No. 18-35892

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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

Plaintiffs/Appellants,

v.

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

Defendants/Appellees.

On Appeal from the United States District Court
for the Western District of Washington
Hon. Richard A. Jones, U.S. District Judge
(Seattle, Case No. 2:17-cv-01609-RAJ)

APPELLEES' ANSWERING BRIEF

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1, defendants Regence BlueShield and Cambia Health Solutions, Inc. certify as follows:

Regence BlueShield is a Washington non-profit corporation, and Cambia Health Solutions, Inc., an Oregon non-profit private corporation, is the non-profit sole member of Regence BlueShield. Cambia Health Solutions, Inc. is a non-insurance holding company and has no parent corporation.

No publicly held corporation owns 10% or more of either company's stock.

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I. INTRODUCTION

This case turns on a provision of the Patient Protection and Affordable Care Act of 2010 ("ACA") that incorporates existing federal anti-discrimination law and applies it to health programs and activities that now receive federal funding pursuant to the ACA. Section 1557 of the ACA ensures that, as with other recipients of federal funding, those health programs and activities do not discriminate by, for example, offering eating disorder coverage to men but not women, or failing to provide accessible buildings and facilities to individuals with disabilities.

Plaintiffs, however, misinterpret Section 1557 in a manner that would run afoul of Congress's intent, overturn existing case law, and dramatically broaden its scope, causing unforeseeable and potentially radical consequences for the health insurance market. Rather than interpret Section 1557 consistent with existing federal law, Plaintiffs claim that a facially neutral benefit exclusion—one that applies to *all* hearing-related treatment (except cochlear implants) for *all* insureds—is discriminatory against disabled persons, because it does not cover treatment for Plaintiffs' disabling condition. In effect, Plaintiffs claim that health insurers must provide coverage for all potentially disabling conditions on the same terms and same basis as any other health condition, and the failure to do so is discrimination "solely on the basis of" disability.

Plaintiffs are wrong. Congress enacted Section 1557 against a well-understood background of disability discrimination law, in particular Section 504 of the Rehabilitation Act. Indeed, Congress expressly incorporated the standards and enforcement mechanisms of Section 504 into Section 1557. And Plaintiffs have no claim under Section 504 or otherwise, because (similar to a benefit exclusion related to eyesight treatment or any number of other facially neutral benefit limitations) the hearing benefit exclusion at issue applies to all insureds on the same basis, disabled or non-disabled alike. It is not "proxy" discrimination, and it does not deny anyone meaningful access to the benefits being offered. Designing a benefit package that limits or excludes coverage to all insureds for certain health conditions that may or may not be disabling is simply not discriminatory under Section 1557 or Section 504, as several courts, including the Supreme Court, have concluded. *See Traynor v. Turnage*, 485 U.S. 535, 549 (1988) ("There is nothing in the Rehabilitation Act that requires that any benefit extended to one category of handicapped persons must also be extended to all other categories of handicapped persons."); *see also Alexander v. Choate*, 469 U.S. 287, 300 (1985).

There is no question that the ACA marked a fundamental shift in the nation's approach to health care generally. As the District Court correctly concluded, however, neither the statutory text and structure, nor any court decision

supports Plaintiffs' effort to dramatically expand disability discrimination law in this manner, which would upend the ACA's complex and careful balancing and wreak unintended consequences on the health insurance market.

II. STATEMENT OF JURISDICTION

Defendants Regence BlueShield and Cambia Health Solutions, Inc. (collectively, "Regence") agree with Plaintiffs' jurisdictional statement.

III. STATEMENT OF THE ISSUE

Whether the District Court was correct to dismiss Plaintiffs' claims pursuant to Section 1557 because Section 1557 incorporates the legal standard of Section 504 of the Rehabilitation Act and Plaintiffs have no plausible claim under Section 504 or otherwise that Regence's hearing loss exclusion—which applies to all insureds regardless of their health condition—discriminates against Plaintiffs "solely by reason of" their alleged disabled status.

IV. ADDENDA

Addenda, preceded by a table of contents, are attached to this brief.

V. STATEMENT OF THE CASE

Plaintiffs filed an action in District Court asserting a single claim based on Section 1557. Plaintiffs alleged that they and other similarly situated persons insured under a Regence BlueShield health plan are subject to discrimination on the basis of disability because their health plan excludes coverage for all treatment

for hearing loss except cochlear implants. The limitation on coverage for hearing loss treatment at issue[1] provides:

> We do not cover routine hearing examinations, programs or treatment for hearing loss, including but not limited to noncochlear hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them.

(ER 312 (Compl. ¶ 9 (quoting Plaintiffs' Regence Policy, Group No. 10018298)).)

The Hearing Loss Exclusion applies to all persons insured under Regence's health plans in Washington, disabled and non-disabled alike. (*Id.*; *see also* ER 314 (Compl. ¶ 14 (defining class as all persons who "have required, require or will require treatment for Hearing Loss")).) Plaintiffs did not allege that the exclusion applies only to hearing loss that qualifies as a disability, nor did they allege that they have been treated any differently than any other insured with respect to the Hearing Loss Exclusion, *viz*., that non-disabled persons received different or better coverage for hearing loss treatment than they did as a result of their disability. Instead, they consistently asserted that the Hearing Loss Exclusion was "categorical" or "blanket." (ER 312-15, 318-19; Op. Brief at 5, 11, 23, 26-28, 47, 54.)

[1] Plaintiffs labeled this provision the "Hearing Loss Exclusion." (ER 312.) Even though this nomenclature is not entirely accurate because the exclusion also applies to routine hearing examinations for insureds with no hearing loss, Regence nonetheless adopts the term in this briefing for convenience.

Plaintiffs alleged that they and other members of the putative class are disabled as a result of diagnosed hearing loss. (ER 314 (Compl. ¶ 16).) Plaintiffs maintained that they require and/or will require medical treatment for their hearing loss, excluding treatment for cochlear implants. (ER 316 (Compl. ¶ 23).) Plaintiffs also asserted that they have paid out-of-pocket for medically necessary treatment for their hearing loss, including audiology examinations and hearing aids. (ER 317 (Compl. ¶ 31).) Because the Hearing Loss Exclusion did not cover that treatment, Plaintiffs alleged that Regence discriminated against them on the basis of their disability "[b]y categorically excluding insureds with Hearing Loss of all medical treatment related to their disability (except for cochlear implants)." (ER 312-13 (Compl. ¶ 10).)

The crux of Plaintiffs' claim was that, because Regence covers treatment to persons with other health conditions (such as coverage for outpatient office visits and durable medical equipment or prosthetic devices), it must do so for insureds who suffer from hearing loss that may be disabling. Failure to provide equal coverage to that latter group, Plaintiffs claim, constitutes disability discrimination pursuant to Section 1557. (ER 312, 317-18 (Compl. ¶¶ 9, 29, 37).) Accordingly, Plaintiffs sought, *inter alia*, an order declaring the Hearing Loss Exclusion "void and unenforceable," an injunction preventing Regence from continuing to apply

the Hearing Loss Exclusion, and damages for medical care not covered as a result of the Hearing Loss Exclusion. (ER 313 (Compl. ¶ 13).)

The District Court granted Regence's motion to dismiss. Analyzing Plaintiffs' claim pursuant to existing discrimination law and cases applying Section 504, the court emphasized that a program or benefit receiving federal funds cannot be defined in a way that effectively denies disabled individuals meaningful access to the program or benefit. In this circumstance, however, the Hearing Loss Exclusion applied to all insureds, whether disabled or not, and is not a denial of access to coverage to disabled individuals on the basis of their disability. As the court concluded: "Plaintiffs' claims for coverage were denied because the benefits they sought were not covered by their insurance plan, not because of their disability." (ER 20.) The court noted that its decision was consistent with several other federal district courts, all of which rejected similar assertions that Section 1557 creates new substantive rights apart from existing discrimination law, and dismissed claims that Section 1557 prohibits the type of coverage exclusion or limitation at issue here. (*See* ER 22 (citing *Se. Pa. Transp. Auth. v. Gilead Scis., Inc.*, 102 F. Supp. 3d 688, 699 (E.D. Pa. 2015); *Briscoe v. Health Care Serv. Corp.*, 281 F. Supp. 3d 725, 738 (N.D. Ill. 2017); *York v. Wellmark, Inc.*, No. 4:16-cv-00627-RGE-CFB (S.D. Iowa Sept. 6, 2017); *Doe v. BlueCross BlueShield of Tenn., Inc.*, No. 2:17-cv-02793-TLP-cgc, 2018 WL 3625012 (W.D. Tenn. July 30,

2018); *Schmitt, et al. v. Kaiser Found. Health Plan of Wash., et al.*, No. 2:17-cv-1611-RSL (W.D. Wash. Sept. 14, 2018)).)[2]

VI. SUMMARY OF ARGUMENT

When Congress enacted the ACA, it included Section 1557 to ensure that existing anti-discrimination law applied with equal force to the new entities receiving federal funding through the statute. Rather than create new substantive rights, Congress chose to expressly incorporate the "grounds" and "enforcement mechanisms" of several current discrimination statutes—including Section 504 of the Rehabilitation Act—into the ACA. As a result, disability discrimination claims under Section 1557 are interpreted consistently with claims brought under Section 504: A facial discrimination claim requires a showing that a policy classifies by disability on its face, and a disparate impact claim requires a disproportionate effect on the disabled and a denial of "meaningful access" to the benefit being offered.

Plaintiffs' Section 1557 claim based on the Hearing Loss Exclusion does not satisfy either of these tests. The Hearing Loss Exclusion is not facially discriminatory because "hearing loss" is not a disability but a health condition that afflicts the disabled and non-disabled alike. Because Regence applies a

[2] In addition to those decisions, at least one other district court in the Ninth Circuit has dismissed a Section 1557 disability discrimination claim. *See Doe One v. CVS Pharmacy, Inc.*, 348 F. Supp. 3d 967 (N.D. Cal. 2018).

nondiscriminatory condition equally across the board to all insureds, it does not discriminate by disability on its face. The Hearing Loss Exclusion also does not violate Section 1557 under a disparate impact theory because all insureds have meaningful access to the benefits offered under the policy. The Supreme Court has made clear that Section 504 does not guarantee benefits tailored to the specific medical needs of the disabled but only equal access to the benefits that are being offered. Because Plaintiffs had the same access to the same benefits as everyone else, there is no liability for disparate impact.

Furthermore, even if discrimination did exist (and it does not), the remedy that Plaintiffs seek—mandatory insurance coverage of any health condition that can result in disability—is not a reasonable accommodation because it would fundamentally alter the scope and nature of Regence's insurance offerings (and the insurance industry generally). Insurers have historically been free to design their plans as they see fit as long as they do not classify based on protected traits or deny access to a specific protected group. In enacting the ACA, Congress provided for coverage of certain essential health benefits, and if it had intended to mandate coverage of every potentially disabling health condition, it could have done so. Absent a Congressional directive otherwise, the Supreme Court's interpretation of Section 504 remains the law: It is equal access that is required, not health care that requires equivalent coverage for all conditions that are potentially disabling.

VII. STANDARD OF REVIEW

The District Court's dismissal of Plaintiffs' Complaint for failure to state a claim on which relief can be granted is reviewed *de novo*. *Knievel v. ESPN*, 393 F.3d 1068, 1072 (9th Cir. 2005).

VIII. ARGUMENT

"To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678, 129 S. Ct. 1937, 173 L. Ed. 2d 868 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570, 127 S. Ct. 1955, 167 L. Ed. 2d 929 (2007)). A claim is facially plausible "when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* "[D]ismissal for failure to state a claim under [Rule] 12(b)(6) is proper if there is a 'lack of a cognizable legal theory or the absence of sufficient facts alleged under a cognizable legal theory.'" *Conservation Force v. Salazar*, 646 F.3d 1240, 1242 (9th Cir. 2011) (quoting *Balistreri v. Pacifica Police Dep't*, 901 F.2d 696, 699 (9th Cir. 1988)).

A. Section 1557 Applies Existing Civil Rights Laws to Health Plans and Activities That Receive Federal Assistance.

The statutory text, legislative history, and case law all point to Section 1557's limited and simple purpose: to incorporate the existing standards of federal civil rights laws to health programs and activities that would be receiving federal

financial assistance through the ACA. Section 1557 did not create a new and far-reaching anti-discrimination right untethered from existing law, nor does it require health insurers to expand coverage to all potentially disabling conditions on an equal basis with all other health conditions that they cover. As the District Court correctly concluded, Plaintiffs' contrary argument—which relies on broad policy pronouncements related to the entire ACA and a misinterpretation of the statute and accompanying regulations—is incorrect.

1. The Text of Section 1557 Does Not Evince an Intent to Alter Existing Disability Discrimination Law.

Section 1557(a) of the ACA provides:

> Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

42 U.S.C. § 18116(a).

In its first sentence, Section 1557(a) forbids discrimination by any federally funded health program or activity "on the grounds prohibited" under Section 504 or three other nondiscrimination statutes. Each of the referenced statutes is a federal civil rights statute that prohibits discrimination in federally funded programs. 42 U.S.C. § 2000d (race, color, and national origin); 20 U.S.C. § 1681(a) (sex); 42 U.S.C. § 6101 (age); 29 U.S.C. § 794(a) (disability). Section 1557(a) uses the same anti-discrimination language as those statutes—"excluded from participation in, be denied the benefits of, or be subjected to discrimination under."

The first sentence of Section 1557(a) makes one basic move. It applies the identities of protected classes and the substantive standards from existing federal civil rights statutes to a new class of federal funding recipients—health programs or activities that would now be receiving some federal financial assistance through the ACA. In effect, Section 1557(a) expanded *who* may be subject to existing federal anti-discrimination mandates, not *what* those anti-discrimination standards are or, importantly, *how* those standards would be applied and interpreted going forward.

The second sentence of Section 1557(a) confirms that point. It directs that "[t]he enforcement mechanisms provided for and available under [the cited statutes] *shall apply* for purposes of violations of this subsection." 42 U.S.C. §

18116(a) (emphasis added). That sentence establishes that the relevant enforcement mechanisms for different discrimination claims—Title IX's enforcement mechanisms for sex-based claims, Section 504's enforcement mechanisms for disability-based claims, etc.—"shall apply" for purposes of determining whether a health program or activity receiving federal funds through the ACA has engaged in discrimination. Those enforcement mechanisms are not combined to create some new, amalgamated standard unique to the ACA. Rather, in both the first and second sentences, Section 1557(a) uses the conjunction "or" rather than "and" to emphasize that each statute's standards would apply individually. Read together, the text of Section 1557(a) shows that "Congress . . . intended 'to import the various different standards and burdens of proof into a Section 1557 claim, depending upon the protected class at issue."' *Doe*, 2018 WL 3625012, at *6 (quoting *Gilead*, 102 F.3d at 698-99).

Additional context also supports that interpretation. Section 1557(b) contains a savings provision ensuring that it does not "invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under" those statutes, or "supersede State laws that provide additional protections against discrimination on any basis described." 42 U.S.C. § 18116(b). As this subsection indicates, Congress meant to preserve the "legal standards" and other aspects of the anti-discrimination statutes that it incorporated. Indeed, referencing longstanding

anti-discrimination statutes was a natural way to extend—using the same language as those statutes—those existing standards to new recipients of federal aid.

2. Other Provisions of the ACA Confirm the Purpose of Section 1557 to Incorporate and Apply Existing Law.

Congress demonstrated in the ACA that it knew how and under what circumstances it would require coverage of certain conditions or treatments. The ACA generally barred insurers from imposing annual or lifetime limits on anything that is an "essential health benefit." "Essential health benefit" is a term of art under the ACA that Congress left to the Secretary of the Department of Health and Human Services ("HHS") to define. 42 U.S.C. § 18022(b). Congress, however, did direct the Secretary to ensure that essential health benefits include "[r]ehabilitative and habilitative services and devices." 42 U.S.C. § 18022(b)(1)(G). Congress further stated that "[t]he Secretary shall ensure that the scope of the essential health benefits . . . is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary." 42 U.S.C. § 18022(b)(2)(A). To enable the Secretary to assess what sorts of benefits were typical in employer plans, Congress required the Secretary of Labor to conduct a survey of employer plans. *Id.* After an extensive process, the Secretary of HHS allowed each state to articulate the scope of essential health benefits in that state. States did so through the adoption of a "benchmark plan."

Washington's benchmark plan covers cochlear implants but not hearing aids. Wash. Admin. Code § 284-43-5640(7)(b)(i) & (c)(iv). Washington Insurance Commissioner regulations provide that a health benefit plan must include cochlear implants as rehabilitative services and may, but is not required to, include hearing aids other than cochlear implants. *Id*.

The ACA did not include hearing aids or services as an essential health benefit, and most states' approved benchmark plans exclude or limit coverage for hearing aids.[3] Plaintiffs do *not* claim that such exclusions violate the "essential health benefit" provisions of the ACA. Yet, in effect, that is the fundamental thrust of their claim: that coverage of every potentially disabling condition is an "essential" requirement of any health plan in order to comply with the anti-discrimination mandate of Section 1557.

Congress simply did not sweep so broadly. If Congress intended to mandate coverage for all potentially disabling conditions, then it would have done so

[3] The benchmark plan offers no coverage for non-cochlear hearing aids in the following states: Alabama, Alaska, California, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Mississippi, Montana, Nebraska, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington State, Washington D.C., West Virginia, and Wyoming. The benchmark plan covers hearing aids only for children, while denying coverage for adults, in the following states: Colorado, Connecticut, Delaware, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, Tennessee, and Wisconsin. Cigna, Essential Health Benefits: Benchmark Plan Comparison 2017 and Later (Jan. 2017), https://www.cigna.com/assets/docs/about-cigna/informed-on-reform/top-11-ehb-by-state-2017.pdf.

expressly, as it did with respect to other ACA provisions. It would have defined as "essential" coverage of any condition that could be potentially disabling, or included one or more treatments on the list of essential health benefits. Although Section 1557 made important changes, it did *not* expressly or by implication make the sea change in insurance benefit design (and cost and structure) that Plaintiffs sought here.

3. Nothing in the Text or Legislative History Suggests That Congress Intended to Alter Existing Understandings of What Does—and Does Not—Constitute Disability Discrimination.

Courts presume that "'Congress is aware of existing law when it passes legislation,'" and "it makes sense to infer Congress' intent to incorporate a background principle into a new statute where the principle has previously been applied in a similar manner." *Mississippi ex rel. Hood v. AU Optronics Corp.*, 571 U.S. 161, 169, 174 (2014) (citation omitted). As a corollary to that rule, "[t]he normal rule of statutory construction is that if Congress intends for legislation to change the interpretation of a judicially created concept, it makes that intent specific." *Midlantic Nat'l Bank v. N.J. Dep't of Envtl. Prot.*, 474 U.S. 494, 501 (1986).

Here, Congress enacted Section 1557 against the long history of statutes and court decisions addressing discrimination on the basis of disability, including claims of discrimination in the context of health insurance benefits. As outlined

below, courts repeatedly addressed similar claims of disability discrimination in the health insurance context under both the Rehabilitation Act and the Americans with Disabilities Act ("ADA"). *See* Part VIII.C.2.b, *infra*. Just as often, courts rejected claims that health insurance plans discriminated against individuals with disabilities by not covering certain procedures, treatments, or medications, unless it could be demonstrated that doing so was solely on the basis of the individual's membership in a protected class.

Indeed, Congress expressly addressed this situation when considering the ADA.[4] At that time, each House and Senate committee discussed and adopted the Supreme Court's interpretation of the Rehabilitation Act to not require benefit programs to provide particular benefits or to treat all classes of disabled persons equally:

> [T]he Committee also wishes to clarify that in its view, as is stated by the U.S. Supreme Court, in *Alexander v. Choate* . . ., employee benefits plans should not be found to be in violation of this legislation under impact analysis simply because they do not address the special needs of every person with a disability, e.g., additional sick leave or medical coverage.

[4] Section 1557 was passed with no legislative comment. It was not mentioned in any floor speeches or debate on the ACA. Such silence is not surprising in light of the interpretation above, which comports with the statutory text and is consistent with the notion that Congress extended existing legal principles to another category of recipient of federal funds.

S. Rep. No. 101-116, at 78 (1989) (Addendum N); H.R. Rep. No. 101-485, at 137 (1990), *reprinted in* 1990 U.S.C.C.A.N. 267, 420 (Addendum M).

Likewise, the Senate Labor and Human Resources Committee report explained that, while coverage cannot be denied or limited "based on" a person's disability, neutral limitations or exclusions applicable to all persons are permitted:

> In addition, employers may not deny health insurance coverage completely to an individual based on the person's diagnosis or disability. For example, while it is permissible for an employer to offer insurance policies that limit coverage for certain procedures or treatments, e.g., only a specified amount per year for mental health coverage, a person who has a mental health condition may not be denied coverage for other conditions such as for a broken leg or for heart surgery because of the existence of the mental health condition. A limitation may be placed on reimbursements for a procedure or the types of drugs or procedures covered[,] e.g., a limit on the number of x-rays or non-coverage of experimental drugs or procedures; but, that limitation must apply to persons with or without disabilities. All people with disabilities must have equal access to the health insurance coverage that is provided by the employer to all employees.

S. Rep. No. 101-116, at 29.

Nothing in Section 1557 expressly changes that longstanding view. And it would be surprising indeed if Congress had intended to make such a significant change in existing disability discrimination law implicitly, particularly by means of a statute that not only expressly incorporates Section 504 but indicates that its enforcement mechanisms "shall apply." "Absent a clear indication from Congress

of a change in policy," *Grogan v. Garner*, 498 U.S. 279, 290 (1991), such a significant shift cannot be inferred from the text of Section 1557. *See also United States v. O'Brien*, 560 U.S. 218, 231 (2010) ("Congress does not enact substantive changes *sub silentio*."); *INS v. Phinpathya*, 464 U.S. 183, 200 (1984) ("Of course, when Congress enacts a new law that incorporates language of a pre-existing law, Congress may be presumed to have knowledge of prior judicial interpretations of the language and to have adopted that interpretation for purposes of the new law.").

Those final points deserve emphasis, as common sense and practicality are properly considered in assessing Congress's intent based on the statutory text. *Paroline v. United States*, 572 U.S. 434, 448 (2014). Congress provided no indication that it intended to eliminate the differences between the various civil rights statutes cited in Section 1557 and create a new anti-discrimination right that applied to persons with disabilities—obviously a class that would have profound implications for the structure, cost, and delivery of health care services. Nothing in the statute or legislative history suggests that persons interacting with health programs and activities should receive different protection than persons interacting with other federally funded programs. Plaintiffs' silence on these points underscores that their arguments lack support in the text and structure of Section 1557.

4. The Regulations Implementing Section 1557 Do Not Broaden the Concept of Disability Discrimination in the Manner Plaintiffs Suggest.

The regulations adopted and finalized in 2016 are consistent with the points outlined above. *See* 42 U.S.C. § 18116(c) (stating that HHS "may promulgate regulations to implement" Section 1557). On September 8, 2015, the Office for Civil Rights of HHS ("OCR") published proposed rules for Section 1557 for notice and comment. HHS, Nondiscrimination in Health Programs and Activities, Proposed Rule, 80 Fed. Reg. 54,172 (Sept. 8, 2015). On May 18, 2016, OCR issued the final rule implementing Section 1557 and responded to numerous comments related to the rule. HHS, Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016) (Addendum L). The final rule provides in relevant part:

> (a) General. A covered entity shall not, in providing or administering health-related insurance or other health-related coverage, discriminate on the basis of race, color, national origin, sex, age, or disability.
>
> (b) Discriminatory actions prohibited. A covered entity shall not, in providing or administering health-related insurance or other health-related coverage:
>
> (1) Deny, cancel, limit, or refuse to issue or renew a health-related insurance plan or policy or other health-related coverage, or deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, or disability;

> (2) Have or implement marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, age, or disability in a health-related insurance plan or policy, or other health-related coverage[.]

45 C.F.R. § 92.207.

By its terms, subsection (a) simply repeats the anti-discrimination mandate of Section 1557. Subsection (b) prohibits specific forms of discrimination, including in "benefit design[]," but does not change the fundamental requirement that the discrimination must be "on the basis" of disability.

OCR's explanation of these regulations is consistent with that view. Explaining both the proposed and final rule, OCR stated:

> Paragraph (a) proposed a general nondiscrimination requirement, and paragraph (b) provided specific examples of prohibited actions. Paragraphs (b)(1) and (2) proposed to address the prohibition on denying, cancelling, limiting, or refusing to issue or renew a health-related insurance plan or policy or other health-related coverage, denying or limiting coverage of a claim, or imposing additional cost sharing or other limitations or restrictions, on the basis of an enrollee's or prospective enrollee's race, color, national origin, sex, age, or disability, and the use of marketing practices or benefit designs that discriminate on these bases.
>
> *In the proposed rule, we did not propose to require plans to cover any particular benefit or service*, but we provided that a covered entity cannot have coverage that operates in a discriminatory manner. For example, the preamble stated that a plan that covers inpatient treatment for eating disorders in men but not women would not be

> in compliance with the prohibition of discrimination based on sex. Similarly, a plan that covers bariatric surgery in adults but excludes such coverage for adults with particular developmental disabilities would not be in compliance with the prohibition on discrimination based on disability.

81 Fed. Reg. at 31,428-29 (emphasis added) (Addendum L).

OCR's explanation makes clear that health insurance plans are *not* required to cover any particular benefit or service in order to comply with the regulations. Rather, once insurers do choose to offer a benefit, they must do so on a nondiscriminatory basis. In this respect, the examples provided by OCR are illustrative. Insurers are free to choose what benefits or services to offer. A potential violation of Section 1557 occurs only when insurers discriminate between protected and non-protected classes when allowing access to those services. This understanding is entirely consistent with longstanding discrimination principles and existing law.

Additional guidance from OCR also supports Regence's argument. Addressing the specific reference to "benefit design," OCR explained:

> OCR recognizes that covered entities have discretion in developing benefit designs and determining what specific health services will be covered in their health insurance coverage or other health coverage. *The final rule does not prevent covered entities from utilizing reasonable medical management techniques; nor does it require covered entities to cover any particular procedure or treatment. It also does not preclude a covered entity from applying neutral, nondiscriminatory standards that*

> *govern the circumstances in which it will offer coverage to all its enrollees in a nondiscriminatory manner*. The rule prohibits a covered entity from employing benefit design or program administration practices that operate in a discriminatory manner.

Id. at 31,434 (emphasis added) (Addendum L).

When addressing the potential costs of compliance with the final regulation, OCR further stated:

> It is important to recognize that this final rule, except in the area of sex discrimination, applies pre-existing requirements in Federal civil rights laws to various entities, the great majority of which have been covered by these requirements for years. Because Section 1557 restates existing requirements, we do not anticipate that covered entities will undertake new actions or bear any additional costs in response to the issuance of the regulation with respect to the prohibition of race, color, national origin, age, or disability discrimination, except with respect to the voluntary development of a language access plan. However, we also note that the prohibition of sex discrimination is new for many covered entities, and we anticipate that the enactment of the regulation will result in changes in action and behavior by covered entities to comply with this new prohibition. We note that some of these actions will impose costs and others will not.

Id. at 31,446 (Addendum L).

Thus, OCR recognized that the final rule only changed the law with respect to one issue: sex discrimination as it applied to benefits related to gender dysphoria and transgender individuals. *See* 45 C.F.R. § 92.207(b)(3)-(5). In all other areas, OCR indicated that the rule "applies pre-existing requirements in

Federal civil rights laws," and OCR did not anticipate new and costly changes in response to those requirements.

5. Plaintiffs' Discussion of Section 1557 Distorts the Text and Is Inconsistent with the Regulations.

a. Plaintiffs' Reliance on Broad Policy Statements of the Entire ACA Is Misplaced.

Plaintiffs' interpretation of both the statutory text and regulations implementing Section 1557 errs in multiple respects. First, Plaintiffs attempt to argue that the broad policy goals of the entire ACA—expanding access to health care for all Americans—should override the actual statutory text of the specific provision at issue. (Op. Brief at 15-20.)

There are two fundamental problems with this approach. First, most of the quotes cited by Plaintiffs are taken out of context, involve unrelated issues or circumstances such as coverage for pre-existing conditions, or are general expressions of the policies advanced by the entire ACA. *E.g.*, 111 Cong. Rec. E462 (Mar. 23, 2010) (Op. Brief, Addendum C) (post-enactment statement discussing brain injuries, the definition of "essential health benefits," and the direction—pursuant to 42 U.S.C. § 18022(b)(4)(B)—that the Secretary of HHS "not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life"); 111 Cong. Rec. H1855 (Mar.

21, 2010) (Op. Brief, Addendum D) (discussing general goals of ACA and end of "discrimination" against people with "preexisting conditions"); 111 Cong. Rec. S13890 (Dec. 24, 2009) (Op. Brief, Addendum E) (same). As such, they are entitled to little weight.

In some cases, for example, Plaintiffs cite the requirement that an essential health benefits package cannot "discriminate[] based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions." 45 C.F.R. § 156.125(a). (*See* Op. Brief at 16.) But Plaintiffs make no claim that Washington's (or any other state's) essential health benefits package violates the ACA by not mandating coverage for hearing loss (or any other sensory-related condition that may be a disability). And the plan at issue here is in full compliance with the ACA's essential health benefits requirements, which are not discriminatory. Neither Section 1557 nor the ACA requires more when it comes to mandated insurance benefits.

Second, and relatedly, "vague notions of a statute's 'basic purpose' are nonetheless inadequate to overcome the words of its text regarding the *specific* issue under consideration." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 261 (1993). That is particularly the case when dealing with "an enormously complex and detailed statute that resolved innumerable disputes between powerful competing

interests—not all in favor of potential plaintiffs." *Id*. at 262. As the Court has observed:

> [I]t frustrates rather than effectuates legislative intent simplistically to assume that whatever furthers the statute's primary objective must be the law. Where, as here, "the language of a provision ... is sufficiently clear in its context and not at odds with the legislative history, ... '[there is no occasion] to examine the additional considerations of "policy" ... that may have influenced the lawmakers in their formulation of the statute.'"

Rodriguez v. United States, 480 U.S. 522, 526 (1987) (per curiam) (alterations in original; citations omitted).

Here, while Congress may have wanted to expand access to health care and ensure fair treatment for those with severe health conditions (including pre-existing or disabling conditions), one cannot simply import those general-purpose statements to the interpretive task at issue in this case. If Congress intended to mandate equal coverage for all potentially disabling conditions (which would have involved a balancing of complex competing priorities of cost, coverage, etc.), it certainly could have done so expressly. Congress did not do so.

b. Plaintiffs Misinterpret the Omission of a Reference to the ADA.

To the extent they address the text of Section 1557, Plaintiffs focus on one omission: the absence of any reference to the ADA. Plaintiffs argue that the exclusion of any reference to the ADA in Section 1557 evinces an intent to change

the benefit designs of programs, or to ensure that insurers must change their benefit designs to cover all potentially disabling conditions. (Op. Brief at 20-21.) Although they rely on ADA case law themselves, Plaintiffs also suggest that, as a result of the omission, ADA case law addressing disability discrimination is inapposite.

Plaintiffs' arguments in this respect are wrong for two reasons. First, Section 1557 cites four civil rights statutes that prohibit discrimination on the basis of race, color, national origin, sex, age, and disability *in federally funded programs*. Each of those statutes shares the same structure, wording, and, most importantly, target: the recipients of federal funding. Section 1557 is one piece of a larger statutory structure designed to prevent discrimination in that context. By contrast, like other civil rights statutes such as Title VII, the ADA is different in that its provisions apply to state and local government entities and private persons. Not incorporating or referring to the ADA in Section 1557 made sense, given Congress's intent to apply existing discrimination standards and enforcement mechanisms in other federally funded programs to health programs and activities that received federal financial assistance as a result of the ACA.

Although the ADA is different with respect to whom it applies, case law discussing both the ADA and Section 504 is fully applicable when defining what constitutes disability discrimination. The two statutes share the same definitions of

disability. *Compare* 42 U.S.C. § 12102(2)(a) (ADA) *with* 29 U.S.C. § 705(9)(B) (Rehabilitation Act). They also contain the same operative language about discrimination. *Compare* 42 U.S.C. § 12132 *with* 29 U.S.C. § 794(a). Moreover, Congress called for a coordinated interpretation of the Rehabilitation Act and the ADA to "prevent[] imposition of inconsistent or conflicting standards for the same requirements" under the two statutes. 42 U.S.C. § 12117(b). Courts in the Ninth Circuit and elsewhere have used their understanding of the Rehabilitation Act to interpret the ADA and vice versa. *See, e.g., Vinson v. Thomas*, 288 F.3d 1145, 1152 n.7 (9th Cir. 2002) (courts "examine cases construing claims under the ADA, as well as section 504 of the Rehabilitation Act, because there is no significant difference in the analysis of rights and obligations created by the two Acts" (citing *Zukle v. Regents of the Univ. of Cal.*, 166 F.3d 1041, 1045 n.11 (9th Cir. 1999))); *McPherson v. Mich. High Sch. Athletic Ass'n*, 119 F.3d 453, 460 (6th Cir. 1997) ("'Because the standards under both of the acts are largely the same, cases construing one statute are instructive in construing the other.'" (citation omitted)). Contrary to Plaintiffs' suggestion, both Rehabilitation Act and ADA cases are relevant because they apply the same concepts and definitions of discrimination to the health insurance context, and, as outlined below, they have done so without reference to the ADA safe harbor or to any distinction between the two statutes.

B. The Hearing Loss Exclusion Is Not Facially Discriminatory Because It Does Not Exclude Coverage on the Basis of Disability.

As discussed above, disability discrimination claims under Section 1557 are interpreted consistent with Section 504 of the Rehabilitation Act, which provides, in relevant part:

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

29 U.S.C. § 794(a) (emphasis added); *see also Lovell v. Chandler*, 303 F.3d 1039, 1052 (9th Cir. 2002) (claim under Section 504 requires showing that plaintiff "was denied the benefit or services solely by reason of her handicap").

"A facially discriminatory policy is one which on its face applies less favorably to a protected group." *Cmty. House, Inc. v. City of Boise*, 490 F.3d 1041, 1048 (9th Cir. 2007) (citing *Frank v. United Airlines, Inc.*, 216 F.3d 845, 854 (9th Cir. 2000)). Plaintiffs fail to state a claim for facial discrimination because the Hearing Loss Exclusion does not distinguish between the disabled and non-disabled, whether on its face or by proxy. *Every* insured under the plans at issue—whether they suffer from disabling hearing loss or any hearing loss at all—receives the same treatment.

1. Hearing Loss Is Not a Disability.

Plaintiffs' facial discrimination theory rests on the logical fallacy that all persons who seek treatment for hearing loss are disabled. Despite the Opening Brief's repeated references to hearing loss as a "disabling condition" or "disabling trait," it is neither. It is a health condition that, in severe enough cases, can be disabling.

The Rehabilitation Act incorporates the ADA's definition of "disability" as, *inter alia*, "a physical or mental impairment that substantially limits one or more major life activities." 42 U.S.C. § 12102(1)(A); 29 U.S.C. § 705(20)(B). In order to conclude that the Hearing Loss Exclusion is a disability-based exclusion, the Court would have to find that every person who seeks hearing treatment, including routine hearing examinations, is disabled under this definition, but as the District Court correctly noted, there are "plan participants that suffer from hearing loss that are not disabled." (ER 21.) Courts in other jurisdictions have likewise acknowledged this fact. *See, e.g.*, *Santiago Clemente v. Exec. Airlines, Inc.*, 213 F.3d 25, 30 (1st Cir. 2000) (finding that plaintiff's level of hearing loss did not constitute a disability); *Ayotte v. McPeek*, No. 08-cv-02508-WJM-MJW, 2011 WL 2531255, at *6 (D. Colo. June 24, 2011) ("[T]he Court finds that Plaintiff's hearing impairment does not rise to the level of a disability under the Rehabilitation Act . . . .").

Because the Hearing Loss Exclusion classifies on the basis of a neutral health condition that affects the disabled and non-disabled alike, it is not facially discriminatory. Plaintiffs seek to obfuscate this fact by conflating their alleged disability with the treatment they seek for it. They contend that the Hearing Loss Exclusion is facially discriminatory because it "denies coverage to [Plaintiffs] for a broad range of treatment and devices based on their disabling condition while covering the same treatment and devices for other *health conditions*." (Op. Brief at 26 (emphasis added).) Plaintiffs do not argue that the Hearing Loss Exclusion denies them coverage that is extended to non-disabled insureds; instead, they assert facial discrimination on the grounds that they allegedly have a greater medical need for treatment that the policy excludes. (*Id.* (alleging facial discrimination for exclusion of office visits for hearing loss and coverage of office visits for other conditions).)[5] Regardless of Plaintiffs' particular medical needs, classification by a medical condition shared by the disabled and non-disabled alike is not discriminatory on its face, and Plaintiffs' facial discrimination theory fails.

2. The Hearing Loss Exclusion Is Not Proxy Discrimination.

Plaintiffs also contend (for the first time on appeal) that "[t]he trial court erred by failing to consider whether the Hearing Loss Exclusion is a form of

[5] Plaintiffs' discussion of *Choate* in the section arguing facial discrimination is misplaced because that case addressed the availability of a disparate impact claim under Section 504. 469 U.S. at 309 (analyzing impact of durational limitation that is "neutral on its face").

'proxy discrimination.'" (Op. Brief at 41.)[6] The District Court did not consider this argument because Plaintiffs did not raise it, nor did they cite the two cases upon which they now seek to rely: *Pacific Shores Properties, LLC v. City of Newport Beach*, 730 F.3d 1142, 1147 (9th Cir. 2013), and *McWright v. Alexander*, 982 F.2d 222, 228 (7th Cir. 1992). Having failed to plead this theory or raise this argument and these authorities below, Plaintiffs are precluded from doing so for the first time now. *Dream Palace v. County of Maricopa*, 384 F.3d 990, 1005 (9th Cir. 2004) (citing *Janes v. Wal-Mart Stores, Inc.*, 279 F.3d 883, 888 n.4 (9th Cir. 2002)).

Even if Plaintiffs can assert this argument on appeal, it should be rejected because hearing loss is not a proxy for disability and, in any event, the Hearing Loss Exclusion is not limited to insureds with hearing loss. Proxy discrimination "arises when the defendant enacts a law or policy that treats individuals differently on the basis of seemingly neutral criteria that are so closely associated with the disfavored group that discrimination on the basis of such criteria is, constructively, facial discrimination against the disfavored group." *Pac. Shores Props.*, 730 F.3d at 1160 n.23. The association must be so close that the neutral criteria are "*almost exclusively* indicators of membership in the disfavored group." *Id.* (emphasis

[6] Although included in Plaintiffs' disparate impact analysis, "[p]roxy discrimination is a form of facial discrimination." *Pac. Shores Props., LLC v. City of Newport Beach*, 730 F.3d 1142, 1160 n.23 (9th Cir. 2013).

added). As discussed above, however, hearing loss routinely affects the non-disabled. Hearing function often declines gradually with age, resulting in many degrees of hearing loss that are not disabling, and other conditions, such as tinnitus, can result in minor hearing loss that is not disabling. *See, e.g.*, *Mack v. CGI Fed., Inc.*, No. 1:17CV297, 2018 WL 7138861, at *1 n.1 (E.D. Va. Sept. 26, 2018) (plaintiff pled insufficient facts to show tinnitus was disabling under ADA).

Furthermore, even if hearing loss were a proxy for disability (and it is not), the Hearing Loss Exclusion still would not constitute proxy discrimination because it applies to insureds who suffer from no hearing loss at all and are seeking only routine hearing examinations. (ER 312 (Compl. ¶ 9).) Because hearing loss afflicts the non-disabled and the Hearing Loss Exclusion applies to insureds regardless of whether they suffer from hearing loss, the exclusion does not classify based on criteria almost exclusively associated with the disabled. Plaintiffs' proxy discrimination theory should be rejected.

3. Medical or Scientific Evidence Is Only Required to Justify Exclusions Based on Protected Traits.

Plaintiffs contend that the Hearing Loss Exclusion violates the ACA because "blanket exclusions in ACA-regulated plans must be based upon medical and scientific evidence that relates to medical necessity and the standard of care for a particular condition." (Op. Brief at 48.) Plaintiffs, however, provide no authority to support this assertion. To the contrary, all of Plaintiffs' citations support only

the fundamentally different point that scientific or medical justification is required for exclusions that classify explicitly based on a protected trait. Because, as discussed above, hearing loss is neither a disability nor a proxy for any protected class, this argument is inapposite.

Plaintiffs' brief repeatedly admits that scientific and medical justification is not required for nondiscriminatory exclusions. (*See, e.g.*, Op. Brief at 48 ("[E]xclusions based upon *protected traits* may only be justified by medical or scientific evidence."); Op. Brief at 50 ("If an insurer cannot produce a legitimate medical or scientific justification for a *disability-based* exclusion . . . , then the exclusion should be prohibited."); Op. Brief at 50 ("DHHS does not identify cost as a possible justification for exclusions based upon *protected traits*." (emphasis added)).) Furthermore, the addenda cited by Plaintiffs virtually all relate to exclusions of transgender health services or treatment for gender dysphoria, both of which HHS has explicitly determined to be facial gender-based classifications. (Op. Brief at 48 (citing Addenda H, I, J).)

Because the Hearing Loss Exclusion does not classify on the basis of disability or any other protected trait, no scientific or medical evidence is necessary to justify the exclusion.

C. Plaintiffs Have Not Sufficiently Pled a Claim for Disparate Impact.

Plaintiffs have also failed to state a claim for disability discrimination pursuant to Section 1557 under a disparate impact theory. The Supreme Court has rejected "the boundless notion that all disparate-impact showings constitute prima facie cases under § 504." *Choate*, 469 U.S. at 299; *see also Crowder v. Kitagawa*, 81 F.3d 1480, 1484 (9th Cir. 1996) ("[J]udicial review over each and every instance of disparate impact discrimination would be overly burdensome."). A disparate impact alone is not actionable, but "an otherwise qualified handicapped individual must be provided with meaningful access to the benefit that the grantee provides." *Choate*, 469 U.S. at 301; *see also Hunsaker v. Contra Costa County*, 149 F.3d 1041, 1043 (9th Cir. 1998) ("Denial of 'meaningful access' is a necessary element of an actionable disparate impact claim.").

Therefore, under the standards applicable to Section 504, as incorporated by Section 1557, in order to state a claim for disability discrimination under a disparate impact theory, Plaintiffs must allege that the Hearing Loss Exclusion has a disparate impact on a protected class and that the impact was so significant as to deny that class meaningful access to the benefit offered. Plaintiffs' Complaint does not sufficiently plead either element. It pleads no facts supporting the conclusory allegation that the disabled as a class are disparately impacted by the Hearing Loss Exclusion, and it alleges only that Regence denied Plaintiffs access

to *adequate* health care rather than to the specific benefits being offered—a position explicitly rejected in *Choate*. Finally, accommodation of Plaintiffs' proposed modification would require every insurance policy to cover every condition that could possibly result in disability, which would constitute a fundamental alteration of the insurance industry not contemplated by Section 504 or Section 1557.

1. Plaintiffs Do Not Allege Sufficient Facts Supporting the Conclusion That the Hearing Loss Exclusion Disparately Impacts the Disabled.

Plaintiffs' Complaint does not allege that the Hearing Loss Exclusion disparately impacts the disabled. To the contrary, it clearly and repeatedly alleges that the Hearing Loss Exclusion discriminates on its face. Plaintiffs twice allege that "[a]n explicit, categorical (or automatic) exclusion or limitation of coverage for all health services related to [a particular race, gender, age or disability] is unlawful *on its face*." (ER 313, 318 (Compl. ¶¶ 10, 38) (emphasis added).)[7] Elsewhere, Plaintiffs refer to Regence's alleged discrimination as "deliberate." (*Id.* ¶ 13.) Finally, they repeatedly identify hearing loss, which appears explicitly in the exclusion, as a qualifying disability in itself. (*Id.* ¶¶ 17, 22, 30, 37.)

[7] Plaintiffs' Complaint misleadingly misquotes this passage from the Federal Register by inserting the bracketed language, which fundamentally changes the meaning of the text. The quoted statement relates solely to "health services related to *gender transition*." 81 Fed. Reg. at 31,429 (emphasis added) (Addendum L).

All of these allegations are consistent with an assertion of a disparate treatment claim, and the Complaint contains no allegations that would support a finding of a disparate impact from a facially neutral policy. It does not allege that the disabled (or even the hearing disabled) will be disproportionately impacted by a policy excluding hearing treatment for all insureds; it does not allege that Plaintiffs or the putative class were denied "meaningful access to the benefit" being provided; and it does not allege any reasonable accommodations that would cure the alleged discrimination. Plaintiffs' disparate impact theory should be rejected due to the lack of any supporting factual allegations.

2. The Hearing Loss Exclusion Does Not Deny Meaningful Access to the Benefits Offered.

In Section 504 and ADA Title II cases, "to challenge a facially neutral . . . policy on the ground that it has a disparate impact on people with disabilities, the policy must have the effect of denying meaningful access to [the] services." *K.M. ex rel. Bright v. Tustin Unified Sch. Dist.*, 725 F.3d 1088, 1102 (9th Cir. 2013) (citing *Crowder*, 81 F.3d at 1484). Plaintiffs contend that the Hearing Loss Exclusion denies them meaningful access to "the very benefits needed to ameliorate their disability and their legal right to a full and fair claims review and appeals process." (Op. Brief at 39.) This argument, however, misconstrues the meaningful access requirement. The Supreme Court has made clear that meaningful access does not require equal results or access to benefits specific to

the needs of the disabled, but rather equal access to the same benefits that are offered to the non-disabled. Because Plaintiffs have meaningful access to the benefits provided by their policy, their ACA claim fails.

a. *Choate* Forecloses Plaintiffs' Request for Coverage Tailored to Their Specific Needs Rather Than Equal Access to the Coverage Offered.

In *Choate*, the plaintiffs alleged that a change from a 20-day to 14-day limitation on inpatient hospital days per year in the state's Medicaid plan violated Section 504 because it would disparately impact the disabled, who had a greater need for inpatient treatment. 469 U.S. at 289-90. The Supreme Court, recognizing that applying Section 504 to "all action disparately affecting the handicapped" would "lead to a wholly unwieldy administrative and adjudicative burden," struck a balance between "the need to give effect to the statutory objectives and the desire to keep Section 504 within manageable bounds." *Id.* at 298-99. The balance it struck was that not all disparate impacts on the disabled would be actionable, but "an otherwise qualified handicapped individual must be provided with meaningful access *to the benefit that the grantee offers*." *Id.* at 301 (emphasis added).

In upholding the new 14-day rule, the Court noted that the provision was neutral on its face and would leave both the disabled and non-disabled "with identical and effective . . . services fully available for their use" and so would "not exclude the handicapped from or deny them the benefits of the 14 days of care *the*

State has chosen to provide." *Id.* at 302 (emphasis added). Importantly, the Court emphasized that the benefit being provided was not a "guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided . . . is [the] particular package of health care services . . . offered—not 'adequate health care.'" *Id.* at 303.

Plaintiffs here seek the same result the Court rejected in *Choate*. They argue that they are denied meaningful access, not to the benefits being offered, but to *additional* benefits and administrative rights not provided to the non-disabled. Plaintiffs contend that they "are denied meaningful access to the . . . benefits that would ameliorate their disability" and are therefore "provided with a less effective package of benefits, programs and activities than other insureds, who will have coverage for medically necessary treatment for their conditions." (Op. Brief at 45-46.) They further argue that they are denied meaningful access to review of the medical necessity of their claims. (*Id.* at 46-47.) *Choate*, however, is clear that Section 504 only requires equal opportunity for participation, not "equal results" for everyone's particular needs. 469 U.S. at 304.

The Court specifically rejected the argument now raised by Plaintiffs—that regulations prohibit providing services that are "not as effective" for the medical needs of the disabled. *Id.* at 304-05 (citing 45 C.F.R. § 84.4(b)). It correctly noted

that the same regulation clarifies that "equally effective" means providing equal opportunity rather than equal results:

> This regulation, while indicating that adjustments to existing programs are contemplated, also makes clear that Tennessee is not required to assure that its handicapped Medicaid users will be as healthy as its nonhandicapped users. Thus, to the extent respondents are seeking a distinct durational limitation for the handicapped, Tennessee is entitled to respond by asserting that the relevant benefit is 14 days of coverage. Because the handicapped have meaningful and equal access to that benefit, Tennessee is not obligated to reinstate its 20-day rule or to provide the handicapped with more than 14 days of inpatient coverage.

Id. at 305-06 (footnote omitted) (citing 45 C.F.R. § 84.4(b)(2)).

Plaintiffs likewise contend that their specific medical needs entitle them to a level of health care services greater than what Regence offers. Here, "the relevant benefit" excludes treatment for hearing loss, and because Plaintiffs have equal access to that benefit on the same basis as non-disabled individuals, Regence is not required to provide additional benefits for Plaintiffs' specific needs.[8]

[8] The Supreme Court's opinion in *Olmstead v. L.C. ex rel. Zimring* does not change this analysis. 527 U.S. 581 (1999). (*See also* Op. Brief at 30-32.) In that case, the Court held that "[u]njustified isolation [of institutionalized patients] . . . is properly regarded as discrimination based on disability." 527 U.S. at 597. It did not, however, change the analysis for evaluating facial discrimination or disparate treatment claims under Section 504. The test for the former remains whether a policy classifies by disability on its face, and (as Plaintiffs admit) the test for the latter remains "whether the exclusion or limitation denies disabled persons 'meaningful access'" to the benefits being provided. (Op. Brief at 36.)

b. This Court and Seven Other Courts of Appeals Have Applied *Choate* to Insurance Benefit Limitations.

Of all the federal appellate opinions applying *Choate*, perhaps the most on point is the Eighth Circuit's ruling in *Krauel v. Iowa Methodist Medical Center*, 95 F.3d 674 (8th Cir. 1996). In *Krauel*, the plaintiff sued her employer for, *inter alia*, disability discrimination under the ADA because her plan failed to cover treatment for infertility. *Id.* at 675-76. The district court granted summary judgment for the defendant, and on appeal, the Eighth Circuit held that such a coverage limitation did not constitute a disability-based distinction. *Id.* at 675. Quoting with approval from enforcement guidance issued by the Equal Employment Opportunity Commission ("EEOC"), the Court noted that "'[a] term or provision is "disability-based" if it singles out a particular disability (*e.g.*, deafness, AIDS, schizophrenia), a discrete group of disabilities (*e.g.*, cancers, muscular dystrophies, kidney diseases), or disability in general (*e.g.*, non-coverage of all conditions that substantially limit a major life activity).'" *Id.* at 677 (quoting EEOC: Interim Enforcement Guidance on Application of ADA to Health Insurance (June 8, 1993), *reprinted in* Fair Emp't Practice Manual (BNA) 405:7115, 7118 ("EEOC Guidance") (Addendum O). "***Insurance distinctions that apply equally to all insured employees, that is, to individuals with disabilities and to those who are not disabled, do not discriminate on the basis of disability.***" *Id.* at 678 (emphasis added) (quoting EEOC Guidance at 405:7117) (Addendum O).

The Eighth Circuit went on to quote other specific examples of non-discriminatory coverage limitations cited by the EEOC:

> "For example, a feature of some employer provided health insurance plans is a distinction between the benefits provided for the treatment of physical conditions on the one hand, and the benefits provided for the treatment of 'mental/nervous' conditions on the other. Typically, a lower level of benefits is provided for the treatment of mental/nervous conditions than is provided for the treatment of physical conditions. Similarly, some health insurance plans provide fewer benefits for 'eye care' than for other physical conditions. Such broad distinctions which apply to the treatment of a multitude of dissimilar conditions and which constrain individuals both with and without disabilities, are not distinctions based on disability. Consequently, although such distinctions may have a greater impact on certain individuals with disabilities, they do not intentionally discriminate on the basis of disability and do not violate the ADA."

Id. (quoting EEOC Guidance at 405:7118) (Addendum O). The Court held that the exclusion of infertility treatment did not discriminate on the basis of disability because it "does not single out a particular group of disabilities, allowing coverage for some individuals with infertility problems, while denying coverage to other individuals with infertility problems. Rather, [it] applies equally to all individuals, in that no one participating in the Plan receives coverage for treatment of infertility problems." *Id.*

This Court expressly adopted the reasoning of *Choate* and *Krauel* in *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1116 (9th Cir. 2000). The

plaintiff asserted disability discrimination under the ADA based on "an insurance policy that gives different levels of benefits to those with different types of disabilities"—in that case, mental versus physical health issues. *Id.* The Court held that "there is no discrimination under the Act where disabled individuals are given the same opportunity as everyone else, so insurance distinctions that apply equally to all employees cannot be discriminatory." *Id.*

The Court noted that its holding is consistent with opinions from seven other federal Courts of Appeals. *Id.*[9] The District of Columbia Circuit, in *Modderno*, 82 F.3d at 1061, reached the same conclusion in a case brought under Section 504, undercutting Plaintiffs' argument that these cases turn on the ADA's "safe harbor" provision. (Op. Brief at 20, 44.) *See also P.C. v. McLaughlin*, 913 F.2d 1033, 1041 (2d Cir. 1990) ("[T]he law governing § 504 did not clearly establish an obligation to meet [the plaintiff's] particular needs vis-a-vis the needs of other handicapped individuals, but mandated only that the services provided to nonhandicapped individuals not be denied [the plaintiff] because he is handicapped.").

[9] Citing *Kimber v. Thiokol Corp.*, 196 F.3d 1092 (10th Cir. 1999); *Rogers v. Dep't of Health & Envtl. Control*, 174 F.3d 431 (4th Cir. 1999); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 608 (3d Cir. 1998); *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1019 (6th Cir. 1997); *EEOC v. CNA Ins. Cos.*, 96 F.3d 1039, 1044 (7th Cir. 1996); *Krauel*, 95 F.3d at 678; *Modderno v. King*, 82 F.3d 1059, 1061 (D.C. Cir. 1996).

Plaintiffs contend that *Weyer* does not apply to claims under Section 1557 because "Congress has now 'spoken more plainly'" that it intends "to control which coverages ha[ve] to be offered." (Op. Brief at 44 (quoting *Weyer*, 198 F.3d at 1116).) As discussed in Part VIII.A.2, *supra*, though the ACA generally requires coverage of certain essential health benefits, it does not do so through Section 1557, which was intended to accomplish a different purpose. Furthermore, the lack of clear direction from Congress was an independent ground for this Court's decision in *Weyer*—separate from the determination that across-the-board insurance limitations are not discriminatory. *Weyer*, 198 F.3d at 1116.

Crowder also does not support Plaintiffs' argument. 81 F.3d 1480. In that case, the Court held that the application of Hawaii's quarantine policy to guide dogs discriminated against the visually impaired because it denied the disabled "meaningful access to state services, programs, and activities while such services, programs, and activities remain open and easily accessible by others." *Id.* at 1484. Because the policy prevented visually impaired individuals who use a guide dog from even entering the state, it denied them meaningful access to the various services and benefits that the state provides. Here, however, the benefits that Regence provides are the policy benefits themselves, which do not include coverage subject to the Hearing Loss Exclusion. Unlike the state benefits in *Crowder*, Regence's policy benefits are equally available to both the disabled and

non-disabled. Furthermore, *Crowder* does not involve the provision of health care or insurance benefits. The Supreme Court's opinion in *Choate* and this Court's opinion in *Weyer* are more analogous to this case and control the analysis. Because the Hearing Loss Exclusion applies equally to all insureds and Plaintiffs have not pleaded facts demonstrating that they were denied meaningful access to their policy benefits, the District Court's order should be affirmed.

3. Plaintiffs' Proposed Remedy Would Fundamentally Alter the Price and Availability of Insurance.

The Hearing Loss Exclusion does not discriminate on the basis of disability for the additional reason that accommodation of Plaintiffs' alleged disability by mandating insurance coverage for their particular health needs would be an unreasonable and fundamental alteration to the way in which insurers price and provide insurance to their members. Plaintiffs seek to enjoin Regence from applying the Hearing Loss Exclusion—thereby mandating that Regence provide full coverage for routine hearing examinations, programs and treatment for hearing loss, and surgery and services related to the implantation of non-cochlear hearing aids. If exclusion of a facially neutral health condition is discriminatory just because it can sometimes be disabling, insurers would be required to cover every such condition. The Court should reject Plaintiffs' attempt to force such a consequential change on the insurance industry.

"An organization that receives federal funds violates § 504 if it denies qualified individuals with a disability a reasonable accommodation that the individual needs in order to enjoy meaningful access to the benefits of public services." *Mark H. v. Hamamoto*, 620 F.3d 1090, 1097 (9th Cir. 2010) (citing *Choate*, 469 U.S. at 301-02). A proposed accommodation is not reasonable if the defendant "'can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.'" *McGary v. City of Portland*, 386 F.3d 1259, 1266 (9th Cir. 2004) (quoting 28 C.F.R. § 35.130(b)(7)).

The Supreme Court in *Choate* rejected the plaintiffs' similar request in that case:

> Section 504 does not require the State to alter this definition of the benefit being offered simply to meet the reality that the handicapped have greater medical needs. To conclude otherwise would be to find that the Rehabilitation Act requires States to view certain illnesses, *i.e.*, those particularly affecting the handicapped, as more important than others and more worthy of cure through government subsidization.

Choate, 469 U.S. at 303-04.

Likewise here, requiring coverage of treatment for hearing loss simply because the disabled allegedly have a greater medical need for it would effectively compel coverage of treatment for every medical condition that could conceivably result in disability in severe enough cases. This would rewrite, by judicial decree, every insurance contract and result in exactly the "wholly unwieldy administrative

and adjudicative burden" the Court sought to avoid with its balancing of competing interests in *Choate*. *Id.* at 298. "[S]uch a requirement, if it existed, would destabilize the insurance industry in a manner definitely not intended by Congress . . . ." *Ford*, 145 F.3d at 608.

IX. CONCLUSION

For the reasons above, Regence respectfully requests that the Court affirm the District Court's order.

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Respectfully submitted,

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STATEMENT OF RELATED CASES

Pursuant to Ninth Circuit Rule 28-2.6, Appellants hereby inform the Court of the related case on appeal to this Court in *Schmitt v. Kaiser Foundation Health Plan of Washington*, Ninth Circuit Case No. 18-35846. *Schmitt* is related to the case at bar because the two cases raise the same or closely related issues. In both cases, the plaintiffs allege that they suffer from disabling hearing loss and that the defendants' exclusions of coverage for routine hearing examinations and treatment of hearing loss discriminates against them on the basis of disability under Section 1557 of the ACA. In *Schmitt*, as in this case, the United States District Court for the Western District of Washington dismissed the plaintiffs' complaint pursuant to Fed. R. Civ. P. 12(b)(6) for failure to state a claim.

CERTIFICATE OF COMPLIANCE WITH RULE 32(a)

Form 6. Certificate of Compliance With Rule 32(a)

Certificate of Compliance With Type-Volume Limitation, Typeface Requirements, and Type Style Requirements

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because:

   ☒ this brief contains 11,328 words excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii), or

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CERTIFICATE OF SERVICE

I hereby certify that on the date set forth below, I electronically filed the **APPELLEES' ANSWERING BRIEF** with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to the following:

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ADDENDA

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Code of Federal Regulations
Title 45. Public Welfare
Subtitle A. Department of Health and Human Services (Refs & Annos)
Subchapter A. General Administration (Refs & Annos)
Part 84. Nondiscrimination on the Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance (Refs & Annos)
Subpart A. General Provisions

45 C.F.R. § 84.4

§ 84.4 Discrimination prohibited.

Effective: June 8, 2005

Currentness

(a) General. No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives Federal financial assistance.

(b) Discriminatory actions prohibited.

(1) A recipient, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap:

(i) Deny a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

(iii) Provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others;

(iv) Provide different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified handicapped person by providing significant assistance to an agency, organization, or person that discriminates on the basis of handicap in providing any aid, benefit, or service to beneficiaries of the recipients program or activity;

(vi) Deny a qualified handicapped person the opportunity to participate as a member of planning or advisory boards; or

(vii) Otherwise limit a qualified handicapped person in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service.

(2) For purposes of this part, aids, benefits, and services, to be equally effective, are not required to produce the identical result or level of achievement for handicapped and nonhandicapped persons, but must afford handicapped persons equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement, in the most integrated setting appropriate to the person's needs.

(3) Despite the existence of separate or different aids, benefits, or services provided in accordance with this part, a recipient may not deny a qualified handicapped person the opportunity to participate in such aids, benefits, or services that are not separate or different.

(4) A recipient may not, directly or through contractual or other arrangements, utilize criteria or methods of administration (i) that have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap, (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program or activity with respect to handicapped persons, or (iii) that perpetuate the discrimination of another recipient if both recipients are subject to common administrative control or are agencies of the same State.

(5) In determining the site or location of a facility, an applicant for assistance or a recipient may not make selections (i) that have the effect of excluding handicapped persons from, denying them the benefits of, or otherwise subjecting them to discrimination under any program or activity that receives Federal financial assistance or (ii) that have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the program or activity with respect to handicapped persons.

(6) As used in this section, the aid, benefit, or service provided under a program or activity receiving Federal financial assistance includes any aid, benefit, or service provided in or through a facility that has been constructed, expanded, altered, leased or rented, or otherwise acquired, in whole or in part, with Federal financial assistance.

(c) Aids, benefits, or services limited by Federal law. The exclusion of nonhandicapped persons from aids, benefits, or services limited by Federal statute or executive order to handicapped persons or the exclusion of a specific class of handicapped persons from aids, benefits, or services limited by Federal statute or executive order to a different class of handicapped persons is not prohibited by this part.

Credits

[70 FR 24319, May 9, 2005]

AUTHORITY: 20 U.S.C. 1405; 29 U.S.C. 794; 42 U.S.C. 290dd–2; 21 U.S.C. 1174.

Notes of Decisions (204)

Current through March 22, 2019; 84 FR 10720.

End of Document

Code of Federal Regulations
Title 45. Public Welfare
Subtitle A. Department of Health and Human Services (Refs & Annos)
Subchapter A. General Administration (Refs & Annos)
Part 92. Nondiscrimination on the Basis of Race, Color, National Origin, Sex, Age, or Disability in Health Programs or Activities Receiving Federal Financial Assistance and Health Programs or Activities Administered by the Department of Health and Human Services or Entities Established Under Title I of the Patient Protection and Affordable Care Act (Refs & Annos)
Subpart C. Specific Applications to Health Programs and Activities

45 C.F.R. § 92.207

§ 92.207 Nondiscrimination in health-related insurance and other health-related coverage.

Effective: July 18, 2016

Currentness

(a) General. A covered entity shall not, in providing or administering health-related insurance or other health-related coverage, discriminate on the basis of race, color, national origin, sex, age, or disability.

(b) Discriminatory actions prohibited. A covered entity shall not, in providing or administering health-related insurance or other health-related coverage:

(1) Deny, cancel, limit, or refuse to issue or renew a health-related insurance plan or policy or other health-related coverage, or deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, or disability;

(2) Have or implement marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, age, or disability in a health-related insurance plan or policy, or other health-related coverage;

(3) Deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available;

(4) Have or implement a categorical coverage exclusion or limitation for all health services related to gender transition; or

(5) Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

(c) The enumeration of specific forms of discrimination in paragraph (b) does not limit the general applicability of the prohibition in paragraph (a) of this section.

(d) Nothing in this section is intended to determine, or restrict a covered entity from determining, whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case.

AUTHORITY: 42 U.S.C. 18116, 5 U.S.C. 301.

Current through March 22, 2019; 84 FR 10720.

End of Document

United States Code Annotated
Title 29. Labor
Chapter 16. Vocational Rehabilitation and Other Rehabilitation Services (Refs & Annos)
General Provisions (Refs & Annos)

29 U.S.C.A. § 705

§ 705. Definitions

Effective: July 22, 2014

Currentness

For the purposes of this chapter:

(1) Administrative costs

The term "administrative costs" means expenditures incurred in the performance of administrative functions under the vocational rehabilitation program carried out under subchapter I, including expenses related to program planning, development, monitoring, and evaluation, including expenses for--

(A) quality assurance;

(B) budgeting, accounting, financial management, information systems, and related data processing;

(C) providing information about the program to the public;

(D) technical assistance and support services to other State agencies, private nonprofit organizations, and businesses and industries, except for technical assistance and support services described in section 723(b)(5) of this title;

(E) the State Rehabilitation Council and other advisory committees;

(F) professional organization membership dues for designated State unit employees;

(G) the removal of architectural barriers in State vocational rehabilitation agency offices and State operated rehabilitation facilities;

(H) operating and maintaining designated State unit facilities, equipment, and grounds;

(I) supplies;

(J) administration of the comprehensive system of personnel development described in section 721(a)(7) of this title, including personnel administration, administration of affirmative action plans, and training and staff development;

(K) administrative salaries, including clerical and other support staff salaries, in support of these administrative functions;

(L) travel costs related to carrying out the program, other than travel costs related to the provision of services;

(M) costs incurred in conducting reviews of rehabilitation counselor or coordinator determinations under section 722(c) of this title; and

(N) legal expenses required in the administration of the program.

(2) Assessment for determining eligibility and vocational rehabilitation needs

The term "assessment for determining eligibility and vocational rehabilitation needs" means, as appropriate in each case--

(A)(i) a review of existing data--

(I) to determine whether an individual is eligible for vocational rehabilitation services; and

(II) to assign priority for an order of selection described in section 721(a)(5)(A) of this title in the States that use an order of selection pursuant to section 721(a)(5)(A) of this title; and

(ii) to the extent necessary, the provision of appropriate assessment activities to obtain necessary additional data to make such determination and assignment;

(B) to the extent additional data is necessary to make a determination of the employment outcomes, and the nature and scope of vocational rehabilitation services, to be included in the individualized plan for employment of an eligible individual, a comprehensive assessment to determine the unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice, including the need for supported employment, of the eligible individual, which comprehensive assessment--

(i) is limited to information that is necessary to identify the rehabilitation needs of the individual and to develop the individualized plan for employment of the eligible individual;

(ii) uses, as a primary source of such information, to the maximum extent possible and appropriate and in accordance with confidentiality requirements--

(I) existing information obtained for the purposes of determining the eligibility of the individual and assigning priority for an order of selection described in section 721(a)(5)(A) of this title for the individual; and

(II) such information as can be provided by the individual and, where appropriate, by the family of the individual;

(iii) may include, to the degree needed to make such a determination, an assessment of the personality, interests, interpersonal skills, intelligence and related functional capacities, educational achievements, work experience, vocational aptitudes, personal and social adjustments, and employment opportunities of the individual, and the medical, psychiatric, psychological, and other pertinent vocational, educational, cultural, social, recreational, and environmental factors, that affect the employment and rehabilitation needs of the individual;

(iv) may include, to the degree needed, an appraisal of the patterns of work behavior of the individual and services needed for the individual to acquire occupational skills, and to develop work attitudes, work habits, work tolerance, and social and behavior patterns necessary for successful job performance, including the utilization of work in real job situations to assess and develop the capacities of the individual to perform adequately in a work environment; and

(v) to the maximum extent possible, relies on information obtained from experiences in integrated employment settings in the community, and other integrated community settings;

(C) referral, for the provision of rehabilitation technology services to the individual, to assess and develop the capacities of the individual to perform in a work environment; and

(D) an exploration of the individual's abilities, capabilities, and capacity to perform in work situations, which shall be assessed periodically during trial work experiences, including experiences in which the individual is provided appropriate supports and training.

(3) Assistive technology terms

(A) Assistive technology

The term "assistive technology" has the meaning given such term in section 3002 of this title.

(B) Assistive technology device

The term "assistive technology device" has the meaning given such term in section 3002 of this title, except that the reference in such section to the term "individuals with disabilities" shall be deemed to mean more than 1 individual with a disability as defined in paragraph (20)(A))[1].

(C) Assistive technology service

The term "assistive technology service" has the meaning given such term in section 3002 of this title, except that the reference in such section--

(i) to the term "individual with a disability" shall be deemed to mean an individual with a disability, as defined in paragraph (20)(A); and

(ii) to the term "individuals with disabilities" shall be deemed to mean more than 1 such individual.

(4) Community rehabilitation program

The term "community rehabilitation program" means a program that provides directly or facilitates the provision of vocational rehabilitation services to individuals with disabilities, and that provides, singly or in combination, for an individual with a disability to enable the individual to maximize opportunities for employment, including career advancement--

(A) medical, psychiatric, psychological, social, and vocational services that are provided under one management;

(B) testing, fitting, or training in the use of prosthetic and orthotic devices;

(C) recreational therapy;

(D) physical and occupational therapy;

(E) speech, language, and hearing therapy;

(F) psychiatric, psychological, and social services, including positive behavior management;

(G) assessment for determining eligibility and vocational rehabilitation needs;

(H) rehabilitation technology;

(I) job development, placement, and retention services;

(J) evaluation or control of specific disabilities;

(K) orientation and mobility services for individuals who are blind;

(L) extended employment;

(M) psychosocial rehabilitation services;

(N) supported employment services and extended services;

(O) customized employment;

(P) services to family members when necessary to the vocational rehabilitation of the individual;

(Q) personal assistance services; or

(R) services similar to the services described in one of subparagraphs (A) through (Q).

(5) Competitive integrated employment

The term "competitive integrated employment" means work that is performed on a full-time or part-time basis (including self-employment)--

(A) for which an individual--

(i) is compensated at a rate that--

(I)(aa) shall be not less than the higher of the rate specified in section 206(a)(1) of this title or the rate specified in the applicable State or local minimum wage law; and

(bb) is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities, and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skills; or

(II) in the case of an individual who is self-employed, yields an income that is comparable to the income received by other individuals who are not individuals with disabilities, and who are self-employed in similar occupations or on similar tasks and who have similar training, experience, and skills; and

(ii) is eligible for the level of benefits provided to other employees;

(B) that is at a location where the employee interacts with other persons who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other persons; and

(C) that, as appropriate, presents opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions.

(6) Construction; cost of construction--

(A) Construction

The term "construction" means--

(i) the construction of new buildings;

(ii) the acquisition, expansion, remodeling, alteration, and renovation of existing buildings; and

(iii) initial equipment of buildings described in clauses (i) and (ii).

(B) Cost of construction

The term "cost of construction" includes architects' fees and the cost of acquisition of land in connection with construction but does not include the cost of offsite improvements.

(7) Customized employment

The term "customized employment" means competitive integrated employment, for an individual with a significant disability, that is based on an individualized determination of the strengths, needs, and interests of the individual with a significant disability, is designed to meet the specific abilities of the individual with a significant disability and the business needs of the employer, and is carried out through flexible strategies, such as--

(A) job exploration by the individual;

(B) working with an employer to facilitate placement, including--

(i) customizing a job description based on current employer needs or on previously unidentified and unmet employer needs;

(ii) developing a set of job duties, a work schedule and job arrangement, and specifics of supervision (including performance evaluation and review), and determining a job location;

(iii) representation by a professional chosen by the individual, or self-representation of the individual, in working with an employer to facilitate placement; and

(iv) providing services and supports at the job location.

(8) Designated State agency; designated State unit--

(A) Designated State agency

The term "designated State agency" means an agency designated under section 721(a)(2)(A) of this title.

(B) Designated State unit

The term "designated State unit" means--

(i) any State agency unit required under section 721(a)(2)(B)(ii) of this title; or

(ii) in cases in which no such unit is so required, the State agency described in section 721(a)(2)(B)(i) of this title.

(9) Disability

The term "disability" means--

(A) except as otherwise provided in subparagraph (B), a physical or mental impairment that constitutes or results in a substantial impediment to employment; or

(B) for purposes of sections 701, 711, and 712 of this title and subchapters II, IV, V, and VII, the meaning given it in

section 12102 of Title 42.

(10) Drug and illegal use of drugs

(A) Drug

The term "drug" means a controlled substance, as defined in schedules I through V of section 202 of the Controlled Substances Act (21 U.S.C. 812).

(B) Illegal use of drugs

The term "illegal use of drugs" means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act. Such term does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provisions of Federal law.

(11) Employment outcome

The term "employment outcome" means, with respect to an individual--

(A) entering or retaining full-time or, if appropriate, part-time competitive employment in the integrated labor market;

(B) satisfying the vocational outcome of supported employment; or

(C) satisfying any other vocational outcome the Secretary of Education may determine to be appropriate (including satisfying the vocational outcome of customized employment, self-employment, telecommuting, or business ownership),

in a manner consistent with this chapter.

(12) Establishment of a community rehabilitation program

The term "establishment of a community rehabilitation program" includes the acquisition, expansion, remodeling, or alteration of existing buildings necessary to adapt them to community rehabilitation program purposes or to increase their effectiveness for such purposes (subject, however, to such limitations as the Secretary of Education may determine, in accordance with regulations the Secretary of Education shall prescribe, in order to prevent impairment of the objectives of, or duplication of, other Federal laws providing Federal assistance in the construction of facilities for community

rehabilitation programs), and may include such additional equipment and staffing as the Commissioner considers appropriate.

(13) Extended services

The term "extended services" means ongoing support services and other appropriate services, needed to support and maintain an individual with a most significant disability in supported employment, that--

(A) are provided singly or in combination and are organized and made available in such a way as to assist an eligible individual in maintaining supported employment;

(B) are based on a determination of the needs of an eligible individual, as specified in an individualized plan for employment; and

(C) are provided by a State agency, a nonprofit private organization, employer, or any other appropriate resource, after an individual has made the transition from support provided by the designated State unit.

(14) Federal share

(A) In general

Subject to subparagraph (B), the term "Federal share" means 78.7 percent.

(B) Exception

The term "Federal share" means the share specifically set forth in section 731(a)(3) of this title, except that with respect to payments pursuant to part B of subchapter I to any State that are used to meet the costs of construction of those rehabilitation facilities identified in section 723(b)(2) of this title in such State, the Federal share shall be the percentages determined in accordance with the provisions of section 731(a)(3) of this title applicable with respect to the State.

(C) Relationship to expenditures by a political subdivision

For the purpose of determining the non-Federal share with respect to a State, expenditures by a political subdivision thereof or by a local agency shall be regarded as expenditures by such State, subject to such limitations and conditions as the Secretary of Education shall by regulation prescribe.

(15) Governor

The term "Governor" means a chief executive officer of a State.

(16) Impartial hearing officer

(A) In general

The term "impartial hearing officer" means an individual--

(i) who is not an employee of a public agency (other than an administrative law judge, hearing examiner, or employee of an institution of higher education);

(ii) who is not a member of the State Rehabilitation Council described in section 725 of this title;

(iii) who has not been involved previously in the vocational rehabilitation of the applicant or eligible individual;

(iv) who has knowledge of the delivery of vocational rehabilitation services, the State plan under section 721 of this title, and the Federal and State rules governing the provision of such services and training with respect to the performance of official duties; and

(v) who has no personal or financial interest that would be in conflict with the objectivity of the individual.

(B) Construction

An individual shall not be considered to be an employee of a public agency for purposes of subparagraph (A)(i) solely because the individual is paid by the agency to serve as a hearing officer.

(17) Independent living core services

The term "independent living core services" means--

(A) information and referral services;

(B) independent living skills training;

(C) peer counseling (including cross-disability peer counseling);

(D) individual and systems advocacy; and

(E) services that--

(i) facilitate the transition of individuals with significant disabilities from nursing homes and other institutions to home and community-based residences, with the requisite supports and services;

(ii) provide assistance to individuals with significant disabilities who are at risk of entering institutions so that the individuals may remain in the community; and

(iii) facilitate the transition of youth who are individuals with significant disabilities, who were eligible for individualized education programs under section 614(d) of the Individuals with Disabilities Education Act (20 U.S.C. 1414(d)), and who have completed their secondary education or otherwise left school, to postsecondary life.

(18) Independent living services

The term "independent living services" includes--

(A) independent living core services; and

(B)(i) counseling services, including psychological, psychotherapeutic, and related services;

(ii) services related to securing housing or shelter, including services related to community group living, and supportive of the purposes of this chapter and of the subchapters of this chapter, and adaptive housing services (including

appropriate accommodations to and modifications of any space used to serve, or occupied by, individuals with disabilities);

(iii) rehabilitation technology;

(iv) mobility training;

(v) services and training for individuals with cognitive and sensory disabilities, including life skills training, and interpreter and reader services;

(vi) personal assistance services, including attendant care and the training of personnel providing such services;

(vii) surveys, directories, and other activities to identify appropriate housing, recreation opportunities, and accessible transportation, and other support services;

(viii) consumer information programs on rehabilitation and independent living services available under this chapter, especially for minorities and other individuals with disabilities who have traditionally been unserved or underserved by programs under this chapter;

(ix) education and training necessary for living in a community and participating in community activities;

(x) supported living;

(xi) transportation, including referral and assistance for such transportation and training in the use of public transportation vehicles and systems;

(xii) physical rehabilitation;

(xiii) therapeutic treatment;

(xiv) provision of needed prostheses and other appliances and devices;

(xv) individual and group social and recreational services;

(xvi) training to develop skills specifically designed for youths who are individuals with disabilities to promote self-awareness and esteem, develop advocacy and self-empowerment skills, and explore career options;

(xvii) services for children;

(xviii) services under other Federal, State, or local programs designed to provide resources, training, counseling, or other assistance, of substantial benefit in enhancing the independence, productivity, and quality of life of individuals with disabilities;

(xix) appropriate preventive services to decrease the need of individuals assisted under this chapter for similar services in the future;

(xx) community awareness programs to enhance the understanding and integration into society of individuals with disabilities; and

(xxi) such other services as may be necessary and not inconsistent with the provisions of this chapter.

(19) Indian; American Indian; Indian American; Indian tribe

(A) In general

The terms “Indian”, “American Indian”, and “Indian American” mean an individual who is a member of an Indian tribe and includes a Native and a descendant of a Native, as such terms are defined in subsections (b) and (r) of section 3 of the Alaska Native Claims Settlement Act (43 U.S.C. 1602).

(B) Indian tribe

The term “Indian tribe” means any Federal or State Indian tribe, band, rancheria, pueblo, colony, or community, including any Alaskan native village or regional village corporation (as defined in or established pursuant to the Alaska Native Claims Settlement Act) and a tribal organization (as defined in section 5304(l) of Title 25).

(20) Individual with a disability

(A) In general

Except as otherwise provided in subparagraph (B), the term "individual with a disability" means any individual who--

(i) has a physical or mental impairment which for such individual constitutes or results in a substantial impediment to employment; and

(ii) can benefit in terms of an employment outcome from vocational rehabilitation services provided pursuant to subchapter I, III, or VI.

(B) Certain programs; limitations on major life activities

Subject to subparagraphs (C), (D), (E), and (F), the term "individual with a disability" means, for purposes of sections 701, 711, and 712 of this title and subchapters II, IV, V, and VII of this chapter, any person who has a disability as defined in section 12102 of Title 42.

(C) Rights and advocacy provisions

(i) In general; exclusion of individuals engaging in drug use

For purposes of subchapter V, the term "individual with a disability" does not include an individual who is currently engaging in the illegal use of drugs, when a covered entity acts on the basis of such use.

(ii) Exception for individuals no longer engaging in drug use

Nothing in clause (i) shall be construed to exclude as an individual with a disability an individual who--

(I) has successfully completed a supervised drug rehabilitation program and is no longer engaging in the illegal use of drugs, or has otherwise been rehabilitated successfully and is no longer engaging in such use;

(II) is participating in a supervised rehabilitation program and is no longer engaging in such use; or

(III) is erroneously regarded as engaging in such use, but is not engaging in such use;

except that it shall not be a violation of this chapter for a covered entity to adopt or administer reasonable policies or procedures, including but not limited to drug testing, designed to ensure that an individual described in subclause (I) or (II) is no longer engaging in the illegal use of drugs.

(iii) Exclusion for certain services

Notwithstanding clause (i), for purposes of programs and activities providing health services and services provided under subchapters I, II, and III, an individual shall not be excluded from the benefits of such programs or activities on the basis of his or her current illegal use of drugs if he or she is otherwise entitled to such services.

(iv) Disciplinary action

For purposes of programs and activities providing educational services, local educational agencies may take disciplinary action pertaining to the use or possession of illegal drugs or alcohol against any student who is an individual with a disability and who currently is engaging in the illegal use of drugs or in the use of alcohol to the same extent that such disciplinary action is taken against students who are not individuals with disabilities. Furthermore, the due process procedures at section 104.36 of title 34, Code of Federal Regulations (or any corresponding similar regulation or ruling) shall not apply to such disciplinary actions.

(v) Employment; exclusion of alcoholics

For purposes of sections 793 and 794 of this title as such sections relate to employment, the term "individual with a disability" does not include any individual who is an alcoholic whose current use of alcohol prevents such individual from performing the duties of the job in question or whose employment, by reason of such current alcohol abuse, would constitute a direct threat to property or the safety of others.

(D) Employment; exclusion of individuals with certain diseases or infections

For the purposes of sections 793 and 794 of this title, as such sections relate to employment, such term does not include an individual who has a currently contagious disease or infection and who, by reason of such disease or infection, would constitute a direct threat to the health or safety of other individuals or who, by reason of the currently contagious disease or infection, is unable to perform the duties of the job.

(E) Rights provisions; exclusion of individuals on basis of homosexuality or bisexuality

For the purposes of sections 791, 793, and 794 of this title--

(i) for purposes of the application of subparagraph (B) to such sections, the term "impairment" does not include homosexuality or bisexuality; and

(ii) therefore the term "individual with a disability" does not include an individual on the basis of homosexuality or bisexuality.

(F) Rights provisions; exclusion of individuals on basis of certain disorders

For the purposes of sections 791, 793, and 794 of this title, the term "individual with a disability" does not include an individual on the basis of--

(i) transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders;

(ii) compulsive gambling, kleptomania, or pyromania; or

(iii) psychoactive substance use disorders resulting from current illegal use of drugs.

(G) Individuals with disabilities

The term "individuals with disabilities" means more than one individual with a disability.

(21) Individual with a significant disability

(A) In general

Except as provided in subparagraph (B) or (C), the term "individual with a significant disability" means an individual with a disability--

(i) who has a severe physical or mental impairment which seriously limits one or more functional capacities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of an

employment outcome;

(ii) whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time; and

(iii) who has one or more physical or mental disabilities resulting from amputation, arthritis, autism, blindness, burn injury, cancer, cerebral palsy, cystic fibrosis, deafness, head injury, heart disease, hemiplegia, hemophilia, respiratory or pulmonary dysfunction, intellectual disability, mental illness, multiple sclerosis, muscular dystrophy, musculo-skeletal disorders, neurological disorders (including stroke and epilepsy), paraplegia, quadriplegia, and other spinal cord conditions, sickle cell anemia, specific learning disability, end-stage renal disease, or another disability or combination of disabilities determined on the basis of an assessment for determining eligibility and vocational rehabilitation needs described in subparagraphs (A) and (B) of paragraph (2) to cause comparable substantial functional limitation.

(B) Independent living services and centers for independent living

For purposes of subchapter VII, the term "individual with a significant disability" means an individual with a severe physical or mental impairment whose ability to function independently in the family or community or whose ability to obtain, maintain, or advance in employment is substantially limited and for whom the delivery of independent living services will improve the ability to function, continue functioning, or move toward functioning independently in the family or community or to continue in employment, respectively.

(C) Research and training

For purposes of subchapter II, the term "individual with a significant disability" includes an individual described in subparagraph (A) or (B).

(D) Individuals with significant disabilities

The term "individuals with significant disabilities" means more than one individual with a significant disability.

(E) Individual with a most significant disability

(i) In general

The term "individual with a most significant disability", used with respect to an individual in a State, means an individual with a significant disability who meets criteria established by the State under section 721(a)(5)(C) of this

title.

(ii) Individuals with the most significant disabilities

The term "individuals with the most significant disabilities" means more than one individual with a most significant disability.

(22) Individual's representative; applicant's representative

The terms "individual's representative" and "applicant's representative" mean a parent, a family member, a guardian, an advocate, or an authorized representative of an individual or applicant, respectively.

(23) Institution of higher education

The term "institution of higher education" has the meaning given the term in section 1002 of Title 20.

(24) Local agency

The term "local agency" means an agency of a unit of general local government or of an Indian tribe (or combination of such units or tribes) which has an agreement with the designated State agency to conduct a vocational rehabilitation program under the supervision of such State agency in accordance with the State plan approved under section 721 of this title. Nothing in the preceding sentence of this paragraph or in section 721 of this title shall be construed to prevent the local agency from arranging to utilize another local public or nonprofit agency to provide vocational rehabilitation services if such an arrangement is made part of the agreement specified in this paragraph.

(25) Local workforce development board

The term "local workforce development board" means a local board, as defined in section 3102 of this title.

(26) Nonprofit

The term "nonprofit", when used with respect to a community rehabilitation program, means a community rehabilitation program carried out by a corporation or association, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual and the income of which is exempt from taxation under section 501(c)(3) of Title 26.

(27) Ongoing support services

The term "ongoing support services" means services--

(A) provided to individuals with the most significant disabilities;

(B) provided, at a minimum, twice monthly--

(i) to make an assessment, regarding the employment situation, at the worksite of each such individual in supported employment, or, under special circumstances, especially at the request of the client, off site; and

(ii) based on the assessment, to provide for the coordination or provision of specific intensive services, at or away from the worksite, that are needed to maintain employment stability; and

(C) consisting of--

(i) a particularized assessment supplementary to the comprehensive assessment described in paragraph (2)(B);

(ii) the provision of skilled job trainers who accompany the individual for intensive job skill training at the worksite;

(iii) job development, job retention, and placement services;

(iv) social skills training;

(v) regular observation or supervision of the individual;

(vi) followup services such as regular contact with the employers, the individuals, the individuals' representatives, and other appropriate individuals, in order to reinforce and stabilize the job placement;

(vii) facilitation of natural supports at the worksite;

(viii) any other service identified in section 723 of this title; or

(ix) a service similar to another service described in this subparagraph.

(28) Personal assistance services

The term "personal assistance services" means a range of services, provided by one or more persons, designed to assist an individual with a disability to perform daily living activities on or off the job that the individual would typically perform if the individual did not have a disability. Such services shall be designed to increase the individual's control in life and ability to perform everyday activities on or off the job.

(29) Redesignated (31)

(30)[2] Pre-employment transition services

The term "pre-employment transition services" means services provided in accordance with section 733 of this title.

(31) Public or nonprofit

The term "public or nonprofit", used with respect to an agency or organization, includes an Indian tribe.

(32) Rehabilitation technology

The term "rehabilitation technology" means the systematic application of technologies, engineering methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas which include education, rehabilitation, employment, transportation, independent living, and recreation. The term includes rehabilitation engineering, assistive technology devices, and assistive technology services.

(33) Secretary

Unless where the context otherwise requires, the term "Secretary"--

(A) used in subchapter I, III, IV, V, VI, or part B of subchapter VII, means the Secretary of Education; and

(B) used in subchapter II or part A of subchapter VII, means the Secretary of Health and Human Services.

(34) State

The term "State" includes, in addition to each of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(35) State workforce development board

The term "State workforce development board" means a State board, as defined in section 3102 of this title.

(36) Statewide workforce development system

The term "statewide workforce development system" means a workforce development system, as defined in section 3102 of this title.

(37) Student with a disability

(A) In general

The term "student with a disability" means an individual with a disability who--

(i)(I)(aa) is not younger than the earliest age for the provision of transition services under section 614(d)(1)(A)(i)(VIII) of the Individuals with Disabilities Education Act (20 U.S.C. 1414(d)(1)(A)(i)(VIII)); or

(bb) if the State involved elects to use a lower minimum age for receipt of pre-employment transition services under this chapter, is not younger than that minimum age; and

(II)(aa) is not older than 21 years of age; or

(bb) if the State law for the State provides for a higher maximum age for receipt of services under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.), is not older than that maximum age; and

(ii)(I) is eligible for, and receiving, special education or related services under part B of the Individuals with Disabilities Education Act (20 U.S.C. 1411 et seq.); or

(II) is an individual with a disability, for purposes of section 794 of this title.

(B) Students with disabilities

The term "students with disabilities" means more than 1 student with a disability.

(38) Supported employment

The term "supported employment" means competitive integrated employment, including customized employment, or employment in an integrated work setting in which individuals are working on a short-term basis toward competitive integrated employment, that is individualized and customized consistent with the strengths, abilities, interests, and informed choice of the individuals involved, for individuals with the most significant disabilities--

(A)(i) for whom competitive integrated employment has not historically occurred; or

(ii) for whom competitive integrated employment has been interrupted or intermittent as a result of a significant disability; and

(B) who, because of the nature and severity of their disability, need intensive supported employment services and extended services after the transition described in paragraph (13)(C), in order to perform the work involved.

(39) Supported employment services

The term "supported employment services" means ongoing support services, including customized employment, needed to support and maintain an individual with a most significant disability in supported employment, that--

(A) are provided singly or in combination and are organized and made available in such a way as to assist an eligible individual to achieve competitive integrated employment;

(B) are based on a determination of the needs of an eligible individual, as specified in an individualized plan for employment; and

(C) are provided by the designated State unit for a period of not more than 24 months, except that period may be extended, if necessary, in order to achieve the employment outcome identified in the individualized plan for employment.

(40) Vocational rehabilitation services

The term "vocational rehabilitation services" means those services identified in section 723 of this title which are provided to individuals with disabilities under this chapter.

(41) Workforce investment activities

The term "workforce investment activities" means workforce investment activities, as defined in section 3 of the Workforce Innovation and Opportunity Act, that are carried out under that Act.

(42) Youth with a disability

(A) In general

The term "youth with a disability" means an individual with a disability who--

(i) is not younger than 14 years of age; and

(ii) is not older than 24 years of age.

(B) Youth with disabilities

The term "youth with disabilities" means more than 1 youth with a disability.

CREDIT(S)

(Pub.L. 93-112, § 7, formerly § 6, as added Pub.L. 105-220, Title IV, § 403, Aug. 7, 1998, 112 Stat. 1097; amended Pub.L. 105-244, Title I, § 102(a)(9)(A), Oct. 7, 1998, 112 Stat. 1620; renumbered § 7 and amended Pub.L. 105-277, Div. A, § 101(f) [Title VIII, § 402(a)(1), (b)(3), (c)(1)], Oct. 21, 1998, 112 Stat. 2681-412, 2681-413, 2681-415; Pub.L. 105-394, Title IV, § 402(a), Nov. 13, 1998, 112 Stat. 3661; Pub.L. 110-325, § 7, Sept. 25, 2008, 122 Stat. 3558; Pub.L. 111-256, § 2(d)(1), Oct. 5, 2010, 124 Stat. 2643; Pub.L. 113-128, Title IV, § 404, July 22, 2014, 128 Stat. 1632.)

Notes of Decisions (204)

Footnotes

1 So in original. The second closing parenthesis probably should not appear.

2 So in original. There is no par. (29).

29 U.S.C.A. § 705, 29 USCA § 705
Current through P.L. 116-5. Title 26 current through 116-9.

End of Document

United States Code Annotated
Title 29. Labor
Chapter 16. Vocational Rehabilitation and Other Rehabilitation Services (Refs & Annos)
Subchapter V. Rights and Advocacy (Refs & Annos)

29 U.S.C.A. § 794

§ 794. Nondiscrimination under Federal grants and programs

Effective: October 1, 2016

Currentness

(a) Promulgation of rules and regulations

No otherwise qualified individual with a disability in the United States, as defined in section 705(20) of this title, shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service. The head of each such agency shall promulgate such regulations as may be necessary to carry out the amendments to this section made by the Rehabilitation, Comprehensive Services, and Developmental Disabilities Act of 1978. Copies of any proposed regulation shall be submitted to appropriate authorizing committees of the Congress, and such regulation may take effect no earlier than the thirtieth day after the date on which such regulation is so submitted to such committees.

(b) "Program or activity" defined

For the purposes of this section, the term "program or activity" means all of the operations of--

(1)(A) a department, agency, special purpose district, or other instrumentality of a State or of a local government; or

(B) the entity of such State or local government that distributes such assistance and each such department or agency (and each other State or local government entity) to which the assistance is extended, in the case of assistance to a State or local government;

(2)(A) a college, university, or other postsecondary institution, or a public system of higher education; or

(B) a local educational agency (as defined in section 7801 of Title 20), system of career and technical education, or other school system;

(3)(A) an entire corporation, partnership, or other private organization, or an entire sole proprietorship--

(i) if assistance is extended to such corporation, partnership, private organization, or sole proprietorship as a whole; or

(ii) which is principally engaged in the business of providing education, health care, housing, social services, or parks and recreation; or

(B) the entire plant or other comparable, geographically separate facility to which Federal financial assistance is extended, in the case of any other corporation, partnership, private organization, or sole proprietorship; or

(4) any other entity which is established by two or more of the entities described in paragraph (1), (2), or (3);

any part of which is extended Federal financial assistance.

(c) Significant structural alterations by small providers

Small providers are not required by subsection (a) to make significant structural alterations to their existing facilities for the purpose of assuring program accessibility, if alternative means of providing the services are available. The terms used in this subsection shall be construed with reference to the regulations existing on March 22, 1988.

(d) Standards used in determining violation of section

The standards used to determine whether this section has been violated in a complaint alleging employment discrimination under this section shall be the standards applied under title I of the Americans with Disabilities Act of 1990 (42 U.S.C. 12111 et seq.) and the provisions of sections 501 through 504, and 510, of the Americans with Disabilities Act of 1990 (42 U.S.C. 12201 to 12204 and 12210), as such sections relate to employment.

CREDIT(S)

(Pub.L. 93-112, Title V, § 504, Sept. 26, 1973, 87 Stat. 394; Pub.L. 95-602, Title I, §§ 119, 122(d)(2), Nov. 6, 1978, 92 Stat. 2982, 2987; Pub.L. 99-506, Title I, § 103(d)(2)(B), Title X, § 1002(e)(4), Oct. 21, 1986, 100 Stat. 1810, 1844; Pub.L. 100-259, § 4, Mar. 22, 1988, 102 Stat. 29; Pub.L. 100-630, Title II, § 206(d), Nov. 7, 1988, 102 Stat. 3312; Pub.L. 102-569,

Title I, § 102(p)(32), Title V, § 506, Oct. 29, 1992, 106 Stat. 4360, 4428; Pub.L. 103-382, Title III, § 394(i)(2), Oct. 20, 1994, 108 Stat. 4029; Pub.L. 105-220, Title IV, § 408(a)(3), Aug. 7, 1998, 112 Stat. 1203; Pub.L. 107-110, Title X, § 1076(u)(2), Jan. 8, 2002, 115 Stat. 2093; Pub.L. 113-128, Title IV, § 456(c), July 22, 2014, 128 Stat. 1675; Pub.L. 114-95, Title IX, § 9215(mmm)(3), Dec. 10, 2015, 129 Stat. 2188.)

EXECUTIVE ORDERS

EXECUTIVE ORDER NO. 11914

Ex. Ord. No. 11914, Apr. 28, 1976, 41 F.R. 17871, which related to nondiscrimination in federally assisted programs, was revoked by Ex. Ord. No. 12250, Nov. 2, 1980, 45 F.R. 72995, set out as a note under section 2000d-1 of Title 42, The Public Health and Welfare.

Notes of Decisions (3295)

29 U.S.C.A. § 794, 29 USCA § 794
Current through P.L. 116-5. Title 26 current through 116-9.

End of Document

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 126. Equal Opportunity for Individuals with Disabilities (Refs & Annos)

42 U.S.C.A. § 12102

§ 12102. Definition of disability

Effective: January 1, 2009

Currentness

As used in this chapter:

(1) Disability

The term "disability" means, with respect to an individual--

(A) a physical or mental impairment that substantially limits one or more major life activities of such individual;

(B) a record of such an impairment; or

(C) being regarded as having such an impairment (as described in paragraph (3)).

(2) Major life activities

(A) In general

For purposes of paragraph (1), major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

(B) Major bodily functions

For purposes of paragraph (1), a major life activity also includes the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

(3) Regarded as having such an impairment

For purposes of paragraph (1)(C):

(A) An individual meets the requirement of "being regarded as having such an impairment" if the individual establishes that he or she has been subjected to an action prohibited under this chapter because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.

(B) Paragraph (1)(C) shall not apply to impairments that are transitory and minor. A transitory impairment is an impairment with an actual or expected duration of 6 months or less.

(4) Rules of construction regarding the definition of disability

The definition of "disability" in paragraph (1) shall be construed in accordance with the following:

(A) The definition of disability in this chapter shall be construed in favor of broad coverage of individuals under this chapter, to the maximum extent permitted by the terms of this chapter.

(B) The term "substantially limits" shall be interpreted consistently with the findings and purposes of the ADA Amendments Act of 2008.

(C) An impairment that substantially limits one major life activity need not limit other major life activities in order to be considered a disability.

(D) An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.

(E)(i) The determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures such as--

(I) medication, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies;

(II) use of assistive technology;

(III) reasonable accommodations or auxiliary aids or services; or

(IV) learned behavioral or adaptive neurological modifications.

(ii) The ameliorative effects of the mitigating measures of ordinary eyeglasses or contact lenses shall be considered in determining whether an impairment substantially limits a major life activity.

(iii) As used in this subparagraph--

(I) the term "ordinary eyeglasses or contact lenses" means lenses that are intended to fully correct visual acuity or eliminate refractive error; and

(II) the term "low-vision devices" means devices that magnify, enhance, or otherwise augment a visual image.

CREDIT(S)

(Pub.L. 101-336, § 3, July 26, 1990, 104 Stat. 329; Pub.L. 110-325, § 4(a), Sept. 25, 2008, 122 Stat. 3555.)

Notes of Decisions (1726)

42 U.S.C.A. § 12102, 42 USCA § 12102
Current through P.L. 116-5. Title 26 current through 116-9.

End of Document

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 126. Equal Opportunity for Individuals with Disabilities (Refs & Annos)
Subchapter I. Employment (Refs & Annos)

42 U.S.C.A. § 12117

§ 12117. Enforcement

Currentness

(a) Powers, remedies, and procedures

The powers, remedies, and procedures set forth in sections 2000e-4, 2000e-5, 2000e-6, 2000e-8, and 2000e-9 of this title shall be the powers, remedies, and procedures this subchapter provides to the Commission, to the Attorney General, or to any person alleging discrimination on the basis of disability in violation of any provision of this chapter, or regulations promulgated under section 12116 of this title, concerning employment.

(b) Coordination

The agencies with enforcement authority for actions which allege employment discrimination under this subchapter and under the Rehabilitation Act of 1973 [29 U.S.C.A. § 701 et seq.] shall develop procedures to ensure that administrative complaints filed under this subchapter and under the Rehabilitation Act of 1973 are dealt with in a manner that avoids duplication of effort and prevents imposition of inconsistent or conflicting standards for the same requirements under this subchapter and the Rehabilitation Act of 1973. The Commission, the Attorney General, and the Office of Federal Contract Compliance Programs shall establish such coordinating mechanisms (similar to provisions contained in the joint regulations promulgated by the Commission and the Attorney General at part 42 of title 28 and part 1691 of title 29, Code of Federal Regulations, and the Memorandum of Understanding between the Commission and the Office of Federal Contract Compliance Programs dated January 16, 1981 (46 Fed.Reg. 7435, January 23, 1981)) in regulations implementing this subchapter and Rehabilitation Act of 1973 not later than 18 months after July 26, 1990.

CREDIT(S)

(Pub.L. 101-336, Title I, § 107, July 26, 1990, 104 Stat. 336.)

Notes of Decisions (1542)

Current through P.L. 116-5. Title 26 current through 116-9.

End of Document

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 126. Equal Opportunity for Individuals with Disabilities (Refs & Annos)
Subchapter II. Public Services (Refs & Annos)
Part A. Prohibition Against Discrimination and Other Generally Applicable Provisions

42 U.S.C.A. § 12132

§ 12132. Discrimination

Currentness

Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

CREDIT(S)

(Pub.L. 101-336, Title II, § 202, July 26, 1990, 104 Stat. 337.)

Notes of Decisions (880)

42 U.S.C.A. § 12132, 42 USCA § 12132
Current through P.L. 116-5. Title 26 current through 116-9.

End of Document

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 157. Quality Affordable Health Care for All Americans
Subchapter III. Available Coverage Choices for All Americans
Part A. Establishment of Qualified Health Plans

42 U.S.C.A. § 18022

§ 18022. Essential health benefits requirements

Currentness

(a) Essential health benefits package

In this title, the term "essential health benefits package" means, with respect to any health plan, coverage that--

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) Essential health benefits

(1) In general

Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

(2) Limitation

(A) In general

The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) Certification

In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) Notice and hearing

In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) Required elements for consideration

In defining the essential health benefits under paragraph (1), the Secretary shall--

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection,[1] so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that--

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 18031(b)(2)(B)(ii)[2] of this title (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and[3]

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains--

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) Rule of construction

Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) Requirements relating to cost-sharing

(1) Annual limitation on cost-sharing

(A) 2014

The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of Title 26 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) 2015 and later

In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall--

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i).

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(2) Repealed. Pub.L. 113-93, Title II, § 213(a)(1), Apr. 1, 2014, 128 Stat. 1047

(3) Cost-sharing

In this title--

(A) In general

The term “cost-sharing” includes--

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of Title 26) with respect to essential health benefits covered under the plan.

(B) Exceptions

Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(4) Premium adjustment percentage

For purposes of paragraph (1)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(d) Levels of coverage

(1) Levels of coverage defined

The levels of coverage described in this subsection are as follows:

(A) Bronze level

A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(B) Silver level

A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(C) Gold level

A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(D) Platinum level

A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) Actuarial value

(A) In general

Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

(B) Employer contributions

The Secretary shall issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of Title 26) may be taken into account in determining the level of coverage for a plan of the employer.

(C) Application

In determining under this title, the Public Health Service Act [42 U.S.C. 201 et seq.], or Title 26 the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, the rules contained in the regulations under this paragraph shall apply.

(3) Allowable variance

The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

(4) Plan reference

In this title, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

(e) Catastrophic plan

(1) In general

A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if--

(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(B) the plan provides--

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

(ii) coverage for at least three primary care visits.

(2) Individuals eligible for enrollment

An individual is described in this paragraph for any plan year if the individual--

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of Title 26 by reason of--

(i) section 5000A(e)(1) of such title (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such title (relating to individuals with hardships).

(3) Restriction to individual market

If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) Child-only plans

If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

(g) Payments to Federally-qualified health centers

If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1396d(l)(2)(B) of this title) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1396a(bb) of this title for such item or service.

CREDIT(S)

(Pub.L. 111-148, Title I, § 1302, Title X, § 10104(b), Mar. 23, 2010, 124 Stat. 163, 896; Pub.L. 113-93, Title II, § 213(a), Apr. 1, 2014, 128 Stat. 1047.)

Footnotes

1 So in original. Probably should be “paragraph,”.

2 So in original. Probably should be “18031(d)(2)(B)(ii)”.

3 So in original. The word “and” probably should not appear.

42 U.S.C.A. § 18022, 42 USCA § 18022
Current through P.L. 116-5. Title 26 current through 116-9.

End of Document

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 157. Quality Affordable Health Care for All Americans
Subchapter VI. Miscellaneous Provisions

42 U.S.C.A. § 18116

§ 18116. Nondiscrimination

Effective: March 23, 2010

Currentness

(a) In general

Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

(b) Continued application of laws

Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (42 U.S.C. 611 et seq.), or to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).

(c) Regulations

The Secretary may promulgate regulations to implement this section.

CREDIT(S)

(Pub.L. 111-148, Title I, § 1557, Mar. 23, 2010, 124 Stat. 260.)

Notes of Decisions (24)

42 U.S.C.A. § 18116, 42 USCA § 18116
Current through P.L. 116-5. Title 26 current through 116-9.

End of Document

Washington Administrative Code
Title 284. Insurance Commissioner, Office of
Chapter 284-43. Health Carriers and Health Plans (Refs & Annos)
Subchapter H. Health Plan Benefits

WAC 284-43-5640

284-43-5640. Essential health benefit categories.

Currentness

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

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

(i) Home and outpatient dialysis services;

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

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

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

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

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

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

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

(i) Infertility treatment and reversal of voluntary sterilization;

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

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

(A) Emergency in nature; or

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Chiropractic care (RCW 48.44.310);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iv) Dialysis services delivered in a hospital;

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

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

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

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

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

(iii) The following types of surgery:

(A) Bariatric surgery and supplies;

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

(C) Sexual reassignment treatment and surgery;

(iv) Reversal of sterilizations;

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

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

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

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

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

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

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

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

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

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

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

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

(i) In utero treatment for the fetus;

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

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

(iv) Infertility diagnosis;

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

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

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

(b) A health benefit plan may, but is not required to, include the following service as part of the EHB-benchmark package. Genetic testing of the child's father is specifically excluded by the base-benchmark plan, and should not be included in determining actuarial value.

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

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

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

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

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

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

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

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

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

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

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

(ii) Chemical dependency detoxification;

(iii) Behavioral treatment for a DSM category diagnosis;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Weight loss drugs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Cochlear implants;

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

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

(iv) Braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatuses used to support,

align or correct deformities or to improve the function of moving parts;

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

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

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

(ii) Exercise equipment for medically necessary conditions;

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

(iv) Hearing aids other than cochlear implants.

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

(i) For purposes of determining actuarial value and complying with the requirements of this section, the issuer must classify as habilitative services and provide coverage for the range of medically necessary health care services and health care devices designed to assist an individual in partially or fully developing, keeping or learning age appropriate skills and functioning within the individual's environment, or to compensate for a person's progressive physical, cognitive, and emotional illness.

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

(iii) A health benefit plan must not limit an enrollee's access to covered services on the basis that some, but not all

of the services in a plan of treatment are provided by a public or government program.

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

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

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

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

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

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

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

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

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

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

(g) An issuer must not classify services to the rehabilitative services category if the classification results in a limitation of coverage for therapy that is medically necessary for an enrollee's treatment for cancer, chronic pulmonary or

respiratory disease, cardiac disease or other similar chronic conditions or diseases. For purposes of this subsection, an issuer must establish limitations on the number of visits and coverage of the rehabilitation therapy consistent with its medical necessity and utilization review guidelines for medical/surgical benefits. Examples of these are, but are not limited to, breast cancer rehabilitation therapy, respiratory therapy, and cardiac rehabilitation therapy. Such services may be classified to the ambulatory patient or hospitalization services categories for purposes of determining actuarial value.

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

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

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

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

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

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. An enrollee's not medically indicated procurement and storage of personal blood supplies provided by a member of the enrollee's family is specifically excluded by the base-benchmark plan, and should not be included by an issuer in establishing a health benefit plan's actuarial value.

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

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

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

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

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

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

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

(vi) Wellness services.

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

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

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

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

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

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

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

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

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

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

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

Credits

WSR 16-01-081, recodified as S 284-43-5640, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), S 284-43-878, filed 9/29/15, effective 9/29/15. Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-15-012 (Matter No. R 2014-03), S 284-43-878, filed 7/3/14, effective 7/3/14. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular S 1302 of PPACA, S 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), S 284-43-878, filed 7/9/13, effective 7/10/13.

Current with amendments adopted through the 18-24 Washington State Register, dated December 19, 2018.

WAC 284-43-5640, WA ADC 284-43-5640

End of Document

ESSENTIAL HEALTH BENEFITS: BENCHMARK PLAN COMPARISON 2017 AND LATER

INFORMED ON REFORM

Each State has had the option to select a new benchmark plan for plan years on and after 1/1/2017, and all benefits included in the benchmark plan are considered to be an Essential Health Benefit (EHB). Benefits that are considered to be EHB cannot include annual and/or lifetime dollar maximums. Large group clients do not have to cover any benefits defined as EHB, but if they do, they cannot impose annual and/or lifetime dollar limits. Additionally, effective on or after 1/1/2017, for ***any plan*** that covers an EHB service *both* in-network and out-of-network, the annual/lifetime dollar limits are prohibited on that EHB service *both* in-network and out-of-network. Depending on which State a client has selected as their EHB State, annual and/or lifetime dollar limits may need to be removed for any benefit defined as EHB for that State.

- Self-funded group clients can choose which state to use as their EHB State.
- Insured-group clients' EHB State must be the same as the clients' contract/situs State, except for HMO plans which must follow the HMO plan state.

The following chart compares the benchmark plans of each State for the top 11 benefits that most commonly include annual or lifetime dollar limits. This chart is not all inclusive. Additional benefits are considered EHB in each state. The below information is based on the new 2017 benchmark plan documents as well as state mandates enacted prior to 1/1/2012.

Top 11 EHB Benefits by State – 2017 and Later											
State	**Acupuncture**	**Autism***	**Bariatric surgery**	**Chiropractic care**	**Durable medical equipment**	**Hearing aids**	**Infertility**	**Routine foot care**	**TMJ**	**Transplants and travel**	**Wigs**
AL	No	Yes	No	Yes	Yes	No	No	No	No	Transplant – Yes Travel – No	No
AK	Yes	Yes	No	Yes	Yes	No	No	No	No	Transplant – Yes Travel – Yes	No
AZ	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	Yes	Yes	No	Yes	Transplant – Yes Travel – Yes	Yes
AR	No	Yes (includes ABA Therapy)	No	Yes	Yes	Yes (Includes Cochlear Implants)	Yes	No	Yes	Transplant – Yes Travel – No	No
CA	Yes	Yes (includes ABA Therapy)	Yes	No	Yes	Cochlear Implant – Yes Other – No	No	No	Yes	Transplant – Yes Travel – No	No
CO	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	Yes (under Age 18)	Yes	No	Yes	Transplant – Yes Travel – Yes	No

EHB benchmark plan comparison – 2017 and later

Top 11 EHB Benefits by State – 2017 and Later											
State	Acupuncture	Autism*	Bariatric surgery	Chiropractic care	Durable medical equipment	Hearing aids	Infertility	Routine foot care	TMJ	Transplants and travel	Wigs
CT	No	Yes (includes ABA Therapy)	No	Yes	Yes	Yes (through Age 12)	Yes	No	Yes	Transplant – Yes Travel – Yes	Yes
DC	No	Yes	No	Yes	Yes	No	Yes	No	Yes	Transplant – Yes Travel – Yes	Yes
DE	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	Yes (under Age 24)	No	No	Yes	Transplant – Yes Travel – Yes	Yes
FL	No	Yes (includes ABA Therapy)**	No	Yes	Yes	No	No	No	Yes	Transplant – Yes Travel – No	No
GA	No	Yes	No	Yes	Yes	Cochlear Implant – Yes Other – No	Yes	No	Yes	Transplant – Yes Travel – Yes	No
HI	No	Yes	Yes	No	Yes	Yes	Yes	No	No	Transplant – Yes Travel – No	No
ID	No	No	No	Yes	Yes	No	No	No	No	Transplant – Yes Travel – Yes	No
IL	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	Bone Anchored – Yes Other – Yes (under age 18)	Yes	No	Yes	Transplant – Yes Travel – Yes	No
IN	No	Yes (includes ABA Therapy)	No	Yes	Yes	No	No	No	Yes	Transplant – Yes Travel – Yes	Yes
IA	No	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Transplant – Yes Travel – No	No
KS	No	No	No	Yes	Yes	Bone Anchored – Yes Other – No	Yes	No	Yes	Transplant – Yes Travel – No	No
KY	No	Yes (includes ABA Therapy)	No	Yes	Yes	Cochlear Implant – Yes Yes (under Age 18)	No	No	Yes	Transplant – Yes Travel – No	Yes
LA	No	Yes (includes ABA Therapy)	No	Yes	Yes	Yes (through Age 17)	No	No	No	Transplant – Yes Travel – No	No
ME	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	Yes (through Age 18)	No	No	No	Transplant – Yes Travel – No	No
MD	Yes	Yes	Yes	Yes	Yes	Cochlear Implant – Yes Yes (under Age 18)	Yes	No	Yes	Transplant – Yes Travel – Yes	Yes
MA	No	Yes (includes ABA Therapy)	No	Yes	Yes	Yes (through Age 21)	Yes	No	Yes	Transplant – Yes Travel – No	Yes

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EHB benchmark plan comparison – 2017 and later

Top 11 EHB Benefits by State – 2017 and Later											
State	**Acupuncture**	**Autism***	**Bariatric surgery**	**Chiropractic care**	**Durable medical equipment**	**Hearing aids**	**Infertility**	**Routine foot care**	**TMJ**	**Transplants and travel**	**Wigs**
MI	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Transplant – Yes Travel – No	No
MN	No	No	No	Yes	Yes	Yes (through Age 18) (includes Bone Anchored)	Yes	No	Yes	Transplant – Yes Travel – No	Yes
MS	No	No	No	Yes	Yes	No	No	No	Yes	Transplant – Yes Travel – Yes	No
MO	No	Yes (includes ABA Therapy)	No	Yes	Yes	Cochlear Implant – Yes Other – Yes for Newborns Only	Yes	No	Yes	Transplant – Yes Travel – Yes	Yes
MT	No	Yes (includes ABA Therapy)	No	Yes	Yes	No	Yes	No	Yes	Transplant – Yes Travel – Yes	No
NE	No	No	No	Yes	Yes	Cochlear Implant – Yes Other - No	No	No	Yes	Transplant – Yes Travel – No	No
NV	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	Yes	Yes	No	Yes	Transplant – Yes Travel – Yes	No
NH	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	Yes	Yes	No	Yes	Transplant – Yes Travel – No	Yes
NJ	Yes	Yes (includes ABA Therapy)	No	Yes	Yes	Yes (through Age 15) (includes Bone Anchored)	Yes	No	Yes	Transplant – Yes Travel – No	No
NM	Yes	Yes (includes ABA Therapy)	Yes	Yes	Yes	Yes (through Age 21)	No	No	Yes	Transplant – Yes Travel – Yes	No
NY	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	Yes (Includes bone anchored)	Yes	No	No	Transplant – Yes Travel – No	Yes
NC	No	No	Yes	Yes	Yes	Yes (through Age 22)	Yes	No	Yes	Transplant – Yes Travel – Yes	No
ND	No	No	Yes	Yes	Yes	No	No	No	Yes	Transplant – Yes Travel – No	No
OH	No	No	No	Yes	Yes	Cochlear Implant – Yes Other – No	No	No	Yes	Transplant – Yes Travel – Yes	Yes
OK	No	Yes	No	No	Yes	Yes (under Age 19)	No	No	No	Transplant – Yes Travel – No	Yes
OR	No	Yes (includes ABA Therapy)	No	No	Yes	Yes (under Age 18) (18+ if enrolled in School)	No	No	No	Transplant – Yes Travel – Yes	Yes
PA	No	Yes (includes ABA Therapy)	No	Yes	Yes	No	Yes	No	No	Transplant – Yes Travel – Yes	No

EHB benchmark plan comparison – 2017 and later

Top 11 EHB Benefits by State – 2017 and Later											
State	Acupuncture	Autism*	Bariatric surgery	Chiropractic care	Durable medical equipment	Hearing aids	Infertility	Routine foot care	TMJ	Transplants and travel	Wigs
PR**	No	Yes	Yes	Yes	Yes	No	No	Yes	No	Transplant – Yes Travel – No	No
RI	No	No	Yes	Yes	Yes	Yes (under age 19)	Yes	No	No	Transplant – Yes Travel – No	Yes
SC	No	Yes (includes ABA Therapy)	No	Yes	Yes	Yes – Cleft Lip/Palate Only No – Other Diagnoses	No	No	No	Transplant – Yes Travel – No	No
SD	No	No	Yes	Yes	Yes	No	No	No	Yes	Transplant – Yes Travel – No	No
TN	No	Yes	No	Yes	Yes	Yes (under Age 18)	Yes	No	Yes	Transplant – Yes Travel – Yes	No
TX	No	Yes (includes ABA Therapy)	No	Yes	Yes	Yes	No	No	Yes	Transplant – Yes Travel – No	No
UT	No	No	No	No	Yes	No	No	No	No	Transplant – Yes Travel – No	No
VT	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	No	Yes	No	Yes	Transplant – Yes Travel – Yes	Yes
VI***	Yes	No	Yes	Yes	Yes	Yes (includes Bone Anchored)	Yes	Yes	Yes	Transplant – Yes Travel – No	Yes
VA	No	No	No	Yes	Yes	Cochlear Implant – Yes Other – No	Yes	No	Yes	Transplant – Yes Travel – Yes	Yes
WA	Yes	No	No	Yes	Yes	Cochlear Implant – Yes Other – No	No	No	Yes	Transplant – Yes Travel – No	No
WV	No	Yes (includes ABA Therapy)	Yes	Yes	Yes	No	No	No	Yes	Transplant – Yes Travel – Yes	No
WI	No	Yes (includes ABA Therapy)	No	Yes	Yes	Yes (under Age 18) (includes Bone Anchored)	Yes	No	Yes	Transplant – Yes Travel – No	No
WY	No	No	Yes	Yes	Yes	No	No	No	No	Transplant – Yes Travel – No	No

* Autism - Since ABA Therapy is a behavioral service, Federal Mental Health Parity regulations prohibit age limits, visit limits or annual/lifetime dollar limits for ABA Therapy even when it is not considered an EHB service.

** For Individual Family Plans business in Florida, ABA therapy will not be treated as EHB. Coverage of some short term rehabilitation services for autism (e.g. physical therapy, speech therapy, occupational therapy) may continue to be required in accordance with federal mental health and substance use disorder parity.

*** Initial guidance stated that EHB no longer applies to Puerto Rico and the Virgin Islands. However, it has since been determined that EHB does apply. Because there are no new benchmark plans for these territories, Cigna will continue to use the 2014 benchmark plans to identify benefits as EHB until HHS releases further guidance.

81 FR 31375-01, 2016 WL 2866668(F.R.)
RULES and REGULATIONS
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Secretary
45 CFR Part 92
RIN 0945-AA02

Nondiscrimination in Health Programs and Activities

Wednesday, May 18, 2016

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

***31376** ACTION: Final rule.

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

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

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

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

SUPPLEMENTARY INFORMATION:

Electronic Access

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

I. Background

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

application of the more general prohibition of discrimination under § 92.101(a). Under both provisions, denial of program access on any of the prohibited bases, including pregnancy or related medical conditions, is prohibited.

Summary of Regulatory Changes

For the reasons set forth in the proposed rule and considering the comments received, we are finalizing the provision as proposed in § 92.206 with technical revisions to clarify our intent and ensure consistency with other parts of the final rule.

Nondiscrimination in Health-Related Insurance and Other Health-Related Coverage (§ 92.207)

In § 92.207 of the proposed rule, we provided specific details regarding the prohibition of discrimination on the basis of race, color, national origin, sex, age, or disability in the provision and administration of health-related insurance or other health-related coverage. We proposed that this prohibition applies to all covered entities that provide or administer health-related insurance or other health-related coverage, including health insurance issuers and group health plans that are recipients of Federal financial assistance and the Department in the administration of its health-related coverage programs. We noted that this section is independent of, but complements, the nondiscrimination provisions that apply to the Health Insurance Marketplaces [FN223] and to issuers of qualified health plans [FN224] under other Departmental regulations, and that entities covered under those provisions and Section 1557 are obligated to comply with both sets of requirements.

Based on the longstanding civil rights principles discussed in connection with the definition of "health program or activity" in § 92.4, we proposed to apply this part to all of the coverage and services of issuers that receive Federal financial assistance, whether those issuers' coverage is offered through the Marketplace [FNSM], outside the Marketplace [FNSM], in the individual or group health insurance markets, or as an employee health benefit program through an employer-sponsored group health plan.[FN225] We provided an example illustrating that an issuer participating in the Marketplace [FNSM], and thereby receiving Federal financial assistance, that also offers plans outside the Marketplace [FNSM] would be covered by the regulation for all of its health plans, as well as when it acts as a third party administrator for an employer-sponsored group health plan.[FN226]

Paragraph (a) proposed a general nondiscrimination requirement, and paragraph (b) provided specific examples of prohibited actions. Paragraphs (b)(1) and (2) proposed to address the prohibition on denying, cancelling, limiting, or refusing to issue or renew a health-related insurance plan or policy or other health-related coverage, denying or limiting coverage of a claim, or imposing additional cost sharing or other limitations or ***31429** restrictions, on the basis of an enrollee's or prospective enrollee's race, color, national origin, sex, age, or disability, and the use of marketing practices or benefit designs that discriminate on these bases.

In the proposed rule, we did not propose to require plans to cover any particular benefit or service, but we provided that a covered entity cannot have coverage that operates in a discriminatory manner. For example, the preamble stated that a plan that covers inpatient treatment for eating disorders in men but not women would not be in compliance with the prohibition of discrimination based on sex. Similarly, a plan that covers bariatric surgery in adults but excludes such coverage for adults with particular developmental disabilities would not be in compliance with the prohibition on discrimination based on disability.

In paragraphs (b)(3) through (5) of the proposed rule, we proposed to address discrimination faced by transgender individuals in accessing coverage of health services. We proposed in paragraph (b)(3) that to deny or limit coverage, deny a claim, or impose additional cost sharing or other limitations or restrictions on coverage of any health service is impermissible discrimination when the denial or limitation is due to the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded by the plan or issuer is different from the one to which such services are ordinarily or exclusively available.[FN227] Under the proposed rule, coverage for medically appropriate health services must be made available on the same terms and conditions under the plan or coverage for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender.

In addition, we noted that many health-related insurance plans or other health-related coverage, including Medicaid programs, currently have explicit exclusions of coverage for all care related to gender dysphoria or associated with gender transition. Historically, covered entities have justified these blanket exclusions by categorizing all transition-related treatment as cosmetic or experimental.[FN228] However, such across-the-board categorization is now recognized as outdated and not

based on current standards of care.[FN229]

OCR proposed to apply basic nondiscrimination principles in evaluating whether a covered entity's denial of a claim for coverage for transition-related care is the product of discrimination. We noted that based on these principles, an explicit, categorical (or automatic) exclusion or limitation of coverage for all health services related to gender transition is unlawful on its face under paragraph (b)(4); in singling out the entire category of gender transition services, such an exclusion or limitation systematically denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex.

Moreover, we proposed in § 92.207(b)(5) to bar a covered entity from denying or limiting coverage, or denying a claim for coverage, for specific health services related to gender transition where such a denial or limitation results in discrimination against a transgender individual. In evaluating whether it is discriminatory to deny or limit a request for coverage for a particular service for an individual seeking the service as part of transition-related care, we provided that OCR will start by inquiring whether and to what extent coverage is available when the same service is not related to gender transition. If, for example, an issuer or State Medicaid agency denies a claim for coverage for a hysterectomy that a patient's provider says is medically necessary to treat gender dysphoria, OCR will evaluate the extent of the covered entity's coverage policy for hysterectomies under other circumstances. We noted that OCR will also carefully scrutinize whether the covered entity's explanation for the denial or limitation of coverage for transition-related care is legitimate and not a pretext for discrimination.

We noted that these provisions do not, however, affirmatively require covered entities to cover any particular procedure or treatment for transition-related care; nor do they preclude a covered entity from applying neutral standards that govern the circumstances in which it will offer coverage to all its enrollees in a nondiscriminatory manner.

We invited comment as to whether the approach of § 92.207(b)(1)-(5) is over- or underinclusive of the types of potentially discriminatory claims denials experienced by transgender individuals in their attempts to access coverage and care, as well as on how nondiscrimination principles apply in this context.

Paragraph (c) of § 92.207 of the proposed rule provided that the enumeration of specific forms of discrimination in paragraph (b) does not limit the general applicability of the prohibition in paragraph (a) of this section. Paragraph (d) of the proposed rule provided that nothing in § 92.207 is intended to determine, or restrict a covered entity from determining, whether a particular health care service is medically necessary or otherwise meets applicable coverage requirements in any individual case.

The comments and our responses regarding § 92.207 are set forth below.

Comment: Numerous commenters requested clarification regarding the rule's applicability to various health programs or activities that are regulated under other Federal requirements and recommended that OCR deem health programs and activities that comply with existing Federal regulations as in compliance with, or exempt from, Section 1557. For example, commenters requested that compliance with CMS regulations pertaining to qualified health plans or insurance benefit design, such as prescription drug formularies designed by a pharmacy and therapeutics committee,[FN230] be deemed compliance with the final rule. Numerous commenters also requested that OCR harmonize its language access requirements with existing CMS regulations. This is addressed in the discussion of § 92.201.

In addition, other commenters sought clarification as to the applicability of the rule to wellness programs [FN231] and value-based insurance designs [FN232] that are regulated by other Federal departments and agencies, and similarly requested that compliance with other Federal laws regarding these programs be deemed compliance with this final rule. Conversely, regarding employer ***31430** wellness programs, one commenter wanted OCR to expressly prohibit covered entities from implementing outcomes-based employee wellness programs that base financial rewards or penalties on outcome standards that are coextensive with or directly related to a disability, such as an outcome standard related to high glucose levels, which are directly related to diabetes.

Response: For the same reasons discussed in connection with the General Comments above,[FN233] we reject the recommendation to deem health programs or activities that comply with other Federal regulations as automatically in

compliance with, or exempt from, the final rule. As a general matter, OCR does not view a covered entity's compliance with other Federal regulations, adopted with different requirements and for different purposes, as determinative of a covered entity's compliance with Section 1557 or other Federal civil rights laws that we enforce. Moreover, deeming compliance in this context must be considered in light of the potential harmful consequences to consumers' health that may occur if covered entities do not adhere to civil rights obligations.

While we reject deeming, OCR will consider a covered entity's compliance with other applicable Federal laws in evaluating a covered entity's compliance with this final rule, and will continue to coordinate with other Federal agencies to promote consistency and avoid duplication in enforcement efforts.

Further, we clarify that evidence-based insurance designs and wellness programs offered through covered entities, such as a health insurance issuer or a group health plan that receives Federal financial assistance, are health programs or activities that are subject to the final rule. We decline to expressly prohibit a particular type of practice by wellness programs in the final rule, as complaints will be reviewed on a case-by-case basis. We note that CMS has made clear that covered entities are responsible for ensuring compliance with other applicable Federal and State laws, including nondiscrimination obligations under Federal laws.[FN234] We remind covered entities that employer-sponsored wellness programs are considered an employee health benefit program and that employers will be subject to liability for discrimination in such programs under the circumstances identified in § 92.208.

Comment: Several commenters expressed concern that covered entities would not be able to revise their health insurance coverage or other health coverage to comply with the regulation within 60 days after publication, and requested that the effective date of the final rule, in particular § 92.207, be delayed until January 1, 2017 or 2018.[FN235] These commenters explained that health insurance plans are filed for review with CMS and State insurance regulators during the year before the calendar year in which the plan is offered for sale. Thus, depending on the publication date of the final rule, the commenters suggested that delaying the effective date to plan years (in the individual market, policy years) beginning in 2017 or 2018 would be necessary for issuers to avoid the administrative challenges associated with applying the final rule's requirements in the middle of a plan year or policy year, including amending benefit designs, revising premium rates if applicable, and refiling the products for review with CMS and State insurance regulators. In addition, the commenters noted that issuers are not permitted to adjust rates mid-year for some insurance products.

By contrast, one commenter supported maintaining the proposed effective date, arguing that the benefits of more immediate implementation of the final rule outweigh any expenses or confusion associated with mid-year policy revisions.

Response: We appreciate the concerns expressed by the commenters but we are maintaining the effective date as 60 days after the date of publication of the final rule, except in the limited circumstances described below. Section 1557 has been in effect since its passage as part of the ACA in March 2010, and covered entities have been subject to its requirements since that time. To delay implementation of the final rule would delay the existing and ongoing protections that Section 1557 currently provides and has provided since enactment.[FN236]

That said, we recognize that some covered entities will have to make changes to their health insurance coverage or other health coverage to bring that coverage into compliance with this final rule. We are sensitive to the difficulties that making changes in the middle of a plan year could pose for some covered entities and are committed to working with covered entities to ensure that they can comply with the final rule without causing excessive disruption for the current plan year.

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

Comment: Several commenters representing issuers and large employers recommended that the rule exempt from Section 1557 benefits that constitute excepted benefits under section 2791(c) of the Public Health Service Act (codified at 42 U.S.C. 300gg-91(c)), which generally are exempt from market reforms under the ACA and HIPAA portability requirements. Excepted benefits include, but are not limited to: limited scope dental and vision plans; coverage only for a specified disease

or illness; and Medicare supplemental health insurance (also known as Medigap).[FN237] Commenters suggested that being excepted from the ACA market reforms and HIPAA portability requirements should result in exemption from Section 1557. Others stated that covering excepted benefits under the rule would serve as a disincentive to employers to provide these benefits due to increased litigation risk.

Response: We are not exempting benefits excepted from ACA market reforms and HIPAA portability requirements from the final rule. If an issuer providing these benefits receives Federal financial assistance and is principally engaged in providing health benefits, all of its operations will be covered by the rule; if it is not principally engaged, we will apply the rule to its federally funded health ***31431** programs and activities. Many of the benefits excepted from the ACA market reforms and HIPAA portability rules will meet the definition of "health program and activity." [FN238]

Nothing in the text of Section 1557 limits its coverage only to health programs and activities created or regulated by other provisions of the ACA. Indeed, Section 1557's incorporation of the four civil rights laws to which it refers, as those laws were amended by the CRRA, conclusively suggests otherwise. Moreover, Title VI, Section 504, and the Age Act independently apply to these benefits,[FN239] and other civil rights laws, such as Title VII, apply to these benefits when they are provided as a fringe benefit of employment by employers covered by that law.

There are several statutorily-defined categories of excepted benefits that are exempt from the ACA market reforms and HIPAA portability requirements if certain conditions are satisfied, such as when medical benefits are incidental or secondary to other insurance benefits, when the benefits are limited in scope or supplemental, or when the benefits are provided as independent, non-coordinated benefits.[FN240] Excepted benefits do not provide comprehensive medical coverage and do not satisfy the individual or employer responsibility provisions under the ACA. But these characteristics do not justify an exemption from the requirements of Section 1557, which reflects the fundamental policy that entities that operate health programs and activities, any part of which receives Federal funds, cannot use those funds to discriminate—however broad or narrow the scope of those health programs and activities may be.

Comment: Some commenters requested that OCR address a number of issues that are not within the purview of OCR or Section 1557, including the scope of essential health benefit coverage and establishing minimum network adequacy requirements.

Response: OCR appreciates the commenters' suggestions, but the commenters' requests are beyond the scope of this regulation. CMS is statutorily responsible for establishing and regulating the scope of essential health benefits and network adequacy requirements for health insurance issuers. Absent any allegation that a covered entity has discriminated on a basis prohibited by Section 1557, OCR lacks authority to address the terms of these CMS regulations.

Comment: Several commenters asked that OCR exercise more stringent and consistent oversight over consumer access to a wide range of specialists and subspecialists. Commenters pointed out that many qualified health plans in the Marketplace[FNSM] offer network-based plans, and enrollee cost-sharing can be substantially lower when care is delivered by an in-network provider. The commenters expressed concern that some issuers appear to systematically exclude from their provider networks high-cost providers or those in certain high-cost specialties. The commenters suggested that narrow networks could potentially be discriminatory if they deprive patients of reasonable access to a specialty provider or if they discourage enrollment by individuals with specific health needs.

Response: OCR agrees that provider networks with a wide range of specialists and subspecialists are beneficial for consumers and appreciates the concerns expressed about the effect of the exclusion of certain specialists from an issuer's network. We clarify, however, that it is beyond the scope of this regulation to establish uniform or minimum network adequacy standards. Qualified health plan issuers are subject to network adequacy requirements under CMS regulations.[FN241]

Comment: Some commenters asked OCR to clarify that issuers cannot discriminate against providers based on a provider's protected status. That is, these commenters recommended that OCR make clear that Section 1557's prohibition of discrimination is not limited in scope to the health care consumer and extends to other entities that may be engaged in health programs and activities.

Response: OCR clarifies that covered entities providing or administering health-related insurance or other health-related coverage may not discriminate against or exclude health care providers they contract with on the basis of the provider's race, color, national origin, sex, age, or disability. OCR reminds covered entities that they may have obligations under other Federal laws prohibiting discrimination against providers [FN242] or against employees.[FN243]

Comment: A few commenters asked OCR to amend § 92.207(a) so that it more clearly describes the various activities that a covered entity may perform that are considered "administering" health-related insurance or other health-related coverage. Specifically, these commenters asked that OCR add language to § 92.207(a) explaining that administering health-related insurance or other health-related coverage may include claims processing, rental of a provider network, designing plan benefits or policies, drafting plan documents, processing or adjudicating appeals, administering disease management services, and pharmacy benefit management.

Response: We appreciate the commenters' suggestion, but we believe the regulatory text is clear as written and does not require further clarification. The term "administering" is broad enough to encapsulate a variety of activities related to the administration of health-related insurance or other health-related coverage.

Comment: We received a number of comments related to the proper handling of claims alleging discrimination in employee health benefit plans that are covered by both this rule and other Federal laws and regulations. For example, several commenters recommended that the rule not apply to the services of third party administrators providing administrative services to self-insured group health plans. These commenters asserted that Congress did not intend for third party administrators to be covered by Section 1557 and asserted that third party administrators do not design plans, are not responsible for determining the benefits covered under the plan, and are required by ERISA [FN244] to administer plans as they are written. Commenters also asserted that coverage of third party administrators would indirectly subject self-insured group health plans to Section 1557 and create an unlevel playing field between third party administrators operated by issuers that receive Federal financial assistance and those that do not, thereby creating a disincentive for self-insured group health plans to contract with third party administrators that participate as issuers in the Marketplace[FNSM] and a resulting ***31432** disincentive for issuers to offer qualified health plans on the Marketplace[FNSM]. These commenters also emphasized that self-insured group health plans are already subject to extensive Federal regulation under ERISA.

Some commenters representing issuers and larger employers also objected to language in footnote 73 [FN245] in the preamble of the proposed rule stating that when an entity that acts as a third party administrator is legally separate from the issuer that receives Federal financial assistance, we will engage in a case-by-case analysis to determine whether the third party administrator is subject to the rule. These commenters stated that the rule should never extend beyond the legal entity that receives the Federal financial assistance.

Response: We are not excluding third party administrator services from the final rule; however, we are adopting specific procedures to govern the processing of complaints against third party administrators.

Third party administrator services are undeniably a health program or activity, as they involve the administration of health services. Under the final rule, if an entity that receives Federal financial assistance is principally engaged in providing or administering health services, health insurance coverage, or other health coverage, then, consistent with the approach taken under the civil rights laws referenced in Section 1557 and under the CRRA, as discussed supra,[FN246] all of its operations are covered. Thus, if an issuer that receives Federal financial assistance is principally engaged in providing health insurance and also provides third party administrator services, there is no principled basis on which to exclude the law's application to the third party administrator services or to treat them differently from other entities and services covered by the rule.

Commenters' assertion that employers or group health plans may have an incentive to contract with third party administrators that are operated by entities that do not receive Federal financial assistance does not justify exempting third party administrator services from the rule. Commenters' rationale would undermine the application of all of the civil rights laws that attach obligations to the receipt of Federal financial assistance; if any competitive disparity exists here, it is no different than in other types of businesses in which some entities receive Federal financial assistance and others do not.

Moreover, the fact that third party administrators are governed by other Federal laws such as ERISA is not a reason to exempt them from Section 1557. ERISA itself explicitly preserves the independent operation of civil rights laws, by

providing that nothing in ERISA "shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law." [FN247] And in any event, the fact that entities are subject to regulation under other Federal statutory schemes adopted for other purposes does not justify insulating them from the obligation to comply with civil rights requirements.[FN248]

Commenters expressed a number of concerns related to the relationship between third party administrators and the employers whose self-insured group health plans they administer. OCR clarifies here that, contrary to the understanding of some commenters, Section 1557's coverage of a third party administrator under the rule does not extend to the coverage of an employer providing a group health plan that is being administered by the third party administrator. The rule addresses employer liability separately from that of issuers that receive Federal financial assistance; [FN249] under Section 1557, an employer is liable for discrimination in its employee health benefit programs only if the employer is principally engaged in health services, health insurance coverage, or other health coverage, or otherwise satisfies one of the criteria set forth in § 92.208. Whether an employer's group health plan is administered by a third party administrator that is a covered entity is not relevant in this analysis.

In response to commenters' arguments on this point, however, OCR recognizes that third party administrators are generally not responsible for the benefit design of the self-insured plans they administer and that ERISA (and likely the contracts into which third party administrators enter with the plan sponsors) requires plans to be administered consistent with their terms.[FN250] Thus, if a plan has a discriminatory benefit design under Section 1557, a third party administrator could be held responsible for plan features over which it has no control.

Based on these comments, OCR is adjusting the way in which it will process claims that involve alleged discrimination in self-insured group health plans administered by third party administrators that are covered entities. Fundamentally, OCR will determine whether responsibility for the decision or other action alleged to be discriminatory rests with the employer or with the third party administrator. Thus, where the alleged discrimination is related to the administration of the plan by a third party administrator that is a covered entity, OCR will process the complaint against the third party administrator because it is that entity that is responsible for the decision or other action being challenged in the complaint. Where, for example, a third party administrator denies a claim because the individual's last name suggests that she is of a certain national origin or threatens to expose an employee's transgender or disability status to the employee's employer, OCR will proceed against the third party administrator as the decision-making entity. Where, by contrast, the alleged discrimination relates to the benefit design of a self-insured plan—for example, where a plan excludes coverage for all health services related to gender transition—and where OCR has jurisdiction over a claim against an employer under Section 1557 because the employer falls under one of the categories in § 92.208, OCR will typically address the complaint against that employer.

As part of its enforcement authority, OCR may refer matters to other Federal agencies with jurisdiction over the entity. Where, for example, OCR lacks jurisdiction over an employer responsible for benefit design, OCR typically will refer or transfer the matter to the EEOC and allow that agency to address the matter. The EEOC has informed OCR that, provided the filing meets the requirements for an EEOC charge, the date a complaint was filed with OCR will be deemed the date it was filed with the EEOC (although any subsequent denial of a renewed coverage request could be separately challenged by a timely complaint).

This approach is consistent with our efforts to ensure coordination with other Federal agencies that can also exercise jurisdiction over the subject of a particular complaint. Thus, we will also coordinate with the Office of Personnel Management (OPM) in the handling of claims alleging discrimination in the Federal Employees Health Benefits (FEHB) Program. OPM is charged by ***31433** Federal statute [FN251] with offering FEHB plans as a fringe benefit of Federal employment and, in that role, approves benefit designs and premium rates, sets rules generally applicable to FEHB carriers, adjudicates and orders payment of disputed health claims, and adjusts policies as necessary to ensure compliance with nondiscrimination standards. As a result, OCR will refer to OPM complaints that allege discrimination in the FEHB Program where OPM is the entity with decision-making authority over the challenged action; OPM will treat these claims as complaints filed against OPM and will seek relief comparable to that available were these claims to be processed by OCR under Section 1557.

In response to the comments requesting additional clarification on footnote 73 in the proposed rule, we reiterate that we will engage in a case-by-case inquiry to evaluate whether a third party administrator is appropriately subject to Section 1557 as a

recipient in situations in which the third party administrator is legally separate from an issuer that receives Federal financial assistance for its insurance plans. This analysis will rely on principles developed in longstanding civil rights case law, such as the degree of common ownership and control between the two entities,[FN252] and will also examine whether the purpose of the legal separation is a subterfuge for discrimination—that is, intended to allow the entity to continue to administer discriminatory health-related insurance or other health-related coverage.[FN253] But we note that a third party administrator is unlikely to be covered by this final rule where it is a legal entity that is truly independent of an issuer's other, federally funded, activities.

Comment: Commenters requested clarification on OCR's approach when evaluating whether a prohibited discriminatory action occurred under § 92.207(b).

Response: We clarify that OCR's approach in applying basic nondiscrimination principles, as discussed in the proposed rule under § 92.207(b)(5) [FN254] relating to coverage for specific health services related to gender transition, is the same general approach that OCR will take when evaluating denials or limitations of coverage for other types of health services. In other words, OCR will evaluate whether a covered entity utilized, in a nondiscriminatory manner, a neutral rule or principle when deciding to adopt the design feature or take the challenged action or whether the reason for its coverage decision is a pretext for discrimination. For example, if a plan limits or denies coverage for certain services or treatment for a specific condition, OCR will evaluate whether coverage for the same or a similar service or treatment is available to individuals outside of that protected class or those with different health conditions and will evaluate the reasons for any differences in coverage. Covered entities will be expected to provide a neutral, nondiscriminatory reason for the denial or limitation that is not a pretext for discrimination.

Comment: One commenter asked OCR to clarify that targeted marketing practices designed to reach certain populations to increase enrollment, such as specific segments of those who are uninsured or underserved, are not considered discriminatory. This commenter pointed out that some issuers sometimes launch targeted campaigns to reach a high number of uninsured in their service areas. In so doing, issuers may study the profile of uninsured populations, and based on the results of that study, may concentrate their marketing efforts on certain demographic groups that are disproportionately uninsured or underserved. The commenter cited a Gallup Poll that indicated that roughly one-third of Hispanics remain uninsured, which the commenter stated creates a particular need for issuers to help educate and expand coverage for this community. The commenter sought reassurance that OCR will not consider it discriminatory to target enrollment efforts where they will make the most difference.

Response: Congress intended the ACA to help uninsured and underserved populations gain access to care. Nothing in this regulation is intended to limit targeted outreach efforts to reach underserved racial or ethnic populations or other underserved populations. Indeed, it is OCR's intention that this regulation will increase access for uninsured and underserved populations, much as other Departmental regulations implementing the ACA have strived to do.[FN255]

Comment: Several commenters recommended that we define "marketing practices" in the regulatory text of § 92.207(b)(2). These commenters suggested that the inclusion of a precise definition for "marketing practices" would serve to clarify the scope of § 92.207(b)(2).

Response: We decline to define "marketing practices" in the final rule because to do so would be overly prescriptive. We emphasize, however, that we intend to interpret the term "marketing practices" broadly; such practices would include, for example, any activity of a covered entity that is designed to encourage individuals to participate or enroll in the covered entity's programs or services or to discourage them from doing so, and activities that steer or attempt to steer individuals towards or away from a particular plan or certain types of plans. We remind covered entities that other Departmental regulations address marketing practices,[FN256] and covered entities are obligated to comply with all applicable Federal and State laws regarding such practices.

Comment: Many commenters recommended that we define "benefit design" in the regulatory text of the final rule. These commenters suggested that the inclusion of a precise definition of "benefit design" would serve to clarify the scope of § 92.207(b)(2). In addition, numerous commenters requested that we codify or provide examples of benefit designs that discriminate on the basis of race, color, national origin, sex, age, or disability. A number of commenters urged OCR to consider specific types of benefit designs as constituting per se discrimination under § 92.207(b)(2) of the final rule.

Response: We appreciate commenters' requests for guidance and clarification regarding potentially discriminatory benefit designs and suggestions for scenarios that constitute per se discrimination. However, we decline to ***31434** define "benefit design" in the final rule because to do so would be overly prescriptive.[FN257] We also decline to codify examples of discriminatory benefit designs because determining whether a particular benefit design results in discrimination will be a fact-specific inquiry that OCR will conduct through its enforcement of Section 1557. For the same reason, we avoid characterizing specific benefit design practices as per se discriminatory in the final rule.[FN258]

OCR will analyze whether a design feature is discriminatory on a case-by-case basis using the framework discussed above. We reiterate that our determination of whether a practice constitutes discrimination will depend on our careful analysis of the facts and circumstances of a given scenario. OCR recognizes that covered entities have discretion in developing benefit designs and determining what specific health services will be covered in their health insurance coverage or other health coverage. The final rule does not prevent covered entities from utilizing reasonable medical management techniques; nor does it require covered entities to cover any particular procedure or treatment. It also does not preclude a covered entity from applying neutral, nondiscriminatory standards that govern the circumstances in which it will offer coverage to all its enrollees in a nondiscriminatory manner. The rule prohibits a covered entity from employing benefit design or program administration practices that operate in a discriminatory manner.

Comment: We received a number of comments requesting that OCR add language to § 92.207(b) clarifying that categorical exclusions of certain conditions, such as coverage related to developmental disabilities or maternity care, are prohibited.

Response: While categorical exclusions of all coverage related to certain conditions could raise significant compliance concerns under Section 1557, OCR believes that existing regulatory language is sufficient to address this scenario. For example, the law has long recognized that discrimination based on pregnancy is a form of sex discrimination,[FN259] and OCR has interpreted Section 1557 in the same manner by defining the term "on the basis of sex" in this regulation to include "discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions." As a result, it is unnecessary to add language in response to commenters' concerns.

We note that some products known as excepted benefits, which are subject to this final rule as discussed supra, provide limited scope benefits or coverage only for a specified disease or illness.[FN260] It would not be discriminatory for such products to include exclusions of coverage for conditions that are outside the scope of the benefits provided in those products. Accordingly, the purpose and scope of the coverage provided under health-related insurance or health-related coverage are factors that OCR will consider in determining whether an exclusion of all coverage for a certain condition is discriminatory under this final rule.

Comment: In light of OCR's statement in the preamble to the proposed rule that "[t]he proposed rule does not require plans to cover any particular benefit or service, but a covered entity cannot have a coverage policy that operates in a discriminatory manner," [FN261] a few commenters asked OCR to clarify that the solution to a potentially discriminatory benefit design could be addition of coverage for a benefit or service.

Response: OCR agrees that the solution to a potentially discriminatory benefit design could be coverage, or added coverage, of a benefit or service.

Comment: The proposed rule invited comment as to whether the approach of § 92.207(b)(1)-(5) is over- or under-inclusive of the types of potentially discriminatory claim denials experienced by transgender individuals in their attempts to access coverage and care, as well as on how nondiscrimination principles apply in this context.[FN262] Many commenters supported OCR's approach in prohibiting a range of practices that discriminate against transgender individuals by denying or limiting coverage for medically necessary and medically appropriate health services. Numerous commenters asserted that the protections at § 92.207(b)(3)-(5) are vital to ensuring that transgender individuals are able to access the health coverage and care they need and urged OCR to preserve these provisions in the final rule.

For instance, many commenters strongly supported the proposed rule's prohibition against categorical or automatic exclusions of coverage for all health services related to gender transition. These commenters further supported the proposed rule's prohibition against otherwise denying or limiting coverage, or denying a claim, for health services related to gender

transition if such a denial or limitation results in discrimination against a transgender individual. These commenters expressed hope that these prohibitions will serve to eliminate the significant barriers that transgender individuals have faced in accessing coverage for transition-related care, such as counseling, hormone therapy, and surgical procedures that they said had previously been denied to them because they have been viewed as cosmetic or experimental. Many commenters also favored the prohibition against denying, limiting, or otherwise restricting coverage for health services that are ordinarily or exclusively available to individuals of one sex based on an individual's gender identity. Commenters indicated that the proposed rule's protections will help to resolve various health care disparities suffered by transgender individuals.

Several commenters, however, opposed the protections that the proposed rule affords to transgender individuals. Some commenters suggested that covered entities should ***31435** be permitted to categorically exclude coverage for transition-related health services based on moral or religious convictions that an individual's biological sex, or sex assigned at birth, should not be altered. Other commenters suggested that OCR is exceeding its legal authority by addressing covered entities' provision of coverage to transgender individuals because discrimination based on gender identity should not be recognized as a form of sex discrimination.

Response: We agree with the commenters who expressed their general support of the protections for transgender individuals afforded by the provisions at § 92.207(b)(3)-(5), and therefore we are keeping the provisions as proposed. We believe that it is important to ensure that civil rights protections are extended to transgender individuals to afford them equal access to health coverage, including for health services related to gender transition. As we stated in the preamble to the proposed rule, the across-the-board categorization of all transition-related treatment, for example as experimental, is outdated and not based on current standards of care.[FN263]

Further, we disagree with commenters who asserted that sex-based discrimination does not include discrimination based on gender identity. As discussed previously,[FN264] OCR's definition of discrimination "on the basis of sex" is consistent with the well-accepted interpretations of other Federal agencies and courts. Further, as previously noted in this preamble,[FN265] we decline to adopt a blanket religious exemption in the final rule as any religious concerns are appropriately addressed pursuant to pre-existing laws such as RFRA and provider conscience laws.

Comment: A significant number of commenters recommended that OCR revise the language in § 92.207(b)(4) that prohibits categorical exclusions or limitations of "all health services related to gender transition" to remove the word "all," and proposed modifications to § 92.207(b)(3)-(5) relating to the medical necessity or medical appropriateness of coverage for health services related to gender transition and sex-specific services. Other commenters, concerned that the rule may be too broadly interpreted, requested clarification as to when gender transition services or sex-specific services must be provided and recommended that the rule specify that such health services are to be provided only when medically necessary or medically appropriate. These commenters also requested that OCR clarify that the rule's intent is not to require covered entities to cover elective services or mandate that it cover certain services. Conversely, other commenters specifically requested that the rule clarify that covered entities cannot deny medically necessary services for gender transition-related care because such treatment is medically necessary for transgender individuals. Further, some commenters suggested that covered entities must provide coverage for procedures or services to treat gender dysphoria or associated with gender transition when substantially similar procedures or services are covered for other conditions. For example, commenters observed that a hysterectomy to treat gender dysphoria is substantially similar to a hysterectomy performed for cancer treatment or prevention in a cisgender woman (i.e., a woman whose gender identity is consistent with her sex assigned at birth).

Response: OCR appreciates the array of comments provided but does not believe it is necessary to revise the regulatory text. As noted in the preamble to the proposed rule, we will evaluate whether a particular exclusion is discriminatory based on the application of longstanding nondiscrimination principles to the facts of the particular plan or coverage. Under these principles, issuers are not required to cover all medically necessary services. Moreover, we do not affirmatively require covered entities to cover any particular treatment, as long as the basis for exclusion is evidence-based and nondiscriminatory.

Thus, we reject commenters' suggestion that the rule require covered entities to provide coverage for all medically necessary health services related to gender transition regardless of the scope of their coverage for other conditions.

At the same time, the rule does require that a covered entity apply the same neutral, nondiscriminatory criteria that it uses for other conditions when the coverage determination is related to gender transition. Thus, if a covered entity covers certain types

of elective procedures that are beyond those strictly identified as medically necessary or appropriate, it must apply the same standards to its coverage of comparable procedures related to gender transition. As a result, we decline to limit application of the rule by specifying that coverage for the health services addressed in § 92.207(b)(3)-(5) must be provided only when the services are medically necessary or medically appropriate.

With regard to § 92.207(b)(3), we recognize that not every health service that is typically or exclusively provided to individuals of one sex will be a health service that is appropriately provided to a transgender individual. Nothing in the rule would, for example, require an issuer to cover a traditional prostate exam for an individual who does not have a prostate, regardless of that individual's gender identity. However, the issuer must cover the health services that are appropriately provided to an individual by applying the same terms and conditions, regardless of an individual's sex assigned at birth, gender identity, or recorded gender.

We also clarify that the prohibition in § 92.207(b)(4) on categorically limiting coverage for all health services related to gender transition is intended to prevent issuers from placing categorical, arbitrary limitations or restrictions on coverage for all gender transition-related services, such as by singling out services related to gender transition for higher co-pays; it is not intended to prevent issuers from placing nondiscriminatory limitations or restrictions on coverage under the plan. We have revised the language of the provision to clarify that intent.

Comment: Some commenters requested that the final rule define "health services related to gender transition."

Response: We decline to include a definition of "health services related to gender transition." OCR intends to interpret these services broadly and recognizes that health services related to gender transition may change as standards of medical care continue to evolve.

The range of transition-related services, which includes treatment for gender dysphoria, is not limited to surgical treatments and may include, but is not limited to, services such as ***31436** hormone therapy and psychotherapy, which may occur over the lifetime of the individual. We believe the flexibility of the general language in the final rule best serves transgender individuals and covered entities.

Comment: Several commenters expressed concern that some issuers do not yet have the technological capability to avoid initial denials of coverage for sex-specific services for transgender individuals due to their computer systems flagging a mismatch between the gender of the individual identified at enrollment and the billing code associated with the biological sex that typically receives the health service. The commenters explained that issuers' computer systems accommodate only binary gender billing codes (e.g., "male" or "female") and cannot accommodate descriptions of an enrollee's gender identity. Further, commenters observed that the Health Insurance Marketplace[FNSM] enrollment application available through HealthCare.gov permits applicants to identify themselves only as male or female and does not currently allow applicants to denote their gender identity. These commenters noted that, as a result, qualified health plan issuers receive incomplete information about an enrollee's gender identity and biological sex. Moreover, these commenters requested that OCR clarify that an initial denial of a transgender enrollee's claim due to the discrepancy between the enrollee's recorded gender and the sex with which the health service is generally associated does not constitute discrimination if the enrollee is able to reverse the denial through an internal appeals process.

Response: As we indicated in the proposed rule,[FN266] we recognize that some issuers use computer systems that accommodate only binary gender billing codes that flag a gender mismatch for coverage of certain sex-specific services. We noted that such flagging, by itself, would not be impermissible if it does not result in a delay or denial of services or a claim for services. We reject, however, the commenters' suggestion that an initial denial of a transgender enrollee's claim should never be considered discriminatory as long as the enrollee is able to correct the denial through the internal appeals process. Requiring transgender enrollees to repeatedly go through the internal appeals process to obtain coverage for certain services would subject these enrollees to a burdensome process that is likely to delay their receipt of coverage.

Moreover, there are available interim methods for correcting initial coverage denials due to computer systems flagging a gender mismatch that issuers can use as their computer systems are updated. For instance, we understand that current billing code practices include general billing code modifiers that are used to identify situations in which issuers need to evaluate further claims that might otherwise be automatically rejected. As a result, issuers could advise health care providers to submit

an existing billing code modifier along with a claim for sex-specific services for a transgender patient to flag the billing for the issuer's further review.[FN267] Issuers are free to develop another method of processing claims for sex-specific services by transgender individuals as long as the process is not overly burdensome and provides timely access to care. We note that commenters have raised concerns about the Health Insurance Marketplace[FNSM] enrollment application and will address these concerns as appropriate.

Comment: One commenter recommended that we extend a safe harbor protection to issuers who demonstrate their good faith compliance with § 92.207(b)(3) for the time period during which they update their computer systems and operations to prevent inappropriate denials of coverage for sex-specific services for transgender enrollees.

Response: While we reject the commenter's recommendation of a safe harbor protection, OCR is willing to work with issuers to help identify potential interim solutions and to come into compliance.

Comment: One commenter requested clarification regarding whether an issuer may require transgender enrollees to provide additional information related to their biological sex to enable the issuer to override inappropriate denials of coverage for sex-specific health services. Another commenter inquired as to whether an issuer is permitted to request information about an applicant's biological sex on an insurance application form.

Response: We understand that, in some instances, a covered entity may need to ask transgender enrollees for additional information, including information related to their biological sex or sex assigned at birth, to facilitate overriding denials of coverage for sex-specific health services due to gender billing code mismatches in their computer systems. We clarify in this preamble that a covered entity is permitted to ask transgender enrollees to provide such additional information, as long as the covered entity does not unduly burden enrollees or make unreasonable inquiries that serve to delay their receipt of coverage. In addition, we clarify that it is permissible for a covered entity to request information about the biological sex of the applicant on an insurance application form to assist the covered entity in identifying the medical appropriateness of sex-specific health services, as long as the information requested is not used in a discriminatory manner, and the collection and use of the information is otherwise lawful and complies with applicable HIPAA privacy requirements.

Comment: Many commenters recommended revisions to § 92.207(d), which provides that nothing in this section is intended to determine, or restrict a covered entity from determining, whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case. Some commenters requested that we revise this provision to ensure that a covered entity does not use criteria that lead to a discriminatory result in its medical necessity or coverage determinations. For example, some commenters suggested that we require covered entities to use certain treatment guidelines when determining medical necessity or coverage for transgender-related health services, such as those published by the WPATH. Conversely, other commenters expressed concern that Section 1557 may unduly restrict a covered entity's ability to evaluate medical necessity in its coverage determinations and requested clarification that covered entities are permitted to require certain treatment, such as mental health services for gender dysphoria, as part of their medical necessity or coverage determinations.

Response: We appreciate the concerns raised by commenters, but we are maintaining the language in § 92.207(d) without revision. OCR will not second-guess a covered entity's neutral ***31437** nondiscriminatory application of evidence-based criteria used to make medical necessity or coverage determinations. Therefore, we refrain from adding any regulatory text that establishes or limits the criteria that covered entities may utilize when determining whether a health service is medically necessary or otherwise meets applicable coverage requirements. Nevertheless, we caution covered entities that, although § 92.207(d) does not dictate the criteria that a covered entity must use, a covered entity must use a nondiscriminatory process to determine whether a particular health service is medically necessary or otherwise meets applicable coverage requirements.

Summary of Regulatory Changes

For the reasons set forth in the proposed rule and considering the comments received, we are finalizing the provisions proposed in § 92.207 with minor technical revisions for clarity, to make our intent clear, and to ensure consistency with other parts of the final rule. We are making technical corrections to paragraphs (b)(1), (b)(3) and (b)(5) to add the word "coverage" where appropriate to reconcile with other parts of the rule. In (b)(1), we are making two modifications to the language. We are reconciling the usage of "health-related insurance" and "other health-related coverage" by adding "related" to those terms in (b)(1). We are also removing reference to "enrollees" as it unintentionally limited application of the paragraph. In (b)(2),

we are replacing text that prohibited employing discriminatory marketing practices or benefit designs with text that prohibits having or implementing discriminatory marketing practices or benefit designs to clarify our intent that both having and applying discriminatory marketing practices and benefit design are prohibited. This clarification does not substantively modify the prohibition set forth in the proposed rule. In (b)(3), we are adding the words "to a transgender individual" for clarity, and are deleting the words "by the plan or issuer" for consistency with other parts of the rule. In (b)(4), we are revising the language to be clear that our intent was to prohibit categorical exclusions or limitations in both benefit design and administration; thus, we are replacing language prohibiting categorical or automatic exclusions or limitations of coverage with language that prohibits having or implementing a categorical exclusion or limitation of coverage. This clarification does not substantively modify the prohibition set forth in the proposed rule. In (b)(5), we also are revising the description of the prohibited actions to reconcile the language with other paragraphs in § 92.207(b).

Employer Liability for Discrimination in Employee Health Benefit Programs (§ 92.208)

In § 92.208, we proposed to address the application of Section 1557 to employers that offer health benefit programs to their employees. Under our proposed approach, where an entity that receives Federal financial assistance provides an employee health benefit program to its employees, it will be liable for discrimination in that employee health benefit program under this part only in three defined circumstances.[FN268] In paragraph (a), we proposed that where an employer is principally engaged in providing or administering health services or health coverage and receives Federal financial assistance, the employer would be subject to Section 1557 in its provision or administration of employee health benefit programs to its employees. Thus, if a hospital provides health benefits to its employees, it will be covered by Section 1557 not only for the services it offers to its patients or other beneficiaries but also for the health benefits it provides to its employees.[FN269]

In paragraph (b), we proposed that where an entity receives Federal financial assistance the primary objective of which is to fund an employee health benefit program, that entity's provision or administration of the health benefit program will be covered by Section 1557 regardless of the business in which the entity is engaged.

In paragraph (c), we proposed that an employer that is not principally engaged in providing or administering health services or health insurance coverage, but that operates a health program or activity (that is not an employee health benefit program) that receives Federal financial assistance, will be covered for its provision or administration of an employee health benefit program, but only with regard to employees in the health program or activity. Thus, we noted that when a State receives Federal financial assistance for its Medicaid program, the State will be governed by Section 1557 in the provision of employee health benefits for its Medicaid employees, but not for its transportation department employees, assuming no part of the State transportation department operates a health program or activity.

In summary, unless the primary purpose of the Federal financial assistance is to fund employee health benefits, we proposed that Section 1557 would not apply to an employer's provision of employee health benefits where the provision of those benefits is the only health program or activity operated by the employer.

We explained that absent the limitations in § 92.208, employers that receive Federal financial assistance for any purpose could be held liable for discrimination in the employee health benefit programs they provide or administer, even where those employers are not otherwise engaged in a health program or activity and where the use of Federal funds for employee health benefits is merely incidental to the purpose of the assistance. We noted that claims of discrimination in such benefits, brought against employers that do not operate other health programs or activities, could be better addressed under other applicable laws. For example, Title VII of the Civil Rights Act of 1964,[FN270] the ADA,[FN271] and the Age Discrimination in Employment Act [FN272] address claims that an employer has discriminated in the provision of benefits, including health benefits, to its employees.

We proposed to apply the same analysis of employer liability under Section 1557 whether the employee health benefit program is self-insured or fully-insured by the employer. We provided that where an employer that would otherwise be covered under this section creates a separate legal entity to administer its employee health benefit plan, the employer would continue to be liable for the nondiscriminatory provision of employee health benefits to its employees; the employer, as a recipient, may not, through contractual or other arrangements, discriminate on ***31438** a prohibited basis against its employees.[FN273]

The comments and our responses regarding § 92.208 are set forth below.

Comment: One commenter expressed the view that while most churches or church boards providing employee health benefits through a church plan would not be covered under § 92.208, some might be covered under § 92.208(c). The commenter expressed the concern that churches that sponsor plans on behalf of numerous employers would not know whether any of those employers operated a health program or activity and received Federal financial assistance and thus would be required to either comply with Section 1557 requirements, even though most or all of the participating employers do not receive Federal financial assistance, or exclude the employer that receives Federal financial assistance from the plan.

Response: The comment reflects a misunderstanding about the application of § 92.208. This section of the regulation applies to employers, not to plan sponsors. In a church plan with multiple participating employers, the plan sponsor will be an entity other than the employer.[FN274] In this scenario, when an employer is covered under § 92.208(c) and the plan sponsor is a different entity that does not receive Federal financial assistance, it is the employer's obligation, not the plan sponsor's, to ensure that the benefits it provides to employees of its health program or activity do not violate Section 1557. We note that a plan sponsor will be separately covered under Section 1557 if it receives Federal financial assistance and is considered a covered entity under this rule.

Comment: One commenter expressed the view that treating a group health plan as an entity principally engaged in health coverage—and thereby subjecting all of its operations to Section 1557—undermines the limitations on employer liability under § 92.208. The commenter expressed concern that any employer that offers a self-insured group health plan to its employees would be accountable under Section 1557 for any discrimination by that group health plan.

Response: The commenter has misunderstood the relationship between the obligations of an employer and the application of the rule to a separate group health plan providing the employer's employee health benefit program. The fact that a group health plan is principally engaged in providing health services, health insurance coverage, or other health coverage, and therefore must comply with Section 1557 in all of its operations does not necessarily mean that an employer offering an employee health benefit program will be liable for a Section 1557 violation by the group health plan.[FN275] Employers will be liable under Section 1557 only under the circumstances set forth in 92.208.

Comment: Two commenters requested clarification of whether tax credits claimed by an employer that purchases health insurance coverage through the Small Business Health Options Program (SHOP) Marketplace[FNSM] and the health insurance plan purchased through a SHOP are covered by the rule.

Response: The tax credit to a small employer participating in the SHOP Marketplace[FNSM] is not considered Federal financial assistance from the Department under this rule because the tax credit is not administered by the Department.

Comment: Some comments suggested eliminating or drastically revising § 92.208 to make clear that all covered entities are covered in their provision of employee health benefits. One commenter suggested adding "employee health benefits plan" to the definition of "health program or activity." Another asserted that § 92.208 is unnecessary because all group health plans are health programs or activities. One commenter recommended that OCR include in the regulatory text the substance of footnote 93 from the preamble of the proposed rule,[FN276] which clarifies that, regardless of whether an employer is liable for a discriminatory employee health benefit plan, an issuer that is a covered entity will be liable for discrimination in the health insurance coverage it offers to employers.

Response: We decline to eliminate or revise § 92.208 in the manner proposed by these commenters. As we explained in the preamble to the proposed rule,[FN277] absent the limitations in § 92.208, employers that receive Federal financial assistance for any purpose could be held liable for discrimination in the employee health benefits they provide or administer, even where those employers are not otherwise engaged in a health program or activity and where the use of Federal funds for employee health benefits is merely incidental to the purpose of the Federal assistance. We do not believe that Congress intended for Section 1557 to apply in such circumstances. We reiterate that issuers that receive Federal financial assistance and are principally engaged in providing or administering health services, health insurance coverage, or other health coverage are liable for the health insurance coverage offered to employers in connection with a group health plan.

Comment: Some commenters asked us to make clear that employer-provided benefits are covered by the rule even if the employer does not contribute to the cost of these benefits and the entire cost is borne by the employee or other beneficiary.

Response: The rule does not limit employer liability for discrimination in employee health benefit programs to those benefits for which the employer pays for part or all of the cost. Thus, if an employer would otherwise be liable for discrimination in an employee health benefit program, the fact that the employer did not pay for part of the cost of these benefits does not remove it from the reach of 92.208.

Summary of Regulatory Changes

For the reasons set forth in the proposed rule and considering the comments received, we are finalizing the provisions proposed in § 92.208 with minor technical revisions to ensure consistency with other parts of the final rule by adding the words "or other health coverage."

Nondiscrimination on the Basis of Association (§ 92.209)

In § 92.209 of the proposed rule, we specifically addressed discrimination ***31439** faced by an individual or an entity on the basis of the race, color, national origin, age, disability, or sex of an individual with whom the individual or entity is known or is believed to have a relationship or association. We explained that the language of Section 1557 makes clear that individuals may not be subject to any form of discrimination "on the grounds prohibited by" Title VI and other civil rights laws; the statute does not restrict that prohibition to discrimination based on the individual's own race, color, national origin, age, disability or sex. Further, we noted that a prohibition on associational discrimination is consistent with longstanding interpretations of existing anti-discrimination laws, whether the basis of discrimination is a characteristic of the harmed individual or an individual who is associated with the harmed individual.[FN278] A prohibition on associational discrimination is also consistent with the approach taken in the ADA, which includes a specific prohibition of discrimination based on association with an individual with a disability.[FN279]

The comments and our responses regarding § 92.209 are set forth below.

Comment: A few commenters recommended that OCR add the words "or deter" to the prohibition on associational discrimination, so that § 92.209 would read as follows: "A covered entity shall not exclude or deter from participation in, deny the benefits of, or otherwise discriminate against an individual or entity in its health programs or activities on the basis of the race, color, national origin, age, disability, or sex of an individual with whom the individual or entity is known or believed to have a relationship or association."

Response: We believe the regulatory text, as it is currently written, encompasses this approach. It is well established in civil rights law that deterrence is a form of exclusion.[FN280]

Comment: Several comments recommended that the rule state that unlawful discrimination based on association occurs when a provider is subject to adverse treatment because the provider is known or believed to furnish, refer or support services that are medically appropriate for, ordinarily available to, or otherwise associated with a patient population protected by Section 1557.

Response: To clarify, the rule prohibits covered entities from discriminating against any individual or entity on the basis of a relationship or association with a member of a protected class. The term "individual or entity" includes providers. Thus, for example, an issuer covered by the rule may not use the fact that a provider's clientele is primarily composed of individuals with limited English proficiency to disqualify an otherwise eligible and qualified provider from participation in the issuer's network; such a decision would discriminate against the provider on the basis of the provider's association with a national origin group. We believe that the regulatory text encompasses this approach.

Comment: Commenters asked OCR to clarify whether § 92.209's prohibition of discrimination on the basis of association prohibits discrimination against individuals in same sex relationships.

Response: We will interpret the language of § 92.209 consistent with our interpretation of the term "on the basis of sex," as described in § 92.4 above.

Summary of Regulatory Changes
For the reasons set forth in the proposed rule and considering the comments received, we are finalizing the provisions proposed in § 92.209 as proposed without modification.

Subpart D—Procedures

Enforcement Mechanisms (§ 92.301)
In proposed § 92.301, we restated the language of Section 1557 regarding enforcement, which provides that the enforcement mechanisms under Title VI, Title IX, the Age Act, or Section 504 apply for violations of Section 1557. We noted that these existing enforcement mechanisms include requiring covered entities to keep records and submit compliance reports to OCR, conducting compliance reviews and complaint investigations, and providing technical assistance and guidance. We further noted that where noncompliance or threatened noncompliance cannot be corrected by informal means, the enforcement mechanisms provided for and available under the civil rights laws referenced in Section 1557 include suspension of, termination of, or refusal to grant or continue Federal financial assistance; referral to the Department of Justice with a recommendation to bring proceedings to enforce any rights of the United States; and any other means authorized by law.[FN281] In addition, we provided that based on the statutory language, a private right of action and damages for violations of Section 1557 are available to the same extent that such enforcement mechanisms are provided for and available under Title VI, Title IX, Section 504, or the Age Act with respect to recipients of Federal financial assistance. We further provided that a private right of action and damages are available for violations of Section 1557 by Title I entities. We invited comment on these positions.

The comments and our responses regarding § 92.301 are set forth below.

Comment: Many commenters requested that OCR clarify that all enforcement mechanisms available under the statutes listed in Section 1557 are available to each Section 1557 plaintiff, regardless of the plaintiff's protected class. Thus, for example, an individual could bring a race claim under the Age Act procedure and an age claim under the Title VI procedure.

Under this approach, given that the Age Act authorizes a private right of action for disparate impact claims, a private right of action would exist for disparate impact claims of discrimination on the basis of race, color, or national origin.

The commenters primarily rely on reasoning in Rumble v. Fairview Health Services,[FN282] in which the U.S. District Court for the District of Minnesota discussed the standards to be applied to Section 1557 private right of action claims and stated: "It appears Congress intended to create a new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of plaintiff's protected class status. Reading Section 1557 otherwise would lead to an illogical result, as different enforcement ***31440** mechanisms and standards would apply to a Section 1557 plaintiff depending on whether plaintiff's claim is based on her race, sex, age, or disability. For example, it would not make sense for a Section 1557 plaintiff claiming race discrimination to be barred from bringing a claim using a disparate impact theory but then allow a Section 1557 plaintiff alleging disability discrimination to do so." [FN283]

Similarly, many commenters requested that the regulation clarify that a private right of action exists for disparate impact claims, arguing, like commenters discussed above, that all enforcement mechanisms should be available to all Section 1557 complainants. A few commenters requested that the availability of a private right of action be addressed in the final rule itself, rather than in the preamble.

Response: OCR interprets Section 1557 as authorizing a private right of action for claims of disparate impact discrimination on the basis of any of the criteria enumerated in the legislation. At the same time, OCR is incorporating its existing procedures for its administrative processing of complaints; thus, we will use our current processes to address age discrimination on the one hand and race, color, national origin, sex, or disability on the other hand. This approach will enable us to be consistent in our processing of complaints under OCR's other authorities in instances where we have concurrent jurisdiction under Section 1557 and the other civil rights laws it references. This approach is not intended to limit the availability of judicial enforcement mechanisms. We note as well that both the proposed and the final rule specify that a private right of action is available under Section 1557.

Comment: A few commenters suggested that the text of the regulation specifically mention the availability of compensatory

damages. Although OCR discussed the availability of compensatory damages in the preamble of the NPRM, commenters recommended that explicit authorization for compensatory damages in the regulation would strengthen the enforcement of Section 1557.

Response: OCR has added a provision to § 92.301 to make clear in the regulation that compensatory damages are available. Our interpretation of Section 1557 as authorizing compensatory damages is consistent with our interpretations of Title VI, Section 504, and Title IX.

Comment: Many commenters requested that OCR involve the Department of Justice (DOJ) in all Section 1557 investigations and compliance reviews where DOJ has concurrent jurisdiction, and that OCR refer cases to DOJ for litigation, where appropriate.

Response: Although OCR recognizes the importance of working with DOJ and other agencies, it would not be a productive use of resources to include DOJ in every case in which it has concurrent jurisdiction. OCR has been enforcing Section 1557 since it became effective in 2010 and continues to investigate and resolve Section 1557 cases over which it has jurisdiction. OCR involves DOJ in investigations where appropriate and will continue to do so. And, as § 92.209 makes clear, OCR has the authority to refer cases to DOJ for litigation where efforts at compliance have been unsuccessful.

Comment: Some commenters recommended that HHS agreements with State agencies and State contracts with Medicaid managed care organizations include nondiscrimination provisions that obligate the State agencies to ensure compliance with nondiscrimination requirements.

Response: OCR agrees that nondiscrimination provisions in contracts help covered entities to ensure that contractors do not discriminate against program beneficiaries. Although this rule does not require such provisions in contracts, OCR has worked with HHS entities to include such language in their contracts in the past, and OCR will continue to look for opportunities to promote compliance with civil rights laws through nondiscrimination provisions in contracting in the future.

Comment: Several commenters recommended that the regulatory text specifically provide that OCR will conduct compliance reviews and perform outreach. These commenters expressed concern that individual complaint resolution, as an enforcement mechanism, will be inadequate to achieve widespread compliance with the Section 1557 final rule.

Response: We recognize the need for OCR to employ the full range of enforcement tools in order to ensure compliance with the law, and we intend to continue in our robust enforcement of Section 1557. We do not believe that any changes to regulatory text are necessary, since the rule contemplates and authorizes the suite of enforcement mechanisms that OCR has long employed.

Comment: Some commenters recommended that HHS, and not States, should be the primary enforcement agency for benefit design issues. These commenters asserted that State enforcement would lead to inconsistent results.

Response: OCR is responsible for enforcement with respect to benefit design issues under Section 1557. States have an important role in ensuring compliance with nondiscrimination requirements respecting insurance, including benefit design, under CMS regulations and applicable State laws. It is beyond the scope of this rulemaking to change State obligations under those laws.

Comment: Some commenters recommended that OCR be required to publish the outcomes of all resolved Section 1557 complaints and statistics regarding Section 1557 complaints received by OCR.

Response: We decline to accept this recommendation, but OCR will continue to include information and corrective action plans and resolution agreements on the OCR Web site.

Comment: Some commenters recommended that OCR allow at least a one-year period with no administrative sanctions if a covered entity can demonstrate good faith compliance. These commenters suggested that this approach will promote compliance while covered entities, OCR, and consumers become familiar with the requirements of the regulation.

Response: We appreciate the commenters' recommendation, but we decline to accept it because, while good faith is relevant under certain CMS regulations with which covered entities may be familiar, courts have not treated good faith as a consideration in assessing whether a covered entity is in compliance with the civil rights laws referenced in Section 1557. We are retaining this principle in interpreting whether a covered entity is in compliance with Section 1557. That said, OCR has the authority and discretion to consider a range of factors when reviewing cases and determining appropriate remedies, including consideration of steps taken by covered entities to ensure compliance with the law, compliance with other Federal regulations regarding the issue, timeframes for implementation of corrective action and resources to facilitate compliance.

Comment: Some commenters suggested that the final rule mandate training for employees of entities required to comply with the requirements of Section 1557.

***31441** Response: Although OCR encourages covered entities to train employees on compliance with Section 1557 periodically, OCR does not believe it is necessary for the final rule to mandate training. However, to facilitate training that covered entities choose to provide, we are preparing and will make available a training curriculum for their use in advance of the effective date of the rule. We also expect to engage in outreach and technical assistance to promote understanding of and compliance with the final rule.

Comment: Several commenters stated that the final rule should require OCR to perform unannounced, onsite reviews of covered entities to ensure compliance with Section 1557.

Response: While OCR may consider performing unannounced, onsite reviews where appropriate, OCR does not believe it is necessary to include a requirement to do so in the final rule.

Comment: Some commenters recommended that the regulation permit class actions and third party complaints in court. Other commenters recommended that the regulation provide for the availability of attorneys' fees in successful private suits. These commenters pointed out that many individuals who are subject to discrimination will be unable to afford a retainer for an attorney. Some commenters recommended that suits be allowed only in the State where the Marketplace[FNSM] is located, not any Federal district court in a district in which a complainant resides.

Response: Although these issues are outside the scope of this regulation, nothing in Section 1557 changes the laws that otherwise would govern eligibility for attorneys' fees, including the Civil Rights Attorney's Fees Award Act of 1976,[FN284] laws that otherwise would govern venue,[FN285] or laws that otherwise would govern initiation of class action lawsuits.[FN286]

Comment: Some commenters suggested that the regulation prohibit issuers from including clauses requiring mandatory binding arbitration of Section 1557 complaints. These commenters asserted that such arbitration is unfair to consumers.

Response: We decline to accept the commenters' suggestion because it is outside the scope of this regulation.

Summary of Regulatory Changes

For the reasons set forth above and in the proposed rule and considering the comments received, we have revised § 92.301 to re-designate existing text as § 92.301(a) and add a new subsection (b) stating that compensatory damages for violations of Section 1557 are available in administrative and judicial actions, as they are under authorities referenced in Section 1557.

Procedures for Health Programs and Activities Conducted by Recipients and State-Based Marketplaces (§ 92.302)

In § 92.302, we proposed the procedures that will apply to enforcement of Section 1557 in health programs and activities conducted by recipients and State-based Marketplaces. We noted that the administrative procedures provided for and available under Title VI are found in the regulation implementing Title VI.[FN287] We explained that these administrative procedures are incorporated into the regulation implementing Title IX [FN288] and Section 504 with respect to recipients.[FN289] In paragraph (a), we proposed to incorporate these procedures into Section 1557 with respect to race, color, national origin, sex, and disability discrimination.

We also explained that the administrative procedures provided for and available under the Age Act are found in the

regulation implementing the Age Act.[FN290] In paragraph (b), we proposed to incorporate these procedures into Section 1557 with respect to age discrimination.

In paragraph (c), we provided that an individual may bring a civil action in a United States District Court in which a recipient or State-based Marketplace[FNSM] is located or does business, as provided for and available under Section 1557.

The comments and our responses regarding § 92.302 are set forth below.

Comment: A few commenters asserted that any enforcement provisions that apply to Health Insurance Marketplaces should apply whether the Marketplace[FNSM] is operated by the State or Federal government.

Response: OCR declines to incorporate the commenter's request that Marketplaces operated by the Federal government be subject to the same enforcement provisions as Marketplaces operated by State governments. Under the regulations implementing Section 504, federally assisted programs, including federally assisted programs operated by States, and federally conducted programs are subject to separate enforcement procedures.[FN291] OCR believes that this approach has worked successfully in the past and has decided to retain separate procedures for federally conducted health programs and activities, including Health Insurance Marketplaces operated by HHS, and other health programs and activities, including Health Insurance Marketplaces operated by States.

Comment: Some commenters suggested that OCR use the enforcement scheme of Title VI for all discrimination under Section 1557. By contrast, some commenters recommended that the final rule should require mediation for all Section 1557 complaints. A few commenters requested that OCR require exhaustion of administrative remedies before individuals could pursue a private right of action.

Response: OCR declines to adopt these recommendations. OCR has decided to retain administrative procedures and application of the procedures consistent with OCR's existing procedures for complaints. Mediation and exhaustion of administrative remedies will still be required for age discrimination allegations in complaints, but not for allegations of other covered types of discrimination.

Summary of Regulatory Changes

For the reasons set forth in the proposed rule and considering the comments received, we are finalizing the provisions proposed in § 92.302 with two modifications. As addressed previously in the discussion of the comments on § 92.5 (Assurances), the text that was previously found at § 92.302(c) has been moved to § 92.302(d), and § 92.302(c) now clarifies OCR's ability to initiate enforcement procedures where a recipient or State-based Marketplace [FNSM] fails to provide OCR with requested information.

Procedures for Health Programs and Activities Administered by the Department (§ 92.303)

In the proposed rule, we noted that Section 1557 expressly states that the enforcement mechanisms provided for and available under Title VI, Title IX, Section 504, or the Age Act shall apply for purposes of violations of Section 1557. We also noted that the administrative procedures provided for and available under Section 504—the only one of these statutes that applies to federally conducted, as well as federally assisted, programs—for programs and activities administered by the ***31442** Department are found in the regulation implementing Section 504.[FN292] We provided that these procedures shall apply with respect to complaints and compliance reviews of health programs or activities administered by the Department, including the Federally-facilitated Marketplaces, concerning discrimination on the basis of race, color, national origin, sex, age, or disability.

In the proposed rule, we proposed to add two provisions that are not found in Section 504 enforcement procedures for programs conducted by the Department. We proposed that the first provision, which reflects OCR's practice under Section 504 and mirrors similar requirements under the Title VI regulation with regard to access to information, is designed to ensure that OCR has the ability to obtain all of the relevant information needed to investigate a complaint or determine compliance in a particular health program or activity administered by the Department.

We further proposed language prohibiting the Department, including Federally-facilitated Marketplaces, from retaliating

against any individual for the purpose of interfering with any right or privilege under Section 1557 or the proposed rule or because the individual has made a complaint, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing under Section 1557 or this proposed rule. We explained that Section 504 of the Rehabilitation Act, to which the Department is already subject, provides that the procedures, rights, and remedies under Title VI are available to any individual aggrieved by an act or failure to act by any recipient of Federal financial assistance or Federal provider of such financial assistance under Section 504. Thus, we noted that the prohibition on retaliation under Title VI [FN293] would apply to the Department under Section 504. We noted that the retaliation provision in the proposed rule is simply an extension of this existing prohibition. We further noted that this provision is also in accordance with a similar requirement for recipients under the Title VI regulations. The Department should hold itself to the same standards to which it holds recipients of Federal financial assistance.[FN294]

Summary of Regulatory Changes

We did not receive any significant comments regarding § 92.303. For the reasons set forth in the proposed rule, we are finalizing the provisions proposed in § 92.303 without modification.

Information Collection Requirements

The notice of proposed rulemaking called for new collections of information under the Paperwork Reduction Act of 1995.[FN295] As defined in implementing regulations,[FN296] "collection of information" comprises reporting, recordkeeping, monitoring, posting, labeling and other similar actions. In this section, we first identify and describe the entities that must collect the information, and then we provide an estimate of the total annual burden. The estimate covers the employees' time for reviewing and posting the collections required.

The final rule calls for the same collections of information as the notice of proposed rulemaking, with one addition: The cost estimates for covered entities to develop and implement a language access plan, should the covered entities choose to do so, given that development and implementation of a language access plan is one of the factors that the Director will consider, if relevant, in assessing whether a covered entity has met its obligation to take reasonable steps to provide meaningful access to each individual with limited English proficiency.

Title: Nondiscrimination in Health Programs and Activities.

OMB Control Number: XXXX-XXXX.

Summary of the Collection of Information: The final rule estimates four categories of information collection: (1) Submission of an assurance of compliance form, per § 92.5; (2) posting of a nondiscrimination notice and posting of taglines, under § 92.8; (3) development and implementation of a language access plan, anticipated per § 92.201; and (4) designation of a compliance coordinator and adoption of grievance procedures for covered entities with 15 or more employees, per § 92.7. Each category is described in the following analysis.

Under the final rule, each entity applying for Federal financial assistance, each health insurance issuer seeking certification to participate in a Marketplace[FNSM], and each entity seeking approval to operate a Title I entity is required to submit an assurance that its health programs and activities will be operated in compliance with Section 1557.

In addition, each covered entity subject to the final rule is required to post a notice of individuals' civil rights and covered entities' obligations, including acknowledging that the covered entity provides auxiliary aids and services, free of charge, in a timely manner, to individuals with disabilities, when such aids and services are necessary to provide an individual with a disability an equal opportunity to benefit from the entity's health programs or activities; and language assistance services, free of charge, in a timely manner, to individuals with limited English proficiency, when those services are necessary to provide an individual with limited English proficiency meaningful access to a covered entity's health programs or activities. Furthermore, each covered entity is required to post taglines in the top 15 languages spoken by individuals with limited English proficiency by relevant State or States, informing individuals with limited English proficiency that language assistance services are available.

Although the final rule does not require covered entities to develop a language access plan, the development and

implementation of a language access plan is one factor that the Director will consider when evaluating a covered entity's compliance with this rule. We anticipate that some proportion of covered entities will develop and implement a language access plan following issuance of the rule.

Additionally, each covered entity that employs 15 or more persons is required to adopt grievance procedures that incorporate appropriate due process standards and that provide for the prompt and equitable resolution of grievances alleging any action that would be prohibited by Section 1557. Each covered entity is also required to designate at least one individual to coordinate its efforts to comply with and carry out its responsibilities under Section 1557, including the investigation of any grievance communicated to it alleging noncompliance with Section 1557.

Need for Information: The requirement that every entity applying for Federal financial assistance, seeking certification to participate in a Health Insurance Marketplace[FNSM], or seeking approval to operate a Title I entity, submit an assurance of compliance, is similar to the current regulatory ***31443** requirements under Title VI,[FN297] Section 504,[FN298] and the Age Act.[FN299] These requirements protect individuals by assuring that covered entities will comply with all applicable nondiscrimination statutes and their implementing regulations.

The posting of a notice of individuals' rights and covered entities' obligations and the posting of taglines in the top 15 languages spoken by individuals with limited English proficiency by relevant State or States are necessary to ensure that individuals are aware of their protections under the law, and are grounded in OCR's experience that failures of communication based on the absence of auxiliary aids and services and language assistance services raise particularly significant compliance concerns under Section 1557, as well as Section 504 and Title VI.

The development and implementation of a language access plan helps ensure meaningful access to persons with limited English proficiency to a covered entity's health programs and activities. While Title VI has long required covered entities to take reasonable steps to provide persons with limited English proficiency meaningful access, the addition of a language access plan brings specificity and increased probability of implementation of the requirement. Although the final rule does not require development and implementation of a language access plan, covered entities may choose to develop and implement a language access plan because the Director will consider, if relevant, the language access plan as one factor when assessing a covered entity's compliance with this rule.

The requirements that every covered entity that employs 15 or more persons adopt grievance procedures and designate at least one individual to coordinate its efforts to comply with and carry out its responsibilities under Section 1557 are similar to requirements included in the Title IX and Section 504 implementing regulations. Through its case investigation experience, OCR has observed that the presence of a coordinator and grievance procedures helps to bring concerns to prompt resolution within an entity, leading to lower compliance costs and more efficient outcomes.

Use of Information: OCR will use this information to ensure covered entities' adherence to the statutory requirements imposed under Section 1557 and this final rule. OCR will enforce the requirements by verifying during investigations of covered entities that an entity has submitted an assurance of compliance and posted the notice and taglines and, for each covered entity that employs 15 or more persons, that an individual has been designated to coordinate its compliance efforts and that appropriate grievance procedures have been adopted, as required.

Description of the Respondents: The respondents are: the Department, each entity that operates a health program or activity, any part of which receives Federal financial assistance, and each entity established under Title I of the ACA that administers a health program or activity. These include such entities as hospitals, home health agencies, community mental health centers, skilled nursing facilities, and health insurance issuers.

Number of Respondents: The number of respondents is estimated to include the 275,002 covered entities affected by the final rule.

Burden of Response: Because the Department provides the assurance of compliance and the final rule provides a sample Notice, sample taglines in 64 languages, and sample grievance procedures, the burden on respondents is minimal. Additionally, because all recipients of Federal financial assistance with 15 or more employees are already expected under other laws to have in place grievance procedures and a designated individual to coordinate their compliance responsibilities,

the burden to comply with this requirement will be minimal for most respondents.

The requirement to sign and submit an assurance of compliance exists under other civil rights regulations (Title VI, Section 504, Title IX, the Age Act), and since the Department provides a copy of the Assurance of Compliance form to covered entities, OCR believes this requirement adds no extra burden. OCR believes that the time, effort, and financial resources necessary to comply with this requirement are considered part of the usual and customary business practice and would be incurred by covered entities during their ordinary course of business.

OCR estimates that the burden for responding to the proposed notice requirement is an average of 17 minutes to download and post the notice and that the burden to download and post taglines in the top 15 languages by relevant State or States is also an average of 17 minutes, for a burden total of 34 minutes on average at each of the 405,534 affected establishments (associated with the affected covered entities) in the first year following publication of the final rule. (See Regulatory Impact Analysis, II. Costs, B.2.for a more detailed explanation of the differences between "firm" and "establishment.") We estimate that administrative or clerical support personnel would perform these functions. Based on the wage rate for a Clerical Support Worker ($15.52) we estimate the annual burden for these two requirements to be approximately $7.1 million after adjusting for overhead and benefits by adjusting the wage rate upward by 100%.

OCR estimates that the burden for developing a language access plan is approximately three hours of medical and health service manager staff time in the first year, and an average of one hour of medical and health service manager staff time per year to update the plan in subsequent years. The value of an hour of time for people in this occupation category, after adjusting for overhead and benefits, is estimated to be $89.24 based on Bureau of Labor Statistics (BLS) data. As discussed later in this analysis, we estimate that approximately 135,000 entities will develop and implement language access plans, as part of the requirement to take reasonable steps to provide meaningful communication with persons with limited English proficiency. These assumptions imply that the total cost of the development of language access plans will be approximately $36.0 million (269,141 entities x 50% of entities x 3 hours per entity x $89.24 per hour) in the first year and approximately $12.0 million (269,141 entities x 50% of entities x 1 hour per entity x $89.24 per hour) per year in subsequent years.

Regarding the requirement that every covered entity that employs 15 or more persons adopt grievance procedures and designate at least one individual to coordinate its efforts to comply with and carry out its responsibilities under Section 1557, based on OCR's complaint workload increase since the enactment of Section 1557, we anticipate that within the first five years following the rule's enactment, complaints will increase approximately 0.5% in the first year, 0.75% in the second year, and 1% in years three through five, but eventually will drop off as covered entities modify their policies and practices in response to this final rule. We estimate that medical and health service managers will handle the grievances, and that a 1% increase in complaints will require 1% of an FTE at each covered entity. Using the annual wage rate for medical and health service managers ($103,680), adjusting for fringe benefits and overhead, and multiplying by the 41,250 entities ***31444** affected by this requirement, we estimate the annual burden for this requirement to be approximately $42.8 million in year one, $64.2 million in year two, and $85.5 million for each year in years three, four, and five following publication.

Thus, the total estimated annual burden cost for the proposed information collection requirements will be approximately $86.0 million in the first year, $76.2 million in the second year, and $97.5 million per year in years three through five following publication of the final rule.

We asked for public comment on the proposed information collection to help us determine:

1. Whether the proposed collection of information is necessary for the proper performance of the functions of OCR, including whether the information will have practical utility;

2. The accuracy of the estimated burden associated with the proposed collection of information;

3. How the quality, utility, and clarity of the information to be collected may be enhanced; and

4. How the burden of complying with the proposed collection of information may be minimized, including through the application of automated collection techniques or other forms of information technology.

We received no comments with specific data in response to numbers one, two, or three above. With regard to question four, we received comments asking that the proposed collection of information be minimized and stating that it is burdensome for covered entities to develop notices to put in several locations in all their facilities. OCR responded by proposing that OCR develop a model notice of important information and model taglines, to minimize the burden on covered entities. The new cost analysis is included above, in this Information Collection section, as well as in the Regulatory Impact Analysis.

Regulatory Impact Analysis

I. Introduction

A. Executive Orders 12866 and 13563

Executive Order 12866 [FN300] directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). Executive Order 13563 [FN301] is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in Executive Order 12866. OMB has determined that this final rule is a "significant regulatory action" under Executive Order 12866. Accordingly, OMB reviewed this final rule.

In general, we received few comments with regard to the Regulatory Impact Analysis (RIA), and thus the analysis in the final rule remains fairly similar to the proposed rule, although there are some changes. The comments will be addressed in each section below, as appropriate.

B. The Need for a Regulation

Section 1557 of the ACA prohibits an individual from being excluded from participation in, denied the benefits of, or otherwise subjected to discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. It applies to any health program or activity, any part of which is receiving Federal financial assistance, and to any program or activity that is administered by an Executive Agency or any entity established under Title I of the ACA.[FN302] The Secretary of the Department is authorized to promulgate regulations to implement Section 1557 under the statute and 5 U.S.C. 301. The purpose of this regulatory action is to implement Section 1557 of the ACA.[FN303]

One of the central aims of the ACA is to expand access to health care and health coverage for all individuals. Equal access for all individuals without discrimination is essential to achieving this goal. Discrimination in the health care context can often lead to poor and inadequate health care or health insurance or other coverage for individuals and exacerbate existing health disparities in underserved communities. Individuals who have experienced discrimination in the health care context often postpone or do not seek needed health care; individuals who are subject to discrimination are denied opportunities to obtain health care services provided to others, with resulting adverse effects on their health status. Moreover, discrimination in health care can lead to poor and ineffective distribution of health care resources, as needed resources fail to reach many who need them. The result is a marketplace comprised of higher medical costs due to delayed treatment, lost wages, lost productivity, and the misuse of people's talent and energy.[FN304]

We received comments suggesting that we consider either writing a more informative than prescriptive regulation or delaying the regulation. The Department's current experience, however, points to the importance of a regulation that is prescriptive in the sense that it provides concrete guidance. The Department continues to receive many complaints of discrimination and continues to provide technical assistance and outreach in order to promote compliance. In addition, the majority of the comments from the public in response to the proposed rule favored speedy issuance of a strong regulation.

To help address the issues of nondiscrimination in health programs and activities, this regulation seeks to clarify the application of the nondiscrimination provision in the ACA to any health program or activity receiving Federal financial assistance from or administered by HHS or any entity established under Title I. Such clarity will promote understanding of and compliance with Section 1557 by covered entities and the ability of individuals to assert and protect their rights under the law.

In addition, Executive Order 13563 directs Federal agencies to improve regulations and regulatory review by promoting the

simplification and harmonization of regulations and to ensure that regulations are accessible, consistent, and easy to understand. Regulations implementing the civil rights laws referenced in Section 1557 contain certain inconsistencies across common areas and subject matters, reflecting, among other things, differences in time and experience when the regulations were issued. The regulation attempts to harmonize these variations where possible.

We received comments asking that the regulation be written in plain language. The approach we adopt in the final rule is to simplify and make uniform, consistent, and easy to understand the various nondiscrimination requirements ***31445** and rights available under Section 1557, as appropriate.

The analysis that follows is similar to the analysis set forth in the proposed rule, except as specified in each of the sections that follow.

C. Examples of Covered Entities and Health Programs or Activities Under the Final Regulation

This final rule applies to any entity that has a health program or activity, any part of which receives Federal financial assistance from the Department, any health program or activity administered by the Department, or any health program or activity administered by an entity created under Title I of the ACA. The following are examples of covered entities as well as health programs or activities under the final rule.

1. Examples of Covered Entities With a Health Program or Activity, Any Part of Which Receives Federal Financial Assistance From the Department

This Department, through agencies such as the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), and the Centers for Medicare and Medicaid Services (CMS), provides Federal financial assistance through various mechanisms to health programs and activities of local governments, State governments, and the private sector. An entity may receive Federal financial assistance from more than one component in the Department. For instance, federally qualified health centers receive Federal financial assistance from CMS by participating in the Medicare or Medicaid programs and also receive Federal financial assistance from HRSA through grant awards. Because more than one funding stream may provide Federal financial assistance to an entity, the examples we provide may not uniquely receive Federal financial assistance from only one HHS component.

(1) Entities receiving Federal financial assistance through their participation in Medicare (excluding Medicare Part B) or Medicaid (about 133,343 facilities).[FN305] Examples of these entities include:

Hospitals (includes short-term, rehabilitation, psychiatric, and long-term)

Skilled nursing facilities/nursing facilities—facility-based

Skilled nursing facilities/nursing facilities—freestanding

Home health agencies

Physical therapy/speech pathology programs

End stage renal disease dialysis centers

Intermediate care facilities for individuals with intellectual disabilities

Rural health clinics

Physical therapy—independent practice

Comprehensive outpatient rehabilitation facilities

Ambulatory surgical centers

Hospices

Organ procurement organizations

Community mental health centers

Federally qualified health centers
(2) Laboratories that are hospital-based, office-based, or freestanding that receive Federal financial assistance through Medicaid payments for covered laboratory tests (about 445,657 laboratories with Clinical Laboratory Improvement Act certification).

(3) Community health centers receiving Federal financial assistance through grant awards from HRSA (1,300 community health centers).[FN306]

(4) Health-related schools in the United States and other health education entities receiving Federal financial assistance through grant awards to support 40 health professional training programs that include oral health, behavioral health, medicine, geriatric, and physician's assistant programs.[FN307]

(5) State Medicaid agencies receiving Federal financial assistance from CMS to operate CHIP (includes every State, the District of Columbia, Puerto Rico, Guam, the Northern Marianas, U.S. Virgin Islands, and American Samoa).

(6) State public health agencies receiving Federal financial assistance from CDC, SAMHSA, and other HHS components (includes each State, the District of Columbia, Puerto Rico, Guam, the Northern Marianas, U.S. Virgin Islands, and American Samoa).

(7) Qualified health plan issuers receiving Federal financial assistance through advance payments of premium tax credits and cost-sharing reductions (which include at least the 169 health insurance issuers in the Federally-facilitated Marketplaces receiving Federal financial assistance through advance payments of premium tax credits and cost sharing reductions and at least 11 issuers operating in the State-Based Marketplaces that we were able to identify).[FN308]

(8) Physicians receiving Federal financial assistance through Medicaid payments, "meaningful use" payments, and other sources, but not Medicare Part B payments, as the Department does not consider Medicare Part B payments to physicians to be Federal financial assistance. The Medicare Access and CHIP Reauthorization Act amended Section 1848 of the Act to sunset "meaningful use" payment adjustments for Medicare physicians after the 2018 payment adjustment.

In the proposed rule, we estimated that the regulation would likely cover almost all licensed physicians because they accept Federal financial assistance from sources other than Medicare Part B. We noted that most physicians participate in more than one Federal, State, or local health program that receives Federal financial assistance, and many practice in several different settings, e.g., they may practice in a hospital but also practice privately and develop nursing home plans of care at the local nursing home. We noted that although we have data, by program, for the number of physicians receiving payment from each program, there is no single, unduplicated count of physicians across multiple programs.[FN309]

In the proposed rule, we provided our best estimate of the number of physicians receiving Federal financial assistance by analyzing and comparing different data sources and drawing conclusions from this analysis. We noted that, based on 2010 Medicaid Statistical Information System data, about 614,000 physicians accept Medicaid payments and are covered under Section 1557 as a result.[FN310] This figure represents about 72% of licensed physicians in the United States when compared to the 850,000 in 2010.[FN311] In addition, we noted that physicians receiving Federal payments from non-Part B Medicare sources would also come under Section 1557.[FN312]

Earlier, before issuing the proposed rule, we identified several grant programs from various Department ***31446** agencies that fund a variety of health programs in which physicians participate and thus come under Section 1557, such as the National Health Service Corps, HRSA-funded community health centers, programs receiving National Institutes of Health (NIH) research grants, and SAMHSA-funded programs. In the proposed rule, we noted that physicians participating in a CMS

gain-sharing demonstration project who receive gain-sharing payments would be covered under Section 1557 even if they did not participate in Medicare and Medicaid or any other health program or activity that receives Federal financial assistance. We also noted that there will be duplication and overlap with physicians who accept Medicaid or Medicare meaningful use payments, or other payments apart from Medicare Part B payments. Nevertheless, we noted that at least some of these physicians add to the total number of physicians reached under Section 1557 because some of them are not duplicates and do not accept Medicaid or Medicare meaningful use payments. We noted that although we do not have an exact number, adding these physicians may bring the total participating in Federal programs other than Medicare Part B to over 900,000.

In the proposed rule, when we compared the upper bound estimated number of physicians participating in Federal programs other than Medicare Part B (over 900,000) to the number of licensed physicians counted in HRSA's Area Health Resource File (approximately 890,000), we concluded that almost all practicing physicians in the United States are reached by Section 1557 because they accept some form of Federal remuneration or reimbursement apart from Medicare Part B.[FN313]

We invited the public to submit information regarding physician participation in health programs and activities that receive Federal financial assistance. We received no comments that would change the estimates that we provided; thus, the analysis in this final rule includes the same numbers of physicians as in the proposed rule.

2. Examples of Health Programs or Activities Conducted by the Department

This final rule applies to the Department's health programs and activities, such as those administered by CMS, HRSA, CDC, Indian Health Service (IHS), and SAMHSA. Examples include the IHS tribal hospitals and clinics operated by the Department and the National Health Service Corps.

3. Examples of Entities Established Under Title I of the ACA

This final rule applies to entities established under Title I of the ACA. According to the CMS Center for Consumer Information and Insurance Oversight (CCIIO), there are Health Insurance Marketplaces covering 51 jurisdictions: (17 State-based-Marketplaces and 34 Federally-facilitated Marketplaces). The final rule covers these Health Insurance Marketplaces.

II. Costs

It is important to recognize that this final rule, except in the area of sex discrimination, applies pre-existing requirements in Federal civil rights laws to various entities, the great majority of which have been covered by these requirements for years. Because Section 1557 restates existing requirements, we do not anticipate that covered entities will undertake new actions or bear any additional costs in response to the issuance of the regulation with respect to the prohibition of race, color, national origin, age, or disability discrimination, except with respect to the voluntary development of a language access plan. However, we also note that the prohibition of sex discrimination is new for many covered entities, and we anticipate that the enactment of the regulation will result in changes in action and behavior by covered entities to comply with this new prohibition. We note that some of these actions will impose costs and others will not.

Section 1557 applies to the Health Insurance Marketplaces. We note that these entities, along with the qualified health plan issuers participating in the Health Insurance Marketplaces, are already covered by regulations issued by CMS that prohibit discrimination on the basis of race, color, national origin, sex, gender identity, sexual orientation, age, or disability. Thus, we note that the impact of Section 1557 on these entities is limited.

We received a few comments that indicated that the costs of compliance may be more than anticipated in the proposed rule. We have revised the analysis in this final rule based upon the comments and upon an updated statistical review of the health programs and activities.

The following regulatory analysis examines the costs and benefits that are attributable to this regulation only.

We first analyze the costs we expect the final rule to create for covered entities. We anticipate that the final rule will place costs on the covered entities in the areas of: (1) Training and familiarization, (2) enforcement, (3) posting of the nondiscrimination notice and taglines, and (4) revisions in policies and procedures, and may place costs on covered entities in

H.R. REP. 101-485(I), H.R. REP. 101-485, H.R. Rep. No. 485(I), 101ST Cong., 2ND Sess. 1990, 1990 U.S.C.C.A.N. 267, 1990 WL 121684 (Leg.Hist.)
****267** P.L. 101-336, AMERICANS WITH DISABILITIES ACT OF 1990

DATES OF CONSIDERATION AND PASSAGE

Senate: September 7, 1989; July 11, 13, 1990
House: May 22, July 12, 1990
Senate Report (Labor and Human Resources Committee) No. 101–116,
Aug. 30, 1989 (To accompany S. 933)
House Report (Public Works and Transportation Committee) No. 101–485(I),
May 14, 1990 (To accompany H.R. 2273)
House Report (Education and Labor Committee) No. 101–485(II),
May 15, 1990 (To accompany H.R. 2273)
House Report (Judiciary Committee) No. 101–485(III),
May 15, 1990 (To accompany H.R. 2273)
House Report (Energy and Commerce Committee) No. 101–485(IV),
May 15, 1990 (To accompany H.R. 2273)
House Conference Report No. 101–558,
June 26, 1990 (To accompany S. 933)
House Conference Report No. 101–596,
July 12, 1990 (To accompany S. 933)
Cong. Record Vol. 135 (1989)
Cong. Record Vol. 136 (1990)
The Senate bill was passed in lieu of the House bill after amending its language to contain much of the text of the House bill. The House Report (Parts I–IV) is set out below and the second House Conference Report follows.

(CONSULT NOTE FOLLOWING TEXT FOR INFORMATION ABOUT OMITTED MATERIAL. EACH COMMITTEE REPORT IS A SEPARATE DOCUMENT ON WESTLAW.)

HOUSE REPORT NO. 101–485(I)

May 14, 1990

***1** The Committee on Public Works and Transportation, to whom was referred the bill (H.R. 2273) to establish a clear and comprehensive prohibition of discrimination on the basis of disability, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

****268 *24** INTRODUCTION

The Americans With Disabilities Act (ADA) will permit the United States to take a long-delayed but very necessary step to welcome individuals with disabilities fully into the mainstream of American society. The specific provisions of the bill which lie within the jurisdiction of the Committee on Public Works and Transportation are primarily within Titles II and III, dealing with publicly and privately provided transportation services.

With regard to pubilicly provided transportation services, the bill requires the purchase of new transit vehicles

for use on fixed route systems which are readily accessible to, and usable by, individuals with disabilities, including individuals who use wheelchairs. The bill also requires the provision of paratransit services for those individuals whose disabilities preclude their use of the fixed route system.

Transit agencies across the United States have already made some progress in the provision of accessible transit services—35% of America's transit buses are currently accessible. As more and more transit authorities make the commitment to provide fully accessible bus service, the percentage of new bus purchases which are accessible has grown to more than 50% annually. By the mid–1990's many American cities will have completely accessible fixed route systems. Furthermore, many of the transit systems in America already provide some type of paratransit services to the disabled. So, the passage of the ADA will not break sharply with existing transit policy. It will simply extend past successes to even more cities, so that this country can continue to make progress in providing much needed transit services for individuals with disabilities.

With regard to privately provided transportation services, which do not receive the high levels of federal subsidies that publicly provided services do, the requirements of the bill vary according to the size and type of vehicle, as well as according to the type of system on which the vehicle operates.

Nonetheless, in all cases, the Americans with Disabilities Act provides strong guarantees that individuals with disabilities will betreated ***25** with respect and dignity while using transporatation services. After all, the Americans With Disabilities Act is ultimately a civil rights bill. The history of the United States is rich with examples of diversity triumphing over discrimination, but not so rich that this country can ever afford to exclude, or segregate in any way, the significant number of its citizens who have disabilities.

SECTION 1. SHORT TITLE; TABLE OF CONTENTS

Subsection (a) of this section provides that the Act may be cited as the "Americans with Disabilities Act of 1990".

SECTION 2. FINDINGS AND PURPOSES

This section describes the findings and purposes of the Act.

****269** SECTION 3. DEFINITIONS

This section defines the terms "auxiliary aids and services", "disability", and "State" for purposes of the Act.

TITLE I—EMPLOYMENT

SECTION 101. DEFINITIONS

This section defines the terms "Commission", "covered entity", "employee", "employer", "Illegal drug", "person", "labor organization", "employment agency", "commerce", "industry affecting commerce", "qualified individual with a disability", "reasonable accommodation", and "undue hardship" for purposes of the Title.

SECTION 102. DISCRIMINATION

Subsection (a) of this section prohibits discrimination against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring or discharge of employees, employee compensation, advancement, job training, and other terms, conditions, and privileges of employment.

SECTION 103. DEFENSES

Subsection (a) of this section provides that a defense to a charge of discrimination under the Act may be that a denial of a job or benefit to a qualified individual with a disability was job-related, consistent with business necessity, and could not be avoided through reasonable accommodation.

SECTION 104. ILLEGAL DRUGS AND ALCOHOL

This section includes provisions regarding the use of alcohol or illegal drugs at the workplace, including provisions regarding tests to determine the use of illegal drugs.

SECTION 105. POSTING NOTICES

This section requires the posting of notices describing the provisions of the Act.

***26** SECTION 106. REGULATIONS

This section requires the Equal Employment Opportunity Commission to issue regulations in an accessible format to carry out this Title not later than one year after the date of the enactment of the Act.

SECTION 107. ENFORCEMENT

This section provides that, with regard to employment, the remedies and procedures set forth in Title VII of the Civil Rights Act of 1964 shall be available to any individual who believes that he or she is being subjected to discrimination under the Act.

****270** SECTION 108. EFFECTIVE DATE

This section provides that Title I become effective 24 months after the date of the enactment of the Act.

TITLE II—PUBLIC SERVICES

SECTION 201. DEFINITIONS

This section defines the terms “demand responsive system”, “fixed route system”, “operates”, “public entity”, “public school transportation”, “public transportation”, “qualified individual with a disability”, and “Secretary” for purpose of the Title.

With regard to fixed route systems, the Committee defines these systems as those which operate along prescribed routes according to fixed schedules. The Committee intends that the “fixed schedule” component of this definition include those systems which operate vehicles at set times of day or at set intervals between vehicles. So long as the schedule is fixed, the system may operate at 5 minute intervals during periods of peak demand and 15 minute intervals during periods of weal demand and still be considered a fixed route system.

With regard to the operation of a system providing public transportation, if a public entity has entered into a contra tual or other arrangement or relationship with a private entity to operate the system, or a portion of the system, the public entity must ensure that the same accessibility requirements are met by the private entity for service provided under a contractual, or other arrangement or relationship as would apply if the public entity were operating the system, or portion of the system, itself.

The Committee intends that the requirements of this legislation not be applied to "public school transportation" as defined in this Act, since such services are subject to the requirements of section 504 of the Rehabilitation Act of 1973, and it is not the intent of the Committee to require school systems receiving Federal financial assistance to meet any different requirements under this legislation than are currently required under seciton 504. Therefore, in promulgating regulations to implement this title, the Department of Transportation should recognize the special arrangements which are currently made with school districts in the provision of pupil transportation.

For example, although the definition speaks to transportation "to and from a public elementary or secondary school and schoolrelated ***27** activities," it is the Committee's intent to include in the scope of this exemption from the provisions of the Act, transportation of pre-Kindergarten children to Head Start or special education programs which receive Federal assistance. Similarly, it is the Committee's intent to include in this exemption transportation arrangements which permit pre-school children of school bus drivers to ride a school bus, or special arrangements allowing pre-school children of teenage mothers to be transported to day care facilities at a school or along the school bus route so that these mothers may continue to attend school.

****271** SECTION 202. PROHIBITION AGAINST DISCRIMINATION

This section, subject to the provisions of the title, prohibits discrimination against a qualified individual with a disability with regard to the services, programs or activities of a public entity.

SECTION 203. PUBLIC ENTITIES OPERATING FIXED ROUTE SYSTEMS

Subsection (a) of this section provides that it shall be considered discrimination for purposes of this Act and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) for a public entity which operates a fixed route system to purchase or lease a new bus, a new rail vehicle, or any other vehicle to be used on a fixed route system unless the vehicle is readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs. Although individuals who use wheelchairs are specifically referenced, the concept of making a vehicle "readily accessible to and usable by individuals with disabilities" involves more than simply making it accessible to an individual using a wheelchair. For example, the regulations implementing this section may require vehicles to incorporate non-slip floors for individuals whose disabilities cause balance problems or specific visual information for thehearing-impaired.

This subsection applies to any solicitation for a vehicle made more than 30 days after the date of the enactment of the Act and applies to any public entity which operates a fixed route system regardless of the size of the community in which the system operates.

With regard to rail vehicles, the Committee intends that the use of "mini-high platforms" or portable wheelchair lifts meet the requirement that these vehicles are readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, so long as a mini-high platform or a portable wheelchair lift is available when needed to board an individual with a disability.

Subsection (b) of this section states that it is discrimination for a public entity which operates a fixed route system to fail to make demonstrated good faith efforts to purchase or lease accessible used vehicles. For purposes of this subsection, remanufactured vehicles shall be treated as used vehicles beginning on the day after the last day of the period by which the usable life of the remanufactured vehicle was extended.

Subsection (c) of this section provides that it is discrimination for a public entity which operates a fixed route system, when remanufacturing a vehicle to extend its usable life by five years or more, ***28** to fail to make that vehicle readily accessible to and usable by individuals with disabilities, to the maximum extent feasible. The word "remanufacture" means that the vehicle is stripped to its frame and rebuilt. Regarding the limitation of "to the maximum extent feasible", the Committee intends that remanufactured vehicles need only be modified to

make them accessible to the extent that the modifications do not adversely affect the structural integrity of the vehicle in a significant way.

****272** A partial exception to subsection (c) is provided for the remanufacturing of any vehicle operating on a segment of a system if that segment is included on the National Register of Historic Places. Vehicles used solely on such segments need only be made accessible to the extent that the modifications needed to provide accessibility to the vehicle do not significantly alter the historic character of such vehicles.

SECTION 204. PARATRANSIT AS A COMPLEMENT TO FIXED ROUTE SERVICE

This section states that it shall be considered discrimination for purposes of this Act and section 504 of the Rehabilitation Act of 1973 for a public entity which operates a fixed route system, other than a system which provides solely commuter bus or commuter rail service, to fail to provide paratransit and other special transportation services to individuals with disabilities. The level of these services provided to individuals with disabilities must be comparable to the level of transit service provided to individuals without disabilities, except with regard to response time, in which case the level of service must only be comparable to the extent practicable. The paratransit service must be provided, beginning 18 months after the date of the enactment of the Act, in accordance with regulations issued by the Department of Transportation within one year after the date of the enactment of the Act.

Since the operations of fixed route and paratransit service differ so markedly, levels of service must only be comparable—not identical. With regard to response time, the Committee acknowledges that paratransit vehicle response time may not meet a standard of comparability with a fixed route system which operates vehicles at short headways. Instead, the legislation states that paratransit vehicle response time need only be "comparable to the extent practicable" to the response time of a vehicle provided on a fixed route system.

Subsection (c) of this section states that these regulations must require each public entity operating a fixed route system to provide paratransit service to any individual with a disability who is unable, as a result of a physical or mental impairment (including a vision impairment) and without the assistance of another individual (except an operator of a wheelchair lift or other boarding assistance device), to board, ride, or disembark from any vehicle on the system which is readily accessible to and usable by individuals with disabilities. The Committee intends "ride" to include both the physical ability to ride on the vehicle as well as the mental ability to understanding when to disembark from the vehicle.

The Committee specifically inserted the words "including a vision impairment" so that section 204 of the bill would unequivocally ***29** cover individuals with vision impairments. Individuals with severe vision impairments traveling in unfamiliar surroundings or recently impaired individuals often need paratransit service since they cannot board, ride, or disembark from fixed route vehicles without assistance. The bill clearly extends paratransit eligibility to the vision impaired under these conditions, so long as the impairment ****273** is sufficiently severe to substantially limit one or more of their major life activities (a component of the definition of disability under this Act).

Similarly, the Committee included the phrase "mental impairment" to ensure that mentally retarded and mentally ill individuals are also entitled to paratransit service if their mental impairment substantially limits one or more of their major life activities and they are unable to board, ride or disembark from a fixed route vehicle.

A public entity operating a fixed route system must also provide paratransit service to any individual with a disability who would otherwise be able to utilize an accessible fixed route vehicle at a time, or within a reasonable period of such time, when the individual wishes to use such a vehicle and one is not available.

In general, the Committee does not intend that the concepts of boarding and disembarking include travel to or from a boarding or disembarking location. However, the Committee included a very narrow exception in recognition of specific impairment-related conditions which certain individuals with disabilities may have. Under the bill, paratransit services must be provided to any individual with a disability who has a specific

impairment-related condition that prevents the individual from traveling to a boarding location or from a disembarking location on a fixed route system. A specific condition related to the impairment of the individual with a disability such as chronic fatigue, blindness, a lack of cognitive ability to remember and follow directions, or a special sensitivity to temperature must be present.

The Committee does not intend for the existence of architectural barriers to trigger eligibility for paratransit under this section if these barriers are not the responsibility of the fixed route operator to remove. In particular, no eligibility for paratransit exists due simply to a lack of curb cuts in the path of travel of an individual with a disability since, in the short term, such barriers can often be navigated around and, more importantly, pressure to eliminate these architectural barriers must be maintained on the state and local governmental entities responsible for eliminating them. In the same way, distance from a boarding or disembarking location alone does not trigger eligibility under this section. In both of these cases, a specific condition related to the impairment of the individual with a disability such as those cited previously must also be present to trigger paratransit eligibility.

The Committee is concerned that a broad interpretation of this exception will discourage the use of fixed route transit systems by individuals with disabilities. The transportation provisions of the legislation carefully balance the increased use of fixed route transit service by individuals with disabilities against expanded, costly paratransit service for those individuals who cannot use fixed route ***30** systems. Both components must be implemented together to maintain this balance and to implement the bill cost-effectively.

The Committee is aware that special circumstances often eliminate or restrict the control that individuals with disabilities exercise over their lives. Therefore, the Committee encourages providers ****274** of special services to individuals with disabilities to locate these services near fixed route transit lines and to work with local fixed route operators to facilitate the use of their transit systems by individuals with disabilities.

Subsection (c) also specifies that paratransit service must be provided to one associate of each individual with a disability. The Committee anticipates occasions on which seats may be available on paratransit vehicles which could be used by additional associates—that is, in addition to the one associate accompanying the individual with a disability—wishing to accompany an individual with a disability. The Committee anticipates that these additional persons may be allowed to ride in the same paratransit vehicle as the individual with a disability and his or her associate, as long as the additional persons are going to the same destination, as the individual with a disability and do not use seats which would have otherwise been used by individuals with disabilities.

The Committee expects each fixed route operator to establish a local certification process to determine eligibility for paratransit service by individuals with disabilities in accordance with the provisions of this Act and the regulations issued pursuant to this section. As explicitly stated in subsection (f), a fixed route operator may regard the requirements of this section as a minimum level of paratransit service to be provided under the Act.

Section (c)(2) provides that paratransit service must be available throughout the public entity's service area, except for any area in which only commuter bus or commuter rail service is operated by the public entity. The Committee intends that any definitions of commuter bus and commuter rail service include widely accepted characteristics of commuter operations such as service almost exclusively in one direction during periods of peak demand, limited stops, use of multi-ride tickets or passes, and routes of extended length, usually from central business districts to outlying suburbs.

With regard to overlapping or contiguous service areas of fixed route systems operated by public entities, it is the Committee's expectation that, to the extent possible, the public entities providing paratransit services in these areas will coordinate the overall paratransit service provided. In fact, it is quite possible that a single public entity might provide better, coordinated paratransit service in the combined, overlapping or contiguous service areas of several fixed route operators (or better coordinate service among these operators) than if each of the operators provided a portion of the service itself.

Therefore, the regulations issued pursuant to this section should not prohibit one public entity, or a public entity in coordination with one or more fixed route operators, from providing or coordinating all of the paratransit service required under the Act in a region, or portion of a region, so long as the total level of service provided met or exceeded the combined level of service which would otherwise be required of all of the affected fixed route operators. ***31** The coordinating public entity would share joint responsibility with the fixed route operator(s) for providing the paratransit service required under the Act. This joint responsibility may include jointly fulfilling the requirements for public participation outlined ****275** in paragraph (6), so long as adequate opportunity for comment and consultation is provided to affected individuals with disabilities within a region, or portion of a region.

Subsection (c)(4) provides that if the paratransit requirements in this section would impose an undue financial burden on a public entity, the entity would not be required to provide service beyond this level of undue financial burden. The Committee intends that the determination of undue financial burden vary according to the financial constraints within which each public entity operates its fixed route system. A flexible numerical formula may be used to determine undue financial burden. Two examples of factors which may be considered when making this determination include the percentage increases in fares or reductions in levels of transit service which would be required to implement this section. Any determination of undue financial burden cannot have assumed the collection of additional revenues, such as those received through increases in local taxes or legislative appropriations, which would not have otherwise been made available to the fixed route operator.

Because a finding of undue financial burden on the part of a fixed route operator will restrict the level of paratransit service provided, the regulations issued pursuant to this section may include a requirement that each fixed route operator consider measures to improve the cost-effectiveness of the delivery of both fixed route and paratransit service provided by that operator before limiting paratransit service under the undue financial burden limitation.

Section (c)(5) specifies that the Secretary of Transportation may require a public entity to provide service beyond the undue financial burden limit. Among others, this provision addresses a potential situation in which a fixed route operator cannot provide even the most basic level of paratransit service without triggering the undue financial burden limitation. In that case, the Committee expects the regulations issued by the Secretary under this section to require a basic level of paratransit service to be provided by the fixed route operator.

Subsection (7) requires a public entity to submit, and begin implementation of, a paratransit service plan meeting the requirements of the regualtions issued pursuant to this section within 18 months after the date of the enactment of this Act. Thereafter, the plan must be revised annually.

Subsection (8) states that a public entity is not required to provide paratransit service provided by another public entity or person in a given service area. A public entity may identify in its paratransit seervice plan other entities or persons which are providing a sufficient level of paratransit service so that the public entity can state that, because of the existence of that service, it has met its obligation to provide paratransit service under the Act. However, the public entity must ensure that the paratransit service is actually being provided throughout the year.

***32** The Committee intends that the DOT regulations issued under this section include provisions requiring adjustments in paratransit service in response to a significant occurrence in an operator's ****276** service area, such as the withdrawal from the marketplace of a private paratransit provider.

A public entity does not have to monitor private organizations that may be providing paratransit service in its service area which have not been identified in its paratransit plan. Instead, since the public entity is ultimately responsible for the provision of the paratransit service required of it under the Act, the public entity must only monitor and ensure adequate service from those entities or persons which it has identified in its paratransit plan as surrogates to meet its responsibilities under the Act.

A public entity violates the paratransit requirements of this section if it fails to submit and begin implementation

of a paratransit plan or modified plan, if required; or if a modified plan fails to meet the requirements of the bill; or if the paratransit service included in the plan is not provided in accordance with the plan.

The Secretary must disapprove a paratransit plan if it does not meet the requirements of this section. If a plan is disapproved, the public entity must submit a modified plan within 90 days of the disapproval.

SECTION 205. PUBLIC ENTITIES OPERATING DEMAND RESPONSIVE SYSTEMS

This section provides that it is discrimination for purposes of this Act and Section 504 of the Rehabilitation Act of 1973 for a public entity operating a demand responsive system to fail to purchase or lease a new vehicle for use on such system that is readily accessible to and usable by individuals with disabilities, unless the entity can demonstrate that its system, when viewed in its entirety, provides a level of service to individuals with disabilities equivalent to that provided to members of the general public without disabilities.

The standard of a system viewed in its entirety providing an equivalent level of service is met when an operator has, or has access to, a vehicle (including a vehicle operated in conjunction with a portable boarding assistance device) which is readily accessible to and usable by individuals with disabilities to meet the needs of such individuals on an "on-call" basis. Essentially, when all aspects of the system are analyzed, an individual with a disability must have an equivalent opportunity to use the system.

SECTION 206. TEMPORARY RELIEF WHERE LIFTS ARE UNAVAILABLE

This section provides for a temporary exemption from accessible bus requirements under sections 203(a) or 205 if wheelchair lifts are not available from a qualified manufacturer, a public entity has made good faith efforts to locate such a manufacturer, and any delay in purchasing new buses would significantly impair transportation services in the community served by the public entity.

The Committee understands that certain fixed route operators may be restricted from using accessible, 102″ wide commuter buses for various reasons. One alternative vehicle which would meet the requirements of the Act is the 96″ commuter bus, which some manufacturers ****277 *33** are apparently unwilling to fully warranty due to the structural modifications necessary to accommodate a wheelchair lift. Another alternative is the 96″ suburban bus, which does not have the structural difficulties in accommodating a lift that a commuter bus does. A fixed route operator would not qualify for a waiver under this section from wheelchair lift purchase requirements for a 96″ commuter bus since an acceptable alternative—the 96″ wide, lift-equipped suburban bus—exists. However, the Committee certainly encourages fixed route operators, commuter bus manufacturers, and the Secretary of Transportation to work towards the development of a fully warranted, accessible, 96″ wide commuter bus, especially in light of recent improvements in lift technology.

SECTION 207. NEW FACILITIES

This section provides that it is discrimination for purposes of this title and section 504 of the Rehabilitation Act of 1973 for a public entity to fail to construct a new facility which will be used in the provision of public transportation services which is readily accessible to and usable by individuals with disabilities.

SECTION 208. ALTERATIONS OF EXISTING FACILITIES

This section provides that if an alteration to a facility used in the provision of public transportation services affects or could affect the usability of the facility, the altered portion must be readily accessible to and usable by individuals with disabilities, to the maximum extent feasible.

If the alteration affects the usability of or access to an area containing a primary function, then the path of travel to the altered area, and the restrooms, telephones and drinking fountains serving the altered area would also

have to be made accessible, to the maximum extent feasible, although these alterations are required only if they are not disproportionate in cost and scope to the overall alterations.

Section 208(b) provides that key stations in rapid, commuter, and light rail systems must be made readily accessible to and usable by individuals with disabilities as soon as practicable, but in no event later than three years after the date of the enactment of the Act. This period may be extended by the Secretary up to a 30–year period for extraordinarily expensive structural changes to, or replacement of, existing facilities, provided that two-thirds of these stations requiring extraordinarily expensive structural changes have been made accessible by the end of 20 years from the date of the enactment of this Act. The Committee intends that the stations completed during this initial 20–year period be widely located throughout the service area of the fixed route operator.

The Committee intends that the criteria established by the Secretary for determining key stations include characteristics such as high ridership, transfer points (including "feeder" points of transfer from other fixed route systems), and high ridership, end-of-the-line stations. When high ridership is the sole factor in determining a key station, consideration should be given to the proximity of that station to other key stations. Each of several closely grouped, ****278 *34** high volume stations need not be designated a key station solely due to a high volume of ridership.

The Committee finds special merit in local settlement agreements (such as those negotiated in New York and Philadelphia) regarding the identification of key stations, when they have been negotiated in good faith by public entities and representatives of the disability community. The Committee expects the criteria established by the Secretary to find that these local agreements fully meet the requirements of this subsection.

SECTION 209. PUBLIC TRANSPORTATION PROGRAMS AND ACTIVITIES IN EXISTING FACILITIES AND ONE CAR PER TRAIN RULE

Subsection (a) of this section requires public transportation programs and activites to be accessible, when viewed in their entirety, other than those conducted in key stations which have not yet been made accessible in accordance with section 208(b).

Section 209(b) required that at least one car per train on intercity, light, rapid, and commuter rail trains of at least two vehicles in length be accessible to individuals with disabilities within five years of the date of the enactment of the Act. The Committee specifically exempted one-car trains, such as streetcars, from the requirements of this subsection.

SECTION 210. REGULATIONS

This section requires the Attorney General and the Secretary of Transportation to issue regulations in an accessible format implementing the legislation within one year of the date of the enactment of the Act. The regulations issued under this section and section 204 by the Secretary must include standards applicable to facilities and vehicles which are consistent with the minimum guidelines and requirements issued by the Architectural and Transportation Barriers Compliance Board in accordance with section 504 of the Act.

With regard to developing standards for wheelchair lifts, wheelchair restraint devices, and other devices necessary to facilitate the use of transit vehicles and facilities by individuals with disabilities, the Committee directs the Secretary to consult with, at a minimum, representatives from the disability community, transit operators, vehicle manufacturers, and wheelchair manufacturers.

The regulations issued pursuant to this section must include a requirement that wheelchair lifts and other boarding assistance devices be maintained in working order and that, when operational and when needed, they be deployed at the request of an individual with a disability.

SECTION 211. ENFORCEMENT

This section provides that the remedies, procedures and rights set forth in Section 505 of the Rehabilitation Act of 1973 shall be available with respect to any individual who believes that he or she is being subjected to discrimination on the basis of disability in violation of this title, including the regulations issued under this title.

****279 *35** SECTION 212. EFFECTIVE DATE

This section provides that the paratransit requirement for operators of fixed route systems take effect 18 months after the date of the enactment of the Act. In general, accessible vehicle purchase requirements take affect 30 days after the date of enactment.

SECTION 213. COMMUTER RAIL SYSTEMS

Subsection (a) of this section provides a partial exemption to the accessible commuter rail vehicle purchase and remanufacturing requirements under section 203 as long as 91) the one car per train requirements under section 209 is met, (2) clear, concise, and adequate notice if provided identifying accessible vehicles and their location on a train, and (3) reasonable provision is made to ensure that additional services provided on nonaccessible vehicles are provided to individuals with disabilities traveling on accessible vehicles.

Section 213(b) requires that additional accessible vehicles must be providedif one accessible car per train is insufficient to meet actual continuing demand for accessible service.

In interpreting “continuing demand”, the Committee intends that the demand be regular and consistent. If a given trains’ accessible car is filled daily to capacity and on any given day or days of the week an additional person in a wheelchair regularly waits for a ride and is not accommodated, that train does not meet continuing demand. A given train need not operate over capacity seven days a week to trigger the additional vehicle provisions, so long as the demand is regular or predictable. For instance, a person may have a part-time job and only ride a train three days a week. A student may ride to attend classes twice a week. A person may travel to the hospital once a week. In all cases, if the demand is continuing yet a train’s accessible vehicle is sometimes filled to capacity, an additional accessible vehicle must be provided.

Regarding one-time special events which cause a sharp increase in wheelchair ridership, the Committee recognizes that all wheelchair users attending such events may not be successfully accommodated. However, if special events which occur on a regular, scheduled basis, such as sporting events or concerts, are found to attract increased ridership by individuals with disabilities, increased accessible capacity must b eprovided. In both cases (determining continuous demand and special events demand), the determination of whether such demand exists and what steps consistent with this subsection must be taken to meet the demand shall be made by the fixed route operator in close and good faith consultation with the disability community in the market area served by the operator. The operator must consult with individuals with disabilities, the majority of which must be individuals with disabilities who use wheelchairs. This consultation, in addition to conductors’ reports on the adequacy of accessible capacity, will provide a means for the disability community to alert the operator to new, continuing demand for accessible service.

When it is determined that continuing demand cannot be met by one accessible car per train, section 213 states that the public entity must use such additional accessible cars per train as may be ****280 *36** necessary to meet such demand. It is the Committee’s intent that the rail operator do so promptly. Usually providing an additional car is a matter of operational adjustments—such as rail yard changes—to place an additional accessible car on a given train. These operational changes can and should be made promptly after a finding of unmet continucing demand is made.

Nothing in Section 213(b) is intended to preclude an operator from meeting continuing demand for accessible service by first taking reasonable steps to increase the number of wheelchair locations available in accessible

cars before adding additional cars. The maximum number of wheelchair locations per car would be decided in conjunction with the advisory committee.

TITLE III—PUBLIC ACCOMMODATIONS AND SERVICES OPERATED BY PRIVATE ENTITIES

SECTION 301. DEFINITIONS

Section 301 defines the terms "commerce," "demand responsive system," "fixed route system," "over-the-road bus," "potential places of employment," "private entity," "public accommodation," "public transportation," and "readily achievable" for purposes of the title.

Consistent with the exemption established in Title II for "public school transportation," the Committee does not intend for the provisions of this title to apply to the transportation of school children to and from a private elementary or secondary school and school-related activities, provided that the school is a recipient of Federal assistance, subject to the provisions of section 504 of the Rehabilitation Act of 1973, and is providing bus service to children with disabilities equivalent to that provided to children without disabilities.

The term "over-the-road bus" is defined as a bus characterized by an elevated passenger deck located over a baggage compartment. The term includes most of the buses typically used in intercity, charter, or tour service.

The term "public transportation" is defined as transportation by bus or rail, or by any other conveyance (other than by aircraft) that provides the general public with general or special service (including charter service) on a regular and continuing basis.

The Committee excluded transportation by aircraft because of the existence of the Air Carrier Access Act of 1986 (P.L. 99–435). However, the term public transportation does include shuttle service operations operated by commercial airlines. Title III does not apply to volunteer-driven commuter ridership arrangements.

Section 301(7) of the legislation sets forth the definition of the term "public accommodation" and lists examples of entities to be included under this definition. The list includes restaurants, hotels, movie theaters, stadiums, grocery stores, professional offices, terminals used for public transportation, museums, zoos, homeless shelters and recreational facilities. An example of an entity excluded from this list, and therefore not considered a public accommodation, would be a construction job site—which is often in a constant state of transition—such as one used in the construction of a new public transportation facility. Religious institutions or entities controlled ****281 *37** by religious institutions are also not covered by the legislation.

SECTION 302. PROHIBITION OF DISCRIMINATION BY PUBLIC ACCOMMODATIONS

Section 302(a) specifies the genreal rule that no individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, and accommodations of any place of public accommodation.

Section 302(b)(1) states that it is discriminatory to subject an individual or class or individuals, directly or indirectly, on the basis of disability, to any of the following:

> denying the opportunity to participate in, or benefit from, goods, services, facilities, privileges, advantages, and accommodations;
>
> affording an opportunity that is not equal to that afforded others;
>
> providng an opportunity that is different or separate, unless such action is necessary to provide the individuals with an opportunity that is as effective as that provided to others; however, an individual with a disability

shall not be denied the opportunity to participate in such programs or activities that are not separate or different.

Section 302(b)(2)(A) is a non-inclusive list of examples of what constitutes "discrimination." These include: imposition or application of eligibility criteria that screen out individuals with disabilities; failure to make reasonable modifications in policies, practices and procedures, failure to take such steps as may be necessary to ensure that no individual with a disability is excluded or treated differently because of the absense of auxiliary aids and services unless it would fundamentally alter the nature of the activity or would result in an undue burden; failure to remove architectural barriers, and communication barriers that are structural in nature, in existing facilities, and transportation barriers in existing vehicles used by an establishment for transporting individuals (not including barriers that can only be removed through the retrofitting of vehcles by the installation of a hydraulic or other lift), where such removal is readily achievable; where an entity can demonstrate that the removal of a barrier is not readily achievable, a failure to make such goods, services, facilities, privileges, advantages, and accommodations available through alternative methods if such methods are readily achieveable. With respect to a facility that is altered in a manner that affects the usability of the facility, the failure to make the alterations is a manner so that, to the maximum extent feasible, the altered portion is readily accessible to and usable by individuals with disabilities. With regard to an alteration that affects the usability of an area containing a primary function, the path of travel to the altered area, and bathrooms, telephones, and drinking fountains serving the remodeled area must also be made readily accessible to and usable by individuals with disabilities, to the extent that these alterations are not disproportionate in cost and scope to the overall alterations.

****282 *38** Section 302(b)(2) also includes specified provisions relating to prigate entities not primarily engaged in the business of transporting people which operate transportation systems. Operations covered by the requirements include, but are not limited to: hotel and motel airport shuttle services, customer and employee shuttle but services operate by private companies and shopping centers, and shuttle operations of recreational facilities such as stadium, zoos, amusement parks and ski resorts.

Provisions in section 302(b)(2) do not apply to private entities primarily engaged in the business of transporting people—which are covered in section 304—or to over-the-road bus operations.

Section 302(b)(2)(B)(i) applies to private entities operating fixed route systems using vehicles with a seating capacity in excess of 16 passengers (including the driver). These entities must purchase or lease new vehicles for use on such systems which are readily accessible to and usable by individals with disabilities whenever a solicitation is made for such vehicles 30 days after the date of the enactment of the Act.

Section 302(b)(2)(B)(ii) applies to fixed route systems using vehicles with a seating capacity of 16 passengers or less (including the driver). If a private entity purchases or leases a new vehicle which is not accessible for use on such system, the entity must operate the system so that, when viewed in its entirety, the system ensures a level of service to individuals with disabilities equivalent to the level of service provided to individuals without disabilities. The standard of a system viewed in its entirety providing an equivalent level of service is met when an operator has, or has access to, a vehicle (including a vehicle operated in conjunction with a portable boarding assistance device) which is readily accessile to and usable by individuals with disabilities to meet the needs of such individuals on an "on-call" basis. Essentially, when all aspects of the system are analyzed, an individual with a disability must have an equivalent opportunity to use the system.

For example, if a hotel near an airport provides fixed route shuttle service to the airport, the hotel need not purchase new vehicles with a seating capacity of 16 or less that are accessible so long as it makes alternative equivalent arrangements for transporting people with disabilities who cannot board the inaccessible vehicles. In addition to the hotel owning an accessible vehicles itself, the hotel may make arrangement with another hotel that has an accessible vehicles that can be made available to provide equivalent shuttle service or may use a portable boarding assistance device in concert with an otherwise inaccessible vehicle to meet the requirement of this cause of the legislation.

Section 302(b)(2)(C) specifies requirements for private entities which operate demand responsive systems. Section 302(b)(2)(C)(i) applies to operators of demand responsible systems which use vehicles with a seating capacity of 16 passengers or less (including the driver). These systems must operate, so that, when viewed in their entirety, the system ensures a level of service to individuals with disabilities equivalent to the level of service provided to individuals without disabilities.

Section 302(b)(2)(C)(ii) provides that vehicles seating more than 16 passengers must be accessible if a solicitation is made more than 30 ****283 *39** days after the date of the enactment of the Act, unless the operator's system, when viewed in its entirety, provides an equivalent level of service to individuals with or without, disabilities.

Section 302(b)(2)(D)(i) specifies that the requirements in subparagraphs (B) and (C) relating to private entities not primarily engaged in the business of transporting people do not apply to over-the-road buses. Over-the-road buses must meet the vehicle and system requirements specified in sections 304 and 306 regardless of whether the private entity operating them is primarily, or not primarily, in the business of transporting people.

Section 302(b)(2)(D)(ii) states that over-the road buses used to provide transportation of individuals by a private entity not primarily engaged in the business of transporting people must comply with the regulations issued under section 306(a)(2).

SECTION 303. NEW CONSTRUCTION IN PUBLIC ACCOMMODATIONS AND POTENTIAL PLACES OF EMPLOYMENT

Section 303 specifies that discrimination includes a failure to design and construct facilities for first occupancy later than 30 months after the date of the enactment of the Act readily accessible to and usable by individuals with disabilities except where an entity can demonstrate that it is structurally impracticable to do so.

SECTION 304. PROHIBITION OF DISCRIMINATION IN PUBLIC TRANSPORTATION SERVICES PROVIDED BY PRIVATE ENTITIES

Section 304(a) states the general rule that prohibits discrimination on the basis of disability in the full and equal enjoyment of transportation services provided by a private entity that is primarily engaged in the business of transporting people and whose operations affect commerce.

Section 304(b)(1) specifies that the term "discriminated against" includes the imposition or application of eligibility criteria that screen out or tend to screen out persons with disabilities from fully enjoying public transportation services, unless such criteria can be shown to be necessary for the provision of such services.

304(b)(2) lists further examples of discrimination, including: a failure such entity to make reasonable modifications consistent with those required under section 302(b)(2)(A)(ii); a failure to provide auxiliary aids and services consistent with the requirements of section 302(b)(2)(A)(iii); and a failure to remove barriers consistent with the requirements of section 302(b)(2)(A)(iv), (v), and (vi).

The examples of discrimination contained in section 304(b) are intended to address situations that are not covered in the specific vehicle and system requirements for private entities primarily engaged in the business of transporting people included in sections 304(b)(3), 304(b)(4), 304(b)(5) and 306. The general rule contained in paragraph (a) and the examples of discrimination contained in paragraph (b) are not intended to override the specific requirements contained in the sections referenced in the previous sentence. For example, an individual with a disability could not make a successful claim under section 304(a) that he or she had been discriminated against in the full and equal enjoyment of public transportation ****284 *40** services on the grounds that an over-the-road bus was not wheechair lift-equipped, if a lift was not required under 304(b)(4) or 306(a)(2).

Section 304(b)(3) requires private entities primarily engaged in the business of transporting people to purchase

new vehicles (other than automobiles, vans with seating capacities of less than 8 passengers, including the driver, or over-the-road buses) that are to be used on a fixed route system which are readily accessible to and usable by individuals with disabilities when solicitations are made 30 days after the date of the enactment of the Act. If such vehicles are to be used solely on a demand responsive system, they need not be accessible if an entity can demonstrate that its system, when viewed in its entirety, provides an equivalent level of service to individuals with disabilities as that provided to the general public.

Section 304(b)(4) requires over-the-road buses to comply with the regulations issued under section 306(a)(2) and makes it discrimination to purchase or lease an over-the-road bus which does not meet those requirements. Two sets of regulations will be issued by the Department of Transportation under section 306(a)(2) which include vehicle-specific requirements for over-the-road buses The content of these regulations is discussed in detail under section 306 of this report.

Section 304(b)(5) requires a van with a seating capacity of less than 8 passengers, including the driver, to be purchased or leased by a private entity so that it is readily accessible to an usable by an individual with a disability, unless the entity can demonstrate that the system for which the van is being purchased or leased, when viewed in its entirety, provides a level of service to individuals with disabilities equivalent to the level of service provided to the general public. Under this subsection, minivans are treated the same whether they are operated in a fixed route system or a demand responsive system. Owning, or having access to, an accessible minivan or a portable boarding assistance device which can be used in concert with an otherwise inaccessible minivan that will meet the needs of disabled passengers on an on-call basis is required under this subsection.

Regardless of vehicle requirements, anyone in the business of providing taxi service shall not discriminate on the basis of disability in the delivery of that service. For example, it would be discrimination under the Act to refuse to pick up a person on the basis of that person's disability. A taxicab driver could not refuse to pick up someone in a wheelchair because he or she believes that the person could not get out of their chair or because he or she does not want to lift the wheelchair into the trunk or back seat of the taxi.

SECTION 305. STUDY

Section 305(a) directs the Office of Technology Assessment (OTA) to conduct a study to determine (1) the access needs of individuals with disabilities to over-the-road buses and to over-the-road bus service; and (2) the most-cost effective methods for providing access to over-the-road buses and over-the-road bus service to individuals with disabilities through all forms of boarding options.

****285 *41** During its hearings on the legislation, the Committee heard conflicting testimony on the cost and reliability of wheelchair lifts or other boarding assistance devices with regard to their use on over-the-road buses. Therefore, before mandating these or any other boarding options in this Act, a thorough study of the access needs of individuals with disabilities to these buses and the cost-effectiveness of different methods of providing such access is required by the Act.

Section 305(b) specifies which issues must be analyzed by the study, but is not intended to be all-inclusive. The analysis required by the legislation includes a review of accessibility issues relating to vehicle-specific aspects of over-the-road buses, as well as to system-wide aspects of over-the-road bus service. Both aspects of over-the-road bus accessibility are included so that neither is favored over the other in the organization of the study.

The contents of the study must include, at a minimum, an analysis of the following:

(1) The anticipated demand by individuals with disabilities for accessible over-the-road buses and over-the-road bus service;

(2) The degree to which such buses and service, including any service required under sections 304(b)(4) and 306(a)(2), are readily accessible to and usable by individuals with disabilities;

(3) The effectiveness of various methods of providing accessibility to such buses and service to individuals with disabilities. All types of methods (including the use of boarding chairs, ramps, wheelchair lifts, and other boarding assistance devices) which may, or may not, involve the physical lifting of a boarding assistance device should be analyzed in terms of their effectiveness.

(4) The cost of providing accessible over-the-road buses and bus service to individuals and disabilities, including consideration of recent technological and cost saving developments in equipment and devices. All types of methods should be analyzed in terms of their cost.

(5) Possible design changes in over-the-road buses that could enhance accessibility, including the installation of accessible restrooms which do not result in a loss of seating capacity. The study should analyze the potential for changes in bus design to better accommodate accessibility equipment. The study should also analyze whether an accessible restroom could be added to an over-the-road bus without resulting in a loss of seating capacity. "Seating capacity" means a reduction in the number of seats on a bus in which passengers can ride comfortably. For example, if a seat were reduced in size in order to accommodate an accessible restroom, the seat would have to be capable of carrying a passenger as comfortably as an existing full seat in order to avoid a finding of a loss in seating capacity.

(6) The impact of accessibility requirements on the continuation of over-the-road bus service, with particular consideration of the impact of such requirements on service to rural communities. This provision recognizes that the intercity bus industry serves approximately 9500 communities that are not served by any other form of intercity public transportation. For the reason, the study must look at the impact various ****286 *42** methods of providing accessibility will have on the industry's ability to continue service (particularly to rural communities) given its economic history, passenger demographics, pressure from competitors, and future economic projections.

Section 305(c) requires the OTA to establish an advisory committee for the purposes of conducting the study and specifies the committee's membership, in terms of number and representation. There are to be equal numbers of members from among (1) private operators and manufacturers of over-the-road buses and (2) individuals with disabilities who are potential riders of such buses. A third group of members are to be selected for their technical expertise on issues included in the study, including manufacturers of boarding assistance equipment and devices. The total number of members from groups (1) and (2) must exceed the number of members from the third group.

Section 305(d) requires the study and OTA's recommendations, including any policy options for legislative action, to be submitted to the President and Congress within 36 months after the date of the enactment of the act. The President must extend each of the deadlines for compliance with the regulations in section 306(a)(2)(B) for one year if the President determines that such compliance will result in a significant reduction in intercity over-the-road bus service.

Section 305(e) requires OTA to provide a preliminary draft of the study to the Architectural and Transportation Barriers Compliance Board (ATBCB), to give the Board an opportunity to comment on the draft study, and to incorporate written comments from the Board received by the OTA within 120 days of the Board's receipt of the draft study as part of the final study.

SECTION 306. REGULATIONS

Section 306(a)(1) requires the Secretary of Transportation to issue regulations in an accessible format to carry out sections 302(b)(2)(B) and (C) and 304 (other than subsection (b)(4)). These regulations will apply to all providers of transportation under title III of the Act and will include all requirements for the provision of such transportation except for the vehicle-specific requirements for over-the-road buses included in section 304(b)(4).

With regard to over-the-road buses, the legislation gives the Secretary rulemaking authority under section 306(a)(1) to implement section 304 only to the extent that any regulations issued under parargaph (1) are not inconsistent with the vehicle-specific requirements for over-the-road buses contained in section 306(a)(2). An example of a general, rather than a vehicle-specific, requirement permitted under section 306(a)(1) which could be applied to over-the-road bus transportation would be a requirement that an indivual with a disability be allowed to board an over-the-road bus in spite of the fact that the bus was not readily accessible to and usable by an individual with a disability.

Section 306(a)(2) requires the Secretary of Transportation to issue regulations for providing access to over-the-road buses in two separate rulemakings.

****287 *43** Section 306(a)(2)(A) specifies the interim requirements for over-the-road buses, to be issued not later than one year after the date of the enactment of the Act to carry out sections 304(b)(4) and 302(b)(2)(D)(ii). Such regulations will require each private entity which uses an over-the-road bus to provide accessibility to such bus; except that such regulations shall not require any structural changes in over-the-road buses in order to provide access for individuals who use wheelchairs during the effective period of such regulations and shall not require the purchase of boarding assistance devices to provide access to such individuals. These interim requirements will be effective until the effective date of the final regulations issued under 306(a)(2)(B).

While these interim requirements are in effect, it will not be considered discrimination for a private entity to purchase or lease an over-the-road bus which is not wheelchair lift-equipped or to which a boarding chair and/or ramp is not provided to board such bus. However, nothing in the legislation prevents an operator from using lifts, boarding chairs, ramps or other boarding assistance devices during the interim period. The regulations in effect during this period may require additions to an over-the-road bus to aid accessibility which do not require structural changes or boarding assistance devices, such as the installation of non-skid strips on stairs. The failure to equip buses with these types of aids, if required by regulations, would subject an operator to a claim of discrimination under section 304(b)(4).

Section 306(a)(2)(B) requires the Secretary of Transportation to review the OTA study and issue final regulations not later than one year after the submission of the study to the Secretary. The regulations shall require, taking into account the purposes of the study under section 305 and any recommendations resulting from such study, each private entity which uses an over-the-road bus to provide transportation to individuals to provide accessibility to such bus to individuals with disabilities. These regulations will be effective 7 years after date of enactment for small providers, as defined by the Secretary, and 6 years after date of enactment for other providers.

The Secretary may define small providers using current ICC class definitions. The extra year for compliance for these providers acknowledges the increased burden that implementation of some accessibility requirements could have on operators with relatively small fleets.

Section 306(a)(2)(C) states that no regulations may require the installation of accessible restrooms in over-the-road buses if such installation would result in a loss of seating capacity. The term “seating capacity” has the same meaning discussed under section 305—a reduction in the number of seats in which passengers can ride comfortably.

Section 306(a)(3) requires that the regulations issued shall include standards applicable to facilitaties and vehicles covered by sections 302(b)(2) and 304.

Section 306(b) specifies that no later than one year after the date of the enactment of the Act, the Attorney General must issue regulations in an accessible format to carry out the remaining provisions of this title not referred to in subsection (a) that include ****288 *44** standards applicable to facilities and vehicles covered under section 302.

Section 306(c) states that standards included in regulations issued under subsections (a) and (b) shall be consistent with the minimum guidelines and requirements issued by the Architectural and Transportation Barriers Compliance Board in accordance with section 504 of the Act. Section 504 of the Act requires ATBCB, within 6 months after the enactment of this Act, to issue minimum guidelines to supplement the existing Minimum Guidelines and Requirements for Accessible Design for purposes of title II and III. The guidelines shall establish additional requirements, consistent with this Act, to ensure that buildings, facilities, and vehicles are accessible, in terms of architecture and design, transportation, and communications, to individuals with disabilities.

The regulations issued pursuant to this section must include a requirement that wheelchair lifts and other boarding assistance devices be maintained in working order and that, when operational and when needed, they be deployed at the request of an individual with a disability.

SECTION 307. EXEMPTIONS FOR PRIVATE CLUBS AND RELIGIOUS ORGANIZATIONS

This section exempts private clubs and religious organizations from coverage under the Act.

SECTION 308. ENFORCEMENT

This section provides that the remedies and procedures of title II of the Civil Rights Act of 1964 are available under this title and provides for enforcement by the Attorney General.

SECTION 309. EFFECTIVE DATE

This section provides that, unless specifically provided otherwise, the provisions of the Act take effect 18 months after the date of enactment of the Act.

TITLE IV—TELECOMMUNICATIONS RELAY SERVICES

SECTION 401. TELECOMMUNICATIONS SERVICES FOR HEARING IMPAIRED AND SPEECH IMPAIRED INDIVIDUALS

This section specifies that a common carrier that offers telephone services to the general public must also provide interstate or intrastate telecommunication relay services so that such services provide individuals who use non-voice terminal devices because of their disabilities opportunities for communication that are equivalent to those provided to their customers who are able to use voice telephone services.

TITLE V—MISCELLANEOUS PROVISIONS

SECTION 501. CONSTRUCTION

This section explains the relationship between section 504 of the Rehabilitation Act of 1973 and this Act and the relationship between this Act and State laws that provide greater protection for ****289 *45** the rights of individuals with disabilities. This Act shall not be construed as regulating the underwriting, classifying or administering of insurance risks.

SECTION 502. PROHIBITION AGAINST RETALIATION AND COERCION

This section includes an anti-retaliation provision and a prohibition against interference, coercion or

intimidation.

SECTION 503. STATE IMMUNITY

This section makes it clear that States are not immune under the 11th Amendment for violations of the Act.

SECTION 504. GUIDELINES BY ATBCB

This section directs the Architectural and Transportation Barriers Compliance Board (ATBCB) to issue minimum guidelines consistent with the Act.

SECTION 505. ATTORNEY'S FEES

This section specifies that in any action or administrative proceeding commenced under the Act, the court, or agency, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee, including litigation expenses, and costs, and the United States shall be liable for the foregoing the same as a private individual.

SECTION 506. TECHNICAL ASSISTANCE

This section includes a technical assistance provision which directs the Attorney General, in consultation with the Chairman of the Equal Employment Opportunity Commission, the Secretary of Transportation, the National Council on Disability, the Chairperson of the Architectural and Transportation Barriers Compliance Board, and the Chairman of the Federal Communications Commission to develop a plan to assist entities covered under the Act, along with other executive agencies and commissions, to understand their responsibilities under the Act.

SECTION 507. FEDERAL WILDERNESS AREAS

This section requires a study on wilderness designations and wilderness land management practices with regard to the use of wilderness areas by individuals with disabilities.

SECTION 508. TRANSVESTITES

This section states that the term "disability" shall not apply to an individual solely on the basis of transvestitism.

SECTION 509. MANDATING THE COVERAGE OF CONGRESS

This section mandates the coverage of Congress under the Act.

SECTION 510. ILLEGAL DRUG USE

This section makes it clear that current users of illegal drugs are not protected from actions based on their current use of illegal drugs.

****290 *46** SECTION 511. DEFINITIONS

This section states that under the Act, the term "disability" does not include "homosexuality", "bisexuality", "transvestitism", "pedophilia", "transsexualism","exhibitionism", "voyeurism", "compulsive gambling",

"kleptomania", "pyromania", "gender identity disorders", "current psychoactive substance use disorders", "current psychoactive substance-induced organic mental disorders", as defined by DSM–III–R which are not the result of medical treatment, or other sexual behavior disorders.

SECTION 512. AMENDMENTS TO THE REHABILITATION ACT

This section includes provisions clarifying actions permitted or prohibited with regard to individuals using alcohol or illegal drugs.

SECTION 513. SEVERABILITY

This section provides severability protection for the various provisions of the Act.

COMPLIANCE WITH CLAUSE 2(1) OF RULE XI OF THE RULES OF THE HOUSE OF REPRESENTATIVES

(1) With reference to clause 2(1)(3)(A) of Rule XI of the Rules of the House of Representatives, no separate findings or recommendations have been formally issued on the subject matter of this legislation by the Subcommittee on Investigations and Oversight. The Subcommittee on Surface Transportation held hearings on the subject matter which resulted in Titles II and III of the reported bill.

(2) With respect to Clause 2(1)(3)(B) of Rule XI of the Rules of the House of Representatives, the bill, as reported, does not provide new budget authority or increased tax expenditures. Accordingly, a statement pursuant to section 308(a) of the Congressional Budget Act is not required.

(3) Pursuant to Clause 2(1)(3)(D) of Rule XI of the Rules of the House of Representatives, no report has been submitted by the Committee on Government Operations pertaining to this subject matter.

(4) With respect to clause 2(1)(3)(C) of Rule XI of the Rules of the House of Representatives, the Committee has received the following report prepared by the Congressional Budget Office under section 403 of the Congressional Budget Act.

The report is as follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 24, 1990.

Hon. GLENN M. ANDERSON,
Chairman, Committee on Public Works and Transportation,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate of H.R. 2273, the Americans with Disabilities Act of 1990, as ordered reported by the Committee on Public Works and Transportation on April 3, 1990.

****291 *47** If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT D. REISCHAUER.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 2273.

2. Bill title: Americans with Disabilities Act of 1990.

3. Bill status: As ordered reported by the House Committee on Public Worls and Transportation on April 3, 1990.

4. Bill purpose: To prohibit discrimination against people with disabilities in areas such as employment practices, public accommodations and services, transportation services and telecommunication services.

5. Estimated cost to the Federal Government:

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

Basis of estimate

Equal Employment Opportunities Commission (EEOC). Title I—Employment—would prohibit discrimination by employers against qualified individuals with disabilities. H.R. 2273 would require the EEOC to issue regulations to carry out Title I and to provide for enforcement of the provisions. Although no specific authorization level is stated in the bill, CBO estimates the cost of these activities would be $1 million in fiscal year 1991, $2 million in fiscal year 1992, $15 million in fiscal year 1993, and $27 million annually in fiscal years 1994–95. This estimate is based on the EEOC's past experience with enforcing civil rights standards and assumes that approximately 259 additional full-time equivalent employees would be needed for the Commission's 50 field offices and that approximately 58 additional staff would be needed for the EEOC headquarters.

Department of Transportation. H.R. 2273 would direct the Secretary of Transportation to issue regulations including standards applicable to the facilities and vehicles covered by these provisions. CBO estimates that the cost to the federal government of developing these regulations would be about $0.5 million in fiscal year 1991. In addition, the federal government might bear some part of the costs of making transit services accessible to the handicapped, which are discussed below. The capital and operating costs of most mass transit systems are heavily subsidized by the federal government through grant by the Urban Mass Transportation Administration. We cannot predict the extent to which these grants might be increased to compensate for the additional costs attributable to H.R. 2273.

Architectural and Transportation Barriers Compliance Board. H.R. 2273 would require the board to issue minimum guidelines ****292 *48** that would supplement existing minimum guidelines for accessible design of buildings, facilities and vehicles. Although no specific authorization level is stated in the bill, CBO estimates the cost of these guidelines would be $0.2 million in fiscal year 1991. This estimate assumes salaries and expense costs of $104,000 and research contract costs of $80,000. Although the bill does not state specifically that the guidelines should be maintained, the board currently maintains the existing guidelines and most likely would maintain the new guidelines. CBO estimates the cost of maintaining the guidelines would be $0.2 million every other year beginning in fiscal year 1992.

Office of Technology Assessment (OTA). The OTA would be required to undertake a study to determine (1) the needs of individuals with disabilities with regard to buses and (2) a cost-effective method for making buses accessible and usable by those with disabilities. In conjunction with this study, the OTA is directed to establish an advisory committee to assist with and review the study. Although no specific authorization level is stated in the bill, CBO estimates the cost of the study and advisory committee would be $0.2 million in fiscal year 1991, $0.3 million in 1992, and $0.1 million in 1993. This estimate is based upon the assumption that the OTA will not have to conduct significant additional field research.

Department of Justice. H.R. 2273 also would require the Attorney General to develop regulations to prohibit discrimination in public services and to investigate alleged violations of public accommodation provisions, which would include undertaking periodic reviews of compliance of covered entities under Title III. These regulations would ensure that a qualified individual with a disability would not be excluded from participation in, or denied benefits by a department, agency, special purpose district or other instrumentality of a state or

local government. We estimate the cost of these activities would be $3 million in fiscal year 1991 and $4 million annually in fiscal years 1992–1995.

Federal Communications Commission (FCC). H.R. 2273 requires the FCC to prescribe and enforce regulations with regard to telecommunications relay services. These regulations include: (1) establishing functional regulations, guidelines and operations for telecommunications relay services, (2) establishing minimum standards that shall be met by common carriers, and (3) ensuring that users of telecommunications relay services pay rates no greater than rates paid for functionally equivalent voice communication services with respect to duration of call, the time of day, and the distance from point of origination to point of termination. While no authorization level is stated, CBO estimates the cost of developing and enforcing these regulations to be $0.1 million in fiscal year 1991, negligible in fiscal year 1992, $0.2 million in 1993, $0.2 million in 1994, and $0.1 million in 1995. The FCC anticipates a lull in fiscal year 1992 because the states would be designing telecommunication relay systems and there wouldn't be much FCC involvement. During fiscal years 1993 and 1994 the certification and evaluation of state programs would occur.

National Council on Disability. H.R. 2273 would require the council to conduct a study on the effect that wilderness land management practices have on the ability of individuals with disabilities ****293 *49** to use and enjoy the National Wilderness Preservation System. Although no authorization level is stated, CBO estimates the cost of this study would be $0.2 million in fiscal year 1991 and $0.1 million in fiscal year 1992.

Other Possible Effects. In addition to the federal costs of establishing and enforcing new regulations, H.R. 2273 could also affect the federal budget indirectly through changes in employment and earnings. If employment patterns and earnings were to change, both federal spending and federal revenues could be affected. There is, however, insufficient data to estimate these secondary effects on the federal budget.

6. Estimated cost to State and local governments: Enactment of H.R. 2273 would result in substantial costs for state and local governments, but CBO cannot estimate the total impact with any certainty. Most of these costs would involve actions required to make public transit systems accessible to the handicapped. In addition, some local governments might incur additional costs to make newly-constructed public buildings accessible, as required by this bill, but most already face similar requirements.

Public Buildings. H.R. 2273 would mandate that newly constructed state and local public buildings be made accessible to the handicapped. All states currently mandate accessibility in newly-constructed, state-owned public buildings and therefore would incur little or no costs if this bill were to be enacted. It is possible, however, in rare cases, for some local governments not to have such law. These municipalities would incur additional costs for making newly-constructed, locally-owned public buildings accessible if this bill were to become law. According to a study conducted by the Department of Housing and Urban Development in 1978, the cost of making a building accessible to the handicapped is less than one percent of total construction costs if the accessibility features are included in the original building design. Otherwise, the costs could be much higher.

Public Transit. CBO cannot provide a comprehensive analysis of the impact of H.R. 2273 on mass transit costs of state and local governments. The scope of the bill's requirements in this area is very broad, many provisions are subject to interpretation, and the potential effects on transit systems are significant and complex. While we have attempted to discuss the major potential areas of cost, we cannot assign a total dollar figure to these costs.

H.R. 2273 would require that all new buses and rail vehicles be accessible to handicapped individuals, including those who use wheelchairs, and that public transit operators offer paratransit services as a supplement to fixed route public transportation. In addition, the bill includes a number of requirements relating to the accessibility of mass transportation facilities. Specifically, all new facilities, alterations to existing facilities, intercity rail stations, and key stations in rapid rail, commuter rail, and light rail systems would have to be accessible to handicapped persons.

Bus and Paratransit Services—CBO estimates that it would cost between $20 million and $30 million a year

over the next several years to purchase additional lift-equipped buses as required by H.R. 2273. Additional maintenance costs would increase each year as ****294 *50** lift-equipped buses are acquired and would reach $15 million by 1995. The required paratransit systems would add to those costs.

Based on the size of the current fleet and on projections of the American Public Transit Association (APTA), CBO expects that public transit operators will purchase about 4,300 buses per year, on average, over the next five years. About 38 percent of the existing fleet of buses is currently equipped with lifts to make them accessible to handicapped individuals and, based on APTA projections, we estimate that an average of 55 percent to 60 percent of future bus purchases will be lift-equipped in the absence of new legislation. Therefore, this bill would require additional annual purchases of about 1,800 lift-equipped buses. Assuming that the added cost per bus for a lift will be $10,000 to $15,000 at 1990 prices, operators would have to spend from $20 million to $30 million per year, on average, for bus acquisitions as a result of this bill.

Maintenance and operating costs of lifts have varied widely in different cities. Assuming that additional annual costs per bus average $1,500, we estimate that it would cost about $2 million in 1991, increasing to $15 million in 1995, to maintain and operate the additional lift-equipped buses required by H.R. 2273.

In addition, bus fleets may have to be expanded to make up for the loss in seating capacity and the increase in boarding time needed to accommodate handicapped persons. The cost of expanding bus fleets is uncertain since the extent to which fleets would need to be expanded depends on the degree to which handicapped persons would use the new lift-equipped buses. If such use increases significantly, added costs could be substantial.

These costs are sensitive to the number of bus purchases each year, which may vary considerably. In addition, these estimates reflect total costs for all transit operators, regardless of size. Costs may fall disproportionately on smaller operators, who are currently more likely to choose options other than lift-equipped buses to achieve handicapped access.

The bill also requires transit operators to offer paratransit or other special transportation services providing a level of service comparable to their fixed route public transportation to the extent that such services would not impose an “undue financial burden.” Because we cannot predict how this provision will be implemented, and because the demand for paratransit services is very uncertain, we cannot estimate the potential cost of the paratransit requirement, but it could be significant. The demand for paratransit services probably would be reduced by the greater availability of lift-equipped buses.

New regulations recently proposed by the Department of Transportation concerning bus and paratransit services include requirements much the same as those in H.R. 2273. Should these proposed rules become final in their current form, the mandates of the bill would have much less effect.

Transit Facilities—We expect that the cost of compliance with the provisions concerning key stations would be significant for a number of transit systems, and could total several hundred million dollars (at 1990 prices) over 30 years. The precise level of these costs would depend on future interpretations of the bill’s requirements ****295 *51** and on the specific options chosen by transit systems to achieve accessibility. The costs properly attributable to this bill would also depend on the degree to which transit operators will take steps to achieve accessibility in the absence of new legislation.

In 1979, CBO published a study, (Urban Transportation for Handicapped Persons: Alternative Federal Approaches, November 1979), that outlined the possible costs of adapting rail systems for handicapped persons. In that study, CBO estimated that the capital costs of adapting key subway, commuter and light rail stations and vehicles for wheelchair users would be $1.1 billion to $1.7 billion, while the additional annual operating and maintenance costs would be $14 million to $21 million.

Based on a 1981 survey of transit operators, the Department of Transportation has estimated that adapting existing key stations and transit vehicles would require additional capital expenditures of $2.5 billion over 30 years and would result in additional annual operating costs averaging $57 million (in 1979 dollars) over that

period. Many groups representing the handicapped asserted that the assumptions and methodology used by the transit operators in this survey tended to overstate these costs severely. The department estimated that the cumulative impact of using the assumptions put forth by these groups could lower the total 30–year costs to below $1 billion.

CBO believes that the figures in both these studies significantly overstate the cost of the requirements of H.R. 2273, because, in the intervening years, several of the major rail systems have begun to take steps to adapt a number of their existing stations for handicapped access. In addition, it seems likely that the number of stations that would be defined as "key" under this bill would be much lower than that assumed in either of those studies. Furthermore, the Metropolitan Transit Authority in New York and the Southeastern Pennsylvania Transportation Authority in Philadelphia, two large rail systems, have entered into settlement agreements with handicapped groups that include plans for adaptation of key stations. These plans would probably satisfy the bill's requirement for accessibility of key stations. Other rail systems are also taking steps to make existing stations accessible. Therefore, we expect that the cost of the bill's requirements concerning key stations would probably not be greater than $1 billion (in 1990 dollars) and might be considerably less.

7. Estimate comparison: None.

8. Previous CBO estimate: CBO prepared an estimate of S. 933, Americans with Disabilities Act of 1989, as ordered reported by the Senate Committee on Labor and Human Resources on August 2, 1989. We prepared an estimate of H.R. 2273, Americans with Disabilities Act of 1989, as ordered reported by the Committee on Education and Labor on November 14, 1989. We also prepared an estimate of H.R. 2273, Americans with Disabilities Act of 1990, as ordered reported by the House Committee on Energy and Commerce on March 13, 1990. The estimates in this bill are similar to those of the Education and Labor and Energy and Commerce versions of H.R. 2273 and are substantially different from those in the Senate bill.

9. Estimate prepared by: Cory Leach and Marjorie Miller.

****296 *52** 10. Estimate approved by: C.G. Nuckols (for James L. Blum, Assistant Director for Budget Analysis).

COST OF LEGISLATION

In accordance with rule XIII(7) of the Rules of the House of Representatives, the cost to the United States in carrying out H.R. 2273, as reported, in fiscal year 1990, and in each of the five following fiscal years, is estimated by the Committee to be costs which appear in the report of the Congressional Budget Office.

VOTE

The Committee ordered the bill reported by a vote of 45 ayes and 5 noes.

***58** ADDITIONAL VIEWS OF MR. JOHN PAUL HAMMERSCHMIDT, MR. ARLAN STANGELAND, MR. WILLIAM F. CLINGER, JR., MR. JIM LIGHTFOOT, MR. DENNIS HASTERT, MR. JAMES M. INHOFE, MR. CASS BALLENGER, MR. BILL EMERSON, MR. JOHN J. DUNCAN, JR., MR. BILL GRANT AND MS. SUSAN MOLINARI

Legislation opening doors to opportunity and independence for millions of Americans has received its long-awaited and deserved attention in the halls of the 101st Congress. The Public Works and Transportation Committee has had a significant role in the effort, and after many months of deliberations, it is with a sense of pride and purpose that we have been able to vote in favor of reporting H.R. 2273, as amended, the Americans

with Disabilities Act, to the House of Representatives.

Transportation holds the key to opportunity for millions of disabled Americans. No longer will the problem of "how to get there" prevent the disabled from participating in recreational activities, running errands, visiting friends, and most of all, taking pride in a job well done. Our avenues, subways, railways and waterways will carry the disabled all across this great nation so that they can live normal and productive lives.

The legislation we have reported represents a great effort to achieve these goals. We have worked long and hard to balance the needs of the disabled with the impacts on providers. We have tried to keep the objectives of mobility first and foremost in our minds in considering the issues raised before us. Many significant provisions of the legislation, particularly those regarding private transportation, have met those goals, and it is these provisions for which we have registered our full support. However, in the legislative process, we know that to arrive at consensus, we sometimes must forgeo all that we would like to achieve, and unfortunately, it is for certain other provisions in the bill, as well as omissions, that we must express our concerns.

The objective of the Americans with Disabilities Act is to provide mobility for all disabled Americans. The legislation, however, does not guarantee the best mobility for all the disabled. Those disabled ****297** Americans who live in smaller or rural areas may find that the Americans with Disabilities Act brings them less mobility, not more.

The bill mandates lifts on every new public transit bus. It also mandates comparable paratransit, except that with regard to response time, the service must be comparable to the extent practicable. The impact of both of these requirements, particularly on smaller transit systems, will be significant. In addition, in smaller areas, the disabled population does not exist in numbers great enough to justify the capital expenditure of lifts. Even in large metropolitan areas where disabled populations are higher, the ridership ***59** figures are low. Seattle, Washington, quotes the highest ridership: one lift use per bus every other day. Significant barriers to lift use exist in every city, whether it be the lack of curb cuts, hilly terrain, sheer distance from the nearest bus stop, or severe weather conditions. Very simply, an adequate paratransit system often provides better mobility to the disabled, particularly in less populated areas, than a lift-equipped fixed route system. It came as no surprise that many disabled across our country prefer it.

We are concerned that the bill makes no allowance for flexibility so that local communities can decide what method of accessibility works best for them. We believe a Federal mandate requiring one solution for all communities is long on theory and short on reality.

A significant amount of paratransit service is currently provided by social service agencies and private non-profit entities. The Department of Health and Human Services alone estimates that transportation represents approximately $1 billion of its total program budgets. The bill puts the legal responsibility for paratransit service on the public transit authority. We are concerned that this linkage will provide a great incentive for other paratransit providers to discontinue their service and devote their limited resources to their basis program offerings rather than transportation service. After all, the ADA lays the burden at someone else's doorstep. In fact, this has already happened to some degree under the existing 504 law and regulations. Transit agencies simply cannot feasibly pick up all of the service that is currently provided, so, once again, some unfortunate disabled Americans will find that the ADA brings them less mobility, not more.

Another concern relates to the bill's effective dates. In the public transportation title, the Department of Transportation is given 12 months to issue complex regulations governing the provision of paratransit service. The law's requirements go into effect 18 months after enactment. What will likely occur is that the effective date will arrive without the issuance of final regulations, leaving transit authorities in the dark regarding their specific responsibilities and subject to discrimination claims. Handicapped rulemakings in the Department of Transportation are traditionally handled through the administrative procedure of a regulatory negotiation rather than the normal notice and comment rulemaking process. Regulatory negotiation involves bringing all affected parties together and negotiating what the regulations should entail. The process is favored by the disability community because there is an enhanced opportunity to express views through this process. By the ****298** very

nature of the process, however, more time is taken to arrive at conclusions. With the range and complexity of issues that must be addressed in a regulation governing paratransit service, and because of the desired use of a regulatory negotiation, we do not believe 12 months is a reasonable amount of time for the Department to act. The bill will penalize transit authorities for agency delay and result in unnecessary litigation, increased transit costs and less mobility and service. We do not believe this was the intent of the ADA.

A concern with the entire bill is its underlying vagueness and confusing new legal terms which will inevitably cause the law to be interpreted by the courts. With legislation that is this significant, ***60** it is unfortunate that major provisions will be decided in the judicial forum rather than by the Congress. For example, provision of paratransit service is limited by the concept of "undue financial burden". The Department of Transportation must issue regulations to determine what constitutes an undue financial burden with very little statutory guidance from the Congress. Invariably, regulations will be challenged and different courts will issue conflicting decisions. This causes even more significant compliance burdens for those attempting to comply with law that is ever changing. We believe this is an unfortunate outcome for such an important piece of legislation.

The bill contains a well reasoned approach to accessibility with the private over-the-road bus industry which we believe represents a full and fair balance of the needs of the disabled and the impacts on the provider. In the spirit of cooperation and compromise, we were able to work out a solution amenable to all parties, which we fully support.

Despite its flaws, the Americans with Disabilities Act is indeed landmark legislation. It is our hope that it will not only open doors and mainstream those who have waited too long, but will serve to topple the true divider amongst ourselves, the disabled attitudes in those of us deemed "abled".

JOHN PAUL HAMMERSCHMIDT.
ARLAN STANGELAND.
BILL CLINGER.
JIM LIGHTFOOT.
DENNIS HASTERT.
JIM INHOFF.
CASS BALLENGER.
BILL EMERSON.
BILL GRANT.
JOHN J. DUNCAN, Jr.,
SUSAN MOLINARI.

****299 *61** MINORITY VIEWS OF MR. BUD SHUSTER, MR. BOB McEWEN, MR. RON PACKARD, MR. MEL HANCOCK, AND MR. CHRISTOPHER COX

We strongly support increased mobility for disabled Americans, but believe the mandates and requirements found in titles II and III of this bill will have detrimental effects on transportation of all Americans, able-bodied and disabled.

This legislation will result in the loss of service to residents of small towns and rural areas as transit agencies seek to cope with the onerous financial burdens imposed upon them by the ADA, not to mention the increased costs that will be borne by all transit riders for equipment and facilities that will be used rarely or not at all. This bill will impact most adversely upon the elderly population that will grow steadily larger as the median age increases. They will be denied needed transportation services because of their ineligibility under the legislation.

We have never opposed civil rights for disabled Americans. Rather, we have supported and attempted to work for a balanced, rational approach to meeting the access needs of all Americans, disabled and able-bodied. During hearings on this legislation we sought to examine the access needs of the disabled and the short-falls of our existing transportation systems. Testimony during the hearings brought out very real needs for disabled Americans, but it also demonstrated a commitment among many transit agencies to meet those needs without

further government interference and mandates. For example, the City of St. Cloud, Minnesota is meeting the needs of their disabled population through a comprehensive paratransit service developed by the transit authority and disabled community. They testified that the ADA will require them to cut their paratransit service and install lift-equipped buses that the disabled community doesn't want.

At the mark-up of this bill several amendments were offered to address these important problems with the bill. Unfortunately, few of the issues raised in the hearings were resolved. As such, we have major concerns about this legislation which are detailed below.

TITLE II, PUBLIC SERVICES

Title II extends a general prohibition of discrimination to public services. It further requires in Section 203, that every new transit bus purchased for public use be accessible to the disabled (lift equipment). Because rural and small cities generally experience lower ridership figures and have lesser resources to draw upon than their larger cousins, this mandate wil have a negative impact on transit entities and service in these areas.

The cost of a new transit bus is approximately $150,000–$175,000. For a transit agency to equip that bus with a wheelchair lift will ***62** require an additional outlay of between $12,000–$15,000 with its attendant average annual maintenance costs of $2000, amounting to a 10 percent surcharge per bus to the transit agency. Total aggregate annual cost to transit authorities to implement the lift mandate ****300** will amount to approximately $30 million a year, when federal transit assistance has been cut 50 percent in real dollar terms in the last 10 years.

When we examine ridership figures for lift-equipped bus fleets we find that they are startlingly low. In Seattle, Washington, for example, the city with the highest reported disabled ridership figures in the nation (their fleet is 80 percent lift equipped), use of lifts averaged .6 lift use per lift-equipped bus per day. Milwaukee, Wisconsin had 50 percent of its fleet accessible and over a three year period experienced disabled ridership figures of .008 lift use per bus per day. They found that fewer than 15 different people used the accessible buses during the three year period. (Milwaukee's estimated wheelchair-bound population is estimated at 7000). New York City has the nation's largest bus fleet with 4200 buses and is nearly 100 percent lift-equipped. The city reports average disabled ridership figures of one lift use per every 19 buses; less than Seattle.

What transit authorities need is the flexibility to meet the access needs of the disabled in their community. Flexibility, rather than an absolute mandate as contained in this legislation would permit local communities—who generally know their ridership needs better than the federal government—the ability of developing a transportation system that provides accessibility to the disabled in the form they want it. A lift-equipped fixed route bus fleet does not result in mobility for all disabled Americans in all areas.

Many disabled and elderly individuals cannot travel to and from a bus stop because of distance, lack of curb cuts, hilly terrain or adverse weather conditions. This legislation, however, would exclude them from eligibility from their only transportation alternative, paratransit service. Only if a disabled person (the elderly population is excluded) cannot actually board, ride or disembark from a lift-equipped bus are they eligible for the door-to-door paratransit service. Their ability to get to the bus stop is not considered a factor.

A limited waiver for small towns and rural areas under 200,000 in population would allow areas that will be hardest hit by this legislation to have the flexibility they need to meet the access needs of the disabled and elderly without disruption and cuts in service. A waiver of this scope would be very narrow. Transit operators in urbanized areas under 200,000 in population represent only 2.2 percent of all transit passenger miles. In addition, a waiver would have the added benefit of requiring consultation with the disabled in the community assuring a local, acceptable approach for all parties.

Section 204 of the legislation contains a requirement that any public entity that operates a fixed route system must also provide paratransit service to eligible disabled persons. This section is one of the most important transportation provisions of the bill because there will always be those disabled that cannot use a fixed route

system, even if that system is fully accessible. In fact, in many situations, ***63** paratransit meets the mobility needs of the disabled better than a lift on each and every transit bus. However, the paratransit provision contained in the ADA requires that paratransit services ****301** provided to the disabled community be comparable, except for response time, which is comparable to the extent practicable.

To require paratransit service to be truly comparable to a regular fixed-route bus service is of major concern to us. Truly comparable service is a very high standard, one which can hardly be met by the existing resources of transit authorities. No transit authority in the country will be able to meet this utopian level of service. A transit authority would have to offer paratransit service that is virtually equivalent to the regular fixed route service.

The cost of providing paratransit service at a comparable level to fixed-route service is unable to be quantified. The Congressional Budget Office and the General Accounting Office, after a request to estimate the cost of such service, reported back to the Congress that they were unable to even come up with an estimate of the cost such service would entail. We find it astounding that we are mandating requirements in the legislation for which costs are unknown. The limitation of "undue financial burden" contained in Section 204 will only result in continuous and quite likely successful suits against the transit agency to require paratransit service above their ability to provide. Moreover, the relief valve of "undue financial burden" will come into play increasingly often as transit authorities, faced with an absolute mandate of equipping every bus with a lift, attempt to shift already scarce resources from paratransit service to wheelchair lifts.

We must understand that paratransit service is not a civil right. It is a service provided to the disabled above and beyond anything an able-bodied person can receive. This service is more like an entitlement, much along the lines of the food stamp program. An ablebodied person that could not get to the bus has no right to this services, a service beyond the scope of a civil rights bill.

Recognizing that this should still be an integral part of a transit authority's commitment to service for those unable to use the fixed-route service, the addition of legislative language in the bill to limit an authority's standard of service to "comparable to the extent practicable" would certainly go far toward insuring that reasonable levels of service would be provided to those that need paratransit. While recognizing the tight fiscal constraints of many transit authorities.

Of additional concern to us is the lack of legislative language in Section 204 that would protect the transit authority, legally responsible to provide paratransit service under the ADA, from having to provide service for a discontinued private provider of paratransit services. The legal requirement that the transit authority be solely responsible for providing service, as in this legislation, places an incentive on the private provider to dump their service onto the transit authority.

In an age of tightening budgets, agencies are already looking to the local transit authorities to provide transportation for their beneficiaries so they can extend the reach of the budgets for basic programs. The result to which this dumping could potentially lead is staggering. Transportation services provided by the Department ***64** of Health and Human Services alone are estimated to approach $1 billion annually. The Urban Mass Transportation Administration's ****302** 16(b)(2) program for comparison, which provides grants to private non-profit organizations serving the elderly and disabled, has a budget of only $35 million annually with which they provide over 20,000 special service vans for 3,500 non-profit agencies.

It is clear that some remedy must be extended to transit authorities or they will be faced with requirements for service, impossible for them to meet with their current limited resources. This situation is already occurring under the Rehabilitation Act of 1973.

Of less obvious concern, but none-the-less objectionable to us, are the effective dates of the ADA. The effective dates contained in the ADA generally require that the Department of Transportation issue regulations governing implementation of specific provisions within twelve months of enactment and sets the effective date for compliance with those regulations to 18 months after enactment.

An immediate problem arises under this requirement if the provisions of the ADA become effective 18 months after the date of enactment and the Department of Transportation has not yet issued the regulation governing their implementation. The transportation authorities will be forced to comply with the legislation without the benefit of regulatory guidance, leading, obviously, to lawsuits. Considering that these regulations will be extremely complex, especially those implementing the paratransit sections, the transit authority will need a minimum of six months after the regulations are issued in order to implement the requirements. Furthermore, since the regulations will most likely be done in a regulatory negotiation that brings all parties together at the table to develop the regulations and involves considerable more time than the normal rulemaking, there is simply not enough time in the bill language for DOT to complete the regulations.

A much more reasonable approach and one which we advocate is for DOT to be subject to a citizens suit that allows a person affected by the regulations—disabled or transit agency—to file suit in the federal district court against DOT if DOT fails to issue the required regulations on time. A provision such as this would give the district court the authority to issue an order requiring DOT to issue the regulations. This approach makes more sense as it penalizes the appropriate party (DOT) rather than the transit agency which has no control over the issuance of the regulations.

TITLE III

Of interest to us in title III of the bill are the provisions relating to private entities operating over-the-road buses. The bill requires that the Office of Technology Assessment undertake a three-year study to determine the access needs of disabled individuals as they relate to over-the-road buses and the most cost-effective methods of achieving accessibility to over-the-road buses. Following the completion of the study, the Secretary of DOT will issue regulations, taking into account the findings of the OTA study, relating to the accessibility for over-the-road buses. Large providers of service will have six years and small providers seven years from the date of enactment of the legislation to comply with the regulations.

****303 *65** The over-the-road bus provisions of this bill represent a compromise agreement developed by many different parties, including the disabled community and the over-the-road bus industry. This final version has been accepted by everyone and is an example of what can be accomplished by a bipartisan negotiating process. We strongly support this language.

BUD SHUSTER.
BOB MCEWEN
RON PACKARD.
MEL HANCOCK.
CHRIS COX.

(Note: 1. PORTIONS OF THE SENATE, HOUSE AND CONFERENCE REPORTS, WHICH ARE DUPLICATIVE OR ARE DEEMED TO BE UNNECESSARY TO THE INTERPRETATION OF THE LAWS, ARE OMITTED. OMITTED MATERIAL IS INDICATED BY FIVE ASTERISKS: *****. 2. TO RETRIEVE REPORTS ON A PUBLIC LAW, RUN A TOPIC FIELD SEARCH USING THE PUBLIC LAW NUMBER, e.g., TO(99-495))

H.R. REP. 101-485(I), H.R. REP. 101-485, H.R. Rep. No. 485(I), 101ST Cong., 2ND Sess. 1990, 1990 U.S.C.C.A.N. 267, 1990 WL 121684 (Leg.Hist.)

Calendar No. 216

101ST CONGRESS *1st Session* | SENATE | REPORT 101-116

THE AMERICANS WITH DISABILITIES ACT OF 1989

AUGUST 30, 1989.—Ordered to be printed

Filed under authority of the order of the Senate of August 2 (legislative day, January 3), 1989

Mr. KENNEDY, from the Committee on Labor and Human Resources, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany S. 933]

The Committee on Labor and Human Resources, to which was referred the bill (S. 933) to establish a clear and comprehensive prohibition of discrimination on the basis of disability, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

CONTENTS

I. INTRODUCTION

On August 2, 1989, the Committee on Labor and Human Resources, by a vote of 16-0, ordered favorably reported S. 933, the

Du Pont has had no increase in compensation costs as a result of hiring the handicapped and no lost-time injuries of the handicapped have been experienced.

With regard to the other concerns, the study showed that the disabled worker performed as well as or better than their non-disabled co-workers. The fears of safety and absenteeism were unfounded.

Some specific findings of the study were as follows:

Ninety-one percent of Du Pont's disabled workers rated average or better in performance.

Only four percent of the workers with disabilities were below average in safety records; more than half were above average.

Ninety-three percent of the workers with disabilities rated average or better with regard to job stability (turnover rate).

Seventy-nine percent of the workers with disabilities rated average or better in attendance.

Fellow employees did not resent necessary accommodations made for employees with disabilities.

In addition, employers may not deny health insurance coverage completely to an individual based on the person's diagnosis or disability. For example, while it is permissible for an employer to offer insurance policies that limit coverage for certain procedures or treatments, e.g., only a specified amount per year for mental health coverage, a person who has a mental health condition may not be denied coverage for other conditions such as for a broken leg or for heart surgery because of the existence of the mental health condition. A limitation may be placed on reimbursements for a procedure or the types of drugs or procedures covered e.g., a limit on the number of x-rays or non-coverage of experimental drugs or procedures; but, that limitation must apply to persons with or without disabilities. All people with disabilities must have equal access to the health insurance coverage that is provided by the employer to all employees.

The ADA does not, however, affect pre-existing condition clauses included in insurance policies offered by employers. Thus, employers may continue to offer policies that contain pre-existing condition exclusions, even though such exclusions adversely affect people with disabilities, so long as such clauses are not used as a subterfuge to evade the purposes of this legislation.

For additional explanations of the treatment of insurance under this legislation, see the discussion in the report on insurance under title V of the legislation.

Section 102(b)(2) of the legislation specifies that "discrimination" includes participating in a contractual or other arrangement or relationship that has the effect of subjecting a qualified applicant or employee with a disability to the discrimination prohibited by this title. Such relationships include a relationship with an employment or referral agency, labor union, an organization providing fringe benefits to an employee of the covered entity, or an organization providing training and apprenticeship programs.

Section 102(b)(3) of the legislation specified that "discrimination" includes utilizing standards, criteria, or methods of administration that have the effect of discrimination on the basis of disability or

a serious threat to the full attainment of the goal of universal service.

In order to realize this goal more fully, Title IV of this legislation amends Title II of the Communications Act of 1934, as amended, by adding a new section 225. This new section imposes on all common carriers providing interstate or intrastate telephone service, an obligation to provide to hearing and speech impaired individuals telecommunications services that enable them to communicate with hearing individuals. These services must be functionally equivalent to telephone service provided to hearing individuals. Carriers are granted the flexibility to determine whether such services are provided by the carrier alone, in concert with other carriers, or through a designee. Hereinafter, this part of the Report will be referring to this new section 225 and not to sections in S. 933, The Americans with Disabilities Act.

Currently, individuals with hearing and speech impairments can communicate with each other over the telephone network with the aid of Telecommunications Devices for the Deaf (TDDs). TDDs use a typewriter-style device equipped with a message display (screen and/or printer) to send a coded signal through the telephone network. However, users of TDDs can communicate only with other users of TDDs. This creates serious hardships for Americans with hearing and/or speech impairments, since access to the community at large is significantly limited.

The Committee intends that section 225 better serve to incorporate the hearing- and speech-impaired communities into the telecommunications mainstream by requiring that telephone services be provided to hearing and/or speech impaired individuals in a manner that is functionally equivalent to telephone services offered to those who do not have these impairments. This requirement will service to bridge the gap between the communications impaired telephone and the community at large. To participate actively in society, one must have the ability to call firends, family, businesses, and employers.

Current technology allows for communications between a TDD user and a voice telephone user by employing a type of relay system. Such systems include a third party operator who completes the connection between the two parties and who transmits messages back and forth in real time between the TDD user and the hearing individual. The originator of the call communicates to the operator either by voice or TDD. The operator then uses a video display system to translate the typed or voice message simultaneously from one medium to the other.

Although the Committee notes that relay systems represent the current state-of-the-art, this legislation is not intended to discourage innovation regarding telecommunications services to individuals with hearing and speech impairments. The hearing- and speech-impaired communities should be allowed to benefit from advancing technology. As such, the provisions of this section do not seek to entrench current technology but rather to allow for new, more advanced, and more efficient technology.

The Committee intends that the FCC have sufficient enforcement authority to ensure that telecommunications relay services are provided nationwide and that certain minimum federal standards are

The U.S. Equal Employment Opportunity Commission

EEOC NOTICE
Number 915.002
Date 6/8/93

1. SUBJECT: Interim Enforcement Guidance on the application of the Americans with Disabilities Act of 1990 to disability-based distinctions in employer provided health insurance.

2. PURPOSE: This interim enforcement guidance sets forth the Commission's position on the application of the Americans with Disabilities Act to disability-based distinctions in employer provided health insurance.

3. EFFECTIVE DATE: Upon issuance.

4. EXPIRATION DATE: As an exception to EEOC Order 205.001, Appendix B, Attachment 4, a(5), this Notice will remain in effect until rescinded or superseded.

5. ORIGINATOR: Americans with Disabilities Act Division, Office of Legal Counsel.

6. INSTRUCTIONS: This enforcement guidance is to be used on an interim basis until the Commission issues final guidance after publication for notice and comment. File after [ ] of Volume II of the Compliance Manual.

7. SUBJECT MATTER:

Notice Concerning The Americans With Disabilities Act Amendments Act Of 2008

The Americans with Disabilities Act (ADA) Amendments Act of 2008 was signed into law on September 25, 2008 and becomes effective January 1, 2009. Because this law makes several significant changes, including changes to the definition of the term "disability," the EEOC will be evaluating the impact of these changes on this document and other publications. See the list of specific changes to the ADA made by the ADA Amendments Act.

I. INTRODUCTION

The interplay between the nondiscrimination principles of the ADA and employer provided health insurance, which is predicated on the ability to make health-related distinctions, is both unique and complex. This interplay is, undoubtedly, most complex when a health insurance plan contains distinctions that are based on disability. The purpose of this interim guidance is to assist Commission investigators in analyzing ADA charges which allege that a disability-based distinction in the terms or provisions of an employer provided health insurance plan violates the ADA.1 This interim guidance does not address the application of the ADA to other issues arising in the context of employer provided health insurance. Nor does it address the application of the ADA to other types of "fringe benefits," such as employer provided pension plans, life insurance, and disability insurance. These subjects will be addressed in future documents.

II. BACKGROUND AND LEGAL FRAMEWORK

The ADA provides that it is unlawful for an employer2 to discriminate on the basis of disability against a qualified

individual with a disability in regard to "job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment." 42 U.S.C. § 12112(a). Section 1630.4 of the Commission's regulations implementing the employment provisions of the ADA further provides, in pertinent part, that it is unlawful for an employer to discriminate on the basis of disability against a qualified individual with a disability in regard to "[f]ringe benefits available by virtue of employment, whether or not administered by the [employer]." 29 C.F.R. § 1630.4(f). Employee benefit plans, including health insurance plans provided by an employer to its employees, are a fringe benefit available by virtue of employment. Generally speaking, therefore, the ADA prohibits employers from discriminating on the basis of disability in the provision of health insurance to their employees.

The ADA also prohibits employers from indirectly discriminating on the basis of disability in the provision of health insurance. Employers may not enter into, or participate in, a contractual or other arrangement or relationship that has the effect of discriminating against their own qualified applicants or employees with disabilities. 42 U.S.C. § 12112(b)(2); 29 C.F.R. § 1630.6(a). Contractual or other relationships with organizations that provide fringe benefits to employees are expressly included in this prohibition. 42 U.S.C. § 12112(b)(2); 29 C.F.R. § 1630.6(b). This means that an employer will be liable for any discrimination resulting from a contract or agreement with an insurance company, health maintenance organization (HMO), third party administrator

(TPA), stop-loss carrier, or other organization to provide or administer a health insurance plan on behalf of its employees.

Another provision of the ADA makes it unlawful for an employer to limit, segregate, or classify an applicant or employee in a way that adversely affects his or her employment opportunities or status on the basis of disability. 42 U.S.C. § 12112(b)(1); 29 C.F.R. § 1630.5. Both the legislative history and the interpretive Appendix to the regulations indicate that this prohibition applies to employer provided health insurance. S. Rep. No. 116, 101st Cong., 1st Sess. (Senate Report) (1989) at 28-29; H.R. Rep. No. 485 part 2, 101st Cong., 2nd Sess. (House Labor Report) (1990) at 58-59; H.R. Rep. No. 485 part 3, 101st Cong., 2nd Sess. (House Judiciary Report) (1990) at 36; Appendix to 29 C.F.R. § 1630.5.

Several consequences result from the application of these statutory provisions. First, disability-based insurance plan distinctions are permitted only if they are within the protective ambit of section 501(c) of the ADA. (See the discussion in Section III, infra.) Second, decisions about the employment of an individual with a disability cannot be motivated by concerns about the impact of the individual's disability on the employer's health insurance plan. Appendix to 29 C.F.R. § 1630.15(a). Third, employees with disabilities must be accorded "equal access" to whatever health insurance the employer provides to employees without disabilities. See Appendix to 29 C.F.R. § 1630.16(f). Fourth, in view of the

statute's "association provision," 42 U.S.C. § 12112(b)(4); 29 C.F.R. § 1630.8, it would violate the ADA for an employer to make an employment decision about any person, whether or not that person has a disability, because of concerns about the impact on the health insurance plan of the disability of someone else with whom that person has a relationship.

As previously noted, this interim guidance is devoted solely to the ADA implications of disability-based health insurance plan distinctions. The ADA implications of other issues arising in the context of employer provided health insurance will be addressed in future guidance.

III. DISABILITY-BASED DISTINCTIONS

A. Framework of Analysis

Whenever it is alleged that a health-related term or provision of an employer provided health insurance plan violates the ADA, the first issue is whether the challenged term or provision is, in fact, a disability-based distinction. If the Commission determines that a challenged health insurance plan term or provision is a disability-based distinction, the respondent will be required to prove that that disability-based distinction is within the protective ambit of section 501(c) of the ADA.

In pertinent part, section 501(c) permits employers, insurers, and plan administrators to establish and/or observe the terms of an insured3 health insurance plan that is "bona fide,"4 based on "underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law," and that is not being used as a "subterfuge" to evade the purposes of the ADA. Section 501(c) likewise permits employers, insurers, and plan administrators to establish and/or observe the terms of a "bona fide" self-insured health insurance plan that is not used as a "subterfuge." 42 U.S.C. § 12201(c). The text of section 501(c) is incorporated into § 1630.16(f) of the Commission's regulations.5

Consequently, if the Commission determines that the challenged term or provision is a disability-based distinction, the respondent will be required to prove that: 1) the health insurance plan is either a bona fide insured health insurance plan that is not inconsistent with state law, or a bona fide self-insured health insurance plan;6 and 2) the challenged disability-based distinction is not being used as a subterfuge. If the respondent so demonstrates, the Commission will conclude that the challenged disability-based distinction is within the protective ambit of section 501(c) and does not violate the ADA. If, on the other hand, the respondent is unable to make this two-pronged demonstration, the Commission will conclude that the respondent has violated the ADA.

B. What Is a Disability-Based Distinction?

It is important to note that not all health-related plan distinctions discriminate on the basis of disability. Insurance distinctions that are not based on disability, and that are applied

equally to all insured employees, do not discriminate on the basis of disability and so do not violate the ADA.7

For example, a feature of some employer provided health insurance plans is a distinction between the benefits provided for the treatment of physical conditions on the one hand, and the benefits provided for the treatment of "mental/nervous" conditions on the other. Typically, a lower level of benefits is provided for the treatment of mental/nervous conditions than is provided for the treatment of physical conditions. Similarly, some health insurance plans provide fewer benefits for "eye care" than for other physical conditions. Such broad distinctions, which apply to the treatment of a multitude of dissimilar conditions and which constrain individuals both with and without disabilities, are not distinctions based on disability. Consequently, although such distinctions may have a greater impact on certain individuals with disabilities, they do not intentionally discriminate on the basis of disability8 and do not violate the ADA.9

Blanket pre-existing condition clauses that exclude from the coverage of a health insurance plan the treatment of conditions that pre-date an individual's eligibility for benefits under that plan also are not distinctions based on disability, and do not violate the ADA. Universal limits or exclusions from coverage of all experimental drugs and/or treatments, or of all "elective surgery," are likewise not insurance distinctions based on disability. Similarly, coverage limits on medical procedures that are not exclusively, or nearly exclusively, utilized for the treatment of a particular disability are not distinctions based on disability. Thus, for example, it would not violate the ADA for an employer to limit the number of blood transfusions or X-rays that it will pay for, even though this may have an adverse effect on individuals with certain disabilities.

> Example 1. The R Company health insurance plan limits the benefits provided for the treatment of any physical conditions to a maximum of $25,000 per year. CP, an employee of R, files a charge of discrimination alleging that the $25,000 cap violates the ADA because it is insufficient to cover the cost of treatment for her cancer. The $25,000 cap does not single out a specific disability, discrete group of disabilities, or disability in general. It is therefore not a disability-based distinction. If it is applied equally to all insured employees, it does not violate the ADA.

In contrast, however, health-related insurance distinctions that are based on disability may violate the ADA. A term or provision is "disability-based" if it singles out a particular disability (e.g., deafness, AIDS, schizophrenia), a discrete group of disabilities (e.g., cancers, muscular dystrophies, kidney diseases), or disability in general (e.g., non-coverage of all conditions that substantially limit a major life activity).

As previously noted, employers may establish and/or observe the terms and provisions of a bona fide benefit plan, including terms or provisions based on disability, that are not a "subterfuge to evade the purposes" of the ADA. Such terms and provisions do not violate the ADA. However, disability-based insurance distinctions that are a

"subterfuge" do intentionally discriminate on the basis of disability and so violate the ADA.

Example 2. R Company's new self-insured health insurance plan caps benefits for the treatment of all physical conditions, except AIDS, at $100,000 per year. The treatment of AIDS is capped at $5,000 per year. CP, an employee with AIDS enrolled in the health insurance plan, files a charge alleging that the lower AIDS cap violates the ADA. The lower AIDS cap is a disability-based distinction. Accordingly, if R is unable to demonstrate that its health insurance plan is bona fide and that the AIDS cap is not a subterfuge, a violation of the ADA will be found.

Example 3. R Company has a health insurance plan that excludes from coverage treatment for any pre-existing blood disorders for a period of 18 months, but does not exclude the treatment of any other pre-existing conditions. R's pre-existing condition clause only excludes treatment for a discrete group of related disabilities, e.g., hemophilia, leukemia, and is thus a disability-based distinction. CP, an individual with acute leukemia who recently joined R Company and enrolled in its health insurance plan, files a charge of discrimination alleging that the disability-based pre-existing condition clause violates the ADA. If R is unable to demonstrate that its health insurance plan is bona fide and that the disability-specific pre-existing condition clause is not a subterfuge, a violation of the ADA will be found.

It should be noted that the ADA does not provide a "safe harbor" for health insurance plans that were adopted prior to its July 26, 1990 enactment. As the Senate Report states, subterfuge is to be determined "regardless of the date an insurance or employer benefit plan was adopted." Senate Report at 85; see also House Labor report at 136-138; House Judiciary Report at 70-71; Appendix to 29 C.F.R. □ 1630.16(f). Consequently, the challenged disability-based terms and provisions of a pre-ADA health insurance plan will be scrutinized under the same subterfuge standard as are the challenged disability-based terms, provisions, and conditions of post-ADA health insurance plans.10

C. The Respondent's Burden of Proof

Once the Commission has determined that a challenged health insurance term or provision constitutes a disability-based distinction, the respondent must prove that the health insurance plan is either a bona fide insured plan that is not inconsistent with state law, or a bona fide self-insured plan. The respondent must also prove that the challenged disability-based distinction is not being used as a subterfuge. Requiring the respondent to bear this burden of proving entitlement to the protection of section 501(c) is consistent with the well-established principle that the burden of proof should rest with the party who has the greatest access to the relevant facts.11 In the health insurance context, it is the respondent employer (and/or the employer's insurer, if any) who has control of the risk assessment, actuarial, and/or claims data relied upon in adopting the challenged disability-based distinction. Charging party employees have no access to such data, and, generally

speaking, have no information about the employer provided health insurance plan beyond that contained in the employer provided health insurance plan description. Consequently, it is the employer who should bear the burden of proving that the challenged disability-based insurance distinction is within the protective ambit of section 501(c).

1. The Health Insurance Plan Is "Bona Fide" and Consistent with Applicable Law

In order to gain the protection of section 501(c) for a challenged disability-based insurance distinction, the respondent must first prove that the health insurance plan in which the challenged distinction is contained is either a bona fide insured health insurance plan that is not inconsistent with state law, or a bona fide self-insured health insurance plan.12 If the health insurance plan is an insured plan, the respondent will be able to satisfy this requirement by proving that: 1) the health insurance plan is bona fide in that it exists and pays benefits, and its terms have been accurately communicated to eligible employees; and 2) the health insurance plan's terms are not inconsistent with applicable state law as interpreted by the appropriate state authorities.13 If the health insurance plan is a self-insured plan, the respondent will only be required to prove that the health insurance plan is bona fide in that it exists and pays benefits, and that its terms have been accurately communicated to covered employees.

2. The Disability-Based Distinction Is Not a Subterfuge

The second demonstration that the respondent must make in order to gain the protection of section 501(c) is that the challenged disability-based distinction is not a subterfuge to evade the purposes of the ADA. "Subterfuge" refers to disability-based disparate treatment that is not justified by the risks or costs associated with the disability. Whether a particular challenged disability-based insurance distinction is being used as a subterfuge will be determined on a case by case basis, considering the totality of the circumstances.

The respondent can prove that a challenged disability-based insurance distinction is not a subterfuge in several ways. A non-exclusive list of potential business/insurance justifications follows.

a. The respondent may prove that it has not engaged in the disability-based disparate treatment alleged. For example, where a charging party has alleged that a benefit cap of a particular catastrophic disability is discriminatory, the respondent may prove that its health insurance plan actually treats all similarly catastrophic conditions in the same way.

b. The respondent may prove that the disparate treatment is justified by legitimate actuarial data,14 or by actual or reasonably anticipated experience, and that conditions with comparable actuarial data and/or experience are treated in the same fashion. In other words, the respondent may prove that the

disability-based disparate treatment is attributable to the application of legitimate risk classification and underwriting15 procedures to the increased risks (and thus increased cost to the health insurance plan) of the disability, and not to the disability per se.

c. The respondent may prove that the disparate treatment is necessary (i.e., that there is no nondisability-based health insurance plan change that could be made) to ensure that the challenged health insurance plan satisfies the commonly accepted or legally required standards for the fiscal soundness of such an insurance plan. The respondent, for example, may prove that it limited coverage for the treatment of a discrete group of disabilities because continued unlimited coverage would have been so expensive as to cause the health insurance plan to become financially insolvent, and there was no nondisability-based health insurance plan alteration that would have avoided insolvency.

d. The respondent may prove that the challenged insurance practice or activity is necessary (i.e., that there is no nondisability-based change that could be made) to prevent the occurrence of an unacceptable change either in the coverage of the health insurance plan, or in the premiums charged for the health insurance plan. An "unacceptable" change is a drastic increase in premium payments (or in co-payments or deductibles), or a drastic alteration to the scope of coverage or level of benefits provided, that would: 1) make the health insurance plan effectively unavailable to a significant number of other employees, 2) make the health insurance plan so unattractive as to result in significant adverse selection16, or 3) make the health insurance plan so unattractive that the employer cannot compete in recruiting and maintaining qualified workers due to the superiority of health insurance plans offered by other employers in the community.

e. Where the charging party is challenging the respondent's denial of coverage for a disability-specific treatment, the respondent may prove that this treatment does not provide any benefit (i.e., has no medical value). The respondent, in other words, may prove by reliable scientific evidence that the disability-specific treatment does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of individuals with the disability who receive the treatment.17

IV. COVERAGE OF DEPENDENTS

The coverage of an employee's dependents under an employer provided health insurance plan is a benefit available to the employee by virtue of employment. Consequently, insurance terms, provisions, and conditions concerning dependent coverage are subject to the same ADA standards, including the application of section 501(c) to disability-based distinctions, as are other insurance terms, provisions, and conditions.

The ADA, however, does not require that the coverage accorded dependents be the same in scope as the coverage accorded the employee. For example, it would not violate the ADA for a health insurance plan to cover prescription drugs for employees, but not to include such coverage for employee dependents. Nor does the ADA require that dependents be accorded the same level of benefits as that accorded the employee. Thus, it would not violate the ADA for a health insurance plan to have a $100,000 benefit cap for employees, but only a $50,000 benefit cap for employee dependents.

V. CHARGE PROCESSING

1. In General

Charges alleging that a term or provision of an employer provided health insurance plan discriminates on the basis of disability should be processed in accordance with the foregoing guidance. When confronted with a charge alleging that a health insurance plan distinction is a disability-based distinction that violates the ADA, the investigator should initially determine whether the challenged insurance term or provision is, in fact, a disability-based distinction . To do this, the investigator should determine whether:

1) the insurance term, provision, or condition singles out a particular disability, discrete group of disabilities, or disability in general; and/or

2) the insurance term, provision, or condition singles out a procedure or treatment used exclusively, or nearly exclusively, for the treatment of a particular disability or discrete group of disabilities (e.g., exclusion of a drug used only to treat AIDS). (Section III. B, supra.)

If it is determined that the challenged insurance term or provision is not a disability-based distinction and is applied equally to all insured employees, the investigator should conclude that the health insurance plan distinction does not violate the ADA.

On the other hand, if the challenged insurance term or provision is found to be a disability-based distinction, the investigator should determine whether the respondent can justify the disability-based distinction by satisfying the requirements of section 501(c) of the ADA. To make this determination, the investigator should take the steps described below.

1) The investigator should obtain evidence from the respondent that the health insurance plan is a bona fide plan. (Section III.C.1, supra.)

2) If the health insurance plan is an insured plan, the investigator should also obtain evidence from the respondent that the health insurance plan is not inconsistent with the applicable state law(s). (Section III.C.1, supra.)

3) The investigator should obtain evidence from the respondent

relevant to any business/insurance justification proffered to justify the disability-based insurance distinction. The evidence obtained should be specific and detailed. For example, if the respondent is relying on actuarial data to justify the disability-based distinction, the investigator should require a detailed explanation of the rationale underlying the disability-based distinction, including the actuarial conclusions arrived at, the actuarial assumptions relied upon to reach those conclusions, and the factual data that supports the assumptions and/or conclusions.

Similarly, if the respondent asserts that the disability-based distinction is justified by actual or reasonably anticipated experience, the investigator should obtain evidence about the respondent's insurance claims experience, and the way in which the respondent has reacted to similar previous experience situations. If the respondent asserts that the disability-based distinction was necessary to prevent the occurrence of an unacceptable change in coverage or premiums, or to assure the fiscal soundness of the health insurance plan, the investigator should obtain evidence of the nondisability-based options for modifying the health insurance plan that were considered and the reason(s) for the rejection of these options. If the respondent asserts that its health insurance plan excludes a disability-specific treatment because it is of no medical value, the investigator should obtain evidence regarding the scientific evidence relied upon by the respondent in reaching that determination. (Section III.C.2, supra.)

Commission staff should direct questions concerning the guidance or its application in particular cases to the Office of Legal Counsel Attorney of the Day.

_____ _____

Date Approved: Tony Gallegos
Chairman

1. In light of the recent amendments to the Rehabilitation Act of 1973, the analysis in this interim guidance also applies to federal sector complaints of discrimination arising under section 501 of that statute.

2. The ADA also prohibits employment agencies, labor organizations, and joint labor management committees from discriminating in employment against qualified individuals with disabilities. However, for convenience, only the term "employer" is used throughout this document.

3. An "insured" health insurance plan is a health insurance plan or policy that is purchased from an insurance company or other organization, such as a health maintenance organization (HMO). This

is in contrast to a "self-insured" health plan, where the employer directly assumes the liability of an insurer. Insured health insurance plans are regulated by both ERISA and state law. Self-insured plans are typically subject to ERISA, but are not subject to state laws that regulate insurance.

4. The term "bona fide" is defined in Section III (C)(1), infra.

5. Section 1630.16(f) states:

(f) Health insurance, life insurance and other benefit plans-

(1) An insurer, hospital, or medical service company, health maintenance organization, or any agent or entity that administers benefit plans, or similar organizations may underwrite risks, classify risks, or administer such risks that are based on or not inconsistent with State law.

(2) A covered entity may establish, sponsor, observe, or administer the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law.

(3) A covered entity may establish, sponsor, observe, or administer the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

(4) The activities described in paragraphs (f)(1), (2) and (3)... are permitted unless these activities are being used as a subterfuge to evade the purposes of [Title I of the ADA].

6. If an employer provided health insurance plan is a "multiple employer welfare arrangement" (MEWA) pursuant to section 3(40) of ERISA, it may be subject to certain state insurance laws even if it is self-insured. See footnote 13, infra.

7. The term "discriminates" refers only to disparate treatment. The adverse impact theory of discrimination is unavailable in this context. See Alexander v. Choate, 469 U.S. 287 (1985), a case brought under 504 of the Rehabilitation Act of 1973. See also the discussion of Choate in the Senate Report at 85; House Labor Report at 137.

8. However, it would violate the ADA for an employer to selectively apply a universal or "neutral" non-disability based insurance distinction only to individuals with disabilities. Thus, for example, it would violate the ADA for an employer to apply a "neutral" health insurance plan limitation on "eye care" only to an employee seeking treatment for a vision disability, but not to other employees who do not have vision disabilities. Charges alleging that a universal or "neutral" non-disability based insurance distinction has been selectively applied to individuals with disabilities should be processed using traditional disparate treatment theory and analysis.

9. This position is consistent with the case law developed pursuant to 504 of the Rehabilitation Act of 1973, as amended,

29 U.S.C. § 794, the statute on which the ADA is patterned. Courts faced with challenges to insurance plan distinctions between physical benefits and mental/nervous benefits under the Rehabilitation Act have held that such distinctions are rational and do not discriminate on the basis of disability. See, e.g., Doe v. Colautti, 592 F.2d 704 (3d Cir. 1979)(holding that Pennsylvania's medical assistance statute was not required by the Rehabilitation Act to provide the same level of benefits for inpatient hospital treatment of mental illness as for inpatient hospital treatment of physical illness; the court noted that care for physical illness and care for mental illness were two different benefits), and Doe v. Devine, 545 F. Supp. 576 (D.D.C. 1982), aff'd on other grounds, 703 F. 2d 1319 (D.C. Cir. 1983)(holding that Blue Cross "cutbacks" in mental health benefits for federal employees are reasonable and do not discriminate on the basis of disability).

10. It has been suggested that the Commission should interpret "subterfuge" under the ADA as having the same meaning as was accorded that term under the Age Discrimination in Employment Act (ADEA) of 1967, 29 U.S.C. § 621 et seq. In Ohio Public Employees Retirement System v. Betts, 492 U.S. 158 (1989), the Court held that a pre-ADEA benefit plan could not be a subterfuge, and that, since the ADEA did not expressly apply to fringe benefits, subterfuge required a showing of the employer's specific intent to discriminate in some non-fringe aspect of the employment relationship. However, both the language of the ADA, expressly covering "fringe benefits," and the Act's legislative history, rejecting the concept of a "safe harbor" for pre-ADA plans, make plain congressional intent that the Betts approach not be applied in the context of the ADA.

11. See Morgado v. Birmingham-Jefferson County Civil Defense Corps., 706 F.2d 1184, 1189 (11th Cir. 1983, cert. denied, 464 U.S. 1045 (1984) (employer relying on Equal Pay Act provision allowing pay differentials for reasons other than sex must prove entitlement to provision's protection because such facts "are peculiarly within the knowledge of the employer"); EEOC v. Whitin Machine Works, Inc., 635 F.2d 1095, 1097 (4th Cir. 1980) (when facts are "within [the] unique knowledge" of the employer, it bears burden of proof concerning those facts); EEOC v. Radiator Specialty Co., 610 F.2d 178, 185 n. 8 (4th Cir. 1979) ("general principle of allocation of proof to the party with the most ready access to the relevant information" requires Title VII defendant to show inappropriateness of labor pool statistics).

12. See footnote 3, supra, for a discussion of the difference between "insured" and "self-insured" insurance plans.

13. The term "applicable state law" refers both to the determination of: 1) which state's laws are applicable to the particular charge (e.g., which state's laws are applicable in the event that the health insurance policy was drawn up in accordance with the laws of the state of Maryland, but the insured employee resides in the state of Virginia) and 2) which laws of that appropriate state are relevant to the particular charge. With respect to health insurance plans that are MEWAs, applicable state law is determined with reference to ERISA section 514 (b)(6)(A). Questions concerning the "applicable state law" should be directed to

the Regional Attorney.

14. Actuarial data that is seriously outdated and/or inaccurate is not legitimate actuarial data. The respondent, for example, will not be able to rely on actuarial data about a disability that is based on myths, fears, or stereotypes about the disability. Nor will a respondent be able to rely on actuarial data that is based on false assumptions about disability, or on assumptions that may have once been, but are no longer, true. For example, a respondent would not be able to justify an exclusion of epilepsy from its insurance plan that is based on an erroneous assumption that people with epilepsy are more likely to have serious accidents (and thus file more claims for insurance benefits) than are individuals who do not have epilepsy.

15. Risk classification refers to the identification of risk factors and the grouping of those factors that pose similar risks. Risk factors may include characteristics such as age, occupation, personal habits (e.g., smoking), and medical history. Underwriting refers to the application of the various risk factors or risk classes to a particular individual or group (usually only if the group is small) for the purpose of determining whether to provide insurance.

16. Adverse selection is the tendency of people who represent poorer-than-average health risks to apply for and/or retain health insurance to a greater extent than people who represent average or above average health risks. Drastic increases in premiums and/or drastic decreases in insurance benefits foster an increase in adverse selection, as those who are considered to be "good" insurance risks drop out and seek enrollment in an insurance plan with lower premiums and/or better benefits. An insurance plan that is subjected to a significant rate of adverse selection may, as a result of the increase in the proportion of "poor risk/high use" enrollees to "good risk/low use" enrollees, become not viable or financially unsound.

17. However, the respondent may be found to have violated the ADA if the evidence reveals that the respondent's health insurance plan covers treatments for other conditions that are likewise of no medical value.

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