

## Chapter 9

# Health Care and Insurance

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### A. Introduction and Overview

Access to health care services is important to all Americans. For individuals with disabilities, it can be even more critical. Yet these individuals often face greater challenges than other Americans in receiving health care services. One barrier is discrimination by health care providers. Individuals with HIV, for example, often face discrimination and refusal to treat, either directly or indirectly. Reasonable accommodations (such as interpreters for individuals who are deaf) and accessible facilities (such as ramps to enter buildings and equipment usable by individuals with mobility impairments) may be necessary to ensure access.

The cost of health care is the most significant barrier, however. Unless an individual has some type of health insurance coverage, health care costs can be prohibitive. Health insurance is most often available through an employment setting. Those without jobs may not be able to afford individual health insurance policies, and even if they can afford them, they may not be able to obtain health insurance or the insurance may not adequately cover the treatments needed by the individual. “Obamacare” or the Patient Protection and Affordable Care Act (“ACA”) has improved this situation considerably by attaining insurance for twenty million people, but there are still issues concerning coverage and availability.

This chapter highlights the key federal statutes that are designed to ensure nondiscrimination in health coverage and to some degree access to health insurance. These statutes include the Rehabilitation Act, the Americans with Disabilities Act, the Health Insurance Portability and Accountability Act, the Genetic Information Non-Discrimination Act, the Patient Protection and Affordable Care Act (“ACA” or “Obamacare”) and various state laws prohibiting discrimination. It should be apparent that these protections are somewhat limited in ensuring adequate health care for individuals with disabilities.

In addition, the chapter highlights some of the unique employment aspects of health care providers who themselves have disabilities, and how nondiscrimination policies address those situations.

### [1] Chapter Goals

The goals for this chapter are to:

- Review the key principles applicable to health care access and persons with disabilities
- Understand the major statutory provisions applicable to the health care setting and persons with disabilities
- Understand how the protection of people with disabilities from discrimination and medical decisionmaking interrelate
- Know the conflicts between medical decisionmaking concerning care, rationing, end of life decisions, right to die legislation, and the rights of persons with disabilities
- Understand the issues raised for persons with disabilities by the Patient Protection and Affordable Care Act (“ACA”)
- Understand how, in the health care setting, the ADA determines who is protected by the statute

- Comprehend the law with regard to architectural barriers and access to health care, and requirements of the ADA for reasonable accommodation and auxiliary aids and services
- Understand the judicial split over whether insurance policies are covered by Title III of the ADA
- Know how federal statutes interrelate to solve problems related to parity between insurance coverage of mental and physical health impairments, and the gaps still existing in coverage
- Know the protections afforded by the Genetic Information Nondiscrimination Act (GINA) in access to insurance coverage

## **[2] Key Concepts and Definitions**

### **Alterations**

Generally refers to a physical change that affects the usability of a facility. Where such changes are made after the effective date of a particular statute (ADA, Rehabilitation Act), the facility must meet specific design standards with respect to those areas that are altered. Repainting and similar kinds of cosmetic changes do not generally trigger requirements under the ADA or Rehabilitation Act.

### **Americans with Disabilities Act**

Enacted in 1990, the ADA requires in Titles II and III that there be no discrimination on the basis of disability in the provision of health care services in hospitals and in offices and clinics of health care providers.

### **Architectural barriers**

This primarily refers to design features that indirectly affect the ability of individuals with mobility and sensory impairments to gain access to the physical facilities and structures of providers in the health care setting.

### **Auxiliary aids and services**

Titles II and III of the ADA require that health care providers give auxiliary aids and services, such as interpreters, to persons with disabilities who need them.

### **Covered facilities and programs**

All aspects of programs receiving federal financial assistance are subject to Section 504 of the Rehabilitation Act, not just those receiving the assistance. For example, the university hospital in a university receiving a federal grant in its arts and sciences department will be covered. Both public entities and private entities may receive federal financial assistance.

### **Design standards**

Detailed sets of regulations provide specifications for a range of issues affecting physical design for both mobility and sensory impairments. These are standards that relate to new construction or that should be followed when there are certain types of alterations or renovations. The standards cover aspects such as slopes, elevators, parking, seating in assembly areas, restrooms, and paths of travel. They also cover signage. Each program or service is unique, and it is impossible to provide with specificity every detail of what would make a program or service as a whole accessible.

### **Existing facilities**

Federal statutes have differing requirements regarding retrofitting physical facilities that were built before the applicable date of the relevant statute. Generally, under Title III of the ADA, public accommodations such as health care offices must remove barriers to the extent it is readily achievable to do so. For private providers of public accommodations receiving federal financial assistance, Section 504 of the Rehabilitation Act requires that barriers in existing facilities be

removed so that the program is accessible when viewed in its entirety.

#### Genetic Information Nondiscrimination Act (“GINA”)

Federal statute that forbids discrimination in insurance based on the insured's and his family's genetic information and family members' manifestation of disease.

#### Health insurance policies and the ADA

There is a question as to whether the substance of the policies of health insurers is governed by Title III of the ADA as a public accommodation. If it is, health insurance policies would not be permitted to write policies that discriminate against particular illnesses or against persons with disabilities.

#### Licensing

Governmental agencies (primarily at the state level) engage in numerous licensing programs that could be covered under Title II of the ADA. These include licensing of businesses (such as building permits) and professional licensing (including health care professions).

#### Medical decisionmaking

There is a question as to whether the ADA and the Rehabilitation Act apply to medical decisions concerning treatment, end-of life decisions, etc.

#### Mental health parity

Refers to the concept that insurance coverage of mental and physical illnesses should be the same. Historically, there existed a large gap between the coverage provided for mental and physical illnesses. Congress has passed various statutes that attempt to close this gap, but not one of them does so one hundred percent.

#### New construction

Depending on the applicable date of the statute at issue (Title III or Section 504), a specific set of detailed design standards apply to new construction by entities providing accommodations to the public, such as offices of health professionals.

#### Patient Protection and Affordable Care Act

“Obamacare” or the “ACA” was passed to give health insurance coverage to millions more Americans who previously had no health insurance because of health status, pre-existing conditions, or expense. While there are problems related to the ACA—specifically many doctors' and hospitals' refusals to accept payment by ACA insurance companies and some insurance companies' refusals to participate—the ACA has improved health care access for individuals with disabilities.

#### Public accommodations

Within Title III of the ADA, this refers to *private* entities that provide accommodations open to the public such as the offices of health care professionals. Title II (for state and local governmentally provided programs) and Section 504 of the Rehabilitation Act (for all entities receiving federal financial assistance) often, but not always, provide for similar requirements as Title III for access to physical facilities and nondiscrimination. The remedies under Title III, however, differ from those under Title II and Section 504.

#### Reasonable accommodations

Unlike most civil rights statutes, the ADA and the Rehabilitation Act require more than nondiscrimination. They also require reasonable accommodation. Some of the requirements are spelled out in regulatory and statutory language (although generally not as all inclusive listings).

Reasonable accommodations include both auxiliary aids and services (such as interpreters) and modification of policies, practices, and procedures (such as allowing assistance animals in places where they are ordinarily prohibited).

This requirement is not intended to require unduly burdensome (administratively or financially) accommodations. Nor is it intended to require that fundamental alterations to a program be made. Case law highlights that the burden is generally on the program to demonstrate that a requested accommodation is not reasonable. It also demonstrates that federal statutes contemplate individualized determinations and an interactive process in determining what accommodations would be reasonable.

Individuals seeking accommodations are not entitled to their preferred or a best accommodation. The accommodation should be reasonable and effective. What is unclear at present is whether the accommodation must be “necessary” for it to be required.

#### Right to Die Legislation

A number of states have passed legislation that gives patients the right to take medication to end their lives under specific, restricted circumstances.

#### Section 504 of the Rehabilitation Act

Section 504 prohibits discrimination against persons with disabilities in programs receiving federal financial assistance. Many ADA Title III programs that provide accommodations for the public receive federal financial assistance, and are therefore also covered by Section 504. Many programs subject primarily to Section 504 of the Rehabilitation Act and Title II (such as public hospitals) may have within them entities subject to Title III, such as bookstores, print shops, or Title II entities may lease or use or facilitate private programs. The determination of which requirements apply—Titles II, III, and/or Section 504—and how they relate can be complex and challenging.

#### Self evaluation

Title II of the ADA requires that state and local governmental programs conduct a self evaluation of the barriers in their programs and prepare a transition plan for addressing barriers.

## **B. Nondiscrimination in Health Care Services**

Until the 1990 passage of the Americans with Disabilities Act (ADA), 42 U.S.C. §12101 et seq., the only major protection from nondiscrimination by health care providers was under Section 504 of the Rehabilitation Act, 29 U.S.C. §794. This section applies only to recipients of federal financial assistance, however, leaving most individuals with disabilities with little remedy against discrimination. Most courts hold that receipt of Medicare or Medicaid constitutes federal financial assistance. Therefore, physicians and hospitals accepting these payments are covered by Section 504.

The ADA of 1990 broadened the protection for persons with disabilities against discrimination in the provision of health care services. Title II prohibits state and local governments providing health care services from discriminating based on disability. Title III prohibits discrimination by twelve categories of public accommodation. Included in the list as public accommodations are offices of health care providers. There is a conflict in the courts over whether health insurance contracts themselves are public accommodations subject to the anti-discrimination mandates of the ADA. For more discussion on the issue of whether health insurance contracts are public accommodations, see Section [D], below. For more information and cases on coverage, see LAURA ROTHSTEIN & JULIA IRZYK, *DISABILITIES AND THE LAW* Sec. 10:1 (2012 and cumulative supplement).

Two major Supreme Court cases have addressed significant issues related to health care and

individuals with disabilities under the Rehabilitation Act.<sup>1</sup> The first is *Alexander v. Choate*, 469 U.S. 287 (1984), excerpted in [Chapter 1](#), in which the Court addressed the question of whether the state of Tennessee's policy of reducing the number of annual days of inpatient hospital care covered by its state Medicaid program violates Section 504. This policy has a disparate impact on individuals with disabilities, but because the proposed fourteen-day limitation does not deny disabled individuals meaningful access to Medicaid services or exclude them from those services, the policy was held not to violate Section 504.

The second decision, *Bowen v. American Hosp. Ass'n*, below, followed several years of political activity beginning in 1982. The issues are quite complex, because they involve religious, moral, medical, ethical, and legal questions and policies. While this kind of issue is not frequently addressed by the courts today, the decision provides an interesting overview of how regulations are promulgated, the deference given to medical providers, and the challenges in addressing these issues in a particularly emotional situation. Note that the Court uses the term “handicapped” that was considered appropriate at the time, instead of the current favored term, “persons with disabilities.”

### **Bowen v. American Hospital Ass'n**

476 U.S. 610 (1986)

STEVENS, J., announced the judgment of the Court.

#### I.

The American Medical Association, the American Hospital Association, and several other respondents challenge the validity of Final Rules promulgated on January 12, 1984, by the Secretary of the Department of Health and Human Services. These Rules establish “Procedures relating to health care for handicapped infants,” and in particular require the posting of informational notices, authorize expedited access to records and expedited compliance actions, and command state child protective services agencies to “prevent instances of unlawful medical neglect of handicapped infants.”

Although the Final Rules comprise six parts, only the four mandatory components are challenged here.<sup>2</sup> Subsection (b) is entitled “Posting of informational notice” and requires every “recipient health care provider that provides health care services to infants in programs or activities receiving Federal financial assistance”—a group to which we refer generically as “hospitals”—to post an informational notice in one of two approved forms. Both forms include a statement that §504 prohibits discrimination on the basis of handicap, and indicate that because of this prohibition “nourishment and medically beneficial treatment (as determined with respect for reasonable medical judgments) should not be withheld from handicapped infants solely on the basis of their present or anticipated mental or physical impairments.” The notice's statement of the legal requirement does not distinguish between medical care for which parental consent has been obtained and that for which it has not. The notice must identify the telephone number of the appropriate child protective services agency and, in addition, a toll-free number for the Department that is available 24 hours a day. Finally, the notice must state that the “identity of callers will be kept confidential” and that federal law prohibits retaliation “against any person who provides information about possible violations.”

Subsection (c), which contains the second mandatory requirement, sets forth “Responsibilities of recipient state child protective services agencies.” Subsection (c) does not mention §504 (or any other federal statute) and does not even use the word “discriminate.” It requires every designated agency to establish and maintain procedures to ensure that “the agency utilizes its full authority pursuant to state law to prevent instances of unlawful medical neglect of handicapped infants.” Mandated procedures must include (1) “[a] requirement that health care providers report on a timely basis ... known or suspected instances of unlawful medical neglect of handicapped infants,” (2) a method by which the

state agency can receive timely reports of such cases, (3) “immediate” review of those reports, including “on-site investigation,” where appropriate, (4) protection of “medically neglected handicapped infants” including, where appropriate, legal action to secure “timely court order[s] to compel the provision of necessary nourishment and medical treatment,” and (5) “[t]imely notification” to HHS of every report of “suspected unlawful medical neglect” of handicapped infants. The preamble to the Final Rules makes clear that this subsection applies “where a refusal to provide medically beneficial treatment is a result, not of decisions by a health care provider, but of decisions by parents.”

The two remaining mandatory regulations authorize “[e]xpedited access to records” and “[e]xpedited action to effect compliance.” Subsection (d) provides broadly for immediate access to patient records on a 24-hour basis, with or without parental consent, “when, in the judgment of the responsible Department official, immediate access is necessary to protect the life or health of a handicapped individual.” Subsection (e) likewise dispenses with otherwise applicable requirements of notice to the hospital “when, in the judgment of the responsible Department official, immediate action to effect compliance is necessary to protect the life or health of a handicapped individual.” The expedited compliance provision is intended to allow “the government [to] see[k] a temporary restraining order to sustain the life of a handicapped infant in imminent danger of death.” Like the provision affording expedited access to records, it applies without regard to whether parental consent to treatment has been withheld or whether the matter has already been referred to a state child protective services agency.

## II.

The Final Rules represent the Secretary's ultimate response to an April 9, 1982, incident in which the parents of a Bloomington, Indiana, infant with Down's syndrome and other handicaps refused consent to surgery to remove an esophageal obstruction that prevented oral feeding. On April 10, the hospital initiated judicial proceedings to override the parents' decision, but an Indiana trial court, after holding a hearing the same evening, denied the requested relief. On April 12 the court asked the local Child Protection Committee to review its decision. After conducting its own hearing, the Committee found no reason to disagree with the court's ruling. The infant died six days after its birth.

Citing “heightened public concern” in the aftermath of the Bloomington Baby Doe incident, on May 18, 1982, the director of the Department's Office of Civil Rights, in response to a directive from the President, “remind[ed]” health care providers receiving federal financial assistance that newborn infants with handicaps such as Down's syndrome were protected by §504.

This notice was followed, on March 7, 1983, by an “Interim Final Rule” contemplating a “vigorous federal role.” The Interim Rule required health care providers receiving federal financial assistance to post “in a conspicuous place in each delivery ward, each maternity ward, each pediatric ward, and each nursery, including each intensive care nursery” a notice advising of the applicability of §504 and the availability of a telephone “hotline” to report suspected violations of the law to HHS. Like the Final Rules, the Interim Rule also provided for expedited compliance actions and expedited access to records and facilities when, “in the judgment of the responsible Department official,” immediate action or access was “necessary to protect the life or health of a handicapped individual.” The Interim Rule took effect on March 22.

On April 6, 1983, respondents American Hospital Association et al. filed a complaint in the Federal District Court for the Southern District of New York seeking a declaration that the Interim Final Rule was invalid and an injunction against its enforcement. Little more than a week later, on April 14, in a similar challenge brought by the American Academy of Pediatrics and other medical institutions, the Federal District Court for the District of Columbia declared the Interim Final Rule “arbitrary and capricious and promulgated in violation of the Administrative Procedure Act.” The District Judge in that case “conclude[d] that haste and inexperience ha[d] resulted in agency action based on inadequate

consideration” of several relevant concerns and, in the alternative, found that the Secretary had improperly failed to solicit public comment before issuing the Rule.

On July 5, 1983, the Department issued new “Proposed Rules” on which it invited comment. Like the Interim Final Rule, the Proposed Rules required hospitals to post informational notices in conspicuous places and authorized expedited access to records to be followed, if necessary, by expedited compliance action. In a departure from the Interim Final Rule, however, the Proposed Rules required federally assisted state child protective services agencies to utilize their “full authority pursuant to State law to prevent instances of medical neglect of handicapped infants.” Mandated procedures mirrored those contained in the Final Rules described above. The preamble and appendix to the Proposed Rules did not acknowledge that hospitals and physicians lack authority to perform treatment to which parents have not given their consent.

After the period for notice and comment had passed, HHS, on December 30, 1983, promulgated the Final Rules and announced that they would take effect on February 13, 1984. On March 12 of that year respondents American Hospital Association et al. amended their complaint and respondents American Medical Association et al. filed suit to declare the new regulations invalid and to enjoin their enforcement. The actions were consolidated....

#### IV.

The Solicitor General is correct that “handicapped individual” as used in §504 includes an infant who is born with a congenital defect. If such an infant is “otherwise qualified” for benefits under a program or activity receiving federal financial assistance, §504 protects him from discrimination “solely by reason of his handicap.” It follows ... that handicapped infants are entitled to “meaningful access” to medical services provided by hospitals, and that a hospital rule or state policy denying or limiting such access would be subject to challenge under §504.

However, no such rule or policy is challenged, or indeed has been identified, in this case. Nor does this case involve a claim that any specific individual treatment decision violates §504. This suit is not an enforcement action, and as a consequence it is not necessary to determine whether §504 ever applies to individual medical treatment decisions involving handicapped infants. Respondents brought this litigation to challenge the four mandatory components of the Final Rules on their face, and the Court of Appeals' judgment which we review merely affirmed the judgment of the District Court which “declared invalid and enjoined enforcement of [the final] regulations, purportedly promulgated pursuant to section 504 of the Rehabilitation Act of 1973.”

#### V.

It is an axiom of administrative law that an agency's explanation of the basis for its decision must include “a ‘rational connection between the facts found and the choice made.’” Agency deference has not come so far that we will uphold regulations whenever it is possible to “conceive a basis” for administrative action.

Before examining the Secretary's reasons for issuing the Final Rules, it is essential to understand the pre-existing state-law framework governing the provision of medical care to handicapped infants. In broad outline, state law vests decisional responsibility in the parents, in the first instance, subject to review in exceptional cases by the State acting as *parens patriae*. Prior to the regulatory activity culminating in the Final Rules, the Federal Government was not a participant in the process of making treatment decisions for newborn infants. We presume that this general framework was familiar to Congress when it enacted §504. It therefore provides an appropriate background for evaluating the Secretary's action in this case.

The Secretary has identified two possible categories of violations of §504 as justifications for federal oversight of handicapped infant care. First, he contends that a hospital's refusal to furnish a handicapped infant with medically beneficial treatment “solely by reason of his handicap” constitutes

unlawful discrimination. Second, he maintains that a hospital's failure to report cases of suspected medical neglect to a state child protective services agency may also violate the statute. We separately consider these two possible bases for the Final Rules.

## VI.

In the immediate aftermath of the Bloomington Baby Doe incident, the Secretary apparently proceeded on the assumption that a hospital's statutory duty to provide treatment to handicapped infants was unaffected by the absence of parental consent. He has since abandoned that view. Thus, the preamble to the Final Rules correctly states that when "a non-treatment decision, no matter how discriminatory, is made by parents, rather than by the hospital, section 504 does not mandate that the hospital unilaterally overrule the parental decision and provide treatment notwithstanding the lack of consent." A hospital's withholding of treatment when no parental consent has been given cannot violate §504, for without the consent of the parents or a surrogate decisionmaker the infant is neither "otherwise qualified" for treatment nor has he been denied care "solely by reason of his handicap."

Indeed, it would almost certainly be a tort as a matter of state law to operate on an infant without parental consent.

Now that the Secretary has acknowledged that a hospital has no statutory treatment obligation in the absence of parental consent, it has become clear that the Final Rules are not needed to prevent hospitals from denying treatment to handicapped infants. The Solicitor General concedes that the administrative record contains no evidence that hospitals have ever refused treatment authorized either by the infant's parents or by a court order. Even the Secretary never seriously maintained that posted notices, "hotlines," and emergency on-site investigations were necessary to process complaints against hospitals that might refuse treatment requested by parents. The parental interest in calling such a refusal to the attention of the appropriate authorities adequately vindicates the interest in enforcement of §504 in such cases.

The Secretary's belated recognition of the effect of parental nonconsent is important, because the supposed need for federal monitoring of hospitals' treatment decisions rests *entirely* on instances in which parents have refused their consent. Thus, in the Bloomington, Indiana, case that precipitated the Secretary's enforcement efforts in this area, as well as in the *University Hospital* case that provided the basis for the summary affirmance in the case now before us, the hospital's failure to perform the treatment at issue rested on the lack of parental consent. The Secretary's own summaries of these cases establish beyond doubt that the respective hospitals did not withhold medical care on the basis of handicap and therefore did not violate §504; as a result, they provide no support for his claim that federal regulation is needed in order to forestall comparable cases in the future.

The Secretary's initial failure to recognize that withholding of consent by parents does not equate with discriminatory denial of treatment by hospitals likewise undermines the Secretary's findings in the preamble to his proposed rulemaking. In that statement, the Secretary cited four sources in support of the claim that "Section 504 [is] not being uniformly followed." None of the cited examples, however, suggests that recipients of federal financial assistance, as opposed to parents, had withheld medical care on the basis of handicap.

In sum, there is nothing in the administrative record to justify the Secretary's belief that "discriminatory withholding of medical care" in violation of 504 provides any support for federal regulation.

## VII.

As a backstop to his manifestly incorrect perception that withholding of treatment in accordance with parental instructions necessitates federal regulation, the Secretary contends that a hospital's failure to report parents' refusals to consent to treatment violates §504, and that past breaches of this kind justify federal oversight.



By itself, §504 imposes no duty to report instances of medical neglect—that undertaking derives from state-law reporting obligations or a hospital's own voluntary practice. Although a hospital's selective refusal to report medical neglect of handicapped infants might violate §504, the Secretary has failed to point to any specific evidence that this has occurred. The 49 actual investigations summarized in the preamble to the Final Rules do not reveal *any* case in which a hospital either failed, or was accused of failing, to make an appropriate report to a state agency. Nor can we accept the Solicitor General's invitation to infer discriminatory nonreporting from the studies cited in the Secretary's proposed rulemaking. Even assuming that cases in which parents have withheld consent to treatment for handicapped infants have gone unreported, that fact alone would not prove that the hospitals involved had discriminated on the basis of handicap rather than simply failed entirely to discharge their state-law reporting obligations, if any, a matter which lies wholly outside the nondiscrimination mandate of §504.

The particular reporting mechanism chosen by the Secretary—indeed the entire regulatory framework imposed on state child protective services agencies—departs from the nondiscrimination mandate of §504 in a more fundamental way. The mandatory provisions of the Final Rules omit any direct requirement that hospitals make reports when parents refuse consent to recommended procedures. Instead, the Final Rules command *state agencies* to require such reports, regardless of the state agencies' own reporting requirements (or lack thereof). Far from merely preventing state agencies from remaining calculatedly indifferent to handicapped infants while they tend to the needs of the similarly situated nonhandicapped, the Final Rules command state agencies to utilize their “full authority” to “prevent instances of unlawful medical neglect of handicapped infants.” The Rules effectively make medical neglect of handicapped newborns a state investigative priority, possibly forcing state agencies to shift scarce resources away from other enforcement activities—perhaps even from programs designed to protect handicapped children outside hospitals. The Rules also order state agencies to “immediate[ly]” review reports from hospitals, to conduct “on-site investigation[s],” and to take legal action “to compel the provision of necessary nourishment and medical treatment”—all without any regard to the procedures followed by state agencies in handling complaints filed on behalf of nonhandicapped infants. These operating procedures were imposed over the objection of several state child protective services agencies that the requirement that they turn over reports to HHS “conflicts with the confidentiality requirements of state child abuse and neglect statutes”—thereby requiring under the guise of nondiscrimination a service which state law denies to the nonhandicapped.

The complaint-handling process the Secretary would impose on unwilling state agencies is totally foreign to the authority to prevent discrimination conferred on him by §504. “Section 504 seeks to assure evenhanded treatment,” “neither the language, purpose, nor history of §504 reveals an intent to impose an affirmative-action obligation” on recipients of federal financial assistance. The Solicitor General also recognizes that §504 is concerned with discrimination and with discrimination alone. In his attempt to distinguish the Secretary's 1976 determination that it “is beyond the authority of section 504” to promulgate regulations “concerning adequate and appropriate psychiatric care or safe and humane living conditions for persons institutionalized because of handicap or concerning payment of fair compensation to patients who perform work,” the Solicitor General explains:

“This conclusion of course was consistent with the fact that, as relevant here, Section 504 is essentially concerned only with discrimination in the relative treatment of handicapped and nonhandicapped persons and does not confer any absolute right to receive particular services or benefits under federally assisted programs.”

The Final Rules, however, impose just the sort of absolute obligation on state agencies that the Secretary had previously disavowed. The services state agencies are required to make available to handicapped infants are in no way tied to the level of services provided to similarly situated nonhandicapped infants. Instead, they constitute an “*absolute* right to receive particular services or

benefits” under a federally assisted program. Even if a state agency were scrupulously impartial as between the protection it offered handicapped and nonhandicapped infants, it could still be denied federal funding for failing to carry out the Secretary's mission with sufficient zeal.

It is no answer to state, as does the Secretary, that these regulations are a necessary “‘metho[d] ... to give reasonable assurance’ of compliance.” For while the Secretary can require state agencies to document their *own* compliance with §504, nothing in that provision authorizes him to commandeer state agencies to enforce compliance by *other* recipients of federal funds (in this instance, hospitals). State child protective services agencies are not field offices of the HHS bureaucracy, and they may not be conscripted against their will as the foot soldiers in a federal crusade.

### VIII.

Even according the greatest respect to the Secretary's action, however, deference cannot fill the lack of an evidentiary foundation on which the Final Rules must rest. The Secretary's basis for federal intervention is perceived discrimination against handicapped infants in violation of §504, and yet the Secretary has pointed to no evidence that such discrimination occurs.

The need for a proper evidentiary basis for agency action is especially acute in this case because Congress has failed to indicate, either in the statute or in the legislative history, that it envisioned federal superintendence of treatment decisions traditionally entrusted to state governance. “[W]e must assume that the implications and limitations of our federal system constitute a major premise of all congressional legislation, though not repeatedly recited therein.” Congress therefore “will not be deemed to have significantly changed the federal-state balance”—or to have authorized its delegates to do so—“unless otherwise the purpose of the Act would be defeated.” “[I]t must appear that there are findings, supported by evidence, of the essential facts ... which would justify [the Secretary's] conclusion.” The administrative record does not contain the reasoning and evidence that is necessary to sustain federal intervention into a historically state-administered decisional process that appears—for lack of any evidence to the contrary—to be functioning in full compliance with §504.

[T]he Department regards its mission as one principally concerned with the quality of medical care for handicapped infants rather than with the implementation of §504. We could not quarrel with a decision by the Department to concentrate its finite compliance resources on instances of life-threatening discrimination rather than instances in which merely elective care has been withheld. But nothing in the statute authorizes the Secretary to dispense with the law's focus on discrimination and instead to employ federal resources to save the lives of handicapped newborns, without regard to whether they are victims of discrimination by recipients of federal funds or not. Section 504 does not authorize the Secretary to give unsolicited advice either to parents, to hospitals, or to state officials who are faced with difficult treatment decisions concerning handicapped children. We may assume that the “qualified professionals” employed by the Secretary may make valuable contributions in particular cases, but neither that assumption nor the sincere conviction that an immediate “on-site investigation” is “necessary to protect the life or health of a handicapped individual” can enlarge the statutory powers of the Secretary.

The administrative record demonstrates that the Secretary has asserted the authority to conduct on-site investigations, to inspect hospital records, and to participate in the decisional process in emergency cases in which there was no colorable basis for believing that a violation of §504 had occurred or was about to occur. The District Court and the Court of Appeals correctly held that these investigative actions were not authorized by the statute and that the regulations which purport to authorize a continuation of them are invalid.

The judgment of the Court of Appeals is affirmed.

### *Questions*

1. Does this decision strike down the use of infant care review committees? See footnote 2 in the *Bowen* decision.

2. The Section 504 regulations included a provision that the decision about whether to treat or not should not include consideration of the negative effect of the child's condition on others, including parents, siblings, and society. Is it possible not to consider those effects? Should the impact on others be a valid consideration?

### Notes

1. *Institutional Ethics Committees*: The types of committees suggested in the regulations addressed in the *Bowen* case have been implemented in a number of hospitals. There are several practical issues relating to the implementation of such committees. These issues include how members of the committee are appointed, what their term of appointment is and how they are removed, what their decisionmaking authority is, what liability is involved, and other practical issues relating to when they meet, whether they vote or reach consensus, etc. For a discussion of these issues, see Alexander Morgan Capron, *Legal Perspectives on Institutional Ethics Committees*, 11 J. COLLEGE & UNIV. L. 417 (1985); Thaddeus Mason Pope, *Multi-Institutional Healthcare Ethics Committees: The Procedurally Fair Internal Dispute Resolution Mechanism*, 31 CAMPBELL L. REV. 257 (2009) (discussing Institutional Ethics Committees' role, function, prevalence, and shortcomings); Thaddeus Mason Pope, *The Growing Power of Healthcare Ethics Committees Heightens Due Process Concerns*, 15 CARDOZO J. CONFLICT RESOL. 425 (2014) (discussing the growing influence of the committees); Anya E. R. Prince & Arlene M. Davis, *Navigating Professional Norms in an Inter-Professional Environment: The "Practice" of Healthcare Ethics Committees*, 15 CONN. PUB. INT. L.J. 115 (2016) (discussing the history, structure, and membership of Healthcare Ethics Committees).

2. *Values as Factors in Decisionmaking*: Decisionmaking involving issues of seriously ill newborns obviously includes values that will be incorporated into standards to be applied. One's moral and/or religious perspective on life will affect whether any of the following standards are applied: biological life should be preserved at all costs; what the infant would want; can the infant relate to life adequately to have some meaning; the cost of the infant's life to others. For a discussion of these issues, see Rebecca Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373 (1986).

3. *Medicaid Prioritization and Health Care Rationing*: As a response to rising health care costs, many states base Medicaid funding prioritization on certain conditions. Medicaid is federally funded, but state administered. For that reason both Section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act could be implicated in challenges that such plans discriminate on the basis of disability in violation of federal discrimination laws. What is the likelihood that plaintiffs would succeed in such an action? For a discussion of this issue, see Robert J. Moosy, Jr., *Health Care Prioritization and the ADA: The Oregon Plan 1991–1993*, 31 HOUS. L. REV. 265 (1994); David Orentlicher, *Rationing and the Americans with Disabilities Act*, 217 JAMA 308 (1994).

4. The ADA and the Rehabilitation Act were amended by the ADA Amendments Act of 2008 (ADAAA), which took effect on January 1, 2009. As earlier chapters demonstrate, Congress passed the amendments to overturn a number of United States Supreme Court opinions interpreting the ADA and their application by the lower federal courts that had the effect of significantly narrowing the definition of individuals with disabilities. Some of these opinions concluded that persons with serious impairments such as intellectual disabilities, deafness, diabetes and cancer were not individuals with disabilities and were therefore not protected by the Act from discrimination. The ADAAA has the effect of including a broader group of persons within the definition of persons with disabilities. For more information on the ADAAA, see [Chapters 1 and 2](#).

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The *Bowen* decision provides a perspective on the application of Section 504 of the Rehabilitation Act to treatment of seriously ill newborns. The decision does not really address the discrimination issue, but rather focuses on the validity of the regulations on this issue promulgated pursuant to Section 504.

The following decision focuses more on the discrimination issue in the context of the ADA and Section 504 of the Rehabilitation Act with respect to withdrawal of treatment from a seriously ill newborn.

### **In re Baby K**

832 F. Supp. 1022 (E.D. Va. 1993)

HILTON, DISTRICT JUDGE:

#### **Findings of Fact**

1. Plaintiff Hospital is a general acute care hospital located in Virginia that is licensed to provide diagnosis, treatment, and medical and nursing services to the public as provided by Virginia law. Among other facilities, the Hospital has a Pediatric Intensive Care Department and an Emergency Department.

2. The Hospital is a recipient of federal and state funds including those from Medicare and Medicaid and is a “participating hospital” pursuant to 42 U.S.C. §1395cc.

3. The Hospital and its staff (including emergency doctors, pediatricians, neonatologists and pediatric intensivists) treat sick children on a daily basis.

4. Defendant Ms. H, a citizen of the Commonwealth of Virginia, is the biological mother of Baby K, an infant girl born by Caesarean section at the Hospital on October 13, 1992. Baby K was born with anencephaly.

5. Anencephaly is a congenital defect in which the brain stem is present but the cerebral cortex is rudimentary or absent. There is no treatment that will cure, correct, or ameliorate anencephaly. Baby K is permanently unconscious and cannot hear or see. Lacking a cerebral function, Baby K does not feel pain. Baby K has brain stem functions primarily limited to reflexive actions such as feeding reflexes (rooting, sucking, swallowing), respiratory reflexes (breathing, coughing), and reflexive responses to sound or touch. Baby K has a normal heart rate, blood pressure, liver function, digestion, kidney function, and bladder function and has gained weight since her birth. Most anencephalic infants die within days of birth.

6. Baby K was diagnosed prenatally as being anencephalic. Despite the counselling of her obstetrician and neonatologist that she terminate her pregnancy, Ms. H refused to have her unborn child aborted.

7. A Virginia court of competent jurisdiction has found defendant Mr. K, a citizen of the Commonwealth of Virginia, to be Baby K's biological father.

8. Ms. H and Mr. K have never been married.

9. Since Baby K's birth, Mr. K has, at most, been only distantly involved in matters relating to the infant. Neither the Hospital nor Ms. H ever sought Mr. K's opinion or consent in providing medical treatment to Baby K.

10. Because Baby K had difficulty breathing immediately upon birth, Hospital physicians provided her with mechanical ventilator treatment to allow her to breathe.

11. Within days of Baby K's birth, Hospital medical personnel urged Ms. H to permit a “Do Not Resuscitate Order” for Baby K that would discontinue ventilator treatment. Her physicians told her that no treatment existed for Baby K's anencephalic condition, no therapeutic or palliative purpose was served by the treatment, and that ventilator care was medically unnecessary and inappropriate.

Despite this pressure, Ms. H continued to request ventilator treatment for her child.

12. Because of Ms. H's continued insistence that Baby K receive ventilator treatment, her treating physicians requested the assistance of the Hospital's "Ethics Committee" in overriding the mother's wishes.

13. A three person Ethics Committee subcommittee, composed of a family practitioner, a psychiatrist, and a minister, met with physicians providing care to Baby K. On October 22, 1992, the group concluded that Baby K's ventilator treatment should end because "such care is futile" and decided to "wait a reasonable time for the family to help the caregiver terminate aggressive therapy." If the family refused to follow this advice, the committee recommended that the Hospital should "attempt to resolve this through our legal system."

14. Ms. H subsequently rejected the committee's recommendation. Before pursuing legal action to override Ms. H's position, the Hospital decided to transfer the infant to another health care facility.

15. Baby K was transferred to a nursing home ("Nursing Home") in Virginia on November 30, 1992 during a period when she was not experiencing respiratory distress and thus did not need ventilator treatment. A condition of the transfer was that the Hospital agreed to take the infant back if Baby K again developed respiratory distress to receive ventilator treatment which was unavailable at the Nursing Home. Ms. H agreed to this transfer.

16. Baby K returned to the Hospital on January 15, 1993 after experiencing respiratory distress to receive ventilator treatment. Hospital officials again attempted to persuade Ms. H to discontinue ventilator treatment for her child. Ms. H again refused. After Baby K could breathe on her own, she was transferred back to the Nursing Home on February 12, 1993.

17. Baby K again experienced breathing difficulties on March 3, 1993 and returned to the Hospital to receive ventilator treatment.

18. On March 15, 1993, Baby K received a tracheotomy, a procedure in which a breathing tube is surgically implanted in her windpipe, to facilitate ventilator treatment. Ms. H agreed to this operation.

19. After no longer requiring ventilator treatment, Baby K was transferred back to the Nursing Home on April 13, 1993 where she continues to live.

20. Baby K will almost certainly continue to have episodes of respiratory distress in the future. In the absence of ventilator treatment during these episodes, she would suffer serious impairment of her bodily functions and soon die.

21. Ms. H visits Baby K daily. The mother opposes the discontinuation of ventilator treatment when Baby K experiences respiratory distress because she believes that all human life has value, including her anencephalic daughter's life. Ms. H has a firm Christian faith that all life should be protected. She believes that God will work a miracle if that is his will. Otherwise, Ms. H believes, God, and not other humans, should decide the moment of her daughter's death. As Baby K's mother and as the only parent who has participated in the infant's care, Ms. H believes that she has the right to decide what is in her child's best interests.

22. On the Hospital's motion, a guardian ad litem to represent Baby K was appointed pursuant to Virginia Code §8.01-9.

23. Both the guardian ad litem and Mr. K share the Hospital's position that ventilator treatment should be withheld from Baby K when she experiences respiratory distress.

24. The Hospital has stipulated that it is not proposing to deny ventilator treatment to Baby K because of any lack of adequate resources or any inability of Ms. H to pay for the treatment.

#### Conclusions of Law

Pursuant to the Declaratory Judgment Act, 28 U.S.C. §2201, the Hospital has sought declaratory

and injunctive relief under four federal statutes and one Virginia statute: the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. §1395dd; the Rehabilitation Act of 1973, 29 U.S.C. §794; the Americans with Disabilities Act of 1990, 42 U.S.C. §12101 et seq.; the Child Abuse Amendments of 1984, 42 U.S.C. §5102 et seq.; and the Virginia Medical Malpractice Act, Va.Code §8.01-581.1 et seq.

### *I. Emergency Medical Treatment and Active Labor Act*

[Discussion of this issue omitted.]

### *II. Rehabilitation Act*

Section 504 of the Rehabilitation Act prohibits discrimination against an “otherwise qualified” handicapped individual, solely by reason of his or her handicap, under any program or activity receiving federal financial assistance. Hospitals such as plaintiff that accept Medicare and Medicaid funding are subject to the Act. Baby K is a “handicapped” and “disabled” person within the meaning of the Rehabilitation Act of 1973. A “handicapped individual” under the Rehabilitation Act “includes an infant who is born with a congenital defect.”

Section 504's plain text spells out the necessary scope of inquiry: Is Baby K otherwise qualified to receive ventilator treatment and is ventilator treatment being threatened with being denied because of an unjustified consideration of her anencephalic handicap? The Hospital has admitted that the sole reason it wishes to withhold ventilator treatment for Baby K over her mother's objections, is because of Baby K's anencephaly—her handicap and disability.

When the Rehabilitation Act was passed in 1973, Congress intended that discrimination on the basis of a handicap be treated in the same manner that Title VI of the Civil Rights Act treats racial discrimination. This analogy to race dispels any ambiguity about the extent to which Baby K has statutory rights not to be discriminated against on the basis of her handicap. It also shatters the Hospital's contention that ventilator treatment should be withheld because Baby K's recurring breathing troubles are intrinsically related to her handicap. No such distinction would be permissible within the context of racial discrimination. In addition, the Hospital was able to perform a tracheotomy on Baby K. This surgery was far more complicated than linking her to a ventilator to allow her to breathe. Just as an AIDS patient seeking ear surgery is “otherwise qualified” to receive treatment despite poor long term prospects of living, Baby K is “otherwise qualified” to receive ventilator treatment despite similarly dismal health prospects. Thus, the Hospital's desire to withhold ventilator treatment from Baby K over her mother's objections would violate the Rehabilitation Act.

### *III. Americans with Disabilities Act*

Section 302 of the Americans with Disabilities Act (“ADA”) prohibits discrimination against disabled individuals by “public accommodations.” The Hospital is a public accommodation under the ADA.

Section 302(a) of the ADA states a general rule of nondiscrimination against the disabled:

“General rule. No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodation of any place of public accommodations by any person who owns, leases (or leases to), or operates a place of public accommodation.” 42 U.S.C. §12182(a).

In contrast to the Rehabilitation Act, the ADA does not require that a handicapped individual be “otherwise qualified” to receive the benefits of participation. Further, section 302(b)(1)(A) of the ADA states that “[i]t shall be discriminatory to subject an individual or class of individuals on the basis of a disability ... to a denial of the opportunity of the individual or class to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of an entity.” 42 U.S.C. §12182(b)(1)(A)(i).

The Hospital asks this court for authorization to deny the benefits of ventilator services to Baby K by reason of her anencephaly. The Hospital's claim is that it is “futile” to keep alive an anencephalic baby, even though the mother has requested such treatment. But the plain language of the ADA does not permit the denial of ventilator services that would keep alive an anencephalic baby when those life-saving services would otherwise be provided to a baby without disabilities at the parent's request. The Hospital's reasoning would lead to the denial of medical services to anencephalic babies as a class of disabled individuals. Such discrimination against a vulnerable population class is exactly what the American with Disabilities Act was enacted to prohibit. The Hospital would therefore violate the ADA if it were to withhold ventilator treatment from Baby K.

#### IV. *Child Abuse Act*

[Discussion of application of Child Abuse Act, Virginia Medical Malpractice Act, and Constitutional and Common Law Issue omitted.]

For the foregoing reasons, the Hospital's request for a declaratory judgment that the withholding of ventilator treatment from Baby K would not violate the Emergency Medical Treatment and Active Labor Act, the Rehabilitation Act of 1973, the Americans with Disabilities Act, the Child Abuse Amendments of 1984, and the Virginia Medical Malpractice Act should be DENIED. Under the Emergency Medical Treatment and Active Labor Act, the Rehabilitation Act of 1973, and the Americans with Disabilities Act, the Hospital is legally obligated to provide ventilator treatment to Baby K. The court makes no ruling as to any rights or obligations under the Child Abuse Amendments of 1984 and under the Virginia Medical Malpractice Act.

#### *Questions*

The lower court in *Baby K* states that, unlike the Rehabilitation Act, the ADA does not require that an individual be otherwise qualified in order to state a claim. Does that statement make any sense? Isn't the requirement that an individual be otherwise qualified implicit in all disability discrimination statutes? Would a deaf patient with serious back problems who went to an ophthalmologist for treatment of the back problems, who subsequently refused to treat him, be able to claim discrimination on the basis of his disability (deafness)? Or would the ophthalmologist be able to claim that the patient is not otherwise qualified because the patient is not seeking the treatment for which the physician has expertise?

#### *Notes*

1. On appeal, the Fourth Circuit did not address the ADA claim. *In re Baby K*, 16 F.3d 590 (4th Cir. 1994). The court instead found that the hospital had violated the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. §1395dd (b), (e)(3)(A), which mandates the provision of life-sustaining treatment in emergency situations. The appellate court did not comment on the ADA or Section 504.

2. *The ADA and Standards of Emergency Care*. Some commentators have questioned the role of courts in resolving “essentially medical matters.” For a discussion of this, see George J. Annas, *Asking the Courts to Set the Standard of Emergency Care—The Case of Baby K*, 330 NEW ENG. J. MED. 1542 (1994). See also Schrode, *Life in Limbo: Revising Policies for Permanently Unconscious Patients*, 31 HOUS. L. REV. 1609 (1995).

3. *Right to Die and Assisted Suicide*. The *Bowen* and *Baby K* cases focus on termination of treatment for seriously ill newborns and infants. The issues are somewhat different with respect to adults and others who are not infants regarding termination of treatment. In 1990, the Supreme Court in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), recognized a right to die in certain instances. That case involved a woman who was comatose and whose condition was irreversible. Since that time, there has been a great deal of media attention to the issue of the right to

die by alert and competent individuals who are suffering from painful, terminal diseases. Substantial attention also has been given to the right to assisted suicide.

States have begun to consider a variety of responses to these difficult and complex legal, medical, ethical, and religious issues. Both Oregon and Washington passed laws that permit a terminally ill patient to request and receive medication to end his or her life. Both of these “Death with Dignity Acts” require that the patient be a state resident, be diagnosed by at least two physicians as terminal and within six months of death, be informed of medical options, be competent, and enter into the decision voluntarily. Both also require oral and written requests and two witnesses in addition to the physicians. Both specify that no person shall qualify solely because of age or disability. The Washington statute specifically states that the medication is to be self-administered, but although the intent behind the Oregon statute is for self-administration of medication, it is not explicit in the statute. See ORS §127.800 (2007); Rev. Code Wash. §70.245.010 (2009). Vermont, and California have passed similar measures. See VT. STAT. ANN. Tit. 18 §§5281–5293 (2013); CAL. HEALTH & SAFETY CODE §§443–443.22 (2015).

The Oregon statute took effect in 1997, while the Washington statute took effect in 2009. A study of ten years of experience with the Oregon statute revealed that only 341 persons ended their lives using the Act's protections of the 296,000 who died in Oregon during the same time period. See Dan Colburn, *Death with Dignity Act Applies to Very Few*, THE OREGONIAN (Aug. 5, 2009). There are also a few cases that address the issue. See *Baxter v. State*, 224 P.3d 1211 (Mont. 2009) (vacating a lower court ruling that there is a right to affirmatively end one's life under the Montana constitution, but holding doctors immune from prosecution when the patient consents to a lethal dose of medicine and self-administers the medication that causes death). The question of a right to die under the New Mexico constitution is under consideration by the New Mexico Supreme Court. *Morris v. Brandenburg*, 356 P.3d 564 (N.M. Ct. App. 2015) (overturning lower court's holding that a right exists), writ of certiorari granted, 8/31/15.

There is a question about whether these laws violate Title II of the ADA. A patient who meets the other requirements, but whose condition physically prevents self-administration may argue that the law discriminates against him because of his disability. How would the courts be likely to treat such a challenge? What if an individual who is severely disabled and in extreme pain, but not terminally ill, wishes to have such a prescription? Would the Oregon and Washington statutes be discriminatory on that basis?

The Oregon Death with Dignity Act has received a substantial amount of media attention. Many of its critics are individuals who are severely disabled. These groups sometimes argue that such statutes will be the precursor of statutes permitting euthanasia of individuals with severe disabilities. See *Judge Weighs Suicide Law*, WASHINGTON POST, Dec. 20, 1994, at A8.

The Supreme Court addressed the Oregon Death with Dignity Act, and held that the U.S. Attorney General may not bar dispensing controlled substances used for assisted suicide where there is a medical regime allowing that conduct. See *Gonzales v. Oregon*, 126 S. Ct. 904, 163 L. Ed. 2d 748 (2006).

For discussions of this issue, see Marc C. Siegel, *Lethal Pity: The Oregon Death with Dignity Act, Its Implications for the Disabled, and the Struggle for Equality in an Able-Bodied World*, 16 LAW & INEQ. J. 259 (1998); Stephen L. Mikoichik, *Assisted Suicide and Disabled People*, 46 DEPAUL L. REV. 987 (1997).

**4. End of Life Issues.** A controversial issue with disability rights implications involves who can make decisions about end of life. The Terry Schiavo case in 2005 received substantial media attention and interest by the public. The case involved a dispute between the husband of Terry Schiavo, who wanted to withhold nutrition and hydration because of his acceptance of medical evidence that she no longer had viable brain activity, and Schiavo's parents, who wanted to continue with her feeding tube.



There were a number of judicial decisions addressing various legal theories in this case. One of those decisions was based on disability discrimination law. In *Schiavo v. Schiavo*, 403 F.3d 1289 (11th Cir. 2005), the court held that even if the hospice that cared for Terry Schiavo was a public accommodation, its compliance with the state judge's order to withhold nutrition and hydration was not discrimination on the basis of disability. The court held that neither the ADA nor the Rehabilitation Act was intended to apply to decisions involving the termination of life support or medical treatment. A number of cases have since *Schiavo* held that the ADA and Rehabilitation Act are not applicable to end of life medical decisions. See *Burger v. Bloomberg*, 418 F.3d 882, 883 (8th Cir. 2005); *Fitzgerald v. Corr. Corp. of Am.*, 403 F.3d 1134, 1144 (10th Cir. 2005). Compare *Tidwell v. Stringer*, 2014 U.S. Dist. LEXIS 75773, 2014 WL 2508955, at 3 (S.D. Ala. June 3, 2014) (stating that the cases do not stand for the proposition that the ADA and Rehabilitation Acts do not apply to medical decisions, but rather that, in those cases, the plaintiffs failed to meet the essential elements of their claims).

**5. National Health Care Reform.** There was no question that the country needed health care reform by the time President Obama took office. Nearly 47 million persons lacked insurance, and, therefore, found it difficult to secure health care. President Obama made health care reform one of the primary objectives of his presidency. The Patient Protection and Affordable Care Act ("ACA") was effective on March 23, 2010, and subsequently survived two challenges before the U.S. Supreme Court. People fear the high cost of the health care reform and potential governmental control over health care decisions. One of the greatest fears was that the government would intrude upon end of life decisions, requiring people who are old, sick and disabled to end their lives. While there is little support for this fear in the ACA, rationing of health care is an important issue to discuss. In effect, rationing of health care already occurs. Those who do not have health insurance generally do not get the care they need. A system that covers everyone will necessarily ration care, some say, or otherwise become prohibitively expensive. See Peter Singer, *Why We Must Ration Health Care*, NY TIMES (July 19, 2009). Others argue that cost cutting measures that change how health care is delivered in less expensive and more effective ways are viable alternatives to rationing. See Atul Gawande, et al., *10 Steps to Better Health Care*, NY TIMES (Aug. 13, 2009).

Attorneys General of several states joined to challenge the ACA's constitutionality because of the provision that requires Americans to buy health insurance (the "individual mandate"). In *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012), the Supreme Court held that the individual mandate was unconstitutional under the Commerce Clause and Necessary and Proper Clause powers, but upheld the individual mandate as constitutional under Congress's taxing power. The Court also held that the provision of the ACA that significantly expanded Medicaid was an invalid exercise of Congress's spending power, because it coerced the states to either accept the expansion or lose existing Medicaid funding. Subsequently, the Supreme Court rejected another challenge to the ACA. See *King v. Burwell*, 135 S. Ct. 2480 (2015) (holding that the tax credits for buying insurance under the ACA apply to both the exchanges established by the states and those established by the federal government when states refused to operate such exchanges).

Persons with disabilities have an important stake in the outcome of the health care reform because of their need for medical services. See Jessica L. Roberts, *Health Law as Disability Rights Law*, 97 MINN. L. REV. 1963 (2013), which addresses health care access for individuals with disabilities, and Mary Crossley, *Disability Cultural Competence in the Medical Profession*, 9 J. HEALTH L. & POL'Y 89 (2015). Disability advocates argued that health care reform is necessary, but they urged federal legislators to amend Medicaid to remove its institutional biases. That is, many persons with disabilities can get benefits under Medicaid only if they are living in institutional settings. Advocates argue that community-based care would be superior and less expensive. Thus, advocates urged Congress to pass the Community Living Assistance Services and Supports Act (CLASS) as part of the ACA. It was passed, but was later repealed. A second bill, the Community Choice Act, would have

given support to families with persons with disabilities without forcing them into poverty by permitting them to collect Medicaid, and would remove the institutional bias of Medicaid. It never passed. See Marshall B. Kapp, *Home and Community-Based Long-Term Services and Supports: Health Reform's Most Enduring Legacy?*, 8 ST. LOUIS U.J. HEALTH L. & POL'Y 9, 27–28 (2014) (noting that by October of 2011, the Obama Administration announced that it would cease efforts to implement CLASS, Congress repealed the Act, and the President signed the repealing legislation).

### ***Hypothetical Problem 9.1***

Consider the following hypothetical problem after reading the Supreme Court opinion in *Bragdon v. Abbott* and the lower court's opinion on remand. In determining whether Shanon is a person with a disability, use the definition of disability recently enacted in the ADAAA.

Shanon Burke is a college student who attends State University. She has a history of asthma, and uses medication and an inhaler for her asthma. She returned to college in August 2016 and within a few weeks, there was a rapid spread among the students of the influenza virus. The University Health Services establishes a protocol for isolating students with the virus, which encourages sick students to stay in their room and to have their parents take them home as soon as possible. By mid-October, Shanon begins to feel ill with influenza symptoms of achiness, high fever, listlessness and vomiting. Because of her asthma, she experiences difficulty breathing. Shanon goes to the student health services, but when she arrives, the health services makes her enter through the backdoor into a “waiting room” for students with flu symptoms. Shanon goes into the waiting room, but the nurse tells her that the health services is overwhelmed and that she should call her parents (who live 6 hours away by car) to pick her up and take her home. The nurse also tells her she may go back to her dorm room for the next 8 hours, but that she should notify her roommate to evacuate the room. The nurse calls Shanon's roommate, Maria, and tells her to leave the room until the next day. The school will clean the room after Shanon leaves and then Maria will be permitted to return to the room.

Shanon is very sick and getting sicker by the moment. She calls her parents to find that they are both out of town, and will not be able to pick her up until the next day. Shanon cannot fly home because the FAA has promulgated a temporary rule stating that persons with flu symptoms may not fly. The Health Services refuses to allow Shanon to stay there because they consider Shanon a threat to the health of workers and other students at the Health Services. Shanon explains to the Health Services that her asthma is much worse and that she cannot breathe. Health Services refuses to give Shanon a bed and sends her back to her empty dorm room. Shanon has a bad night, and her parents arrive early the next day. Shanon can barely breathe and her parents rush her to the closest hospital emergency room where they begin to treat Shanon. While Shanon survives, her lungs are seriously damaged and her asthma is much worse as a result of the University Health Services' refusal to treat her.

Does Shanon have an action against the University under Title II or Title III of the ADA or under Section 504 of the Rehabilitation Act? If so, what is the University's best defense? Analyze the arguments the University will make and the response that Shanon's attorney will make when Shanon brings a lawsuit against the University. What type of evidence should the University counsel attempt to find to support its case? What evidence should Shanon's attorney look for to support her case?

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The previous cases addressed discrimination by terminating treatment. Discrimination can occur, of course, in the context of denial of treatment or providing treatment in a segregated setting or only where additional costs are paid. Historically, litigation involving health care discrimination arises most frequently in the context of individuals seeking treatment who have HIV or AIDS. The following case addresses that issue. While previous Supreme Court cases had addressed health care in the context of the Rehabilitation Act, this was the first health care access case decided under the

**Bragdon v. Abbott**

524 U.S. 624 (1998)

JUSTICE KENNEDY delivered the opinion of the Court.

We address in this case the application of the Americans with Disabilities Act of 1990 (ADA) to persons infected with the human immunodeficiency virus (HIV). We granted certiorari to review, first, whether HIV infection is a disability under the ADA when the infection has not yet progressed to the so-called symptomatic phase; and, second, whether the Court of Appeals, in affirming a grant of summary judgment, cited sufficient material in the record to determine, as a matter of law, that respondent's infection with HIV posed no direct threat to the health and safety of her treating dentist.

[Author's Note: This portion of the opinion addresses only whether HIV is a direct threat. The portion regarding whether Sidney Abbott is disabled under the ADA is described in [Chapter 2](#).]

I

Respondent Sidney Abbott has been infected with HIV since 1986. When the incidents we recite occurred, her infection had not manifested its most serious symptoms. On September 16, 1994, she went to the office of petitioner Randon Bragdon in Bangor, Maine, for a dental appointment. She disclosed her HIV infection on the patient registration form. Petitioner completed a dental examination, discovered a cavity, and informed respondent of his policy against filling cavities of HIV-infected patients. He offered to perform the work at a hospital with no added fee for his services, though respondent would be responsible for the cost of using the hospital's facilities. Respondent declined.

The petition for certiorari presented three other questions for review. The questions stated:

3. When deciding under title III of the ADA whether a private health care provider must perform invasive procedures on an infectious patient in his office, should courts defer to the health care provider's professional judgment, as long as it is reasonable in light of then-current medical knowledge?
4. What is the proper standard of judicial review under title III of the ADA of a private health care provider's judgment that the performance of certain invasive procedures in his office would pose a direct threat to the health or safety of others?
5. Did petitioner, Randon Bragdon, D. M. D., raise a genuine issue of fact for trial as to whether he was warranted in his judgment that the performance of certain invasive procedures on a patient in his office would have posed a direct threat to the health or safety of others?

Of these, we granted certiorari only on question three. The question is phrased in an awkward way, for it conflates two separate inquiries. In asking whether it is appropriate to defer to petitioner's judgment, it assumes that petitioner's assessment of the objective facts was reasonable. The central premise of the question and the assumption on which it is based merit separate consideration.

Again, we begin with the statute. Notwithstanding the protection given respondent by the ADA's definition of disability, petitioner could have refused to treat her if her infectious condition “pose[d] a direct threat to the health or safety of others.” 42 U.S.C. §12182(b)(3). The ADA defines a direct threat to be “a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.” *Ibid*. Parallel provisions appear in the employment provisions of Title I. §§12111(3), 12113(b).

The ADA's direct threat provision stems from the recognition in *School Bd. of Nassau Cty. v. Arline*, 480 U.S. 273, 287 (1987), of the importance of prohibiting discrimination against individuals with disabilities while protecting others from significant health and safety risks, resulting, for

instance, from a contagious disease. In *Arline*, the Court reconciled these objectives by construing the Rehabilitation Act not to require the hiring of a person who posed “a significant risk of communicating an infectious disease to others.” Congress amended the Rehabilitation Act and the Fair Housing Act to incorporate the language. It later relied on the same language in enacting the ADA. Because few, if any, activities in life are risk free, *Arline* and the ADA do not ask whether a risk exists, but whether it is significant.

The existence, or nonexistence, of a significant risk must be determined from the standpoint of the person who refuses the treatment or accommodation, and the risk assessment must be based on medical or other objective evidence. As a health care professional, petitioner had the duty to assess the risk of infection based on the objective, scientific information available to him and others in his profession. His belief that a significant risk existed, even if maintained in good faith, would not relieve him from liability. To use the words of the question presented, petitioner receives no special deference simply because he is a health care professional. It is true that *Arline* reserved “the question whether courts should also defer to the reasonable medical judgments of private physicians on which an employer has relied.” At most, this statement reserved the possibility that employers could consult with individual physicians as objective third-party experts. It did not suggest that an individual physician's state of mind could excuse discrimination without regard to the objective reasonableness of his actions.

Our conclusion that courts should assess the objective reasonableness of the views of health care professionals without deferring to their individual judgments does not answer the implicit assumption in the question presented, whether petitioner's actions were reasonable in light of the available medical evidence. In assessing the reasonableness of petitioner's actions, the views of public health authorities, such as the U.S. Public Health Service, CDC, and the National Institutes of Health, are of special weight and authority. The views of these organizations are not conclusive, however. A health care professional who disagrees with the prevailing medical consensus may refute it by citing a credible scientific basis for deviating from the accepted norm.

We have reviewed so much of the record as necessary to illustrate the application of the rule to the facts of this case. For the most part, the Court of Appeals followed the proper standard in evaluating the petitioner's position and conducted a thorough review of the evidence. Its rejection of the District Court's reliance on the Marianos affidavits was a correct application of the principle that petitioner's actions must be evaluated in light of the available, objective evidence. The record did not show that CDC had published the conclusion set out in the affidavits at the time petitioner refused to treat respondent.

A further illustration of a correct application of the objective standard is the Court of Appeals' refusal to give weight to the petitioner's offer to treat respondent in a hospital. Petitioner testified that he believed hospitals had safety measures, such as air filtration, ultraviolet lights, and respirators, which would reduce the risk of HIV transmission. Petitioner made no showing, however, that any area hospital had these safeguards or even that he had hospital privileges. His expert also admitted the lack of any scientific basis for the conclusion that these measures would lower the risk of transmission. Petitioner failed to present any objective, medical evidence showing that treating respondent in a hospital would be safer or more efficient in preventing HIV transmission than treatment in a well-equipped dental office.

We are concerned, however, that the Court of Appeals might have placed mistaken reliance upon two other sources. In ruling no triable issue of fact existed on this point, the Court of Appeals relied on the 1993 CDC Dentistry Guidelines and the 1991 American Dental Association Policy on HIV. This evidence is not definitive. As noted earlier, the CDC Guidelines recommended certain universal precautions which, in CDC's view, “should reduce the risk of disease transmission in the dental environment.” U.S. Dept. of Health and Human Services, Public Health Service, CDC,

Recommended Infection Control Practices for Dentistry. The Court of Appeals determined that, “[w]hile the guidelines do not state explicitly that no further risk-reduction measures are desirable or that routine dental care for HIV-positive individuals is safe, those two conclusions seem to be implicit in the guidelines’ detailed delineation of procedures for office treatment of HIV-positive patients.” In our view, the Guidelines do not necessarily contain implicit assumptions conclusive of the point to be decided. The Guidelines set out CDC’s recommendation that the universal precautions are the best way to combat the risk of HIV transmission. They do not assess the level of risk.

Nor can we be certain, on this record, whether the 1991 American Dental Association Policy on HIV carries the weight the Court of Appeals attributed to it. The Policy does provide some evidence of the medical community’s objective assessment of the risks posed by treating people infected with HIV in dental offices. It indicates:

Current scientific and epidemiologic evidence indicates that there is little risk of transmission of infectious diseases through dental treatment if recommended infection control procedures are routinely followed. Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed. Such infection control procedures provide protection both for patients and dental personnel.

We note, however, that the Association is a professional organization, which, although a respected source of information on the dental profession, is not a public health authority. It is not clear the extent to which the Policy was based on the Association’s assessment of dentists’ ethical and professional duties in addition to its scientific assessment of the risk to which the ADA refers. Efforts to clarify dentists’ ethical obligations and to encourage dentists to treat patients with HIV infection with compassion may be commendable, but the question under the statute is one of statistical likelihood, not professional responsibility. Without more information on the manner in which the American Dental Association formulated this Policy, we are unable to determine the Policy’s value in evaluating whether petitioner’s assessment of the risks was reasonable as a matter of law.

The court considered materials submitted by both parties on the cross motions for summary judgment. The petitioner was required to establish that there existed a genuine issue of material fact. Evidence which was merely colorable or not significantly probative would not have been sufficient.

We acknowledge the presence of other evidence in the record before the Court of Appeals which, subject to further arguments and examination, might support affirmance of the trial court’s ruling. For instance, the record contains substantial testimony from numerous health experts indicating that it is safe to treat patients infected with HIV in dental offices. We are unable to determine the import of this evidence, however. The record does not disclose whether the expert testimony submitted by respondent turned on evidence available in September 1994.

There are reasons to doubt whether petitioner advanced evidence sufficient to raise a triable issue of fact on the significance of the risk. Petitioner relied on two principal points: [f]irst, he asserted that the use of high-speed drills and surface cooling with water created a risk of airborne HIV transmission. The study on which petitioner relied was inconclusive, however, determining only that “[f]urther work is required to determine whether such a risk exists.” Petitioner’s expert witness conceded, moreover, that no evidence suggested the spray could transmit HIV. His opinion on airborne risk was based on the absence of contrary evidence, not on positive data. Scientific evidence and expert testimony must have a traceable, analytical basis in objective fact before it may be considered on summary judgment.

Second, petitioner argues that, as of September 1994, CDC had identified seven dental workers with possible occupational transmission of HIV. These dental workers were exposed to HIV in the course of their employment, but CDC could not determine whether HIV infection had resulted. It is now known that CDC could not ascertain whether the seven dental workers contracted the disease because they did not present themselves for HIV testing at an appropriate time after their initial

exposure. It is not clear on this record, however, whether this information was available to petitioner in September 1994. If not, the seven cases might have provided some, albeit not necessarily sufficient, support for petitioner's position. Standing alone, we doubt it would meet the objective, scientific basis for finding a significant risk to the petitioner.

We conclude the proper course is to give the Court of Appeals the opportunity to determine whether our analysis of some of the studies cited by the parties would change its conclusion that petitioner presented neither objective evidence nor a triable issue of fact on the question of risk. In remanding the case, we do not foreclose the possibility that the Court of Appeals may reach the same conclusion it did earlier. A remand will permit a full exploration of the issue through the adversary process.

The determination of the Court of Appeals that respondent's HIV infection was a disability under the ADA is affirmed. The judgment is vacated, and the case is remanded for further proceedings consistent with this opinion.

### *Notes and Questions*

1. On remand, the Court of Appeals in *Bragdon* once again held that there was inadequate evidence of a direct threat, and affirmed the grant of summary judgment to the plaintiff. The court stated:

In compliance with the Court's directive, we have reexamined the evidence to determine whether summary judgment was warranted. In order to reverse our course, we would have to find, contrary to our original intuition, either that (i) Ms. Abbott did not merit judgment as a matter of law even in the absence of disputed facts, or (ii) that Dr. Bragdon had submitted sufficient evidence to create a genuine issue of material fact as to his direct threat defense. In our reexamination, we apply conventional summary judgment jurisprudence, drawing all reasonable factual inferences in favor of Dr. Bragdon. Despite the leniency of this approach, we do not indulge "conclusory allegations, improbable inferences, and unsupported speculation."

#### *A. Ms. Abbott's Evidence.*

The Supreme Court raised questions regarding whether the Guidelines, which state that use of the universal precautions therein described "should reduce the risk of disease transmission in the dental environment," necessarily imply that the reduction of risk would be to a level below that required to show direct threat. We have reconsidered this point.

The CDC did not write the 1993 Guidelines in a vacuum, but, rather, updated earlier versions issued in 1986 and 1987, respectively. The 1986 text calls the universal precautions "effective for preventing hepatitis B, acquired immunodeficiency syndrome, and other infectious diseases caused by bloodborne viruses." The 1987 edition explains that use of the universal precautions eliminates the need for additional precautions that the CDC formerly had advocated for handling blood and other bodily fluids known or suspected to be infected with bloodborne pathogens. Neither the parties nor any of the amici have suggested that the 1993 rewrite was intended to retreat from these earlier risk assessments, and we find no support for such a position in the Guidelines' text. Thus, we have again determined that the Guidelines are competent evidence that public health authorities considered treatment of the kind that Ms. Abbott required to be safe, if undertaken using universal precautions.

Second, the Court questioned the appropriate weight to accord the Policy, expressing concern that the Policy might be based in whole or in part on the Association's view of dentists' ethical obligations, rather than on a pure scientific assessment. The supplemental briefing that we requested yielded a cornucopia of information regarding the process by which the Policy was assembled. We briefly recount the undisputed facts.

The Association formulates scientific and ethical policies by separate procedures, drawing on different member groups and different staff complements. The Association's Council on Scientific Affairs, comprised of 17 dentists (most of whom hold advanced dentistry degrees), together with a

staff of over 20 professional experts and consultants, drafted the Policy at issue here. By contrast, ethical policies are drafted by the Council on Ethics, a wholly separate body. Although the Association's House of Delegates must approve policies drafted by either council, we think that the origins of the Policy satisfy any doubts regarding its scientific foundation.

For these reasons, we are confident that we appropriately relied on the Guidelines and the Policy. Moreover, as the Supreme Court acknowledged, these two pieces of evidence represent only a fraction of the proof advanced to support Ms. Abbott's motion. For example, she proffered the opinions of several prominent experts to the effect that, in 1994, the cavity-filling procedure could have been performed safely in a private dental office, as well as proof that no public health authority theretofore had issued warnings to health care providers disfavoring this type of treatment for asymptomatic HIV-positive patients. These materials, in and of themselves, likely suffice to prove Ms. Abbott's point. Thus, we again conclude, after due reevaluation, that Ms. Abbott served a properly documented motion for summary judgment.

#### *B. Dr. Bragdon's Evidence.*

We next reconsider whether Dr. Bragdon offered sufficient proof of direct threat to create a genuine issue of material fact and thus avoid the entry of summary judgment. In *Abbott II*, we canvassed eight items of evidence adduced by Dr. Bragdon in an effort to demonstrate a genuine issue of material fact. The Supreme Court suggested that one such piece of evidence—the seven cases that the CDC considered “possible” HIV patient-to-dental worker transmissions—should be reexamined.

The Court's concern revolved around how the word “possible” was understood in this context at the relevant time. To frame the issue, the Court noted that the CDC marks an HIV case as a “possible” occupational transmission if a stricken worker, who had no other demonstrated opportunity for infection, simply failed to present himself for testing after being exposed to the virus at work. The Court speculated that if this definition of “possible” was not available in September 1994, the existence of seven “possible” cases “might have provided some, albeit not necessarily sufficient, support for [Dr. Bragdon's] position.” In other words, if a dentist knew of seven “possible” occupational transmissions to dental workers without understanding that “possible” meant no more than that the CDC could not determine whether workers were infected occupationally, he might reasonably regard the risk of treating an HIV-infected patient to be significant.

Upon reexamination of the record, we find that the CDC's definition of the word “possible,” as used here, had been made public during the relevant period. The record contains two scientific articles published before Ms. Abbott entered Dr. Bragdon's office which explained this definition. Since an objective standard pertains here, the existence of the list of seven “possible” cases does not create a genuine issue of material fact as to direct threat.

In his supplemental briefing and oral argument, Dr. Bragdon has drawn our attention again to the CDC's report of 42 documented cases of occupational transmission of HIV to health-care workers (none of whom were dental workers). He repeats his argument that, because dental workers are subject to dangers similar to those faced by other health-care workers, these cases can be extrapolated to create an issue of fact as to the degree of risk to dental workers in September 1994. We previously held that this evidence was insufficient without a documented showing that the risks to dentists and other health-care workers are comparable, and the appellant offers us no cogent reason to change our view. The Supreme Court did not question our position on this front, and Dr. Bragdon points to no record support that we previously might have overlooked.

Our assessment of Dr. Bragdon's, and his amici's, other reprised arguments similarly remains unchanged. Each piece of evidence to which they direct us is still “too speculative or too tangential (or, in some instances, both) to create a genuine issue of material fact.”

2. Once the hospital is on notice that a physician to whom it extends practice privileges is discriminating against individuals with disabilities, is the hospital also in violation of the ADA if it continues to extend privileges to that physician? Even if the physician is not subject to Section 504, if discriminatory conduct by a physician with privileges is made known to the hospital, does it have an obligation to investigate and to take appropriate action? If it fails to do so, is it in violation of Section 504? See also *Doe v. Jamaica Hosp.*, 202 A.D.2d 386, 608 N.Y.S.2d 518 (1994) (physician who refused to treat a patient with AIDS would not be subject to §504 because the physician did not receive federal financial assistance).

3. Would it matter whether both the ADA and Section 504 were being violated? Which avenue of redress should be used? Why?

4. *Medical Care for Patients with HIV*. In addition to *Bragdon*, there have been a number of other decisions where courts have found violations of the ADA or Section 504 by health care providers who refused to treat individuals with HIV. In *Miller v. Spicer*, 822 F. Supp. 158 (D. Del. 1993), the court held that there was a violation of Section 504 when an emergency room surgeon refused to treat an individual whom he thought to be HIV-positive. A complaint against Philadelphia emergency medical technicians and firefighters involved a refusal to assist people with AIDS. Part of the settlement included an agreement to undergo AIDS awareness training. *U.S. Department of Justice Complaint No. 204-62-24* (settled March 18, 1994). A refusal to treat an HIV-positive patient cost a dental care center \$100,000 in damages and penalties. The settlement with the Department of Justice also included an agreement to establish a policy prohibiting bias on the basis of AIDS and staff training. *United States v. Castle Dental Soc'y*, No. CA-H933140 (S.D. Tex., settled Sept. 22, 1994). See also LAURA ROTHSTEIN & JULIA IRZYK, *DISABILITIES AND THE LAW* §10.04 (2012 and cumulative supplement).

In *Lesley v. Hee Man Chie*, 250 F.3d 47 (1st Cir. 2001), the court held that a pregnant woman who was transferred to a different hospital after testing HIV positive was not discriminated against because she was unable to show that the transfer was not linked to legitimate medical necessity. In *Green v. City of Welch*, 467 F. Supp. 2d 656 (S.D. W. Va. 2006), the court allowed a suit to go forward where the estate of a man with HIV claimed CPR assistance was denied to the decedent because of his HIV status. For other cases, see LAURA ROTHSTEIN & JULIA IRZYK, *DISABILITIES AND THE LAW* §10:2 (2012 and cumulative supplement).

## **C. Architectural Barriers, Auxiliary Aids and Services, and Reasonable Accommodation**

The previous section highlights situations in which an individual with a disability might be refused or denied health care services because of prejudices of the provider. While this may often be the case of individuals with HIV or with individuals with intellectual disabilities, the more common barrier to health care service access involves architectural barriers and the need for reasonable accommodations, including auxiliary aids and services or other accommodations.

It is probable that most major health care programs, such as hospitals and clinics, have accessible ramped entrances, because wheelchairs and gurneys are commonly used in these facilities. These facilities are also likely to be accessible with respect to restrooms and other similar facilities. The facilities that are less likely to be accessible are health care offices located in the residence of the provider or in commercial facilities other than hospitals and clinics.

Although most major hospitals are recipients of federal financial assistance, individual physicians and other health care providers, as a general rule, are not. For that reason, the Americans with Disabilities Act is substantially more comprehensive in its protection of individuals with disabilities than Section 504 of the Rehabilitation Act. The physical facility access requirements are much



stronger under the ADA, as [Chapter 4](#) on Public Accommodations illustrates. A private health care provider such as a doctor's office or clinic generally would fall within the definition of a “public accommodation” under Title III of the ADA, and thus would be required to remove barriers to the extent it is readily achievable to do so, in addition to being required to make new construction accessible. The importance of access to health care providers is recognized in the regulations relating to *new construction and alterations* of buildings that are to be used for public accommodations. There is an exemption that allows certain of these facilities to be built without an elevator, where the facility has fewer than three stories or has less than 3,000 square feet per story. 28 C.F.R. §36.401(d). This exemption does *not* apply, however, when the facility is intended to be used for professional offices of health care providers. The guidance explains this regulation:

A public accommodation, such as the professional office of a health care provider, is required to remove architectural barriers to its facility to the extent that such barrier removal is readily achievable (see §36.304), but it is not otherwise required by this part to undertake new construction or alterations. This part does not require that an existing two story building that houses the professional office of a health care provider be altered for the purpose of providing elevator access. If, however, alterations to the area housing the office of the health care provider are undertaken for other purposes, the installation of an elevator might be required, but only if the cost of the elevator is not disproportionate to the cost of the overall alteration. Neither the Act nor this part prohibits a health care provider from locating his or her professional office in an existing facility that does not have an elevator.

28 C.F.R. pt. 36, App. C, §36.404.

By contrast to the ADA, Section 504 of the Rehabilitation Act only applies to recipients of federal financial assistance, such as hospitals. Before the passage of the ADA, these facilities were required to be accessible when viewed in their entirety. Under the ADA, if the facility is operated by a state or local governmental entity, Title II accessibility requirements would apply. If the facility is privately operated, Title III would apply in many instances.

Because the ADA requirement that elevators be built for new construction or alterations of health care facilities may not reach existing health care facilities, and the Rehabilitation Act's application only to facilities receiving federal financial assistance, a wheelchair user who wants to visit a dentist office on the second floor of an old building without an elevator may have no remedy under the ADA or the Rehabilitation Act. Under both statutes, however, the service providers may be expected to relocate a visit as an accommodation (such as a lawyer meeting in an alternative location). This will be unlikely to work, however, in the instance of health care providers whose unique equipment cannot be easily moved.

The ADA regulations also provide guidance on places of public accommodation in private residences. They require that the portions of the residence used exclusively for the residence need not meet access requirements. Those portions that are used as public accommodations, however, must meet access requirements in areas including the front sidewalk, the entrance, and portions of the residence (including restrooms) used by the public. 28 C.F.R. Section 36.207.

A related challenge for individuals with mobility and similar impairments can be that the health care office is accessible with respect to getting in and around the facility, but the equipment is not accessible. Special chairs for eye exams and dental treatment, for example, may be difficult to use for someone with a mobility impairment. Examination tables may be technically “accessible,” but the providers may not be experienced at assisting individuals with spinal cord injuries in getting on and off a table for routine medical types of exams, such as annual gynecological exams.

With the advent of managed care, individuals with disabilities who have chronic health care needs face unique obstacles. In many managed care programs, the selection of physicians is limited, as is access to specialists without going through the primary care physician. An individual with mobility

impairments may have particular difficulties if the offices of the listed providers are not accessible. Even if they are accessible, transportation difficulties may be a severe barrier. The bus system may not be completely accessible, and even if it is accessible, substantially more time might be required to use an accessible transportation system. In addition, although the entrance to the provider's office might be accessible, fixed equipment, such as a dental chair, might not be accessible for an individual with a mobility impairment. In *Anderson v. Department of Pub. Welfare*, 1 F. Supp. 2d 456 (E.D. Pa. 1998), the court held that health maintenance providers must ensure that the services viewed in their entirety are accessible, but this does not resolve many of the details about what that means.

There is minimal case law to provide guidance on physical access in health care provider facilities. Relevant litigation revolves around what constitutes a third floor and what constitutes an “alteration” for purposes of the ADA to trigger compliance. There are, however, some settlements of lawsuits. See 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, 33–37 (2008) (discussing several lawsuits raising these issues that have settled and noting “there are relatively few cases brought challenging inaccessible facilities or equipment in the context of medical care” and “[t]he paucity of private actions is unfortunate, but not surprising.”); Elizabeth Pendo, *Reducing Disparities Through Health Care Reform: Disability and Accessible Medical Equipment*, 2010 UTAH L. REV. 1057 (providing additional details on lawsuits that have settled in this area, including ones for architectural barriers and inaccessible equipment). There is also some judicial guidance on the issue of reasonable accommodations in the health care provider context.

One area that has received substantial judicial attention involves the issue of providing interpreter service to individuals who are deaf at hospitals and in other health care settings. The issue can involve the feasibility of ensuring that appropriate communication services are available as well as the cost for providing such services.

### ***Hypothetical Problem 9.2***

Read the following hypothetical Problem, and, after reading *Aikens* and *Mayberry*, prepare to discuss the problem.

Charlie Cortez is a two year old child who was born with a hearing impairment. Charlie's parents, Anna and Mario Cortez, do not have hearing impairments. They suspect there is something wrong with Charlie's hearing because he does not react to loud noises and because his speech is delayed. They go to a group of doctors in Los Angeles who specialize in hearing difficulties to have Charlie diagnosed. The diagnosis is that Charlie has a hearing impairment, and that a device called the cochlear implant would improve his hearing. The doctor they see, Jon Walter, recommends that Anna and Mario take Charlie to Dr. Hugh Malloy, who he believes is one of the best ear surgeons in the City. Dr. Walter tells Anna and Mario that Dr. Malloy has a hearing impairment himself and that he has a son with a hearing impairment. When Anna and Mario take Charlie to see Dr. Malloy, through an interpreter, he tells them that Charlie would likely be able to hear fairly well and would develop good speech habits if had a cochlear implant. Dr. Malloy, however, tells them that he will not do the surgery on Charlie. He believes that persons with deafness from birth should learn to sign and read lips and to become part of the community of persons who are deaf. The device will keep Charlie from that experience, and it is Malloy's practice to refuse to give children cochlear implants because, although he had his own son get a cochlear implant, he believes it is more harmful than not having the cochlear implant because of the separation from the deaf community. Anna and Mario are very upset and want to force Dr. Malloy to perform the surgery because they know he is the best ear surgeon in town. When he refuses, they visit a lawyer to see if they have a cause of action of discrimination against Dr. Malloy based on the ADA. Consider the different arguments the plaintiffs' and defendant's lawyers would make in this case. Would it make a difference if Dr. Malloy were the only specialist in town who knew how to put in cochlear implants?

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The following two cases raise the issue in different contexts. First, in *Aikins*, the court addressed the obligation in a hospital setting, including liability issues related to both the hospital and the treating physician. The *Mayberry* decision looks at the issue with respect to the individual health care provider.

**Aikins v. St. Helena Hospital**  
843 F. Supp. 1329 (N.D. Cal. 1994)

FERN M. SMITH, DISTRICT JUDGE:

Background

The events giving rise to this lawsuit occurred between October 30 and November 4, 1992. Mrs. Aikins is a deaf woman whose husband, Harvey Aikins, suffered a massive cardiac arrest at approximately 8:00 p.m. on October 30, 1992. Following Mr. Aikins's attack, Mrs. Aikins went to the home of some neighbors and had them call 911. According to Mrs. Aikins, the paramedics arrived at her home approximately four minutes after the call to 911, which defendants assert was approximately fifteen minutes after Mr. Aikins suffered the attack. The paramedics then transported Mr. Aikins to St. Helena Hospital.

Dr. Lies was working in St. Helena's emergency room when Mr. Aikins was brought in. Dr. Lies is an independent contractor on staff at the hospital. He exercises no authority over hospital policy. When the paramedics informed Dr. Lies that they had arrived within four minutes of Mr. Aikins's attack, Dr. Lies decided to perform an emergency angioplasty. He attempted to consult Mrs. Aikins and to obtain her consent, but Mrs. Aikins could not understand him and requested that interpreters be provided. A hospital operator with some knowledge of fingerspelling was summoned and attempted to fingerspell Dr. Lies's comments for Mrs. Aikins. The woman became frustrated, however, and gave up her efforts within a minute. Shortly thereafter, Mrs. Aikins's neighbors arrived and attempted to mediate between Dr. Lies and Mrs. Aikins. Dr. Lies asserts that the neighbors "were quite able to communicate with [Mrs. Aikins]" and relayed to her his opinion that, with immediate medical intervention, Dr. Lies might be able to save Mr. Aikins's life. Mrs. Aikins submits that the neighbors only passed her a terse note stating that Mr. Aikins may have had a massive cardiac arrest and that he was "brain dead."

Subsequently, Mrs. Aikins went to the hospital's administrative office and made further attempts to secure interpreter services. At approximately 9:00 p.m., she was approached by a member of the hospital staff who sought to obtain her signature on forms consenting to the emergency procedure. Although the forms say that "[y]our signature on this form indicates ... (2) that the operation procedure set forth above has been adequately explained to you by your physician, (3) that you have had a chance to ask questions, [and] (4) that you have received all of the information you desire concerning the operation or procedure....," Mrs. Aikins claims that she was told only that "Dr. Lies needed [her] signature to permit him to perform surgery to save [her] husband's life." Dr. Lies claims that, although he believed that it was unnecessary under the circumstances to obtain Mrs. Aikins's consent to the surgery, "given [her] disability, [he] wanted her to be involved."

Later that evening, Dr. Lies contacted Mrs. Aikins's daughter, Francine Stern, to request that she fly up to Calistoga from Los Angeles to help her mother. Ms. Stern, who was Mr. Aikins's stepdaughter, is a fluent signer. Ms. Stern told Dr. Lies that she would be unable to come up until November 2nd.

Mrs. Aikins went to her husband's room at approximately 12:30 on the night of the operation. She claims that the nurse on duty told her that Mr. Aikins would not survive without life support and that Mrs. Aikins then requested that life support be discontinued. She then went to the administrative office, accompanied by a deaf friend, to request interpreter services again. Both the office and another

nurse whom Mrs. Aikins and her friend later encountered in Mr. Aikins's room allegedly told Mrs. Aikins that the hospital had no means of procuring interpreter services.

The following day, October 31, 1992, Mr. Aikins showed no neurologic improvement, prompting Dr. Lies to question Mrs. Aikins about the length of time between the heart attack and the arrival of the paramedics. Dr. Lies submits that it was during this questioning, seemingly conducted through Mrs. Aikins's in-laws, that he first learned that fifteen minutes, not four, had elapsed between Mr. Aikins's heart attack and the commencement of CPR. Based on this new information, Dr. Lies ordered an EEG. The EEG was performed on November 1, 1992, at 9:00 a.m. and revealed that Mr. Aikins had no brain activity.

On November 2nd, Mrs. Aikins's daughter arrived and participated in a meeting with Dr. Lies and Mrs. Aikins. Mrs. Aikins claims that this meeting was the first opportunity that she had to communicate directly with Dr. Lies and to receive complete answers to her questions. As a result of the meeting, Mrs. Aikins requested that her husband's life support be discontinued. Mr. Aikins died two days later.

## Discussion

### *I. Plaintiffs' Standing to Seek Injunctive Relief*

Defendants have challenged CAD's [California Association of the Deaf] standing to participate in this lawsuit.

The Supreme Court has developed a three-part test for standing, a constitutional prerequisite growing out of Article III's "case or controversy" requirement. See U.S. Const. art. III, §2, cl. 1. The first prong of the test is the "injury in fact" requirement: "[T]he plaintiff must have suffered an 'injury in fact'—an invasion of a legally-protected interest which is (a) concrete and particularized; and (b) 'actual or imminent, not "conjectural" or "hypothetical."'" The second and third elements of the test are causation and redressability. As it is clear that defendants caused whatever violation of the relevant statutes may have occurred, and that a favorable decision of this Court would redress any injuries caused by violation of the statutes, only the first aspect of the inquiry is at issue here.

*City of Los Angeles v. Lyons*, 461 U.S. 95 (1983), established that a plaintiff seeking injunctive relief premised upon an alleged past wrong must demonstrate a "real and immediate threat" of repeated future harm to satisfy the injury in fact prong of the standing test.

Mrs. Aikins has not shown her standing to seek injunctive relief under *Lyons*. In her complaint, Mrs. Aikins alleges only that she is a deaf individual and within the protection of the ADA, the Rehabilitation Act, and various state statutes. Mrs. Aikins further states that she owns a mobile home seven miles from St. Helena Hospital and that she stays at the home for several days each year. These allegations do not establish the "real and immediate threat" of future harm that *Lyons* requires. Mrs. Aikins has shown neither that she is likely to use the hospital in the near future, nor that defendants are likely to discriminate against her when she does use the hospital. The Court cannot infer from Mrs. Aikins's limited experience with Dr. Lies and St. Helena Hospital that defendants routinely fail to comply with applicable anti-discrimination statutes.

Plaintiffs rely on *Greater Los Angeles Council on Deafness, Inc., et al., Plaintiffs-Appellants, v. Malcolm Baldrige*, 827 F.2d at 1353, to establish their standing for injunctive relief. In that case, plaintiffs were GLAD, a nonprofit organization dedicated to furthering the interests of deaf and hearing-impaired individuals, an attorney for GLAD who had filed an administrative complaint with the Department of Commerce, and two deaf individuals acting on their own behalf and as representatives of a class of similarly situated persons. Plaintiffs sought a writ of mandamus against the Department of Commerce, alleging that the department had failed to act on an administrative complaint that charged a public television station with violation of the Rehabilitation Act for failure to provide closed-captioned hearing. Plaintiffs alleged that the department's failure to act on the

complaint was itself a violation of the Act. In holding that plaintiffs had standing to pursue their claim for injunctive relief, the Ninth Circuit noted that “[t]he actual or threatened injury required by Article III may exist solely by virtue of a statute that creates legal rights, the invasion of which creates standing.” The court found that the Rehabilitation Act was such a statute.

*Council on Deafness* is distinguishable from this case. Implicitly at issue in that case was whether defendant's alleged violation of the Rehabilitation Act was an “injury in fact” sufficient to confer standing on plaintiffs. If the claimed violation constituted an injury, there was no question as to the imminence of the harm occasioned by the injury. Plaintiffs had filed an administrative complaint, on which defendant had failed to act; thus, the claimed injury was ongoing. Here, by contrast, imminence has not been shown. Although an alleged violation of the ADA and the Rehabilitation Act is an injury sufficient to give rise to an Article III case or controversy, Mrs. Aikins has not shown that defendants' alleged discrimination is ongoing and that she is likely to be served by defendants in the near future. Mrs. Aikins's claims for injunctive relief are accordingly dismissed with leave to amend to show that Mrs. Aikins faces a real and immediate threat of future injury at the hands of defendants.

CAD's standing to seek injunctive relief suffers from the same defects. An association seeking to bring suit on behalf of its members must show: (1) that its members would have standing to sue in their own right; (2) that the interests that it seeks to protect are germane to the organization's purpose; and (3) that neither the claim asserted nor the relief requested require the participation of individual members. CAD has alleged only that it is a nonprofit organization with at least eight hundred members, organized for the purpose of serving the needs of deaf individuals “through advocacy, education and referral,” and that some members of CAD “have been or likely will be served by defendants....” Although these allegations are sufficient to satisfy the second and third requirements for associational standing, they fail to show that CAD's members would have standing to sue in their own right. CAD's claims are accordingly dismissed with leave to amend to show standing to seek injunctive relief only.

#### Plaintiffs' Claims under the Americans with Disabilities Act

Plaintiffs claim that defendants violated the Americans with Disabilities Act (“ADA”) by denying Mrs. Aikins access to information in connection with the treatment of her husband. The ADA provides, in pertinent part: “No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.” 42 U.S.C. §12182(a).

##### A. *The ADA Does Not Apply to Dr. Lies*

Dr. Lies contends that plaintiffs' claims against him under the ADA must fail because the Act does not apply to him in his capacity as an independent contractor with St. Helena. The regulations implementing the ADA alter the language of the statute slightly to read as follows: “No individual shall be discriminated against on the basis of disability ... by any private entity who owns, leases (or leases to), or operates a place of public accommodation.” 28 C.F.R. §36.201(a) (1993). The preamble to the regulation notes that the change was designed to make clear that the regulation “places the ADA's nondiscrimination obligations on ‘public accommodations’ rather than on ‘persons’ or ‘places of public accommodation.’” 36 C.F.R. App. B §36.104 (1993).

The statute and the regulation both indicate that individuals may be liable under the ADA if they “own, lease (or lease to), or operate” a place of public accommodation. 42 U.S.C. §12182(a); 28 C.F.R. §35.201(a) (1993). The use of language relating to ownership or operation implies a requirement of control over the place providing services. Dr. Lies, however, is an independent contractor with St. Helena. He is not on the hospital's board of directors, and he has no authority to enact or amend hospital policy. Because he lacks the power to control hospital policy on the use of

interpreters, this Court holds that Dr. Lies is not a proper defendant under the ADA.

Plaintiffs contend that this construction of the ADA undercuts the Act's purpose. Noting that the Act defines "public accommodation" to include the "professional office of a health care provider," 42 U.S.C. §12181(7)(F), plaintiffs maintain that the Act would clearly cover Dr. Lies had he provided services to Mr. and Mrs. Aikins at his own office. They argue that he should not be able to escape liability under the ADA merely because in this case he provided services outside his office. "To hold otherwise," plaintiffs suggest, "would allow individuals to discriminate whenever they provide part of their services outside of their place of public accommodation while disallowing the very same type of discrimination for those services provided at the place of public accommodation."

Plaintiffs' policy argument does not warrant a departure from the statute's implicit requirement of ownership or control. The Court's construction of the Act is not at odds with the ADA's fundamental purpose of eliminating discrimination against individuals with disabilities, see 42 U.S.C. §12101(b) (1), because it retains accountability for those in a position to ensure nondiscrimination.

*B. St. Helena Has Not Shown That It Complied with the Act as a Matter of Law*

St. Helena does not dispute that the ADA applies to it, see 42 U.S.C. §12181(7)(F), but claims that it complied with the Act as a matter of law. Alternatively, St. Helena argues that compliance is excused, as it would impose an undue burden on the hospital. The regulations implementing the ADA provide that a "public accommodation shall furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities." 28 C.F.R. §36.303(c) (1993). This requirement is tempered by the general qualification that a public accommodation may treat disabled individuals in need of auxiliary aids and services differently from other individuals if "the public accommodation can demonstrate that [ensuring equality of treatment] would ... result in an undue burden, i.e., significant difficulty or expense." §36.303(a) (1993).

St. Helena bases its contention that it complied with the ADA as a matter of law on the following evidence and allegations: that its human resources department had in place a policy of providing interpreters to those in need of them; that the hospital posted signs notifying the public that information about T.D.D. services could be obtained by going to the switchboard; that the switchboard operator and the office of human resources maintained lists of interpreters; that Mr. Aikins's medical records contain a statement that "there were interpreters present at all times during the discussion with the patient and the family"; and that "the complaint is replete with descriptions of instances where information was exchanged between plaintiff Aikins and members of the St. Helena hospital staff." Defendant argues alternatively that provision of an interpreter on a twenty-four hour a day basis would impose an undue burden on the hospital.

The record does not reveal that St. Helena complied with the ADA as a matter of law. St. Helena has not demonstrated that it communicated effectively with plaintiff Aikins during her husband's stay in the hospital. Indeed, the hospital's allegations that communication was effective are undercut not only by plaintiff's own account of the episode but also by the fact that, for between twenty-four to thirty-six hours, Dr. Lies was under the concededly mistaken impression that Mr. Aikins had been without CPR for only four minutes following his heart attack, a critical fact. Furthermore, although the regulations provide that the hospital "shall furnish" appropriate auxiliary aids and services for non-hearing individuals, §36.303(c), it appears that St. Helena relied almost exclusively on Mrs. Aikins to provide her own interpreters. There exists a genuine dispute as to the issue of St. Helena's compliance with the ADA.

Finally, the Court cannot say as a matter of law that provision of interpreters would have imposed an undue burden on the hospital. The regulations set out criteria for determining whether a proposed accommodation imposes an undue burden within the meaning of section 36.303(a). Section 36.104 provides, in pertinent part:

In determining whether an action would result in an undue burden, factors to be considered include —(1) The nature and cost of the action needed under this part; (2) The overall financial resources of the site or sites involved in the action; the number of persons employed at the site; the effect on expenses and resources; legitimate safety requirements that are necessary for safe operation ...; or the impact otherwise of the action upon the operation of the site; (3) The geographic separateness, and the administrative or fiscal relationship of the site or sites in question to any parent corporation or entity; (4) If applicable, the overall financial resources of any parent corporation or entity; the overall size of the parent corporation or entity with respect to the number of its employees; the number, type, and location of its facilities; and (5) If applicable, the type of operation or operations of any parent corporation or entity, including the composition, structure, and functions of the workforce of the parent corporation or entity.

§36.104 (1993). The question whether provision of interpreter services on some basis would pose an undue burden on St. Helena raises material issues of fact.

*Dobard v. San Francisco Bay Area Rapid Transit District*, 1993 U.S. Dist. LEXIS 13677, 3 Am. Disabilities Cas. (BNA) 203 (N.D. Cal. Sept. 7, 1993), cited by defendant, does not warrant a different conclusion. In that case defendant transit authority provided plaintiff with both a sign language interpreter and a sound amplification device in connection with his attendance at a public board meeting. Plaintiff argued that defendant nonetheless violated the ADA by refusing to provide plaintiff with a computer aided transcription device, the auxiliary aid of his choice. The court in *Dobard* found that plaintiff had failed to state a claim for violation of the ADA, as defendant was not required to employ the most advanced technology but only to ensure that communication was effective. Plaintiffs herein are not arguing for an absolute right to a particular auxiliary aid. Rather, they claim a right to effective communication with the hospital. St. Helena, unlike the defendant in *Dobard*, allegedly made no effort to provide Mrs. Aikins with auxiliary aids, relying upon Mrs. Aikins to marshal her own communication resources.

### III. Plaintiffs' Claims under the Rehabilitation Act

#### A. Mrs. Aikins is an “Otherwise Qualified” Individual Within the Meaning of the Act

[Dr. Lies apparently concedes that he is subject to Section 504 by receiving Medicare and Medicaid reimbursements.]

Defendant Lies argues that plaintiffs' claims under section 504 should be dismissed because plaintiff Aikins is not an “otherwise qualified” individual within the meaning of the Act.

[In another decision] the Second Circuit concluded that the Act applies to all services offered by a covered entity, not just those relating to the entity's central function. “The fact that a particular recipient institution is primarily engaged in the provision of one category of service does not exempt it from Regulation 104.3(k) in its provision of other services.”

Although [that decision] is not binding upon this Court, its reasoning is sound. That Mrs. Aikins was not a patient at St. Helena should not preclude her from raising claims under the Rehabilitation Act based on the hospital's failure to communicate effectively with her in connection with its treatment of her husband. Mrs. Aikins was “otherwise qualified” to discuss her husband's condition with hospital officials, including Dr. Lies.

Defendant Lies next argues that California law precludes Mrs. Aikins from being “otherwise qualified” in the circumstances presented by this case. He submits that Mrs. Aikins's consent to the procedures performed on her husband was not necessary; as a consequence she was not required to be consulted or kept informed of her husband's condition. Defendant attempts to analogize from *Bowen v. American Hospital Association*, 476 U.S. 610 (1986), wherein a plurality of the Court stated that a “hospital's withholding of treatment when no parental consent has been given cannot violate §504.” The plurality reasoned that, in the absence of the required parental consent, the infant is neither

“otherwise qualified” within the meaning of the Act, nor denied treatment “solely because of his handicap.” Defendant maintains that Mrs. Aikins is not “otherwise qualified” because her consent to her husband's treatment was not required.

Defendant's argument is unavailing. Dr. Lies's argument that emergency circumstances vitiated the requirement of informed consent is undercut by his own statement that, “[t]hough it was clear to me that Mr. Aikins presented an immediate medical emergency, thus making informed consent unnecessary, I had time to, and so did seek to, advise Mrs. Aikins and obtain her consent.” Having undertaken to obtain Mrs. Aikins's consent, defendant was obligated to do so in a nondiscriminatory manner. More important, Mrs. Aikins's claims relating to inadequate communication span a period of almost seventy-two hours, from the time of her husband's admission to the hospital until the time that his life support was disconnected. Whatever emergency existed at the time of Mr. Aikins's admission to the hospital had subsided by the time the decision was made to discontinue his life support. Finally *Bowen* is distinguishable. That case essentially involved a failure of causation. It was the parents' refusal of consent, not the infant's disability, that would have resulted in the denial of treatment. By contrast, it was precisely Mrs. Aikins's disability that caused defendants to communicate with her in an allegedly inadequate manner.

#### *B. Defendants Have Not Shown That They Complied with the Act as a Matter of Law*

Defendants finally argue that they complied with the Rehabilitation Act as a matter of law. Defendant Lies argues that Mr. Aikins received precisely the same treatment that he would have received had Mrs. Aikins not been deaf. Defendant St. Helena maintains that it provided all that it was required to provide under the Act.

Both arguments are without merit. Even if Mr. Aikins received exactly the care that he would have received had Mrs. Aikins not been deaf, Dr. Lies misses the point. Mrs. Aikins's claims relate to her exclusion from meaningful participation in the decisions affecting her husband's treatment, not to the appropriateness of the treatment itself. As to the hospital's argument, the Court cannot infer from defendant's reference to its policies on interpreters and its own self-serving statements that it communicated effectively with plaintiff at all times that it complied with the Rehabilitation Act as a matter of law.

#### *IV. Availability of Damages under the Federal Statutes*

Defendants argue that Mrs. Aikins is not entitled to compensatory relief under either the ADA or the Rehabilitation Act. They are correct about the ADA. In cases involving claims under subchapter three of the ADA, the Act provides only for injunctive relief. Section 12188(a)(1) states that the remedies available to persons subjected to discrimination in violation of that subchapter are those set forth in 42 U.S.C. §2000a-3(a). 42 U.S.C. §12188(a)(1). §2000a-3(a) provides:

Whenever any person has engaged or there are reasonable grounds to believe that any person is about to engage in any act or practice prohibited by section 2000a-2 of this title, a civil action for preventive relief ... may be instituted by the person aggrieved....

42 U.S.C. §2000a-3(a). [T]he Supreme Court [has] held that a plaintiff suing under section 2000a-3(a) cannot recover damages. Plaintiffs appear to concede the unavailability of compensatory relief under the ADA in their opposition papers.

Because plaintiffs lack standing on the present record to assert claims for injunctive relief, the unavailability of damages under the ADA requires dismissal of all claims under the ADA. Such dismissal is without prejudice to plaintiffs' reinstating the ADA claims for injunctive relief upon a proper showing of standing.

As to Mrs. Aikins's claims under the Rehabilitation Act, the Ninth Circuit has held that damages are available for violations of the Act. Section 794a provides, in pertinent part: “The remedies, procedures, and rights set forth in title VI of the Civil Rights Act of 1964 [codified at 42 U.S.C.



section 2000d et seq.] shall be available to any person aggrieved by any act or failure to act by any recipient of Federal assistance ... under section 794 of this title.” 29 U.S.C. §794a(a)(2). The settled interpretation of section 794a in the Ninth Circuit is that money damages are available for violations of section 504 of the Rehabilitation Act.

### *V. Plaintiffs' State Law Claims*

[Discussion of state law claims omitted.]

### ***Questions***

1. What would Mrs. Aikins' damages be? Suppose the hospital billed Mrs. Aikins for procedures that she would not have approved had there been adequate communication? Would she and/or her insurance provider be able to recover the costs of those procedures?

2. If this were a state or local governmental hospital, would Mrs. Aikins be entitled to damages under Title II of the ADA?

3. In Part IV of *Aikins*, the court dismissed the plaintiffs' claims for injunctive relief under the ADA for lack of standing, but made clear that dismissal was without prejudice of reinstating the ADA claim for injunctive relief “upon a proper showing of standing.” Considering the entire *Aikins* opinion, what would constitute a proper showing of standing that would permit reinstatement of the ADA claim for injunctive relief?

### **Mayberry v. Von Valtier**

843 F. Supp. 1160 (E.D. Mich. 1994)

WOODS, DISTRICT JUDGE:

Defendant, Cheryl C. Von Valtier, is a physician licensed to practice medicine in the State of Michigan. Plaintiff, Shirley Mayberry, is a 67 year-old deaf woman. Since 1987, Dr. Von Valtier has treated Ms. Mayberry as her family physician. Ms. Mayberry testified that she was able to lipread until she completely lost her hearing in 1990, and that she is able to understand simple notes. Ms. Mayberry and Dr. Von Valtier communicated during physical examinations by passing notes back and forth, or by using a signor. The signor was often one of Ms. Mayberry's children, and on three occasions a professional interpreter had been used. Dr. Von Valtier testified that visits with Ms. Mayberry took twice as long with an interpreter than when they passed notes, but that she did not mind spending the extra time.

On March 15, 1991, Ms. Mayberry brought her daughter Claudia Langston to her appointment with Dr. Von Valtier. Ms. Langston told Dr. Von Valtier that her mother's hearing had gotten progressively worse. During that visit, Dr. Von Valtier discovered that the back pain Ms. Mayberry had earlier complained of was higher than she had originally understood. Dr. Von Valtier wrote the following note on her chart: “[Ms. Mayberry] [s]tates pain has not moved, but this is higher than I had understood her to say. Probably due to poor communication.” Ms. Langston swears in her affidavit that Dr. Von Valtier told her that an interpreter made communication with Ms. Mayberry clearer and easier than writing notes. In addition, Dr. Von Valtier told her that she wanted Ms. Mayberry to have an interpreter when she was seen at her medical office.

On three occasions, Ms. Mayberry had an interpreter from Deaf, Hearing and Speech Services—Senior Citizens present during appointments with Dr. Von Valtier. On two of those occasions, once in 1989 and once in 1990, Dr. Von Valtier did not have to pay for the interpreter. On the third occasion, December 18, 1992, Ms. Mayberry was due to have a general examination, and she requested an interpreter because she felt she needed one. Dr. Von Valtier's office consented to pay for the interpreter's services pursuant to its duty under the Americans with Disabilities Act. Dr. Von Valtier wrote to Ms. Mayberry on January 7, 1993, summarizing the results of her examination.

Dr. Von Valtier was billed \$28.00 by Monalee Ferrero for her interpreting services. Dr. Von Valtier paid the bill, and sent the following letter to Ms. Ferrero.

Enclosed is payment for your services to Shirley Mayberry in this office 12/18/92. The Medicare payment for Mrs. Mayberry's office visit has been received, and I would now like to explain why I won't be able to utilize your services in the future, or indeed why I really can't afford to take care of Mrs. Mayberry at all. My regular fee for a 15 minute office visit is \$40.00. I spent about 45 minutes with Mrs. Mayberry on December 12, 1992, for this I was paid \$37.17 by Medicare and (hopefully) \$9.29 by Mrs. Mayberry. My office overhead expense rate is a rather steady 70% of my gross receipts, which means that for that 45 minutes I was able to "pocket" \$13.94, that is, until I paid your bill for \$28.00. I certainly hope that the Federal Government does not further slash this outrageous profit margin. A copy of this letter was also sent to Ms. Mayberry.

After Ms. Mayberry received the letter addressed to Ms. Ferrero, she became angry and called Dr. Von Valtier's office to ask for her records. Ms. Mayberry admits that she did not ask Dr. Von Valtier what she intended by the letter. Ms. Mayberry interpreted the letter to mean that Dr. Von Valtier would not hire an interpreter for her again, and that she had been discharged as a patient. At her deposition, Dr. Von Valtier explained that the letter was poorly written and ambiguous, and it was not her intention to discharge Ms. Mayberry from her practice, nor did she intend to refuse to pay for an interpreter in the future. Dr. Von Valtier claims to have a specific protocol for discharging patients, and that protocol was not initiated in this case. Dr. Von Valtier sums up the purpose of her letter as a protest of the Americans with Disabilities Act, saying:

I felt that although this ADA is the law of the land, and I have to obey it, I don't think it's fair. I wanted to protest it. I feel that I have a right to protest it even though I have to obey it. And this was one protest that I could make because of the fact that for six years, Shirley Mayberry and I successfully communicated with each other with pencil and paper.

Plaintiff's complaint alleges that she has been denied future treatment by defendant because she is deaf. Plaintiff alleges that defendant's actions in refusing to provide interpreter services in the future, and in terminating her medical care, amounts to discrimination in violation of the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Federal Rehabilitation Act of 1973, and the Michigan Handicappers' Civil Rights Act.

#### *A. Americans with Disabilities Act (ADA)*

The ADA defines discrimination as including a failure to take necessary steps to ensure that no individual with a disability is denied services because of the absence of auxiliary aids and services. The Department of Justice has promulgated regulations to implement the ADA, and states in its commentary on the final regulations: The auxiliary aid requirement is a flexible one. A public accommodation can choose among various alternatives as long as the result is effective communication. The regulations include examples of auxiliary aids and services required to be furnished where necessary to ensure effective communication. The examples given for persons with hearing losses include qualified interpreters and notetakers. 28 CFR §36.303(b)(1). The effective communication requirement of the ADA has been interpreted such that Congress expects places of public accommodation to consult with disabled persons when it comes to auxiliary aids for effective communication, but Congress does not mandate primary consideration of their expressed choices. 28 CFR 36.303, App. B.

The construction provision of the ADA states that the standards of title V of the Rehabilitation Act of 1973, and its regulations, are to apply, except where the ADA has explicitly adopted a different standard. 42 U.S.C. §12201(a). In order to make out a prima facie case under title III of the ADA, the plaintiff must prove (1) that she has a disability; (2) that defendant's office is a place of public accommodation; and (3) that she was discriminated against by being refused full and equal enjoyment of medical treatment because of her disability. Defendant maintains that intent to discriminate is a

fourth element of plaintiff's prima facie case, relying on traditional disparate-treatment/disparate-impact and burden-shifting analyses used in discrimination cases.

Federal courts have struggled with the issue of whether intent to discriminate is an element to stating a prima facie case under the Rehabilitation Act. This Court will look to the cases interpreting the Rehabilitation Act for guidance, as there are no reported cases analyzing the requirements for sustaining a claim under the effective communication by a public accommodation provisions of the ADA. The [Supreme] Court [has] refused to hold that all showings of disparate impact on the handicapped constitute prima facie cases under §504, nor would it hold that proof of discriminatory intent was necessary in every case.

A disparate impact case is one in which a facially neutral practice impacts more harshly on one group of people than on others. For example, if defendant Von Valtier had announced a policy not to hire sign language interpreters for any patient, the impact would obviously be more profound on deaf patients. Such a policy, however, is not facially neutral in the same manner as the policy to reduce the number of annual inpatient hospital days that state Medicaid would pay for, which was the issue in *Alexander v. Choate*. The case presently before the Court does not involve a disparate impact, as plaintiff alleges that defendant specifically declined to provide her with an interpreter because she was disabled. Even though the Supreme Court addressed the issue of intent in a case where the discrimination complained of was in the form of a policy's impact rather than specific treatment, other courts have come to the same conclusion.

One of the stated purposes of the ADA is “to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.” 42 U.S.C. §12101(b)(1). Congress specifically found that “individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion [and] the discriminatory effects of ... communication barriers...” 42 U.S.C. §12101(a)(5). Given that statement, Congress appears to have intended the ADA to address the discriminatory effects of benign actions or inaction, as well as intentional discrimination. Based on the cases analyzing alleged violations of §504, the Court concludes that the Rehabilitation Act does not require a plaintiff to prove discriminatory intent in order to make out a prima facie case of handicap discrimination. The Court will apply the modified burden-shifting analysis developed in cases under the Rehabilitation Act to the ADA.

In order to set forth a prima facie case under title III of the ADA, plaintiff must prove that she has a disability, that defendant's office is a place of public accommodation, and that she was denied full and equal medical treatment because of her disability. Plaintiff must additionally show that she was denied treatment under circumstances which give rise to the inference that such denial was based solely on her handicap. If plaintiff succeeds in stating a prima facie case, the burden shifts to defendant to prove either that plaintiff was not denied medical treatment, or that such denial was not unlawful. The burden then shifts back to plaintiff to rebut defendant's reasons as pretext for unlawful discrimination.

In her attempt to make out a prima facie case under title III of the ADA, plaintiff has clearly proven that she has a disability and that defendant's office is a place of public accommodation. Plaintiff has also produced evidence giving rise to an inference that she was unlawfully discriminated against by being refused full and equal enjoyment of medical treatment because of her disability. As proof that defendant intended to refuse to hire an interpreter in the future, and to discharge plaintiff, plaintiff submits defendant's own words in the February 22, 1993 letter to Ms. Ferrero. In addition, plaintiff provides the affidavit of her daughter Ms. Langston which states that defendant wanted plaintiff to bring an interpreter to future appointments. Plaintiff also points to a note written by defendant on plaintiff's chart, that defendant misunderstood the exact location of plaintiff's pain due to poor communication. Finally, plaintiff submits a note written by defendant which instructs plaintiff to see an ophthalmologist, and suggests that she “take someone with her who signs so you can explain problem & answer their questions completely.”

The burden of proof shifts to defendant to prove that she did not refuse to hire an interpreter for plaintiff, nor did she refuse to treat plaintiff in the future. Defendant may attempt to show that an interpreter was not necessary to ensure effective communication with plaintiff during her medical appointments. Furthermore, places of public accommodation are exempt from complying with the ADA if they can demonstrate that taking such steps would fundamentally alter the nature of the services being offered, or would result in an undue burden. 42 U.S.C. §12182(b)(2)(A)(iii). Defendant, however, admitted at her deposition that she could afford to pay Ms. Ferrero's fee for interpreter services.

Defendant maintains that her letter to Ms. Ferrero was a protest of the ADA, and that she could adequately communicate with plaintiff by passing notes back and forth. The issue is how far defendant was willing to take her protest. It is true that plaintiff did not ask defendant what she intended by her letter, but it is not implausible for plaintiff to believe that defendant meant her words literally. Plaintiff has submitted evidence which would tend to show that passing notes did not result in effective communication with defendant. Commentary by the Department of Justice states that “[i]t is not difficult to imagine a wide range of communications involving areas such as health, legal matters, and finances that would be sufficiently lengthy or complex to require an interpreter for effective communication.” 28 CFR §36.303, App. B.

Plaintiff has come forth with enough evidence to survive summary judgment on her ADA claim. Plaintiff, however, is not entitled to money damages under the ADA, which limits the remedies available to private individuals to those set forth in the Civil Rights Act of 1964, 42 U.S.C. §2000a-3(a). 42 U.S.C. §12188(a)(1). Such remedies include permanent or temporary injunctions and restraining orders. Only when the Attorney General becomes involved in the matter may the Court award monetary damages to aggrieved persons. 42 U.S.C. §12188(b)(2)(B). Plaintiff is permitted to seek injunctive relief under the ADA, as well as attorneys fees. 42 U.S.C. §12188(b)(2), 12205.

[Rehabilitation Act and state law claims discussion is omitted.]

Defendant's motion for summary judgment is *Denied* in its entirety.

### *Questions*

1. Does the fact that Dr. Von Valtier could “afford to pay” for the interpreter mean that it is not an undue burden?
2. Would it make a difference in the analysis of undue burden if the accommodation needed were a ramp to permit access to individuals with a mobility impairment instead of an interpreter?
3. Would it matter if Dr. Von Valtier had a large number of patients with hearing impairments who needed interpreter service?

### *Notes*

1. The ADAAA states that auxiliary aids and services include “qualified interpreters or other effective methods of making aurally delivered materials available to individuals with hearing impairments.” 42 U.S.C. §12103 (1)(A).

On July 23, 2010, the Department of Justice issued final regulations effective March 15, 2011. 75 Fed. Reg. 56,164–236 (September 15, 2010) (Title II) and 75 Fed. Reg. 56,236–358 (September 15, 2010) (Title III). The new regulations amend both Title II and Title III regulations. One of the issues addressed in the revised regulations is the obligation regarding effective communication with persons with hearing impairments. The new regulations provide that the obligation extends to companions of individuals with disabilities. The guidance addressed the need to make an individualized assessment based on nature, length, and complexity of the communication, and the context. Individuals with disabilities should generally be consulted about the type of aid, but the public accommodation

ultimately makes the decision so long as it is effective. The regulations clarify that an individual is not required to bring another individual to interpret nor to rely on an adult accompanying the individual to interpret. Exceptions are allowed in appropriate emergency situations. 28 C.F.R. §35.160 and §36.303(c). The Title II regulations further specify requirements regarding public entities using video remote interpreting services including quality of the equipment and interpreters and qualifications of users of the technology. 28 C.F.R. §35.160(d).

**2. *Mental Health Counseling Services for Individuals with Hearing Impairments.*** When the health care treatment in question involves psychological or psychiatric counseling where confidentiality is an important issue, are recipients of the treatment or counseling who are deaf entitled to have counselors who themselves sign and who understand the needs of the deaf community? The following excerpt from *Tugg v. Towey*, 864 F. Supp. 1201 (S.D. Fla. 1994), notes the court's response to several individuals with hearing impairments seeking counseling following Hurricane Andrew in Florida in 1993. The court granted a preliminary injunction, noting the following:

Section 35.164 [of Title II, ADA regulations] also places a limit on the lengths a public entity must go to provide auxiliary aids. It states that a public entity is not required to take any action if “it can demonstrate [the action] would result in a fundamental alteration in the nature of a device, program or activity or [create] an undue financial and administration burden.” ... Under those circumstances the public entity has the burden of demonstrating that providing the auxiliary aid for the disabled individual would create such a hardship. This determination must be made by the head of the public entity, who must set forth in writing the reasons why the entity cannot comply with the wishes of the disabled individual, after considering all available resources.

At the hearing, the Court invited the Defendants to address the issue of the harm they will suffer if the injunction is entered. Specifically, the Court asked for a cost benefit analysis the Defendants had conducted concluding that (1) providing the Plaintiffs with mental health counselors who possessed sign language ability and experience working with the deaf was too expensive to fit within the HRS budget and (2) that HRS's chosen alternative of providing qualified interpreters would cost the Defendants less money or create a lesser burden.

The Defendants replied that no such cost benefit analysis had been conducted. The evidence produced at the hearing indicated that under HRS's intended plan, it will cost an HRS contracting mental health provider a minimum of \$35 per hour to provide a sign language interpreter in addition to the cost of the mental health counselor. Without the benefit of any accurate figures, logic would indicate that it would cost less to employ one individual to perform two tasks (signing and counseling) than two individuals to perform those same tasks. Counsel for the Defendants disputed this at the hearing, stating that because the pool of individuals meeting these qualifications is so small [estimating that the number in Dade and Monroe counties is four] the cost of securing their services would be higher. The Defendants, however, did not produce evidence to support this argument. The Defendants also did not demonstrate that they had complied with the requirements ... which [mandate] that the public entity set forth its findings as to why it rejected the auxiliary aid sought by a disabled individual after considering all available resources.

What if the plaintiffs seeking such services were in a small rural area of North Dakota? Is it likely that defendants would be more likely to ultimately succeed in demonstrating both undue financial and undue administrative burden?

**3. In *Aikins*,** it was the wife of the patient, not the patient himself, seeking the accommodation. In another case involving accommodation of someone other than the patient, a visitor to a hospital patient requested that she be able to hook up her breathing apparatus to the hospital's oxygen port when visiting her husband's room. The court held that the hospital was not required to provide this accommodation. *Dryer v. Flower Hospital*, 383 F. Supp. 2d 934 (N.D. Ohio 2005).

In 2013, the Justice Department reached five settlements to remedy alleged violations of the ADA. The agreements resolve allegations that five health care providers—including a hospital, skilled

nursing facilities, a rehabilitation center, and a doctor's office—violated the ADA by failing to provide effective communication to people who are deaf or have hearing loss in the provision of medical services. For information on these settlements see the Department of Justice's *Barrier-Free Health Care Initiative*, a partnership of the Civil Rights Division and U.S. Attorney's offices across the nation, to target enforcement efforts on a critical area for individuals with disabilities, by accessing the Department of Justice ADA website at [ADA.gov](http://ADA.gov).

4. Department of Justice ADA regulations, effective March 15, 2011, amend both Title II and Title III regulations. Included in the revised regulations are provisions relating to physical design generally and specifically to dispersal of accessible patient bedrooms in medical care facilities, 28 C.F.R. §36.406(g). 75 Fed. Reg. 56,164–236 (September 15, 2010) (Title II) and 75 Fed. Reg. 56,236–358 (September 15, 2010) (Title III).

Other provisions give guidance regarding use of automated-attendant systems (such as voice mail and messaging) and require that systems must provide effective real-time communication with individuals using auxiliary aids and services, including TTYs or other FCC-approved relay systems. 28 C.F.R. §35.161.

## **D. Health Insurance**

The previous sections addressed the challenges of discrimination, environmental barriers, and the need for reasonable accommodations as barriers to health care for individuals with disabilities. While these barriers are significant, the major barrier is having health insurance to pay for health care services. Because much health insurance is tied to the workplace, individuals with disabilities face two problems.

First, they must be able to obtain and keep a job to access employer-provided health insurance. Employers concerned about the high cost of health care for individuals with disabilities have a disincentive in many cases to hire such individuals even though it violates disability discrimination laws to do so. And as health insurance costs rise, employers may increasingly decide not to provide health insurance to any of their employees. In doing so, however, employers would face penalties under the ACA. Whether such penalties are sufficient to deter employers from foregoing offering health insurance benefits is unclear. Individuals with disabilities may be able to receive health care insurance, however, through Medicare (if they are permanently and totally disabled) or Medicaid (if they are disabled and with very limited income), or through the ACA, which now provides for health care exchanges for persons who do not work or do not get their health insurance at work.

Second, some individuals with disabilities, because of the limitations of their conditions, may not be able to work. The Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. §300gg, passed in 1996, prohibits disability-based discrimination in health insurance only with regard to employer-sponsored group health plans. HIPAA is important because it prohibits treating health conditions as a preexisting condition for purposes of limiting or excluding benefits. Thus, a person who changes employment becomes eligible for health insurance with the new employer, and, if unemployed, may continue his health insurance at an increased cost.

While previously obtaining health care coverage through an individual health insurance policy was not a viable option for many individuals with disabilities who were not employed because it was extremely expensive to purchase individual health insurance, some of these concerns have been ameliorated by the ACA. The ACA does not permit insurers to exclude coverage of preexisting conditions or to use health status when considering eligibility. In theory and in practice, the ACA has made it much more possible and affordable for persons with disabilities to get access to health insurance. See Jessica L. Roberts, *Health Law as Disability Rights Law*, 97 MINN. L. REV. 1963 (2013) (demonstrating how facilitating access to private insurance through state exchanges and

abolition of preexisting condition consideration broadens access); Michael R. Ulrich, JD, MPH, *Health Affairs Blog Post: Challenges for People with Disabilities Within the Health Care Safety Net*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 247, 250 (2015) (ACA has taken important steps toward filling the gaps in our insurance system). Nonetheless, Medicaid remains the source for long-term home and community-based services, and individuals with disabilities who do not qualify for Medicaid may face costly insurance plans to get these services. See Silvia Yee, *The Affordable Care Act and People with Disabilities*, GPSolo, Mar/Apr./2015, at 16. Moreover, there are increasing reports that many health care providers—doctors and hospitals—are refusing to accept insurance provided by the ACA, and that insurance companies are refusing to write policies or are raising their premiums. See Kimberly Leonard, *Doctors, Hospitals Say “No” to Obamacare Plans*, <http://www.usnews.com/news/articles/2015/11/04/doctors-hospitals-wont-accept-obamacare-marketplace-plans>; Elisabeth Rosenthal, *Sorry, We Don't Take Obamacare*, N.Y. TIMES, May 15, 2016, at SR1, available at <http://nyti.ms/27nbtw8>; Reed Abelson & Margot Sanger-Katz, *Obamacare Premiums Are Rising, Not a Little*, N.Y. TIMES, June 16, 2016, at B1, available at <http://nyti.ms/1UzHojD>; Carolyn Y. Johnson, *UnitedHealth Group to Exit Obamacare Exchanges in All but a “Handful” of States*, WASHINGTON POST WONKBLOG, Apr. 19, 2016, <https://www.washingtonpost.com/news/wonk/wp/2016/04/19/unitedhealth-group-to-exit-obamacare-exchanges-in-all-but-a-handful-of-states/>.

With respect to insurance providers, there are a number of issues under the ADA, the Rehabilitation Act, and even some state laws. The first question is whether the ADA was intended to exempt health insurance programs from Title III application because traditionally health insurance has been regulated by the states. Most courts have not found there to be an exemption.

With respect to all insurance (health, life, and other insurance) there is an additional issue—whether Title III would apply only to accessing the service and not to distinctions related to the coverage itself. There is no question that insurance offices are public accommodations covered by Title III. There is, however, an unresolved question as to whether Title III regulates the *content* of the insurance policy. The majority and dissenting opinions in the next case illustrate the reasoning behind the two views.

### **John Doe and Richard Smith v. Mutual of Omaha Insurance Company**

179 F.3d 557 (7th Cir. 1999)

OPINION BY: JUDGE RICHARD POSNER

Mutual of Omaha appeals from a judgment that the AIDS caps in two of its health insurance policies violate the public accommodations provision of the Americans with Disabilities Act. One policy limits lifetime benefits for AIDS or AIDS-related conditions (ARC) to \$25,000, the other limits them to \$100,000, while for other conditions the limit in both policies is \$1 million. Mutual of Omaha has stipulated that it “has not shown and cannot show that its AIDS Caps are or ever have been consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification, or state law.” It also concedes that AIDS is a disabling condition within the meaning of the Americans with Disabilities Act. Since the Supreme Court held in *Bragdon* that infection with the AIDS virus (HIV) is a disabling condition from the onset of the infection before any symptoms appear, it is apparent that both ARC and AIDS are disabilities. Mutual of Omaha does not question this, but argues only that the Americans with Disabilities Act does not regulate the content of insurance policies.

Title III of the Act, in section 302(a), provides 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, or accommodations of any place of public accommodation” by the owner, lessee, or operator of such a place. The core meaning of this provision, plainly enough, is that the owner or

operator of a store, hotel, restaurant, dentist's office, travel agency, theater, Web site, or other facility (whether in physical space or in electronic space) that is open to the public cannot exclude disabled persons from entering the facility and, once in, from using the facility in the same way that the nondisabled do. The owner or operator of, say, a camera store can neither bar the door to the disabled nor let them in but then refuse to sell its cameras to them on the same terms as to other customers.

Mutual of Omaha does not refuse to sell insurance policies to such persons—it was happy to sell health insurance policies to the two plaintiffs. But because of the AIDS caps, the policies have less value to persons with AIDS than they would have to persons with other, equally expensive diseases or disabilities. This does not make the offer to sell illusory, for people with AIDS have medical needs unrelated to AIDS, and the policies give such people as much coverage for those needs as the policies give people who don't have AIDS. If all the medical needs of people with AIDS were AIDS-related and thus excluded by the policies, this might support an inference that Mutual of Omaha was trying to exclude such people, and such exclusion, as we shall see, might violate the Act. But that is not argued.

Since most health-insurance policies contain caps, the position urged by the plaintiffs would discriminate among diseases. Diseases that happened to be classified as disabilities could not be capped, but equally or more serious diseases that are generally not disabling, such as heart disease, could be. Moreover, the plaintiffs acknowledge the right of an insurance company to exclude coverage for an applicant's pre-existing medical conditions. If the applicant is already HIV-positive when he applies for a health-insurance policy, the insurer can in effect cap his AIDS-related coverage at \$0. This “discrimination” is not limited to AIDS or for that matter to disabilities, which is why the plaintiffs do not challenge it; but it suggests that the rule for which they contend is at once arbitrary and unlikely to do much for people with AIDS.

The insurance company asks us to compare this case to one in which a person with one leg complains of a shoestore's refusal to sell shoes other than by the pair, or in which a blind person complains of a bookstore's refusal to stock books printed in Braille. We do not understand the plaintiffs to be contending that such complaints are actionable under section 302(a), even though there is a sense in which the disabled individual would be denied the full and equal enjoyment of the services that the store offers. In fact, it is apparent that a store is not required to alter its inventory in order to stock goods such as Braille books that are especially designed for disabled people. But it is apparent as a matter of interpretation rather than compelled by a simple reading which would place the present case on the other side of the line; and so the case cannot be resolved by reference simply to the language of section 302(a).

The common sense of the statute is that the content of the goods or services offered by a place of public accommodation is not regulated. A camera store may not refuse to sell cameras to a disabled person, but it is not required to stock cameras specially designed for such persons. Had Congress purposed to impose so enormous a burden on the retail sector of the economy and so vast a supervisory responsibility on the federal courts, we think it would have made its intention clearer and would at least have imposed some standards. It is hardly a feasible judicial function to decide whether shoestores should sell single shoes to one-legged persons and if so at what price, or how many Braille books the Borders or Barnes and Noble bookstore chains should stock in each of their stores. There are defenses to a prima facie case of public-accommodation discrimination, but they would do little to alleviate the judicial burden of making standardless decisions about the composition of retail inventories. The only defense that might apply to the Braille case or the pair of shoes case is that the modification of a seller's existing practices that is necessary to provide equal access to the disabled “would fundamentally alter the nature of ... [the seller's] services,” and it probably would not apply to either case and certainly not to the Braille one.

The plaintiffs might be able to distinguish the shoestore hypothetical by pointing out that a nondisabled person might be in the market for one shoe simply because he had lost a shoe; in refusing



to sell single shoes the store thus would not be refusing to adapt its service to a class of customers limited to disabled people. But the Braille case, and many others that we can imagine (such as a furniture store's decision not to stock wheelchairs, or a psychiatrist's refusal to treat schizophrenia, as distinct from his refusing to treat schizophrenics for the psychiatric disorders in which he specializes, or a movie theater's refusal to provide a running translation into sign language of the movie's soundtrack), cannot be so distinguished, although some of them might find shelter in the “fundamental alteration” defense. All are cases of refusing to configure a service to make it as valuable to a disabled as to a nondisabled customer.

It might seem that the AIDS caps could be distinguished from the “refusal to stock” cases because the caps include complications of AIDS. If being infected by HIV leads one to contract pneumonia, the cost of treating the pneumonia is subject to the AIDS cap; if a person not infected by HIV contracts pneumonia, the costs of treating his pneumonia are fully covered. It looks, therefore, like a difference in treatment referable solely to the fact that one person is disabled and the other not.

But this is not correct. The essential point to understand is that HIV doesn't cause illness directly. What it does is weaken and eventually destroy the body's immune system. As the immune system falters, the body becomes prey to diseases that the system protects us against. These “opportunistic” diseases that HIV allows, as it were, to ravage the body are exotic cancers and rare forms of pneumonia and other infectious diseases. To refer to them as “complications” of HIV or AIDS is not incorrect, but it is misleading, because they are the chief worry of anyone who has the misfortune to be afflicted with AIDS. An AIDS cap would be meaningless if it excluded the opportunistic diseases that are the most harmful consequences of being infected by the AIDS virus.

What the AIDS caps in the challenged insurance policies cover, therefore, is the cost of fighting the AIDS virus itself and trying to keep the immune system intact plus the cost of treating the opportunistic diseases to which the body becomes prey when the immune system has eroded to the point at which one is classified as having AIDS. The principal opportunistic diseases of AIDS, such as Kaposi's sarcoma, *Pneumocystis carinii pneumonia*, AIDS wasting, and esophageal candidiasis, are rarely encountered among people who are not infected by HIV—so rarely as to be described frequently as “AIDS-defining opportunistic infections.” The frequency of *Pneumocystis carinii* pneumonia, for example, “among patients infected with human immunodeficiency virus (HIV) far exceeds that among other immuno-compromised hosts” and is “a leading cause of opportunistic infection and death among AIDS patients in industrialized countries.” It is these *distinctive* diseases that are the target (along with the costs of directly treating infection by HIV) of the AIDS caps. This is not a case of refusing, for example, to provide the same coverage for a broken leg, or other afflictions not peculiar to people with AIDS, to such people, which would be a good example of discrimination by reason of disability.

It is true that as the immune system collapses because of infection by HIV, the patient becomes subject to opportunistic infection not only by the distinctive AIDS-defining diseases but also by a host of diseases to which people not infected with HIV are subject. Even when they are the same disease, however, they are far more lethal when they hit a person who does not have an immune system to fight back with. Which means they are not *really* the same disease. This is not a point that is peculiar to AIDS. The end stage of many diseases is an illness different from the one that brought the patient to that stage; nowadays when a person dies of pneumonia, it is usually because his body has been gravely weakened by some other ailment. If a health insurance policy that excluded coverage for cancer was interpreted not to cover the pneumonia that killed a patient terminally ill with cancer, this would not be “discrimination” against cancer.

To summarize the discussion to this point, we cannot find anything in the Americans with Disabilities Act or its background, or the nature of AIDS and AIDS caps, to justify so radically expansive an interpretation as would be required to bring these cases under section 302(a) without

making an unprincipled distinction between AIDS caps and other product alterations—unless it is section 501(c)(1) of the Act. That section provides that Title I (employment discrimination against the disabled) and Title III (public accommodations, the title involved in this case) “shall not be construed to prohibit or restrict an insurer ... from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law,” unless the prohibition or restriction is “a subterfuge to evade the purposes” of either title. §12201(c). Even with the “subterfuge” qualification, section 501(c) is obviously intended for the benefit of insurance companies rather than plaintiffs and it may seem odd therefore to find the plaintiffs placing such heavy weight on what is in effect a defense to liability. But a defense can cast light on what is to be defended against, that is, what the *prima facie* case of a violation is. Suppose, for example, that a statute regulated the sale of “animals” but it was unclear whether the legislature had meant to include fish. Were there a statutory exclusion for goldfish, it would be pretty clear that “animals” included fish, since otherwise there would be no occasion for such an exclusion. And, with that clarified, the advocate of regulating the sale of a particular goldfish would have to show only that the exclusion was somehow inapplicable to him. That is the plaintiffs' strategy here. They use the insurance provision to show that section 302(a) regulates content, then argue that the excluding provision is narrow enough to allow them to challenge the coverage limits in Mutual of Omaha's policies. There is even some legislative history, which the plaintiffs hopefully call “definitive,” to section 501(c) that suggests that an insurance company can limit coverage on the basis of a disability only if the limitation is based either on claims experience or on sound actuarial methods for classifying risks. And Mutual of Omaha conceded itself out of relying on section 501(c)'s safe harbor by stipulating that it cannot show that its AIDS caps are based on sound actuarial principles or claims experience or are consistent with state law.

The plaintiffs argue, consistent with our goldfish example, that the insurance exemption has no function if section 302(a) does not regulate the content of insurance policies, and so we should infer that the section does not regulate that content. But this reasoning is not correct. If it were, it would imply that section 302(a) regulates the content not only of insurance policies but also of all other products and services, since the section is not limited to insurance. The insurance industry may have worried that the section would be given just the expansive interpretation that the district court gave it in this case, and so the industry may have obtained the rule of construction in section 501(c) just to backstop its argument that section 302(a) regulates only access and not content. Or it may have worried about being sued under section 302(a) for refusing to sell an insurance policy to a disabled person. Remember that the right of full and equal enjoyment as we interpret it includes the right to buy on equal terms and not just the right to enter the store. For Mutual of Omaha to take the position that people with AIDS are so unhealthy that it won't sell them health insurance would be a *prima facie* violation of section 302(a). But the insurance company just might be able to steer into the safe harbor provided by section 501(c), provided it didn't run afoul of the “subterfuge” limitation, as it would do if, for example, it had adopted the AIDS caps to deter people who know they are HIV positive from buying the policies at all.

The legislative history is consistent with this interpretation. Both committee reports on which the plaintiffs rely give the example of refusing to sell an insurance policy to a blind person, as does the gloss placed on section 501(c) by the Department of Justice. A refusal to sell insurance to a blind person is not the same thing as a provision in the policy that if the insured becomes blind, the insurer will not pay the expense of his learning Braille. We find nothing in the language or history of the statute to suggest that the latter refusal would be unlawful. The Department's *Technical Assistance Manual, supra*, §III-3.11000, contains somewhat broader language than either the statute or the regulation or the committee reports, language about insurers' being forbidden to discriminate on the basis of disability in the sale, terms, or conditions of insurance contracts; but basically this just parrots the statute and the regulation and does not indicate a focused attention to coverage limits. There is, as we have pointed out, a difference between refusing to sell a health-insurance policy at all to a person

with AIDS, or charging him a higher price for such a policy, or attaching a condition obviously designed to deter people with AIDS from buying the policy (such as refusing to cover such a person for a broken leg), on the one hand, and, on the other, offering insurance policies that contain caps for various diseases some of which may also be disabilities within the meaning of the Americans with Disabilities Act.

We conclude that section 302(a) does not require a seller to alter his product to make it equally valuable to the disabled and to the nondisabled, even if the product is insurance. This conclusion is consistent with all the appellate cases to consider this or cognate issues.

EVANS, *CIRCUIT JUDGE*, dissenting.

The Americans with Disabilities Act is a broad, sweeping, protective statute requiring the elimination of discrimination against individuals with disabilities. Because I believe the insurance policies challenged in this case discriminate against people with AIDS in violation of the ADA, I dissent.

The majority believes we are being asked to regulate the content of insurance policies—something we should not do under the ADA. But as I see it we are not being asked to regulate content; we are being asked to decide whether an insurer can discriminate against people with AIDS, refusing to pay for them the same expenses it would pay if they did not have AIDS. The ADA assigns to courts the task of passing judgment on such conduct. And to me, the Mutual of Omaha policies at issue violate the Act.

Chief Judge Posner's opinion likens the insurance company here to a camera store forced to stock cameras specially designed for disabled persons. While I agree that the ADA would not require a store owner to alter its inventory, I think the analogy misses the mark. The better analogy would be that of a store which lets disabled customers in the door, but then refuses to sell them anything but inferior cameras. To pick up on another analogy raised at oral argument, we are not being asked to force a restaurant to alter its menu to accommodate disabled diners; we are being asked to stop a restaurant that is offering to its nondisabled diners a menu containing a variety of entrees while offering a menu with only limited selections to its disabled patrons. Section 501(c)'s "safe harbor" would allow Mutual of Omaha to treat insureds with AIDS differently than those without AIDS if the discrimination were consistent with Illinois law or could be justified by actuarial principles or claims experience. But Mutual of Omaha conceded that its AIDS and ARC caps do not fall under the ADA's safe harbor protection.

The parties stipulated that the very same affliction (e.g., pneumonia) may be both AIDS-related and not AIDS-related and that, in such cases, coverage depends solely on whether the patient has AIDS. In my view that is more than enough to trigger an ADA violation. Chief Judge Posner reasons that, although the policies appear to discriminate solely based on an insured's HIV status, they really don't, when you consider the nature of AIDS. He suggests that the phrase "AIDS related conditions" embodies a unique set of symptoms and afflictions that would make it easy for the insurance company to determine with certainty whether an expense incurred for a particular illness is "AIDS-related" and therefore subject to the cap. His analysis—charitable to Mutual of Omaha to be sure—may very well be medically sound. But it doesn't come from the insurance policies. The policies don't even hint at what illnesses or afflictions might fall within the ARC exclusion. Nor has the medical community embraced an accepted definition for what "conditions" are "AIDS-related." The practical effect of all this, as Mutual of Omaha concedes, is that coverage for certain expenses would be approved or denied based solely on whether the insured had AIDS. Given that the ADA is supposed to signal a "clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities," I would use the statute to right the wrong committed by Mutual of Omaha.

### *Notes and Questions*

1. Which arguments are more convincing? Those of Judge Posner in the majority opinion in *Mutual of Omaha* or those of Judge Evans' dissent? Why? For other cases deciding this issue, see *Sirva Relocation, LLC v. Richie*, 794 F.3d 185, 199 (1st Cir. 2015) (noting that many circuits permit “an employer to offer disparate benefits based on the type of disability that may afflict an employee,” but that the issue is not resolved given a split among the districts within the First Circuit); *Baron v. Dulinski*, 928 F. Supp. 2d 38, 43 (D.D.C. 2013) (“Title III does not reach the terms of the policies offered by an insurer”). Compare *Chabner v. United of Omaha Life Insurance Co.*, 225 F.3d 1042 (9th Cir. 2000) (holding that Title III does not permit individuals to challenge the substantive provisions of insurance contracts), and *Carparts Distrib. Ctr., Inc. v. Automotive Wholesaler's Ass'n*, 37 F.3d 12 (1st Cir. 1994) (Title III not limited to physical structure). The issue has not yet been resolved by the Supreme Court.

2. In a preliminary order in the case of *Carparts Distrib. Ctr., Inc. v. Automotive Wholesaler's Ass'n*, 37 F.3d 12 (1st Cir. 1994), the court overruled the lower court, and held that Title III (Public Accommodations) was not limited to actual physical structures with definite physical boundaries in which an individual would physically enter to use the facilities or obtain services. This decision means that a health benefit plan provided through an employer might be considered to be a Title III public accommodation. The case involves a health benefit plan offered to auto parts distributor members. The plan placed a cap on AIDS-related illnesses. The case also was brought under Title I. The First Circuit held that a health care plan that acts as an agent of an employer or is controlled by the employer may be subject to Title I of the ADA. For a more recent decision in this issue, review *Parker*, in [Chapter 4\[B\]](#), *supra*.

3. For an argument that *Doe* was wrongly decided, see Jeffrey W. Stempel, *An Inconsistently Sensitive Mind: Richard Posner's Cerebration of Insurance Law and Continuing Blind Spots of Economicalism*, 7 CONN. INS. L.J. 7, 65–68 (2000–2001) (arguing that Judge Posner should not have equated the situation present in *Doe* in which the plaintiff was already a policyholder with a decision to deny coverage to someone who has AIDS as a pre-existing condition).

4. There was a second reason upon which Judge Posner relied to find no violation of Title III. He concluded that if Title III regulates the content of an insurance policy, it would violate the McCarran-Ferguson Act, which prohibits courts from construing any federal act that does not directly regulate insurance to impair state insurance law. This is likely the strongest argument for finding that the ADA does not apply to the content of insurance policies, see Jeffrey W. Stempel, 7 CONN. INS. L.J. 7, 69 (2000–2001), but, at least according to Professor Stempel, is still insufficient for finding for the insurance company.

5. 42 U.S.C. §12201(c) (Section 501(c)) creates an exception to Title III. It states:

(c) Insurance. Subchapters I through III of this chapter [Titles I through III] and Title IV of this Act shall not be construed to prohibit or restrict—

1. an insurer, hospital, or medical service company, health maintenance organization, or any agent or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
2. a person or organization covered by this chapter from establishing, sponsoring, observing or administering 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; or
3. a person or organization covered by this chapter from establishing, sponsoring, observing, or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

Paragraphs (1), (2) and (3) shall not be used as a subterfuge to evade the purposes of subchapter I and III of this chapter. [titles I and III].

Why did the plaintiffs in *Mutual of Omaha* raise this section to support their claim? Why did Mutual of Omaha not use this section as a defense? Explain. For a discussion of Section 501(c) and its legislative history, see H. Miriam Farber, Note, *Subterfuge: Do Coverage Limitations and Exclusions in Employer-Provided Health Care Plans Violate the Americans with Disabilities Act?* 69 N.Y.U. L. REV. 850 (1994).

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Assuming that health insurance programs are subject to the ADA, either as an employment benefit under Title I or as a public accommodation under Title III, there are a number of other issues that arise with respect to individuals with disabilities. One major issue is whether caps on benefits or denial of benefits for certain conditions is permissible. Related to that issue is whether insurers must provide parity for mental and physical conditions. The ADA expects that distinctions be based on legitimate actuarial data or reasonable experience.

Finally, employees may not be terminated to deprive them of employment benefits, including insurance. The Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§1000–1461 prohibits that directly, and the ADA may also apply in some cases to prohibit such action.

For case citations and further discussion related these issues, see LAURA ROTHSTEIN & JULIA IRZYK, *DISABILITIES AND THE LAW* §10.02 (2012 and cumulative supplement).

Access to health insurance is a complex matter for individuals with disabilities. The issues to be addressed in this area include whether health insurance is even covered under the ADA, whether differential treatment for different conditions is permissible, and whether discrimination in health insurance in other respects is permitted.

### *Notes*

**1. Caps on Fertility Treatment:** As was noted above, insurance plans that deny coverage for certain diseases may be found to violate the ADA. Would a cap on fertility treatment or a denial of benefits for fertility treatment violate the ADA? Is this issue affected by the decision in *Bragdon v. Abbott*, earlier in this Chapter. Would an insurance company's decision not to fund Viagra be affected by the ADA?

**2. Mental Health Parity.** Historically, one of the most contentious issues about discriminatory treatment involved the distinction between benefits for treating physical conditions and mental health conditions. Most courts dealing with this issue have held that the ADA does not prohibit an employer under Title I from offering a plan that grants differential benefits for physical and mental illnesses. See, e.g., *Fuller v. J.P. Morgan Chase & Co.*, 423 F.3d (2d Cir. 2005) (holding that it is not a violation of the ADA for an employer-provided long term disability plan to distinguish between physical and mental illness and even though the plaintiff's bipolar disease may have a biological cause, the disorder was still caused by a mental illness). This controversy ultimately resulted in the passage of mental health parity legislation in 2008.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), 29 U.S.C. §1185a and 42 U.S.C. §300gg-5, took effect in January 2009. Its purpose was to assure parity in the insurance coverage of mental health and addiction related treatments with coverage of other non-mental health and addiction treatments. The MHPAEA applies to group health plans or health insurance coverage offered in connection with group plans that provide both medical and surgical benefits and new mental health or substance use disorder benefits. It states that:

1. financial requirements such as deductibles, copayments, co-insurance and out-of-pocket expenses that are applicable to the mental health or substance use disorder benefits may not be more restrictive than those applied to medical and surgical benefits;
2. there can be no separate cost sharing requirements that are applicable only with respect to mental

health or substance use disorder benefits; and

3. limits on frequency of treatment, number of visits, days of coverage or other similar limits on the scope of duration of treatment applicable to mental health or substance use disorders may not be more restrictive than those for other medical and surgical benefits.

The MHPAEA does not apply to group health plans of small employers with fewer than 50 employees, and it has cost exemptions for plans whose costs rise as a result of compliance with the Act 2% or more in the first plan year and 1% in any subsequent year. The cost exemption allows the plan not to adhere to the MHPAEA for one plan year.

While the MHPAEA contains these exceptions and exemptions, it improves insurance parity for mental health and addiction disorder services over the previous Mental Health Parity Act of 1996. The Mental Health Parity Act of 1996 regulated only spending caps, and required that plans offering mental health coverage have the same caps for mental and physical health. Insurers were able to side-step these requirements by converting spending caps to inpatient-day and outpatient-visit limits. The MHPAEA does not permit this behavior. Nonetheless, it applies only when the group plans offer mental health benefits or substance use benefits. It does *not* mandate coverage of mental illnesses or illnesses related to substance abuse. Besides the federal restrictions on insurance coverage, there are at least 46 states that provide some form of mental health parity legislation.

Of course, the Patient Protection and Affordable Care Act (“Obamacare” or the “ACA”) has made inroads into the problems that had not been solved by the MHPA and the MHPAEA. Here is an outline of the coverage by all three of these acts, and an explanation of the problems still existing:<sup>1</sup>

#### Coverage and Existing Problems of the MHPA, MHPAEA, and ACA

- 1.1 MHPA (1996) This statute regulated only *large* group health plans that *voluntarily offered* mental health benefits in addition to physical health benefits.
- 1.2 The regulated large group health plans mentioned in 1.1 were required to ensure parity in terms of lifetime and annual spending limits between those voluntarily offered physical health benefits and voluntarily offered mental health benefits. Thus, it would be a violation of MHPA for a large group health plan, for example, to have a \$1 million lifetime spending cap on voluntarily covered cancer care, and a \$10,000 lifetime spending cap on voluntarily covered major depression care.
- 1.3 The MHPA *did not regulate small group health plans or individual health plans or any other health plans*. Therefore, it would be perfectly legal for a coffee shop with 10 employees to have good (high) physical health insurance benefits and bad (low) or no mental health benefits.
- 1.4 The MHPA did not require regulated large group health plans to offer any mental health benefits. (Since it doesn't regulate small group plans or individual plans, it also therefore did not require small group plans or individual plans to offer any mental health benefits.) Thus, it would be legal under the MHPA for a regulated large group plan (and of course a non-regulated small group plan or individual plan, that isn't regulated at all under the statute) to only offer physical health insurance benefits (e.g., cancer, pregnancy) but no mental health insurance benefits (e.g., depression, addiction).
- 2.1 MHPAEA (2008) This statute was an improvement on the MHPA, but, like the MHPA, it only regulated *large group health plans* that *voluntarily offered* mental health benefits in addition to physical health benefits.
- 2.2 Regulated large group health plans under the MHPAEA had to ensure parity in terms of *financial requirements* (e.g., deductibles, copayments, co-insurance amounts) and *treatment limitations* (e.g., inpatient day limitations, outpatient visit limitations) between offered

physical health insurance benefits and offered mental health insurance benefits. Therefore, it would be a violation of MHPAEA for a regulated large group health plan to have a \$500 deductible for cancer care but a \$1,000 deductible for depression care. It would also be a violation of MHPAEA for a regulated large group health plan, for example, to cover 365 inpatient hospital days for cancer care but only 10 inpatient hospital days for suicide prevention.

2.3 The MHPAEA, like the MHPA, *did not regulate small group health plans or individual health plans or any other health plans*. Therefore, it would be legal, for example, for a coffee shop with 10 employees to have good (high) physical health insurance benefits and bad (low) or no mental health benefits.

2.4 The MHPAEA, like the MHPA, did not even require regulated large group health plans to offer any mental health benefits. (Since it doesn't regulate small group plans or individual plans, it also, therefore, did not require small group plans or individual plans to offer any mental health benefits.) Therefore, it would be legal under the MHPAEA for a regulated large group plan (and of course a non-regulated small group plan or individual plan) to offer only physical health insurance benefits (e.g., cancer, pregnancy) and no mental health insurance benefits (e.g., depression, addiction).

3.1 ACA (2010) The ACA was designed to fill the gaps in coverage under the MHPA and the MHPAEA. The ACA extended the parity requirements in the MHPA and the MHPAEA to individual and small group plans.

3.2 In addition, the ACA requires individual and small group plans to offer mental health and substance use disorder benefits. This is extremely important because it is the first time in history that these benefits were required by federal law. Under the ACA, this is called a “mandatory insurance benefit.”

3.3 Unfortunately, the provision that makes mental health and substance use disorder benefits mandatory in individual and small group plans does not apply to large group health plans (e.g., the health plans of Target, Walmart, and other large corporations etc.) self-insured health plans, and grandfathered health plans (i.e., health plans that were in effect as of March 23, 2010, and that have not substantially increased cost sharing or substantially lowered insurance benefits). In the state of Nevada, for example, less than 10% of individuals have their insurance through an individual or small group health plan. Therefore, only 10% of Nevadans receive the new mandatory mental health and substance use disorder insurance benefits and other essential health benefits (EHBs). Of course, large employers may voluntarily offer these benefits, and many do, but they are not required to do so. For further explanation and an argument for the extension of the ACA provision requiring mental health and substance abuse coverage to large group health plan market, the grandfathered health plan market, and the self insured health market, see Stacey A. Tovino, *A Proposal for Comprehensive and Specific Essential Mental Health and Substance Use Disorder Benefits*, 38 American J.L. & Med. 471 (2012); Stacey A. Tovino, *All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law*, 49 Harvard J. Legis. 1 (2012).

3. *Applicability of the ADA to Employer Provided Insurance*. Health benefits provided directly by the employer might be covered under Title I of the ADA. While the ADA is a broad non-discrimination mandate, it offers a safe harbor to insurance companies and employers whose risk assessment leads to more expensive insurance to persons with disabilities so long as the purpose of the assessment is not a subterfuge to evade the purposes of the Act.

4. *National Health Care Reform*. President Obama's national health care reform envisioned that most of the uninsured Americans would have coverage through their employers, Medicare or Medicaid, a private insurer, a publicly funded insurance program (the “public option”), or non-profit



co-operatives. The ACA was passed and enacted into law. It is currently the law, and it has survived two challenges in the Supreme Court.

**5. Genetic Information Non-Discrimination Act (GINA).** GINA applies both to employers who provide insurance and to health insurance providers. See [Chapter 3](#) for a discussion of GINA and employers' responsibilities. For health insurers, the Act amended the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act, the Internal Revenue Code of 1986, and the Social Security Act (medigap provisions). For group insurance plans, GINA prohibits the use of genetic information to increase group rates. It also prohibits the group health plan or a health insurer offering insurance in connection with a group plan from requiring genetic tests of individuals or family members, or from using the results of such genetic tests to set premiums. A “research exception” permits insurers to request, but not require, genetic testing under certain conditions, including that taking a genetic test must be voluntary, that non-compliance may not affect insurance premiums, and that the information gleaned from a genetic test may not be used for underwriting purposes. The Act also prohibits group health insurers from requesting, requiring or purchasing genetic information for underwriting purposes.

With reference to individual health insurance plans, the Act prohibits insurers from using genetic information for establishing rules for eligibility, and for setting premium rates. It also prohibits using the manifestation of a disease in a family member of the applicant for insurance for eligibility or premium rates, and prohibits use of genetic information as a “pre-existing condition” for the individual. It does not prohibit the use of the manifestation of disease *of the individual seeking insurance* for purposes of defining eligibility or rates, or of a family member if the family member is covered by the policy in question.

## E. Summary

This chapter deals with the protections afforded by the ADA, the Rehabilitation Act, and other federal statutes to persons with disabilities in the context of receiving health care. Those protections include the right of access to health care in a health care setting that is the equal to that for persons without disabilities, the right of access to newly constructed or altered health care facilities without architectural barriers, and the right of reasonable accommodations in health care settings such as auxiliary aids and services. It may also include a right to substantive parity in health insurance, but most courts have held that Title III of the ADA does not apply to the substance of health insurance policies.

Besides the ADA and the Rehabilitation Act, a number of recently-enacted federal statutes promote access to health care through insurance and payment of medical expenses for persons with disabilities. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Affordable Care Act attempt to guarantee more equitable insurance coverage of impairments of mental and physical health. Another statute, the Genetic Information Nondiscrimination Act, protects against discrimination in insurance based on a person's or his family's genetic makeup.

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1. Two other Supreme Court decisions have addressed health care issues indirectly, but these decisions do not have the significant precedential application that is found in the three decisions discussed in this chapter. *Irving Indep. Sch. Dist. v. Tatro*, 468 U.S. 883 (1984), excerpted in [Chapter 7\[B\]\[2\]](#), *supra*, was not a Rehabilitation Act case. It addressed the question of whether catheterization is a “related service” rather than a “medical service” to determine whether schools are obligated to provide this service within the mandates of the Individuals with Disabilities Education Act (formerly the Education for All Handicapped Children Act). *Traynor v. Turnage*, 485 U.S. 535 (1988), discussed in [Chapter 2\[B\]\[6\]](#), *supra*, involved a Veterans' Administration policy against providing educational benefits for primary alcoholics (alcoholism based on willful misconduct). The decision is not a health care access case, but since the same reasoning could apply to



health care benefits, it should be mentioned at this point. The Court held that this policy does not violate Section 504. This decision was based on an assessment that congressional intent was clear when Congress indicated that these benefits should not be made available to veterans whose delay in requesting them was a result of their own willful misconduct. The regulations implementing this legislation distinguish between primary alcoholism and secondary alcoholism which relates to organic diseases and disabilities resulting from the chronic use of alcohol. 38 C.F.R. §3.301(c)(2).

2. In subsection (a) the Department “encourages each recipient health care provider that provides health care services to infants” to establish an “Infant Care Review Committee (ICRC)” to assist in the development of treatment standards for handicapped infants and to provide assistance in making individual treatment decisions. In subsection (f), the Department describes its version of a model ICRC. Subsection (f) also provides that “[t]he activities of the ICRC will be guided by ... [t]he interpretative guidelines of the Department.” These guidelines, which are “illustrative” and “do not independently establish rules of conduct,” set forth the Department's interpretation of §504. Although they do not contain any definition of “discrimination,” they do state that §504 is not applicable to parents and that the regulation applies to only two categories of activities of hospitals: (1) refusals to provide treatment or nourishment to handicapped infants whose parents have consented to, or requested, such treatment; and (2) the failure or refusal to take action to override a parental decision to withhold consent for medically beneficial treatment or nourishment. With respect to the second category, the guidelines state that the hospital may not “solely on the basis of the infant's present or anticipated future mental or physical impairments, fail to follow applicable procedures on reporting such incidents to the child protective services agency or to seek judicial review.” With respect to the first category, the guidelines do not state that §504 categorically prohibits a hospital from withholding requested treatment or nourishment “solely on the basis of present or anticipated physical or mental impairments of an infant.” Rather, the substantive guidelines and two of the illustrative examples recognize that the etiology of and prognosis for particular handicapping conditions may justify “a refusal to treat solely on the basis of those handicapping conditions.” (§504 does not require “futile treatment”); (§504 does not require treatment of anencephaly because it would “do no more than temporarily prolong the act of dying”); (same with severely premature and low birth weight infants). In general, the guidelines seem to make a hospital's liability under §504 dependent on proof that (1) it refused to provide requested treatment or nourishment solely on the basis of an infant's handicapping condition, and (2) the treatment or nourishment would have been medically beneficial. The guidelines also describe how HHS will respond to “complaints of suspected life threatening noncompliance” with §504 in this context, progressing from telephone inquiries to the hospital to obtain information about the condition of the infant, to requests for access to records, and finally to onsite investigations and litigation in appropriate cases. The guidelines do not draw any distinction between cases in which parental consent has been withheld and those in which it has been given. Nor do they draw any distinction between cases in which hospitals have made a report of parental refusal to consent to treatment and those in which no report to a state agency has been made. They do announce that the “Department will also seek to coordinate its investigation with any related investigations by the state child protective services agency so as to minimize potential disruption,” indicating that the Department's investigations may continue even in cases that have previously been referred to a state agency.

1. Thank you to Stacey Tovino, Lehman Professor of Law and Director of the Health Law Program at William S. Boyd School of Law, UNLV, for explaining this complicated subject and for creating this outline.