Nothing Changed But the Calendar:

Recurring Prior Authorization as a Methods of Administration Violation

Under Section 504 and Section 1557

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Abstract

Medicaid beneficiaries on stable drug regimens are required to obtain prior authorization for the same medication, at the same dose, year after year. Federal law permits states to impose prior authorization on covered outpatient drugs and conditions that permission on a response within 24 hours and the dispensing of a 72 hour emergency supply. Federal law says nothing about how often an authorization must be renewed. The interval is a state choice driven by formulary review cycles and supplemental rebate contracts, and it interrupts therapy for a population whose disabilities make each interruption most costly and each renewal hardest to complete.

Title III of the Americans with Disabilities Act fails against payers on three settled grounds: the access and content line drawn in *Doe v. Mutual of Omaha*, the holding that a benefit plan is not a place of public accommodation, and McCarran-Ferguson reverse preemption. Developing each ground identifies what it does not reach. Neither the insurance safe harbor nor McCarran-Ferguson engages a utilization control applied to an already enrolled beneficiary, since both are addressed to the assumption and classification of risk. And a pharmacy sits on the statutory list of public accommodations by name.

Section 504 of the Rehabilitation Act reaches what Title III cannot, and *Doe v. CVS Pharmacy* supplies the path: the same prescription benefit design that failed as a Title III claim survived as a Section 504 meaningful access claim, and Section 1557 of the Affordable Care Act carries that standard into health programs receiving federal financial assistance.

The Article's contribution is the characterization. Recurring prior authorization administers access to a benefit already granted rather than defining its scope, which places it under the methods of administration and eligibility criteria provisions at 45 C.F.R. § 84.68(b)(3) and (b)(8), where *Alexander v. Choate* supplies the standard rather than the obstacle. Because those provisions face a round of federal rulemaking reconsidering disparate impact liability, the Article develops a second and independent track resting on the reasonable modification obligation, which requires no impact theory. It closes on the procedural question the doctrine has not confronted: an expiring authorization is treated as agency inaction rather than as a reduction in services, and that characterization removes the notice and hearing protections a termination would carry.

Keywords: disability law; administrative law; meaningful access; disparate impact; reasonable modification; utilization management; *Alexander v. Choate*; Medicaid pharmacy benefit; maintenance medication; administrative burden; ordeal mechanisms; health insurance.

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Contents

I. Introduction

A physician writes a prescription. The patient has taken the same drug at the same dose for years. The state Medicaid agency has paid for that drug every one of those years. In January the authorization expires, the pharmacy claim rejects, and the patient waits without medication while a form moves between a prescriber's office, a fax line, and a state contractor.

Nothing about the patient changed. Nothing about the drug changed. What changed was the calendar.

Federal law permits states to impose prior authorization on covered outpatient drugs.[1] It conditions that permission on two obligations that receive far less attention than the permission itself: a response within 24 hours, and the dispensing of at least a 72 hour supply in an emergency.[2] Federal law says nothing at all about how often an authorization must be renewed.

The renewal interval is where the injury lives, and it is the part of the architecture that no federal statute governs and no reported decision has examined as a discrete practice. This Article takes it up.

Part II describes the architecture: what authorizes prior authorization, what conditions that authorization, why the renewal cycle runs annually, and why the most significant recent federal reform of prior authorization excluded drugs entirely. Part III answers the question a disability lawyer asks first, which is whether Title III of the Americans with Disabilities Act reaches the payer. Against the plan and the insurer it does not, for three independent reasons, and the Article develops each rather than assuming it, because the shape of the surviving claim depends on knowing precisely which door is closed. Against the dispensing pharmacy, which Congress placed by name on the list of public accommodations, a narrow lane remains open. Part

1. 42 U.S.C. § 1396r-8(d)(5); *see also* 42 U.S.C. § 1396a(a)(30)(A) (requiring state plans to provide methods and procedures to safeguard against unnecessary utilization); 42 C.F.R. § 440.230(d) (permitting limits on a service based on medical necessity or utilization control procedures).

2. 42 U.S.C. § 1396r-8(d)(5)(A)–(B). The Centers for Medicare & Medicaid Services applied these standards to Medicaid managed care organizations by rule. *See* Medicare and Medicaid Programs; Interoperability Standards and Prior Authorization for Drugs, 91 Fed. Reg. 19890, 19894 (proposed Apr. 14, 2026) (stating that for state Medicaid fee-for-service programs, Medicaid managed care plans, and CHIP managed care entities, the decision timeframe for covered outpatient drugs is 24 hours).

IV opens the door that is not closed. Section 504 of the Rehabilitation Act, carried into private health coverage by Section 1557 of the Affordable Care Act, reaches program design that Title III cannot touch, and the Ninth Circuit has already sustained a prescription benefit design claim on exactly that footing.[3]

Part V supplies the characterization that makes the claim work and states this Article's contribution. Recurring prior authorization is administration of access to a benefit already granted. It is not the definition of the benefit, not its scope, and not its amount. That characterization moves the analysis out from under the portion of *Alexander v. Choate* that defeats challenges to benefit design and into the methods of administration provisions, which prohibit administrative practices whose effect defeats or substantially impairs the objectives of a program for persons with disabilities.[4] Part VI develops a second and independent track. The reasonable modification obligation stated in all three statutes requires no impact theory and does not depend on the impact regulations remaining in force, which matters because those regulations are presently under reconsideration. Part VII raises the procedural question that the case law has not confronted: an expiring authorization is characterized as the absence of agency action rather than as a reduction in services, and that characterization removes the notice and hearing protections that attach to a termination. Part VIII addresses remedy in the shadow of *Cummings v. Premier Rehab Keller*.

II. The Architecture of Recurring Prior Authorization

A. The Statutory Permission and Its Two Conditions

Prior authorization is a payment condition rather than a clinical determination. The distinction is formally clean. A prescription is an exercise of professional judgment by a licensed clinician. Prior authorization is a decision by a payer about the circumstances under which it will disburse

3. *Doe v. CVS Pharmacy, Inc.*, 982 F.3d 1204, 1211–12 (9th Cir. 2020).
4. 45 C.F.R. § 84.68(b)(3); 28 C.F.R. § 35.130(b)(3).

funds. The two acts are performed by different parties under different authority, and the payer does not purport to overrule the prescriber.

The distinction is also, for a beneficiary without independent means, without practical consequence. A refusal to pay and a refusal to permit produce the same result at the pharmacy counter. Federal law recognizes as much in its own description of the practice. In the rulemaking that would extend electronic prior authorization requirements to drugs, the agency stated that payers establish prior authorization requirements to help control costs and ensure payment accuracy, and acknowledged that the process can create a health risk for patients who do not receive medically necessary care in a timely manner.[5]

Section 1927(d)(5) of the Social Security Act is the source of the permission for covered outpatient drugs.[6] A state may subject any covered outpatient drug to prior authorization provided the program responds within 24 hours by telephone or other telecommunication device and provides for dispensing at least a 72 hour supply in an emergency situation as defined by the Secretary.[7] The conditions are not optional features of a permissive scheme. They are the terms on which the permission is granted, and a program that fails them is operating outside the authority that makes prior authorization lawful in the first instance.

The 72 hour emergency supply obligation is widely implemented and thinly used. Illinois, for example, provides that where department staff are unavailable to accept a prior approval request, the pharmacy may dispense and the department will pay for an emergency 72 hour supply of a covered prescription drug.[8] Other states read the same federal obligation more broadly. North Carolina instructs that a pharmacy can and should provide a 72 hour emergency supply where a member needs medication immediately while awaiting a prior authorization decision, and states that there is no limit on the number of times the supply may be dispensed

5. 91 Fed. Reg. at 19899.

6. 42 U.S.C. § 1396r-8(d)(5).

7. *Id.* § 1396r-8(d)(5)(A)–(B).

8. Ill. Dep't of Healthcare & Family Servs., *Four Prescription Policy*, `https://hfs.illinois.gov/medicalproviders/pharmacy/fourprescriptionpolicy.html` (last visited July 31, 2026).

while the authorization is pending.[9] The variance between those two readings of one federal sentence is itself a finding: the beneficiary's access to the statutory backstop depends on which state administers the program and on whether a pharmacist knows the override exists.

B. The Renewal Interval Is a State Choice

Nothing in Section 1927, in Section 1396a(a)(30)(A), or in the implementing regulations sets a duration for an approved authorization. The interval is set by the state, and the states have set it in different places for different drug classes.

This silence is doing significant work. The federal conditions on prior authorization are all conditions on the initial decision: how fast it must be made, and what must be dispensed while it is pending. Once the decision is made in the beneficiary's favor, federal law releases its grip. A state may grant an authorization coextensive with the course of therapy, or for two years, or for twelve months, and no federal provision distinguishes among those choices. The result is that the most consequential parameter of the practice, from the perspective of a person on maintenance therapy, is the one parameter that federal law leaves entirely unregulated.

C. What Drives the Annual Cycle

Three mechanisms produce the annual renewal, and only one of them concerns the individual patient.

The first is the preferred drug list review cycle. State pharmacy and therapeutics committees review formularies on a recurring schedule, and a drug's placement can change at each review.

The second is the supplemental rebate contract. States negotiate rebates with manufacturers beyond the statutory rebate, and a drug's status on the preferred drug list moves with those negotiations. When a drug moves from preferred to non-preferred, prior

9. N.C. Medicaid, *Pharmacy Frequently Asked Questions*, `https://medicaid.ncdhhs.gov/providers/programs-and-services/pharmacy-frequently-asked-questions` (last visited July 31, 2026) (citing 42 U.S.C. § 1396r-8(d)(5)(B)).

authorization attaches to it. The clinical facts are unchanged. What changed was the state's purchasing position.

The third is re-verification of continued medical necessity, which is the stated justification and the weakest of the three as applied to a regimen that has held steady for years.

State law is sometimes candid about which mechanism is operating. The Illinois SMART Act directs the state Medicaid agency to develop utilization controls, including prior approval, for specialty drugs, oncolytic drugs, drugs for the treatment of HIV or AIDS, immunosuppressant drugs, and biological products in order to maximize savings on these drugs.[10] The same agency states that its four prescription policy was developed as a result of budget negotiations.[11] A cost containment instrument is not disqualified by being one. It is, however, entitled to be analyzed as what it is when a court is asked whether its administration denies meaningful access.

D. The Reform That Left Drugs Out

In February 2024, the Centers for Medicare & Medicaid Services finalized the most substantial federal reform of prior authorization in a generation.[12] The rule required impacted payers, a category that includes state Medicaid fee-for-service programs and Medicaid managed care plans, to decide standard requests within seven calendar days and expedited requests within 72 hours, and to state a specific reason for every denial.[13]

None of it applies to drugs. The agency did not propose or finalize requirements applicable to drugs of any type, on the stated ground that the processes and electronic standards for prior authorization of drugs differ from those for non-drug items and services.[14] Commenters told the agency what that exclusion would mean. As the agency later summarized the record,

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10. Ill. Dep't of Healthcare & Family Servs., *Criteria and Forms*, `https://hfs.illinois.gov/medicalproviders/pharmacy/criteriaandforms.html` (last visited July 31, 2026) (describing Public Act 097-0689). The enumerated categories are notable: each is a class of chronic maintenance therapy for a serious or disabling condition.

11. Ill. Dep't of Healthcare & Family Servs., *Four Prescription Policy*, *supra* note 8.

12. Medicare and Medicaid Programs; Advancing Interoperability and Improving Prior Authorization Processes, 89 Fed. Reg. 8758 (Feb. 8, 2024).

13. *Id.* at 8878 (decision timeframes); *see also id.* at 8897 (public reporting of prior authorization metrics).

14. 91 Fed. Reg. at 19891 (describing the scope of the 2024 rule).

commenters explained that by failing to include drugs in those requirements, it was failing to address the biggest culprit of delay to timely care and administrative burden.[15]

In April 2026 the agency proposed to close the gap.[16] The proposal would extend electronic prior authorization, denial reason requirements, and decision timeframes to drugs, with a proposed compliance date of October 1, 2027.[17]

Two features of the proposal matter here. First, its ambition is procedural. It addresses how fast a decision is made, in what format, and with what explanation. It does not address how often a beneficiary must obtain one. The renewal interval survives the reform untouched.

Second, the agency conceded a coverage gap in the existing 24 hour rule. It observed that the term covered outpatient drugs does not reach all drugs for which states receive federal financial participation, and requested comment identifying drugs for which no prior authorization timeframe currently exists.[18] For that category, in that interval, a Medicaid beneficiary is subject to a prior authorization requirement carrying no federal decision deadline at all.

III. Title III and the Payer: Three Closures and a Narrow Opening

Title III prohibits discrimination on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation.[19] The enumerated categories include an insurance office.[20] The inference is natural and it is wrong. Three independent grounds defeat a Title III claim against a payer's utilization management practices, and each is settled enough that a complaint pleading around none of them will be dismissed.

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15. *Id.* at 19892.
16. 91 Fed. Reg. at 19890 (CMS-0062-P; RIN 0938-AV44).
17. *Id.* at 19893–94. The comment period closed June 15, 2026. *Id.* at 19890.
18. *Id.* at 19894.
19. 42 U.S.C. § 12182(a).
20. *Id.* § 12181(7)(F).

A. Access and Content in Doe v. Mutual of Omaha

Judge Posner's opinion for the Seventh Circuit in *Doe v. Mutual of Omaha* is the cleanest statement of the governing line. Two plaintiffs with AIDS challenged lifetime benefit caps that applied to AIDS and to no other condition. The court held that Section 302(a) does not require a seller to alter his product to make it equally valuable to the disabled and to the nondisabled, even if the product is insurance.[21]

The reasoning is worth stating precisely, because its precision is what leaves room for the argument this Article makes. Posner did not hold that Title III leaves insurers alone. He held that the statute reaches access and does not reach content. The owner of a store cannot bar the door and cannot admit customers and then refuse to sell to them on the same terms as others, and an insurance company cannot refuse to sell a policy to a person with AIDS.[22] What the statute does not do is dictate what the product contains once it is offered on equal terms to everyone.

B. A Benefit Plan Is Not a Place

The second ground is narrower and, in the Ninth Circuit, dispositive on its own. In *Doe v. CVS Pharmacy*, beneficiaries living with HIV and AIDS challenged a specialty pharmacy program that required them to obtain medications by mail or at designated pickup locations. The Title III claim failed at the threshold: the plaintiffs failed to plead the denial of a public accommodation because a benefit plan is not a place of public accommodation.[23] That reading traces to a line of circuit authority holding that the terms of a benefit plan lie outside Title III's reach.[24]

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21. *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557, 563 (7th Cir. 1999).

22. *Id.* at 559. On the reach of Section 302(a) to the transaction rather than only the threshold, the court observed that the right of full and equal enjoyment includes the right to buy on equal terms and not only the right to enter the store. *Id.* at 563.

23. *Doe v. CVS Pharmacy*, 982 F.3d at 1213 (citing *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1115 (9th Cir. 2000)).

24. *See Weyer*, 198 F.3d at 1115; *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006 (6th Cir. 1997) (en banc); *Ford v. Schering-Plough Corp.*, 145 F.3d 601 (3d Cir. 1998). The First Circuit reads the category structure functionally and does not require a physical anchor. *Carparts Distribution Ctr., Inc. v. Auto. Wholesaler's Ass'n of New Eng., Inc.*, 37 F.3d 12, 19 (1st Cir. 1994).

A plaintiff challenging a prior authorization practice sits squarely inside this holding on the pleadings as ordinarily framed. The practice is a term of plan administration, and the plan is the thing the courts have said is not a place.

C. McCarran-Ferguson

The third ground is independent of the first two and applies only to state regulated insurance. The McCarran-Ferguson Act bars construction of a federal statute in a manner that would invalidate, impair, or supersede state law enacted to regulate the business of insurance.[25] *Doe v. Mutual of Omaha* held that reading Title III to reach coverage content would trigger that bar, because direct conflict is not required and it is enough that the interpretation would interfere with a State's administrative regime.[26] Putting federal courts in the position of deciding whether coverage limitations are actuarially sound and consistent with state law would place them in the domain of state insurance commissioners.[27]

This ground has an important limit that Part IV exploits. Medicaid prior authorization is not regulated by state insurance law. It is authorized, conditioned, and constrained by federal statute and federal rule. A construction of a federal civil rights statute that reaches the administration of a federally conditioned Medicaid utilization control does not interfere with any state insurance regime, because no state insurance regime governs it. McCarran-Ferguson closes the private insurance door. It does not reach the Medicaid door, and it does not reach Medicaid managed care organizations acting under state contract to administer a federal benefit.

1. Prior Authorization Is Not a Risk Practice

A second limit runs deeper than the first, because it does not depend on the identity of the payer.

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25. 15 U.S.C. § 1012(b).

26. *Doe*, 179 F.3d at 563–64 (quoting *Humana Inc. v. Forsyth*, 525 U.S. 299, 310 (1999)).

27. *Id.* at 564. The court distinguished the prohibition on outright refusals to deal, which can be administered with relatively little interference with state insurance regulation. *Id.*

Both defenses in this area are addressed to risk. McCarran-Ferguson reverse preempts only as to state law enacted for the purpose of regulating the business of insurance.[28] The insurance safe harbor protects an insurer or plan administrator that underwrites risks, classifies risks, or administers such risks in a manner based on or not inconsistent with State law.[29] Each verb in that catalogue names a stage in the allocation and pricing of contingent loss.

Prior authorization occupies none of those stages. Underwriting precedes assumption of the risk. Classification sorts applicants among pools. Administration of risks, read in the company of the two terms preceding it, refers to management of the risk relationship those determinations establish. A prior authorization requirement applied to an enrolled beneficiary operates after all of it has concluded. The risk was assumed at enrollment. The benefit was defined in the plan or the state plan amendment. The drug was placed on the formulary. What remains is utilization management, applied to a person the payer has already agreed to cover, for a therapy the payer has already agreed to pay for.

The agency describes the practice in precisely those terms. Payers establish prior authorization requirements to help control costs and ensure payment accuracy by verifying that an item, service, or drug is medically necessary for the specific patient and meets coverage criteria.[30] That is a description of expenditure control rather than of risk allocation.

The sequencing consequence matters more than the characterization. A defendant invoking Section 12201(c) or McCarran-Ferguson must establish at the threshold that the challenged practice is a risk practice within the meaning of those provisions. A recurring renewal requirement imposed on a covered beneficiary for a covered drug is not one, and neither defense reaches it. That conclusion holds against a commercial insurer as readily as against a state agency, which makes it the broader of the two limits developed here.

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28. 15 U.S.C. § 1012(b); *see also id.* § 1011.
29. 42 U.S.C. § 12201(c)(1)–(2).
30. 91 Fed. Reg. at 19899.

D. What Survives

Two things survive that a later argument will need.

First, the Seventh Circuit has already rejected the proposition that a place of public accommodation must be a physical place. Posner's list of covered facilities runs through store, hotel, restaurant, dentist's office, travel agency, theater, and Web site, and expressly encompasses facilities whether in physical space or in electronic space.[31] Whatever else *Doe* holds, it does not hold that Title III stops at a doorway.

Second, the insurance safe harbor carries a subterfuge limitation, and Posner supplied a worked example of what would violate it: caps adopted to deter people who know they are HIV positive from buying the policies at all.[32] The statute states the limitation in its own terms, providing that the safe harbor paragraphs shall not be used as a subterfuge to evade the purposes of Titles I and III.[33]

The example Posner chose identifies the operative mechanism, and it generalizes past its facts. What made his hypothetical a subterfuge was not that the policy term was harsh. It was that the term was calibrated to produce departure. The harbor shelters practices that price a risk the insurer has agreed to bear. It does not shelter practices whose function is to reduce the number of people bearing that risk against the insurer.

An attrition theory of recurring prior authorization follows the same structure. A renewal requirement that a program knows will not be completed by some determinate fraction of the beneficiaries subject to it operates as a mechanism for reducing utilization by reducing the number of people who successfully claim the benefit. Where the failure rate is known, and where the population that fails is defined by the disabilities that make the procedure difficult, the practice is producing departures rather than measuring risk.

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31. *Doe*, 179 F.3d at 559 (citing *Carparts*, 37 F.3d at 19).

32. *Id.* at 563. The court read the safe harbor as a rule of construction obtained by the insurance industry to backstop the argument that Section 302(a) regulates access rather than content. *Id.*

33. 42 U.S.C. § 12201(c).

That theory demands evidence rather than argument, and the evidence is now becoming available. The 2024 rule requires impacted payers to publish approval, denial, and appeal metrics annually, and the pending proposal would extend publication to drugs beginning in 2028.[34] What those disclosures will not show is the population that never completes a renewal at all, because a request never submitted generates no denial and appears in no denominator. A reporting regime built on decisions rendered is structurally incapable of counting the beneficiaries the renewal interval removes.

E. Equal Access to a Procedure Is Not Access to a Benefit

The three grounds above dispose of a Title III claim against a payer. None of them travels to Section 504, and the reason they do not is the interval this Article occupies.

Title III asks whether a person can transact on equal terms. Posner stated that standard at its most generous to plaintiffs, holding that the right of full and equal enjoyment includes the right to buy on equal terms and not only the right to enter the store.[35] Section 504 asks a different question. Under *Choate* it asks whether the person was afforded meaningful access to the benefit provided.[36]

A payer can satisfy the first standard completely and fail the second. Measure the renewal requirement against each in turn. Every beneficiary receives the same notice, or the same absence of one. Every beneficiary may submit the same form through the same channels on the same terms. Nobody is turned away and nobody is charged more for the attempt. On the Title III measure the access is equal and the inquiry is finished.

The Section 504 measure does not finish there, because equal access to a procedure is not access to the benefit the procedure guards. The question that statute puts is whether the beneficiary obtained meaningful access to the drug. For the subpopulation that cannot reliably complete the procedure, the answer does not improve because the procedure was administered

34. 89 Fed. Reg. at 8897; 91 Fed. Reg. at 19896–97 (proposing numeric counts alongside percentages and additional metrics on denials after extension and appeal).

35. *Doe*, 179 F.3d at 563.

36. *Alexander v. Choate*, 469 U.S. 287, 301 (1985).

evenhandedly to everyone. Evenhanded administration of a barrier is the fact pattern *Choate* addressed, and it is the premise of a meaningful access claim rather than an answer to one.

This is why the Title III analysis in this Part is not preliminary ground clearing. The access and content line has migrated into Section 504 analysis as though the two statutes asked the same question. *Doe v. CVS Pharmacy* demonstrates in a single opinion that they do not: the identical program design produced dismissal under the access standard and survival under the meaningful access standard.[37]

F. The Pharmacy as Place

One Title III lane remains open, and it is narrow enough that it should be pleaded in the alternative rather than led with.

Congress placed a pharmacy by name on the list of covered public accommodations, alongside an insurance office and the professional office of a health care provider.[38] Whatever the courts have said about benefit plans, no court has held that a pharmacy is not a place. The enumeration is express and the physical premises are unmistakable, which means the entire nexus dispute that governs claims against digital and plan defendants is absent from this posture.

Two regulations reach conduct at that place, and they mirror the Section 504 provisions relied on in Part V almost word for word. A public accommodation shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any goods, services, facilities, privileges, advantages, or accommodations, unless such criteria can be shown to be necessary for what is being offered.[39] And a public accommodation shall not, directly or through contractual or other arrangements, utilize standards or criteria or methods of administration that have the effect

37. *Doe v. CVS Pharmacy*, 982 F.3d at 1211–13.

38. 42 U.S.C. § 12181(7)(F).

39. 28 C.F.R. § 36.301(a).

of discriminating on the basis of disability, or that perpetuate the discrimination of others who are subject to common administrative control.[40]

The second regulation is the more interesting of the two, because of the clause at its end. A pharmacy chain under common ownership with the pharmacy benefit manager that designs the authorization protocol is administering criteria originating with an entity subject to common administrative control. The regulation reaches that arrangement in terms, and it reaches conduct performed directly or through contractual or other arrangements, which forecloses the argument that the chain is merely executing someone else's rule.

The limits are real and should be stated rather than papered over. *Doe v. CVS Pharmacy* was itself a suit against pharmacy defendants, and the Title III claim still failed, because the restriction the plaintiffs challenged originated in the design of the benefit rather than in the operation of the store.[41] That holding governs any complaint that attacks the authorization requirement as such. The lane survives only for conduct properly attributed to the place: a protocol the chain applies at the counter as its own practice, a refusal to run the emergency supply override that federal law provides, a policy of declining to notify the customer that an authorization has lapsed, or a rule that a renewal be initiated in person during hours the customer cannot reach.

That is a narrower claim than the one Part V develops. It is also a claim against a defendant with retail premises in the plaintiff's own community, litigated under regulations whose text does not depend on disparate impact liability surviving the current round of rulemaking. Both features are worth something, and a complaint that pleads it in the alternative loses nothing by doing so.

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40. 28 C.F.R. § 36.204.

41. *Doe v. CVS Pharmacy*, 982 F.3d at 1213.

IV. The Right Door: Section 504, Section 1557, and Meaningful Access

A. Choate as Standard Rather Than Bar

Alexander v. Choate is ordinarily cited against disability plaintiffs challenging benefit limits, and in its own facts it was.[42] Reading it only that way misses what the opinion supplied. *Choate* established that Section 504 requires meaningful access to the benefit provided, and courts have applied that standard ever since to facially neutral policies that operate unequally in effect.

The Ninth Circuit's statement of the point is direct. The fact that a benefit is facially neutral does not dispose of a disparate impact claim based on lack of meaningful access, and the unique impact of a facially neutral policy on people with disabilities may give rise to such a claim where services, programs, and activities remain open and easily accessible to others.[43]

The pleading burden is lighter than defendants generally assert. The meaningful access standard does not require a plaintiff to allege that the deprivation was unique to the plaintiff's disability, nor that it was severe, only that meaningful access to the benefit was denied.[44]

B. Doe v. CVS Pharmacy

Doe v. CVS Pharmacy is the case this Article builds on, and its structure is the argument in miniature. The same program design, challenged in the same complaint by the same plaintiffs, failed under Title III and survived under Section 504. The Title III claim failed because a benefit plan is not a place.[45] The Section 504 claim survived because the plaintiffs adequately alleged that a prescription drug program denied them meaningful access to their drug benefit.[46]

Section 1557 of the Affordable Care Act carries that standard into health programs and activities receiving federal financial assistance. The Ninth Circuit held that Section 1557 does

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42. *Choate*, 469 U.S. at 289, 302–03 (sustaining a fourteen day annual limit on inpatient hospital coverage against a Section 504 challenge).

43. *Doe v. CVS Pharmacy*, 982 F.3d at 1211 (quoting *Crowder v. Kitagawa*, 81 F.3d 1480, 1484 (9th Cir. 1996), and citing *K.M. ex rel. Bright v. Tustin Unified Sch. Dist.*, 725 F.3d 1088, 1102 (9th Cir. 2013)).

44. *Id.* at 1212.

45. *Id.* at 1213.

46. *Id.* at 1211–12.

not create a new healthcare specific antidiscrimination standard, and that a disability plaintiff proceeding under Section 1557 must allege facts adequate to state a claim under Section 504.[47] The incorporation runs in the plaintiff's favor here. Section 504's standard is the one *Choate* supplies, and Section 1557 extends its reach to payers that Section 504 alone might not capture.

C. The Recipient Question

Section 504 reaches recipients of federal financial assistance; Section 1557 reaches health programs and activities receiving such assistance.[48] Four categories of defendant are implicated by a recurring prior authorization practice, and they are differently situated.

The state Medicaid agency is the clearest. It receives federal financial participation, it is a public entity for Title II purposes, and it sets or approves the renewal interval.

The Medicaid managed care organization is the most interesting. It is a private company administering a public benefit under state contract and funded by capitation drawn from federal and state dollars. It is subject to the federal prior authorization conditions by rule.[49] It is also, for exactly that reason, outside the McCarran-Ferguson shelter that protects a commercial insurer, because the practice at issue is governed by federal Medicaid law rather than by state insurance law.

The pharmacy benefit manager is the hardest, and the agency has said why. The proposed drug rule states that its requirements do not apply directly to pharmacy benefit managers, while acknowledging that a manager contracted to conduct prior authorization may perform the compliance work, and that ultimate responsibility for regulatory compliance rests on the payer.[50] A regime in which the entity that performs the challenged act is not directly regulated, and the entity that is regulated did not perform it, is a structure worth naming.

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47. *Id.* at 1208. The court declined to permit plaintiffs to select the most favorable standard among the four statutes Section 1557 incorporates. *Id.*

48. 29 U.S.C. § 794(a); 42 U.S.C. § 18116(a).

49. *See* 91 Fed. Reg. at 19894 (describing the 24 hour covered outpatient drug timeframe as applicable to Medicaid managed care plans).

50. *Id.* at 19898.

The commercial insurer is reachable through Section 1557 where it participates in a federally assisted health program, and *Doe v. CVS Pharmacy* did not resolve whether the particular defendants there received federal financial assistance, remanding that question.[51] The threshold is a factual one and it is where a practitioner's work will be.

1. Program or Activity and the Principally Engaged Entity

The reach question has two parts that are frequently collapsed. The first asks whether an entity receives federal financial assistance. The second asks how far into that entity the resulting obligation extends.

On the second question, the Section 1557 regulation adopts a structure that materially exceeds a funding-follows-the-dollar analysis. Where an entity is principally engaged in the business of providing health care or health insurance coverage, the obligation reaches all of its operations rather than only the funded component.[52] That structure descends from the definition of program or activity that Congress supplied for Section 504 itself, under which assistance to a corporation principally engaged in providing health care reaches the entire corporation.[53]

The consequence for the vertically integrated payer is substantial and it can be worked concretely. An enterprise that owns a retail pharmacy chain, a pharmacy benefit manager, a health insurance issuer carrying Medicare Advantage and Medicaid managed care contracts, and a clinic network billing Medicare is principally engaged in providing and administering health care and health insurance coverage on any reading of the phrase. If the statutory reach follows the corporation, the entity that designs a prior authorization protocol is a covered recipient with respect to that protocol, without regard to which subsidiary booked which federal dollar.

Two cautions attach. The first is that the funding predicate must be pleaded from current receipts, because a Section 504 obligation attaches during the period assistance is received and does not survive the close of that period. A grant that terminated years earlier establishes nothing

51. *Doe v. CVS Pharmacy*, 982 F.3d at 1210 n.3.

52. 45 C.F.R. pt. 92; Nondiscrimination in Health Programs and Activities, 89 Fed. Reg. 37522 (May 6, 2024).

53. 29 U.S.C. § 794(b)(3)(A)(ii).

about present duties. The second is that the 2024 regulation has been the subject of sustained litigation and partial nonenforcement, though the contested provisions concern the scope of sex discrimination rather than disability or the definition of assistance.[54] A claim resting on the regulation should be pleaded so that it does not fall if the regulation does, which is the subject of Part V.E and Part VI.

V. Administration, Not Definition

A. The Methods of Administration Provisions

The Section 504 regulations prohibit a recipient, directly or through contractual or other arrangements, from utilizing criteria or methods of administration that have the effect of subjecting qualified individuals with disabilities to discrimination, or that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program with respect to persons with a disability.[55] Title II carries a parallel provision.[56]

The language is doing something the benefit design cases are not. It reaches the methods by which a program is run, and it reaches effects rather than only intentions. A recipient may define its benefit as it chooses within the bounds of the underlying program statute. How it administers access to the benefit it has defined is a separate question governed by a separate rule.

A second provision in the same subsection fits the renewal interval more exactly, and it has attracted almost no attention in the coverage literature. A recipient shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any program or activity, unless

54. *See, e.g.*, *Texas v. Becerra*, No. 6:24-cv-211 (E.D. Tex.) (staying the 2024 rule as to Texas and Montana); *Tennessee v. Becerra*, No. 1:24-cv-161 (S.D. Miss.) (staying nationwide certain provisions extending sex discrimination to gender identity).

55. 45 C.F.R. § 84.68(b)(3). This provision was redesignated from 45 C.F.R. § 84.4(b)(4) effective July 8, 2024. Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance, 89 Fed. Reg. 40066 (May 9, 2024). Authority decided under the prior designation remains good law.

56. 28 C.F.R. § 35.130(b)(3).

such criteria can be shown to be necessary for the provision of the program or activity being offered.[57]

Three features of that text repay attention. It reaches criteria that tend to screen out, which states an effects standard on its face and requires no showing of intent. It reaches a class of individuals with disabilities, which accommodates a claim brought on behalf of the subpopulation on maintenance therapy rather than requiring an individualized showing. And it supplies a defined defense: necessity for the provision of the program being offered. That defense structure is more favorable to a plaintiff than an open reasonableness inquiry, because it puts the recipient to a showing about the program it actually operates. A state that authorized a therapy for three years, or for the duration of treatment, and then shortened the interval to twelve months for reasons recorded in its own budget documents will have difficulty establishing that twelve months is necessary when its own prior practice was otherwise.

B. Why the Interval Is Administration

Here is the characterization on which this Article rests.

When a Medicaid program requires annual reauthorization of a drug it has covered for a decade, it is not narrowing the benefit. The drug remains covered. The dose remains covered. The medical necessity determination is not revisited on the merits in any meaningful sense, because in the ordinary case the renewal is granted on the same record that supported the original authorization. What the interval does is interpose a recurring administrative procedure between the beneficiary and a benefit the program has already agreed to provide.

That is a method of administration in the ordinary sense of the phrase and in the regulatory sense. It is not the scope of the benefit, which *Choate* places largely beyond Section 504's reach. It is the procedure for obtaining a benefit whose scope is not in dispute.

The distinction is not a semantic maneuver, and it can be tested. Ask what relief the plaintiff seeks. A plaintiff challenging benefit scope asks the program to cover something it does

57. 45 C.F.R. § 84.68(b)(8).

not cover, which is the request *Choate* rejected. A plaintiff challenging the renewal interval asks for continuity in the delivery of something the program already covers. The first request expands the benefit. The second asks that the benefit arrive.

C. Distribution of Burden Inside the Protected Class

A neutral renewal requirement distributes its cost unevenly across the class the statute protects, and the unevenness is not random.

The cost of an interruption is a function of what the drug does. For a course of therapy with a defined endpoint, a gap of several days is an inconvenience. For maintenance therapy sustaining psychiatric stability, seizure control, immunosuppression, or transplant viability, the same gap carries consequences that do not resolve when the medication resumes. A scoping review of prior authorization across six neurologic conditions, including epilepsy, multiple sclerosis, Parkinson disease, and Alzheimer disease, found delays in care to be the most frequently identified consequence for patients, reported in sixty percent of included studies, with increased disease activity reported in twenty-five percent.[58] The categories the Illinois legislature singled out for utilization control are, without exception, categories of the second kind.

The delay is not incidental to the design and it is measurable. In an analysis of more than 200,000 branded medication dispensations that faced an initial prior authorization rejection in 2024, thirty-five percent were processed within one day and the remainder took a median of six days, with an interquartile range of three to twelve; fewer than half of the total were approved on the first review. Two findings in that study bear directly on the argument here. Medicaid beneficiaries had lower approval rates than other patients. And prescriptions that were refills, which is to say continuing rather than new therapy, were less likely to be processed the same day than new prescriptions.[59] A system that moves more slowly for the patient who has been on the drug longest is not calibrated to clinical risk.

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58. Evelyn Gotlieb, Leah J. Blank & Nathalie Jetté, *Barriers and Consequences of Prior Authorization for Neurologic Medications*, 83 JAMA Neurology 181, 181 (2026).

59. Yang Wang, Joseph Levy & T. Joseph Mattingly, *Prior Authorization and Associated Delays and Denials of Branded Medication Dispensation*, 7 JAMA Health Forum e260760 (2026).

The cost of completing the renewal is a function of what the disability does. The procedure requires tracking an expiration date that no one announces, reaching a prescriber's office by telephone during business hours, following a document through offices that do not communicate with one another, and doing it again in a year. Executive function impairment, agoraphobia, psychiatric disability, cognitive disability, and communication disability each raise the cost of that sequence. The burden also lands on the patient personally rather than on the clinician alone: in a survey of patients who had experienced prior authorization for cancer care, sixty-seven percent reported having to become personally involved in the process, twenty percent reported spending eleven or more hours on it, and self-reported anxiety during the process was roughly double respondents' usual anxiety.[60]

The result is a policy that is neutral on its face and inverted in effect: it imposes the heaviest procedural burden on the beneficiaries least able to carry it and most harmed by failing. That is the shape of a meaningful access claim under *Choate* as *Doe v. CVS Pharmacy* applied it, and it does not require a showing that the deprivation is unique or severe.[61]

D. The Targeting Objection

The strongest defense of a renewal requirement is not that it is harmless. It is that the difficulty is the point, and that the difficulty does useful work.

That position has a literature behind it. Nichols and Zeckhauser argued that qualification tests and tedious administrative procedures perform a sorting function, imposing costs that the less needy will decline to bear while the intended beneficiaries persist.[62] On that account the burden is a revealed preference instrument. A beneficiary who completes the renewal has demonstrated that the drug is worth the trouble, and one who does not has supplied information

60. Fumiko Chino et al., *The Patient Experience of Prior Authorization for Cancer Care*, 6 JAMA Network Open e2338182 (2023).

61. *Doe v. CVS Pharmacy*, 982 F.3d at 1212.

62. Albert L. Nichols & Richard J. Zeckhauser, *Targeting Transfers Through Restrictions on Recipients*, 72 Am. Econ. Rev. 372, 376 (1982) (Papers & Proceedings), *quoted in* Carolyn J. Heinrich et al., *Consequences of Administrative Burden for Social Safety Nets that Support the Healthy Development of Children*, 41 J. Pol'y Analysis & Mgmt. 11 (2022) (examining safety net access through the administrative burden and ordeals lens). The interior pin is as attributed by Heinrich; the reporter and page span are independently confirmed.

about valuation that the program could not otherwise obtain. The costs are conceded and defended as the price of targeting scarce funds accurately.

The objection deserves to be stated at full strength for two reasons. It is the most respectable justification available to a state defendant, and it moves decisionmakers. In a survey experiment among local politicians, justifications increased tolerance for administrative burdens, with budget protection the most effective and targeting the neediest also showing effect.[63] A court will hear this argument.

It fails here, for three reasons that operate independently.

The first is that the sorting logic requires an assumption the disability context reverses. An ordeal targets accurately only where the cost of bearing it falls as need rises. The administrative burden literature identifies the opposite relationship and names the mechanism. Scarcity, health problems, and cognitive decline create what one group of authors call a human capital catch-22, increasing the likelihood that a person needs state assistance while simultaneously undermining the executive functioning required to negotiate the burdens encountered in seeking it.[64] Where that holds, frictions do not sort on need and instead fall hardest on the disadvantaged.[65] That literature also holds that administrative burdens frequently reinforce existing social inequality rather than correcting for it.[66] A population defined by disability is the case in which the assumption is least likely to hold, because the traits that establish membership in the class are frequently the same traits that raise the cost of the procedure.

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63. A. Halling & S. Van de Walle, *Do Justifications Affect Tolerance for Administrative Burdens? Evidence From a Survey Experiment Among Policymakers*, 60 Soc. Pol'y & Admin. 12, 12 (2025).

64. J. Christensen et al., *Human Capital and Administrative Burden: The Role of Cognitive Resources in Citizen-State Interactions*, 80 Pub. Admin. Rev. 127, 127 (2020).

65. J. K. Madsen, K. S. Mikkelsen & D. P. Moynihan, *Burdens, Sludge, Ordeals, Red Tape, Oh My!: A User's Guide to the Study of Frictions*, 100 Pub. Admin. 375 (2022) (comparing four accounts of friction, including ordeal mechanisms and administrative burden, and distinguishing them by their predicted distributive effects).

66. M. Chudnovsky & R. Peeters, *The Unequal Distribution of Administrative Burden: A Framework and an Illustrative Case Study for Understanding Variation in People's Experience of Burdens*, 55 Soc. Pol'y & Admin. 527 (2021).

The second reason is specific to renewal and does not depend on the first. An ordeal purchases information about how much the applicant values the benefit. For a maintenance regimen that information is already in the program's possession. A beneficiary who has filled the same prescription at the same dose for a decade has revealed the valuation continuously, in claims data the program generated, paid, and holds. Charging that person an annual fee in time and stress to disclose a preference the program has already recorded is not targeting. It is collecting the same fact twice and pricing the second collection in interrupted therapy.

The third reason is that the review is not performing the screening function the justification assumes. In a cohort of patients prescribed infusible medications for rheumatologic conditions, seventy-one percent of prescriptions required prior authorization and twenty-one percent of those were initially denied, yet ninety-six percent of all requests were ultimately approved; the authors concluded that the value of the requirement and its effect on patient safety should be reevaluated.[67] A gate that opens for nearly everyone who reaches it is not sorting the population passing through. It is delaying it.

The legal consequence follows without needing to resolve the policy dispute. Under the effects standard the question is what the practice does rather than what it was meant to do,[68] and a targeting rationale that does not target answers neither the effects question nor the necessity showing that the eligibility criteria provision requires.[69]

E. Pleading the Claim So It Survives the Regulation

An argument that rests entirely on a regulation is only as durable as the regulation, and the disparate impact regulations across the federal civil rights statutes are presently under active revision. In July 2026 the Department rescinded portions of its Title VI regulations to conform to

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67. Zachary S. Wallace et al., *Treatment Delays Associated With Prior Authorization for Infusible Medications: A Cohort Study*, 72 Arthritis Care & Rsch. 1543, 1543 (2020) (concluding that because the great majority of requests are ultimately approved, the value of prior authorization requirements and their impact on patient safety should be reevaluated, and also finding that denials were associated with greater glucocorticoid exposure in the following three months).

68. 45 C.F.R. § 84.68(b)(3).

69. *Id.* § 84.68(b)(8).

an executive order directing agencies to reconsider disparate impact liability.[70] The Section 504 regulations at 45 C.F.R. part 84 remain in force as of this writing, and the provisions relied on here carry an effective date of July 8, 2024.[71] Prudence counsels against assuming that condition is permanent.

The claim developed here does not depend on it. *Choate* construed the statute. Its holding that Section 504 requires meaningful access to the benefit provided is a judicial construction of 29 U.S.C. § 794, and the Court reached it while expressly declining to rest on the implementing regulations.[72] An agency that withdraws a regulation does not thereby amend a Supreme Court construction of the statute the regulation implements.

The distinction from Title VI is also load bearing and should be stated rather than assumed. Disparate impact claims under Title VI rest on regulations rather than on the statute, and the Supreme Court held that no private right of action exists to enforce them.[73] Section 504 is differently situated, and at least one circuit has so held.[74] The partial dissent in that case reads the statutory phrases against the majority, reasoning that Title II bars discrimination only because of or due to disability status and therefore requires intentional discrimination, and that Section 504's phrase solely by reason of makes the point clearer still.[75]

The drafting consequence is straightforward. Plead the statute first and the regulation second. Cite 45 C.F.R. § 84.68(b)(3) and (b)(8) as the Department's contemporaneous

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70. Rescinding Portions of the U.S. Department of Health and Human Services Title VI Regulations To Align With the Statutory Text and Conform to Executive Order 14281, 91 Fed. Reg. 46746 (July 24, 2026) (RIN 0945-AA29).

71. 45 C.F.R. § 84.68 (eff. July 8, 2024).

72. *Choate*, 469 U.S. at 301.

73. *Alexander v. Sandoval*, 532 U.S. 275, 293 (2001) (holding that Title VI displays no intent to create a freestanding private right of action to enforce regulations promulgated under Section 602).

74. *Payan v. Los Angeles Cmty. Coll. Dist.*, 11 F.4th 729, 740 (9th Cir. 2021) (holding, after supplemental briefing directed to the question, that a private right of action exists to enforce disparate impact regulations under Title II of the ADA and Section 504, and reasoning that disability classifications draw rational basis review and that the statutes were addressed to thoughtless indifference rather than only to animus).

75. *Id.* (Lee, J., dissenting in part). That reading deserves an answer rather than silence, and the answer does not depend on the regulations. *Choate* construed the statute to require meaningful access while acknowledging that Section 504 does not reach every disparate effect, which is a construction the dissent's reading cannot accommodate without treating the Supreme Court's own qualification as surplusage. *See Choate*, 469 U.S. at 299.

articulation of a standard the Supreme Court had already located in the statute, rather than as the source of the obligation.

VI. The Second Track: Failure to Modify

A. Why a Second Track

Everything developed to this point runs on one engine. A facially neutral practice distributes its burden unequally inside the protected class, and the recipient answers for the effect. That is a disparate impact claim however it is labeled, and it carries two dependencies that a litigant should not want in a single-track complaint.

The first is doctrinal. *Sandoval* foreclosed private enforcement of disparate impact regulations under Title VI, and the answer for Section 504 rests on circuit authority rather than on a holding of the Supreme Court.[76] The second is regulatory. The impact provisions across the federal civil rights statutes are under active reconsideration, and the Department has already rescinded portions of its Title VI regulations on that basis.[77]

A second theory exists that carries neither dependency, and it has been available the entire time.

B. The Provisions and What Distinguishes Them

Each of the three statutes requires reasonable modification of policies, practices, or procedures where modification is necessary to avoid discrimination on the basis of disability, subject to a fundamental alteration defense.[78] The obligation is not a disparate impact obligation. It does not require proof that a neutral rule fell unequally on a group, and it does not depend on the impact regulations remaining in force. It asks whether a policy operated as a barrier to this claimant

76. *Payan*, 11 F.4th at 740; *cf. Sandoval*, 532 U.S. at 293.

77. 91 Fed. Reg. 46746 (July 24, 2026).

78. 45 C.F.R. § 84.68(b)(7)(i) (recipients); 28 C.F.R. § 35.130(b)(7)(i) (public entities); 42 U.S.C. § 12182(b)(2)(A)(ii) (public accommodations).

and whether an available change to it would remove the barrier without altering the nature of the program.

The Ninth Circuit drew the operative distinction while separating the two theories in the same litigation that supplies this Article's impact anchor. A claim for accommodation is directed at an individualized request or need, while modification sought in response to a disparate impact finding is directed at changing a policy or practice to improve systemic accessibility.[79] A complaint may occupy both positions. The class allegation attacks the interval as a systemic barrier. The individual allegation asks that this beneficiary's authorization be handled differently because the standard procedure does not work for this beneficiary.

C. What the Modification Is

A modification claim requires the claimant to identify the modification, which is a discipline the impact claim does not impose and which improves the complaint in both tracks.

Several are available and none of them asks the program to cover a drug it does not cover. Authorization may be granted coextensive with the course of therapy for a maintenance regimen, which is a duration many programs already use for some drugs. Renewal may be triggered by a change in the clinical picture rather than by a date, which preserves the utilization review the state says it wants while removing the calendar as the trigger. Renewal may be initiated by the program on the pharmacy claims record it already holds, rather than by the beneficiary on a form. Notice may issue with lead time sufficient to complete the process, in a format the beneficiary can act on. The emergency supply the statute already requires may be dispensed automatically on a rejected claim rather than on request.[80]

The ordering above is not arbitrary, and a claimant should be prepared to explain why. Across fifty-one field experiments reporting 187 effect sizes, interventions that reduced compliance demands by supplying assistance raised actual benefit receipt by an estimated 8.31 percentage points on average, while interventions that reduced learning demands by supplying

79. *Payan*, 11 F.4th at 740.

80. 42 U.S.C. § 1396r-8(d)(5)(B).

information raised it by 3.39 points.[81] Notice is a learning intervention and belongs in the request; the modifications that carry the most weight are the ones that remove the compliance step entirely. Automatic enrollment is the most effective format studied in the parallel context of a simplified benefit process,[82] and a study of administrative rules across three American safety net programs found that provisions automating enrollment and renewal were among those most associated with higher program inclusivity.[83] Program-initiated renewal off the claims record is the automation analogue in this setting, and it is the modification a plaintiff should lead with.

The fundamental alteration defense is the state's answer, and it is weaker here than in the ordinary case. The defense asks whether the modification would alter the nature of the program. A state that already grants multi-year authorizations for some therapies has conceded that a longer interval is within the nature of the program it operates. A state that reviews utilization on a clinical trigger elsewhere in its own scheme has conceded the same about triggers. The defense is available where the modification would dismantle utilization review altogether, and none of the modifications above does that. A state that answers by describing the review it would lose must also account for the approval rate that review produces, because a process that ultimately approves nearly every request it receives cannot have been doing much of what the defense claims would be lost.[84]

D. Two Tracks, One Record

The tracks share a factual record and do not share a legal fate. The same evidence establishes both: what the interval is, what completing it requires, who fails to complete it, what happens to them when they do, and what the program does for other drugs and other beneficiaries.

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81. Karl-Emil Bendtsen, *Increasing Take-Up of Social Benefits: A Meta-Analysis of Field Experiments*, 45 J. Pol'y Analysis & Mgmt. e70085 (2026).

82. Rosa Kleinman, *Transaction Costs and the Take-Up of Social Safety Net Programs: Evidence From the Combined Application Project*, 45 J. Pol'y Analysis & Mgmt. e70086 (2026) (finding that a joint-filing and automatic-enrollment format most effectively increased take-up among a categorically eligible population).

83. Ashley Fox, Wenhui Feng & Megan Reynolds, *The Effect of Administrative Burden on State Safety-Net Participation: Evidence From Food Assistance, Cash Assistance, and Medicaid*, 83 Pub. Admin. Rev. 367, 367 (2023).

84. *See* Wallace et al., *supra* note 67, at 1543.

What differs is exposure. If disparate impact liability under Section 504 is narrowed by rulemaking or by a court that reads the statutory phrases as the *Payan* dissent does, the first track contracts and the second is untouched, because the modification obligation is stated in the statutes and rests on no impact theory. If the modification claim founders on the fundamental alteration defense, the impact claim proceeds on effects without needing to identify any particular fix. Neither outcome takes the case.

VII. The Procedural Question: Expiration as Non-Decision

Medicaid beneficiaries are entitled to notice and an opportunity for a hearing when the agency takes action to terminate, suspend, or reduce covered services, and to continuation of benefits pending the hearing where the request is timely.[85]

An expiring prior authorization produces the same practical result as a reduction in services and attracts none of these protections, because the agency has not decided anything. The authorization ran its term. No adverse action issued. There is nothing to notice and nothing to appeal until a renewal request is submitted and denied, and the interruption occurs in the interval before that happens.

The characterization is the whole of it. A beneficiary who has received a drug continuously for years, and who stops receiving it because a form expired, has experienced a reduction in services in every sense the protections were written to address. Whether the agency reached that result by deciding or by declining to decide is a fact about the agency's internal process rather than a fact about the beneficiary's access to care. The doctrinal question is whether the notice and hearing provisions attach to agency action as a formal category or to the practical deprivation they exist to prevent, and it has not been litigated as such.

85. 42 C.F.R. §§ 431.220, 431.230(b); *see Goldberg v. Kelly*, 397 U.S. 254, 264 (1970) (holding that termination of public assistance benefits without a prior evidentiary hearing denies procedural due process).

VIII. Remedy

Cummings v. Premier Rehab Keller held that emotional distress damages are unavailable under the Spending Clause antidiscrimination statutes.[86] The holding is a serious constraint here, because interrupted psychiatric or neurological medication produces harm that presents in exactly the register *Cummings* forecloses.

The constraint is not total. Compensatory damages remain available for economic harm, and at least two circuits have sustained recovery for lost opportunities as economic rather than emotional harm.[87] The live question after *Payan* is what counts as a lost opportunity, which is a question about the scope of the right wearing the clothes of a question about remedy.

For a plaintiff in this posture the practical guidance follows from that. Concede emotional distress. Plead the economic consequences of interruption with specificity: missed work, lost employment, emergency department utilization, hospitalization, and the cost of obtaining the drug outside the program. Seek injunctive and declaratory relief as the primary remedy, because the practice recurs annually and the relief that matters is prospective.

IX. Conclusion

The prior authorization literature and the reform effort are both organized around speed. How quickly must a payer decide, in what format must the request arrive, and what must the denial say. The April 2026 proposed rule is a careful and substantial contribution to that project and it will improve conditions for a great many people.

It leaves the renewal interval exactly where it found it. A federal scheme that regulates the velocity of a decision and says nothing about its frequency has addressed the experience of a person seeking a new therapy and has not addressed the experience of a person who has been

86. *Cummings v. Premier Rehab Keller, P.L.L.C.*, 596 U.S. 212 (2022).

87. *Payan v. Los Angeles Cmty. Coll. Dist.*, 169 F.4th 971, 977–79 (9th Cir. 2026) (holding that *Cummings* bars emotional distress damages under Title II through the incorporation chain at 42 U.S.C. § 12133 and 29 U.S.C. § 794a(a)(2), while preserving compensatory damages for lost educational opportunities as economic harm); *A.W. ex rel. J.W. v. Coweta Cnty. Sch. Dist.*, 110 F.4th 1309, 1315–16 (11th Cir. 2024).

on the same therapy for a decade. The second person is the more common case in a disability population, and for that person the burden is not that the decision is slow. It is that the decision recurs.

Section 504 reaches this, and it reaches it through a characterization the case law has not yet been asked to make. Recurring prior authorization is a method of administering access to a benefit already granted. It is analyzed under the provisions that govern methods of administration, where the question is effect rather than intent, and where *Choate*'s meaningful access standard is the operative test rather than an obstacle. A program may set its formulary. What it may not do is administer access to that formulary in a manner whose effect falls hardest on the beneficiaries the program exists to serve.

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❧ ❧