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

Nothing Changed But the Calendar

Recurring prior authorization as a methods of administration violation under Section 504 and Section 1557

Federal law says how fast a payer must decide. It says nothing about how often a beneficiary must ask again.

Travis Gilly, *Nothing Changed But the Calendar: Recurring Prior Authorization as a Methods of Administration Violation Under Section 504 and Section 1557*, working paper, July 2026 (v0.9)

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ONE JANUARY

A physician writes a prescription. The patient has taken the same drug at the same dose for years. The state has paid for it 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.*

SOURCES 42 U.S.C. § 1396r-8(d)(5); 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 440.230(d).

THE CLAIM IN ONE LINE

Recurring prior authorization administers access to a benefit already granted. It does not define the benefit.

WHERE THE ANALYSIS USUALLY GOES

Benefit design

Scope, amount, duration. This is the ground on which *Choate* defeated a challenge to a fourteen day inpatient cap, and it is largely beyond Section 504's reach.

WHERE THIS CLAIM GOES

Methods of administration

The procedure for obtaining a benefit whose scope is not in dispute. Here the regulation asks what a practice does, not what it was meant to do.

A plaintiff challenging benefit scope asks the program to cover something it does not cover. A plaintiff challenging the renewal interval asks that a benefit the program already covers actually arrive.

SOURCES 45 C.F.R. § 84.68(b)(3), (b)(8); 28 C.F.R. § 35.130(b)(3); *Alexander v. Choate*, 469 U.S. 287, 301-03 (1985).

II

The Architecture of Recurring Prior Authorization

What federal law permits, conditions, and leaves alone

The most consequential parameter of the practice is the one parameter federal law leaves entirely unregulated.

THE PERMISSION, AND ITS PRICE

A state may require prior authorization for any covered outpatient drug. Two conditions come with the permission.

They 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.

24 **hours to respond**, by telephone or other telecommunication device.

72 **hours of supply**, dispensed in an emergency situation as defined by the Secretary.

0 **words on renewal.** Federal law says nothing about how often an authorization must be obtained again.

SOURCES 42 U.S.C. § 1396r-8(d)(5)(A)-(B); Medicare and Medicaid Programs; Interoperability Standards and Prior Authorization for Drugs, 91 Fed. Reg. 19890, 19894 (proposed Apr. 14, 2026).

THE BACKSTOP, READ TWO WAYS

One federal sentence, two state readings.

ILLINOIS

Available when staff are unavailable

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.

NORTH CAROLINA

Can and should, without a cap

A pharmacy can and should provide a 72 hour supply where a member needs medication immediately while awaiting a decision, and there is no limit on the number of times it may be dispensed while the authorization is pending.

> *The beneficiary's access to the statutory backstop depends on which state administers the program, and on whether a pharmacist knows the override exists.*

SOURCES Ill. Dep't of Healthcare & Family Servs., *Four Prescription Policy* (last visited July 31, 2026); N.C. Medicaid, *Pharmacy Frequently Asked Questions* (last visited July 31, 2026) (citing 42 U.S.C. § 1396r-8(d)(5)(B)).

THREE MECHANISMS, ONE PATIENT

Only one of the three has anything to do with the person taking the drug.

1

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.

2

The supplemental rebate contract

When a drug moves from preferred to non-preferred, prior authorization attaches to it. The clinical facts are unchanged. What changed was the state's purchasing position.

3

Re-verification of medical necessity

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 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. Each of those is a class of chronic maintenance therapy for a serious or disabling condition.

SOURCES Ill. Dep't of Healthcare & Family Servs., *Criteria and Forms* (describing Public Act 097-0689) (last visited July 31, 2026); Ill. Dep't of Healthcare & Family Servs., *Four Prescription Policy* (last visited July 31, 2026).

THE 2024 RULE, AND THE 2026 PROPOSAL

The reform regulates the velocity of a decision. It says nothing about its frequency.

FEBRUARY 2024

Impacted payers, including state Medicaid fee-for-service programs and Medicaid managed care plans, must decide standard requests within seven calendar days and expedited requests within 72 hours, and state a specific reason for every denial. None of it applies to drugs.

WHAT COMMENTERS SAID

As the agency later summarized the record, 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.

APRIL 2026

The agency proposed to extend electronic prior authorization, denial reason requirements, and decision timeframes to drugs, with a proposed compliance date of October 1, 2027. The renewal interval survives the reform untouched.

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

SOURCES Advancing Interoperability and Improving Prior Authorization Processes, 89 Fed. Reg. 8758, 8878, 8897 (Feb. 8, 2024); Interoperability Standards and Prior Authorization for Drugs, 91 Fed. Reg. 19890, 19891-94 (proposed Apr. 14, 2026).

III

Title III and the Payer

Three closures, and one narrow opening

The shape of the surviving claim depends on knowing precisely which door is closed.

WHY THE NATURAL INFERENCE FAILS

An insurance office is on the list. That does not put utilization management inside Title III.

CLOSURE ONE

Access, not content

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. An insurer cannot refuse to sell to a person with AIDS. What the statute does not do is dictate what the product contains.

CLOSURE TWO

A benefit plan is not a place

Beneficiaries living with HIV and AIDS challenged a specialty pharmacy program requiring mail or designated pickup. The Title III claim failed at the threshold. A prior authorization practice is a term of plan administration, and the plan is the thing the courts have said is not a place.

CLOSURE THREE

McCarran-Ferguson

Direct conflict is not required; it is enough that the interpretation would interfere with a state's administrative regime. Deciding whether coverage limits are actuarially sound would place federal courts in the domain of state insurance commissioners.

Each is settled enough that a complaint pleading around none of them will be dismissed. But McCarran-Ferguson closes the private insurance door only. Medicaid prior authorization is authorized, conditioned, and constrained by federal statute and federal rule, so no state insurance regime governs it.

SOURCES 42 U.S.C. §§ 12181(7)(F), 12182(a); *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557, 559, 563-64 (7th Cir. 1999) (quoting *Humana Inc. v. Forsyth*, 525 U.S. 299, 310 (1999)); *Doe v. CVS Pharmacy, Inc.*, 982 F.3d 1204, 1213 (9th Cir. 2020) (citing *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1115 (9th Cir. 2000)); *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); 15 U.S.C. § 1012(b).

THE DEEPER LIMIT ON BOTH DEFENSES

Both defenses are addressed to risk. Prior authorization is not a risk practice.

THE STAGES THE STATUTES NAME

Underwriting precedes assumption of the risk.

Classification sorts applicants among pools.

Administration of risks, read in the company of the two terms preceding it, means management of the risk relationship those determinations establish.

WHERE THE RENEWAL SITS

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 it in those terms: payers establish prior authorization to help control costs and ensure payment accuracy. That is expenditure control rather than risk allocation.

> *A defendant invoking either provision must establish at the threshold that the challenged practice is a risk practice. A recurring renewal requirement imposed on a covered beneficiary for a covered drug is not one, and that holds against a commercial insurer as readily as against a state agency.*

SOURCES 15 U.S.C. §§ 1011-1012(b); 42 U.S.C. § 12201(c)(1)-(2); Interoperability Standards and Prior Authorization for Drugs, 91 Fed. Reg. 19890, 19899 (proposed Apr. 14, 2026).

WHAT SURVIVES THE CLOSURES

The harbor shelters practices that price a risk. It does not shelter practices calibrated to produce departure.

THE SUBTERFUGE LIMIT

The safe harbor paragraphs shall not be used as a subterfuge to evade the purposes of Titles I and III. The worked example given was a cap adopted to deter people who know they are HIV positive from buying the policies at all. What made that a subterfuge was not harshness. It was calibration to produce departure.

THE ATTRITION THEORY

A renewal requirement a program knows will not be completed by some determinate fraction of the beneficiaries subject to it reduces utilization by reducing the number of people who successfully claim the benefit. Where the failure rate is known, and the population that fails is defined by the disabilities that make the procedure difficult, the practice produces departures rather than measuring risk.

THE EVIDENCE, AND THE HOLE IN IT

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. 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 cannot count the beneficiaries the renewal interval removes.

SOURCES 42 U.S.C. § 12201(c); *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557, 559, 563 (7th Cir. 1999) (citing *Carparts Distribution Ctr., Inc. v. Auto. Wholesaler's Ass'n of New Eng., Inc.*, 37 F.3d 12, 19 (1st Cir. 1994)); 89 Fed. Reg. 8758, 8897 (Feb. 8, 2024); 91 Fed. Reg. 19890, 19896-97 (proposed Apr. 14, 2026).

TWO STATUTES, TWO QUESTIONS

Equal access to a procedure is not access to the benefit the procedure guards.

THE MEASURE	TITLE III	SECTION 504
The question	Can the person transact on equal terms, including the right to buy on equal terms and not only to enter the store?	Was the person afforded meaningful access to the benefit provided?
Applied to the renewal	Same notice, or the same absence of one. Same form, same channels, same terms. Nobody turned away, nobody charged more.	For the subpopulation that cannot reliably complete the procedure, the answer does not improve because the procedure was administered evenhandedly.
Result	The inquiry is finished.	The inquiry begins.

Evenhanded administration of a barrier is the fact pattern *Choate* addressed. It is the premise of a meaningful access claim rather than an answer to one.

SOURCES *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557, 563 (7th Cir. 1999); *Alexander v. Choate*, 469 U.S. 287, 301 (1985); *Doe v. CVS Pharmacy, Inc.*, 982 F.3d 1204, 1211-13 (9th Cir. 2020).

THE ONE OPEN LANE

Whatever the courts have said about benefit plans, no court has held that a pharmacy is not a place.

WHAT THE LANE COVERS

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 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.

The methods of administration rule also reaches criteria originating with an entity under common administrative control, and conduct performed directly or through contractual or other arrangements. That forecloses the argument that a chain is merely executing someone else's rule.

THE LIMITS, STATED NOT 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. That governs any complaint attacking the authorization requirement as such.

Two features are still worth something: a defendant with retail premises in the plaintiff's own community, and regulations whose text does not depend on disparate impact liability surviving the current round of rulemaking.

SOURCES 42 U.S.C. § 12181(7)(F); 28 C.F.R. § 36.301(a); 28 C.F.R. § 36.204; *Doe v. CVS Pharmacy, Inc.*, 982 F.3d 1204, 1213 (9th Cir. 2020).

IV

The Right Door

Section 504, Section 1557, and meaningful access

The same program design, challenged in the same complaint by the same plaintiffs, failed under Title III and survived under Section 504.

CHOATE, READ FOR WHAT IT SUPPLIED

Section 504 requires meaningful access to the benefit provided.

The case is ordinarily cited against disability plaintiffs challenging benefit limits, and in its own facts it was: it sustained a fourteen day annual limit on inpatient hospital coverage. Reading it only that way misses what the opinion supplied.

FACIALLY NEUTRAL IS NOT A DEFENSE

The fact that a benefit is facially neutral does not dispose of a claim based on lack of meaningful access, and the unique impact of a neutral policy on people with disabilities may give rise to one where services, programs, and activities remain open and easily accessible to others.

THE PLEADING BURDEN

Lighter than defendants generally assert. The 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.

SOURCES *Alexander v. Choate*, 469 U.S. 287, 289, 301-03 (1985); *Doe v. CVS Pharmacy, Inc.*, 982 F.3d 1204, 1211-12 (9th Cir. 2020) (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)).

THE ARGUMENT IN MINIATURE

One complaint, one program design, two opposite results.

DISMISSED

The Title III claim

Failed because a benefit plan is not a place of public accommodation.

SUSTAINED

The Section 504 claim

Survived because the plaintiffs adequately alleged that a prescription drug program denied them meaningful access to their drug benefit.

Section 1557 carries that standard into health programs and activities receiving federal financial assistance. The court held that Section 1557 does not create a new healthcare specific antidiscrimination standard, and that a disability plaintiff proceeding under it must allege facts adequate to state a claim under Section 504, declining to let plaintiffs select the most favorable of the four statutes Section 1557 incorporates. 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 Section 504 alone might not capture.

SOURCES *Doe v. CVS Pharmacy, Inc.*, 982 F.3d 1204, 1208, 1211-13 (9th Cir. 2020); 29 U.S.C. § 794(a); 42 U.S.C. § 18116(a).

WHO IS THE RECIPIENT

Four defendants, differently situated.

The state Medicaid agency

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 managed care organization

A private company administering a public benefit under state contract, funded by capitation drawn from federal and state dollars, subject to the federal timeframes by rule, and outside the McCarran-Ferguson shelter for that same reason.

The pharmacy benefit manager

The hardest, and the agency has said why. The proposed rule does not apply directly to managers, while acknowledging that a manager contracted to conduct prior authorization may perform the compliance work and that ultimate responsibility rests on the payer.

The commercial insurer

Reachable through Section 1557 where it participates in a federally assisted health program. Whether particular defendants receive assistance was left open on remand, and the threshold is factual.

> *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.*

SOURCES 29 U.S.C. § 794(a); 42 U.S.C. § 18116(a); 91 Fed. Reg. 19890, 19894, 19898 (proposed Apr. 14, 2026); *Doe v. CVS Pharmacy, Inc.*, 982 F.3d 1204, 1210 n.3 (9th Cir. 2020).

HOW FAR THE OBLIGATION REACHES

Where the entity is principally engaged in health care or coverage, the duty reaches all of its operations.

That structure materially exceeds a funding-follows-the-dollar analysis, and it descends from the definition of program or activity Congress supplied for Section 504 itself, under which assistance to a corporation principally engaged in providing health care reaches the entire corporation.

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 on any reading of the phrase. If the reach follows the corporation, the entity that designs the protocol is a covered recipient with respect to that protocol, without regard to which subsidiary booked which federal dollar.

TWO CAUTIONS

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

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.

SOURCES 45 C.F.R. pt. 92; Nondiscrimination in Health Programs and Activities, 89 Fed. Reg. 37522 (May 6, 2024); 29 U.S.C. § 794(b)(3)(A)(ii); *Texas v. Becerra*, No. 6:24-cv-211 (E.D. Tex.); *Tennessee v. Becerra*, No. 1:24-cv-161 (S.D. Miss.).

V

Administration, Not Definition

The characterization on which the claim rests

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.

TWO PROVISIONS, ONE SUBSECTION

The text reaches the methods by which a program is run, and it reaches effects rather than intentions.

45 C.F.R. § 84.68(B)(3)

Methods of administration

No recipient may, directly or through contractual or other arrangements, use criteria or methods of administration that have the effect of subjecting qualified individuals with disabilities to discrimination, or the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to persons with a disability.

45 C.F.R. § 84.68(B)(8)

Eligibility criteria

No recipient may 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 the criteria can be shown to be necessary for the provision of the program being offered.

THREE FEATURES OF (B)(8)

Tend to screen out states an effects standard on its face and requires no showing of intent.

A class accommodates a claim brought for the subpopulation on maintenance therapy.

Necessity is a defined defense, 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.

SOURCES 45 C.F.R. § 84.68(b)(3), (b)(8) (redesignated from 45 C.F.R. § 84.4(b)(4) eff. July 8, 2024; Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance, 89 Fed. Reg. 40066 (May 9, 2024)); 28 C.F.R. § 35.130(b)(3).

THE TEST THAT SEPARATES THE TWO

Annual reauthorization of a drug covered for a decade does not narrow the benefit. It interposes a procedure.

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.

A BENEFIT SCOPE CHALLENGE

Asks the program to cover something it does not cover. That is the request *Choate* rejected, and it expands the benefit.

A RENEWAL INTERVAL CHALLENGE

Asks for continuity in the delivery of something the program already covers. It does not expand the benefit. It asks that the benefit arrive.

SOURCES 45 C.F.R. § 84.68(b)(3); *Alexander v. Choate*, 469 U.S. 287, 302-03 (1985).

NEUTRAL ON ITS FACE, INVERTED IN EFFECT

The heaviest procedural burden lands on the beneficiaries least able to carry it and most harmed by failing.

60%

of studies in a scoping review across six neurologic conditions identified delays in care as a consequence for patients, the most frequently identified one. Increased disease activity appeared in twenty-five percent.

6

days, the median wait for the rejected dispensations not processed within one day, of more than 200,000 branded medications facing an initial rejection in 2024. Interquartile range three to twelve.

67%

of patients surveyed about prior authorization for cancer care reported having to become personally involved in the process. Twenty percent spent eleven or more hours on it, and reported anxiety ran roughly double their usual level.

Refills

were less likely to be processed the same day than new prescriptions, and Medicaid beneficiaries had lower approval rates than other patients. A system that moves more slowly for the patient who has been on the drug longest is not calibrated to clinical risk.

The cost of interruption tracks 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.

The cost of completing it tracks what the disability does. Tracking an expiration date nobody announces, reaching a prescriber by telephone during business hours, following a document through offices that do not communicate, and doing it again in a year. Executive function impairment, agoraphobia, psychiatric, cognitive, and communication disability each raise that cost.

SOURCES Evelyn Gotlieb, Leah J. Blank & Nathalie Jetté, *Barriers and Consequences of Prior Authorization for Neurologic Medications*, 83 JAMA Neurology 181 (2026); Yang Wang, Joseph Levy & T. Joseph Mattingly, *Prior Authorization and Associated Delays and Denials of Branded Medication Dispensation*, 7 JAMA Health Forum e260760 (2026); Fumiko Chino et al., *The Patient Experience of Prior Authorization for Cancer Care*, 6 JAMA Network Open e2338182 (2023); *Doe v. CVS Pharmacy, Inc.*, 982 F.3d 1204, 1212 (9th Cir. 2020).

THE OBJECTION AT FULL STRENGTH

“The difficulty is the point, and the difficulty does useful work.”

That position has a literature behind it. 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. On that account the burden is a revealed preference instrument: a beneficiary who completes the renewal has demonstrated the drug is worth the trouble, and one who does not has supplied information about valuation the program could not otherwise obtain.

WHY IT DESERVES FULL STRENGTH

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.

WHAT FOLLOWS

A court will hear this argument. The costs are conceded and defended as the price of targeting scarce funds accurately, so the answer has to engage the sorting logic rather than the sincerity.

SOURCES Albert L. Nichols & Richard J. Zeckhauser, *Targeting Transfers Through Restrictions on Recipients*, 72 Am. Econ. Rev. 372, 376 (1982), *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); A. Halling & S. Van de Walle, *Do Justifications Affect Tolerance for Administrative Burdens?*, 60 Soc. Pol'y & Admin. 12 (2025).

THREE REASONS IT FAILS HERE

A targeting rationale that does not target answers neither the effects question nor the necessity showing.

1

The assumption reverses

An ordeal targets accurately only where the cost of bearing it falls as need rises. The literature identifies the opposite: scarcity, health problems, and cognitive decline create a human capital catch-22, raising the likelihood a person needs assistance while undermining the executive functioning required to negotiate the burdens encountered in seeking it. A population defined by disability is the case where the assumption is least likely to hold.

2

The program already has the information

An ordeal purchases information about how much the applicant values the benefit. A beneficiary who has filled the same prescription at the same dose for a decade has revealed that valuation continuously, in claims data the program generated, paid, and holds. Charging that person an annual fee in time and stress is collecting the same fact twice and pricing the second collection in interrupted therapy.

3

The gate is not screening

In a cohort 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. A gate that opens for nearly everyone who reaches it is not sorting the population passing through. It is delaying it.

SOURCES J. Christensen et al., *Human Capital and Administrative Burden*, 80 Pub. Admin. Rev. 127 (2020); J. K. Madsen, K. S. Mikkelsen & D. P. Moynihan, *Burdens, Sludge, Ordeals, Red Tape, Oh My!*, 100 Pub. Admin. 375 (2022); M. Chudnovsky & R. Peeters, *The Unequal Distribution of Administrative Burden*, 55 Soc. Pol'y & Admin. 527 (2021); Zachary S. Wallace et al., *Treatment Delays Associated With Prior Authorization for Infusible Medications: A Cohort Study*, 72 Arthritis Care & Rsch. 1543 (2020); 45 C.F.R. § 84.68(b)(3), (b)(8).

DURABILITY

An agency that withdraws a regulation does not amend a Supreme Court construction of the statute the regulation implements.

THE RISK

In July 2026 the Department rescinded portions of its Title VI regulations to conform to an executive order directing agencies to reconsider disparate impact liability. The Section 504 regulations at 45 C.F.R. part 84 remain in force as of this writing, with an effective date of July 8, 2024. Prudence counsels against assuming that condition is permanent.

WHY TITLE VI DOES NOT GOVERN

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. Section 504 is differently situated, and at least one circuit has held that a private right of action exists to enforce the impact regulations under Title II and Section 504.

THE DRAFTING CONSEQUENCE

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

The partial dissent in that circuit decision reads the statutory phrases the other way, reasoning that Title II bars discrimination only because of disability status and that Section 504's phrase solely by reason of makes the point clearer still. 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 that reading cannot accommodate without treating the Court's own qualification as surplusage.

SOURCES 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); 45 C.F.R. § 84.68 (eff. July 8, 2024); *Alexander v. Choate*, 469 U.S. 287, 299, 301 (1985); *Alexander v. Sandoval*, 532 U.S. 275, 293 (2001); *Payan v. Los Angeles Cmty. Coll. Dist.*, 11 F.4th 729, 740 (9th Cir. 2021), and *id.* (Lee, J., dissenting in part).

A SECOND AND INDEPENDENT TRACK

The reasonable modification obligation requires no impact theory, and it has been available the entire time.

WHY A SECOND TRACK

Everything to this point runs on one engine: a 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. *Sandoval* foreclosed private enforcement of impact regulations under Title VI, and the answer for Section 504 rests on circuit authority rather than a holding of the Supreme Court. The impact provisions are also under active reconsideration.

WHAT THE OBLIGATION ASKS

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. It does not require proof that a neutral rule fell unequally on a group. It asks whether a policy operated as a barrier to this claimant, and whether an available change would remove the barrier without altering the nature of the program.

BOTH POSITIONS AT ONCE

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 to improve systemic accessibility. A complaint may occupy both. 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.

SOURCES 45 C.F.R. § 84.68(b)(7)(i); 28 C.F.R. § 35.130(b)(7)(i); 42 U.S.C. § 12182(b)(2)(A)(ii); *Payan v. Los Angeles Cmty. Coll. Dist.*, 11 F.4th 729, 740 (9th Cir. 2021); *Alexander v. Sandoval*, 532 U.S. 275, 293 (2001); Rescinding Portions of the HHS Title VI Regulations, 91 Fed. Reg. 46746 (July 24, 2026).

WHAT TO ASK FOR, IN ORDER

Lead with the modification that removes the compliance step, not the one that improves the notice.

- Renewal initiated by the program on the pharmacy claims record it already holds, rather than by the beneficiary on a form.
- Authorization granted coextensive with the course of therapy for a maintenance regimen, a duration many programs already use for some drugs.
- Renewal triggered by a change in the clinical picture rather than by a date, which preserves the review the state says it wants and removes the calendar as the trigger.
- The emergency supply the statute already requires, dispensed automatically on a rejected claim rather than on request.
- Notice with lead time sufficient to complete the process, in a format the beneficiary can act on.

8.31 percentage points, the average rise in actual benefit receipt from interventions that reduced compliance demands by supplying assistance.

3.39 points, from interventions that reduced learning demands by supplying information. Across fifty-one field experiments reporting 187 effect sizes.

Notice is a learning intervention and belongs in the request. It is not the one to lead with.

THE FUNDAMENTAL ALTERATION DEFENSE

Weaker here than in the ordinary case. 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, and a state that reviews utilization on a clinical trigger elsewhere has conceded the same about triggers. None of the modifications above dismantles utilization review. A state that answers by describing the review it would lose must also account for the approval rate that review produces.

SOURCES 42 U.S.C. § 1396r-8(d)(5)(B); Karl-Emil Bendtsen, *Increasing Take-Up of Social Benefits: A Meta-Analysis of Field Experiments*, 45 J. Pol'y Analysis & Mgmt. e70085 (2026); Rosa Kleinman, *Transaction Costs and the Take-Up of Social Safety Net Programs*, 45 J. Pol'y Analysis & Mgmt. e70086 (2026); Ashley Fox, Wenhui Feng & Megan Reynolds, *The Effect of Administrative Burden on State Safety-Net Participation*, 83 Pub. Admin. Rev. 367 (2023); Zachary S. Wallace et al., 72 Arthritis Care & Rsch. 1543 (2020).

THE PROCEDURAL QUESTION

An expiring authorization is treated as agency inaction, and inaction carries no notice and no hearing.

WHAT A TERMINATION CARRIES

Notice and an opportunity for a hearing when the agency takes action to terminate, suspend, or reduce covered services, and continuation of benefits pending the hearing where the request is timely.

WHAT AN EXPIRATION CARRIES

None of it. 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.

> *Whether the agency reached that result by deciding or by declining to decide is a fact about the agency's internal process, not 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. It has not been litigated as such.

SOURCES 42 C.F.R. §§ 431.220, 431.230(b); *Goldberg v. Kelly*, 397 U.S. 254, 264 (1970).

WHAT TO ASK A COURT FOR, AND WHY IT MATTERS

The burden is not that the decision is slow. It is that the decision recurs.

REMEDY AFTER CUMMINGS

Emotional distress damages are unavailable under the Spending Clause antidiscrimination statutes, which is a serious constraint here because interrupted psychiatric or neurological medication produces harm in exactly that register. 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.

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.

THE FINDING

The reform effort is organized around speed: how quickly a payer must decide, in what format the request must arrive, what the denial must say. It leaves the renewal interval exactly where it found it. A 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 person who has been on the same therapy for a decade. The second person is the more common case in a disability population.

> *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.*

SOURCES *Cummings v. Premier Rehab Keller, P.L.L.C.*, 596 U.S. 212 (2022); *Payan v. Los Angeles Cmty. Coll. Dist.*, 169 F.4th 971, 977-79 (9th Cir. 2026); *A.W. ex rel. J.W. v. Coweta Cnty. Sch. Dist.*, 110 F.4th 1309, 1315-16 (11th Cir. 2024); 45 C.F.R. § 84.68(b)(3), (b)(8).

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