No. 18-5897

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

JOHN DOE,
Plaintiff-Appellant,

v.

BLUECROSS BLUESHIELD OF TENNESSEE, INC.,
Defendant-Appellee.

On Appeal from a Judgment of the United States District Court for the Western District of Tennessee, Civil Action No. 2:17-cv-02793 (Parker, J.)

BRIEF OF APPELLEE BLUECROSS BLUESHIELD OF TENNESSEE, INC.

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1 and 6th Cir. R. 26.1, BlueCross BlueShield of Tennessee, Inc. makes the following disclosure:

1. Is said party a subsidiary or affiliate of a publicly owned corporation? If yes, list below the identity of the parent corporation or affiliate and the relationship between it and the named party:

No.

2. Is there a publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome? If yes, list the identity of such corporation and the nature of the financial interest.

No.

/s/ Todd Kim
Todd Kim

Dated: January 22, 2019

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STATEMENT IN SUPPORT OF ORAL ARGUMENT

BlueCross BlueShield of Tennessee, Inc. supports oral argument to ensure the Court has full opportunity to entertain both sides' contentions in this important case.

INTRODUCTION

The district court properly dismissed this attempt to upend the health insurance industry. Coverage under a health benefit plan, and a plan member's financial responsibility relating to a covered service, commonly depend upon whether the member chooses to use in-network or out-of-network providers. John Doe challenges how his former employer, through a benefit plan administered by BlueCross BlueShield of Tennessee, Inc. ("BCBST"), limits coverage for designated specialty medications to designated, network specialty pharmacies. Doe asserts that the Patient Protection and Affordable Care Act ("ACA"), the Rehabilitation Act, the Americans with Disabilities Act ("ADA"), and Tennessee common law entitle him instead to fill his prescription at his pharmacy of choice, because any contrary requirement constitutes unlawful discrimination against those who, like him, have HIV.

There is no merit to Doe's claims. BCBST does not discriminate unlawfully by administering a health plan that routes specialty medications covering a variety of different medical conditions to specific pharmacies, where everyone under the plan can obtain specialty medications with full coverage in precisely the same way. Binding precedent recognizes that this practice—which Doe terms "the Program"—is not illegal merely because it may have different effects on different classes of individuals, including those with HIV. And as binding precedent further recognizes,

Doe cannot claim discrimination where his complaint concerns benefits to which he lacks any entitlement. Under the Program, he undisputedly gets the benefits provided under his health benefit plan, including coverage of his prescription medications. The in-person consultation with his specific community pharmacist he further desires is simply not a plan benefit. Moreover, he *can* still consult with that pharmacist even if he fills one specific prescription elsewhere.

It is telling that Doe repeatedly tries to ignore or distort the plain statutory text he cannot overcome—for instance, the requirements that he show that he suffers discrimination "solely by reason of" his HIV disability and that BCBST "operates" his community pharmacy through the Program. He repeatedly mischaracterizes the district court's sound reasoning—for instance, by charging the district court with ignoring arguments he never made. And, indeed, Doe repeatedly shifts course from the arguments he actually preserved below to new but equally unsupported arguments.

Accepting Doe's theory would have stark consequences for employer sponsors of group health plans, health insurers and plan administrators, and the health care industry more broadly. Network requirements help manage health care costs for the benefit of members. Doe, however, would require plan sponsors and administrators acting on their behalf ultimately to accede to individual members' choices on how to make prescription medications available, and thus would

significantly increase costs for all members. And his legal theory would not stop there, but would implicate pricing and all other aspects of a health insurer's or administrator's treatment of members with disabilities. Plan sponsors must retain the authority to define what benefits they will provide to members, and neither federal statutes nor Tennessee common law cited by Doe says otherwise. The district court thus correctly held that his theories are fatally flawed. Its judgment should be affirmed.

STATEMENT OF THE ISSUES

1. Whether the district court was correct to dismiss Doe's ACA claim, where the ACA incorporates the legal standard of Section 504 of the Rehabilitation Act and where the complaint demonstrates that he cannot prove, consistent with that Act, that BCBST denied him benefits under his health plan or discriminated against him "solely by reason of" his HIV status.

2. Whether the district court was correct to dismiss Doe's ADA claim, where the complaint disproves his theory that BCBST "operates" his community pharmacy within the ADA's meaning and where this Court's precedent makes clear that the ADA does not regulate the health plan that BCBST administers.

3. Whether the district court was correct to dismiss Doe's contract claim, where he does not dispute that he must identify some contract provision that BCBST violated, yet does not identify any such provision.

4. Whether the Court should reject Doe's request for a remand for leave to amend the complaint a second time, where he has repeatedly failed to specify how he would do so and where in any event the district court was correct to hold that any further amendment would be futile because Doe's legal theories are infirm.

STATEMENT OF THE CASE

1. Doe Receives Health Benefits From His Former Employer Through A Plan Administered By BCBST, Under Which Specialty Medications Are Covered By A Program With Designated Specialty Pharmacies.

Doe receives health benefits under a group health plan sponsored by his former employer. Am. Compl., R.38, PageID #323 ¶ 70.[1] As the health plan's sponsor, his former employer entered into a "Group Agreement" by which it "delegated discretionary authority to [BCBST] to make any benefit or eligibility determinations" and "construe the terms" of the health plan. Memo. in Supp. of Mot. to Dismiss Ex. A, R.40-1, PageID #381. The plan sponsor "retains the authority to determine whether [members] are eligible for Coverage." *Id.*

The health plan offered by Doe's former employer through BCBST provides benefits for physician care and prescription drugs (among many other health care items and services). *Id.*, PageID #439-59. Certain prescription drugs that BCBST

[1] The facts set forth come from the allegations in Doe's amended complaint, which are assumed true for present purposes, and from "document[s] … referred to in the complaint" that are "central to the plaintiff's claim[s]." *Greenberg v. Life Ins. Co. of Va.*, 177 F.3d 507, 514 (6th Cir. 1999).

determines "require special handling" are considered specialty medications and are covered through a network of designated specialty pharmacies. Am. Compl., R.38, PageID #266-67 ¶ 3, #326 ¶ 80.[2] Doe's health plan does not provide benefits if members obtain specialty medications outside of the specialty pharmacy network. *Id.*, PageID #266-68 ¶¶ 3-4. The network includes both mail-order pharmacies and "typically … a couple" brick-and-mortar pharmacies for in-person pickup in each county in Tennessee. *Id.*, PageID #266-67 ¶ 3.

Under this Program, over four hundred drugs are designated as specialty medications. *Id.*, PageID #286-317 ¶ 50. The Program covers specialty medications for over fifty conditions, including cancer, osteoporosis, severe cholesterol, and allergic rhinitis (*i.e.*, runny nose). *Id.* Doe concedes that "specialty pharmacies may be appropriate for some patients or some medications." *Id.*, PageID #317 ¶ 51.

2. Doe Objects To The Program Because He Wants The Plan's Coverage Of His Specialty Medication To Extend To His Community Pharmacist.

Doe is HIV-positive and takes Genvoya—an HIV drug that is a specialty medication under his health plan. Am. Compl., R.38, PageID #276 ¶ 22. The

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[2] The Program website, cited in the complaint (Am. Compl., R.38, PageID #271 n.4), details further advantages: "[p]atient care coordinators"; "[e]ducational materials"; "[a]bility to call and consult with clinical pharmacists"; "[p]otential savings on specialty medications"; and "[p]roduct delivery anywhere you choose." BCBST, *Specialty Medications Program*, http://www.bcbst.com/manage-my-plan/pharmacies-and-prescriptions/specialty-medications-program.page (last visited Jan. 19, 2019).

Program thus requires him to obtain Genvoya from the specialty pharmacy network in order for the medication to be covered by the health plan. *Id.* Some but not all prescription drugs that treat HIV are specialty medications subject to the Program. *See id.*, PageID #287 ¶ 50 & n.6.

After being informed of the Program, Doe began receiving Genvoya by mail-order. *Id.*, PageID #276-77 ¶ 22. He does not dispute that he has continued to receive his medication in a timely manner. Doe alleges that BCBST failed to inform him at first that he could obtain Genvoya in-person at a brick-and-mortar specialty pharmacy location as well, and further that BCBST fails to publicize that option, such that the Program is "effectively a mandatory mail-order program." *Id.*, PageID #265-66 ¶ 1, #324-26 ¶¶ 76-77.

Doe asked BCBST if he could "opt out of the Program" to fill his Genvoya prescription at his preferred community pharmacy, rather than through BCBST's network of specialty pharmacies, yet still receive the full benefits provided by his health plan. *Id.*, PageID #324 ¶ 75. BCBST denied his request in accordance with the terms of the health plan. *Id.*, PageID #324-25 ¶ 76; Am. Compl. Ex. A, R.38-1, PageID #346-48. BCBST later sent Doe a letter identifying specialty pharmacies available to him, including brick-and-mortar and mail-order options. Am. Compl., R.38, PageID #272 ¶ 11. Doe now gets Genvoya from a brick-and-mortar option about an hour's drive away. *Id.*, PageID #278 ¶ 25, #325 ¶ 77. He does not deny,

however, that the Program affords him closer options for in-person pickup such as CVS pharmacies, even if he does not consider them true "specialty pharmacies" but rather "drop shipment location[s] purely for pick-up." *Id.*, PageID #272-73 ¶ 11. The complaint also does not disclose how far Doe's community pharmacy is from Doe's residence.

Doe asserts that the Program "target[s]" HIV-positive members, even if it covers medications for "other disabilities," not just "HIV/AIDS Medications." *Id.*, PageID #265 ¶ 1, #285-86 ¶ 48. He asserts that community pharmacists can assist HIV-positive patients with "drug side effects, adverse drug reactions, and adherence to specialty medications." *Id.*, PageID #281 ¶ 34. Some HIV-medications like Atripla, he adds, may have side effects visible to community pharmacists during face-to-face encounters. *Id.*, PageID #281 ¶ 35.

HIV-positive members would be going to community pharmacists anyway, Doe insists, because "most HIV/AIDS patients are prescribed both specialty and non-specialty medications." *Id.*, PageID #281-82 ¶¶ 33, 37-38. Doe never denies that he or other members are free to discuss all their medications with their community pharmacists (and their doctors), no matter where the medications are obtained—indeed, he alleges that a community pharmacist is "typically aware of [a] patient's entire medical history" and has "a comprehensive view of the patient's complete medication load" and "on-going communications with physicians and

patients." *Id.*, PageID #281 ¶ 34. Nevertheless, according to Doe, the Program forces HIV-positive members to make "a potentially life-threatening decision": either "(1) forego essential counseling from an expert pharmacist at a community pharmacy … or (2) pay thousands of dollars out-of-pocket for their medications at their community pharmacy." *Id.*, PageID #267-68 ¶ 4.

Doe also maintains that the Program raises other concerns for HIV-positive members. He notes the privacy interest of those individuals with "complex, chronic conditions" that, like HIV, are "subject to social stigma" and alleges that the Program threatens HIV-positive members' privacy: "Medication shipped by mail … could be inadvertently seen by a neighbor who does not know about his illness." *Id.*, PageID #277 ¶ 24, #317-18 ¶ 51. Further, leaving a package outside potentially could "degrade the potency and stability" of some HIV medications, and mailed medications could be lost or stolen. *Id.*, PageID #271 ¶ 8, #326-27 ¶ 83 & n.69. Doe also has various other complaints unrelated to the delivery method for specialty medications, such as the requirement that members generally must wait until late in a prescription's term before refilling it. *Id.*, PageID #270-71 ¶ 7.

Doe contends that BCBST's "real, undisclosed reason [for the Program] is profit." *Id.*, PageID #317 ¶ 51. He alleges that the Program "reduce[s] drug costs and overhead." *Id.*, PageID #341 ¶ 151.

3. Doe Sues BCBST, Claiming A Legal Entitlement To Receive Genvoya From The Pharmacist Of His Choice.

Insisting that the law guarantees members "pharmacists of their choice," Am. Compl., R.38, PageID #286 ¶ 49, #327-28 ¶ 87, Doe sued BCBST (but not his former employer as the plan sponsor) for equitable and declaratory relief and damages in a putative class action. *Id.*, PageID #342-43. He asserted claims under the ACA (Count I) and Title III of the ADA (Count II), and for breach of contract under Tennessee common law (Count III). *Id.*, PageID #331-40 ¶¶ 100-46. (Doe also asserted a claim for unjust enrichment (Count IV), *id.*, PageID #340-42, ¶¶ 147-54, but he does not challenge the district court's dismissal of that claim on appeal.)

Section 1557 of the ACA established that the protections of Section 504 of the Rehabilitation Act are available to individuals participating in any health program or activity receiving federal financial assistance. It reads, as relevant:

> [A]n individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 ["Title VI"], title IX of the Education Amendments of 1972 ["Title IX"], the Age Discrimination Act of 1975 ["Age Act"], or [Section 504 of the Rehabilitation Act], be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance … . The enforcement mechanisms provided for and available under [those statutes] shall apply for purposes of violations of this subsection.

42 U.S.C. § 18116(a) (citations omitted).[3] Section 1557 does not "invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under" those statutes, or "supersede State laws that provide additional protections against discrimination on any basis described." 42 U.S.C. § 18116(b).

Section 504 of the Rehabilitation Act in turn reads, as relevant:

> No otherwise qualified individual with a disability in the United States, as defined in section 705(20) of this title,[4] shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance … .

29 U.S.C. § 794(a).

Section 1557 does not refer to the ADA. Title II of the ADA, applicable to public services, has provisions that have much of the language found in Section 504 but omit the important word "solely." *See* 42 U.S.C. § 12132; *Lewis v. Humboldt Acquisition Corp.*, 681 F.3d 312, 315-16 (6th Cir. 2012) (en banc). Title III, applicable to places of public accommodation, reads as relevant:

> No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

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[3] Relevant provisions are reproduced in full in the addendum to this brief.

[4] As relevant, an individual with a disability includes one with "a physical or mental impairment that substantially limits one or more major life activities of such individual." 29 U.S.C. § 705(20)(B) (referring to 42 U.S.C. § 12102(1)(A)).

42 U.S.C. § 12182(a). A "public accommodation" must be a "physical place." *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1010 (6th Cir. 1997) (en banc); *see* 42 U.S.C. § 12181(7) (defining "[p]ublic accommodation" to include physical places such as a "pharmacy").

4. The District Court Dismisses Doe's Amended Complaint For Failure To State A Claim.

A. BCBST's motions to dismiss, and Doe's failure to proffer specific amendments in response.

After Doe filed his original complaint (Compl., R.1, PageID #1-50), BCBST moved to dismiss under Fed. R. Civ. P. ("Rule") 12(b)(6). Mot. to Dismiss, R.33, PageID #125-27. BCBST explained that, by incorporating Section 504's standard as to disability-discrimination claims, the ACA required Doe to show he was denied benefits or suffered discrimination "solely by reason of" his HIV disability. Memo. in Supp. of Mot. to Dismiss, R.34, PageID #136-39. He had not properly alleged either disparate treatment or disparate impact, however, and this Court's precedent casts doubt on whether the Rehabilitation Act even permits a disparate-impact claim. *Id.* This Court's precedent also bars his claim under Title III of the ADA, which does not regulate health plans. *Id.*, PageID #141-44. Finally, the contract claim fails because Doe did not identify a contract provision that had been breached. *Id.*, PageID #144-45.

Rather than oppose the motion, Doe filed an amended complaint. Am. Compl., R.38, PageID #265-345. Because the amended complaint did not address the deficiencies BCBST had identified, BCBST moved to dismiss it for the same reasons. Mot. to Dismiss, R.39, PageID #349-51; Memo. in Supp. of Mot. to Dismiss, R.40, PageID #352-72.

This time, Doe filed an opposition. Resp. in Opp. to Mot. to Dismiss, R.52, PageID #511-34. He contended that the ACA broadly authorizes disparate-impact discrimination claims whether or not Section 504 itself would, and alternatively that he had stated a claim under Section 504's standard. *Id.*, PageID #518-22. Either way, he conceded he would have to show at least a "significantly adverse impact" in particular on those with an HIV disability. *Id.*, PageID #521-22. Alternatively, he asserted, certain complaint paragraphs sufficiently alleged that BCBST adopted the Program with discriminatory intent. *Id.*, PageID #522-23. Doe did not assert a theory based on BCBST's deliberate indifference to a violation of Doe's ACA rights, however, or on a theory that the Program denied him meaningful access to his health plan benefits. As for the ADA, Doe's theory was not that the health plan itself was subject to Title III, but that BCBST was "operat[ing]" his community pharmacy within the statute's meaning. *Id.*, PageID #525-28. For his contract claim, Doe contended that the Program made coverage of the health plan benefits so unreasonably limited as to constitute a breach. *Id.*, PageID #529-31. At the end of

the opposition, he requested a chance to amend his complaint again, but did not proffer any specific amendments or file a formal motion for leave to amend. *Id.*, PageID #532.

B. The district court's order.

The district court granted BCBST's motion to dismiss the amended complaint with prejudice. Mem. Op. and Order ("Order"), R.68, PageID #601-25; Judgment, R.69, PageID #626. On the ACA claim, the court held that the "plain and unambiguous" statutory text incorporated Section 504's standard as to Doe's disability-discrimination claim. Order, R.68, PageID #610-12. Doe, however, had not plausibly alleged that BCBST denied him benefits or discriminated against him "solely by reason of" his HIV disability. *Id.*, PageID #607-09, 615-17. Nothing in the amended complaint plausibly alleged discriminatory intent, and indeed Doe's allegation that BCBST was motivated by "profit" undermined any suggestion that such intent was the "sole[]" reason for the Program. *Id.*, PageID #608. Meanwhile, there was "good reason to believe that a disparate impact theory is not available" under the Rehabilitation Act at all, *id.*, PageID #612 (quoting *Crocker v. Runyon*, 207 F.3d 314, 321 (6th Cir. 2000)), and in any event Doe had not plausibly alleged the "significantly adverse or disproportionate impact" on those with HIV that he would have to show under his theory, *id.*, PageID #609. Instead, as the court explained:

> The [Program] list includes medications for conditions that are not disabilities under the ADA or the Rehab Act. Thus, BCBST plan enrollees who are not disabled yet take specialty medications subject to the Program must endure the same procedural and logistical hurdles that HIV/AIDS patients face. This is fatal to Plaintiff's claim because Plaintiff cannot allege that BCBST forces HIV/AIDS patients to obtain their medications under the Program on the basis of their disability.

Id., PageID #616.

The district court also rejected Doe's claim under Title III of the ADA. It recognized that Doe purported to set forth a theory that BCBST was "operat[ing]" his community pharmacy. *Id.*, PageID #618. His real complaint, however, is not "that he cannot use a community pharmacy at all," but "that his health insurance provider will not pay for one of his medications if he goes to his local pharmacy" as opposed to an in-network specialty pharmacy. *Id.*, PageID #619-20. Because "the essence" of Doe's amended complaint "centers on the terms of [BCBST's] specialty medication Program under his health insurance plan," his ADA claim is foreclosed by this Court's precedent. *Id.* (citing *Parker* and its progeny).

Finally, the district court rejected Doe's contract claim for Doe's failure "to identify a specific provision of the health plan that [BCBST] breached," where under Tennessee law "[p]erformance of a contract according to its terms cannot be characterized as bad faith." *Id.*, PageID #621-22 (quoting *Wallace v. Nat'l Bank of Commerce*, 938 S.W.2d 684, 687 (Tenn. 1996)).

SUMMARY OF ARGUMENT

The Court should affirm because the district court was correct to hold that Doe's claims are untenable as a matter of law and unsupported by the factual allegations in the amended complaint.

I. Each component of Doe's ACA claim fails: the ACA does not relax the Section 504 standard for discrimination claims but rather directs that it "shall apply," and he cannot satisfy Section 504 because he has not been denied benefits or subjected to discrimination "solely by reason of" his HIV disability.

A. By its plain text, Section 1557 of the ACA forbids discrimination "on the ground prohibited" by Section 504 or other nondiscrimination statutes and directs that each statute's enforcement mechanism "shall apply." The text thus establishes that Section 1557 incorporates Section 504's standard as to disability-discrimination claims. Doe does not explain how the text could be read to adopt some uncertain new standard that neither he nor the statute defines. Nor does Doe present any reason why Congress would unmoor Section 1557 from established Section 504 case law, or privilege plaintiffs suing sponsors and administrators of health plans under Section 1557 over those suing other entities directly under Section 504.

B. Doe has no plausible claim under Section 504's standard because BCBST has not denied him any benefit or subjected him to discrimination "solely

by reason of" his HIV status. What the complaint instead shows is that the Program is neutral: it includes some but not all medications that treat HIV, many medications that treat other conditions considered to be disabilities, and many medications that treat conditions with no connection to a disability. Whatever conditions they have, all members obtaining these medications must follow the same processes for their medications to be covered under their health plan. The Supreme Court has made clear that a program does not violate Section 504 just because it may have different effects on different classes of individuals, and so courts on similar facts have routinely dismissed Section 504 claims under Rule 12(b)(6). Doe does not even claim support from any case with similar facts.

An independent reason why Doe's ACA claim fails is that Doe has no legal entitlement to the pharmacy of his choice. Doe's health plan entitles him to coverage for specialty medications when he uses network specialty pharmacies. He undisputedly can receive his Genvoya through the Program and with full benefits, either by mail-order or in-person at a nearby pharmacy (and of course he also has coverage for physician care). His health plan does not entitle him to receive Genvoya from his community pharmacy. But, as he has conceded consistent with precedent of both the Supreme Court and this Court, he can assert a Section 504 claim only as to the benefits to which he is legally entitled. In other words, Section 504 does not grant him license to re-write his health plan.

Doe's contrary arguments fail, and are largely forfeited. *First*, he abandons the unsupported intentional-discrimination argument he made below and replaces it with a deliberate-indifference argument he did not make, and which also finds no support in the complaint. *Second*, the only theory he has preserved—that the Program has a significantly disproportionate effect on those with HIV—fails on both the facts and the law. On the facts, the complaint does not plausibly allege such an effect; it discusses ways the Program affects those with HIV without disputing that others are affected in similar ways. Moreover, as to the benefits the health plan actually provides, there is no dispute that all members can obtain specialty medications with full coverage. On the law, Supreme Court precedent makes plain that, given the inherent differences between the disabled and non-disabled, a disproportionate effect standing alone is not enough to establish Section 504 liability. At minimum, the challenged practice must also deprive the plaintiff of meaningful access to the benefit at issue. *Third*, Doe forfeited any meaningful-access claim by failing to argue it below. It would fail regardless because, like all plan members, Doe can obtain his specialty medication, receive medical care from his doctors, and even consult as he wishes about his Genvoya with his community pharmacist even if he obtains it from a network specialty pharmacy.

Validating Doe's legal theories would implicate the risk of potentially "boundless" liability that the Supreme Court has found "troubling," and would

subject sponsors of health plans, administrators, and health insurers to heavy and counterproductive administrative burdens. It will often be impossible for them to avoid treating those with different disabilities differently. As Doe would have it, the Rehabilitation Act would account for those differences by requiring BCBST to let individual members choose services *à la carte* and still receive full benefits—to all members' detriment as costs soar. The Court should reject Doe's demand for his "pharmacist of choice."

II. Doe's claim under Title III of the ADA also fails both under a plain reading of the statutory text and binding precedent. His theory is that BCBST "operates" his community pharmacy through the Program, but he would make nonsense of that essential word: he alleges merely that the Program has a "nexus" with the pharmacy rather than that BCBST exercises operational control over it. Indeed, it is undisputed that Doe can fill his Genvoya prescription at his community pharmacy if he wants—his distinct complaint is that his health plan will not provide benefits if he does so.

Moreover, binding precedent from this Court establishes that a plaintiff cannot use Title III against health plans like the one BCBST administers for Doe's former employer. While Doe insists that he is not attempting to do so, the district court properly recognized that the essence of his ADA claim is squarely foreclosed by this precedent.

III. There is also no merit to Doe's contract claim, for multiple reasons, including that he premises it on his meritless statutory claims. Further, he does not challenge the district court's ruling that Doe's claim fails because he does not identify a specific provision of the health plan that BCBST breached. That ruling, in any event, was plainly correct under Tennessee law.

IV. Finally, no remand for leave to amend the complaint again is warranted, for two independent reasons. *First*, Doe has repeatedly failed to explain how he would amend the complaint if granted leave. Under binding precedent, the district court did not abuse its discretion in holding that it would be futile to grant leave to amend the complaint where Doe has refused to explain how he would do so. Moreover, his failure to explain how he would amend the complaint even on appeal is separate reason for this Court to reject his remand request.

Second, as that failure itself suggests, Doe has no way to amend the complaint to make it legally sufficient. The district court was entirely correct to recognize as much. This Court thus should affirm.

STANDARD OF REVIEW

The Court reviews a dismissal under Rule 12(b)(6) de novo. *Shuler v. Garrett*, 743 F.3d 170, 172 (6th Cir. 2014). While Doe also calls for de novo review of the denial of his request for an opportunity to amend the complaint, he mistakenly cites cases where the district court denied motions for leave, with proposed amended

complaints, based on futility. Doe Br. 16. The Court reviews a ruling that amendment would be futile only for abuse of discretion where, as here, the plaintiff made no formal motion but only requested leave in opposition to the defendant's motion to dismiss, without proffering proposed amendments. *Beydoun v. Sessions*, 871 F.3d 459, 469 (6th Cir. 2017); *Robbins v. New Cingular Wireless PCS, LLC*, 854 F.3d 315, 322 (6th Cir. 2017).

ARGUMENT

I. Doe's ACA Claim Fails Because He Cannot Plausibly Allege That He Suffered Discrimination "Solely By Reason Of" His HIV Status.

The district court was right on both key points as to Doe's ACA claim. *First*, by its plain text, the ACA authorizes disability-discrimination claims based on the legal standard established in Section 504 of the Rehabilitation Act, not Doe's amorphous new standard. *Second*, Doe has no plausible claim under the actual standard because BCBST has not denied him any benefit or subjected him to discrimination "solely by reason of" his HIV status, under all possible readings of those words, including the only one Doe actually preserved for appeal. He undisputedly still has access to, and is still getting, his medication, and he has no legal entitlement to force new terms into his health benefit plan.

A. The ACA addresses disability discrimination using the Rehabilitation Act's standard, not some undefined new standard.

In its first sentence, Section 1557 of the ACA forbids discrimination under any federally-funded health program or activity "on the ground prohibited" by

Section 504 or three other nondiscrimination statutes. 42 U.S.C. § 18116(a). The second sentence further directs that "[t]he enforcement mechanisms provided for and available under [those statutes] shall apply for purposes of violations of this subsection." *Id.* As the district court concluded, Section 1557 "is plain and unambiguous." Order, R.68, PageID #611. Its text shows that "Congress … intended 'to import the various different standards and burdens of proof into a Section 1557 claim, depending upon the protected class at issue.'" *Id.* (quoting *Se. Pa. Transp. Auth. v. Gilead Scis., Inc.*, 102 F. Supp. 3d 688, 698 (E.D. Pa. 2015)). Thus, for Doe's disability-discrimination claim, the ACA incorporates the Rehabilitation Act's "solely by reason of" standard.

Doe's contrary view is that Section 1557 brushes aside existing standards for a "sweeping new anti-discrimination standard." Doe Br. 20. He does not describe his new standard with any specificity, but apparently it would require sponsors of health plans and plan administrators and health insurers to eliminate any practice that would disparately impact individuals with different disabilities. He reasons that because *some* of the referenced statutes allow *some* types of disparate-impact claims, Section 1557 by incorporating "enforcement mechanisms" makes a broad disparate-impact theory available as to *any* protected class—no matter what the underlying statutes say. Doe Br. 20-24.

This argument is inconsistent with the text of Section 1557, beginning with the sentence Doe highlights: "The enforcement mechanisms provided for and available under [the four cited statutes] shall apply for purposes of violations of this subsection." 42 U.S.C. § 18116(a); *see* Doe Br. 20. This sentence plainly "establish[es] the enforcement mechanisms available under the ACA for different discrimination claims"—Section 504's enforcement mechanisms for disability-based claims, Title IX's for sex-based claims, and so on. *Briscoe v. Health Care Serv. Corp.*, 281 F. Supp. 3d 725, 738 (N.D. Ill. 2017). For each type of disability claim, the relevant enforcement mechanism "shall apply."

Doe never analyzes this sentence, which simply does not say that there would be a single standard amalgamating enforcement mechanisms under the four referenced statutes. Such intent would have been expressed with entirely different language. Section 1557 would have set forth clearly what standard Congress meant to adopt; "repeating the references to the civil-rights statutes and expressly incorporating their distinct enforcement mechanisms would have been a pointless (and confusing) exercise." *Id.* And even if Congress had meant, curiously, to establish a new standard without specifying what that standard *is*, at least it would have written the word "and" instead of referring to "[Title VI], [Title IX], [the Age Act], *or* [Section 504]." 42 U.S.C. § 18116(a) (emphasis added). The text shows

that Congress contemplated each statute applying individually, not collectively—that is, only one "shall apply" at a time. *Id.*

Reading the statute as a whole dispels any remaining doubt. To the extent the sentence about enforcement mechanisms does not settle things, *cf. Lewis*, 681 F.3d at 316 ("Enforcement provisions generally do not alter substantive standards of care."), the prior sentence does. It proscribes discrimination "on the ground prohibited under [Title VI], [Title IX], [the Age Act], or [Section 504]." 42 U.S.C. § 18116(a). That is a natural way to say that Section 1557 incorporates both the identities of protected classes and the substantive standards of care from the referenced statutes while carrying forward the various differences between those statutes. For instance, Section 1557 leaves intact how Title IX and the Age Act employ different disparate-impact analyses, *compare Nelson v. Christian Bros. Univ.*, 226 F. App'x 448, 454 (6th Cir. 2007) (looking to Title VII for guidance as to Title IX), *with Smith v. City of Jackson, Miss.*, 544 U.S. 228, 240-43 (2005) ("[T]he scope of disparate-impact liability under [the Age Act] is narrower than under Title VII."), and how "Title VI itself directly reach[es] only instances of intentional discrimination" on the basis of race, *Alexander v. Choate*, 469 U.S. 287, 293 (1985).

The wording of this sentence also refutes Doe's interpretation. If, for instance, a health plan sponsor or administrator were to adopt a practice that would affect one

protected class in a way that would be prohibited *only* as to a different protected class, the sponsor or administrator would not have done so on a "ground prohibited under" *any* of the referenced statutes. 42 U.S.C. § 18116(a). Had Congress meant to do what Doe supposes, it would have used the plural "grounds" and the word "and," not the singular "ground" prohibited by Section 504 "or" the other statutes. It did not because, as the ACA's inclusion of a savings provision further shows, Congress meant to *preserve* the "legal standards" and other aspects of the antidiscrimination statutes it referenced, not stitch them together into something unrecognizable. 42 U.S.C. § 18116(b).

In addition to ignoring the statutory text, Doe presents no good reason why Congress would have done what he proposes. Why would Congress, rather than having courts continue applying the established jurisprudence under each statute, adopt a new, unspoken standard and leave the courts with the task of sorting everything out—even when, for instance, the rules under one statute might conflict with those under another?[5] More fundamentally, why would Congress have meant to eliminate the *intended* differences between the referenced statutes? In the Section 504 context, as discussed below, the Supreme Court has made clear that, if disparate-

[5] For example, exhaustion of administrative remedies is required under the Age Act but not Title IX. *See* 42 U.S.C. § 6104(f); *Cannon v. Univ. of Chi.*, 441 U.S. 677, 706 n.41 (1979).

impact claims are available at all, that availability must be carefully controlled to honor Congress's intent, *Alexander*, 469 U.S. at 298-99—why would Congress have favored Doe via protections supposedly afforded under the ACA over those suing directly under Section 504? He has no good answers.

Nothing changes with Doe's references to Congress's overall purposes in the ACA, to a regulation adopted by the Office of Civil Rights ("OCR") of the Department of Health and Human Services, and to *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). Doe Br. 20-24. *First*, while Congress may have wanted expand access to health care and ensure fair treatment for those with HIV in particular (Doe Br. 20-22), "vague notions of a statute's 'basic purpose'" yield to "the words of its text regarding the *specific* issue under consideration." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 261 (1993).

Second, the cited OCR rule undermines rather than supports Doe. Far from saying that Section 1557 *heightens* the relevant standards, it is careful to warn against the opposite: "Neither Section 1557 nor this part shall be construed to apply a *lesser* standard for the protection of individuals from discrimination than the standards applied [in the underlying statutes and regulations]." 42 C.F.R. § 92.3 (emphasis added).[6] This language too demonstrates that a court must "look[] to

[6] Doe mistakenly adds language to this quote ("*all of which are incorporated into Section 1557 by reference*") that is not in the sources he cites. Doe Br. 23.

Section 504 to determine the pleading requirements for a disability discrimination claim under the ACA." *In re Express Scripts/Anthem ERISA Litig.*, 285 F. Supp. 3d 655, 687 (S.D.N.Y. 2018).

Third, *Chevron* is irrelevant here. Doe demands deference to language in a Federal Register notice that reflects OCR's response to a comment during rulemaking. Doe Br. 23. *Chevron*, however, applies only to agency interpretations made with the force of law. *Christensen v. Harris Cty.*, 529 U.S. 576, 586-87 (2000). Further, while OCR in that sentence does interpret Section 1557 to allow disparate-impact claims, Doe himself (correctly) understood OCR to mean that each underlying statute *itself* allowed disparate-impact claims, not that Section 1557 would alter those statutes. Am. Compl., R.38, PageID #320 ¶ 60 (quoting 81 Fed. Reg. 31376, 31440 (2016)). And finally, *Chevron* could not authorize a departure from the intent of Congress clearly apparent in Section 1557's text. *Briscoe*, 281 F. Supp. 3d at 738. "[T]hat intention is the law and must be given effect." *Chevron*, 467 U.S. at 843 n.9.

B. Doe has suffered no discrimination under the Rehabilitation Act's "solely by reason of" standard.

The relevant law is thus Section 504 of the Rehabilitation Act, which requires Doe to show that, even though he has full access to his medication through a neutral program that applies to medications treating all sorts of different conditions, he was "denied the benefits of" or "subjected to discrimination under" his health plan

"solely by reason of" his HIV status. 29 U.S.C. § 794(a). Again Doe ignores the statutory text, never confronting the "solely by reason of" standard and not bothering even to quote it correctly. *E.g.*, Doe Br. 32 ("solely because of"), 33 ("solely on the basis of"). The text of Section 504 and the complaint itself show that, for multiple independent reasons, Doe has no claim that crosses the plausibility threshold. *See Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007).

1. The complaint demonstrates that the challenged program is neutral and does not target plan members with HIV.

The complaint's description of the Program shows that, as Doe admits, it is "outwardly neutral," Doe Br. 26, and that it neither targets HIV-positive members nor otherwise violates Section 504's "solely by reason of" standard.

Most obviously, while the complaint alleges conclusorily that BCBST "target[s]" plan members with HIV/AIDS, it concedes that the Program covers medications for "other disabilities," not just "HIV/AIDS Medications." Am. Compl., R.38, PageID #265 ¶ 1, #285-86 ¶ 48; *see Bright v. Gallia Cty., Ohio*, 753 F.3d 639, 652 (6th Cir. 2014) ("Conclusory allegations or legal conclusions masquerading as factual allegations will not suffice."). Only sixteen of over *four hundred* specialty medications subject to the Program are alleged to treat HIV/AIDS. *Id.*, PageID #286-317 ¶ 50. Indeed, the complaint details how the Program covers specialty medications for at least fifty-one other conditions. *Id.* As the district court straightforwardly recognized, "This is fatal to Plaintiff's claim because Plaintiff

cannot allege that BCBST forces HIV/AIDS patients to obtain their medications under the Program on the basis of their disability." Order, R.68, PageID #616. *Every* member obtaining specialty medications, whether they have HIV or not, must follow exactly the same processes in order for the medications to be covered under their health plan. The Program does not deny benefits or discriminate by reason of disability, let alone "solely" so, but rather makes distinctions based on the nature of individual drugs, for which different delivery mechanisms may be sensible as all considerations are taken into account. *See Lewis*, 681 F.3d at 316 (recognizing that the word "solely" gives the Section 504 standard "more … bite").

Making any claim of discrimination even less plausible, the Program applies widely to members who are not disabled at all. The complaint lists many disabilities that specialty medications treat without disputing that these medications may also treat unlisted ailments that would not substantially limit any "major life activities." 29 U.S.C. § 705(9)(B); 42 U.S.C. § 12102(4)(A). Further, many of the listed conditions are not normally disabling, let alone *always* so—for instance, anemia, osteoporosis, and severe cholesterol. Am. Compl., R.38, PageID #289 ¶ 50, #303 ¶ 50, #310 ¶ 50; *see, e.g.*, *Christian v. St. Anthony Med. Ctr.*, 117 F.3d 1051, 1052 (7th Cir. 1997) ("Obviously, having high cholesterol is not in itself disabling … ."). The complaint even lists "[a]llergic rhinitis," where Doe cannot claim that having a runny nose is *ever* disabling. Am. Compl., R.38, PageID #288-89 ¶ 50; Doe Br. 31.

The complaint also makes plain that HIV-positive members use other medications that are *not* subject to the Program. It concedes that "most HIV/AIDS patients are prescribed both specialty and non-specialty medications," and also take over-the-counter medications. Am. Compl., R.38, PageID #281-82 ¶¶ 33, 37. It also concedes that some HIV-specific medications are not subject to the Program, even if Doe says these are "largely" obsolete. *Id.*, PageID #287 ¶ 50 n.6. In the 2017 formulary, only 14 out of more than 100 antivirals, like Doe's Genvoya, were designated as specialty medications. BCBST, *Your Guide to Prescription Drug Benefits* 7-10, https://web.archive.org/web/20170924134517/http://www.bcbst.com/docs/providers/RX-11-2017.pdf (last visited Jan. 19, 2019).[7] In short, the Program includes some but not all medications used to treat HIV, many that treat other conditions that are considered disabling, and many that treat conditions that are not at all disabling.

The plausibility of any claim under Section 504's standard becomes all the more remote considering what the complaint says about the Program's purposes. The complaint indicates that BCBST designates medications for the Program

[7] The Court may inspect the formulary because it was central to the complaint. Am. Compl., R.38, PageID #286 ¶ 50 n.5; *see Greenberg*, 177 F.3d at 514. The URL provided here links to an archived version of the link in the complaint, http://www.bcbst.com/docs/providers/RX-11-2017.pdf, which currently goes to the 2018 formulary.

because they "require special handling." Am. Compl., R.38, PageID #326 ¶ 80. While the complaint goes on to accuse BCBST of "hypocrisy" because customer service personnel for the Program may lack adequate training, *id.*, PageID #317 ¶ 51, it never actually contests that special handling can be necessary. Indeed, it affirmatively concedes that "specialty pharmacies may be appropriate for some patients or some medications." *Id.*; *see supra* note 2 (listing other reasons for the Program).

The complaint contends that the Program includes "high-cost medication" and BCBST's "real, undisclosed reason [for the Program] is profit." Am. Compl., R.38, PageID #286 ¶ 50, #317 ¶ 51. But the complaint also alleges that the Program "reduce[s] drug costs and overhead," *id.*, PageID #341 ¶ 151, and so, read as a whole, suggests that BCBST seeks to "profit" from the Program in order to save costs, for the benefit of all members. In any event, even if Doe means "profit" in the sense of benefiting owners or executives,[8] the district court was correct that this allegation further undermines any claim that the "sole[]" reason for the Program is anyone's HIV status. Order, R.68, PageID #608.

[8] BCBST, however, is a taxable entity incorporated under the Tennessee Nonprofit Corporation Act. BCBST, *About Our Company*, https://www.bcbst.com/about/our-company (last visited Jan. 19, 2019).

As the Supreme Court has explained, the Rehabilitation Act does not "guarantee the handicapped equal results," but instead "evenhanded treatment and the opportunity for handicapped individuals to participate in and benefit from programs receiving federal assistance." *Alexander*, 469 U.S. at 304 (citing *Se. Cmty. College v. Davis*, 442 U.S. 397 (1979)); *Jones v. City of Monroe*, 341 F.3d 474, 479 (6th Cir. 2003); *see Modderno v. King*, 82 F.3d 1059, 1060 (D.C. Cir. 1996). The complaint alleges at most inequality of results, not of treatment or opportunity.

That is why courts ruling on motions to dismiss ACA discrimination claims on similar facts consistently have held dismissal appropriate. Doe does not deny as much, and fails to explain away the decisions the district court cited. *Express Scripts*, 285 F. Supp. 3d at 687 (dismissing ACA claim based on pricing of "specialty" HIV medication absent allegations comparing pricing of other medication); *Se. Pa. Transp. Auth.*, 102 F. Supp. 3d at 700 (dismissing ACA claim absent allegations that manufacturer "changes the prices of its drugs depending upon whether the potential consumer has Hepatitis C"). And after Doe filed his brief, another district court in California dismissed virtually the identical claim, brought by the same counsel. *Doe One v. CVS Pharmacy*, No. 18-cv-01031-EMC, 2018 WL 6574191 (N.D. Cal. Dec. 12, 2018); *see also E.S. v. Regence BlueShield*, No. C17-01609-RAJ, 2018 WL 4566053, at *3 (W.D. Wash. Sept. 24, 2018) (similar

regarding exclusion from coverage of hearing loss treatment). The district court was correct to join these growing ranks.

2. Doe undisputedly receives the benefit at issue—coverage for his medication—and has no coverage under his health plan for in-person consultation with his community pharmacist.

An independent reason why Doe has no Section 504 claim is that he does not allege that the Program denies, or discriminates regarding, the actual benefits of his health plan. He undisputedly can receive his Genvoya through the Program, either by mail-order or in-person at a nearby pharmacy, with full benefits (including coverage for physician care regarding his medication). Am. Compl., R.38, PageID #265-66 ¶ 1, #272-73 ¶¶ 10-11, #280 ¶ 32. While he wants to get Genvoya from his "pharmacist of choice," *id.*, PageID #285-86 ¶¶ 48-49, #327-28 ¶ 87, his health plan does not provide that benefit, as it covers specialty medications only when obtained through the Program. Memo. in Supp. of Mot. to Dismiss Ex. A, R.40-1, PageID #474; *see* Am. Compl. Ex. A, R.38-1, PageID #346.

As Doe has conceded, he can assert a Section 504 claim only as to the "benefits to which [he is] legally entitled." Am. Compl., R.38, PageID #320 ¶ 59. Indeed, the Supreme Court in *Alexander* rejected a Section 504 claim because it did not claim a denial of "the benefit that the grantee offers." 469 U.S. at 301; *see id.* at 303 ("[T]he benefit provided through Medicaid is a particular package of health care services … ."). It is, after all, Doe's former employer as the health plan sponsor, not

Doe as a member, that decides what the plan will cover. *Cf. id.* at 307 (noting Medicaid provider's discretion "to choose the proper mix of amount, scope, and duration limitations on services"). "Section 504 does not require [a provider] to alter [the] definition of the benefit being offered simply to meet the reality that the handicapped have greater medical needs." *Id.* at 303.

This Court faithfully followed these teachings in *Jones*. The Section 504 plaintiff there, who suffered from multiple sclerosis, sought special parking privileges from her city. 341 F.3d at 475. Applying *Alexander*, the Court rejected her arguments, explaining: "The benefit that [the city] is providing to all of its citizens … is free downtown parking at specific locations; it is not free downtown parking that is accessible to wherever a citizen, disabled or non-disabled, chooses to go or work." *Id.* at 479. Just as she did not have a right under Section 504 to her parking "of choice," Doe lacks one to his pharmacy of choice. *Id.*; *see Ruskai v. Pistole*, 775 F.3d 61, 79 (1st Cir. 2014) (similarly explaining that "*Alexander* treats as outside Section 504's target" complaints about disproportionate effects of airport security scanning). For this reason too, Doe has no Section 504 claim.

3. Doe's responses are mostly forfeited and all meritless.

Doe provides a number of arguments that conflict with his arguments below, ignore the statutory text, and mischaracterize the district court's sound reasoning. The Court need not resolve any unsettled points of law to reject these arguments,

because Doe has no viable claim under any of the legal theories he presents, including under the lone theory he actually preserved for appeal.

a. Doe abandons the intentional-discrimination theory he pressed below, and his new deliberate-indifference theory is both forfeited and meritless.

Despite having to show discrimination "solely by reason of" his disability, Doe abandons his claim that BCBST was motivated by his disability in adopting the Program. The district court rejected his argument that certain paragraphs of the complaint adequately so alleged, Order, R.68, PageID #607-09, and he does not renew that argument. That choice is understandable, given how the Program applies widely to all specialty medications, not merely those used to treat HIV, and how any assertion of discriminatory intent in the complaint is conclusory.

Instead, Doe now asserts that BCBST has been deliberately indifferent to the violation of the rights of those disabled by HIV. Doe Br. 29-30. He never made this argument below, so it is unfair for him to charge that the district court "ignor[ed]" allegations relating to deliberate indifference. Doe Br. 31. This Court should decline to address this issue "raised for the first time on appeal." *Jolivette v. Husted*, 694 F.3d 760, 770 (6th Cir. 2012).

A deliberate-indifference claim would fail anyway. As Doe admits, deliberate indifference would be relevant only as a proxy for intentional discrimination, because he would have to show that BCBST knew of a "strong likelihood" the

Program would violate Section 504. Doe Br. 29. Much as he has failed to substantiate any intentional-discrimination theory, Doe does not identify any allegation in his complaint that plausibly suggests that BCBST had that knowledge yet was deliberately indifferent. *Id.* That is because the complaint contains no such allegation. While he discusses allegations that BCBST delayed in informing him of in-person pickup options and that BCBST would not allow him to opt out of the Program, Doe Br. 30, these general complaints about operation of the Program simply do not suggest deliberate indifference to a strong likelihood that it would discriminate against Doe solely by reason of his HIV.

b. Doe does not plausibly show a significantly disproportionate impact on HIV-positive members, and that would be insufficient anyway.

The only theory that Doe presents to this Court that he preserved below is based on the Program's allegedly disproportionate impact on those with an HIV disability. This theory, however, fails both on the facts alleged in the complaint and on the law.

As Doe essentially conceded and the district court held, he would have to demonstrate at least "a significantly adverse or disproportionate impact on" those with an HIV disability. Order, R.68, PageID #609 (quoting *B.C. v. Mount Vernon Sch. Dist.*, 837 F.3d 152, 158 (2d Cir. 2016)); *see* Resp. in Opp. to Mot. to Dismiss, R.52, PageID #521. While the complaint alleges that the Program affects those with

an HIV disability, it does not plausibly allege a significantly disproportionate effect. Instead, the district court properly recognized that, even setting aside the absence of statistical or otherwise "particularly compelling" allegations, the complaint fails because it concedes that "plan enrollees who are not disabled yet take specialty medications subject to the Program must endure the same procedural and logistical hurdles that HIV/AIDS patients face." Order, R.68, PageID #615-16.

Doe fails to overcome that basic fact. For instance, while he alleges that HIV-positive members may have issues regarding "adverse drug interactions" such that in-person consultation with pharmacists would be beneficial, Am. Compl., R.38, PageID #268 ¶ 4, the complaint never disputes that the same is true for many others with different conditions. Moreover, nothing prevents an HIV-positive member from discussing *all* of his medications with the community pharmacist he desires to—and will continue to—see, including medications obtained from specialty pharmacies. *Id.*, PageID #282 ¶¶ 37-38. After all, he affirmatively alleges that community pharmacists will continue to have "a comprehensive view of the patient's complete medication load" and "on-going communications with physicians and patients." *Id.*, PageID #282 ¶ 34.

Similarly, even if members with HIV may have greater privacy needs than those with some other conditions due to stigma, the complaint does not plausibly allege a significantly disproportionate effect. While some members, like Doe, may

prefer to obtain their medications from their community pharmacists to protect their privacy, *id.*, PageID #317-18 ¶ 51, the complaint never denies that many others believe the mail-order option better promotes their own privacy interests. Moreover, even though Doe's theory is that BCBST discriminates "solely by reason of" HIV status, the complaint "acknowledge[s] that HIV/AIDS is not the only condition [subject to the Program] that is stigmatized." *Doe One*, 2018 WL 6574191, at *7 (construing identical complaint language).

The lack of a significantly disproportionate effect as to those with HIV is especially clear as to the actual benefit at issue. Members can obtain specialty medications with full benefits at least through mail order, if not also in-person at nearby pharmacies. *See* Am. Compl., R.38, PageID #266 ¶ 3 (alleging that every county typically has multiple brick-and-mortar specialty pharmacies). There is no allegation that access differs *at all* for specialty medications to treat HIV as compared to specialty medications to treat other conditions. For instance, while Doe complains of the need to wait until late in a prescription's term before refilling, *id.*, PageID #270 ¶ 7, he does not deny that this is a Program-wide, not HIV-specific, requirement (or that there are legitimate reasons for this utilization control). Similarly, while the complaint alleges that some HIV medications are vulnerable to heat exposure during mail-order delivery, *id.*, PageID #326 ¶ 83, it does not deny that the same is true for some drugs for other disabilities (or that other risks are

present for medications obtained at community pharmacies rather than through specialty pharmacies).

Doe's disparate-impact theory also fails on the law. While Doe on this point (and others) relies on carefully snipped language from non-binding decisions, the Supreme Court in *Alexander* "reject[ed] the boundless notion that all disparate-impact showings constitute prima facie cases under § 504." 469 U.S. at 299. "[A]ssum[ing] without deciding that § 504 reaches at least some conduct that has an unjustifiable disparate impact upon the handicapped," the Court disallowed the claim there because the challenged practice did not deprive anyone of "meaningful access" to the benefit at issue—despite undisputed evidence that the practice disproportionately affected the disabled. *Id.* at 289-90, 299, 303-06; *see Ability Ctr. of Greater Toronto v. City of Sandusky*, 385 F.3d 901, 908-09 (6th Cir. 2004) (applying *Alexander* to ADA claim). While Doe attempts, belatedly, to claim a denial of meaningful access (as discussed next), the theory he has actually preserved—one based on significantly disproportionate impact *regardless* of whether meaningful access is denied—thus fails on the law as well as the facts.

c. Doe forfeited any "meaningful access" theory, and in any event that theory too would fail.

Finally, the Court should not consider Doe's final theory, that the Program violates Section 504 because it deprives HIV-positive plan members of meaningful access to their benefits, such that BCBST must make a reasonable accommodation

to provide him that access. Doe Br. 36-37. He forfeited any such theory by failing to present it in opposing BCBST's motion to dismiss. *See Jolivette*, 694 F.3d at 770. Indeed, he affirmatively argued that to establish a prima facie case he was required to make the distinct showing of a "significantly adverse impact" on those with an HIV disability. Resp. in Opp. to Mot. to Dismiss, R.52, PageID #521.

Nevertheless, Doe now says, the district court not only ruled on a "meaningful access" claim but also got the law wrong by ruling that only a "*complete[] depriv[ation]* … of access to his HIV/AIDS medication" would be actionable. Doe Br. 36. That charge is incorrect. Read as a whole, the passage he misleadingly excerpts is about the "purpose" of Section 504 and how, as the *Alexander* Court recognized, it is not intended to bar practices simply because they may have "unpleasant effects" on the disabled. Order, R.68, PageID #616 (quoting *Ruskai*, 775 F.3d at 78-79). There was no ruling on a "meaningful access" claim because Doe never presented one for ruling.

The claim would fail even if it were preserved. As discussed, all members can obtain their full plan benefits for specialty medications (and medical care from their doctors) and also consult as they wish about all their medications with their community pharmacists.[9] Moreover, whatever the complaint may say as to the class

[9] Doe attempts to "bolster[]" his claim by asserting a violation of 45 C.F.R. § 156.122(e). Doe Br. 42. The regulation on its face allows use of specialty

Doe's counsel wish to represent, the allegations as to Doe himself make plain that he has meaningful access to the actual benefits of his health plan and to his HIV medication, Genvoya. While he alleges that *other* HIV medications like Atripla may have side effects visible to community pharmacists during face-to-face encounters, Am. Compl., R.38, PageID #281 ¶ 35, he does not allege as much for Genvoya. While he alleges that Genvoya is *potentially* subject to harm through heat exposure, *id.*, PageID #326-27 ¶ 83, he does not claim his Genvoya has ever actually been harmed. And to the extent he objects to mail-order delivery, while he contends that a brick-and-mortar specialty pharmacy is an hour away from his residence, *id.*, PageID #278 ¶ 26, he never compares that travel time with how long it takes him to get to his pharmacy of choice. Furthermore, he does not dispute that there are nearer CVS pharmacies in the specialty pharmacy network where he can pick up his medications in person, *id.*, PageID #272-73 ¶ 11.[10] A showing of a deprivation of "meaningful access" requires "significantly more severe deprivation[]." *Doe One*, 2018 WL 6574191, at *9 (citing cases).

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pharmacies in some circumstances. In any event, he does not explain how any violation would translate to a denial of meaningful access, and he forfeited reliance on the regulation by failing to cite it in opposing the motion to dismiss.

[10] While Doe alleges that he learned of his in-person options only belatedly, *id.*, PageID #272-73 ¶ 11, that is irrelevant to his prospective request for an injunction, and his request for damages fails because he concedes it requires intentional discrimination, Doe Br. 29.

Moreover, "[t]here is good reason to believe that a disparate impact theory is not available under the Rehabilitation Act" at all. *Crocker*, 207 F.3d at 321. The district court was correct to recognize that Section 504, unlike the ADA, requires that the denial of benefits or discrimination be "solely" by reason of the plaintiff's disability. Order, R.68, PageID #613-14 (discussing *Lewis*, 681 F.3d at 314-16). The premise of a disparate-impact theory, however, is that the defendant is taking action for some reason *other* than the disability. Thus, while Doe says his theory is compatible with the statutory text, he never explains how this could be so. Doe Br. 29. Indeed, Section 504 "was patterned after Title VI," *Cmty. Television of S. Cal. v. Gottfried*, 459 U.S. 498, 509 (1983), which "itself directly reach[es] only instances of intentional discrimination." *Alexander*, 469 U.S. at 293.[11] In any event, this case does not require the Court to decide this or any other unsettled issue of law, given all the other deficiencies in Doe's ACA claim.

4. A holding that Doe has a viable claim would validate a theory of virtually unbounded liability for health plans.

This case exemplifies the dangers of "boundless" liability under the Rehabilitation Act that the Supreme Court found "troubling" if courts accept improperly expansive disparate-impact theories. *Alexander*, 469 U.S. at 298-99.

[11] Doe asserts a disparate-impact theory only under Section 504 itself, leaving for another day the question whether such a theory could be viable under any regulations that implement Section 504.

"Because the handicapped typically are not similarly situated to the nonhandicapped," imposing liability based only on the different ways in which a given policy affects the disabled and non-disabled would foster "a wholly unwieldy administrative and adjudicative burden." *Id.* at 298. Such a regime would require every "recipient of federal funds first to evaluate the effect on the handicapped of every proposed action … and then to consider alternatives for achieving the same objectives." *Id.* "[T]here is nothing to suggest that such was Congress' purpose," *id.* at 299, and so even-handed policies that merely affect the disabled and non-disabled differently fall outside the scope of the Rehabilitation Act. *See Ruskai*, 775 F.3d at 78-79.

It is precisely this type of policy that Doe challenges here. As explained, the complaint does not plausibly allege that BCBST's specialty pharmacy requirements target members with HIV. Nor does it plausibly allege that the Program solely or uniquely disadvantages members with Doe's disability, or deprives those members of meaningful access to the benefit provided under Doe's health plan. Rather, Doe's theory of liability rests on the ways in which the Program may affect Doe and other HIV-positive members differently than those with other conditions. *E.g.*, Am. Compl., R.38, PageID #267-68 ¶ 4 (focusing on privacy concerns and issues pertaining to "adverse drug interactions").

Sustaining that claim here would therefore implicate the "troubling" risk of potentially "boundless" liability and subject sponsors of group health plans, administrators like BCBST, and health insurers to the unwarranted administrative burdens discussed in *Alexander*. Neutral policies obviously may have different effects on those with different disabilities. Even assuming health plan sponsors and administrators could design policies that somehow eliminate those different effects, the options for plan benefits would be extremely limited and likely unsustainable if sponsors and administrators could be held liable under the Rehabilitation Act (as incorporated in the ACA) each time their neutral policies have different effects on those with different disabilities.

This case vividly illustrates as much. Here, for example, BCBST could exempt specialty HIV medications from the Program, making them available only at community pharmacies. Such a decision, however, could expose it to suit from members with other disabilities with medications subject to the Program who wish similar treatment. At the same time, it could subject BCBST to suit by HIV-positive and other members who, unlike Doe, prefer the Program as is, because they rely on the expertise and pharmaceutical delivery mechanisms of BCBST's specialty pharmacy program and could claim, for instance, that requiring in-person visits to community pharmacists needlessly impinges on their privacy.

The end result under Doe's vision of the law is that BCBST must give all members the drugs they want through whatever delivery mechanisms they want, notwithstanding sensible distinctions between different classes of drugs. Indeed, this is what Doe requests in his complaint. *See* Am. Compl., R.38, PageID #286 ¶ 49 (demanding "full access to the pharmacies and pharmacists of [members'] choice"). Obviously, however, such an approach would, at a minimum, drastically increase costs, thus increasing premiums and adversely affecting all members. Moreover, the implications of Doe's theory are not limited to delivery mechanisms for drugs, but would extend to pricing and all other services for treating members with disabilities. *See, e.g.*, *Se. Pa. Transp. Auth.*, 102 F. Supp. 3d at 700 (dismissing claim about pricing of Hepatitis C drug because "[w]hile obviously only patients with a Hepatitis C diagnosis would try to acquire these drugs in the first place, that type of obvious barrier is an example of the Supreme Court's concern in *Alexander v. Choate* about interpreting Section 504 so as to reach all claims of disparate impact discrimination").

In short, Doe imagines the Rehabilitation Act, incorporated through the ACA, as a radical uniformity mandate. Yet there is nothing to suggest that Congress meant to displace "the historic and nearly universal practice inherent in the insurance industry of providing different benefits for different disabilities." *EEOC v. Staten Island Sav. Bank*, 207 F.3d 144, 149 (2d Cir. 2000). "Congress … does not, one

might say, hide elephants in mouseholes," *Whitman v. Am. Trucking Ass'ns, Inc.*, 531 U.S. 457, 468 (2001), and would have spoken more clearly had it intended to revolutionize the health insurance market in the manner Doe envisions, with its stunning and unworkable consequences. *See Staten Island Savings Bank*, 207 F.3d at 149. The district court's dismissal of Doe's ACA claim should be affirmed.

II. Doe's ADA Claim Fails Because He Cannot Plausibly Allege That BCBST "[O]perates" His Community Pharmacy.

The district court was also right to dismiss Doe's disability discrimination claim under Title III of the ADA. Again, Doe's theory flouts the plain text of the relevant statute, as BCBST does not "operate[]" a place of public accommodation—in this case, Doe's community pharmacy—under any possible reading of that word. Moreover, binding precedent establishes that Title III does not regulate health plans like the one BCBST administers for Doe's former employer.

A. The only place of public accommodation at issue is Doe's community pharmacy, which BCBST does not "operate[]."

Title III of the ADA prohibits discrimination "in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), *or operates* a place of public accommodation." 42 U.S.C. § 12182(a) (emphasis added). The Program does not violate Title III for the simple reason that BCBST

does not "operate[]" (let alone "own[]" or "lease[]") the only place of public accommodation that Doe identifies, his community pharmacy.

As the Fifth Circuit has explained, "operate" in this context "means 'to put or keep in operation,' 'to control or direct the functioning of,' [or] 'to conduct the affairs of; manage"'—all common dictionary definitions of the term. *Neff v. Am. Dairy Queen Corp.*, 58 F.3d 1063, 1066 (5th Cir. 1995) (internal alterations and citations omitted). Thus, the pertinent inquiry under Title III relates to whether the defendant has control over the facility in question. *See id.* at 1066-69 (holding that franchisor did not "operate" franchisee's store because it did not "control[] the modification of the franchise[] to improve [its] accessibility to the disabled"). And any doubts about this reading are dispelled by the statutory canon of *noscitur a sociis*, as the word "operates" is accompanied by the words "owns" and "leases" in the statute—words undeniably associated with physical dominion. *See Parker*, 121 F.3d at 1014 (recognizing need to interpret statutory terms in light of accompanying words).

Applying this standard, Doe has not alleged and cannot allege that BCBST retains control over his community pharmacy, such that BCBST can be deemed to "operate[]" his community pharmacy. To the contrary, Doe concedes that he can fill his prescription at his community pharmacy if he chooses to do so. *See, e.g.*, Am. Compl., R.38, PageID #267-68 ¶ 4; Doe Br. 43 n.7. Again, the district court had it

exactly right when it recognized that his complaint is not "that he cannot use a community pharmacy at all," but "that his health insurance provider will not pay for one of his medications if he goes to his local pharmacy." Order, R.68, PageID #619-20. That is not a complaint about BCBST "operat[ing]" the pharmacy, but a separate complaint about whether Genvoya will be covered *by the health plan* when procured at the pharmacy of Doe's choice.

Doe cannot square his theory with the statutory text, and does not try. Instead, he contends that he has alleged a sufficient "nexus" between BCBST's Program and his purportedly diminished access to the goods and services of his community pharmacy. Am. Compl., R.38, PageID #336 ¶ 123; *see* Doe Br. 47. But Doe's "nexus" theory is not authorized by the statutory text; having a "nexus" with a place of public accommodation is plainly not the same as "operat[ing]" it. *See U.S. Dep't of Transp. v. Paralyzed Veterans of Am.*, 477 U.S. 597, 610-11 (1986) (rejecting argument "that airports and airlines are 'inextricably intertwined' and that the 'indissoluble nexus between them is the provision of commercial air transportation'" because argument would give Section 504 "a scope broader than its language implies, and one never intended by Congress").

Moreover, adopting Doe's reading would undo the carefully crafted limitations Congress placed on Title III. For instance, if Congress intended the ADA to reach parties connected to places of public accommodation only through a vaguely

articulated "nexus," Congress likely would have crafted the exemptions from the ADA to exempt a broader range of private entities from the mandates of the statute. *See* 42 U.S.C. § 12187 (exempting private clubs and religious organizations). Even when "Congress may be unanimous in its intent to stamp out some vague social or economic evil … , the final language of the legislation may reflect hard-fought compromises." *Bd. of Governors of the Fed. Reserve Sys. v. Dimension Fin. Corp.*, 474 U.S. 361, 374 (1986). "[T]he effectuation of congressional intent" requires application of "the plain language of the statute itself." *Id.* at 373-74.

B. This Court has already made clear that Title III does not regulate health plans.

Doe's adventurous reading of Title III appears to be an attempt to escape the binding Sixth Circuit precedent that bars his real complaint, which is with the employer-sponsored health plan itself rather than BCBST's supposed "operat[ion]" of his community pharmacy.

Specifically, in *Parker*, a participant in an employer-sponsored long-term disability plan filed suit against the insurance company that sold the disability policy to her employer. 121 F.3d at 1008. She alleged that the employer's allowance of greater disability coverage for physical disorders than for mental disorders impeded her access to a place of public accommodation—the insurer's office—and therefore constituted disability discrimination actionable under Title III. *Id.* at 1008-10. In rejecting that claim, this Court concluded that "[a] benefit plan offered by an

employer is not a good offered by a place of public accommodation." *Id.* at 1010. This Court has reaffirmed *Parker* on multiple occasions, explaining that "[a] public accommodation is limited to a physical place and cannot be applied to the contents of employer-furnished benefit plans." *Kolling v. Blue Cross & Blue Shield of Mich.*, 318 F.3d 715, 716 (6th Cir. 2003); *Lenox v. Healthwise of Ky., Ltd.*, 149 F.3d 453, 457 (6th Cir. 1995).

As the district court well explained, even though Doe purports to claim that "BCBST effectively 'operates' pharmacies," "the essence" of his complaint "centers on the terms of [BCBST's] specialty medication program under his health insurance plan," not the goods and services offered at his community pharmacy. Order, R.68, PageID #618-19. Under *Parker* and its progeny, then, Doe "may not use his plan benefits … to support a valid claim … under Title III." *Id.*

III. Doe's Contract Claim Fails For Multiple Reasons.

Like his statutory claims, Doe's breach of contract claim is meritless for several reasons, each warranting dismissal with prejudice. Initially, Doe premises his common-law cause of action entirely on the success of his federal statutory claims. Doe Br. 53. Because those claims fail as a matter of law, dismissal of Doe's breach of contract claim is warranted on this basis alone.

Further, Doe does not meaningfully contest the district court's basis for dismissing his breach of contract claim—namely, that Doe failed "to identify a

specific provision of the health plan that [BCBST] has breached." Order, R.68, PageID #621. Doe has therefore forfeited any challenge to the district court's ruling. *See Caudill v. Hollan*, 431 F.3d 900, 915 n.13 (6th Cir. 2005).

In any event, that ruling was plainly correct. In claiming a violation of BCBST's duty of good faith and fair dealing, Doe quotes a Tennessee Supreme Court decision but omits the language on which the district court relied: "[p]erformance of a contract according to its terms cannot be characterized as bad faith." *Compare* Order, R.68, PageID #622 (quoting *Wallace*, 938 S.W.2d at 687), *with* Doe Br. 54 (quoting inapposite language from *Wallace*). Nowhere does Doe allege that BCBST breached the actual terms of his health plan. *See* Doe Br. 54 (conceding that BCBST breached no "express term").

Lastly, Doe's new theory that Tennessee common law implicitly recapitulates federal statutes, allowing plaintiffs to sue for violations of federal law under state law, is not only forfeited, but also entirely unsupported. He cites *Vargo v. Lincoln Brass Works, Inc.*, 115 S.W.3d 487 (Tenn. Ct. App. 2003), Doe Br. 55, but it does not come close to saying that state common law incorporates federal statutes. 115 S.W.3d at 491 (recognizing that "employment relationship[s]" are shaped by both "applicable federal and state law" and "agreement of the parties"). This is unsurprising, as Tennessee courts presumably would not intentionally transform state common law into a mechanism for plaintiffs to circumvent exhaustion and

other prerequisites to federal statutory claims. Doe's contract claim is meritless, and was properly dismissed.

IV. No Remand For Leave To Further Amend The Complaint Is Warranted.

A. Remand is unwarranted because Doe has repeatedly failed to explain how he would amend the complaint if granted leave.

The Court should reject Doe's last-ditch request for remand because he has spurned every opportunity to specify how he proposes to amend the complaint again. He failed to do so after BCBST moved to dismiss his initial complaint, instead filing an amended complaint with the same deficiencies. He failed to do so again after BCBST moved to dismiss that amended complaint. And he has failed to do so on appeal, requesting remand without detailing any potential amendments. *E.g.*, Doe Br. 35 (requesting "leave to amend to address the issues raised by the trial court"), 51 n.9 (requesting opportunity for unspecified amendment "to clarify BCBST's control over community pharmacies"). This conduct speaks volumes: Doe has no way he can salvage the complaint, and so there is no need for remand to allow him a *fourth* chance to proffer specific amendments, only for dismissal and another appeal to follow.

Indeed, binding precedent dictates that there should be no remand. This Court has held that the district court does not abuse its discretion in denying even a formal motion for leave to amend when the plaintiff has "submitted none of th[e] facts to aid the court in deciding whether justice required the court to grant leave." *Beydoun*,

871 F.3d at 469 (quoting *Roskam Baking Co. v. Lanham Machinery Co.*, 288 F.3d 895, 906 (6th Cir. 2002)). More clearly, there is no abuse of discretion in finding futility when all the plaintiff has submitted is "a bare request in an opposition to a motion to dismiss—without any indication of the particular grounds on which amendment is sought." *Id.* (quoting *PR Diamonds, Inc. v. Chandler*, 364 F.3d 671, 699 (6th Cir. 2004)). The district court cannot be faulted when the plaintiff has "never informed the district court of what facts he would use to supplement his claim, thus allowing him to withstand a motion to dismiss." *Id.* at 470. Doe was "not entitled to an advisory opinion from the [district court] informing [him] of the deficiencies of the complaint and then an opportunity to cure those deficiencies"—let alone multiple opportunities after BCBST repeatedly informed him of the flaws in his legal theories. *La. Sch. Emps.' Ret. Sys. v. Ernst & Young, LLP*, 622 F.3d 471, 477 (6th Cir. 2010) (emphasis omitted).

Even setting aside Doe's failures in the district court, his refusal to explain how he would amend the complaint even on appeal is independent reason to reject his remand request. As the Court has sensibly recognized, "one cannot argue for reversal for being denied leave to amend without being able to identify what else he would have added to his complaint." *Courie v. Alcoa Wheel & Forged Prods.*, 577 F.3d 625, 633 (6th Cir. 2009) (upholding district court's denial of leave to amend on futility grounds); *see Beydoun*, 871 F.3d at 470 ("[E]ven on appeal, [plaintiff] does

not include any specific allegations that, if true, would allow us to conclude that [his] rights were violated."). The Court should not allow Doe to sandbag the district court and BCBST by making his reply brief the first place he proffers specific amendments to his complaint. *See United States v. Abboud*, 438 F.3d 554, 589 (6th Cir. 2006) ("An argument first presented to the Court in a reply brief is waived.").

B. Amendment would be futile because the affirmative allegations of the complaint show that Doe has no viable claim.

In any event, the district court was absolutely correct that amendment would be futile because the complaint itself demonstrates that Doe's legal theories are beyond remediation. Order, R.68, PageID #624-25. His claim under the ACA (incorporating Section 504) fails because, as described in the complaint, the Program does not deny him benefits or discriminate against him "solely by reason of" his disability. To the contrary, it is neutral on its face, applies to those with many different disabling conditions and those with none, and leaves Doe with meaningful access to the benefit at issue. Moreover, the sole theory of liability he has preserved on this claim fails as a matter of law. Similarly, Doe's claim under Title III of the ADA fails because his theory that BCBST "operates" his community pharmacy by administering the terms of his health plan fails both under the plain statutory text and this Court's precedent. No new factual allegations could save these claims, because Doe's legal theories are fatally flawed.

CONCLUSION

This Court should affirm the judgment of the district court.

Dated: January 22, 2019

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMIT

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Dated: January 22, 2019

CERTIFICATE OF SERVICE

In compliance with Fed. R. App. P. 25 and 6th Cir. R. 25, I hereby certify that on January 22, 2019, I electronically filed this brief with the Clerk of the Court for the United States Court of Appeals for the Sixth Circuit using the appellate CM/ECF system. I further certify that I am a registered CM/ECF user and that all parties are registered CM/ECF users, and therefore service will be accomplished by the appellate CM/ECF system.

/s/ Todd Kim
Todd Kim

ADDENDUM

DESIGNATION OF RELEVANT DISTRICT COURT DOCUMENTS

1. Complaint (R.1, PageID #1-50)

2. Motion to Dismiss Complaint (R.33, PageID #125-27)

3. Memorandum of Law in Support of Motion to Dismiss Complaint and Ex. A (R.34, PageID #128-47; R.34-1, PageID #148-258)

4. First Amended Complaint and Ex. A (R.38, PageID #265-345; R.38-1, PageID #346-48)

5. Motion to Dismiss First Amended Complaint (R.39, PageID #349-51)

6. Memorandum of Law in Support of Motion to Dismiss First Amended Complaint and Ex. A (R.40, PageID #352-72; R.40-1, PageID #373-483)

7. Response in Opposition to Motion to Dismiss First Amended Complaint (R.52, PageID #511-34)

8. Memorandum Opinion and Order Granting Motion to Dismiss First Amended Complaint (R.68, PageID #601-25)

9. Judgment (R.69, PageID #626)

10. Notice of Appeal and Ex. A (R.70, PageID #627-29; R.70-1, PageID #630-54)

RELEVANT STATUTORY PROVISIONS

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

> (a) In general
>
> 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 insurance, 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.
>
> (b) Continued application of laws
>
> Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 794 of title 29, or the Age Discrimination Act of 1975 (42 U.S.C. 61[0]1 et seq.), or to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).
>
> (c) Regulations
>
> The Secretary may promulgate regulations to implement this section.

Section 504(a) of the Rehabilitation Act (codified at 29 U.S.C. § 794(a)):

> (a) Promulgation of rules and regulations—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. The head of each such agency shall promulgate such regulations as may be necessary to carry out the amendments to this section made by the Rehabilitation, Comprehensive Services, and Developmental Disabilities Act of 1978. Copies of any proposed regulation shall be submitted to appropriate authorizing committees of the Congress, and such regulation may take effect no earlier than the thirtieth day after the date on which such regulation is so submitted to such committees.

Section 302(a) of the Americans with Disabilities Act (codified at 42 U.S.C. § 1281(a)):

> No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.