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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

GRACE SMITH, et al.,
Plaintiffs,

v.

CALIFORNIA DEPARTMENT OF
MANAGED HEALTH CARE, et al.,
Defendants.

Case No. [21-cv-07872-HSG](#)

**ORDER DENYING DEFENDANTS’
MOTION TO DISMISS, GRANTING IN
PART AND DENYING IN PART
PLAINTIFFS’ REQUEST FOR
JUDICIAL NOTICE, AND GRANTING
DEFENDANTS’ REQUESTS FOR
JUDICIAL NOTICE**

Re: Dkt. Nos. 34-1, 77, 81, 83

Pending before the Court is the Motion to Dismiss the Second Amended Complaint (“SAC”) filed by the California Health and Human Service Agency and the Department of Managed Health Care (“Defendants”). *See* Dkt. No. 77. The Court finds this matter appropriate for disposition without oral argument and the matter is deemed submitted. *See* Civil L.R. 7-1(b). For the reasons discussed below, the Court **DENIES** the motion, Dkt. No. 77. The Court relatedly **GRANTS in part and DENIES in part** Plaintiffs’ associated request for judicial notice, Dkt. No. 81, and **GRANTS** Defendants’ requests for judicial notice, Dkt. Nos. 34-1, 83.

I. BACKGROUND

The plaintiffs in this case are two disabled individuals and the nonprofit California Foundation for Independent Living Centers (“CFILC”), an “organization that serves and supports more than twenty Independent Living Centers across the state and leads several state-wide programs for Californians with disabilities.” SAC ¶¶ 3, 4. Plaintiffs initially filed this putative class action lawsuit on October 7, 2021, alleging that Kaiser Foundation Health Plan, Inc. (“Kaiser”), the Department of Managed Health Care (“DMHC”), and DMHC Director Mary Watanabe unlawfully excluded or limited coverage for wheelchairs in the California EHB-

1 Benchmark plan (“the Plan”).¹ Plaintiffs filed an amended complaint the following month, Dkt.
2 No. 12, which state defendants moved to dismiss, Dkt. Nos. 33 and 34, and defendant Kaiser
3 moved to compel to arbitration, Dkt. No. 32. On September 27, 2022, the Court issued two
4 orders: one granting Kaiser’s motion to compel arbitration, Dkt. No. 66, and the other granting
5 state defendants’ motion to dismiss the complaint on the ground that suit against DMHC and
6 Director Watanabe was barred under the doctrine of sovereign immunity. *See* Dkt. No. 67 (“MTD
7 I Order”). The Court granted Plaintiffs leave to amend. *Id.*

8 On October 25, 2022, Plaintiffs filed the SAC, dropping Director Watanabe and adding the
9 California Health and Human Services Agency (“CHHSA”) as a named defendant.² *See* Dkt. No.
10 67 (“SAC”). As before, Plaintiffs allege that Defendants’ exclusion of, or unreasonable limitation
11 on, wheelchair coverage in the Plan discriminates against people with disabilities in violation of
12 Section 504 of the Rehabilitation Act and Section 1557 of the Affordable Care Act (“ACA”).

13
14 ¹ The Court provided additional background on the benchmark approach to insurance coverage
15 under the ACA in its prior order. *See* Dkt. No. 67 (“MTD I Order”) at 1–2. In that order, the
16 Court did not have occasion to rule on Defendants’ request, Dkt. No. 34-1, for judicial notice of
17 (1) the California EHB-Benchmark plan document and (2) the letter from the Secretary of the
18 California Health and Human Service Agency transmitting that plan to the agency’s national
19 counterpart upon selection. However, because Defendants’ second Motion to Dismiss appears to
20 renew this request, the Court now rules on it. *See* Dkt. No. 77 at 8 (“The motion will be and is
21 based on . . . the previously filed . . . Request for Judicial Notice (ECF 34-1)”). Judicial notice
22 “permits a court to notice an adjudicative fact if it is ‘not subject to reasonable dispute,’” which
23 means the fact is “‘generally known,’ or ‘can be accurately and readily determined from sources
24 whose accuracy cannot reasonably be questioned.’” *Khoja v. Orexigen Therapeutics, Inc.*, 899
25 F.3d 988, 999 (9th Cir. 2018) (quoting Fed. R. Evid. 201(b)). Additionally, where a plaintiff’s
26 claim “necessarily relies” on a document of unchallenged authenticity that was not physically
27 attached to the complaint, a court may construe the document as part of the complaint on a motion
28 to dismiss. *Marder v. Lopez*, 450 F.3d 445, 448 (9th Cir. 2006). The cover letter and Plan
document proffered by Defendants are foundational to Plaintiffs’ claims and were part of a public
agency’s governmental communications, and not reasonably susceptible to dispute about accuracy
or authenticity. Accordingly, the Court **GRANTS** Defendants’ request for judicial notice of the
agency cover letter and Plan document, Dkt. No. 34-1, to the extent that these documents contain
undisputed facts about the existence and terms of Plan coverage.

² The Complaint and First Amended Complaint also included allegations against Kaiser
Foundation Health Plan, Inc. (“Kaiser”), *see* Dkt. Nos. 1, 12, but the SAC did not. Defendants
query whether this omission indicates that Kaiser has been dropped from the case, but Plaintiffs
confirm that claims against Kaiser are omitted “only because the claims against them cannot be
litigated in this forum now during the pendency of the stay.” Dkt. No. 80 at 1, n.1. Though for
simplicity the Court refers throughout this order to CHHSA and DMHC as “Defendants,” the
Court recognizes that Kaiser remains a defendant in this case, and from the most recent arbitration
status report, the Court understands that Plaintiffs and Kaiser commenced arbitration on March 26,
2023, and face a deadline of October 28, 2024 for the receipt of the arbitration award. *See* Dkt.
No. 85 at 2.

1 SAC ¶¶ 68–82. Defendants then filed this motion arguing that Plaintiffs’ SAC should be
2 dismissed because i) sovereign immunity bars suit against both Defendants; ii) Plaintiffs lack
3 standing; iii) Plaintiffs’ claims are time-barred; and iv) Plaintiffs fail to state a claim for disability
4 discrimination. Dkt. No. 77 (“Mot.”).

5 **II. LEGAL STANDARD**

6 **A. Rule 12(b)(1)**

7 A motion to dismiss filed pursuant to Rule 12(b)(1) is a challenge to the court’s subject
8 matter jurisdiction. *See* Fed. R. Civ. P. 12(b)(1). “Federal courts are courts of limited
9 jurisdiction[,]” and it is “presumed that a cause lies outside this limited jurisdiction.” *Kokkonen v.*
10 *Guardian Life Ins. of Am.*, 511 U.S. 375, 377 (1994). The party invoking the jurisdiction of the
11 federal court bears the burden of establishing that the court has subject matter jurisdiction to grant
12 the relief requested. *Id.* The issue of Article III standing is jurisdictional and is therefore
13 “properly raised in a motion to dismiss under Federal Rule of Civil Procedure 12(b)(1)[.]” *White*
14 *v. Lee*, 227 F.3d 1214, 1242 (9th Cir. 2000).

15 Rule 12(b)(1) motions to dismiss based on an asserted lack of subject matter jurisdiction
16 may be “facial” or “factual.” *See White*, 227 F.3d at 1242. In a facial attack, the jurisdictional
17 challenge is confined to the allegations pled in the complaint. *See Wolfe v. Strankman*, 392 F.3d
18 358, 362 (9th Cir. 2004). The challenger asserts that the complaint’s allegations are insufficient
19 “on their face” to invoke federal jurisdiction. *Safe Air Safe Air for Everyone v. Meyer*, 373 F.3d
20 1035, 1039 (9th Cir. 2004). To resolve this challenge, the court assumes that those allegations are
21 true and draws all reasonable inference in favor of the party opposing dismissal. *See Wolfe*, 392
22 F.3d at 362.

23 On the other hand, where the jurisdictional attack is factual, “the challenger disputes the
24 truth of the allegations that, by themselves, would otherwise invoke federal jurisdiction.” *Wood*
25 *v. City of San Diego*, 678 F.3d 1075, 1083 n.8 (9th Cir. 2012) (quoting *Safe Air*, 373 F.3d at
26 1039). Once challenged, the plaintiff must support her jurisdictional allegations with “competent
27 proof.” *Hertz Corp. v. Friend*, 559 U.S. 77, 96–97 (2010). To resolve a factual attack, the court
28 need not “presume the truthfulness of the plaintiff’s allegations” in the complaint and “may

1 review evidence beyond the complaint without converting the motion to dismiss into a motion for
2 summary judgment.” *Wood*, 678 F.3d at 1083 n.8 (quoting *Safe Air*, 373 F.3d at 1039); *see also*
3 *Land v. Dollar*, 330 U.S. 731, 735 n.4 (1947) (“[W]hen a question of the District Court’s
4 jurisdiction is raised . . . the court may inquire by affidavits or otherwise, into the facts as they
5 exist.”). However, where “the jurisdictional issue and substantive claims are so intertwined that
6 resolution of the jurisdictional question is dependent on factual issues going to the merits, the
7 district court should employ the standard applicable to a motion for summary judgment.” *Autery*
8 *v. United States*, 424 F.3d 944, 956 (9th Cir. 2005) (quoting *Rosales v. United States*, 824 F.2d
9 799, 803 (9th Cir.1987)).

10 **B. Rule 12(b)(6)**

11 Federal Rule of Civil Procedure 8(a) requires that a complaint contain “a short and plain
12 statement of the claim showing that the pleader is entitled to relief.” *See* Fed. R. Civ. P. 8(a)(2).
13 A defendant may move to dismiss a complaint for failing to state a claim upon which relief can be
14 granted under Rule 12(b)(6). “Dismissal under Rule 12(b)(6) is appropriate only where the
15 complaint lacks a cognizable legal theory or sufficient facts to support a cognizable legal theory.”
16 *Mendondo v. Centinela Hosp. Med. Ctr.*, 521 F.3d 1097, 1104 (9th Cir. 2008). To survive a Rule
17 12(b)(6) motion, a plaintiff need only plead “enough facts to state a claim to relief that is plausible
18 on its face.” *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). A claim is facially plausible
19 when a plaintiff pleads “factual content that allows the court to draw the reasonable inference that
20 the defendant is liable for the misconduct alleged.” *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009).

21 In reviewing the plausibility of a complaint, courts “accept factual allegations in the
22 complaint as true and construe the pleadings in the light most favorable to the nonmoving party.”
23 *Manzarek v. St. Paul Fire & Marine Ins. Co.*, 519 F.3d 1025, 1031 (9th Cir. 2008). Nevertheless,
24 courts do not “accept as true allegations that are merely conclusory, unwarranted deductions of
25 fact, or unreasonable inferences.” *In re Gilead Scis. Secs. Litig.*, 536 F.3d 1049, 1055 (9th Cir.
26 2008) (quoting *Sprewell v. Golden State Warriors*, 266 F.3d 979, 988 (9th Cir. 2001)).

27 Even if the Court concludes that a 12(b)(6) motion should be granted, the “court should
28 grant leave to amend even if no request to amend the pleading was made, unless it determines that

1 the pleading could not possibly be cured by the allegation of other facts.” *Lopez v. Smith*, 203
2 F.3d 1122, 1127 (9th Cir. 2000) (en banc) (quotation omitted).

3 **III. DISCUSSION**

4 **C. Sovereign Immunity**

5 **i. Factual Background**

6 In its prior ruling, the Court held that DMHC did not waive its sovereign immunity
7 because Plaintiffs did not adequately allege that 1) DMHC was currently receiving any direct
8 federal funding that could subject it to suit, and 2) the receipt of federal funding by a sister
9 department within CHHSA could be imputed to DMHC so as to abrogate its immunity. MTD I
10 Order at 5–9.³ However, the Court permitted Plaintiffs to amend their complaint.

11 When they did so, Plaintiffs kept DMHC and added CHHSA as a defendant to the suit.
12 *See generally* SAC. But Defendants argue in their motion that Plaintiffs’ amended pleadings still
13 do not demonstrate CHHSA’s present receipt of federal funds – let alone the imputation of any
14 associated waiver from CHHSA to DMHC – sufficient to now allow Plaintiffs’ claims to
15 overcome the Eleventh Amendment bar. Mot. at 18–22. Plaintiffs contend that CHHSA has
16 waived its sovereign immunity by its recent receipt of federal assistance, and that CHHSA’s
17 waiver is imputable to DMHC under *Sharer v. Oregon*, 581 F.3d 1176, 1180 (9th Cir. 2009). Dkt.
18 No. 80 (“Opp.”) at 8–14. While it is a close question, the Court ultimately finds, after considering
19 both parties’ factual contentions, that Plaintiffs have adequately alleged that CHHSA’s receipt of
20 federal funds waives its sovereign immunity, and that CHHSA’s waiver is imputable to DMHC.⁴

21 **ii. Legal Framework**

22 The Eleventh Amendment to the U.S. Constitution embodies the principle of “sovereign
23 immunity” and bars a federal court from hearing claims by private citizens against state
24 governments, their agencies, or the officials of those agencies unless the state consents to suit, or

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26 ³ For ease of reference, the Court refers to the PDF pages rather than the document’s internal
27 pagination unless otherwise noted.

28 ⁴ Plaintiffs also continue to argue that Defendant DMHC is independently covered by Section 504
and Section 1557. Opp. at 14. The Court already rejected this argument in its prior order on
Defendants’ first motion to dismiss, and finding no new facts or arguments advanced that would
affect that analysis, does so again here. *See* MTD I Order at 6–7.

1 Congress has expressly abrogated the state’s immunity. *See Seminole Tribe v. Florida*, 517 U.S.
2 44, 54–57 (1996); *Coll. Sav. Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S.
3 666, 669–70 (1999).

4 As the Court previously explained, one way for an otherwise immune sovereign entity to
5 consent to suit is by accepting federal funding that was conditioned on a waiver of that immunity.
6 MTD I Order at 5; *see Holley v. California Dep’t of Corr.*, 599 F.3d 1108, 1111-12 (9th Cir.
7 2010). To constitute a valid waiver of sovereign immunity, a state’s consent to suit must be
8 “unequivocally expressed in the statutory text.” *Id.* (citations omitted). But even a valid waiver
9 based on the acceptance of federal funds “encompasses a department or agency receiving federal
10 funds in *only* those periods during which the funds are accepted.” *Sharer*, 581 F.3d at 1180
11 (emphasis added); MTD Order I at 6–7.⁵

12 Both Sections 504 and 1557 express this clear waiver. *See* Opp. at 8–9; *see also Douglas*
13 *v. California Dep’t of Youth Auth.*, 271 F.3d 812, 820–21 (9th Cir.) (discussing waiver under
14 Section 504), *amended*, 271 F.3d 910 (9th Cir. 2001); *Espino v. Regents of the Univ. of California*,
15 No. 222CV05880SPGJPR, 2023 WL 3549464 at *12 (C.D. Cal. Mar. 31, 2023) (discussing
16 waiver under Section 1557). Specifically, the statutes subject to suit “any program or activity”
17 any part of which is extended federal funds. 29 U.S.C. § 794(b) (Rehabilitation Act); 42 U.S.C. §
18 18116(a) (ACA). Significantly, the Rehabilitation Act defines “program or activity” to mean “all
19 the operations of” a given covered entity. 29 U.S.C. § 794(b).

20 **iii. Application to CHHSA**

21 Defendants argue that Plaintiffs have not “establish[ed] that . . . CHHSA has waived its
22 Eleventh Amendment immunity through receipt of federal funding” because they “fail to allege
23 any facts actually showing that” CHHSA receives federal funds. Mot. at 21. Even though they
24 did not submit additional evidence with their motion, the Court construes Defendants’ argument as

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26 ⁵ This aspect of the *Sharer* court’s discussion was limited to Section 504, as it did not have section
27 1557 claims in front of it (nor could it have, since the case predated the ACA). However, this
28 Court sees no reason that *Sharer*’s holding should not apply to Section 1557 claims, and the
parties do not furnish any. As such, the Court finds that like Section 504 claims, Section 1557
claims against an immune sovereign are allowed only during the period(s) in which that entity
accepts federal funds.

1 a factual Rule 12(b)(1) challenge to Plaintiffs’ jurisdictional allegations. *See Wood*, 678 F.3d at
2 1083. Plaintiffs therefore bear the burden of showing “competent proof” that the Court properly
3 has jurisdiction over CHHSA. *Hertz Corp.*, 559 U.S. at 96–97.

4 Plaintiffs aver in their complaint that CHHSA “receives billions of dollars of federal
5 financial assistance each year.” SAC ¶ 29. To support this allegation once challenged, Plaintiffs
6 submit state budget documents along with their opposition. Of most relevance, they provide a
7 2021-2022 CHHSA Budget Report (Dkt. No. 81-1, Ex. 1) and an excerpt from a California
8 Manual of State Funds (Dkt. No. 81-2, Ex. 2).⁶ The 2021-2022 budget document prominently
9 states “Health and Human Services” on its first title page and in the upper margin on every page
10 after that, and details the budgets and funding sources for CHHSA’s subsidiary departments and
11 entities. Notably, each line item in the budget is associated with a specific funding code. To
12 orient the Court to the most relevant funding code, Plaintiffs use the Manual of State Funds to
13 show that code “0890 Federal Trust Fund” refers to the state account “for the deposit of all
14 moneys received by the state from the federal government where the expenditure is administered
15 through or under the direction of any state agency.” Dkt. No. 81-2, Ex. 2 at 2. Plaintiffs request,
16 and the Court grants, judicial notice of these two documents.⁷ Dkt. No. 81. It further uses these

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18 ⁶ The Court notes that Plaintiffs label these two exhibits inconsistently. In their request for
19 judicial notice, Plaintiffs discuss Exhibit 1 and 2, *see* Dkt. No. 81, but the cover pages of Dkt. Nos.
20 81-1 and 81-2 identify the documents as “Exhibit 10” and “Exhibit 11,” respectively. For clarity,
21 the Court will refer to them as Exhibits 1 and 2, as Plaintiffs do in their discussion.

22 ⁷ The two documents at issue (Dkt. Nos. 81-1, Ex. 1 (CHHSA budget); 81-2, Ex. 2 (manual
23 excerpt)) are public records, the authenticity of which Defendants do not challenge. Accordingly,
24 the Court finds it appropriate to take judicial notice of undisputed facts within those documents
25 under *Khoja*, and **GRANTS** Plaintiffs’ request as to these documents. *Khoja*, 899 F.3d at 999.
26 However, to resolve the factual dispute at hand, the Court must grapple not only with the
27 undisputed facts (e.g. that DHCS’s budget has a line item of \$84,094,146 [in thousands] from
28 funding account “0890 Federal Trust Fund,” *see* Dkt. No. 81-1, Ex. 1 at 57), but also inferences
arising out of those facts (e.g. that DHCS received more than \$84 billion in federal funds during
the 2021-22 budget cycle). In the absence of declarations from either side spelling out these
inferences, the Court looks to the parties’ own treatment of the budget documents. For example,
Defendants, based on the funding accounts represented in the budget, observe that “DMHC’s
funding appears to come from the Managed Care Fund.” Reply at 8. And Plaintiffs, in their
Request for Judicial Notice, observe that the budget documents show that “several health
programs and activities operated by HHS and DHCS are funded from the state’s Federal Trust
Fund.” Dkt. No. 81 at 3. These and other instances demonstrate the parties’ shared assumption
that it is reasonable to read the budget documents as reliably representing (1) the flow of actual
money, (2) the departmental recipient of that money, and (3) the source (i.e. funding account) of
that money. Since neither party has challenged these premises, and the Court finds them

1 documents to resolve the factual dispute raised by Defendants. *See Land*, 330 U.S. at 731 n.4.

2 In reviewing the budget documents, the Court concludes that Plaintiffs have provided
3 “competent proof” to support their allegation that CHHSA “receives billions of dollars of federal
4 financial assistance each year.” SAC ¶ 29. Of the 20 entities accounted for in the budget
5 document (which, again, is identified with CHHSA by its coversheet and on the top margin of
6 every page), the Court identifies twelve CHHSA entities that received funds from “0890 Federal
7 Trust Fund.”⁸ *See generally* Dkt. No. 81-1, Ex. 1. By the Court’s math, those federal funds –
8 which, per the Manual of Funds, are “administered through or under the direction of any state
9 agency” – totaled over \$97.5 billion dollars in the 2021-2022 budget cycle. Dkt. No. 81-2, Ex. 2
10 at 2 (emphasis added). While the federal money might ultimately flow to CHHSA departmental
11 subsidiaries, the definition of the “0890” funding account in the Manual of Funds tethers funding
12 flowing from that account to the *agency*, which in this case is CHHSA. The Court is of the view
13 that taken together, these facts are sufficient to support Plaintiffs’ allegations regarding CHHSA’s
14 receipt of federal funds. But should any doubt linger, the Court further observes that the budget
15 document provided by *Defendants* (and judicially noticed by the Court, *see* n.10) shows that
16 CHHSA *itself* (i.e. for its specific agency functions) received federal funds in the 2021-2022
17 budget cycle. *See* Dkt. No. 83 at 4. According to this document, CHHSA received more than \$13

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20 reasonable, it will rely on them in resolving the jurisdictional challenge. If Defendants
21 substantively dispute any inferences made by the Court in reviewing the budget documents
22 presented (namely, that they accurately represent the flow, source, and departmental recipient of
23 funds, including federal funds demarcated by the “0890 Federal Trust Fund” funding account
24 code), they can raise that argument on summary judgment.

25 ⁸ Based on the Court’s review of the budget document Plaintiffs provided, it infers that the
26 following CHHSA entities received federal funding from the “0890 Federal Trust Fund” account
27 during the 2021-22 budget cycle: State Council on Developmental Disabilities (Dkt. 81-1, Ex. 1 at
28 4), Emergency Medical Services Authority (*id.* at 7), Office of Statewide Health Planning and
Development (*id.* at 15), Department of Aging (*id.* at 32), Commission on Aging (*id.* at 43),
Department of Health Care Services (*id.* at 58), Department of Public Health (*id.* at 95),
Department of Developmental Services (*id.* at 141), Department of Community Services and
Development (*id.* at 170), Department of Rehabilitation (*id.* at 178), Department of Child Support
Services (*id.* at 188), and Department of Social Services (*id.* at 194). The Court further infers that
the following entities did not receive federal funding from the “0890 Federal Trust Fund” during
that budget cycle: Department of Managed Health Care, California Senior Legislature, California
Children and Families Commission, Department of State Hospitals, Mental Health Services
Oversight and Accountability Commission, California Health Benefit Exchange, State
Independent Living Council, and State-Local Realignment, 1991.

1 million dollars that funding cycle from “0890 Federal Trust Fund,” which was applied to the
2 “0280 Secretary of California Health and Human Services” program code. *Id.* at 4, 7.

3 Since the CHHSA budget documents appear to show that CHHSA receives federal funds
4 not only for the functions of at least a dozen of its subsidiary entities but also for its specific
5 agency functions, the Court concludes that Plaintiffs’ allegations concerning CHHSA’s receipt of
6 federal funds have evidentiary support. At this stage and on these facts, the Court finds that
7 CHHSA receives federal funds sufficient to waive its sovereign immunity, such that the Court has
8 jurisdiction over Plaintiffs’ claims against CHHSA.

9 **iv. Application to DMHC**

10 Since Plaintiffs’ suit involves not just CHHSA but also DMHC – a department the Court
11 previously ruled does not itself currently receive federal funds, *see* MTD Order I at 8–9 –
12 Plaintiffs must show that imputing CHHSA’s waiver of sovereign immunity to DMHC is proper.
13 Plaintiffs contend that because DMHC is a part of an agency that receives federal funds, Sections
14 504 and 1557 apply based on the statutory definitions. The Rehabilitation Act covers “programs
15 or activities receiving federal financial assistance,” and defines “programs or activities” to mean
16 “all the operations of” a department or agency, “*any part of which*” receives federal funds. 29
17 U.S.C. § 794 (emphasis added). Similarly, the ACA extends to “any health program or activity,
18 *any part of which* is receiving federal financial assistance.” 42 U.S.C. § 18116 (emphasis added).
19 Since by virtue of being a subsidiary department, DMHC is a part of the operations of CHHSA –
20 an agency that receives federal funds – Plaintiffs reason that DMHC has plainly waived immunity
21 based on the statutory text. *Opp.* at 9–10, 12–13.

22 Defendants disagree. Relying on *Sharer*, they argue that Plaintiffs’ read of “program and
23 activity” is overbroad. *Mot.* at 19–20; *Dkt. No. 82 (“Reply”)* at 6–9.

24 The Court, based on *Sharer*’s instruction to “interpret ‘program or activity’ broadly,” 581
25 F.3d at 1178, finds Plaintiffs’ statutory argument persuasive, but turns to *Sharer* to assess the
26 ultimate soundness of imputing CHHSA’s waiver to DMHC. In that case, Lois Sharer, a former
27 employee of Oregon’s Office of Public Defense Services (“OPDS”), brought a disability
28 discrimination suit against the State of Oregon and her former bosses under Section 504 and other

1 provisions. *Id.* at 1176. Defendant argued at the summary judgment stage that even though the
2 judicial branch within which OPDS was located received federal funds, Sharer had not established
3 that OPDS itself was a “program or activity receiving Federal financial assistance.” The district
4 court agreed, and the Ninth Circuit affirmed. In reaching that decision, the Ninth Circuit first
5 analyzed whether Oregon’s judicial branch could be considered a “unitary ‘department’ or
6 ‘agency’ for section 504 purposes.” *Id.* at 1179. It found it could not, observing that Oregon
7 statutes referred to the “judicial department” (meaning “the judicial branch of government in its
8 entirety”) separately from two entities organized within it – the “Judicial Department” and the
9 “Public Defense Services Commission” (of which OPDS was a subunit) – and that those two
10 entities were themselves administratively “distinct.” *Id.* Having determined that the “judicial
11 department” was not “unitary,” the Court next weighed whether the “Judicial Department” (which
12 did receive federal funding) and the Commission (which did not) were “sufficiently independent
13 from one another to constitute separate ‘department[s]’ or ‘agenc[ies]’ under section 504.” *Id.* at
14 1180. It reasoned that because they had different funding sources and a separate leadership
15 structure without overlapping supervision, they were separate entities for Section 504 purposes.
16 *Id.* Accordingly, neither imputation of waiver from the “judicial department” to OPDS nor
17 imputation from the “Judicial Department” to OPDS was permissible, and OPDS was immune
18 from suit. *Id.*

19 Naturally, Defendants argue that the facts here are sufficiently analogous to *Sharer* to
20 warrant the same conclusion. They contend that Plaintiffs have not “alleged a sufficient
21 connection between DMHC and CHHSA that would permit them to be considered a single entity,”
22 and that DMHC and CHHSA are “are organized under different statues,” “have different
23 directors,” and “have different sources of funding,” such that waiver cannot be imputed from one
24 entity to the other. Mot. at 20; *see also* Reply at 7–9. Plaintiffs, on the other hand, maintain that
25 they have done enough to show this connection: in their SAC, they allege that CHHSA receives
26 “federal financial assistance each year” such that its “programs and activities” – of which DMHC
27 is one – “are subject to [] inclusion and anti-discrimination requirements.” SAC ¶ 29. Plaintiffs
28 additionally allege that DMHC is a “sub-department” of CHHSA, SAC ¶53, and that CHHSA

1 “oversees . . . all programs, services, and activities of [DMHC]” and “must approve DMHC’s
2 budget and seek to improve its organizational structure, operating policies, and management
3 information systems.” SAC ¶ 17 (citing Cal. Gov’t Code § 12803(a); Cal. Health & Safety Code §
4 1341(a)). CHHSA’s secretary, Plaintiffs argue, is bound to “hold responsible the head of DMHC
5 for its administrative, fiscal, and program performance, and must periodically review DMHC’s
6 operations and evaluate its performance.” *Id.* (citing Cal. Gov’t Code § 12800(b)). Based on
7 these allegations, Plaintiffs argue that it is proper to conclude that “Defendant DMHC is not an
8 independent Commission that acts outside of [C]HHSA direction and authority,” but is rather “a
9 component of [CHHSA] and is under the agency’s authority, jurisdiction, and supervision.” *Opp.*
10 at 11.

11 At this stage (notably an earlier one than was at issue in *Sharer*), the Court agrees with
12 Plaintiffs. This case concerns the connections between a state agency (CHHSA) that receives
13 federal assistance and a subordinate department (DMHC) that does not. While *Sharer* stands for
14 the proposition that one agency’s hierarchical subordination to another does not alone justify
15 imputing waiver, Plaintiffs have pointed to the statutes just recited to suggest that DMHC and
16 CHHSA are connected by more than their “nominal” positions on an organizational chart. SAC ¶¶
17 17, 29, 53; Reply at 7.

18 Given that a key part of the *Sharer* analysis involved examining the supervisory structure
19 of the subunit, it is significant in the Court’s view that the CHHSA secretary is “responsible for
20 the sound fiscal management of each department . . . within [CHHSA],” including DMHC. Cal.
21 Gov. Code § 12800(b). To carry out that responsibility, the secretary must “review and approve
22 the proposed budget of each department,” “hold the head of each department . . . responsible for
23 management control over the [department’s] administrative, fiscal, and program performance,”
24 “review the operations and evaluate the performance at appropriate intervals of each department,”
25 and “seek continually to improve the organization structure, the operating policies, and the
26 management information systems of each department.” *Id.* Though the Court recognizes that
27 department directors are also endowed by statute with significant responsibilities – namely “the
28 performance of all duties, the exercise of all powers and jurisdiction, and the assumption and

1 discharge of all responsibilities vested by law in the department” – that does not displace, at least
2 for purposes of the assessing this Rule 12(b) challenge, the CHHSA secretary’s statutory
3 obligations to carry out administrative and programmatic oversight of DMHC departmental
4 activities. Cal. Health & Safety Code § 1341(c). This dynamic differs appreciably from *Sharer*,
5 where, in part because the Commission “was not subject to the exercise of administrative authority
6 and supervision by the Chief Justice,” the entities were deemed independent. *Sharer*, 581 F.3d at
7 1180.⁹

8 In the absence of argument from Defendants as to how the entities’ codification in different
9 California codes and funding from different sources demonstrates functional (rather than on-
10 paper) independence, the Court is not persuaded at this stage and as a matter of law that DMHC is
11 independent enough from CHHSA to constitute a separate “department” or “agency” under
12 Section 504 considering the secretary’s statutory programmatic and administrative oversight role.

13 ¹⁰ In reaching this conclusion, the Court finds relevant that the state agency at issue here is not
14 coextensive with an entire multi-purpose branch of government, as it was in *Sharer*. Rather,
15 CHHSA is a discrete agency within the executive branch focused on advancing health and human
16 services through the functions of the departments (like DMHC) under its purview, such that
17 DMHC is arguably a part of this agency’s “program[s] or activit[ies].” 29 U.S.C. § 794(b)
18 (defining “program or activity”). So while the Court appreciates that sovereign immunity must
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20 ⁹ To reach this conclusion, the Court did not need to rely on Exhibits 3, 4, 5, 6, 7, and 8 in
21 Plaintiffs’ Request for Judicial Notice. See Dkt. No. 81 and Dkt. No. 81-3, Ex. 3; 81-4, Ex. 4; 81-
22 5, Ex. 5; 81-6, Ex. 6; 81-7, Ex. 7; 81-8, Ex. 8. As such, the Court **DENIES** Plaintiffs’ Requests
for Judicial Notice as to these documents.

23 ¹⁰ Defendants argue that CHHSA and DMHC are funded by different sources, and request that the
24 Court take judicial notice of CHHSA’s 21-22 State Budget to show that the “Managed Care Fund”
25 is not among the listed funding source accounts for CHHSA. Dkt. No. 83 at 3, Ex. A. Like the
26 documents discussed above at footnote 7, this is a public record of uncontested authenticity, so the
27 Court **GRANTS** Defendants’ request for judicial notice of certain undisputed facts in it. *Khoja*,
899 F.3d at 999. Specifically, the Court notes that the Managed Care Fund is not listed in the
28 “Funding” section on page 4 of Dkt. No. 83. Defendants additionally observe that a document
urged as judicially noticeable by *Plaintiffs* – the CHHSA 2021-22 Budget Report discussed above
– shows that the “bulk of DMHC’s funding appears to come from the Managed Care Fund.”
Reply at 8 (citing Dkt. No. 81-1). The Court takes notice of that fact. Dkt. No. 81-1, Ex. 1 at 28.
Finally, as also discussed above, the Court takes notice of the fact that CHHSA was budgeted to
receive more than \$13 million dollars from “0890 Federal Trust Fund” in the 2021-2022 budget
cycle. Dkt. No. 83 at 4.

1 not be imputed too readily, it does not find for purposes of this motion to dismiss that imputation
2 in this instance offends that principle, especially where *Sharer* counsels that the Ninth Circuit
3 “interpret[s] ‘program or activity’ broadly.” *Sharer*, 581 F.3d at 1178. Here, the imputation of
4 CHHSA’s receipt of federal funds to a department under its supervision that advances the same
5 substantive mandate “leaves unaffected both other state agencies and the State as a whole[,]” and
6 does not contravene a state’s prerogative to “avoid Section 504’s waiver requirement on a
7 piecemeal basis.” *Jim C. v. United States*, 235 F.3d 1079, 1081 (8th Cir. 2000).

8 The Court accordingly **DENIES** Defendants’ motion to dismiss Plaintiffs’ complaint on
9 sovereign immunity grounds.

10 **D. Standing**

11 Defendants argue that Plaintiffs’ allegations do not support standing because they have not
12 established traceability and redressability. Mot. at 22–25. Plaintiffs counter that standing is
13 proper, Opp. at 17–24, and the Court agrees.

14 To establish standing, a plaintiff must “present an injury that is concrete, particularized,
15 and actual or imminent; fairly traceable to the defendant’s challenged behavior; and likely to be
16 redressed by a favorable ruling.” *Davis v. Federal Election Comm’n*, 554 U.S. 724, 733 (2008).
17 Though courts generally decline to “endorse standing theories that rest on speculation about the
18 decisions of independent actors,” where an injury is alleged to arise out of the “predicable actions
19 of third parties who are responding to actions of government defendants,” traceability as to those
20 government defendants is not defeated. *Dep’t of Com. v. New York*, 139 S. Ct. 2551, 2565–66
21 (2019). And redressability – a “relatively modest” requirement – can be shown where a favorable
22 ruling would result in a “change in legal status,” and where a “practical consequence of that
23 change would amount to a significant increase in the likelihood that the plaintiff would obtain
24 relief that directly redresses the injury suffered.” *Renee v. Duncan*, 623 F.3d 787, 797–98 (9th
25 Cir. 2010) (citations omitted), *opinion supplemented on reh’g*, 686 F.3d 1002 (9th Cir. 2012). In
26 other words, a plaintiff need not “guarantee” that redressability would follow. *Id.*

27 Here, Plaintiffs have put forward a non-speculative causal chain for their injuries:
28 Defendants promulgated the allegedly discriminatory Plan, which led predictably to Kaiser

1 excluding or imposing limits on wheelchair coverage, which caused Kaiser’s denial of Plaintiffs’
2 wheelchair benefits, which injured Plaintiffs. While Defendants argue that there is “no nexus”
3 between Defendants’ conduct and Plaintiffs’ harm, Mot. at 23, Plaintiffs adequately allege that the
4 promulgated regulations *are* that nexus, and that CHHSA acted through DMHC in taking this
5 challenged action.¹¹ SAC ¶¶ 31, 53. The fact that Defendants codified and implemented these
6 regulations at the direction of the legislature does not remove them from the causal chain, as
7 Defendants seem to suggest. *Id.*

8 It also does not immunize them from challenge to their actions. Defendants reason that
9 their role in merely “codifying” the legislature’s benchmark plan defeats redressability. Mot. at
10 24–25. They argue that this Court cannot issue an order directing them to cover benefits the
11 legislature declined to cover. *Id.* But in support of that position, they cite only to cases standing
12 for the unremarkable propositions that federal courts cannot modify statutory terms while
13 interpreting the plain text of a statute, or unilaterally amend state statutes. *Id.* (citing *Bostock v.*
14 *Clayton Cty., Ga.*, 140 S. Ct. 1731, 1738 (2020); *Preskar v. U.S.*, 248 F.R.D. 576, 584 (E.D. Cal.
15 2008)). Plaintiffs ask this Court to do neither. Plaintiffs instead ask the Court to redress the
16 alleged disability discrimination by ordering Defendants to come into compliance with their
17 responsibilities under the Rehabilitation Act and ACA. As *Crower v. Kitagawa*, 81 F.3d 1480
18 (9th Cir. 1996), and other cases demonstrate, this Court can issue such an order. *See* Opp. at 21–
19 22. Finding no support for Defendants’ suggestion that agency regulation should be shielded from
20 challenge if implemented at the direction of the legislature, the Court finds that Plaintiffs have
21 satisfied the “relatively modest” requirement of showing redressability. *Renee*, 623 F.3d at 797.

22 Accordingly, the Court **DENIES** Defendants’ motion to dismiss on standing grounds.
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25 ¹¹ The Court understands Defendants’ position that Plaintiffs’ allegations about the relationship
26 between CHHSA and DMHC are conclusory since they are based almost exclusively on statutory
27 language, *see* Reply at 11, but finds that at this early stage of litigation, Plaintiffs have little else
28 on which to rely and have sufficiently alleged that at least formally, CHHSA acts through its
departments. Just as the *Sharer* court did, the Court finds it appropriate at this stage to draw
preliminary conclusions about real-world facts from the face of statutes defining agency
relationships. If factual developments ultimately undermine those conclusions, Defendants are not
barred from challenging standing in the future.

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E. Statute of Limitations

Defendants argue that Plaintiffs’ claims are foreclosed by a four-year statute of limitations because Defendants did not take any action since promulgating the Plan in 2016 that could conceivably give rise to Plaintiffs’ claim. Mot. at 31. Plaintiffs disagree and maintain that the time to bring their discrimination claims has not lapsed given that Defendants’ allegedly discriminatory regulation is still in place. Opp. at 15–17. At this point in the proceedings, the Court finds dismissal on this basis unwarranted.

At the motion to dismiss stage, any statute of limitations bar must be “apparent on the face of the complaint.” *Rivera v. Peri & Sons Farms, Inc.*, 735 F.3d 892, 902 (9th Cir. 2013). A motion to dismiss based on a statute of limitations affirmative defense “may be granted only if the assertions in the complaint, read with the required liberality, would not permit the plaintiff[s] to prove” that their claims are not time-barred. *Pisciotta v. Teledyne Indus., Inc.*, 91 F.3d 1326, 1131 (9th Cir. 1996).

In arguing that Plaintiffs’ claims are time-barred, Defendants assert that “the right to bring a civil suit challenging the adoption of a regulation ‘accrues upon the completion of the administrative proceedings[,]’” such that Plaintiffs needed to bring their claim within four years of the Plan’s promulgation on November 28, 2016. Reply at 12 (quoting *Wind River Min. Corp. v. United States*, 946 F.2d 710, 716 (9th Cir. 1991)). Defendants cite numerous cases brought under the Administrative Procedure Act (“APA”) to support this contention, without ever explaining why the Court should apply the holdings from APA regulatory challenges to this disability discrimination case. See Reply at 12–13. In fact, Defendants not only characterize these APA cases as “the governing law[,]” but dismiss the relevance of Plaintiffs’ proffered disability discrimination caselaw on the basis of it involving “physical barriers or denials of employment or disability services.” *Id.* at 12.

The inapplicability of Plaintiffs’ cases – the holdings of which set out a different conception of claim accrual for statute of limitations purposes in the context of disability discrimination claims – is not obvious to the Court. In their complaint, Plaintiffs allege that Defendants “codifi[y] and enforce[.]” the Plan, which “deni[es] meaningful access to durable

1 medical equipment including wheelchairs” on an ongoing basis. SAC ¶ 76. Based on *Pickern v.*
2 *Holiday Quality Foods*, 293 F.3d 1133 (9th Cir. 2002), and other authorities, Plaintiffs argue that
3 their allegations support the notion that they face a “continuing violation” into the present, such
4 that their legal challenge is not stale. Opp. at 16. The Court need not definitively decide what
5 framework applies at this juncture, because Defendants have not met their burden of showing that,
6 construed “liberally,” the face of Plaintiffs’ complaint forecloses *any* possibility that their claims
7 are timely.

8 For this reason, the Court **DENIES** Defendants’ motion to dismiss Plaintiffs’ complaint as
9 time-barred.

10 **F. Discrimination Claim**

11 Lastly, Defendants argue that Plaintiffs have not stated a claim for disability
12 discrimination. Mot. at 26–31. While the Court has some skepticism that Plaintiffs ultimately
13 will be able to prove their claims, they have done enough to proceed for now.

14 To establish a violation under the ACA, a plaintiff must meet the elements of a
15 Rehabilitation Act claim. *Doe v. CVS Pharmacy, Inc.*, 982 F.3d 1204, 1210 (9th Cir. 2020), *cert.*
16 *dismissed*, 142 S. Ct. 480 (2021). And under the Rehabilitation Act, a plaintiff must show that: (1)
17 he or she is a “qualified individual with a disability,” (2) he or she was “either excluded from
18 participation in or denied the benefits of” the “services, programs, or activities” of an entity, “or
19 was otherwise discriminated against by the [. . .] entity,” (3) the entity that denied him or her the
20 services received federal financial assistance, and (4) “such exclusion, denial of benefits, or
21 discrimination was by reason of his [or her] disability.” *Payan v. L.A. Cmty. Coll. Dist.*, 11 F.4th
22 729, 737–38 (9th Cir. 2021). “Rather than try to classify particular instances of discrimination as
23 intentional or disparate-impact, [courts] focus[] on whether disabled persons had been denied
24 ‘meaningful access’ to state-provided services” and look to “the standard articulated in [*Alexander*
25 *v. Choate*]” to do so. *CVS Pharmacy*, 982 F.3d at 1210 (citing *Mark H. v. Lemahieu*, 513 F.3d
26 922, 937 (9th Cir. 2008)). Under the test set forth in *Choate*, courts first consider “the nature of
27 the benefit [plaintiffs] were allegedly denied” and then “whether the plan provided meaningful
28 access to the benefit.” *Id.* (citing *Alexander v. Choate*, 469 U.S. 287 (1985)).

1 Construing the pleadings in the light most favorable to the Plaintiffs, as it must, the Court
2 finds that Plaintiffs have adequately alleged that they were denied meaningful access to a benefit
3 (i.e. wheelchair coverage) needed to address a condition that is a proxy for their mobility
4 disability. Plaintiffs allege that the Plan adopted by Defendants excludes wheelchairs as a listed
5 essential health benefit in the durable medical equipment (DME) subcategory, while recognizing
6 that the Plan provides coverage for wheelchairs of up to \$2,000 annually, subject to a “home use”
7 rule.¹² SAC ¶ 7. Plaintiffs allege that an appropriate, medically necessary wheelchair (defined as
8 one that “meets the user’s needs and environmental conditions, provides a proper fit and postural
9 support, has properly configured technology, and is safe and durable”) is the “standard of care for
10 people with mobility disabilities who cannot walk or have difficulty walking.” *Id.* ¶ 42. Plaintiffs
11 allege that access to such a wheelchair benefits people with mobility disabilities in countless ways,
12 such as by enabling them to “participate fully in community life,” “access education, employment,
13 [and] family life,” “reduce the risk” of institutionalization, and enjoy greater independence and
14 improved health. *Id.* ¶¶ 43, 44. However, Plaintiffs allege that an appropriate wheelchair (and its
15 attendant benefits) is largely out of reach for them and others similarly situated because one costs
16 “far more than what many insured individuals in California can pay out of pocket.” *Id.* ¶ 45.
17 Plaintiffs estimate that manual wheelchairs intended for daily use cost between \$3,000 and \$5,000,
18 and that “most power wheelchairs cost a few thousand dollars,” but can reach as high as \$50,000.
19 *Id.* Considering these costs, Plaintiffs maintain that the \$2,000 coverage limitation on wheelchairs
20 is an insurance benefit design that prevents people with disabilities from “meaningfully accessing”
21 medically necessary durable medical equipment. *Id.* ¶¶ 71, 73. Because the fit between the
22 denied benefit (wheelchairs) and the disability (limited mobility) is so close, they argue that the
23 Plan discriminates by proxy. *Id.* ¶ 72.

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¹² The Court notes that the parties disagree on the definition of “home use” and the resulting import of this rule. Plaintiffs allege that the home use rule disallows coverage for any wheelchairs used outside the home. SAC ¶ 7 n.2. Defendants contend that a more reasonable inference is that the qualifier “home use” stands in contrast to clinical or hospital use, and does not proscribe a wheelchair’s operation outside the home. Mot. at 13 n.2. The Court declines to decide at this point which definition is correct, because under either, the Court is of the view that Plaintiffs have done enough to state a disability discrimination claim at this early stage of litigation.

1 Defendants, unsurprisingly, have a different view. They argue that wheelchairs are not a
 2 covered benefit under the ACA, such that denial of their coverage is not actionable. Mot. at 26–
 3 28. While it is true that wheelchairs do not appear as an enumerated type of DME covered under
 4 ACA regulations or the Plan in the “rehabilitative and habilitative services and devices” category,
 5 compliance with a state’s EHB-benchmark plan does not necessarily guarantee compliance with
 6 Section 1557. *Schmitt v. Kaiser Found. Health Plan of Washington*, 965 F.3d 945, 955–56 (9th
 7 Cir. 2020). This is because the ACA requires that to qualify as EHB-benchmark plan, a state-
 8 selected benchmark plan must not only include the ten specified categories of benefits – of which
 9 rehabilitative and habilitative services and devices are one – but also must “not include
 10 discriminatory benefit designs that contravene the non-discrimination standards[.]” *Id.* at 956. In
 11 other words, inclusion of the ten specified categories of essential health benefits is a “minimum
 12 requirement,” but not a safe harbor. *Id.* at 955. Benchmark plans can be challenged for failing to
 13 provide the essential health benefits guaranteed under the ACA if their benefit design, or the
 14 implementation of their benefit design, discriminates on the basis of disability. *Id.* And benefit
 15 designs extend to “covered benefits, *benefits limitations or restrictions*, and cost-sharing
 16 mechanisms, such as coinsurance, copayments, and deductibles.” *Id.* (emphasis in original).

17 Under *Schmitt*, then, Plaintiffs can challenge the Plan’s exclusion or limitation of
 18 wheelchair benefits. Defendants suggest that here, however, Plaintiffs seek to define the relevant
 19 benefit as an unfounded entitlement to “unlimited wheelchair coverage.” Mot. at 30. But the
 20 Court does read the complaint to argue for an “unlimited” wheelchair coverage benefit under the
 21 Plan. Instead, construing their pleadings in the light most favorable to them, Plaintiffs allege that
 22 given the annual coverage limitations imposed by the Plan on wheelchairs, and the alleged cost of
 23 wheelchair purchase and maintenance, they are effectively denied *any* wheelchair benefit. *See*
 24 SAC ¶¶ 7, 45, 76, 81. They also allege that wheelchair coverage falls under the scope of DME
 25 benefits, which is a subcategory within the rehabilitative and habilitative service and device
 26 category. *Id.* ¶ 40. Like the prescription drug benefits at issue in *Doe v. CVS Pharmacy*,
 27 rehabilitative and habilitative services and devices are essential benefits that must be covered
 28 under the ACA. *CVS Pharmacy*, 982 F.3d at 1210. As such, the Court is satisfied at this stage

1 that Plaintiffs have pled entitlement to a benefit.

2 Defendants argue that even assuming that Plaintiffs are entitled to DME such as
3 wheelchairs, they cannot properly show they were denied meaningful access to that benefit.
4 Defendants contend that the fact that the Plan does not cover wheelchairs to the extent that
5 Plaintiffs would like does not mean that they are excluded, or that the imposition of a \$2,000
6 annual cap is discriminatory, especially since there are non-discriminatory reasons why
7 wheelchairs might not be covered as DME. Mot. at 29; Reply at 15. Defendants additionally
8 contend that any discrimination by proxy theory fails because, based on *Schmitt*, Plaintiffs “allege
9 no facts giving rise to an inference of intentional discrimination by the exclusion itself.” Mot. at
10 30 (quoting *Schmitt*, 965 F.3d at 959).

11 However, Defendants misquote *Schmitt*. In *Schmitt*, the court observed that the plaintiff
12 “allege[d] no facts giving rise to an inference of intentional discrimination *besides* the exclusion
13 itself.” *Schmitt*, 965 F.3d at 959 (emphasis added). Because the proxy’s “fit” in that case was not
14 “sufficiently close” to make a discriminatory inference plausible, the plaintiff’s claims did not
15 survive. *Id.* at 960. However, the *Schmitt* court did not require, as Defendants seem to suggest,
16 that a plaintiff allege facts to show anything other than a close fit between the benefit exclusion or
17 limitation and the disability. A properly pled exclusion *is* the circumstance that gives rise to an
18 inference of disability discrimination; a plaintiff need not allege *additional* facts showing
19 intentional discrimination. *Id.*

20 Here, Plaintiffs have alleged that they are denied meaningful access to wheelchairs, a type
21 of rehabilitative device, because the Plan promulgated by Defendants allegedly limits wheelchair
22 coverage to an extent that means virtually no wheelchairs are fully covered. They argue that this
23 is discriminatory because the coverage limitation denies a benefit (the ability to obtain an
24 appropriate wheelchair) needed to address a condition that is a proxy for their mobility disability.
25 SAC ¶ 72. Unlike in *Schmitt*, the denial of coverage of appropriate wheelchairs is neither an
26 overinclusive proxy for mobility disability (because nondisabled people do not need wheelchairs
27 on an ongoing basis) nor an underinclusive one (because for people with mobility disabilities,
28 there is arguably no alternative to an appropriate wheelchair). Opp. at 28–29. The Court is

1 therefore satisfied that Plaintiffs have alleged a sufficiently close proxy to give rise to an inference
2 of discrimination. The Court reiterates that whether Plaintiffs can adduce sufficient facts to
3 actually prove their allegations about fit – for example, by showing that wheelchairs are on the
4 main prohibitively expensive in light of the \$2,000 cap – is an entirely separate question for a later
5 stage of the case.

6 Finally, the Court comments briefly on Defendants’ warning that finding for Plaintiffs will
7 mean that, moving forward, “any service or device that has not been designated by the State as an
8 essential health benefit, and that is needed by a disabled person, must be covered in order to avoid
9 discrimination.” *Id.* While the Court is not persuaded that so drastic a result must follow even if
10 Plaintiffs ultimately win this case, it certainly views Defendants’ prediction as overstated at this
11 stage. As the Court has repeatedly emphasized, the allegations credited in this order are ones that
12 Plaintiffs must ultimately substantiate in order to prevail. If they fail to do so, Defendants can
13 raise any appropriate arguments based on a more developed record.

14 **IV. CONCLUSION**

15 The Court **DENIES** Defendants’ motion to dismiss, Dkt. No. 77. It also **GRANTS in part**
16 **and DENIES in part** Plaintiffs’ request for judicial notice, Dkt. No. 81, and **GRANTS**
17 Defendants’ requests for judicial notice, Dkt. Nos. 34-1, 83.

18 The Court further **SETS** a telephonic case management conference on December 19, 2023,
19 at 2:00 p.m. All counsel shall use the following dial-in information to access the call:

20 Dial-In: 888-808-6929

21 Passcode: 6064255

22 All attorneys and pro se litigants appearing for a telephonic case management conference
23 are required to dial in at least 15 minutes before the hearing to check in with the courtroom
24 deputy. For call clarity, parties shall NOT use speaker phone or earpieces for these calls, and
25 where at all possible, parties shall use landlines.

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The Court **DIRECTS** the parties to meet and confer and submit a joint case management statement by December 12, 2023. At the case management conference, the parties should be prepared to discuss how to move this case forward efficiently.

IT IS SO ORDERED.

Dated: 11/22/2023


HAYWOOD S. GILLIAM, JR.
United States District Judge