the impacts they complained of arose from the type of drug purchased rather than their disease; ER-188–89; they had not "sufficiently alleged that enrollees with HIV/AIDS are

disparately impacted by the Program's restrictions relative to other enrollees," given the Complaint's lack of comparative allegations, *id.*; and they had not alleged a deprivation of "meaningful access" for ACA purposes, a "place of public accommodation" for ADA purposes, or intentional discrimination under any statute, ER-190–98. The District Court commented that Does I–V effectively sought "to change the terms of their benefit plan[s] so that they (and not other plan enrollees) obtain their HIV/AIDS medication from non-CVS pharmacies at in-network prices" and that "[t]he logical extension of Plaintiffs' discrimination challenge could threaten the basic structure of [HMOs and PPOs]," which are built around in-network providers. ER-191–92.

On the ERISA claims, the District Court found the denial-of-benefits claim failed because Does I–V did not specify any "terms under their plans entitl[ing] them" to the benefit sought through the lawsuit—i.e., "continued access to community pharmacies as an 'in-network' benefit." ER-202. It also dismissed the other ERISA claims (breach of fiduciary duty; full-and-fair review), which Does I–V have not appealed. ER-203–11.

The District Court dismissed the UCL claim because there was no predicate violation of law to establish "unlawfulness," ER-198–99, or sufficient allegations to plead "unfairness" under the threshold tests, ER-199–202. Having found each

substantive count failed to state a claim, the District Court also dismissed the separate claim for declaratory relief. ER-211.

On appeal, Does I–V challenge the dismissal of their ACA, ADA, Unruh, UCL, and ERISA denial-of-benefits claims. They have not appealed the dismissal of their other ERISA claims, nor properly appealed the dismissal of their request for declaratory relief.

STANDARD OF REVIEW

This Court reviews *de novo* dismissals under Rule 12(b)(6). *Knievel v. ESPN*, 393 F.3d 1068, 1072 (9th Cir. 2005). Although Rule 12(b)(6) requires a court to construe material facts in favor of the pleader, it "need not accept as true allegations that contradict matters properly subject to judicial notice or by exhibit" or those that are "merely conclusory, unwarranted deductions of fact, or unreasonable inferences." *Sprewell v. Golden State Warriors*, 266 F.3d 979, 988 (9th Cir. 2001). This Court also reviews *de novo* questions of law, including any interpretation of statutes. *Cousins v. Lockyer*, 568 F.3d 1063, 1067 (9th Cir. 2009). The Court may affirm on any ground supported by the record, regardless of whether that ground was considered or relied upon by the District Court. *Thompson v. Paul*, 547 F.3d 1055, 1058–59 (9th Cir. 2008).

SUMMARY OF THE ARGUMENT

The Court should affirm the judgment of the District Court in full.

I. The ACA claim was properly dismissed for multiple reasons. ***First***, Does I–V say the Program discriminates by disproportionately impacting individuals with HIV/AIDS. However, in June 2019, following the District Court's decision in this case, the Sixth Circuit concluded after a thorough statutory analysis that disparate impact is not an actionable theory under § 504 the Rehabilitation Act of 1975, which provides the substantive standard that governs the ACA claim here. *See Doe v. BlueCross BlueShield of Tenn., Inc. ("BlueCross")*, 926 F.3d 235 (6th Cir. 2019). It reached that conclusion in an identical case challenging an insurer's mail-order requirement for specialty medications. Although the District Court did not consider this particular question of law, this Court is free to—and should—follow the cogent reasoning of *BlueCross*.

Second, even if the Rehabilitation Act did recognize disparate impact claims, the ACA claim here fails because Does I–V have not plausibly pled a disparate impact. Their Complaint does not allege sufficient facts that the Program disproportionately effects HIV/AIDS patients compared to other enrollees in Does I–V's same prescription plans who also purchase specialty medications. Moreover, any conceivable disparate impacts are not "solely by reason" of their

disability, 42 U.S.C. § 18116, but rather a result of ***the type of medication*** they are purchasing. Anyone purchasing a specialty medicine—disabled or not, suffering from HIV/AIDS or not—must fill the prescription through Caremark Specialty to receive in-network prices.

Third, Does I–V cannot show a deprivation of "meaningful access to the benefit the grantee offers," as required by *Alexander v. Choate*, 469 U.S. 287, 301 (1985). Under their prescription plans, Does I–V have no entitlement to purchase specialty medicines at in-network prices except when filled by Caremark Specialty and shipped through the mail or to a CVS pharmacy for pick up. CVS unquestionably provides Does I–V's prescriptions in compliance with those plan terms and, thus, Does I–V have not been "deprived" of any right "offered" by their employers' plans. The Program's restriction on the pharmacies at which Does I–V can receive the best price for specialty medicines is not analogous to the situations this Circuit has found deprived other plaintiffs of meaningful access.

Finally, the Complaint fails properly to plead the ACA's jurisdictional requirement: that the CVS Appellees' are intended and actual recipients of federal funding in connection with the Program. The District Court found it unnecessary to reach this argument, but it independently justifies affirmance.

II. Dismissal of the ADA claim should likewise be affirmed. Because the type of medicine determines the prices members pay at different pharmacies,

Does I–V cannot demonstrate discrimination "on the basis of" disability for purposes of the ADA. Moreover, controlling precedent holds that the ADA's "place of public accommodation" requirement is not satisfied where, as here, the plaintiff's theory of discrimination challenges the terms of an insurance plan. *See, e.g.*, *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104 (9th Cir. 2000); *Chabner v. United of Omaha Life Ins.*, 225 F.3d 1042, 1046–47 (9th Cir. 2000).

III. The Unruh Act claim was also properly dismissed. A plaintiff cannot state an Unruh Act claim without pleading either a violation of the ADA or intentional discrimination. The Complaint here does not adequately allege either.

IV. Dismissal of the ERISA denial-of-benefits claim should likewise be affirmed. Does I–V have no entitlement under their employers' prescription plans to receive in-network pricing on specialty medicines purchased outside the Program. In-network pricing on specialty medicines at community pharmacies is not a "benefit" under their plans, and thus it cannot have been "denied" under ERISA. Does I–V are seeking to ***change*** their benefit plans, not to ***enforce*** them.

V. The Complaint claim fails to state a UCL claim under that statute's "unlawful" or "unfair" prongs. The Complaint says CVS's conduct was unlawful because it violated the ACA, ADA, ERISA, and Unruh Act. For the reasons discussed herein, however, the District Court rightly rejected those claims, leaving no predicate violation of law for a UCL claim. In addition, insofar as Does I–V

suggest the Program violates other laws (*e.g.*, California's constitutional right of privacy and 45 C.F.R. § 156.122(e)), those assertions are not well-pled, conflict with the administering agency's guidance about the regulation, or both. Likewise, the Complaint contains no well-pled allegations demonstrating that the UCL's various tests for "unfairness" are satisfied here.

ARGUMENT

I. THE DISTRICT COURT CORRECTLY DISMISSED THE AFFORDABLE CARE ACT CLAIM.

"[I]t is Appellants' contention that the Program's design has a discriminatory ***effect*** on those with disabilities." Br. 53;[5] *see* ER-47, 74, 76, 83 (¶¶ 92, 108, 120, 145). The Complaint does not allege that CVS designed its Program for specialty medications to discriminate ***intentionally*** against people with HIV/AIDS.[6] Because disparate impact is the theory presented here, the Court

[5] All emphases in this brief are added, unless otherwise indicated.

[6] To the contrary, Does I–V repeatedly confirmed in the proceedings below that their Complaint is confined to disparate impact discrimination. *See* ER-187 ("Plaintiffs appear to concede[] that they are not alleging an intentional discrimination claim."); ER-109–10, ER-116–17 (counsel conceding the Complaint lacks any "indication of intentional singling out of this particular group"); *see also*, *e.g.*, SER-17 ("Plaintiffs in this action allege a disparate *impact* on HIV/AIDS patients") (emphasis in original). Insofar as Does I–V would attempt to argue on appeal they are claiming intentional discrimination, such an argument has been waived. *See, e.g.*, *In re Mercury Interactive Corp. Secs. Litig.*, 618 F.3d 988, 992 (9th Cir. 2010) ("[A]n issue will generally be deemed waived on appeal if the argument was not 'raised sufficiently for the trial court to rule on it.'") (internal quotation marks and citation omitted).

may affirm the dismissal of Does I–V's claim under § 1557 of the ACA for any of five independent reasons.

A. Disability-Based Disparate Impacts Are Not Actionable Discrimination Under the ACA.

Does I–V allege that CVS violates § 1557 of the ACA by purportedly discriminating against them based on their HIV/AIDS status. Section 1557 provides:

> ***[A]n individual shall not, on the ground prohibited under*** title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or ***section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794)***, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance. . . . The enforcement mechanisms provided by and available under such title VI, title IX, ***section 504***, or such Age Discrimination Act shall apply for purposes of violation of this subsection.

42 U.S.C. § 18116(a). In turn, § 504 of the Rehabilitation Act, states that "[n]o otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subject to discrimination" under any program receiving Federal financial assistance or under activities conducted by certain Federal agencies. 29 U.S.C. § 794(a).

Six months after the District Court's dismissal here, in identical circumstances, the Sixth Circuit interpreted § 1557 of the ACA with respect to

disability discrimination. *See Doe v. BlueCross BlueShield of Tenn., Inc.*, 926 F.3d 235 (6th Cir. 2019). There, a plaintiff with HIV/AIDS claimed discrimination where, in order to receive in-network pricing, his insurance plan required enrollees to obtain specialty medications through the mail or for pick-up at certain brick-and-mortar pharmacies. *Id.* at 237–38. Like Does I–V here, that plaintiff alleged the insurer's mail-order requirement disparately impacted him by rendering his preferred pharmacy unaffordable and violating his privacy. *Id.* at 237–38, 241. Writing for a unanimous panel, Judge Jeffery Sutton analyzed (1) how § 1557 of the ACA adopts the substantive standard for discrimination set forth in § 504 of the Rehabilitation Act rather than establishing a new standard for disability discrimination, *id.* at 238–41; and (2) why the text, statutory history, and limits of the Rehabilitation Act's reach articulated by the Supreme Court collectively demonstrate "§ 504 does not prohibit disparate-impact discrimination," *id.* at 241–43.

The *BlueCross* analysis is correct on both points. Concerning point (1), the *BlueCross* court noted that the ACA creates a private right of action "on ***the ground*** prohibited" by each of four specific statutes, a phrase incorporating "the forbidden source of discrimination" by reference to what each specific statute precludes. *BlueCross*, 926 F.3d at 238 (internal quotation marks omitted). Likewise, § 1557 explicitly says those statutes' respective "enforcement

mechanisms" "shall apply" to corresponding ACA discrimination claims, indicating that, in enacting the ACA, Congress consciously rejected "creat[ing] a brand-new single standard for what qualifies as discrimination." *Id*. at 239. Had Congress intended to create a new standard, it would have been unnecessary and illogical to reference the existing statutes' enforcement mechanisms. *Id.* Accordingly, the private right of action under § 1557 "picks up the standard of care," *id*., from the applicable underlying statute—here, the Rehabilitation Act. Of the four statutes incorporated by reference in § 1557, only the Rehabilitation Act governs discrimination concerning the disabled.

Does I–V's arguments directly contradict this common-sense reading of the statute. They argue that the ACA created "[n]ew [a]nti-[d]iscrimination standards," Br. 16–22, relying almost exclusively on an unpublished district court opinion, *Rumble v. Fairview Health Services,* 2015 WL 1197415, at *11 (D. Minn. Mar. 16, 2015), Br. 17–18. *BlueCross* implicitly rejected *Rumble*'s analysis, and every court to address this aspect of *Rumble* has disagreed with it. *See, e.g., Briscoe v. Health Care Serv. Corp.*, 281 F. Supp. 3d 725, 738 (N.D. Ill. 2017) ("If Congress intended for a single standard to apply to all § 1557 discrimination claims, repeating the references to the civil-rights statutes and expressly incorporating their distinct enforcement mechanisms would have been a pointless (and confusing) exercise."); *Se. Pa. Transp. Auth. v. Gilead Scis., Inc. ("SEPTA")*,

102 F. Supp. 3d 688, 698–99 (E.D. Pa. 2015) ("Congress's express incorporation of the enforcement mechanisms from those four federal civil rights statutes, as well as its decision to define the protected classes by reference thereto, manifests an intent to import the various different standards and burdens of proof into a Section 1557 claim, depending upon the protected class at issue."); *York v. Wellmark, Inc.*, 2017 WL 11261026, at *15–16 (S.D. Iowa Sept. 6, 2017) ("Congress clearly intended to incorporate the statutes' specific enforcement mechanisms rather than create a general catch-all standard applicable to all discrimination claims."); *cf. E.S. ex rel. R.S. v. Regence BlueShield*, 2018 WL 4566053, at *3–4 (W.D. Wash. Sept. 24, 2018) ("reject[ing] the contention that section 1557 creates new substantive rights apart from existing discrimination law").

Concerning point (2), the *BlueCross* court explained that § 504 of the Rehabilitation Act was "'patterned after Title VI [of the Civil Rights Act of 1964],'" which itself does not reach disparate-impact discrimination. 926 F.3d at 242 (quoting *Cmty. Television of S. Cal. v. Gottfried*, 459 U.S. 498, 509 (1983)); *see, e.g.*, *Alexander v. Sandoval*, 532 U.S. 275, 280–81 (2001) (Title VI case). Examining § 504's text, it then found Congress plainly intended to prohibit only intentional discrimination and not discriminatory effect:

> Disparate-impact discrimination occurs when an entity acts for a nondiscriminatory reason but nevertheless disproportionately harms a protected group. But the Rehabilitation Act bars discrimination "solely by reason of her or his disability." That language does not encompass

> actions taken for nondiscriminatory reasons. The language, as well, applies only to individuals who are "otherwise qualified" for the program at issue, meaning that the Act allows the disabled to be "disparately affected by legitimate job criteria." All of this explains why we have remarked that "[t]here is good reason to believe that a disparate impact theory is not available under the Rehabilitation Act." We agree, and so hold.

BlueCross, 926 F.3d at 241–42 (alteration in original) (citations omitted).

The Supreme Court has never squarely decided whether disparate-impact discrimination is actionable under § 504. Rather, its seminal Rehabilitation Act case "assume[d] without deciding that § 504 reaches at least some conduct that has an unjustifiable disparate impact upon the handicapped," and then held the conduct in that particular case was not actionable. *Choate*, 469 U.S. at 299, 302–04. The *Choate* Court acknowledged that this assumption allowed it to "decline . . . to decide" which of "two powerful but countervailing considerations"[7] determines the precise reach of the statute. *Id*. at 299. It emphasized, however, that the statute requires only "evenhanded treatment," not "equal results." *Id.* at 303–04. Both the

[7] The considerations were (1) "the desire to keep § 504 within manageable bounds," which the Supreme Court recognized would be impossible if "each recipient of federal funds [must] first [] evaluate the effect on the handicapped of every proposed action that might touch on the interests of the handicapped, and then [] consider alternatives for achieving the same objectives with less severe disadvantage[s] to the handicapped"; and (2) the fact that "much of the conduct that Congress sought to alter in passing the Rehabilitation Act would be difficult if not impossible to reach were the Act to proscribe only conduct fueled by a discriminatory intent." *Choate*, 469 U.S. at 296–99.

BlueCross court and the District Court here cited the considerations identified by *Choate* and explained why they justified dismissing an ACA disability-discrimination claim in the context of a network restriction for specialty drugs. *BlueCross*, 926 F.3d at 242; ER-187, 192.

In this Circuit, no case has held explicitly that disparate-impact discrimination is actionable under § 504 after considered analysis of that section's text and statutory history, although several panels—typically citing *Choate* and its hedging language—have ***assumed*** such a theory is viable to some extent.[8] In light of *BlueCross*'s cogent reasoning, that assumption should be reassessed as applied to § 504 claims.

This Court is free to, and should, adopt the Sixth Circuit's reasoning in *BlueCross*; hold that disparate-impact discrimination is not an actionable theory for disability-based claims under § 504; and affirm the District Court's dismissal of Does I–V's ACA claim on this independent basis.

[8] *See*, *e.g.*, *Mark H. v. Lemahieu*, 513 F.3d 922, 936 (9th Cir. 2008) (noting that *Choate* "declin[ed] to decide whether § 504 encompasses disparate impact discrimination"); *Crowder v. Kitagawa*, 81 F.3d 1480, 1484 (9th Cir. 1996) ("The [Supreme] Court held, however, that judicial review over each and every instance of disparate impact discrimination would be overly burdensome . . . .").

B. Does I–V Failed Plausibly to Plead a Disparate Impact Based on Their Disability.

Even if this Court again assumes that certain disparate impacts can be actionable under § 504, the District Court's dismissal still must be affirmed. The Complaint fails to plausibly plead each of the three necessary elements: (1) the Program does not ***"disparately impact"*** Does I–V ***"solely by reason of"*** having HIV/AIDS; (2) the Program does not deprive Does I–V of ***"meaningful access to the benefit that the grantee offers,"*** i.e., the prescription coverage their employers offer; and (3) the Complaint does not adequately plead the statute's jurisdictional hook, ***"Federal financial assistance."*** *See, e.g.*, 29 U.S.C. § 794(a); *Choate*, 469 U.S. at 290, 301, 308; *Weinreich v. L.A. Cty. Metro. Transp. Auth.*, 114 F.3d 976, 978 (9th Cir. 1997).

1. The Program does not disparately impact Does I–V "solely by reason of" having HIV/AIDS.

The District Court correctly dismissed the ACA claim because: (1) the impacts Does I–V allege do not arise from having HIV/AIDS, but from purchasing specialty medicines; and (2) the Complaint lacks factual allegations demonstrating that HIV/AIDS patients are disproportionately harmed by the Program compared to others who also purchase specialty medicines under the Program. ER-188–190.

Causation. The Program treats Does I–V the same as any patient purchasing a specialty medicine. Whether the patient has HIV/AIDS or not, so

long as he or she purchases a specialty medicine, the Program's requirements apply, and he or she receives the Program's services and experiences the attendant inconveniences Does I–V allege. "[A]ll specialty medicines," including more than 300 non-HIV/AIDS medications, "must be filled through the Program." ER-30, 47–71 & n.6 (¶¶ 43, ¶¶ 93–95). The customer is free to forego his specialty drug coverage and fill his specialty prescription using a pharmacy other than Caremark Specialty, but he pays out-of-network prices to do so. *E.g.*, ER-16 (¶ 1). These facts, the District Court reasoned, are "fatal to Plaintiffs' claim because it means they cannot allege they were treated differently ***on the basis of their HIV/AIDS status***." ER-188 (alterations and internal quotation marks omitted).

Because ***the classification (specialty vs. non-specialty) of the medication ordered*** determines the applicable network and pricing terms of Does I–V's purchases, their medical condition is not the "reason," let alone the "sole[] . . . reason," 29 U.S.C. § 794(a), for any adverse impacts they allege. In this way, CVS's Program is like the facially-neutral programs challenged in other ACA cases in which courts dismissed a disparate-impact claim for lacking a causal connection between the plaintiff's disability, the challenged conduct, and the alleged impacts. *See*, *e.g.*, *Doe v. BlueCross Blueshield of Tennessee, Inc. ("BlueCross II"),* 2018 WL 3625012, at *8 (W.D. Tenn. July 30, 2018) ("BCBST plan enrollees who are not disabled yet take specialty medications subject to the

Program must endure the same procedural and logistical hurdles that HIV/AIDS patients face."), *aff'd*, 926 F.3d 235 (6th Cir. 2019); *E.S.*, 2018 WL 4566053, at *3 ("Plaintiffs' claims for coverage were denied because the benefits they sought were not covered by their insurance plan, not because of their disability" and those benefit restrictions "applied to all insureds, whether disabled or not"); *In re Express Scripts/Anthem ERISA Litig.*, 285 F. Supp. 3d 655, 688–89 (S.D.N.Y. 2018) (co-insurance rates for HIV drugs were not alleged to be disparately higher than those for non-HIV drugs and thus HIV subscribers had not pleaded disproportionate effect); *SEPTA*, 102 F. Supp. 3d at 700–01 (absence of "allegations that Gilead changes the prices of its drugs depending upon whether the potential consumer has Hepatitis C" was a "fatal defect[] in plaintiffs' allegations regarding causation—that is, their failure to show how Gilead's actions discriminate on the basis of disability"). Like the plaintiffs in these cases, Does I–V cannot show a policy harming them "solely by reason of" their HIV/AIDS status as opposed to by reason of having purchased specialty drugs. 29 U.S.C. § 794(a).

Disparate Impact. The Complaint also lacks sufficient allegations that HIV/AIDS patients shoulder any comparatively greater burdens of the Program than do other purchasers of specialty medicines. ER-188 ("Plaintiffs have not sufficiently alleged that enrollees with HIV/AIDS are disparately impacted by the Program's restrictions relative to other enrollees."). The Complaint thus fails to

plead a disparate impact. For example, as the District Court observed, the Complaint (1) alleges "no statistical evidence sufficient to show that Defendant's Program has a 'significantly adverse or disproportionate impact on . . . HIV/AIDS patients," and (2) fails to "compare the Program's impact on HIV/AIDS patients with its impact on non-HIV/AIDS patients in any other way." ER-189–90 (quoting in part *BlueCross II*, 2018 WL 3625012, at *8).

Omissions of this nature routinely doom attempts to plead disparate impact discrimination. Indeed, as this Court noted in *Rodde v. Bonta*, the *Choate* Court rejected § 504 claims precisely because the policy at issue amounted to a "facially neutral reduction" that limited services "*equally* for *all* who rel[ied] on them." 357 F.3d 988, 997 (9th Cir. 2004) (first emphasis added). *Accord, e.g.*, *BlueCross II*, 2018 WL 3625012, at *8 (dismissal where "no statistical evidence," no "significantly adverse or disproportionate impact," and no "particularly compelling" facts suggesting disproportionate harm were alleged); *cf. Roberts v. City of Chicago*, 817 F.3d 561, 566 (7th Cir. 2016) (dismissal where complaint was "devoid of any 'factual content . . . tending to show that the City's testing process . . . caused a relevant and statistically significant disparity between' disabled and non-disabled applicants") (internal citation omitted). This result makes sense, since an outsized effect on the protected class versus the non-protected class is what demonstrates a ***disparate*** impact, as opposed to merely a ***negative*** impact.

See, e.g., *Tsombanidis v. W. Haven Fire Dep't*, 352 F.3d 565, 575–77 (2d Cir. 2003) ("The basis for a successful disparate impact claim involves a comparison between two groups—those affected and those unaffected by the facially neutral policy."). Because the Complaint does not contain comparative allegations, the ACA claim fails.[9]

To be sure, the Complaint baldly asserts "patients with HIV and AIDS are disproportionately impacted by the Program compared to other patients, even compared to patients prescribed non-HIV/AIDS specialty medications." ER-47 (¶ 92). But that one assertion is conclusory and lacks the detail necessary to satisfy Rule 12(b)(6). *See, e.g.*, *In re NVIDIA Corp. Sec. Litig.*, 768 F.3d 1046, 1051 (9th Cir. 2014) (courts ignore "allegations that are conclusory"). What is more, the Complaint's other allegations undermine the assertion; many specialty medicines treat people with other "complex, chronic conditions" besides HIV/AIDS, including "illnesses subject to social stigma where privacy is a significant concern." ER-47 (¶ 93). If even non-HIV/AIDS patients are subject to the Program's same alleged stigmatizing and privacy indignities as HIV/AIDS patients, one cannot credibly say the Program ***disproportionately*** impacts

[9] For the same reasons, Does I–V's claims under the ADA, Unruh Act, and UCL should fail. Disparate-impact discrimination is the central thesis of the claims asserted under each of these statutes.

HIV/AIDS patients, as the District Court noted. ER-189–90; *accord, e.g., Rodde*, 357 F.3d at 996–97 (noting that *Choate* found no disparate impact where Medicaid's limitation on coverage "left all patients 'with identical and effective hospital services fully available for their use, with both classes of users subject to the same durational limitation'") (quoting *Choate*, 469 U.S. at 302–04).

In their Brief, Does I–V occasionally imply the Program discriminates against the disabled population generally, rather than against people with HIV/AIDS specifically. ***First***, that is not the Complaint's theory, which plainly focuses on alleged discriminatory effects to HIV/AIDS patients specifically. *E.g.*, ER-16, 47, 74, 76, 83 (¶¶ 1, 92, 108, 120, 145). At oral argument below, Does I–V's counsel reaffirmed, "[W]e're saying as compared to the other folks in the specialty program, folks with HIV are disparately impacted." ER-118–19, 135 ("We're also saying that the specialty network . . . is okay, probably, for a lot of folks who don't have unique needs of an HIV individual."). ***Second***, Does I–V affirmatively alleged (and the Complaint otherwise itself reflects) that some drugs on the Program formulary do not treat disabled people. ER-48 n.8. ***Third***, any argument that the Program discriminates against the disabled generally must presume (erroneously) that everyone (or nearly everyone) suffering from a particular condition treated by a specialty medicine qualifies as "disabled" for purposes of federal statutes. This is not the law. Whether someone is disabled is

based on an individualized assessment of various factors, not solely on medical diagnosis. *See, e.g.*, *Sch. Bd. of Nassau County, Fla. v. Arline*, 480 U.S. 273 (1987) (individualized examination of whether plaintiff with tuberculosis was a "handicapped individual" under the Rehabilitation Act); *Albertson's, Inc. v. Kirkinburg*, 527 U.S. 555, 566 (1999) (noting the "statutory obligation to determine the existence of disabilities on a case-by-case basis" under the ADA's functionally identical definition of disability); *accord, e.g.*, *Lord v. Arizona*, 286 F. App'x 364, 365 (9th Cir. 2008) (individualized assessment); *Moore v. J.B. Hunt Transport, Inc.*, 221 F.3d 944, 950–51 (7th Cir. 2000) (same); *Mendez v. Gearan*, 956 F. Supp. 1520, 1524 (N.D. Cal. 1997) ("While the Court has no doubt that an impairment with fluctuating effects such as depression can, *in some circumstances*, substantially limit a major life activity, the Court cannot find . . . that *plaintiff's depression* substantially limits any of her major life activities."). Numerous cases have rejected a plaintiff's claim of disability despite his having a condition treated by a specialty drug on the Program formulary. *See* ECF 118 at 7 n.8 (citing, by way of example, cases on 12 different conditions). Even as to HIV/AIDS, the Supreme Court has declined to hold that it is a disability *per se* under the law. *Bragdon v. Abbott*, 524 U.S. 624, 641–42 (1998). Thus, any references in Appellants' Brief to discrimination against the disabled *writ large* rely on a clover

chain of flawed assumptions and, by no means, rehabilitate their inadequate Complaint.

Does I–V's Brief repeatedly asserts that they "lost access" to "85% of Network Pharmacies" under the Program. Br. 7, 9, 16, 27. That percentage appears nowhere in the Complaint. Nor is it relevant: Even assuming specialty medicines are available at in-network prices only when filled by mail order or shipped to 15% of brick-and-mortar network pharmacies, ***everyone*** purchasing specialty medicines is subject to the same conditions, whether suffering from HIV/AIDS or not. Thus, on the merits, this unpled percentage does not demonstrate a disparate impact.[10]

2. The Program does not deprive Does I–V of "meaningful access to the benefit the grantee offers."

The ACA claim also fails because Does I–V fail to plausibly allege being deprived "meaningful access to the benefit that the grantee offers"—i.e., to the particular prescription coverage their employers' plans provide employees. *Choate*, 469 U.S. at 301; *id.* at 302–04 (relevant "benefit provided" is the "package" of "individual services offered—not 'adequate health care'"); *Rodde*, 357 F.3d at 996 (noting the *Choate* Court "concluded that the planned reduction

[10] The percentage comes from general numbers on the Internet. Br. 6 n.5 (citing website). Neither the Complaint nor the Brief explain how those numbers tie to the terms of Does I–V's plans or how 85% was calculated.

was not discriminatory because it did not deny the disabled the ***benefits of the 14 days of care the state chose to provide***"). As offered by their employers, Does I–V's prescription plans require employees to fill specialty prescriptions through Caremark Specialty to receive in-network pricing; Does I–V indisputably have received coverage in accordance with those terms; and thus, they received precisely what is offered to every enrollee. Does I–V have not been deprived access, much less meaningful access, to the prescription coverage "the grantee"—their employer—offers. *Choate*, 469 U.S. at 301.

This follows directly from *Choate*. There, disabled plaintiffs challenged a Tennessee Medicaid rule limiting inpatient hospital coverage to 14 days, claiming that disabled Medicaid patients typically require more time to recover than non-disabled Medicaid patients. *Id.* at 290. The Court affirmed dismissal of the plaintiffs' disparate-impact claim at the pleading stage. It rejected the notion that disabled patients' "greater need for prolonged inpatient care" meant, in order "to provide meaningful access to Medicaid services, Tennessee must single out the handicapped for ***more*** than 14 days of coverage." *Id.* at 302–03 (emphasis in original). Tennessee had "substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage," and "Section 504 [of the Rehabilitation Act] d[id] not require [it] to alter [its] definition of the [Medicaid] benefit being offered simply to meet the reality that the handicapped have greater

medical needs." *Id*. at 303. Tennessee was not required to offer benefits that would provide the disabled "equal results;" the statute requires only "evenhanded treatment." *Id.* at 304.

Here, Does I–V have not demonstrated any benefit offered by their prescription plans to which they have been deprived meaningful access. They concede they have received the specialty coverage provided by their plans: in-network pricing on specialty drugs filled through the Program. ER-16–17, 19–20 (¶¶ 9–13). As the District Court reasoned, as in *Choate*, "§ 504 does not require CVS to alter the terms of their benefit plan[s] to provide the Plaintiffs 'meaningful access' to specialty medications at favorable prices outside the Program's network." ER-191. The Employers have delivered exactly what was promised to all enrollees for specialty medications.[11] Does I–V seek pricing benefits they ***wish*** their plans provided—in-network pricing without using the specialty Program, *see* Br. 44—rather than benefits to which they are entitled but have been deprived. *See* ER-23–25, 28–30, 37, 80 (¶¶ 21–22, 27, 32, 40–41, 43, 45, 67, 130). Despite Does

[11] Of course, Does I–V have not asserted (let alone pled) any law or regulation requiring employers to offer health benefits in the first place, let alone any particular benefit package. Employers decide "the form or structure of the Plan such as who is entitled to receive Plan benefits and in what amounts, or how such benefits are calculated," *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 444 (1999), and "are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans," *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995).

I–V's attempt to reframe the argument, pricing is at the core of their Complaint, as the District Court recognized:

> Plaintiffs are able to access their HIV/AIDS drugs ***at in-network prices*** as long as they go to a CVS Pharmacy or subscribe to delivery by mail. . . . At bottom, Plaintiffs are seeking to change the terms of their benefit plan so that they (and not other plan enrollees) can obtain their HIV/AIDS medications from non-CVS pharmacies ***at in-network-prices***.

ER-191–92. Allowing litigants to use anti-discrimination laws to dictate what prices they receive at which pharmacies would "threaten the basic structure" of network-based plans, which can only "provide insurance coverage at favorable rates by requiring enrollees to access care from a defined set of in-network physicians." ER-192

Does I–V argue that the District Court defined their "benefit" too narrowly by focusing on the price for specialty medicines, Br. 33, rather than their "prescription drug benefit as a whole," *id*. But even setting price aside, Does I–V have no entitlement to prescription coverage of the nature they desire—i.e., coverage free from the service annoyances or shortcomings they associate with the Program (*e.g.*, lack of pharmacists specially trained in HIV/AIDS, lack of automatic refills, risk of lost or stolen packages). *E.g.*, ER-30, 41, 43–45 (¶¶ 44, 74, 80, 85). Everyone purchasing a specialty medication, whether suffering from HIV/AIDS or not, faces these same alleged inconveniences. And, of course, Does I–V are free to forego their in-network mail order benefit and fill their

prescriptions at community pharmacies with familiar pharmacists of their choice at out-of-network prices.[12] Quite the opposite of depriving Does I–V of their "prescription drug benefit," the Complaint's own allegations confirm that Does I–V continue to obtain their specialty and non-specialty medicines. *E.g.*, ER-23–26, 30, 33–34, 39 (¶¶ 24–26, 31, 34, 44, 55, 58, 70). On the Ninth Circuit's own analysis in *Rodde*, that aligns this case with the likes of *Choate*, rather than the likes of *Rodde*. *Compare Rodde*, 357 F.3d at 997 (no disparate impact in *Choate* where "nothing in the record suggested 'that . . . the handicapped . . . cannot be effectively treated, at least in part, with fewer than 14 days' coverage") (quoting *Choate*, 469 U.S. at 302 n.22), *with id.* (finding sufficient disparate impact where closure of hospital "eliminat[ed] healthcare services" for certain disabled individuals).

The supposed harms alleged here—inferior service through mail-order pharmacies and CVS retail pharmacies—are qualitatively different from the severe restrictions this Court has found deprived disabled individuals of "meaningful access" in other factual contexts. *See, e.g.*, *Rodde v. Bonta*, 357 F.3d 988, 991, 997

[12] Notably, the ability to "[t]alk to a pharmacist and nurse specially trained in your condition" is a primary reason health plans increasingly are adopting mail-order requirements for specialty medicines. *See* https://www.cvsspecialty.com/wps/portal/specialty (last visited Aug. 6, 2019); SER-145; SER-518.

(9th Cir. 2004) (closure of county's only hospital providing particular services that disabled individuals disproportionately required amounted to "wholesale elimination of services relied upon disproportionately by the disabled because of their disabilities"); *Crowder v. Kitagawa*, 81 F.3d 1480, 1485 (9th Cir. 1996) (Hawaii's 120-day quarantine for dogs arriving to the island, which "effectively preclud[ed]" individuals requiring seeing-eye dogs from using various state-provided services). The Program here does not restrict Appellants' *access* to any medications, including their HIV/AIDS medications. Their criticisms concern the quality of CVS's services and the prices they must pay to obtain specialty medicines from pharmacies they say provide better service than their covered plan benefits.[13]

[13] Does I–V's other cited cases also involved very different deprivations of *government-provided* services. Br. 36–37 (relying on *M.S. v. County of Ventura*, 2017 WL 10434015, at *3, *18–19 (C.D. Cal. Mar. 7, 2017) (one in three individuals *in criminal custody* was denied any access to county's primary mental health facility for prisoners); *Scott v. Garcia*, 370 F. Supp. 2d 1056, 1075 (C.D. Cal. 2005) (*prison's* failure to accommodate prisoner's medical eating needs); *Cal. Found. for Indep. Living Ctrs. v. County of Sacramento*, 142 F. Supp. 3d 1035 (E.D. Cal. 2015) (county airport's failure to plan for needs of disabled in emergency evacuation plans and training); *Marisol A. ex rel. Forbes v. Giuliani*, 929 F. Supp. 662, 685 (S.D.N.Y. 1996) (gross and complete neglect of foster care teenager's medical needs until his death), *aff'd per curiam*, 126 F.3d 372 (2d Cir. 1997); and *Henrietta D. v. Bloomberg*, 331 F.3d 261 (2d Cir. 2003) (viable reasonable accommodation claim where New York City failed 77% of the time to comply with its own statutorily-mandated program designed to provide accommodations to assist HIV/AIDS citizens in accessing public benefits)).

3. The Complaint does not allege adequately CVS's receipt of "Federal financial assistance."

The District Court found it unnecessary to reach CVS's argument that the Complaint fails adequately to plead the statutory requirement of "Federal financial assistance," ER-193 n.6, but the Court may affirm on this ground too. In this Circuit, § 504's (and thus the ACA's) anti-discrimination prohibitions apply only to programs that "affirmatively choose to receive federal aid," not where the program simply "benefit[ted] from it." *Castle v. Eurofresh, Inc.*, 731 F.3d 901, 908–09 (9th Cir. 2013); *accord Sharer v. Oregon*, 581 F.3d 1176, 1181 (9th Cir. 2009) (inquiring whether funding was "earmarked for [the particular] purpose" fulfilled by the relevant program); *Smith v. Tobinworld*, 2016 WL 3519244, at *5 (N.D. Cal. June 28, 2016) ("[C]ourts should focus . . . on the intention of the government and determine whether [it] intended to provide assistance or merely to compensate the funding recipient."). The Complaint lacks sufficient allegations to plead such specifics about the funding requirement, stating only that:

> CVS Caremark's Program is a "health program or activity . . . receiv[ing] Federal financial assistance" subject to the requirements of 42 U.S.C. section 18116. As one example of CVS's federal funding, CVS's specialty and retail pharmacies participate in and receive reimbursement from Medicare.

ER-83 (¶ 143). This short paragraph is inadequate. The first sentence merely parrots the statutory text, and the second sentence's vague "Medicare" reference does not identify "the terms of the underlying grant statute" (*e.g.*, Medicare Part A,

Part B),[14] connect the "Medicare" funding to any program or activity challenged here, or say to which of the three (very different) CVS Appellees the allegation applies. That the CVS Appellees are corporate affiliates does not overcome these pleading deficiencies, even assuming one of the companies receives federal funds in connection with the Program. *See Dunlap v. Ass'n of Bay Area Gov'ts*, 996 F. Supp. 962, 968 (N.D. Cal. 1998) (jurisdictional requirement not satisfied just defendants were "inextricably intertwined").

C. The Failure-to-Accommodate Theory Is Not Pled, Was Not Preserved, and Fails to State a Claim.

Does I–V argue that they properly alleged an ACA claim by asserting a "Failure-to-Accommodate Theory." Br. 39–46. Their Brief contends that CVS discriminated by its "failure" to force the Employers to offer specialty drugs at in-network prices at Does I–V's preferred community pharmacies. This argument does nothing to call the District Court's dismissal into question, for three reasons.

First, Does I–V have ***never*** argued a failure-to-accommodate claim before mentioning it in their Brief. Neither the Complaint nor two rounds of motion-to-

[14] *See Indep. Hous. Servs. v. Fillmore Ctr. Assocs.*, 840 F. Supp. 1328, 1340 (N.D. Cal. 1993) ("The Supreme Court directs that the court identify the recipient of the federal financial assistance by looking to the *terms of the underlying grant statute*."); *Vasquez v. Smith's Food & Drug Ctrs., Inc.*, 2017 WL 1233840, at *5 (D. Ariz. Apr. 4, 2017) (drug store did not receive "federal financial assistance" merely by allowing customers to redeem Medicare benefits there).

dismiss briefing included any reference to any failure-to-accommodate claim or allegation. *See* ER-14–104; SER-1–56. Unsurprisingly, then, the District Court's 40-page opinion makes no mention of any failure-to-accommodate claim.[15] A party is not permitted to "raise an issue for the first time on appeal merely because [the] party believes that he might prevail if given the opportunity to try a case again on a different theory." *Ecological Rights Found. v. Pac. Gas & Elec. Co.*, 713 F.3d 502, 511 (9th Cir. 2013) (quoting *Forbush v. J.C. Penney Co.*, 98 F.3d 817, 822 (5th Cir. 1996)) (internal quotation marks omitted); *accord, e.g.*, *Dream Palace v. County of Maricopa*, 384 F.3d 990, 1005 (9th Cir. 2004) (rule "ensure[s] that legal arguments are considered with the benefit of a fully developed factual record, offers appellate courts the benefit of the district court's prior analysis, and prevents the parties from sandbagging their opponents with new arguments on appeal"). Yet that is precisely what Does I–V attempt here. This Court should not consider this new failure-to-accommodate argument.[16]

---

[15] The Complaint did allege that Does I–V requested to "opt-out" of the Program and that they appealed the denial of those requests. ER-100–01 (¶¶ 220, 224). But that was alleged merely to support the ERISA allegation that they were denied a full-and-fair review, *id.*, and to show they "exhausted available administrative remedies with regard to opting-out of the Program" before filing their ERISA claims, ER-39 (¶ 71).

[16] In a single line of their Brief, Does I–V also contend that the District Court "should have granted Appellants leave to amend to allege sufficient detail regarding this [failure-to-accommodate] claim." Br. 45. (This is the only "claim" as to which they contest a supposed denial of leave to amend, and thus any other

Second, even if a failure-to-accommodate claim were properly before this Court, it would fail on the merits. Accommodation claims typically arise where an underlying statutory or regulatory scheme explicitly imposes a duty to accommodate. Where Titles I and II of the ADA and the Fair Housing Act, for example, impose such duties, *see, e.g.*, 42 U.S.C. § 3604(f)(3)(B); 28 C.F.R. § 35.130(b)(7), none of Does I–V's claims in this case concerns those laws. It is thus no surprise that nearly all of Does I–V's cited cases are suits against public service providers governed by other regulatory regimes. *See* Br. 41 (citing cases). Although specific regulations implementing the Rehabilitation Act also impose accommodation duties in certain contexts, none remotely applies to the circumstances here. *See, e.g.*, 28 C.F.R. § 41.53 (employment setting); 45 C.F.R. § 84.12 (same); 34 C.F.R. § 104.44 (academic setting). Nor does the case on which Does I–V specifically rely for the legal standard for a § 504 accommodation claim. *See* Br. 40 (citing *Vinson v. Thomas*, 288 F.3d 1145, 1154 (9th Cir. 2002)

---

argument about the with-prejudice nature of the District Court's dismissal has been waived on appeal.) Of course, the District Court was not presented with any request for leave to amend any failure-to-accommodate allegations, because the Complaint *makes no such allegations*, and Does I–V raised no such arguments below. In any event, the Brief fails to explain what "additional facts they would plead" to make or cure a failure-to-accommodate claim, *see Kendall v. Visa U.S.A., Inc.*, 518 F.3d 1042, 1052 (9th Cir. 2008), which suggests amendment would be futile and is unwarranted, *see Carrico v. City & County of San Francisco*, 656 F.3d 1002, 1008 (9th Cir. 2011).

(explaining when a "*public entity*" must make reasonable modifications pursuant to 28 C.F.R. § 35.130(b)(7))).

In cases against private defendants like CVS, failure-to-accommodate claims first require an adequate showing of either intentional discrimination or disparate impact before considering accommodations. *See, e.g.*, *Fortyune v. Am. Multi-Cinema, Inc.*, 364 F.3d 1075, 1082 (9th Cir. 2004) (finding a "discriminatory effect in practice" before considering whether the plaintiff had "also show[n] that AMC . . . fail[ed] to make a reasonable modification"); *accord* ER-146. As explained in Parts I.B.1 and I.B.2 above, Does I–V have not demonstrated discrimination in the first instance, and therefore, there is nothing to accommodate. In any event, an "accommodation" here would not be CVS's to make, since ***the Employers*** decide, in their broad discretion, what (if any) prescription coverage they offer employees. *See supra* p. 9.

II. THE DISTRICT COURT CORRECTLY DISMISSED THE AMERICANS WITH DISABILITIES ACT CLAIM.

Title III of the ADA prohibits discrimination "on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation." 42 U.S.C. § 12182(a). The District Court correctly held that Does I–V cannot plead at least two elements of an ADA claim—(1) a "place of

public accommodation," and (2) discrimination "on the basis of" disability. ER-193–96; 42 U.S.C. § 12182(a); *Fortyune v. Am. Multi-Cinema, Inc.*, 364 F.3d 1075, 1080, 1082 (9th Cir. 2004).

A. Does I–V's Prescription Plans Are Not a "Place of Public Accommodation."

Does I–V's theory of discrimination attacks the terms of their prescription plans—namely, the Program's requirement that, in order to obtain in-network pricing on specialty drugs, enrollees must fill such prescriptions through mail-order or for pick up at a CVS retail pharmacy. *See*, *e.g.*, ER-86–87; *see also* ER-194 (District Court: "It is the ***term*** of the insurance plan overall that is at issue here.") (emphasis in original).

Circuit precedent bars any ADA claim proceeding on this theory. In *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104 (9th Cir. 2000), this Court interpreted Title III to require that places of public accommodation "must be physically accessible to the disabled but need not provide insurance that treats the disabled equally with the non-disabled." *Id.* at 1115 (internal quotation marks omitted). It rejected the plaintiff's claim premised on a disability insurance policy that provided coverage for physical disabilities up to age 65, but only two years of coverage for mental health disabilities, *id.* at 1108–09, because "Title III does not address the terms of the policies that [a defendant] sells," *id.* at 1115. *Weyer* grounded its holding on the statute's "place of public accommodation"

requirement, reasoning that the requirement is not met when the terms of an insurance policy are what allegedly discriminates.

After *Weyer*, this Court reaffirmed that any ADA claim premised upon an insurance policy's terms fails to satisfy the statute's "place of public accommodation" requirement. *Chabner v. United of Omaha Life Ins.*, 225 F.3d 1042, 1047 (9th Cir. 2000). *Chabner* held the ADA does not prohibit an insurance company's application of a non-standard premium on life insurance sold to a disabled enrollee, based on a supposed increased mortality risk. *Id.* at 1045–47. It reasoned that the premiums charged for a life insurance policy pertained to the "content" of the insurance company's offerings, rather than "access" to them. *Id.* at 1047.

The holdings in *Weyer* and *Chabner* are consistent with the dispositions in insurance-policy ADA cases in other circuits. *See*, *e.g.*, *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 612–13 (3d Cir. 1998) (disability benefits under an employer-offered insurance plan "do not qualify as a public accommodation"); *McNeil v. Time Ins.*, 205 F.3d 179, 186–89 (5th Cir. 2000) (ADA does not reach an insurance policy restricting coverage for HIV/AIDS treatment to $10,000 during the first two years because an insurance' policy's terms are not a place of public accommodation); *Parker v. Metro. Life Ins.*, 121 F.3d 1006, 1012 (6th Cir. 1997) ("Title III does not govern the content of a long-term disability policy offered by

an employer."). For example, in the *BlueCross* mail-order case discussed extensively above, the Sixth Circuit held "[the plaintiff's] health plan simply does not qualify as a public accommodation," and thus dismissed an ADA claim identical to Does I–V's claim here. 926 F.3d at 244.

Attempting to shoehorn their claims into the Title III rubric, Does I–V contend the community pharmacies at which they seek to obtain in-network prices for specialty drugs are places of public accommodation. Br. 47; ER-87–89 (¶¶ 157–64). Similar to the *BlueCross* plaintiff, they argue their ADA claim is cognizable because CVS "effectively 'operates'" those community pharmacies through "contracting and financial incentives" that dictate the prices those pharmacies offer for various drugs. Br. 47. The District Court correctly rejected this argument, finding the Program imposes no barrier to Does I–V's access to those pharmacies, even if it makes specialty purchases at them more expensive:

> Although Plaintiffs attempt to reframe the argument to cast community pharmacies as the "places of public accommodation" at issue, CVS does not "bar Plaintiffs' and Class Members' access to" those pharmacies. Rather, the *terms* of the benefit plan administered by CVS force Plaintiffs to pay higher prices for specialty medications if they choose to fill their prescriptions at community pharmacies.

ER-194 (emphasis in original).

Nor is the public accommodation requirement satisfied, as Does I–V suggest, merely by pleading some "connection" or "nexus" between the defendant's conduct and "an actual physical place." Br. 50; ER-88 (¶ 162). The

policy or condition being challenged must itself "concern accessibility" to the place of public accommodation at issue. *Robles v. Domino's Pizza, LLC*, 913 F.3d 898, 905 (9th Cir. 2019), *petition for cert. filed* (U.S. June 13, 2019) (No. 18-1539); *accord Weyer*, 198 F.3d at 1115; *Chabner*, 225 F.3d at 1047. In *Robles*, this Court recently emphasized this distinction and reaffirmed that *Weyer* and *Chabner* remain the controlling precedent in cases challenging the effect of an insurance policy's terms. *See* 913 F.3d at 905.

The cases Does I–V cite cannot avoid this precedent. Br. 47–51. The non-binding *Zamora-Quezada* case from a Texas district court predates the Fifth Circuit's adoption of the same principle announced in *Weyer* and *Chabner*. *See McNeil*, 205 F.3d at 186–89. And Does I–V's only cited case from this Circuit did not involve insurance. *Lentini v. Cal. Ctr. for Arts Escondido*, 370 F.3d 837, 849 (9th Cir. 2004) (theater's director of sales "operate[d]" the theater for ADA purposes).

B. There Is No Discrimination "on the Basis of" Disability.

For the same reasons the Complaint's allegations fail to demonstrate discrimination "solely by reason of" Does I–V's disability under the ACA, *see supra* Part I.B.1, they fail to demonstrate discrimination "on the basis of" disability for ADA purposes. Because this *prima facie* element is lacking, the District Court correctly dismissed the ADA claim. ER-194–96.

Weyer again is dispositive. "[T]here 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." *Weyer*, 198 F.3d at 1116. Other circuits employ this same rule, holding that facially neutral insurance terms cannot create ADA liability. *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 678 (8th Cir. 1996) ("Insurance distinctions that apply equally to all insured [members], that is, to individuals with disabilities and to those who are not disabled, do not discriminate on the basis of disability."); *Chaudhry v. Neighborhood Health P'ship, Inc.*, 2005 WL 6103746, at *5 (S.D. Fla. May 4, 2005) ("Courts have routinely upheld health-related distinctions that apply equally to all insured employees."), *aff'd per curiam*, 178 F. App'x 900 (11th Cir. 2006); *accord Rogers v. Dep't of Health & Envtl. Control*, 174 F.3d 431 (4th Cir. 1999); *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1101–02 (10th Cir. 1999); *Ford*, 145 F.3d at 608; *Parker*, 121 F.3d at 1015; *EEOC v. CAN Ins.*, 96 F.3d 1039, 1044 (7th Cir. 1996).

Because ***everyone*** enrolled in Does I–V's prescription plans is subject to the Program, HIV-positive or not, their ADA claim fails like the identical claim did in *Doe v. Coventry Health Care, Inc.*, No. 15-cv-62685-CMA (S.D. Fla. filed Dec. 22, 2015). There, an HIV/AIDS sufferer filed a putative class action alleging his health insurer's adoption of a mail-order requirement for "high cost specialty

medications" caused discrimination in violation of the ADA. Finding "the mail-order program applies to more than just HIV/AIDS medications," the court held the requirement did not constitute "disability-based discrimination" and dismissed the claim. *See* Addendum N (Order, *Doe v. Coventry Health Care, Inc.*, No. 15-cv-62685-CMA (S.D. Fla. May 5, 2016)).

Does I–V argue the holdings of *Weyer*, *Coventry Health Care*, and other cases conflict with *Raytheon Co. v. Hernandez*, 540 U.S. 44 (2003). Br. 54. But *Raytheon* concerned employment hiring practices alleged to be ***intentionally*** discriminatory, 540 U.S. at 53; it did not even consider, let alone reject, the question of disparate impact premised on neutral insurance terms that was at issue in *Weyer*, *Krauel*, and others. Here, the allegedly harmful effects of the Program arise "on the basis of" purchasing a specialty drug, not having HIV/AIDS.

Finally, Does I–V misstate the record in claiming the District Court "required [them] to allege an 'intent' element on their ADA claim." Br. 51. The court did no such thing. After noting that "insurance distinctions that apply equally to all employees" foreclosed any claim for a "discriminatory ***effect***" under the ADA, ER-195 (emphasis in original), the District Court addressed their alternative argument that allegations of intentional discrimination could support an ADA claim. It never suggested—let alone held—that intentional conduct is ***necessary*** to state an ADA claim. *See id.* (citing *Lentini*, 370 F.3d at 846).

Regardless, the District Court correctly rejected any argument concerning intentional discrimination. ***First***, the Complaint plainly alleges a disparate-impact theory, consistently pleading that HIV/AIDS patients are "disproportionately impacted," "predominantly impact[ed]," and "particularly hard hit" by the Program. ER-16, 47, 76–77, 83 (¶¶ 1, 92, 108, 120, 145). Does I–V's Brief states unequivocally that "it is Appellants' contention that the Program's design has a discriminatory ***effect*** on those with disabilities." Br. 53.

By contrast, the phrases "intentionally discriminatory" and "intentionally target" each appear only once in the 224-paragraph Complaint, and in conclusory fashion without any supporting factual detail. ER-75, 86 (¶¶ 114, 153). As the District Court noted, these vague assertions were "undermined" by other allegations that were specific and well-pled—i.e., that "CVS made accommodations or assisted Plaintiffs," on at least two occasions, for example, providing same-day courier services to avoid lapses in treatment, ER-197 (citing Compl. ¶¶ 43, 60). Such actions are inconsistent with any animus. The District Court rightly "consider[ed] the complaint in its entirety" in deciding if Does I–V had stated a plausible claim. *Tellabs, Inc. v. Makor Issues & Rights, Ltd.*, 551 U.S. 308, 322 (2007).

Second, as the District Court noted, the Complaint's own allegations establish that most drugs subject to the Program treat conditions other than

HIV/AIDS and some, the Complaint says, "may not treat a disability." ER-48–71 & n.8. The Complaint cites a hyperlink to the Program's specialty formulary, ER-48 n.6, which includes, for example, contraceptives and drug therapies for common conditions such as asthma and psoriasis. Because the formulary includes drugs treating both non-HIV/AIDS conditions and non-disabilities, the Complaint itself undermines any vague suggestion that the Program's design suggests intentional discrimination.

III. THE DISTRICT COURT CORRECTLY DISMISSED THE CALIFORNIA UNRUH CIVIL RIGHTS ACT CLAIM.

The Complaint fails to state a claim under California's Unruh Civil Rights Act. Cal. Civ. Code § 51(b). A claim under the Unruh Act often derives from an ADA claim, because "a violation of . . . the federal Americans with Disabilities Act . . . shall also constitute a violation of [the Unruh Act]." *Id.* § 51(f). Because Does I–V failed to state a claim under the ADA for the reasons discussed above, they could only state an Unruh Act claim by alleging intentional discrimination. *Greater L.A. Agency on Deafness, Inc. v. CNN, Inc.*, 742 F.3d 414, 425 (9th Cir. 2014) ("Thus, to establish a violation of the Unruh Act independent of a claim under the Americans with Disabilities Act ('ADA'), GLAAD must plead and prove intentional discrimination in public accommodations in violation of the terms of the Act.).

As described *supra*, the Complaint lacks any well-pled allegations of intentional discrimination. Instead, "it is Appellants' contention that the Program's design has a discriminatory ***effect*** on those with disabilities," Br. 53, and disparate impact is the focus of the Complaint, *see* ER-47, 76–77, 83 (¶¶ 92, 108, 120, 145). The Complaint's two vague allusions to "intentional[]" misconduct or "target[ing]" are inadequate "naked assertions devoid of further factual enhancement" which cannot save the claim. *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (alterations and internal quotation marks omitted).

IV. THE DISTRICT COURT CORRECTLY DISMISSED THE ERISA CLAIM FOR DENIAL OF BENEFITS.

Does I–V appeal the dismissal of their denial-of-benefits claim under § 502(a)(1)(B) of the Employee Retirement and Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B).[17] ***First***, Does I–V have not identified (and cannot identify) any term in their prescription plans ***entitling*** them to what they have been denied: "continued access to community pharmacies as an 'in-network' benefit" for specialty drugs. ER-96 (¶ 201); *see* Br. 54–55. This is fatal to a claim under § 502(a)(1)(B). *See, e.g.*, *Clair v. Harris Tr. & Sav. Bank*, 190 F.3d 495, 497 (7th

[17] The Brief does not mention the ERISA claims for breach of fiduciary duty and full and fair review. Any claim for error concerning dismissal of those claims has been abandoned and cannot be raised in reply. *See, e.g.*, *Brown v. Rawson-Neal Psychiatric Hosp.*, 840 F.3d 1146, 1148 (9th Cir. 2016) ("We generally do not consider issues that are not raised in the appellant's opening brief.").

Cir. 1999) ("[O]nly benefits specified in the plan can be recovered" under § 502(a)(1)(B).); *Flint v. ABB, Inc.*, 337 F.3d 1326, 1329 (11th Cir. 2003) (same); *see also Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285, 300 (2009) (claim "stands or falls by the terms of the plan").

Here, the Complaint explicitly alleges Does I–V's plans ***do not*** provide them a right to in-network prices on specialty drugs purchased at community pharmacies, and this has been true since their Employers adopted the Program in 2015 or 2016. *See* ER-19–21, 23–25, 28–30, 37, 80 (¶¶ 9–14, 21–22, 27, 32, 40–41, 43, 45, 67, 130). Indeed, that change is what prompted Does I–V to sue.

Because their Complaint's own allegations establish the determinative fact, the Brief backtracks. It argues the Complaint "never alleged that the Plans were validly amended" in 2015 or 2016, pointing to a single sentence in the Complaint claiming that "the implementation of the Program caused a reduction in or elimination of benefits without a change in actual coverage." Br. 55 (quoting ER-94 (¶ 196)) (alterations and internal quotation marks omitted). As an initial and dispositive matter, Does I–V have never presented a no-valid-amendment argument before in this case—not in their Complaint and not in opposing any defendant's motion to dismiss below. *See* SER-1–56. This theory was not preserved and cannot salvage their claim. *See, e.g.*, *In re Mercury*, 618 F.3d at 992.

Moreover, what the Complaint has "never alleged" concerning the process Does I–V's employers took in 2015 and 2016 to modify their benefits packages cannot forestall dismissal. ***Does I–V*** bore the burden of alleging facts sufficient to show "***the pleader*** is entitled to relief." Fed. R. Civ. P. 8 & 12. They cannot now save their claim by arguing the Complaint ***omits facts*** they now want the Court to assume are true in order to reverse the District Court's decision. Does I–V have the procedure backwards.

In all events, their substantive argument—that their ERISA claim survives dismissal because "the Program . . . worked an unlawful reduction in [] benefits," Br. 54—contradicts black-letter law. The "'anti-cutback' rule," on which Does I–V rely, "prohibits any amendment of a ***pension plan*** that would reduce a participant's 'accrued benefit.'" *Cent. Laborers' Pension Fund v. Heinz*, 541 U.S. 739, 741 (2004) (quoting 29 U.S.C. § 1054(g)). But the rule "does not apply to employee welfare benefit plans," like those at issue here. ER-214 (citing *Anderson v. Suburban Teamsters of N. Ill. Pension Fund Bd. of Trs.*, 588 F.3d 641, 650 (9th Cir. 2009)); *accord* 29 U.S.C. § 1051(1) (exempting "employee welfare benefit plans" from ERISA, Part 2 ("Participation and Vesting")). "Therefore, an employer may unilaterally modify or terminate medical benefits at any time absent the employer's contractual agreement to the contrary." *Halbach v. Great-W. Life & Annuity Ins.*, 561 F.3d 872, 877 (8th Cir. 2009) (internal quotation marks

omitted). And Does I–V have not alleged or cited any contractual restriction on their employers' ability to modify, withdraw, or restrict the locations at which specialty drugs may be purchased at in-network prices.

Second, the Court may also affirm the dismissal of the ERISA claim because the Complaint—which was amended once already—failed to name as a defendant the entity that contracted with the Employers, CaremarkPCS Health, L.L.C. *See* ER-205–06. None of the CVS Appellees contracted with the Employers and, thus, they cannot possibly owe any obligations under ERISA. *See id.*

Third, CVS joins in the arguments raised in the Employers' separate briefs explaining why dismissal of the denial-of-benefits claim was appropriate.

V. THE DISTRICT COURT CORRECTLY DISMISSED THE CALIFORNIA UNFAIR COMPETITION LAW CLAIM.

Does I–V lastly claim the Program violates California's Unfair Competition Law ("UCL") because it is "unlawful" or "unfair." Br. 57–58; ER-71, 92 (¶¶ 98, 186). The District Court correctly rejected both assertions.

As to the UCL's "unlawful" prong, ***first***, the claim fails because there is no predicate violation of the ACA, ADA, ERISA, or the Unruh Act for the reasons outlined above. *See, e.g.*, *Martinez v. Wells Fargo Home Mortg., Inc.*, 598 F.3d 549, 557 (9th Cir. 2010). ***Second***, insofar as Does I–V argue unlawfulness based on an ACA regulation concerning "Essential Health Benefits" ("EHB"), ER-77 (¶ 122) (citing 45 C.F.R. § 156.122(e)); Br. 57 (same), the Complaint pleads no

facts establishing that the EHB regulation applies to their plans, much less to any CVS entity's provision of services to those plans. The Department of Health and Human Services has clarified that the regulation does not apply to all plans: "self-insured group health plans, large group market plans, and grandfathered health plans are not required to offer EHB."[18] The Complaint does not specify whether Does I–V's plans are of a type exempted from the regulation, and, tellingly, their Brief effectively admits that they are. Br. 3 n.3. Whether the regulation applies to Does I–V's plans or not, it plainly does not contradict the Program. Medications requiring "special handling"—as specialty drugs do, ER-48 (¶ 94)—are exempt from the regulation, 45 C.F.R. § 156.122(e)(1)(ii). Furthermore, "Plaintiffs' benefit plan ***does*** allow them to access their specialty medicines at in-network retail pharmacies—CVS pharmacies." ER-199 (emphasis in original).

Third, Does I–V wrongly suggest the Program is unlawful because it violates Californians' constitutional right of privacy. But, as the District Court found, the Complaint at most alleged a single isolated incident of a retail pharmacist's "indiscretion . . . in announcing to anyone within earshot that Plaintiffs were taking HIV/AIDS medicines," ER-201 (citing Compl. ¶ 76), which

[18] Dep't of Health & Human Servs., FAQs on Essential Health Benefits Bulletin (Feb. 17, 2012) at Q&A 10, https://www.cms.gov/cciio/resources/files/downloads/ehb-faq-508.pdf.

bears no relationship to the Program's design or operation. In all events, isolated incidents cannot support ***class action*** claims under the UCL, like those filed by Does I–V. *See, e.g.*, *Harmon v. Hilton Grp., PLC*, 554 F. App'x 634, 635 (9th Cir. 2014); *Marolda v. Symantec Corp.*, 672 F. Supp. 2d 992, 1004 (N.D. Cal. 2009).

As to the UCL's "unfairness" prong, the Complaint makes only conclusory allegations that lack any meaningful detail, *see* ER-93 (¶ 189), and fail to plausibly satisfy the necessary UCL thresholds: that (1) the Program is "tethered" to a violation of a constitutional, statutory, or regulatory provision, or otherwise risks an anti-trust violation; or (2) the Program's utility is outweighed by its costs, *see, e.g.*, *Graham v. Bank of Am., N.A*, 172 Cal. Rptr. 3d 218, 233 (Ct. App. 2014) (identifying legal tests). Given the dearth of specific allegations, the District Court properly reached this conclusion even after construing the Complaint in the light most favorable for Does I–V. ER-198–202; *see, e.g.*, *Falahati v. JPMorgan Chase Bank*, 2009 WL 10675065, at *4 n.4 (C.D. Cal. Dec. 22, 2009) ("California courts regularly dismiss UCL claims 'where the complaint fails to allege facts showing that a business practice is unfair, unlawful, or fraudulent.'") (quoting *Bardin v. Daimlerchrysler Corp.*, 39 Cal. Rptr. 3d 634, 644 (Ct. App. 2006)).

VI. THE "SEPARATE CLAIM" FOR DECLARATORY RELIEF WAS NOT PROPERLY APPEALED.

The District Court properly dismissed the final count in the Complaint asserting a separate cause of action for "Declaratory Relief." ER-101, 217. Does

I–V have not properly appealed that ruling, referencing it only in the heading to Part V of their Argument and nowhere else in their Brief. The issue has been waived. *See, e.g.*, *Navajo Nation v. United States Forest Serv.*, 535 F.3d 1058, 1079 n.26 (9th Cir. 2008). In any event, "the "Declaratory Judgment Act does not . . . provide an independent cause of action," *Keene Corp. v. Fiorelli*, 14 F.3d 726, 731 (2d Cir. 1993); thus, because each of Does I–V's substantive causes of action failed to state a claim, dismissal of the declaratory relief claim was appropriate.

CONCLUSION

For these reasons, the Court should affirm the District Court's dismissal with prejudice of Does I–V's Complaint and its entry of judgment in favor of CVS.

DATED: August 7, 2019

Respectfully submitted,

By: /s/ Sarah Lochner O'Connor

Enu Mainigi
Grant A. Geyerman
Sarah Lochner O'Connor
WILLIAMS & CONNOLLY LLP
725 Twelfth Street, N.W.
Washington, DC 20005
(202) 434-5000

Tami S. Smason
FOLEY & LARDNER LLP
555 S. Flower Street
Suite 3300
Los Angeles, CA 90071
(213) 972-4500

Counsel for Appellees
CVS Pharmacy, Inc., Caremark, L.L.C., and
Caremark California Specialty Pharmacy,
L.L.C.

STATEMENT REGARDING ORAL ARGUMENT

CVS respectfully submits that, given the importance of the issues presented, oral argument would be helpful to the disposition of this appeal.

STATEMENT OF RELATED CASES

There are no cases relating to the instant case pending in this Court.

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 8. Certificate of Compliance for Briefs

Instructions for this form: http://www.ca9.uscourts.gov/forms/form08instructions.pdf

9th Cir. Case Number(s) 19-15074

I am the attorney or self-represented party.

This brief contains 13,031 **words**, excluding the items exempted by Fed. R. App. P. 32(f). The brief's type size and typeface comply with Fed. R. App. P. 32(a)(5) and (6).

I certify that this brief *(select only one)*:

- (•) complies with the word limit of Cir. R. 32-1.
- ( ) is a **cross-appeal** brief and complies with the word limit of Cir. R. 28.1-1.
- ( ) is an **amicus** brief and complies with the word limit of Fed. R. App. P. 29(a)(5), Cir. R. 29-2(c)(2), or Cir. R. 29-2(c)(3).
- ( ) is for a **death penalty** case and complies with the word limit of Cir. R. 32-4.
- ( ) complies with the longer length limit permitted by Cir. R. 32-2(b) because *(select only one):*
  - ( ) it is a joint brief submitted by separately represented parties;
  - ( ) a party or parties are filing a single brief in response to multiple briefs; or
  - ( ) a party or parties are filing a single brief in response to a longer joint brief.
- ( ) complies with the length limit designated by court order dated _____.
- ( ) is accompanied by a motion to file a longer brief pursuant to Cir. R. 32-2(a).

Signature s/ Sarah Lochner O'Connor **Date** August 7, 2019

(use "s/[typed name]" to sign electronically-filed documents)

Feedback or questions about this form? Email us at forms@ca9.uscourts.gov

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 15. Certificate of Service for Electronic Filing

Instructions for this form: http://www.ca9.uscourts.gov/forms/form15instructions.pdf

9th Cir. Case Number(s): 19-15074

I hereby certify that I electronically filed the foregoing/attached document(s) on this date with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit using the Appellate Electronic Filing system.

Service on Case Participants Who Are Registered for Electronic Filing:
[ ] I certify that I served the foregoing/attached document(s) via email to all registered case participants on this date because it is a sealed filing or is submitted as an original petition or other original proceeding and therefore cannot be served via the Appellate Electronic Filing system.

Service on Case Participants Who Are NOT Registered for Electronic Filing:
[ ] I certify that I served the foregoing/attached document(s) on this date by hand delivery, mail, third party commercial carrier for delivery within 3 calendar days, or, having obtained prior consent, by email to the following unregistered case participants *(list each name and mailing/email address)*:

Description of Document(s) *(required for all documents)*:

Brief of Appellees CVS Pharmacy, Inc., Caremark, L.L.C., and Caremark California Specialty Pharmacy, L.L.C.

Signature /s/ Sarah Lochner O'Connor **Date** August 7, 2019
(use "s/[typed name]" to sign electronically-filed documents)

ADDENDA

Table of Contents

Addendum A

KeyCite Red Flag - Severe Negative Treatment
Unconstitutional or PreemptedHeld Unconstitutional as Not Severable Texas v. United States, N.D.Tex., Dec. 14, 2018

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 157. Quality Affordable Health Care for All Americans
Subchapter VI. Miscellaneous Provisions

42 U.S.C.A. § 18116

§ 18116. Nondiscrimination

Effective: March 23, 2010
Currentness

(a) In general

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 794 of Title 29, 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 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

(b) Continued application of laws

Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 794 of Title 29, or the Age Discrimination Act of 1975, or to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).

(c) Regulations

The Secretary may promulgate regulations to implement this section.

CREDIT(S)

(Pub.L. 111-148, Title I, § 1557, Mar. 23, 2010, 124 Stat. 260.)

Notes of Decisions (26)

42 U.S.C.A. § 18116, 42 USCA § 18116

Current through P.L. 116-36.

End of Document

Addendum B

KeyCite Red Flag - Severe Negative Treatment
Unconstitutional or PreemptedPreempted by Joren v. Napolitano, 7th Cir.(Ill.), Feb. 07, 2011

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

United States Code Annotated
Title 29. Labor
Chapter 16. Vocational Rehabilitation and Other Rehabilitation Services (Refs & Annos)
Subchapter V. Rights and Advocacy (Refs & Annos)

29 U.S.C.A. § 794

§ 794. Nondiscrimination under Federal grants and programs

Effective: October 1, 2016
Currentness

(a) Promulgation of rules and regulations

No otherwise qualified individual with a disability in the United States, as defined in section 705(20) of this title, shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service. The head of each such agency shall promulgate such regulations as may be necessary to carry out the amendments to this section made by the Rehabilitation, Comprehensive Services, and Developmental Disabilities Act of 1978. Copies of any proposed regulation shall be submitted to appropriate authorizing committees of the Congress, and such regulation may take effect no earlier than the thirtieth day after the date on which such regulation is so submitted to such committees.

(b) "Program or activity" defined

For the purposes of this section, the term "program or activity" means all of the operations of--

(1)(A) a department, agency, special purpose district, or other instrumentality of a State or of a local government; or

(B) the entity of such State or local government that distributes such assistance and each such department or agency (and each other State or local government entity) to which the assistance is extended, in the case of assistance to a State or local government;

(2)(A) a college, university, or other postsecondary institution, or a public system of higher education; or

(B) a local educational agency (as defined in section 7801 of Title 20), system of career and technical education, or other school system;

(3)(A) an entire corporation, partnership, or other private organization, or an entire sole proprietorship--

(i) if assistance is extended to such corporation, partnership, private organization, or sole proprietorship as a whole; or

(ii) which is principally engaged in the business of providing education, health care, housing, social services, or parks and recreation; or

(B) the entire plant or other comparable, geographically separate facility to which Federal financial assistance is extended, in the case of any other corporation, partnership, private organization, or sole proprietorship; or

(4) any other entity which is established by two or more of the entities described in paragraph (1), (2), or (3);

any part of which is extended Federal financial assistance.

(c) Significant structural alterations by small providers

Small providers are not required by subsection (a) to make significant structural alterations to their existing facilities for the purpose of assuring program accessibility, if alternative means of providing the services are available. The terms used in this subsection shall be construed with reference to the regulations existing on March 22, 1988.

(d) Standards used in determining violation of section

The standards used to determine whether this section has been violated in a complaint alleging employment discrimination under this section shall be the standards applied under title I of the Americans with Disabilities Act of 1990 (42 U.S.C. 12111 et seq.) and the provisions of sections 501 through 504, and 510, of the Americans with Disabilities Act of 1990 (42 U.S.C. 12201 to 12204 and 12210), as such sections relate to employment.

CREDIT(S)

(Pub.L. 93-112, Title V, § 504, Sept. 26, 1973, 87 Stat. 394; Pub.L. 95-602, Title I, §§ 119, 122(d)(2), Nov. 6, 1978, 92 Stat. 2982, 2987; Pub.L. 99-506, Title I, § 103(d)(2)(B), Title X, § 1002(e)(4), Oct. 21, 1986, 100 Stat. 1810, 1844; Pub.L. 100-259, § 4, Mar. 22, 1988, 102 Stat. 29; Pub.L. 100-630, Title II, § 206(d), Nov. 7, 1988, 102 Stat. 3312; Pub.L. 102-569, Title I, § 102(p)(32), Title V, § 506, Oct. 29, 1992, 106 Stat. 4360, 4428; Pub.L. 103-382, Title III, § 394(i)(2), Oct. 20, 1994, 108 Stat. 4029; Pub.L. 105-220, Title IV, § 408(a)(3), Aug. 7, 1998, 112 Stat. 1203; Pub.L. 107-110, Title X, § 1076(u)(2), Jan. 8, 2002, 115 Stat. 2093; Pub.L. 113-128, Title IV, § 456(c), July 22, 2014, 128 Stat. 1675; Pub.L. 114-95, Title IX, § 9215(mmm)(3), Dec. 10, 2015, 129 Stat. 2188.)

EXECUTIVE ORDERS

EXECUTIVE ORDER NO. 11914

Ex. Ord. No. 11914, Apr. 28, 1976, 41 F.R. 17871, which related to nondiscrimination in federally assisted programs, was revoked by Ex. Ord. No. 12250, Nov. 2, 1980, 45 F.R. 72995, set out as a note under section 2000d-1 of Title 42, The Public Health and Welfare.

Notes of Decisions (3305)

29 U.S.C.A. § 794, 29 USCA § 794
Current through P.L. 116-36.

End of Document

Addendum C

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 126. Equal Opportunity for Individuals with Disabilities (Refs & Annos)
Subchapter III. Public Accommodations and Services Operated by Private Entities (Refs & Annos)

42 U.S.C.A. § 12182

§ 12182. Prohibition of discrimination by public accommodations

Currentness

(a) General rule

No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

(b) Construction

(1) General prohibition

(A) Activities

(i) Denial of participation

It shall be discriminatory to subject an individual or class of individuals on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements, to a denial of the opportunity of the individual or class to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of an entity.

(ii) Participation in unequal benefit

It shall be discriminatory to afford an individual or class of individuals, on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements with the opportunity to participate in or benefit from a good, service, facility, privilege, advantage, or accommodation that is not equal to that afforded to other individuals.

(iii) Separate benefit

It shall be discriminatory to provide an individual or class of individuals, on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements with a good, service, facility, privilege, advantage, or accommodation that is different or separate from that provided to other individuals, unless such

action is necessary to provide the individual or class of individuals with a good, service, facility, privilege, advantage, or accommodation, or other opportunity that is as effective as that provided to others.

(iv) Individual or class of individuals

For purposes of clauses (i) through (iii) of this subparagraph, the term "individual or class of individuals" refers to the clients or customers of the covered public accommodation that enters into the contractual, licensing or other arrangement.

(B) Integrated settings

Goods, services, facilities, privileges, advantages, and accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual.

(C) Opportunity to participate

Notwithstanding the existence of separate or different programs or activities provided in accordance with this section, an individual with a disability shall not be denied the opportunity to participate in such programs or activities that are not separate or different.

(D) Administrative methods

An individual or entity shall not, directly or through contractual or other arrangements, utilize standards or criteria or methods of administration--

(i) that have the effect of discriminating on the basis of disability; or

(ii) that perpetuate the discrimination of others who are subject to common administrative control.

(E) Association

It shall be discriminatory to exclude or otherwise deny equal goods, services, facilities, privileges, advantages, accommodations, or other opportunities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

(2) Specific prohibitions

(A) Discrimination

For purposes of subsection (a), discrimination includes--

(i) the imposition or application of eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any goods, services, facilities, privileges,

advantages, or accommodations, unless such criteria can be shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered;

(ii) a failure to make reasonable modifications in policies, practices, or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations;

(iii) a failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the good, service, facility, privilege, advantage, or accommodation being offered or would result in an undue burden;

(iv) a failure to remove architectural barriers, and communication barriers that are structural in nature, in existing facilities, and transportation barriers in existing vehicles and rail passenger cars used by an establishment for transporting individuals (not including barriers that can only be removed through the retrofitting of vehicles or rail passenger cars by the installation of a hydraulic or other lift), where such removal is readily achievable; and

(v) where an entity can demonstrate that the removal of a barrier under clause (iv) is not readily achievable, a failure to make such goods, services, facilities, privileges, advantages, or accommodations available through alternative methods if such methods are readily achievable.

(B) Fixed route system

(i) Accessibility

It shall be considered discrimination for a private entity which operates a fixed route system and which is not subject to section 12184 of this title to purchase or lease a vehicle with a seating capacity in excess of 16 passengers (including the driver) for use on such system, for which a solicitation is made after the 30th day following the effective date of this subparagraph, that is not readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs.

(ii) Equivalent service

If a private entity which operates a fixed route system and which is not subject to section 12184 of this title purchases or leases a vehicle with a seating capacity of 16 passengers or less (including the driver) for use on such system after the effective date of this subparagraph that is not readily accessible to or usable by individuals with disabilities, it shall be considered discrimination for such entity to fail to operate such system so that, when viewed in its entirety, such system ensures a level of service to individuals with disabilities, including individuals who use wheelchairs, equivalent to the level of service provided to individuals without disabilities.

(C) Demand responsive system

For purposes of subsection (a), discrimination includes--

(i) a failure of a private entity which operates a demand responsive system and which is not subject to section 12184 of this title to operate such system so that, when viewed in its entirety, such system ensures a level of service to individuals with disabilities, including individuals who use wheelchairs, equivalent to the level of service provided to individuals without disabilities; and

(ii) the purchase or lease by such entity for use on such system of a vehicle with a seating capacity in excess of 16 passengers (including the driver), for which solicitations are made after the 30th day following the effective date of this subparagraph, that is not readily accessible to and usable by individuals with disabilities (including individuals who use wheelchairs) unless such entity can demonstrate that such system, when viewed in its entirety, provides a level of service to individuals with disabilities equivalent to that provided to individuals without disabilities.

(D) Over-the-road buses

(i) Limitation on applicability

Subparagraphs (B) and (C) do not apply to over-the-road buses.

(ii) Accessibility requirements

For purposes of subsection (a), discrimination includes (I) the purchase or lease of an over-the-road bus which does not comply with the regulations issued under section 12186(a)(2) of this title by a private entity which provides transportation of individuals and which is not primarily engaged in the business of transporting people, and (II) any other failure of such entity to comply with such regulations.

(3) Specific construction

Nothing in this subchapter shall require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.

CREDIT(S)

(Pub.L. 101-336, Title III, § 302, July 26, 1990, 104 Stat. 355.)

Notes of Decisions (473)

42 U.S.C.A. § 12182, 42 USCA § 12182
Current through P.L. 116-36.

End of Document

Addendum D

KeyCite Yellow Flag - Negative Treatment
Unconstitutional or PreemptedLimited on Preemption Grounds by Media.net Advertising FZ-LLC v. Netseer, Inc., N.D.Cal., July 28, 2016

West's Annotated California Codes
Business and Professions Code (Refs & Annos)
Division 7. General Business Regulations (Refs & Annos)
Part 2. Preservation and Regulation of Competition (Refs & Annos)
Chapter 5. Enforcement (Refs & Annos)

West's Ann.Cal.Bus. & Prof.Code § 17200

§ 17200. Unfair competition; prohibited activities

Currentness

As used in this chapter, unfair competition shall mean and include any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising and any act prohibited by Chapter 1 (commencing with Section 17500) of Part 3 of Division 7 of the Business and Professions Code.

Credits
(Added by Stats.1977, c. 299, p. 1202, § 1. Amended by Stats.1992, c. 430 (S.B.1586), § 2.)

Editors' Notes

VALIDITY

This section is recognized as preempted by federal law, as to furnishers of information to credit reporting agencies, in Howard v. Blue Ridge Bank, N.D.Cal.2005, 371 F.Supp.2d 1139.

This statute was held preempted, as to claims involving interstate sales of wholesale electricity, by the Federal Power Act, under which the Federal Energy Regulatory Commission was granted exclusive jurisdiction over interstate sales of wholesale electricity, in the decision of In re Enron Corp., 2005, 328 B.R. 75.

*This section was held preempted by the Home Owners' Loan Act (HOLA), in the case of Silvas v. E*Trade Mortg. Corp., S.D.Cal.2006, 421 F.Supp.2d 1315, affirmed 514 F.3d 1001.*

This section was held preempted by the Fair Credit Reporting Act (FCRA) with respect to alleged injuries arising from the reporting of credit information to a credit reporting agency in the decision of Johnson v. JP Morgan Chase Bank DBA Chase Manhattan, E.D.Cal.2008, 536 F.Supp.2d 1207.

This section was held preempted by the Federal Communications Act of 1934 with respect to rates and market entry of commercial mobile service providers in the decision of In re Apple iPhone 3G Products Liability Litigation, N.D.Cal.2010, 728 F.Supp.2d 1065, leave to file for reconsideration denied 2010 WL 3119789.

Notes of Decisions (5343)

West's Ann. Cal. Bus. & Prof. Code § 17200, CA BUS & PROF § 17200
Current with urgency legislation through Ch. 161 of the 2019 Reg.Sess. Some statute sections may be more current, see credits for details.

End of Document

West's Annotated California Codes
Business and Professions Code (Refs & Annos)
Division 7. General Business Regulations (Refs & Annos)
Part 2. Preservation and Regulation of Competition (Refs & Annos)
Chapter 5. Enforcement (Refs & Annos)

West's Ann.Cal.Bus. & Prof.Code § 17201

§ 17201. Person

Currentness

As used in this chapter, the term person shall mean and include natural persons, corporations, firms, partnerships, joint stock companies, associations and other organizations of persons.

Credits
(Added by Stats.1977, c. 299, p. 1202, § 1.)

Notes of Decisions (17)

West's Ann. Cal. Bus. & Prof. Code § 17201, CA BUS & PROF § 17201
Current with urgency legislation through Ch. 161 of the 2019 Reg.Sess. Some statute sections may be more current, see credits for details.

End of Document

West's Annotated California Codes
Business and Professions Code (Refs & Annos)
Division 7. General Business Regulations (Refs & Annos)
Part 2. Preservation and Regulation of Competition (Refs & Annos)
Chapter 5. Enforcement (Refs & Annos)

West's Ann.Cal.Bus. & Prof.Code § 17202

§ 17202. Authority to grant specific or preventive relief

Currentness

Notwithstanding Section 3369 of the Civil Code, specific or preventive relief may be granted to enforce a penalty, forfeiture, or penal law in a case of unfair competition.

Credits
(Added by Stats.1977, c. 299, p. 1202, § 1.)

Notes of Decisions (12)

West's Ann. Cal. Bus. & Prof. Code § 17202, CA BUS & PROF § 17202
Current with urgency legislation through Ch. 161 of the 2019 Reg.Sess. Some statute sections may be more current, see credits for details.

End of Document

KeyCite Red Flag - Severe Negative Treatment
Unconstitutional or PreemptedPreempted by Guadagno v. E*Trade Bank, C.D.Cal., Dec. 29, 2008

West's Annotated California Codes
Business and Professions Code (Refs & Annos)
Division 7. General Business Regulations (Refs & Annos)
Part 2. Preservation and Regulation of Competition (Refs & Annos)
Chapter 5. Enforcement (Refs & Annos)

West's Ann.Cal.Bus. & Prof.Code § 17203

§ 17203. Injunctive Relief--Court Orders [1]

Effective: November 3, 2004
Currentness

Any person who engages, has engaged, or proposes to engage in unfair competition may be enjoined in any court of competent jurisdiction. The court may make such orders or judgments, including the appointment of a receiver, as may be necessary to prevent the use or employment by any person of any practice which constitutes unfair competition, as defined in this chapter, or as may be necessary to restore to any person in interest any money or property, real or personal, which may have been acquired by means of such unfair competition. Any person may pursue representative claims or relief on behalf of others only if the claimant meets the standing requirements of Section 17204 and complies with Section 382 of the Code of Civil Procedure, but these limitations do not apply to claims brought under this chapter by the Attorney General, or any district attorney, county counsel, city attorney, or city prosecutor in this state.

Credits

(Added by Stats.1977, c. 299, p. 1202, § 1. Amended by Stats.1992, c. 430 (S.B.1586), § 3; Initiative Measure (Prop. 64, § 2, approved Nov. 2, 2004, eff. Nov. 3, 2004).)

Editors' Notes

VALIDITY

*This section was held preempted by Office of Thrift Supervision regulations in the decision of Guadagno v. E*Trade Bank, C.D.Cal.2008, 592 F.Supp.2d 1263.*

Notes of Decisions (435)

Footnotes

1 Section caption supplied by Prop. 64.

West's Ann. Cal. Bus. & Prof. Code § 17203, CA BUS & PROF § 17203
Current with urgency legislation through Ch. 161 of the 2019 Reg.Sess. Some statute sections may be more current, see credits for details.

End of Document

West's Annotated California Codes
Business and Professions Code (Refs & Annos)
Division 7. General Business Regulations (Refs & Annos)
Part 2. Preservation and Regulation of Competition (Refs & Annos)
Chapter 5. Enforcement (Refs & Annos)

West's Ann.Cal.Bus. & Prof.Code § 17204

§ 17204. Actions for Injunctions by Attorney General, District Attorney, County Counsel, and City Attorneys [1]

Effective: January 1, 2009
Currentness

Actions for * * * relief pursuant to this chapter shall be prosecuted exclusively in a court of competent jurisdiction by the Attorney General or a district attorney or by a county counsel authorized by agreement with the district attorney in actions involving violation of a county ordinance, or * * * by a city attorney of a city having a population in excess of 750,000, or by a city attorney in a city and county or, with the consent of the district attorney, by a city prosecutor in a city having a full-time city prosecutor in the name of the people of the State of California upon their own complaint or upon the complaint of a board, officer, person, corporation, or association, or by a person who has suffered injury in fact and has lost money or property as a result of the unfair competition.

Credits

(Added by Stats.1977, c. 299, p. 1202, § 1. Amended by Stats.1991, c. 1195 (S.B.709), § 1; Stats.1991, c. 1196 (A.B.1755), § 1; Stats.1992, c. 385 (S.B.1911), § 1; Stats.1993, c. 926 (A.B.2205), § 2; Initiative Measure (Prop. 64, § 3, approved Nov. 2, 2004, eff. Nov. 3, 2004); Stats.2007, c. 17 (S.B.376), § 1; Stats.2008, c. 179 (S.B.1498), § 23.)

Notes of Decisions (571)

Footnotes

1 Section caption supplied by Prop. 64.

West's Ann. Cal. Bus. & Prof. Code § 17204, CA BUS & PROF § 17204
Current with urgency legislation through Ch. 161 of the 2019 Reg.Sess. Some statute sections may be more current, see credits for details.

End of Document

West's Annotated California Codes
Business and Professions Code (Refs & Annos)
Division 7. General Business Regulations (Refs & Annos)
Part 2. Preservation and Regulation of Competition (Refs & Annos)
Chapter 5. Enforcement (Refs & Annos)

West's Ann.Cal.Bus. & Prof.Code § 17205

§ 17205. Cumulative remedies

Currentness

Unless otherwise expressly provided, the remedies or penalties provided by this chapter are cumulative to each other and to the remedies or penalties available under all other laws of this state.

Credits
(Added by Stats.1977, c. 299, p. 1202, § 1.)

Notes of Decisions (41)

West's Ann. Cal. Bus. & Prof. Code § 17205, CA BUS & PROF § 17205
Current with urgency legislation through Ch. 161 of the 2019 Reg.Sess. Some statute sections may be more current, see credits for details.

End of Document

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

West's Annotated California Codes
Business and Professions Code (Refs & Annos)
Division 7. General Business Regulations (Refs & Annos)
Part 2. Preservation and Regulation of Competition (Refs & Annos)
Chapter 5. Enforcement (Refs & Annos)

West's Ann.Cal.Bus. & Prof.Code § 17206

§ 17206. Civil Penalty for Violation of Chapter [1]

Effective: June 27, 2012
Currentness

(a) Any person who engages, has engaged, or proposes to engage in unfair competition shall be liable for a civil penalty not to exceed two thousand five hundred dollars ($2,500) for each violation, which shall be assessed and recovered in a civil action brought in the name of the people of the State of California by the Attorney General, by any district attorney, by any county counsel authorized by agreement with the district attorney in actions involving violation of a county ordinance, by any city attorney of a city having a population in excess of 750,000, by any city attorney of any city and county, or, with the consent of the district attorney, by a city prosecutor in any city having a full-time city prosecutor, in any court of competent jurisdiction.

(b) The court shall impose a civil penalty for each violation of this chapter. In assessing the amount of the civil penalty, the court shall consider any one or more of the relevant circumstances presented by any of the parties to the case, including, but not limited to, the following: the nature and seriousness of the misconduct, the number of violations, the persistence of the misconduct, the length of time over which the misconduct occurred, the willfulness of the defendant's misconduct, and the defendant's assets, liabilities, and net worth.

(c) If the action is brought by the Attorney General, one-half of the penalty collected shall be paid to the treasurer of the county in which the judgment was entered, and one-half to the General Fund. If the action is brought by a district attorney or county counsel, the penalty collected shall be paid to the treasurer of the county in which the judgment was entered. Except as provided in subdivision (e), if the action is brought by a city attorney or city prosecutor, one-half of the penalty collected shall be paid to the treasurer of the city in which the judgment was entered, and one-half to the treasurer of the county in which the judgment was entered. The aforementioned funds shall be for the exclusive use by the Attorney General, the district attorney, the county counsel, and the city attorney for the enforcement of consumer protection laws.

(d) The Unfair Competition Law Fund is hereby created as a special account within the General Fund in the State Treasury. The portion of penalties that is payable to the General Fund or to the Treasurer recovered by the Attorney General from an action or settlement of a claim made by the Attorney General pursuant to this chapter or Chapter 1 (commencing with Section 17500) of Part 3 shall be deposited into this fund. Moneys in this fund, upon appropriation by the Legislature, shall be used by the Attorney General to support investigations and prosecutions of California's consumer protection laws, including implementation of judgments obtained from such prosecutions or investigations and other activities which are in furtherance of this chapter or Chapter 1 (commencing with Section 17500) of Part 3. Notwithstanding Section 13340 of the Government Code, any civil penalties deposited in the fund pursuant to the National Mortgage Settlement, as provided in Section 12531 of the Government

Code, are continuously appropriated to the Department of Justice for the purpose of offsetting General Fund costs incurred by the Department of Justice.

(e) If the action is brought at the request of a board within the Department of Consumer Affairs or a local consumer affairs agency, the court shall determine the reasonable expenses incurred by the board or local agency in the investigation and prosecution of the action.

Before any penalty collected is paid out pursuant to subdivision (c), the amount of any reasonable expenses incurred by the board shall be paid to the Treasurer for deposit in the special fund of the board described in Section 205. If the board has no such special fund, the moneys shall be paid to the Treasurer. The amount of any reasonable expenses incurred by a local consumer affairs agency shall be paid to the general fund of the municipality or county that funds the local agency.

(f) If the action is brought by a city attorney of a city and county, the entire amount of the penalty collected shall be paid to the treasurer of the city and county in which the judgment was entered for the exclusive use by the city attorney for the enforcement of consumer protection laws. However, if the action is brought by a city attorney of a city and county for the purposes of civil enforcement pursuant to Section 17980 of the Health and Safety Code or Article 3 (commencing with Section 11570) of Chapter 10 of Division 10 of the Health and Safety Code, either the penalty collected shall be paid entirely to the treasurer of the city and county in which the judgment was entered or, upon the request of the city attorney, the court may order that up to one-half of the penalty, under court supervision and approval, be paid for the purpose of restoring, maintaining, or enhancing the premises that were the subject of the action, and that the balance of the penalty be paid to the treasurer of the city and county.

Credits

(Added by Stats.1977, c. 299, p. 1202, § 1. Amended by Stats.1979, c. 897, p. 3101, § 2; Stats.1991, c. 1195 (S.B.709), § 2; Stats.1991, c. 1196 (A.B.1755), § 2; Stats.1992, c. 430 (S.B.1586), § 4; Stats.1997, c. 17 (S.B.947), § 11; Initiative Measure (Prop. 64, § 4, approved Nov. 2, 2004, eff. Nov. 3, 2004); Stats.2005, c. 74 (A.B.139), § 23, eff. July 19, 2005; Stats.2007, c. 17 (S.B.376), § 2; Stats.2012, c. 32 (S.B.1006), § 1, eff. June 27, 2012.)

Notes of Decisions (77)

Footnotes

1 Section caption supplied by Prop. 64.

West's Ann. Cal. Bus. & Prof. Code § 17206, CA BUS & PROF § 17206

Current with urgency legislation through Ch. 161 of the 2019 Reg.Sess. Some statute sections may be more current, see credits for details.

End of Document

West's Annotated California Codes
Business and Professions Code (Refs & Annos)
Division 7. General Business Regulations (Refs & Annos)
Part 2. Preservation and Regulation of Competition (Refs & Annos)
Chapter 5. Enforcement (Refs & Annos)

West's Ann.Cal.Bus. & Prof.Code § 17207

§ 17207. Violation of injunction prohibiting unfair competition; civil penalty; actions to assess and recover; venue; prosecutors; expenses of investigation and prosecution

Currentness

(a) Any person who intentionally violates any injunction prohibiting unfair competition issued pursuant to Section 17203 shall be liable for a civil penalty not to exceed six thousand dollars ($6,000) for each violation. Where the conduct constituting a violation is of a continuing nature, each day of that conduct is a separate and distinct violation. In determining the amount of the civil penalty, the court shall consider all relevant circumstances, including, but not limited to, the extent of the harm caused by the conduct constituting a violation, the nature and persistence of that conduct, the length of time over which the conduct occurred, the assets, liabilities, and net worth of the person, whether corporate or individual, and any corrective action taken by the defendant.

(b) The civil penalty prescribed by this section shall be assessed and recovered in a civil action brought in any county in which the violation occurs or where the injunction was issued in the name of the people of the State of California by the Attorney General or by any district attorney, any county counsel authorized by agreement with the district attorney in actions involving violation of a county ordinance, or any city attorney in any court of competent jurisdiction within his or her jurisdiction without regard to the county from which the original injunction was issued. An action brought pursuant to this section to recover civil penalties shall take precedence over all civil matters on the calendar of the court except those matters to which equal precedence on the calendar is granted by law.

(c) If such an action is brought by the Attorney General, one-half of the penalty collected pursuant to this section shall be paid to the treasurer of the county in which the judgment was entered, and one-half to the State Treasurer. If brought by a district attorney or county counsel the entire amount of the penalty collected shall be paid to the treasurer of the county in which the judgment is entered. If brought by a city attorney or city prosecutor, one-half of the penalty shall be paid to the treasurer of the county in which the judgment was entered and one-half to the city, except that if the action was brought by a city attorney of a city and county the entire amount of the penalty collected shall be paid to the treasurer of the city and county in which the judgment is entered.

(d) If the action is brought at the request of a board within the Department of Consumer Affairs or a local consumer affairs agency, the court shall determine the reasonable expenses incurred by the board or local agency in the investigation and prosecution of the action.

Before any penalty collected is paid out pursuant to subdivision (c), the amount of the reasonable expenses incurred by the board shall be paid to the State Treasurer for deposit in the special fund of the board described in Section 205. If the board has no such special fund, the moneys shall be paid to the State Treasurer. The amount of the reasonable expenses incurred by a local consumer affairs agency shall be paid to the general fund of the municipality or county which funds the local agency.

Credits

(Added by Stats.1977, c. 299, p. 1202, § 1. Amended by Stats.1979, c. 897, p. 3102, § 3; Stats.1991, c. 1195 (S.B.709), § 3; Stats.1991, c. 1196 (A.B.1755), § 3.)

Notes of Decisions (1)

West's Ann. Cal. Bus. & Prof. Code § 17207, CA BUS & PROF § 17207
Current with urgency legislation through Ch. 161 of the 2019 Reg.Sess. Some statute sections may be more current, see credits for details.

End of Document

West's Annotated California Codes
Business and Professions Code (Refs & Annos)
Division 7. General Business Regulations (Refs & Annos)
Part 2. Preservation and Regulation of Competition (Refs & Annos)
Chapter 5. Enforcement (Refs & Annos)

West's Ann.Cal.Bus. & Prof.Code § 17208

§ 17208. Commencement of action; limitations; revival

Currentness

Any action to enforce any cause of action pursuant to this chapter shall be commenced within four years after the cause of action accrued. No cause of action barred under existing law on the effective date of this section shall be revived by its enactment.

Credits
(Added by Stats.1977, c. 299, p. 1202, § 1.)

Notes of Decisions (92)

West's Ann. Cal. Bus. & Prof. Code § 17208, CA BUS & PROF § 17208
Current with urgency legislation through Ch. 161 of the 2019 Reg.Sess. Some statute sections may be more current, see credits for details.

End of Document

West's Annotated California Codes
Business and Professions Code (Refs & Annos)
Division 7. General Business Regulations (Refs & Annos)
Part 2. Preservation and Regulation of Competition (Refs & Annos)
Chapter 5. Enforcement (Refs & Annos)

West's Ann.Cal.Bus. & Prof.Code § 17209

§ 17209. Proceedings involving violations, application or construction of this chapter; notice to Attorney General and county district attorney

Effective: January 1, 2005
Currentness

If a violation of this chapter is alleged or the application or construction of this chapter is in issue in any proceeding in the Supreme Court of California, a state court of appeal, or the appellate division of a superior court, each person * * * filing any brief or petition with the court in that proceeding shall serve * * * , within three days of filing with the court, a copy of * * * that brief or petition * * * on the Attorney General, directed to the attention of the Consumer Law Section at a service address designated on the Attorney General's official Web site for service of papers under this section or, if no service address is designated, at the Attorney General's office in San Francisco, California, and on the district attorney of the county in which the lower court action or proceeding was originally filed. * * * Upon the Attorney General's or district attorney's request, each person who has filed any other document, including all or a portion of the appellate record, with the court in addition to a brief or petition * * * shall * * * provide a copy of that document without charge to the Attorney General or the district attorney within five days * * * of the * * * request. The time for service may be extended by the Chief Justice or presiding justice or judge for good cause shown. No judgment or relief, temporary or permanent, shall be granted or * * * opinion issued until proof of service of * * * the brief or petition on the Attorney General and district attorney is filed with the court.

Credits

(Added by Stats.1992, c. 385 (S.B.1911), § 2. Amended by Stats.1998, c. 931 (S.B.2139), § 9, eff. Sept. 28, 1998; Stats.2004, c. 529 (A.B.1711), § 4.)

Editors' Notes

LAW REVISION COMMISSION COMMENTS

1998 Amendment

Section 17209 is amended to reflect the creation of an appellate division in the superior court. Cal. Const. art. VI, § 4. [28 Cal.L.Rev.Comm. Reports 51 (1998)].

Notes of Decisions (6)

West's Ann. Cal. Bus. & Prof. Code § 17209, CA BUS & PROF § 17209
Current with urgency legislation through Ch. 161 of the 2019 Reg.Sess. Some statute sections may be more current, see credits for details.

End of Document

West's Annotated California Codes
Business and Professions Code (Refs & Annos)
Division 7. General Business Regulations (Refs & Annos)
Part 2. Preservation and Regulation of Competition (Refs & Annos)
Chapter 5. Enforcement (Refs & Annos)

West's Ann.Cal.Bus. & Prof.Code § 17210

§ 17210. Distribution of handbills in hotels without permission

Effective: January 1, 2000
Currentness

(a) For purposes of this section, "hotel" means any hotel, motel, bed and breakfast inn, or other similar transient lodging establishment, but it does not include any residential hotel as defined in Section 50519 of the Health and Safety Code. "Innkeeper" means the owner or operator of a hotel, or the duly authorized agent or employee of the owner or operator.

(b) For purposes of this section, "handbill" means, and is specifically limited to, any tangible commercial solicitation to guests of the hotel urging that they patronize any commercial enterprise.

(c) Every person (hereinafter "distributor") engages in unfair competition for purposes of this chapter who deposits, places, throws, scatters, casts, or otherwise distributes any handbill to any individual guest rooms in any hotel, including, but not limited to, placing, throwing, leaving, or attaching any handbill adjacent to, upon, or underneath any guest room door, doorknob, or guest room entryway, where either the innkeeper has expressed objection to handbill distribution, either orally to the distributor or by the posting of a sign or other notice in a conspicuous place within the lobby area and at all points of access from the exterior of the premises to guest room areas indicating that handbill distribution is prohibited, or the distributor has received written notice pursuant to subdivision (e) that the innkeeper has expressed objection to the distribution of handbills to guest rooms in the hotel.

(d) Every person (hereinafter "contractor") engages in unfair competition for purposes of this chapter who causes or directs any other person, firm, business, or entity to distribute, or cause the distribution of, any handbill to any individual guest rooms in any hotel in violation of subdivision (c) of this section, if the contractor has received written notice from the innkeeper objecting to the distribution of handbills to individual guest rooms in the hotel.

(e) Every contractor who causes or directs any distributor to distribute, or cause the distribution of, any handbills to any individual guest rooms in any hotel, if the contractor has received written notice from the innkeeper or from any other contractor or intermediary pursuant to this subdivision, objecting to the distribution of handbills to individual guest rooms in the hotel has failed to provide a written copy of that notice to each distributor prior to the commencement of distribution of handbills by the distributor or by any person hired or retained by the distributor for that purpose, or, within 24 hours following the receipt of the notice by the contractor if received after the commencement of distribution, and has failed to instruct and demand any distributor to not distribute, or to cease the distribution of, the handbills to individual guest rooms in any hotel for which such a notice has been received is in violation of this section.

(f) Any written notice given, or caused to be given, by the innkeeper pursuant to or required by any provision of this section shall be deemed to be in full force and effect until such time as the notice is revoked in writing.

(g) Nothing in this section shall be deemed to prohibit the distribution of a handbill to guest rooms in any hotel where the distribution has been requested or approved in writing by the innkeeper, or to any individual guest room when the occupant thereof has affirmatively requested or approved the distribution of the handbill during the duration of the guest's occupancy.

Credits

(Added by Stats.1999, c. 354 (S.B.1171), § 1.)

West's Ann. Cal. Bus. & Prof. Code § 17210, CA BUS & PROF § 17210
Current with urgency legislation through Ch. 161 of the 2019 Reg.Sess. Some statute sections may be more current, see credits for details.

End of Document

Addendum E

Code of Federal Regulations
Title 45. Public Welfare
Subtitle A. Department of Health and Human Services (Refs & Annos)
Subchapter B. Requirements Relating to Health Care Access (Refs & Annos)
Part 156. Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges (Refs & Annos)
Subpart B. Essential Health Benefits Package (Refs & Annos)

45 C.F.R. § 156.122

§ 156.122 Prescription drug benefits.

Effective: August 11, 2016
Currentness

(a) A health plan does not provide essential health benefits unless it:

(1) Subject to the exception in paragraph (b) of this section, covers at least the greater of:

(i) One drug in every United States Pharmacopeia (USP) category and class; or

(ii) The same number of prescription drugs in each category and class as the EHB–benchmark plan;

(2) Submits its formulary drug list to the Exchange, the State or OPM; and

(3) For plans years beginning on or after January 1, 2017, uses a pharmacy and therapeutics (P & T) committee that meets the following standards.

(i) Membership standards. The P & T committee must:

(A) Have members that represent a sufficient number of clinical specialties to adequately meet the needs of enrollees.

(B) Consist of a majority of individuals who are practicing physicians, practicing pharmacists and other practicing health care professionals who are licensed to prescribe drugs.

(C) Prohibit any member with a conflict of interest with respect to the issuer or a pharmaceutical manufacturer from voting on any matters for which the conflict exists.

(D) Require at least 20 percent of its membership to have no conflict of interest with respect to the issuer and any pharmaceutical manufacturer.

(ii) Meeting standards. The P & T committee must:

(A) Meet at least quarterly.

(B) Maintain written documentation of the rationale for all decisions regarding formulary drug list development or revision.

(iii) Formulary drug list establishment and management. The P & T committee must:

(A) Develop and document procedures to ensure appropriate drug review and inclusion.

(B) Base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and other such information as it determines appropriate.

(C) Consider the therapeutic advantages of drugs in terms of safety and efficacy when selecting formulary drugs.

(D) Review policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, and therapeutic interchange.

(E) Evaluate and analyze treatment protocols and procedures related to the plan's formulary at least annually.

(F) Review and approve all clinical prior authorization criteria, step therapy protocols, and quantity limit restrictions applied to each covered drug.

(G) Review new FDA–approved drugs and new uses for existing drugs.

(H) Ensure the issuer's formulary drug list:

(1) Covers a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states, and does not discourage enrollment by any group of enrollees; and

(2) Provides appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time.

(b) A health plan does not fail to provide EHB prescription drug benefits solely because it does not offer drugs approved by the Food and Drug Administration as a service described in § 156.280(d) of this subchapter.

(c) A health plan providing essential health benefits must have the following processes in place that allow an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber, as appropriate) to request and gain access to clinically appropriate drugs not otherwise covered by the health plan (a request for exception). In the event that an exception request is granted, the plan must treat the excepted drug(s) as an essential health benefit, including by counting any cost-sharing towards the plan's annual limitation on cost-sharing under § 156.130 and when calculating the plan's actuarial value under § 156.135.

(1) Standard exception request. For plans years beginning on or after January 1, 2016:

(i) A health plan must have a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request a standard review of a decision that a drug is not covered by the plan.

(ii) A health plan must make its determination on a standard exception and notify the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following receipt of the request.

(iii) A health plan that grants a standard exception request must provide coverage of the non-formulary drug for the duration of the prescription, including refills.

(2) Expedited exception request.

(i) A health plan must have a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request an expedited review based on exigent circumstances.

(ii) Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

(iii) A health plan must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 24 hours following receipt of the request.

(iv) A health plan that grants an exception based on exigent circumstances must provide coverage of the non-formulary drug for the duration of the exigency.

(3) External exception request review. For plans years beginning on or after January 1, 2016:

(i) If the health plan denies a request for a standard exception under paragraph (c)(1) of this section or for an expedited exception under paragraph (c)(2) of this section, the health plan must have a process for the enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request that the original exception request and subsequent denial of such request be reviewed by an independent review organization.

(ii) A health plan must make its determination on the external exception request and notify the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following its receipt of the request, if the original request was a standard exception request under paragraph (c)(1) of this section, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception request under paragraph (c)(2) of this section.

(iii) If a health plan grants an external exception review of a standard exception request, the health plan must provide coverage of the non-formulary drug for the duration of the prescription. If a health plan grants an external exception review of an expedited exception request, the health plan must provide coverage of the non-formulary drug for the duration of the exigency.

(4) Application of coverage appeals laws.

(i) A State may determine that a health plan in the State satisfies the requirements of this paragraph (c) if the health plan has a process to allow an enrollee to request and gain access to clinically appropriate drugs not otherwise covered by the health plan that is compliant with the State's applicable coverage appeals laws and regulations that are at least as stringent as the requirements of this paragraph (c) and include:

(A) An internal review;

(B) An external review;

(C) The ability to expedite the reviews; and

(D) Timeframes that are the same or shorter than the timeframes under paragraphs (c)(1)(ii), (c)(2)(iii), and (c)(3)(ii) of this section.

(d)(1) For plan years beginning on or after January 1, 2016, a health plan must publish an up-to-date, accurate, and complete list of all covered drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a drug can be obtained, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS, the U.S. Office of Personnel Management, and the general public. A formulary drug list is easily accessible when:

(i) It can be viewed on the plan's public Web site through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number; and

(ii) If an issuer offers more than one plan, when an individual can easily discern which formulary drug list applies to which plan.

(2) A QHP in the Federally-facilitated Exchange must make available the information described in paragraph (d)(1) of this section on its Web site in an HHS–specified format and also submit this information to HHS, in a format and at times determined by HHS.

(e) For plan years beginning on or after January 1, 2017, a health plan providing essential health benefits must have the following access procedures:

(1) A health plan must allow enrollees to access prescription drug benefits at in-network retail pharmacies, unless:

(i) The drug is subject to restricted distribution by the U.S. Food and Drug Administration; or

(ii) The drug requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

(2) A health plan may charge enrollees a different cost-sharing amount for obtaining a covered drug at a retail pharmacy, but all cost sharing will count towards the plan's annual limitation on cost sharing under § 156.130 and must be accounted for in the plan's actuarial value calculated under § 156.135.

Credits

[79 FR 30350, May 27, 2014; 80 FR 10871, Feb. 27, 2015; 81 FR 12349, March 8, 2016; 81 FR 53032, Aug. 11, 2016]

AUTHORITY: 42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, 18082, and 26 U.S.C. 36B.

Current through August 1, 2019; 84 FR 37750.

End of Document

Addendum F

28 C.F.R. § 35.130

§ 35.130 General prohibitions against discrimination.

Effective: October 11, 2016
Currentness

<For statute(s) affecting validity, see: 42 U.S.C.A. § 12101 et seq.>

(a) No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.

(b)(1) A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability—

(i) Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

(iii) Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

(iv) Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;

(vi) Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards;

(vii) Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving the aid, benefit, or service.

(2) A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.

(3) A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:

(i) That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;

(ii) That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or

(iii) That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control or are agencies of the same State.

(4) A public entity may not, in determining the site or location of a facility, make selections—

(i) That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or

(ii) That have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.

(5) A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination on the basis of disability.

(6) A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination on the basis of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.

(7)(i) A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

(ii) A public entity is not required to provide a reasonable modification to an individual who meets the definition of "disability" solely under the "regarded as" prong of the definition of "disability" at § 35.108(a)(1)(iii).

(8) A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.

(c) Nothing in this part prohibits a public entity from providing benefits, services, or advantages to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.

(d) A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

(e)(1) Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.

(2) Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.

(f) A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.

(g) A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

(h) A public entity may impose legitimate safety requirements necessary for the safe operation of its services, programs, or activities. However, the public entity must ensure that its safety requirements are based on actual risks, not on mere speculation, stereotypes, or generalizations about individuals with disabilities.

(i) Nothing in this part shall provide the basis for a claim that an individual without a disability was subject to discrimination because of a lack of disability, including a claim that an individual with a disability was granted a reasonable modification that was denied to an individual without a disability.

Credits

[Order No. 3180–2010, 75 FR 56178, Sept. 15, 2010; Order No. 3702–2016, 81 FR 53225, Aug. 11, 2016]

AUTHORITY: 5 U.S.C. 301; 28 U.S.C. 509, 510; 42 U.S.C. 12134, 12131, and 12205a.

Notes of Decisions (1850)

Current through August 1, 2019; 84 FR 37750.

End of Document

Addendum G

Code of Federal Regulations
Title 28. Judicial Administration
Chapter I. Department of Justice
Part 41. Implementation of Executive Order 12250, Nondiscrimination on the Basis of Handicap in Federally Assisted Programs (Refs & Annos)
Subpart C. Guidelines for Determining Discriminatory Practices
Employment

28 C.F.R. § 41.53

§ 41.53 Reasonable accommodation.

Currentness

A recipient shall make reasonable accommodation to the known physical or mental limitations of an otherwise qualified handicapped applicant or employee unless the recipient can demonstrate that the accommodation would impose an undue hardship on the operation of its program.

AUTHORITY: Executive Order 12250, 45 FR 72995; sec. 504, Rehabilitation Act of 1973, Pub.L. 93–112, 87 Stat. 394 (29 U.S.C. 794); sec. 111(a), Rehabilitation Act Amendments of 1974, Pub.L. 93–516, 88 Stat. 1619 (29 U.S.C. 706).

Notes of Decisions (12)

Current through August 1, 2019; 84 FR 37750.

End of Document

Addendum H

Code of Federal Regulations
Title 34. Education
Subtitle B. Regulations of the Offices of the Department of Education
Chapter I. Office for Civil Rights, Department of Education
Part 104. Nondiscrimination on the Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance (Refs & Annos)
Subpart E. Postsecondary Education

34 C.F.R. § 104.44

§ 104.44 Academic adjustments.

Currentness

(a) Academic requirements. A recipient to which this subpart applies shall make such modifications to its academic requirements as are necessary to ensure that such requirements do not discriminate or have the effect of discriminating, on the basis of handicap, against a qualified handicapped applicant or student. Academic requirements that the recipient can demonstrate are essential to the instruction being pursued by such student or to any directly related licensing requirement will not be regarded as discriminatory within the meaning of this section. Modifications may include changes in the length of time permitted for the completion of degree requirements, substitution of specific courses required for the completion of degree requirements, and adaptation of the manner in which specific courses are conducted.

(b) Other rules. A recipient to which this subpart applies may not impose upon handicapped students other rules, such as the prohibition of tape recorders in classrooms or of dog guides in campus buildings, that have the effect of limiting the participation of handicapped students in the recipient's education program or activity.

(c) Course examinations. In its course examinations or other procedures for evaluating students' academic achievement, a recipient to which this subpart applies shall provide such methods for evaluating the achievement of students who have a handicap that impairs sensory, manual, or speaking skills as will best ensure that the results of the evaluation represents the student's achievement in the course, rather than reflecting the student's impaired sensory, manual, or speaking skills (except where such skills are the factors that the test purports to measure).

(d) Auxiliary aids.

(1) A recipient to which this subpart applies shall take such steps as are necessary to ensure that no handicapped student is denied the benefits of, excluded from participation in, or otherwise subjected to discrimination because of the absence of educational auxiliary aids for students with impaired sensory, manual, or speaking skills.

(2) Auxiliary aids may include taped texts, interpreters or other effective methods of making orally delivered materials available to students with hearing impairments, readers in libraries for students with visual impairments, classroom equipment adapted for use by students with manual impairments, and other similar services and actions. Recipients need not provide attendants, individually prescribed devices, readers for personal use or study, or other devices or services of a personal nature.

Credits
[65 FR 68055, Nov. 13, 2000]

AUTHORITY: 20 U.S.C. 1405; 29 U.S.C. 794; Pub.L. 111–256, 124 Stat. 2643.

Notes of Decisions (5)

Current through August 1, 2019; 84 FR 37750.

End of Document

Addendum I

Code of Federal Regulations
Title 45. Public Welfare
Subtitle A. Department of Health and Human Services (Refs & Annos)
Subchapter A. General Administration (Refs & Annos)
Part 84. Nondiscrimination on the Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance (Refs & Annos)
Subpart B. Employment Practices

45 C.F.R. § 84.12

§ 84.12 Reasonable accommodation.

Effective: June 8, 2005
Currentness

(a) A recipient shall make reasonable accommodation to the known physical or mental limitations of an otherwise qualified handicapped applicant or employee unless the recipient can demonstrate that the accommodation would impose an undue hardship on the operation of its program or activity.

(b) Reasonable accommodation may include: (1) Making facilities used by employees readily accessible to and usable by handicapped persons, and (2) job restructuring, part-time or modified work schedules, acquisition or modification of equipment or devices, the provision of readers or interpreters, and other similar actions.

(c) In determining pursuant to paragraph (a) of this section whether an accommodation would impose an undue hardship on the operation of a recipient's program or activity, factors to be considered include:

(1) The overall size of the recipient's program or activity with respect to number of employees, number and type of facilities, and size of budget;

(2) The type of the recipient's operation, including the composition and structure of the recipient's workforce; and

(3) The nature and cost of the accommodation needed.

(d) A recipient may not deny any employment opportunity to a qualified handicapped employee or applicant if the basis for the denial is the need to make reasonable accommodation to the physical or mental limitations of the employee or applicant.

Credits
[70 FR 24319, May 9, 2005]

AUTHORITY: 20 U.S.C. 1405; 29 U.S.C. 794; 42 U.S.C. 290dd–2; 21 U.S.C. 1174.

Notes of Decisions (204)

Current through August 1, 2019; 84 FR 37750.

End of Document

Addendum J

KeyCite Yellow Flag - Negative Treatment
Unconstitutional or PreemptedLimitation Recognized by Saunders v. Farmers Ins. Exchange, W.D.Mo., Mar. 16, 2007

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 45. Fair Housing (Refs & Annos)
Subchapter I. Generally (Refs & Annos)

42 U.S.C.A. § 3604

§ 3604. Discrimination in the sale or rental of housing and other prohibited practices

Currentness

As made applicable by section 3603 of this title and except as exempted by sections 3603(b) and 3607 of this title, it shall be unlawful--

(a) To refuse to sell or rent after the making of a bona fide offer, or to refuse to negotiate for the sale or rental of, or otherwise make unavailable or deny, a dwelling to any person because of race, color, religion, sex, familial status, or national origin.

(b) To discriminate against any person in the terms, conditions, or privileges of sale or rental of a dwelling, or in the provision of services or facilities in connection therewith, because of race, color, religion, sex, familial status, or national origin.

(c) To make, print, or publish, or cause to be made, printed, or published any notice, statement, or advertisement, with respect to the sale or rental of a dwelling that indicates any preference, limitation, or discrimination based on race, color, religion, sex, handicap, familial status, or national origin, or an intention to make any such preference, limitation, or discrimination.

(d) To represent to any person because of race, color, religion, sex, handicap, familial status, or national origin that any dwelling is not available for inspection, sale, or rental when such dwelling is in fact so available.

(e) For profit, to induce or attempt to induce any person to sell or rent any dwelling by representations regarding the entry or prospective entry into the neighborhood of a person or persons of a particular race, color, religion, sex, handicap, familial status, or national origin.

(f)(1) To discriminate in the sale or rental, or to otherwise make unavailable or deny, a dwelling to any buyer or renter because of a handicap of--

(A) that buyer or renter, [1]

(B) a person residing in or intending to reside in that dwelling after it is so sold, rented, or made available; or

(C) any person associated with that buyer or renter.

(2) To discriminate against any person in the terms, conditions, or privileges of sale or rental of a dwelling, or in the provision of services or facilities in connection with such dwelling, because of a handicap of--

(A) that person; or

(B) a person residing in or intending to reside in that dwelling after it is so sold, rented, or made available; or

(C) any person associated with that person.

(3) For purposes of this subsection, discrimination includes--

(A) a refusal to permit, at the expense of the handicapped person, reasonable modifications of existing premises occupied or to be occupied by such person if such modifications may be necessary to afford such person full enjoyment of the premises except that, in the case of a rental, the landlord may where it is reasonable to do so condition permission for a modification on the renter agreeing to restore the interior of the premises to the condition that existed before the modification, reasonable wear and tear excepted. [2]

(B) a refusal to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford such person equal opportunity to use and enjoy a dwelling; or

(C) in connection with the design and construction of covered multifamily dwellings for first occupancy after the date that is 30 months after September 13, 1988, a failure to design and construct those dwellings in such a manner that--

(i) the public use and common use portions of such dwellings are readily accessible to and usable by handicapped persons;

(ii) all the doors designed to allow passage into and within all premises within such dwellings are sufficiently wide to allow passage by handicapped persons in wheelchairs; and

(iii) all premises within such dwellings contain the following features of adaptive design:

(I) an accessible route into and through the dwelling;

(II) light switches, electrical outlets, thermostats, and other environmental controls in accessible locations;

(III) reinforcements in bathroom walls to allow later installation of grab bars; and

(IV) usable kitchens and bathrooms such that an individual in a wheelchair can maneuver about the space.

(4) Compliance with the appropriate requirements of the American National Standard for buildings and facilities providing accessibility and usability for physically handicapped people (commonly cited as "ANSI A117.1") suffices to satisfy the requirements of paragraph (3)(C)(iii).

(5)(A) If a State or unit of general local government has incorporated into its laws the requirements set forth in paragraph (3)(C), compliance with such laws shall be deemed to satisfy the requirements of that paragraph.

(B) A State or unit of general local government may review and approve newly constructed covered multifamily dwellings for the purpose of making determinations as to whether the design and construction requirements of paragraph (3)(C) are met.

(C) The Secretary shall encourage, but may not require, States and units of local government to include in their existing procedures for the review and approval of newly constructed covered multifamily dwellings, determinations as to whether the design and construction of such dwellings are consistent with paragraph (3)(C), and shall provide technical assistance to States and units of local government and other persons to implement the requirements of paragraph (3)(C).

(D) Nothing in this subchapter shall be construed to require the Secretary to review or approve the plans, designs or construction of all covered multifamily dwellings, to determine whether the design and construction of such dwellings are consistent with the requirements of paragraph 3(C).

(6)(A) Nothing in paragraph (5) shall be construed to affect the authority and responsibility of the Secretary or a State or local public agency certified pursuant to section 3610(f)(3) of this title to receive and process complaints or otherwise engage in enforcement activities under this subchapter.

(B) Determinations by a State or a unit of general local government under paragraphs (5)(A) and (B) shall not be conclusive in enforcement proceedings under this subchapter.

(7) As used in this subsection, the term "covered multifamily dwellings" means--

(A) buildings consisting of 4 or more units if such buildings have one or more elevators; and

(B) ground floor units in other buildings consisting of 4 or more units.

(8) Nothing in this subchapter shall be construed to invalidate or limit any law of a State or political subdivision of a State, or other jurisdiction in which this subchapter shall be effective, that requires dwellings to be designed and constructed in a manner that affords handicapped persons greater access than is required by this subchapter.

(9) Nothing in this subsection requires that a dwelling be made available to an individual whose tenancy would constitute a direct threat to the health or safety of other individuals or whose tenancy would result in substantial physical damage to the property of others.

CREDIT(S)

(Pub.L. 90-284, Title VIII, § 804, Apr. 11, 1968, 82 Stat. 83; Pub.L. 93-383, Title VIII, § 808(b)(1), Aug. 22, 1974, 88 Stat. 729; Pub.L. 100-430, §§ 6(a)-(b)(2), (e), 15, Sept. 13, 1988, 102 Stat. 1620, 1622, 1623, 1636.)

Notes of Decisions (1247)

Footnotes

1 So in original. The comma probably should be a semicolon.

2 So in original. The period probably should be a semicolon.

42 U.S.C.A. § 3604, 42 USCA § 3604

Current through P.L. 116-36.

End of Document

Addendum K

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

United States Code Annotated
Title 29. Labor
Chapter 18. Employee Retirement Income Security Program (Refs & Annos)
Subchapter I. Protection of Employee Benefit Rights (Refs & Annos)
Subtitle B. Regulatory Provisions
Part 5. Administration and Enforcement

29 U.S.C.A. § 1132

§ 1132. Civil enforcement

Effective: December 16, 2014
Currentness

<Notes of Decisions for 29 USCA § 1132 are displayed in mulitple documents.>

(a) Persons empowered to bring a civil action

A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6), (7), (8), or (9) of subsection (c) or under subsection (i) or (l);

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection;

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title [1] or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts;

(10) in the case of a multiemployer plan that has been certified by the actuary to be in endangered or critical status under section 1085 of this title, if the plan sponsor--

(A) has not adopted a funding improvement or rehabilitation plan under that section by the deadline established in such section, or

(B) fails to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section,

by an employer that has an obligation to contribute with respect to the multiemployer plan or an employee organization that represents active participants in the multiemployer plan, for an order compelling the plan sponsor to adopt a funding improvement or rehabilitation plan or to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section and the funding improvement or rehabilitation plan; or

(11) in the case of a multiemployer plan, by an employee representative, or any employer that has an obligation to contribute to the plan, (A) to enjoin any act or practice which violates subsection (k) of section 1021 of this title (or, in the case of an employer, subsection (l) of such section), or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) [2] of Title 26 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under

subsection (a)(5) with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if--

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(3) Except as provided in subsections (c)(9) and (a)(6) (with respect to collecting civil penalties under subsection (c)(9)), the Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 1191b(a)(1) of this title). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title, section 1021(e)(1) of this title, section 1021(f) of this title, or section 1025(a) of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(1) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021(d) of this title with respect to any participant or beneficiary or who fails to meet the requirements of section 1021(e)(2) of this title with respect to any person or who fails to meet the requirements of section 1082(d)(12)(E)[2] of this title with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 a day for each violation by any person of subsection (j), (k), or (l) of section 1021 of this title or section 1144(e)(3) of this title.

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 1021(g) of this title.

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 1024(a)(6) of this title, the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $100 a day from the date of such failure (but in no event in excess of $1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary may assess a civil penalty against a plan administrator of up to $100 a day from the date of the plan administrator's failure or refusal to provide notice to participants and beneficiaries in accordance with subsection (i) or (m) of section 1021 of this title. For purposes of this paragraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

(8) The Secretary may assess against any plan sponsor of a multiemployer plan a civil penalty of not more than $1,100 per day--

(A) for each violation by such sponsor of the requirement under section 1085 of this title to adopt by the deadline established in that section a funding improvement plan or rehabilitation plan with respect to a multiemployer plan which is in endangered or critical status, or

(B) in the case of a plan in endangered status which is not in seriously endangered status, for failure by the plan to meet the applicable benchmarks under section 1085 of this title by the end of the funding improvement period with respect to the plan.

(9)(A) The Secretary may assess a civil penalty against any employer of up to $100 a day from the date of the employer's failure to meet the notice requirement of section 1181(f)(3)(B)(i)(I) of this title. For purposes of this subparagraph, each violation with respect to any single employee shall be treated as a separate violation.

(B) The Secretary may assess a civil penalty against any plan administrator of up to $100 a day from the date of the plan administrator's failure to timely provide to any State the information required to be disclosed under section 1181(f)(3)(B)(ii) of this title. For purposes of this subparagraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

(10) Secretarial enforcement authority relating to use of genetic information

(A) General rule

The Secretary may impose a penalty against any plan sponsor of a group health plan, or any health insurance issuer offering health insurance coverage in connection with the plan, for any failure by such sponsor or issuer to meet the requirements

of subsection (a)(1)(F), (b)(3), (c), or (d) of section 1182 of this title or section 1181 or 1182(b)(1) of this title with respect to genetic information, in connection with the plan.

(B) Amount

(i) In general

The amount of the penalty imposed by subparagraph (A) shall be $100 for each day in the noncompliance period with respect to each participant or beneficiary to whom such failure relates.

(ii) Noncompliance period

For purposes of this paragraph, the term "noncompliance period" means, with respect to any failure, the period--

(I) beginning on the date such failure first occurs; and

(II) ending on the date the failure is corrected.

(C) Minimum penalties where failure discovered

Notwithstanding clauses (i) and (ii) of subparagraph (D):

(i) In general

In the case of 1 or more failures with respect to a participant or beneficiary--

(I) which are not corrected before the date on which the plan receives a notice from the Secretary of such violation; and

(II) which occurred or continued during the period involved;

the amount of penalty imposed by subparagraph (A) by reason of such failures with respect to such participant or beneficiary shall not be less than $2,500.

(ii) Higher minimum penalty where violations are more than de minimis

To the extent violations for which any person is liable under this paragraph for any year are more than de minimis, clause (i) shall be applied by substituting "$15,000" for "$2,500" with respect to such person.

(D) Limitations

(i) Penalty not to apply where failure not discovered exercising reasonable diligence

No penalty shall be imposed by subparagraph (A) on any failure during any period for which it is established to the satisfaction of the Secretary that the person otherwise liable for such penalty did not know, and exercising reasonable diligence would not have known, that such failure existed.

(ii) Penalty not to apply to failures corrected within certain periods

No penalty shall be imposed by subparagraph (A) on any failure if--

(I) such failure was due to reasonable cause and not to willful neglect; and

(II) such failure is corrected during the 30-day period beginning on the first date the person otherwise liable for such penalty knew, or exercising reasonable diligence would have known, that such failure existed.

(iii) Overall limitation for unintentional failures

In the case of failures which are due to reasonable cause and not to willful neglect, the penalty imposed by subparagraph (A) for failures shall not exceed the amount equal to the lesser of--

(I) 10 percent of the aggregate amount paid or incurred by the plan sponsor (or predecessor plan sponsor) during the preceding taxable year for group health plans; or

(II) $500,000.

(E) Waiver by Secretary

In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by subparagraph (A) to the extent that the payment of such penalty would be excessive relative to the failure involved.

(F) Definitions

Terms used in this paragraph which are defined in section 1191b of this title shall have the meanings provided such terms in such section.

(11) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1320b-14(c)(8)[2] of Title 42.

(12) The Secretary may assess a civil penalty against any sponsor of a CSEC plan of up to $100 a day from the date of the plan sponsor's failure to comply with the requirements of section 1085a(j)(3) of this title to establish or update a funding restoration plan.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan--

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of--

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of Title 26.

(h) Service upon Secretary of Labor and Secretary of the Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of Title 26) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of Title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of Title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of Title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor

Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries

(1) In the case of--

(A) any breach of fiduciary responsibility under (or other violation of) part 4 of this subtitle by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)--

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5).

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that--

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9)) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of Title 26.

(m) Penalty for improper distribution

In the case of a distribution to a pension plan participant or beneficiary in violation of section 1056(e) of this title by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.

CREDIT(S)

(Pub.L. 93-406, Title I, § 502, Sept. 2, 1974, 88 Stat. 891; Pub.L. 96-364, Title III, § 306(b), Sept. 26, 1980, 94 Stat. 1295; Pub.L. 99-272, Title X, § 10002(b), Apr. 7, 1986, 100 Stat. 231; Pub.L. 100-203, Title IX, §§ 9342(c), 9344, Dec. 22, 1987, 101 Stat. 1330-372, 1330-373; Pub.L. 101-239, Title II, § 2101(a), (b), Title VII, §§ 7881(b)(5)(B), (j)(2), (3), 7891(a)(1), 7894(f)(1), Dec. 19, 1989, 103 Stat. 2123, 2438, 2442, 2445, 2450; Pub.L. 101-508, Title XII, § 12012(d)(2), Nov. 5, 1990, 104 Stat.1388-573; Pub.L. 103-66, Title IV, § 4301(c)(1) to (3), Aug. 10, 1993, 107 Stat. 376; Pub.L. 103-401, §§ 2, 3, Oct. 22, 1994, 108 Stat. 4172; Pub.L. 103-465, Title VII, § 761(a)(9)(B)(ii), Dec. 8, 1994, 108 Stat. 5033; Pub.L. 104-191, Title I, § 101(b), (e)(2), Aug. 21, 1996, 110 Stat. 1951, 1952; Pub.L. 104-204, Title VI, § 603(b)(3)(E), Sept. 26, 1996, 110 Stat. 2938; Pub.L. 105-34, Title XV, § 1503(c)(2)(B), (d)(7), Aug. 5, 1997, 111 Stat. 1062; Pub.L 107-204, Title III, § 306(b)(3), July 30, 2002, 116 Stat. 783; Pub.L. 108-218, Title I, §§ 102(d), 103(b), 104(a)(2), Apr. 10, 2004, 118 Stat. 602, 603, 606; Pub.L. 109-280, Title I, § 103(b)(2), Title II, § 202(b), (c), Title V, §§ 502(a)(2), (b)(2), 507(b), 508(a)(2)(C), Title IX, § 902(f)(2), Aug. 17, 2006, 120 Stat. 816, 884, 885, 940, 941, 949, 951, 1039; Pub.L. 110-233, Title I, § 101(e), May 21, 2008, 122 Stat. 886; Pub.L. 110-458, Title I, §§ 101(c)(1)(H), 102(b)(1)(H), (I), Dec. 23, 2008, 122 Stat. 5097, 5101; Pub.L. 111-3, Title III, § 311(b)(1)(E), Feb. 4, 2009, 123 Stat. 70; Pub.L. 113-97, Title I, § 102(b)(6), Apr. 7, 2014, 128 Stat. 1117; Pub.L. 113-235, Div. O, Title I, § 111(d), Dec. 16, 2014, 128 Stat. 2793.)

Notes of Decisions (6764)

Footnotes

1 So in original. Probably should be “subtitle”.

2 See References in Text note set out under this section.

29 U.S.C.A. § 1132, 29 USCA § 1132

Current through P.L. 116-36.

End of Document

Addendum L

United States Code Annotated
Title 29. Labor
Chapter 18. Employee Retirement Income Security Program (Refs & Annos)
Subchapter I. Protection of Employee Benefit Rights (Refs & Annos)
Subtitle B. Regulatory Provisions
Part 2. Participation and Vesting (Refs & Annos)

29 U.S.C.A. § 1051

§ 1051. Coverage

Currentness

This part shall apply to any employee benefit plan described in section 1003(a) of this title (and not exempted under section 1003(b) of this title) other than--

(1) an employee welfare benefit plan;

(2) a plan which is unfunded and is maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees;

(3)(A) a plan established and maintained by a society, order, or association described in section 501(c)(8) or (9) of Title 26, if no part of the contributions to or under such plan are made by employers of participants in such plan, or

(B) a trust described in section 501(c)(18) of Title 26;

(4) a plan which is established and maintained by a labor organization described in section 501(c)(5) of Title 26 and which does not at any time after September 2, 1974, provide for employer contributions;

(5) any agreement providing payments to a retired partner or a deceased partner's successor in interest, as described in section 736 of Title 26;

(6) an individual retirement account or annuity described in section 408 of Title 26, or a retirement bond described in section 409 of Title 26 (as effective for obligations issued before January 1, 1984);

(7) an excess benefit plan; or

(8) any plan, fund or program under which an employer, all of whose stock is directly or indirectly owned by employees, former employees or their beneficiaries, proposes through an unfunded arrangement to compensate retired employees for benefits which were forfeited by such employees under a pension plan maintained by a former employer prior to the date such pension plan became subject to this chapter.

CREDIT(S)

(Pub.L. 93-406, Title I, § 201, Sept. 2, 1974, 88 Stat. 852; Pub.L. 96-364, Title IV, § 411(a), Sept. 26, 1980, 94 Stat. 1308; Pub.L. 101-239, Title VII, §§ 7891(a)(1), 7894(c)(1)(A), (11)(A), Dec. 19, 1989, 103 Stat. 2445, 2448, 2449.)

Notes of Decisions (70)

29 U.S.C.A. § 1051, 29 USCA § 1051
Current through P.L. 116-36.

End of Document

Addendum M

KeyCite Yellow Flag - Negative Treatment
Unconstitutional or PreemptedLimited on Preemption Grounds by National Federation of the Blind v. United Airlines Inc., 9th Cir.(Cal.), Jan. 19, 2016

West's Annotated California Codes
Civil Code (Refs & Annos)
Division 1. Persons (Refs & Annos)
Part 2. Personal Rights (Refs & Annos)

West's Ann.Cal.Civ.Code § 51

§ 51. Unruh Civil Rights Act; equal rights; business establishments; violations of federal Americans with Disabilities Act

Effective: January 1, 2016
Currentness

(a) This section shall be known, and may be cited, as the Unruh Civil Rights Act.

(b) All persons within the jurisdiction of this state are free and equal, and no matter what their sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, * * * sexual orientation, citizenship, primary language, or immigration status are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever.

(c) This section shall not be construed to confer any right or privilege on a person that is conditioned or limited by law or that is applicable alike to persons of every sex, color, race, religion, ancestry, national origin, disability, medical condition, marital status, * * * sexual orientation, citizenship, primary language, or immigration status, or to persons regardless of their genetic information.

(d) Nothing in this section shall be construed to require any construction, alteration, repair, structural or otherwise, or modification of any sort whatsoever, beyond that construction, alteration, repair, or modification that is otherwise required by other provisions of law, to any new or existing establishment, facility, building, improvement, or any other structure, nor shall anything in this section be construed to augment, restrict, or alter in any way the authority of the State Architect to require construction, alteration, repair, or modifications that the State Architect otherwise possesses pursuant to other laws.

(e) For purposes of this section:

(1) “Disability” means any mental or physical disability as defined in Sections 12926 and 12926.1 of the Government Code.

(2)(A) “Genetic information” means, with respect to any individual, information about any of the following:

(i) The individual's genetic tests.

(ii) The genetic tests of family members of the individual.

(iii) The manifestation of a disease or disorder in family members of the individual.

(B) "Genetic information" includes any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by an individual or any family member of the individual.

(C) "Genetic information" does not include information about the sex or age of any individual.

(3) "Medical condition" has the same meaning as defined in subdivision (i) of Section 12926 of the Government Code.

(4) "Religion" includes all aspects of religious belief, observance, and practice.

(5) "Sex" includes, but is not limited to, pregnancy, childbirth, or medical conditions related to pregnancy or childbirth. "Sex" also includes, but is not limited to, a person's gender. "Gender" means sex, and includes a person's gender identity and gender expression. "Gender expression" means a person's gender-related appearance and behavior whether or not stereotypically associated with the person's assigned sex at birth.

(6) "Sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, * * * sexual orientation, citizenship, primary language, or immigration status" includes a perception that the person has any particular characteristic or characteristics within the listed categories or that the person is associated with a person who has, or is perceived to have, any particular characteristic or characteristics within the listed categories.

(7) "Sexual orientation" has the same meaning as defined in subdivision (s) of Section 12926 of the Government Code.

(f) A violation of the right of any individual under the federal Americans with Disabilities Act of 1990 (* * * Public Law 101-336) [1] shall also constitute a violation of this section.

(g) Verification of immigration status and any discrimination based upon verified immigration status, where required by federal law, shall not constitute a violation of this section.

(h) Nothing in this section shall be construed to require the provision of services or documents in a language other than English, beyond that which is otherwise required by other provisions of federal, state, or local law, including Section 1632.

Credits

(Added by Stats.1905, c. 413, p. 553, § 1. Amended by Stats.1919, c. 210, p. 309, § 1; Stats.1923, c. 235, p. 485, § 1; Stats.1959, c. 1866, p. 4424, § 1; Stats.1961, c. 1187, p. 2920, § 1; Stats.1974, c. 1193, p. 2568, § 1; Stats.1987, c. 159, § 1; Stats.1992, c. 913 (A.B.1077), § 3; Stats.1998, c. 195 (A.B.2702), § 1; Stats.2000, c. 1049 (A.B.2222), § 2; Stats.2005, c. 420 (A.B.1400), § 3; Stats.2011, c. 261 (S.B.559), § 3; Stats.2011, c. 719 (A.B.887), § 1.5; Stats.2015, c. 303 (A.B.731), § 25, eff. Jan. 1, 2016; Stats.2015, c. 282 (S.B.600), § 1, eff. Jan. 1, 2016.)

Notes of Decisions (719)

Footnotes

1 For public law sections classified to the U.S.C.A., see USCA-Tables.

West's Ann. Cal. Civ. Code § 51, CA CIVIL § 51

Current with urgency legislation through Ch. 161 of the 2019 Reg.Sess. Some statute sections may be more current, see credits for details.

End of Document

Addendum N

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 15-62685-CIV-ALTONAGA/McAliley

JOHN DOE,

Plaintiff,

v.

COVENTRY HEALTH CARE, INC., *et al.*,

Defendants.
_____/

ORDER

THIS CAUSE came before the Court on Defendants, Coventry Health Care, Inc.; Coventry Health and Life Insurance Company; Coventry Health Plan of Florida, Inc.; and Coventry Health Care of Florida, Inc.'s (together, "Coventry['s]") Motion to Dismiss . . . ("Motion") [ECF No. 13] filed February 26, 2016.[1] Plaintiff, John Doe ("Plaintiff") filed an Opposition . . . ("Opposition") [ECF No. 43] on March 28, 2016; and Coventry filed its Reply . . . ("Reply") [ECF No. 56] on April 11, 2016. Coventry also filed an Amended Request for Judicial Notice . . . ("Request") [ECF No. 29] on March 7, 2016. Plaintiff filed his Opposition . . . ("Request Opposition") [ECF No. 38] on March 24, 2016; Coventry filed its Reply . . . ("Request Reply") [ECF No. 49] on April 4, 2016. The Court has carefully reviewed the parties' written submissions, the record, and applicable law.[2]

[1] In its Motion, Coventry requests a hearing. After reviewing the parties' submissions, the Court deems a hearing unnecessary.

[2] On May 2, 2016, Plaintiff filed a Notice of Filing John Doe's Supplemental Declaration . . . ("Supplemental Declaration") [ECF No. 59]. Plaintiff provides no reason why the Court should consider this Supplemental Declaration, filed more than one month after he filed his Opposition, and three weeks after Coventry filed its Reply.

I. BACKGROUND[3]

Plaintiff, a Florida resident, has been enrolled in a health plan sold or administered by Coventry since September 2015. (*See* Compl. ¶ 36). From September 2015 through November 2015, he was able to obtain his HIV specialty medications through his local pharmacy. (*See id.* ¶ 57). Sometime in November 2015, Plaintiff was informed by a Coventry representative he would need to use a mail-order provider to receive his HIV medications going forward. (*See id.*).

Plaintiff challenges Coventry's practice of requiring health plan enrollees to obtain specialty medications to treat HIV/AIDS from a third-party mail-order pharmacy rather than from in-person, community pharmacies.[4] (*See id.* ¶¶ 1, 3). Specifically, he alleges Coventry renders its "health plan benefits illusory by transforming HIV/AIDS drug purchases at community pharmacies from an 'in-network' covered benefit to either an 'out-of-network' payment subject to 'non-Network Benefit' charges under the terms of their health plans or . . . providing no coverage at all if they do not [use the mail-order system], resulting in an outright denial of required health plan benefits." (*Id.* ¶ 3 (alterations added)). Despite attempts "to resolve this matter informally," Coventry has not allowed Plaintiff to opt out of the mail-order program. (*Id.* ¶ 6).

Plaintiff alleges Coventry's mail-order system harms enrollees in a number of ways: (1) it deprives them of in-person counseling from an expert pharmacist (*see id.* ¶ 4); (2) it exposes enrollees to health risks, because prescriptions are not allowed to be refilled early, which can

[3] When reviewing a motion to dismiss, a court must construe the complaint in the light most favorable to the plaintiff and take the factual allegations therein as true. *See Urquilla-Diaz v. Kaplan Univ.*, 780 F.3d 1039, 1050 (11th Cir. 2015).

[4] Plaintiff also seeks to represent a class of similarly situated persons. (*See* Compl. ¶ 72). Because a class has not yet been certified, this Order refers only to Plaintiff and not those he seeks to represent.

lead to delays in acquiring the necessary medication (*see id.* ¶ 7); (3) it infringes on enrollees' right to privacy, by requiring the mail delivery of medication to apartment buildings or enrollees' workplaces (*see id.* ¶ 8); (4) it increases the risk of medication being lost or stolen (*see id.* ¶ 9); and (5) it creates the possibility the medications will be less effective, if exposed to heat for extended periods of time (*see id.* ¶ 9).

At bottom, Plaintiff alleges Coventry's practice vis-à-vis HIV/AIDS medication is a discriminatory practice "specifically directed at [enrollees] on the basis of their HIV status." (*Id.* ¶ 29 (alteration added)). He contends this practice violates: (1) the anti-discrimination provisions of the Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA"), 42 U.S.C. section 300gg-4 (Count I), and 42 U.S.C. section 18116 (Count II); (2) provisions of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. sections 1132(a)(1)(B) (Count III), 1109(a) (Count IV), 1132(a)(3) (Count V), and 1132(a)(3) and (c) (Count VI); and (3) the Americans with Disabilities Act ("ADA"), 42 U.S.C. 12101 *et seq.* (Count VII). (*See generally* Compl.). Due to Coventry's practice, Plaintiff seeks: (1) disgorgement and restitution of Coventry's revenues, profits, and other benefits obtained from the discriminatory practice; (2) an injunction enjoining Coventry from continuing the discriminatory practice; and (3) compensatory and statutory damages, as well as attorney's fees and costs. (*See id.* 40).

Coventry moves to dismiss the Complaint under Federal Rules of Civil Procedure 12(b)(1) and (6).

II. LEGAL STANDARDS

A plaintiff must satisfy three requirements to survive a motion to dismiss under Federal Rule of Civil Procedure 12(b)(1) for lack of standing: (1) injury in fact; (2) causal connection between the injury and the defendant's action; and (3) redressability. *See Houston v. Marod*

Supermarkets, Inc., 733 F.3d 1323, 1328 (11th Cir. 2013). When injunctive relief is sought, a plaintiff must also demonstrate "a sufficient likelihood that he will be affected by the allegedly unlawful conduct in the future." *Id.* (citation omitted). Such future harm must be "real and immediate — as opposed to [] merely conjectural or hypothetical." *Id.* at 1329 (alteration added; citation omitted). A defendant can assert either a facial or factual attack on a plaintiff's standing. *See Dapeer v. Neutrogena Corp.*, 95 F. Supp. 3d 1366, 1371 (S.D. Fla. 2015). "Facial attacks challenge subject matter jurisdiction based on the allegations in the complaint. . . . By contrast, factual attacks contest the truth of the allegations, which, by themselves, would be sufficient to invoke federal jurisdiction." *Id.* (internal quotation marks and citations omitted). "In resolving a factual attack, the district court may consider evidence outside the pleading, such as testimony and affidavits." *Id.* (citation omitted).

Additionally, "[t]o survive a motion to dismiss [under Rule 12(b)(6)], a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (alterations added) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). Although this pleading standard "does not require 'detailed factual allegations,' . . . it demands more than an unadorned, the defendant-unlawfully-harmed-me accusation." *Id.* (alteration added) (quoting *Twombly*, 550 U.S. at 555). Pleadings must contain "more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." *Twombly*, 550 U.S. at 555 (citation omitted). Indeed, "only a complaint that states a plausible claim for relief survives a motion to dismiss." *Iqbal*, 556 U.S. at 679 (citing *Twombly*, 550 U.S. at 556). To meet this "plausibility standard," a plaintiff must "plead[] factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* at 678 (alteration added) (citing *Twombly*, 550 U.S. at

556). "The mere possibility the defendant acted unlawfully is insufficient to survive a motion to dismiss." *Sinaltrainal v. Coca-Cola Co.*, 578 F.3d 1252, 1261 (11th Cir. 2009) (citation omitted), *abrogated on other grounds by Mohamad v. Palestinian Auth.*, 132 S. Ct. 1702 (2012).

III. ANALYSIS

Coventry argues: (1) Plaintiff's claim for injunctive relief should be dismissed for lack of standing; (2) Counts I and II should be dismissed because there are no private rights of action for the sections of the Affordable Care Act Coventry allegedly violated; and (3) Plaintiff fails to state a claim in Counts I through V and Count VII.[5] (*See generally* Mot.). In support of the Motion, Coventry also requests the Court take judicial notice of: (1) excerpts of the 2015 Coventry Schedule of Benefits for Plaintiff's employer; (2) the 2016 Coventry Schedule of Benefits for Plaintiff's employer; and (3) excerpts of the 2015 Coventry formulary for Plaintiff's employer. (*See generally* Request). The Court addresses the Request first, followed by the Motion.

A. Request for Judicial Notice

Ordinarily, a court will not consider materials outside the complaint when ruling on a motion to dismiss; if it does, the court must convert the motion to one for summary judgment. *See SFM Holdings, Ltd. v. Banc of Am. Sec., LLC*, 600 F.3d 1334, 1337 (11th Cir. 2010). However, there is an exception where "an extrinsic document . . . is (1) central to the plaintiff's claim, and (2) its authenticity is not challenged." *Id.* (alteration added; citations omitted). Separately, a court may take judicial notice of "a fact that is not subject to reasonable dispute because it . . . can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned." FED. R. EVID. 201(b) (alteration added).

[5] Coventry's Motion does not address Count VI. (*See* Reply 1 n.1).

Coventry asks the Court to take judicial notice of three exhibits attached to the Declaration of Margaret Goldstein ("Goldstein Declaration") [ECF No. 29-1]. (*See generally* Request). Plaintiff argues the Court should not consider the exhibits because: (1) they are not attached to the Complaint; (2) they are not central to Plaintiff's claims; and (3) Plaintiff has not had the opportunity to verify the documents' authenticity. (*See* Request Opp. 2).

Despite Coventry's characterizations to the contrary, none of the cases it cites involves a court taking judicial notice of documents. Rather, those cases rely on documents incorporated into a complaint by reference. *See, e.g.*, *Horsley v. Feldt*, 304 F.3d 1125, 1134 (11th Cir. 2002) (stating "[o]ur Rule 12(b)(6) decisions have adopted the 'incorporation by reference' doctrine" and not mentioning judicial notice (alteration added; citation omitted)); *Day v. Taylor*, 400 F.3d 1272, 1276 (11th Cir. 2005) (relying on *Horsley*); *Bickley v. Caremark RX, Inc.*, 461 F.3d 1325, 1329 n.7 (11th Cir. 2006) (relying on incorporation by reference doctrine, without mentioning judicial notice); *Saunders v. Liberty Life Assurance Co. of Boston*, No. 5:14-CV-1181-JHE, 2014 WL 6773252, at *2 (N.D. Ala. Dec. 2, 2014) (relying on *Bickley* to consider document outside complaint). These two doctrines, while similar, are distinct. *See United States ex rel. Osheroff v. Humana, Inc.*, 776 F.3d 805, 811 (11th Cir. 2015) ("We have explained, however, that a district court may consider an extrinsic document even on Rule 12(b)(6) review if it is (1) central to the plaintiff's claim, and (2) its authenticity is not challenged. . . . In addition, a district court may consider judicially noticed documents." (alteration added; citations omitted)).[6] Therefore,

[6] To be fair, Plaintiff also conflates the doctrines of incorporation by reference and judicial notice. (*See* Request Opp. 5 (citing to *Day* and *Horsley* for judicial notice standard, despite neither case mentioning judicial notice)).

Coventry fails to demonstrate the Court should take judicial notice of the health plan documents.[7]

Coventry also apparently, albeit obliquely, requests the Court consider the exhibits to the Goldstein Declaration because they are incorporated into the Complaint by reference. (*See* Request 2). Plaintiff argues the Goldstein Declaration and plan documents are not referenced in the Complaint. (*See* Request Opp. 3–4). The Court agrees as to the Goldstein Declaration itself; in any event, as Coventry notes, Coventry included the Goldstein Declaration solely for the purpose of authenticating the documents attached, not for the Court to actually consider its statements. (*See* Request Reply 3 n.2).

As to the plan documents, Plaintiff contends they are not referenced in the Complaint because he only "refers generally to Coventry plans" for 2015. (Request Opp. 4). But a Complaint need not reference a document explicitly for the Court to consider it on a motion to dismiss. *See SFM Holdings*, 600 F.3d at 1337 (finding no error where district court considered agreement between parties despite complaint only referring to "account opening documents").

Next, Plaintiff asserts the documents are not central to the Complaint. He states the documents are not central if they do not pertain to Plaintiff's actual policy. (*See* Request Opp. 6). And, while the Goldstein Declaration "purports to establish that these documents do pertain to Plaintiff's policy," the Court should disregard them because "Plaintiff has had no opportunity through discovery to confirm or dispute [the] statements" in the Goldstein Declaration. (*Id.* (alteration added)). This is not truly an argument against the documents' centrality; rather,

[7] Courts often take judicial notice of publicly available documents, which Coventry has failed to demonstrate the ones at issue are. *See, e.g., Osheroff*, 776 F.3d at 811 & n.4, 812 (stating courts "may take judicial notice of publicly filed documents" and finding no error in district court judicially noticing newspaper articles and a transcript of a state court hearing); *In re ING Groep, N.V. ERISA Litig.*, 749 F. Supp. 2d 1338, 1344 (N.D. Ga. 2010) (taking judicial notice of "generally known market conditions" and "publicly available SEC filings").

Plaintiff appears to be assailing their authenticity. In many situations in which a Court considers documents at the motion to dismiss phase, the plaintiff will not have conducted discovery.

Plaintiff also argues the Coventry Defendants "failed to argue in their Request for Judicial Notice how, if at all, these documents are central to Plaintiff's claims." (*Id.* 6). Coventry states in conclusory fashion the documents are central without explaining how. (*See generally* Request). Additionally, it states Plaintiff "implicitly references" the documents, and shows where (*id.* 2), but whether a document is referenced is a separate concern from whether it is central, which Coventry does not address.

In the Request Reply, Coventry explains why it believes the documents are central to Plaintiff's claims. (*See* Request Reply 4–5). Notably, the paragraphs in the Complaint it identifies are different from the ones identified in the Request, where Plaintiff "implicitly references" the documents. (*Compare* Request 2, *with* Request Reply 3–4). It is well established that a party may not raise new arguments in a reply brief. *See Foley v. Wells Fargo Bank, N.A.*, 849 F. Supp. 2d 1345, 1349 (S.D. Fla. 2012) (citing Eleventh Circuit precedent). When parties do raise new arguments in reply, courts generally decline to consider them. *See id.* Coventry's explanations regarding the documents' centrality, where none existed in the Request, is not proper rebuttal argument. Because Coventry's Request failed to argue how the documents were central to Plaintiff's Complaint, the Court declines to consider the documents attached to the Goldstein Declaration. The Court now turns to Coventry's Motion.

B. Shotgun Pleading

To begin, Plaintiff must replead each count of his Complaint because, as currently pleaded, it is a shotgun pleading. "The most common type [of shotgun pleading] — by a long shot — is a complaint containing multiple counts where each count adopts the allegations of all

preceding counts, causing each successive count to carry all that came before and the last count to be a combination of the entire complaint." *Weiland v. Palm Beach Cty. Sheriff's Office*, 792 F.3d 1313, 1321 (11th Cir. 2015) (alteration added). The Eleventh Circuit has "instructed district courts to prohibit, as fatally defective, shotgun pleadings." *B.L.E. ex rel. Jefferson v. Georgia*, 335 F. App'x 962, 963 (11th Cir. 2009). Here, each of the Complaint's counts "incorporates by reference each of the preceding paragraphs as though fully set forth herein," including the paragraphs from the preceding counts. (Compl. ¶¶ 81, 89, 97, 104, 115, 124, 136).

C. Plaintiff's Request for Injunctive Relief

Coventry argues Plaintiff lacks standing to obtain injunctive relief because, as of January 1, 2016, Plaintiff's medications will "be available through [] local, in-network pharmacies." (Mot. 5 (alteration added)). In support, Coventry attaches the Declaration of Elizabeth Engelhardt ("Engelhardt Declaration") [ECF No. 13-2]. Plaintiff argues he has standing because standing is determined based on the conditions at the time the Complaint was filed. (*See* Opp. 6).[8]

To demonstrate he has standing, Plaintiff must show: (1) he has suffered an injury in fact; (2) the injury is fairly traceable to the defendant's conduct; and (3) a favorable decision would redress the injury. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–61 (1992). To seek injunctive relief, a plaintiff must also show a real and immediate threat of future injury. *Focus on the Family v. Pinellas Suncoast Transit Auth.*, 344 F.3d 1263, 1274 (11th Cir. 2003). Standing is a matter of jurisdiction and can be challenged either facially or factually. *See Holy Cross Hosp., Inc. v. Baskot*, No. 10-62133-CIV, 2010 WL 5418999, at *2 (S.D. Fla. Dec. 23,

[8] Plaintiff submitted with his Response two declarations: (1) the Declaration of John Doe . . . ("Doe Declaration") [ECF No. 44-1]; and (2) the Declaration of Alan M. Mansfield . . . [ECF No. 45-1]. Coventry argues the Court should not consider Plaintiff's submissions. (*See* Reply 1 n.2). Since the Court decides in Plaintiff's favor regarding his request for injunctive relief without needing to rely on his two declarations, the Court need not decide the issue.

2010). As Coventry asks the Court to consider the Engelhardt Declaration (*see* Mot. 4 n.2), it presents a factual attack on the Court's jurisdiction.

Coventry asserts "Plaintiff's allegations of having actually been subject to a mail-order requirement are equivocal at best, and in any event, there is no indication that Plaintiff will be subject to a mandatory mail-order requirement in the future" since Coventry has purportedly ended the mail-order requirement. (*Id.* 5). As to the latter assertion, standing "must be determined as of the time at which the plaintiff's complaint is filed." *Focus on the Family*, 344 F.3d at 1275 (citing cases). Thus, whether Coventry ended the mail-order requirement after the Complaint was filed is irrelevant. *See id.*; *see also Doe v. Aetna, Inc.*, No. 14cv2986-LAB (DHB), 2016 WL 1028363, at *3 (S.D. Cal. Mar. 15, 2016).

Regarding whether Plaintiff was actually subject to the mail-order requirement, the Complaint is quite clear he was. (*See* Compl. ¶¶ 37, 57–59). Nothing in the Engelhardt Declaration contradicts Plaintiff's allegations. (*See generally* Engelhardt Decl.). In Reply, Coventry argues Plaintiff has not adequately alleged future harm because he stated he "currently obtains" his medications from a community pharmacy. (Reply 2 (emphasis omitted) (quoting Compl. ¶ 36)). Even so, Plaintiff alleges a real and immediate threat of future injury, as "he was informed by [Coventry's] representatives as late as December 22, 2015 that his participation in the Program is mandatory." (Compl. ¶ 37 (alteration added)). Thus, Plaintiff's prayer for injunctive relief may continue. *See Doe*, 2016 WL 1028363, at *3 ("At the time that Plaintiffs filed their respective complaints, however, they had ample reason to believe that Aetna's proposed program would be put into effect. Indeed, Aetna told them that it would; Plaintiffs merely took Aetna's word for it.").

D. Count I

Plaintiff alleges Coventry's mail-order program violates section 2705 of the Affordable Care Act, 42 U.S.C. 300gg-4. (*See* Compl. ¶¶ 81–88). Coventry first argues Count I should be dismissed because section 300gg-4 does not provide a private right of action. (*See* Mot. 6–7).

A private right of action "to enforce federal law must be created by Congress." *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001) (citation omitted). "The judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right of action but also a private remedy." *Id.* (citation omitted). Congress may create the right explicitly or implicitly; in either case the focus is on congressional intent. *See id.*; *Touche Ross & Co. v. Redington*, 442 U.S. 560, 575 (1979). "Without [congressional intent], a cause of action does not exist and courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute." *Alexander*, 532 U.S. at 286–87 (alteration added; citation omitted).

Coventry contends courts have made clear section 300gg-4 does not provide a private right of action. (*See* Mot. 6). In support, it cites one case from the Southern District of New York, which did not address section 300gg-4 directly but rather stated broadly: "the ACA does not provide for any independent private right of action to enforce its provisions." (*Id.* (citing *N.Y. State Psychiatric Ass'n, Inc. v. UnitedHealth Grp.*, 980 F. Supp. 2d 527, 544 (S.D.N.Y. 2013), *rev'd in part on other grounds*, 798 F.3d 125 (2d Cir. 2015))). The *UnitedHealth* court cited only to 29 U.S.C. section 1185d, which states: "the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart." 29 U.S.C. §

1185d(a)(1). Accordingly, the Affordable Care Act "is incorporated into ERISA and so is enforceable by ERISA plan participants only in accordance with the terms of ERISA § 502(a)." *UnitedHealth*, 980 F. Supp. 2d at 544 (citing *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004)).

The Court disagrees with the *UnitedHealth* court's conclusions. *Davila*, on which *UnitedHealth* relies, was decided before the passage of the Affordable Care Act and held: "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Davila*, 542 U.S. at 209. Such a holding has little value here, as "[o]ne federal statute does not preempt another." *Randolph v. IMBS, Inc.*, 368 F.3d 726, 730 (7th Cir. 2004) (citation omitted; alteration added) ("When two federal statutes address the same subject in different ways, the right question is whether one implicitly repeals the other — and repeal by implication is a rare bird indeed." (citations omitted)).

While 29 U.S.C. section 1185d does incorporate portions of the Affordable Care Act into ERISA, it does so only for "group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans." *Id.* By contrast, 42 U.S.C. section 300gg-4 — the section on which Count I is premised — applies to both "group or individual health insurance coverage." *Id.* It is not necessarily true therefore that section 300gg-4 does not have an independent private right of action just because it was incorporated into ERISA for purposes of group health plans.

Instead, the Court must conduct the usual analysis to determine whether Congress intended a private right of action for violations of section 300gg-4. This appears to be a matter of first impression; the Court is unaware of any cases in which a court has considered whether

section 300gg-4 provides a private right of action, and the parties have not presented any. The Court begins by examining congressional intent.

"The first rule in statutory construction is to determine whether the language at issue has a plain and unambiguous meaning with regard to the particular dispute." *Shotz v. City of Plantation, Fla.*, 344 F.3d 1161, 1167 (11th Cir. 2003) (internal quotation marks and citation omitted). When "the import of the words Congress has used is clear . . . we need not resort to legislative history, and we certainly should not do so to undermine the plain meaning of the statutory language." *Id.* (internal quotation marks and citation omitted; alteration in original).

Section 300gg-4 contains rights-creating language; it "does more than create a generalized duty for the public benefit, states more than declarative language, and focuses more than just on the person regulated." *Shotz*, 344 F.3d at 1167 (internal quotation marks omitted) (citing *Alexander*, 532 U.S. at 289). The statute prevents a group health plan and a health insurance issuer from establishing rules for eligibility of any individual based on a number of factors, including disability. *See* 42 U.S.C. § 300gg-4(a). This language is similar to those preventing discrimination, such as the anti-retaliation provisions of the ADA. *Compare Shotz*, 344 F.3d at 1167 (finding "explicit rights-creating language"), *with* 42 U.S.C. § 300gg-4(a).

The problem for Plaintiff, however, is there is no evidence of intent to create a private remedy for a violation of section 300gg-4. Plaintiff argues "private enforcement is necessary to ensure anti-discrimination laws are enforced." (Opp. 10). But such a statement has no bearing on what Congress intended, nor do the articles Plaintiff cites in support. *See Alexander*, 532 U.S. at 286–87 ("[C]ourts may not create a [cause of action], no matter how desirable that might be as a policy matter, or how compatible with the statute." (alterations added)). Rather, section 300gg-4 speaks of the power of government agencies to effectuate its terms, without any indicia of

private enforcement.[9] *See* 42 U.S.C. §§ 300gg-4(a)(9), (m), (n). Congress incorporated private enforcement into other sections of the Affordable Care Act but did not do so here. *See* 42 U.S.C. § 18116 (discussed *infra*). "[I]mplying a private right of action on the basis of congressional silence is a hazardous enterprise, at best." *Touche Ross*, 442 U.S. at 570 (alteration added). Thus, Count I is dismissed.[10]

E. Count II

In Count II, Plaintiff alleges Coventry's program violates section 1557 of the Affordable Care Act, 42 U.S.C. section 18116. (*See* Compl. ¶¶ 89–96). As with Count I, Coventry asserts there is no private right of action for violations of section 18116. (*See* Mot. 6–7).

Coventry argues violations of section 18116 can only be enforced through the statutes mentioned in section 18116, such as section 504 of the Rehabilitation Act of 1973. (*See id.* 7). Coventry seems to suggest a plaintiff must bring a cause of action under the statutes mentioned in section 18116 rather than under 18116 itself. (*See id.*). Unlike with section 300gg-4, other courts have considered this question already.

Section 18116 contains language expressly incorporating four civil rights statutes and states the "enforcement mechanisms provided for and available under such [civil rights statutes] shall apply for purposes of violations of this subsection." 42 U.S.C. § 18116 (alteration added).

[9] Plaintiff's cases, not cited for the private remedy argument (*see* Opp. 10 n.7), are readily distinguishable in any event. Under 42 U.S.C. section 12203, a subsection regarding remedies and procedures is included. *See Shotz*, 344 F.3d at 1169. *Schwier v. Cox*, 340 F.3d 1284 (11th Cir. 2003), dealt with whether a statute created a federal right enforceable under section 1983, a distinct, albeit similar inquiry. *See id.* at 1290. Since the right was being asserted through section 1983, the Eleventh Circuit only needed to address whether the Privacy Act created a federal right, not whether it provided a private remedy. *See generally id.* Additionally, although the Court finds the statutory language clear and need not reach legislative history, the history Plaintiff cites is unpersuasive (*see* Opp. 10 n.8). While the language Plaintiff cites speaks to the end of discrimination for those with pre-existing conditions, including those with HIV, it does nothing to evince intent to allow individuals the ability to privately enforce section 300gg-4.

[10] Since there is no private right of action for violations of section 300gg-4, the Court need not decide Coventry's other arguments regarding Count I. (*See* Mot. 8–10).

This language creates both a private right of action and a private remedy. *See Rumble v. Fairview Health Servs.*, No. 14-cv-2037, 2015 WL 1197415, at *7 n.3 (D. Minn. Mar. 16, 2015) (finding same); *Se. Penn. Transp. Auth. v. Gilead Sciences, Inc.*, 102 F. Supp. 3d 688, 699 (E.D. Pa. 2015); *Callum v. CVS Health Corp.*, No. 4:14-cv-3481-RBH, 2015 WL 5782077, at *18–19 (D.S.C. Sept. 19, 2015).

Contrary to Coventry's suggestion (*see* Mot. 7), section 18116 does not require a plaintiff to assert a claim under one of the four statutes it references; rather it imports the enforcement mechanisms of those statutes to allow a plaintiff to assert directly a claim for violating section 18116. Coventry's citation to *Southeastern Pennsylvania* (*see id.*), does not help. That court stated: "Congress's express incorporation of the enforcement mechanisms from those four federal civil rights statutes . . . manifests an intent to import the various different standards and burdens of proof into a Section 1557 claim [codified at 42 U.S.C. section 18116], depending upon the protected class at issue." *Se. Penn.*, 102 F. Supp. 3d at 698–99 (alterations added). It then analyzed the complaint to determine whether the plaintiffs had sufficiently alleged discrimination on the basis of disability or race. *See id.* at 699–702.[11] Accordingly, section 18116 provides Plaintiff a private right of action.

Next, Coventry argues Plaintiff fails to adequately plead a claim under section 18116, based on the requirements of section 504 of the Rehabilitation Act. (*See* Mot. 13–14). "To state a claim under Section 504, a plaintiff must demonstrate that she is (1) a qualified individual with a disability (2) who was denied the benefits of a program or activity which receives federal funds

[11] The *Southeastern Pennsylvania* and *Rumble* courts come to different conclusions as to whether Congress intended courts to analyze claims under section 18116 based on the protected class at issue, *see Se. Penn.*, 102 F. Supp. 3d at 699 n.3, or whether Congress intended to create a "new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff's protected class status," *Rumble*, 2015 WL 1197415, at *11. The parties both analyze Count II under the standards of the Rehabilitation Act, 29 U.S.C. section 794, and thus the Court does not decide the issue.

(3) on the basis of her disability." *Se. Penn.*, 102 F. Supp. 3d at 699. Coventry challenges only whether Plaintiff has been denied the benefits of a program or activity.[12]

Coventry contends Plaintiff fails to state a claim because: (1) he is enrolled in Coventry's health plan; and (2) receives coverage for his HIV medications. (*See* Mot. 14). According to Coventry, while Plaintiff does not receive his medications from the provider of his choice, such an allegation does not give rise to an actionable claim. (*See id.*). Plaintiff argues lack of coverage for receipt of his medication from an in-person pharmacy effectively denies him coverage. (*See* Opp. 13). In Reply, Coventry emphasizes the lack of any statute or other authority guaranteeing "Plaintiff the right to choose his pharmacy provider." (Reply 8).

Plaintiff adequately states a claim. It is true, as Coventry argues, the Rehabilitation Act requires disabled individuals to "be provided with meaningful access to the benefit that the grantee offers." (Mot. 14 (citing *Alexander v. Choate*, 469 U.S. 287, 301 (1985))). But this language is not as comforting as Coventry apparently believes. The very thing Plaintiff alleges Coventry's mail-order program denies him is meaningful access to the medication he requires because mail-order delivery: (1) exposes Plaintiff to health risks should the delivery be left outside in the heat, along with added risks of deliveries being delayed, lost, or stolen; (2) denies him the more comprehensive counseling he would receive from an in-person pharmacy; and (3) violates his right to privacy by requiring he receive his medication at his home or workplace. (*See* Compl. ¶¶ 8, 25, 26, 62, 93; *see also* Opp. 12).

These deficiencies in the mail-order program, coupled with the inability to opt-out, force Plaintiff to choose between receiving the medication from an inadequate program covered by insurance or an in-person pharmacy without insurance and at great expense. (*See* Compl. ¶¶ 93–

[12] While Coventry makes a passing reference that Plaintiff fails to "conclusively establish" its health plan qualifies as a program or activity or Coventry receives federal financial assistance, it does not meaningfully argue these points and assumes them for purposes of its argument. (Mot. 13).

94). At this stage in the proceedings, the Court cannot say as a matter of law the mail-order program provides meaningful access and is not actionable discrimination.

Southeastern Pennsylvania, to which Coventry cites, appears similar at first glance but is distinguishable.[13] (*See* Mot. 14). In *Southeastern Pennsylvania*, the plaintiffs had Hepatitis C and were recommended by their doctors to take a certain drug which was not covered by their insurance company. *See* 102 F. Supp. 3d at 700. Rather than sue the insurance company, however, the plaintiffs sued the drug manufacturer, arguing the manufacturer discriminated against them by charging too much for the drug they needed. *See id.* The court held the high price of the drug was not enough to sustain a claim for discrimination. *See id.*

In contrast, Plaintiff contests Coventry's practice regarding a whole class of drugs, alleging the manner in which Coventry decides to treat these specialty medications exposes him to health, privacy and/or monetary injuries. (*See generally* Compl.). These allegations do more than simply allege discrimination based on a price differential. And how a class of drugs is treated, rather than an insurer's choice to cover one type of drug over another, presents a more plausible inference of discrimination. *See Iqbal*, 556 U.S. at 678.[14] Count II may proceed.

---

[13] Coventry's attempt to distinguish *Callum* is also unpersuasive. (*See* Reply 8). Coventry argues the plaintiff in *Callum* was denied the right to fill his prescriptions at the defendant pharmacy. (*See id.*). This overstates the case. The plaintiff was denied the opportunity to shop *after hours*. *See Callum*, 2015 WL 5782077, at *2–3. He clearly had access to the defendant pharmacy during business hours; nonetheless, the court held he had been denied the right to have his prescriptions filled because the defendant did not let him shop after hours. *See id.* at *23. Here, Plaintiff complains not about his inability to receive his medications at all, but the manner in which he must receive them. His situation is more analogous to *Callum* than Coventry lets on.

[14] *Quinones v. UnitedHealth Group Inc.*, No. 14-00497 LEK-RLP, 2015 WL 6159116 (D. Haw. Oct. 19, 2015), on which Coventry relies, granted judgment on the pleadings in favor of the defendant because the plaintiff challenged the "level of care, not access to Medicaid itself." *Id.* at *3. As the Court explains, *supra*, Plaintiff claims he, along with all other persons prescribed HIV/AIDS medications and subject to the mail-order program, is denied meaningful access to the drugs.

F. Counts III–VI

Coventry next argues Plaintiff has failed to allege exhaustion of administrative remedies, as required by ERISA, for Counts III through VI, and he fails to state a claim for Counts III, IV, and V. (*See* Mot. 7–12). The Court begins with the exhaustion requirement as to all ERISA counts and then addresses the individual counts as necessary.

a. Exhaustion of Administrative Remedies

Coventry insists Counts III–VI should be dismissed because Plaintiff has failed to allege he exhausted his administrative remedies under ERISA.[15] (*See* Mot. 7–8). Plaintiff contends his allegations suffice and in the alternative exhaustion would have been futile. (*See* Opp. 14).

"It is well-established in the Eleventh Circuit that claimants are generally required to exhaust their administrative remedies prior to instituting suit in federal court under ERISA." *Biohealth Med. Lab., Inc. v. Conn. Gen. Life Ins. Co.*, No. 1:15-cv-23075-KMM, 2016 WL 375012, at *4 (S.D. Fla. Feb. 1, 2016) (citations omitted) (collecting cases). Such requirements are strictly enforced, subject to "certain caveats reserved for exceptional circumstances." *Perrino v. S. Bell Tel. & Tel. Co.*, 209 F.3d 1309, 1315 (11th Cir. 2000). A district court may excuse exhaustion when "resort to administrative remedies would be futile or the remedy inadequate . . . or where a claimant is denied meaningful access to the administrative review scheme." *Biohealth*, 2016 WL 375012, at *4 (citations and internal quotation marks omitted; alteration added). "Claimants must make a clear and positive showing of futility in order to overcome the exhaustion requirement." *Id.* (internal quotation marks and citation omitted).

Plaintiff fails to adequately allege exhaustion. He alleges he "attempted to resolve this matter informally with COVENTRY prior to bringing this action, but has exhausted all

[15] Although Coventry argues it is not moving to dismiss Count VI (*see* Reply 1 n.1), the Court reads the Motion and Reply as requesting Count VI be dismissed for a failure to exhaust administrative remedies.

reasonable requirements, rendering any further attempts or requirements to do so futile." (Compl. ¶ 6). Other paragraphs in the Complaint fail to provide much more meaningful information, except to state some of these calls lasted over an hour and Plaintiff was told he had to use the mail-order program. (*See id.* ¶¶ 37, 38, 57, 59). These allegations are plainly insufficient. *See Urology Ctr. of Ga., LLC v. Blue Cross Blue Shield Health Plan of Ga., Inc.*, No. 5:09-cv-161 (CAR), 2010 WL 797204, at *3 (M.D. Ga. Mar. 4, 2010). Plaintiff himself seems to understand this, spending little space defending the position and offering no case law in support. (*See* Opp. 14).

Even considering the additional allegations in the Doe Declaration,[16] Plaintiff's allegations fail. (*See* Doe Decl. ¶¶ 6, 9). Paragraph 6 merely reiterates the fact Plaintiff spoke to several of Coventry's representatives. (*See id.* ¶ 6). Paragraph 9 states no one told Plaintiff he could appeal (*see id.* ¶ 9), but this will not do. *See Biohealth*, 2016 WL 375012, at *4 ("Ignorance of a claim procedure does not defeat the exhaustion requirement." (citation omitted)). Thus, Plaintiff fails to adequately allege exhaustion. *See Urology*, 2010 WL 797204, at *3 (plaintiff's allegations "merely create the impression [plaintiff] made a few frustrated phone calls . . . before giving up. There is no indication [plaintiff] ever filed a formal grievance . . . [,] ever attempted to obtain copies of plan documents[,] . . . [or] that [plaintiff] attempted to make contact with [employees of greater seniority]" (alterations added)); *Biohealth*, 2016 WL 375012, at *5 (allegations insufficient where they "merely allege that [the defendant] ignored

[16] Under *Turner v. Burnside*, 541 F.3d 1077 (11th Cir. 2008), courts should treat a defense of failure to exhaust administrative remedies like a defense of lack of jurisdiction. *See id.* at 1082. Thus, "the court looks to the factual allegations in the defendant's motion to dismiss and those in the plaintiff's response, and if they conflict, takes the plaintiff's version of the facts as true. If, in that light, the defendant is entitled to have the complaint dismissed for failure to exhaust administrative remedies, it must be dismissed." *Id.* (citation omitted).

[the plaintiff's] payment demands and failed to provide them with an adequate administrative remedy" (alterations added)).[17]

Furthermore, the Court is not inclined to excuse exhaustion based on Plaintiff's bare allegations. *See Biohealth*, 2016 WL 375012, at *4 ("District courts enjoy considerable discretion" to find exhaustion futile). Plaintiff asks the Court to find exhaustion futile because "Coventry had a stated policy and practice that would have preordained the outcome of any administrative appeal." (Opp. 14). There is little in the Complaint to support such a conclusion. Indeed, Plaintiff merely states further attempts to resolve the matter, after several phone calls with Coventry's representatives, would be futile, without more. (*See* Compl. ¶ 6). Moreover, the cases he cites in support, in addition to not being binding, are distinguishable. For instance, *Corsini v. United Healthcare Corp.*, 965 F. Supp. 265 (D.R.I. 1997), involved a "long-standing policy that has been applied consistently." *Id.* at 269. Such is not the case here, where Plaintiff was able to obtain his medication from an in-person pharmacy until November 2015 (*see* Compl. ¶ 57), one month before the filing of the Complaint. Additionally, *Rosario v. King & Prince Seafood Corp.*, No. CV 204-036, CV 205-044, 2006 WL 2367130 (S.D. Ga. Mar. 7, 2016), deals with whether all class members had to satisfy exhaustion when the named plaintiffs had already done so, and is thus inapplicable. *See id.* at *13.

Plaintiff also argues futility "is most forcefully demonstrated by Coventry's continued stance . . . the [] plan permits the Program and does not require an opt-out option. Coventry would obviously have taken the same position on appeal." (Opp. 14 (alterations added)). This proves too much. While it may be of some relevance, it cannot carry great weight — otherwise,

[17] That Plaintiff's employer emailed Coventry does not satisfy exhaustion either, especially where it is not clear whether the email was sent to the equivalent of a low-level Coventry representative. (*See* Doe Decl. ¶ 9). Additionally, it is not clear from the Doe Declaration whether the response "no" refers to the ability to appeal, the ability to opt-out or both (to the extent it is even the response received, as Plaintiff states only it is his "understanding"). (*Id.*).

by merely contesting a lawsuit, a defendant would be demonstrating the futility of a plaintiff's lack of administrative remedy exhaustion, rendering the requirement meaningless. Plaintiff cites two cases in support, neither of which is from this Circuit. (*See id.* 15). They are distinguishable[18] and, in any event, courts in this Circuit "have consistently equated the concept of futility with the inability of a litigant to present his or her claim . . . without reference to the probable outcome of the administrator's review." *Spivey v. S. Co.*, 427 F. Supp. 2d 1144, 1155 (N.D. Ga. 2006) (alteration added) (citing cases); *In re Managed Care Litig.*, No. 00-133-MD, No. 02-22027-CIV, 2011 WL 677369, at *6 (S.D. Fla. Jan. 19, 2011) ("The law in the Eleventh Circuit is clear that futility cannot be established by presuming that the outcome of the appeal would be adverse on the merits.").

In addition to failure to exhaust administrative remedies, the Court finds Counts IV and V should be dismissed for other reasons.[19]

b. Count IV

Coventry argues Count IV should be dismissed because: (1) Coventry is not a fiduciary regarding the actions complained about; and (2) 29 U.S.C. section 1109 provides remedies to the plan, not to individual beneficiaries. (*See* Mot. 10–11). The Court need not address Coventry's first argument since the second is dispositive.

Plaintiff, rather than directly counter Coventry's assertion, attempts sleight of hand. He cites a case which clearly states a plaintiff cannot bring a claim under section 1109 for individual relief, and yet appears to argue the claim is proper because it could have been brought under 29

[18] For instance, in *Unger v. US West, Inc.*, 889 F. Supp. 419 (D. Colo. 1995), the court found futility because the relevant plan did not provide any process or procedural protections by which the plaintiff could bring a claim. *Id.* at 423. While Plaintiff argues in Count V Coventry lacks a full and fair review process, Count V is entirely conclusory, as discussed *infra*.

[19] The Court declines to decide Coventry's other arguments for dismissal of Count III. (*See* Mot. 8–10).

U.S.C. section 1132(a)(3). (*See* Opp. 17). Count IV is clearly alleged under section 1109, not 1132(a)(3). On that reason alone it must fail. *See Castro v. Hartford Life & Accident Ins. Co.*, No. 5:11-cv-446-Oc-34TBS, 2011 WL 4889174, at *8 (M.D. Fla. Oct. 4, 2011).[20]

c. Count V

Coventry argues Plaintiff's allegations are insufficient as to Count V. (*See* Mot. 12). Plaintiff spends only a few sentences defending Count V, stating: "Coventry's across-the-board refusal to permit members to opt out of the Program denied its plan members a 'full and fair review' of their claims." (Opp. 17). Plaintiff fails to allege in anything but conclusory fashion Coventry "failed to provide a reasonable claims procedure for opting-out of the Program and failed to provide information regarding any opt-out right or any appeal of adverse opt-out determinations." (Compl. ¶ 119; *see also id.* ¶ 120). Plaintiff alleges he spoke with Coventry representatives in an attempt to "resolve this matter informally." (*Id.* ¶ 6). He states during these conversations he asked to opt-out of the mail-order program. (*See id.* ¶ 37). But none of these informal calls say anything about Coventry's procedures. He does not say Coventry representatives told him he could not appeal or that he did in fact try to appeal.[21] (*See* Mot. 12 ("Plaintiff does not allege he ever filed a claim for benefits, or that, if he did, he appealed any adverse decision.")). His allegations are bereft of any reference to his health plan documents, the

[20] The Court does not decide whether a claim under section 1132(a)(3) would be proper. However, it is skeptical a claim under 1132(a)(3) would be proper where Count III, premised on section 1132(a)(1)(B), likely provides appropriate relief. *See Castro*, 2011 WL 4889174, at *8 (citing cases and dismissing section 1132(a)(3) claim where section 1132(a)(1)(B) claim provided appropriate relief).

[21] The Doe Declaration may state Plaintiff's employer was told the opt-out determination was unappealable, but it is unclear. *See supra* n.17. Even if it were clear, the statement is not part of the Complaint.

procedures outlined therein, or any attempt to retrieve those documents, should he not have access to them. These conclusory allegations are an independent reason to dismiss Count V.[22]

G. Count VII

As for Plaintiff's claim the mail-order program violates the ADA, Coventry argues it should be dismissed because: (1) there is no exclusion from participation or denial of benefits on the basis of disability; and (2) the alleged discriminatory conduct was not by a place of public accommodation. (*See id.* 14–15). Plaintiff does not dedicate much space to Coventry's first argument, instead focusing on the second. (*See* Opp. 18–20). Unfortunately for Plaintiff, Coventry's first argument is dispositive.

Plaintiff seems to take for granted Coventry's inclusion of HIV/AIDS medications in the mail-order program is the product of disability-based discrimination. (*See id.* 19 & n.16). A "disability-based distinction occurs when an insurance plan singles out a particular disability[,] . . . a discrete group of disabilities . . . , or a disability in general and provides lesser benefits." *See Chaudhry v. Neighborhood Health P'ship, Inc.*, No. 04-22819-CIV, 2005 WL 6103746, at *5 (S.D. Fla. May 4, 2005) (alterations added; internal quotation marks and citation omitted). Plaintiff states conclusorily the mail-order program "only applies to certain high cost specialty medications designed to treat very complicated disorders." (Compl. ¶ 139). By this statement, Plaintiff acknowledges the mail-order program applies to more than just HIV/AIDS medications, and thus the program does not single out a particular disability. It is possible the other medications in the program all treat illnesses which would meet the definition of disability under the ADA, but Plaintiff alleges no facts to support such a notion. *See Chaudhry*, 2005 WL

[22] The Court declines to decide Coventry's additional arguments for dismissal of Count V. (*See* Mot. 12). In any event, the Court notes the usual remedy for a violation of ERISA procedures is to remand the case for a full and fair review. *See Till v. Lincoln Nat'l Life Ins. Co.*, No. 2:14-CV-721-WKW, 2016 WL 1631796, at *13 (M.D. Ala. Apr. 25, 2016).

6103746, at *5 ("Not all health-related distinctions can be considered as disability-based distinctions."). Therefore, Count VII fails to state a claim.

IV. CONCLUSION

For the foregoing reasons, it is

ORDERED AND ADJUDGED as follows:

1. Defendant's Request [**ECF No. 29**] is **DENIED**.
2. Defendant's Motion [**ECF No. 13**] is **GRANTED**.
3. Count I of Plaintiff's Complaint is **DISMISSED with prejudice**.
4. Counts II, III, IV, V, VI, and VII are **DISMISSED without prejudice**.
5. Plaintiff has until **May 27, 2016** to file an amended complaint.

DONE AND ORDERED in Miami, Florida, this 5th day of May, 2016.

CECILIA M. ALTONAGA
UNITED STATES DISTRICT JUDGE

cc: counsel of record