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Elizabeth Pendo
University of Washington School of Law

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THE COSTS OF UNCERTAINTY: THE DOJ'S STALLED PROGRESS ON ACCESSIBLE MEDICAL EQUIPMENT UNDER THE AMERICANS WITH DISABILITIES ACT

ELIZABETH PENDO*

I. INTRODUCTION

Imagine seeking medical care for serious pressure sores for a year, but your doctor never examining the sores because you could not get on the examination table in her office. Or imagine going more than fifteen years without an annual well-woman examination for the same reason, or your doctor guessing at the right dosage for a prescription because there was no scale that she could use to weigh you.

Although these scenarios may be difficult for many to imagine, they are common experiences for individuals with mobility disability.¹ The Trump administration's attacks on the Patient Protection and Affordable Care Act (ACA) and its aggressive deregulatory agenda have made headlines.² This Article brings attention to an underappreciated story at the nexus of these two efforts—the Department of Justice's (DOJ) decision to abandon progress toward legal standards for accessible medical equipment necessary to provide health care for millions of Americans.

* Copyright © 2019 Elizabeth Pendo. Joseph J. Simeone Professor of Law, Saint Louis University School of Law, Saint Louis, Missouri. Thank you to the AALS Section on Disability Law and my co-panelists for the opportunity to present the ideas in this article as part of the 2018 AALS Annual Meeting program, and to Audrey Larsen (JD anticipated May 2019) for her excellent research assistance.

1. These are the stories of the named plaintiffs in the first class action lawsuit challenging inaccessible medical equipment. See Tamar Lewin, *Disabled Patients Win Sweeping Changes from H.M.O.*, N.Y. TIMES (Apr. 13, 2001), <https://www.nytimes.com/2001/04/13/us/disabled-patients-win-sweeping-changes-from-hmo.html>.

2. See, e.g., Maggie Haberman & Robert Pear, *Trump Tells Congress to Repeal and Replace Health Care Law 'Very Quickly'*, N.Y. TIMES (Jan. 10, 2017), <https://www.nytimes.com/2017/01/10/us/repeal-affordable-care-act-donald-trump.html>; Thomas Kaplan, *'Let Obamacare Fail,' Trump Says as G.O.P. Health Bill Collapses*, N.Y. TIMES (July 18, 2017), <https://www.nytimes.com/2017/07/18/us/politics/republicans-obamacare-repeal-now-replace-later.html>; Eric Lipton & Binyamin Appelbaum, *Leashes Come Off Wall Street, Gun Sellers, Polluters and More*, N.Y. TIMES (Mar. 5, 2017), <https://www.nytimes.com/2017/03/05/us/politics/trump-deregulation-guns-wall-st-climate.html>.

According to 2016 data from the Centers for Disease Control and Prevention, one in four adults, or sixty-one million individuals, are living with disability in the U.S.³ Mobility disabilities, which involve difficulty walking or climbing stairs, are the most common type of disability, affecting thirteen percent of adults, and are expected to increase as the population ages.⁴ Individuals with mobility disability need the same basic health care as individuals without disability, and the same access to examination tables, weight scales, mammography equipment, and other diagnostic imaging technologies to deliver it. However, a growing body of research documents physical barriers to health care for individuals with disability including lack of accessible medical equipment.⁵

The Americans with Disabilities Act⁶ (ADA) and § 504 of the Rehabilitation Act⁷ (§ 504 or Rehabilitation Act) mandate equal access to health care programs, services, and facilities for individuals with disability, but neither law provides specific standards and requirements for accessible medical equipment. In recent years and especially since the passage of the ACA, there has been significant progress toward development of explicit standards and other requirements for accessible medical equipment. But on December 26, 2017, the DOJ withdrew four Advance Notices of Proposed Rulemaking (ANPRM) relating to Titles II and III of the ADA, including the ANPRM that would have set standards and requirements for accessible medical equipment.⁸

In prior work, I exposed the impact of inaccessible medical and diagnostic equipment on health care for people with mobility disability and identified remedies under the ADA and ACA.⁹ This article integrates my prior work with more recent legal developments and shows how the DOJ's abrupt abandonment

3. Catherine A. Okoro et al., *Prevalence of Disabilities and Health Care Access by Disability Status and Type Among Adults — United States, 2016*, 67 CTDS. FOR DISEASE CONTROL & PREVENTION MORBIDITY MORTALITY WKLY. REP. 882, 882 (2018), <https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6732a3-H.pdf>.

4. *Id.* at 882–83.

5. See *Advancing Equal Access to Diagnostic Services: Recommendations on Standards for the Design of Medical Diagnostic Equipment for Adults with Disabilities*, U.S. ACCESS BD. (Dec. 6, 2013), <https://www.access-board.gov/guidelines-and-standards/health-care/about-this-rulemaking/advisory-committee-final-report/2-background>.

6. Americans with Disabilities Act, 42 U.S.C. § 12101 (2012).

7. Rehabilitation Act of 1973, 29 U.S.C. §§ 701, 794 (2012).

8. Nondiscrimination on the Basis of Disability; Notice of Withdrawal of Four Previously Announced Rulemaking Actions, 82 Fed. Reg. 60,923 (Dec. 26, 2017).

9. See generally Elizabeth Pendo, *Shifting the Conversation: Disability, Disparities and Health Care Reform*, 6 FLA. INT'L U. L. REV. 85 (2011); Elizabeth Pendo, *Reducing Disparities through Health Care Reform: Disability and Accessible Medical Equipment*, 4 UTAH L. REV. 1057 (2010) [hereinafter Pendo, *Reducing Disparities through Health Care Reform*]; Elizabeth Pendo, *Disability, Equipment Barriers, and Women's Health: Using the ADA to Provide Meaningful Access*, 2 ST. LOUIS U. J. HEALTH L. & POL'Y 15 (2008) [hereinafter Pendo, *Using the ADA to Provide Meaningful Access*].

of efforts disadvantages patients with disability and health care providers and institutions alike.¹⁰ Part II outlines the legal framework that governs accessible medical equipment and the accelerating progress toward specific standards and requirements before the DOJ's actions. Part III examines the DOJ's decision to abandon efforts to set specific standards and requirements for accessible medical equipment. Finally, Part IV suggests that litigation challenging inaccessible medical equipment, among other strategies to improve access, is likely to continue in the absence of clear standards.

II. PROGRESS TOWARD LEGAL STANDARDS AND REQUIREMENTS

The two primary federal disability civil rights laws that address equal access to health care are the ADA and the Rehabilitation Act. The purpose of the ADA is to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disability.¹¹ The ADA prohibits discrimination based on disability in employment (Title I), public services (Title II), public transportation, places of public accommodation (Title III), and telecommunications (Title IV).¹² The ADA protects individuals with a disability, defined as a physical or mental impairment that substantially limits a major life activity, individuals with a history of disability, and individuals who are regarded as having a disability.¹³ Congress amended the ADA in 2008 to clarify that the statutory definition of disability should be construed in favor of broad coverage of individuals.¹⁴

The ADA expands the protections of the earlier Rehabilitation Act, which prohibits discrimination based on disability in programs and activities funded by federal agencies and federal employment.¹⁵ Section 504 of the Rehabilitation Act requires hospitals, clinics, and other health care agencies that accept Medicaid funds, Medicare funds, or any other form of federal funding, to ensure equal access to programs and services.¹⁶ The ADA and § 504 of the Rehabilitation Act are similar in most respects, and courts have used cases under the Rehabilitation Act to assist in interpreting the ADA.¹⁷

10. See generally Lisa I. Iezzoni & Elizabeth Pendo, *Accessibility of Medical Diagnostic Equipment – Implications for People with Disability*, 378 NEW ENG. J. MED. 1371 (2018).

11. 42 U.S.C. § 12101(b) (2012).

12. *Id.* §§ 12111, 12112, 12131, 12132, 12181, 12182.

13. *Id.* § 12102(1).

14. *Id.* § 12102.

15. 29 U.S.C. § 701(b) (2012).

16. *Id.* §§ 701(a)(1), 794(b)(3)(A)(ii). Several courts have found that receipt of Medicare or Medicaid funds constitutes receipt of federal financial assistance within the meaning of the Rehabilitation Act. See, e.g., *Henrietta D. v. Bloomberg*, 331 F.3d 261, 272 (2d Cir. 2003) (noting the lack of dispute on point under the Rehabilitation Act and the ADA).

17. See, e.g., *Davis v. Shah*, 821 F.3d 231, 259–60 (2d Cir. 2016) (citing *Henrietta D.*, 331 F.3d at 272; *Helen L. v. DiDario*, 46 F.3d 325, 330 n.7 (3d Cir. 1995)).

Title II of the ADA prohibits discrimination against individuals with disability by public entities, including state and local public health programs, services, and activities, regardless of receipt of federal funding.¹⁸ Courts have applied the requirements of Title II to state Medicaid programs¹⁹ and state and county hospitals.²⁰ Finally, Title III of the ADA prohibits discrimination by places of accommodation that serve the public, including private offices of health care providers and private hospitals.²¹

Together, the ADA and the Rehabilitation Act require that health care facilities and the offices of health care providers be accessible to people with disability. Although there are some differences between the specific requirements of Title II and Title III of the ADA, in general, accessibility in health care settings incorporates: physical access to health care services and facilities, including accessible spaces and the removal of barriers;²² effective communication, including auxiliary aids and services such as the provision of sign language interpreters or materials in alternative formats;²³ and reasonable modification of policies, practices, and procedures when necessary to accommodate individual needs.²⁴

ADA regulations for Title II and Title III set specific standards for physical accessibility of “fixed features” in and around health care facilities and offices, such as parking lots, entrances, stairs and elevators, examination rooms, and restrooms.²⁵ The regulations, known as the “2010 ADA Standards for Accessible Design”, were enacted based upon design guidelines for buildings and facilities generated by the U.S. Access Board, an independent federal agency created by § 502 of the Rehabilitation Act.²⁶ The “2010 ADA Standards for Accessible Design” require that newly constructed and altered state and local government facilities, places of public accommodation, and commercial facilities are readily accessible to, and usable by, individuals with disability.²⁷ However, the regulations do not set specific standards for “non-fixed furniture and equipment” which includes medical diagnostic equipment (MDE).

18. See 42 U.S.C. § 12131(1) (2012).

19. See Pendo, *Using the ADA to Provide Meaningful Access*, *supra* note 9 (reviewing cases applying Title II to state Medicaid programs).

20. See *Gray v. Cty. of Kern*, 704 F. App'x 649, 650 (9th Cir. 2017); *Judice v. Hosp. Serv.* Dist. No. 1, 919 F. Supp. 978, 980 (E.D. La. 1996).

21. See 42 U.S.C. § 12181(7)(F); 42 U.S.C. § 12182(a); 28 C.F.R. § Pt. 36 App'x B at 696 (2008).

22. 28 C.F.R. § 35.150(a) (2011); 28 C.F.R. § 36.304 (2010).

23. 28 C.F.R. § 35.160 (2018); 28 C.F.R. § 36.303(a)-(c) (2018).

24. 28 C.F.R. § 35.130(b)(7) (2018); 28 C.F.R. § 36.302(a) (2018).

25. 28 C.F.R. § 35.151(h) (2010); 28 C.F.R. § 36.406(g) (2010).

26. DEP'T OF JUSTICE, 2010 ADA STANDARDS FOR ACCESSIBLE DESIGN 1, 198 (2010), https://www.ada.gov/regs2010/2010ADASTandards/2010ADASTandards_prt.pdf.

27. *Id.* at 1.

A. *Opportunities to Set Specific MDE Standards Prior to the ACA*

Since the passage of the ADA, there have been several attempts to enact specific standards for medical equipment through regulation and legislation. In 1991, the DOJ proposed a regulation under Title III of the ADA addressing a number of requirements, including that all newly purchased furniture or equipment be accessible to the extent it is available.²⁸ The DOJ omitted the section dealing with furniture and equipment from the final rule, noting “there were no appropriate accessibility standards addressing many types of furniture and equipment.”²⁹ The DOJ also stated that the accessibility of furniture and equipment could be “addressed under other sections,” presumably the regulations under the program accessibility, reasonable modification, auxiliary aids and services, and barrier removal requirements.³⁰

Almost fifteen years later in 2004, the DOJ issued an ANPRM that invited public comment on adoption of standards for furniture and equipment under ADA Title II and Title III.³¹ Despite concerns raised by members of the disability community about the need for specific requirements for medical equipment,³² the DOJ again declined to set specific standards.³³ In the final rule for Title III, the DOJ did state its intent to analyze the economic impact of future regulations governing specific types of free-standing equipment, which would include medical equipment.³⁴

There was a legislative attempt to establish specific standards for types of medical equipment commonly used for diagnostic purposes (medical diagnostic equipment or MDE) through the Promoting Wellness for Individuals with

28. Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 56 Fed. Reg. 35,544, 35,572 (July 26, 1991) (to be codified at 28 C.F.R. pt. 36).

29. *Id.*

30. *Id.*

31. Nondiscrimination on the Basis of Disability in State and Local Government Services; Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 69 Fed. Reg. 58,768, 58,768, 58,775 (proposed Sept. 30, 2004) (to be codified at 28 C.F.R. pts. 35, 36).

32. *See* Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 75 Fed. Reg. 56,236, 56,315 (Sept. 15, 2010) (to be codified at 28 C.F.R. pt. 36).

33. Nondiscrimination on the Basis of Disability in State and Local Government Services, 73 Fed. Reg. 34,466, 34,474–75 (proposed June 17, 2008) (to be codified at 28 C.F.R. pt. 35); Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 73 Fed. Reg. 34,508, 34,517 (proposed June 17, 2008) (to be codified at 28 C.F.R. pt. 36).

34. Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 75 Fed. Reg. at 56,315–16.

Disabilities Act of 2007 (Promoting Wellness Act).³⁵ The Act called for the Access Board to develop detailed standards for examination tables, examination chairs, weight scales, and mammography and other imaging equipment within nine months.³⁶ The Promoting Wellness Act set standards for all purchases of such equipment in the interim, including: examination tables that are height-adjustable between at least eighteen inches to thirty-seven inches; weight scales usable by individuals seated in a wheelchair or other personal mobility aid; and mammography machines and other commonly used radiological equipment useable by people in a standing or seated position, including people seated in a wheelchair.³⁷ Finally, the Promoting Wellness Act sought to establish a program for “promoting good health, disease prevention, and wellness and for the prevention of secondary conditions for individuals with disabilities,” and for additional education and training for physicians.³⁸ The Promoting Wellness Act was introduced in 2006, 2007, and 2009, but was not enacted.³⁹

B. Access Board Issues MDE Standards Pursuant to ACA

The ACA contains provisions to expand access to insurance coverage, improve health care quality, improve the health care delivery system, control health care costs, and eliminate health inequities, many of which benefit the population generally, including people with disability.⁴⁰ The ACA also contains provisions that address discrimination and other barriers that contribute to health inequities,⁴¹ including the barriers to disability health targeted by the Promoting Wellness Act. Section 4203 of the ACA, “Removing Barriers and Improving Access to Wellness for Individuals with Disabilities,” amended the Rehabilitation Act by adding § 510, which calls for the Access Board, in consultation with the Food and Drug Administration (FDA), to develop accessibility standards for MDE defined as examination tables, examination chairs, weight scales, mammography equipment, x-ray machines, and other radiological equipment commonly used for diagnostic purposes.⁴²

35. Promoting Wellness for Individuals with Disabilities Act of 2007, S. 1050, 110th Cong. (2007-08).

36. H.R. 3294, 110th Cong. (2007).

37. S. 1050.

38. *Id.*

39. S. 3717, 109th Cong. (2006); S. 1050; H.R. 3294; H.R. 1938, 111th Cong. (2009).

40. See NAT'L COUNCIL ON DISABILITY, THE IMPACT OF THE AFFORDABLE CARE ACT ON PEOPLE WITH DISABILITIES: A 2015 STATUS REPORT 3, 5 (2016), <https://ncd.gov/publications/2016/impact-affordable-care-act-people-disabilities-2015-status-report>.

41. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,422, 31,444 (May 18, 2016).

42. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4203, 124 Stat. 119, 570 (2010) (codified as amended at 29 U.S.C. § 794f (2010)).

The Access Board published its final standards on January 9, 2017, effective February 8, 2017 (Access Board Final Standards on MDE).⁴³ As part of its multi-year rulemaking process, the Access Board held a public meeting, invited notice and comment on proposed standards, and consulted with the MDE Accessibility Advisory Committee, which included consumer representatives from disability groups, manufacturers of MDE, health care providers, and standard-setting organizations, among others.⁴⁴ As required by the ACA, the Access Board Final Standards on MDE set specific requirements for the size, structure and function of examination tables, examination chairs, weight scales, mammography equipment, x-ray machines, and other radiological equipment commonly used for diagnostic purposes in a range of health care settings.⁴⁵

The MDE Advisory Committee also issued a detailed report, “Advancing Equal Access to Diagnostic Services: Recommendations on Standards for the Design of Medical Diagnostic Equipment for Adults with Disabilities.”⁴⁶ The report provides background on the process used by the committee, the types and uses of equipment addressed, and specific access considerations. It also identifies issues for further consideration such as: equipment used to provide health care to children and individuals disabled by extreme obesity; equipment used for treatment and rehabilitation, and not just diagnosis; permissibility of alternate means of access when equipment cannot be made accessible; and the need for data and research on a range of issues related to MDE.

C. DOJ Poised to Create ADA Regulations

Before the Access Board’s standards, the DOJ issued an ANPRM on the adoption of standards and other requirements under ADA Title II and Title III for equipment and furniture including accessible medical equipment (2010 ANPRM).⁴⁷ The 2010 ANPRM notes that a final rule will be issued after the Access Board completes its MDE standards and that the DOJ “will have the option to adopt them for ADA implementation and, if it does so, will, at that time, develop specific scoping requirements to establish the required number of accessible diagnostic elements for specific facility types.”⁴⁸

43. Standards for Accessible Medical Diagnostic Equipment, 82 Fed. Reg. 2810 (Jan. 9, 2017) (to be codified at 36 C.F.R. pt. 1195).

44. *Overview of the Final Standards for Medical Diagnostic Equipment*, U.S. ACCESS BD., <https://www.access-board.gov/guidelines-and-standards/health-care/about-this-rulemaking/background/overview-of-the-mde-standards> (last visited Mar. 24, 2019).

45. *Id.*

46. *Advancing Equal Access to Diagnostic Services: Recommendations on Standards for the Design of Medical Diagnostic Equipment for Adults with Disabilities*, *supra* note 5.

47. Nondiscrimination on the Basis of Disability by State and Local Governments and Places of Public Accommodation; Equipment and Furniture, 75 Fed. Reg. 43,452 (proposed July 26, 2010).

48. *Id.* at 43,455.

The DOJ provided guidance to providers and institutions in the meantime. The same month it issued the 2010 ANPRM, the DOJ, along with the U.S. Department of Health and Human Services, Office for Civil Rights, issued *Access to Medical Care for Individuals with Mobility Disabilities*, a technical assistance document that offers specific advice to health care providers on ADA Title II and III requirements in health care settings with respect to individuals with mobility disability.⁴⁹ Part 4 of the document addresses accessible medical equipment, noting “[a]vailability of accessible medical equipment is an important part of providing accessible medical care, and doctors and other providers must ensure that medical equipment is not a barrier to individuals with disabilities.”⁵⁰

III. DOJ’S DECISION TO HALT PROGRESS

On December 26, 2017, the DOJ formally withdrew four ANPRMs relating to Titles II and III of the ADA, including the 2010 ANPRM that would have set standards and other requirements for accessible medical equipment.⁵¹ This section examines the impact of the DOJ’s decision to abandon its efforts during the last stage of the process.

A. *Response to Deregulatory Executive Orders*

The DOJ withdrew the 2010 ANPRM in response to executive orders issued by President Trump. Executive Order 13,771, *Reducing Regulation and Controlling Regulatory Costs*, issued on January 30, 2017, directs executive branch agencies to cut at least two prior regulations for any new regulation issued.⁵² The purpose of the order is “to be prudent and financially responsible in the expenditure of funds, from both public and private sources,” and the order emphasizes that “it is essential to manage the costs associated with the governmental imposition of private expenditures required to comply with Federal regulations.”⁵³ A second order, Executive Order 13,777, *Enforcing the Regulatory Reform Agenda*, imposes a new administrative process for review of existing regulations for “repeal, replacement, or modification.”⁵⁴ Executive Order 13,777 enumerates several review criteria for such review and directs agencies to prioritize “rules that are outdated, unnecessary, or ineffective.”⁵⁵

49. OFFICE FOR CIVIL RIGHTS, U.S. DEP’T OF HEALTH & HUMAN SERVS., *ACCESS TO MEDICAL CARE FOR INDIVIDUALS WITH MOBILITY DISABILITIES* (2010).

50. *Id.* at 8.

51. *Nondiscrimination on the Basis of Disability; Notice of Withdrawal of Four Previously Announced Rulemaking Actions*, 82 Fed. Reg. 60,932 (announced Dec. 26, 2017).

52. Exec. Order No. 13771, 82 Fed. Reg. 9339 (Feb. 3, 2017).

53. *Id.*

54. Exec. Order No. 13,777, 82 Fed. Reg. 12,285 (Mar. 1, 2017).

55. *Id.*

Pursuant to these orders, on December 26, 2017, the DOJ withdrew four ANPRMs relating to Titles II and III of the ADA: the first two addressed accessibility of web information, the third is the 2010 ANPRM, and the last addressed accessibility of an internet-based 911 system.⁵⁶ The DOJ also rescinded ADA guidance documents. On November 17, 2017, then-Attorney General Jeff Sessions issued a memo stating that the DOJ will no longer issue guidance that have the effect of “adopting new regulatory requirements or amending the law” outside the federal government.⁵⁷ Soon after, Sessions announced that the DOJ rescinded twenty-five guidance documents, including ten ADA guidance documents,⁵⁸ which he characterized as “improper or unnecessary.”⁵⁹ None of the rescinded guidance were directly related to health care or medical equipment, and the 2010 technical assistance, *Access to Medical Care for Individuals with Mobility Disabilities*, is still available at ADA.gov.⁶⁰

B. *Serious Harms, Missed Benefits*

The DOJ’s decision to abandon rulemaking efforts raises concerns about its commitment to ensuring access to health care for people with disability. Failure to move forward with the rulemaking process is a missed opportunity to realize important and long-overdue gains for their health and well-being. The MDE Accessibility Standards Advisory Committee identified examples of potential benefits of standards for the health and wellbeing of patients with disability in its final report:

[I]mproving diagnostic efficiency for people with disability, perhaps resulting in earlier diagnosis of conditions at more treatable stages than with previous equipment and thus improving patients’ outcome; decreasing the risk of falls, injuries, and discomfort to patients during diagnostic procedures; and increasing the likelihood that persons with disabilities will choose to undergo diagnostic testing because they no longer anticipate discomfort and difficulties during testing.⁶¹

56. Nondiscrimination on the Basis of Disability; Notice of Withdrawal of Four Previously Announced Rulemaking Actions, 82 Fed. Reg. 60,932 (announced Dec. 26, 2017).

57. Press Release, Dep’t of Justice, Attorney General Jeff Sessions Ends the Department’s Practice of Regulation by Guidance (Nov. 17, 2017), <https://www.justice.gov/opa/pr/attorney-general-jeff-sessions-ends-department-s-practice-regulation-guidance>.

58. *Withdrawn Technical Assistance and Guidance Documents*, ADA, https://www.ada.gov/ta_withdrawn.html (last visited Mar. 24, 2019).

59. Press Release, Dep’t of Justice, Attorney General Jeff Sessions Rescinds 25 Guidance Documents (Dec. 21, 2017), <https://www.justice.gov/opa/pr/attorney-general-jeff-sessions-rescinds-25-guidance-documents>.

60. See OFFICE FOR CIVIL RIGHTS, U.S. DEP’T OF HEALTH & HUMAN SERVS, ACCESS TO MEDICAL CARE FOR INDIVIDUALS WITH MOBILITY DISABILITIES (2010), https://www.ada.gov/medicare_mobility_ta/medicare_ta.pdf (last visited Apr. 19, 2019).

61. *Advancing Equal Access to Diagnostic Services: Recommendations on Standards for the Design of Medical Diagnostic Equipment for Adults with Disabilities: Additional and Unaddressed*

Withdrawal of the 2010 ANPRM also leaves health care providers and institutions without clear guidance on standards for medical equipment necessary to provide accessible, quality care to people with disability.⁶² It also leaves them without guidance on important requirements related to medical equipment such as scoping, which refers to the amount of equipment or furniture needed in different types of facilities to meet the needs of individuals with disability needing access to those facilities, and event or time frames that should trigger the replacement or modification of inaccessible equipment or furniture with accessible equipment or furniture.⁶³

Withdrawal of the 2010 ANPRM is also a missed opportunity to reap benefits for individuals with disability who rely on different types of medical equipment for their care. The Access Board Final Standards on MDE address medical equipment commonly used for *diagnostic* purposes as required by the ACA.⁶⁴ The 2010 ANPRM was broader: it indicated that the DOJ may issue regulations to ensure the accessibility of medical equipment used for *treatment, rehabilitative*, or both purposes.⁶⁵ To that end, it solicited input on a broad range of medical equipment including: lifts used to transfer patients with mobility disability; infusion pumps; rehabilitative equipment; ancillary equipment such as positioning straps or cushions, padding, rails or bars, sliding boards or sheets and gait belts for transfers; air mattresses and cushions, stools, or other pressure relief equipment; accessible call buttons and telephones; and hospital beds and gurneys.⁶⁶

C. *No New Data to Aid DOJ's Reevaluation*

The DOJ stated that it withdrew the 2010 ANPRM because it was “reevaluating whether regulation of non-fixed equipment and furniture is necessary and appropriate.”⁶⁷ Decades of research on the barrier of inaccessible medical equipment and years of DOJ enforcement, guidance, and rule-making activity related to medical equipment make clear that specific standards and other equipment-related requirements are both necessary and appropriate. In addition, withdrawal of the 2010 ANPRM cuts off a primary avenue for new

Issues, U.S. ACCESS BD. (Dec. 6, 2013), <https://www.access-board.gov/guidelines-and-standards/health-care/about-this-rulemaking/advisory-committee-final-report/8-additional-and-unaddressed-issues>.

62. Iezzoni & Pendo, *supra* note 10, at 1371.

63. *Id.*

64. Standards for Accessible Medical Diagnostic Equipment, 82 Fed. Reg. 2810 (2017).

65. Nondiscrimination on the Basis of Disability by State and Local Governments and Places of Public Accommodation: Equipment and Furniture, 75 Fed. Reg. 43,452, 43,455 (proposed July 26, 2010).

66. *Id.* at 43,456.

67. Nondiscrimination on the Basis of Disability; Notice of Withdrawal of Four Previously Announced Rulemaking Actions, 82 Fed. Reg. 60,923 (announced Dec. 26, 2017).

information on a range of issues related to MDE standards and requirements from the public, members of the disability community, government entities, health care providers and institutions, manufacturers of MDE, and standard-setting organizations, among others.⁶⁸

Nor will the DOJ have data about the current availability of accessible medical equipment in health care facilities to aid its reevaluation. Section 4302 of the ACA, “Understanding Health Disparities: Data Collection and Analysis,” requires that all reporting from the Secretary of Health and Human Services (HHS) on federally conducted or supported health care or public health programs include separate data on race, ethnicity, sex, primary language, and disability status.⁶⁹ Section 4302 also requires collection of disability-specific data on the barriers to health care experienced by people with disability.⁷⁰ It directs the HHS to identify locations where individuals with disabilities access different types of care and to determine the number of providers with accessible facilities and accessible medical and diagnostic equipment and the number of employees trained in disability awareness and in caring for patients with disabilities.⁷¹ The disability-specific data has not been collected because Congress has not appropriated funding.⁷²

D. *Costs of Continuing Uncertainty*

It is not clear if withdrawal of the 2010 ANPRM was motivated by perceived cost to health care providers and institutions. Certainly, cost concerns figured prominently in Executive Order 13,771 and the deregulatory agenda of President Trump’s administration.⁷³ Specific legal standards and requirements for MDE may impose compliance costs for some health care providers and entities to the extent that their existing equipment is not accessible.⁷⁴ Withdrawal of the 2010 ANPRM halts the process of gathering information on the costs and benefits of accessible medical equipment—and of different requirements for scoping and triggering events—from a wide range of stakeholders including health care providers and institutions.

68. Nondiscrimination on the Basis of Disability by State and Local Governments and Places of Public Accommodation; Equipment and Furniture, 75 Fed. Reg. at 43,455.

69. 42 U.S.C. § 4302 (2012); *see generally* Elizabeth Pendo, *Collecting New Data on Disability Health Inequities*, HASTINGS CTR. REP. Mar.-Apr. 2016, at 7, 7.

70. 42 U.S.C. § 4302 (2012).

71. *Id.*

72. NAT’L COUNCIL ON DISABILITY, MONITORING AND ENFORCING THE AFFORDABLE CARE ACT: A ROADMAP FOR PEOPLE WITH DISABILITIES 13–14 (2016), https://ncd.gov/sites/default/files/NCD_ACA_Report03_508.pdf.

73. Exec. Order No. 13,771, 82 Fed. Reg. 9339 (Feb. 3, 2017).

74. Architectural and Transportation Barriers Compliance Board, Standards for Accessible Medical Diagnostic Equipment, 82 Fed. Reg. 2810 (Jan. 9, 2017) (to be codified at 36 C.F.R. pt. 1195).

The assumption that explicit guidance will impose significant additional costs also misreads current legal requirements. Health care providers and entities are already obligated to ensure equal access to health care for individuals with disability. Without accessible tables, chairs, scales, and imaging equipment, people with disability do not have full and equal access to the most basic health care services.⁷⁵ Therefore, despite the lack of specific regulatory language, accessible medical equipment is required pursuant to program accessibility, reasonable modification, auxiliary aids and services, and barrier removal requirements.⁷⁶ This understanding of the obligation to provide accessible medical equipment has been repeatedly affirmed by the DOJ in ADA rulemaking processes,⁷⁷ guidance documents,⁷⁸ and in its enforcement activity.⁷⁹ The requirement of accessible medical equipment also has been affirmed by the federal courts in public and private enforcement actions, which I have reviewed in prior writings.⁸⁰ Finally, the ADA addresses cost concerns, for example requiring only “reasonable” modifications that do not place an “undue burden” on health care entities.⁸¹

IV. OPPORTUNITIES IN THE CURRENT CLIMATE

The DOJ’s decision to abandon the 2010 ANPRM signals a retreat from the goal of equal and accessible health care for individuals with disability shared by both the ADA and ACA. Although a recommitment to setting specific regulatory standards and requirements for accessible medical equipment is the best solution, it is unlikely in the near future. This section highlights three opportunities for progress in the current climate in the face of administrative inaction.

First, the Access Board Final Standards on MDE are an important achievement. They can be used as a policy tool to promote accessible care for

75. Nondiscrimination on the Basis of Disability by State and Local Governments and Places of Public Accommodation; Equipment and Furniture, 75 Fed. Reg. 43,452, 43,455 (proposed July 26, 2010).

76. *Id.* at 43,454; See Pendo, *Using the ADA to Provide Meaningful Access*, *supra* note 9, at 37–38.

77. See generally 75 Fed. Reg. 43,452; see also, Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,422 (May 18, 2016).

78. OFFICE FOR CIVIL RIGHTS *supra*, note 49.

79. See, e.g., *Settlement Agreement Between the United States of America and the Beth Israel Deaconess Medical Center under Title III of the Americans with Disabilities Act*, ADA (Oct. 1, 2009), <https://www.ada.gov/bidmsa.htm>; see, e.g., *Settlement Agreement Among the United States of America Plaintiffs Equal Rights Center, Dennis Christopher Butler, Rosemary Ciotti, George Aguehoude, and Marsha Johnson and Washington Hospital Center*, ADA (Dec. 29, 2005), <https://www.ada.gov/whc.htm>.

80. See Pendo, *Reducing Disparities Through Health Care Reform*, *supra* note 9, at 1066–71 (2010); see also Pendo, *Using the ADA to Provide Meaningful Access*, *supra* note 9, at 32–37.

81. 42 U.S.C. § 12182(b)(2)(A)(ii–iii) (2012); 28 C.F.R. § 36.303(a) (2016).

individuals with disability despite the DOJ's refusal to consider them for adoption as ADA regulations. As I and my coauthor Professor Lisa I. Iezzoni have written elsewhere, the Access Board Final Standards on MDE have been adopted by the Veteran's Administration and are being used by state governments and community groups to increase access to health care for individuals with disability.⁸² Although not legally enforceable, the Access Board's Final Standards on MDE can be used as a reference point in private settlements.⁸³ Similarly, health care offices, institutions, and organizations could adopt voluntary policies and programs relating to accessible medical equipment based on Access Board Final Standards for MDE and the MDE Advisory Committee's report.

Second, organizations representing individuals with disability can continue to demand DOJ action on the issue.⁸⁴ Disability advocates and organizations are visible on health care issues and could apply political pressure as they did in opposition to rollbacks of the ACA's insurance reforms and changes to the Medicaid program.⁸⁵ The prominence of health care in the midterm elections on the state and federal level may present an opportunity to call for a recommitment to federal efforts to ensure equal and accessible care, including accessible medical equipment.⁸⁶

82. Elizabeth Pendo & Lisa I. Iezzoni, Department of Health and Human Services, Office of Disease Prevention & Health Promotion, *The Role of Law and Policy in Achieving the Healthy People 2020 Disability and Health Goals Around Access to Health Care, Activities Promoting Health and Wellness, Independent Living and Participation, Collecting Data in the United States* (forthcoming). Supported by the Centers for Disease Control and Prevention, ODPHP, and the CDC Foundation through a grant from the Robert Wood Johnson Foundation.

83. See, e.g., Settlement Agreement at 95, *Bronx Indep. Living Servs., et. al. v. Union Cmty. Health Ctr., Inc. and St. Barnabas Hosp.*, No. 1:15-CV-05934-VEC (S.D.N.Y. Jul. 29, 2015), <https://dralegal.org/press/community-health-center-bronx-adopts-innovative-plan-improve-health-care-services-patients-disabilities/>.

84. See, e.g., Letter from Neil Romano, Chairman, Nat'l Council on Disability, to Jeff Sessions, U.S. Att'y Gen. (Aug. 13, 2018), <https://www.ncd.gov/publications/2018/letter-us-attorney-general-sessions-accessible-medical> (regarding the necessity and appropriateness of the Accessible Medical Equipment Regulation).

85. See Katie Reilly, *Disability Advocates Forcibly Removed from Senate Protest Say It Was Worth It: 'We Have the Right to Live'*, TIME MAG. (June 23, 2017), <http://time.com/4831386/disability-advocate-protest-gop-health-care-bill/>; Abigail Abrams, *'Our Lives are at Stake' How Donald Trump Inadvertently Sparked a New Disability Rights Movement*, TIME MAG. (Feb. 26, 2018), <http://time.com/5168472/disability-activism-trump/>; see also Mary Crossley, *Threats to Medicaid and Health Equity Intersections*, 12 ST. LOUIS U. J. HEALTH L. & POL'Y (forthcoming June 2019) (examining advocacy by groups representing people with disability and people of color in opposition to repeal of the ACA and changes to the Medicaid program).

86. ASHLEY KIRZINGER ET AL., KFF ELECTION TRACKING POLL: HEALTH CARE IN THE 2018 MIDTERMS, KAISER FAM. FOUND. 1, 4 (2018), <http://files.kff.org/attachment/Topline-KFF-Election-Tracking-Poll-Health-Care-in-the-2018-Midterms>.

Third, health care providers and institutions may call for explicit guidance, especially if litigation challenging inaccessible medical equipment, among other accessibility issues, continues its current course. Although the DOJ's current commitment to vigorously enforce the ADA in health care settings may be in doubt, private challenges to inaccessible medical care, including physical barriers and inaccessible medical equipment, will continue.⁸⁷ As noted in the prior section, the DOJ's decision to withdraw the 2010 ANPRM did not change the legal obligations of health care providers and entities under the ADA, it just denied them explicit guidance on how to satisfy them. A similar call for clear rules over a patchwork of court decisions was made in a letter from 103 members of Congress from both parties to then-Attorney General Jeff Sessions urging the DOJ to set specific ADA standards for web accessibility.⁸⁸

Requirements imposed by other health care laws may provide additional avenues for access claims. Section 1557 of the ACA incorporates the non-discrimination requirements of § 504 of the Rehabilitation Act with regard to any health program or activity that receives federal financial assistance or that is administered by an executive agency or any entity established under the ACA.⁸⁹ The 2016 Final Rule implementing § 1557 does not contain specific standards or requirements for medical equipment, but reaffirms that "a health program or activity's use of medical diagnostic equipment would be covered by § 1557 under the general prohibition of discrimination on the basis of disability."⁹⁰

The 2016 Medicaid/CHIP Managed Care Final Rule directly addresses accessibility for individuals with disability, including medical equipment. It provides: managed care providers must provide physical access, accommodations, and accessible equipment for consumers disability; provider directories must indicate accessibility features including accessible equipment for all physicians, hospitals, pharmacies, behavioral health providers, and long term supports and services; and state network adequacy standards must consider the ability of managed care organization network providers to ensure physical access, reasonable accommodations, culturally competent communications, and

87. *See, e.g.*, Settlement Agreement, Sandra Lamb v. NRAD Medical Associates, et al., No. 17-CV-1181 (E.D.N.Y. 2017); Settlement Agreement, Bronx Indep. Living Serv. v. Union Cmty. Health Ctr., Inc., No. 1:15-CV-05934 (S.D.N.Y. 2016).

88. Letter from 103 Members of U.S. Congress to Jeff Sessions, U.S. Att'y Gen., (June 20, 2018), <https://www.adatitleiii.com/wp-content/uploads/sites/121/2018/06/ADA-Final-003.pdf> (last visited Mar. 3, 2019) (urging the Department of Justice to stem the tide of website accessibility lawsuits under the ADA); *but see* Letter from Stephen Boyd, Assistant Att'y Gen., to Ted Budd, Congressman (Sept. 25, 2018), <https://www.adatitleiii.com/wp-content/uploads/sites/121/2018/10/DOJ-letter-to-congress.pdf>.

89. 42 U.S.C. § 18116 (2012).

90. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,422 (May 18, 2016).

accessible equipment for Medicaid enrollees with disability.⁹¹ Finally, states may impose requirements relating to accessible medical equipment, among other accessibility requirements.⁹²

V. CONCLUSION

Disability is a fundamental part of the human condition. One in four Americans lives with disability, and many, if not most of us, will experience disability over our lifespan. Given these numbers and their predicted increase as the population ages, it is critical that health care and the medical equipment necessary to deliver it be accessible to people with disability.

This Article has carefully examined progress toward development of specific legal standards and requirements for accessible medical equipment, and the decision by the DOJ to abandon a rulemaking process that would have created such standards as ADA regulations. One conclusion is that the DOJ's decision to halt federal efforts to create specific standards and requirements for accessible medical equipment is a missed opportunity to address a range of issues related to inaccessible medical equipment for millions of Americans with disability. A second conclusion is that lack of clear standards also imposes confusion and costs on health care providers and institutions. Finally, although the best solution is a clear federal standard, political, policy, and litigation strategies remain available in the meantime.

91. 42 C.F.R. §§ 438.10, 438.68, 438.206 (2016); RF Singer et al., *Increasing the Physical Accessibility of Health Care Facilities*, CTRS. FOR MEDICARE AND MEDICAID SERV., OFF. MINORITY HEALTH 7 (2017), <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Brief-Physical-AccessibilityBrief.pdf>.

92. Singer et al., *supra* note 91, at 6–7.

STUDENT COMMENTS

