

**The ACA and Application of § 1557 and Title VI of the Civil Rights Act of 1964  
to the Health Insurance Exchanges  
January 2011**

Prepared by: Mara Youdelman

This memo analyzes how the nondiscrimination provision enacted as § 1557 of the Patient Protection and Affordable Care Act (ACA) and Title VI of the Civil Rights Act of 1964 should apply to the Health Insurance Exchanges (Exchanges) created by the ACA and the health insurance plans that participate in these Exchanges.<sup>1</sup>

**I. Background**

Almost 20% of the United States' population speaks a language other than English at home. Over 24 million, or 8.7% of the population, speak English less than very well and should be considered limited English proficient (LEP) for health care purposes.<sup>2</sup> This includes 47% of Spanish speakers, 33% of speakers of other Indo-European languages, 49% of speakers of Asian and Pacific Islander languages, and 30% of speakers of other languages.

Numerous studies have documented the problems associated with a lack of language services, including one by the Institute of Medicine, which stated that:

Language barriers may affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision-making, or ethical compromises (e.g. difficulty obtaining informed consent). Linguistic difficulties may also result in decreased adherence with medication regimes, poor appointment attendance, and decreased satisfaction with services. (Cites omitted.)<sup>3</sup>

Over one quarter of LEP patients who needed, but did not get, an interpreter reported they did not understand their medication instructions, compared with only 2% of those who did not need an interpreter and those who needed and received one.<sup>4</sup> Lack of language services limits the amount and quality of care LEP individuals receive.<sup>5</sup> For example, patients are less likely to understand medication

---

<sup>1</sup> For more information on how the ACA addressed language access, see NHeLP's Issue Brief, "Language Access and Health Care Reform", available at <http://www.healthlaw.org>.

<sup>2</sup> American Community Survey, *Selected Social Characteristics in the United States: 2006-2008*; see also American Community Survey, 2008, Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over, Table B16001, available at <http://factfinder.census.gov>.

<sup>3</sup> Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* at 17 (2002).

<sup>4</sup> See Dennis P. Andrulis, Nanette Goodman & Carol Pryor, The Access Project, *What a Difference an Interpreter Can Make* at 7, (Apr. 2002).

<sup>5</sup> See, e.g., Glenn Flores et al., *Errors in medical interpretation and their*

instructions when they do not have access to language services.<sup>6</sup> LEP patients in emergency rooms get access to fewer services.<sup>7</sup>

Indeed, language barriers have been found to be as significant as the lack of insurance in predicting use of health services. Health care providers surveyed in four major metropolitan areas identified language difficulties as a major barrier to immigrants' access to health care and a serious threat to medical care quality. These providers also expressed concern that they could not get information to make good diagnoses and that patients might not understand prescribed treatment.<sup>8</sup> On the other hand, while Latino children generally have much less access to medical care than do white children, that gap becomes negligible when their parents' English-speaking skills are comparable to those of Whites.<sup>9</sup>

In addition, there are issues as to the quality of care received by those patients without interpreter services. At the actual point of service, providers will have communication issues with patients who cannot explain their symptoms or readily understand questions or instructions. This increases barriers to care, and often creates dangerous delays, unnecessary and risky procedures, increasing the chances of negative outcomes. Bad outcomes and delayed access increases health care system costs. In a report recently released by the National Health Law Program, a survey of one malpractice carrier's closed claims to identify claims involving language barriers found 2.5% of the cases involved language issues and cost the carrier over \$5 million in damages, settlements and legal fees.<sup>10</sup> With language services, individuals suffering from chronic conditions or conditions can be treated easily through primary and preventive care. If routine access is effectively denied, these conditions are exacerbated and require costly emergency interventions and treatment.

## II. ACA § 1557

---

*potential clinical consequences in pediatric encounters*, 111(1) *Ped.* 6-14 (2003); TK Ghandi et al. *Drug complications in outpatients*, 15 *J. of Gen. Internal Med.* 149-154 (2000); Derosé K Pitkin et al., *Limited English proficiency and Latinos' use of physician services*, *Medical Care Research and Review* 2000, 57(1):76-91. See also, Elizabeth Jacobs, et al., *Language Barriers in Health Care Settings: An Annotated Bibliography of the Research Literature*, The California Endowment (2003), available at [http://www.calendow.org/uploadedFiles/language\\_barriers\\_health\\_care.pdf](http://www.calendow.org/uploadedFiles/language_barriers_health_care.pdf).

<sup>6</sup> Suzanne Sataline, *Immigrants' First Stop: The Line for English Classes*, *The Christian Science Monitor* (Aug. 27, 2002).

<sup>7</sup> See Dennis P. Andrulis, Nanette Goodman & Carol Pryor, *What a Difference an Interpreter Can Make at 7*, *The Access Project* (Apr. 2002).

<sup>8</sup> Leighton Ku & Alyse Freilich, Urban Institute, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston* at ii-iii (Feb. 2001). See also Jennifer Cho & Beatriz M. Solis, L.A. Care Health Plan, *Healthy Families Culture & Linguistic Resources Survey: A Physician Perspective on their Diverse Member Population* (Jan. 2001) (51% of doctors reported their patients do not adhere to treatments because of culture and language barriers).

<sup>9</sup> See Robin M. Weinick & Nancy A. Krauss, *Racial and Ethnic Differences in Children's Access to Care*, 90 *AM. J. PUBLIC HEALTH* 1771 (Nov. 2000).

<sup>10</sup> *The High Costs of Language Barriers in Medical Malpractice* (2010), available at <http://www.healthlaw.org>.

The ACA expressly extended the protections of Title VI, Title IX, Section 504 of the Rehabilitation Act and the Age Discrimination Act to apply to the Exchanges themselves through a nondiscrimination requirement.<sup>11</sup> Section 1557 explicitly extends these civil rights provisions to “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.”<sup>12</sup> The nondiscrimination protections in these statutes thus apply to any provisions initiated by the ACA, including the tax credits and cost-sharing subsidies in the Exchanges.<sup>13</sup> Thus plans would have a responsibility to provide appropriate language services, in addition to Title VI of the Civil Rights Act of 1964, because of this nondiscrimination requirement. Because the Exchanges are created by Title I of ACA, they are subject to this provision and cannot discriminate on the basis of “national origin” which, as discussed below, the Supreme Court and HHS have defined to include meaningful language access.

### III. Title VI of the Civil Rights Act of 1964

Under Title VI of the Civil Rights Act of 1964,<sup>14</sup> no federal funds can be used in a discriminatory manner, whether intentionally, or, pursuant to federal regulations, through disparate impact. Title VI applies to all programs receiving Federal financial assistance, including private entities. Congress has defined covered programs to include “an entire corporation . . . if assistance is extended to such corporation . . . or which is principally engaged in the business of providing education, health care . . . .”<sup>15</sup> A program also includes “[t]he 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.”<sup>16</sup> Discrimination under Title VI has been determined to include preventing meaningful access to federally funded services for “national origin minorities” with limited English proficiency (Title VI prohibits discrimination on the basis of national origin). In 1974, the Supreme Court concluded that programs with a discriminatory impact against individuals based on their language are akin to those which discriminate based on national origin.<sup>17</sup> In 2000, President Clinton issued an Executive Order enlisting all Federal agencies to expand LEP access to their programs and grantees.<sup>18</sup> The Order instructed Federal agencies to develop LEP guidelines for Federal financial assistance received through their activities in accordance with the Department of Justice (DOJ).<sup>19</sup>

---

<sup>11</sup> Pub. L. No. 111-148, 124 Stat. 119 (2010). That statute was amended by the Health Care and Education Reconciliation Act (Pub. L. No. 111-152, 124 Stat. 1029 (2010)), which the President signed on March 30, 2010; the resulting combined legislation is referred to in this issue brief as “the ACA”. ACA § 1557 (2010).

<sup>12</sup> *Id.* § 1557(a) (2010) (emphasis added).

<sup>13</sup> *Id.*

<sup>14</sup> See 42 U.S.C. § 2000d (2006).

<sup>15</sup> 42 U.S.C. § 2000d-4a (2006).

<sup>16</sup> 45 C.F.R. § 80.13(g) (2010).

<sup>17</sup> See *Lau v. Nichols*, 414 U.S. 563 (1974).

<sup>18</sup> Exec. Order No. 13,166, 68 Fed. Reg. 50121 (August 16, 2000).

<sup>19</sup> *Id.* (indicating that agencies LEP guidance should be approved by the DOJ). See DOJ Policy Guidance Document, 65 Fed. Reg. 50,123 (Aug. 16, 2000), available at <http://www.lep.gov>.

**a. HHS' regulations and interpretations**

The Department of Health and Human Services (“HHS”) applies Title VI’s nondiscrimination provisions to its programs receiving Federal financial assistance including “money paid, property transferred, or other Federal financial assistance.”<sup>20</sup> Programs and recipients of Federal financial assistance are particularly prohibited from “[p]rovid[ing] any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others under the program.”<sup>21</sup> Federal financial assistance has been interpreted and enforced to cover a broad range of programs receiving federal funds. HHS has issued regulations explicitly, but not exclusively, naming programs that are obligated to comply with Title VI, which should thus provide appropriate language services.<sup>22</sup> HHS considers sub-recipients of Federal financial assistance to be covered by Title VI.<sup>23</sup>

**b. Court Interpretations of Title VI and other Civil Rights Laws**

The courts have found that health care providers currently covered by Title VI include private and public hospitals accepting Federal financial assistance through Medicare Part A or Medicaid payments.<sup>24</sup> Title VI is “closely tracked”<sup>25</sup> by Section 504 of the Rehabilitation Act,<sup>26</sup> Title IX of the Education Amendments Act of 1972,<sup>27</sup> and the Age Discrimination Act.<sup>28</sup> The case law concerning these other acts and their definitions of “federal financial assistance” are thus informative on the extent that Title VI will apply. For example, under the Rehabilitation Act, courts have found that an entity receives “federal financial assistance” when the payment is intended as a subsidy from the government.<sup>29</sup> However, this is not always a necessity, as financial assistance does not have to result in financial gain or increment in assets to be considered covered by Title VI.<sup>30</sup>

---

<sup>20</sup> See 45 C.F.R. § 80.2 (2010); see also 45 C.F.R. § 80.13 (2010) (defining Federal financial assistance as including “grants and loans of Federal funds, (2) the grant or donation of Federal property and interests in property . . . [and] any Federal agreement, arrangement, or other contract which has as one of its purposes the provision of assistance.”).

<sup>21</sup> *Id.* at § 80.3(a)(ii).

<sup>22</sup> 45 C.F.R. § 80, App. A (2010).

<sup>23</sup> 68 Fed. Reg. 47,311, 47,313 (2003).

<sup>24</sup> See *Bowen v. American Hospital Assn.*, 476 U.S. 610, 624 (1986) (affirming hospital was recipient of “financial assistance” through its participation in the Medicare and Medicaid programs); see also *Fobbs v. Holy Cross Health Sys. Corp.*, 29 F. 3d 1439, 1447 (9th Cir. 1994); *U.S. v. Harris Methodist Ft. Worth*, 970 F. 2d 94, 1447 (5th Cir. 1992) (finding that the anti-discrimination provisions of Title VI apply to staff privileges at hospital receiving federal funds); *Rackley v Bd. of Trustees*, 238 F Supp 512 (D.C. 1965) (state or private hospitals receiving federal funds bound by Title VI).

<sup>25</sup> See *Medley v. Ginsberg*, 492 F. Supp. 1294, 1306-07 (D. W. Va. 1980) (citing *Trageser v. Libbie Rehab. Ctr., Inc.*, 590 F.2d 87, 88 (4th Cir. 1978)).

<sup>26</sup> 29 U.S.C. § 794 (2006).

<sup>27</sup> 20 U.S.C. § 1681 *et seq.* (2006).

<sup>28</sup> 42 U.S.C. § 6101 *et seq.* (2006).

<sup>29</sup> *Shotz v. Am. Airlines*, 323 F. Supp. 2d 1315, 1317-18 (D. Fla. 2004) (citing *DeVargas v. Mason & Hanger-Silas Mason Co., Inc.*, 911 F.2d 1377, 1382 (10th Cir. 1990)).

<sup>30</sup> See *Bob Jones Univ. v. Johnson*, 396 F. Supp. 597 (DC 1974), *aff'd without op.*, 539 F.2d 514 (4th Cir. 1975).

#### **IV. Section 1557 and Title VI applies to the Health Insurance Exchanges through ACA §§ 1401, 1402, 1411, 1412 Premium and Cost-Sharing Reduction Tax Credits**

##### **c. The Exchanges under ACA**

The ACA authorizes the American Health Benefit Exchanges (“Exchanges”) which will allow states to create a centralized forum for individuals to seek access to qualified insurance plans.<sup>31</sup> Under the Exchanges, a spectrum of insurance plans with different levels of coverage will be available for purchase by individuals unable to obtain insurance through their employers or other means.<sup>32</sup> The federal government will subsidize Exchange plan payments (including premiums and cost-sharing) for individuals with incomes below 400% of the federal poverty level (FPL), through premium tax credits and cost-sharing reductions.<sup>33</sup>

The ACA sets up parameters for individual income levels that will qualify for subsidies and cost-sharing.<sup>34</sup> The federal government will directly pay the tax credits to qualified insurance plans in advance of the covered period.<sup>35</sup> After receiving an advance determination of an individual’s income level and advance payments, the insurer will reduce the individual’s premium accordingly.<sup>36</sup> Individuals will be responsible for paying the rest of their premium.<sup>37</sup> Likewise, ACA authorizes cost-sharing reductions for some low-income individuals. Upon determining an individual’s appropriate cost-sharing percentage, the issuer of a qualified health plan “will notify the Secretary of such reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions.”<sup>38</sup>

Congress has made it clear that although these credits are individual tax credits, the payments will not be considered as having gone to the individual, but rather to the insurance company issuing the plans. According to the ACA:

(1) any credit or refund allowed or made to any individual by reason of section 36B of the Internal Revenue Code of 1986 (as added by section 1401) shall not be taken into account as income and shall not be taken into account as resources for the month of receipt and the following 2 months; and (2) any cost-sharing reduction payment or advance payment of the credit allowed under such section 36B that is made under section 1402 or 1412 shall be treated as made to the qualified health plan in which an individual is enrolled and not to that individual.<sup>39</sup>

---

<sup>31</sup> ACA § 1311 (2010); *see also* §§ 1301-1302 (2010) (stipulating requirements for “qualified health plans”).

<sup>32</sup> ACA § 1302 (2010) (creating parameters for essential health benefits packages and establishing levels of coverage for silver, bronze, gold and platinum plans).

<sup>33</sup> *See* ACA § 1401-1412 (2010).

<sup>34</sup> ACA § 1401 (2010).

<sup>35</sup> ACA §§ 1412(a)(3)-(c) (2010).

<sup>36</sup> ACA §§ 1412(c)(B)(i)-(ii) (2010).

<sup>37</sup> I.R.C § 38B(b)(2) (2006) as amended by ACA § 1401 (2010).

<sup>38</sup> ACA § 1402(c)(3)(A) (2010).

<sup>39</sup> ACA § 1415 (2010).

This policy is intended to protect individuals from being penalized for receiving a tax credit when applying for other income-based assistance. The payments are not considered individual assets, but rather assistance to individuals, similar to Medicaid. The structure of the payments is different than Medicaid, however, in that the federal government is not reimbursing providers for care given. The government will essentially subsidize insurers to provide a predetermined level of coverage to certain eligible low-income individuals. The insurers are ultimately paying the providers, but the effect is the same – federal funds are assisting and supplementing individuals’ share of health care costs. The insurers therefore meet Title VI and HHS’s definitions of “programs,” and the payments qualify as “federal financial assistance.”

The arrangement for direct payment of premium subsidies to the plans and the many requirements placed on the plans/issuers related to the federal funding indicate that the plans participating in the Exchanges are receiving Federal financial assistance.

**d. Similarities between the Exchanges and Medicaid/Medicare**

According to the legal standards outlined above, Federal payments to insurers for premiums and cost-sharing should qualify as Federal financial assistance for purposes of Title VI. However, some may argue that the federal payments to the insurers will fall under an exception to Title VI for “contracts of insurance.”<sup>40</sup>

While Title VI and HHS regulations do in fact exempt contracts of insurance,<sup>41</sup> a recipient’s status as an insurer does not create a contract of insurance. The Exchanges and federal premium subsidies and payments to reduce cost-sharing under the ACA are more closely akin to the funding scheme provided through the Medicaid and CHIP programs than an insurance or guaranty contract. The government is not insuring the companies, but providing subsidies for a service – expanding insurance coverage for low-income individuals.<sup>42</sup> Under the Exchanges, the government is engaging the issuers of the plan to provide a service that the government could otherwise provide (as it does in Medicare). The premium subsidies and payments for cost-sharing offsets will effectively be reaching individuals above the levels of income covered by Medicaid and CHIP programs, but without a high enough income to afford private insurance. Instead of extending Medicaid to individuals at these income levels, Congress decided to subsidize health insurance through non-governmental insurers. Further, Congress expressed its intent to create seamless programs as the ACA requires the states to offer common applications for Medicaid, CHIP and the Exchanges.<sup>43</sup> Individuals who rise to a higher income level and lose Medicaid status will have to purchase health insurance pursuant to the individual mandate and most will likely go through the Exchanges.<sup>44</sup> As a result, there will likely be many individuals who change eligibility between the

---

<sup>40</sup> See 42 U.S.C. § 2000d-4 (2006).

<sup>41</sup> *Id.* For an explanation of a “contract of insurance”, see *Gallagher v. Croghan Colonial Bank*, 89 F.3d 275, 277 (6th Cir. 1996) (Default insurance for bank's disbursement of Federal student loans is a “contract of insurance,” and excluded from coverage by agency regulations).

<sup>42</sup> See ACA §§ 1401-1412 (2010); see also U.S. COMMISSION ON CIVIL RIGHTS, CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY 857 (1980) (citing 110 Cong. Rec. 13378 (1964)) (discussing Senator Pastore’s remarks regarding amendment to Title VI).

<sup>43</sup> ACA § 1413(b)(1)(A)(i) (2010).

<sup>44</sup> ACA §§ 1501,10106 (2010).

various insurance sources, so Medicaid patients are very likely to use the Exchange plans, and vice versa as income levels fluctuate.

The premium subsidies will be paid directly by the federal government to the insurers to supplement recipients' costs.<sup>45</sup> These payments work similarly to payments from the federal government to providers reimbursed by Medicare Part A, Medicaid and CHIP who are covered by Title VI and are not allowed to discriminate against protected individuals in any of their functions. Under Medicare Part A, the federal government pays provider facilities directly for the services they provide to patients and patients, depending on income, are also responsible for co-pays and premiums.<sup>46</sup> These reimbursements are considered "federal financial assistance" to hospitals.<sup>47</sup> And Medicaid providers – which include managed care plans – are subject to Title VI because they are receiving federal funds.<sup>48</sup> State Medicaid programs directly pay providers for their services, using state funds matched by federal government funds.<sup>49</sup> Even though the federal government never makes a direct payment to the plans, they are receiving federal funds for the purposes of § 1557 and Title VI.

While individuals are enrollees in Medicare, Medicaid and CHIP, the payments for services rendered or premiums are not paid by these individuals but by the federal government. This is exactly how the federal subsidies in the Exchanges will operate – the payments are designated to cover the premiums or cost-sharing of a particular individual but are paid directly to the insurer.

**e. Legislative Intent indicates that § 1557 and Title VI should apply to the Exchanges**

In addition to the recognition that subsidies and cost-sharing payments from the federal government to plans in the Exchanges constitute Federal financial assistance under Title VI, there is additional evidence from ACA of Congress' intent to apply § 1557 and Title VI.

The Joint Committee on Taxation provided some guidance as to the legislative intent of ACA in their Committee Report accompanying the Reconciliation bill.<sup>50</sup> The report provides a summary of the intended procedures by which the Exchanges will be administered. The Committee's language reinforces the notion that the insurance plans under the Exchanges will be receiving public subsidies akin to Medicaid and Medicare stating:<sup>51</sup>

The individual receives a premium assistance credit based on income and the Treasury pays the premium assistance credit *amount directly to the insurance plan* in which the individual is

---

<sup>45</sup> See ACA § 1412 (2010).

<sup>46</sup> See Centers for Medicare & Medicaid Services, Medicare Physician Fee Schedules, [http://www.cms.gov/PhysicianFeeSched/01\\_overview.asp](http://www.cms.gov/PhysicianFeeSched/01_overview.asp).

<sup>47</sup> Cf note 24.

<sup>48</sup> Bowen, 476 U.S. at 624.

<sup>49</sup> 42 U.S.C. § 1396 *et seq.*

<sup>50</sup> Joint Committee on Taxation, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as amended, in combination with the "Patient Protection and Affordable Care Act"* 18 (JCX-18-10), March 21, 2010 available at <http://www.jct.gov/publications.html?func=startdown&id=3673>.

<sup>51</sup> *Id.*

enrolled. The individual then pays to the plan in which he or she is enrolled the dollar difference between the premium tax credit amount and the total premium charged for the plan.<sup>52</sup>

## V. Policy Implications

If the Exchanges are set up to assist insurers and individuals in contracting for mandatory health care coverage, individuals participating in the Exchanges should be entitled to the protections under § 1557 and Title VI. When a limited English proficient individual is seeking information from an Exchange or plan or receiving services covered by the plan, language services should be provided as needed. Insurance companies receiving direct payments from the federal government to provide quality coverage at reduced prices should not be able to discriminate among patients or limit equal access to meaningful services. Once an entity receives Federal financial assistance or is subject through another part of § 1557, it must not discriminate against anyone through their organization.<sup>53</sup>

To comply with § 1557 and Title VI and provide meaningful access to care, Exchanges must provide language services to assist LEP individuals in navigating the Exchange and selecting insurance. Further, plans and insurers participating in the Exchange must provide and pay for their providers to provide effective language services and ensure providers do not delay services because they do not have sufficient language services. Such provisions may include funding and providing interpreters on the plan level, or reimbursing providers for language services they incur. HHS has issued guidance regarding Title VI compliance that specifically enumerates steps HHS-assisted entities should take to include LEP populations.<sup>54</sup> Reimbursable LEP services include: translation of all vital documents for areas with concentrations of language groups, translation of “taglines” to provide LEP patients with information on how to access appropriate language services, in-person interpreter services, and over-the-phone interpreting as well as bilingual providers and staff members. Specific language requirements subject to Title VI will vary on regional needs.

Without § 1557 and Title VI protections or access to sufficient language services, LEP patients seeking care will effectively be denied the right to meaningful coverage by a federally-subsidized program. If the Exchanges and insurers and plans participating in the Exchanges are not required to comply with the law, patients will certainly encounter discriminatory practices based on their national origin and language. Such practices could include anything from plans or providers refusing to accept LEP patients, not providing adequate language services for LEP patients, or forcing patients to pay for their own interpreters or translated materials. The intent of the Exchanges, which is to provide access to health care coverage at an affordable amount by subsidizing cost-sharing and premium rates, would be significantly undermined. Without proper reimbursement, providers will have few incentives to pay for interpreters or treat LEP patients.

Statutory language, legislative intent, and the importance of providing high quality health care to all provide strong reasons to ensure that regulations governing the Exchanges require both the provision

---

<sup>52</sup> *Id.*

<sup>53</sup> *Fobbs v. Holy Cross Health Sys. Corp.*, 29 F. 3d 1439, 1447-1448 (9th Cir. 1994) (citing *Wrenn v. Kansas*, 561 F. Supp. 1216, 1221 (D. Kan. 1983)) (finding that Title VI protections extend to a federally assisted hospital’s employment procedures).

<sup>54</sup> *See* 68 F.R. 47,311 (Aug. 8, 2003).

and payment by these entities for language services needed by LEP individuals. The Title VI LEP provisions set forth in 68 Fed. Reg. 97311 should serve as the guide for implementing these requirements.

**For further information, please contact:**

Mara Youdelman

[youdelman@healthlaw.org](mailto:youdelman@healthlaw.org)

[www.healthlaw.org](http://www.healthlaw.org)