**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 (Civ. No. 3:18-1031) (Chen, J.)

## PETITION FOR PANEL REHEARING AND REHEARING EN BANC BY APPELLEES CVS PHARMACY, INC., CAREMARK, L.L.C., AND CAREMARK CALIFORNIA SPECIALTY PHARMACY, INC.

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## INTRODUCTION

A panel of this Court held for the first time that claims of disparate-impact disability discrimination are cognizable under Section 1557 of the Affordable Care Act ("ACA"). Appellees CVS Pharmacy, Inc., Caremark, L.L.C., and Caremark California Specialty Pharmacy, L.L.C. (collectively, "CVS"), respectfully move for en banc or panel rehearing of that incorrect holding, which creates a division in the Circuits on this significant issue of federal antidiscrimination law. Rehearing is warranted for multiple reasons.

First, the panel's decision directly split with the Sixth Circuit, which faithfully applied the Supreme Court's modern jurisprudence and held that no right of action for disparate-impact disability discrimination exists. *Doe v. BlueCross BlueShield of Tenn., Inc.*, 926 F.3d 235, 241–42 (6th Cir. 2019). The split could not be clearer: The Sixth Circuit rejected disparate-impact liability in a substantively identical case, brought by the same counsel on behalf of identically situated plaintiffs. Yet the panel broke with the Sixth Circuit, without acknowledging the circuit split and without explanation, other than citing to a prior Ninth Circuit decision that did not decide the issue. Panel Opinion ("Op.") 12 (attached as Addendum A). The en banc Court should grant rehearing to give due consideration to this significant issue before creating a clear split in the Circuits. *See* 9th Cir. R. 35-1; Fed. R. App. P. 35(b)(1)(B).

Second, even assuming the Court were to disagree with the Sixth Circuit and recognize a disparate-impact claim for disability discrimination, the

panel adopted an unbounded legal standard that conflicts with the Supreme Court's decision in *Alexander v. Choate*, 469 U.S. 287 (1985), and court of appeals decisions interpreting that decision. The Court in *Choate* assumed, without deciding, that some disparate-impact claims for disability discrimination may exist. 469 U.S. at 299. Recognizing that all health plan benefits come at a cost and that federal anti-discrimination laws do not guarantee adequate health care, the Supreme Court carefully limited any such claims to circumstances where the plan denied disabled persons "meaningful access," "solely by reason of" their disability, to a "benefit the grantee [health plan] offers." *Id.* at 290 (citing 29 U.S.C. § 794), 301.

The panel departed sharply from the *Choate* standard. It held that plan members with HIV/AIDS may claim a disparate impact from a provision in their employer-sponsored health plans that offers all beneficiaries in-network pricing for specialty medicines only when the specialty prescription is filled by mail order or by drop shipment to a CVS pharmacy. The benefit Plaintiffs seek—in-network pricing for specialty medicines at a pharmacy of their choice—is not a benefit their employers' plans offer to anyone. And specialty medicines treat a wide range of conditions, some disabling, some not; so the inconveniences Plaintiffs experience from the specialty-medicine benefit are not "solely by reason of" a disability. Additionally, the panel's analysis of the Plaintiffs' "benefit" relied on a separate provision of the ACA, and federal regulations, that do not even apply to the employer-sponsored plans at issue in this case.

Under the panel's reasoning, any number of commonplace plan limitations—and the very premise of network-based health plans—could be subject to challenge. This threatens enormous consequences for the costs of health care nationwide: When a private health plan is required to provide particular benefits to a class of beneficiaries, the plan must reduce benefits elsewhere, or the overall cost of the plan will increase. Congress and the responsible federal regulators have not determined to impose on large, private health plans the cost of providing "adequate health care" or "necessary" pharmaceutical services to every member; this Court should not do so either. En banc rehearing, or panel reconsideration, is essential to address this issue of exceptional national importance. *See* Fed. R. App. P. 35(b)(1)(A)-(B); Fed. R. App. P. 40.

## STATEMENT

1. Plaintiffs-appellants John Does I–V are five anonymous individuals who take HIV/AIDS medicines. Op. 6. They receive health benefits through employer-sponsored health plans. *Id.* Those benefits include prescriptions for medications at reduced in-network prices, subject to certain conditions. *Id.* For specialty medicines, Plaintiffs' plans require them either to receive their prescription by mail or to pick up the prescription at a CVS retail pharmacy. *Id.* This specialty-medicine rule applies to all plan members and all specialty medications. *Id.* at 5; ER-30 (¶ 43). The specialty drug

list includes more than 300 drugs, including not only the HIV/AIDS medications at issue, but also contraceptive devices and treatment for common conditions like psoriasis, osteoporosis, arthritis, and asthma. *See* ER-48–71 & n.6 (¶ 94).

Plaintiffs sued to receive in-network pricing on their specialty prescriptions at any "community pharmacies" of their choice, even though other members of their plans taking specialty medicines for other conditions cannot do so. Op. 5. Plaintiffs do not claim the specialty-medicine rule is intentionally discriminatory. Instead, they allege a disparate-impact theory of discrimination, claiming "patients with HIV and AIDS are disproportionately impacted . . . compared to other patients." ER-47 (¶ 92).

2. Plaintiffs' putative class-action complaint asserted claims against CVS under Section 1557 of the ACA, 42 U.S.C. § 18116, and other federal and state statutes. In December 2018, the District Court (Chen, J.) granted CVS's motion to dismiss in full in a 40-page opinion. ER-179–218 (available at *Doe One v. CVS Pharmacy, Inc.*, 348 F. Supp. 3d 967 (N.D. Cal. 2018)). Regarding the ACA claim, the District Court reasoned that Plaintiffs could not allege differential treatment "on the basis of their HIV/AIDS status" because the alleged limitations on their access to HIV/AIDS drugs reflected

the general classification of those drugs as specialty drugs, which cover treatments for disabled and non-disabled individuals alike. ER-188–89. The Court further held that Plaintiffs had not "sufficiently alleged that enrollees with HIV/AIDS are disparately impacted . . . relative to other enrollees" taking specialty medications, *id.*, and that Plaintiffs had not alleged a deprivation of "meaningful access" to a benefit their plans offered, *id.* at 190–91.

3. While this appeal was pending, the Sixth Circuit decided *BCBS*, in which identically-situated plaintiffs (those taking HIV/AIDS medications), represented by the same plaintiffs' counsel, pursued the same claims on the same theory (disparate-impact discrimination through a mail-order requirement for specialty medicines). In a unanimous opinion by Judge Sutton, the Sixth Circuit held that the ACA's antidiscrimination provision, Section 1557, does not permit claims for disparate-impact discrimination. CVS thus urged the panel to reach the same conclusion as *BCBS*, or alternatively to affirm based on the District Court's reasoning. Dkt. 65 at 16–23.

4. In a December 9, 2020 decision, the panel instead reversed the District Court's disparate-impact holding and remanded the ACA claim. The panel agreed with the Sixth Circuit in *BCBS* that Section 1557 of the ACA does not "create[] a new healthcare-specific anti-discrimination standard."

Op. 9–11. The panel thus correctly held that the legal standard applicable to disability discrimination claims under the ACA is that of Section 504 of the Rehabilitation Act. *Id.*

But the panel then concluded that Section 504 of the Rehabilitation Act (and, by extension, the ACA) permits claims of disparate-impact discrimination. Op. 14–15. The panel reached that conclusion without analysis, citing a prior Ninth Circuit decision, *Mark H. v. Lemahieu*, 513 F.3d 922 (9th Cir. 2008). Op. 12. But *Lemahieu* merely assumed, as the Supreme Court had in *Choate*, that Section 504 may be construed "somewhat more broadly" than permitting only strict intentional-discrimination claims. 513 F.3d at 937. Despite relying heavily on *BCBS* elsewhere in its opinion, the panel did not acknowledge that the Sixth Circuit had reached the opposite conclusion about the availability of disparate-impact claims under Section 504 and the ACA.

The panel then held that Plaintiffs had stated a claim for disparate impact under the Section 504 standard described in *Choate*: whether the plaintiff was denied "meaningful access," "solely by reason of" a disability, "to the benefit that the grantee [health plan] offers." 469 U.S. at 290, 301. The panel

broadly interpreted the "benefit" in this case as "prescription drug benefit[s]" generally, not the specialty drug benefit Plaintiffs' plans offer. Op. 14. The panel concluded that Plaintiffs stated a claim by alleging that the specialty-drug rule prevented them "from obtaining the same quality of pharmaceutical care that non-HIV/AIDS patients may obtain in filling non-specialty prescriptions." *Id.*[1]

## REASONS FOR GRANTING REHEARING

### A. The Panel's Decision Creates a Circuit Split on a Critically Important Question of Federal Antidiscrimination Law

This is a classic case for rehearing. The panel's decision broke with the Sixth Circuit to hold that a disparate-impact claim for disability discrimination is available under Section 504 of the Rehabilitation Act, and thus under the ACA, which incorporates that standard for assessing disability discrimination claims against federally-funded health plans. *See* Op. 11.

1. The split is open and obvious. The Sixth Circuit in *BCBS* held that Section 504 does not allow disparate-impact claims in a suit brought by the same plaintiffs' counsel, on the same legal theories, on behalf of identically situated plaintiffs. As the Sixth Circuit noted, the Supreme Court in

[1] The panel also reversed the dismissal of plaintiffs' California Unfair Competition Law claim to the extent it is premised on a predicate ACA violation. Op. 20. The panel affirmed the district court's dismissal of Plaintiffs' remaining claims.

*Choate* had assumed—without deciding—that a narrow category of disparate-impact claims might be actionable under Section 504. But the Sixth Circuit recognized that the Supreme Court's subsequent caselaw, including *Alexander v. Sandoval*, 532 U.S. 275 (2001), interprets federal antidiscrimination statutes to foreclose such a claim. *See* 926 F.3d at 241–42.

The panel nonetheless recognized a disparate-impact theory, allowing Plaintiffs to proceed with a "disparate impact claim based on lack of meaningful access." Op. 14. The panel did not acknowledge it was creating a circuit split, even while it cited *BCBS* prominently and favorably on other issues. *E.g.*, Op. 9, 11, 17. The panel's only explanation for this holding was to cite a prior panel decision in *Mark H. v. Lemahieu*, 513 F.3d 922 (9th Cir. 2008), Op. 12, which suggested Section 504 may be construed "somewhat more broadly" than allowing only intentional-discrimination claims, but did not hold that it allows disparate-impact claims, 513 F.3d at 937. No Ninth Circuit decision—until this one—has relied on *Lemahieu* to permit a disparate-impact claim under Section 504.

In fact, just months ago, another panel of this Court expressly found that "it is unclear whether a disparate impact theory remains permissible under the Rehabilitation Act after *Sandoval*." *Schmitt v. Kaiser Found. Health Plan of Washington*, 965 F.3d 945, 953–54 (9th Cir. 2020). *Schmitt* declined to decide the issue because the plaintiffs in that case alleged inten-

tional, not disparate-impact, discrimination. *Id.*[2] The panel's decision to recognize a disparate-impact disability claim under Section 504 and the ACA, without addressing *BCBS*, calls out for en banc review.

2. Rehearing is all the more necessary because the Sixth Circuit's decision is correct, and at a minimum presents substantial and persuasive arguments that this Court should address before creating a stark circuit split.

As the Sixth Circuit noted, the Supreme Court's assumption in *Choate* (that Section 504 might permit some disparate-impact claims) rested on an analogy to Title VI of the Civil Rights Act, which concerns racial discrimination. *BCBS*, 926 F.3d at 242. Section 504 was modeled on Title VI. But sixteen years after *Choate,* the Supreme Court held in *Sandoval* that Title VI creates a private right of action *only* for intentional discrimination, not disparate-impact discrimination. 532 U.S. at 279–81; *accord Schmitt*, 965 F.3d at 953–54 (noting that the Supreme Court in *Sandoval* repudiated its prior cases interpreting Title VI to encompass disparate impact claims). The Sixth Circuit in *BCBS* thus concluded that Section 504's "essentially identical" text "leaves no room for the statute to prohibit disparate-impact discrimination." *BCBS*, 926 F.3d at 242–43. With "thirty years of hindsight" after *Choate*, the

[2] *Schmitt* reached this conclusion despite citing *Lemahieu*. *Id.* at 954. Prior Ninth Circuit panel decisions occasionally applied *Choate*'s assumed standard of disparate-impact in cases under various disability-discrimination statutes, but none of them actually decided the question *Choate* left open: whether a disparate-impact claim is cognizable under Section 504. *See, e.g.*, *Crowder v. Kitagawa,* 81 F.3d 1480 (9th Cir. 1996) (ADA claim).

Sixth Circuit further observed that "[e]ven entertaining the idea of disparate-impact liability in this area invites fruitless challenges to legitimate, and utterly nondiscriminatory, distinctions, as this case aptly shows." *Id.* at 242.

The panel's *sub silentio* disagreement with the Sixth Circuit has wide-ranging national implications, especially now that Section 1557 of the ACA has expanded the discrimination claims available under Section 504 to certain private health care plans receiving federal financial assistance. Whether disparate impact is a cognizable theory for disability discrimination fundamentally alters the rights and obligations of numerous employers, businesses and disabled individuals across the country. The panel decision therefore threatens "national uniformity" on a "rule of national application." 9th Cir. R. 35-1.

### B. The Panel's Disparate-Impact Standard Also Conflicts with Supreme Court and Circuit Decisions

Even assuming that disparate-impact liability were a viable legal theory under Section 504 and the ACA, rehearing is warranted because the panel adopted a radically expansive standard for such liability that conflicts with *Choate* and multiple decisions of this and other courts. If allowed to stand, the panel decision threatens to open the door to "disparate impact" claims based on any number of commonplace plan designs, with potentially enormous costs to the healthcare system.

In *Choate*, the Supreme Court rejected the position that "all disparate-impact showings" could "constitute prima facie cases under § 504." 469 U.S.

at 299. When it assumed that some disparate-impact claims were permissible, the Supreme Court drew narrow bounds: A plaintiff would need to show he was denied "meaningful access," "solely by reason of" his disability, "to the benefit that the grantee offers." *Id.* at 301. The Court was careful (i) to reject the "boundless notion" that a plaintiff could base a claim on broad notions of "adequate healthcare," rather than a specific benefit, *id.* at 299, 303; and (ii) to require a showing that the plaintiff's disability was the "sole," cause of the denial of meaningful access to that offered benefit, *id.* at 287.

The D.C. Circuit has reasoned that the *Choate* standard means a plaintiff cannot bring a disparate-impact claim under Section 504 "based on the terms of an insurance plan," even where limitations in the plan have a "disproportionate effect on the disabled." *Modderno v. King*, 82 F.3d 1059, 1061 n.1 (D.C. Cir. 1996). As *Modderno* pointed out, when *Choate* preserved the possibility of some disparate-impact claims under Section 504, it cited "architectural barriers, job qualifications, and access to public transportation and educational services," not insurance coverage or health care services. *Id.*

The panel defied *Choate*'s reasoning on both points. First, the panel erroneously defined the "benefit" not in terms of what the plan offers but in terms of a (nonexistent) federal requirement that the plans provide Plaintiffs with the specific prescription drug coverage they claim is "essential." Second, the panel erred by finding a denial of that benefit "solely by reason of" disability without any consideration of whether similarly situated, non-disabled persons are affected by the same alleged restrictions.

1. *Choate* makes clear that the relevant "benefit" is defined by the plan—"the benefit that the grantee offers"—not by a federal standard of "adequate healthcare." 469 U.S. at 301, 303.[3] Section 504 permits a plan to decide what benefits to offer, including "an across-the-board limit on coverage." *Modderno*, 82 F.3d at 1061. The question is not whether the offered benefit meets a plaintiff's healthcare needs, but whether the plaintiff lacks meaningful access to the benefit.

In *Choate*, the "benefit provided" was Tennessee Medicaid's "particular package of heath care services, such as 14 days of inpatient coverage." 469 U.S. at 303. In this case, the benefit provided is the employer-plans' particular package of prescription-drug services, including access to specialty medicines by mail order. *Choate* expressly rejected the argument that "the benefit provided . . . is the amorphous objective of 'adequate health care.'" *Id.* It therefore found no violation even though disabled persons claimed, based on statistical evidence, that Tennessee Medicaid's 14-day limitation on hospital care was inadequate for their needs. *Id.* at 289-90, 302-04. But in

[3] That is how courts have understood *Choate*. *See BCBS*, 926 F.3d at 241 (asking whether the plaintiff had been "denied the benefits of . . . his plan"); *Cercpac v. Health & Hosps. Corp.*, 147 F.3d 165, 167–68 (2d Cir. 1988) (Section 504 claim not viable where "plaintiffs asserted only the denial of specialized services for the disabled—rather than services made available by the [plan] to non-disabled persons"); *DeBord v. Bd. of Educ. of Ferguson-Florrisant Sch. Dist.*, 126 F.3d 1102, 1105 (8th Cir. 1997) (assessing relevant "benefit" as specific in-school medicine administration school policy offered, not excess dosages called for by plaintiff-student's prescription).

this case, the panel embraced the argument that the benefit was "the prescription drug benefit as a whole," including all "aspects of pharmaceutical care that [Plaintiffs] deem critical to their health" and necessary for "effective treatment." Op. 12–14. That standard conflicts with *Choate*.

The panel erroneously concluded that *Choate* requires a court to "look[] to the benefit's statutory source" to determine its scope. Op. 13. As a result, the panel defined the benefit by reference to a provision of the ACA describing "essential health benefits." *Id.* The panel misunderstood *Choate*. Because the health plan at issue in *Choate* was a Tennessee Medicaid plan, the Supreme Court had occasion to cite the Medicaid statutes. 469 U.S. at 303. But the Court did not look to those statutes to define the benefit; rather, it relied on those statutes to "make[] . . . clear" that Medicaid sponsors have "substantial discretion" to "choose to define the benefit it will be providing[.]" *Id.*. The benefit was "the 14 days of care the State ha[d] *chosen to provide*." *Id.* at 302 (emphasis added); *accord Rodde v. Bonta*, 357 F.3d 988, 996 (9th Cir. 2004) (*Choate* "concluded that the [14-day limit] was not discriminatory because it did not deny the disabled the benefits of the 14 days of care the state chose to provide"). In this case, it was wrong for the panel to look to ACA directives to define the benefit, because neither the ACA nor any federal agency or program is the *grantee* offering the asserted "benefit." The employer plans are the grantees, so the only relevant benefits are what those plans offer: defined specialty-prescription benefits under defined, facially neutral terms.

The panel also misapprehended the ACA and federal healthcare regulations on which it based its definition of the "benefit." First, the panel elsewhere held that the ACA "does not create a new healthcare-specific anti-discrimination standard." Op. at 11. The panel should not then have treated the ACA as enshrining a broad standard of access to "pharmaceutical care," which would create precisely the "new healthcare-specific federal anti-discrimination standard" that the panel purported to reject. Op. 9, 12–14.

Second, the panel concluded that Plaintiffs' "benefit" encompasses "the prescription drug benefit as a whole" because it believed "the ACA requires that health plans cover prescription drugs as an 'essential health benefit.'" Op. 12–13 (citing 42 U.S.C. § 18022). But the ACA's essential-health-benefit requirements *do not apply to Plaintiffs' health plans*. Plans must provide essential health benefits only when—unlike the plans at issue here—they are providing "health insurance coverage in the individual and small group market[s]." 42 U.S.C. § 300gg-6(a). "Under the [ACA], self-insured, group health plans, large group market plans, and grandfathered plans are not required to offer [essential health benefits]."[4] The panel thus clearly erred in concluding that Plaintiffs could be entitled to essential healthcare benefits under plans that are statutorily *exempt* from providing them.

[4] 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. CVS's briefing specifically alerted the panel to this issue. *See* CVS Br. at 52–53; CVS Suppl. Ltr. Br., Dkt. 124-1, at 3, 9; CVS Rule 28(j) Ltr., Dkt. 118, at 2.

2. The panel also applied the wrong standard of causation. The panel reasoned that the specialty-medicine rule denies persons with HIV/AIDS "meaningful access" because it requires them to obtain their specialty medicines by mail order or by drop-shipment to a CVS pharmacy. Under Section 504, a lack of meaningful access alone is not enough. The lack of meaningful access must be "solely by reason of" the plaintiff's disability. 42 U.S.C. § 794(a). The panel thus needed to, but did not, compare the impact of the specialty-medicine limitations on persons with HIV/AIDS against the impact of the same specialty-medicine limitations on plan members without HIV/AIDS (or any other disability). *See Choate*, 469 U.S. at 302–03 & n.22 (considering whether the record reflected that any insufficiency of the 14-day in-patient coverage limitation was the result of "illnesses uniquely associated with the handicapped"). After all, the specialty medicines subject to the plans' terms treat a wide range of conditions other than HIV/AIDS, many of them non-disabling. *See* ER-48–71 & n.6.[5]

This court emphasized this causation requirement in *Weinreich v. Los Angeles County Metropolitan Transportation Authority*, 114 F.3d 976 (9th Cir. 1997). *Weinreich* found that the transit authority could require users to

[5] The Sixth Circuit in *BCBS* aptly described Anthem's similar specialty-medicine formulary: "Some of the included medicines are apt to be used by those with disabilities. But plenty of others are not . . . . The common trait linking the listed drugs is cost, not the disabled status of their users." 926 F.3d at 241.

recertify their disability every three years, even though it excluded the plaintiff from using the transit system. The plaintiff's exclusion "was due to his financial circumstances" because he could not afford to pay a certifying doctor, "not to his medical disability." *Id.* at 978–79. This court specifically rejected the argument that a denial of "meaningful access" on its own entitled the plaintiff to relief under federal anti-discrimination laws. *Id.* at 979.

The Second Circuit recently affirmed a district court's similar dismissal of Section 1557 disability-discrimination claims—in a case brought by the same law firms that represent these Plaintiffs. *See Doe v. Express Scripts, Inc.*, --- Fed. App'x ---, 2020 WL 7133860 (2d Cir. Dec. 7, 2020) (summary order), *affirming In re Express Scripts/Anthem ERISA Litig.*, 285 F. Supp. 3d 655(S.D.N.Y. 2018). There, Plaintiffs with HIV/AIDS claimed discrimination based on alleged inflated pricing for their specialty medications. The court dismissed their complaint because it lacked adequate allegations that the negative impacts were caused by their *HIV/AIDS status*, rather than by the type of drug they sought.

The Eighth Circuit likewise has expressly noted that a disparate-impact analysis must distinguish the characteristics of a plaintiff's prescription from the plaintiff's disability. *See DeBord v. Bd. of Educ. of Ferguson-Florissant Sch. Dist.*, 126 F.3d 1102, 1105 (8th Cir. 1997) (rejecting claim that school policy of not administering medications in excess of recommended dose discriminated on the basis of disability, because the "student's excess

prescription, not the student's disability, prevents the student from receiving medication").

The panel's analysis departed from these other Circuits' faithful application of Section 504 and *Choate*. Instead of comparing the specialty-medicine rule's impact on the disabled group with the same rule's impact on the non-disabled group, the panel compared HIV/AIDS members' experience obtaining specialty medications under the rule with that of non-HIV/AIDS members obtaining *non-specialty medications outside of the rule*. Op. 14. That is not the relevant comparison. Access to a different group of medicines is a different plan benefit; Plaintiffs do not allege a denial of access to non-specialty medications.

Had the panel undertaken the proper causation analysis, it should have reached the same conclusions as *Choate* and these other Circuit decisions (and the District Court below). The panel's reasoning would dramatically change the standard for pleading federal disability discrimination in this Circuit such that there is no longer a requirement that the asserted harms arise from disabled status. Were the panel's decision to stand, it would effectively write out of Section 504 the long-standing statutory causation requirement that the plaintiff's disabled status be the *sole basis* for the discrimination.

### C. The Panel's Decision Will Harm the Healthcare System Nationwide

Left undisturbed, the panel's approach risks transforming Section 504 and the ACA from a means for the disabled to pursue equal access to plan

benefits into a requirement that healthcare plans "alter [the] definition of the benefit being offered simply to meet the reality that the handicapped have greater medical needs." *Choate*, 469 U.S. at 304. If plans must provide new or more expansive benefits on demand, individual litigants could undo plans' careful and cost-based choices about the "proper mix" of benefits and limitations through piecemeal litigation. *Id.* at 303.

Every plan benefit requires a tradeoff—either an increased price for the plan or a reduced benefit somewhere else to offset the cost. If plans must provide benefits measured by the "quality" of each member's healthcare outcome, then it will be impossible to contain plan costs. Common plan designs like HMOs and PPOs, which offer differing levels of benefits and in-network options at differing costs, could be eliminated by demands that they tailor their benefits to ensure "effective treatment," Op. 14, no matter the cost. These tradeoffs are not for courts to decide, particularly where Congress has chosen not to.

CVS supports the goal of better healthcare, but the panel's opinion is not the approach that Congress intended.

## CONCLUSION

The petition for rehearing should be granted.

Respectfully submitted,

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**UNITED STATES COURT OF APPEALS**
**FOR THE NINTH CIRCUIT**

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

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**UNITED STATES COURT OF APPEALS**
**FOR THE NINTH CIRCUIT**

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# Addendum A

**FOR PUBLICATION**

# UNITED STATES COURT OF APPEALS
# FOR THE NINTH CIRCUIT

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|---|---|
| JOHN DOE, One; JOHN DOE, Two; JOHN DOE, Three; JOHN DOE, Four; on behalf of themselves and all others similarly situated; JOHN DOE, Five,<br>*Plaintiffs-Appellants*,<br><br>v.<br><br>CVS PHARMACY, INC.; CAREMARK, LLC; CAREMARK CALIFORNIA SPECIALTY PHARMACY, LLC; NATIONAL RAILROAD PASSENGER CORPORATION, DBA Amtrak; LOWE'S COMPANIES, INC.; TIME WARNER, INC.,<br>*Defendants-Appellees*,<br><br>and<br><br>CAREMARK RX, LLC; CVS HEALTH CORPORATION,<br>*Defendants.* | No. 19-15074<br><br>D.C. No. 3:18-cv-01031-EMC<br><br>OPINION |

Appeal from the United States District Court
for the Northern District of California
Edward M. Chen, District Judge, Presiding

Argued and Submission Deferred June 12, 2020
Submitted December 1, 2020
San Francisco, California

Filed December 9, 2020

Before: MILAN D. SMITH, JR. and ANDREW D. HURWITZ, Circuit Judges, and TIMOTHY M. BURGESS,* District Judge.

Opinion by Judge Milan D. Smith, Jr.

## SUMMARY**

### Affordable Care Act

The panel affirmed in part and vacated in part the district court's order dismissing an action brought under the Affordable Care Act and other statutes by individuals living with HIV/AIDS whose pharmacy benefits manager for their employer-sponsored health plans required them to obtain specialty medications through its designated specialty pharmacy for those benefits to be considered "in-network."

The panel held that Section 1557 of the ACA incorporates the anti-discrimination provisions of various civil rights statutes, and prohibits discrimination on the basis

* The Honorable Timothy M. Burgess, Chief United States District Judge for the District of Alaska, sitting by designation.

** This summary constitutes no part of the opinion of the court. It has been prepared by court staff for the convenience of the reader.

of race, color, or national origin pursuant to Title VI of the Civil Rights Act of 1964, on the basis of sex pursuant to Title IX of the Education Amendments Act of 1972, on the basis of age pursuant to the Americans with Disabilities Act, and on the basis of disability pursuant to Section 504 of the Rehabilitation Act. Agreeing with the Sixth Circuit, the panel held that Section 1557 did not create a healthcare-specific anti-discrimination standard that would permit a discrimination claim under any of the enforcement mechanisms of the ACA regardless of plaintiffs' protected class. Accordingly, because plaintiffs claimed discrimination on the basis of their disability, to state a claim for a Section 1557 violation, they were required to allege facts adequate to state a claim under Section 504 of the Rehabilitation Act.

Vacating in part and remanding for further proceedings, the panel held that plaintiffs stated a claim for disability discrimination under the ACA. Applying the Section 504 framework, the panel concluded that plaintiffs adequately alleged that they were denied meaningful access to their prescription drug benefit under their employer-sponsored health plans because defendants' program prevented them from receiving effective treatment for HIV/AIDS.

The panel affirmed the district court's dismissal of plaintiffs' claim of disability discrimination pursuant to the Americans with Disabilities Act on the ground that a benefit plan is not a place of "public accommodation." The panel also affirmed the district court's denial of plaintiffs' claim for benefits pursuant to ERISA and their cause of action under California's Unfair Competition Law, except to the extent it was predicated on a violation of the ACA.

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## OPINION

M. SMITH, Circuit Judge:

Does I–V (Does) are individuals living with HIV/AIDS who have employer-sponsored health plans, and who rely on those plans to obtain prescription drugs. Until recently, Does could fill their prescriptions at community pharmacies, where they were able to consult knowledgeable pharmacists who were familiar with their personal medical histories and could make adjustments to their drug regimens to avoid dangerous drug interactions or remedy potential side effects. Does allege these services, among others, are critical to HIV/AIDS patients, who must maintain a consistent medication regimen to manage their chronic disease.

Now, Does' pharmacy benefits manager, CVS Caremark, requires all health plan enrollees to obtain specialty medications, including HIV/AIDS drugs, through its designated specialty pharmacy for those benefits to be considered "in-network." The in-network specialty pharmacy dispenses specialty drugs only by mail or drop shipments to CVS pharmacy stores for pickup. Does allege this program violates the anti-discrimination provisions of the Affordable Care Act (ACA), the Americans with Disabilities Act (ADA), and the California Unruh Civil Rights Act (Unruh Act); denies them benefits to which they

are entitled under the Employee Retirement Security Act (ERISA); and violates California's Unfair Competition Law (UCL). The district court granted Defendants' motion to dismiss. We affirm in part, vacate in part, and remand for further proceedings consistent with this opinion.

## FACTUAL AND PROCEDURAL BACKGROUND

Plaintiff-Appellants Does are individuals living with HIV/AIDS who rely on employer-sponsored health plans for their medications. Defendant-Appellees CVS Pharmacy, Inc., a retail pharmacy company, CVS Caremark, LLC, a pharmacy benefits manager, and Caremark California Specialty Pharmacy LLC, a specialty pharmacy (together, CVS), are affiliates of non-party CVS Health Corporation. Defendant-Appellees Lowe's Companies, Inc., Time Warner, Inc., and National Passenger Co. (d/b/a Amtrak) (together, Employer Defendants) provide prescription benefits to Does through employer-based health plans.

Does allege that their prescription benefit plans allow them to obtain specialty medications, such as their HIV/AIDs prescriptions, at "in-network" prices only through Caremark California Specialty Pharmacy (CSP), which delivers medications to clients by mail or to a CVS pharmacy for pickup (the Program). If Does do not obtain their HIV/AIDS medications through CSP, those medications are not considered "in-network" benefits covered by the health plans, which results in higher prices amounting to thousands more dollars per month. Before CVS enrolled Does in the Program, Does could obtain HIV/AIDS medications from any in-network pharmacy, including from non-CVS pharmacies (Network Pharmacies), and receive their full insurance benefits.

Does allege that enrollment in the Program forces them to forego essential counseling and consultation from specialty pharmacists, who are

> best positioned to: (i) detect potentially life-threatening adverse drug interactions and dangerous side effects, some of which may only be detected visually; (ii) immediately provide new drug regimens as their disease progresses; and (iii) provide essential advice and counseling that help HIV/AIDS patients and families navigate the challenges of living with a chronic and sometimes debilitating condition.

The Program also forces those who are prescribed non-specialty medications to fill certain prescriptions at community pharmacies and other specialty drugs through the Program. Does allege "[t]his 'separate and unequal' splitting of prescription providers also makes it difficult, if not impossible, for CVS Caremark to track potentially life-threatening drug interactions."

According to Does, filling their prescriptions through the Program causes them substantial difficulties and puts their privacy at risk. They allege they must be present at the time of delivery to avoid missing deliveries, having medications stolen, or having medications damaged by being left out in the elements. They also report making multiple trips to CVS pharmacies—sometimes at great distances from their homes—to correct prescriptions that were filled incorrectly, and risking their privacy when CVS pharmacy staff shout their names and medications in front of other customers. Deliveries to the home or the workplace risk notifying neighbors or coworkers that Does have HIV/AIDS.

Several Does have requested to opt out of the Program. Those requests were denied.

Does allege the "Program constitutes a material and discriminatory change in Class Members' coverage, a significant reduction in or elimination of prescription drug benefits, and a violation of the standards of good health care and clinically appropriate care for HIV/AIDS patients." Does assert the following claims against CVS and the Employer Defendants: (1) violation of the anti-discrimination provisions of the ACA, 42 U.S.C. § 18116; (2) violations of the ADA, 42 U.S.C. § 12182; (3) state law violations of the UCL and the Unruh Act; and (4) claims under ERISA for benefits due under the plan, 29 U.S.C. § 1132(a)(1)(B), breach of fiduciary duty, 29 U.S.C. § 1132(a)(3), and failure to provide full and fair review, 29 U.S.C. § 1132(a)(3).

Following briefing and oral argument, the district court dismissed Does' complaint with prejudice. This appeal followed.

## STANDARDS OF REVIEW

"We review de novo a district court's dismissal under Rule 12(b)(6) of the Federal Rules of Civil Procedure." *Curtis v. Irwin Indus., Inc.*, 913 F.3d 1146, 1151 (9th Cir. 2019). In doing so, "[w]e accept all factual allegations in the complaint as true and construe the pleadings in the light most favorable to the nonmoving party." *Id.* (internal quotation marks omitted). "We also review de novo a district court's interpretation and construction of a federal statute." *Holmes v. Merck & Co.*, 697 F.3d 1080, 1082 (9th Cir. 2012).

## ANALYSIS

### A

Section 1557 of the ACA incorporates the anti-discrimination provisions of various civil rights statutes, and prohibits discrimination on the basis of race, color, or national origin pursuant to Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), on the basis of sex pursuant to Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 *et seq.*), on the basis of age pursuant to the ADA (42 U.S.C. § 6101 *et seq.*), and on the basis of disability pursuant to Section 504 of the Rehabilitation Act (29 U.S.C. § 794). 42 U.S.C. § 18116. Does argue that Section 1557 creates a new healthcare-specific anti-discrimination standard that permits a discrimination claim under any of the enforcement mechanisms of the statute regardless of Does' protected class status. Accordingly, Does maintain that they state a Section 1557 claim for disability discrimination on a disparate impact theory, regardless of whether Section 504 of the Rehabilitation Act would permit a disparate impact claim. In *Schmitt v. Kaiser Foundation Health Plan of Washington*, we left open the question of whether the ACA created a healthcare-specific anti-discrimination standard that allowed plaintiffs to choose standards from a menu provided by other anti-discrimination statutes. 965 F.3d 945, 954 (9th Cir. 2020). We answer now in the negative.

The Sixth Circuit rejected an identical argument in *Doe v. BlueCross BlueShield of Tennessee, Inc.*, 926 F.3d 235 (6th Cir. 2019). The court concluded that the statutory text of Section 1557—which prohibits discrimination "on the ground prohibited under" Title VI, Title IX, the Age Discrimination Act, or the Rehabilitation Act—did not lend itself to an interpretation that would permit a plaintiff to

"pick the statute with the lightest standard from this menu of four options and use that standard of liability in prosecuting his claim for disability discrimination." *Id.* at 238. Rather, the court interpreted the word "ground" to refer to

> the forbidden source of discrimination: race, color, and national origin (Title VI); sex (Title IX); age (Age Discrimination Act); and disability (Rehabilitation Act). When "ground" is paired with "prohibited," as in "on the ground prohibited," the statute picks up the type of discrimination—the standard for determining discrimination—prohibited under each of the four incorporated statutes. If the claimant seeks relief for discrimination "on the ground prohibited" by § 504 of the Rehabilitation Act, for example, he must show differential treatment "solely by reason of" disability, 29 U.S.C. § 794(a), not some other standard of care.

*Id.* The court reasoned that, while the ACA prohibits discrimination based on several different grounds, "[b]y referring to four statutes, Congress incorporated the legal standards that define discrimination under each one." *Id.* at 239.

The second sentence of Section 1557 supports that interpretation. It states that "[t]he enforcement mechanisms provided for and available under such title VI, title IX, [S]ection 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection." 42 U.S.C. § 18116(a). The Sixth Circuit interpreted the phrase "enforcement mechanism" to "cover[] the distinct methods available under the four listed statutes for compelling

compliance with the substantive requirements of each statute," noting that "[i]f the first sentence created a brand-new single standard for what qualifies as discrimination, why would Congress use four distinct families of enforcement mechanisms to compel compliance with that standard rather than creating a matching single mechanism?" *BlueCross BlueShield*, 926 F.3d at 239. The Sixth Circuit thus concluded that Section 1557 "prohibits discrimination against the disabled in the provision of federally supported health programs under § 504 of the Rehabilitation Act. In doing so, the ACA picks up the standard of care for showing a violation of *§ 504*, not the other laws incorporated by the statute." *Id.*

We find *BlueCross BlueShield* persuasive and hold that Section 1557 does not create a new healthcare-specific anti-discrimination standard. Because Does claim discrimination on the basis of their disability, to state a claim for a Section 1557 violation, they must allege facts adequate to state a claim under Section 504 of the Rehabilitation Act.

**B**

Section 504 of the Rehabilitation Act provides, "No otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance[.]" 29 U.S.C. § 794.

In *Alexander v. Choate*, 469 U.S. 287 (1985), the Supreme Court concluded that not all disparate-impact showings qualify as prima-facie cases under Section 504. *Id.* at 299. *Choate* involved a challenge by Medicaid recipients to a proposed reduction in the number of inpatient hospital days covered by Tennessee's Medicaid program from 20 to

14. *Id.* at 289. The plaintiffs argued the reduction would disproportionately affect people with disabilities, who typically required more in-patient care, and thus discriminated against people with disabilities in violation of Section 504. *Id*. at 290. Rather than try to classify particular instances of discrimination as intentional or disparate-impact, the Court focused on whether disabled persons had been denied "meaningful access" to state-provided services. *Id.* at 302. In discussing whether disabled individuals had meaningful access to plan benefits under the 14-day in-patient limitation, the Court did not limit its consideration to whether the policy applied on the same terms to people with disabilities as it did to those without. It also considered whether the in-patient limitation would have the effect of systematically excluding people with disabilities. *Id.* After considering Section 504's regulations, the federal Medicaid Act, and HHS guidelines, the Court ultimately concluded that "[b]ecause the handicapped have meaningful and equal access to that benefit, Tennessee is not obligated to . . . provide the handicapped with more than 14 days of inpatient coverage." *Id.* at 306. We assess Section 504 claims under the standard articulated in *Choate*. *Mark H. v. Lemahieu*, 513 F.3d 922, 937 (9th Cir. 2008).

**1.**

Under the test outlined in *Choate*, we first consider the nature of the benefit Does were allegedly denied. The district court defined the benefit as an entitlement "to obtain HIV/AIDS medication for favorable prices at non-CVS pharmacies," but Does argue the denied benefit is meaningful access to "the prescription drug benefit as a whole[.]" Construing the allegations in the light most favorable to Does, we agree with Does' articulation of the benefit. The crux of Does' complaint is that the Program

discriminates against them by eliminating various aspects of pharmaceutical care that they deem critical to their health. Moreover, looking to the benefit's statutory source, as the Supreme Court did in *Choate*, 469 U.S. at 303, the ACA requires that health plans cover prescription drugs as an "essential health benefit." 42 U.S.C. § 18022(b)(1)(F). The district court's definition unduly narrowed the benefit to obtaining specialty drugs at favorable prices from certain pharmacies, when Does' characterization of the benefit tracks the ACA, asserting more than just cost-related differences.

**2.**

Second, we analyze whether the plan provided meaningful access to the benefit. The district court erroneously evaluated the benefits under the ACA at issue here against the guarantees, or lack thereof, of the Medicaid Act.

In *Choate*, the Supreme Court relied on the Medicaid Act to determine the scope of the concerned Medicaid benefit, observing that "[t]he Act gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in 'the best interests of the recipients.'" *Id.* at 303 (quoting 42 U.S.C. § 1396a(a)(19)). The Court concluded that disabled Medicaid recipients had not been denied meaningful access to a benefit to which they were entitled, *id.* at 306, because the Medicaid Act did not guarantee Medicaid recipients "adequate health care," or the "level of health care precisely tailored to his or her particular needs," *id* at 303.

Consistent with *Choate*, the district court in this case should have looked to the ACA to determine whether Does

adequately alleged they were denied meaningful access to an ACA-provided benefit. Indeed, Does have adequately alleged that they were denied meaningful access to their prescription drug benefit, including medically appropriate dispensing of their medications and access to necessary counseling. Due to the structure of the Program as it relates to HIV/AIDS drugs, Does claim, they cannot receive effective treatment under the Program because of their disability.

Courts also look to the regulations promulgated pursuant to the statute at issue to inform the meaningful access inquiry. *See Choate*, 469 U.S. at 304–06; *K.M. ex rel. Bright v. Tustin Unified Sch. Dist.*, 725 F.3d 1088, 1102 (9th Cir. 2013). The ACA regulations require that "any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals," and must "not be directed at individual participants or beneficiaries based on [disability]." 45 C.F.R. § 146.121(b)(1)(i)(B). Moreover, the regulations state, "An issuer does not provide [essential health benefits] if its benefit design, or *the implementation of its benefits design*, discriminates based on an individual's . . . disability[.]" *Id.* § 156.125(a) (emphasis added). Does allege the structure and implementation of the Program discriminates against them on the basis of their disability by preventing HIV/AIDS patients from obtaining the same quality of pharmaceutical care that non-HIV/AIDS patients may obtain in filling non-specialty prescriptions, thereby denying them meaningful access to their prescription drug benefit. Those allegations are sufficient to state an ACA disability discrimination claim.

The fact that the benefit is facially neutral does not dispose of a disparate impact claim based on lack of meaningful access. Following *Choate*, we recognized that

the unique impact of a facially-neutral policy on people with disabilities may give rise to a disparate impact claim where state "services, programs, and activities remain open and easily accessible to others." *Crowder v. Kitagawa*, 81 F.3d 1480, 1484 (9th Cir. 1996); *see also K.M.*, 725 F.3d at 1102 ("We have relied on *Choate*'s construction of Section 504 in ADA Title II cases, and have held that to challenge a facially neutral government policy on the ground that it has a disparate impact on people with disabilities, the policy must have the effect of denying meaningful access to public services."). Here, Does have alleged that even though the Program applies to specialty medications that may not be used to treat conditions associated with disabilities, the Program burdens HIV/AIDS patients differently because of their unique pharmaceutical needs. Specifically, they claim that changes in medication to treat the continual mutation of the virus requires pharmacists to review all of an HIV/AIDS patient's medications for side effects and adverse drug interactions, a benefit they no longer receive under the Program. Thus, the fact that the Program may apply to plan enrollees in a facially neutral way does not necessarily defeat a § 504 claim.

Finally, the district court erred by requiring that Does plead allegations showing the Program impacts people with HIV/AIDS in a unique or severe manner. The meaningful access standard in *Choate* does not require Does to allege that their deprivation was unique to those living with HIV/AIDS, nor that the deprivation was severe—only that they were not provided meaningful access to the benefit.

Construing the allegations in the light most favorable to Does, Does stated a claim for disability discrimination under the ACA. Applying the § 504 framework, Does adequately alleged that they were denied meaningful access to their

prescription drug benefit under their employer-sponsored health plans because the Program prevents them from receiving effective treatment for HIV/AIDS.[1] Accordingly, we vacate the district court's dismissal of Does' ACA claim and remand for further proceedings.[2]

**C**

Does also challenge the district court's dismissal of their claim of disability discrimination pursuant to the ADA. To succeed on this claim, a "plaintiff must show that (1) she is disabled within the meaning of the ADA; (2) the defendant is a private entity that owns, leases, or operates a place of public accommodation; and (3) the plaintiff was denied public accommodations by the defendant because of her disability." *Molski v. M.J. Cable, Inc.*, 481 F.3d 724, 730 (9th Cir. 2007). Does fail to plead the denial of a public accommodation because a benefit plan is not a place of "public accommodation." *See Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1115 (9th Cir. 2000). *Weyer* distinguished between the ADA's requirement of equal *access*—that a place of public accommodation like "a bookstore cannot discriminate against disabled people in granting access"—and *content*—that the same bookstore

[1] Does also try to fashion a failure-to-accommodate claim pursuant to Section 504 of the Rehabilitation Act and the Unruh Act by piecing together allegations from their complaint and statements from the district court's order. Because this theory was raised for the first time on appeal, we do not address it. *See Dream Palace v. City of Maricopa*, 384 F.3d 990, 1005 (9th Cir. 2004).

[2] CVS argues this court should also affirm the district court's dismissal of the ACA claim because Does did not adequately allege CVS's receipt of "federal financial assistance." The district court should address this issue on remand in the first instance.

"need not assure that the books are available in Braille as well as print." *Id.* Thus, "an insurance office must be physically accessible to the disabled but need not provide insurance that treats the disabled equally with the non-disabled." *Id.* (quoting *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 613 (3d Cir. 1998)).

We affirmed *Weyer* in *Chabner v. United of Omaha Life Insurance Co.*, 225 F.3d 1042, 1047 (9th Cir. 2000), holding that the ADA did not apply to the terms of a non-standard life insurance premium based on an increased mortality rate. *Id.* at 1045–47. We upheld the "content" versus "access" distinction, reasoning that the insurance company administering the plan was not a place of public accommodation because "the employees received their benefits through employment, and not through a public accommodation." *Id.* at 1047. The Sixth Circuit's decision in *BlueCross BlueShield* concluded the same: "Doe targets BlueCross's operation of his *health care plan*, not its control over his *pharmacy*. And Doe's health plan simply does not qualify as a public accommodation."[3] *BlueCross BlueShield*, 926 F.3d at 244.

[3] The Third, Fifth, and Sixth Circuits are in accord. *See Ford v. Schering-Plough Corp.*, 145 F.3d at 613 (3d Cir. 1998); *McNeil v. Time Ins. Co.*, 205 F.3d 179, 188 (5th Cir. 2000) ("[W]e read Title III to prohibit an owner, etc., of a place of public accommodation from denying the disabled access to the good or service and from interfering with the disableds' full and equal enjoyment of the goods and services offered. But the owner, etc., need not modify or alter the goods and services that it offers in order to avoid violating Title III."); *Parker v. Metro. Life Ins. Co.*, 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. The applicable regulations clearly set forth that Title III regulates the availability of the goods and services the place of public

The same is true here. Does are subject to the Program pursuant to the terms of their employer-provided health plans. Those plans require them to pay higher prices for specialty drugs at Network Pharmacies if Does choose to fill their prescriptions there, but those plans do not themselves deny Does access to those locations.

Because Does have not plausibly alleged that their benefit plan is a place of public accommodation, they cannot maintain a claim of discrimination under the ADA. We therefore need not address the question of whether Does were denied access to their health plan on the basis of their disability within the meaning of the ADA. We affirm the district court's dismissal of Does' ADA claim.

**D**

Does next argue that the district court erred by dismissing their claim for benefits pursuant to ERISA. ERISA provides a right of action for plan participants or beneficiaries "to recover benefits due . . . under the terms of [a] plan, to enforce [ ] rights under the terms of the plan, or to clarify [ ] rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). To plead a violation of the statute, a plaintiff must allege "the existence of an ERISA plan," and identify "the provisions of the plan that entitle [them] to benefits." *Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 99 F. Supp. 3d 1110, 1155 (C.D. Cal. 2015). The district court dismissed this claim because Does failed to identify a specific term in their health

accommodation offers as opposed to the contents of goods and services offered by the public accommodation.").

care plan that conferred the benefits they claim they were denied.

Does do not challenge this holding on appeal, or otherwise offer specific plan terms that undermine that holding. While Does continue to argue that the Program denies them the benefit under their health plan to obtain medications at any in-network community pharmacies, they have not identified any provision in their plans conferring such a benefit.

Rather, Does argue for the first time on appeal that their Plans were not "validly amended" to implement the Program, and that the Program's corresponding changes to the procedures by which Does must obtain their HIV/AIDS drugs "caused a reduction in or elimination of benefits *without a change in actual coverage*." Because Does raise this argument for the first time on appeal, it is waived, *Clemens v. CenturyLink Inc.*, 874 F.3d 1113, 1117 (9th Cir. 2017), and we affirm the district court's dismissal of this claim.

**E**

Finally, Does argue that the district court erred by dismissing their claim pursuant to the UCL. The UCL prohibits "unlawful, unfair or fraudulent business act[s] or practices[s]." Cal. Bus. & Prof. Code § 17200. "Each of these three adjectives captures a 'separate and distinct theory of liability.'" *Rubio v. Capital One Bank*, 613 F.3d 1195, 1203 (9th Cir. 2010) (quoting *Kearns v. Ford Motor Co.*, 567 F.3d 1120, 1127 (9th Cir. 2009)). Does argue the district court erred by dismissing their UCL claim premised on the "unlawful" and "unfair" prongs. We address each prong in turn.

**1.**

A § 17200 action "to redress an unlawful business practice 'borrows' violations of other laws and treats [them] . . . as unlawful practices independently actionable." *Farmers Ins. Exch. v. Superior Court*, 826 P.2d 730, 734 (Cal. 1992). Does allege CVS violated the UCL by violating the ACA, ADA, Unruh Act, and 45 C.F.R. § 156.122(e). The district court concluded the UCL claim failed to the extent the predicate ACA, ADA, and Unruh Act claims failed. Because we hold that Does stated a claim under the ACA, we vacate the district court's holding on the UCL claim as to the ACA predicate.

Does also argue the court erred in dismissing the UCL claim premised on a violation of 45 C.F.R. § 156.122(e). That regulation requires health plans providing essential benefits to "allow enrollees to access prescription drug benefits at in-network retail pharmacies, unless . . . [t]he drug requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy."

Does point to paragraphs in their complaint that describe or recite the regulation to argue they stated a claim pursuant to the UCL. However, those allegations are conclusory and do not allege facts demonstrating how CVS violated the regulation. Moreover, the district court properly concluded that "[t]he regulation does not guarantee Plaintiffs' access to out-of-network pharmacies." Does' health plans *do* allow them to access prescription drugs from in-network retail pharmacies, just not in the way that Does would like. That is not sufficient to state a UCL claim.

**2.**

The complaint did not expressly allege a UCL violation on account of an unfair business practice, but the district court construed it to so plead. The court interpreted the relevant portion of the complaint to mean that "the Program causes [Does] harm in the form of less convenient access to their prescription medication, and that Defendants' decision to enroll Plaintiffs in the Program was 'ultimately motivated by profit.'" Does dispute this interpretation, arguing that "[w]hat made the business practice at issue 'unfair' was how the Program was actually applied, resulting in conduct that violated public policy and harmed consumers." Does appear to base that allegation on three different tests courts use to evaluate unfairness under the UCL.

Under the UCL's unfairness prong, courts consider either: (1) whether the challenged conduct is "tethered to any underlying constitutional, statutory or regulatory provision, or that it threatens an incipient violation of an antitrust law, or violates the policy or spirit of an antitrust law," *Durell v. Sharp Healthcare*, 183 Cal. App. 4th 1350, 1366 (2010)); (2) whether the practice is "immoral, unethical, oppressive, unscrupulous or substantially injurious to consumers," *Morgan v. AT&T Wireless Servs., Inc.*, 177 Cal. App. 4th 1235, 1254 (2009); or (3) whether the practice's impact on the victim outweighs "the reasons, justifications and motives of the alleged wrongdoer." *Id*.

Applying the tethering test, Does do not mention the public policy allegedly violated, either in the complaint or the briefing, nor do they explain how, the Program violated that policy. *See McKell v. Wash. Mut., Inc.*, 142 Cal. App. 4th 1457, 1473 (2006). And, as to the balancing test, Does assert in a conclusory fashion that CVS's conduct "outweighs any justification, motive or reason therefor," but

they do not allege how that is so. As to the "immoral" test, Does challenge the district court's conclusion that profit motive is not enough to show "immoral, unethical, oppressive, unscrupulous or substantially injurious" conduct, and argue that resolution of the claim under the immoral test "requires a review of evidence from both sides and is independent of any contractual relationship between the parties," such that the court erred in dismissing the claim. But the complaint left the district court to guess what conduct Plaintiffs alleged satisfied the "unfair" prong of the UCL. Does allege no facts that would support their position, and their conclusory recitation of one of the UCL's legal standards does not clarify what conduct they claim is unfair, or on what allegations in the complaint Does rely for this claim. The claim is not adequately pled to give proper notice of Does' claim and the grounds on which it lies. *See* Fed. R. Civ. P. 8(a)(2). We therefore affirm the district court's denial of the UCL unfairness claim.

**F**

Does argue in their reply brief that reversal of the district court's "erroneous holdings" should revive its claim for declaratory relief. Because Does did not mention the declaratory relief claim in their opening brief, they waived this issue. *Friends of Yosemite Valley v. Kempthorne*, 520 F.3d 1024, 1033 (9th Cir. 2008).

**CONCLUSION**

For the foregoing reasons, we vacate the district court's dismissal of Does' ACA claim and UCL claim to the extent

it is predicated on a violation of the ACA. We affirm the district court's dismissal of all other claims.

**AFFIRMED in part, VACATED, in part, AND REMANDED.**