No. 20-1374

In the
Supreme Court of the United States

CVS PHARMACY, INC.; CAREMARK, L.L.C.; CAREMARK CALIFORNIA SPECIALTY PHARMACY, L.L.C.,
Petitioners,

v.

JOHN DOE, ONE, ET AL., ON BEHALF OF THEMSELVES AND ALL OTHERS SIMILARLY SITUATED,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF NATIONAL HEALTH LAW PROGRAM AND DISABILITY RIGHTS CALIFORNIA, IN SUPPORT OF RESPONDENTS AND SUGGESTING AFFIRMANCE

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

REGULATIONS

OTHER AUTHORITIES

INTEREST OF THE AMICI[1]

The *amici curiae* are the National Health Law Program (NHeLP) and Disability Rights California. NHeLP is a public interest law firm working to advance access to quality health care and protect the legal rights of lower-income people and people with disabilities. NHeLP engages in education, policy analysis, administrative advocacy, and litigation at the state and federal levels. Throughout its more than 50-year history, NHeLP has fought to address discrimination in health care based on disability, gender, race, national origin, age, and other protected classes. Disability Rights California (DRC) is the Protection and Advocacy agency mandated under state and federal law to advance the legal rights of Californians with disabilities. DRC was established in 1978 and is the largest disability rights legal advocacy in the nation. Disability Rights California works to ensure a barrier-free, inclusive, diverse world that values each individual, their voice, and their right to equal opportunity.

While each *Amicus* has particular interests, they collectively bring to the Court an in-depth understanding of how the Patient Protection and Affordable Care Act (ACA) changed the landscape of health care discrimination, including the introduction of Section 1557 as an enforcement mechanism of the ACA's protections.

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[1] *Amici* counsel have obtained consent from both parties for the filing of this brief. No party's counsel authored this brief in whole or in part. No person, other than *amici* and *amici*'s counsel, contributed money to fund preparation or submission of this brief.

SUMMARY OF ARGUMENT

Prior to the enactment of the ACA, discrimination in health insurance was business as usual. Women and older adults typically faced higher premiums and cost-sharing, limited access to services, and were more frequently denied enrollment compared to other groups. Individuals with disabilities and chronic health conditions were commonly denied health insurance coverage, faced annual and lifetime benefit limits, and could not find affordable coverage. Even if such individuals could find coverage, it would often exclude pre-existing conditions or otherwise limit benefits. Many of these discriminatory practices were challenged in court, but plaintiffs generally found success in only narrow circumstances, leaving many discriminatory practices embedded in health insurance.

Congress significantly changed health insurance coverage when it enacted the ACA and included within it provisions to outlaw discriminatory insurance practices. Section 1557 of the ACA is an important component of the law's coverage protections and compliance mechanisms. While referring to the remedies of major pre-existing civil rights statutes, Section 1557 does not incorporate them. Rather, it creates a new prohibition on discrimination in most health programs, including many private insurance plans. Section 1557 prohibits discrimination by health care entities receiving federal financial assistance based on race, color, national origin, sex, age, and disability, and it creates a private right of action for individuals to complain of discrimination.

The changes the ACA made to industry practices and its inclusion of new health care specific anti-discrimination provisions in Section 1557 mean that case law applying the previously existing civil rights laws is not necessarily instructive when determining the scope of protections and remedies post-ACA. Courts asked to address such claims, including ones of disparate impact, must follow this shift by applying the language of the ACA and agency interpretation of it, and cannot simply import precedents interpreting pre-existing non-discrimination statutes.

ARGUMENT

I. CONGRESS CRAFTED THE ACA TO CURB OR ELIMINATE PREVIOUSLY ALLOWED DISCRIMINATORY PRACTICES BY INSURERS.

The ACA changed the private insurance industry by, among other things, prohibiting many of the issuance, renewal, and plan design practices insurers used to avoid costs, many of which may have been facially neutral but had a disparate impact on certain population groups. Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148 (2010), as amended in the Health Care and Education Reconciliation Act, Pub. L. No. 111-152 (2010).

The ACA ushered in significant protections for individuals in several different areas, including enrollment, cost-sharing, premium rates, and benefit design. The Act's requirements for preventive services and "essential health benefits" (EHBs) within health plans helped address longstanding discriminatory

practices. Many of the provisions explicitly targeted discrimination in their title. *See, e.g.,* 42 U.S.C. §§ 300gg-3 ("Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status"); 300gg(a) ("Prohibiting Discriminatory Premium Rates"); 300gg-4 ("Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status"); 18116 ("Nondiscrimination"). The ACA also shifted regulation of health insurance coverage from largely state-based insurance law to include greater federal oversight. *See* Sara Rosenbaum et al., *Crossing the Rubicon: The Impact of the Affordable Care Act on the Content of Insurance Coverage for Persons with Disabilities,* 25 Notre Dame J. L. Ethics & Pub. Pol'y 235 (2014).

The ACA did not, however, require that all health insurance plans cover all treatments for all people. Rather, it created comprehensive, affordable coverage that does not deny or limit services on an arbitrary or discriminatory basis. *See* 42 U.S.C. § 300gg-6 (describing comprehensive coverage). The ACA also did not eliminate all mechanisms by which health insurance plans can limit the benefits offered or deny coverage of requested services. While insurers cannot base premium rates on health status, disability, or other factors, they can vary premium rates on coverage of an individual or family, rating area, age (with limitations), and tobacco use. *Id.* § 300gg. Plans may also use clinically indicated, reasonable medical management techniques when approving or denying services, such as requiring prior authorization or step therapy. *See* 45 C.F.R. § 156.125; *see also* ACA; HHS Notice of Benefit and Payment Parameters for 2016

Final Rule, 80 Fed. Reg. 10,750 (Feb. 27, 2015), https://www.govinfo.gov/content/pkg/FR-2015-02-27/pdf/2015-03751.pdf [hereinafter "2016 NBPP Rule"]. Insurers may also shift costs back to the insured through uniform copays and deductibles, subject to limitations to ensure affordability. *See* 42 U.S.C. §§ 18022(c); 300gg-6 (limiting cost-sharing and setting annual out-of-pocket limits); *see generally, e.g.,* Valarie K. Blake, *An Opening for Civil Rights in Health Insurance After the Affordable Care Act*, 36 B.C. J. L. & Soc. Just. 235, 256 (2016) (discussing penalty for violating cost-sharing requirements). Group and individual insurers may also vary premiums based on participation in employer wellness programs, although those programs also may not discriminate. 42 U.S.C. §§ 300gg-4; 300gg-4(j) (regarding wellness programs); § 300gg-18 (regarding rate setting). The Act also sets up a rating system for health insurance plans offered on the ACA marketplaces, dividing plans into bronze, silver, gold, and platinum. *Id.* §§ 18022(a); 18022(d). While plans are allowed to use these practices to limit costs, they can no longer deliberately, or simply through a failure to change their historical practices, discriminate in their use. *See, e.g., id.* §§ 18022; 18116(a); 300gg-4.

Before the ACA, the business model of health insurance incentivized insurers to avoid covering individuals who would have high health care needs or who would otherwise be costly to the plans. Insurers had an array of mechanisms at their disposal to deny enrollment, limit benefits, and impose high costs on the insured. Plans could impose condition-specific coverage exclusions, design their benefits to discourage people

with high needs from enrolling, or deny needed care once they were enrolled. Insurers could base premium rates on various factors, including gender and whether the individual had pre-existing conditions. *See generally, e.g.,* Blake, *supra* (describing pre-ACA health insurance discrimination and the ACA changes that addressed those issues); Rosenbaum, *Crossing the Rubicon*, *supra* (describing ACA nondiscrimination provisions generally and the function of essential health benefits).

II. THE ACA PROHIBITS MANY HEALTH INSURANCE PRACTICES THAT COURTS HAD PREVIOUSLY REFUSED TO ENJOIN.

A. The ACA reset disability discrimination in health care.

Many of the ACA's non-discrimination protections target insurance practices that had previously been unsuccessfully challenged in court as disability discrimination. For example, pre-ACA, insurers commonly imposed caps on the amount of a service for a particular condition (e.g., limits on numbers of visits) or general caps on lifetime benefits (e.g., a $25,000 annual or lifetime limit on coverage for AIDS-related conditions). These practices were challenged under Section 504 of the Rehabilitation Act. 29 U.S.C. § 794. However, courts repeatedly ruled against such plaintiffs, focusing on access to an insurance policy rather than the coverage content within the policy, and holding that regulation of insurance was the purview of state insurance commissions. *See, e.g., McNeil v. Time Ins. Co.*, 205 F.3d 179, 182 (5th Cir. 2000) ($10,000 limit on coverage for AIDS-related care was

not disability discrimination); *Doe v. Mut. of Omaha Ins. Co.* 179 F.3d 557, 588 (7th Cir. 1999) (policies with lifetime limits did not discriminate based on disability and regulating insurance was the purview of the state insurance commissioner); *Modderno v. King*, 82 F.3d 1059, 1062 (D.C. Cir. 1996) (permitting $75,000 lifetime cap on mental health benefits even though there was no comparable limit on physical health benefits); *McGann v. H&H Music Co.*, 946 F.2d 401 (5th Cir. 1991) (permitting a lifetime limit on benefits).

The Americans with Disabilities Act ("ADA") was also an ineffective tool for individuals with disabilities, largely because of the ADA's "safe harbor" provision. *See* 42 U.S.C. § 12201(c). This provision says the ADA "shall not be construed to prohibit or restrict" insurers and others from establishing or administering benefit plans that "are based on underwriting risks, classifying risk, or administering risks that are based on or not inconsistent with State law." *Id*. Although the statute goes on to say that the safe harbor provision "shall not be used as subterfuge to evade the purposes of [the ADA]," many of the cases relying upon the ADA to challenge discriminatory health insurance decisions did not even reach the subterfuge question because, at the outset, they rejected claims based on the access and content distinction. *Id.*; *see* Samuel R. Bagenstos, *The Future of Disability Law,* 114 Yale L. J. 1, 41 (2004)*; see, e.g., Doe v. Mutual of Omaha, Ins.,* 179 F.3d at 557. *Compare Leonard F. v. Israel Discount Bank of N.Y.,* 199 F.3d 99 (2d Cir. 1999) (benefit plan created before the ADA was not subterfuge as subterfuge requires intent), *with Doukas v. Metropolitan Life Ins. Co.,* 950 F. Supp. 422 (D.N.H. 1996) (underwriting practices,

whether used with conscious discriminatory intent or not, that were in use before the ADA can be subterfuge to evade the ADA's purposes).

Other challenges to limits and exclusions in health insurance based on disability discrimination commonly faltered at the holding in *Alexander v. Choate*. 469 U.S. 287 (1985). After *Choate,* plaintiffs challenging disability discrimination in health insurance using Section 504 were generally successful if they could show that they were denied access to the benefit—such as being denied enrollment. By contrast, even though *Choate* did not preclude claims based on content of a benefit, challenges to the content or adequacy of the benefit often failed. *See, e.g., Rome v. MTA/N.Y. City Transit,* No. 97-CV-2945 (JG), 1997 WL 1048908, at *4 (E.D.N.Y. Nov. 18, 1997) (speech therapy not covered for autism but for other conditions); *see also* Bagenstos, *supra,* at 41 nn.168-70 (listing cases that, citing *Choate*, refused to analyze whether coverage that excluded benefits based on diagnosis/treatment was discriminatory). Thus *Choate* and other decisions incentivized insurers to find ways, such as through plan design, costs, or limits, to deter people from enrolling in their plan. Blake, *supra,* at 240-42.

The ACA does not merely protect individuals from industry practices that prevent them from gaining access to affordable health insurance. It also includes multiple provisions to prevent discrimination in the content of plans, benefit design, and scope of coverage. As noted above, under the ACA, plans are now required to provide comprehensive health insurance coverage that includes "essential health benefits" ("EHBs"). 42

U.S.C. § 300gg-6. The statute requires coverage of services that come within ten general EHBs as defined by the Secretary of Health and Human Services ("HHS"). *Id*. at § 18022(a)-(b) (also authorizing HHS to add EHBs). According to the statute, "[T]he Secretary shall . . . not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability or expected length of life[.]" *Id*. at § 18022(b)(4)(B). The EHB design must also take into account health needs of a diverse population, including those with disabilities. *Id*. § 18022(b)(4)(C)-(D). Insurers cannot comply with EHB requirements if their coverage discriminates. *Id*. § 18022(4). The EHB framework is designed to ensure not only that people have access to an affordable health plan but also that they have access to a broad array of necessary services within those plans.

B. The ACA protections for women and older adults prohibit previously permitted discriminatory practices.

The ACA explicitly prohibits previously well-accepted insurance practices that had discriminated against classes of individuals. Before the ACA, use of gender ratings by 92 percent of the best-selling plans on the individual market annually cost women approximately $1 billion more than they would if they were men. *See* Nat'l Women's Law Ctr., *Case Against the ACA Threatens to Devastate Women's Health and Economic Security* 1 (May 2021), https://nwlc.org/wp-content/uploads/2020/11/ACA-2020-11-09-1.pdf [hereinafter NWLC ACA Factsheet]. The ACA's list of

allowable factors for setting premium rates does not include gender. *See* 42 U.S.C. § 300gg(a)(1)(A). Plans prior to the ACA would also deny enrollment because of prior cesarean delivery, prior pregnancy, or receiving treatment for domestic or sexual violence. NWLC ACA Factsheet, *supra*, at 1. The prohibitions against the use of pre-existing conditions to deny enrollment or coverage prevents plans from such enrollment and service denials. 42 U.S.C. § 300gg-4. Other provisions, such as coverage of essential health benefits and preventive services without out-of-pocket expenses, ameliorated existing difference between men and women accessing needed care. NWLC ACA Factsheet, supra.

The ACA also addressed age-related discrimination. Many adults aged 50-64 who did not have coverage through an employer had difficulty obtaining health coverage prior to the ACA. If an insurer was willing to offer individual coverage to someone in this group, the rates charged were very high based on age or pre-existing conditions, often making the coverage unaffordable. *See* Jane Sung, AARP, *Protecting Affordable Health Insurance for Older Adults: The Affordable Care Act's Limit on Age Rating* 1 (Jan. 2017), https://www.aarp.org/content/dam/aarp/ppi/2017-01/Protecting-Affordable-Health-Insurance-for-Older.pdf. Average out-of-pocket premium and health care costs for this coverage were two and half times higher than for employer coverage. *Id.* at 2. The ACA limited to the extent to which age can be factored into premiums. 42 U.S.C. §§ 300gg(a)(1)(A) (limiting age rating to 3:1, meaning that adults 50-64 cannot be charged more than three times the amount a younger

adult is charged for the same coverage); 300gg-3; 300gg-4. Such changes, along with the Act's pre-existing conditions protections, have a significant impact on availability of coverage and cost. *See* NWLC ACA Factsheet, *supra,* at 1-2; AARP, Protecting Health Insurance for Older Adults, *supra*, at 1-3.

In summary, before the ACA, insurers were allowed to engage in many practices that were discriminatory, yet had not been found to be illegal. The ACA purposefully created standards for health insurance that address both access and content, establish a basic structure for comprehensive health coverage through the broad categories of EHBs, and prohibit marketing practices and benefit designs that would discourage enrollment based on health needs.

III. THE ACA'S COMPLIANCE SCHEME RECOGNIZES THE SEISMIC INDUSTRY SHIFT AND THE NEED FOR LAYERED ENFORCEMENT BY GOVERNMENT REGULATORS AND PRIVATE ENFORCEMENT.

The ACA made a significant shift in what health insurance coverage means in the United States—no more could people be denied coverage for pre-existing conditions, denied services because they had reached an annual or lifetime limit, or denied preventive services. *See supra* Section I. The Act also introduced multiple layers of compliance that span from state and federal enforcement to individual enforcement rights.

A. Enforcement by government regulators.

Government regulators have ACA compliance roles in certification and enforcement. For example, before Qualified Health Plans (QHPs) may be sold on the ACA's marketplaces, they must undergo a review and certification process conducted by states or HHS. *See generally* Ctrs. for Medicare & Medicaid Servs., State Exchange Models, Qualified Health Plan Certification, https://www.qhpcertification.cms.gov/s/QHP. States and HHS also share compliance responsibilities related to EHB standards, with HHS issuing annual guidance letters regarding plan requirements. Ctrs. for Medicare & Medicaid Servs, Ctr. for Consumer Info. & Ins. Oversight, Final 2016 Letter to Issuers in the Federally-Facilitated Marketplace 37-38 (Feb. 20, 2015), https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/184740_2016_Letter_to_Issuers_2_20_2015_R.pdf. [hereinafter "2016 Letter to Issuers"]. Other nondiscrimination protections, such as guaranteed issue, rate review, the ban on annual and lifetime caps for certain benefits, and cost sharing protections, are largely monitored by states.

HHS has also issued regulations and sub-regulatory guidance to identify practices that the ACA prohibits. *See, e.g.,* 2016 NBPP Rule, 80 Fed. Reg. at 10,822 (regulating past practices such as the overuse of utilization management, discriminatory plan design, and high cost-sharing); Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Info. & Ins. Oversight, Final 2017 Letter to Issuers in the Federally-facilitated Marketplace 48 (Feb. 29, 2016),

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf [hereinafter "2017 Letter to Issuers"] (listing medical conditions HHS would use to evaluate for discriminatory plan design).[2]

HHS uses a combination of standards, examples, and methodologies to identify discriminatory plan practices. In one example, HHS describes how benefits can be provided in a discriminatory manner, for instance, through mail-order only pharmacy, stating "making drugs available only by mail order could discourage enrollment by, and thus discriminate against, transient individuals and individuals who have conditions that they wish to keep confidential." 2016 NBPP Rule, 80 Fed. Reg. at 10821. Three of HHS's methodologies are particularly relevant for this case: (1) Discriminatory Intent Analysis; (2) Outlier Analysis; and (3) Standard of Care Analysis.

Discriminatory intent analysis. Although plans are not required to cover any particular treatment, an exclusion must be based on nondiscriminatory evidence. HHS, Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,375, 31,433-34 (May 18,

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[2] Letters to Issuers are issued annually and incorporate prior years by reference except where changes are indicated. The guidance applies to plans sold through the federally facilitated marketplaces and state-based marketplaces using the federal platform, but HHS encourages state-based marketplaces follow the guidance for plan review and other functions. *See* Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight (CCIIO) resources website, https://www.cms.gov/CCIIO/Resources/Letters/index.html.

2016) https://www.govinfo.gov/content/pkg/FR-2016-05-18/pdf/2016-11458.pdf [hereinafter "2016 Section Final 1557 Rule"].[3] The analysis includes questions like: Did the entity use a neutral rule or principle? Was the reason for the coverage decision a pretext for discrimination? Is coverage for the same or a similar service/treatment available to individuals outside the protected class or those with different health conditions? *Id.* at 31,229-33.

Outlier Analysis provides a method to compare a plan's benefit content and cost-sharing structure to other plans to identify outliers. *See* 2016 Letter to Issuers, at 38-40; 2016 Section 1557 Final Rule, 81 Fed. Reg. at 31,434. For example, HHS guidance notes that outlier analysis may show a plan has placed all drugs used to treat a certain medical condition in the highest cost sharing tiers and that this is a discriminatory plan benefit design prohibited under the ACA. *See* 2016 Section 1557 Final Rule, 81 Fed. Reg. at 31,434, n. 258; 2016 NBPP Rule, 80 Fed. Reg. 10,822 (also noting outlier analysis may reveal a plan is improperly subjecting a large number of drugs within a particular category or class to prior authorization and/or step therapy).[4]

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[3] Parts of the regulation, not relevant here, are currently enjoined, with litigation ongoing. *See, e.g., Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Hum. Servs.,* 485 F. Supp. 3d 1, 64-65 (D.D.C. May 4, 2021).

[4] Subsequent research using the outlier analysis found the practice of placing drugs for HIV, MS, and cancer in the highest cost-sharing tier was widespread. See Douglas B. Jacobs & Benjamin D. Sommers, *Using Drugs to Discriminate — Adverse Selection in*

Standard of Care Analysis reviews available treatment recommended by nationally recognized clinical guidelines for four selected medical conditions to ensure plans are offering sufficient drugs to treat the conditions. 2016 Letter to Issuers, at 41; *see also* 2016 NBPP Rule, 80 Fed. Reg. at 10,822-23. In an example, HHS concluded that plans that cover some treatments for HIV, but fail to cover the single tablet therapy (which is the standard of care), are discriminatory. 2016 NBPP Rule, 80 Fed. Reg. at 10,822-23 (prohibiting plans from requiring patients to access prescription drugs through mail order-only pharmacies) (codified at 45 C.F.R. § 156.122(e)). Notably, HHS recognized that insurers may find mail order pharmacies more cost-effective, but that:

> [O]btaining prescription drugs through mail order may not be a viable option when an individual does not have a stable living environment and does not have a permanent address. In those cases, individuals may not always have the ability to keep a mail order pharmacy delivery confidential. There are also cases in which a drug needs to be provided immediately (for example, antibiotics or pain relievers) . . . [M]aking drugs available only by mail order would discourage enrollment by, and

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the Insurance Marketplace, New Eng. J. Med. 372,399-402 (Jan. 29, 2015); John V. Jacobi et al., *Health Insurer Market Behavior After the Affordable Care Act: Assessing the Need for Monitoring, Targeted Enforcement and Regulatory Reform*, 120 Penn. St. L. Rev. 109, 174 (2015) (discussing the need for continued assessment of plans and forms of discrimination).

> thus discriminate against, transient individuals and certain individuals who have conditions that they wish to keep confidential.

ACA; HHS Notice of Benefit and Payment Parameters for 2016, 79 Fed. Reg. 70,674, 70760 & 70722 (proposed Nov. 26, 2014), https://www.govinfo.gov/content/pkg/FR-2014-11-26/pdf/2014-27858.pdf; *see also* ACA; HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12,204, 12,312-13 (Mar. 8, 2016), https://www.govinfo.gov/content/pkg/FR-2016-03-08/pdf/2016-04439.pdf (declining request to retract EHB prohibition on mail order only pharmacy requirements).

B. Enforcement by individuals.

The ACA also provides that individuals may also file complaints in court.[5] Section 1557 creates a health-care-specific civil right and specifically prohibits discrimination in health care coverage. *See* 42 U.S.C. § 18116(a); *see also Rumble v. Fairview Health Servs.,* No. 14-CV-2037, 2015 WL 1197415 (D. Minn. Mar. 16,

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[5] As was the case prior to enactment of the ACA, individuals may file administrative complaints with the HHS Office for Civil Rights. *See, e.g.,* 45 C.F.R. § 92.5(b); *see also* Nat'l Health Law Program & The AIDS Inst., Re: Discriminatory Pharmacy Benefits Design in Select Qualified Health Plans Offered in Florida, Administrative Complaint filed with HHS OCR (May 28, 2014), https://healthlaw.org/resource/nhelp-and-the-aids-institute-complaint-to-hhs-re-hiv-aids-discrimination-by-fl/(identifying discrimination through the use of an outlier analysis of adverse tiering of HIV/AIDS medication into the highest cost sharing tiers by four of 36 silver-level plans sold through the Florida marketplace).

2015); *Schmitt v. Kaiser Found. Health Plan of Wash.*, 965 F.3d 945, 949 (9th Cir. 2020) (noting that section 1557 imposes "an affirmative obligation not to discriminate in the provision of health care" and recognizing claim for discriminatory benefit design). Congress can be presumed to have had knowledge of the courts' interpretations of existing anti-discrimination laws when it enacted Section 1557 and while borrowing from these laws, Congress did not incorporate them. *See Lorillard v. Pons*, 434 U.S. 575, 581 (1978). Rather, Section 1557 establishes a new standalone enforcement mechanism that prohibits discrimination that was allowed prior to the ACA, and that creates new enforcement mechanisms that reach not only intentional discrimination but also activities that have a discriminatory impact.

Section 1557 is distinct from other ACA provisions because its language focuses on protections for individuals, rather than requirements for health care entities. To begin, Section 1557 refers to four existing civil rights statutes to establish which individuals are protected:

> [A]n individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments Act of 1972 (20 U.S.C. et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity.

42 U.S.C. § 18116(a). Thus, Section 1557 prohibits discrimination on the "ground prohibited under" four statutes: race, color or national origin (the ground under title VI of the Civil Rights Act; sex (the ground under title IX of the Education Amendments of 1972; age (the ground under the Age Discrimination Act of 1975; and disability (the ground under section 504 of the Rehabilitation Act).[6] In contrast to how it established the grounds for discrimination (namely, the "grounds under" the reference statutes), Section 1557 broadly applies the enforcement mechanisms that are "provided for and available under" the referenced statutes:

> The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

42 U.S.C. § 18116(a).

The words Congress chose make it clear that individuals can avail themselves of any of the enforcement mechanisms available under the referenced statutes, not just the piecemeal application of mechanisms contained within each individually. If Section 1557 were limited by the constraints of the referenced statutes, its passage would have been largely unnecessary, as the four civil rights statutes already apply to organizations "in the business of providing . . . health care." *See, e.g.*, 29 U.S.C. §794 (Rehabilitation Act). Moreover, Section 1557 should be

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[6] Significantly, section 1557 incorporates Section 504 and not the ADA or its safe harbor provision.

read within the context and purpose of the statute as a whole. *National Federation of Independent Business v. Sebelius*, 567 U.S. 519, 547 (2012) (noting in the ACA, "Congress addressed the problem of those who cannot obtain insurance coverage because of preexisting conditions or other health issues.").

Congress also used specific terms—"provided for and available under"—when establishing Section 1557's enforcement mechanisms. The term "provided for" means "as contained in the statutes." See William C. Burton, Burton's Legal Thesaurus 44, 527 (5th ed.) (2013). Section 1557 then broadens the enforcement mechanisms to those "available under" the statutes, thus including the enforcement mechanisms available in regulations promulgated pursuant to the statutes. *See Kungys v. United States*, 485 U.S. 759, 778 (1988) (It is a "cardinal rule of statutory interpretation that no provision should be construed to be entirely redundant.") Use of the word "and" between the two elements indicates both elements must be satisfied. *See, e.g., Pueblo of Santa Ana v. Kelly*, 932 F. Supp. 1284, 1292 (D.N. Mex. 1996).

By referencing both the statutes and their regulatory frameworks, Congress established broad enforcement mechanisms, including disparate treatment and disparate impact, for Section 1557. The regulations for Title VI, for example, "extend beyond acts of intentional discrimination and reach conduct and practices that, even if facially neutral, have a disproportionate adverse impact on members of minority groups." Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare*

System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v. Sandoval, 3 Yale J. Health Pol'y L. & Ethics 215, 218 (2003) (noting that federal agencies promulgated twenty-two sets of rules implementing the Civil Rights Act); *see also* Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn't Be So Easy*, 58 Fordham L. Rev. 939, 948 (1990) (listing regulations defining discrimination to encompass both intentional and disparate impact discrimination). By expressly including enforcement mechanisms "available under" the statutes, Congress has authorized disparate impact claims to be brought under Section 1557.

Congress further distinguished Section 1557's enforcement mechanisms and the grounds of discrimination by changing the order of the referenced statutes. Congress lists the grounds of discrimination as Title VI, Title IX, Age Discrimination Act, and Section 504. In the enforcement mechanisms, it changes that order and the wording used to group the statutes: "under such title VI, title IX, section 794, or such Age Discrimination Act." 42 U.S.C. § 18116(a). Had Congress intended to attach the remedies to the grounds, Section 1557 could have simply said, "enforcement mechanisms attaching to the grounds available under the statutes listed above." Instead, Congress rearranged and grouped together the enforcement mechanisms available under three statutes—"such" title VI, title IX, and Section 794—while carving out "or such Age Discrimination Act of 1975."

This is not surprising. Unlike the other three civil rights statutes referenced in Section 1557, the Age Discrimination Act is not self-implementing and requires regulations to establish and enforce its protections. *See* 42 U.S.C. § 6102. HHS's regulations recognize this, noting for example the required mediation of all age discrimination complaints, and exhaustion of administrative remedies pursuant to 45 C.F.R. §§ 91.43, 91.50. HHS declined to require exhaustion for non-age related claims, prior to the filing of a civil lawsuit. 2016 Final Rule, 81 Fed. Reg. 31,462; Nondiscrimination in Health and Health Education Programs or Activities, 85 Fed. Reg. 37,160, 37,203 (June 19, 2020), https://www.govinfo.gov/content/pkg/FR-2020-06-19/pdf/2020-11758.pdf

Some courts have interpreted Section 1557 to apply different enforcement mechanisms and standards depending on whether someone's claim is based on race, sex, age, or disability. These cases assume that Congress meant to tether the standards and enforcement mechanisms available based on the statute that defines the grounds for discrimination. *See, e.g., Southeastern Penn. v. Gilead*, 102 F. Supp. 3d 688, 699 n.3 (E.D. Pa. 2015); *Briscoe v. Health Care Serv. Corp.*, 281 F. Supp. 3d 725, 738 (N.D. Ill. 2017); *see also, e.g., Doe v. BlueCross BlueShield of Tennessee, Inc.*, 926 F.3d 235, 241 (6th Cir. 2019). But the courts in these cases misconceive the statutory language and context. Section 1557 does not incorporate separate remedies, legal standards, and burdens of proof applicable to each prohibited basis of discrimination based on the statutes from which each was incorporated. *See* Sarah G. Steege, *Finding A Cure in*

the Courts: A Private Right of Action for Disparate Impact in Health Care, 16 Mich. J. Race & L. 439, 462 (2011) ("[T]here is no indication in § 1557 that each listed statute's enforcement mechanisms apply only to its own protected classes.").

Section 1557 recognizes that people often experience discrimination based on more than one protected category. For example, if a Black woman experiences discrimination in seeking health care, it may be impossible to separate out only one of these identities as the basis of discrimination. A majority of federal courts have correctly recognized that discrimination on the basis of a combination or the interrelationship of multiple protected characteristics is actionable under federal non-discrimination laws. These courts recognize that "where two bases of discrimination exist, the two grounds cannot be neatly reduced to distinct components" because they often "do not exist in isolation." *Shazor v. Prof'l Transit Mgmt.*, 744 F.3d 948, 957-58 (6th Cir. 2014). For example, "African American women are subjected to unique stereotypes that neither African American men nor white women must endure." *Id.*; *see also, e.g., Harris v. Maricopa County Superior Court*, 631 F.3d 963, 976 (9th Cir. 2011); *Jefferies v. Harris Co. Community Action Ass'n*, 615 F.2d 1025, 1032 (5th Cir. 1980); *Jeffers v. Thompson*, 264 F. Supp. 3d 314, 326 (D. Md. 2003). Congress did not intend that the enforcement mechanisms and standards available under Section 1557 be tied to the nature of the claim, but instead created an enforcement mechanism tailored to allow affected individuals to address the discriminatory practices the ACA was designed to ameliorate.

CONCLUSION

Congress enacted the ACA to address the failure of existing laws, including non-discrimination statutes, to ensure access to health care coverage and protect individuals from discrimination in that coverage. As part of the comprehensive reform effort, Section 1557 also guarantees that individuals will have access to health care and services that do not discriminate against them based on their race, sex, age, or disability. As courts evaluate claims of discrimination, they must consider the array of protections included in the ACA, how the Act's provisions prohibit discrimination that was previously permitted under law, and the new approaches the Act prescribes to eliminate discrimination. This Court should apply this new lens when evaluating discriminatory practices, including those that have a disparate impact.

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