No.

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; JOHN DOE, TWO; JOHN DOE, THREE; JOHN DOE, FOUR; 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

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Section 1557 of the Patient Protection and Affordable Care Act ("ACA") creates a private right of action for discrimination on the basis of race, sex, age, and disability in federally funded health programs and activities. 42 U.S.C. § 18116(a). This private right of action incorporates the "enforcement mechanisms" of other federal antidiscrimination statutes, including the Rehabilitation Act of 1973, 29 U.S.C. § 794, which prohibits disability discrimination. The questions presented are:

1. Whether section 504 of the Rehabilitation Act, and by extension the ACA, provides a disparate-impact cause of action for plaintiffs alleging disability discrimination.

2. If section 504 and the ACA create disparate-impact claims, whether such claims extend to the facially neutral terms and conditions of health insurance plans.

PARTIES TO THE PROCEEDING

Petitioners CVS Pharmacy, Inc., Caremark, L.L.C., and Caremark California Specialty Pharmacy, L.L.C. were defendants in the district court and appellees in the Ninth Circuit. National Railroad Passenger Corporation ("Amtrak"), Lowe's Companies, Inc., and Time Warner Inc. were also defendants in the district court and appellees in the Ninth Circuit.

John Does I–V were plaintiffs in the district court and appellants in the Ninth Circuit.

CORPORATE DISCLOSURE STATEMENT

Petitioner CVS Pharmacy, Inc. is a wholly owned subsidiary of CVS Health Corporation. Petitioners Caremark, L.L.C. and Caremark California Specialty Pharmacy, L.L.C. are wholly owned indirect subsidiaries of CVS Health Corporation.

CVS Health Corporation is a publicly traded company, but no publicly traded corporation owns 10 percent or more of its stock. CVS Health Corporation is the only publicly traded corporation that owns, directly or indirectly, a 10 percent or more interest in petitioners CVS Pharmacy, Inc., Caremark, L.L.C., or Caremark California Specialty Pharmacy, L.L.C.

STATEMENT OF RELATED PROCEEDINGS

This case arises from the following proceedings:

- *John Doe, One, et al. v. CVS Pharmacy, Inc., et al.*, No. 19-15074, 9th Cir. (Dec. 9, 2020) (opinion vacating in part, remanding in part, and affirming in part dismissal of plaintiffs' claims);
- *John Doe, One, et al. v. CVS Pharmacy, Inc., et al.*, No. 18-cv-01031, N.D. Cal. (Dec. 12, 2018) (order granting motion to dismiss); and
- *John Doe, One, et al. v. CVS Pharmacy, Inc., et al.*, No. 19-15074, 9th Cir. (Jan. 15, 2021) (order denying motion for rehearing).

There are no other proceedings in state or federal trial or appellate courts, or in this Court, directly related to this case within the meaning of this Court's Rule 14.1(b)(iii).

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Petitioners CVS Pharmacy, Inc., Caremark, L.L.C., and Caremark California Specialty Pharmacy, L.L.C. respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

The court of appeals' opinion is available at 982 F.3d 1204 (9th Cir. 2020). Pet.App.1a-23a. The district court's opinion is available at 348 F. Supp. 3d 967 (N.D. Cal. 2018). Pet.App.24a-79a.

JURISDICTION

The court of appeals' judgment was entered on December 9, 2020. Pet.App.2a. The petition for rehearing or rehearing en banc was denied on January 15, 2021. Pet.App.81a-82a. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Section 504 of the Rehabilitation Act (29 U.S.C. § 794(a)) provides in relevant part:

> No otherwise qualified individual with a disability in the United States, as defined in section 705(20) of this title, shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service.

Section 1557(a) of the Patient Protection and Affordable Care Act (42 U.S.C. § 18116(a)) provides:

> Except as otherwise provided for in this title (or an amendment made by this title), an 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 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, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insur-

> ance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). 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.

STATEMENT

This case presents a square conflict among the circuits on two related questions of exceptional importance that were outcome-determinative below. The first question is whether plaintiffs can bring disparate-impact claims for disability discrimination under the Rehabilitation Act and the Patient Protection and Affordable Care Act ("ACA"). The Rehabilitation Act prohibits federally funded programs like public school districts, state Medicaid programs, and local transportation departments from discriminating "solely by reason of . . . disability." 29 U.S.C. § 794(a). In *Alexander v. Choate*, 469 U.S. 287 (1985), this Court left open whether the Rehabilitation Act creates a cause of action based on disparate impact. Since then, the ACA exploded the range of potential defendants by extending the Rehabilitation Act's nondiscrimination obligations to virtually any public or private healthcare activity that receives federal funds.

The ensuing 4-1 split over whether disparate-impact claims for disability discrimination are cognizable has placed CVS and scores of other healthcare companies, including hospitals, pharmacies, insurers, and pharmacy benefit managers, in an untenable bind. The Sixth Circuit holds that a disparate-impact theory is inconsistent with the text of the Rehabilitation Act and the ACA. *See Doe v. BlueCross BlueShield of Tenn., Inc.*, 926 F.3d 235, 241-

43 (6th Cir. 2019). That court broke with four other circuits—the Second, Seventh, Ninth, and Tenth—where plaintiffs can target defendants' facially neutral policies on the theory that those policies disproportionately affect individuals with disabilities.

CVS condemns discrimination on the basis of disability. But this widely acknowledged and irreconcilable circuit split hamstrings companies that operate nationwide and cannot adopt multiple business strategies in circuits with conflicting legal rules. As a result, the split effectively forces companies with a national footprint to choose between proactively following the most restrictive legal standard or subjecting themselves to litigation seeking overhaul of common benefit-plan terms. This split also encourages rampant forum-shopping, funneling lawsuits to the four circuits that have endorsed a plaintiff-friendly regime that the Sixth Circuit has expressly disavowed.

This case illustrates the untenable consequences of this widely acknowledged circuit conflict. The same plaintiffs' law firms brought copycat complaints against multiple insurers and pharmacy benefit managers in multiple circuits. Plaintiffs asserted substantially identical disparate-impact claims, alleging that restrictions their health plans placed on specialty medications should not apply to them because those restrictions disadvantaged HIV-AIDS patients more than other patients. Plaintiffs lost in the Sixth Circuit because that court categorically rejected disparate-impact liability under the Rehabilitation Act and the ACA. But the Ninth Circuit, in the decision below, reached the diametrically opposite result. The Ninth Circuit held not only that disparate-impact liability is a generally viable theory, but also that such liability extends to claims challenging routine terms and conditions of health plans. This Court routinely grants review when dueling

decisions impose starkly different obligations under the same facts.

The decision below also created a second, related split that heightens the need for review and threatens to inflict untenable costs on thousands of potential defendants subject to the Rehabilitation Act or the ACA. Until the decision below, even circuits that allowed disparate-impact claims have held that plaintiffs cannot attack facially neutral terms and conditions of health benefit plans based on an alleged disparate impact on individuals with disabilities. The Second, Third, Tenth, and District of Columbia Circuits have rejected claims that health plan sponsors must tailor their packages of benefits to address the particular medical needs of individuals with disabilities. Those circuits reason that the Rehabilitation Act provides for equal treatment, not particular healthcare benefits.

But the Ninth Circuit, in the decision below, created a direct conflict with those circuits, holding that plaintiffs with disabilities can bring disparate-impact suits that challenge the conditions their health plans place on prescription drugs. Pet.App.13a-16a. The Ninth Circuit's deeply flawed decision to extend disparate-impact liability into this novel context threatens to upend insurance plans and skyrocket healthcare costs nationwide. The instability caused by the decision below is especially unacceptable as companies like CVS grapple with the COVID-19 pandemic.

This case is an ideal vehicle for resolving these critically important and recurring questions. Now is the time to resolve the issue this Court left open in *Choate*, which has intractably divided the lower courts. Both questions—whether a disparate-impact claim exists at all, and if so, whether it applies to the facially neutral terms of a health benefit plan—are squarely and cleanly presented

and were outcome-determinative below. The facts of this case provide an excellent framework for considering the contours of a disparate-impact theory based on disability. No further percolation is needed; both splits are stark and well-developed. And this Court should intervene immediately, because allowing these splits to persist injects intolerable uncertainty on issues central to the Nation's healthcare system.

A. Statutory Background

Section 504 of the Rehabilitation Act prohibits disability discrimination by recipients of federal funding. 29 U.S.C. § 794; *Barnes v. Gorman*, 536 U.S. 181, 184-85 (2002). More specifically, the Act provides that an individual shall not "be excluded from participation in, denied the benefits of, or be subjected to discrimination" "solely by reason of her or his disability." 29 U.S.C. § 794(a).

The ACA incorporates section 504 of the Rehabilitation Act and other existing federal antidiscrimination laws and extends them into new healthcare settings. Section 1557 of the ACA provides that individuals "shall not . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination" under any federally funded health program or activity on the basis of race, sex, age, or disability. 42 U.S.C. § 18116(a).

The ACA provides a private right of action to enforce this equal-access guarantee. *Id.* Section 1557 does not define a new, standalone cause of action, but instead incorporates the "enforcement mechanisms" already provided by four other federal antidiscrimination laws—Title VI of the Civil Rights Act, which prohibits race discrimination; Title IX of the Education Amendments of 1972,

which prohibits sex discrimination; section 504 of the Rehabilitation Act, which prohibits disability discrimination; and the Age Discrimination Act of 1975. *Id.*

The ACA and its implementing regulations thus expanded the universe of potential defendants subject to discrimination actions. *See* Abbe Gluck et al., *The Affordable Care Act's Litigation Decade*, 108 Geo. L.J. 1471, 1505-06 (2020). The ACA prohibits discrimination in "any health program or activity," public or private, that receives federal funds. 42 U.S.C. § 18116(a). That prohibition extends to health insurance contracts that were never before subject to section 504. *See* 45 C.F.R. § 92.3(a)–(c). Thus, an employer that offers drug plans to retirees subsidized by the federal government may be subject to section 1557. *See* Kaiser Family Found., *An Overview of the Medicare Part D Prescription Drug Benefit* (Oct. 14, 2020), <https://tinyurl.com/n3tpj5wc>. So too is an insurance company that offers plans on the health insurance exchanges. *See* 85 Fed. Reg. 37,160, 37,173-74 (June 19, 2020).

The scope of liability under the ACA tracks the scope of liability under each of the pertinent discrimination statutes it incorporates. Pet.App.9a-11a; *Doe v. BlueCross BlueShield of Tenn., Inc.*, 926 F.3d 235, 238-41 (6th Cir. 2019); *accord* 45 C.F.R. §§ 92.2(b), 92.5(a); 85 Fed. Reg. 37,160, 37,202 (adopting same interpretation). In effect, the ACA provides four separate causes of action depending on the type of discrimination alleged. As relevant here, the same substantive standards apply to claims for disability discrimination under the ACA and claims under section 504 of the Rehabilitation Act, 29 U.S.C. § 794(a).

Three of the four statutes incorporated by the ACA reach only intentional discrimination and do not create a disparate-impact cause of action. *See BlueCross*, 926 F.3d

at 240. *Choate* expressly left open whether the fourth statute, the Rehabilitation Act, provides a disparate-impact claim for disability discrimination. 469 U.S. at 299.

B. Factual Background

1. Petitioner CVS Pharmacy, Inc. provides pharmacy services to millions of American consumers through nearly 10,000 retail pharmacies nationwide. CVS Health Corp., 2020 Form 10-K at 2 (Feb. 16, 2021), <https://tinyurl.com/tepwphny>. These retail locations do not just dispense prescriptions; they now stand on the front lines of the COVID-19 pandemic. To date, CVS pharmacies have conducted more than 10 million COVID-19 tests and administered more than 2 million vaccine doses. *See* CVS Health, Press Release, *CVS Health Named One of "World's Most Admired Companies" by Fortune Magazine for Seventh Consecutive Year* (Feb. 1, 2021), <https://tinyurl.com/u5cmcjdj>.

CVS subsidiaries also operate one of the largest pharmacy benefit management businesses in the United States, administering health and drug plans for over 100 million members. *See* 2020 Form 10-K at 2. "Pharmacy benefit managers (PBMs) are a little-known but important part of the process by which many Americans get their prescription drugs." *Rutledge v. Pharm. Care Mgmt. Ass'n*, 141 S. Ct. 474, 478 (2020). Pharmacy benefit managers administer prescription drug benefits on behalf of insurers or health plan sponsors—typically, employers that provide health insurance for their employees. Pharmacy benefit managers help employers and other clients contain the high cost of prescription drugs by negotiating lower prices and rebates from drug manufacturers, creating incentives for patients to use cheaper generic drugs, and developing networks of preferred pharmacies that will accept lower prices for prescriptions in exchange for

their inclusion in the network. *See In re Express Scripts/Anthem ERISA Litig.*, 285 F. Supp. 3d 655, 663 (S.D.N.Y. 2018); Acad. of Managed Care Pharm., *Preferred Pharmacy Networks* (May 20, 2019), <https://tinyurl.com/ 3kyvbapw>.

Of particular importance here, pharmacy benefit managers develop and manage drug formularies, or lists of drugs covered at different price points or levels of cost-sharing. *In re Express Scripts*, 285 F. Supp. 3d at 663. These efforts by pharmacy benefit managers will save employers and consumers an estimated $1 trillion on prescription drugs over the next 10 years. *See* Pharm. Care Mgmt. Ass'n, *The Value of PBMs*, <https://www.pcmanet.org/the-value-of-pbms/>.

One key driver of the overall cost of a benefit plan to employers is the expense of "specialty" medicines. Specialty drugs include drugs that treat rare conditions, have special handling or storage requirements, or simply cost more than typical medicines. *See* Pew Charitable Trusts, *Specialty Drugs and Health Care Costs* 1 (Dec. 2016), <https://tinyurl.com/48rcst96>. "For some chronic conditions, a year of treatment with a specialty drug can exceed $100,000." *Id.* at 2. Although only a small percentage of patients use specialty drugs, these drugs will likely account for 60 percent of total drug spending in 2021. Rachel K. Anderson, *Dose Optimization Interventions Yield Significant Drug Cost Savings*, Specialty Pharm. Continuum (2020), <https://tinyurl.com/mk7t3dtk>.

Pharmacy benefit managers often control the disproportionate costs and complexities of specialty drugs by contracting with specialty pharmacies. Pharmacy benefit managers and the plans they serve then encourage patients to fill their specialty prescriptions within a network

of designated specialty pharmacies. Those specialty pharmacies are specially qualified to serve patients who take these medications. Specialty pharmacies also stock and dispense specialty drugs at lower costs and can address special storage and handling requirements. *See, e.g.*, Pharm. Care Mgmt. Ass'n, *PBM Specialty Pharmacies Improve Patient Outcomes and Reduce Costs* 1, 3-6, 9 (2017), <https://tinyurl.com/kzwcjv7z>.

Increasingly, plans provide the greatest savings and services to their members by using specialty pharmacies that deliver by mail. *See, e.g.*, Visante, *Mail-Service and Specialty Pharmacies to Save More than $300 Billion for Consumers, Employers, and Other Payers Over the Next 10 Years* (Sept. 2014), <https://tinyurl.com/5kykvv8d>. Mail delivery demonstrably contains costs and improves patient outcomes. Patients who obtain their medicines by mail tend to adhere to their drug regimens better than patients who go in person to a retail pharmacy. *See* Julie A. Schmittdiel et al., *The Comparative Effectiveness of Mail Order Pharmacy Use vs. Local Pharmacy Use on LDL-C Control in New Statin Users*, 26 J. Gen. Internal Med. 1396, 1398 (2011). Pharmacy mail delivery also became an unexpected boon during the pandemic. Mail-order prescriptions rose 21 percent in 2020, a trend expected to continue even after the pandemic subsides. Jared S. Hopkins, *Mail-Order Drug Delivery Rises During Coronavirus Lockdowns*, Wall St. J. (May 12, 2020), <https://tinyurl.com/5cvdvp5s>.

2. This is one of multiple cases where plaintiffs have attempted to use the ACA's private right of action to attack insurance companies and pharmacy benefit managers that administer millions of Americans' health care plans. Respondents in this case are HIV-positive. Pet.App.26a. As alleged in the complaint, they receive

prescription drug coverage through their employers—Lowe's, Time Warner, and Amtrak. Plaintiffs allege that those employers use one or more CVS entities to manage their prescription drug benefits. Pet.App.6a, 26a.

Respondents' benefit plans cover the HIV medications they take. Pet.App.26a. The plans also offer these drugs at favorable, in-network prices. *Id.* To receive the in-network prices, respondents must have their specialty medications mailed to them, or accept drop shipment to a CVS pharmacy. *Id.* Respondents can also buy their HIV medications at other pharmacies, but if respondents choose that route, they pay higher, out-of-network prices. *Id.* These limitations are not unique to HIV medications; the plans impose these same delivery conditions on all medications classified as specialty drugs. Pet.App.26a, 37a.

Respondents' health plans categorize more than 300 drugs as specialty medications. Pet.App.37a. Beyond HIV medications, these specialty medications include contraceptive devices and treatments for common conditions like psoriasis, osteoporosis, arthritis, and asthma. CVS Specialty Pharm. Dist. Drug List (April 2018), <https://tinyurl.com/2p54et4h>. Respondents do not allege that their health plans intentionally place medicines or devices on the specialty list *because* they are used to treat HIV or any other disabling condition. This classification derives, instead, from the medicines' unique characteristics, including cost and special handling needs.

Respondents brought a putative class action in the Northern District of California seeking an exemption from the delivery conditions their benefit plans place on specialty medications, in addition to damages and other remedies. Pet.App.24a, 28a-29a. They assert that these plan terms have disproportionate effects on plan members with HIV or AIDS, in violation of section 1557 of the

ACA. Pet.App.26a. They further seek a court order forcing their health plans to make their specialty medications available at in-network prices at community pharmacies of their choice—a benefit not available to other, nondisabled plan participants who also take specialty medications. Pet.App.5a-7a, 26a-29a, 41a-42a. Respondents disavow any claim of intentional discrimination. Pet.App.35a-36a. Instead, they contend that section 1557 of the ACA, which incorporates section 504 of the Rehabilitation Act, provides a disparate-impact cause of action that permits them to challenge the terms and conditions of their benefit plans. Pet.App.13a-15a, 34a-36a.

The Northern District of California was not the only forum where respondents' counsel tested their disparate-impact theory. The same plaintiffs' lawyers brought similar claims in federal courts in Florida, New York, and Tennessee against various insurance companies and pharmacy benefit managers that placed materially identical conditions on specialty medications. The plaintiffs settled the two Florida cases. *See Doe v. Cigna Health & Life Ins.*, No. 15-cv-60894 (S.D. Fla., filed Apr. 27, 2015); *Doe v. Coventry Health Care, Inc.*, No. 15-cv-62685 (S.D. Fla., filed Dec. 22, 2015). The federal district court in New York dismissed the disparate-impact claim because the plaintiffs failed to plead facts showing the specialty medication policies had disproportionate impacts on HIV-AIDS patients, and the Second Circuit affirmed without elaboration. *In re Express Scripts*, 285 F. Supp. 3d at 688-89, *aff'd*, 837 F. App'x 44 (2d Cir. 2020).

The district court in Tennessee likewise dismissed the disparate-impact claims, and the Sixth Circuit affirmed, concluding that neither the Rehabilitation Act nor the ACA supports a disparate-impact theory. *See BlueCross BlueShield*, 926 F.3d at 241-43 (Sutton, J.). Plaintiffs did

not seek certiorari from the Sixth Circuit's judgment against them.

C. Proceedings Below

1. The district court granted CVS's motion to dismiss the complaint with prejudice. Pet.App.44a, 79a. The district court held that "Section 504 protects persons with disabilities from both intentional and disparate-impact discrimination." Pet.App.35a. The court then reasoned that such a disparate-impact claim requires plaintiffs to allege both that (1) a defendant's policy or practice produces different results on the basis of disability and (2) the impact on individuals with disabilities is "so significant" as to deny them "meaningful access" to a plan benefit or service. Pet.App.36a.

The court held that respondents' disparate-impact claim failed on both elements. Pet.App.36a-44a. As to disparate results, the court concluded that the plan treated patients differently depending on whether they received specialty drugs, *not* depending on their HIV-positive status, because specialty drugs treat both disabling and nondisabling conditions. Pet.App.36a-40a. The district court also concluded that the modest delivery conditions respondents' plans place on specialty medications did not deny them meaningful access to these drugs. Pet.App.43a-44a.

The district court further concluded that respondents could not use the ACA to force their insurance providers "to alter the terms" of their facially neutral plans to accommodate respondents' particular medical needs. Pet.App.41a. "If enrollees could avail themselves of out-of-network providers at in-network rates by contending that in-network care is inferior for any particular disabil-

ity, then the basis of the HMO/PPO model would be undermined." Pet.App.43a. "There is nothing in the ACA or its legislative history to suggest that this type of expansion was Congress' intent when enacting the statute." *Id.* (cleaned up).[1]

2. The Ninth Circuit vacated the district court's judgment in relevant part and remanded the disparate-impact claim for further proceedings. Pet.App.16a, 23a. With respect to the first question presented here, the Ninth Circuit held that "the unique impact of a facially-neutral policy on people with disabilities may give rise to a disparate impact claim." Pet.App.15a. The court's analysis spanned only two paragraphs and did not consider the statutory text or discuss the Sixth Circuit's *BlueCross* decision; it merely cited to earlier circuit precedents. Pet.App.12a, 15a (citing, *e.g.*, *Mark H. v. Lemahieu*, 513 F.3d 922, 937 (9th Cir. 2008)). Nor did the court acknowledge that it was splitting from the Sixth Circuit, which had held in the virtually identical *BlueCross* case that the ACA and the Rehabilitation Act do not embrace disparate-impact claims. The court's silence did not result from any lack of awareness: CVS relied on the Sixth Circuit *BlueCross* case in

[1] The district court also dismissed with prejudice respondents' claims against CVS under Title III of the Americans with Disabilities Act, the California Unruh Civil Rights Act, and the California Unfair Competition Law. Additionally, it dismissed with prejudice all of the claims respondents asserted against both CVS and their employers under the Employee Retirement Income Security Act ("ERISA"), as well as the catchall claim for declaratory relief. Pet.App.25a, 49a, 51a, 56a, 79a. The Ninth Circuit affirmed those rulings, vacating only the district court's dismissal of the ACA claim and the state-law unfair competition claim against CVS to the extent it is predicted on a violation of the ACA. Pet.App.23a. Thus, the employer defendants are no longer part of the case.

its briefing, and the panel cited it favorably for other points. Pet.App.9a-11a, 17a-18a.

With respect to the second question presented, the Ninth Circuit held that respondents could bring a disparate-impact claim under the ACA to attack the sufficiency of their pharmacy benefit plans. Pet.App.13a-16a. The Ninth Circuit concluded that the district court had erred by requiring respondents to allege that their plan terms "impact[] people with HIV/AIDS in a unique or severe manner." Pet.App.16a. It held that respondents had stated a claim by alleging that their plan denied them "medically appropriate dispensing of their medications." Pet.App.14a. In essence, the Ninth Circuit concluded that the ACA's equal-treatment provision may provide a substantive entitlement to pharmacy care respondents "deem critical to their health." Pet.App.13a.

Petitioners filed a petition for rehearing or rehearing en banc, which the Ninth Circuit denied. Pet.App.81a-82a.

REASONS FOR GRANTING THE PETITION

The Ninth Circuit's decision deepens a square, widely acknowledged conflict among the circuits concerning whether section 504 of the Rehabilitation Act, and therefore the ACA, creates a disparate-impact cause of action for disability discrimination. And the decision below opens a second split on whether disparate-impact claims may be applied to the terms and conditions of health insurance plans. Both questions are squarely and cleanly presented and were outcome-determinative below. The Ninth Circuit's flawed decision creates significant practical and legal consequences for managing health insurance costs at a time when insurers and healthcare providers

are already confronting the yearlong COVID-19 pandemic. And the insurance context in which this case arises provides a useful framework for addressing, and resolving, the concerns this Court has raised with disparate-impact liability more generally—concerns that apply well beyond the healthcare arena.

This Court's intervention is especially warranted because the Ninth Circuit divided from the Sixth Circuit on substantially identical facts. The same law firms advanced the same legal theories on behalf of identically situated plaintiffs against nationwide companies in each of these circuits. Yet those courts reached polar opposite results. Only this Court's immediate intervention can provide consistency and clarity with respect to the implementation of these important federal statutes, which affect thousands of public agencies and private companies around the country.

I. The Decision Below Splits with Other Circuits

A. The Circuits Are Intractably Divided on Whether Section 504 Creates Disparate-Impact Liability

Nearly 40 years ago, this Court in *Choate* left open whether section 504 authorizes disparate-impact causes of action for disability discrimination. The courts of appeals have fractured 4-1 on that question, which now controls liability under the ACA as well. This widely acknowledged split cries out for the Court's immediate resolution.

1. The Sixth Circuit held in a unanimous opinion authored by Judge Sutton that section 504 "does not prohibit disparate-impact discrimination." *BlueCross BlueShield*, 926 F.3d at 241. The Sixth Circuit acknowledged that this holding opened a split with its sister circuits, but it concluded that the plain text of the statute

permits no other result. *Id.* at 242-43. Section 504 prohibits discrimination "*solely by reason of* . . . disability." 29 U.S.C. § 794(a) (emphasis added). "That language does not encompass actions taken for nondiscriminatory reasons," and thus does not authorize disparate-impact suits, which target facially neutral actions based on disparities in their effects. 926 F.3d at 242.

The Sixth Circuit noted that Title VI of the Civil Rights Act, on which section 504 is modeled, does not authorize disparate-impact liability. *Id.* In *Alexander v. Sandoval*, 532 U.S. 275, 279-81 (2001), this Court held that Title VI creates a private right of action only for intentional discrimination. Because Title VI does not reflect congressional intent to create a disparate-impact claim, neither federal agencies nor the courts could recognize one. *Id.* at 293. In light of *Sandoval*, the Sixth Circuit concluded that section 504's "essentially identical" text "leaves no room for the statute to prohibit disparate-impact discrimination." *BlueCross*, 926 F.3d at 243.

The Sixth Circuit also pointed to practical and fairness concerns with imposing disparate-impact liability in this context. Because individuals with disabilities and individuals without disabilities are not similarly situated in many ways, even "neutral" and "well-intentioned" policies or rules may disparately affect individuals with disabilities. *Id.* at 242. "Even entertaining the idea of disparate-impact liability in this area invites fruitless challenges to legitimate, and utterly nondiscriminatory, distinctions, as this case aptly shows." *Id.*

Thus, the Sixth Circuit affirmed dismissal of a disparate-impact claim substantively identical to the claim in this case, brought by the same plaintiffs' counsel on behalf of similarly situated HIV-AIDS patients. *Id.* at 237.

2. Four other circuits, including the Ninth Circuit in the decision below, embrace the exact opposite position and allow plaintiffs to pursue disparate-impact causes of action for disability discrimination under the Rehabilitation Act, and thus under the ACA. In the Second, Seventh, Ninth, and Tenth Circuits, plaintiffs can pursue the very theory that the Sixth Circuit categorically barred.

Start with the Second Circuit. That court has long held that the Rehabilitation Act creates a disparate-impact cause of action. *Reg'l Econ. Cmty. Action Program, Inc. v. City of Middletown*, 294 F.3d 35, 48 (2d Cir. 2002). The court has affirmed this approach in multiple cases, *see Brooklyn Ctr. for Psychotherapy, Inc. v. Phil. Indem. Ins.*, 955 F.3d 305, 311-12 (2d Cir. 2020); *Fulton v. Goord*, 591 F.3d 37, 43 (2d Cir. 2009), instructing that plaintiffs state a cognizable claim by alleging "a significantly adverse or disproportionate impact on persons of a particular type produced by the defendant's facially neutral acts or practices." *B.C. v. Mount Vernon Sch. Dist.*, 837 F.3d 152, 158 (2d Cir. 2016).

The law in the Seventh Circuit is equally clear that "at least some disparate impact discrimination is covered" under section 504 of the Rehabilitation Act. *McWright v. Alexander*, 982 F.2d 222, 229 (7th Cir. 1992). And the Seventh Circuit has expressly affirmed its agreement with the Second Circuit that "[a] plaintiff may prove a violation of the . . . Rehabilitation Act by showing . . . disparate impact." *Valencia v. City of Springfield*, 883 F.3d 959, 967 (7th Cir. 2018) (citing *Reg'l Econ. Cmty. Action Program*, 294 F.3d at 48).

The Tenth Circuit likewise recognizes disparate-impact claims under the Rehabilitation Act. *N.M. Ass'n for Retarded Citizens v. New Mexico*, 678 F.2d 847, 854 (10th Cir. 1982). The Tenth Circuit considered whether this

Court's opinion in *Sandoval* required revisiting that conclusion—but, in stark contrast with the Sixth Circuit, it concluded that "*Sandoval* does not affect plaintiffs' right to bring a disparate impact claim under section 504 of the Rehabilitation Act." *Robinson v. Kansas*, 295 F.3d 1183, 1187 (10th Cir. 2002). In the Tenth Circuit's view, *Sandoval* does not control because the Civil Rights Act and the Rehabilitation Act serve different purposes, notwithstanding their "essentially identical" text. *Id.* The Tenth Circuit doubled down on that position a year later, reaffirming that "Congress sought with § 504 . . . to remedy a broad, comprehensive concept of discrimination against individuals with disabilities, including disparate impact discrimination." *Chaffin v. Kan. State Fair Bd.*, 348 F.3d 850, 859-60 (10th Cir. 2003).

In the decision below, the Ninth Circuit further cemented the split, holding that the Rehabilitation Act provides for disparate-impact claims. Pet.App.12a-16a. And the Ninth Circuit has given no indication it intends to revisit that ruling and conform its law to the Sixth Circuit's. To the contrary, CVS featured the Sixth Circuit's *BlueCross* decision in its appeal brief, and the full Ninth Circuit rejected a petition for rehearing en banc in which CVS again highlighted the clear conflict. Pet.App.81a-82a.

In short, no further percolation is necessary. Multiple circuits hold that the Rehabilitation Act creates a disparate-impact claim, even after *Sandoval* held that no such claim is available under a substantially identical statute. The Sixth Circuit, holding otherwise, openly criticized that position as inconsistent with *Sandoval* and the statutory text. And the Ninth Circuit sharpened the split by breaking with the Sixth in a substantially identical case. Only this Court can break the impasse by resolving the

question it left open in *Choate*.

3. The federal government, scholars, and practitioners have all recognized this glaring split. The Department of Health and Human Services, the agency charged with interpreting the ACA's antidiscrimination provisions, acknowledges that "there is a split on the question" of whether section 504 embraces disparate-impact claims "with respect to disability." HHS, *Nondiscrimination in Health and Health Education Programs and Activities*, 84 Fed. Reg. 27,846, 27,851 & n.22 (June 14, 2019) (contrasting Sixth Circuit with Seventh and Tenth Circuits).

Scholars and practitioners have also highlighted the division among the circuits over "whether litigants can bring disparate impact disability discrimination cases under section 1557" of the ACA. Gluck, *The Affordable Care Act's Litigation Decade*, 108 Geo. L.J. at 1507; *see also* Bryan D. Bolton, *Sixth Circuit Rejects Disparate Impact Discrimination Claim against Health Insurer Under the Affordable Care Act*, IADC Comm. Newsletter (Aug. 2019), <https://tinyurl.com/ydxvus7p> (opining that certiorari is needed to resolve split between Sixth Circuit and other circuits); Jordan Mamorsky, *A Sigh of Relief for Employers Subject to Potential ACA Disparate Impact Discrimination Claims*, Wagner Law Group (July 23, 2019), <https://tinyurl.com/66j7umw> (outlining split between Sixth Circuit and Seventh and Tenth Circuits).

4. The split is especially untenable because the Sixth and the Ninth Circuits reached different results on materially identical facts. For companies that operate in both circuits, these dueling decisions threaten a Hobson's choice. These companies can either decide now to take a uniform national approach that conforms to the Ninth Circuit's more restrictive requirements, notwithstanding the costs and harm to their businesses. Or they can run the

risk that litigants will wield the Ninth Circuit's ruling to upend the way these businesses operate in the future. This Court should not allow the Ninth Circuit to interpret the Rehabilitation Act and the ACA for the entire country.

This Court has not hesitated to grant certiorari when splits on identical facts have materialized and placed identically situated parties at the mercy of warring opinions. In *Christopher v. SmithKline Beecham Corp.*, 567 U.S. 142, 153 (2012), the Court resolved a 1-1 split that imposed competing wage-and-hour obligations on pharmaceutical companies in the Second Circuit (Novartis) and the Ninth Circuit (SmithKline). In *AT&T Corp. v. Hulteen*, 556 U.S. 701 (2009), the Court heard a case in which the Seventh and Ninth Circuits disagreed on whether the "very same" seniority system violated Title VII. *See* Pet. for Cert., No. 07-543, 2007 WL 3129920, at *2 (Oct. 22, 2007). In *Ballard v. Commissioner*, 544 U.S. 40, 51-52 (2005), the Court granted certiorari after three circuits split 2-1 in appeals involving three co-defendants who participated in the same alleged tax scheme. And in *Advocate Health Care Network v. Stapleton*, 137 S. Ct. 1652, 1657 (2017), the Court reviewed three circuit decisions that divided on the validity of the same cause of action filed against church-affiliated benefit plans around the country.

The case for this Court's intervention is equally compelling here. Businesses have no good choices when the exact same policies that would subject them to disparate-impact liability in one circuit are permissible in another. The Court should grant certiorari to ensure coherent, uniform interpretation of important federal laws on an issue of recurring importance.

B. The Ninth Circuit Is a Stark Outlier in Applying a Disparate-Impact Theory to Insurance Plans

Even in circuits that allow a disparate-impact claim

under the ACA and the Rehabilitation Act, the Ninth Circuit's decision below opened a second direct conflict over whether plaintiffs may use those laws to attack the terms and conditions of health benefit plans.

1. All four circuits to consider analogous claims have rejected challenges to facially neutral benefit plans. In these circuits, benefit plans pass muster under the Rehabilitation Act as long as they offer the same suite of benefits to disabled and nondisabled individuals, even if individuals with disabilities have different or greater medical needs.

Take the D.C. Circuit, which has instructed that a plaintiff can *never* state a disparate-impact claim under section 504 based "on the terms of an insurance plan." *Modderno v. King*, 82 F.3d 1059, 1061 n.1 (D.C. Cir. 1996). In the D.C. Circuit's view, disparate-impact claims might be available under section 504 to remedy "such matters as architectural barriers, job qualifications, and access to public transportation" that prevent people with disabilities from taking advantage of services generally available to the public. *Id.* But section 504 is not a tool for mandating health plans tailored to the medical needs of individuals with disabilities. *Id.* As Judge Ginsburg stated in his concurrence: "As long as the [plan] offers the same coverage to all insureds, regardless of disability, it cannot be said to discriminate on the basis of disability." *Id.* at 1066.

Similarly, the Second Circuit rejected a claim that the Rehabilitation Act required New York to continue providing specialized clinical care to disabled children at a facility convenient to their homes. *See CERCPAC v. Health and Hosps. Corp.*, 147 F.3d 165, 168 (2d Cir. 1998). The court reasoned that "the disabilities statutes do not guarantee any particular level of medical care for disabled persons." *Id.* And the plaintiffs had not alleged they were

denied any benefits or services available to nondisabled children. *Id.*

The Third Circuit dismissed a claim that an employer must modify its health insurance plan to provide the same level of benefits to employees with mental and physical disabilities. In *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 608 (3d Cir. 1998), it held that employers satisfy their equal-treatment obligations when they afford all employees "the opportunity to join the same plan with the same schedule of coverage." *Id.* "So long as every employee is offered the same plan regardless of that employee's contemporary or future disability status, then no discrimination has occurred." *Id.* Although *Ford* concerned a claim under the Americans with Disabilities Act ("ADA"), it extensively cited and applied Rehabilitation Act precedents in reaching that conclusion.

Likewise, the Tenth Circuit held in *Taylor v. Colorado Department of Health Care Policy and Financing*, 811 F.3d 1230, 1236 (10th Cir. 2016), that a state Medicaid plan need not engineer a new benefit requested by a patient with disabilities—transportation to medical appointments—because that benefit was not generally available to all plan participants. The Tenth Circuit affirmed that the Rehabilitation Act simply required the State to offer the same benefits to all Medicaid recipients regardless of their disability status. The State need not "alter a benefit's scope 'simply to meet the reality that certain handicapped have greater medical needs.'" *Id.* at 1234 (quoting *Choate*, 469 U.S. at 303) (brackets omitted).

In short, these circuits hold that the Rehabilitation Act requires only that health plans or providers offer the same package of benefits regardless of a person's disability status. Each of these circuits has squarely rejected claims that health plans or providers must offer services

to people with disabilities on special terms not available to others. And in each of these circuits, CVS would have prevailed. Respondents' allegations—that their unique medical needs justify an exemption from the specialty medicine rules that apply to all plan participants—would not have stated a cause of action in each of these circuits.

2. In direct conflict with these four circuits' decisions, the Ninth Circuit held here that section 504 and the ACA provide a cause of action for plaintiffs seeking to modify the terms of a benefit plan to suit the medical needs of people with particular disabilities. Where other circuits have underscored that the Rehabilitation Act does not guarantee any particular level of medical care, the Ninth Circuit held that respondents had "adequately alleged" that their plan restrictions interfered with "effective treatment" of their condition and denied them "medically appropriate dispensing of their medications." Pet.App.14a. Now, the Ninth Circuit stands alone in opening its doors to disparate-impact claims under the Rehabilitation Act that would force plans to tailor benefits to particular disabled patients' medical needs.

Absent this Court's intervention, companies would face unacceptable uncertainty. In the wake of the Ninth Circuit's novel application of disparate-impact liability to the terms and conditions of health plans, employers and other plan sponsors must decide whether to increase their plan members' costs across the board in anticipation of accommodating exemptions to their carefully chosen plan terms. Otherwise, employers and plan sponsors risk litigation and possible injunctions where courts step in and micromanage how plans should structure their offerings. Pharmacies and prescription drug distributors face uncertainty in inventory management and distribution channels if they can no longer rely on health plans' network

limitations to funnel certain prescriptions through mail-order and specialty pharmacies. Pharmacy benefit managers must question which of their proven tools for managing costs and promoting safe and effective drug benefits—such as drug formularies and preferred networks—could be invalidated by litigants armed with the Ninth Circuit's opinion. The decision below thus hamstrings many major companies in managing one of the most critical elements of their business: predicting and balancing costs with patient needs and the mix of services and conditions that can be deployed to meet them efficiently.

II. The Decision Below Is Wrong

The Ninth Circuit was wrong to conclude that section 504 embraces disparate-impact claims. Private rights of action require a clear statement of congressional intent. *Sandoval*, 532 U.S. at 286-87. But the text of section 504 betrays no intent to create a private remedy for disparate-impact discrimination. And even if section 504 were interpreted to reach *some* claims of disparate impact, the Ninth Circuit profoundly erred in applying this theory to the facially neutral terms of health plan contracts.

1. The plain text of section 504 forecloses the argument that Congress intended to create a disparate-impact cause of action for disability discrimination. As this Court recently recognized, Congress uses distinct language to convey its intent to allow a disparate-impact remedy—for example, it prohibits conduct that "*otherwise*" adversely affects the members of a protected class or "*otherwise*" makes a benefit unavailable to them. *Tex. Dep't of Housing & Cmty. Affs. v. Inclusive Cmtys. Project, Inc.*, 576 U.S. 519, 534 (2015) (emphasis added). "This results-oriented language counsels in favor of recognizing disparate-impact liability." *Id.*

Section 504 contains no such telltale phrasing. The statute strictly limits liability to cases in which discrimination occurs "*solely by reason of* . . . disability." 29 U.S.C. § 794(a) (emphasis added). As the Sixth Circuit correctly recognized, "[t]hat language does not encompass actions taken for nondiscriminatory reasons." *BlueCross*, 926 F.3d at 242.

In other contexts, this Court has instructed that "solely by reason of" means "for no reason other than." *Husted v. A. Philip Randolph Inst.*, 138 S. Ct. 1833, 1842 (2018) (interpreting 52 U.S.C. § 21083(a)(4)(A)). Thus, when section 504 proscribes discrimination "solely by reason of" a disability, it prohibits discrimination that occurs "for no reason other than" that disability. Had Congress intended to provide for a disparate-impact claim—a claim that targets the inadvertent effects of a facially neutral law—it could not have chosen more ill-fitting language.

In *Choate*, this Court assumed without deciding that section 504 might embrace some disparate-impact liability. 469 U.S. at 299. But *Sandoval* resolved that open question. That case held that Title VI of the Civil Rights Act provides a private right of action only for intentional race discrimination, not for disparate impacts. 532 U.S. at 280. As the Sixth Circuit recognized, the "essentially identical text" of the remedial provisions in the Rehabilitation Act and Civil Rights Act "leaves no room" for argument that a disparate-impact claim is available under one statute but not the other. *BlueCross*, 926 F.3d at 243.

Section 1557 of the ACA incorporates the private rights of action in section 504 and Title VI and underscores the need to interpret them in tandem. *See* pp. 6-8, *supra*. If the Ninth Circuit's decision stands, then plaintiffs alleging disability discrimination under the ACA will

have a disparate-impact claim, while plaintiffs alleging racial discrimination—or any other kind of discrimination—in the exact same context will not. *See BlueCross*, 926 F.3d at 240. Congress could not have intended such an odd result.

2. Even if section 504 reaches some disparate-impact claims, the Ninth Circuit's decision in this case would still be wrong. Section 504 cannot be used to challenge the terms and conditions of a facially neutral health insurance plan. *See Modderno*, 82 F.3d at 1061 n.1.

Numerous scholars have recognized that disparate-impact claims cannot rationally be applied to insurance plans because such plans "are *designed* to discriminate on the basis of physical or mental characteristics that indicate actuarial risk—some of them disabilities protected by" section 504. Melissa Cole, *Beyond Sex Discrimination*, 43 Ariz. L. Rev. 501, 521-22 (2001) (emphasis added). "This understanding fuels the argument that insurance plans should not be subject to [section 504] because imposing such liability would fundamentally alter the nature of the business of insurance itself." *Id.* at 522; *see also* Mary Crossley, *Becoming Visible: The ADA's Impact on Health Care for Persons with Disabilities*, 52 Ala. L. Rev. 51, 77-81 (2000) (similar); *Choate*, 469 U.S. at 302-04 (concluding that plaintiffs could not use section 504 to attack package of "individual services offered").

Indeed, Congress specifically *exempted* employers from liability under the ADA for providing health insurance plans that create disparate impacts on people with disabilities. The ADA prohibits employers from discriminating on the basis of disability in "employee compensation" and specifically bars them from contracting for "fringe benefits" that do the same. 42 U.S.C. § 12112(a)–(b). But the statute specifically exempts insurance plans

that use bona fide underwriting criteria. *Id.* § 12201(c); *see Ford*, 145 F.3d at 614-15 (Alito, J., concurring) (applying safe harbor to reject challenge to mental health benefits in employer-sponsored plan). Congress could not possibly have intended for the general cause of action under section 504 to provide a claim that the more specific provisions in the ADA explicitly withdraw.

The facts of this case illustrate why applying section 504 to health insurance or pharmacy benefit plans makes no sense. Plaintiffs challenge delivery conditions their plan places on specialty medications, including their HIV medications. Specialty medications typically include drugs that treat complex medical conditions or rare diseases; that have unique storage or shipment requirements; that are dispensed through injection or inhalation; or that have a high cost. *See* Pharm. Care Mgmt. Ass'n, *What Is a Specialty Drug?*, <https://tinyurl.com/mpc4ak3y>. These drugs have characteristics that separate them from inexpensive generics or other drugs available at a neighborhood pharmacy. It is perfectly rational for a health plan to impose conditions that respond to the nature of these *drugs*—not to the disability status of the individuals who require them. "The common trait linking the listed drugs is cost, not the disabled status of their users." *BlueCross*, 926 F.3d at 241. These sorts of decisions do not reflect discrimination "solely by reason of" a disability, as section 504 requires. 29 U.S.C. § 794(a).

III. The Questions Presented Are Recurring, Exceptionally Important, and Squarely Presented

1. Whether section 504 encompasses disparate-impact liability is a question of recurring and pressing importance. As an initial matter, the universe of potential defendants affected by this question is enormous, span-

ning both the public and private sectors. Traditional defendants in Rehabilitation Act cases include public agencies like school districts and state universities, state Medicaid plans, and public transportation departments, as well as federally funded healthcare facilities, like hospitals. *See, e.g.*, *Choate*, 469 U.S. at 289 (Medicaid); *Ruskai v. Pistole*, 775 F.3d 61, 77-81 (1st Cir. 2014) (Transportation Security Administration); *DeBord v. Bd. of Educ.*, 126 F.3d 1102, 1105-06 (8th Cir. 1997) (school district). The ACA vastly expands the statute's reach to include additional healthcare activities and entities, such as the health insurance industry.

Disparate-impact liability creates unique hazards for any of these defendants. Unlike claims for intentional discrimination, "[d]isparate impact cases, by their nature, do not involve clear-cut violations of the law." Jennifer C. Braceras, *Killing the Messenger: The Misuse of Disparate Impact Theory to Challenge High-Stakes Educational Tests*, 55 Vand. L.R. 1111, 1193 (2002). Perhaps for that reason, these claims fail a great majority of the time. One scholar examined disparate-impact rulings over a multiyear period ending in 2001 and found that discrimination plaintiffs prevailed in federal appeals courts less than 20 percent of the time, with only slightly better success rates in the district courts. Michael Selmi, *Was the Disparate Impact Theory a Mistake?*, 53 UCLA L.R. 701, 738-40 (2006).

Even when disparate-impact claims ultimately fail, they impose enormous litigation costs on defendants. Particularly when brought as class actions (as here), disparate-impact claims threaten defendants with the specter of an injunction requiring costly adaptations to programs or services. "The size of the cases, and the prospect of costly injunctive relief, suggest that these claims are

likely to be litigated at some level rather than quickly settled." *Id.* at 737.

Equally problematic, disparate-impact claims thrust courts into a policymaking role that properly belongs to the political branches or private enterprise. When a public agency or private company is ordered to remedy a disparate impact, it may have to fund these changes at the expense of other priorities. Weighing the costs and benefits of these changes is quintessentially a legislative (or business) task. Federal courts stray from their role in making "the sort of broad-based distributive decision[s]" that disparate-impact claims often involve. *See Choate*, 469 U.S. at 308.

The challenges respondents have brought to the pharmacy benefits provided by their employers implicate these very concerns. Respondents assert that the restrictions their health plans impose on specialty medications should not apply to them because of their disability. But allowing the exemption that respondents seek would require a tradeoff. If CVS and plan sponsors like respondents' employers cannot use these common cost-containment strategies, then either the cost of the pharmacy plan will increase overall or benefits must be reduced for other patients with different medical needs. Courts simply are not equipped to make judgments about how to allocate benefits and services in a way that takes the interests of all plan participants into account.

The Department of Justice made precisely this point in *Modderno*, where the D.C. Circuit concluded that disparate-impact claims could not be applied to health insurance plans. 82 F.3d at 1061 & n.1. The United States sponsored the health plan at issue there and opposed the plaintiff's position that the plan was required to provide

the same level of benefits for mental and physical disabilities. The government explained that this theory, if accepted, would "invite challenges to virtually every exercise of [its] discretion with respect to the allocation of benefits amongst an encyclopedia of illnesses." Br. of United States, *Modderno v. King*, No. 94-5400 (D.C. Cir. Jan. 12, 1996), 1995 WL 17204324, at *9-10 (quotation omitted).

If the Ninth Circuit's opinion is allowed to stand, these ill-conceived attacks on health insurance plans will only proliferate. Plaintiffs have already repeatedly attempted to use the ACA's private right of action to challenge a wide variety of health plans and policies, from allegedly discriminatory pricing of Hepatitis C drugs, *SEPTA v. Gilead Scis., Inc.*, 102 F. Supp. 3d 688 (E.D. Pa. 2015), to a pharmacy's policy of limiting dosages for opioid prescriptions, *Smith v. Walgreens Boots Alliance, Inc.*, No. 20-cv-05451, 2021 WL 391308, at *7-8 (N.D. Cal. Feb. 3, 2021). This sort of piecemeal litigation is no way to construct a benefit policy that balances the needs of many different patients.

2. This case is an ideal vehicle for addressing both questions presented. The case comes up for review from the denial of a motion to dismiss and does not require the Court to navigate a lengthy factual record. It has no procedural or jurisdictional defects that would impede this Court's review.

What is more, the Ninth Circuit's resolution of both questions was outcome-determinative. Had respondents brought their claims in the Sixth Circuit—as their lawyers did on behalf of a class of identically situated plaintiffs—there is no question they would have been rejected. The Sixth Circuit announced that the "open question" under *Choate* about whether the Rehabilitation Act permits disparate-impact claims was now definitively "close[d]."

BlueCross, 926 F.3d at 241. Yet, in the Ninth Circuit, the issue is not only alive but thriving, paving the way for the very lawsuit the Sixth Circuit found so noxious. The stark split between the Sixth and Ninth Circuits provides an unusual opportunity for the Court to consider the reasoning of two circuits unclouded by the factual distinctions that often provide a basis for distinguishing cases. Likewise, had respondents brought their claims in any other circuit save the Ninth, those courts would not have allowed disparate-impact claims that seek to rewrite the terms of health benefit plans.

Additionally, the facts of this case, involving a challenge to pharmacy benefit plans, provide an instructive setting in which to consider the distributive concerns with disparate-impact claims more generally. Indeed, the two questions presented—whether a disparate-impact theory, if available at all, may be applied to insurance or pharmacy benefit plans—are inextricably intertwined. Granting certiorari on both issues would give this Court the greatest flexibility in resolving this case.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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