No. 23-4331

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

C. P., by and through his parents, Patricia Pritchard and Nolle Pritchard; and PATRICIA PRITCHARD, *et al.*,
Plaintiff-Appellee,

v.

BLUE CROSS BLUE SHIELD OF ILLINOIS,
Defendant-Appellant.

On Appeal from the United States District Court
for the Western District of Washington
No. 3:20-cv-06145-RJB
Hon. Robert J. Bryan

AMICUS CURIAE BRIEF OF NATIONAL WOMEN'S LAW CENTER, AUTISTIC SELF ADVOCACY NETWORK, AUTISTIC WOMEN & NONBINARY NETWORK, CAMPAIGN FOR SOUTHERN EQUALITY, DISABILITY RIGHTS EDUCATION & DEFENSE FUND, EQUALITY CALIFORNIA, GLBTQ LEGAL ADVOCATES & DEFENDERS, NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, POSITIVE WOMEN'S NETWORK-USA, SERVICE EMPLOYEES INTERNATIONAL UNION, AND TRANSGENDER LEGAL DEFENSE & EDUCATION FUND IN SUPPORT OF APPELLEES AND AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

The amici curiae, National Women's Law Center, Autistic Self Advocacy Network, Autistic Women & Nonbinary Network, Campaign for Southern Equality, Disability Rights Education & Defense Fund, Equality California, GLBTQ Legal Advocates & Defenders, National Partnership for Women & Families, Positive Women's Network-USA, Service Employees International Union, and Transgender Legal Defense & Education Fund are not corporations and have no parent corporations. No publicly held corporation owns any stock in any of the amici curiae.

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INTEREST OF THE AMICI CURIAE[1]

Amici[2] are eleven organizations committed to eliminating discrimination in healthcare, including in the provision of health coverage. Amici advocate for a diverse range of communities, including women and girls, especially women of color and low-income women; lesbian, gay, bisexual, transgender and queer+ ("LGBTQ+") people; people living with HIV; the autistic community; and people with disabilities.

Amici have significant experience working to advance equal and effective access to quality health care. This experience underscores that judicial enforcement of Section 1557 of the Affordable Care Act that is consistent with the statute's full breadth and promise is crucial to ensuring that all people—regardless of their race, color, national origin, sex, disability status, or age—receive the care they need to thrive. Amici have an interest in countering the arguments made by Appellant and its amici, which would imperil the ACA's critical nondiscrimination protections for millions of people in the United States.

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[1] This brief is filed with the consent of all parties. No party's counsel authored the brief in whole or in part or contributed money intended to fund preparing or submitting the brief. No person, other than amici curiae, their members, or their counsel, contributed money intended to fund preparing or submitting the brief.

[2] Amici are the National Women's Law Center ("NWLC"), Autistic Self Advocacy Network, Autistic Women & Nonbinary Network, Campaign for Southern Equality, Disability Rights Education and Defense Fund, Equality California, GLBTQ Legal Advocates & Defenders, National Partnership for Women & Families, Positive Women's Network-USA, Service Employees International Union, and Transgender Legal Defense & Education Fund.

PRELIMINARY STATEMENT

The Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119, was groundbreaking legislation intended to reform the health insurance industry and establish "a comprehensive national plan" to "increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538, 583 (2012). A key tool for achieving the ACA's mission is Section 1557, which broadly prohibits discrimination based on race, color, national origin, sex, disability, and age in "*any* health program or activity, *any part of which* is receiving Federal financial assistance …." 42 U.S.C. §18116(a) (emphases added).

The plain text, structure, legislative history, and purpose of the ACA all make unambiguously clear that Congress intended Section 1557 to apply broadly to *all* operations of *any* health coverage issuer or administrator federally funded in part because the programs and activities of such entities are plainly "health" related. As the Ninth Circuit has already recognized, "Section 1557 … prohibits discrimination … *in the health care system*—as relevant here, *in health insurance contracts*." *Schmitt v. Kaiser Found. Health Plan of Wash.*, 965 F.3d 945, 951 (9th Cir. 2020) (emphases added). Thus, Section 1557 "prohibits covered *health insurers* from discriminating," including based on sex. *Id.* at 948 (emphasis added).

Notwithstanding the plain text and purpose of the statute and the Ninth Circuit's previous statements on the matter, Appellant Blue Cross Blue Shield of Illinois ("BCBSIL") argues that its operations as a third-party administrator ("TPA") of a discriminatory employer-sponsored self-funded plan are exempt from

Section 1557 for two independent reasons. First, relying entirely on the U.S. Department of Health and Human Services ("HHS")'s 2020 Rule interpreting Section 1557,[3] BCBSIL asserts that Section 1557's nondiscrimination obligations categorically do not apply to health insurers, except narrowly as to their specific federally funded activities, because health insurers are not "principally engaged in the business of providing healthcare." Appellant's Opening Brief ("AOB") at 3, 47-55. Second, BCBSIL argues that even if the issuance and administration of health coverage is considered a "health program or activity," ERISA categorically immunizes a TPA's activities from Section 1557 liability, including when it administers discriminatory plans, so long as it administers the plan in accordance with its terms. *See* AOB 3, 28-41.

Not only are these arguments meritless as a matter of statutory construction and ERISA law, but, if accepted, they could deprive the nearly two-thirds of people in the United States with private health insurance[4] (including the more than

[3] HHS has published three sets of final rules interpreting Section 1557: Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016) (the "2016 Rule"); Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (the "2020 Rule"); Nondiscrimination in Health Programs and Activities, 89 Fed. Reg. 37,522 (May 6, 2024) (the "2024 Rule"). The 2024 Rule was published after BCBSIL's Opening Brief was filed in this case. The majority of the 2024 Rule will be effective July 5, 2024. *See* 89 Fed. Reg. at 37,693.

[4] *See* Katherine Keisler-Starkey et al., U.S. Census Bureau, *Health Insurance Coverage in the United States 2022* (Sept. 2023), at 2 Tbl. 1, https://www.census.gov/content/dam/Census/library/publications/2023/demo/p60-281.pdf [hereinafter *Health Insurance Coverage*] (roughly 216 million people are in "private plan[s]," including employer-based and direct-purchase insurance).

100 million with employer-sponsored self-funded plans)[5] of the fundamental protections against discrimination in healthcare that Congress intended when enacting Section 1557. Unchecked by Section 1557, health insurers would be free to design, sell, and administer discriminatory health plans. Indeed, exempting health coverage issuers and administrators from Section 1557 threatens a return to a pre-ACA landscape of rampant discrimination in health insurance, particularly targeting women, young people, people with disabilities, people of color, and people in need of pregnancy-related and gender-affirming care. These are the very harms Congress sought to eradicate with Section 1557. Section 1557 cannot be construed in a manner that would permit a result so contrary to Congress's plainly expressed intent.

ARGUMENT

I. The Text, Structure, and Purpose of Section 1557 Unambiguously Establish that Congress Intended the ACA's Nondiscrimination Requirements to Apply to All Operations of Health Coverage Issuers and Administrators that Accept Federal Funds.

A. The Issuance and Administration of Health Coverage Is Plainly a "Health Program or Activity."

Section 1557 prohibits discrimination in "*any* health program or activity, *any part of which* is receiving Federal financial assistance …." 42 U.S.C. §18116(a)

[5] Roughly 180 million people in the United States receive employment-based health coverage. *Id.* at 2, Tbl 1. Of those, approximately 65% of workers are on self-funded plans. Gary Claxton et al., Kaiser Family Found., Employer Health Benefits: 2022 Annual Survey 156 (2022), https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf [hereinafter *Employer Health Benefits*].

(emphasis added). "It is well settled that 'the starting point for interpreting a statute is the language of the statute itself.'" *Pac. Coast Fed. of Fishermen's Ass'ns v. Glaser*, 945 F.3d 1076, 1083 (9th Cir. 2019) (quoting *Gwaltney of Smithfield, Ltd. v. Chesapeake Bay Found., Inc.*, 484 U.S. 49, 56 (1987)). "In ascertaining the plain meaning of the statute, the court must look to the particular statutory language at issue, as well as the language and design of the statute as a whole." *K Mart Corp. v. Cartier, Inc.*, 486 U.S. 281, 291 (1988).

Although the phrase "health program or activity" is not defined in the statute, as a matter of plain language, the issuance and administration of health coverage are activities related to health. *Cf. Snyder-Hill v. Ohio State Univ.*, 48 F.4th 686, 708 (6th Cir. 2022) (adopting Second and Third Circuits' broad reading of "education program or activity" in Title IX as covering any entity with "features such that one could reasonably consider its mission to be, at least in part, educational"). Moreover, the use of the word "any" before "health program or activity" also makes clear that Congress intended to encompass *all* programs and activities relating to health. *See Ali v. Fed. Bureau of Prisons*, 552 U.S. 214, 218-19 (2008) (noting that the use of "any … suggests a broad meaning"); *Desire, LLC v. Manna Textiles, Inc.*, 986 F.3d 1253, 1279 (9th Cir. 2021) (holding that, "read most naturally," the use of the adjective "any" means the statute refers to "an undetermined number" of the noun in the phrase).

"By extending nondiscrimination protections to individuals under 'any health program or activity,' Congress clearly intended to prohibit discrimination by any entity acting within the 'health' system," including "a health insurance

provider," which "undoubtedly implicates the health of persons falling within the scope of ACA protections." *Fain v. Crouch*, 545 F.Supp.3d 338, 342 (S.D.W. Va. 2021). And because Section 1557 expressly applies to a health program or activity if "*any part of*" it accepts federal funds, 42 U.S.C. §18116(a), the plain text encompasses *all* operations of a covered health-related entity, regardless of whether the particular operation is federally funded. *See T.S. by & through T.M.S. v. Heart of CarDon, LLC*, 43 F.4th 737, 744 (7th Cir. 2022) ("[S]ection 1557's prohibition on discrimination is not, by its own terms, limited to the discrete portion of a covered entity that receives federal financial assistance…"); *infra* Part I.B.

Accordingly, contrary to BCBSIL's radical position, for more than a decade, courts have consistently applied Section 1557 to health coverage—and health plan members throughout the country have relied on the law's invaluable protections. *See, e.g.*, *Kadel v. Folwell*, 100 F.4th 122, 163-64 (4th Cir. 2024) (holding state health insurance plan's exclusion of coverage for gender affirming care violated Section 1557); *Doe v. CVS Pharm., Inc.*, 982 F.3d 1204, 1207 (9th Cir. 2020) (applying Section 1557 to pharmacy benefit manager allegedly discriminating against people with disabilities); *E.S. v. Regence Blueshield*, No. C17-1609, 2024 WL 1173805, at *3-5 (W.D. Wash. Mar. 19, 2024) (allowing Section 1557 claim to proceed against health insurer for exclusion of coverage for hearing aids); *Berton v. Aetna Inc.*, No. 23-cv-01849, 2024 WL 869651, at *3-4 (N.D. Cal. Feb. 29, 2024) (allowing Section 1557 claim to proceed against TPA for definition of infertility that places greater burdens on women in LGBTQ+ relationships).

Section 1557's expansive scope is further supported by "legislative history[] and the statute's overall purpose." *Pac. Coast Fed'n*, 945 F.3d at 1084 (quoting *Ileto v. Glock, Inc.*, 565 F.3d 1126, 1133 (9th Cir. 2009)); *see also Robinson v. Shell Oil Co.*, 519 U.S. 337, 341 (1997) ("The plainness or ambiguity of statutory language is determined by reference to the language itself, the specific context in which that language is used, *and the broader context of the statute as a whole*.") (emphasis added). Section 1557 is a civil rights law embedded in a broader remedial statute, the ACA, which itself is a "series of interlocking reforms designed to expand coverage in the individual health insurance market." *King v. Burwell*, 576 U.S. 473, 478-79 (2015). One key method for ensuring that health coverage is available to all has been to ensure that it is provided on a nondiscriminatory basis.[6]

Before the ACA, health insurers regularly singled out women, people of color, people with disabilities, young people, and people in need of pregnancy-related and gender affirming care for exclusions of coverage, substantial out-of-pocket payments, higher premiums, and other discriminatory treatment. For example, prior to the ACA's enactment, insurers used individuals' health status, including pre-existing health conditions and disabilities, "to determine whether that

[6] BCBSIL appears to suggest that the district court erred by considering the ACA's overall purpose in interpreting Section 1557, relying on *Navajo Nation v. HHSA*, 285 F.3d 864, 869 (9th Cir. 2002), which BCBSIL states was "vacated on other grounds." AOB 55. BCBSIL's reliance on the *Navajo Nation* panel opinion is mistaken. "[A] decision may be *reversed* on other grounds, but a decision that has been *vacated* has no precedential authority whatsoever." *Durning v. Citibank, N.A.*, 950 F.2d 1419, 1424 n.2 (9th Cir. 1991).

person could enroll in a plan, to set that person's monthly premium, and to modulate the types of coverage available after enrollment."[7] Insurers regularly rejected applicants for health coverage for "pre-existing conditions" that disproportionately impact Black, Indigenous, and other people of color, such as lupus, diabetes, and severe obesity,[8] as well as for a variety of gender-related reasons, including if the applicant was pregnant, had a history of Cesarean deliveries, or was a domestic violence survivor.[9] Additionally, in a prevalent practice known as "gender rating," insurers charged women more than men for the same health coverage, even when a plan excluded maternity coverage *and* a woman was a non-smoker and a man was a smoker.[10] Insurers also deemed gender

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[7] Elizabeth Guo et al., *Eliminating Coverage Discrimination Through the Essential Health Benefit's Anti-Discrimination Provisions*, 107 Am. J. Pub. Health 253, 253 (2017).

[8] *See* Gary Claxton et al., Pre-Existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA 4, 10 (Dec. 2016), https://files.kff.org/attachment/Issue-Brief-Pre-existing-Conditions-and-Medical-Underwriting-in-the-Individual-Insurance-Market-Prior-to-the-ACA; Lupus Health Disparities in the United States 3 (Oct. 2020), https://www.lupus.org/sites/default/files/media/documents/Health-Disparities-Executive-Summary-D3.pdf; National Institute of Diabetes and Digestive and Kidney Diseases, Overweight and Obesity Statistics (Sept. 2021), https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity; Centers for Disease Control, National Diabetes Statistics Report Appx. Tbl. 3 (2020), https://www.cdc.gov/diabetes/php/data-research/appendix.html#cdc_report_pub_study_section_3-table-3.

[9] *See* NWLC, Nowhere to Turn: How the Individual Health Insurance Market Fails Women 8 (2008), https://nwlc.org/wp-content/uploads/2015/08/NWLCReport-NowhereToTurn-81309w.pdf.

[10] *See* NWLC, Still Nowhere to Turn: Insurance Companies Treat Women Like a Pre-existing Condition 5-7 (Oct. 2009), https://nwlc.org/wp-content/uploads/2015/08/stillnowheretoturn.pdf.

dysphoria to be a pre-existing condition that justified denying coverage—discrimination that was further compounded by plan benefit designs that targeted transgender people, including through categorical exclusions of coverage for gender affirming care.[11] Plans also discriminated against young people by categorically excluding pregnancy care for child dependents[12] and targeted people with chronic conditions by including coverage caps.[13]

Congress recognized that discrimination in health insurance—particularly sex discrimination—posed a significant barrier to the ACA's goals. *See, e.g.*, Health Care and Education Reconciliation Act of 2010, 156 Cong. Rec. H1582 (daily ed. Mar. 17, 2010) (statement of Rep. Garamendi) ("This is the point to the insurance companies. The day the President signs [the ACA], your discriminatory practices are over. You will not be able to discriminate against Americans because of their health status, their marital status, whether they are male or female."); 155 Cong. Rec. S10,263 (daily ed. Oct. 8, 2009) (statement of Sen. Boxer) ("Women have even more at stake. Why? Because they are discriminated against by insurance companies, and that must stop, and it will stop when we pass insurance reform.").

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[11] *See* Transgender Law Center, Transgender Health Benefits: Negotiating for Inclusive Coverage 5 (2014), https://bit.ly/3gKG8gh.

[12] *See* Michelle Andrews, *Some Plans Deny Pregnancy Coverage for Dependent Children*, KFF Health News (Aug. 6, 2012), https://kffhealthnews.org/news/under-26-pregnancy-coverage-michelle-andrews-080712/.

[13] *See* Abigail Abrams, *How Obamacare Helped Americans with Disabilities*, Time (Aug. 2, 2021), https://time.com/6086359/obamacare-health-insurance-people-disabilities/.

To tackle these problems, Congress enacted several specific insurance reforms, including the guaranteed-issue and community-rating provisions, which ended "gender rating" in the individual and small group markets and denials and rate increases based on pre-existing conditions. 42 U.S.C. §§300gg(a), 300gg-1(a). Alongside these and other specific provisions, Congress enacted Section 1557 to "remedy the shameful history of invidious discrimination and the stark disparities in outcomes in our health care system" and "ensure that all Americans are able to reap the benefits of health insurance reform equally, without discrimination." Health Care and Education Reconciliation Act of 2010, 156 Cong. Rec. S.1842 (daily ed. Mar. 23, 2010) (statement of Sen. Leahy). As the cornerstone of Congress's efforts to eradicate discrimination in health coverage, Section 1557 provides an express catch-all prohibition against discrimination.

Given that health coverage is the primary focus of the ACA, it is nonsensical to interpret "health programs and activities" to tacitly exclude most activities of health coverage issuers and administrators.[14] Health insurance is inextricably tied

[14] BCBSIL wrongly suggests that employer-sponsored health plans never receive federal funding. Employees can use Medicaid premium assistance funds, which HHS "plays a role in providing or administering," 2024 Rule, 89 Fed. Reg. at 37,536, to pay their plan premiums. *See* Dep't of Labor, Premium Assistance Under Medicaid and the Children's Health Insurance Program 1 (Jan. 31, 2024), https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/chipra/model-notice.pdf. These funds constitute "Federal financial assistance," triggering nondiscrimination obligations. *Cf. Radcliff v. Landau*, 883 F.2d 1481, 1483 (9th Cir. 1989) (noting that students' use of Basic Education Opportunity Grants or veterans benefits to pay tuition subjects a school to Title VI). Thus, even under BCBSIL's proposed definition of "health program or activity," any commercial plan it issues or administers may still be subject to Section 1557.

to both individual and public health: research has found that "[p]eople without insurance coverage have lower access to care than people who are insured," "are more likely to delay or forgo care due to costs," and are less likely "to receive preventive care and services for major health conditions and chronic diseases."[15] And contrary to BCBSIL and its Amici the ERISA Industry Committee ("ERIC") and America's Health Insurance Plans, Inc.'s ("AHIP") (together, "ERIC Br.") representations, health coverage issuers and administrators play a crucial gatekeeping role with regard to millions of individuals' access to healthcare. Health insurance companies design and market health benefit plans that they either underwrite or administer (or both), determine eligibility for benefits using internal clinical and coverage policies, and thus control whether millions of individuals can obtain the healthcare they need. *See infra* Part I.B. BCBSIL's construction of Section 1557 not only defies the plain text of the statute, it would fundamentally gut the protections of Section 1557, leaving millions of people in the United States vulnerable to the very forms of discrimination in health coverage that the ACA was designed to eradicate.

[15] Jennifer Tolbert et al., Kaiser Family Found., Key Facts about the Uninsured Population, (Dec. 18, 2023), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/; *see also* H.R. Rep. No. 111-388 (2009) at 79-81 (describing that women without health insurance were more likely to forgo preventive services like mammograms, Pap tests, and blood-pressure checks).

B. BCBSIL's Attempt to Excise Health Coverage from Section 1557 Contorts Both Section 1557 and the Civil Rights Restoration Act.

None of BCBSIL's arguments for limiting the broad scope of covered entities are persuasive.

First, BCBSIL asserts that the district court erroneously looked to the statute's use of "contracts of insurance" to demonstrate that Section 1557 was intended to cover health insurers, not just providers. AOB 52-54. It is true that Congress expressly provided that "Federal financial assistance" to a covered "health program or activity" could include "contracts of insurance" as well as "credits" and "subsidies." 42 U.S.C. §18116(a). But that only *supports* the inclusion of health coverage in the scope of the statute, as all three forms of assistance are provided to insurance companies. As one district court explained, "[i]t is unclear to whom this clause would apply if not health insurance issuers." *Fain*, 545 F.Supp.3d at 342. As for "credits" and "subsidies," the ACA is clear that the Federal government provides such assistance to *health insurance companies*. *See* ACA §1412(a)(3) (providing that the Secretary of the Treasury make "advance payments of such credit or reductions to the issuers of the qualified health plans"); *id.* §1415 ("[A]ny … advance payment of credit [for cost sharing authorized by ACA §§1402 and 1412] shall be treated as made to the qualified health plan in which an individual is enrolled and not to that individual.").[16]

[16] This interpretation of the statute was clear long before the first regulations were issued. *See* Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 How. L.J. 855, 873-74 (2012)

Second, BCBSIL argues that health insurers and administrators are not bound by Section 1557, except narrowly as to their specific federally funded activities, by relying on the soon-to-be-rescinded 2020 Rule's erroneous understanding of the Civil Rights Restoration Act of 1987 ("CRRA").[17] According to BCBSIL, Section 1557 should apply to the entirety of a health entity only when it is "principally engaged in the business of providing … health care," which it then construes narrowly to mean only direct patient-care services and to exclude the provision of health insurance. AOB 50-52 (citing 20 U.S.C. §1687(3)(A)(ii)).

This argument subverts not only the express purpose of Section 1557, but also of the CRRA itself, a statute Congress passed to overrule Supreme Court decisions that "unduly narrowed or cast doubt upon the broad application of Title

("Moreover, Section 1557's specificity that federal financial assistance includes 'credits' and 'subsidies' unequivocally establishes that Section 1557's antidiscrimination mandate covers private insurance companies, physicians, and other providers who will be receiving new federal tax credits and subsidies authorized by the ACA.").

[17] BCBSIL is wrong to suggest that the 2020 Rule's narrow construction of "health program or activity" is "controlling," or at least "persuasive and entitled to deference." AOB 52. Under the familiar *Chevron* framework, an agency's interpretation is considered only where a statute is ambiguous, using "'traditional tools of statutory construction,' including an examination of the statute's text, the structure of the statute, and (as appropriate) legislative history." *Corrigan v. Haaland*, 12 F.4th 901, 907 (9th Cir. 2021) (quoting *Chevron U.S.A. Inc. v. NRDC, Inc.*, 467 U.S. 837, 843 n.9 (1984)). Here, "traditional tools of statutory construction" make unambiguously clear that Congress intended Section 1557's nondiscrimination requirements to apply to all activities, including TPA activities, of health insurers, any part of which receives federal financial assistance. Because it is directly at odds with the text, structure, and purpose of the statute, the 2020 Rule is neither controlling nor entitled to deference. *See Chevron*, 467 U.S. at 843-844 & n.9.

IX [and other civil rights laws]" and "to restore the … broad, institution-wide application of those laws as previously administered." 102 Stat. 28, Pub. L. 100-259 (100th Cong. Mar. 22, 1988), Sec. 2(1)-(2). Specifically, Congress enacted the CRRA to supersede *Grove City College v. Bell*, 465 U.S. 555, 570-74 (1984), in which the Supreme Court "narrowly construed the phrase 'program or activity'" within Title IX to mean that only those specific programs or activities for which an institution received federal funding were subject to the law's nondiscrimination mandate, rather than the institution as a whole, *Radcliff*, 883 F.2d at 1483. The CRRA was designed to reinstate Congress's intended, broader construction of "program or activity" such that the "[r]eceipt of federal financial assistance by any … portion of a [covered entity] subjects the entire [entity]" to coverage. *Id.*

Even if Section 1557's reference to "any health program or activity" could be construed as limited to "entities principally engaged in the business of providing healthcare," nothing in the CRRA suggests that a health insurance company is *not* in the business of providing healthcare. To the contrary, courts interpreting the CRRA have long construed it broadly, finding Section 504 applicable to all operations of private healthcare entities, including health insurance companies, that receive Medicare or Medicaid payments. *See, e.g.*, *Zamora-Quezada v. HealthTexas Med. Grp. of San Antonio*, 34 F.Supp.2d 433, 440 (W.D. Tex. 1998) (health maintenance organizations ("HMOs") received Medicare funds, "making all their operations subject to section 504" (citing 29 U.S.C. §794(b)(3)(A)(i))); *Dorer v. Quest Diagnostics Inc.*, 20 F.Supp.2d 898, 900 (D. Md. 1998) (laboratory that received Medicare and Medicaid payments subject to Section 504); *cf.*

Bernard B., et al. v. Blue Cross & Blue Shield of Greater N.Y., 528 F.Supp. 125, 132 (S.D.N.Y. 1981), *aff'd*, 679 F.2d 7 (2d Cir. 1982) (health insurer subject to Section 504 if Medicare funds considered federal financial assistance).[18]

The common-sense conclusion that health insurance is part of "the business of providing health care" is confirmed by the text, structure, and purpose of the ACA, which reflect Congress's understanding that insurance is essential to the provision of healthcare. Other parts of the ACA define "health care" or "medical care" as including "insurance." *See, e.g.*, 42 U.S.C. §18113(b) (defining "the term 'health care entity' [to] include[ ] . . . a health insurance plan"); 42 U.S.C. §300gg-91(a)(2)(C) (including "amounts paid for insurance" in the definition of the term "medical care"). These ACA provisions reflect an understanding that health insurance is part and parcel of access to healthcare in the United States, making health coverage straightforwardly "the business of providing health care." BCBSIL's hair-splitting attempt to distinguish between the business of providing healthcare directly to patients and providing "only a means to pay health care providers," AOB 51, entirely ignores the practical reality of over 300 million people in the United States (more than 92% of the country) who rely on private health coverage to access healthcare.[19]

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[18] The CRRA's legislative history makes clear that its list of private entities for which all operations are covered, including those providing "health care," was not designed to limit the types of entities covered by nondiscrimination statutes, but rather included to ensure that if a private "corporation provides a public service, such as social services, education, or housing, the entire corporation is covered." S. Rep. 100-64 at 4 (1987).

[19] *Health Insurance Coverage*, *supra* note 4, at 2 Tbl. 1.

To contend that the "issuance of health insurance" is not the "provision of health care," BCBSIL relies solely on definitions in *unrelated* statutes. *See* AOB at 51-52 (citing 5 U.S.C. §5371(a) (concerning federal employees in the healthcare sector, defining "health care" only "[f]or the purposes of this section," and including not only "direct patient-care services" but also "services incident to direct patient-care services"); 45 C.F.R., Subchapter C (addressing administrative data standards in the Social Security Act)). But "[t]he same or similar words may have different meanings when used in different statutes motivated by different legislative purposes." *Singh v. Ashcroft*, 386 F.3d 1228, 1233 n.8 (9th Cir. 2004). Transposing a smattering of external definitions into the ACA's nondiscrimination provision makes no sense.

Finally, the irrationality of BCBSIL's interpretation of "health program or activity" is amplified by comparison to the 2024 Rule, which defines "health program or activity" to mean "[a]ny project, enterprise, venture, or undertaking to: (i) *Provide or administer* health-related services, *health insurance coverage*, or other health-related coverage," among other types of health-related services, and further includes "[a]ll of the operations of any entity principally engaged in the provision or administration of any health projects, enterprises, ventures, or undertakings … including, but not limited to, a … health insurance issuer." 89 Fed. Reg. at 37,694 (to be codified at 45 C.F.R §92.4). This expansive definition gives effect to Congress's broad language and intent in enacting Section 1557.

C. Section 1557's Application to Health Coverage Activities Extends to TPAs of Self-Funded Plans.

BCBSIL has pointed to no statutory language in Section 1557 or the ACA that would limit the breadth of "any" to exclude its TPA activities from "health programs or activities," nor could it. "Nothing in Section 1557, explicitly or implicitly, suggests that TPAs are exempt from the statute's nondiscrimination requirements." *Tovar v. Essentia Health*, 342 F.Supp.3d 947, 956 (D. Minn. 2018).

Not only is there no textual basis for BCBSIL's proposal, excluding TPAs from Section 1557's coverage would severely frustrate Congress's intent to eradicate discrimination in health coverage generally. By and large, private health coverage plans are either "fully insured" or "self-funded." A fully insured health plan is issued and underwritten by an insurance company, which receives premiums and pays covered medical claims. *See* ERIC Br. 3. With self-funded health plans, the employer ultimately pays for all covered medical claims from its own funds, but typically contracts with a TPA (or "claims administrator")—often a health insurance company—to administer the plan. *Id.* at 3-4. Of the nearly 180 million people in the United States covered by employer-sponsored health plans,[20] approximately *sixty-five percent* are enrolled in self-funded plans, like the plans BCBSIL administers here.[21]

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[20] *Health Insurance Coverage*, *supra* note 4, at 2 Tbl. 1.

[21] *Employer Health Benefits*, *supra* note 5, at 156. The total percentage of individuals on self-funded employer-sponsored health benefit plans may be greater; this statistic includes only "workers," not their dependents.

BCBSIL and its Amici try to characterize the role of TPAs as purely ministerial, merely providing payments for healthcare, *see, e.g.*, AOB 7-8, but in reality TPAs often play a gatekeeping role to benefits in self-funded plans, just as insurance issuers do in fully insured plans. TPA services may include managing member enrollment, processing claims, making benefit eligibility determinations, and managing provider networks. ERIC Br. 4. Additionally, TPAs often design the self-funded coverage products that they administer. *See id.* at 6 ("To assist an employer plan sponsor when setting up their self-funded plan, a TPA or other plan service provider may, as a specific service or merely as a matter of convenience, offer the employer various templates to help inform them about the plan design process."). This means that the TPA will often provide the employer an off-the-shelf plan, from which the employer then might choose to deviate, but only with help from—and approval by—the TPA.[22]

Based on these realities of the healthcare payer system, immunizing TPAs from liability for their own discriminatory conduct would eviscerate Section 1557's promise for the vast majority of individuals with private health coverage. Congress could not have intended such a result.

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[22] *See* 2024 Rule, 89 Fed. Reg. at 37,626 & n.279 ("[T]hird party administrators often design the plans that they offer to self-insured group health plans and offer standard plan design options"); *see also, e.g.*, Blue Cross Blue Shield of N.D., Self-Funding, Alternative Financial Arrangements for Group Benefit Plans 1 (2019), https://www.bcbsnd.com/content/dam/bcbsnd/documents/brochures/employers/29300143_BND-Self-Funding-Brochure.pdf ("Groups with 26 or more employees enrolled have a choice of several standard design plan options available. There is additional flexibility for custom designed benefit plans for groups with more than 50 employees enrolled.").

II. Section 1557's Applicability to TPAs Does Not Conflict with ERISA and Indeed Aligns with the Nondiscrimination Obligations of Employer Plan Sponsors.

BCBSIL and its Amici also argue that even if federally funded health insurers are generally subject to Section 1557, their discriminatory activities as TPAs of self-funded plans should still be exempt from Section 1557 so long as they act in accordance with the plans' terms. AOB 28-47; ERIC Br. 3-11. Essentially, BCBSIL and its Amici argue that ERISA *requires* them to administer discriminatory plan terms and precludes a construction of Section 1557 that would hold them liable for doing so. These arguments both misconstrue the scope of ERISA and ignore the reality of TPAs' role in designing and administering health benefits plans.

A. ERISA Does Not Require TPAs to Draft or Agree to Administer Discriminatory Plan Terms.

Although BCBSIL and its Amici try to portray TPAs as mere "conduits" that perform only "ministerial" duties, that grossly distorts reality. In practice, as discussed *supra*, TPAs often play a central role in designing and drafting the very terms of the plan that the sponsor adopts and then contracts with the TPA to administer. *Cf. Tovar v. Essentia Health*, 857 F.3d 771, 778 (8th Cir. 2017) (where a TPA designs discriminatory plan terms that an employer then adopts, the plaintiff's injuries can be traceable to, and redressable through a damage award against, the TPA).

Nothing in ERISA requires a TPA to draft discriminatory plan language at a plan sponsor's request, or help a sponsor transform its discriminatory policy

preferences into "technical language." *See* AOB 41. Section 1557's prohibition on discriminatory drafting therefore does not conflict with ERISA.[23] *See Tovar*, 342 F.Supp.3d at 954 (plaintiff stated claim that TPA violated Section 1557, even if the plan sponsor controlled the plan terms, because ERISA "carves out room for TPAs to comply with other federal laws"). This analysis reflects the case law in analogous discrimination contexts: under Title VII, for example, this court has "long held that a customer's discriminatory preference does not justify an employer's discriminatory practice." *Tamosaitis v. URS Inc.*, 781 F.3d 468, 482 (9th Cir. 2015). Section 1557 likewise prohibits covered entities, including TPAs, from drafting discriminatory plan terms, regardless of whether the plan sponsor requests that feature. There is no conflict between Section 1557 and ERISA.

[23] The preamble to the 2024 Rule, although not binding, persuasively explains that drafting discriminatory plan terms is prohibited under Section 1557:

> Where a covered third party administrator plays a role in designing benefits for self-insured group health plan coverage, it must not do so in a manner that results in discrimination on a prohibited basis. This is so even if the plan sponsor requests that the covered third party administrator develop a certain plan design that includes a discriminatory feature. For example, if a plan sponsor requested that a covered third party administrator develop a plan design that excluded all enrollees of a certain race, there would be no question that a third party administrator could not design such a plan without violating section 1557. … [W]hile the plan sponsor may be the entity requesting the particular design feature[,] the covered third party administrator would still be liable as the entity that designed such a plan, notwithstanding the plan sponsor's request.

89 Fed. Reg. at 37,627.

Of course, BCBSIL's argument that it is bound by ERISA to administer discriminatory terms is based on the existence of a contract between it (as a TPA) and the sponsor's plan. But nothing in ERISA requires that a TPA agree to administer any particular plan, let alone one with discriminatory terms. Section 1557, however, prohibits such an agreement if the entity offering TPA services accepts federal funds.

In any event, ERISA expressly provides that "[n]othing in this subchapter shall be construed to alter, amend, modify, invalidate, *impair, or supersede* any law of the United States …." 29 U.S.C. §1144(d) (emphasis added). As TPAs fall within the scope of Section 1557's prohibition on discrimination, *see supra* Part I, allowing TPAs to discriminate in administration of claims under ERISA would *supersede* Section 1557 and *impair* Congress's intent in passing it. Accordingly, as multiple courts have held, ERISA does not immunize TPAs for their own discriminatory acts in agreeing to administer a discriminatory plan. *See, e.g.*, *Scott v. St. Louis Univ. Hosp.*, 600 F.Supp.3d 956, 960 (E.D. Mo. 2022); *Tovar*, 342 F.Supp.3d at 954 ("The Court will not construe ERISA to impair Section 1557.").

B. Applying Section 1557 to TPAs Aligns Their Nondiscrimination Obligations with Those of Plan Sponsors.

BCBSIL's Amici argue that imposing Section 1557 liability on TPAs will create massive disruption in the health insurance market by upsetting settled expectations of employer plan sponsors, workers (particularly those in collective bargaining units), and TPAs. *See* ERIC Br. 11-27. According to BCBSIL's Amici, "[e]mployer plan sponsors contract with TPAs for the explicit purpose of having

their self-funded plans administered as the employers designed them … within their own established cost containment parameters." *Id.* at 13-14. The implication is that prohibiting TPAs from administering discriminatory plans will prevent plan sponsors from finding anyone to administer those plans and will thereby force them to provide health benefits on a nondiscriminatory basis.

But employers are not permitted to discriminate in the health coverage they provide their employees. Of course, employers that are covered entities under Section 1557 may not include discriminatory terms. And Title VII also makes it unlawful for an employer "to discriminate against any individual with respect to his [or her] compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin." 42 U.S.C. §2000e-2(a)(1). "[H]ealth insurance is squarely a benefit within Title VII," and Title VII thus prohibits employers from discriminating against their employees on any protected ground in their provision of health benefits. *Lange v. Houston County*, 101 F.4th 793, 800 (11th Cir. 2024) (holding employer liable under Title VII for denying transgender employee coverage for gender-affirming care). And, as the Eleventh Circuit recently explained, "costs savings do not excuse discrimination, nor may they be used to circumvent liability under Title VII." *Id*. Far from creating conflict with an employer's freedoms, imposing Section 1557 liability on TPAs aligns with the existing obligations of employers to provide health coverage on a nondiscriminatory basis.

III. Excluding Health Coverage Issuers and Administrators Would Eviscerate Section 1557, Leaving Millions Vulnerable to Discrimination.

BCBSIL and its Amici urge this Court to exclude from Section 1557's scope either nearly all operations of health insurers or at minimum their TPA activities. Either result would have devastating consequences for millions of people, leaving them largely without recourse for any discrimination they face in their health coverage and threatening a return to a pre-ACA landscape of rampant discrimination in health insurance.

BCBSIL blithely ignores this inevitable outcome, asserting that victims of discriminatory health plans should instead sue the plan sponsor. But suing a plan sponsor would be both legally and practically difficult, if not impossible, for a large proportion of the affected plan participants. First, Section 1557 reaches employment discrimination only if the employer is a covered entity—*i.e.*, a federally funded health program or activity. 42 U.S.C. §18116(a). Because most employers are neither health programs nor recipients of federal funding, they are not subject to Section 1557. Notably, the only cases BCBSIL cites "in which plaintiffs sued the plan sponsors" involved sponsors that were healthcare providers or public entities. *See T.S.*, 43 F.4th at 739 (healthcare provider's self-funded plan); *Kadel v. Folwell*, 620 F.Supp.3d 339, 388 (M.D.N.C. 2022) (state healthcare plan); *Hammons v. Univ. of Md. Med. Sys. Corp.*, 649 F.Supp.3d 104, 111-17 (D. Md. 2023), *appeal filed*, No. 23-1452 (4th Cir. Apr. 26, 2023) (no plan sponsor; suit against hospital). Most members of employer-sponsored plans are not in that position.

Nor do other nondiscrimination laws fill the gap created by BCBSIL's untenable construction of Section 1557. Although, as discussed above, employees may sue their own employer under Title VII for providing discriminatory health benefits based on their *own* protected characteristics, many people receive coverage through their spouse or parent's employer, not their own. Courts have rejected claims under Title VII brought by employees based on the protected characteristics of their dependents, holding that the "plain text of Title VII … requir[es] an employee … to have suffered discrimination on the basis of *her own* protected characteristic." *Tovar*, 857 F.3d at 776 (emphasis added); *see also Scott*, 600 F.Supp.3d at 962-63, 965. And dependent plan beneficiaries, who are not "employees" of the plan sponsor, may lack statutory standing to sue under Title VII themselves. *See Tovar*, 857 F.3d at 775-77. Moreover, because Title VII applies only to employment discrimination, it provides no protection for individuals enrolled in student health plans or plans sponsored by other non-employer entities. 42 U.S.C. §2000e-2(a).

Even where an employee has a viable Title VII or state law claim,[24] the substantial risks associated with suing one's employer prevent many from being able to vindicate their rights as a practical matter. Although retaliation against an

[24] An additional limitation is that Title VII excludes employers with fewer than fifteen employees, *see* 42 U.S.C. §2000e(b), and many states do not protect all employees from discrimination under state law. *See* Movement Advancement Project, Employment Nondiscrimination, https://www.lgbtmap.org/equality-maps/employment_non_discrimination_laws (last visited May 23, 2024) (16 states lack explicit prohibitions on discrimination based on sexual orientation or gender identity).

employee for exercising their rights is generally prohibited, that does not eliminate the very real fear—and the very real possibility—that an employer will unlawfully retaliate. Indeed, fear of retaliation is the primary reason so few employees report unlawful harassment and discrimination in the workplace.[25] Retaliatory termination can have devastating consequences, leading not only to economic hardship and additional emotional distress, but also the loss of employer-sponsored health coverage altogether. These risks are heightened for LGBTQ+ people, who disproportionately face employment discrimination, job instability, and unemployment—with even greater risks for LGBTQ+ individuals of color.[26]

Moreover, for employees whose employers do not know that they are transgender, pregnant, HIV-positive, disabled, or dealing with any number of other health statuses, being forced to sue their employers can entail exposure and the likelihood of an employer getting discovery as to "the private medical information of a current employee." *Roberts v. Clark Cnty. Sch. Dist.,* 312 F.R.D. 594, 600 (D. Nev. 2016) (discussing concerns of a transgender employee). Such disclosure of

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[25] Lily Zheng, *Do Your Employees Feel Safe Reporting Abuse and Discrimination?*, Harv. Bus. Rev. (Oct. 8, 2020), https://hbr.org/2020/10/do-your-employees-feel-safe-reporting-abuse-and-discrimination.

[26] *See, e.g.*, National Center for Transgender Equality, The Report of the 2015 U.S. Transgender Survey 10 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Executive-Summary-Dec17.pdf ("The unemployment rate among [transgender] respondents (15%) was three times higher than the unemployment rate in the U.S. population (5%), with Middle Eastern, American Indian, multiracial, Latino/a, and Black respondents experiencing higher rates … One in six (16%) respondents who have ever been employed—or 13% of all respondents in the sample—reported losing a job because of their gender identity or expression in their lifetime.").

personal medical and health information not only is a serious incursion on an employee's privacy, but also exposes the employee to additional risk of further discrimination at work.

Finally, ERISA does not supply the desired relief from employers or the plans themselves. An ERISA claim for benefits pursuant to 29 U.S.C. §1132(a)(1)(B) only entitles a plan participant to "recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." Of course, recovering benefits due under plan terms is of no help where the problem is that the plan terms themselves unlawfully exclude those benefits. *See Scott*, 600 F.Supp.3d at 960 (explaining that plaintiff brought Section 1557 claim rather than ERISA claim because "the Plan expressly excludes coverage for sex transition and she has no rights to enforce under the Plan"). Nor is 29 U.S.C. §1132(a)(3) helpful, as this provision only permits equitable relief to enforce or redress violations of ERISA or of the plan itself, and ERISA does not independently prohibit discrimination in health plan terms.

In sum, not all plan members and beneficiaries have an alternative right of action against the plan sponsor, and for those who do, the risks inherent in suing one's employer are significantly greater than in suing their health plan's issuer or TPA. Excluding health insurers and TPAs from Section 1557's coverage would thus eviscerate nondiscrimination protections for millions of people who receive their health coverage from employers. Relying on the possibility that individuals can vindicate "alternative" rights against a plan sponsor, an approach not available

to all and involving great personal and professional risks, would undermine the entire purpose of the ACA, re-enabling plan sponsors and health insurance companies alike to discriminate with impunity. Such a regressive result is clearly not what Congress intended in passing the ACA and Section 1557.

CONCLUSION

For the foregoing reasons, the decision below should be affirmed.

Dated: June 20, 2024

Respectfully submitted,

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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9th Cir. Case Number(s) 23-04331

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CERTIFICATE OF SERVICE

I hereby certify that on June 20, 2024, I electronically filed the foregoing with the Clerk of Court of the United States Court of Appeals for the Ninth Circuit using the Appellate Case Management System ("ACMS"). I certify that all participants in the case are registered ACMS users and that service will be accomplished by the ACMS system.

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s/ Barbara J. Chisholm
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