No. 20-1374

In the Supreme Court of the United States

CVS PHARMACY, INC.; CAREMARK, L.L.C.; AND CAREMARK CALIFORNIA SPECIALTY PHARMACY, L.L.C.,
PETITIONERS,

v.

JOHN DOE ONE, JOHN DOE TWO, JOHN DOE THREE, JOHN DOE FOUR, AND JOHN DOE FIVE, ON BEHALF OF THEMSELVES AND ALL OTHERS SIMILARLY SITUATED,
RESPONDENTS.

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

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

Gerald S. Flanagan*
**Counsel of Record*
Daniel L. Sternberg
Benjamin R. Powell
Consumer Watchdog
6330 San Vicente Blvd.
Suite 250
Los Angeles, CA 90043
(310) 392-0522
jerry@consumerwatchdog.org

Alan M. Mansfield
Whatley Kallas LLP
16870 W. Bernardo Dr.
Suite 400
San Diego, CA 92127

Henry C. Quillen
Whatley Kallas LLP
159 Middle St., Suite 2C
Portsmouth, NH 03801

Questions Presented

Section 1557 of the Patient Protection and Affordable Care Act ("ACA") creates a private right of action for discrimination "on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d *et seq*.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 *et seq*.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 *et seq*.), or section 794 of Title 29" under "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance." 42 U.S.C. § 18116(a). The ground of discrimination prohibited by section 794 of Title 29, more commonly referred to as Section 504 of the Rehabilitation Act ("Section 504"), is discrimination on the basis of disability.

In *Alexander v. Choate*, 469 U.S. 287 (1985), this Court unanimously held that under Section 504, allegations that a defendant denied a disabled person meaningful access to a benefit would be sufficient to state a claim for disability discrimination. In the present case, the court of appeals relied on *Choate* to hold that Respondents' operative complaint stated a claim under the ACA's antidiscrimination provision because it alleges that Petitioners discriminate against people with a disability—HIV—by denying them meaningful access to medications and pharmacy services needed for the treatment of their condition.

The questions presented are:

1. Whether Respondents stated a claim for disability discrimination under the standards of

Section 504, as incorporated in Section 1557 of the ACA, by alleging a denial of meaningful access to prescription drug benefits on the basis of disability where Respondents are no longer provided the benefits that Petitioners provide to non-disabled enrollees.

2. Whether Respondents may alternatively state a claim under Section 504, as incorporated in Section 1557, in the form of a proxy discrimination claim.

3. Whether Respondents may alternatively state a claim under Section 504, as incorporated in Section 1557, in the form of a failure-to-accommodate claim.

Table of Contents

Table of Authorities

Page

Cases

Page

Cases (contd.)

Page

Cases (contd.)

Page

Cases (contd.)

Page

Cases (contd.)

Statutes and Regulations

Other Authorities

Page

Other Authorities (contd.)

INTRODUCTION

As people living with HIV, Respondents are members of a group who have historically faced unequal access to healthcare on the basis of their disability. Before the ACA, health insurers would often deny such individuals access to health insurance outright, exclude coverage of pre-existing conditions, or otherwise limit benefits on the basis of their disability.[1]

The ACA explicitly outlawed these discriminatory policies and ensured that all Americans have equal and comprehensive access to healthcare. Because people living with HIV "have suffered disproportionately from lack of healthcare access, Congress included a number of consumer protections [in the ACA] prohibiting health insurance providers from denying . . . coverage."[2] According to the Centers for Disease Control and Prevention, the ACA "is one of the most important pieces of legislation in the fight against HIV in our history."[3] To achieve equal and comprehensive access to care, the ACA contains a landmark civil rights provision, Section 1557, which prohibits discrimination on the basis of disability, age, sex, and race by any health program or activity that

---

[1] Valarie K. Blake, *An Opening for Civil Rights in Health Ins. After the Affordable Care Act*, 36 B.C. J. L. & Soc. Just. 235, 254–57 (2016).

[2] Mark Bolin, *The Affordable Care Act and People Living with HIV/AIDS: A Roadmap to Better Health Outcomes*, 23 Annals Health L. 28, 31 (2014).

[3] The Affordable Care Act Helps People Living with HIV/AIDS, HIV.gov, https://bit.ly/3flqsAS (last visited May 25, 2021).

receives any form of federal financial assistance. 42 U.S.C. § 18116.

People living with HIV can survive and thrive despite their diagnosis if they have access to anti-viral medications and pharmacy services in a medically appropriate manner. However, the limitations and exclusions imposed by Petitioners (collectively, "CVS") under their specialty medication program (the "Program") put Respondents' lives at risk by restricting Respondents to mail order–only delivery of their HIV medications with no access to consultations from a pharmacist or other critical services. CVS provides two separate and unequal prescription drug benefits: one for those with disabilities, and one for everyone else. Through this lawsuit, Respondents seek the same benefits to which non-disabled people currently have access. In the decision below ("*CVS*"), the Ninth Circuit held that Respondents' allegations that CVS denied them "meaningful access" to prescription drug benefits stated a claim of disability discrimination under Section 1557 of the ACA, which incorporates Section 504's prohibition of disability discrimination. The court relied on this Court's construction of Section 504 of the Rehabilitation Act in *Alexander v. Choate*, 469 U.S. 287 (1985).

Petitioners' first Question Presented is premised on the assertion that the Ninth Circuit's decision conflicts with the Sixth Circuit's decision in *Doe v. BlueCross BlueShield of Tenn., Inc.*, 926 F.3d 235 (6th Cir. 2019) ("*BlueCross*"). *BlueCross* held that "disparate impact" claims are not actionable under Section 504 or, by extension, in cases claiming disability discrimination under Section 1557. But the

CVS decision below did not address disparate impact claims in general; rather, it held, consistent with the consensus of the circuits since *Choate*, that claims that a pharmacy benefits provider has denied disabled persons meaningful access to benefits are actionable under *Choate*. *BlueCross*, by contrast, did not even mention the denial of meaningful access standard—let alone rule on it. However, other Sixth Circuit decisions both before and after *BlueCross* have approvingly cited *Choate*'s meaningful access standard. *BlueCross* thus does not reflect a definitive rejection by the Sixth Circuit of the possibility that a denial of meaningful access is actionable under Section 1557. Therefore, *BlueCross* and *CVS* do not present the kind of well-developed, entrenched inter-circuit conflict that merits review by this Court. In fact, the decision below is the *only* appellate decision to evaluate a Section 1557 cause of action under the meaningful access doctrine.

Review by this Court is also not warranted for several additional reasons.

First, the interlocutory nature of this appeal at the motion to dismiss stage strongly counsels against review. The decision below does not even finally resolve whether Respondents' complaint states a prima facie case. Their ACA claim is subject to an ongoing challenge in the district court under Rule 12(b)(6), the outcome of which could negate the need for further review. In addition, there are alternative grounds upon which Respondents' allegations may ultimately be sustained under the ACA, as well as any number of ways the case could be resolved at trial, which would obviate any need for a decision on the

adequacy of Respondents' denial of meaningful access allegations. Even if the ultimate resolution of this case is such that that issue remains outcome-determinative, review by this Court would benefit from complete development of the facts as well as from any further development of the law to occur in the interim.

Second, after the Petition was filed, the Biden administration announced it is drafting new regulations to interpret Section 1557 that are likely to significantly affect both Questions Presented by the Petition, as well as other questions yet to be resolved in this case. Those developments as well as ongoing legal challenges to the current regulations could, at a minimum, significantly inform this Court's consideration of the issues presented by the Petition or obviate any perceived need for review altogether.

Third, Petitioners' second Question Presented, regarding Section 504's application to "terms and conditions of health insurance plans" overlooks that the issue here is not the direct application of Section 504 to health insurance plans, but the application of Section 1557 of the ACA. The very purpose of Section 1557 was to apply Section 504 to private healthcare companies like pharmacy benefit managers ("PBMs") and health insurers that receive federal financial assistance. 42 U.S.C. § 18116(a). CVS cites no support for the proposition that the ACA was not intended to apply to the private healthcare market.

Finally, the decision below was correct. Under the Program, Respondents are relegated to an *inferior and unequal* prescription drug benefit solely because

of their disability—HIV—which results in a loss of meaningful access to the benefit that CVS provides. Whereas *Choate* ultimately found the plaintiffs were not denied meaningful access because the disabled and non-disabled had *equal* access to the benefit, here, it is the *inferior and unequal benefit* provided only to those with disabilities that gives rise to Respondents' loss of meaningful access. This case is therefore more straightforward than *Choate*. The Program is not a facially neutral policy like the fourteen-day hospital stay limitation that applied to both disabled persons and non-disabled in *Choate*. Here, the exclusions and restrictions under the Program provide disabled people a *lesser* benefit that denies access to the full range of pharmacy services, while the non-disabled get the *full* prescription drug benefit.

Far from undermining the HMO and PPO system of healthcare, the decision below reaffirms it by ensuring disabled persons have access to the same in-network providers and prescription drug benefits as everyone else. Should a final judgment by the district court, affirmed on appeal, find for Respondents under the "meaningful access" standard, or any of the alternative grounds supporting the Respondents' claim, no *new prescription drug benefit need be provided* to Respondents. Respondents simply seek equal access to the same pharmacy benefits currently available to other enrollees.

The Court should deny the Petition.

STATEMENT OF THE CASE

A. Factual Background

Respondents are enrolled in employer-sponsored health plans. CVS provides the prescription benefits under those plans that Respondents depend on to sustain their lives. Pet.App.6a.

Before CVS unilaterally enrolled Respondents in the Program, Respondents could access the full range of pharmacy benefits offered by CVS to other enrollees. Pet.App.7a. Respondents could obtain their HIV medications from any participating in-network pharmacies and pharmacists, including from non-CVS pharmacies that employ pharmacists who are knowledgeable about their medical history, specialize in HIV medications, and "could make adjustments to their medication to avoid dangerous drug interactions or remedy potential side effects." ("Network Pharmacies"). Pet.App.5a. "[T]hese services, among others, are critical to HIV patients, who must maintain a consistent medication regimen to manage their chronic disease." *Id*.

The Program applies to a targeted list of so-called "specialty medications" used to "treat complex and chronic conditions."[4] Respondents are subject to the Program solely by reason of their need for prescription drugs to treat their disability—HIV. Under the Program, Respondents must now obtain HIV medications solely by mail order for those benefits to

---

[4] CVS Specialty Pharmacy, What is a specialty medication?, https://bit.ly/3eLUnTM (last visited May 25, 2021).

be considered "in-network" and forego essential services. Purchasing medications outside the specialty pharmacy network would require Respondents to pay full price for their HIV medications costing thousands of dollars each month, making them unaffordable and unavailable to all but the wealthy. Pet.App.7a. Other individuals who do not have disabilities may still access the full range of pharmacy benefits and may obtain their prescriptions from any Network Pharmacy, including non-CVS pharmacies.

Respondents allege that the limitations imposed by the Program deny them medically appropriate access to medications.

First, "the Program forces [Respondents] to forego essential counseling . . . from specialty pharmacists, who are best positioned to: (i) detect potentially life-threatening adverse drug interactions and dangerous side effects . . . ; (ii) immediately provide new drug regimens as their disease progresses; and, (iii) provide essential advice and counseling that help HIV patients and families navigate the challenges of living with a chronic and sometimes debilitating condition." *Id*.

Second, the Program requires Respondents who are also prescribed non-specialty medications to fill those prescriptions at Network Pharmacies while obtaining their prescriptions for HIV medications through the Program. "[T]his 'separate and unequal' splitting of prescription providers also makes it difficult, if not impossible, for [CVS] to track potentially life-threatening drug interactions." *Id*.

Third, routine delivery delays, stolen medications, and missed dosages endemic to the Program result in increased viral loads for HIV patients, threatening serious health consequences. *Id*.

Fourth, the Program threatens Respondents' privacy and reinforces deep-seated societal stigma associated with HIV that can have broad ranging psychological, economic, and health effects. Pet.App.8a.[5]

Though CVS claims specialty pharmacies are "specially qualified to serve patients," Pet.10, because the Program operates as mail order–only and does not permit access to pharmacists and other critical services as alleged in the Complaint, the Program in reality amounts to a "significant reduction in or elimination of prescription drug benefits, and a violation of the standards of good health care and clinically appropriate care for HIV/AIDS patients." Pet.App.8a. Because this case was decided on a Rule 12(b)(6) motion, Petitioners are not entitled to gainsay that conclusion.

To address the loss of meaningful access caused by the Program, Respondents sought an accommodation in the form of "opting out" of the Program and accessing the same pharmacy benefits and Network Pharmacies currently available to other CVS enrollees. These requests were denied. *Id*. Though

---

[5] "HIV stigma and discrimination can pose complex barriers to prevention, testing, treatment, and support for people living with or at risk for HIV." Activities Combating HIV Stigma and Discrimination, HIV.gov, https://bit.ly/3fnXmkb (last visited May 25, 2021).

Petitioners unfairly lampoon counsel for Respondents as bringing "copycat" litigation, in fact counsel for Respondents have litigated six other lawsuits—against Aetna, Anthem, Blue Cross of California, Cigna, Coventry Healthcare, and UnitedHealthcare—where those companies' specialty medication programs similarly denied meaningful access to the prescription drug benefit offered. All agreed to an opt-out accommodation in one form or another. For example, in a settlement reached with Aetna and Coventry—*both of which are now owned by Petitioners*—these two companies acknowledged that members have the right to opt out of mail order–only delivery of HIV medications and may access all other pharmacy services and pharmacists available to other members.[6] That prior litigation thus achieved the exact reasonable accommodation sought in this action: providing HIV-positive individuals access to the same prescription drug benefits and in-network pharmacies to which other non-disabled enrollees have access.

B. Procedural Posture

Respondents filed their initial complaint on February 16, 2018. In the operative complaint that was at issue before the court of appeals, Respondents asserted claims for violation of: (1) Section 1557 of the ACA; (2) ERISA; (3) the Americans with Disabilities Act; (4) the California Unfair Competition Law

---

[6] Press Release, Consumer Watchdog, Aetna/Coventry Members May Obtain HIV/AIDS Meds at Retail Pharmacies (July 31, 2017), https://bit.ly/3eSMrjt.

("UCL"); (5) the California Unruh Civil Rights Act; and (6) for Declaratory Relief.

In the ACA cause of action, Respondents alleged that they were entitled to a reasonable accommodation to ensure meaningful access to the prescription drug benefit provided by Petitioners. Following briefing and oral argument, the district court dismissed the complaint with prejudice. Pet.App.79a. Respondents appealed all causes of action.

On appeal, the court of appeals reversed the dismissal of the ACA discrimination claim. The court held that because Respondents "claim discrimination on the basis of their disability, to state a claim for a Section 1557 violation, they must allege facts adequate to state a claim under section 504 of the Rehabilitation Act." Pet.App.11a. In defining the benefit, consistent with *Choate*, *CVS* held a court must look to the "statutory source"—in this case, the ACA. Pet.App.13a (relying on *Choate*, 469 U.S. at 303). "The district court's definition unduly narrowed the benefit to obtaining specialty drugs at favorable prices from certain pharmacies, when [Respondents'] characterization of the benefit tracks the ACA, asserting more than just cost-related differences." *Id.*

CVS acknowledged, as *Choate* instructed, "that not all disparate-impact showings qualify as prima-facie cases under Section 504." Pet.App.12a. Furthermore, *CVS* recognized that "rather than try to classify particular instances of discrimination as intentional or disparate-impact," *Choate* directed that the "meaningful access" standard objectively determines

whether a policy violates Section 504, which can occur with or without a discriminatory motive. *Id*. Accordingly, *CVS* concluded, as did *Choate*, that a violation of Section 504 may occur where a policy denies a disabled person meaningful access to a benefit to which they are entitled, notwithstanding that the policy applies to both disabled and non-disabled people. *See* Pet.App.15a–16a ("[T]he fact that the Program may apply to plan enrollees in a facially neutral way does not necessarily defeat a § 504 claim."); *Choate*, 469 U.S. at 301–02 (applying meaningful access standard to facially neutral policy limiting hospital stays to fourteen days). Consistent with *Choate*, the panel decision ultimately held that Respondents "have adequately alleged that they were denied meaningful access to their prescription drug benefit, including medically appropriate dispensing of their medications . . . under the Program because of their disability." Pet.App.14a.

The court of appeals vacated the district court's dismissal of Respondents' ACA claim and UCL claim and affirmed the dismissal of all other claims. Pet.App.23a. The panel also voted unanimously to deny Petitioners' petition for panel rehearing. Pet.App.81a–81b. No judge voted to rehear the matter en banc. *Id.*

The court of appeals did not decide two alternative grounds that would support the determination that Respondents stated a claim of disability discrimination under the ACA. First, *CVS* did not consider Respondents' proxy discrimination claim, which arises when a defendant discriminates based on a seemingly neutral criteria that is so closely affiliated

with a protected status that it is effectively facial discrimination—here, discrimination on the basis of a medication only used to treat HIV. Second, the *CVS* decision did not consider Respondents' failure-to-accommodate claim regarding Petitioners' refusal to grant Respondents' reasonable accommodation in the form of opting out of the Program. Pet.App.16a n.1.

The court of appeals' ruling further acknowledged that "CVS argues this court should also affirm the district court's dismissal of the ACA claim because [Respondents] did not adequately allege CVS's receipt of 'federal financial assistance.' The district court should address this issue on remand in the first instance." Pet.App.16a n.2. Shortly after remand to the district court, Petitioners informed Respondents "that they intend to challenge the adequacy of the [Complaint] with respect to 'federal financial assistance,' including that the [Complaint] does not name any entity for which Plaintiffs sufficiently allege both responsibility for the allegedly discriminatory conduct and receipt of the necessary federal funding." Joint Status Report, ECF No. 159. Pursuant to stipulation of the Parties, Respondents filed a Second Amended Complaint ("SAC") addressing these issues. By further agreement, Petitioners' deadline to respond to the SAC by filing their motion challenging the sufficiency of the pleadings regarding the "federal financial assistance" issue is currently July 30, 2021. Order, ECF No. 168.

REASONS FOR DENYING THE PETITION

I. This Case Does Not Present a Conflict Among the Circuits That Requires This Court's Resolution.

In the decision below, the court of appeals straightforwardly read this Court's decision in *Choate* to support a holding that, although Section 504 of the Rehabilitation Act—and hence Section 1557 of the ACA—does not outlaw all conduct with a disparate impact on the disabled, it does prohibit actions that deny disabled people "meaningful access" to benefits, even in the absence of proof of intentional discrimination. *See Choate*, 469 U.S. at 301. The Ninth Circuit's decision was the first to apply the "meaningful access" standard to a claim brought under the ACA, but it reflected the longstanding consensus of the circuits after *Choate* that denial of meaningful access to benefits constitutes actionable discrimination.

Indeed, at least eleven circuits agree that, under *Choate*, denying disabled individuals meaningful access to a benefit offered by a defendant can violate Section 504, even if the defendant does not intend to discriminate. *See* Pet.18 (citing cases in the Second, Seventh, Ninth, and Tenth Circuits that apply the meaningful access standard without requiring an intentional denial); *Ruskai v. Pistole*, 775 F.3d 61, 78 (1st Cir. 2014) (applying meaningful access standard and holding it "well established" that "proof of discriminatory animus is not always required in an action under section 504"); *Nathanson v. Med. Coll. of Pa.,* 926 F.2d 1368, 1384–85 (3d Cir. 1991) (applying

the meaningful access standard and noting *Choate* "emphasized that the Rehabilitation Act was directed particularly at unintentional conduct."); *Brennan v. Stewart*, 834 F.2d 1248, 1261 (5th Cir. 1988) (similar); *Norcross v. Sneed*, 755 F.2d 113, 117 n.4 (8th Cir. 1985) (similar); *Nat'l Fed'n of the Blind, Inc. v. Lamone*, 813 F.3d 494, 504–07 (4th Cir. 2016) (adopting meaningful access standard, and concluding online voting program denied "plaintiffs with meaningful access to Maryland's absentee voting program"); *Berg v. Fla. Dep't of Labor & Empl. Sec., Div. of Vocational Rehab.*, 163 F.3d 1251, 1254 (11th Cir. 1998) (relying on *Choate* and its meaningful access standard); *Am. Council of the Blind v. Paulson*, 525 F.3d 1256, 1269 (D.C. Cir. 2008) (unintended result of "thoughtlessness and indifference" that denied meaningful access violated Section 504). And as set forth below, even the Sixth Circuit has agreed with this conclusion.

A. The Sixth Circuit's *BlueCross* Decision Does Not Address the Meaningful Access Standard, and Other Sixth Circuit Caselaw Supports It.

CVS's argument that the circuits are now "[i]ntractably [d]ivided," Pet.16, rests on a single recent decision of the Sixth Circuit, *BlueCross*. But *BlueCross*, while affirming dismissal of a complaint challenging a prescription program similar to the one at issue here, did not address whether claims of denial of meaningful access are actionable under Section 504 as incorporated in Section 1557. The words "meaningful access" do not even appear in the *BlueCross* opinion. Instead, the court in *BlueCross*

framed the issue as whether the standard of liability for disability discrimination under Section 504, and hence Section 1557, "include[s] a relaxed form of disparate-impact discrimination." 926 F.3d at 238. The court concluded that the answer to that question was no, in part because of the absence of language in the statute prohibiting actions that merely "adversely affect" the disabled and the difficulty of completely avoiding policies that "disparately affect" the disabled. *Id*. at 242.

But nowhere in *BlueCross*'s analysis did the court address whether Section 504 can be read to outlaw actions that do not merely disparately affect the disabled, but effectively deny them meaningful access to the benefits of a program altogether. Indeed, the court stated that the plaintiffs in that case had not argued that they were denied benefits in violation of the statute. *See id.* at 241. Rather, it characterized the argument it rejected as being that a disparate impact alone was sufficient to support a claim, *see id*., and it defined the "[d]isparate-impact discrimination" it decided Section 504 does not reach as an action taken "for a nondiscriminatory reason" that "disproportionately harms a protected group." *Id*. Nothing in *BlueCross* addresses a claim based not just on disproportionate harm, but on a denial of meaningful access to benefits. CVS's claim of inter-circuit conflict thus rests on the assertion that *BlueCross* decided, sub silentio, a question never mentioned in the opinion.

Such a reading of *BlueCross* is particularly untenable in light of Sixth Circuit precedent both before and after that decision recognizing that, under

Choate, Section 504 is not limited to claims of intentional discrimination, but extends to actions that, intentionally or not, deny meaningful access to benefits solely because of disability. More than a year after *BlueCross*, in *Waskul v. Washtenaw County Community Mental Health*, 979 F.3d 426 (6th Cir. 2020), the Sixth Circuit recognized that, under *Choate*, Section 504 is *not* limited to intentionally discriminatory conduct—a recognition inconsistent with Petitioners' broad reading of *BlueCross*. *See id.* at 459 n.13. *Waskul* was consistent with the Sixth Circuit's pre-*BlueCross* statement in *Ability Center of Greater Toledo v. City of Sandusky*, 385 F.3d 901 (6th Cir. 2004) that "[w]hat the Rehabilitation Act ultimately requires, the Court determined [in *Choate*], was that otherwise qualified disabled individuals 'be provided with meaningful access to the benefit that the grantee offers.'" *Id.* at 909 (quoting *Choate*, 469 U.S. at 301). *See also Monette v. Elec. Data Sys. Corp.*, 90 F.3d 1173, 1178 n.5 (6th Cir. 1996) (citing *Choate*'s "meaningful access" discussion with approval), *abrogated in part on other grounds by Lewis v. Humboldt Acquisition Corp.*, 681 F.3d 312 (6th Cir. 2012).[7] *BlueCross* did not acknowledge *Ability Center*, and *Waskul* did not refer to *BlueCross*.

Most notably, in *Jones v. City of Monroe, MI*, 341 F.3d 474 (6th Cir. 2003), *abrogated in part on other grounds as recognized by Hindel v. Husted*, 875 F.3d

[7] In *Lewis*, the en banc court abrogated *Monette* and other prior decisions only to the extent that they applied Section 504's "solely by reason of . . . disability" causation standard to cases under the Americans with Disabilities Act ("ADA"). Neither the meaningful access standard nor the application of *Alexander v. Choate* were before the court in *Lewis*.

344 (6th Cir. 2017), both the panel majority and the dissent explicitly agreed that "a proper application of *Choate*" required determining whether, as a result of facially neutral restrictions defendants imposed, the plaintiff was "denied meaningful access to the parking benefit provided." *Id.* at 479; *see id.* at 484–85 (Cole, J., dissenting) (same) (citing *Choate*, 469 U.S. at 301).[8] The disagreement among the panel in *Jones* concerned whether the plaintiff was denied meaningful access to a benefit—*not* whether the "meaningful access" standard provided the correct framework for such evaluation. Similarly, in a panel decision issued just a few months before *BlueCross*, the court applied *Choate*'s meaningful access standard, recognizing that "[r]easonable accommodation may be necessary to ensure meaningful access; and a refusal to modify a program or policy may, in view of the circumstances, become unreasonable and discriminatory." *Bedford v. Michigan*, 722 F. App'x 515, 518 (6th Cir. 2018). And in *Cook v. Hairston*, 948 F.2d 1288, 1991 WL 253302, at *3 (6th Cir. 1991) (unpublished table decision), the court struck down an Ohio regulation because it "denied the appellants meaningful access to the Medicaid program." Emphasizing that in *Choate* this Court "considered several factors," including that the regulation was "neutral on its face," *Cook* "conclude[d] that the regulation, as implemented, had a disparate impact upon [plaintiffs] as handicapped individuals" and the State of Ohio failed to provide a reasonable accommodation that would ensure meaningful access

[8] The Sixth Circuit in *Hindel* recognized that *Jones* was among the decisions applying Section 504's causation standard to ADA claims that were abrogated to that extent by *Lewis*.

to benefits they were entitled to under the Medicaid program. *Id.* at *3–4. Thus, before and after *BlueCross*, the Sixth Circuit in both binding circuit precedents and unpublished dispositions carefully followed *Choate*'s "meaningful access" standard to determine whether facially neutral policies violated Section 504.

In light of the Sixth Circuit's adherence to the widely accepted view that a court of appeals panel cannot overrule precedents established by prior panels, *see Gaddis ex rel. Gaddis v. Redford Tp.*, 364 F.3d 763, 770 (6th Cir. 2004), *BlueCross* cannot reasonably be read to overturn the Sixth Circuit's longstanding recognition that a denial of meaningful access to a benefit is actionable under Section 504. The absence of any explicit statement in the opinion that it was even addressing that issue or any express acknowledgment of previous Sixth Circuit decisions accepting the meaningful access standard renders such a reading even more untenable.

Even if *BlueCross* could be so read, however, its disagreement with Sixth Circuit precedent would amount only to an intra-circuit conflict, and this Court's consistent policy is to "allow the courts of appeals to clean up intra-circuit divisions on their own, in part because their doing so may eliminate any conflict with other courts of appeals." *Joseph v. United States*, 574 U.S. 1038 (2014) (Kagan, J., with whom Ginsburg, J., and Breyer, J., join, respecting denial of certiorari). Unless and until the Sixth Circuit definitively holds that allegations of a denial of meaningful access to benefits that would be actionable under *Choate* in every other circuit fails to state a

claim under Section 504 and/or Section 1557, any assertion that Sixth Circuit precedent conflicts with the decision below and the consensus of the rest of the circuits will remain unfounded.

B. No Review Is Warranted.

Even if the Sixth Circuit's position can be viewed as in conflict with that of the Ninth and other circuits, the lopsided nature of the conflict, and its recency, argue against review now. The Court should await either further development of law by other circuits or a much more definitive ruling by the Sixth Circuit—for example, an explicit rejection by that court sitting en banc of a complaint alleging a denial of meaningful access that would be actionable in other circuits—before considering whether to weigh in.

Withholding review now would also have the benefit of allowing other courts of appeals to weigh in on the persuasiveness of *BlueCross's* reasoning, whether it extends to claims of denial of meaningful access, and how *Choate* applies in the context of the ACA. Indeed, the Ninth Circuit's ruling in *CVS* marks the first time any circuit has considered *Choate's* "meaningful access" standard in a discrimination claim under Section 1557. No other such case presenting that issue has yet reached any court of appeals. The issue would benefit from "the crucible of adversarial testing on which [this Court] usually depend[s], along with the experience of our thoughtful colleagues on the district and circuit benches . . . . Other circuits may improve that guidance over time too. And eventually we can bless the best of it." *Maslenjak v. United States*, 137 S. Ct. 1918, 1931–32

(2017) (Gorsuch, J., Thomas, J., concurring); *see also McCray v. New York*, 461 U.S. 961, 962 (1983) (Stevens, J.) (certiorari denied where "further consideration of the substantive and procedural ramifications of the problem by other courts will enable us to deal with the issue more wisely at a later date").

For example, further consideration by the Sixth Circuit of the relationship between its holding in *BlueCross* and precedents concerning the meaningful access standard may resolve any perceived differences between circuits, and/or further highlight agreement (or disagreement) between the Sixth Circuit and Ninth Circuit regarding the meaningful access standard at issue in this case. Decisions of other circuits may likewise produce a consensus that the decisions are reconcilable, or may articulate more sharply opposing views that this Court may need to choose between. And, as discussed below, both further developments in this case and pending regulatory actions are likely to provide useful information about whether there is an issue requiring this Court's intervention. As matters now stand, however, there is no need for this Court to resolve the issue CVS presents in the Petition.

II. The Interlocutory Posture of This Case Makes It Particularly Unsuited for Review.

Review in this case would be particularly inappropriate because the action is only in its earliest stages, with significant unresolved issues that could either obviate completely any reason for review or provide critically important factual development that

would inform any ultimate resolution of key legal questions. In the decision below, the Ninth Circuit held only that Respondents adequately alleged that they were denied meaningful access to the benefit offered by CVS. Pet.App.16a. Indeed, the district court has not even completed its analysis of whether the complaint states a prima facie case, as CVS has other threshold arguments that remain to be determined by the district court under Rule 12(b)(6)—most notably its challenge to the adequacy of Respondents' allegations that CVS received "federal financial assistance." An order dismissing Respondents' complaint under Rule 12(b)(6) for reasons not at issue in the Petition, or the full development of the record and the success or failure of Respondents' claims on the merits for any number of other reasons, would obviate any need to revisit the standards for evaluating Section 1557 disability discrimination claims and the application of *Choate*.

For just such reasons, this Court has long adhered to the policy of disfavoring review of such interlocutory decisions. The "[C]ourt should not issue a writ of certiorari to review a decree of the circuit court of appeals on appeal from an interlocutory order, unless it is necessary to prevent extraordinary inconvenience and embarrassment in the conduct of the cause." *Am. Constr. Co. v. Jacksonville, Tampa & Key W. Ry. Co.*, 148 U.S. 372, 384 (1893); *see also Estelle v. Gamble*, 429 U.S. 97, 114 (1976) (Stevens, J., dissenting) (emphasizing this Court's "normal practice of denying interlocutory review"); *Va. Military Inst. v. United States*, 508 U.S. 946 (1993) (Scalia, J., respecting denial of certiorari) (Delaying an exercise of certiorari jurisdiction "does not, of

course, preclude [petitioner] from raising the same issues in a later petition, after final judgment has been rendered.")

Following this Court's policy of avoiding interlocutory review would be particularly appropriate here. A decision on the legal question of whether disability discrimination claims based on denial of meaningful access are actionable would be much better informed by a determination, based on a fully developed trial or summary judgment record, of whether, and if so how, the facts and circumstances of the challenged Program amount to a denial of meaningful access under the standards applied by the Ninth Circuit and other circuits. Waiting will also give the Court the benefit of considering the issues raised herein regarding the evolving nature of the Section 1557 implementing regulations, including a recently announced rulemaking. *See infra* § IV.

III. Section 1557 Applies Section 504 to the Terms of Health Insurance Plans.

CVS's second Question Presented, and its supporting argument that application of Section 504 to "the terms and conditions of health plan benefits" conflicts with other circuits and threatens the healthcare system, *see* Pet.22–25, overlooks that the issue here is not the direct application of Section 504 to health insurance plans, but the application of Section 1557.[9] Relying on inapposite pre-ACA

[9] Respondents disagree with Petitioners' second Question Presented as it implies that the Program relates to health insurance; it does not. It relates to the provision of healthcare services in the form of prescription drugs.

authority, CVS's assertions do not provide a basis for granting certiorari.

Extending the application of specific civil rights statutes, including Section 504, to "any health program or activity, any part of which is receiving Federal financial assistance" was the entire purpose of Section 1557. 42 U.S.C. § 18116(a). Whatever may have been the case before the ACA's passage, there is no doubt that the standards of Section 504 as incorporated in Section 1557 prohibit discrimination by health insurers and other companies in the private healthcare market with respect to the terms and conditions of health plans that receive the requisite federal financial assistance. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 522 (2012) (The ACA is "intended to induce the purchase of health insurance.")

CVS's assertion that even if Section 1557 is otherwise applicable to "facially neutral" acts or practices, the decision below is an "outlier" in applying it to health benefit plans relies almost exclusively on pre-ACA precedents. CVS's citation to pre-ACA caselaw is telltale, as is its reference to the positions of "numerous scholars" expressed a full decade before adoption of the ACA. *See* Pet.27, 29. The cases relied on by CVS, *Modderno v. King*, 82 F.3d 1059 (D.C. Cir. 1996), *CERCPAC v. Health & Hospitals Corp.*, 147 F.3d 165 (2d Cir. 1998), and *Ford v. Schering-Plough Corp.*, 145 F.3d 601 (3d Cir. 1998), all pre-date Section 504's incorporation into Section 1557 and therefore are irrelevant to whether the ACA's antidiscrimination provision applies to "the terms and conditions of health plan benefits."

Moreover, while CVS acknowledges that to "pass muster" under pre-ACA Section 504 caselaw they are required to "offer the same suite of benefits to disabled and non-disabled individuals," Pet.22, CVS violates these very standards. CVS provides two separate and distinct prescription drug benefits: one for disabled persons, one for everyone else. CVS's citation to *Taylor v. Colorado Department of Health Care Policy & Financing*, 811 F.3d 1230 (10th Cir. 2016)—the only post-ACA decision cited in support of CVS's claim of conflict over its second Question Presented—does not suggest that such discrimination is immune from scrutiny under Section 1557. That case addressed a request by a disabled person to create "a new benefit" that was "not generally available to all plan participants." Pet.23. This is not the case here: as described above, Respondents seek the same benefits non-disabled enrollees currently receive.

IV. Uncertainty Surrounding Concurrent Rulemaking and Pending Legal Challenges to ACA Regulations Renders Granting Certiorari Premature.

The regulations implementing the ACA, and Section 1557 in particular, are in a state of great legal flux and uncertainty. As the regulatory environment central to CVS's Petition is likely to change significantly during the pendency of this case, the Court would be better served by denying certiorari.

Section 1557 has been the subject of two prior rulemakings within the past five years, and the Biden administration is in the process of initiating two new rulemaking proceedings fundamental to the issues

presented by the Petition. Just two weeks prior to filing Respondents' brief, the Biden administration announced it is preparing new regulations interpreting Section 1557. Joint Status Report, *New York v. U.S. Dep't of Health & Human Servs.* ("*HHS*"), No. 1:20-cv-05583-AKH (S.D.N.Y. May 14, 2021). The issues to be addressed include, for example, the scope of Section 1557's application to health insurers, which is central to CVS's second Question Presented, and the interpretation of Section 1557 in light of this Court's decision in *Bostock v. Clayton Cty.*, 140 S. Ct. 1731 (2020). *Id.*

Compounding this uncertainty, the current administration also recently announced its intent to issue a Notice of Proposed Rulemaking interpreting various statutes, including Section 504, "to robustly address unlawful discrimination on the basis of disability in certain vital HHS-funded health and human services programs." Semiannual Regulatory Agenda, 86 Fed. Reg. 16892, 16895 (March 31, 2021). This rulemaking will also likely include issues related to CVS's Questions Presented.

In addition to the soon-to-be initiated rulemaking proceedings, the current rule interpreting Section 1557 adopted during the Trump administration (the "2020 Rule") is the subject of several pending legal challenges that could, at a minimum, significantly inform this Court's consideration of the issues presented by CVS—or obviate altogether any perceived need for review.[10] For example, in the *HHS*

[10] Two federal district courts have already preliminarily enjoined HHS from enforcing aspects of the 2020 Rule. *See Walker v. Azar*,

case twenty-two states and the District of Columbia call for rescission of the 2020 Rule, which significantly narrowed relevant provisions of regulations issued by the Obama administration interpreting Section 1557, published at 81 Fed. Reg. 31375–31473 (May 18, 2016) (the "2016 Rule").[11] The lawsuit alleges that the 2020 Rule violates, *inter alia*, the Administrative Procedure Act, 5 U.S.C. § 706(2)(A), (C). Compl. ¶ 15, ECF No. 1. Among other issues pertinent here, the States allege that "[t]he 2020 Rule . . . (a) violates the plain text of Section 1557 by excluding [certain] private health insurance companies . . . from the Rule's scope," and eliminates express federal protections for vulnerable populations. Mot. Summ. J. at 1–2, ECF No. 61.

The States' pending summary judgment motion in *HHS* requests "that the Court vacate and set aside the 2020 Rule" *in its entirety*. *Id.* at 3. At the request of the United States, the litigation was stayed February 18, 2021 to permit new leadership at the Department of Health and Human Services to review the challenged rule and to determine whether any further proceedings are necessary. Order Granting Unopposed Mot. to Stay, ECF No. 141. The case remains stayed in light of the United States' ongoing reassessments of the challenged rule and its intent to

---

No. 20-CV-2834, 2020 WL 4749859 (E.D.N.Y Aug. 17, 2020); *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Human Servs.*, 485 F. Supp. 3d 1 (D.D.C. 2020).

[11] There are also two pending challenges to the 2016 Rule's interpretation of Section 1557. *See Franciscan Alliance v. Becerra*, No. 20-10093 (5th Cir. Apr. 15, 2021); *The Religious Sisters of Mercy v. Becerra*, No. 21-01890 (8th Cir. filed Apr. 20, 2021).

initiate a rulemaking proceeding on Section 1557. If the current administration ultimately decides not to defend the 2020 Rule, or if the 2020 Rule is struck down by the court, the 2016 Rule will be back in effect. Alternatively, the Biden administration is proposing changes to the 2020 Rule that could eliminate or narrow any further proceedings in that case. Joint Status Report, ECF No. 142.

Any of these outcomes could dramatically change the nature of the issues before the Court.

First, CVS's second Question Presented regarding whether Section 1557 "extend[s] to the facially neutral terms and conditions of health insurance plans," Pet.21–22, 28, is directly implicated in *HHS* and the current administration's pending regulatory action on Section 1557. Whereas the 2016 Rule broadly considered health insurance to be subject to Section 1557, the 2020 Rule explicitly states that health insurance is subject to Section 1557 in only certain limited circumstances. *See* 45 C.F.R. § 92.3(b)–(c). The resolution of which Section 1557 regulation is operative could be outcome determinative and moot the issues presented by the Petition, or at a minimum raise a separate issue for appellate review.

Consistent with the plain language of the statute, the 2016 Rule acknowledged that Section 1557 applies to all "health program[s] or activit[ies]" including health providers and "health-related insurance coverage, or other health related coverage, and the provision of assistance to individuals in obtaining health-related services or health-related insurance coverage." 81 Fed. Reg. at 31467 (former 45 C.F.R.

§ 92.4). Conversely, under the 2020 Rule, "an entity principally or otherwise engaged in the business of providing health insurance shall not, by virtue of such provision, be" subject to Section 1557 under all circumstances. 45 C.F.R. § 92.3(c). The reformulation reflected in the 2020 Rule is based on the conclusion, at odds with the intent of the ACA and Section 1557, that health insurers are not "principally engaged in the business of providing healthcare." *Id*. In the *HHS* litigation, the States argue that in the 2020 Rule, "HHS unlawfully rewrites the statute and adopts an interpretation at odds with Section 1557's text and the ACA's overarching objective of eliminating barriers to health insurance coverage in the United States." Mot. Summ. J. at 27–28.

Second, the 2020 Rule contains provisions, directly at issue in the *HHS* litigation, that go to the heart of the "federal financial assistance" issue CVS will address in its soon-to-be-filed Rule 12(b)(6) challenge. *See* 45 C.F.R. § 92.3(a)–(b). The 2016 Rule acknowledged, consistent with the plain language of the statute, that Section 1557 provides a private right of action against a health program or activity as long as "any part of" the entity involved in the discrimination receives federal financial assistance. 81 Fed. Reg. at 31466. However, the 2020 Rule "purports to define the unambiguous statutory phrase 'any health program or activity, *any part of* which is receiving Federal financial assistance,' 42 U.S.C. § 18116(a) (emphasis added)," Mot. Summ. J. at 27, as limited to "the operations of entities *principally engaged in the business of* providing healthcare that receive Federal financial assistance." 45 C.F.R. § 92.3(b) (emphasis added).

To the extent a defendant is deemed to be not "principally engaged in the business of providing healthcare," the 2020 Rule purports to narrowly apply Section 1557 only in certain instances where the *specific program or activity* at issue in the discrimination claim receives federal financial assistance. *See id*. Whether CVS receives applicable "federal funding" is disputed by CVS and will be litigated in its Rule 12(b)(6) challenge.

Third, if the 2020 Rule were vacated and the 2016 Rule reinstated, CVS's first Question Presented regarding disparate impact claims would be directly implicated. Though the 2020 Rule interpreted Section 1557 as not creating a new healthcare-specific antidiscrimination standard that permits a disparate impact discrimination claim in all instances, *see* 85 Fed. Reg. 37160, 37202 (June 19, 2020), HHS's Office for Civil Rights reached the opposite conclusion during the 2016 rulemaking proceeding. *See* 81 Fed. Reg. at 31439–40 ("OCR interprets Section 1557 as authorizing a private right of action for claims of disparate impact discrimination on the basis of any of the criteria enumerated in the legislation."). If the 2016 Rule is reinstated, then Respondents will have an additional ground supporting the denial of CVS's motion to dismiss below.

V. There Are Alternative Grounds for Affirmance That the Court Would Have to Address Before Reaching the Issues Raised by Petitioners.

This Court sits "to correct wrong judgments, not to revise opinions," *Herb v. Pitcairn*, 324 U.S. 117, 126

(1945), and the judgment below is correct for more reasons than the court below even discussed. This Court may affirm the "judgment below . . . on any ground permitted by the law and record." *Murr v. Wisconsin*, 137 S. Ct. 1933, 1949 (2017). Two alternative grounds, discussed herein, justify affirmance of *CVS*'s holding that Respondents' well-pleaded allegations are sufficient to state a claim under Section 1557. *Granfinanciera, S.A. v. Nordberg*, 492 U.S. 33, 38 (1989) ("a prevailing party may . . . 'defend its judgment on any ground properly raised below whether or not that ground was relied upon, rejected, or even considered'" by the circuit court). The reasonable possibility that Respondents could prevail on either a claim of proxy discrimination or failure-to-accommodate is yet another reason the Court should deny certiorari. Respondents would obtain the same relief based on these claims, which could make the meaningful access claim, as well as the "disparate impact" issue presented by Petitioners here, moot.

A. Proxy Discrimination

Apart from the reasons described by the *CVS* court, Respondents may also state a claim for relief under Section 1557 in the form of a proxy discrimination claim.

Proxy discrimination occurs when a defendant discriminates based on seemingly neutral criteria—here, on the basis of a medication used to treat a disability—that is so closely affiliated with a disability or protected group that it is effectively facial discrimination. *See McWright v. Alexander*, 982 F.2d 222, 228 (7th Cir. 1992) (concluding "gray hair" was a

close enough fit to "old age" such that allegations an employer rejected all applicants with gray hair stated a claim of age discrimination, even if there are young people with gray hair). Just as "[a]ncestry can be a proxy for race," *Rice v. Cayetano*, 528 U.S. 495, 514 (2000), and a voting literacy test implicitly invokes a racial classification, *Guinn v. United States*, 238 U.S. 347, 364–65 (1915), so too can HIV medication be a proxy for disability.

CVS asserts that the Program's "classification derives . . . from the medicines' unique characteristics" —in other words, whether the medication is classified as specialty or non-specialty, Pet.11—*not* Respondents' HIV disability. Yet, as a direct result of CVS's designation of HIV medications as "specialty medications," Respondents are provided a significantly narrower prescription drug benefit compared to other CVS enrollees that results in the loss of meaningful access.[12] Pet.App.16a. This is discrimination by proxy. To the extent proxy discrimination is deemed a form of intentional discrimination, Respondents have alleged and preserved a claim for intentional discrimination (though the *CVS* court did not consider it). *See*, *e.g.*, Opening Br. at 13, ECF No. 31 (district court "wrongly concluded Appellants'

[12] The hypocrisy of CVS and amici on this point cannot be overstated. On the one hand, CVS claims that, because people prescribed HIV medications may require extra monitoring and support, these medications should be placed in a "specialty" tier. On the other hand, CVS provides such medications with the lowest level of oversight and consultation.

allegations are insufficient to allege an intentional discrimination claim under Section 1557").

B. Failure-to-Accommodate

Respondents' complaint also states a prima facie case for a failure-to-accommodate claim. Respondents (1) are disabled, *see Bragdon v. Abbott*, 524 U.S. 624, 655 (1998) (holding HIV is a disability); (2) otherwise qualified for the prescription drug benefits at issue; and (3) requested that Petitioners provide a reasonable accommodation by permitting Respondents to access the same pharmacy benefits that other enrollees not subject to the Program may access. These opt-out requests were denied as a matter of formal corporate policy. *See US Airways, Inc. v. Barnett*, 535 U.S. 391 (2002).

"[W]hile a grantee need not be required to make 'fundamental' or 'substantial' modifications to accommodate the handicapped, it may be required to make 'reasonable' ones." *Choate*, 469 U.S. at 300. Far from threatening the structure of HMO and PPO plans, as CVS alleges, the accommodation Respondents seek is facially reasonable. They requested the same benefits and access to the same Network Pharmacies and the same pharmacists other CVS enrollees have access to. Calling what Respondents seek a "modification[]" *at all* is a stretch—Respondents seek to compel CVS simply to undo the disability-based restrictions imposed by the Program. Should a final judgment eventually find for Respondents, *no new prescription drug benefit need be provided* to Respondents. Respondents only seek

equal access to the broader pharmacy benefits currently available to other enrollees.

CVS did not consider Respondents' failure-to-accommodate claim because the circuit court found "this theory was raised for the first time on appeal." Pet.App.16a n.1. However, Respondents did present the claim to the district court, including in response to Petitioners' initial motion to dismiss that resulted in the *CVS* decision. Pet.App.50a. The district court wrongly denied the claim, citing one-time exceptions providing only short delays in initially implementing the Program. *Id.* Therefore, the failure-to-accommodate claim can properly be considered by this Court as an alternative basis of for upholding the judgment in *CVS*. *See Granfinanciera, S.A.*, 492 U.S. at 38.

Moreover, even if the court of appeals was correct not to address it in the appeal, the failure-to-accommodate claim would remain available to Respondents to raise in the district court on remand as it was not decided by *CVS*. *See Musacchio v. United States*, 577 U.S. 237, 244–45 (2016) ("[W]hen a court *decides* upon a rule of law, that decision should continue to govern the same issues in subsequent stages in the same case.") (emphasis added) (internal citation omitted).

VI. *CVS* Does Not Present Significant Consequences for Litigants, Courts, or the Public.

The real-world impact of the decision below is much less extensive than CVS would have the Court

believe. *See Rice v. Sioux City Mem'l Park Cemetery*, 349 U.S. 70, 74 (1955). (The problem for this Court to address must be "beyond the academic or the episodic.")

As empirically demonstrated by settlements with virtually every major healthcare company in the United States allowing members to opt out of mail order–only delivery of HIV medications—including two CVS subsidiaries, Aetna and Coventry—*CVS* would not blow up the HMO and PPO system of healthcare. In fact, it strengthens it by assuring all members have access to the same benefits and same in-network providers.

Nor does *CVS* impose any new legal obligations on health insurers or employers. If anything, *CVS* hewed to a conservative line by agreeing with the Sixth Circuit that Section 1557 did not "create a new healthcare-specific anti-discrimination standard." *Compare* Pet.App.11a *with BlueCross,* 926 F.3d at 239. Similarly, *CVS* did not alter the scope of entities (or conduct) subject to disability discrimination claims. Amici's arguments, much like Petitioners', ignore that *Choate* balanced two "countervailing considerations—the need to give effect to the statutory objectives and the desire to keep § 504 within manageable bounds" by limiting liability to instances where disparate impact discrimination arises to a loss of "meaningful access." 469 U.S. at 299. In nearly forty years since this Court's unanimous decision, *Choate* has not resulted in the parade of horribles amici speculate upon. *Hubbard v. United States*, 514 U.S. 695, 718–20 (1995) (Rehnquist, C.J., dissenting) (reversing a 40-year-old unanimous

decision is at odds with *stare decisis* and "subverts the very principle on which a hierarchical court system is built").

VII. CVS's Specialty Medication Program Provides Lesser Benefits to the Disabled in Violation of the ACA and Section 1557.

The panel in *CVS* held that because Respondents "claim discrimination on the basis of their disability, to state a claim for a Section 1557 violation, they must allege facts adequate to state a claim under section 504 of the Rehabilitation Act." Pet.App.11a. Section 504's language is clear and unambiguous: it bars discrimination "solely by reason of" disability, which means "for no reason other than." *Husted v. A. Philip Randolph Inst.*, 138 S. Ct. 1833, 1842 (2018). Here, Respondents are subject to the Program for no reason other than their disability.

Moreover, meaningful access, as *Choate* explained and Petitioners concede, must be defined in the broad context of the purposes of the underlying statute and regulations at issue. *Choate*, 469 U.S. at 301–03; Pet.App.14a. The ACA specifically addressed prior inequities in access to healthcare by, for example, prohibiting companies from charging patients more as a result of their disability, 42 U.S.C. § 300gg, and prohibiting coverage limitations due to pre-existing conditions. *Id.* at §§ 300gg-1, 300gg-2.

The ACA extended these protections to "group health plans," which include self-insured plans. Group health plans may not discriminate based on pre-existing conditions or discriminate based on health

status. *Id.* at § 300gg-3. Additionally, "a group health plan . . . may not establish rules for eligibility . . . or coverage based on . . . health status, medical condition, medical history, [or] disability." 42 U.S.C. § 300gg-4. ACA regulations applying to group health plans similarly require that "'any restriction on a benefit . . . must apply uniformly to all similarly situated individuals,' and must 'not be directed at individual participants . . . based on [disability].'" Pet.App.14a.

Section 1557 complements and enforces these antidiscrimination provisions and provides an additional basis for addressing discrimination in the private healthcare market, including in healthcare delivery, by applying a civil rights framework. Pharmacies and PBMs like those CVS operates provide healthcare services subject to Section 1557. *See*, *e.g.*, 85 Fed. Reg. at 37229 (PBMs are subject to Section 1557's notice requirements).

Thus, while pre-ACA caselaw interpreting Section 504 serves as a useful guide for evaluating the kind of conduct that violates the ACA, this Court must interpret and apply Section 504 in the context of the ACA.

CVS attacks the merits of the panel's decision below arguing that this Court's ruling in *Alexander v. Sandoval*, 532 U.S. 275 (2001)—interpreting Title VI of the Civil Rights Act as providing a private right of action only for intentional race discrimination—should control the interpretation of Respondents' Section 1557 cause of action. However, this supposition ignores *Choate*'s extensive discussion

concerning the reasons Title VI standards should *not* be incorporated into Section 504. 469 U.S. at 292–95 & n.7. In addition to *Choate*, other precedent of this Court makes clear that the strict adoption of Title VI standards into Section 504 would be in error. *See CONRAIL v. Darrone*, 465 U.S. 624 (1984) (Section 504 did not incorporate Title VI's substantive limitations).

Moreover, CVS's targeting of a list of "specialty drugs" and providing disabled people requiring those medications a different, lesser benefit is intentional conduct. *See Schmitt v. Kaiser*, 965 F.3d 945, 955 (9th Cir. 2020). Such a "discriminatory benefit design" reflects intentional conduct and a discriminatory purpose. *Id.*

In sum, Respondents' allegations and arguments regarding the denial of meaningful access, proxy discrimination, and failure-to-accommodate all must be read in light of the ACA's statutory scheme and antidiscrimination provisions.

CONCLUSION

There is no split between the Ninth Circuit and the Sixth Circuit that requires the Court's attention at this time.

Furthermore, given the early stage of the litigation and alternate grounds available to support the decision below, the Court should adhere to its policy of avoiding interlocutory review.

Finally, uncertainty surrounding regulations interpreting Section 1557, including provisions that go to the heart of Petitioners' Questions Presented, counsels against review at this time.

The Petition should be denied.

Respectfully submitted,

Gerald S. Flanagan*
*Counsel of Record
Daniel L. Sternberg
Benjamin R. Powell
Consumer Watchdog
6330 San Vicente Blvd.
Suite 250
Los Angeles, CA 90043
(310) 392-0522
jerry@consumerwatchdog.org

Alan M. Mansfield
Whatley Kallas LLP
16870 W. Bernardo Dr.
Suite 400
San Diego, CA 92127

Henry C. Quillen
Whatley Kallas LLP
159 Middle St., Suite 2C
Portsmouth, NH 03801

June 1, 2021