The Honorable Richard A. Jones

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

E.S., by and through her parents, R.S. and J.S., and JODI STERNOFF, both on their own behalf, and on behalf of all similarly situated individuals,

Plaintiffs,

v.

REGENCE BLUESHIELD; and CAMBIA HEALTH SOLUTIONS, INC., f/k/a THE REGENCE GROUP,

Defendants.

NO. 2:17-cv-1609-RAJ

PLAINTIFFS' MOTION FOR RECONSIDERATION OF DISMISSAL OF STATE LAW CLAIMS

OR, IN THE ALTERNATIVE

CERTIFICATION OF QUESTION TO THE WASHINGTON STATE SUPREME COURT

Noted for Consideration: March 29, 2024

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I. INTRODUCTION

Although concluding that Plaintiffs properly alleged a cause of action under Section 1557 of the ACA, the Court dismissed Plaintiffs' claims predicated upon state law. Specifically, the Court held that because the essential health benefits ("EHB") benchmark rule, WAC 284-43-5642(1)(b)(vii), specifically provides that coverage for "externally worn or surgically implanted hearing aids" is not required to comply with EHB, "Regence's plan cannot be discriminatory as a matter of law." Dkt. No. 68, p. 10, lns. 18–20. As a result, the Court dismissed the Plaintiffs' claims under the WLAD and CPA, in addition to the state law claim for declaratory relief.

Plaintiffs respectfully seek reconsideration for two reasons: (1) the commissioner made it clear in a 2020 addition to WAC 284-43-5642 that compliance with the listed EHB in the regulation ***does not*** immunize a health carrier from compliance with state or federal anti-discrimination laws, and (2) even if the commissioner concluded that plans that comply with EHB are automatically non-discriminatory—and he did not—any such determination (whether in regulation or otherwise) would be void because it violates an unambiguous statute.

II. ARGUMENT

A. The Court Should Reconsider Its Conclusion that Compliance with the Essential Health Benefits Benchmarks Equates to Compliance with the WLAD.

1. The Regulation Itself Mandates Both Compliance with RCW 48.43.0128 and Consistency with Section 1557 of the ACA.

The Court's conclusion that compliance with WAC 284-43-5642(1)(b)(vii) renders Regence's plan non-discriminatory as a matter of law overlooks Section 12 of that same regulation. Section 12, added in response to the legislature's expansion of anti-discrimination law to benefit design in 2020, provides that the benefits listed in the regulation only set a floor of required coverage. As it directs, carriers must, above and beyond that floor, still provide other benefits:

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> "…***required by current state law and be consistent with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557***, including those codified at 81 Fed. Reg. 31375 et seq. (2016), that were in effect on January 1, 2017."

WAC 284-43-5642(12) (emphasis added). This section was specifically added in 2020 to ensure that carriers would understand that they cannot just rely on WAC 284-43-5642(1)-(10) in formulating benefit designs.[1] The regulatory history confirms this. A commentator wrote that "WAC 284-43-5642 permits the exclusion of treatment for hearing loss, obesity and other services" and requested that the commissioner "make it clear that the non-discrimination section applies to all categories of essential health benefits." *App. A*, p. 12. ***The commissioner responded by explaining that the rule, by virtue of new Section 12, already achieves that purpose***:

> ***The statement in WAC 284-43-5642 (12) is a statement of general application. It is not necessary to restate it in every specific category subsection of the rule as it applies to any covered EHB***. The Commissioner respectfully notes that the commenter misread the EHB rule; the rule is structured to list the category of the essential health benefit, describe what the base benchmark plan for the state covers, describe what it excludes, and then require coverage of services that the benchmark plan (which was filed prior to the ACA) improperly excludes or limits, and explain which benefits must be included in that category when using the Center for Medicare and Medicaid Services AV calculator. ***The rule does***

[1] The EHB language cited by the Court as permitting the exclusion of hearing aids under state law, *see* Dkt. No. 68, p. 10, lns. 18–20, was originally codified in ***2015***. *See App. D*, attached hereto. This language has never changed. *Compare App. D* (former WAC 284-43-878(1)(b)(vii)) (2015) ("Hearing care, routine hearing examinations, programs or treatment for hearing loss including, but not limited to, externally worn or surgically implanted hearing aids and services necessary to implant them…) *with* WAC 284-43-5642(1)(b)(vii) (same). When the hearing aid language was originally created, exclusion on the basis of disability was permitted as "fair discrimination." *See* Former RCW 48.30.300(2) ("This subsection does not prohibit fair discrimination on the basis of … the presence of any sensory, mental or physical handicap when bona fide statistical differences in risk or exposure have been substantiated.") The OIC never evaluated whether the hearing aid exclusion was discriminatory in 2015 because nothing in state law precluded it.

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> ***not state that the excluded benefits may continue to be excluded***; instead it states that they are improperly excluded.

App. A, p. 12 (emphasis added). If the commissioner's intent was to permit carriers to exclude hearing aids, then he would have simply said so. Instead, he responded by explaining that (1) the new Section 12 already broadly addresses the issue, (2) the benchmark plan was never designed or intended to permit exclusions, and (3) the rule does not allow carriers to take the position that "excluded benefits may continue to be excluded" simply because they are listed in the EHB. Additional sections in the CES provide further support. For example, in response to a comment that the "EHB rules in WAC appear to permit carriers to exclude some benefits in discriminatory ways," the OIC again did not take the position that compliance with EHBs was automatically non-discriminatory. *See App. A*, CES, p. 6. On the contrary, the OIC, again referring to Section 12, "add[ed] reference to current state laws that prohibit discrimination in several sections of the rule" to ensure that carriers understood that they must comply with both EHB and anti-discrimination laws independently. *Id.*, p. 6; *see also* p. 8 (In response to concerns that "carriers may incorporate blanket exclusions of coverage that have the effect of discriminating against persons in a protected class," the OIC included Section 12 to WAC 284-43-5642; the OIC did not state that EHB compliance is automatically non-discriminatory).

In short, the Court's conclusion that compliance with WAC 284-43-5642(1)(b)(vii) is dispositive of Plaintiff's state law claims is problematic for a couple of reasons:

First, Section 12 directs that carriers must, notwithstanding anything else in WAC 284-43-5642, still ensure that their benefit designs comply with other state laws, such as RCW 48.43.0128. The EHBs outlined in the regulation do not create some sort of "uber-exemption" that permits discrimination in benefit design otherwise unambiguously prohibited by state law.

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Second, the Court's conclusion that the Plaintiffs have stated a cause of action under Section 1557, but not state law, conflicts with the regulation's directive that as a matter of state law a carrier's benefit design must "be consistent with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557." WAC 284-43-5642(12). As it currently stands, the Court's conclusion that Plaintiffs have a cause of action under Section 1557, but not state law, is inconsistent with the purpose of Section 12—that carriers must concurrently comply with state law and Section 1557.[2]

2. A Regulation Cannot Permit What is Prohibited by Statute.

Even if the Court were to conclude that the commissioner somehow intended that compliance with the EHB rule to be, *per se,* nondiscriminatory—and it should not do so—no deference to such a determination is proper here. *O.S.T. v. Regence BlueShield*, 181 Wn.2d 691, 700 n.9 (2014). In *O.S.T.,* Regence BlueShield argued that its plans could not, as a matter of law, violate the Mental Health Parity Act because they were accepted after review by the OIC. The Washington State Supreme Court rejected Regence's position holding that the OIC had no power to override an ambiguous statute:

> Assuming that this [the OIC allowing a policy with an exclusion for neurodevelopmental therapies] constitutes an agency interpretation, ***we afford the agency interpretation deference only if the interpretation is not contrary to the plain language of the statute***. *Port of Seattle v. Pollution Control Hr'gs Bd.*, 151 Wn.2d 568, 612, 90 P.3d 659 (2004). According to the plain language of the mental health parity act, insurers must provide coverage for mental health services, including

[2] On this issue, federal law tracks state law: compliance with EHB does not render a plan non-discriminatory. *See* 45 C.F.R. § 156.110(d); 81 Fed. Reg. 31377 (attached as *App. B*) (Federal regulator "declines to adopt a deeming approach" that compliance with EHB automatically renders a plan non-discriminatory); *see* 78 Fed. Reg. 12846 (attached as *App. C*) ("To the extent a state benchmark plan includes a discriminatory benefit design, non-discrimination regulations … require issuers to meet the benchmark requirements in a nondiscriminatory manner"); *Schmitt v. Kaiser,* 965 F.3d at 955 ("[The] state-selected benchmark plan is only the starting point.").

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> neurodevelopmental therapies, if they are medically necessary to treat mental disorders recognized in the *DSM-IV-TR*. RCW 48.44.341. ***Regence BlueShield's exclusion was contrary to the plain language of the mental health parity act, and OIC's action (or inaction) is irrelevant***.

Id. at 700, n.9 (emphasis added); *High Sierra Hikers Ass'n v. Blackwell*, 390 F.3d 630, 638 (9th Cir. 2004) ("If the statute is clear and unambiguous, no deference is required and the plain meaning of Congress will be enforced."). And, of course, a statute always takes precedence over a regulation.[3]

RCW 48.43.0128 is unambiguous: a health plan subject to the law "may not … in its benefit design or implementation of its benefit design, discriminate against individuals because of their … present or predicted disability, … or other health conditions." RCW 48.43.0128(1). There is only one justification for any discriminatory benefit design under this law—when the benefit design is based on "reasonable medical management techniques." RCW 48.43.0128(2). No exception is made for health plans that comply with EHB requirements. Nor is the commissioner given any power to create exemptions to this statute. As a result, even if OIC concluded that compliance with EHB requirements automatically renders a plan non-discriminatory—and it did not—that conclusion would be contrary to the plain language of the statute.[4]

RCW 48.02.060(1)(a) does not change this result. That statute requires the commissioner to "enforce the provisions of this code." RCW 48.02.060(2). Nothing gives the commissioner the authority to grant exceptions to RCW 48.43.0128, and the authority to promulgate rules is not absolute: those rules must "effectuate[]" the statutory

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[3] Likewise, a specific prohibition—like declaring certain benefit designs to be discriminatory—takes precedence over a more general law, such as the one that creates the EHB. *Branch v. Umphenour*, 936 F.3d 994, 1003 (9th Cir. 2019) ("[I]t is a cardinal rule of statutory interpretation that a specific limitation takes precedence over a general grant of authority.").

[4] The Washington Attorney General's Office has also taken the position that the OIC's approval of insurance policies does not exempt a carrier from a discrimination claim. *See App. E*, p. 5.

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requirements" set forth by the legislature. Here, the legislature has made it very clear that discriminatory benefit designs are a form of discrimination. It has outlawed them in unambiguous statutory language. The commissioner has no authority to override that directive in a regulation or rule.

B. If the Court Does Not Reconsider, Then It Should Certify a Question to the Washington State Supreme Court.

Certification is a method to "obtain authoritative answers to unclear questions of state law." *Toner for Toner v. Lederle Labs.*, 779 F.2d 1429, 1432 (9th Cir. 1986). The Court has broad discretion to certify. *Lehman Bros. v. Schein*, 416 U.S. 386, 391, 94 S. Ct. 1741 (1974). Certification is proper "where the issues of law are complex and have 'significant policy implications.'" *McKown v. Simon Prop. Group Inc.*, 689 F.3d 1086, 1091 (9th Cir. 2012) (*quoting Perez-Farias v. Global Horizons, Inc.*, 668 F.3d 588, 593 (9th Cir. 2011)). Under Washington law, certification is proper "[w]hen in the opinion of [the] federal court before whom a proceeding is pending, it is necessary to ascertain the local law of this state in order to dispose of such proceeding and the local law has not been clearly determined…." RCW 2.60.020; *see McKown*, 689 F.3d at 1091.

The issue of whether compliance with the EHB benchmark immunizes a carrier from claims of disability discrimination has implications far beyond this case. As noted by commenters in the CES (*see App. A*), there are multiple ways that the EHB benefit design could be read as discriminating against classes of Washington insureds. Preventing discrimination in insurance transactions is a critical state concern. RCW 49.60.030(1). Rooting out such discrimination is, in fact, a "public policy of the highest priority." *Int'l Union of Operating Eng'rs v. Port of Seattle*, 176 Wn.2d 712, 721 (2013).

If the Court still has any lingering concerns about this issue, then it should certify the following question: Does a health carrier's compliance with the essential health

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benefits benchmark benefit design under WAC 284-43-5642(1)–(10) immunize it from liability under the Washington Law Against Discrimination and the Washington Consumer Protection Act?

III. CONCLUSION

Plaintiffs respectfully request that the Court reconsider its conclusion that compliance with WAC 284-43-5642(1)(b)(vii) means that Plaintiffs, as a matter of law, have no cause of action under the WLAD and CPA, and no entitlement to declaratory relief. In the alternative, the Plaintiffs ask the Court to certify this important question of first impression to the Washington State Supreme Court.

DATED: March 29, 2024.

I certify that the foregoing contains 1813 words, in compliance with the Local Civil Rules.

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APPENDIX A

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Mike Kreidler- Insurance Commissioner

As required by

The Washington State Administrative Procedures Act

Chapter 34.05 RCW

Matter No. **R2019-10**

CONCISE EXPLANATORY STATEMENT; RESPONSIVENESS SUMMARY; RULE DEVELOPMENT PROCESS; AND IMPLEMENTATION PLAN

Relating to the adoption of

The Affordable Care Act Protections rules

January 16, 2020

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Section 1: Introduction

Revised Code of Washington (RCW) 34.05.325 (6) requires the Office of Insurance Commissioner (OIC) to prepare a "concise explanatory statement" (CES) prior to filing a rule for permanent adoption. The CES shall:

1. Identify the Commissioner's reason's for adopting the rule;
2. Describe differences between the proposed rule and the final rule (other than editing changes) and the reasons for the differences; and
3. Summarize and respond to all comments received regarding the proposed rule during the official public comment period, indicating whether or not the comment resulted in a change to the final rule, or the Commissioner's reasoning in not incorporating the change requested by the comment; and
4. Be distributed to all persons who commented on the rule during the official public comment period and to any person who requests it.

Section 2: Reasons for Adopting the Rule

The Washington State Legislature enacted SHB 1870 (c 33, 2019 Laws) with an effective date of April 17, 2019. The law requires the commissioner to adopt rules to ensure that enumerated protections of the Affordable Care Act are in effect in Washington state if the federal government repeals those protections. Specific focus in the law was preservation of the essential health benefits, non-discrimination requirements and consumer protections against annual or lifetime limits, pre-existing condition exclusions, unfair rescission of coverage, waiting periods for group coverage and guaranteed issue.

The law also requires the commissioner to establish Explanation of Coverage requirements if the federal ACA standards are revised; authorizes the commissioner to establish open enrollment periods to include all persons, not just those under age 19; establishes the essential health benefits as a state law requirement; and establishes out of pocket cost sharing limits if no federal standard exists.

The legislation requires the Commissioner to implement its requirements in rule, consistent with federal rules and guidance implementing the Affordable Care Act (ACA) that were in effect on January 1, 2017.

The rule is adopted to ensure that the statutory requirements are implemented and to amend current rules that are not aligned with the legislation's requirements.

Section 3: Rule Development Process

On July 2, 2019, formal rulemaking began with publication of the CR101 in the Washington State Register (WSR 19-14-108). Comments were accepted through August 5, 2019.

On August 20, 2019, the OIC issued a stakeholder draft of the rule. OIC staff met with stakeholders on August 26, 2019 and provided a call-in option. Final comments on the stakeholder draft were accepted through September 3, 2019.

After considering the discussion during the meeting, and reviewing written comments submitted by carriers and consumer advocates, the OIC revised the draft text, and issued a second stakeholder draft on October 4, 2019. A meeting to discuss that draft was held on October 18, 2019, by phone.

The CR102 was published in the Washington State Register on November 6, 2019, as WSR 19-22-104. Pursuant to notice, a public hearing was held on December 13, 2019 in Tumwater WA. Two persons testified, representing Premera and Regence, respectively.

The CR103 was published in the Washington State Register on January 16, 2020 as WSR 20-03-114. The effective date of the rule is February 18, 2020.

Section 4: Differences between Proposed and Final Rule

A grammatical change was made in WAC 284-43-5930(1) to correct use of the term “effect”.

The final rule contained a grammatical edit in WAC 284-43-5950, deleting the word “the” before the citation to 81 Fed. Reg. 31375 and adding the citation phrase of “et seq.” after “31375” and before “(2016).” Clarifying language was added to that section making it consistent with references to issuers in other sections.

Consistent clarifying language was added to references made throughout the rule set to 42 USC 18116, section 1557, and implementing rules, as well as references to specific state anti-discrimination laws, providing the specific citation rather than a general reference to current state law.

In WAC 284-43-5642 (12) a typographical error in the reference to 42 USC 18116 was corrected.

In WAC 284-43-5642 (3) a technical correction to the language was made to clarify that carriers are not required to categorize inpatient hospitalization services to two separate Actuarial Value categories.

Section 5: Responsiveness Summary

CR101

Commenter	Comments	Response
Angela Mansfield	If ACA is found unconstitutional by federal courts, put a process and protections in place to help people who buy coverage on the Exchange transition to private individual health plans.	In 2018, the legislature passed a bill embedding the Exchange in WA statute, independent of the ACA.
Cambia Health Solutions (Regence, Asuris, Bridgespan)	• For the rulemaking, adhere to what the federal government requires in statute and regulation. • Sec. 13 – SBC – clarify in rule that carriers can meet their duty under this provision by offering SBC's that meet the federal SBC requirements. If the federal law is repealed or invalidated, carriers would then be required to offer SBCs that follow state regulations set by your office. Requiring carriers to provide both a state and federal SBC could be confusing for applicants. In addition, two SBCs that offer basically the same information, is duplicative without offering greater value to applicants.	The Commissioner considered the request, and agrees that two SBC formats and standards – federal and state - should be avoided unless the federal government repeals portions of the ACA in effect. Section 13 will be the subject of separate rulemaking if and when the federal government changes current requirements related to the SBC.
Premera/Lifewise	• OIC should not engage in rulemaking on SHB 1870 at this time • Most useful next step would be for OIC to create a crosswalk of SHB 1870 to the applicable ACA provisions.	The Commissioner respectfully disagrees, as certain provisions of the ACA are now required to be part of state law, and current rules conflict with or are silent regarding the OIC's implementation of those standards.
Ken White/OD	Please identify the specific rules that would be changed.	The published proposed text accompanying the CR102, and the final text adopted at the CR103 stage of the rulemaking provides this information.

Stakeholder Draft #1

Commenter	Comments	Response
Aetna, Assoc. of WA Healthcare Plans (AWHP), Kaiser, Premera	No need for rulemaking now, as there is uncertainty about what ACA changes will occur at federal level. State law has sufficient protection with the plain language of SHB 1870. Rulemaking should wait until the federal government acts on the subjects of sec. 7 – 16 of the bill.	The Commissioner respectfully disagrees, as certain provisions of the ACA are now required to be part of state law, and current rules conflict with or are silent regarding the OIC's implementation of those standards.
AWHP, Kaiser, Premera	Notice and language protections go beyond scope of SHB 1870, because they overlap with current federal law and deal with non-discrimination	The Commissioner believes that a rule confirming that the protections of sec. 1557 of the ACA as in place on January 1, 2017 is necessary given the pending federal rule proposal reversing those protections. If that reversal is made final, the OIC would otherwise have limited time to ensure those protections are in state law. Because seamless consumer protection is important in the event of

		federal repeal, the Commissioner placed language in the rule consistent with that concern. The legislation being implemented also specifically codifies non-discrimination protections and requires the Commissioner to engage in rulemaking to implement the section. *See,* RCW 48.43.0128.
Raleigh Watts (cdchc.org)	Restore protections for trans patients, for access to reproductive services and language access in WA rules	At the time of developing the rules implementing SHB 1870, the proposed federal repeal of these section 1557 protections was not final. The Commissioner included reference language in the rule text to ensure seamless consumer protection in the event of repeal.
Northwest Health Law Advocates, NW Justice Project	1. The proposed draft doesn't go far enough to include other state laws against discrimination (SB 5602, WA law against discrimination), doesn't include judicial interpretation of the 2017 federal laws/regulations, and may prevent the commissioner from exercising discretion where federal law is silent. Include requirements linking EHB decisions to non-discrimination requirements; the EHB rules in WAC appear to permit carriers to exclude some benefits in discriminatory ways, e.g. Rx benefit – prohibiting an unreasonable restriction on the treatment of patients. Permits blanket exclusions of coverage; see preamble to 1557 rule (81 Fed. Reg. 31434 (May 18, 2016).	1. While several sections of the federal rules implementing section 1557 of the ACA are currently proposed for repeal, they have not yet been repealed. However, because the Commissioner is concerned about seamless consumer protection, the language in the rule text is changed to reference the standard carriers must apply to be compliant, based on the standards in effect 1/1/17 under section 1557 of the ACA. The Commissioner declines the suggestion to restate all non-discrimination standards in state law in these rules; but does add reference to current state laws that prohibit discrimination in several sections of the rule. When assessing carrier conduct, the rules are read as a body of the whole, harmonized and applied overall. The Commissioner did not insert language into the rule about the OIC's discretion when enforcing provisions. There is an existing body of law regarding the deference given to a regulator's interpretation of its enabling laws and rules in their application on which the Commissioner may rely.
	2. Supports the transplant waiting period requirement, but need to amend WAC 284-43-5642 (3)(c)(i) because it states the base benchmark plan allows a waiting period.	2. The Commissioner declines the request to amend the transplant waiting period language, as the referenced section specifically prohibits carriers from imposing the

		base benchmark plan's waiting period for transplant services.
	3. Incorporate the gender affirming care nondiscrimination language referenced in SB 5602 in this rule set.	3. SHB 1870 codifies the ACA into state law. The ACA does not reference gender affirming care. Rules implementing SB 5602 have been adopted.
	4. Support the proposed text's new sections on nondiscrimination, language and tag lines.	4. The Commissioner appreciates the comment.
	5. Amend section 5940(1) to add references to 'nor any of its officials, employees, agents or representatives may…, in (1) (b) (1) remove the extra "or" before sexual" and add a comma after "age."	5. The Commissioner has directed staff to carefully read the rule before submitting it for adoption and appreciates the editing suggestions.
	6. Incorporate each definition in the current federal ACA rules for terms OIC uses in its draft rules. E.g. auxiliary aids & services vs the HHS definition of "qualified" interpreters. Don't expect those using the rule to find the federal preamble to 1557 and apply it. Additional examples of terms to define using current federal definitions: national origin, individual with limited English proficiency, on the basis of sex and qualified bilingual/multilingual staff, qualified interpreter, taglines.	6. The Commissioner will determine the need for additional rulemaking if and when final federal rules are adopted related to section 1557 of the ACA.
	7. Support new WAC 284-43-5960, 5970, 5980 Change the drafting of 5970 from that used by HHS – suggested language provided for purpose of clarity.	7. The Commissioner appreciates the comment.
	8. Add language referencing nongrandfathered individual and small group health plans to the interpreter and technology access standards sections.	

Stakeholder Draft #2

Commenter	Comments	Response
Cambia	1. Recommend omitting the numeric citation to definitions throughout the rule set, since those numbers in RCW 48.43.005 change often.	1. The Commissioner made this change.
	2. Change the example in WAC 284-43-5930, so that it is not a blanket statement that a specific practice is discriminatory.	2. The Commissioner included the suggested change.
	3. Modify WAC 284-43-5400 by removing the phrase "fair and" from the requirement for issuers to take steps to provide meaningful access.	3.The Commissioner believes the comment references WAC 284-43-5950. The final rule includes the "fair and reasonable" standard because the concept of equity in providing access to

		care is an important requirement, in addition to the reasonableness of steps a carrier takes to comply with the rule.
Northwest Health Law Advocates	1. The 'safe harbor' provisions in sections 5930 through 5970 do not take into account compliance with other state law requirements such as those in SB 5602, or the state Laws against Discrimination. They prevent the Commissioner from applying his own interpretation and enforcement authority, and does not require interpretations of the 2017 regulations and guidance by a court or tribunal. Suggested language was included: The Commissioner may rely on state and federal law, and federal regulations and guidance issued by the United States Department of Health and Services Office of Civil Rights in effect as of January 1, 2017 to enforce compliance with this section.	1. The Commissioner did not use the suggested language provided in the comment letter, as it states that the Commissioner may rely on the law, which is an unnecessary statement to include in the regulations. The Commissioner did, however, include language in the final rule requiring carrier compliance with state law as well as federal law, and stated the minimum standard the Commissioner will use when reviewing carrier conduct for compliance with the rules.
	2. Restructure the EHB rules to draw a link between WAC 284-43-5602 – 5642 and WAC 284-43-5940. Otherwise carriers may incorporate blanket exclusions of coverage that have the effect of discriminating against persons in a protected class. The comment explains the need to conduct fact inquiries in certain situations as noted by the Department of Health & Human Services in the preamble to the rules re section 1557 of the ACA. The request was that a subsection be added to each of the EHB rules stating that nothing permits a plan to violate WAC 284-43-5630 or WAC 284-43-5640.	2.The Commissioner added (12) to WAC 284-43-5642 requiring compliance with both state law, as well as the federal rules implementing section 1557 of the ACA that were in effect on January 1, 2017.
	3. Revise WAC 284-43-5642 (3)(c)(i) to prohibit the waiting period on transplant services.	3. WAC 284-43-5642 (3)(c)(i) already prohibited the waiting period on transplant services that is present in the benchmark plan. The final rule includes a requirement that all services in the hospitalization category must comply with the laws against discrimination, includes specific citations to those laws, and makes a clear statement that health plans may not include the limitation that permits a waiting period for transplant services or the exclusion of coverage for sexual reassignment treatment, surgery or counseling services.
	4. NOHLA continues to agree with the letter regarding including gender affirming care non-discrimination language – please refer to that letter.	4.The term gender affirming care is not included in the ACA nor the regulations implementing section 1557.
	5. Add language to the rules that restate definitions and provisions in federal law that are currently proposed	5. The Commissioner will engage in rulemaking to include these provisions in

	for amendment: 45 CFR 92.4, 45 CFR 92.202 and .204; 45 CFR 92.101.	state law, pursuant to the authority provided in ESHB 1870, if and when the federal rules are repealed.
	6. Add language to WAC 284-43-5940 that makes it applicable to officials, employees, agents or representatives.	6. While this is typically a contractual standard, and the Commissioner regulates carriers based on the actions of these types of individuals, the Commissioner included this in the final rule.
	7. Include multiple definitions in the current ACA rules for section 1557 in this rule set.	7. If the federal rule is repealed, the Commissioner will engage in rulemaking to incorporate its specific requirements into the insurance administrative code. At present, the final rule includes multiple statements that the rules implementing section 1557 of the ACA is the applicable law, and provides a compliance standard as a bridge between the time of repeal and more specific rulemaking.
	8. Add two sections to the rule set that specify effective communications per 28 CFR 35.160 through 35.164 and prohibiting undue financial or administrative burdens when making programs available via technology.	8. Because these federal rules are still in effect, the Commissioner will not include these suggested sections in this rule set.
Northwest Health Law Advocates	In a second letter, NOHLA suggested the following: 1. Revise the sections in the rule set that reference section 1557, to include language requiring consistency with federal and state law. 2. An October 11, 2019 federal court decision in Franciscan Alliance In v. Azar vacated certain sections of the 1557 rules. The draft WACs do not reserve the protections vacated and therefore the 'safe harbor' provisions should be deleted. 3. Remove the word "or" that follows "identity" in WAC 284-43-5840 (1)(b)(1). 4. Add the words "in intent or effect" to the end of WAC 284-43-5940 (1)(a).	The Commissioner made changes in the final rule consistent with these suggestions, with the exception of adding the words "in intent or effect." Such statutory construction direction is unnecessary in the rule.
Premera	1. Change the example in WAC 284-43-5930 by altering it or removing it so that it is stated in terms of "may" rather than "is."	1. The Commissioner amended the example.
	2. WAC 284-43-5950: remove the word "fair" from the standard for the steps a carrier must take, as it is inconsistent with the language in current nondiscrimination laws and regulations.	2. The concept of equity is part of assessing whether an action meets non-discrimination standards. It is distinct from taking reasonable steps. The final rule retains the requirement that steps for access for those with limited English proficiency must be fair and reasonable.

Joint letter from ACS-CAN; American Diabetes Association, American Lung Association in WA, Arthritis Foundation, Bleeding Disorder Foundation in WA, Crohn's & Colitis Foundation; Epilepsy Foundation Washington; The Leukemia & Lymphoma Society; NAMI-WA; National Multiple Sclerosis Foundation, Susan G Komen Puget Sound	Comments expressed appreciation for the protections that the ACA offers, and that the OIC is doing the rulemaking to implement SHB 1870. The letter specifically notes approval for guaranteed issue, prohibition of annual and lifetime limits, protections against discriminatory benefit design, and retaining the essential health benefits.	The Commissioner appreciates the comments.

CR102

Commenter	Comments	Response
American Civil Liberties Union; Ingersoll Gender Center; Planned Parenthood Votes Northwest and Hawaii; Gender Justice League; Planned Parenthood of the Great Northwest & the Hawaiian Islands, Northwest Health Law Advocates, Legal Voice	The ACLU and other entities provided new language suggestions that differed from their prior comments on the previous stakeholder drafts. Of particular concern is: ○ The risk that automatic initial denials will occur in processing claims ○ Prohibit discrimination of more than the rights of transgender individuals in the discrimination prohibitions ○ Include reference to gender affirming care rather than 'gender transition.' The groups ask that the same language appearing in 2SSB 5602 [year not included] be specifically stated in these rules.	Assuming that the commenters are referencing 2SSB 5602 (c 399, 2019 laws), the Commissioner declines the request of the organizations. C 399, 2019 laws amended RCW 48.43.072, which addresses contraceptive coverage, and added sections (7) and (8) to that section, which clearly states some of the language the advocates want placed in this rule. The Office of the Insurance Commissioner does not restate clear language from a statute in a rule as it is unnecessary to add the language in rule when it already appears in a relevant, applicable statute. The purpose of this rulemaking is to implement the protections required by SHB 1870. That legislation defines the scope of this rulemaking.
Cambia, Premera Blue Cross	The change to WAC 284-43-5640 (3)(c)(i) precludes normal use of the CMS AV calculator when filing individual and small group health plans.	The Commissioner revised the rule to make this technical correction to the section, clarifying that the exclusion of inpatient hospitalization for mental health

		services is prohibited under the essential health benefits in Washington, but when using the AV calculator, carriers should include mental health inpatient services delivered in a hospital in the inpatient hospitalization category.
National Multiple Sclerosis Society	• Monitor the 30-day supply change permission at page 30-31 of the proposed rule. • Thank you for recognizing formulary placement as a potential issue for discrimination against those experiencing a chronic disease.	The Commissioner appreciates the comments.
Northwest Health Law Advocates; Northwest Justice Project; Legal Voice	In addition to signing on to the letter above, three advocates submitted a second letter with additional comments. 1. Concerned that the WAC 284-43-3050 does not explicitly list every document to which the explanation of a right to review applies, and suggests adding a new (f) explaining that the protections apply to adverse benefit determinations and all other significant communications through the review process 2. Change WAC 284-43-3050 (4) (b) to add a specific instruction on "how to request notices" (reference to notices for non-English language speakers about oral assistance). 3. WAC 284-43-3050 (4) (b) only applies in specific circumstances. By not addressing additional notice requirements in 284-43-5950, issuers will apply the requirement in (4) (b) to all notices. 4. Delete (4)(c) which permits issuers to use NCQA certification to establish compliance with the requirements of WAC 284-43-3050(4), since NCQA may not enforce to federal standards or the 2017 requirements may change, making compliance out of sync with certification.	1.The Commissioner did not include the specific citation to 45 CFR 92.8 in the final rule text, because the rule amendment references all federal rules in effect on January 1 2017, inclusive of 45 CFR 92.8. The Commissioner directed staff to monitor for compliance with that federal rule as well as any others related to ensuring access for those where language may be a barrier. 2. The information includes direction on how to request the notices, so there is no need to make this change. 3. WAC 284-43-5950 is the more general requirement for issuers, and is modified by WAC 284-43-3050 in only the specific situations enumerated in WAC 284-43-3050. Therefore we are not concerned that issuers will limit the application of WAC 284-43-5950 to the ten languages required for adverse benefit determination notices, since the 15 language requirement is more generally required for all other types of notices. The OIC monitors for compliance with this requirement and will enforce appropriately. 4. RCW 48.43.530 was amended in 2011 (c 314, laws of 2011) to implement the affordable care act in Washington. NCQA certification is a standard to which the legislature has often directed the Commissioner to use to benchmark rule requirements. Since the current requirements are still in effect, the

		Commissioner will wait to address this potential situation if and when it arises.
	5. WAC 284-43-5642 permits the exclusion of treatment for hearing loss, obesity and other services described in section (12) (1)(b). Make it clear that the non-discrimination section applies to all categories of essential health benefits.	5. The statement in WAC 284-43-5642 (12) is a statement of general application. It is not necessary to restate it in every specific category subsection of the rule as it applies to any covered EHB. The Commissioner respectfully notes that the commenter misread the EHB rule; the rule is structured to list the category of the essential health benefit, describe what the base benchmark plan for the state covers, describe what it excludes, and then require coverage of services that the benchmark plan (which was filed prior to the ACA) improperly excludes or limits, and explain which benefits must be included in that category when using the Center for Medicare and Medicaid Services AV calculator. The rule does not state that the excluded benefits may continue to be excluded; instead it states that they are improperly excluded.
	6. Change the citation in WAC 284-43-5642 is section 42 USC 18116, not 18115.	6. The Commissioner appreciates the comment. The revision is in the final rule.
	7. Add more examples of blanket exclusions than the one included, which was added at NOHLA's request.	7.The Commissioner declines the request to add numerous examples of blanket exclusions or references to federal law. The Commissioner's staff will review forms to ensure that discriminatory exclusions are not included.
	8. Be ready to amend the rules if the federal regulations are amended.	8. The Commissioner will be vigilant.
	9. Do not include the phrase "fair" in requiring steps as the federal rules do not require it.	9. The Commissioner has kept the phrase "fair" in the requirement because it permits staff to examine issuer actions based on concepts of equity.
	10. Do not limit WAC 284-43-5950 to enrollees – it applies to individuals who may need help enrolling.	10. The Commissioner finds that requirements for the Summary of Benefits and Coverage specifically state they apply to individuals and enrollees. The non-discrimination section of ESHB 1870 (Sec. 15) prohibits discrimination in the design or implementation of the design (adjudication of claims). Sec. 16 of the bill applies to marketing but only references those with significant health needs, not the other categories of discrimination. To the extent that federal

		law in place on 1/1/2017 requires translation for applicants, the Commissioner will enforce to that standard, but does not find the authority in the authorizing statute to add the language specifically requested by the commenter.

Section 6: Implementation Plan

A. Implementation and enforcement of the rule.

The Commissioner will implement and enforce the rules by applying the standards as part of the Office of the Insurance Commissioner's regulation of carriers. Compliance with the rule will be determined through OIC's review of health plan forms. The Policy & Legislative Affairs division will monitor whether federal rules in effect on January 1, 2017 related to the Affordable Care Act provisions addressed in ESHB 1870, as codified, are repealed or amended by the federal government, and engage in future rulemaking as necessary.

B. How the Agency intends to inform and educate affected persons about the rule.

Type of Inquiry	Division
Consumer assistance	Consumer Assistance & Protection Division
Rule content	Policy Division
Authority for rules	Policy Division
Enforcement of rule	Company Supervision, Legal
Market Compliance	Rates & Forms, Company Supervision

C. How the Agency intends to promote and assist voluntary compliance for this rule.

The agency will review carriers' implementation of the rule through our review and approval of carriers' health plan form filings. This will allow the agency to confirm that carriers are aware of the rules and the underlying legislation. The

risk of enforcement activity or disapproval of forms or rates for violating the rules has a sentinel effect that promotes voluntary compliance.

D. How the Agency intends to evaluate whether the rule achieves the purpose for which it was adopted.

The agency will monitor complaints, filing objections sent and received on filed forms and rates, and market conduct exams or market continuum actions resulting in enforcement activity or corrective action plans to determine whether companies are complying with the rule, or if there is a need to amend the rules to ensure compliance with ESHB 1870.

Appendix A

CR-102 Hearing Summary

Summarizing Memorandum

To: Mike Kreidler
Insurance Commissioner

From: Jane Beyer
Presiding Official, Hearing on Rule-making

Matter No. R 2019-10

Topic of Rule-making: Affordable Care Act Protections

This memorandum summarizes the hearing on the above-named rule making, held on December 13, 2019 at 10am at 5000 Capitol Blvd, Tumwater Washington over which I presided in your stead.

The following agency personnel were present: Wendy Conway

In attendance and not testifying:

Simon Vismantas/ Kaiser Fdn. Health Plan of Washington
Erin Dziedzic, Dziedzic Public Affairs
Alex Aston, Dziedzic Public Affairs

In attendance and testifying:
Jane Douthit, Cambia Health Solutions
Katie Rogers, Premera

Contents of the presentations made at hearing:

The Cambia and Premera representatives testified regarding the same issue. They noted that the amendatory language in the proposed rule at WAC 284-43-5642(3)(b) is inconsistent with the classification of hospital services required under the Affordable Care Act's Actuarial Value (AV) calculator.

The hearing was adjourned.

SIGNED this 13th day of December ,2019

Jane Beyer
Presiding Official

APPENDIX B

FEDERAL REGISTER

Vol. 81 Wednesday,
No. 96 May 18, 2016

Part IV

Department of Health and Human Services

Office of the Secretary

45 CFR Part 92

Nondiscrimination in Health Programs and Activities; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

45 CFR Part 92

RIN 0945–AA02

Nondiscrimination in Health Programs and Activities

AGENCY: Office for Civil Rights (OCR), Office of the Secretary, HHS.

ACTION: Final rule.

SUMMARY: This final rule implements Section 1557 of the Affordable Care Act (ACA) (Section 1557). Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. The final rule clarifies and codifies existing nondiscrimination requirements and sets forth new standards to implement Section 1557, particularly with respect to the prohibition of discrimination on the basis of sex in health programs other than those provided by educational institutions and the prohibition of various forms of discrimination in health programs administered by the Department of Health and Human Services (HHS or the Department) and entities established under Title I of the ACA. In addition, the Secretary is authorized to prescribe the Department's governance, conduct, and performance of its business, including, here, how HHS will apply the standards of Section 1557 to HHS-administered health programs and activities.

DATES: *Effective Date:* This rule is effective July 18, 2016.

Applicability Dates: The provisions of this rule are generally applicable on the date the rule is effective, except to the extent that provisions of this rule require changes to health insurance or group health plan benefit design (including covered benefits, benefits limitations or restrictions, and cost-sharing mechanisms, such as coinsurance, copayments, and deductibles), such provisions, as they apply to health insurance or group health plan benefit design, have an applicability date of the first day of the first plan year (in the individual market, policy year) beginning on or after January 1, 2017.

FOR FURTHER INFORMATION CONTACT: Eileen Hanrahan at (800) 368–1019 or (800) 537–7697 (TDD).

SUPPLEMENTARY INFORMATION:

Electronic Access

This **Federal Register** document is also available from the **Federal Register** online database through *Federal Digital System (FDsys)*, a service of the U.S. Government Printing Office. This database can be accessed via the Internet at *http://www.gpo.gov/fdsys*.

I. Background

Section 1557 of the ACA provides that an individual shall not, on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (Title VI), 42 U.S.C. 2000d *et seq.* (race, color, national origin), Title IX of the Education Amendments of 1972 (Title IX), 20 U.S.C. 1681 *et seq.* (sex), the Age Discrimination Act of 1975 (Age Act), 42 U.S.C. 6101 *et seq.* (age), or Section 504 of the Rehabilitation Act of 1973 (Section 504), 29 U.S.C. 794 (disability), 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, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the Act or its amendments. Section 1557 states that the enforcement mechanisms provided for and available under Title VI, Title IX, Section 504, or the Age Act shall apply for purposes of addressing violations of Section 1557.

Section 1557(c) of the ACA authorizes the Secretary of the Department to promulgate regulations to implement the nondiscrimination requirements of Section 1557. In addition, the Secretary is authorized to prescribe regulations for the Department's governance, conduct, and performance of its business, including how HHS applies the standards of Section 1557 to HHS-administered health programs and activities.[1]

A. Regulatory History

On August 1, 2013, the Office for Civil Rights of the Department (OCR) published a Request for Information (RFI) in the **Federal Register** to solicit information on issues arising under Section 1557. OCR received 402 comments; one-quarter (99) were from organizational commenters, with the remainder from individuals.

On September 8, 2015, OCR issued a proposed rule, "Nondiscrimination in Health Programs and Activities," in the **Federal Register**, and invited comment on the proposed rule by all interested parties.[2] The comment period ended on November 9, 2015. In total, we received approximately 24,875 comments on the proposed rule. Comments came from a wide variety of stakeholders, including, but not limited to: Civil rights/advocacy groups, including language access organizations, disability rights organizations, women's organizations, and organizations serving lesbian, gay, bisexual, or transgender (LGBT) individuals; health care providers; consumer groups; religious organizations; academic and research institutions; reproductive health organizations; health plan organizations; health insurance issuers; State and local agencies; and tribal organizations. Of the total comments, 23,344 comments were from individuals. The great majority of those comments were letters from individuals that were part of mass mail campaigns organized by civil rights/advocacy groups.

B. Overview of the Final Rule

This final rule adopts the same structure and framework as the proposed rule: Subpart A sets forth the rule's general provisions; Subpart B contains the rule's nondiscrimination provisions; Subpart C describes specific applications of the prohibition on discrimination to health programs and activities; and Subpart D describes the procedures that apply to enforcement of the rule.

OCR has made some changes to the proposed rule's provisions, based on the comments we received. Among the significant changes are the following.

Section 92.4 now provides a definition of the term "national origin."

OCR decided against including a blanket religious exemption in the final rule; however, the final rule includes a provision noting that insofar as application of any requirement under the rule would violate applicable Federal statutory protections for religious freedom and conscience, such application would not be required.

OCR has modified the notice requirement in § 92.8 to exclude publications and significant communications that are small in size from the requirement to post all of the content specified in § 92.8; instead, covered entities will be required to post only a shorter nondiscrimination statement in such communications and publications, along with a limited number of taglines. OCR also is translating a sample nondiscrimination statement that covered entities may use in fulfilling this obligation. It will be available by the effective date of this rule.

In addition, with respect to the obligation in § 92.8 to post taglines in at least the top 15 languages spoken nationally by persons with limited English proficiency, OCR has replaced the national threshold with a threshold

[1] 5 U.S.C. 301.

[2] 80 FR 54172 (Sept. 8, 2015).

requiring taglines in at least the top 15 languages spoken by limited English proficient populations statewide.

OCR has changed § 92.101 to provide that sex-specific health programs or activities are allowable only where the covered entity can demonstrate an exceedingly persuasive justification, *i.e.*, that the sex-specific program is substantially related to the achievement of an important health-related or scientific objective.

OCR has changed § 92.201, addressing the obligation to take reasonable steps to provide meaningful access. That section now requires the Director to evaluate, and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue to the individual with limited English proficiency, and to take into account all other relevant factors, including whether the entity has developed and implemented an effective language access plan, appropriate to its particular circumstances. The final rule deletes the specific list of illustrative factors set out in the proposed rule.

Also, OCR has changed § 92.203, addressing accessibility of buildings and facilities for individuals with disabilities, to require covered entities that were covered by the 2010 Americans with Disabilities Act (ADA) Standards for Accessible Design prior to the effective date of this final rule to comply with those standards for new construction or alterations by the effective date of the final rule. The final rule also narrows § 92.203's safe harbor for building and facility accessibility so that compliance with the Uniform Federal Accessibility Standards (UFAS) will be deemed compliance with this part only if construction or alteration was commenced before the effective date of the final rule and the facility or part of the facility was not covered by standards under the ADA. As nearly all covered entities under the final rule are already covered by the ADA standards, these changes impose a de minimis cost.

Section 92.301 has been changed to clarify that compensatory damages for violations of Section 1557 are available in administrative and judicial actions to the extent they are available under the authorities referenced in Section 1557. Finally, we have added a severability clause to § 92.2, to indicate our intention that the rule be construed to give the maximum effect permitted by law to each provision.

In responding to the comments it received on the proposed rule, OCR has provided a thorough explanation of each of these changes in the preamble. OCR has also clarified some of the nondiscrimination requirements of Section 1557 and made some technical changes to the rule's provisions. In addition, we have added some definitions to proposed § 92.4, as summarized in the preamble to this final rule.

II. Provisions of the Proposed Rule and Analysis and Responses to Public Comments

A. General Comments

OCR received a large number of comments asking that we categorically declare in the final rule that certain actions are or are not discriminatory. For example, some commenters asked that OCR state that a modification to add medically necessary care, or a prohibition on exclusions of medically necessary services, is never a fundamental alteration to a health plan. Similarly, other commenters asked that OCR include a statement in the final rule that an issuer's refusal to cover core services commonly needed by individuals with intellectual disabilities is discrimination on the basis of disability. Still other commenters asked that OCR state that limiting health care and gender transition services to transgender individuals over the age of 18 is discriminatory. Other commenters asked that OCR state that it is discriminatory to require individuals with psychiatric disabilities to see a mental health professional in order to continue receiving treatment for other conditions.

Many of these same commenters asked that OCR supplement the final rule with in-depth explanations and analyses of examples of discrimination. For example, several commenters asked that OCR add an example of discrimination in research trials. Similarly, many other commenters asked that OCR add an example of what they considered to be disability discrimination in health insurance practices, such as higher reimbursement rates for care in segregated settings.

OCR appreciates the commenters' desire for further information on the application of the rule to specific circumstances. OCR's intent in promulgating this rule is to provide consumers and covered entities with a set of standards that will help them understand and comply with the requirements of Section 1557. Covered entities should bear in mind the purposes of the ACA and Section 1557—to expand access to care and coverage and eliminate barriers to access—in interpreting requirements of the final rule. But we neither address every scenario that might arise in the application of these standards nor state that certain practices as a matter of law are "always" or "never" permissible. The determination of whether a certain practice is discriminatory typically requires a nuanced analysis that is fact-dependent. Nonetheless, OCR has included in the preamble a number of examples of issues and circumstances that may raise compliance concerns under the final rule.

OCR also received several comments, primarily from representatives of the insurance industry, recommending that where specific Centers for Medicare & Medicaid Services (CMS) or State requirements apply to covered entities, OCR should either (1) harmonize all standards with existing CMS rules, or (2) allow issuers to be deemed compliant with Section 1557 if they are compliant with existing Federal or State law. For example, some commenters requested that compliance with CMS regulations that pertain to qualified health plans or insurance benefit design, such as prescription drug formularies designed by a pharmacy and therapeutics committee, be deemed compliance with the final rule on Section 1557. These commenters were concerned that CMS or a State might approve a plan that OCR might later find discriminatory. The commenters sought clarification on how OCR will handle cases involving health plans regulated by multiple authorities, and suggested that a "deeming" approach would reduce confusion and avoid duplication of costs and administrative effort. Other commenters asked that compliance with language access standards promulgated by CMS or the States be deemed compliance with the final rule; those comments are discussed in more detail in the preamble at § 92.201.

OCR recognizes the efficiencies inherent in harmonizing regulations to which covered entities are subject under various laws. Indeed, entities covered under Section 1557 are likely also subject to a host of other laws and regulations, including CMS regulations, the Genetic Information Nondiscrimination Act of 2008,[3] the Family and Medical Leave Act, the ADA, Title VII of the Civil Rights Act of 1964, and State laws. OCR will coordinate as appropriate with other Federal agencies to avoid inconsistency and duplication in enforcement efforts.

That said, OCR declines to adopt a deeming approach whereby compliance with another set of laws or regulations automatically constitutes compliance with Section 1557. As to State laws, it

[3] Public Law 110–233, 122 Stat. 881 (2008).

is inappropriate to define requirements under Federal law based on what could be the varying, and potentially changing, requirements of different States' approaches. As to other Federal laws, OCR will give consideration to an entity's compliance with the requirements of other Federal laws where those requirements overlap with Section 1557. In such cases, OCR will work closely with covered entities where compliance with this final rule requires additional steps. But in the final analysis, OCR must, in its capacity as the lead enforcement agency for Section 1557, maintain the discretion to evaluate an entity's compliance with the standards set by the final rule. This is consistent with the approach taken by other agencies to civil rights obligations, in which compliance with one set of requirements, adopted under different laws or for different purposes, is not considered automatic compliance with civil rights obligations.

Subpart A—General Provisions

Purpose and Effective Date (§ 92.1)

In § 92.1, we proposed that the purpose of this part is to implement Section 1557 of the ACA, which prohibits discrimination in certain health programs and activities on the grounds prohibited under Title VI, Title IX, the Age Act, and Section 504, which together prohibit discrimination on the basis of race, color, national origin, sex, age, or disability.

We also proposed that the effective date of the Section 1557 implementing regulation shall be 60 days after the publication of the final rule in the **Federal Register**.

The comments and our responses regarding the proposed effective date are set forth below.

Comment: Some commenters asserted that 60 days after publication of the final rule did not allow sufficient time for entities to come into compliance with Section 1557 and requested that the effective date be one year after publication of the final rule. Similarly, one commenter stated that State agencies covered by Section 1557 need at least 150 days to come into compliance with Section 1557. The commenter stated that State agencies need additional time to assess the impacts, align nondiscrimination requirements from multiple Federal agencies, and make the required policy, operational, and system changes.

Response: OCR does not believe that extending the effective date beyond 60 days is warranted, except with regard to specific provisions for which there is a later applicability date, as set forth below. Most of the requirements of Section 1557 are not new to covered entities, and 60 days should be sufficient to come into compliance with any new requirements.

Summary of Regulatory Changes

For the reasons set forth in the proposed rule and considering the comments received, we are finalizing the provisions as proposed in § 92.1 with one modification. We recognize that some covered entities will have to make changes to their health insurance coverage or other health coverage to bring that coverage into compliance with this final rule. We are sensitive to the difficulties that making changes in the middle of a plan year could pose for some covered entities and are committed to working with covered entities to ensure that they can comply with the final rule without causing excessive disruption for the current plan year. Consequently, to the extent that provisions of this rule require changes to health insurance or group health plan benefit design (including covered benefits, benefits limitations or restrictions, and cost-sharing mechanisms, such as coinsurance, copayments, and deductibles), such provisions, as they apply to health insurance or group health plan benefit design, have an applicability date of the first day of the first plan year (in the individual market, policy year) beginning on or after January 1, 2017.

Application (§ 92.2)

Section 92.2 of the proposed rule stated that Section 1557 applies to all health programs and activities, any part of which receives Federal financial assistance from any Federal agency. It also stated that Section 1557 applies to all programs and activities that are administered by an Executive Agency or any entity established under Title I of the ACA.

In paragraph (a), we proposed to apply the proposed rule, except as otherwise provided in § 92.2, to: (1) All health programs and activities, any part of which receives Federal financial assistance administered by HHS; (2) health programs and activities administered by the Department, including the Federally-facilitated Marketplaces; and (3) health programs and activities administered by entities established under Title I of the ACA, including the State-based Marketplaces.

In paragraph (b), we proposed limitations to the application of the final rule. We proposed the adoption of the existing limitations and exceptions that already, under the statutes referenced in Section 1557, govern the health programs and activities subject to Section 1557. We noted that these limitations and exceptions are found in the Age Act and in the regulations implementing the Age Act, Section 504, and Title VI, which apply to all programs and activities that receive Federal financial assistance.

In paragraph (b)(1), we proposed to incorporate the exclusions found in the Age Act, such that the provisions of the proposed rule would not apply to any age distinction contained in that part of a Federal, State, or local statute or ordinance adopted by an elected, general purpose legislative body which provides any benefits or assistance to persons based on age, establishes criteria for participation in age-related terms, or describes intended beneficiaries to target groups in age-related terms.[4] We requested comment on whether the exemptions found in Title IX and its implementing regulation should be incorporated into the final rule. We noted that unlike the Age Act, Section 504, and Title VI, which apply to all programs and activities that receive Federal financial assistance (including health programs and activities), Title IX applies only in the context of education programs and not to the majority of the health programs and activities subject to the proposed rule. In addition, we noted that many of Title IX's limitations and exceptions do not readily apply in a context that is grounded in health care, rather than education.

We invited comment on whether the regulation should include any specific exemptions for health service providers, health plans, or other covered entities with respect to requirements of the proposed rule related to sex discrimination. We stated that we wanted to ensure that the proposed rule had the proper scope and appropriately protected sincerely held religious beliefs to the extent that those beliefs may conflict with provisions of the proposed regulation. We noted that certain protections already exist with respect to religious beliefs, particularly with respect to the provision of certain health-related services; for example, we noted that the proposed rule would not displace the protections afforded by provider conscience laws,[5] the Religious Freedom Restoration Act (RFRA),[6] provisions in the ACA related to abortion services,[7] or regulations issued

[4] *See* 42 U.S.C. 6103(b).

[5] *See, e.g.*, 42 U.S.C. 300a–7; 42 U.S.C. 238n; Consolidated and Further Continuing Appropriations Act 2015, Public Law 114–53, Div. G, § 507(d) (Dec. 16, 2015).

[6] 42 U.S.C. 2000bb–1.

[7] *See, e.g.*, 42 U.S.C. 18023.

APPENDIX C

FEDERAL REGISTER

Vol. 78 Monday,
No. 37 February 25, 2013

Part II

Department of Health and Human Services

45 CFR Parts 147, 155, and 156
Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 147, 155, and 156

[CMS–9980–F]

RIN 0938–AR03

Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

AGENCY: Department of Health and Human Services.

ACTION: Final rule.

SUMMARY: This final rule sets forth standards for health insurance issuers consistent with title I of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act. Specifically, this final rule outlines Exchange and issuer standards related to coverage of essential health benefits and actuarial value. This rule also finalizes a timeline for qualified health plans to be accredited in Federally-facilitated Exchanges and amends regulations providing an application process for the recognition of additional accrediting entities for purposes of certification of qualified health plans.

DATES: Effective April 26, 2013.

FOR FURTHER INFORMATION CONTACT:
Leigha Basini at (301) 492–4307, for general information.
Adam Block at (410) 786–1698, for matters related to essential health benefits, actuarial value, and minimum value.
Tara Oakman at (301) 492–4253, for matters related to accreditation.

SUPPLEMENTARY INFORMATION:

Table of Contents

Acronym List:

Because of the many organizations and terms to which we refer by acronym in this final rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

AV Actuarial Value
CHIP Children's Health Insurance Program
CMS Centers for Medicare & Medicaid Services
DOL U.S. Department of Labor
EHB Essential Health Benefits
ERISA Employee Retirement Income Security Act (29 U.S.C. section 1001, et seq.)
FDA U.S. Food and Drug Administration
FEDVIP Federal Employees Dental and Vision Insurance Program
FEHBP Federal Employees Health Benefits Program
FSA Flexible Spending Arrangement
HEDIS Healthcare Effectiveness Data and Information Set
HHS U.S. Department of Health and Human Services
HIOS Health Insurance Oversight System
HMO Health Maintenance Organization
HRA Health Reimbursement Arrangement
HSA Health Savings Account
IOM Institute of Medicine
ICR Information Collection Requirements
IRS Internal Revenue Service
MV Minimum Value
NAIC National Association of Insurance Commissioners
OMB Office of Management and Budget
OPM U.S. Office of Personnel Management
PHSAct Public Health Service Act
PRA Paperwork Reduction Act
QHP Qualified Health Plan
SHOP Small Business Health Options Program
SSA Social Security Administration
The Act Social Security Act
The Code Internal Revenue Code of 1986
USP United States Pharmacopeia

Executive Summary: Beginning in 2014, all non-grandfathered health insurance coverage in the individual and small group markets, Medicaid benchmark and benchmark-equivalent plans, and Basic Health Programs (if applicable) will cover essential health benefits (EHB), which include items and services in 10 statutory benefit categories, such as hospitalization, prescription drugs, and maternity and newborn care, and are equal in scope to a typical employer health plan. In addition to offering EHB, non-grandfathered health insurance plans will meet specific actuarial values (AVs): 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. These AVs, called "metal levels," will assist consumers in comparing and selecting health plans by allowing a potential enrollee to compare the relative payment generosity of available plans. Taken together, EHB and AV will significantly increase consumers' ability to compare and make an informed choice about health plans.

The Department of Health and Human Services (HHS) has provided information on EHB and AV standards in several phases. On December 16, 2011, HHS released a bulletin [1] (the EHB Bulletin) following a report from the U.S. Department of Labor (DOL) [2] describing the scope of benefits typically covered under employer-sponsored coverage and an HHS-commissioned study from the Institute of Medicine (IOM) [3] recommending the criteria and methods for determining and updating the EHB. The EHB Bulletin outlined an intended regulatory approach for defining EHB, including a benchmark-based framework. Shortly thereafter, on January 25, 2012, HHS released an illustrative list of the largest three small group market products by state, which was updated on July 2, 2012.[4] HHS further clarified the approach described in the EHB Bulletin through a series of Frequently Asked Questions (FAQs),[5] released on

[1] "Essential Health Benefits Bulletin." December 16, 2011. Available at: *http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.*

[2] "Selected Medical Benefits: A report from the Department of Labor to the Department of Health and Human Services." April 15, 2011. Available at: *http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf.*

[3] Institute of Medicine, "Essential Health Benefits: Balancing Coverage and Cost." October 6, 2011. Available at: *http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx.*

[4] "Essential Health Benefits: List of the Largest Three Small Group Products by State." July 3, 2012. Available at: *http://cciio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf.PDF.*

[5] "Frequently Asked Questions on Essential Health Benefits Bulletin." February 17, 2012.

commenters on the use of USP as the system, there was no universal system identified as a potential alternative. We chose the current version USP Model Guidelines (version 5) because it is publicly available and many pharmacy benefit managers are familiar with it. We believe the USP model best fits the needs for the years 2014 and 2015 during the transitional EHB policy and we have developed a crosswalk tool to count the number of drugs available in each USP category and class. We intend to work with issuers, states and the NAIC to facilitate state use of the USP Model Guidelines Version 5.0 as a classification system and as a comparison tool.

Comment: Several commenters requested additional detail regarding the requirement that that a plan "must have procedures in place that allow an enrollee to request clinically appropriate drugs not covered by the health plan."

Response: Additional guidance regarding our expectations for the required exceptions process is forthcoming in sub-regulatory guidance. We note the importance of this option for those whose medical needs require a very narrow range of pharmaceuticals, and emphasize that our research has shown that a large number of plans already offer this option in the market today. It is expected that plans that currently have such a process in place will not be expected to modify their existing process.

Comment: Many commenters suggested that HHS should clarify in § 156.120(c) (as explained above, now renumbered as § 156.122(c)) of the final regulation that plans must have procedures in place that ensure enrollees have access to clinically appropriate drugs, not just allow the enrollee to request such a drug. While the preamble of the proposed rule includes a statement of this standard, the proposed rule does not.

Response: We have added language from the proposed rule preamble to § 156.122(c) directing plans to have procedures to allow an enrollees to gain access to clinically appropriate drugs.

Comment: Commenters urged HHS to provide guidance as to which drugs are covered by § 156.280(d) so that the final rule is clear as to which drugs are actually exempted.

Response: We have revised the language to specify that we are referring to drugs approved by the U.S. Food and Drug Administration (FDA) as a § 156.280(d) service.

Summary of Regulatory Changes

We are finalizing the provisions in § 156.120 of the proposed rule (renumbered as § 156.122 in the final rule), with the following modifications: We have added language to § 156.122(c) based on the proposed rule's preamble text directing plans to have procedures to allow an enrollees to gain access to clinically appropriate drugs. We have revised the language in subparagraph (b) to specify that we are referring to drugs approved by the U.S. Food and Drug Administration (FDA) as a § 156.280(d) service.

f. Prohibition on Discrimination (§ 156.125)

Section 1302(b)(4) of the Affordable Care Act directs the Secretary to address certain standards in defining EHB, including elements related to balance, discrimination, the needs of diverse sections of the population, and denial of benefits. The proposed regulations would provide an approach to addressing discrimination that would allow states to monitor and identify discriminatory benefit designs, or the implementation thereof.

To address potentially discriminatory practices, we proposed in paragraph (a) that an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, or present or predicted disability, degree of medical dependency, quality of life, or other health conditions. In paragraph (b), we proposed that §§ 156.200 and156.225 also apply to all issuers required to provide coverage of EHB, prohibiting discrimination based on factors including but not limited to race, gender, disability, and age as well as marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.

These provisions would provide a framework and legal standard from which to develop analytic tools to test for discriminatory plan benefits. Such analyses could include evaluations to identify significant deviation from typical plan offerings including such as limitations for benefits with specific characteristics.

The comments and our responses to § 156.125 are set forth below.

Comment: Several commenters indicated their belief that section 1302(b)(4) of the Affordable Care Act does not prohibit discrimination in benefit implementation in the standards for providing EHBs.

Response: Section 1302(b)(4) of the Affordable Care Act specifies that EHB not include "coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life." We believe that this range of prohibited discrimination implicitly encompasses not just the categories of benefits included in the benefit design but also the implementation of that design.

Comment: A number of commenters recommended that we expand this section to prohibit discrimination based on sex, gender identity, sexual orientation, having a particular medical condition, and other factors.

Response: The regulation as written prohibits benefit discrimination on the grounds articulated by Congress in section 1302(b)(4) of the Affordable Care Act, as well as those in 45 CFR 156.200(e), which include race, color, national origin, disability, age, sex, gender identity and sexual orientation.

Comment: Many commenters requested that we add more detail to the regulation regarding standards of nondiscrimination, the framework for monitoring and enforcement, as well as clarification of the roles of the states and the federal government. Several commenters expressed concern that enrollees with certain health conditions might by discriminated against by an issuer's failure to include appropriate specialists in their network.

Response: Enforcement of the PHS Act provisions codified in this rule is governed by section 2723 of the PHS Act, which first looks to states and then to the Secretary where a state has does not substantially enforce. The approach to nondiscrimination will reserve flexibility for both HHS and the states to respond to new developments in benefit structure and implementation and to be responsive to varying circumstances across the states. We agree with the commenters that network adequacy is an important part of plan coverage. Compliance with network adequacy requirements is outside of the scope of this regulation.

Comment: Several commenters expressed concern over state benchmarks that they believed contained discriminatory benefit designs and worried that issuers in those states would be required to copy those designs.

Response: To the extent that a state benchmark plan includes a discriminatory benefit design, non-discrimination regulations at § 156.110(d) and § 156.125 require issuers to meet the benchmark requirements in a nondiscriminatory matter.

APPENDIX D

WSR 15-20-042
PERMANENT RULES
OFFICE OF
INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2015-02—Filed September 29, 2015, 1:48 p.m., effective September 29, 2015, 1:48 p.m.]

[WAC 284-43-878 excerpted below]

WAC 284-43-878 Essential health benefit categories.

(1) A health benefit plan must cover "ambulatory patient services." For purposes of determining a plan's actuarial value, an issuer must classify as ambulatory patient services medically necessary services delivered to enrollees in settings other than a hospital or skilled nursing facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury, in a substantially equal manner to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as ambulatory patient services:

(i) Home and outpatient dialysis services;

(ii) Hospice and home health care, including skilled nursing care as an alternative to hospitalization consistent with WAC 284-44-500, 284-46-500, and 284-96-500;

(iii) Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies;

(iv) Urgent care center visits, including provider services, facility costs and supplies;

(v) Ambulatory surgical center professional services, including anesthesiology, professional surgical services, and surgical supplies and facility costs;

(vi) Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures; and

(vii) Provider contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value for this category.

(i) Infertility treatment and reversal of voluntary sterilization;

(ii) Routine foot care for those that are not diabetic;

(iii) Coverage of dental services following injury to sound natural teeth, but not excluding services or appliances necessary for or resulting from medical treatment if the service is:

(A) Emergency in nature; or

(B) Requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease. Oral surgery related to trauma and injury must be covered.

(iv) Private duty nursing for hospice care and home health care, to the extent consistent with state and federal law;

(v) Adult dental care and orthodontia delivered by a dentist or in a dentist's office;

(vi) Nonskilled care and help with activities of daily living;

(vii) Hearing care, routine hearing examinations, programs or treatment for hearing loss including, but not limited to, externally worn or surgically implanted hearing aids, and the surgery and services necessary to implant them, other than for cochlear implants, which are covered, and for hearing screening tests required under the preventive services category, unless coverage for these services and devices are required as part of, and classified to, another essential health benefits category;

(viii) Obesity or weight reduction or control other than covered nutritional counseling.

(c) The base-benchmark plan establishes specific limitations on services classified to the ambulatory patient services category that conflict with state or federal law as of January 1, 2014. The base-benchmark plan limits nutritional counseling to three visits per lifetime, if the benefit is not associated with diabetes management. This lifetime limitation for nutritional counseling is not part of the state EHB-benchmark plan. An issuer may limit this service based on medical necessity, and may establish an additional reasonable visit limitation requirement for nutritional counseling for medical conditions when supported by evidence based medical criteria.

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) Ten spinal manipulation services per calendar year without referral;

(ii) Twelve acupuncture services per calendar year without referral;

(iii) Fourteen days' respite care on either an inpatient or outpatient basis for hospice patients, per lifetime;

(iv) One hundred thirty visits per calendar year for home health care.

(e) State benefit requirements classified to this category are:

(i) Chiropractic care (RCW 48.44.310);

(ii) TMJ disorder treatment (RCW 48.21.320, 48.44.460, and 48.46.530);

(iii) Diabetes-related care and supplies (RCW 48.20.391, 48.21.143, 48.44.315, and 48.46.272).

(2) A health benefit plan must cover "emergency medical services." For purposes of determining a plan's actuarial value, an issuer must classify care and services related to an emergency medical condition to the emergency medical services category, in a substantially equal manner to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as emergency services:

(i) Ambulance transportation to an emergency room and treatment provided as part of the ambulance service;

(ii) Emergency room and department-based services, supplies and treatment, including professional charges, facility costs, and outpatient charges for patient observation and medical screening exams required to stabilize a patient experiencing an emergency medical condition;

(iii) Prescription medications associated with an emergency medical condition, including those purchased in a foreign country.

(b) The base-benchmark plan does not specifically exclude services classified to the emergency medical care category.

(c) The base-benchmark base plan does not establish specific limitations on services classified to the emergency medical services category that conflict with state or federal law as of January 1, 2014.

(d) The base-benchmark plan does not establish visit limitations on services in this category.

(e) State benefit requirements classified to this category include services necessary to screen and stabilize a covered person (RCW 48.43.093).

(3) A health benefit plan must cover "hospitalization." For purposes of determining a plan's actuarial value, an issuer must classify as hospitalization services the medically necessary services delivered in a hospital or skilled nursing setting including, but not limited to, professional services, facility fees, supplies, laboratory, therapy or other types of services delivered on an inpatient basis, in a substantially equal manner to the base-benchmark plan.

(a) A health benefit plan must include the following services which are specifically covered by the base-benchmark plan and classify them as hospitalization services:

(i) Hospital visits, facility costs, provider and staff services and treatments delivered during an inpatient hospital stay, including inpatient pharmacy services;

(ii) Skilled nursing facility costs, including professional services and pharmacy services and prescriptions filled in the skilled nursing facility pharmacy;

(iii) Transplant services, supplies and treatment for donors and recipients, including the transplant or donor facility fees performed in either a hospital setting or outpatient setting;

(iv) Dialysis services delivered in a hospital;

(v) Artificial organ transplants based on an issuer's medical guidelines and manufacturer recommendations;

(vi) Respite care services delivered on an inpatient basis in a hospital or skilled nursing facility.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value:

(i) Hospitalization where mental illness is the primary diagnosis to the extent that it is classified under the mental health and substance use disorder benefits category;

(ii) Cosmetic or reconstructive services and supplies except in the treatment of a congenital anomaly, to restore a physical bodily function lost as a result of injury or illness, or related to breast reconstruction following a medically necessary mastectomy;

(iii) The following types of surgery:

(A) Bariatric surgery and supplies;

(B) Orthognathic surgery and supplies unless due to temporomandibular joint disorder or injury, sleep apnea or congenital anomaly; and

(C) Sexual reassignment treatment and surgery;

(iv) Reversal of sterilizations;

(v) Surgical procedures to correct refractive errors, astigmatism or reversals or revisions of surgical procedures which alter the refractive character of the eye.

(c) The base-benchmark plan establishes specific limitations on services classified to the hospitalization category that conflict with state or federal law as of January 1, 2014. The base-benchmark plan allows for a transplant waiting period. This waiting period is not part of the state EHB-benchmark plan.

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) Sixty inpatient days per calendar year for illness, injury or physical disability in a skilled nursing facility;

(ii) Thirty inpatient rehabilitation service days per calendar year. This benefit may be classified to this category for determining actuarial value or to the rehabilitation services category, but not to both.

(e) State benefit requirements classified to this category are:

(i) General anesthesia and facility charges for dental procedures for those who would be at risk if the service were performed elsewhere and without anesthesia (RCW 48.43.185);

(ii) Reconstructive breast surgery resulting from a mastectomy which resulted from disease, illness or injury (RCW 48.20.395, 48.21.230, 48.44.330, and 48.46.280);

(iii) Coverage for treatment of temporomandibular joint disorder (RCW 48.21.320, 48.44.460, and 48.46.530);

(iv) Coverage at a long-term care facility following hospitalization (RCW 48.43.125).

(4) A health benefit plan must cover "maternity and newborn" services. For purposes of determining a plan's actuarial value, an issuer must classify as maternity and newborn services the medically necessary care and services delivered to women during pregnancy and in relation to delivery and recovery from delivery, and to newborn children, in a substantially equal manner to the base-benchmark plan.

(a) A health benefit plan must cover the following services which are specifically covered by the base-benchmark plan and classify them as maternity and newborn services:

(i) In utero treatment for the fetus;

(ii) Vaginal or cesarean childbirth delivery in a hospital or birthing center, including facility fees;

(iii) Nursery services and supplies for newborns, including newly adopted children;

(iv) Infertility diagnosis;

(v) Prenatal and postnatal care and services, including screening;

(vi) Complications of pregnancy such as, but not limited to, fetal distress, gestational diabetes, and toxemia; and

(vii) Termination of pregnancy. Termination of pregnancy may be included in an issuer's essential health benefits package, but nothing in this section requires an issuer to offer the benefit, consistent with 42 U.S.C. 18023 (b)(a)(A)(i) and 45 C.F.R. 156.115.

(b) A health benefit plan may, but is not required to, include the following service as part of the EHB-benchmark

package. Genetic testing of the child's father is specifically excluded by the base-benchmark plan, and should not be included in determining actuarial value.

(c) The base-benchmark plan establishes specific limitations on services classified to the maternity and newborn category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan requirements for these services are:

(i) Maternity coverage for dependent daughters must be included in the EHB-benchmark plan on the same basis that the coverage is included for other enrollees;

(ii) Newborns delivered of dependent daughters must be covered to the same extent, and on the same basis, as newborns delivered to the other enrollees under the plan.

(d) The base-benchmark plan's limitations on services in this category include coverage of home birth by a midwife or nurse midwife only for low risk pregnancy.

(e) State benefit requirements classified to this category include:

(i) Maternity services that include diagnosis of pregnancy, prenatal care, delivery, care for complications of pregnancy, physician services, and hospital services (RCW 48.43.041);

(ii) Newborn coverage that is not less than the post-natal coverage for the mother, for no less than three weeks (RCW 48.43.115);

(iii) Prenatal diagnosis of congenital disorders by screening/diagnostic procedures if medically necessary (RCW 48.20.430, 48.21.244, 48.44.344, and 48.46.375).

(5) A health benefit plan must cover "mental health and substance use disorder services, including behavioral health treatment." For purposes of determining a plan's actuarial value, an issuer must classify as mental health and substance use disorder services, including behavioral health treatment, the medically necessary care, treatment and services for mental health conditions and substance use disorders categorized in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, including behavioral health treatment for those conditions, in a substantially equal manner to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as mental health and substance use disorder services, including behavioral health treatment:

(i) Inpatient, residential and outpatient mental health and substance use disorder treatment, including partial hospital programs or inpatient services;

(ii) Chemical dependency detoxification;

(iii) Behavioral treatment for a DSM category diagnosis;

(iv) Services provided by a licensed behavioral health provider for a covered diagnosis in a skilled nursing facility;

(v) Prescription medication prescribed during an inpatient and residential course of treatment;

(vi) Acupuncture treatment visits without application of the visit limitation requirements, when provided for chemical dependency.

(b) A health benefit plan may, but is not required to include, the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value.

(i) Counseling in the absence of illness, other than family counseling when the patient is a child or adolescent with a covered diagnosis and the family counseling is part of the treatment for mental health services;

(ii) Mental health treatment for diagnostic codes 302 through 302.9 in the DSM-IV, or for "V code" diagnoses except for medically necessary services for parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger, and bereavement for children five years of age or younger, unless this exclusion is preempted by federal law;

(iii) Not medically necessary court-ordered mental health treatment.

(c) The base-benchmark plan establishes specific limitations on services classified to the mental health and substance abuse disorder services category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan requirements for these services are:

(i) Coverage for eating disorder treatment must be covered when associated with a diagnosis of a DSM categorized mental health condition;

(ii) Chemical detoxification coverage must not be uniformly limited to thirty days. Medical necessity, utilization review and criteria consistent with federal law may be applied by an issuer in designing coverage for this benefit;

(iii) Mental health services and substance use disorder treatment must be delivered in a home health setting on parity with medical surgical benefits, consistent with state and federal law.

(d) The base-benchmark plan's visit limitations on services in this category include: Court ordered treatment only when medically necessary.

(e) State benefit requirements classified to this category include:

(i) Mental health services (RCW 48.20.580, 48.21.241, 48.44.341, and 48.46.285);

(ii) Chemical dependency detoxification services (RCW 48.21.180, 48.44.240, 48.44.245, 48.46.350, and 48.46.355);

(iii) Services delivered pursuant to involuntary commitment proceedings (RCW 48.21.242, 48.44.342, and 48.46.292).

(f) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) (MHPAEA) applies to a health benefit plan subject to this section. Coverage of mental health and substance use disorder services, along with any scope and duration limits imposed on the benefits, must comply with the MHPAEA, and all rules, regulations and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26) where state law is silent, or where federal law preempts state law.

(6) A health benefit plan must cover "prescription drug services." For purposes of determining a plan's actuarial value, an issuer must classify as prescription drug services the medically necessary prescribed drugs, medication and drug therapies, in a manner substantially equal to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan and classify them as prescription drug services:

(i) Drugs and medications both generic and brand name, including self-administrable prescription medications, consistent with the requirements of (b) through (f) of this subsection;

(ii) Prescribed medical supplies, including diabetic supplies that are not otherwise covered as durable medical equipment under the rehabilitative and habilitative services category, including test strips, glucagon emergency kits, insulin and insulin syringes;

(iii) All FDA approved contraceptive methods, and prescription based sterilization procedures for women with reproductive capacity;

(iv) Certain preventive medications including, but not limited to, aspirin, fluoride, and iron, and medications for tobacco use cessation, according to, and as recommended by, the United States Preventive Services Task Force, when obtained with a prescription order;

(v) Medical foods to treat inborn errors of metabolism.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-

benchmark plan, and should not be included in establishing actuarial value for this category:

(i) Insulin pumps and their supplies, which are classified to and covered under the rehabilitation and habilitation services category; and

(ii) Weight loss drugs.

(c) The base-benchmark plan establishes specific limitations on services classified to the prescription drug services category that conflict with state or federal law as of January 1, 2014. The EHB-benchmark plan requirements for these services are:

(i) Preauthorized tobacco cessation products must be covered consistent with state and federal law;

(ii) Medication prescribed as part of a clinical trial, which is not the subject of the trial, must be covered in a manner consistent with state and federal law.

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) Prescriptions for self-administrable injectable medication are limited to thirty day supplies at a time, other than insulin, which may be offered with more than a thirty day supply. This limitation is a floor, and an issuer may permit supplies greater than thirty days as part of its health benefit plan;

(ii) Teaching doses of self-administrable injectable medications are limited to three doses per medication per lifetime.

(e) State benefit requirements classified to this category include:

(i) Medical foods to treat phenylketonuria (RCW 48.44.440, 48.46.510, 48.20.520, and 48.21.300);

(ii) Diabetes supplies ordered by the physician (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143). Inclusion of this benefit requirement does not bar issuer variation in diabetic supply manufacturers under its drug formulary;

(iii) Mental health prescription drugs to the extent not covered under the hospitalization or skilled nursing facility services, or mental health and substance use disorders categories (RCW 48.44.341, 48.46.291, 48.20.580, and 48.21.241).

(f) An issuer's formulary is part of the prescription drug services category. The formulary filed with the commissioner must be substantially equal to the base-benchmark plan formulary, both as to U.S. Pharmacopoeia therapeutic category and classes covered and number of drugs in each class. If the base-benchmark formulary does not cover at least one drug in a category or class, an issuer must include at least one drug in the uncovered category or class.

(i) An issuer must file its formulary quarterly, following the filing instructions defined by the insurance commissioner in WAC 284-44A-040, 284-46A-050, and 284-58-025.

(ii) An issuer's formulary does not have to be substantially equal to the base-benchmark plan formulary in terms of formulary placement.

(7) A health benefit plan must cover "rehabilitative and habilitative services."

(a) For purposes of determining a plan's actuarial value, an issuer must classify as rehabilitative services the medically necessary services that help a person keep, restore or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt or disabled, in a manner substantially equal to the base-benchmark plan.

(b) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as rehabilitative services:

(i) Cochlear implants;

(ii) In-patient rehabilitation facility and professional services delivered in those facilities;

(iii) Outpatient physical therapy, occupational therapy and speech therapy for rehabilitative purposes;

(iv) Braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts;

(v) Durable medical equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax.

(c) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value:

(i) Off the shelf shoe inserts and orthopedic shoes;

(ii) Exercise equipment for medically necessary conditions;

(iii) Durable medical equipment that serves solely as a comfort or convenience item; and

(iv) Hearing aids other than cochlear implants.

(d) **Supplementation:** The base-benchmark plan does not cover certain federally required services under this category. A health benefit plan must cover habilitative services, but these services are not specifically covered in the base-benchmark plan. Therefore, this category is supplemented. The state EHB-benchmark plan requirements for habilitative services are:

(i) For purposes of determining actuarial value and complying with the requirements of this section, the issuer must classify as habilitative services and provide coverage for the

range of medically necessary health care services and health care devices designed to assist an individual in partially or fully developing, keeping or learning age appropriate skills and functioning within the individual's environment, or to compensate for a person's progressive physical, cognitive, and emotional illness.

(ii) As a minimum level of coverage, an issuer must establish limitations on habilitative services on parity with those for rehabilitative services. A health benefit plan may include reference based limitations only if the limitations take into account the unique needs of the individual and target measurable, and specific treatment goals appropriate for the person's age, and physical and mental condition. When habilitative services are delivered to treat a mental health diagnosis categorized in the most recent version of the DSM, the mental health parity requirements apply and supersede any rehabilitative services parity limitations permitted by this subsection.

(iii) A health benefit plan must not limit an enrollee's access to covered services on the basis that some, but not all of the services in a plan of treatment are provided by a public or government program.

(iv) An issuer may establish utilization review guidelines and practice guidelines for habilitative services that are recognized by the medical community as efficacious. The guidelines must not require a return to a prior level of function.

(v) Habilitative health care devices may be limited to those that require FDA approval and a prescription to dispense the device.

(vi) Consistent with the standards in this subsection, speech therapy, occupational therapy, physical therapy, and aural therapy are habilitative services. Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational or custodial services are not classified as habilitative services.

(vii) An issuer must not exclude coverage for habilitative services received at a school-based health care center unless the habilitative services and devices are delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEA) requirements and included in an individual educational plan (IEP).

(e) The base-benchmark plan's visit limitations on services in this category include:

(i) In-patient rehabilitation facility and professional services delivered in those facilities are limited to thirty service days per calendar year; and

(ii) Outpatient physical therapy, occupational therapy and speech therapy are limited to twenty-five outpatient visits per calendar year, on a combined basis, for rehabilitative purposes.

(f) State benefit requirements classified to this category include:

(i) State sales tax for durable medical equipment; and

(ii) Coverage of diabetic supplies and equipment (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143).

(g) An issuer must not classify services to the rehabilitative services category if the classification results in a limitation of coverage for therapy that is medically necessary for an enrollee's treatment for cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases. For purposes of this subsection, an issuer must establish limitations on the number of visits and coverage of the rehabilitation therapy consistent with its medical necessity and utilization review guidelines for medical/surgical benefits. Examples of these are, but are not limited to, breast cancer rehabilitation therapy, respiratory therapy, and cardiac rehabilitation therapy. Such services may be classified to the ambulatory patient or hospitalization services categories for purposes of determining actuarial value.

(8) A health plan must cover "laboratory services." For purposes of determining actuarial value, an issuer must classify as laboratory services the medically necessary laboratory services and testing, including those performed by a licensed provider to determine differential diagnoses, conditions, outcomes and treatment, and including blood and blood services, storage and procurement, and ultrasound, X ray, MRI, CAT scan and PET scans, in a manner substantially equal to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as laboratory services:

(i) Laboratory services, supplies and tests, including genetic testing;

(ii) Radiology services, including X ray, MRI, CAT scan, PET scan, and ultrasound imaging;

(iii) Blood, blood products, and blood storage, including the services and supplies of a blood bank.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. An enrollee's not medically indicated procurement and storage of personal blood supplies provided by a member of the

enrollee's family is specifically excluded by the base-benchmark plan, and should not be included by an issuer in establishing a health benefit plan's actuarial value.

(9) A health plan must cover "preventive and wellness services, including chronic disease management." For purposes of determining a plan's actuarial value, an issuer must classify as preventative and wellness services, including chronic disease management, the services that identify or prevent the onset or worsening of disease or disease conditions, illness or injury, often asymptomatic, services that assist in the multidisciplinary management and treatment of chronic diseases, services of particular preventive or early identification of disease or illness of value to specific populations, such as women, children and seniors, in a manner substantially equal to the base-benchmark plan.

(a) A health benefit plan must include the following services as preventive and wellness services:

(i) Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices;

(ii) Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force for prevention and chronic care, for recommendations issued on or before the applicable plan year;

(iii) Services, tests and screening contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians;

(iv) Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness services guidelines;

(v) Chronic disease management services, which typically include, but are not limited to, a treatment plan with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, measuring care quality and outcomes, and support for patient self-management through education or tools; and

(vi) Wellness services.

(b) The base-benchmark plan does not exclude any services that could reasonably be classified to this category.

(c) The base-benchmark plan does not apply any limitations or scope restrictions that conflict with state or federal law as of January 1, 2014.

(d) The base-benchmark plan does not establish visit limitations on services in this category.

(e) State benefit requirements classified in this category are:

(i) Colorectal cancer screening as set forth in RCW 48.43.043;

(ii) Mammogram services, both diagnostic and screening (RCW 48.21.225, 48.44.325, and 48.46.275);

(iii) Prostate cancer screening (RCW 48.20.392, 48.21.227, 48.44.327, and 48.46.277).

(10) State benefit requirements that are limited to those receiving pediatric services, but that are classified to other categories for purposes of determining actuarial value, are:

(a) Neurodevelopmental therapy to age six, consisting of physical, occupational and speech therapy and maintenance to restore or improve function based on developmental delay, which cannot be combined with rehabilitative services for the same condition (RCW 48.44.450, 48.46.520, and 48.21.310). This state benefit requirement may be classified to ambulatory patient services or mental health and substance abuse disorder including behavioral health categories;

(b) Congenital anomalies in newborn and dependent children (RCW 48.20.430, 48.21.155, 48.44.212, and 48.46.250). This state benefit requirement may be classified to hospitalization, ambulatory patient services or maternity and newborn categories.

(11) This section expires on December 31, 2016.

NEW SECTION

APPENDIX E

The Honorable Judge Oishi, Dept. 24
Noted for Hearing: August 13, 2021 at 10:30 a.m.
With Oral Argument

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF KING

STATE OF WASHINGTON,

Plaintiff,

v.

AGA SERVICE COMPANY; and JEFFERSON INSURANCE COMPANY

Defendants.

NO. 21-2-05989-5 SEA

STATE OF WASHINGTON'S RESPONSE TO DEFENDANTS' RULE 12(b)(6) MOTION

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I. INTRODUCTION

This is a clear-cut case of disability discrimination in insurance. Washington law prohibits unfair insurance practices that rely on stereotypes and assumptions, rather than data, about people with disabilities. The Legislature has stated some version of this prohibition in multiple provisions of the Washington Insurance Code, as well as the Consumer Protection Act (CPA) and Washington Law Against Discrimination (WLAD). That the Legislature felt the need to repeatedly codify its policy against insurance discrimination shows the importance to Washington lawmakers of eradicating this type of unfair insurance practice. Allianz violates these commands by assuming—without data or good reason—that it may justifiably treat Washingtonians with mental health disabilities worse in the sale of its travel insurance products. And make no mistake, only Washingtonians with mental health disabilities, their family members, or their travel companions are excluded from certain Allianz travel insurance benefits caused by a mental health disability. Coverage turns specifically on this protected characteristic. This is plain discrimination, and Washington law does not allow it.

In an effort to avoid the straightforward application of Washington law, Defendants (collectively Allianz) argue that its "Mental Health Exclusion" is not discrimination at all. The Court should not be persuaded. Allianz's exclusion refuses coverage if the insured's trip cancellation is due to a mental disability. That is facially discriminatory. Since Allianz has produced no data to substantiate its Mental Health Exclusion, relying instead on assumptions about the costs that would be associated with covering Washingtonians with mental health disabilities in the same way that Allianz covers all other insureds, Allianz violates state law. At minimum, Allianz bears the burden of proof at trial to show that it had data sufficient to support this exclusion before it sold millions of discriminatory policies statewide. And separately, Allianz's Mental Health Exclusion is unfair and deceptive under Washington's consumer protection law. Because the State's Complaint alleges facts that robustly state seven causes of action—and because Allianz's only response is to try improperly to prove its

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affirmative defenses based on alleged facts outside the Complaint—Allianz's motion should be denied.

II. RELIEF REQUESTED

The State requests that the Court deny Allianz's Motion to Dismiss.

III. STATEMENT OF FACTS

Between 2014 and August 2019 alone, Allianz sold over 2.2 million travel insurance policies to Washington consumers. Compl. ¶ 4.2. These policies cover travel costs incurred when an insured has to cancel or interrupt a trip because of some unforeseeable event, like a heart attack or severe storm. *Id.* ¶ 4.1. Nearly all of Allianz's policies sold in Washington contain a Mental Health Exclusion that excludes coverage for trip-cancellation or trip-interruption losses when caused by a mental, emotional, or nervous health disorder (or related physical symptom) of the insured or the insured's family member or traveling companion. *Id.* ¶ 4.4.

Under its Mental Health Exclusion, Allianz categorically denies every claim for reimbursement of trip cancellation or trip interruption losses that were caused by an insured's mental health disability, or related physical symptom. *Id.* ¶ 1.2. And it does so regardless of the level of documentation the insured submits; Allianz denies the claim even when the insured's medical provider verifies both the mental health disability and that it caused the travel loss. *Id.* ¶¶ 1.2, 4.19. In other words, even though Allianz's travel insurance policies provide coverage for travel losses for all kinds of events, there is no coverage if those losses are related to the insured's mental health disability. *Id.* ¶¶ 1.2, 4.19.

The State alleges that Allianz's Mental Health Exclusion violates several state laws. In Washington, an insurer may not restrict, modify, exclude, increase, or reduce the amount of benefits payable, or any term, rate, condition or type of coverage on the basis of the presence of any mental health disability of the insured or prospective insured, unless it is both: (1) fair discrimination, and (2) substantiated by a bona fide statistical difference in risk or exposure. *Id.* ¶ 5.16; RCW 48.30.300. In addition, the State alleges that it is unlawful for an insurer to make

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or permit unfair discrimination between insureds "having substantially like insuring, risk, and exposure factors, and expense elements, in the terms and conditions of any insurance contract, or in the rate or amount of premium charged therefore, or in the benefits payable or in any other rights or privileges accruing thereunder." *Id.* ¶ 5.21; RCW 48.18.480. Allianz has never substantiated any statistical difference in risk, exposure, or expense between insureds with mental health disabilities and those without, before implementing its Mental Health Exclusion. *Id.* ¶ 4.6. They still have not. *Id.* ¶ 4.22. Hundreds of Washingtonians with mental health disabilities have been harmed by Allianz's discriminatory practices. *Id.* ¶ 4.8. Discovery will undoubtedly reveal more.

In addition, the State alleges that Allianz's practices are unfair and deceptive. *See* RCW 19.86.020. Its advertising and public-facing policies contain representations and omissions that are likely to mislead Washingtonians into believing that Allianz will cover travel losses based on the mental health condition of the insured, their family member, or their travel companion. Compl. ¶ 4.31. For instance, disclosure of the Mental Health Exclusion is difficult to find on www.allianztravelinsurance.com. *Id.* ¶ 4.27, Exhibit A. It is mentioned in just four webpages, each buried under multiple, successive links, and each with a title that does not indicate that information about mental health coverage will be found at the end. *Id.* And Allianz fails to mention the Mental Health Exclusion in places a reasonable consumer would expect, like in a list of events that its policies do not cover or in an article discussing mental health issues that impact travelers. *Id.* ¶¶ 4.29, 4.30. As a result, many Washington consumers with mental health disabilities do not know that they are excluded and treated differently by Allianz until their claim is denied. *Id.* ¶¶ 4.8-4.19.

Allianz has refused to change its practices and continues to sell policies that are discriminatory, unfair, deceptive, and that harm Washington families. The State has sufficiently alleged each of its claims, and Allianz's motion to dismiss should be denied.

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IV. STATEMENT OF ISSUES

1. Do the facts in the Complaint state a claim that Allianz's Mental Health Exclusion is unfair discrimination under RCW 48.30.300 and RCW 48.18.480?

2. Do the facts in the Complaint state a claim that Allianz had not substantiated a statistical justification for its Mental Health Exclusion, as required by RCW 48.30.300 and RCW 48.18.480?

3. Do the facts in the Complaint state a claim that Allianz's Mental Health Exclusion violates the WLAD, specifically RCW 49.60.030(1)(e)?

4. Do the facts in the Complaint state a claim that Allianz's Mental Health Exclusion is an unfair or deceptive business practice prohibited by the CPA, RCW 19.86.020?

V. EVIDENCE RELIED UPON

As required for a motion under CR 12(b)(6), the State's Response is based on the allegations in the Complaint.

VI. ARGUMENT AND AUTHORITY

A. Allianz Cannot Meet the Motion to Dismiss Standard

For purposes of this motion, the State's allegations and all reasonable inferences based on them must be accepted as true. *FutureSelect Portfolio Mgmt., Inc. v. Tremont Grp. Holdings, Inc.*, 180 Wn.2d 954, 962-63, 331 P.3d 29 (2014). "Generally, in ruling on a CR 12(b)(6) motion to dismiss, the trial court may only consider the allegations contained in the complaint and may not go beyond the face of the pleadings." *Rodriguez v. Loudeye Corp.*, 144 Wn. App. 709, 725, 189 P.3d 168 (2008). The Court may also consider "hypothetical facts supporting the [State's] claim," *Id.* at 963, and "[d]ismissal is warranted only if the court concludes, beyond a reasonable doubt, the plaintiff cannot prove 'any set of facts which would justify recovery.'" *Id.* at 962-63 (quoting *Tenore v. AT&T Wireless Servs.*, 136 Wn.2d 322, 329-30, 962 P.2d 104 (1998)). Ultimately, a Rule 12(b)(6) motion "should be granted sparingly and with care and only in the unusual case in which plaintiff includes allegations that show on the face of the complaint that

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there is some insuperable bar to relief." *J.S. v. Vill. Voice Media Holdings, LLC*, 184 Wn.2d 95, 100, 359 P.3d 714 (2015) (quotations omitted).

This Court should deny Allianz's Motion to Dismiss for three reasons. First, Allianz's Mental Health Exclusion is unfair discrimination under binding Washington Supreme Court precedent. Second, Allianz cannot prove from the facts alleged in the Complaint that it substantiated the statistical justification that the Washington Insurance Code requires before discriminating against consumers with mental health disabilities. And third, Allianz attempts to defend its deceptive disclosure of its Mental Health Exclusion by disputing facts alleged in the Complaint and by introducing new, disputed facts outside of the Complaint, which is inappropriate at the motion to dismiss stage. For these reasons, this Court should deny Allianz's Motion to Dismiss in its entirety.

B. The Office of the Insurance Commissioner (OIC) Has Not Approved Allianz's Mental Disability Discrimination

As a threshold matter, the Washington Supreme Court expressly rejected Allianz's argument that OIC's approval of the form of an insurance policy means that a specific provision of the policy complies with the insurance code. *Durant v. State Farm Mut. Auto. Ins. Co.*, 191 Wn.2d 1, 12-14, 419 P.3d 400 (2018) (rejecting insurer's "reli[ance] on the assertion that its auto policy containing the [challenged] provision had been repeatedly approved by the OIC"). The *Durant* Court found that OIC had *not* approved the specific provision at issue, even where OIC had previously communicated its disagreement with the policy language to the defendant; had asked carriers with such non-compliant language to submit new, conforming policy forms; and still approved the policy forms with the non-conforming language. *Id.* Just because Allianz's form was approved does not mean that OIC approved the substance of Allianz's mental health discrimination. Moreover, as to Washington's CPA claim, OIC has no role whatsoever in reviewing Allianz's public-facing advertising on its website and determining whether it is unfair or deceptive.

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C. Allianz's Mental Health Exclusion is Unfair Discrimination Under the Washington Insurance Code

The Washington Insurance Code prohibits unfair discrimination. RCW 48.30.300(2) ("this subsection does not prohibit *fair* discrimination . . .") (emphasis added); RCW 48.18.480 ("No insurer shall make or permit any *unfair* discrimination . . .") (emphasis added). Those statutes bar Allianz's Mental Health Exclusion as unfair discrimination under the standard set by the Washington Supreme Court.

An exclusion in an insurance policy unfairly discriminates for purposes of the Washington Insurance Code when the discrimination is "closely related to" the protected characteristic. *Edwards v. Farmers Ins. Co. of Wash.*, 111 Wn.2d 710, 719-20, 763 P.2d 1226 (1988). The issue in *Edwards* was whether an "other insurance" provision in an auto insurance policy unfairly discriminates based on marital status in violation of RCW 48.30.300. *Id.* At 716. Although *Edwards* specifically concerned RCW 48.30.300, the "closely related to" standard for determining unfair discrimination in insurance applies to all Washington anti-discrimination statutes, such as RCW 48.18.480. *See Id.* at 718-20 ("an anti-discrimination statute [in Washington] applies more broadly" so as to prohibit circumstances where discrimination in coverage is "closely related" to an insured's protected characteristic, even though other factors may also contribute to determining coverage).

In *Edwards*, a husband and wife had two separate Farmers auto insurance policies, one for each of their respective cars. *Id.* at 712. While driving his wife's car, the husband was killed by an underinsured motorist. *Id.* The husband's estate sought to recover benefits under both policies. *Id.* at 710. Each policy's "other insurance" provision expressly limited recovery to the policy with the higher limit if the insured's spouse lived in the same house, such as the husband and wife in *Edwards*. *Id.* at 716. Farmers, like Allianz here, argued that the "other insurance" provision was not unfair discrimination under RCW 48.30.300 because coverage did not turn "*solely*" on marital status. *Id.* at 717 (emphasis added). For example, a cohabitating, unmarried

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couple; a married couple living separately; or a cohabitating, married couple with a Farmers policy and a policy from another auto insurer all could recover under both policies. *Id.* In other words, coverage not only depended on marriage, but also on additional facts about the couple's living situation and whether Farmers had issued both policies. *Id.* In rejecting Farmers' argument, the *Edwards* Court explained that Farmers' "other insurance" provision was closely related to marriage because it "turn[ed] specifically on marriage," even though other factors could also contribute to determine coverage. *Id.* at 719-20. Thus, the "other insurance" provision was unfairly discriminatory in violation of RCW 48.30.300. *Id.* at 720.

Edwards squarely controls here. In both the auto policy at issue in *Edwards* and Allianz's travel insurance policies challenged here, the availability of trip cancellation and interruption coverage is closely related to—and turns specifically on—the presence of a protected characteristic of an insured. In fact, the discrimination in Allianz's Mental Health Exclusion is considerably more "closely related" to an insured's mental health condition than the discrimination in Farmers' "other insurance" provision was to an insured's marital status. In *Edwards*, while coverage turned specifically on the insured's marital status, the insured's living situation also affected coverage. Here, coverage turns specifically on whether a mental health condition of a covered person caused the travel loss. If the travel loss was caused by the mental health condition of the insured or another covered person, coverage is excluded, period.

The *Goetz* case that Allianz cites, Mot. to Dismiss at 5-6, clearly supports the State. *Goetz* illustrates the difference between coverage denials based on a protected characteristic—like marital status or disability—versus coverage denials grounded in some other basis. *Goetz* concerned an accidental death policy that prohibited coverage for pre-existing health conditions, both physical and mental. *Goetz v. Life Ins. Co. of N. Am.*, 272 F. Supp. 3d 1225, 1229-30 (E.D. Wash. 2017). *Goetz* simply recognized that an *accidental* death insurer may limit coverage to *accidents*, which pre-existing health conditions—whether physical or mental—are not. *Id.* at 1236. Indeed, the court was careful to make clear that the policy "did *not* deny coverage

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because [the insured] suffered from [a disability]." *Id.* (emphasis added). Since no pre-existing health condition, whether a disability or not, can be an accident, it is not surprising that the district court in *Goetz* held that accidental death coverage "does not turn exclusively on the presence or absence of a disability." *Id.* In fact, whether the insured in *Goetz* had a disability is irrelevant for determining coverage. In contrast, coverage in Allianz's policies—like the policy found unlawful in *Edwards*—depends specifically on the presence or absence of a protected characteristic.

Further, the Washington Supreme Court has explained that *Emerson*—the very case the *Goetz* court relied on—does not stand for the proposition that an insurance clause discriminates only when coverage "turns exclusively on" the protected characteristic. *Edwards*, at 719-20. Rather, the Supreme Court in *Edwards* stated that the insurance policy in *Emerson* excluded family members, and thus coverage did not turn specifically on marriage and was not closely related to marriage; whereas coverage in the *Edwards* policy "is made to turn specifically on marriage, and then is further qualified with more restrictive qualifications." *Id.* Again, Allianz's Mental Health Exclusion turns first—and conclusively—on the presence of a mental health disability. Under the binding standard set out in *Edwards*, Allianz's policy violates RCW 48.30.300.

Allianz further misreads *Cohen* as supporting its argument that RCW 48.18.480 only prohibits discrimination when based on the presence of a protected characteristic; and not if any other factors contribute to the denial of coverage determination. Mot. to Dismiss at 10. Rather, the *Cohen* court recited the general principle that "if the sole basis for a limitation of coverage were membership in a protected class, the insurance provision would violate public policy." *Am. Home Assur. Co. v. Cohen*, 124 Wn.2d 865, 878, 881 P.2d 1001 (1994); *accord Edwards*, 111 Wn.2d at 717 ("There can be no doubt that these statutes apply when the discrimination is based solely on the person's status as a married person. For example, if an insurer refuses to issue insurance to an individual solely because he is married, there is no dispute

that marital status discrimination has occurred."). *Cohen* said nothing about the situation present in *Edwards* and this case, where more than one factor may contribute to determine coverage, yet the discrimination in coverage is unfair because it is closely related to—or "turn[s] specifically" on—a protected class. *Id.* at 719-20.

Further, Allianz's argument that the Mental Health Exclusion does not discriminate based on an insured's disability status because it applies to everyone defies common sense. Only Washingtonians with mental health disabilities, their family members, or their travel companions, will be denied coverage under the Mental Health Exclusion. And Allianz will deny coverage only where the cause of the travel loss is because of their mental disability—the very reason they are in a protected class. Such discrimination is unfair under *Edwards* and Supreme Court precedent explaining that unlawful discrimination cannot be excused by redefining the discrimination as based on some characteristic other than protected class status. *State v. Arlene's Flowers, Inc.*, 193 Wn.2d 469, 503, 441 P.3d 1203, 1220 (2019), *cert. denied,* 19-333, 2021 WL 2742795 (U.S. July 2, 2021) (rejecting argument that state law prohibition against discrimination based on sexual orientation somehow did not reach discrimination based on closely-related conduct, i.e., getting married to someone of the same sex) (citing *Hegwine v. Longview Fibre Co., Inc.*, 162 Wn.2d 340, 349, 172 P.3d 688 (2007) (pregnancy discrimination is a form of sex discrimination, and the two cannot be separated), and *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 270 (1993) ("[a] tax on wearing yarmulkes is a tax on Jews")).

In sum, *Edwards* is both controlling and clear: the reach of Washington anti-discrimination statutes, like RCW 48.30.300 and RCW 48.18.480, are in no way limited to "sole-factor" cases. *Id.* at 718. The *Edwards* court expressly rejected that narrow interpretation of the anti-discrimination mandate of the Washington Insurance Code. *Id.*; RCW 48.30.300(1); RCW 48.18.480. Because Allianz's Mental Health Exclusion is closely related to—i.e., depends specifically on—whether the losses were caused by the protected trait of mental health disability,

the policy is unlawful. The Court should deny Allianz's motion to dismiss the State's first, second, third, fifth, sixth, and seventh causes of action.

D. Allianz Violated RCW 48.30.300 and RCW 48.18.480 by Failing to Substantiate the Mental Health Exclusion

Even if its Mental Health Exclusion were fair discrimination under Washington law, Allianz would still have to show that it substantiated a statistical justification for discriminating against Washingtonians prior to selling policies that reduce coverage based on mental health disabilities. *See* RCW 48.30.300 ("this subsection does not prohibit fair discrimination on the basis of sex, or marital status, or the presence of any disability *when bona fide statistical differences in risk or exposure have been substantiated*") (emphasis added); RCW 48.18.480 ("No insurer shall make or permit any unfair discrimination *between insureds or subjects of insurance having substantially like insuring, risk, and exposure factors, and expense elements* . . .") (emphasis added). These requirements are more than technical or procedural; they shield protected classes from baseless discrimination: in enacting RCW 48.30.300 and RCW 48.18.480, "the Legislature is concerned about protecting certain classes of individuals from unfair or irrational discrimination in the insurance setting." *Cohen*, 124 Wn.2d at 877.

Allianz's Motion to Dismiss completely bypasses these statutory requirements. As alleged in the Complaint, Allianz only attempted to substantiate its Mental Health Exclusion in response to the State's investigation into its discriminatory practices (and, even then, failed to do so). Compl. ¶ 4.6. Contrary to Allianz's suggestion, the State squarely alleges discrimination between "substantially like claims." Complaint ¶ 5.21. At the pleading stage, the Court must accept as true the State's allegations that Allianz never substantiated whether or not insureds whose travel insurance losses were caused by mental health conditions are substantially like insureds without such disabilities. Compl. ¶¶ 4.6, 4.22, 5.21. The same is true for the State's allegations that Allianz also failed to substantiate bona fide statistical differences in risk or

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exposure based on mental disability. Compl. ¶ 4.6-4.7. All the while, Allianz denied hundreds of claims under its Mental Health Exclusion. Compl. 4.7-4.8.

Allianz apparently relied on assumptions about mental illness, rather than any actuarial data, in deciding to discriminate based on mental disability in travel insurance coverage. Allianz's motion confirms that the company has nothing more than speculation to support its Mental Health Exclusion, citing cost and premium data in the State's Complaint that "*suggest* that individuals with [mental or nervous health disorders] are not 'substantially like' other insureds." Mot. to Dismiss at 10 (emphasis added). This is the wrong takeaway, because what these numbers show is the small impact to Allianz of covering disabled Washingtonians without discrimination. Complaint ¶¶ 4.23-4.24. But more importantly for purposes of this motion, Allianz's "suggestion" about what the evidence may later show is insufficient to prevail under CR 12(b)(6). In no way do Allianz's assumptions clear the bar imposed by RCW 48.30.300 and RCW 48.18.480. The State's claims based on RCW 48.18.480 cannot be dismissed, and this is a separate basis for the Court to deny Allianz's motion with respect to the State's first, second, third, fifth, and sixth causes of action.

E. Washington is Seeking to Enforce Rules of Non-Discrimination and Fair Dealing, Not to Impose an Affirmative Coverage Requirement

Allianz's characterization of the State's claims as an "affirmative coverage requirement" is misplaced. Nowhere in the Complaint does the State allege that Allianz's policies must cover travel-related losses caused by mental health conditions because they cover such losses caused by physical health conditions. The State references Allianz's coverage of physical disabilities to make a straightforward point about the baselessness of Allianz's justification for its Mental Health Exclusion. Allianz claims that "it is difficult to fairly and objectively verify mental and nervous health disorders and to accurately assess the causal connection between a covered loss and a mental or nervous health disorder." Compl. ¶ 4.20. But that claim ignores Allianz's own business practices: Allianz could verify a mental disability cause of loss just as it

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does a physical disability cause of loss—e.g., through a medical provider. This unexplained inconsistency is evidence that Allianz's justification for its Mental Health Exclusion is unsupported and that the Mental Health Exclusion is unfair.

Since the State is not pressing an "affirmative coverage requirement," Allianz's citations to the *Weyer* cases[1] are inapt. *Weyer* analyzed an employer's group disability policy under the Americans With Disabilities Act and presumed that Washington state anti-discrimination laws would be interpreted the same way. *Weyer II*, at 1119. That presumption is wrong under Washington Supreme Court precedent: "Our legislature has made it clear that the WLAD is broader than its federal counterpart, the Americans with Disabilities Act of 1990 (ADA), and we decline to use federal interpretations of the ADA to constrain the protections offered by the WLAD." *Taylor v. Burlington N. R.R. Holdings, Inc.*, 193 Wn.2d 611, 617, 444 P.3d 606 (2019).

Moreover, both the Ninth Circuit and Division I of the Washington Court of Appeals have recognized that specific statutory requirements restrict the *Weyer* court's general holding that an employer's group disability policy does not discriminate by providing less coverage for mental disabilities as long as people with mental disabilities can access the same policy. *Wash. State Commc'n Access Project v. Regal Cinemas, Inc.*, 173 Wn. App. 174, 191-92, 293 P.3d 413 (2013) ("the ADA's requirement that establishments provide auxiliary aids and services limits *Weyer*'s general rule that public accommodations do not have to provide different services for the disabled.") (quoting *Arizona ex rel. Goddard v. Harkins Amusement Enterprises, Inc.*, 603 F.3d 666, 671-72 (9th Cir. 2010)). After all, "a courthouse that was accessible only by steps could not avoid ADA liability by arguing that everyone—including the wheelchair bound—has equal access to the steps." *Regal Cinemas*, 173 Wn. App. at 192 (quoting *Harkins*, 603 F.3d at 672).

[1] *Weyer v. Twentieth Century Fox Film Corp.*, No. C96-1661WD, 1997 WL 896421 (W.D. Wash. Oct. 24, 1997) (*Weyer I*) and its subsequent appellate court decision *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1118-19 (9th Cir. 2000) (*Weyer II*).

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Here, the State's position is *not* that Washington's anti-discrimination statutes prohibit insurers from taking health conditions or disability into account at all. Rather, the State's position is that coverage cannot turn on the presence of a mental health disability—at least where such discrimination has not been shown to be fair and statistically substantiated. The State has specifically and repeatedly outlawed unfair discrimination in the insurance context and those statutes constrain *Weyer*'s holding by requiring insurers to substantiate a statistical basis to discriminate based on "the presence of *any* disability." RCW 48.30.300(2) (emphasis added). Allianz has no actuarial basis to justify excluding coverage for travel losses caused by mental or nervous health disorders. Compl. ¶¶ 4.21-4.22. While it is not clear whether the *Weyer* insurer had performed this analysis, it did offer another, more expensive policy that did not have the mental health coverage limitation. *Weyer I*, at *1; *Weyer II*, 198 F.3d at 1116. Allianz, in contrast, not only did not do the required analysis before categorically denying all travel loss claims caused by mental health disability, it also does not offer trip cancellation and trip interruption policies without the Mental Health Exclusion. *See Rodde v. Bonta*, 357 F.3d 988, 997 (9th Cir. 2004) (considering the ability to access services elsewhere in determining whether closing of a hospital was discriminatory). In any case, as established above, the Mental Health Exclusion is unfair discrimination under the *Edwards* standard, which the *Weyer* courts did not consider.[2] *Edwards*, not the *Weyer* decisions, is binding precedent.

[2] *Weyer II* considered whether the group disability plan violated RCW 49.60.178, which "applies only to a cancellation, a failure to issue or renew, or a refusal to issue or renew an insurance policy," and RCW 49.60.215, which prohibits disability discrimination in public accommodations. *Weyer,* 198 F.3d at 1118. RCW 49.60.030(1)(e), the statute at issue here, is broader in scope than RCW 49.60.178. *See Howell v. Dep't of Soc. & Health Servs.*, 7 Wn. App. 2d 899, 921, 436 P.3d 368, *as amended on denial of reconsideration* (May 23, 2019) (Lawrence-Berry, CJ concurring) (the provisions in RCW 49.60.030(1) are broader in scope than their more specific counterparts in RCW 49.60).

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F. The State States a Claim for Disability Discrimination Under the WLAD, Because Allianz's Mental Health Exclusion Is Facially Discriminatory and Allianz's Only Defense Is the Same Affirmative Defense that It Cannot Prove at this Stage of the Case

The Mental Health Exclusion is unfair discrimination under the Washington Insurance Code, and also violates the WLAD's prohibition on discrimination in insurance transactions. Allianz improperly collapses the State's WLAD claims into the Insurance Code claims, but that interpretation fails to recognize that the WLAD is a separate statute conferring rights and remedies different from the Insurance Code. Given that Allianz cannot show compliance with the Washington Insurance Code from the allegations in the State's Complaint, Allianz's failure to address the elements of the WLAD should alone be enough for the Court to deny Allianz's motion regarding the State's first and second causes of action.

If the Court goes further, it should start with the WLAD's purpose "to deter and to eradicate discrimination in Washington." *Marquis v. City of Spokane*, 130 Wn.2d 97, 109, 922 P.2d 43 (1996) (citations omitted). It was enacted "for the protection of the public welfare, health, and peace of the people of this state. RCW 49.60.010. For these reasons, the Legislature mandated that the WLAD's provisions "shall be construed liberally for the accomplishment of the purposes thereof." RCW 49.60.020. This "statutory mandate of liberal construction requires that [Washington courts] view with caution any construction that would narrow the coverage of the law." *Marquis*, 130 Wn.2d at 108.

RCW 49.60.030(1)(e) of the WLAD ensures "[t]he right to engage in insurance transactions . . . without discrimination," unless the practice is "not unlawful" under RCW 48.30.300. As discussed above, Allianz cannot obtain dismissal based on its fact-intensive affirmative defense that it substantiated its discrimination before engaging in it, as required by RCW 48.30.300. Instead, the facts alleged in the complaint show that the Mental Health Exclusion violates RCW 49.60.030(1)(e).

Under the WLAD's insurance provision, the State must sufficiently allege the following elements:

> (1) [the plaintiff] is a member of a protected class;
>
> (2) the defendant is involved in the transaction of matters subsequent to the execution of an insurance contract and matter arising out of it;
>
> (3) the defendant discriminated against the plaintiff by treating him or her differently than it treated persons outside of the protected class; and
>
> (4) the plaintiff's protected status was a substantial factor in causing the alleged discrimination.

Barrajas v. Travelers Home and Marine Ins. Co., No. 2:16-CV-0432-TOR, 2017 WL 3634076, at *3 (E. D. Wash. Mar. 1, 2017) (analyzing a claim of racial discrimination in an insurance transaction).

The Complaint alleges facts showing each of the above elements. R.S. from Wenatchee, for example, was diagnosed with Alzheimer's disease a month before he and his wife were to travel. Compl. ¶ 4.10. Likewise, the examples of insureds described in Complaint paragraphs 4.11, 4.12, 4.13, 4.15, 4.16, and, 4.18 each have mental health disabilities, just like the hundreds of other Washingtonians who have been harmed by the exclusion.[3] As for the second element,

[3] Allianz criticizes the State because "seven out of ten" examples provided in the Complaint involve a disability on the part of someone other than the insured. This is factually incorrect, as noted above: Actually, seven of the ten examples alleged in the Complaint involve a member of the traveling party—i.e., an insured—needing to cancel the trip due to a mental health event. Also, Allianz's criticism is legally irrelevant for purposes of the discrimination analysis. The State is the plaintiff here and brings this action to bar Allianz from categorically denying claims for travel losses simply because a mental health disability was the cause. The Mental Health Exclusion does not, as Allianz represents, apply "equally to insureds with [mental health disabilities] as it does to those without [mental health disabilities.]" Mot. to Dismiss at 7. It impacts only those insureds with mental health disabilities or insureds whose family members or travel companions have them. That is discrimination on its face. The State brings this action not only to protect Washingtonians with mental health disabilities but also to safeguard "the public welfare, health, and peace of the people of this state," and to defend "the institutions and foundation of a free democratic state" from the "menace[]" of Allianz's disability discrimination. RCW 49.60.010.

the complaint alleges that Allianz underwrote, offered, and sold to Washington residents travel insurance policies containing the Mental Health Exclusion, and Allianz processed and denied all claims for travel losses caused by a mental health condition. Compl. ¶¶ 3.2, 3.3, 4.2, 4.4, 4.7, 4.19. Allianz's actions described in the complaint are indisputably "insurance transactions." RCW 48.01.060.

The complaint further alleges that Allianz denied coverage of trip-related losses caused by mental health conditions while at the same time covering such losses caused by reasons not related to a mental health condition. Compl. ¶¶ 4.4, 4.19. These facts sufficiently plead the third and fourth elements of the State's WLAD claim: Allianz discriminates based on mental disability because only Washingtonians with mental disabilities are categorically denied coverage for travel losses caused by their health condition. In this way, Allianz indisputably treats Washingtonians with mental health conditions worse than other Washingtonians, and the insured's mental health condition is a substantial factor for the discrimination. The disability discrimination in Allianz's Mental Health Exclusion is plain: no coverage for travel losses caused by a covered person's mental health condition. Allianz's facially discriminatory policy is unlawful under the WLAD, and it cannot prove its affirmative defense at this stage of the case. Accordingly, this Court should deny Allianz's Motion to Dismiss the State's WLAD claims.

G. The State States a Claim that Allianz's Mental Health Exclusion is Both Unfair and Deceptive under the Consumer Protection Act

Allianz cannot obtain dismissal of the State's causes of action brought under the Consumer Protection Act. The State alleges that Allianz's sale of insurance policies that include the Mental Health Exclusion and its denial of claims under the exclusion are both unfair and deceptive acts under long-established consumer-protection law, including because Allianz's public-facing communications do not adequately disclose the existence of the Mental Health Exclusion. Compl. ¶¶ 5.7-5.15. As a consequence, Allianz has misled—and will likely continue to mislead—reasonable consumers to believe that mental health events are in fact covered by

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Allianz policies. *Id.* ¶¶ 5.12, 5.14. In its Motion to Dismiss, Allianz asserts new facts outside the four corners of the Complaint to bolster its claims that the Mental Health Exclusion is not unfair or deceptive. This alone shows that there are issues of fact that must be explored through discovery and then tried. Given that Allianz cannot show, based on the facts alleged by the State in the Complaint, that its actions do not violate the CPA, this Court should deny Allianz's Motion to Dismiss the State's third and fourth causes of action.

1. The State sufficiently alleges that the Mental Health Exclusion is unfair under the CPA

Not only does Allianz's Mental Health Exclusion fail to meet the anti-discrimination standards set forth in the Washington Insurance Code and the WLAD, it is unfair under the CPA. To establish a CPA violation, the State must prove: 1) an unfair or deceptive act or practice; 2) that occurs in trade or commerce; and 3) has a public interest impact. *State v. Kaiser*, 161 Wn. App. 705, 719, 254 P.3d 850 (2011). Washington courts have engaged in a "gradual process of judicial inclusion and exclusion," in determining what actions are "unfair" and "deceptive." *Klem v. Wash. Mut. Bank*, 176 Wn.2d 771, 785, 295 P.3d 1179 (2013) (citations omitted).

In determining whether an act or practice is unfair under the CPA, Washington courts have considered whether the defendant's conduct "offends public policy as it has been established by statutes, the common law or otherwise—whether, in other words, it is within at least the penumbra of some common-law, statutory, or other established concept of unfairness." *Rush v. Blackburn*, 190 Wn. App. 945, 962, 361 P.3d 217 (2015) (citations omitted). The Washington Supreme Court has invalidated insurance coverage exclusions for violating public policy when innocent victims have been denied coverage "for no good reason." *Mut. of Enumclaw Ins. Co. v. Wiscomb*, 97 Wn.2d 203, 207-08, 643 P.2d 441 (1982) (holding that family or household exclusion clauses in automobile insurance policies violate public policy of assuring protection to the innocent victims of auto accidents).

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Based on the facts alleged in the complaint, Allianz's practice is unfair. Allianz has no good reason to justify its Mental Health Exclusion. As explained above, Allianz discriminated based on mental disability without first substantiating any actuarial basis for its discrimination, as required by RCW 48.30.300 and RCW 48.18.480. Instead, Allianz discriminated based on a discriminatory and wrong stereotype: that it is somehow more difficult to verify travel losses caused by mental health disabilities. Compl. ¶ 4.20. But the flimsiness of this justification is obvious: Allianz would be able, through the insured's medical provider, to fairly and objectively verify the insured's mental disorder and that it caused the travel loss. *See Rodriguez*, 144 Wn. App. at 725 (the court can consider hypothetical facts supporting the State's claim on a motion to dismiss). Indeed, the State expects the evidence to show that Allianz verifies physical health causes of loss in precisely that way. Yet, Allianz categorically denies claims for travel losses caused by mental or nervous health disorders, even when the insured's medical provider verifies the disorder and that it caused the travel loss. Compl. ¶ 4.19.

While the State—unlike private litigants—is not required to show injury to consumers to prove its CPA claim, *Kaiser*, 161 Wn. App. at 719, the court may look at the impact of Allianz's actions on Washingtonians as one factor in determining whether the Mental Health Exclusion is an unfair act or practice prohibited by the CPA. *See Rush*, 190 Wn. App. at 963 (in deciding whether the practice at issue was unfair, the court considered whether it caused substantial injury to consumers). Between January 1, 2014, and August 11, 2019, Allianz sold at least 2.2 million travel insurance policies to Washingtonians, and denied hundreds of claims based on the Mental Health Exclusion, resulting in injury to at least 485 Washingtonians. Compl. ¶¶ 4.2, 4.7. The injury to Washingtonians continues to this day, and demonstrates the public impact of Allianz's actions. At this juncture, Allianz cannot show that the Mental Health Exclusion is not unfair as a matter of law, and therefore the State's complaint cannot be dismissed.

2. Allianz deceives Washingtonians in inadequately disclosing its Mental Health Exclusion

Allianz's failure to adequately disclose its Mental Health Exclusion is deceptive. The CPA prohibits deceptive acts or practices in the course of any trade or commerce. RCW 19.86.020. Deception exists where there is a misrepresentation, omission, or practice that is likely to mislead a reasonable consumer. *State v. Mandatory Poster Agency, Inc.*, 199 Wn. App. 506, 512, 398 P.3d 1271 (2017). A defendant need not *intend* to deceive consumers to be held liable under the CPA, as long as their communications had the *capacity* to deceive a substantial portion of the public. *Hangman Ridge v. Safeco Title Ins.*, 105 Wn.2d 778, 785, 719 P.2d 531 (1986).

While the question of whether an alleged act is deceptive is a question of law, *Holiday Resort Cmty. Ass'n v. Echo Lake Assocs., LLC,* 134 Wn. App. 210, 226, 135 P.3d 499 (2006), it can be answered at this early stage of the case only if the underlying facts are undisputed. *Mandatory Poster*, 199 Wn. App. at 512. And, whether a defendant's statement has the capacity to deceive a substantial portion of the public is a question of fact. *Holiday Resort Cmty. Ass'n*, 134 Wn. App. at 226.

Here, even though the Mental Health Exclusion is disclosed in its travel insurance policies and on at least some pages of Allianz's consumer-facing website, its conduct cannot be deceptive as a matter of law. For example, Allianz claims that the Mental Health Exclusion is "clearly" disclosed as the seventh of 25 general exclusions listed on page 21 of the 38-page "example" policy form. Mot. to Dismiss at 3; Exhibit A to the Decl. of Maren Norton.[4] Yet, Washington's allegations are that that this disclosure cannot be as clear as Allianz asserts, since hundreds of Washington consumers over the last seven years have made claims for travel losses caused by a mental or nervous health disorder with the expectation that their Allianz policy would cover those losses. Compl. ¶ 1.2. Allianz's Motion to Dismiss raises factual disputes that

[4] The Court cannot accept, at the CR 12(b)(6) stage, the factual assertion from Allianz's counsel that this single policy is an "example" for purposes of the entire case.

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require discovery, and that must be resolved following development of the full record about Allianz's public representations—it cannot be decided on a motion to dismiss.

Indeed, as alleged, Allianz engages in deceptive practices by failing to adequately disclose the Mental Health Exclusion in its public-facing platforms and policies and by making misrepresentations and omissions regarding its mental health-related coverage, such that their actions have and will likely continue to mislead a substantial number of consumers. Compl. ¶ 4.31. First, while Allianz's website does contain scattered mentions of the Mental Health Exclusion, those mentions are either difficult to find or not in a place where a reasonable consumer would expect to see them, unless the customer specifically searches for "mental health." Compl. ¶ 4.27. As alleged, the Mental Health Exclusion is mentioned in only four places on the vast Allianz website, and each mention requires a consumer to click on multiple links to locate that information. *Id.* Some of these links that eventually, though not directly, would take a consumer to a page that mentions the Mental Health Exclusion have generic titles, such as "Travel Insurance 101" or "More Travel Resources."

Although Allianz attempts to counter the State's claim regarding deceptiveness by illustrating that searches for several specific mental health-related terms bring up the Mental Health Exclusion within the first two search results, *see* Mot. to Dismiss at 13, the Court should ignore these allegations as they amount to a dispute of the facts that is inappropriate to consider or resolve on a motion to dismiss. *See FutureSelect*, 180 Wn.2d at 962-63. Even if the Court did consider these allegations, they simply emphasize that a consumer would have to specifically search for mental health or a mental health condition to find a page on the Allianz website that disclosed the Mental Health Exclusion. In short, unless a consumer specifically searches for mental health, finding the Mental Health Exclusion on Allianz's website is the proverbial needle-in-the-haystack exercise. *Id.*

Second, Allianz's representations, omissions, and corporate policies, on its public website are likely to mislead consumers because they leave the reasonable consumer with the

net impression that an Allianz travel insurance policy would cover travel losses caused by mental or nervous health disorders. Compl. ¶ 4.31; *Mandatory Poster*, 199 Wn. App. at 519 ("A deceptive act or practice is measured by the net impression on a reasonable consumer."). Allianz claims on its website that it can help fill gaps in health insurance, such as urgent care for physical or mental health conditions that some health insurers do not cover. Compl. ¶ 4.28. Whether this statement is true, as Allianz argues, Mot. to Dismiss at 12, is irrelevant because by omitting crucial information, it gives the reasonable consumer the wrong impression. *Panag v. Farmers Ins. Co. of Wash.*, 166 Wn.2d 27, 50, 204 P.3d 885 (2009) (a communication that contains truthful information can still be deceptive for the purposes of the CPA); *F.T.C. v. Cyberspace.com LLC*, 453 F.3d 1196, 122 (9th Cir. 2006) ("A solicitation may be likely to mislead by virtue of the net impression it creates even though the solicitation also contains truthful disclosures."). Allianz's public facing statements make specific mention of the impact that mental health-related events can have on travelers. Allianz's website contains a page titled, "How Business Travel Puts Wellness at Risk. And How We Can Fix It," which notes that psychological disorders are the number one health insurance claim for business travelers. Compl. ¶ 4.30. Critically, what Allianz fails to clarify is that Allianz policies may cover urgent medical costs caused by a mental health condition *but not* trip cancellation or trip interruption caused by a mental health condition.

Third, Allianz's anti-discrimination statement presents another opportunity for a reasonable consumer to be misled, as it promises a commitment to diversity and inclusion and no tolerance of any form of discrimination or mistreatment based on a personal characteristic. *Id.* at ¶ 4.26. While Allianz cites *Trujillo v. Nw Tr. Servs, Inc.*, 183 Wn.2d 820, 355 P.3d 1100 (2015), for the contention that its anti-discrimination statement could not mislead a substantial portion of the public, the case stands for no such thing. *Trujillo* does not even involve a general anti-discrimination statement; therefore, Allianz cites no authority for its assertion that a general

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anti-discrimination statement could not mislead a substantial number of consumers into believing that Allianz does not discriminate on the basis of disability.

Finally, the State has alleged at least one instance where Allianz affirmatively misled a consumer about the existence and effect of the Mental Health Exclusion. When purchasing her policy, Mercer Island resident L.T. asked specific questions about coverage for mental-health events, and was told by Allianz's customer service department that her policy would cover mental health-related claims. Compl. at ¶ 4.15. The State will seek evidence in discovery to determine whether Allianz's sales team provided this completely incorrect, and therefore deceptive, information to other prospective purchasers in Washington. At this stage of the case, dismissal is unwarranted.

The State has made a prima facie case that Allianz's conduct is both unfair and deceptive under the CPA. Given that the state seeks further discovery regarding Allianz's advertising and public statements so that this Court may engage in a case-specific analysis of the totality of Allianz's conduct, the Court should deny the request to dismiss the State's fourth cause of action.

VII. CONCLUSION

For the foregoing reasons, the State respectfully requests that the Court deny Defendant's Rule 12(b)(6) Motion to Dismiss.

DATED this 2nd day of August, 2021 at Seattle, Washington.

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I certify that this memorandum contains 7,821 words in compliance with the Local Civil Rules.

CERTIFICATE OF SERVICE

I hereby certify that the foregoing document was electronically filed and served on Defendant's counsel through the King County Superior Court e-filing system. I further certify that I caused these documents to be delivered via email to the defendants' attorney.

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