

Legal Briefings

The ADA and the Healthcare Industry¹

Introduction

Healthcare is one of the most important issues of our time. Ensuring that healthcare is accessible – and how best to achieve such access – is a topic central to nearly every political discussion. People with disabilities have been vocal advocates, fighting to ensure that the disability community has access to vital healthcare related services.

While many of our healthcare discussions focus on the availability of health insurance, ensuring meaningful access for people with disabilities requires much more. Healthcare providers must ensure equal access by taking affirmative steps to ensure non-discrimination, to provide effective communication, to modify their policies, to remove barriers that may be architectural, programmatic, or attitudinal in nature. In many ways, the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act provide the legal framework to ensure equal access and remove these barriers.

Through an analysis of recent case law and settlement agreements, this legal brief reviews how the ADA and similar laws have been used to advance the rights of people with disabilities to pursue equal access to healthcare. This legal brief first reviews how Titles II and III apply to patients and companions with disabilities, providing an overview of important topics including non-discrimination, service animals, discrimination against individuals with HIV, effective communication, accessible medical equipment, and insurance coverage. Then, this legal brief reviews how the employment provisions of the ADA under Title I apply to applicants and employees with disabilities in the healthcare field.

I. Title II/Title III: Patients and Companions with Disabilities

A. Coverage Issues

Almost all healthcare organizations are covered by either Title II or Title III of the ADA, as well as Section 504 of the Rehabilitation Act.² Which law applies depends on whether the healthcare provider is public or private, and whether it receives federal funding.

Public hospitals are covered by Title II of the ADA, which applies to the programs, services, and activities of state or local governments, or instrumentalities of state or local government.³ Private hospitals are covered by Title III of the ADA, as “healthcare provider[s]” and “hospital[s]” are specifically listed within the definition of places of public accommodation.⁴

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Title III does exempt “religious organizations or entities controlled by religious organizations, including places of worship,” and this exemption *can* apply to private, religious hospitals.⁵ This was the recent discussion of Title III’s religious exception in ***Reed v. Columbia St. Mary’s***

Hospital, 915 F.3d 473 (7th Cir. 2019).⁶ In ***Reed***, a patient filed a lawsuit under Title III asserting that it failed to accommodate her disabilities by deliberately withholding from her a device she used to speak and then discriminated against her by putting her in a “seclusion” room as punishment. The hospital defended itself by asserting that it fell within the ADA’s religious exemption. The district court agreed and granted the hospital’s motion for summary judgment. However, the Seventh Circuit Court of Appeals reversed this decision on the basis of procedural reasons. It noted that the religious exemption was an affirmative defense and concluded that the hospital waived this defense by failing to plead it in its answer. The Seventh Circuit took the time, however, to emphasize that the defense is “complex, both factually and legally” and noted that “no federal appellate court has yet construed this religious exemption.”⁷ ***But see Cole v. Saint Francis Medical Center, 2016 WL 7474988 (E.D. Mo. Dec. 29, 2016)*** (finding the religious exemption to be properly raised and finding that the hospital was under the jurisdiction of the Bishop of the Roman Catholic Dioceses).

Even if the religious exemption applies, however, private, religious healthcare providers are not completely immune to disability laws. Section 504 of the Rehabilitation Act applies to *any* healthcare provider that receives federal funding, regardless of whether it is public or private and regardless of whether it is religious.⁸ Accordingly, the only exception to coverage of anti-discrimination laws is for private, religious healthcare providers that do not accept any federal funds. Even those, however, should remember that they may have requirements under state and local anti-discrimination laws or building codes. And although private, religious healthcare providers may not be covered by Title III of the ADA, they are still covered by Title I—ADA’s employment discrimination provisions—in most employment situations.

As a general rule, what is prohibited by Titles II or III of the ADA is also prohibited by the Section 504, but there are differences. One is that the U.S. Department of Health and Human Services (HHS), rather than the U.S. Department of Justice (DOJ), promulgates regulations implementing and interpreting Section 504, which apply specifically to entities that receive HHS funding.⁹ Another difference is that under Section 504, a plaintiff may receive compensatory damages if he shows intentional discrimination because the healthcare provider waived the defense of sovereign immunity when it accepted the federal funds.¹⁰ In contrast, under Title III of the ADA, a plaintiff may not receive compensatory damages, as such remedy is not afforded by statute. With respect to Title II entities, compensatory damages are statutorily permitted, and are recoverable for intentional discrimination.¹¹

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While it is undisputed that traditional healthcare providers fall within the definition of “place of public accommodation” under Title III, the current status of non-traditional healthcare organizations is less clear. There is a current split in the courts about whether one particular type of provider—plasma donation centers—are covered by the ADA. As background, at plasma donation centers, the business draws and processes blood from donors, separates and reserves the plasma, and then returns the blood to the donors. Donors are paid for their donations, and the centers sell the plasma to pharmaceutical companies.

The Tenth Circuit Court of Appeals concluded that plasma donation centers are covered by the ADA in *Levorsen v. Octapharma Plasma, Inc.*, 828 F.3d 1227 (10th Cir. 2016).¹² There, a plaintiff with borderline schizophrenia was not permitted to donate blood, despite doing so in the past, due to his psychiatric disability. The plaintiff filed a lawsuit under Title III of the ADA, but the district court dismissed the case, concluding that plasma donation centers are not within the scope of Title III because they are not places of public accommodation. The appellate court disagreed and reversed this decision. In so doing, the Tenth Circuit reviewed the statutory text and concluded that plasma donation centers fall within the meaning of place of public accommodation because they are service establishments. Specifically, the court noted that plasma donation centers are places of business whose work benefited or assisted others, even though they produced no tangible goods in the course of operations. The court expressly rejected the defendant’s argument that it was not a service establishment because it received no direct payment from its donor customers, finding nothing in the ADA language to support such an interpretation. *See also Matheis v. CSL Plasma*, 346 F.Supp. 3d 723 (M.D. Pa. 2018) (allowing plaintiff with PTSD who was rejected as a plasma donor because she used a service dog to proceed, finding that a plasma donation center is a service establishment).

However, the Fifth Circuit Court of Appeals reached the opposite conclusion in *Silguero v. CSL Plasma*, 907 F.3d 323 (5th Cir. 2018).¹³ This case was brought by two plaintiffs—one a person who used a cane as a mobility aid and one with anxiety who used a service animal—who were not permitted to donate plasma. The Fifth Circuit determined that this plasma donation center was not a “service establishment” because it did not provide any *service* to the plasma donors.¹⁴ The court opined that the donor was the one providing the service, not the center, and supported this decision by noting that the company pays the participants, whereas in a more typical service establishment, the participants pay the company. This is an issue to watch, especially as the ADA’s definition of place of public accommodation can arise in various contexts in the healthcare field.

B. Discrimination in the Healthcare Field

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The federal anti-discrimination laws—Title II, Title III and Section 504—prohibit discrimination on the basis of disability.¹⁵ Generally speaking, healthcare providers must provide patients, patients’ companions, and others with disabilities equal access and an equal opportunity to participate in a healthcare provider’s services, programs, and activities.

In recent years, there has been a focus on discrimination on the basis of opioid dependence. In attempt to address these issues, in January 2019, the DOJ reached a settlement with **Selma Medical Associates, Inc.**¹⁶ This settlement arose after the DOJ received a complaint from an individual who alleged that Selma Medical, a medical facility that provides primary and specialty care in Winchester, Virginia, discriminated against him on the basis of disability in violation of Title III. Specifically, the complainant alleged that Selma Medical refused to accept him for a new family practice appointment—or even schedule an appointment—because he was being treated with Suboxone, a prescription medication approved by the U.S. Food and Drug Administration for treating opioid use disorder (OUD).

To resolve this dispute, the medical facility agreed to adopt a non-discrimination statement, disseminate it to all employees who interact with patients and managers, post it in its reception area, and add it to its website. The facility also agreed to provide annual ADA training for all management and staff who interact with patients, and finally, to file a report within 30 days of any request for new treatment by someone with OUD (or for continued treatment by a patient whose disorder became newly known). The status of that request must be documented and, if denied, must include an explanation of such denial along with supporting documentation. The facility must also make DOJ aware of any allegation that it engaged in discrimination against a person with OUD.

C. Service Animals

The ADA requires all entities subject to Titles II and III to modify their no-pets policy to permit access for people with disabilities who have service animals. The regulations interpreting Titles II and III define a service animal as a “dog that is *individually trained to do work or perform tasks* for the benefit of an individual with a disability.”¹⁷ The regulations also make clear that a service animal may be trained to perform any of a wide assortment of tasks, including, but not limited to, guiding an individual who is blind, retrieving or carrying items, pulling a wheelchair, assisting an individual with balance and stability, alerting an individual to certain sounds or allergens, and reminding an individual to take medication.

As one recent DOJ settlement agreement makes clear, simply because the entity is a healthcare provider, most standard rules about service animals still apply. In March 2018, the

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DOJ reached a settlement with ***Hardin County Emergency Medical Services***, after a complainant asserted that his service animal was not allowed to accompany him in an ambulance.¹⁸ Despite its focus on healthcare, this settlement looks similar to many others DOJ settlement agreements regarding service animals. Hardin County EMS agreed that it will not discriminate against individuals with disabilities, that it will make reasonable modifications of policies, practices, or procedures when necessary, including making such modifications to permit the user of a service animal by an individual with a disability. The agreement sets forth when it is proper to exclude a service animal, which mirror the allowable exclusions from DOJ's regulations—when the animal is out of control and the animal's handler does not take effective action to control it or when the animal is not housebroken. Similarly, the agreement outlines the only two questions that can be asked before determining whether to permit the animal to accompany the person: whether the animal is required because a disability and what work or task has the animal been trained to perform.

Given the unique nature of the healthcare field, however, there are often questions about whether it is proper to exclude a service animal for the safety of the patient, other patients, or others. DOJ addressed this issue by stating:

...a healthcare facility must also permit a person with a disability to be accompanied by a service animal in all areas of the facility in which that person would otherwise be allowed. There are some exceptions, however. The Department follows the guidance of the Centers for Disease Control and Prevention (CDC) on the use of service animals in a hospital setting. Zoonotic diseases can be transmitted to humans through bites, scratches, direct contact, arthropod vectors, or aerosols.

Consistent with CDC guidance, it is generally appropriate to exclude a service animal from limited-access areas that employ general infection-control measures, such as operating rooms and burn units. See Centers for Disease Control and Prevention, Guidelines for Environmental Infection Control in Health-Care Facilities: Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (June 2003), available at http://www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf (last visited June 24, 2010). A service animal may accompany its handler to such areas as admissions and discharge offices, the emergency room, inpatient and outpatient rooms, examining and diagnostic rooms, clinics, rehabilitation therapy areas, the cafeteria and vending areas, the

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pharmacy, restrooms, and all other areas of the facility where healthcare personnel, patients, and visitors are permitted without taking added precautions.¹⁹

It is important to remember that when determining whether it is appropriate to exclude a service animal, healthcare providers must conduct an individualized assessment, considering all possible reasonable accommodations in good faith, instead of relying solely on blanket bans. Similarly, any concerns about safety must be sufficiently individualized instead of mere speculation.

For example, in *Tamara v. El Camino Hospital*, 964 F. Supp. 2d 1077 (N.D. Cal. 2013), a hospital argued that allowing a service animal to accompany the plaintiff in a psychiatric unit would pose a direct threat because the harness could be used as a weapon and the presence of the animal could upset other patients.²⁰ There, the district court ruled that these potential risks were merely speculative, and there was no evidence that the hospital had engaged in an individualized analysis of whether the particular patient and her service animal actually posed these threats. Furthermore, the court noted that even if these risks were genuine, the hospital had failed to assess whether any accommodations could be made that would ameliorate the threats, as it was required to do.

Compare that to *Roe v. Providence Health System-Oregon*, 655 F. Supp. 2d 1164 (D. Ore. 2009), where a healthcare facility successfully demonstrated that the presence of a service animal was a direct threat to the safety of welfare of other patients and staff by conducting an individualized analysis and attempting to implement accommodations to reduce the risk.²¹ In *Roe*, the plaintiff who used a service animal was an intermittent patient of the hospital. Throughout the years, a number of problems arose. For instance, the dog's "putrid odor" resulted in patient transfers; the animal growled at a nurse who was caring for the patient, making it difficult for staff to assist the patient in and out of bed; there was a concern that the animal had a skin infection, which could possibly spread; and there was not a handler always available to relieve the dog while the plaintiff was bedridden. Despite these incidents, the hospital did not seek to exclude the animal completely. Instead, it offered a compromise by requesting that the patient close her door while the dog was present and offered to provide a HEPA filter. The patient, however, refused and instead brought an ADA lawsuit against the hospital for failure to permit her service animal. The court concluded that the service animal posed a direct threat based on his conduct and skin infection. The court also noted that the plaintiff had failed to agree to any of the accommodations proposed by the hospital in attempt to address the risks, and thus, the hospital had sufficiently engaged in an individualized inquiry. In addition to dismissing the plaintiff's case, the court further enjoined her from bringing her service animal to the hospital if she planned to return. **See also Consent Decree between Tracy**

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and Stan Rousseau and Adventist Healthcare West, 4:17-cv-02985 (N.D. Cal. March 13, 2018) (updating its service animal policy to ensure access to all areas of the hospital open to patients, but including right to exclude service animals who pose a direct threat to the safety or welfare of the hospital’s patients or staff).²²

D. Discrimination against People with HIV

A review of ADA case law within the healthcare field reveals a number of cases brought by people with HIV that raise a number of legal issues, including questions about direct threat, eligibility criteria, and reasonable modifications.

Regarding direct threat, Title II and III entities cannot disqualify a qualified individual with a disability due to safety fears without first conducting a direct threat analysis. In the healthcare content, there have been cases where people with disabilities, including people with HIV/AIDS, are excluded from treatment based on myths, stereotypes or knee-jerk reactions. The U.S. Supreme Court explored the question of direct threat in the first ADA case that it ever heard, one which coincidentally involved a plaintiff with HIV. ***Bragdon v. Abbott, 524 U.S. 624 (1998)***, involved a dentist who had denied treatment in his office to an HIV-positive patient, citing the direct threat to his own safety that he alleged treating this patient would pose.²³ In its ruling for the plaintiff, the Court reiterated the duty of a covered entity to make an individualized inquiry as to the circumstances of the particular plaintiff, and noted “that courts should assess the objective reasonableness of the views of healthcare professionals without deferring to their individual judgments.”²⁴

One recent case brought by the DOJ is a good example of issues regarding eligibility criteria and reasonable modifications for individuals with HIV. In ***United States v. Asare, 2018 WL 2465378 (S.D.N.Y. June 1, 2018)***, the DOJ brought a case on behalf of a number complainants with HIV who sought male breast reduction surgery, but who had been denied services from the healthcare provider.²⁵ The doctor’s office cited his blanket policy against operating upon HIV-positive patients who were also taking antiretroviral medications, as plaintiffs all were. The DOJ asserted that this practice screened out potential patients taking antiretroviral medication. The court outlined the ADA’s restriction against “the imposition or application of eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities ... unless such criteria can be shown to be necessary.”²⁶ The court found for the DOJ in light of the fact that the healthcare provider provided no evidence that this policy was necessary. Furthermore, the court noted that, even if defendant had established that the complainants posed a safety risk, the provider still failed to offer any reasonable accommodations, or to consider any of those the complainants themselves proposed. Finally,

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the court concluded that the defendant could not claim that such accommodations would constitute a fundamental alteration to his workplace, as he had failed to even investigate any such accommodations by way of the interactive process.

As the *Asare* case demonstrates, the DOJ has been active in using the ADA to fight discrimination against people based on their HIV status. Another example is the DOJ's settlement with *Pain Management Care (PMC)*.²⁷ PMC is a healthcare provider in Indiana that refused to treat a potential patient because he has HIV. As a result of the settlement, PMC agreed that it will develop a written non-discrimination policy to be included in any internal policy handbook, guidance or materials, as well as post the policy on the front page of its website and include it on all external publications or advertisements. Specifically, this policy shall state: "Pain Management Care, P.C., does not discriminate on the basis of disability, including HIV. All individuals, including persons with HIV, have an equal opportunity to treatment from Pain Management Care, P.C."²⁸ As part of the agreement, PMC also agreed to provide ADA training to its management and employees that regularly interact with patients, which will include requirements under Title III of the ADA, including a focus on individuals with HIV, PMC's settlement agreement with the DOJ, and PMC's new policies. PMC also agreed that it will report to the DOJ when it receives a request for new treatment by any individual with HIV, as well as keep the DOJ informed of the patient's request for treatment and any decisions to deny or stop treatment. Finally, PMC paid \$20,000 in compensatory damages to the aggrieved party as well as \$10,000 in civil penalty to the DOJ.

This is just one of many examples of settlement agreements entered into by the DOJ on behalf of individuals with HIV/AIDS in the healthcare field.²⁹ These settlement agreements have a number of similarities, and typically include a pledge by the provider to adopt and implement a non-discrimination policy, to submit to ongoing monitoring by DOJ, and to provide Title III training for staff and administrators. Many agreements also include financial settlements for the aggrieved parties.

E. Effective Communication

Title II, Title III and Section 504 all include powerful language about the right of an individual to receive the necessary auxiliary aids and services necessary for effective communication. Regulations promulgated under Title II state two requirements. First, they provide that "[a] public entity shall take appropriate steps to ensure that communications with applicants, participants, members of the public, and companions with disabilities are *as effective* as communications with others."³⁰ Second, they specify that public entities must "furnish appropriate auxiliary aids and services where necessary to afford an individual with a disability

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an equal opportunity to participate in, and enjoy the benefits of, a service, program, or activity conducted by a public entity.”³¹

The Title III regulations similarly require places of public accommodation “to furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities.”³²

Regulations promulgated by HHS require medical providers that receive federal funds to “establish a procedure for effective communication with persons with impaired hearing for the purpose of providing emergency healthcare.”³³ In addition to this general regulation, hospitals with fifteen or more employees are required to “provide appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills, where necessary to afford such persons an equal opportunity to benefit from the service in question.”³⁴

Both the DOJ and private litigants have used the ADA to actively address issues of effective communication in the healthcare field and thus, a high percentage of ADA cases against healthcare providers question whether the provider met its obligation to provide auxiliary aids and services when necessary to ensure effective communication.

1. ASL Interpreters and Video Remote Interpreting

One of the most pervasive questions in cases involving effective communication comes down to whether a covered entity was required to provide a particular auxiliary aid or service. Similar to other aspects of the ADA, the ADA’s effective communication requirements do not specify which auxiliary aid should be provided in every instance. And under the ADA, there is no one-size-fits-all solution when it comes to the provision of auxiliary aids and services. Instead, there must be an assessment of the nature, length, complexity, and context of the communication and the person’s typical method of communication.³⁵

However, the DOJ has provided some guidance to help healthcare providers understand their obligations.³⁶ The DOJ explains that in some cases, it may be sufficient for a provider to communicate with the individual simply by means of typed or handwritten notes. For example, written notes may suffice in cases involving simple and routine procedures wherein conversation is minimal, such as with routine lab tests or regular allergy shots. However, sign language interpreters should be used for communications that are more complex, such as discussions of medical history, diagnoses, procedures, treatment decisions, or communications regarding in-home care.

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While the determination of what auxiliary aid and service is appropriate is a fact-specific and individualized inquiry, given the complex nature of healthcare, there are many times when the provision of a sign language interpreter will be the only effective way to communicate with a Deaf person.

A good example of a case addressing the need for ASL interpreters for effective communication is *Crane v. Lifemark Hospitals, Inc.*, 898 F.3d 1130 (11th Cir. 2018).³⁷ In this case, the plaintiff is deaf and has chronic depressive and anxiety disorders. He was taken to the hospital and evaluated under a state law, called the “Baker Act” to see if he posed a direct threat to himself or others. He asked for an interpreter, but one was not provided. Instead, he communicated during this important evaluation through written notes and the doctor’s own basic sign language skills. Although the patient was in the hospital for three days, an interpreter was not provided until the third day, once the decision had already been made. The patient then brought an ADA case against the hospital. The trial court found for the hospital, concluding that the hospital met its duty to conduct an evaluation and therefore, provided effective communication. However, on appeal to the Eleventh Circuit Court of Appeals, the court found for the patient and reversed and remanded this decision. In so doing, it emphasized that the focus in an ADA case is not whether the medical personnel met the basic requirements of the Baker Act or made correct decision but whether the patient had an equal opportunity to communicate medically relevant information. Here, the court concluded that a reasonable jury could find that the patient could not based on his affidavit stating that he could not explain or detail his feelings, along with the doctor’s own notes, which acknowledged difficulty with communication.

Another case that reminds healthcare providers about the importance of using an ASL interpreter when discussing a complicated medical procedure with an individual who is deaf and typically uses ASL to communicate is *Liese v. Indian River County Hospital District*, 701 F.3d 334 (11th Cir. 2012).³⁸ In *Liese*, the court considered a discrimination claim brought by two plaintiffs, a husband and wife, who were both deaf, after the wife underwent an emergency procedure to remove her gallbladder through laparoscopic surgery. Despite plaintiffs’ requests for an on-site sign language interpreter, hospital personnel communicated with plaintiffs only by mouthing words, writing notes, and pantomiming. In this case, finding sufficient evidence that the limited auxiliary aids that defendant had provided were ineffective, the court ruled in favor of plaintiffs, reversing the district court’s decision to grant summary judgment. The Eleventh Circuit noted that “under circumstances in which a patient must decide whether to undergo immediate surgery involving the removal of an organ under a general anesthetic, an understanding of the necessity, risks, and procedures surrounding the surgery is paramount.”³⁹ The court determined that the aforementioned communication methods utilized by defendant

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However, depending on the complexity of the communication and the patient's ability to understand, some courts have concluded that providing an ASL interpreter is not necessary. In ***Martin v. Halifax Healthcare Systems, 2015 WL 4591796 (11th Cir. July 31, 2015)***, the Eleventh Circuit reviewed the claims of several plaintiffs who were deaf and who had at various times been treated at a particular hospital.⁴⁰ The hospital system had provided a number of auxiliary aids and services for past visits, including ASL interpreters. Focusing on one particular incident where one of the plaintiffs said he had to communicate through written note instead of through an ASL interpreter during a visit to the emergency room. The court found for the hospital, noting that an interpreter had not been necessary because the plaintiff received typed instructions and indicated that he understood them. Accordingly, according to the court, the hospital had achieved effective communication.

The DOJ settlement with **Overlake Medical Center** addresses a number of potential problems when providing effective communication in the healthcare setting, including issues with the timely provision of on-site interpreters, use of companions to interpret, and more.⁴¹ In this case, a complainant, who is deaf, failed to receive an interpreter for various points throughout her labor and delivery experience. Specifically, she had requested an interpreter 10 days in advance and while she had an interpreter on a few sporadic occasions, she largely did not during her initial evaluation, her labor induction, the discussion about her informed consent, and most of her labor and delivery. As a result, the complainant's mother, who was not familiar with medical terminology and was not proficient in ASL, was called upon to interpret through the rest of her labor and delivery, including her cesarean section. Because the complainant's mother was in the room, and because the complainant was limited to one family member, the child's father was not permitted to be in the room for the delivery. Bringing this to the DOJ's attention, the complainant asserted that she, her companion, and her mother were discriminated against.

Among other highlights, this settlement requires the medical provider to provide appropriate auxiliary aids and services as necessary, determining what is appropriate in consultation with the deaf or hard of hearing person at the time an appointment is scheduled or the time of arrival (particularly if someone other than the patient schedules the appointment). There is also a list of circumstances in which an interpreter is generally presumed to be necessary for effective communication. The Medical Center must designate an Assistive Device Point Person, who shall be available 24/7 and will know where aids are and how to use them and will be responsible for maintaining them. The settlement requires interpreters to be provided in a timely manner, for non-scheduled requests, within 2 hours for an on-site interpreter and 30 minutes for VRI.

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Central to any review of case law about ASL interpreters is a discussion about the use of Video Remote Interpreting (VRI). VRI is technology that connects the user with an off-site interpreter through the use of a video conferencing system in order to facilitate communication. The DOJ's regulations include VRI as an example of a type of auxiliary aid and service for people who are deaf or hard of hearing. VRI offers some potential advantages, including cost savings for short appointments and the fact that it may be used for patients in rural areas where sign language interpreters may not be readily available, or in emergency situations where interpreters are not available on site.

However, there are a number of steps that must be taken for VRI to function effectively, which are spelled out in DOJ's regulations.⁴² Specifically, the healthcare provider must have a high-speed, wide-bandwidth video connection available in order to prevent low-quality video images. Moreover, staff must be properly trained in order to set up and operate the VRI system efficiently.

Even when these steps are met, VRI may still not be effective in all situations and has certain inherent limitations. For example, DOJ has expressed concerns regarding the use of VRI to communicate with individuals who may have difficulty accessing the screen because they have limited vision, or because of their positioning due to injury.⁴³ Likewise, the National Association of the Deaf (NAD) has expressed concern that healthcare providers may rely too heavily on VRI at the exclusion of more appropriate methods of communications, and that VRI can be ineffective where systems experience technical issues or where provider staff are not properly trained in its use.⁴⁴

Both the DOJ and private parties have negotiated specific terms in their settlement agreements to help healthcare providers understand when VRI will not be effective.⁴⁵ For example, agreements include language stating that an on-site sign language interpreter will generally be required where the patient has limited movement in their head, arms, or hands; where a patient has vision issues; where a patient has cognitive issues or is under the influence of drugs or alcohol; where a patient is in significant pain, including labor; where the medical issue is complex; if there are space limitations in the treatment facility; or at any time it is clear that the alternative method of communication is no longer effective.⁴⁶

One example of an agreement that provides additional detail is the settlement reached in *Morales v. Saint Barnabas Medical Center*.⁴⁷ There, the hospital committed to satisfy DOJ regulatory requirements going forward, including an assurance that its VRI equipment would

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only be used so long as it projected a clear and high-quality image. Furthermore, the hospital promised never to use VRI in circumstances where it was not effective or appropriate, such as where a patient cannot readily see or understand it, where the information exchanged is highly complex, where hospital staff cannot activate or operate the equipment expeditiously, or where no designated high speed Internet line is available. The hospital further agreed to provide a live interpreter whenever VRI is not effective, or where a patient indicates that it is not meeting his or her needs. **See also *Moss v. Newark Beth Israel Med. Ctr.*, 13-cv-4360 (D.N.J. Consent Order, Feb. 16, 2017)** (outlining when VRI will not be effective).⁴⁸

Courts have also had the opportunity to assess the effectiveness of VRI in the medical context. In ***Silva v. Baptist Health South Florida*, 856 F.3d 824 (11th Cir. 2017)**, plaintiffs sued the defendant hospital system for its alleged failure to provide them with effective communication over the course of their many medical visits.⁴⁹ Defendant had not accommodated their requests for live sign language interpreters, and had instead persistently relied upon VRI to communicate with plaintiffs during their visits. Plaintiffs alleged that defendant's use of VRI violated their rights under both Title III and the Rehabilitation Act, due to chronic technical difficulties and practical limitations incurred during use of defendant's VRI system. Specifically, plaintiffs asserted that the VRI machine was often inoperable or unusable, that the picture on the monitor was commonly blocked, frozen or degraded, and that hospital staff frequently did not know how to use the equipment or to resolve technical problems.

At first, the district court ruled in favor of defendants, finding that it had provided plaintiffs with effective communication. In its ruling, the court noted that plaintiffs had presented no evidence that defendants had ever misdiagnosed them or given them improper medical treatment, and that plaintiffs had not identified any particular information that defendants had communicated, but that plaintiffs had not understood. Accordingly, the court found that plaintiffs lacked standing to seek injunctive relief, and granted defendants' motion for summary judgment. On appeal, however, the Eleventh Circuit Court of Appeals reversed, and remanded the case for further proceedings. The court found that the lower court had applied the incorrect standard in its review, and that ADA and Rehabilitation Act claims are not to be evaluated by the same criteria as those applied to medical malpractice claims. Specifically, the court noted that the proper focus should be upon the nature of the communication itself, not the consequences of the failed communication. The court considered the question of whether any of the plaintiffs had experienced a real hindrance due to their disability, affecting their ability to exchange material medical information with their healthcare professionals. Here, Plaintiffs provided evidence that they were hindered due to the difficulties using VRI, and the absence of live interpreters. Furthermore, the court noted that plaintiffs had no duty to identify exactly what information they were unable to understand or convey. As a point of reference, the court cited DOJ regulations regarding the appropriate use of and training for VRI. Finally, the court found

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that plaintiffs did in fact have standing, as they regularly used the defendant hospital, lived nearby, and were likely to return in the future.

Given the consequences at stake in many conversations conducted with healthcare providers, it is important for healthcare providers to ensure effective communication both so that their information communicated is understood and due to the often emotional conversations involved in healthcare cases. For example, consider the situation in ***Shaika v. Gnadon Huetten Memorial Hospital*, 2015 WL 4092390 (M.D. Pa. July 7, 2015)**.⁵⁰ Here, the plaintiff was a deaf mom whose daughter had died at the hospital after being rushed there for emergency treatment as a result of a heroin overdose. The plaintiff asked for an interpreter when she arrived at the hospital, but none was provided. The hospital tried to use its VRI machine, but it malfunctioned so the hospital staff resorted to communicating with plaintiff through written notes, which was how plaintiff learned that her daughter had died. While the plaintiff understood that her daughter had died, she was unable to understand any additional information about the circumstances of her death. When challenged, the court found for the plaintiff by denying the hospital's motion to dismiss the plaintiff's claim that the hospital acted with deliberate indifference to plaintiff's right to effective communication.⁵¹

It is well-settled that the ADA's effective communication obligations extend to companions with disabilities. For purposes of the ADA, a "companion" is defined as "a family member, friend, or associate of an individual" accessing either the public entity or place of public accommodation, "who, along with such individual, is an appropriate person with whom the [public entity or public accommodation] should communicate."⁵²

A recent case about the rights of companions raises some questions for healthcare providers and the disability community. In ***Durand v. Fairview Health Services*, 902 F.3d 836 (8th Cir. 2018)**, an adult patient was admitted to the ICU for renal failure.⁵³ His parents were Deaf and the hospital provided them with an ASL interpreter for some, but not all, communications. The patient had designated his sister as his sole healthcare agent and authorized his other siblings to receive medical information. Due to the lack of interpreters, the patient's sister was forced to interpret for her parents. The parents filed a lawsuit for failure to provide effective communication and his sister filed for associational discrimination. The Eighth Circuit Court of Appeals found for the healthcare system and affirmed summary judgment for the hospital. In so doing, it explained that under the ADA and Section 504, the healthcare provider was required to provide meaningful access, which was an equal opportunity to gain the same benefit as their hearing peers. It also emphasized that the parents were family members, but

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not decision-makers. Accordingly, when it determined whether effective communication was provided, it considered the fact that the patient's parents were not authorized to receive medical information and that the patient's condition developed into an urgent, emergency situation; accordingly, the medical team had to make immediate, time-sensitive decisions so it was reasonable to prioritize conversations with parties with decision-making authority. It concluded on these facts, the healthcare provider met its burden.

Regarding the patient's sister's claim, the court also found for the hospital. It noted that there is a circuit split about the scope of associational standing where some courts require the injury to be causally related to the denial of a federally required service or personally denied a benefit. The court concluded that here, there were no injuries that were causally related to the denial because the parents were not denied a required service.

Compare that, however, to *Loeffler v. Staten Island University Hospital*, 582 F.3d 268 (2nd Cir. 2009), where the Second Circuit reviewed a case involving a hospital patient and his wife, both of whom were deaf and required sign language interpreters for effective communication.⁵⁴ Because the hospital failed to provide either interpreters or any viable alternative means of communication during the patient's stay, his adolescent children were forced to interpret. The court found that the children had suffered an independent injury, causally related to the hospital's failure to provide auxiliary aids and services to their parents. As it was, the children had been required to fill the gap left by the hospital's indifference and ADA violations. The court noted that the children were required to miss school because they had to be on-call to provide interpretation, and that they were "needlessly and involuntarily exposed to their father's condition," placing them at risk of emotional trauma due to their young age.⁵⁵

DOJ has also addressed the issue of companion communication in a settlement that it reached with a nursing home facility, stemming from a complaint filed by the daughter and granddaughter of one of the facility's residents.⁵⁶ Complainants were both hard of hearing and had requested that the facility provide them with a sign language interpreter to aid in their communications with staff regarding the resident's status and care. When the facility denied this request, complainants asserted that this was a violation of their right to effective communication. DOJ maintained that the nursing facility had an obligation to provide auxiliary aids and services to both complainants as "legally cognizable companions." It noted that the daughter was listed as the patient's emergency contact and next of kin, thus should have had an interpreter for various communications, including communications with staff regarding care issues, treatment options, and discharge planning. Instead, the facility relied on an unqualified staff member who lacked the requisite skills to interpret for complainants. In the settlement, the facility agreed to amend its policies to provide appropriate auxiliary aids and services to both patients and their companions going forward.

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A key component of the ADA's obligation to provide effective communication is to ensure that written materials are accessible to people with are blind or visually impaired. Healthcare is one industry that provides a significant amount of important information in writing and thus, it is not surprising that there have been cases and settlement agreements about the appropriate way to make written material accessible.

One example comes from *Figueroa v. Azar (HHS/CMS), 16-cv-30027 (D. Mass.)*, where the plaintiffs asserted that HHS violated Section 504 by denying blind Medicare beneficiaries meaningful and equally effective access to Medicare information.⁵⁷ This case settled after years of litigation, and HHS will ensure that its communications and notices from Medicare are available in an accessible format, including without limitation, large print, Braille, audio, electronic format. HHS will promote the availability of accessible materials to beneficiaries, as well as issue best practices to Medicare Health/Drug Plans about how to ensure accessibility for patients who are blind and visually impaired. Further, it will implement a policy that extends the time for a beneficiary to answer time-sensitive communications to account for the time it takes to process requests for alternate formats so that individuals seeking alternative formats are not prejudiced in terms of completing specific deadlines.

It goes without saying that prescription medications are very important to the successful management of a medical condition. Despite this great importance, it was difficult for many people to access the information printed on a standard prescription container. However, a recent innovation called "talking" prescription containers is a great way to ensure effective communication and accommodate many people with disabilities. Practically speaking, a talking prescription container is a device that attaches to the label on a prescription container and can read its printed information aloud. This device can also emit an alarm to remind the prescription-holder that it is time to take the medication. This is an excellent example of the various types of auxiliary aids and services that can lead to effective communication, especially with the advance of new technologies.

Attorneys Lainey Feingold and Linda Dardarian have been on the forefront of advocating for talking prescriptions and have succeeded, primarily, though an advocacy strategy called structured negotiation. Structured negotiation is a collaborative and solution-driven advocacy and dispute resolution method conducted without litigation. For example, in 2014, as a result of structured negotiation, **Walgreens** agreed to launch a nationwide program to offer talking prescription devices to its blind and visually impaired customers.⁵⁸ In addition, structured

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negotiation led to the implementation of talking prescriptions at numerous leading pharmacy corporations.⁵⁹

3. Website Accessibility

The ADA's requirement to provide effective communication has also been interpreted to mean that information relayed on the websites of healthcare providers must be accessible to people with disabilities. As more healthcare providers relay information electronically, it is even more important to ensure that such information is accessible to everyone. However, digital barriers can prevent an individual from a disability from accessing basic medical information, as well as scheduling appointments or otherwise accessing the information that is available electronically enjoyed by their nondisabled counterparts.

Digital barriers take many forms. Some people with disabilities use adaptive technology, such as screen reading software, to access digital content. As a result, it is important that websites and electronic information be formatted in a way that keeps accessibility in mind. For instance, any information communicated visually through images must include a narrative description called alternative text. Additionally, some people with disabilities may be unable to control a mouse due to limited dexterity; as a result, it may be difficult to navigate a website featuring links and buttons that are not spaced and ordered thoughtfully on the page. Healthcare providers that communicate information through online videos must ensure that these videos are captioned so that people who are deaf and hard of hearing have meaningful access to that content.

In the healthcare field, just like for talking prescription containers, structured negotiation has provided an effective medium for obtaining website modification, and ensuring ongoing accessibility of healthcare providers' online materials.⁶⁰ As part of many settlement agreements, healthcare organizations agree to conform their website to the Web Content Accessibility Guidelines (WCAG) 2.0, Conformance Level AA Success Criteria.

For instance, in 2017, **Massachusetts Eye and Ear**, through structured negotiation, agreed to ensure that its website met WCAG 2.0, AA, adopt a Web Accessibility Policy, engage in usability testing, undergo an annual audit by an outside consultant, and designate an employee as the Web Accessibility Coordinator.⁶¹ Additionally, while not specifically within the context of healthcare providers, the DOJ has required public accommodations to implement website accessibility measures as a part of settlement agreements, and presumably will do so in the healthcare setting.⁶²

D. Administration of Medication

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Ensuring that individuals' health-related needs do not become a barrier to enjoying equal access to places of public accommodation or public entities has been a priority issue for the DOJ in recent years. Specifically, the DOJ has pursued various enforcement actions on behalf of children with diabetes who might otherwise be excluded by child care providers unwilling to modify their practices to provide basic diabetes management care, such as assistance monitoring their blood glucose levels, administering insulin, or administering glucagon in emergency situations.

For example, in 2018, the DOJ announced a settlement with **Kindercare**, a company that operates 1,800 facilities for child care and camp.⁶³ DOJ became involved after Kindercare refused to help administer insulin via syringe or pen to kids with diabetes. However, now, as a result of the settlement agreement, Kindercare has agreed that it will evaluate modification requests on an individualized basis using objective evidence and current medical standards. It also agreed that when approved by a parent and found appropriate by a healthcare professional, it will support providing training to childcare staff to provide routine diabetes care to a children, and that providing such care, including administering insulin by pen, syringe or pump, is generally reasonable. To remedy past problems, Kindercare agreed to contact all families who were denied this request in past year and provide monetary compensation in the form of \$8,000 to each of the three aggrieved families. Kindercare will revise and publicize these new policies, including providing a sample diabetes plan. DOJ's efforts with Kindercare are not unique. Also in 2018, the DOJ announced a settlement with the **Learning Care Group (LCG)**, another one of the nation's largest for-profit child care providers, whereby LCG agreed to provide reasonable accommodations for children with insulin-dependent diabetes, as well as financial settlements to the complainants.⁶⁴

In addition to ensuring the appropriate assistance with insulin, DOJ has reached settlement agreements with childcare providers who refuse to provide emergency medication, if necessary, for kids with diabetes. In 2015, the DOJ settled with **Winnewald Day Camp** which had refused to provide the accommodations necessary for a prospective camper with diabetes to attend its program. In the settlement agreement, the camp pledged to develop an ADA/diabetes policy, to henceforth Individually assess the needs of each camper and prospective camper with diabetes, to assist all such campers and to make reasonable efforts to comply with their diabetes medical management plans (DMMPs), and to provide training for camp staff by a qualified professional, including instruction on the administration of insulin and emergency medication (glucagon).⁶⁵

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Additionally, beginning in 2016, DOJ entered into settlement agreements with a number of local YMCAs, in order to ensure inclusion of children with diabetes at those facilities as well. By way of these agreements the individual YMCAs have generally committed to modifying their existing policies, including by adopting DMMPs, to training staff regarding basic diabetes management, monitoring, and the administration of insulin and glucagon, to promoting general awareness of Title III nondiscrimination principles, and to ongoing oversight by DOJ.⁶⁶

In 2015, DOJ opened an investigation for a camp that refused to admit camper with epilepsy who required emergency medication (Diastat) for seizures. DOJ and the camp reached a settlement in which the camp agreed it would train staff to administer Diastat. The camp also agreed to adopt a Seizure Emergency Action Plan and Physician's Order for the administration of Diastat so that it has individual instructions. In the agreement, DOJ stated "it is the United States' position that it generally will be a reasonable modification by title III of the ADA for certain public accommodations, such as camps and child care service providers, to train laypersons to administer Diastat."⁶⁷ However, in a case with similar facts that went to trial, a judge found that it was not a reasonable accommodation for a special education recreational program to administer Diastat to a child with epilepsy.⁶⁸ It is anticipated that this issue will continue to be one in which stakeholders disagree and more ADA litigation will be filed.

E. Accessible Medical Facilities and Equipment

Hospitals, doctor's offices and other healthcare providers have an obligation to make their facilities accessible to people with disabilities wherever possible, including an obligation to remove physical access barriers and to purchase and maintain medical equipment that accommodates the needs of patients with disabilities.

When Congress passed the ACA, it also amended Section 510 of the Rehabilitation Act, which authorized the U.S. Access Board to develop accessibility standards for medical diagnostic equipment. The U.S. Access Board developed such standards, which became effective on February 8, 2017, and which establish minimum technical criteria ensuring that patients with disabilities can independently enter, use and exit from medical diagnostic equipment to the maximum extent possible. Unfortunately for people with disabilities, these standards do not include a requirement about the minimum number of types of accessible medical equipment required in different types of healthcare facilities. Further, these standards have not been adopted by the DOJ so are not enforceable as federal regulations. However, the MDE Standards do provide guidance for healthcare providers about how to meet their ADA obligations. As just

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a few examples, the Standards discuss wheelchair accessible scales; adjustable exam tables; and accessible mammography equipment.⁶⁹

In addition to these 2017 Standards, in July 2010, DOJ issued guidance in a fact sheet pertaining to these requirements with regard to people with mobility disabilities, which continues to be valuable today.⁷⁰ This document recaps the duty of medical facilities to provide full and equal access to their healthcare services and facilities, as well as reasonable modifications to policies, practices, and procedures when necessary to make healthcare services fully available to individuals with disabilities, unless such modifications would fundamentally alter the nature of the services.

In recent years, DOJ has reached comprehensive agreements with healthcare facilities that are resulting in systemic change. These agreements frequently require facilities to increase the accessibility of patient rooms, exam rooms and medical equipment, bathrooms, as well as to conduct staff training, revise accessibility policies and procedures and hire someone to oversee the remediation efforts set forth in the agreement.⁷¹

In addition to DOJ's efforts, several systemic agreements by private litigants have worked to make healthcare facilities and equipment accessible through structured negotiation.⁷²

Also, numerous private suits have been brought against healthcare providers for failing to provide accessible facilities and medical equipment. In ***Metzler v. Kaiser, Case No. 829265-2 (Sup. Ct. for the State of Cal., Alameda Co.)***, people with mobility impairments filed litigation alleging that Kaiser fails to full and equal access to its healthcare facilities across the state of California.⁷³ Subsequently, the case settled and is one of the first comprehensive settlements with major healthcare provider. Settlement terms include: 1) hiring an Access Coordinator who has expertise in ensuring accessible healthcare for people with disabilities; 2) establishing an Access Plan to identify and remedy access barriers in Kaiser facilities statewide; and surveying medical equipment for accessibility and developing a procurement plan for acquisition of accessible equipment.⁷⁴

Healthcare is a broad group and of course, includes specialized services, such as radiology services and diagnostic imaging. The DOJ reached a settlement agreement with **Thomas Jefferson University Hospitals Inc. and Outpatient Imaging Affiliates** to ensure that patients with mobility disabilities are able to access these important specialized services.⁷⁵ The complainant has cerebral palsy, osteoporosis and uses a wheelchair. He filed a complaint with DOJ asserting that he attempted to receive a bone density scan as a walk-in patient but,

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because of his disability, he needed help transferring from his wheelchair to the specific machine. He asserts that the radiological technician said that they did not have staff available to transfer him and thus, he was not transferred and was unable to receive medical services. As part of the settlement, Jefferson Outpatient agreed to adopt a non-discrimination policy which, importantly, provides that staff will ask the patient exactly what type of assistance he needs and how he prefers to be assisted to provide a safe and effective transfer. Jefferson Outpatient also agreed to train all staff who interact with patients on the requirements of Title III as they apply to healthcare facilities and on techniques for safely assisting individuals with mobility disabilities to transfer to imaging or examination tables. This training will be incorporated in its new orientation for all future employees. Jefferson Outpatient will ensure that it has staff available to assist with transferring, and also represents that it has taken steps to ensure that each of its outpatient facilities has a Hoyer lift, or other patient lift designed to safely transfer a patient. The DOJ reached a similar agreement with **Charlotte Radiology**, where a patient was offered only a forearm scan of bone density in lieu of a hip scan because the provider refused to assist her in transferring to the appropriate machine.⁷⁶

Sometimes training about how best to transfer is not enough, however, as certain medical technology requires that the patient be seated in a very particular area for an adequate examination, as is the case with optometry and ophthalmology equipment. In ***Luna v. America's Best Contacts and Eyeglasses, Inc.*, 11-cv-01783 (N.D. Ill. Complaint filed Mar. 15, 2011)**, a class action was brought by three wheelchair users who were unable to receive an eye exam because inaccessible examination rooms and equipment at 337 stores.⁷⁷ The parties entered into a comprehensive class settlement, which included the defendant agreeing to 1) retain an ADA Consultant to perform accessibility surveys and monitor remediation efforts; 2) secure ADA training for all personnel; 3) update policies and procedures for treating people with disabilities; and 4) each store must have: a chair glide, accessible eyeglass and contacts fitting locations, and accessible exam room.⁷⁸

III. Insurance

A. Insurance and the ADA

Ensuring that people with disabilities have access to insurance is an important goal; unfortunately for people with disabilities, the ADA has not proven to be a highly effective legal vehicle to pursue this fight.

People with disabilities have used the ADA to challenge certain aspects of insurance policies, such as insurance policies that place limits on particular disabilities. Historically, this issue arose

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because insurance companies were capping the amount of coverage available for people seeking treatment for mental health and HIV/AIDS. Most recently, this issue has arisen as insurance companies are capping coverage for people with autism.

In these actions, courts first consider whether the insurance policy itself is covered by the ADA and, if so, whether the policy amounts to unlawful discrimination under the ADA.

Regarding the first question, the issue is whether an insurance company or insurance policy falls within Title III of the ADA, which applies to “places of public accommodation.”⁷⁹ Some courts construe this statutory language to require an actual, physical space to invoke ADA protection.

This narrow interpretation can be found in *Parker v. Metropolitan Life Insurance Co.*, 121 F.3d 1006 (6th Cir. 1997).⁸⁰ Here, the plaintiff challenged the disparity between the insurance policy’s treatment of physical and mental health impairments. Whereas the employee’s long-term disability insurance policy covered physical impairments until the employee turned sixty-five, it limits mental health coverage to twenty-four months. The employee brought a lawsuit under Title III of the ADA, but the district court dismissed her case and the appellate court affirmed this dismissal. The courts reasoned that because the plaintiff obtained her insurance through her employer, instead of through an office with a physical space (such as an insurance officer), it fell outside the scope of Title III protection. *See also Ford v. Schering-Plough Corp.*, 145 F.3d 601 (3d Cir. 1998) (concluding that Title III did not apply to the insurance policies in question because there was no nexus between the policy and the physical insurance office).

Although many of these insurance cases are decades old, this issue remains very real for many people. In one recent case, *Doe v. Bluecross Blueshield of Tenn., Inc.*, 2018 WL 3625012 (W.D. Tenn. 2018), a plaintiff with HIV/AIDS brought an ADA case asserting that his insurance plan classified his medications as specialty medications that must be obtained via mail order.⁸¹ However, the court followed the *Parker* rationale and concluded that the insurance plan was not a public accommodation.

However, there is a split among the courts on the question of ADA coverage. Other courts have held that Title III does not require a physical space, which allowed cases against insurance companies to proceed past that threshold question, including *Carparts Distribution Ctr., Inc. v. Automotive Wholesaler’s Association of New England, Inc.*, 37 F.3d 12 (1st Cir. 1994).⁸² In *Carparts*, the First Circuit reviewed the ADA’s definition of public accommodations, and concluded that it does not explicitly limit coverage for entities that have a physical structure. In support of this determination, the court explained that by including “travel service” as an

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example of a place of public accommodation, Congress must have intended not to limit Title III to physical structures because many travel services conduct business by mail or by phone and customers never enter a physical site. It then concluded that: “[i]t would be irrational to conclude that persons who enter an office to purchase services are protected by the ADA, but persons who purchase the same services over the telephone or by mail are not. Congress could not have intended such an absurd result.”⁸³ The court also reasoned that “[t]o exclude this broad class of businesses from the reach of Title III and limit the application of Title III to physical structures which persons must enter to obtain goods and services would run afoul of the purposes of the ADA and would severely frustrate Congress’s intent that individuals with disabilities fully enjoy the goods, services, privileges and advantages, available indiscriminately to other members of the general public.”⁸⁴

Another legal argument that has been used successfully by insurance companies is that the ADA does not regulate the content of the goods or services offered by the public accommodation and thus, challenging the capping of benefits for one particular impairment was beyond the reach of the ADA.

One example is *Pudlin v. AXA Equitable Life Ins. Co.*, 2016 WL 3566232 (S.D.N.Y. 2016), a plaintiff challenged the different treatment provided to people with mental health and physical disabilities, specifically alleging violations of the policy’s 90-day treatment limit.⁸⁵ The court dismissed the plaintiff’s complaint, concluding that complaints about the administration of policy terms are outside the ADA’s prohibition of discrimination. Similarly, in *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557 (7th Cir. 1999), the plaintiff brought an ADA case asserting that it was discriminatory for an insurance company to cap benefits for HIV-related care at \$100,000, while permitting care for other disabilities up to \$1 million.⁸⁶ The Seventh Circuit Court of Appeals found in favor of the insurance company, even though it conceded that it had no actuarial basis for the disparity in caps between other healthcare and HIV-related benefits. The court did rule that it could be an ADA violation to exclude a person with HIV from receiving insurance coverage; however, this was not the case here where the plaintiff did have access to the policy.

However, there have been a small group of cases finding that people with disabilities can challenge insurance policies under the ADA—especially if there is an argument that the exclusion of a particular treatment is a disability-based exclusion. One example is *Reid v. BCBSM, Inc.*, 984 F. Supp. 2d 949 (D. Minn. 2013), an insurance policy excluded coverage of behavioral therapy for people with Autism Spectrum Disorder (ASD).⁸⁷ A mom filed suit on behalf of herself and her son to challenge this exclusion under Title III of the ADA. Blue Cross

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filed a motion to dismiss arguing that people with ASD were not excluded from the policy, and as long as people had access to the policy there was no ADA violation. The court denied the motion to dismiss. Because the exclusion of a specific behavioral treatment only affected people with ASD, the court found it was discriminatory under the ADA. The court noted that plaintiff had sufficiently alleged that Blue Cross provided intensive behavioral therapy for other conditions, and that differential treatment and the singling out of ASD meant that plaintiff had stated a cause of action that Blue Cross was in violation of Title III of the ADA.

B. Insurance and the Affordable Care Act

Another avenue for challenging discrimination in insurance policies is the Patient Protection and Affordable Care Act (ACA). As background, the ACA regulations include non-discrimination requirements by providing that no covered entity shall “deny, cancel, limit, or refuse to issue or renew a health-related insurance plan or policy or other health-related coverage, or deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, or disability.”⁸⁸

How this regulation is applied is not yet fully understood. One recent attempt to pursue this avenue can be found in *Schmitt v. Kaiser Foundation Health Plan of Washington*, 2018 WL 4385858 (W.D. Wash. 2018).⁸⁹ Plaintiffs with hearing loss used the ACA to challenge the exclusion of hearing treatment from their insurance plans; they argued that since office visits, surgeries and medical equipment were covered for some conditions, it was discriminatory to not cover analogous hearing-loss related conditions. The court characterized this argument as “attractive in its simplicity” given that the plaintiffs’ coverage was limited based on their disability. However, the court ultimately rejected it, explaining that when enacting the ADA, Congress had allowed insurers to develop various levels of coverage with a range of deductibles, so long as they included the Essential Health Benefits, a list that does not include most hearing-loss services. Accordingly, it concluded that requiring insurers to cover every condition and treatment equally would mean that the ACA automatically converts every policy into a gold-level plan, which was not its intent. The rule, the court continued, is that if a plan offers benefits for services related to a particular disorder, it must do so for everyone who has that disorder, regardless of disability (or the other protected classes). The court did identify a potential path to relief—if plaintiffs could show that the insurance company acted with discriminatory intent in limiting coverage and could not offer a neutral nondiscriminatory reason (such as business judgment)—but noted the difficulty in distinguishing between these explanations. In any event, the court concluded that because hearing loss does not necessarily

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constitute a disability, and patients with disabling hearing loss received the same benefits as those who have hearing loss and are not disabled, there was no discrimination.

Another attempt to challenge insurance practices as discriminatory under the ACA can be found in *Doe One v. CVS Pharmacy, Inc.*, 348 F. Supp. 3d 967 (N.D. Cal. 2018).⁹⁰ This case was brought by a plaintiff with HIV/AIDS, who challenged his health insurance plan's policy that his medications could be filled only via mail order or at CVS to receive in-network pricing. The court dismissed this complaint, concluding that even if it did disparately impact people with HIV/AIDS, it did not deprive them of meaningful access in violation of the ACA.

IV. Title I in the context of healthcare

Title I of the ADA is intended to protect individuals from disability-related discrimination in the workplace and when applying for employment.⁹¹ Such discrimination includes employers "not making reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability."⁹² Reasonable accommodations are defined as "[m]odifications or adjustments ... that enable a qualified individual with a disability to perform the essential functions of [a] position ... or ... enjoy equal benefits and privileges of employment."⁹³ An employer is required to provide such accommodations absent a showing of undue hardship, which is defined as "an action requiring significant difficulty or expense."⁹⁴ To be considered "otherwise qualified," an employee must demonstrate his ability to perform the essential functions of a given position with or without a reasonable accommodation.⁹⁵ An employer is obliged to engage in an interactive process with any otherwise-qualified employee with a disability who has requested an accommodation to identify accommodations that may be reasonable and appropriate for the situation at hand.⁹⁶ The following is an exploration of recent federal case law examining and applying these Title I standards to employment cases arising in the healthcare field.

A. Essential Job Functions

Courts have identified ensuring patient safety as one of the very most essential job functions of healthcare workers, and thus true risks to patient safety can be adequate grounds for denying employment or accommodations requested by employees. However, employers must take care that the job descriptions they rely upon to define what is an essential function actually reflects the work of the position. Also, employers must remember to always consider whether an accommodation would enable the employee to meet the essential function of ensuring patient

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safety when engaging in this analysis. Further, as the cases below outline, issues of patient safety can also be evaluated as a direct threat.

Employers should not overly rely upon job descriptions when determining whether an employee can meet the essential functions of the job. For instance, in ***Gale v. Trinity Health Systems*, 2019 WL 339927 (S.D. Ohio Jan. 28, 2019)**, a woman with spina bifida applied to be an EKG technician at a health center.⁹⁷ The job description required that she be able to lift 50 pounds, but her physical exam revealed that she could only lift 25 pounds. She wasn't hired and sued under the ADA. The healthcare provider argued that she was not qualified to perform the essential functions and relied almost exclusively on the job description. The court found that there were material issues of fact and denied the defendant's motion to dismiss. Although the 50 pound requirement was in the job description, there were competing facts suggesting that the ability to lift 50 pounds was not essential. The court held that the inquiry of whether a function is essential "should be based upon more than statements in a job description and should reflect the actual functioning and circumstances of the particular enterprise involved."⁹⁸ Here, there was testimony that both the CEO and COO had made statements that lifting 50 pounds wasn't essential for an EKG technician, prompting the court to make clear that "[t]estimony from the plaintiff's supervisor that a job function is actually marginal may effectively rebut a written description that states that a job function is essential."⁹⁹

As noted above, concerns about patient safety often arise in healthcare worker cases. In ***Winnie v. Infectious Disease Assoc. P.A.*, 750 Fed. Appx. 954 (11th Cir. Nov. 8, 2018)**, nurses were highly trained to administer potent drugs through intravenous injection.¹⁰⁰ Nurses were required to use both arms and hands to perform their job. Although the nurses worked as a team, they all needed to perform all of the job duties. After being on the job, the nurse in this case had rotator cuff surgery and the healthcare provider granted her two months of paid leave to recover from her surgery. However, at the end of the two months, she remained under restrictions, including a restriction not to use her left arm for two more months. She sought to return to her job arguing that she could use her one, uninjured arm to do her job. The employer disagreed and terminated her and then hired another nurse due to extremely high volume of patients. The court agreed with the employer finding that the evidence showed that nurses in this practice were required to use both of their arms and hands to perform their job duties and thus, she wasn't currently qualified to perform the essential functions of the job. (This case is discussed further below with respect to how the plaintiff's request for additional leave was found to be an undue hardship.)

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In *Leme v. Southern Baptist Hospital of Florida, Inc.*, 248 F.Supp.3d 1319 (M.D. Fla. 2017), a Florida district court reviewed the Title I claim of a plaintiff with a visual impairment who had been employed by a hospital as an anesthesia technician.¹⁰¹ During plaintiff's initial training period, he had had difficulty on account of his limited vision in performing some of the standard functions of his position. For example, he had difficulty visually inspecting lines to ensure that they were free of bubbles before connecting those lines to patients, as well as correctly connecting the lines themselves. In light of these difficulties and defendant's resulting concerns for patient safety, defendant advised plaintiff that he could no longer work in this position, and allowed him to apply for other positions at the hospital. In response, plaintiff proposed various possible accommodations to enable him to continue in the role of technician. However, the record provided evidence as to why each of these accommodations was either an undue burden or presented further safety risks. As such, the court found that plaintiff failed to establish that he was a qualified individual who was able to perform the essential functions of the job with or without accommodation, and granted defendant's motion for summary judgment.

Other courts have also found for employers on the grounds that plaintiffs have failed to identify *any* available reasonable accommodations in light of the essential nature of the job or workplace in question. In *Dickerson v. Secretary, Dept. of Veterans Affairs Agency*, 489 Fed.Appx. 358, 2012 WL 3892196 (11th Cir. Sept. 7, 2012), the Eleventh Circuit reviewed a Rehabilitation Act discrimination claim brought by a nurse with scent allergies and chemical sensitivities against the VA medical center where she had been employed.¹⁰² The court found that plaintiff had failed to identify any reasonable accommodation that would enable her to perform the essential functions of her job on defendant's premises, as she had identified no areas where she could work free of exposure to the substances to which she would react adversely. Therefore, the court affirmed the summary judgment ruling in favor of defendant.

Elsewhere, in *Wulff v. Sentara Healthcare, Inc.*, 513 Fed.Appx. 267, 2013 WL 781958 (4th Cir. March 4, 2013), a nurse sued her former employer, a hospital, based upon its refusal to accommodate her total restriction from lifting in the workplace, as prescribed by her doctor.¹⁰³ Defendant had in fact accommodated plaintiff's initial prescribed lifting limit of ten pounds with one arm.¹⁰⁴ However, after plaintiff's doctor changed the restriction to ban plaintiff from lifting altogether, defendant asserted that lifting was an essential function of plaintiff's job, and that as such this accommodation could not be granted. Defendant placed plaintiff on medical leave in light of this total lifting restriction, prompting plaintiff to sue claiming that her rights under the ADA had been violated. In her suit, plaintiff did not focus directly upon defendant's failure

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to accommodate her total lifting restriction. Rather, she claimed that her doctor erred in so broadening the restriction, and that defendant should have recognized in light of all circumstances that plaintiff was fit to continue working within the original limit. However, the Fourth Circuit disagreed and affirmed summary judgment for defendant. The court noted that it had been plaintiff's duty to present her disagreement with the total ban to her prescribing physician, rather than to defendant, though she never did so. Additionally, the court found that Title I affords employers the right to rely upon the opinions of employees' physicians, and that employers have no duty to conduct their own analyses or formulate their own medical conclusions in such circumstances.

Similarly, in ***Anderson v. E. Conn. Health Network, Inc.*, 2015 WL 43935521 (D. Conn. July 16, 2015)**, plaintiff was an experienced surgeon who had begun to decline in his work due to depression.¹⁰⁵ He sometimes "slurred his speech and mumbled," "repeatedly sutured his own glove" during surgery, had toothpaste on his face while meeting patients, and asked an anesthesiologist to give him an injection of painkillers for his back pain while in the middle of an operation.¹⁰⁶ Plaintiff took 60 days of paid leave and began to negotiate the terms of his return. Defendant hospital proposed to accommodate plaintiff by limiting the kind of procedures he could perform and providing a proctor to monitor him until his performance improved. Plaintiff objected to these terms on the basis that they would technically constitute a disciplinary action that would have to be reported to the national medical malpractice oversight board. The court ruled for defendant, finding its proposed accommodations to have been adequate, and that it was unreasonable to expect an employer to tailor accommodations in order to avoid standard reporting procedures designed to ensure patient safety.

However, courts have also found that patient safety cannot be used as an excuse to disqualify an applicant or employee without true evidence to support it, especially when the defendant claims the employee posed a direct threat. For instance, in ***Osborne v. Baxter Healthcare Corp.*, 798 F.3d 1260 (10th Cir. 2015)**, the Tenth Circuit reviewed a Title I claim brought by a woman who was deaf and who had been conditionally hired as a monitor for plasma donors, but whose employment offer was rescinded by defendant plasma donation center after her physical examination revealed her disability.¹⁰⁷ The hiring managers contended that plaintiff's disability would make it impossible for her to fulfill essential functions of the job, including hearing audible alarms on medical equipment and hearing donors calling for assistance when in need or distress. Defendant argued that both these limitations presented direct threats to donor safety. Plaintiff proposed several possible accommodations to mitigate the risks, including the installation of flashing or vibrating alerts and providing call buttons for individual donors.

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However, defendant was unwilling to accept any of the proposed accommodations in order to facilitate plaintiff's employment.

The Tenth Circuit reversed the district court's grant of summary judgment for defendant and remanded for further proceedings, finding that material issues of fact existed as to whether defendant could provide plaintiff with the requested accommodations. In its ruling, the court considered the statistical evidence presented by both sides and applied the direct threat criteria set forth in *School Board of Nassau County v. Arline*.¹⁰⁸ It noted that donors experienced adverse reactions to plasmapheresis fewer than 5 times annually. And while it acknowledged that relatively minor adverse reactions such as dizziness can progress to serious conditions without prompt medical attention, nevertheless it noted that "plasma donation carries a historically low risk—about 0.0004%—of significant adverse donor reactions," a risk that would be further decreased by the proposed accommodations.¹⁰⁹ The court found that the "infinitesimal risk" that a donor would experience a significant adverse reaction *and* that plaintiff would fail to notice a visual or vibrating alert did not constitute a direct threat.¹¹⁰ Plaintiff "must only show that her proposed accommodation is reasonable on its face...she need not show that the accommodation would eliminate every *de minimis* health or safety risk that [defendant] can hypothesize."¹¹¹

Employers should also consider reasonable accommodations that would reduce the threat; the following cases are examples where employers prevailed due, in part, to their exploration and attempts to find workable accommodations to address safety issues. In *Stern v. St. Anthony's Health Ctr.*, 788 F.3d 276 (7th Cir. 2015), the Seventh Circuit affirmed summary judgment in favor of a hospital that had terminated one of its doctors on account of the doctor's memory problems.¹¹² The court agreed with the hospital's conclusion that the doctor's memory issues precluded him from performing essential functions of his job, and that the accommodations that the doctor had proposed prior to being terminated were less than reasonable in light of the hospital's legitimate concern for the safety of its patients. Indeed, the court noted that "[t]he ADA does not require an employer to walk on a razor's edge – in jeopardy of violating the [ADA] if it fired such an employee, yet in jeopardy of being deemed negligent if it retained him and he hurt someone."¹¹³

Likewise, in *Olsen v. Capital Region Med. Ctr.*, 713 F.3d 1149 (8th Cir. 2013), the Eighth Circuit affirmed summary judgment in favor of a healthcare facility which had removed plaintiff as a mammography technician after finding that her epilepsy posed a risk to patient safety and prevented her from performing the essential functions of her job.¹¹⁴ The court found that plaintiff's epileptic seizures caused her to frequently lose consciousness, including while performing her work and caring for patients, and thus posed a clear and imminent risk with

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regard to her own safety and that of others in the workplace. Plaintiff's seizures persisted despite the various measures that defendant had implemented in its earnest efforts to accommodate plaintiff's condition. The court thus found the evidence to establish that the direct threat posed by plaintiff's disability could not be adequately mitigated through reasonable accommodations in order to ensure patient and workplace safety.

In ***EEOC v. St. Joseph's Hospital, Inc.*, 842 F.3d 1333 (11th Cir. 2016)**, the Eleventh Circuit reviewed a Title I claim brought by a nurse who had been reassigned from her position based on defendant's contention that she posed a direct threat in light of her disability.¹¹⁵ Defendant required a cane in order to ambulate, and defendant said that the cane posed a safety hazard within the psychiatric ward within which the nurse was working. The hospital removed her from her station in the psychiatric ward, whereupon she was permitted to apply for other positions within the hospital. However, plaintiff was never hired for any of the other positions for which she applied, and was then terminated at the end of defendant's standard internal transfer period. The court found that defendant had provided plaintiff with a reasonable accommodation by allowing her to apply for other positions through the hospital's internal job board, even though defendant did not exempt plaintiff from its competitive hiring process. The court noted that the ADA "does not require reassignment without competition for, or preferential treatment of, the disabled."¹¹⁶

In ***Stevens v. Rite Aid Corp.*, 851 F.3d 224 (2d Cir. 2017)**, a pharmacist brought a Title I discrimination claim against defendant employer after it removed him from his position on the grounds that he posed a direct threat to pharmacy customers.¹¹⁷ Plaintiff had trypanophobia (a fear of needles), thus could no longer fulfill all his job responsibilities after defendant changed its corporate policy and began requiring its pharmacists to administer injections to patients who needed them. Plaintiff was unable to safely administer shots because his condition made him prone to fainting. He contended that defendant should have accommodated him by offering desensitization therapy or by hiring a nurse to administer shots in his stead. However, the Second Circuit ruled that the ADA does not require employers to offer medical treatment or to create altogether new position simply in order to accommodate employees whose disabilities do genuinely pose a direct threat in the workplace.

In some cases, an accommodation request is denied, not because the healthcare worker poses a danger to customers, but instead because of a conflict between co-workers. In ***Williams v. New York City Department of Health and Mental Hygiene*, 299 F.Supp.3d 418 (S.D.N.Y. 2018)**, a nurse, who had arthritis and herniated disks worked at a particular tuberculosis facility.¹¹⁸ A lab associate who reported to the nurse filed a discrimination claim against the nurse based on race. The EEOC found discrimination and recommended that the nurse be transferred to a

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different facility. The nurse filed a reasonable accommodation request seeking to remain at the facility. She claimed that driving a car longer than one hour caused her back and leg pain, and the new facility was two hours from her home. When she refused to report to the new facility, she was charged with failing to report to work and she resigned in lieu of being disciplined. She then sued under the ADA for failure to accommodate. The court held that the nurse's proposed accommodation was unreasonable as a matter of law and dismissed her case. Because of the EEOC's discrimination determination, it wasn't reasonable for the nurse to remain at her current location and she refused to discuss any other alternative. Even if the nurse showed that the City did not respond to her requests, an employee may not recover based on the employer's failure to engage in the interactive process if she cannot show that a reasonable accommodation existed.

B. Overcoming the "undue hardship" defense

Some courts have taken a more employee-friendly approach to the question of reasonable accommodations in the healthcare workplace. For example, in *Searls v. Johns Hopkins Hosp.*, **158 F.Supp.3d 427 (D. Md. 2016)**, a Maryland district court considered the matter of a hospital which had rescinded its job offer to a deaf nurse after she requested a full-time ASL interpreter as an accommodation.¹¹⁹ The nurse was subsequently hired by a different hospital, where she was provided with her requested accommodation and consistently received positive work evaluations. In response to the nurse's Title I discrimination claim, defendant offered three justifications for its refusal to provide the interpreter and its decision to cancel the job offer. First, it maintained that, even with an ASL interpreter, the nurse would not have been able to communicate with patients, which was an essential function of the job. Second, it claimed that the cost of providing the nurse with a full-time interpreter presented an undue burden for defendant. Third, defendant alleged that the nurse's inability to hear audible alarms in the workplace presented a direct threat to patient safety.

In light of the nurse's successful job performance at the other hospital, the court found that she had been capable of performing the essential functions of the original position. Furthermore, the court noted that, although an interpreter relays information between the nurse and her patients, it is the nurse who decides which questions to ask and who makes medical decisions for herself. The court accepted this as proof that she could have performed the essential functions of the original job. The evidence also indicated that the primary reason the defendant had revoked its job offer to plaintiff was the \$120,000 annual cost of providing the interpreter plaintiff had requested. However, the court noted that this cost still constituted only a negligible portion of defendant's annual operating budget, and thus was unpersuaded by defendant's argument that this cost presented an undue burden. Indeed, defendant presented

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no evidence to this effect, instead emphasizing the fact that the budget included no provision for such accommodations. The court ruled that whether an employer budgeted for reasonable accommodation is “an irrelevant factor in assessing undue hardship.” If it were relevant, “the employer could budget \$0 for reasonable accommodations and thereby always avoid liability.”¹²⁰

The court was similarly unpersuaded by defendant’s direct threat argument, finding it to be based on “post-hoc rationalizations and [was] therefore suggestive of pretext.”¹²¹ Defendant had made no individual assessment of the nurse’s ability to do her job with the assistance of an interpreter; it simply assumed that she would not be able to respond to auditory alerts. Finding all three of defendant’s arguments to have failed, the court granted plaintiff’s motion for partial summary judgment.

The Eleventh Circuit Court of Appeals recently found that a healthcare provider was able to meet the undue hardship defense with respect to a nurse who sought an extension of leave as a reasonable accommodation. In *Winnie v. Infectious Disease Assoc. P.A.*, 750 Fed. Appx. 954 (11th Cir. Nov. 8, 2018), a case referenced previously in the context of essential functions, a nurse had rotator cuff surgery.¹²² The practice granted the nurse two months of paid leave to recover from her surgery. However, at the end of the two months, she remained under restrictions that prevented her from working as an IV nurse, including a restriction on using her left arm for two more months. At the time, the patient count at the practice was at an all-time high, and there was testimony that the other nurses were “exhausted and overworked,” presenting a danger to patients. Because of the high patient crisis and urgent staffing needs, the practice terminated the nurse and replaced her. The court found that the nurse’s proposed accommodation of additional leave would pose an undue hardship and the termination was justified.¹²³

C. Employee leave as a reasonable accommodation

The question of employee leave as a reasonable accommodation is another issue that arrives frequently in the healthcare context. The U.S. Equal Employment Opportunity Commission (EEOC) has weighed in on this issue by way of some of its recent regulatory actions. In one recent example, the EEOC reached a settlement with a healthcare clinic which had terminated one of its nurses who had taken medical leave in order to undergo breast cancer treatment.¹²⁴

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When the nurse had exhausted the initial three months of leave to which she was legally entitled, she advised her employer that she was still undergoing treatment, and thus was not yet able to return to work. After four months, the clinic terminated the nurse, despite her advising them that she would be able to return to her job without restrictions in just two more months. After her termination, the nurse brought suit against the clinic alleging employment discrimination based on her disability, and the EEOC ultimately reached a settlement wherein the clinic agreed to substantial financial damages for the nurse, as well as to revise its leave policies and to enhance disability-awareness training for its staff and administrators. The EEOC reached a similar settlement with a healthcare provider which had a policy of awarding attendance points for medical-related absences, did not permit intermittent leave, and did not allow leave or extensions of leave as a reasonable accommodation.¹²⁵

Another issue that arises with respect to health worker leave is whether the healthcare provider's position that the employee isn't safe to return is actually a pretext to discrimination. For example, in *EEOC v. Wesley Health Systems LLC*, 2018 WL 5986753 (S.D. Miss. Nov. 14, 2018), a nurse took leave for an injured shoulder and her doctor subsequently released her to return to work with lifting restrictions.¹²⁶ The medical center determined that she could not safely return to work because lifting and pushing were essential functions of her job that could not be accommodated and she was ultimately terminated. She sued under Title I of the ADA. The court denied summary judgment to the employer. The evidence showed that the employer did not want the employee to return to work because she was a "chronic complainer." This raised a triable issue of fact that the employer never intended to accommodate the employee and used her restrictions as an excuse to terminate her.¹²⁷

D. Reassignment as a reasonable accommodation

Reassignment is an accommodation under the ADA.¹²⁸ In order to secure this accommodation, employees must be able to show that the position is vacant and that he or she is qualified for the position. It is well-established that reassignment is the accommodation of last resort and that employers have the right to first try to accommodate the employee in his or her current position before exploring the accommodation of reassignment. If reassignment is the only option, the employer should first try to accommodate the employee in a job that has similar

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status and pay, and only when such positions are deemed unavailable, can a lesser position be deemed reasonable.

In the healthcare context, reassignment can arise because employees believe that a particular job location would adversely impact their disability. For instance, in ***Boyte v. Department of Veterans Affairs*, 2018 WL 898680 (M.D. Tenn. Feb. 14, 2018)**, a VA nurse had a hearing impairment that increased her susceptibility to MRSA (methicillin-resistant staphylococcus aureus) infection.¹²⁹ She made an accommodation request that she be moved to a position that did not require direct contact with patients. She provided the VA with a list of five comparable positions, but instead she was offered a file clerk position at a lower salary. She accepted the offer under protest and then filed suit under the Rehabilitation Act. The VA moved to dismiss her case and the court denied the motion finding that there was evidence of other positions available at her pay grade that she was not offered. The court also found there were triable issues as to whether the VA failed to engage in the interactive process when the VA allegedly didn't respond to the list of five positions that the nurse provided.

E. Medical marijuana use by employees as a reasonable accommodation

With their focus on ensuring patient and workplace safety, many healthcare employers require drug testing for their employees and applicants, and have commonly maintained zero-tolerance policies with regard to employee use of drugs, including marijuana. Until very recently, employers were consistently able to defend against wrongful termination claims brought by employees who were licensed medical marijuana users under their respective state laws, simply by claiming preemption under the federal Controlled Substance Act (CSA).¹³⁰ The CSA classifies marijuana as an illegal controlled substance, and makes no exception for its medicinal use. Additionally, the ADA excludes “any employee or applicant who is currently engag[ed] in the illegal use of drugs, when the covered entity acts on the basis of such use.”¹³¹ However, recently a number of courts in states with laws authorizing medical marijuana use, and which provide explicit employment protections in that context, have ruled in favor of employees who used medical marijuana, and have specifically found that federal law does not preempt the applicable state law protections. With a majority of states now having adopted legislation authorizing the legal use of medical marijuana, this trend in the case law suggests that employers will no longer simply be able to rely on CSA preemption, will need to take greater care to engage in the interactive process with employees who are medical marijuana users, and must be prepared to accept this use at least in certain cases as a reasonable accommodation in accordance with Title I.

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The first state court rule signaling this new trend appears to have been ***Callaghan v. Darlington Fabrics Corp.*, 2017 WL 2321181 (R.I. Super. May 23, 2017)**, wherein the Rhode Island Superior Court found that an employer had violated the anti-discrimination provisions of the state's medical marijuana law by denying employment to an applicant who held a state-issued medical marijuana card.¹³² In its ruling, the court noted that plaintiff's possession of the card should have put the employer on notice of plaintiff's status as a person with a disability (in this case, a chronic and debilitating medical condition), which the employer should have recognized was the basis on which plaintiff had qualified for the card to begin with. This in turn placed an obligation upon the employer to engage in the interactive process with plaintiff and to provide reasonable accommodations, and its failure to do either constituted disability discrimination. Furthermore, the court found that the CSA did not preempt the anti-discrimination provisions of the state law, as the purposes of the state and federal laws were different.

Also, in ***Barbuto v. Advantage Sales and Marketing, LLC*, 477 Mass. 456 (July 17, 2017)**, the Massachusetts Supreme Judicial Court ruled in favor of an employee with Crohn's Disease and who used marijuana legally, but who was terminated from her job after failing a drug test.¹³³ The court reversed an earlier dismissal in favor of the defendant employer, finding that the employee could make a cognizable claim under the state's anti-discrimination statute. Recognizing potential legitimate purposes for the off-site use of medical marijuana, and that such use is not automatically preempted by the CSA, the court found that in some cases employers may have a duty to permit such use by employees as a reasonable accommodation.

And, at the federal level, in ***Noffsinger v. SSC Niantic Operating Co. LLC*, 2017 WL 3401260 (D. Conn. Aug. 8, 2017)**, the U.S. District Court for the District of Connecticut ruled in favor of a medical marijuana user whose employment was terminated after she tested positive for marijuana in the course of the job application process.¹³⁴ The court found that the ADA did not preempt the state medical marijuana law's anti-discrimination employment provision, and that the state statute did not conflict with the relevant federal laws because the latter were not intended to preempt state anti-discrimination laws. This represents the first federal ruling to recognize that the CSA does not preempt a state law's anti-discrimination provisions.

E. Employee rights to medical privacy and to refuse certain medical procedures required for the position

1. Medical examinations

Courts have also examined the issue of employee medical privacy in the context of Title I. For example, courts have reviewed the extent to which employees and applicants are entitled to keep their medical information confidential where this information may be relevant to their

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work performance. In *Port Authority Police Benevolent Association, Inc. v. Port Authority of New York and New Jersey*, 2017 WL 4838320 (S.D.N.Y. Oct. 24, 2017), a New York federal district court reviewed a suit brought by a union of police officers, challenging their employer's administration of three different medical examinations as a condition of their employment.¹³⁵ These included an annual general examination as well as two fitness for duty (FFD) examinations. In considering the viability of defendant's policy requiring these examinations in light of plaintiff's concerns regarding the medical privacy of union members, the court noted that, per the requirements of the ADA, such examinations must be job-related and consistent with business necessity. More specifically, it stated that defendant's policy must be vital to defendant's business, that the group subject to the policy must be consistent with the policy's purpose, and that the policy must be narrowly tailored to serve its objectives.

With regard to the annual general examination, the court granted summary judgment in favor of the union. While as a general matter the court acknowledged that these examinations served the vital purpose of ensuring that officers were capable of performing their safety-sensitive jobs, it also noted that the subject class was too broad, as defendant administered these examinations to all officers, regardless of their titles and job assignments, which the court noted was not consistent with the policy's public safety rationale. Additionally, the court found that the exam was overbroad in its own scope, as it could identify conditions that had no bearing on officers' abilities to do their jobs.

As to defendant's FFD examination for workplace injuries, the court granted summary judgment in favor of defendants. The court found that these examinations did serve vital purposes, insofar as they helped to determine workers' eligibility for compensation, and helped defendant to review workers' claims before authorizing treatment. Additionally, the court recognized that defendant applied these examinations to only a narrow group, those officers who were injured on the job, and that the examination itself was narrow in scope, investigating only each employee's "chief complaint" and limited to formulating a working diagnosis.¹³⁶

However, the court granted summary judgment for plaintiffs with regard to the other FFD, which defendant administered to officers who had non-workplace injuries and who afterward took five days or more of sick leave. In its analysis, the court addressed each of defendant's justifications for this examination. It was unpersuaded by the defendant's argument that the examination served the vital purpose of curbing excessive employee absences (the court finding that this was not necessarily a vital business purpose), but agreeing that the examinations were essential to ensuring that employees were fit and safe to return to their positions after incurring injuries. Even so, much as with the annual examinations, the court found these examinations to be overbroad, as they were administered to all such officers regardless of their

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job tasks, and as defendant had offered no evidence that officers taking five or more days of sick leave posed any particular safety risks upon returning to work.

In another case considering medical examinations in light of ADA protections, ***Wright v. Illinois Dep't of Children & Family Svcs.*, 798 F.3d 513 (7th Cir. 2015)**, the Seventh Circuit reviewed a claim brought by an Illinois social worker who had been removed from contact with children in her work in response to concerns expressed regarding her conduct.¹³⁷ Following plaintiff's encounter with a child who resided at a state-administered facility, the facility's doctor barred plaintiff from further contact with the child. The doctor issued a medical report questioning plaintiff's ability to work with children, and stating that "her mental health needs to be assessed."¹³⁸ A supervising administrator had also expressed concern regarding plaintiff, given her long-standing behavior patterns including her failures to follow orders. Consequently, defendant ordered plaintiff to undergo a FFD examination, which plaintiff repeatedly refused to do, and then brought suit alleging that this examination constituted discrimination under Title I.

At trial, the jury found that the examination was neither job-related nor consistent with business necessity. The district court thus denied defendant's motion for judgment as a matter of law. On appeal, the Seventh Circuit upheld the decision in plaintiff's favor, reiterating the lower court's findings and noting that all employees, regardless of whether they have a qualifying disability under the ADA, are protected by the ADA's restrictions on medical examinations and inquiries. An employer must have a reasonable belief based on objective evidence that a medical condition will impair the employee's ability to perform essential job functions OR that the employee will pose a threat due to a medical condition. The employer bears the burden of establishing the existence of a business necessity, and this burden is "quite high."¹³⁹

The appellate court cited rather extensive evidence to support its conclusion regarding the lack of any apparent business necessity. It noted testimony that when a FFD examination was pending, standard agency practice was to place the employee on desk duty, and yet here Plaintiff was permitted to continue overseeing her normal case load (of 22 cases) for almost two months, and was actually assigned to an additional case during that time. This inconsistent application of agency policy suggested that there was no genuine concern for children's safety. Additionally, an administrator testified that had she truly believed that the Plaintiff was a risk to children, she would have removed her cases. Internal agency e-mails also indicated that the examination was unrelated to the Plaintiff's ability to do her job.

Also, in ***Kroll v. White Lake Ambulance Authority*, 763 F.3d 619 (6th Cir. 2014)**, the Sixth Circuit reviewed a claim brought by an emergency medical technician who, several years into her

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employment with an ambulance company, begun a “tumultuous” affair with a married colleague.¹⁴⁰ After the affair went bad, plaintiff’s co-workers began to report instances of plaintiff behaving erratically, including several occasions on which she was seen crying in the parking lot, and at least one on which she was seen arguing on her cell phone while driving an ambulance. Plaintiff’s manager decided to force her to seek mental health counseling, observing that her “life was a mess” and stating his wish to help her.¹⁴¹ At no time did the manager express any concerns about plaintiff’s job performance. Plaintiff acknowledged that she had some emotional issues, but refused to enter treatment because she could not afford it. After plaintiff refused treatment, she was not scheduled to work any further shifts.

Plaintiff filed a complaint alleging defendant had violated the ADA by forcing her to submit to a medical examination that was not “shown to be job-related with business necessity.”¹⁴²

Defendant argued that the examination was necessary because plaintiff’s recent behavior constituted a direct threat to patient safety. However, the court was not persuaded. In its ruling, the court acknowledged that in “public safety” workplaces, an employer may require a psychological examination on “slighter evidence than in other types of workplaces because employees are ‘in positions where they can do tremendous harm if they act irrationally,’ and thus pose a greater threat to themselves and others.”¹⁴³ Nevertheless, the court noted that a few isolated incidents of abnormal behavior do not amount to a direct threat, even in a public safety workplace. Defendant cited no objective evidence to support its belief that plaintiff’s behavior threatened either any business necessity or patient safety. Indeed, the court noted that defendant’s actions appeared to have been driven more by its moral convictions than by any objective concerns regarding safety. Therefore, the Sixth Circuit reversed the lower court’s summary judgment ruling in favor of defendant.

Elsewhere, the DOJ recently finalized a settlement agreement with an Indiana municipality in the wake of inappropriate disclosures of a police officer’s medical information made during public proceedings.¹⁴⁴ In that case, the municipality’s police chief had requested medical information from the officer in question, who was at that time on medical leave from his job. The chief then recommended charges to the municipality’s Merit Commission, forwarding the officer’s medical information to the Commission in the process. In the ensuing public hearing, the Commission voted to permit the officer to keep his employment, but the officer’s medical privacy was violated in the course of the proceedings. Both the police chief and the municipality’s attorney publicly disclosed private information regarding the officer’s disability, as well as their concerns regarding the officer’s fitness for work. Additionally, the Commission attorney provided the media with the charging documents, which contained information regarding the officer’s prescription medications, medical treatment, and psychological evaluations. In the agreement with DOJ, the municipality agreed to a financial settlement with

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the officer, as well as to revise its policies, practices and procedures regarding confidentiality, and to provide training to employees regarding confidentiality requirements.

Another issue that has arisen in the courts is whether employers can refuse to undergo certain medical procedures deemed required for all employees. In ***Hustvet v. Allina Health Systems*, 910 F.3d 399 (8th Cir. 2018)**, a healthcare organization merged into a larger company.¹⁴⁵ Employees of the merging company were required to complete a health assessment screening. An employee disclosed she was not immunized for rubella and the parent company said that her employment was conditioned on having the measles, mumps and rubella vaccine. When she refused, she was terminated and filed suit claiming the parent company engaged in an unlawful medical inquiry. Specifically, she argued that the inquiry was impermissible since she never received an offer of employment. The court disagreed noting that she was told she would “soon be” an employee of the parent company if she met the health screening requirements.¹⁴⁶

She also argued in the alternative that she was a “continuous” employee and therefore the health screening was impermissibly imposed after she was employed.¹⁴⁷ The court found that she was technically terminated after the merger occurred and the parent company required the health screening before it made her an employee. The court also found that even if she were considered an employee, the inquiry was justified as it was job related and consistent with business necessity. Accordingly, the court found the termination was justified and not a violation of the ADA.

Similarly, in ***Ruggiero v. Mount Nittany Medical Center*, 736 Fed.Appx. 35 (3d Cir. June 5, 2018)**, a healthcare provider required all clinical employees to receive the Tdap (Tetanus, Diphtheria and Pertussis) Vaccine.¹⁴⁸ A nurse with severe anxiety requested that she not be required to undergo the vaccination. She provided a doctor’s note indicating that due to her severe anxiety and her history of food allergies, environmental allergy, and eosinophilic esophagitis, the risk of the Tdap injection outweighed the benefits. The employer responded that the documentation was inadequate and the nurse was still required to get the vaccine. She then requested permission to wear a mask as an accommodation, which was also denied. When she continued to refuse to submit to the vaccine, she was terminated. She filed suit under the ADA and after the district court dismissed her claim. She appealed to the Third Circuit Court of Appeals. Rather than exploring whether the examination was permissible under the ADA, the Third Circuit instead found that the nurse’s allegations raised the plausible inference that the center failed to properly engage in the interactive process once she raised her disability and requested an accommodation. She had requested either an exemption from the vaccine requirement or permission to wear a mask, but both requests were denied without an alternative being proposed,

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or even explored. Accordingly, the court found the nurse had raised sufficient allegations that the employer prematurely ended the interactive process.

2. Wellness plans

Another developing issue presenting questions of medical privacy is that of employee wellness plans. These plans often require employees to submit to medical examinations and inquiries in order to participate. Some of these plans are tied to employer-sponsored health insurance, while others are not. Employers often provide strong “incentives” for employees to participate in their wellness plans, including greatly reduced healthcare costs. And while the ADA imposes restrictions on certain medical examinations and inquiries, employers find limited exceptions to these restrictions by way of the ADA’s safe harbor provision and the “voluntary” nature of employee participation.¹⁴⁹

The EEOC recently litigated cases regarding wellness programs. In one such case, ***EEOC v. Orion Energy Systems, Inc.*, 2016 WL 5107019 (E.D. Wis. Sept. 19, 2016)**, the EEOC settled with an employer after an employee whom it had terminated accused the employer of retaliating against her for complaining that the employer’s wellness program violated the ADA.¹⁵⁰ Employees who opted out of this wellness plan were required to pay their entire monthly health insurance premium. After investigating the claim, the EEOC filed suit in a Wisconsin district court. The court dismissed cross-motions for summary judgment, and set the case for trial. In its ruling, the court found that the ADA safe harbor provision was inapplicable in these circumstances, but that the employer could still avail itself of the “voluntariness” exception in spite of the very strong financial incentives for its employees to join in the wellness program.¹⁵¹ The parties settled prior to trial, with the consent decree providing for a financial settlement for the employee in question, and with the employer agreeing to ensure that its wellness plans going forward would comply with the ADA’s voluntariness provisions, and that it would not retaliate against any employees raising concerns of this nature in the future.¹⁵²

The EEOC filed suit in a different Wisconsin federal district court in order to challenge another employer’s wellness program on ADA grounds. In ***EEOC v. Flambeau, Inc.*, 846 F.3d 941 (7th Cir. 2017)**, the central issue was whether a wellness plan falls within the ADA’s safe harbor provision if it is part of the employer’s health insurance plan.¹⁵³ The Seventh Circuit ultimately upheld the lower court’s ruling that this is so, dismissing the EEOC’s appeal on the narrow grounds that the claim was moot due to the complaining employee having since resigned his position.

More recently and significantly, the District Court for the District of Columbia vacated EEOC rules pertaining to wellness plans, in ***AARP v. United States Equal Employment Opportunity***

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Commission, 2017 WL 6542014 (D.D.C. Dec. 20, 2017), finding that the agency was moving too slowly in revising these rules per the earlier instruction of the court.¹⁵⁴ In 2016, AARP filed suit seeking an injunction against a recently-adopted EEOC rule that permitted employers to impose penalties of up to 30% of the cost of coverage to encourage employees to disclose information that was protected under the ADA and the Genetic Information Nondiscrimination Act (GINA), without rendering such disclosures involuntary. In August 2017, the court agreed that the EEOC's rulemaking process had been arbitrary, and sent the rule back to the agency for further revision. Finding the EEOC's projected timeline for completing its revisions to be unacceptably slow, the court responded to AARP's motion to alter or amend its earlier judgment by vacating the rule altogether, effective January 1, 2019. This deadline has passed without new regulations enacted.

F. Doctors as Independent Contractors

As a final point regarding Title I, it may be noted that doctors are frequently not able to position avail themselves of Title I protections. This is because doctors seldom work as direct employees of hospitals and healthcare facilities, and more commonly serve as independent contractors who provide medical services in and use the facilities of privately-owned hospitals and clinics. As such, a common issue in the healthcare context is whether doctors who work as independent contractors can bring claims for disability discrimination under Section 504 of the Rehabilitation Act. A recent case on this issue is ***Flynn v. Distinctive Home Care, Inc.*, 812 F.3d 422 (5th Cir. 2016)**, where the Fifth Circuit concluded that independent contractors can sue under Section 504 for employment discrimination.¹⁵⁵ The court reasoned that Section 504 is broad and applies to all of a covered entity's programs and activities. It also found that while the Rehabilitation Act incorporates the ADA's substantive non-discrimination provisions, it does not incorporate the ADA's definition of employer. This is the majority position, although other courts have found that independent contractors cannot sue under the Rehabilitation Act.¹⁵⁶

Conclusion

Ensuring access to healthcare remains one of the most important, and most complex, issues of our time. While people with disabilities regularly encounter barriers to accessible healthcare, such as inaccessible equipment, lack of communication access, and general attitudinal barriers still exist, progress has been made as a result of the advocacy efforts of the disability community, private litigants, the DOJ, and healthcare providers who desire to provide their services to all. This issue is far from over; moving forward, we expect to see more litigation about emerging issues, especially about ones focused on technology, such as accessible medical equipment, VRI and websites. We also hope to see a greater recognition about the importance

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of accessible healthcare for people with disabilities. Moreover, we can expect further development of the ADA's employment provisions with respect to how they apply to the unique context of healthcare providers and healthcare workers with disabilities. All ADA-stakeholders should continue to follow these legal developments to continue to strive toward healthcare that is accessible to everyone.

¹ This legal brief was written by Barry C. Taylor, Vice President of Civil Rights and Systemic Litigation, and Rachel M. Weisberg, Employment Rights Helpline Manager and Attorney, with Equip for Equality, the Illinois Protection and Advocacy Agency. The authors thank Jessica Purohit, PILI Fellow, and Will Kaplowitz, Volunteer Attorney, for their valuable assistance. This brief was written with funding from the Great Lakes ADA Center.

² 42 U.S.C. §§ 12131–12134 (Title II of the ADA); 42 U.S.C. §§ 12181–12189 (Title III of the ADA); 29 U.S.C. § 794 (Section 504 of the Rehabilitation Act).

³ 28 C.F.R. § 35.104.

⁴ 42 U.S.C. § 12181(7)(F).

⁵ *Id.* at § 12187.

⁶ *Reed v. Columbia St. Mary's Hospital*, 915 F.3d 473 (7th Cir. 2019).

⁷ *Id.* at 483.

⁸ 29 U.S.C. § 794.

⁹ 45 C.F.R. Part 84.

¹⁰ 29 U.S.C. § 794; 42 U.S.C. § 2000d-7.

¹¹ State-run public hospitals potentially have the ability to assert sovereign immunity; as a result, compensatory damages in such cases would be available only if the court finds that Congress appropriately abrogated sovereign immunity under Title II for claims regarding healthcare. *See Tennessee v. Lane*, 541 U.S. 509 (2004) (concluding that Congress lawfully abrogated state sovereign immunity for denial to courtroom access because it is a fundamental right).

¹² *Levorsen v. Octapharma Plasma, Inc.*, 828 F.3d 1227 (10th Cir. 2016).

¹³ *Silguero v. CSL Plasma*, 907 F.3d 323 (5th Cir. 2018).

¹⁴ *Id.* at 329.

¹⁵ 42 U.S.C. § 12182(a) (Title III); 42 U.S.C. § 12132 (Title II); 45 C.F.R. Part 84 (Section 504).

¹⁶ *Settlement Agreement Between the United States of America and Selma Medical Associates, Inc.*, available online at www.ada.gov/selma_medical_sa.html (Jan. 31, 2019).

¹⁷ 28 C.F.R. 36.104.

¹⁸ *Settlement Agreement Between the United States Attorney's Office for the Western District of Kentucky and Hardin County Emergency Medical Services*, available online at www.ada.gov/hardin_ems_sa.html (March 26, 2018).

¹⁹ See *Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities*, 28 CFR Part 36, [CRT Docket No. 106; AG Order No. 3181-2010] RIN 1190-AA44, U.S. Department of Justice, Civil Rights Division, Final rule, Published September 15, 2010, effective March 15, 2011, at page 56272.

²⁰ *Tamara v. El Camino Hospital*, 964 F. Supp. 2d 1077, 1085-86 (N.D. Cal. 2013).

²¹ *Roe v. Providence Health System-Oregon*, 655 F. Supp. 2d 1164 (D. Ore. 2009).

²² Consent Decree between Tracy and Stan Rousseau and Adventist Healthcare West, 4:17-cv-02985, available online at www.leagle.com/decision/infcco20180314a71 (N.D. Cal. March 13, 2018).

²³ *Bragdon v. Abbott*, 524 U.S. 624 (1998).

²⁴ *Id.* at 650.

²⁵ *United States v. Asare*, 2018 WL 2465378 (S.D.N.Y. June 1, 2018).

²⁶ *Id.* at *4.

²⁷ Settlement Agreement between the United States of America and Pain Management Care, P.C., available at www.ada.gov/pmc/pain_mgmt_care_cd.html (April 12, 2016).

²⁸ *Id.*

²⁹ See Settlement Agreement between the United States of America and Advanced Plastic Surgery Solutions, available online at www.ada.gov/adv_plastic_surgery_sa.html (involving a medical clinic that refused to accept a prospective patient because she had HIV) (December 11, 2017); Settlement Agreement between the United States of America and North Florida OB-GYN Associates, P.A., available online at www.ada.gov/north_florida_sa.html (involving a gynecologist who refused to perform a tubal ligation procedure on a patient because she had HIV) (January 19, 2016); Settlement Agreement between the United States of America and Mercy Suburban Hospital, available online at www.ada.gov/mercy_hospital_sa.html (involving a hospital which had declined to provide bariatric services for a patient who had HIV) (November 18, 2015); Settlement Agreement between the United States of America and Dentex Dental Mobile, Inc., available online at www.ada.gov/dentex_sa.htm (involving a dental clinic which discriminated against an individual with HIV by refusing to provide treatment) (March 13, 2015); Settlement Agreement between the United States of America and Genesis Healthcare System, available online at www.ada.gov/genesis_healthcare_sa.htm (involving a physician who had discriminated against a patient by failing to provide treatment and by improperly referring the patient elsewhere) (January 15, 2015).

³⁰ 28 C.F.R. § 35.160(a)(1) (Emphasis added).

³¹ 28 C.F.R. § 35.160(b)(1).

³² 28 C.F.R. § 36.303(c).

³³ 45 C.F.R. § 84.52(c).

³⁴ *Id.* § 84.52(d)(1).

³⁵ 28 C.F.R. § 36.303(c)(1)(ii) (Title III); 28 C.F.R. § 35.160(b)(2)(Title II); U.S. Department of Justice-Effective Communication, available at www.ada.gov/effective-comm.htm (last accessed 5/13/2019).

³⁶ For further information, See DOJ guidance found at 28 CFR 35, App. A.

³⁷ *Crane v. Lifemark Hospitals, Inc.*, 898 F.3d 1130 (11th Cir. 2018).

³⁸ *Liese v. Indian River County Hospital District*, 701 F.3d 334 (11th Cir. 2012).

³⁹ *Id.* at 343.

⁴⁰ *Martin v. Halifax Healthcare Systems, Inc.*, 2015 WL 4591796 (11th Cir. July 31, 2015).

⁴¹ Settlement Agreement Between the United States of America and Overlake Medical Center, available online at www.ada.gov/overlake_sa.html (Jan. 2017).

⁴² For VRI performance standards applicable to Title III, see 28 C.F.R. § 36.303(f); for Title II standards, see 28 C.F.R. § 35.160(d).

⁴³ For further DOJ guidance and comments, see “ADA Requirements: Effective Communication,” available online at www.ada.gov/effective-comm.htm.

⁴⁴ See, “Minimum Standards for Video Remote Interpreting Services in Medical Settings,” available online at www.nad.org/issues/technology/vri/position-statement-hospitals.

⁴⁵ See, e.g., Settlement Agreement between the United States of America and Baupinder S. Mangat, M.D. and Seminole Neurology Associates, P.A, www.ada.gov/mangat_sna_sa.html (December 1, 2017); Settlement Agreement between the United States of America and Grady Memorial Hospital www.ada.gov/grady_sa.html (February 9, 2016); Settlement Agreement between the United States of America and Promedica Toledo Hospital, www.ada.gov/promedica_toledo_hospital_sa.html (January 28, 2016); Settlement Agreement between the United States of America and Srivinas Mukkamala, M.D., July 17, 2015, www.ada.gov/mukkamala_sa.html; Settlement Agreement between the United States of America and Arshad Pervez, M.D., www.ada.gov/pervez_sa.html (July 17, 2015); Settlement Agreement between the United States of America and Fairfax Nursing Center, Inc., www.ada.gov/fairfax_nursing_ctr_sa.html (July 10, 2015); Resolution Agreement between the United States of America and St. Francis Hospital and Medical Center, www.ada.gov/fairfax_nursing_ctr_sa.html (March 23, 2015); Consent Order between Susanna and Thomas Paulay and WSNCHS North, Inc., St. Joseph Hospital (October 14, 2016).

⁴⁶ Settlement Agreement between the United States of America and Highline Medical Center, www.ada.gov/highline_med_ctr_sa.html (August 22, 2017); see also, Civil Rights Education and Enforcement Center’s Quick Guide to Sign Language Interpreters in Medical Settings, available at <https://creelaw.org/creecs-quick-guide-to-sign-language-interpreters-in-medical-settings/>

⁴⁷ *Morales v. Saint Barnabas Medical Center*, 13-cv-06363 (D.N.J. Consent Order, Feb. 14, 2017), available online at www.equipforequality.org/news-item/health-care-consent-orders.

⁴⁸ See also *Moss v. Newark Beth Israel Med. Ctr.*, 13-cv-4360 (D.N.J. Consent Order, Feb. 16, 2017), available online at www.equipforequality.org/news-item/health-care-consent-orders.

⁴⁹ *Silva v. Baptist Health South Florida*, 856 F.3d 824 (11th Cir. 2017).

⁵⁰ *Shaika v. Gaden Huetten Memorial Hosp.*, 2015 WL 4092390 (M.D. Pa. July 7, 2015).

⁵¹ *Id.* at *10.

⁵² 28 C.F.R. § 35.160(a)(1) (Title II); 28 C.F.R. § 36.303(c)(1)(i)(Title III).

⁵³ *Durand v. Fairview Health Services*, 902 F.3d 836 (8th Cir. 2018).

⁵⁴ *Loeffler v. Staten Island University Hosp.*, 582 F.3d 268 (2nd Cir. 2009).

⁵⁵ *Id.* at 280-81.

⁵⁶ Settlement Agreement between the United States of America and Fairfax Nursing Center, Inc., available online at www.ada.gov/fairfax_nursing_ctr_sa.html (July 10, 2015).

⁵⁷ *Figuroa v. Azar (HHS/CMS)*, 16-cv-30027 (D. Mass.), available online at www.browngold.com/medicare-information-accessible-blind-beneficiaries (April 2019).

⁵⁸ “Walgreens Now Offers Talking Prescription Labels,” available online at www.lflegal.com/2014/06/walgreens-talking, as well as “CVS/Pharmacy Now Offers ‘Talking’ Prescription Labels for Individuals with Vision Impairments Through Online Pharmacy,” available online at [www.http://acb.org/content/cvspharmacy-now-offers-“talking“-prescription-labels-individuals-vision-impairments-through](http://acb.org/content/cvspharmacy-now-offers-“talking“-prescription-labels-individuals-vision-impairments-through).

⁵⁹ For example, CVS MinuteClinic agreed to take additional steps to ensure that individuals with visual impairments receive treatment and other important information in accessible formats, and to arrange for sign language interpreters at the request of individuals who are deaf, available online at www.cvshhealth.com/content/minuteclinic-enhance-accessibility-patients-disabilities (August 21, 2015); Agreement Between American Council for the Blind and Rite Aid, available online at www.lflegal.com/2016/02/rite-aid-press/ (February 18, 2016); Agreement Between American Council for the Blind and Humana Inc., available online at www.lflegal.com/2015/09/humana-press/ (September 30, 2015).

⁶⁰ See, e.g., WellPoint Accessible Information Agreement, available online at www.lflegal.com/2014/02/wellpoint-agreement (February 12, 2014); American Cancer Society Accessible Website and Alternative Formats Agreement, available online at www.lflegal.com/2011/02/acs-agreement (February 23, 2011); Settlement Agreement with Rite-Aid.com, available online at www.lflegal.com/2008/04/rite-aid-web-agreement (March 31, 2008).

⁶¹ Agreement between Mass. Eye and Ear and Bay State Council of the Blind, available online at www.lflegal.com/2017/01/meei-agt/ (January 26, 2017).

⁶² See, e.g., Settlement Agreement between the United States of America and the City of Milwaukee, Wisconsin, available online at www.ada.gov/milwaukee_pca/milwaukee_sa.html (June 9, 2016).

⁶³ Settlement Agreement between the United States of America and Kindercare Education LLC, available online at www.ada.gov/kinder_care_sa.html (Sept. 25, 2018).

⁶⁴ See, “Justice Department Reaches Settlement with Learning Care Group to Resolve ADA Violations” (March 20, 2018), available online at www.justice.gov/opa/pr/justice-department-reaches-settlement-learning-care-group-inc-resolve-ada-violations.

⁶⁵ See, Winnewald Day Camp Settlement Agreement (June 2015), available online at www.justice.gov/usao-nj/file/765696/download; see also “Summer Camps and the ADA,” U.S. Department of Justice Bulletin, available online at www.justice.gov/file/campadaflyerpdf/download.

⁶⁶ See, e.g., Settlement Agreement between the United States of America and Arlington-Mansfield Area YMCA (February 24, 2016), available online at www.ada.gov/arlington_ymca.html, (agreement also included a cash settlement for complainant; Settlement Agreement between the United States and Philadelphia Freedom Valley YMCA (May 19, 2016), available online at www.ada.gov/rocky_run-sa.html; Settlement Agreement between the United States of America and YMCA of the Triangle (July 27, 2016), available online at www.ada.gov/ymca_triangle_sa.html; Settlement Agreement between the United States of America and YMCA of Metro Chicago (December 21, 2016), available online at www.justice.gov/usao-ndil/pr/united-states-announces-settlement-ymca-metro-chicago-ensure-compliance-americans.

⁶⁷ Settlement Agreement between the United State of America and Camp Bravo (June 24, 2015), available online at www.ada.gov/camp_bravo_sa.html

⁶⁸ *U.S. v. NISRA*, 168 F.Supp.3d 1082 (N.D. Ill. 2016).

⁶⁹ For accessibility standards for medical diagnostic equipment, see the guidelines provided by the United States Access Board, available online at www.access-board.gov/guidelines-and-standards/health-care/about-this-rulemaking.

⁷⁰ See, “Access to Medical Care for Individuals with Mobility Disabilities,” available online at www.ada.gov/medicare_medcar_mobility_ta/medcare_ta.htm.

⁷¹ See, e.g., settlement agreements between the United States and Washington Hospital Center (accessible online at www.ada.gov/whc.htm), Beth Israel Deaconess Medical Center (available online at www.ada.gov/bidmsa.htm), and Dr. Robia Ashfaq (available online at www.justice.gov/crt/settlement-agreement-between-united-states-america-and-dr-robila-ashfaq).

⁷² See e.g., Settlement Agreement with UCSF Medical Center, available online at www.lflegal.com/2008/09/ucsf-settlement-agreement/ (September 21, 2008); Settlement Agreement with Massachusetts General Hospital and Brigham and Women’s Hospital, available online at www.lflegal.com/2009/06/boston-press/ (June 26, 2009).

⁷³ *Metzler v. Kaiser*, Case No. 829265-2 (Sup. Ct. for the State of Cal., Alameda Co.).

⁷⁴ The settlement is available online at www.equipforequality.org/wp-content/uploads/2018/09/Kaiser-Settlement.pdf

⁷⁵ Voluntary Compliance Agreement between the United States of America and Thomas Jefferson University Hospitals Inc. & Outpatient Imaging Affiliates, available online at www.ada.gov/TJ_univ_hosp_sa.html (April 16, 2019).

⁷⁶ Settlement Agreement between the United States of America and Charlotte Radiology, P.A., available online at www.ada.gov/charlotte_radiology_sa.html (Aug. 13, 2018).

⁷⁷ *Luna v. America’s Best Contacts and Eyeglasses, Inc.*, 1:11-cv-01783 (N.D. Ill. Complaint filed Mar. 15, 2011) Settlement agreement available online at www.equipforequality.org/wp-content/uploads/2018/09/Americas-Best-Stipulation-and-Class-Settlement-Agreement.pdf

⁷⁸ See also, *Montano v. Bonnie Brae Convalescent Hosp., Inc.*, 79 F. Supp. 3d 1120 (C.D. Cal. 2015)(nursing home violated Title III of the ADA by failing to modify the room and bathroom used by a resident with quadriplegia); *Judy v. Lee Mem. Health Sys.*, 2008 WL 897705 (M.D. Fla. Mar. 31, 2008)(hospital’s decision to exclude valet parking for patients who use cars with hand controls was a violation of Title III of the ADA).

⁷⁹ 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)(emphasis added).

⁸⁰ *Parker v. Metropolitan Life Insurance Co.*, 121 F.3d 1006 (6th Cir. 1997).

⁸¹ *Doe v. Bluecross Blueshield of Tenn., Inc.*, 2018 WL 3625012 at *1 (W.D. Tenn. 2018),

⁸² *Carparts Distribution Ctr., Inc. v. Automotive Wholesaler’s Association of New England, Inc.*, 37 F.3d 12 (1st Cir. 1994).

⁸³ *Id.*

⁸⁴ *Id.* at 20.

⁸⁵ *Pudlin v. AXA Equitable Life Ins. Co.*, 2016 WL 3566232 (S.D.N.Y. 2016).

⁸⁶ *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557 (7th Cir. 1999).

⁸⁷ *Reid v. BCBSM, Inc.*, 984 F. Supp. 2d 949, 955 (D. Minn. 2013).

⁸⁸ 45 C.F.R. § 92.207(b).

⁸⁹ *Schmitt v. Kaiser Foundation Health Plan of Washington*, 2018 WL 4385858 (W.D. Wash. 2018).

⁹⁰ *Doe One v. CVS Pharmacy, Inc.*, 348 F. Supp. 3d 967 (N.D. Cal. 2018).

⁹¹ 42 U.S.C. § 12111.

⁹² 42 U.S.C. §12112(b)(5)(A).

⁹³ 29 C.F.R. § 1630.2(o)(1)(ii).

⁹⁴ 42 U.S.C. §12111(10)(A).

⁹⁵ 29 C.F.R. § 1630.2(m).

⁹⁶ 29 C.F.R. § 1630.2(o)(3).

⁹⁷ *Gale v. Trinity Health Systems*, 2019 WL 339927 (S.D. Ohio Jan. 28, 2019).

⁹⁸ *Id.* at *7.

⁹⁹ *Id.*

¹⁰⁰ *Winnie v. Infectious Disease Assoc. P.A.*, 750 Fed. Appx. 954 (11th Cir. Nov. 8, 2018).

¹⁰¹ *Leme v. Southern Baptist Hospital of Florida, Inc.*, 248 F.Supp.3d 1319 (M.D. Fla. 2017).

¹⁰² *Dickerson v. Secretary, Dept. of Veterans Affairs Agency*, 489 Fed.Appx. 358, 2012 WL 3892196 (11th Cir. Sept. 7, 2012) (Note that this case involves the Rehabilitation Act rather than the ADA. This is because the employer in question was a federally-funded agency, thus subject to the Rehabilitation Act. As the Rehabilitation Act was the legislative predecessor and basis for the later-enacted ADA, and applies essentially the same requirements to employers as those described above in ADA Title I, this case is included here largely as an illustrative example).

¹⁰³ *Wulff v. Sentara Healthcare, Inc.*, 513 Fed.Appx. 267, 2013 WL 781958 (4th Cir. March 4, 2013).

¹⁰⁴ *Id.* at 267-68.

¹⁰⁵ *Anderson v. E. Conn. Health Network, Inc.*, 2015 WL 4393552 at *1 (D. Conn. July 16, 2015).

¹⁰⁶ *Id.*

¹⁰⁷ *Osborne v. Baxter Healthcare Corp.*, 798 F.3d 1260, 1264-65 (10th Cir. 2015).

¹⁰⁸ *Id.* at 1269, citing *School Board of Nassau County v. Arline*, 480 U.S. 273, 287-88 (1987).

¹⁰⁹ *Id.* at 1275.

¹¹⁰ *Id.* at 1277-78.

¹¹¹ *Id.* at 1278.

¹¹² *Stern v. St. Anthony's Health Ctr.*, 788 F.3d 276, 279 (7th Cir. 2015).

¹¹³ *Id.* at 295.

¹¹⁴ *Olsen v. Capital Region Med. Ctr.*, 713 F.3d 1149, 1150-51 (8th Cir. 2013).

¹¹⁵ *EEOC v. St. Joseph's Hospital, Inc.*, 842 F.3d 1333 (11th Cir. 2016).

¹¹⁶ *Id.* at 1345.

¹¹⁷ *Stevens v. Rite Aid Corp.*, 851 F.3d 224 (2d Cir. 2017).

¹¹⁸ *Williams v. New York City Department of Health and Mental Hygiene*, 299 F.Supp.3d 418 (S.D.N.Y. 2018).

¹¹⁹ *Searls v. Johns Hopkins Hosp.*, 158 F.Supp.3d 427, 430 (D. Md. 2016).

¹²⁰ *Id.* at 438.

¹²¹ *Id.* at 439.

¹²² *Winnie v. Infectious Disease Assoc. P.A.*, 750 Fed. Appx. 954 (11th Cir. Nov. 8, 2018).

¹²³ *Id.* at 962.

¹²⁴ See "Dialysis Clinic To Pay \$190,000 To Settle EEOC Disability Discrimination Suit" (September 14, 2015), available online at www.eeoc.gov/eeoc/newsroom/release/9-14-15.cfm.

¹²⁵ See "Pactive to Pay \$1.7 Million to Settle EEOC Disability Discrimination Class Investigation" (November 5, 2015), available online at www.eeoc.gov/eeoc/newsroom/release/11-5-15a.cfm.

¹²⁶ *EEOC v. Wesley Health Systems LLC*, 2018 WL 5986753 (S.D. Miss. Nov. 14, 2018).

¹²⁷ *Id.* at *4.

¹²⁸ Enforcement Guidance: Reasonable Accommodation and Undue Hardship Under the Americans with Disabilities Act (2002) which can be accessed at www.eeoc.gov/policy/docs/accommodation.html

¹²⁹ *Boyte v. Department of Veterans Affairs*, 2018 WL 898680 (M.D. Tenn. Feb. 14, 2018).

¹³⁰ 21 U.S.C. § 801 *et seq.*

¹³¹ 42 U.S.C. § 12114 (a). For examples of past state court rulings in favor of employers in this context, see *Coats v. Dish Network, LLC*, 350 P.3d 849 (Co. 2015), in which the Colorado Supreme Court found for an employer which had been sued for violating a state “lawful activity” statute, after the employer cited its own drug policy in terminating an employee with quadriplegia who used medical marijuana in the evening to reduce muscle spasms; *Ross v. RagingWire Telecommunications, Inc.*, 174 P.3d 200 (Cal. 2008); *Johnson v. Columbia Falls Aluminum Co., LLC*, 213 P.3d 789 (Mont. 2009); *Emerald Steel Fabricators, Inc. v. Bureau of Labor & Indus.*, 230 P.3d 518 (Or. 2010); *Roe v. TeleTech Customer Care Mgmt.*, 257 P.3d 586 (Wash. 2011).

¹³² *Callaghan v. Darlington Fabrics Corp.*, 2017 WL 2321181 (R.I.Super. May 23, 2017).

¹³³ *Barbuto v. Advantage Sales and Marketing, LLC*, 477 Mass. 456 (July 17, 2017).

¹³⁴ *Noffsinger v. SSC Niantic Operating Co. LLC*, 2017 WL 3401260 (D. Conn. Aug. 8, 2017).

¹³⁵ *Port Authority Police Benevolent Association, Inc. v. Port Authority of New York and New Jersey*, 2017 WL 4838320 (S.D.N.Y. Oct. 24, 2017).

¹³⁶ *Id.* at *8.

¹³⁷ *Wright v. Illinois Dep’t of Children & Family Svcs.*, 798 F.3d 513 (7th Cir. 2015).

¹³⁸ *Id.* at 518.

¹³⁹ *Id.* at 515.

¹⁴⁰ *Kroll v. White Lake Ambulance Authority*, 763 F.3d 619, 620 (6th Cir. 2014).

¹⁴¹ *Id.* at 622.

¹⁴² *Id.*

¹⁴³ *Id.* at 626.

¹⁴⁴ Settlement Agreement Between the United States and the City of New Albany, Indiana (17-cv-185 (S.D. Ind. Agreement reached Oct 4, 2017)), available online at www.ada.gov/new_albany/new_albany_sa.html.

¹⁴⁵ *Hustvet v. Allina Health Systems*, 910 F.3d 399 (8th Cir. 2018).

¹⁴⁶ *Id.* at 407.

¹⁴⁷ *Id.*

¹⁴⁸ *Ruggiero v. Mount Nittany Medical Center*, 736 Fed.Appx. 35 (3d Cir. June 5, 2018).

¹⁴⁹ In 2016, the EEOC released final rules regarding wellness programs addressing both the safe harbor and voluntariness exceptions. These regulations, along with an accompanying “Q&A,” are available online at www.eeoc.gov/laws/regulations/qanda-ada-wellness-final-rule.cfm

¹⁵⁰ *EEOC v. Orion Energy Systems, Inc.*, 2016 WL 5107019 (E.D. Wis. Sept. 19, 2016).

¹⁵¹ *Id.*

¹⁵² See “Wisconsin Employer Resolves EEOC Case Involving Wellness Program and Retaliation,” available online at www.eeoc.gov/eeoc/newsroom/release/4-5-17a.cfm

¹⁵³ *Equal Employment Opportunity Commission v. Flambeau, Inc.*, 846 F.3d 941, 946 (7th Cir. 2017).

¹⁵⁴ *AARP v. United States Equal Employment Opportunity Commission*, 2017 WL 6542014 (D.D.C. Dec. 20, 2017).

¹⁵⁵ *Flynn v. Distinctive Home Care, Inc.*, 812 F.3d 422 (5th Cir. 2016).

¹⁵⁶ See also *Schrader v. Fred A. Ray, M.D., P.C.*, 296 F.3d 968 (10th Cir. 2002) (holding that Section 504 does not incorporate the ADA's requirement that the employer have “fifteen or more employees”); *Fleming v. Yuma Reg'l Med. Ctr.*, 587 F.3d 938 (9th Cir. 2009) (“[T]he Rehabilitation Act covers discrimination claims by an independent contractor.”). But see *Wojewski v. Rapid City Reg'l Hosp.*, 450 F.3d 338 (8th Cir. 2006) (“[W]e affirm ... summary judgment to the defendants because [plaintiff] was not an employee of the hospital.”).