No. 20-1374

In the Supreme Court of the United States

CVS PHARMACY, INC., ET AL.,

Petitioners,

V.

JOHN DOE, ONE, ET AL.,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICUS CURIAE*[1]

The Chamber of Commerce of the United States of America (Chamber) is the world's largest business federation. It represents approximately 300,000 direct members and indirectly represents the interests of more than three million companies and professional organizations of every size, in every industry sector, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files amicus curiae briefs in cases, like this one, that raise issues of concern to the Nation's business community.

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[1] The parties have consented to the filing of this brief. No counsel for a party authored this brief in whole or in part, and no such counsel, any party, or any other person or entity—other than *amicus curiae*, its members, and its counsel—made a monetary contribution intended to fund the preparation or submission of this brief.

INTRODUCTION AND SUMMARY OF ARGUMENT

The Chamber condemns discrimination on the basis of disability. But the facially neutral pharmacy benefit management practices at issue here are not discriminatory. The Chamber agrees with petitioners that the Rehabilitation Act—and, by extension, the Affordable Care Act—does not confer a disparate-impact cause of action for plaintiffs alleging disability discrimination. But even assuming that such a cause of action exists, this Court's decision in *Alexander v. Choate,* 469 U.S. 287 (1985), forecloses the claims raised by respondents in this case. In *Choate*, and in numerous follow-on cases in the circuits, courts have consistently recognized that plaintiffs may not invoke the Rehabilitation Act to rework facially neutral health-benefits schemes on the ground that the plaintiffs' particular health conditions require a special offering of benefits. The Ninth Circuit's decision below diverges markedly from this settled understanding and creates a significant circuit split even among those circuits that recognize disparate-impact claims under the Rehabilitation Act.

That conflict is one of surpassing legal and practical importance. It warrants this Court's review now. The Ninth Circuit's decision, if left undisturbed, would threaten the basic operation of U.S. healthcare markets—not just in the Ninth Circuit, but around the country—and would effectively press the federal courts into service as the Nation's health-benefits policymakers. That is because *every* facially neutral health-benefits policy affects differently situated beneficiaries differently depending on those beneficiaries' underlying health conditions. The

Rehabilitation Act does not require employers and insurers to "alter [their] definition of the benefit being offered" in order to make up for the "reality" that some beneficiaries "have greater medical needs" than others. *Choate*, 469 U.S. at 303. And as this Court explained in *Choate*, the rule adopted by the Ninth Circuit below is "virtually unworkable," *id.* at 308, and will impose "a wholly unwieldy administrative and adjudicative burden" on insurers and courts alike, *id.* at 298.

Certiorari should be granted.

ARGUMENT

I. THE DECISION BELOW CONFLICTS WITH *CHOATE* AND THE DECISIONS OF SEVERAL CIRCUITS

In *Alexander v. Choate*, 469 U.S. 287 (1985), this Court assumed without deciding that the Rehabilitation Act permits plaintiffs to challenge certain facially neutral policies and practices that impose a disparate impact on persons with disabilities. The Ninth Circuit's decision implicates an important split that has developed among the circuits on the question left unresolved by *Choate*: whether disparate-impact claims are cognizable at all under the Rehabilitation Act. *See* Pet. 16-21. The Chamber agrees with petitioners that this Court should finally resolve that question by granting certiorari on the first question presented.

The Chamber submits this brief to underscore the importance of the second question presented by the petition. Even assuming that the Rehabilitation Act permits some disparate-impact claims, it does not permit the disparate-impact claims at issue in this

case. The Ninth Circuit's contrary decision is impossible to reconcile with this Court's reasoning in *Choate*, and it squarely conflicts with the decisions of several other circuits that otherwise permit some disparate-impact claims under the Rehabilitation Act. The Ninth Circuit now stands as the only circuit in the country that permits plaintiffs to bring disparate-impact Rehabilitation Act challenges to facially neutral health-insurance policies. That conflict independently warrants certiorari.

A. The Ninth Circuit's Decision Cannot Be Reconciled With This Court's Decision In *Choate*

1. Section 504 of the Rehabilitation Act—which Congress incorporated by reference in the Affordable Care Act—provides 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 subjected to discrimination under any program or activity receiving Federal financial assistance." 29 U.S.C. § 794(a) (emphasis added).[2]

In *Choate*, this Court "assume[d] without deciding that § 504 reaches at least some conduct that has an unjustifiable disparate impact" on persons with disabilities, but firmly "reject[ed] the boundless notion that all disparate-impact showings constitute prima facie cases under § 504." 469 U.S. at 299.

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[2] The Affordable Care Act guarantees that "an individual shall not, on the ground prohibited under . . . [section 504 of the Rehabilitation Act], be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, an part of which is receiving Federal financial assistance." 42 U.S.C. § 18116(a).

Relying largely on legislative history, the *Choate* Court explained 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 construed to proscribe only conduct fueled by a discriminatory intent." *Id.* at 296-97. Yet the Court also recognized that there was "nothing" in the legislative history to "suggest" that "Congress intended § 504 to embrace all claims of disparate-impact discrimination." *Id.* at 299. The Court sought to reconcile these "two powerful but countervailing considerations," *id.*, by limiting disparate-impact liability to those circumstances where persons with a disability who were otherwise qualified to receive a benefit were deprived of "meaningful access" to that benefit, *id.* at 301.

In drawing that line, the Court was careful to emphasize that "meaningful access" to healthcare benefits does not entail a "guarantee [of] . . . equal results" from those benefits. *Id.* at 304. Nor does "meaningful access" guarantee that healthcare benefits would be distributed "in the way most favorable, or least disadvantageous" to individuals with disabilities. *Id.* at 308. As the Court recognized, the Rehabilitation Act's scope is more targeted: "to assure evenhanded treatment and the opportunity for [disabled] individuals to participate in and benefit from programs receiving federal assistance." *Id.* at 304. Thus, where a health-benefit program is "neutral on its face" and allows for "meaningful access" to persons with disabilities, it does not violate the Rehabilitation Act. *Id.* at 302.

2. The prescription drug benefit scheme at issue here is neutral on its face and allows for meaningful access to persons with disabilities. Under that

scheme, respondents and others enrolled in respondents' employer-sponsored healthcare plans may obtain access to specialty prescription drugs through either "in-network" or "out-of-network" pharmacies. Pet. App. 26a. Plan participants who wish to pay a lower out-of-pocket price for their prescription drugs must use "in-network" facilities, meaning that they must either visit a CVS pharmacy or have the prescription drugs mailed to their homes directly. *Id.* Plan participants seeking to obtain specialty prescription drugs may also obtain those drugs through "out-of-network" pharmacies, but must incur higher out-of-pocket costs in connection with those "out-of-network" purchases. *Id.* This "in-network"/"out-of-network" pricing scheme applies to all "specialty medications," which include a wide range of prescription drugs that treat a wide range of conditions experienced by persons with disabilities and persons without disabilities. *Id.* at 26a, 37a.

The district court and the Ninth Circuit both recognized that this benefit scheme is not facially discriminatory; its application depends on "the type of medication sought," rather than disability. *Id.* at 41a; *see also id.* at 15a (recognizing that "the benefit [at issue here] is facially neutral"). And the district court also correctly recognized that the scheme provides respondents with meaningful access to their prescription drug benefit because they "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." *Id.* at 42a. *Choate* makes clear that this is enough: respondents' insurers need not redefine the benefit so as to provide it "in the way most favorable, or least disadvantageous" to respondents. 469 U.S. at 308.

3. The Ninth Circuit reversed on grounds that are impossible to reconcile with *Choate*. It held that, notwithstanding respondents' access to in-network benefits, respondents adequately alleged that they were denied "meaningful access to their prescription drug benefit" in light of their allegations that the scheme "burdens HIV/AIDS patients differently because of their unique pharmaceutical needs," and "prevent[s] HIV/AIDS patients from obtaining *the same quality of pharmaceutical care* that non-HIV/AIDS patients may obtain in filling non-specialty prescriptions." Pet. App. 15a (emphasis added).

The Ninth Circuit's conclusion that respondents are entitled under the Rehabilitation Act to an equal "quality of pharmaceutical care" due to "their unique pharmaceutical needs" flies in the face of *Choate*'s warning that Rehabilitation Act claims should be measured against the actual "benefit provided"—not against the "amorphous objective of 'adequate health care.'" *Choate*, 469 U.S. at 303. Rather, as this Court recognized in *Choate,* where, as here, a benefit provided to persons with disabilities is "identical" to that provided to persons without disabilities, the provider need not "alter [the] definition of the benefit being offered simply to meet the reality that [persons with disabilities] have greater medical needs." *Id.*

In other words, providers need not "view certain illnesses, *i.e.*, those particularly affecting [persons with disabilities], as more important than others and more worthy of cure through . . . subsidization." *Id.* at 303-04. Yet that is precisely what respondents demand: they argue that, due to their "unique pharmaceutical needs," they should be able to obtain a subsidized benefit that no one else enjoys—the right to obtain specialty medications at out-of-network

pharmacies for in-network prices. Pet. App. 15a. *Choate* plainly forecloses such a claim.

B. The Ninth Circuit's Decision Directly Conflicts With The Decisions Of Several Other Circuits

The Ninth Circuit's deviation from *Choate* puts it in conflict with other circuits that have understood that facially neutral health-benefits policies providing the same benefits to persons with disabilities and persons without disabilities do not violate the Rehabilitation Act, even when those policies impose disparate burdens on persons with disabilities. This Court should grant certiorari to resolve that split.

1. On materially identical facts to those presented here, and in a case brought by the same plaintiffs' counsel, the Sixth Circuit has held that pharmacy benefit plans of the kind at issue in this case do not discriminate on the basis of disability because they are "neutral on [their] face." *See Doe v. BlueCross BlueShield of Tenn., Inc.*, 926 F.3d 235, 241 (6th Cir. 2019). In *Doe*, Judge Sutton wrote for the court that *Choate* "expressed reservations about the effects of disparate-impact liability in this area" because "many neutral (and well-intentioned) policies disparately affect the disabled." *Id.* at 242. Drawing on close textual analysis and "thirty years of hindsight," the Sixth Circuit then went "one step further" than the *Choate* Court did. *Id.* It recognized 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.* It therefore proceeded to hold, in conflict with the decision below, that "§ 504 does not cover disparate-impact claims" of any kind. *Id.*

2. Even those circuits that have assumed or held that the Rehabilitation Act permits *some* disparate-impact claims have nevertheless recognized—consistent with *Choate*—that the Rehabilitation Act does not permit disparate-impact claims in the context presented here. As the D.C. Circuit has explained, *Choate*'s "holding . . . would seem to rule out a successful § 504 disparate impact claim based on the terms of an insurance plan." *Modderno v. King*, 82 F.3d 1059, 1061 n.1 (D.C. Cir. 1996), *cert. denied*, 519 U.S. 1094 (1997).

The Second Circuit's decision in *CERCPAC v. Health & Hospitals Corp.*, 147 F.3d 165 (2d Cir. 1998) similarly drew on *Choate* to explain that a Rehabilitation Act claim arising from alleged discrimination in the provision of healthcare services must establish that the plaintiffs have been denied services that are "available to [persons] without disabilities." *Id.* at 168. A complaint establishing only that persons with disabilities will suffer deficient "quality of service" as a result of the challenged practice does not state a claim for relief under the Rehabilitation Act because "the disabilities statutes do not guarantee any particular level of medical care for disabled persons." *Id.*

And the Tenth Circuit, which—like the Second Circuit—recognizes some disparate-impact claims under the Rehabilitation Act, *see* Pet. 18-19, nevertheless has held that a state Medicaid plan that "provide[s] identical Medicaid benefits to every similarly situated recipient, disabled or not," passes muster under the Rehabilitation Act. *Taylor v. Colo. Dep't of Health Care Policy & Fin.*, 811 F.3d 1230, 1234 (10th Cir. 2016).

These decisions, which properly recognize that healthcare benefits need not be redefined to adjust for "the reality" that persons with disabilities have "greater medical needs," *id.* (quoting *Choate*, 469 U.S. at 303), clearly conflict with the decision below, which permits respondents to challenge the facially neutral benefits plans offered by petitioners on the basis of respondents' "unique pharmaceutical needs." Pet. App. 15a. Certiorari is warranted to resolve this split.

II. CERTIORARI IS NECESSARY TO AVERT THE SEVERE ECONOMIC BURDENS AND OTHER PRACTICAL PROBLEMS CAUSED BY THE DECISION BELOW

The Ninth Circuit's decision has enormous practical ramifications for the Nation's health insurers, employers, and healthcare consumers. Most immediately, it will wreak havoc with the Nation's pharmacy benefit management plans. The vast majority of Americans receive their prescription drug coverage through such plans, and the Ninth Circuit's decision will fundamentally alter the economics of those plans, driving up healthcare costs for employers and health-plan beneficiaries alike. As petitioners have pointed out, the economic impact of the Ninth Circuit's decision will be felt nationwide as pharmacy benefit managers scramble to adjust their business models to the Ninth Circuit's novel rule. Even worse, the Ninth Circuit's erroneous decision opens the door to a host of other disparate-impact claims that would significantly interfere with healthcare markets more broadly. The severe economic consequences that will flow from the Ninth Circuit's decision are reason enough for a writ of certiorari.

Just as troubling is the extent to which the Ninth Circuit's decision would vest federal courts with sweeping new responsibilities to make complex and sensitive policy choices regarding Americans' health-insurance plans. The decision below threatens to mire federal courts in an endless series of decisions that implicate difficult economic tradeoffs and choices between competing consumer preferences. Article III courts are hardly well-suited to make those policy determinations in the complex field of health insurance. Indeed, Congress made clear when it passed the Americans with Disabilities Act that it is unwilling to make these policy determinations with respect to health-insurance plans, or to delegate those decisions to the federal courts. Federal courts should not take on policymaking responsibilities that Congress has pointedly forsworn. This Court's decision in *Choate* anticipated these problems and instructed courts to avoid them by dismissing Rehabilitation Act challenges to facially neutral health-benefits plans.

The Ninth Circuit's failure to heed *Choate*'s warning will thrust federal courts into a misguided and ill-suited role in healthcare markets and expose those markets to new and unintended burdens. This Court's intervention is needed now.

A. The Decision Below Threatens The Operation Of U.S. Healthcare Markets

1. Over ninety percent of Americans with health-insurance coverage receive their prescription-drug insurance benefits through a pharmacy benefit manager (PBM). *See* Joanna Shepherd, *Pharmacy Benefit Managers, Rebates, and Drug Prices: Conflicts of Interest in the Market for Prescription*

Drugs, 38 Yale L. & Pol'y Rev. 360, 364 (2020). PBMs "have been important players in the managed care arena since the 1980's because they are able to make bulk purchases of drugs by buying for millions of customers. Their purchasing power makes it possible for them to wrest an array of discounts, rebates and fees from drug manufacturers." Milt Freudenheim, *Employers Unite in Effort to Curb Prescription Costs*, N.Y. Times (Feb. 3, 2005), https://nyti.ms/330zbmt.

"[P]rivate sector entities, such as employers, HMOs, and unions . . . typically hire" PBMs to act as "middlemen among the drug plan, pharmacies, and drug manufacturers." Shepherd, 38 Yale L. & Pol'y Rev. at 364. PBMs are also widely used to manage prescription drug coverage through Medicare and Medicaid. *See* U.S. Government Accountability Office, *Medicare Part D: Use of Pharmacy Benefit Managers and Efforts to Manage Drug Expenditures and Utilization* 14 (July 2019), https://www.gao.gov/assets/gao-19-498.pdf (noting PBMs' role in "pharmacy network development" and "rebate and other price concession negotiations" in Medicare Part D benefit plans); Rachel Dolan & Marina Tian, *Management and Delivery of the Medicaid Pharmacy Benefit*, Kaiser Family Foundation (Dec. 6, 2019), https://www.kff.org/medicaid/issue-brief/management-and-delivery-of-the-medicaid-pharmacy-benefit/ (finding that "states are increasingly utilizing PBMs in their Medicaid prescription drug programs").

One of the principal methods by which PBMs seek to lower drug prices is through "selective contracting"—that is, the use of "exclusive arrangements with retail pharmacies that promise to steer insured individuals to in-network pharmacies."

Joanna Shepherd, *Selective Contracting in Prescription Drugs: The Benefits of Pharmacy Networks*, 15 Minn. J.L. Sci. & Tech. 1027, 1028-29 (2014). Numerous studies have shown that exclusive pharmacy networks help to reduce the price paid for prescription drugs by benefits plans and consumers. *See id.* at 1051; *see also, e.g.*, Patricia M. Danzon & Mark V. Pauly, *Health Insurance and the Growth in Pharmaceutical Expenditures*, 45 J.L. & Econ. 587, 603 (2002) (noting that the use of "selective pharmacy networks," in conjunction with the use of "formularies of preferred drugs," is "estimated to reduce the cost of [prescription-drug] coverage by about 20-30 percent"); Trevor J. Royce et al., *Impact of Pharmacy Benefit Managers on Oncology Practices and Patients*, 16 JCO Oncology Practice 276, 277 (2020), https://ascopubs.org/doi/pdf/10.1200/JOP.19.00606 (noting that "health plans that use PBM-preferred pharmacy networks have demonstrated lower pharmacy costs"). For U.S. employers and their health-plan beneficiaries, the use of selective pharmacy networks is a crucial bulwark against runaway prescription-drug costs, particularly in the increasingly costly realm of specialty drugs. *Cf.* Sharona Hoffman & Isaac D. Buck, *Specialty Drugs and the Health Care Cost Crisis*, 55 Wake Forest L. Rev. 55, 64 (2020) (noting that "specialty drugs" accounted for only 19 percent of Americans' drug spending in 2004, rising to 41 percent in 2018).

2. The Ninth Circuit's decision threatens the basic structure of these widespread cost-saving PBM practices. Under the Ninth Circuit's rule, any plaintiff with a disability could plausibly raise a claim that the use of exclusive pharmacy networks is discriminatory so long as the plaintiff pleads that she

is unable to obtain the "same quality of pharmaceutical care" as other beneficiaries in light of her "unique pharmaceutical needs." Pet. App. 14a-15a. Because innumerable medical conditions are susceptible to classification as disabilities, the number of plaintiffs who could potentially present such claims is quite large. *See, e.g.*, *School Bd. of Nassau Cnty., Fla. v. Arline*, 480 U.S. 273, 281 (1987) (tuberculosis); *Desmond v. Mukasey*, 530 F.3d 944, 956-58 (D.C. Cir. 2008) (sleeplessness); *Gilbert v. Frank*, 949 F.2d 637, 640-41 (2d Cir. 1991) (polycystic kidney disease); *Reynolds v. Brock*, 815 F.2d 571, 573-74 (9th Cir. 1987) (epilepsy); *Gordon v. District of Columbia*, 480 F. Supp. 2d 112, 117 (D.D.C. 2007) (arthritis); *Harding v. Cianbro Corp.*, 436 F. Supp. 2d 153, 178 (D. Me. 2006) (fibromyalgia); *Hiller v. Runyon*, 95 F. Supp. 2d 1016, 1021 (S.D. Iowa 2000) (testicular cancer); *Peacock v. County of Marin*, 953 F. Supp. 306, 309 (N.D. Cal. 1997) (myopia correctable by contact lenses); *Walders v. Garrett*, 765 F. Supp. 303, 308-09 (E.D. Va. 1991) (chronic fatigue immune dysfunction syndrome).

As a practical matter, the Ninth Circuit's invitation to litigation over the "unique pharmaceutical needs" of countless classes of plaintiffs with various medical conditions will make the kind of selective contracting arrangements at issue in this case—which, as noted above, are commonly used to reduce prescription-drug costs—entirely unworkable. Health-benefits plans cannot waive network exclusivity for every class of beneficiaries who claim to have unique pharmaceutical needs without undermining the economic model on which those arrangements rest.

Pharmacies "compete aggressively" to be included in exclusive networks by "offering price discounts for filling prescriptions," but only because inclusion in an exclusive network offers the prospect of "significant sales." Shepherd, 15 Minn. J. L. Sci. & Tech. at 1029. The more exclusive the network, the "steeper [the] price discounts." *Id.* at 1030. An "exclusive" network shot through with exceptions for beneficiaries whose medical conditions are susceptible to definition as disabilities simply would not offer the incentives that drive pharmaceutical price discounting. At the very least, as petitioners note, claims such as those presented here will "impose enormous litigation costs on defendants" that will significantly detract from the economies of scale that selective-contracting arrangements provide. Pet. 29.

What is more, the economic damage of the Ninth Circuit's misadventure will not be limited to the Ninth Circuit. As petitioners point out, the Ninth Circuit's decision "hamstrings companies that operate *nationwide*," and "effectively forces companies with a national footprint to choose between proactively following" the Ninth Circuit's rule or else "subjecting themselves to litigation seeking overhaul of common benefit-plan terms." Pet. 4 (emphasis added). Millions of Americans who obtain discounts on their prescription drugs by virtue of selective contracting will feel the effects of the Ninth Circuit's decision.

3. The Ninth Circuit's decision also risks the disruption of health-benefits plans more generally. The "selective contracting" principle at stake in this case is not unique to the pharmacy benefit context. As the district court recognized below, the "logical extension of Plaintiffs' discrimination challenge could threaten the basic structure of Health Maintenance

Organizations ('HMOs') and Preferred Provider Organization insurance plans ('PPOs')." Pet. App. 42a. Long before PBMs began engaging in selective contracting, "insurers create[d] plans such as health maintenance organizations (HMOs) that form exclusive arrangements with physicians, hospitals, and other health care providers to whom the HMO will steer patients." Shepherd, 38 Yale L. & Pol'y Rev. at 365. "A substantial body of empirical research has shown that selective contracting by managed care plans such as HMOs has *lowered* the prices that both insurers and patients pay for health care." *Id.* (emphasis added); *see also, e.g.*, Glenn A. Melnick et al., *The Effects of Market Structure and Bargaining Position on Hospital Prices*, 11 J. Health Econ. 217, 231-32 (1992) (discussing the policy implications of selective contracting and its effects on hospital prices).

The district court properly recognized that if "enrollees could avail themselves of out-of-network providers at in-network rates by contending that in-network care is inferior for any particular disability, then the basis of the HMO/PPO model would be undermined." Pet. App. 43a. In light of the Ninth Circuit's decision below, that kind of interference is easy to imagine: a class of insureds with a particular disability might allege, for instance, that an insurance plan's exclusion of a particular hospital from its preferred-provider network is discriminatory because the excluded hospital better serves the needs of persons with that disability. *Cf. Rodde v. Bonta*, 357 F.3d 988, 997 (9th Cir. 2004) (forbidding Los Angeles County health officials from closing a rehabilitation center because it was "relied upon disproportionately by the disabled because of their

disabilities"). So long as plaintiffs could plausibly allege that they had "unique [medical] needs" by virtue of their disability, and that the limitations of the insurer's provider network prevented plaintiffs from receiving the "same quality of [medical] care that [non-disabled] patients" could obtain from the insurer's network providers, their case would be indistinguishable from the case presented here. Pet. App. 14a-15a.

Of course, almost *every* medical condition entails "unique . . . needs," and those needs are often better served by some medical providers than by others. Selective contracting arrangements limit the universe of providers from which beneficiaries may receive discounted care, which is bound to disparately impact various beneficiaries with varying medical needs. The Ninth Circuit's rule, carried to its logical conclusion, treats every such disparate impact as a form of prima facie discrimination any time the beneficiaries' medical condition happens to be a disability—which, as shown above, will very frequently be the case. *See supra* at 14. The upshot is that only a null set of benefits plans that are "precisely tailored" to each beneficiary's "particular needs" would escape litigation risk under the Rehabilitation Act. *Choate*, 469 U.S. at 303.

The disruptive potential of the Ninth Circuit's decision with respect to the operation of U.S. healthcare markets is incalculable, as this Court recognized in *Choate*. Opening the door to disparate-impact liability in this context would impose an "unworkable requirement" on all insurers to conduct an "analysis of the effect" of the terms of their plans on every "class" of persons with disabilities, and then to "balance the harms and benefits to various groups

to determine . . . the extent to which" those terms disparately impact persons with various disabilities. *Choate*, 469 U.S. at 308. The "obvious . . . administrative costs of implementing such a regime" are impossible to quantify, but they are clearly "far from minimal." *Id.* And those extraordinary, and unintended, costs would be borne by benefit sponsors (employers, labor unions, and governments) as well as beneficiaries themselves.

The Rehabilitation Act does not require this expensive and destabilizing review of facially neutral health-benefits policies. *See id.* at 308-09. But the Ninth Circuit's decision will require a wide variety of market actors to reassess (and potentially alter) a host of facially neutral health-benefits policies that undergird the health care received by millions of Americans. The enormous economic burdens created by the Ninth Circuit's decision greatly heighten the need for this Court's review.

B. The Decision Below Forces Federal Courts To Make Arbitrary Policy Choices Affecting The Healthcare Options Of All Americans

The Ninth Circuit's decision in this case also will impose an unintended "adjudicative burden" on federal courts. *Choate*, 469 U.S. at 298. The decision will enmesh courts in a host of difficult health-policy problems that are unlikely to be coherently resolved through case-by-case adjudication. And that policy-laden adjudicative enterprise is all the more misplaced in light of Congress's deliberate forbearance from policymaking in this context. This Court should grant certiorari now to prevent federal

courts in the Ninth Circuit from assuming the role of healthcare policymakers.

1. The Ninth Circuit's decision instructs that respondents' claims should proceed so that, on remand, the district court may consider whether petitioners' prescription drug benefit program "prevents [respondents] from receiving effective treatment for HIV/AIDS." Pet. App. 16a. The decision below provides no guidance that would narrow or channel this inquiry: on its face, the decision compels the district court to undertake an apparently freewheeling examination of the "effective[ness]" of the benefits offered by petitioners. *Id.* How is a federal court supposed to do that?

To be sure, there are excellent policy arguments that the benefits offered by petitioners *are* effective mechanisms for the distribution of prescription drugs. For instance, there is widespread scientific evidence that patients who take prescription medications for chronic conditions tend to experience better health outcomes when they receive their medications by mail—as petitioners offer—rather than through pickup at a local brick-and-mortar pharmacy. *See, e.g.*, Phil Schwab et al., *A Retrospective Database Study Comparing Diabetes-Related Medication Adherence and Health Outcomes for Mail-Order Versus Community Pharmacy*, 25 J. Managed Care & Specialty Pharmacy 332, 337 (2019); Julie A. Schmittdiel et al., *The Comparative Effectiveness of Mail Order Pharmacy Use vs. Local Pharmacy Use on LDL-C Control in New Statin Users*, 26 J. Gen. Internal Med. 1396, 1401 (2011). And one study of veterans with HIV/AIDS who receive their medications through VA's mail-order pharmacy benefit system found that patients reported "strongly

positive experiences" with their mail-order pharmacy benefit overall. *See* Karishma Rohanraj Desai et al., *Mail-Order Pharmacy Experience of Veterans Living with AIDS/HIV*, 14 Rsch. Soc. & Admin. Pharmacy 153, 159 (2017).

The more important point, however, is that asking courts to make determinations about the effectiveness of particular health benefits is a lost errand: different people with different medical conditions and different preferences will often have different responses to the same health benefits. Some consumers "value expanded accessibility and choice of pharmacy"; others "prioritize lower drug prices over expansive accessibility." Shepherd, 15 Minn. J.L. Sci. & Tech. at 1047. Whether a particular health-benefit scheme is "effective" may depend in large part on those preferences. *Cf.* Schmittdiel et al., *supra*, at 1399-400 (arguing that "[s]ystem-level efforts to promote mail order use in patients that may benefit from its use, while preserving patient choice in what type of pharmacy services they prefer to use . . . could lead to improved outcomes"). Of course, what respondents have sought in this case is the best of all worlds: total freedom of choice of provider *and* the lower costs that come with a selective-contract benefit plan. But those preferences are in tension with one another: insurers cannot obtain the lower prices that come with selective contracting without funneling beneficiaries to preferred providers. *See supra* at 15.

Asking courts to sort through the various preferences of different beneficiaries, and to make binding determinations as to which of those preferences is entitled to legal protection—all in an adversarial format that is not designed to test the preferences of anyone other than the parties to the

case—is a recipe for unpredictable, unhelpful, and arbitrary acts of judicial intervention in a staggeringly complex field. Given the number of facially neutral health-benefits policies that could come within the ambit of the Ninth Circuit's rule, *see supra* at 15-17, the potential for misdirected judicial policymaking is virtually unlimited. Markets and policy experts, not courts, are the proper authorities here. *See* Shepherd, 15 Minn. J.L. Sci. & Tech. at 1046 ("[C]ompetition . . . encourages payers (and employers) to establish pharmacy service arrangements that offer the level of accessibility that subscribers prefer." (quoting Letter from Fed. Trade Comm'n to Patrick C. Lynch, R.I. Att'y Gen., and Juan M. Pichardo, Deputy Majority Leader, R.I. State Senate 5 (Apr. 8, 2004), http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.patrick-c.lynch-and-hon.juan-m.pichardo-concerning-competitive-effects-ri-general-assembly-bills-containing-pharmaceutical-freedom/ribills.pdf)).

2. What makes this misguided enterprise all the more improper is that the Ninth Circuit's decision forces federal courts to make policy choices that Congress has pointedly refused to make and refused to delegate to the courts, either in the Rehabilitation Act or the Americans with Disabilities Act (ADA). The Senate committee report accompanying the ADA explained that "employee benefit plans should not be found to be in violation of this legislation under impact analysis simply because they do not address the special needs of every person with a disability, e.g., additional sick leave or medical coverage," and noted that "insurers and employers [should have] the same opportunities they would enjoy in the absence of

[the ADA] to design and administer insurance products and benefit plans in a manner that is consistent with basic principles of insurance risk classification." S. Rep. No. 101-116, at 85-86 (1989) (citing *Choate*, 469 U.S. 287).

Policymakers in Congress—the branch charged with making policy judgments—have thus recognized what *Choate* made plain: to require employers and insurers to make "distributive decision[s] . . . always . . . in the way most favorable, or least disadvantageous" to persons with disabilities would "lead to a wholly unwieldy administrative and adjudicative burden." 469 U.S. at 298, 308. The Ninth Circuit's decision in this case plunges federal courts into a policy thicket that Congress itself has deliberately steered clear of. This Court should step in now to head off that reckless and ill-fated venture.

CONCLUSION

The petition for certiorari should be granted.

Respectfully submitted,

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