Health Law: Quality & Liability

Professor Thaddeus M. Pope

Reading Packet for Week 5 (Fall 2018)

Weekly Summary

In weeks three and four, we examined EMTALA, one type of federal healthcare nondiscrimination statute. This week, we look a few more federal nondiscrimination statutes: the Americans with Disabilities Act (ADA) and ACA section 1557. Like EMTALA, these statutes help assure patient access to medical care by limiting the ability of providers to refuse treatment for invidious reasons.

Note that like EMTALA these laws impose not only negative duties (e.g. prohibition on refusals to treat) but also positive duties. For example, these "unfunded mandates" include the duty to provide certified interpreter services to patients who are deaf or who have limited English proficiency.

Reading

All the following materials are collected into this single PDF document:

Background on Disability

- Prevalence of Disabilities and Health Care Access by Disability Status and Type Among Adults, MMWR (Aug. 2018)

ADA

- ADA Statute, 42 U.S.C. §§ 12101-02 & 12181-82
- Bragdon v. Abbott (U.S. 1998)
- Glanz v. Vernick (D. Mass. 1991)
- McElroy v. Nebraska Medical Center (D. Neb. 2007)
- Durand v. Fairview Health Servs (8th Cir. Sept. 2018)

Background on Limited English Proficiency

- Pazanowski, Hospitals: Patients Who Don't Speak English Have Rights Too, Bloomberg Law News (Aug. 2018)

Section 1557

- DHHS, General FAQ
- DHHS, FAQ on LEP
- DHHS, FAQ on Disabilities
- DHHS, FAQ on Sex

Objectives

By the end of this week, you will be able to:

- Analyze and apply key statutory, regulatory, and caselaw principles regarding the ADA (2.4).
- Analyze and apply the three prima facie elements of a claim under the ADA as well as key defenses (2.5).
- Distinguish how the ADA is enforced by private litigants from how it is enforced by OCR and the DOJ (2.6).
- Analyze and apply key statutory, regulatory, and caselaw principles regarding ACA section 1557 (2.7).

Prevalence of Disabilities and Health Care Access by Disability Status and Type Among Adults — United States, 2016

Catherine A. Okoro, PhD[1]; NaTasha D. Hollis, PhD[1]; Alissa C. Cyrus, MPH[1]; Shannon Griffin-Blake, PhD[1]

Persons with disabilities face greater barriers to health care than do those without disabilities (*1*). To identify characteristics of noninstitutionalized adults with six specific disability types (hearing, vision, cognition, mobility, self-care, and independent living),* and to assess disability-specific disparities in health care access, CDC analyzed 2016 Behavioral Risk Factor Surveillance System (BRFSS) data. The prevalences of disability overall and by disability type, and access to health care by disability type, were estimated. Analyses were stratified by three age groups: 18–44 years (young adults), 45–64 years (middle-aged adults), and ≥65 years (older adults). Among young adults, cognitive disability (10.6%) was the most prevalent type. Mobility disability was most prevalent among middle-aged (18.1%) and older adults (26.9%). Generally, disability prevalences were higher among women, American Indians/Alaska Natives (AI/AN), adults with income below the federal poverty level (FPL), and persons in the South U.S. Census region. Disability-specific disparities in health care access were prevalent, particularly among young and middle-aged adults. These data might inform public health programs of the sociodemographic characteristics and disparities in health care access associated with age and specific disability types and guide efforts to improve access to care for persons with disabilities.

BRFSS is an ongoing state-based, random-digit–dialed telephone survey of noninstitutionalized U.S. adults aged ≥18 years.† The median survey response rate among the 50 states and the District of Columbia in 2016 was 47.0%.§ The 2016 BRFSS survey included questions about six disability types (hearing, vision, cognition, mobility, self-care, and independent living).¶ Respondents were identified as having one of the disability types if they answered "yes" to the relevant question. Persons who responded "yes" to at least one disability question were identified as having any disability. Persons who responded "no" to all six questions were identified as having no disability. Missing responses and respondents who answered "don't know" or who declined to answer were excluded. Four health care access measures (i.e., health insurance coverage, having a usual health care provider, receipt of a routine check-up within the past year, and having an unmet health care need because of cost) were included.** Prevalences (with 95% confidence intervals) were calculated for any disability and disability type by sex, race/ethnicity,†† FPL,§§ and U.S. Census region, and for health care access measures, by disability status and types. All analyses were stratified by age group (18–44, 45–64, and ≥65 years). Analyses accounted for the complex sampling design.

One in four noninstitutionalized U.S. adults (25.7%, representing an estimated 61.4 million persons) reported any disability (Table 1) (Figure). Mobility was the most prevalent disability type (13.7%), followed by cognition (10.8%), independent living (6.8%), hearing (5.9%), vision (4.6%), and self-care (3.7%). Prevalences of any disability, hearing, mobility, and independent living disabilities were higher among older adults, whereas prevalence of cognitive disability was highest

* Based on Section 4302 of the Affordable Care Act, the U.S. Department of Health and Human Services issued data collection standard guidance to include a standard set of disability identifiers in all national population health surveys. https://aspe.hhs.gov/datacncl/standards/aca/4302/index.pdf.

† https://www.cdc.gov/brfss/.

§ Response rates for BRFSS are calculated using the standard set by the American Association for Public Opinion Research response rate formula 4 (http://www.aapor.org/AAPOR_Main/media/publications/Standard-Definitions20169theditionfinal.pdf). The response rate is the number of respondents who completed the survey as a proportion of all eligible and likely eligible persons. https://www.cdc.gov/brfss/annual_data/2016/pdf/2016-sdqr.pdf.

¶ The interviewer first reads a preamble to the telephone survey respondent ("The following questions are about health problems or impairments you may have. Some people who are deaf or have serious difficulty hearing may or may not use equipment to communicate by phone."), followed by the six specific disability type questions. The questions are "Are you deaf or do you have serious difficulty hearing?" (hearing); "Are you blind or do you have serious difficulty seeing, even when wearing glasses?" (vision); "Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?" (cognition); "Do you have serious difficulty walking or climbing stairs?" (mobility); "Do you have difficulty dressing or bathing?" (self-care); and "Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?" (independent living).

** Health insurance coverage was ascertained by a "yes" response to the question "Do you have any kind of health care coverage, including health insurance, prepaid plans such as health maintenance organizations, government plans such as Medicare, or Indian Health Service?" Having a usual health care provider was assessed first with the question "Do you have one person you think of as your personal doctor or health care provider?" Persons who responded "no" were asked the question "Is there more than one, or is there no person who you think of as your personal doctor or health care provider?" Responses for having a usual health care provider were dichotomized into one or more and none. Receipt of a routine check-up was assessed with the question "About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition." Responses for having had a routine check-up within the preceding 12 months were dichotomized into within the past year or not within the past year. Unmet health care need because of cost was ascertained by a "yes" response to the question "Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?"

†† Persons in all racial groups were non-Hispanic. Persons who self-identified as Hispanic might have been of any race.

§§ Poverty categories are based on the ratio of the respondent's annual household income to the appropriate simplified 2015 federal poverty threshold (given family size: number of adults (1–14) in the household and number of children (≥0) in the household) defined by the U.S. Census Bureau. This ratio is multiplied by 100 to be expressed as a percentage, and federal poverty thresholds were then used to categorize respondents into four FPL categories: 1) <100% of FPL (poor), 2) ≥100%–<200% of FPL (near poor), 3) ≥200% of FPL (not poor), and 4) unknown.

TABLE 1. Weighted unadjusted prevalence estimates of disability among adults, by type of disability* and selected characteristics — Behavioral Risk Factor Surveillance System, 2016

Characteristic	No. of respondents†,§	Type of disability¶						
		Hearing	Vision	Cognition	Mobility	Self-care	Independent living	Any
		% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)
Total (18–44 yrs)	**121,674**	**2.0 (1.8–2.1)**	**2.7 (2.5–2.9)**	**10.6 (10.3–10.9)**	**4.8 (4.6–5.0)**	**1.7 (1.5–1.8)**	**4.5 (4.3–4.7)**	**16.6 (16.2–16.9)**
Sex								
Men	58,295	2.4 (2.2–2.6)	2.4 (2.2–2.6)	9.5 (9.0–9.9)	4.0 (3.8–4.3)	1.6 (1.4–1.8)	3.5 (3.3–3.8)	15.2 (14.7–15.7)
Women	63,356	1.6 (1.4–1.7)	3.0 (2.8–3.3)	11.7 (11.3–12.2)	5.6 (5.3–5.9)	1.7 (1.6–1.9)	5.5 (5.2–5.8)	17.9 (17.4–18.5)
Race/Ethnicity**								
White	80,322	2.0 (1.9–2.2)	2.2 (2.0–2.4)	10.9 (10.5–11.2)	4.5 (4.3–4.8)	1.6 (1.4–1.7)	4.8 (4.5–5.0)	16.3 (16.2–16.9)
Black	11,837	1.4 (1.2–1.7)	3.6 (3.1–4.2)	11.1 (10.2–12.0)	6.6 (6.0–7.4)	2.1 (1.7–2.6)	4.7 (4.1–5.5)	18.1 (17.0–19.3)
Hispanic	16,297	2.1 (1.8–2.5)	3.7 (3.3–4.3)	10.3 (9.5–11.1)	5.0 (4.5–5.5)	1.6 (1.4–1.9)	4.0 (3.5–4.5)	17.6 (16.6–18.5)
AI/AN	2,255	3.5 (2.4–5.0)	3.8 (2.8–5.2)	18.8 (15.9–22.1)	8.6 (6.8–10.9)	2.3 (1.5–3.7)††	8.4 (6.6–10.8)	27.7 (24.4–31.2)
Asian	4,754	0.8 (0.5–1.3)††	1.3 (0.9–1.8)	4.5 (3.7–5.6)	1.1 (0.7–1.6)	N/A§§	1.1 (0.8–1.6)	7.2 (6.2–8.4)
Other race/Multiracial	4,508	3.7 (2.8–4.9)	3.4 (2.7–4.3)	16.0 (14.1–18.1)	7.5 (6.3–9.1)	3.0 (2.2–4.1)	8.4 (6.9–10.1)	24.9 (22.7–27.3)
Federal poverty level (FPL)¶¶								
<100% of FPL (poor)	18,824	3.3 (2.9–3.7)	5.3 (4.8–5.8)	18.2 (17.3–19.1)	10.4 (9.7–11.1)	3.5 (3.1–3.9)	9.4 (8.7–10.1)	27.8 (26.7–28.9)
≥100%–<200% of FPL (near poor)	24,116	2.1 (1.8–2.3)	3.2 (2.8–3.6)	12.8 (12.1–13.6)	5.7 (5.2–6.2)	2.0 (1.7–2.3)	5.8 (5.3–6.3)	20.1 (19.2–21.0)
≥200% of FPL (not poor)	59,273	1.3 (1.2–1.4)	1.3 (1.1–1.5)	5.5 (5.2–5.9)	2.0 (1.9–2.3)	0.7 (0.6–0.8)	1.7 (1.5–1.9)	9.3 (8.9–9.7)
Unknown	19,461	2.3 (2.0–2.7)	3.2 (2.8–3.7)	13.4 (12.6–14.2)	5.4 (4.9–5.9)	2.0 (1.7–2.3)	5.5 (5.0–6.0)	19.9 (19.0–20.9)
U.S. Census region								
Northeast	23,348	1.4 (1.2–1.7)	2.4 (2.1–2.7)	9.5 (8.9–10.2)	4.2 (3.8–4.6)	1.5 (1.3–1.8)	4.4 (3.9–4.8)	15.3 (14.5–16.1)
Midwest	29,963	2.0 (1.7–2.2)	2.1 (1.9–2.4)	10.9 (10.3–11.5)	4.9 (4.5–5.3)	1.8 (1.5–2.0)	4.6 (4.2–5.0)	16.4 (15.7–17.1)
South	39,745	2.2 (2.0–2.5)	3.4 (3.1–3.8)	11.5 (11.0–12.1)	5.6 (5.3–6.0)	1.8 (1.6–2.0)	4.8 (4.5–5.2)	18.1 (17.5–18.8)
West	28,618	1.9 (1.7–2.2)	2.3 (2.1–2.7)	9.5 (8.9–10.1)	3.9 (3.5–4.3)	1.4 (1.2–1.7)	4.1 (3.7–4.5)	15.2 (14.5–15.9)
Total (45–64 yrs)	**174,413**	**5.9 (5.6–6.1)**	**6.1 (5.9–6.4)**	**11.9 (11.6–12.2)**	**18.1 (17.7–18.5)**	**5.5 (5.3–5.7)**	**8.2 (7.9–8.5)**	**28.6 (28.2–29.1)**
Sex								
Men	76,489	7.6 (7.3–8.0)	5.8 (5.4–6.2)	10.2 (9.8–10.6)	16.1 (15.5–16.6)	5.5 (5.2–5.9)	6.9 (6.6–7.4)	27.1 (26.5–27.7)
Women	97,910	4.2 (3.9–4.4)	6.4 (6.1–6.8)	13.5 (13.0–13.9)	20.1 (19.5–20.6)	5.4 (5.2–5.8)	9.4 (9.0–9.8)	30.1 (29.5–30.7)
Race/Ethnicity**								
White	135,958	5.9 (5.7–6.2)	4.6 (4.4–4.8)	10.8 (10.5–11.1)	16.2 (15.9–16.6)	4.7 (4.5–4.9)	7.4 (7.1–7.6)	26.2 (25.8–26.7)
Black	14,851	5.0 (4.4–5.8)	9.6 (8.7–10.6)	14.5 (13.5–15.6)	25.3 (24.0–26.6)	7.9 (7.1–8.7)	10.5 (9.7–11.4)	35.5 (34.1–37.0)
Hispanic	10,400	6.0 (5.1–7.0)	11.2 (10.0–12.5)	14.4 (13.2–15.7)	21.8 (20.4–23.4)	7.4 (6.5–8.4)	9.5 (8.6–10.6)	35.5 (33.7–37.2)
AI/AN	2,910	14.3 (11.7–17.2)	11.5 (9.7–13.6)	23.9 (20.7–27.3)	33.3 (29.9–36.9)	10.3 (8.4–12.7)	16.6 (14.0–19.5)	49.2 (45.5–52.8)
Asian	2,836	2.9 (1.9–4.4)††	N/A§§	6.4 (4.6–8.8)	7.6 (5.7–10.2)	N/A§§	4.4 (2.7–7.1)††	15.3 (12.5–18.4)
Other race/Multiracial	4,216	8.8 (7.2–10.8)	9.3 (7.5–11.6)	20.4 (16.6–24.9)	28.6 (24.7–32.9)	11.3 (7.9–16.0)	17.1 (13.4–21.7)	41.6 (37.6–45.6)
Federal poverty level (FPL)¶¶								
<100% of FPL (poor)	16,128	9.0 (8.2–9.8)	16.4 (15.2–17.6)	30.0 (28.5–31.5)	42.3 (40.7–44.0)	15.7 (14.5–17.0)	22.8 (21.4–24.2)	57.9 (56.3–59.6)
≥100%–<200% of FPL (near poor)	30,911	8.7 (8.0–9.4)	9.9 (9.1–10.8)	18.5 (17.6–19.3)	29.1 (28.1–30.1)	9.1 (8.5–9.7)	13.3 (12.6–14.0)	44.5 (43.3–45.7)
≥200% of FPL (not poor)	102,245	4.1 (3.8–4.3)	2.4 (2.2–2.6)	5.4 (5.1–5.7)	8.9 (8.5–9.3)	2.1 (1.9–2.3)	3.2 (3.0–3.5)	16.6 (16.1–17.1)
Unknown	25,129	6.8 (6.3–7.4)	7.5 (6.8–8.2)	14.3 (13.4–15.1)	20.9 (19.9–21.8)	5.9 (5.4–6.5)	9.6 (9.0–10.3)	31.9 (30.8–33.1)
U.S. Census region								
Northeast	37,594	4.8 (4.4–5.3)	4.9 (4.5–5.4)	10.2 (9.6–10.8)	16.0 (15.2–16.8)	4.6 (4.2–5.1)	7.3 (6.8–7.8)	25.6 (24.7–26.5)
Midwest	42,247	5.9 (5.6–6.3)	5.1 (4.7–5.5)	10.9 (10.4–11.5)	16.9 (16.3–17.6)	5.0 (4.6–5.4)	7.3 (6.9–7.7)	27.0 (26.3–27.8)
South	57,726	6.7 (6.3–7.2)	7.6 (7.1–8.1)	13.7 (13.1–14.3)	21.5 (20.9–22.2)	6.6 (6.2–7.1)	9.6 (9.1–10.1)	32.7 (31.9–33.5)
West	36,846	5.2 (4.7–5.6)	5.6 (5.1–6.2)	11.1 (10.4–11.8)	15.3 (14.5–16.1)	4.8 (4.3–5.3)	7.4 (6.8–8.1)	25.8 (24.9–26.8)

See table footnotes on the next page.

among middle-aged (11.9%) and young adults (10.6%), and lowest among older adults (9.5%). Among middle-aged and older adults, the prevalences of vision disability (6.1% and 6.6%, respectively) and self-care disability (5.5% in both) were similar. Among all age groups, the prevalences of any disability and of each type were higher among women than among men, with the exceptions of hearing and self-care. The reported prevalence of hearing disability was higher among men than among women for all age groups (young adults: men = 2.4% versus women = 1.6%; middle-aged adults: 7.6% versus 4.2%; and older adults: 19.4% versus 11.3%), and the reported prevalences of self-care disability were approximately the same. Generally, among young and middle-aged adults, the highest prevalences of any disability and of each type were reported among AI/AN and persons in the "other race/multiracial" group, whereas the lowest prevalences were reported among Asians. Among older adults, approximately half of AI/AN (54.9%), Hispanics (50.5%), and persons in the "other race/multiracial" group (49.9%) reported any disability. Within each age group, the prevalences of any and each

TABLE 1. (*Continued*) Weighted unadjusted prevalence estimates of disability among adults, by type of disability* and selected characteristics — Behavioral Risk Factor Surveillance System, 2016

Characteristic	No. of respondents†,§	Type of disability¶ Hearing % (95% CI)	Vision % (95% CI)	Cognition % (95% CI)	Mobility % (95% CI)	Self-care % (95% CI)	Independent living % (95% CI)	Any % (95% CI)
Total (≥65 yrs)	**162,724**	**14.9 (14.5–15.3)**	**6.6 (6.4–6.9)**	**9.5 (9.2–9.9)**	**26.9 (26.5–27.4)**	**5.5 (5.2–5.8)**	**9.8 (9.4–10.1)**	**41.7 (41.1–42.2)**
Sex								
Men	64,224	19.4 (18.7–20.1)	6.2 (5.8–6.7)	8.8 (8.3–9.4)	22.8 (22.1–23.5)	5.1 (4.7–5.5)	6.5 (6.1–7.0)	40.9 (40.0–41.7)
Women	98,488	11.3 (10.8–11.7)	7.0 (6.6–7.3)	10.1 (9.7–10.6)	30.3 (29.6–30.9)	5.8 (5.4–6.2)	12.3 (11.8–12.8)	42.3 (41.6–43.0)
Race/Ethnicity**								
White	138,816	15.5 (15.1–15.9)	5.9 (5.6–6.2)	8.4 (8.1–8.7)	25.5 (25.0–25.9)	4.6 (4.3–4.8)	8.8 (8.5–9.1)	40.2 (39.6–40.7)
Black	10,022	10.2 (8.7–11.9)	8.8 (7.8–10.0)	12.3 (11.0–13.7)	33.6 (31.6–35.6)	8.4 (7.3–9.7)	13.3 (11.9–14.8)	46.7 (44.6–48.8)
Hispanic	4,583	14.0 (12.1–16.3)	10.8 (9.2–12.5)	15.5 (13.4–17.7)	33.3 (30.7–36.1)	9.4 (7.8–11.3)	15.4 (13.4–17.6)	50.5 (47.7–53.4)
AI/AN	1,702	25.3 (21.2–29.9)	8.9 (6.9–11.5)	17.0 (13.8–20.7)	37.5 (33.0–42.2)	10.0 (7.6–13.1)	14.9 (12.1–18.2)	54.9 (50.0–59.8)
Asian	1,739	9.6 (5.7–15.7)††	N/A§§	9.4 (5.6–15.4)††	22.5 (16.7–29.6)	N/A§§	5.1 (3.0–8.6)††	34.8 (28.2–42.1)
Other race/Multiracial	3,073	17.9 (14.7–21.6)	8.5 (6.6–11.0)	14.4 (11.9–17.3)	34.6 (30.9–38.6)	8.8 (6.6–11.5)	12.9 (10.1–16.4)	49.9 (45.8–54.0)
Federal poverty level (FPL)¶¶								
<100% of FPL (poor)	7,962	18.1 (16.2–20.1)	13.7 (12.1–15.6)	18.2 (16.5–20.0)	43.5 (41.1–45.9)	12.0 (10.6–13.7)	19.5 (17.8–21.4)	59.6 (57.1–62.0)
≥100%–<200% of FPL (near poor)	41,124	17.4 (16.6–18.3)	9.3 (8.7–10.0)	13.2 (12.4–14.0)	36.4 (35.3–37.5)	7.8 (7.1–8.5)	13.7 (12.9–14.5)	53.1 (52.0–54.1)
≥200% of FPL (not poor)	79,774	12.8 (12.2–13.3)	4.1 (3.7–4.4)	5.5 (5.1–5.9)	18.7 (18.0–19.3)	3.0 (2.7–3.3)	5.1 (4.8–5.5)	31.9 (31.1–32.6)
Unknown	33,864	15.5 (14.7–16.4)	6.8 (6.3–7.3)	11.2 (10.5–12.0)	28.4 (27.4–29.5)	6.0 (5.4–6.8)	12.0 (11.2–12.8)	43.7 (42.5–44.8)
U.S. Census region								
Northeast	31,466	12.9 (12.1–13.8)	5.7 (5.1–6.3)	8.2 (7.5–9.0)	26.2 (25.1–27.3)	5.2 (4.6–5.9)	9.2 (8.5–10.0)	39.3 (38.1–40.5)
Midwest	39,575	15.0 (14.4–15.6)	5.9 (5.5–6.4)	8.2 (7.8–8.7)	25.2 (24.5–26.0)	4.7 (4.3–5.1)	9.0 (8.5–9.5)	40.3 (39.4–41.1)
South	56,913	15.8 (15.1–16.5)	7.8 (7.3–8.3)	11.1 (10.6–11.7)	28.8 (28.0–29.6)	6.0 (5.5–6.4)	11.0 (10.4–11.5)	44.3 (43.4–45.2)
West	34,770	14.9 (13.9–15.9)	6.2 (5.5–7.0)	9.1 (8.3–10.1)	26.1 (24.8–27.5)	5.6 (4.9–6.5)	8.8 (8.1–9.7)	40.4 (39.0–41.8)
Total (all age groups)	**458,811**	**5.9 (5.7–6.0)**	**4.6 (4.5–4.8)**	**10.8 (10.6–11.0)**	**13.7 (13.5–13.9)**	**3.7 (3.6–3.8)**	**6.8 (6.7–6.9)**	**25.7 (25.4–25.9)**

Abbreviations: AI/AN = American Indian/Alaska Native; CI = confidence interval; N/A = not available.

* Respondents were asked "Are you deaf or do you have serious difficulty hearing?" (hearing); "Are you blind or do you have serious difficulty seeing, even when wearing glasses?" (vision); "Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?" (cognition); "Do you have serious difficulty walking or climbing stairs?" (mobility); "Do you have difficulty dressing or bathing?" (self-care); and "Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?" (independent living). Respondents who declined to answer, reported "don't know," and other missing responses were excluded from the analyses.

† Respondents with missing information on disability are not included; all groups might not add to the same respondent total or to the overall total.

§ Unweighted sample size.

¶ Each disability type might not be independent; a respondent might have two or more disability types.

** Persons in all racial groups were non-Hispanic. Persons who self-identified as Hispanic might have been of any race.

†† Relative standard error = 0.20–0.30.

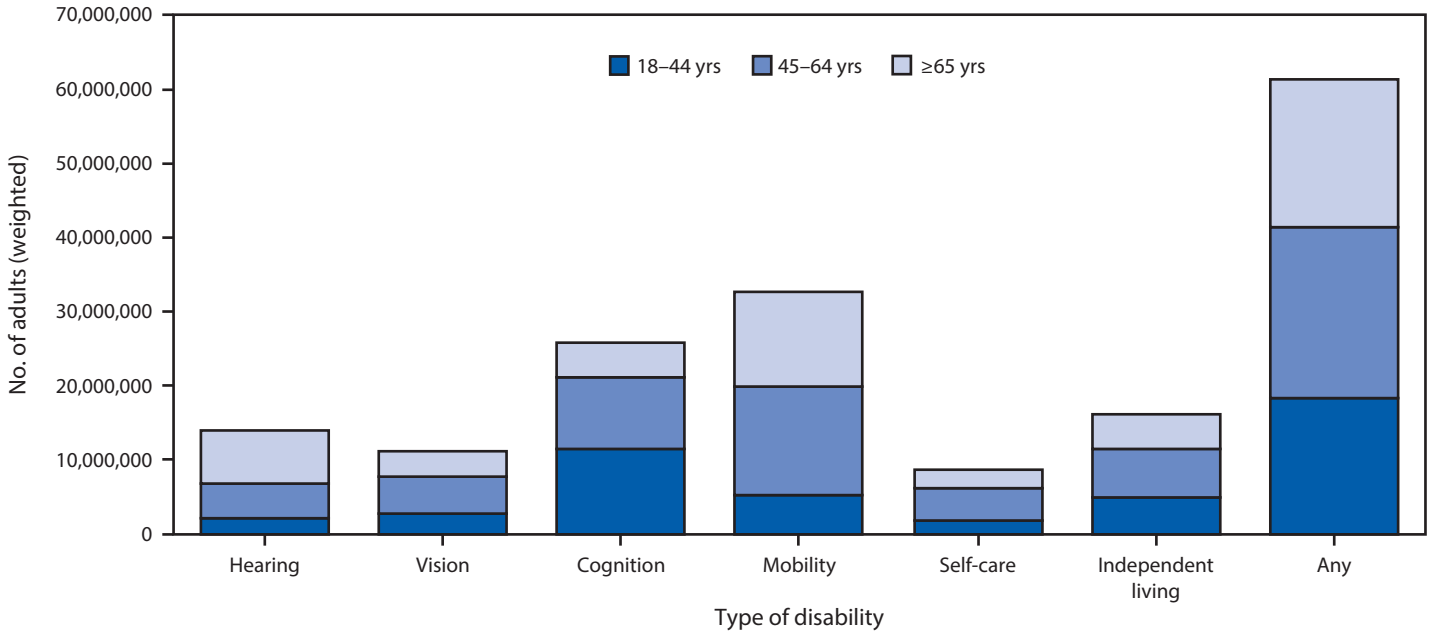
§§ Estimate not available because relative standard error >0.30.

¶¶ Poverty categories are based on the ratio of the respondent's annual household income to the appropriate simplified 2015 federal poverty threshold (given family size: number of adults (1–14) in the household and number of children (≥0) in the household) defined by the U.S. Census Bureau. This ratio is multiplied by 100 to be expressed as a percentage, and federal poverty thresholds were then used to categorize respondents into four FPL categories: 1) <100% of FPL (poor), 2) ≥100%–<200% of FPL (near poor), 3) ≥200% of FPL (not poor), and 4) unknown.

disability type declined with decreasing poverty. Across all age groups, higher prevalences of any disability and of each type were generally reported in the South compared with other U.S. Census regions.

In 2016, for each disability type, prevalences of health insurance coverage, having a usual health care provider, and receiving a check-up during the preceding 12 months increased with increasing age group, whereas, with the exception of persons with a vision disability, the prevalence of having an unmet health care need because of cost decreased (Table 2). Young and middle-aged adults with a vision disability had the lowest prevalences of having health insurance coverage (74.9% and 81.3%, respectively), a usual health care provider (64.0% and 82.3%, respectively), and, among younger adults, of having received a check-up during the preceding 12 months (58.0%). Within these age groups, adults with a self-care disability had the highest prevalences of having health insurance coverage (83.1% and 88.8%, respectively) and a usual health care provider (76.3% and 89.0%, respectively), similar to middle-aged adults with an independent living disability (89.0%). The prevalences of having received a routine check-up during the past 12 months were higher among young adults with a mobility disability (69.1%) and middle-aged adults with a self-care disability (81.6%). Having a health care need that was unmet because of cost considerations was most prevalent among younger adults with an independent living disability (36.7%) and middle-aged adults with a vision disability (35.5%), and was least prevalent among younger and middle-aged adults with a hearing disability (31.2% and 24.1%, respectively). Most health care access measures were similar by disability type among older adults, with the exception of having an unmet health care need because of cost, which ranged from 7.3% (hearing) to 14.0% (self-care).

FIGURE. Estimated number of adults with any disability, by specific type of disability and age group — Behavioral Risk Factor Surveillance System, 2016



Discussion

This is the first report of disability prevalence measured using the U.S. Department of Health and Human Services six-question set through BRFSS and that examines sociodemographic characteristics and disparities in health care access by age group and disability type. In 2016, one in four noninstitutionalized U.S. adults reported any disability; a previous CDC report found a disability in one in five U.S. adults (*2*). The higher disability prevalence reported here likely resulted from the addition of the hearing disability question in 2016. The reported prevalence of hearing disability (5.9%) is consistent with other reports (*3*–*5*), and there were negligible (i.e., <1%) increases in prevalences of the other five disability types from 2013 to 2016.

Social determinants of health, such as sex, race/ethnicity, socioeconomic status, geographic location, and access to and use of quality health services influence the health and well-being of populations (*6*). Consistent with previous research (*2*), this analysis identified disparities in prevalences of any disability and disability type by sex, race/ethnicity, socioeconomic status, and geographic region. Women reported higher prevalences of any disability and of each disability type (except hearing and self-care) than did men. Higher prevalences of disability were reported by persons living in poverty; middle-aged adults living in poverty reported nearly five times the prevalence of mobility disability as did those who reported household income ≥200% of FPL. In this study, persons residing in the South U.S. Census region generally reported higher prevalences of disability. Chronic conditions associated with leading causes of disability (i.e., arthritis and heart trouble) (*7*) and associated lifestyle factors (e.g., smoking, overweight and obesity, and hypertension), are more prevalent in the South than in other U.S. Census regions.[¶¶] The multiple determinants of health underscore the need for cross-sector approaches to effectively mitigate health inequities experienced by persons with disabilities.

Similar to previous research (*8*,*9*), this analysis identified disability-specific disparities in health care access, particularly among young and middle-aged adults. Disability-specific factors, such as severity of disability, age at disability onset, or having multiple disability types or comorbidities might partially explain why persons in these age groups, and those reporting self-care and mobility disabilities, had higher prevalences of access to care than did those reporting vision and hearing disabilities (*5*,*9*). Among persons aged ≥65 years, the primary disparity was in unmet health care need because of cost; adults reporting self-care disability had nearly twice the prevalence of cost-related unmet health care need than did those reporting hearing disability. By age 65 years, approximately 98% of Americans have access to Medicare coverage (*10*) and might have increased access to health care services. Nonetheless, older adults reporting self-care disability might face more financial strain because of a higher level of medical need compared with persons without such disability (*1*).

[¶¶] https://www.cdc.gov/brfss/brfssprevalence/index.html.

TABLE 2. Weighted unadjusted prevalence estimates for four health care access measures among adults with any disability, by age group and disability type* — Behavioral Risk Factor Surveillance System, 2016

Age group (yrs)	Characteristic	No. of respondents†	Type of disability§						
			Hearing	Vision	Cognition	Mobility	Self-care	Independent living	Any
			% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)
18–44	**Health insurance coverage**								
	Yes	16,446	76.9 (73.7–79.7)	74.9 (72.1–77.5)	78.6 (77.2–79.8)	82.0 (80.3–83.6)	83.1 (79.9–85.9)	81.2 (79.3–83.0)	78.9 (77.8–79.9)
	No	3,690	23.1 (20.1–26.3)	25.1 (22.5–27.9)	21.5 (20.2–22.8)	18.0 (16.4–19.7)	16.9 (14.1–20.2)	18.8 (17.0–20.7)	21.2 (20.1–22.2)
	Usual health care provider								
	Yes	14,188	64.4 (61.1–67.5)	64.0 (61.0–66.9)	66.1 (64.6–67.5)	74.1 (72.1–76.0)	76.3 (72.8–79.5)	70.4 (68.2–72.4)	66.3 (65.2–67.5)
	No	5,967	35.6 (32.5–38.9)	36.0 (33.1–39.0)	34.0 (32.5–35.4)	25.9 (24.0–27.9)	23.7 (20.5–27.2)	29.7 (27.6–31.8)	33.7 (32.6–34.9)
	Unmet health care need because of cost during past 12 mos.								
	Yes	6,234	31.2 (28.3–34.2)	34.8 (32.0–37.7)	33.4 (32.0–34.8)	35.6 (33.6–37.7)	36.2 (32.9–39.6)	36.7 (34.6–38.9)	31.4 (30.3–32.5)
	No	13,957	68.8 (65.8–71.7)	65.2 (62.3–68.0)	66.6 (65.2–68.0)	64.4 (62.3–66.4)	63.8 (60.4–67.1)	63.3 (61.1–65.4)	68.6 (67.5–69.7)
	Routine check-up within past 12 mos.								
	Yes	12,509	60.5 (57.3–63.7)	58.0 (54.9–61.0)	61.4 (59.9–62.9)	69.1 (67.0–71.1)	67.9 (64.2–71.4)	64.4 (62.1–66.5)	61.7 (60.5–62.9)
	No	7,324	39.5 (36.3–42.7)	42.0 (39.0–45.1)	38.6 (37.1–40.1)	30.9 (28.9–33.0)	32.1 (28.6–35.8)	35.7 (33.5–37.9)	38.3 (37.1–39.5)
45–64	**Health insurance coverage**								
	Yes	44,085	87.1 (85.4–88.6)	81.3 (79.3–83.1)	86.3 (85.2–87.4)	88.4 (87.6–89.2)	88.8 (87.4–90.2)	88.4 (87.2–89.5)	87.0 (86.3–87.7)
	No	4,918	13.0 (11.4–14.6)	18.7 (16.9–20.7)	13.7 (12.6–14.8)	11.6 (10.8–12.4)	11.2 (9.8–12.6)	11.6 (10.5–12.9)	13.0 (12.3–13.7)
	Usual health care provider								
	Yes	43,142	84.9 (83.1–86.4)	82.3 (80.4–84.1)	85.3 (84.1–86.4)	88.3 (87.5–89.1)	89.0 (87.6–90.2)	89.0 (87.9–90.0)	85.8 (85.1–86.5)
	No	5,835	15.2 (13.6–16.9)	17.7 (15.9–19.6)	14.7 (13.6–15.9)	11.7 (10.9–12.5)	11.0 (9.8–12.4)	11.0 (10.0–12.1)	14.2 (13.5–14.9)
	Unmet health care need because of cost during past 12 mos.								
	Yes	11,506	24.1 (22.4–25.9)	35.5 (33.3–37.8)	31.8 (30.5–33.2)	27.2 (26.2–28.3)	31.9 (29.9–34.1)	31.9 (30.2–33.6)	25.9 (25.1–26.8)
	No	37,472	75.9 (74.1–77.6)	64.5 (62.2–66.7)	68.2 (66.8–69.5)	72.8 (71.7–73.8)	68.1 (65.9–70.1)	68.1 (66.4–69.8)	74.1 (73.2–74.9)
	Routine check-up within past 12 mos.								
	Yes	37,876	74.5 (72.7–76.2)	75.0 (73.1–76.9)	76.8 (75.6–78.0)	80.3 (79.4–81.2)	81.6 (80.0–83.1)	80.9 (79.6–82.2)	77.0 (76.1–77.7)
	No	10,596	25.5 (23.8–27.3)	25.0 (23.1–26.9)	23.2 (22.0–24.4)	19.7 (18.8–20.6)	18.4 (16.9–20.0)	19.1 (17.8–20.4)	23.1 (22.3–23.9)
≥65	**Health insurance coverage**								
	Yes	65,481	97.9 (97.4–98.3)	97.0 (96.1–97.8)	97.4 (96.8–97.9)	97.7 (97.4–98.0)	97.7 (96.9–98.2)	97.0 (96.2–97.6)	97.8 (97.6–98.1)
	No	1,191	2.1 (1.7–2.6)	3.0 (2.2–3.9)	2.6 (2.1–3.2)	2.3 (2.0–2.6)	2.4 (1.8–3.1)	3.0 (2.4–3.8)	2.2 (1.9–2.4)
	Usual health care provider								
	Yes	63,068	94.7 (94.1–95.3)	93.4 (92.4–94.3)	93.4 (92.4–94.3)	95.8 (95.4–96.2)	95.7 (94.7–96.5)	95.6 (95.0–96.2)	94.9 (94.5–95.3)
	No	3,491	5.3 (4.7–5.9)	6.6 (5.7–7.6)	6.6 (5.7–7.6)	4.2 (3.8–4.6)	4.3 (3.5–5.3)	4.4 (3.8–5.0)	5.1 (4.7–5.5)
	Unmet health care need because of cost during past 12 mos.								
	Yes	4,838	7.3 (6.7–8.0)	12.8 (11.4–14.3)	13.7 (12.5–14.9)	9.3 (8.7–10.0)	14.0 (12.3–15.9)	12.1 (10.9–13.4)	8.2 (7.7–8.7)
	No	61,761	92.7 (92.0–93.3)	87.2 (85.7–88.6)	86.4 (85.1–87.5)	90.7 (90.0–91.3)	86.0 (84.1–87.7)	87.9 (86.6–89.1)	91.8 (91.3–92.3)
	Routine check-up within past 12 mos.								
	Yes	58,551	90.1 (89.3–90.9)	89.0 (87.7–90.2)	89.0 (87.9–90.0)	91.0 (90.3–91.5)	90.1 (88.6–91.3)	89.4 (88.3–90.5)	90.2 (89.7–90.7)
	No	7,157	9.9 (9.1–10.7)	11.0 (9.8–12.3)	11.0 (10.0–12.1)	9.1 (8.5–9.7)	10.0 (8.7–11.4)	10.6 (9.5–11.7)	9.8 (9.3–10.3)

Abbreviation: CI = confidence interval.

* Respondents were asked "Are you deaf or do you have serious difficulty hearing?" (hearing); "Are you blind or do you have serious difficulty seeing, even when wearing glasses?" (vision); "Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?" (cognition); "Do you have serious difficulty walking or climbing stairs?" (mobility); "Do you have difficulty dressing or bathing?" (self-care); and "Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?" (independent living). Respondents who declined to answer, reported "don't know," and other missing responses were excluded from the analyses.

† Unweighted sample size.

§ Each disability type might not be independent; a respondent might have two or more disability types.

The findings in this report are subject to at least four limitations. First, BRFSS data are cross-sectional, and causality among sociodemographic characteristics, health care access, and disability cannot be inferred. Second, disability estimates are likely underestimates because BRFSS is only administered to noninstitutionalized adults and excludes persons living in long-term care facilities, such as older adults who might have higher disability prevalences. This could, in part, explain the higher prevalence estimates of cognitive disability among middle-aged and young adults compared with older adults, and the similar estimates of vision disability and self-care disability among middle-aged and older adults. In addition, questions used to assess hearing, vision, cognition, and mobility disabilities were designed to capture serious difficulty in these basic actions; thus, adults with milder difficulties might not be identified. Third, BRFSS data were self-reported and might be subject to self-report biases. Finally, nonresponse bias remains a possibility, although the weighting methodology used by BRFSS adjusts for nonresponse bias.

Prevalence of disability varied by age group and sociodemographic characteristics. Health care access varied by age group and disability type. Identifying disparities in access to health care highlights disability types and selected demographic groups***

*** Disability and Health Data System (https://dhds.cdc.gov/), an online, interactive data tool developed and maintained by CDC, presents yearly state-level data on prevalence of disability as well as approximately 30 demographic and health indicators, including health care access, for adults with disabilities overall and by type.

Summary

What is already known about this topic?

In 2013, based on questions to assess five disability types (i.e., vision, cognition, mobility, self-care, and independent living), one in five U.S. adults reported a disability.

What is added by this report?

In 2016, using the U.S. Department of Health and Human Services six-question set, one in four (61 million) U.S. adults reported any disability; nearly 6% reported hearing disability. Adults with disabilities, particularly those aged 18–44 and 45–64 years, experienced disparities in health care access by disability type.

What are the implications for public health practice?

Public health programs might benefit from the information provided in this report to develop and improve interventions, accessibility, and outreach to reduce disparities in health care access.

that might benefit most from interventions that improve health care access, receipt of needed health services, and coordinated care. These have the potential to improve health behaviors, prevent secondary conditions, delay the progression of disability, or, through early detection of disease, permit early intervention that might improve health outcomes. Improved understanding of disability-specific differences in health care access and the provision of medical care might improve the specificity and effectiveness of interventions, accessibility, and outreach to reduce disability-specific disparities in health care access.

[1]Division of Human Development and Disability, National Center on Birth Defects and Developmental Disabilities, CDC.

Corresponding author: Catherine A. Okoro, cokoro@cdc.gov, 770-488-5220.

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Conflict of Interest

No conflicts of interest were reported.

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AMERICANS WITH DISABILITIES ACT - as amended in 2008

42 U.S.C 12101 Findings and purpose

(a) Findings. The Congress finds that
(1) physical or mental disabilities in no way diminish a person's right to fully participate in all aspects of society, yet many people with physical or mental disabilities have been precluded from doing so because of discrimination; others who have a record of a disability or are regarded as having a disability also have been subjected to discrimination;
(2) historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;
(3) discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services;
(4) unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination;
(5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, the discriminatory effects of architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities;
(6) census data, national polls, and other studies have documented that people with disabilities, as a group, occupy an inferior status in our society, and are severely disadvantaged socially, vocationally, economically, and educationally;
(7) the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals; and
(8) the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity.

(b) Purpose. It is the purpose of this chapter
(1) to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;
(2) to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;
(3) to ensure that the Federal Government plays a central role in enforcing the standards established in this chapter on behalf of individuals with disabilities; and
(4) to invoke the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities.

Sec. 12101 note: Findings and Purposes of ADA Amendments Act of 2008, Pub. L. 110-325, § 2, Sept. 25, 2008, 122 Stat. 3553, provided that:

(a) Findings. Congress finds that
(1) in enacting the Americans with Disabilities Act of 1990 (ADA), Congress intended that the Act "provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities" and provide broad coverage;
(2) in enacting the ADA, Congress recognized that physical and mental disabilities in no way diminish a person's right to fully participate in all aspects of society, but that people with physical or mental disabilities are frequently precluded from doing so because of prejudice,

antiquated attitudes, or the failure to remove societal and institutional barriers;
(3) while Congress expected that the definition of disability under the ADA would be interpreted consistently with how courts had applied the definition of a handicapped individual under the Rehabilitation Act of 1973, that expectation has not been fulfilled;
(4) the holdings of the Supreme Court in Sutton v. United Air Lines, Inc., 527 U.S. 471 (1999) and its companion cases have narrowed the broad scope of protection intended to be afforded by the ADA, thus eliminating protection for many individuals whom Congress intended to protect;
(5) the holding of the Supreme Court in Toyota Motor Manufacturing, Kentucky, Inc. v. Williams, 534 U.S. 184 (2002) further narrowed the broad scope of protection intended to be afforded by the ADA;
(6) as a result of these Supreme Court cases, lower courts have incorrectly found in individual cases that people with a range of substantially limiting impairments are not people with disabilities;
(7) in particular, the Supreme Court, in the case of Toyota Motor Manufacturing, Kentucky, Inc. v. Williams, 534 U.S. 184 (2002), interpreted the term "substantially limits" to require a greater degree of limitation than was intended by Congress; and
(8) Congress finds that the current Equal Employment Opportunity Commission ADA regulations defining the term "substantially limits" as "significantly restricted" are inconsistent with congressional intent, by expressing too high a standard.

(b) Purposes. The purposes of this Act are
(1) to carry out the ADA's objectives of providing "a clear and comprehensive national mandate for the elimination of discrimination" and "clear, strong, consistent, enforceable standards addressing discrimination" by reinstating a broad scope of protection to be available under the ADA;
(2) to reject the requirement enunciated by the Supreme Court in Sutton v. United Air Lines, Inc., 527 U.S. 471 (1999) and its companion cases that whether an impairment substantially limits a major life activity is to be determined with reference to the ameliorative effects of mitigating measures;
(3) to reject the Supreme Court's reasoning in Sutton v. United Air Lines, Inc., 527 U.S. 471 (1999) with regard to coverage under the third prong of the definition of disability and to reinstate the reasoning of the Supreme Court in School Board of Nassau County v. Arline, 480 U.S. 273 (1987) which set forth a broad view of the third prong of the definition of handicap under the Rehabilitation Act of 1973;
(4) to reject the standards enunciated by the Supreme Court in Toyota Motor Manufacturing, Kentucky, Inc. v. Williams, 534 U.S. 184 (2002), that the terms "substantially" and "major" in the definition of disability under the ADA "need to be interpreted strictly to create a demanding standard for qualifying as disabled," and that to be substantially limited in performing a major life activity under the ADA "an individual must have an impairment that prevents or severely restricts the individual from doing activities that are of central importance to most people's daily lives";
(5) to convey congressional intent that the standard created by the Supreme Court in the case of Toyota Motor Manufacturing, Kentucky, Inc. v. Williams, 534 U.S. 184 (2002) for "substantially limits", and applied by lower courts in numerous decisions, has created an inappropriately high level of limitation necessary to obtain coverage under the ADA, to convey that it is the intent of Congress that the primary object of attention in cases brought under the ADA should be whether entities covered under the ADA have complied with their obligations, and to convey that the question of whether an individual's impairment is a disability under the ADA should not demand extensive analysis; and
(6) to express Congress' expectation that the Equal Employment Opportunity Commission will revise that portion of its current regulations that defines the term "substantially limits" as "significantly restricted" to be consistent with this Act, including the amendments made by this Act.

42 U.S.C. 12102 Definition of disability

As used in this chapter:
(1) Disability. The term "disability" means, with respect to an individual
(A) a physical or mental impairment that substantially limits one or more major life activities of such individual;
(B) a record of such an impairment; or
(C) being regarded as having such an impairment (as described in paragraph (3)).

(2) Major Life Activities
(A) In general. For purposes of paragraph (1), major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.
(B) Major bodily functions. For purposes of paragraph (1), a major life activity also includes the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

(3) Regarded as having such an impairment. For purposes of paragraph (1)(C):
(A) An individual meets the requirement of “being regarded as having such an impairment” if the individual establishes that he or she has been subjected to an action prohibited under this chapter because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.
(B) Paragraph (1)(C) shall not apply to impairments that are transitory and minor. A transitory impairment is an impairment with an actual or expected duration of 6 months or less.

(4) Rules of construction regarding the definition of disability. The definition of “disability” in paragraph (1) shall be construed in accordance with the following:
(A) The definition of disability in this chapter shall be construed in favor of broad coverage of individuals under this chapter, to the maximum extent permitted by the terms of this chapter.
(B) The term “substantially limits” shall be interpreted consistently with the findings and purposes of the ADA Amendments Act of 2008.
(C) An impairment that substantially limits one major life activity need not limit other major life activities in order to be considered a disability.
(D) An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.
(E) (i) The determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures such as
(I) medication, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies;
(II) use of assistive technology;
(III) reasonable accommodations or auxiliary aids or services; or
(IV) learned behavioral or adaptive neurological modifications.
(ii) The ameliorative effects of the mitigating measures of ordinary eyeglasses or contact lenses shall be considered in determining whether an impairment substantially limits a major life activity.
(iii) As used in this subparagraph
(I) the term “ordinary eyeglasses or contact lenses” means lenses that are

intended to fully correct visual acuity or eliminate refractive error; and
(II) the term “low-vision devices” means devices that magnify, enhance, or otherwise augment a visual image.

42 U.S.C. 12181 Definitions

As used in this subchapter: . . .
(7) Public accommodation. The following private entities are considered public accommodations for purposes of this subchapter, if the operations of such entities affect commerce . . .
(F) a laundromat, dry-cleaner, bank, barber shop, beauty shop, travel service, shoe repair service, funeral parlor, gas station, office of an accountant or lawyer, pharmacy, insurance office, professional office of a health care provider, hospital, or other service establishment;

42 U.S.C. 12182 Prohibition of discrimination by public accommodations

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

(b) Construction
(1) General prohibition
(A) Activities
(i) Denial of participation. It shall be discriminatory to subject an individual or class of individuals on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements, to a denial of the opportunity of the individual or class to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of an entity. . . .

(2) Specific prohibitions
(A) Discrimination. For purposes of subsection (a) of this section, discrimination includes
(i) 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 from fully and equally enjoying any goods, services, facilities, privileges, advantages, or accommodations, unless such criteria can be shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered;
(ii) a failure to make reasonable modifications in policies, practices, or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations;
(iii) a failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the good, service, facility, privilege, advantage, or accommodation being offered or would result in an undue burden;
(iv) a failure to remove architectural barriers, and communication barriers that are structural in nature, in existing facilities, and transportation barriers in existing vehicles

and rail passenger cars used by an establishment for transporting individuals (not including barriers that can only be removed through the retrofitting of vehicles or rail passenger cars by the installation of a hydraulic or other lift), where such removal is readily achievable; and
(v) where an entity can demonstrate that the removal of a barrier under clause (iv) is not readily achievable, a failure to make such goods, services, facilities, privileges, advantages, or accommodations available through alternative methods if such methods are readily achievable. (2) Specific prohibitions
(A) Discrimination. For purposes of subsection (a) of this section, discrimination includes
(i) 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 from fully and equally enjoying any goods, services, facilities, privileges, advantages, or accommodations, unless such criteria can be shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered;
(ii) a failure to make reasonable modifications in policies, practices, or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations;
(iii) a failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the good, service, facility, privilege, advantage, or accommodation being offered or would result in an undue burden;
(iv) a failure to remove architectural barriers, and communication barriers that are structural in nature, in existing facilities, and transportation barriers in existing vehicles and rail passenger cars used by an establishment for transporting individuals (not including barriers that can only be removed through the retrofitting of vehicles or rail passenger cars by the installation of a hydraulic or other lift), where such removal is readily achievable; and
(v) where an entity can demonstrate that the removal of a barrier under clause (iv) is not readily achievable, a failure to make such goods, services, facilities, privileges, advantages, or accommodations available through alternative methods if such methods are readily achievable.

(3) Specific construction. Nothing in this subchapter shall require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.

524 U.S. 624, 118 S.Ct. 2196, 141 L.Ed.2d 540, 66 USLW 4601, 8 A.D. Cases 239, 12 NDLR P 227, 98 Cal. Daily Op. Serv. 5021, 98 Daily Journal D.A.R. 6973, 98 CJ C.A.R. 3268, 11 Fla. L. Weekly Fed. S 726
(Cite as: 524 U.S. 624, 118 S.Ct. 2196)

Supreme Court of the United States
Randon BRAGDON, Petitioner,
v.
Sidney ABBOTT et al.
No. 97-156.

Argued March 30, 1998.
Decided June 25, 1998

Patient infected with the human immunodeficiency virus (HIV) brought action under the Americans with Disabilities Act (ADA) against dentist who refused to treat her in his office. The United States District Court for the District of Maine, 912 F.Supp. 580, granted summary judgment in favor of patient, and dentist appealed. The First Circuit Court of Appeals, 107 F.3d 934, affirmed. Dentist petitioned for certiorari. The Supreme Court, Justice Kennedy, held that: (1) HIV infection is a "disability" under the ADA, even when the infection has not yet progressed to the so-called symptomatic phase, as a physical impairment which substantially limits the major life activity of reproduction, and (2) with regard to "direct threat" provision of the ADA, the existence, or nonexistence of a significant health risk from treatment or accommodation of a disabled person must be determined from standpoint of the person who refused the treatment or accommodation, but the risk assessment must be based on medical or other objective evidence, and not simply on that person's good-faith belief that a significant risk existed.

Vacated and remanded.

Justice Stevens filed concurring opinion in which Justice Breyer, joined.

Justice Ginsburg filed concurring opinion.

Chief Justice Rehnquist filed opinion concurring in the judgment in part and dissenting in part, in which Justices Scalia and Thomas joined, and in

KENNEDY, J., delivered the opinion of the Court, in which STEVENS, SOUTER, GINSBURG, and BREYER, JJ., joined. STEVENS, J., filed a concurring opinion, in which BREYER, J., joined, *post,* p. 2213. GINSBURG, J., filed a concurring opinion, *post,* p. 2213. REHNQUIST, C.J., filed an opinion concurring in the judgment in part and dissenting in part, in which SCALIA and THOMAS, JJ., joined, and in Part II of which O'CONNOR, J., joined, *post,* p. 2214. O'CONNOR, J., filed an opinion concurring in the judgment in part and dissenting in part, *post,* p. 2217.

John W. McCarthy, Bangor, ME, for petitioner.

Bennett H. Klein, for respondent.

Lawrence G. Wallace, Washington, DC, for United States as amicus curiae by special leave of the Court.

For U.S. Supreme Court briefs, see:1998 WL 4678 (Pet.Brief)1998 WL 47514 (Resp.Brief)1998 WL 47518 (Resp.Brief)1998 WL 96285 (Reply.Brief)

***628** Justice KENNEDY delivered the opinion of the Court.

We address in this case the application of the Americans with Disabilities Act of 1990(ADA), 104 Stat. 327, 42 U.S.C. § 12101 *et seq.,* to persons infected with the human immunodeficiency virus

(HIV). We granted certiorari to review, first, whether HIV infection is a disability under the ADA when the infection has not yet progressed to the so-called symptomatic phase; and, second, whether the Court of Appeals, in affirming a grant of summary judgment, cited sufficient material in the record to determine, as a matter of law, that respondent's infection with HIV posed no direct threat to the health and safety of her treating dentist. 522 U.S. 991, 118 S.Ct. 554, 139 L.Ed.2d 396 (1997).

I

Respondent Sidney Abbott (hereinafter respondent) has been infected with HIV since ****2201** 1986. When the incidents we recite occurred, her infection had not manifested its most serious symptoms. On September 16, 1994, she went to the office of petitioner Randon Bragdon in Bangor, Maine, for a dental appointment. She disclosed her HIV infection on the ***629** patient registration form. Petitioner completed a dental examination, discovered a cavity, and informed respondent of his policy against filling cavities of HIV-infected patients. He offered to perform the work at a hospital with no added fee for his services, though respondent would be responsible for the cost of using the hospital's facilities. Respondent declined.

Respondent sued petitioner under state law and § 302 of the ADA, 104 Stat. 355, 42 U.S.C. § 12182, alleging discrimination on the basis of her disability. The state-law claims are not before us. Section 302 of the ADA provides:

"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 ... operates a place of public accommodation." § 12182(a).

The term "public accommodation" is defined to include the "professional office of a health care provider." § 12181(7)(F).

A later subsection qualifies the mandate not to discriminate. It provides:

"Nothing in this subchapter shall require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others." § 12182(b)(3).

The United States and the Maine Human Rights Commission intervened as plaintiffs. After discovery, the parties filed cross-motions for summary judgment. The District Court ruled in favor of the plaintiffs, holding that respondent's HIV infection satisfied the ADA's definition of disability. 912 F.Supp. 580, 585-587 (D.Me.1995). The court held further that petitioner raised no genuine issue of material fact as to whether respondent's HIV infection would have ***630** posed a direct threat to the health or safety of others during the course of a dental treatment. *Id.*, at 587-591. The court relied on affidavits submitted by Dr. Donald Wayne Marianos, Director of the Division of Oral Health of the Centers for Disease Control and Prevention (CDC). The Marianos affidavits asserted it is safe for dentists to treat patients infected with HIV in dental offices if the dentist follows the so-called universal precautions described in the Recommended Infection-Control Practices for Dentistry issued by CDC in 1993 (1993 CDC Dentistry Guidelines). 912 F.Supp., at 589.

The Court of Appeals affirmed. It held respondent's HIV infection was a disability under the ADA, even though her infection had not yet progressed to the symptomatic stage. 107 F.3d 934, 939-943 (C.A.1 1997). The Court of Appeals also agreed that treating the respondent in petitioner's office would not have posed a direct threat to the health and safety of others. *Id.*, at 943-948. Unlike the District Court, however, the Court of Appeals declined to rely on the Marianos affidavits. *Id.*, at 946, n. 7. Instead the court relied on the 1993 CDC Dentistry Guidelines,

as well as the Policy on AIDS, HIV Infection and the Practice of Dentistry, promulgated by the American Dental Association in 1991 (1991 American Dental Association Policy on HIV). 107 F.3d, at 945-946.

II

We first review the ruling that respondent's HIV infection constituted a disability under the ADA. The statute defines disability as:

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

"(B) a record of such an impairment; or

"(C) being regarded as having such an impairment." § 12102(2).

***631** We hold respondent's HIV infection was a disability under subsection (A) of the definitional section of the statute. In light of this conclusion, we need not consider the applicability of subsections (B) or (C).

****2202** Our consideration of subsection (A) of the definition proceeds in three steps. First, we consider whether respondent's HIV infection was a physical impairment. Second, we identify the life activity upon which respondent relies (reproduction and childbearing) and determine whether it constitutes a major life activity under the ADA. Third, tying the two statutory phrases together, we ask whether the impairment substantially limited the major life activity. In construing the statute, we are informed by interpretations of parallel definitions in previous statutes and the views of various administrative agencies which have faced this interpretive question.

A

[1][2] The ADA's definition of disability is drawn almost verbatim from the definition of "handicapped individual" included in the Rehabilitation Act of 1973, 87 Stat. 361, as amended, 29 U.S.C. § 706(8)(B) (1988 ed.), and the definition of "handicap" contained in the Fair Housing Amendments Act of 1988, 102 Stat. 1619, 42 U.S.C. § 3602(h)(1) (1988 ed.). Congress' repetition of a well-established term carries the implication that Congress intended the term to be construed in accordance with pre-existing regulatory interpretations. See *FDIC v. Philadelphia Gear Corp.*, 476 U.S. 426, 437-438, 106 S.Ct. 1931, 1937-1938, 90 L.Ed.2d 428 (1986); *Commissioner v. Estate of Noel*, 380 U.S. 678, 681-682, 85 S.Ct. 1238, 1240-1241, 14 L.Ed.2d 159 (1965); *ICC v. Parker*, 326 U.S. 60, 65, 65 S.Ct. 1490, 1492-1493, 89 L.Ed. 2051 (1945). In this case, Congress did more than suggest this construction; it adopted a specific statutory provision in the ADA directing as follows:

"Except as otherwise provided in this chapter, nothing in this chapter shall be construed to apply a lesser standard than the standards applied under title V of the ***632** Rehabilitation Act of 1973 (29 U.S.C. § 790 et seq.) or the regulations issued by Federal agencies pursuant to such title." 42 U.S.C. § 12201(a).

The directive requires us to construe the ADA to grant at least as much protection as provided by the regulations implementing the Rehabilitation Act.

1

[3] The first step in the inquiry under subsection (A) requires us to determine whether respondent's condition constituted a physical impairment. The Department of Health, Education and Welfare (HEW) issued the first regulations interpreting the Rehabilitation Act in 1977. The regulations are of particular significance because, at the time, HEW was the agency responsible for coordinating the implementation and enforcement of § 504 of that statute. *Consolidated Rail Corporation v. Darrone*, 465 U.S. 624, 634, 104 S.Ct. 1248, 1254-1255, 79 L.Ed.2d 568, (1984) (citing Exec. Order No. 11914,

3 CFR § 117 (1976-1980 Comp.)). Section 504 prohibits discrimination against individuals with disabilities by recipients of federal financial assistance. 29 U.S.C. § 794. The HEW regulations, which appear without change in the current regulations issued by the Department of Health and Human Services, define "physical or mental impairment" to mean:

"(A) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or

"(B) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities." 45 CFR § 84.3(j)(2)(i) (1997).

***633** In issuing these regulations, HEW decided against including a list of disorders constituting physical or mental impairments, out of concern that any specific enumeration might not be comprehensive. 42 Fed.Reg. 22685 (1977), reprinted in 45 CFR pt. 84, App. A, p. 334 (1997). The commentary accompanying the regulations, however, contains a representative list of disorders and conditions constituting physical impairments, including "such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, and ... drug addiction and alcoholism." *Ibid.*

****2203** In 1980, the President transferred responsibility for the implementation and enforcement of § 504 to the Attorney General. See, *e.g.*, Exec. Order No. 12250, 3 CFR § 298 (1981). The regulations issued by the Justice Department, which remain in force to this day, adopted verbatim the HEW definition of physical impairment quoted above. 28 CFR § 41.31(b)(1) (1997). In addition, the representative list of diseases and conditions originally relegated to the commentary accompanying the HEW regulations were incorporated into the text of the regulations. *Ibid.*

HIV infection is not included in the list of specific disorders constituting physical impairments, in part because HIV was not identified as the cause of AIDS until 1983. See Barre-Sinoussi et al., Isolation of a T-Lymphotropic Retrovirus from a Patient at Risk for Acquired Immune Deficiency Syndrome (AIDS), 220 Science 868 (1983); Gallo et al., Frequent Detection and Isolation of Cytopathic Retroviruses (HTLV-III) from Patients with AIDS and at Risk for AIDS, 224 Science 500 (1984); Levy et al., Isolation of Lymphocytopathic Retroviruses from San Francisco Patients with AIDS, 225 Science 840 (1984). HIV infection does fall well within the general definition set forth by the regulations, however.

The disease follows a predictable and, as of today, an unalterable course. Once a person is infected with HIV, the ***634** virus invades different cells in the blood and in body tissues. Certain white blood cells, known as helper T-lymphocytes or CD4+ cells, are particularly vulnerable to HIV. The virus attaches to the CD4 receptor site of the target cell and fuses its membrane to the cell's membrane. HIV is a retrovirus, which means it uses an enzyme to convert its own genetic material into a form indistinguishable from the genetic material of the target cell. The virus' genetic material migrates to the cell's nucleus and becomes integrated with the cell's chromosomes. Once integrated, the virus can use the cell's own genetic machinery to replicate itself. Additional copies of the virus are released into the body and infect other cells in turn. Young, The Replication Cycle of HIV-1, in The AIDS Knowledge Base, pp. 3.1-2 to 3.1-7 (P. Cohen, M. Sande, & P. Volberding eds., 2d ed.1994) (hereinafter AIDS Knowledge Base); Folks & Hart, The Life Cycle of Human Immunodeficiency Virus Type 1, in AIDS: Etiology, Diagnosis, Treatment and Prevention 29-39 (V. DeVita et al. eds., 4th ed.1997)

(hereinafter AIDS: Etiology); Greene, Molecular Insights into HIV-1 Infection, in The Medical Management of AIDS 18-24 (M. Sande & P. Volberding eds., 5th ed.1997) (hereinafter Medical Management of AIDS). Although the body does produce antibodies to combat HIV infection, the antibodies are not effective in eliminating the virus. Pantaleo et al., Immunopathogenesis of Human Immunodeficiency Virus Infection, in AIDS: Etiology 79; Gardner, HIV Vaccine Development, in AIDS Knowledge Base 3.6-5; Haynes, Immune Responses to Human Immunodeficiency Virus Infection, in AIDS: Etiology 91.

The virus eventually kills the infected host cell. CD4+ cells play a critical role in coordinating the body's immune response system, and the decline in their number causes corresponding deterioration of the body's ability to fight infections from many sources. Tracking the infected individual's CD4+ cell count is one of the most accurate measures of the course of the disease. Greene, Medical Management of ***635** AIDS 19, 24. Osmond, Classification and Staging of HIV Disease, in AIDS Knowledge Base 1.1-8; Saag, Clinical Spectrum of Human Immunodeficiency Virus Diseases, in AIDS: Etiology 204.

The initial stage of HIV infection is known as acute or primary HIV infection. In a typical case, this stage lasts three months. The virus concentrates in the blood. The assault on the immune system is immediate. The victim suffers from a sudden and serious decline in the number of white blood cells. There is no latency period. Mononucleosis-like symptoms often emerge between six days and six weeks after infection, at times accompanied by fever, headache, enlargement of the lymph nodes (lymphadenopathy), muscle pain (myalgia), rash, lethargy, gastrointestinal disorders, and neurological disorders. Usually these symptoms abate within 14 to 21 days. HIV antibodies appear in the bloodstream within 3 weeks; circulating ****2204** HIV can be detected within 10 weeks. Carr & Cooper, Primary HIV Infection, in Medical Management of AIDS 89-91; Cohen & Volberding, Clinical Spectrum of HIV Disease, in AIDS Knowledge Base 4.1-7; Crowe & McGrath, Acute HIV Infection, in AIDS Knowledge Base 4.2-1 to 4.2-4; Saag, AIDS: Etiology 204-205.

After the symptoms associated with the initial stage subside, the disease enters what is referred to sometimes as its asymptomatic phase. The term is a misnomer, in some respects, for clinical features persist throughout, including lymphadenopathy, dermatological disorders, oral lesions, and bacterial infections. Although it varies with each individual, in most instances this stage lasts from 7 to 11 years. The virus now tends to concentrate in the lymph nodes, though low levels of the virus continue to appear in the blood. Cohen & Volberding, AIDS Knowledge Base 4.1-4, 4.1-8; Saag, AIDS: Etiology 205-206; Staprans & Feinberg, Natural History and Immunopathogenesis of HIV-1 Disease, in Medical Management of AIDS 29, 38. It was once ***636** thought the virus became inactive during this period, but it is now known that the relative lack of symptoms is attributable to the virus' migration from the circulatory system into the lymph nodes. Cohen & Volberding, AIDS Knowledge Base 4.1-4. The migration reduces the viral presence in other parts of the body, with a corresponding diminution in physical manifestations of the disease. The virus, however, thrives in the lymph nodes, which, as a vital point of the body's immune response system, represents an ideal environment for the infection of other CD4+ cells. Staprans & Feinberg, Medical Management of AIDS 33-34. Studies have shown that viral production continues at a high rate. Cohen & Volberding, AIDS Knowledge Base 4.1-4; Staprans & Feinberg, Medical Management of AIDS 38. CD4+ cells continue to decline an average of 5% to 10% (40 to 80 cells/mm3) per year throughout this phase. Saag, AIDS: Etiology 207.

A person is regarded as having AIDS when his or her CD4+ count drops below 200 cells/mm3 of blood or when CD4+ cells comprise less than 14% of his or her total lymphocytes. U.S. Dept. of

Health and Human Services, Public Health Service, CDC, 1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults, 41 Morbidity and Mortality Weekly Rep., No. RR-17 (Dec. 18, 1992); Osmond, AIDS Knowledge Base 1.1-2; Saag, AIDS: Etiology 207; Ward, Petersen, & Jaffe, Current Trends in the Epidemiology of HIV/AIDS, in Medical Management of AIDS 3. During this stage, the clinical conditions most often associated with HIV, such as *pneumocystis carninii* pneumonia, Kaposi's sarcoma, and non-Hodgkins lymphoma, tend to appear. In addition, the general systemic disorders present during all stages of the disease, such as fever, weight loss, fatigue, lesions, nausea, and diarrhea, tend to worsen. In most cases, once the patient's CD4+ count drops below 10 ***637** cells/mm3, death soon follows. Cohen & Volberding, AIDS Knowledge Base 4.1-9; Saag, AIDS: Etiology 207-209.

In light of the immediacy with which the virus begins to damage the infected person's white blood cells and the severity of the disease, we hold it is an impairment from the moment of infection. As noted earlier, infection with HIV causes immediate abnormalities in a person's blood, and the infected person's white cell count continues to drop throughout the course of the disease, even when the attack is concentrated in the lymph nodes. In light of these facts, HIV infection must be regarded as a physiological disorder with a constant and detrimental effect on the infected person's hemic and lymphatic systems from the moment of infection. HIV infection satisfies the statutory and regulatory definition of a physical impairment during every stage of the disease.

2

The statute is not operative, and the definition not satisfied, unless the impairment affects a major life activity. Respondent's claim throughout this case has been that the HIV infection placed a substantial limitation on her ability to reproduce and to bear children. App. 14; 912 F.Supp., at 586, 107 F.3d, at 939. Given the pervasive, and invariably fatal, course of the disease, its effect on ****2205** major life activities of many sorts might have been relevant to our inquiry. Respondent and a number of *amici* make arguments about HIV's profound impact on almost every phase of the infected person's life. See Brief for Respondent Abbott 24-27; Brief for American Medical Association as *Amicus Curiae* 20; Brief for Infectious Diseases Society of America et al. as *Amici Curiae* 7-11. In light of these submissions, it may seem legalistic to circumscribe our discussion to the activity of reproduction. We have little doubt that had different parties brought the suit they would have maintained that an HIV infection imposes substantial limitations on other major life activities.

[4] ***638** From the outset, however, the case has been treated as one in which reproduction was the major life activity limited by the impairment. It is our practice to decide cases on the grounds raised and considered in the Court of Appeals and included in the question on which we granted certiorari. See, *e.g.*, *Blessing v. Freestone*, 520 U.S. 329, 340, n. 3, 117 S.Ct. 1353, 1359, n. 3, 137 L.Ed.2d 569 (1997) (citing this Court's Rule 14.1(a)); *Capitol Square Review and Advisory Bd. v. Pinette*, 515 U.S. 753, 760, 115 S.Ct. 2440, 2445-2446, 132 L.Ed.2d 650 (1995). We ask, then, whether reproduction is a major life activity.

[5] We have little difficulty concluding that it is. As the Court of Appeals held, "[t]he plain meaning of the word 'major' denotes comparative importance" and "suggest[s] that the touchstone for determining an activity's inclusion under the statutory rubric is its significance." 107 F.3d, at 939, 940. Reproduction falls well within the phrase "major life activity." Reproduction and the sexual dynamics surrounding it are central to the life process itself.

[6] While petitioner concedes the importance of reproduction, he claims that Congress intended the ADA only to cover those aspects of a person's life which have a public, economic, or daily character.

Brief for Petitioner 14, 28, 30, 31; see also *id.*, at 36-37 (citing *Krauel v. Iowa Methodist Medical Center*, 95 F.3d 674, 677 (C.A.8 1996)). The argument founders on the statutory language. Nothing in the definition suggests that activities without a public, economic, or daily dimension may somehow be regarded as so unimportant or insignificant as to fall outside the meaning of the word "major." The breadth of the term confounds the attempt to limit its construction in this manner.

[7] As we have noted, the ADA must be construed to be consistent with regulations issued to implement the Rehabilitation Act. See 42 U.S.C. § 12201(a). Rather than enunciating a general principle for determining what is and is not a major life activity, the Rehabilitation Act regulations instead provide a representative list, defining the term to include "functions such as caring for one's self, performing manual ***639** tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 45 CFR § 84.3(j)(2)(ii) (1997); 28 CFR § 41.31(b)(2) (1997). As the use of the term "such as" confirms, the list is illustrative, not exhaustive.

These regulations are contrary to petitioner's attempt to limit the meaning of the term "major" to public activities. The inclusion of activities such as caring for one's self and performing manual tasks belies the suggestion that a task must have a public or economic character in order to be a major life activity for purposes of the ADA. On the contrary, the Rehabilitation Act regulations support the inclusion of reproduction as a major life activity, since reproduction could not be regarded as any less important than working and learning. Petitioner advances no credible basis for confining major life activities to those with a public, economic, or daily aspect. In the absence of any reason to reach a contrary conclusion, we agree with the Court of Appeals' determination that reproduction is a major life activity for the purposes of the ADA.

[8] The final element of the disability definition in subsection (A) is whether respondent's physical impairment was a substantial limit on the major life activity she asserts. The Rehabilitation Act regulations provide no additional guidance. 45 CFR pt. 84, App. A, p. 334 (1997).

****2206** Our evaluation of the medical evidence leads us to conclude that respondent's infection substantially limited her ability to reproduce in two independent ways. First, a woman infected with HIV who tries to conceive a child imposes on the man a significant risk of becoming infected. The cumulative results of 13 studies collected in a 1994 textbook on AIDS indicates that 20% of male partners of women with HIV became HIV-positive themselves, with a majority of the studies finding a statistically significant risk of infection. Osmond & Padian, Sexual Transmission of HIV, in AIDS ***640** Knowledge Base 1.9-8, and tbl. 2; see also Haverkos & Battjes, Female-to-Male Transmission of HIV, 268 JAMA 1855, 1856, tbl. (1992) (cumulative results of 16 studies indicated 25% risk of female-to-male transmission). (Studies report a similar, if not more severe, risk of male-to-female transmission. See, *e.g.*, Osmond & Padian, AIDS Knowledge Base 1.9-3, tbl. 1, 1.9-6 to 1.9-7.)

Second, an infected woman risks infecting her child during gestation and childbirth, *i.e.*, perinatal transmission. Petitioner concedes that women infected with HIV face about a 25% risk of transmitting the virus to their children. 107 F.3d, at 942, 912 F.Supp., at 587, n. 6. Published reports available in 1994 confirm the accuracy of this statistic. Report of a Consensus Workshop, Maternal Factors Involved in Mother-to-Child Transmission of HIV-1, 5 J. Acquired Immune Deficiency Syndromes 1019, 1020 (1992) (collecting 13 studies placing risk between 14% and 40%, with most studies falling within the 25% to 30% range); Connor et al., Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type 1 with Zidovudine Treatment, 331 New England J. Med. 1173, 1176 (1994) (placing risk at 25.5%); see also Staprans &

Feinberg, Medical Management of AIDS 32 (studies report 13% to 45% risk of infection, with average of approximately 25%).

Petitioner points to evidence in the record suggesting that antiretroviral therapy can lower the risk of perinatal transmission to about 8%. App. 53; see also Connor, *supra*, at 1176 (8.3%); Sperling et al., Maternal Viral Load, Zidovudine Treatment, and the Risk of Transmission of Human Immunodeficiency Virus Type 1 from Mother to Infant, 335 New England J. Med. 1621, 1622 (1996) (7.6%). The United States questions the relevance of the 8% figure, pointing to regulatory language requiring the substantiality of a limitation to be assessed without regard to available mitigating measures. Brief for United States as *Amicus Curiae* 18, n. 10 (citing 28 CFR pt. 36, App. B, p. 611 (1997); ***641** 29 CFR pt. 1630, App., p. 351 (1997)). We need not resolve this dispute in order to decide this case, however. It cannot be said as a matter of law that an 8% risk of transmitting a dread and fatal disease to one's child does not represent a substantial limitation on reproduction.

The Act addresses substantial limitations on major life activities, not utter inabilities. Conception and childbirth are not impossible for an HIV victim but, without doubt, are dangerous to the public health. This meets the definition of a substantial limitation. The decision to reproduce carries economic and legal consequences as well. There are added costs for antiretroviral therapy, supplemental insurance, and long-term health care for the child who must be examined and, tragic to think, treated for the infection. The laws of some States, moreover, forbid persons infected with HIV to have sex with others, regardless of consent. Iowa Code §§ 139.1, 139.31 (1997); Md. Health Code Ann. § 18-601.1(a) (1994); Mont.Code Ann. §§ 50-18-101, 50-18-112 (1997); Utah Code Ann. § 26-6-3.5(3) (Supp.1997); *id.*, § 26-6-5 (1995); Wash. Rev.Code § 9A.36.011(1)(b) (Supp.1998); see also N.D. Cent.Code § 12.1-20-17 (1997).

[9] In the end, the disability definition does not turn on personal choice. When significant limitations result from the impairment, the definition is met even if the difficulties are not insurmountable. For the statistical and other reasons we have cited, of course, the limitations on reproduction may be insurmountable here. Testimony from the respondent that her HIV infection controlled her decision not to have a child is unchallenged. App. 14; 912 F.Supp., at 587, 107 F.3d, at 942. In the context of reviewing summary judgment, we must take it to be ****2207** true. Fed. Rule Civ. Proc. 56(e). We agree with the District Court and the Court of Appeals that no triable issue of fact impedes a ruling on the question of statutory coverage. Respondent's HIV infection is a physical impairment which substantially limits a major life activity, as the ADA defines it. In view of our holding, we ***642** need not address the second question presented, *i.e.*, whether HIV infection is a *per se* disability under the ADA.

B

[10] Our holding is confirmed by a consistent course of agency interpretation before and after enactment of the ADA. Every agency to consider the issue under the Rehabilitation Act found statutory coverage for persons with asymptomatic HIV. Responsibility for administering the Rehabilitation Act was not delegated to a single agency, but we need not pause to inquire whether this causes us to withhold deference to agency interpretations under *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844, 104 S.Ct. 2778, 2782-2783, 81 L.Ed.2d 694 (1984). It is enough to observe that the well-reasoned views of the agencies implementing a statute "constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance." *Skidmore v. Swift & Co.*, 323 U.S. 134, 139-140, 65 S.Ct. 161, 164, 89 L.Ed. 124 (1944).

One comprehensive and significant administrative precedent is a 1988 opinion issued by the Office of Legal Counsel of the Department of Justice (OLC) concluding that the Rehabilitation Act "protects

symptomatic and asymptomatic HIV-infected individuals against discrimination in any covered program." Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals, 12 Op. Off. Legal Counsel 264, 264-265 (Sept. 27, 1988) (preliminary print) (footnote omitted). Relying on a letter from Surgeon General C. Everett Koop stating that, "from a purely scientific perspective, persons with HIV are clearly impaired" even during the asymptomatic phase, OLC determined asymptomatic HIV was a physical impairment under the Rehabilitation Act because it constituted a "physiological disorder or condition affecting the hemic and lymphatic systems." *Id.*, at 271 (internal quotation marks omitted). OLC determined further that asymptomatic HIV imposed a substantial limit on the major life activity of reproduction. The opinion said:

***643** "Based on the medical knowledge available to us, we believe that it is reasonable to conclude that the life activity of procreation ... is substantially limited for an asymptomatic HIV-infected individual. In light of the significant risk that the AIDS virus may be transmitted to a baby during pregnancy, HIV-infected individuals cannot, whether they are male or female, engage in the act of procreation with the normal expectation of bringing forth a healthy child." *Id.*, at 273.

In addition, OLC indicated that "[t]he life activity of engaging in sexual relations is threatened and probably substantially limited by the contagiousness of the virus." *Id.*, at 274. Either consideration was sufficient to render asymptomatic HIV infection a handicap for purposes of the Rehabilitation Act. In the course of its opinion, OLC considered, and rejected, the contention that the limitation could be discounted as a voluntary response to the infection. The limitation, it reasoned, was the infection's manifest physical effect. *Id.*, at 274, and n. 13. Without exception, the other agencies to address the problem before enactment of the ADA reached the same result. Federal Contract Compliance Manual App. 6D, 8 FEP Manual 405:352 (Dec. 23, 1988); *In re Ritter*, No. 03890089, 1989 WL 609697, *10 (EEOC, Dec. 8, 1989); see also Comptroller General's Task Force on AIDS in the Workplace, Coping with AIDS in the GAO Workplace: Task Force Report 29 (Dec. 1987); Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic 113-114, 122-123 (June 1988). Agencies have adhered to this conclusion since the enactment of the ADA as well. See 5 CFR § 1636.103 (1997); 7 CFR § 15e.103 (1998); 22 CFR § 1701.103 (1997); 24 CFR § 9.103 (1997); 34 CFR § 1200.103 (1997); 45 CFR §§ 2301.103, 2490.103 (1997); *In re Westchester County Medical Center*, [1991-1994 Transfer Binder] CCH Employment Practices Guide ¶5340, ****2208** pp. 6110-6112 (Apr. 20, 1992), aff'd, *id.*, ¶5362, pp. 6249-6250 (Dept. of Health & Human Servs. Departmental Appeals Bd., Sept. 25, 1992); ***644** *In re Rosebud Sioux Tribe*, No. 93-504-1, 1994 WL 603015 (Dept. of Health & Human Servs. Departmental Appeals Bd., July 14, 1994); *In re Martin*, No. 01954089, 1997 WL 151524, *4 (EEOC, Mar. 27, 1997).

Every court which addressed the issue before the ADA was enacted in July 1990, moreover, concluded that asymptomatic HIV infection satisfied the Rehabilitation Act's definition of a handicap. See *Doe v. Garrett*, 903 F.2d 1455, 1457 (C.A.11 1990), cert. denied, 499 U.S. 904, 111 S.Ct. 1102, 113 L.Ed.2d 213 (1991); *Ray v. School Dist. of DeSoto County*, 666 F.Supp. 1524, 1536 (M.D.Fla.1987); *Thomas v. Atascadero Unified School Dist.*, 662 F.Supp. 376, 381 (C.D.Cal.1986); *District 27 Community School Bd. v. Board of Ed. of New York*, 130 Misc.2d 398, 413-415, 502 N.Y.S.2d 325, 335-337 (Sup.Ct.1986); cf. *Baxter v. Belleville*, 720 F.Supp. 720, 729 (S.D.Ill.1989) (Fair Housing Amendments Act); *Cain v. Hyatt*, 734 F.Supp. 671, 679 (E.D.Pa.1990) (Pennsylvania Human Relations Act). (For cases finding infection with HIV to be a handicap without distinguishing between symptomatic and asymptomatic HIV, see *Martinez ex rel. Martinez v. School Bd. of Hillsborough Cty., Florida*, 861 F.2d 1502, 1506 (C.A.11 1988); *Chalk v. United States Dist. Ct.*, 840 F.2d

701, 706 (C.A.9 1988); *Doe v. Dolton Elementary School Dist. No. 148,* 694 F.Supp. 440, 444-445 (N.D.Ill.1988); *Robertson v. Granite City Community Unit School Dist. No. 9,* 684 F.Supp. 1002, 1006-1007 (S.D.Ill.1988); *Local 1812, AFGE v. United States Dept. of State,* 662 F.Supp. 50, 54 (D.D.C 1987); cf. *Association of Relatives and Friends of AIDS Patients v. Regulations and Permits Admin.,* 740 F.Supp. 95, 103 (D.Puerto Rico 1990) (Fair Housing Amendments Act).) We are aware of no instance prior to the enactment of the ADA in which a court or agency ruled that HIV infection was not a handicap under the Rehabilitation Act.

Had Congress done nothing more than copy the Rehabilitation Act definition into the ADA, its action would indicate ***645** the new statute should be construed in light of this unwavering line of administrative and judicial interpretation. All indications are that Congress was well aware of the position taken by OLC when enacting the ADA and intended to give that position its active endorsement. H.R.Rep. No. 101-485, pt. 2, p. 52 (1990) (endorsing the analysis and conclusion of the OLC opinion); *id.*, pt. 3, at 28, n. 18 (same); S.Rep. No. 101-116, pp. 21, 22 (1989) (same). As noted earlier, Congress also incorporated the same definition into the Fair Housing Amendments Act of 1988. See 42 U.S.C. § 3602(h)(1). We find it significant that the implementing regulations issued by the Department of Housing and Urban Development (HUD) construed the definition to include infection with HIV. 54 Fed.Reg. 3232, 3245 (1989) (codified at 24 CFR § 100.201 (1997)); see also *In re Williams,* 2A P-H Fair Housing-Fair Lending ¶25,007, pp. 25,111-25,113 (HUD Off. Admin. Law Judges, Mar. 22, 1991) (adhering to this interpretation); *In re Elroy R. and Dorothy Burns Trust,* 2A P-H Fair Housing-Fair Lending ¶25,073, p. 25,678 (HUD Off. Admin. Law Judges, June 17, 1994) (same). Again the legislative record indicates that Congress intended to ratify HUD's interpretation when it reiterated the same definition in the ADA. H.R.Rep. No. 101-485, pt. 2, at 50; *id.*, pt. 3, at 27; *id.*, pt. 4, at 36; S.Rep. No. 101-116, at 21.

[11] We find the uniformity of the administrative and judicial precedent construing the definition significant. When administrative and judicial interpretations have settled the meaning of an existing statutory provision, repetition of the same language in a new statute indicates, as a general matter, the intent to incorporate its administrative and judicial interpretations as well. See, *e.g., Lorillard v. Pons,* 434 U.S. 575, 580-581, 98 S.Ct. 866, 869-870, 55 L.Ed.2d 40 (1978). The uniform body of administrative and judicial precedent confirms the conclusion we reach today as the most faithful way to effect the congressional design.

***646** C

Our conclusion is further reinforced by the administrative guidance issued by the Justice ****2209** Department to implement the public accommodation provisions of Title III of the ADA. As the agency directed by Congress to issue implementing regulations, see 42 U.S.C. § 12186(b), to render technical assistance explaining the responsibilities of covered individuals and institutions, § 12206(c), and to enforce Title III in court, § 12188(b), the Department's views are entitled to deference. See *Chevron,* 467 U.S., at 844, 104 S.Ct., at 2782-2783.

The Justice Department's interpretation of the definition of disability is consistent with our analysis. The regulations acknowledge that Congress intended the ADA's definition of disability to be given the same construction as the definition of handicap in the Rehabilitation Act. 28 CFR § 36.103(a) (1997); *id.*, pt. 36, App. B, pp. 608, 609. The regulatory definition developed by HEW to implement the Rehabilitation Act is incorporated verbatim in the ADA regulations. § 36.104. The Justice Department went further, however. It added "HIV infection (symptomatic and asymptomatic)" to the list of disorders constituting a physical impairment. § 36.104(1)(iii). The technical assistance the Department has issued pursuant to 42

U.S.C. § 12206 similarly concludes that persons with asymptomatic HIV infection fall within the ADA's definition of disability. See, *e.g.*, U.S. Dept. of Justice, Civil Rights Division, The Americans with Disabilities Act: Title III Technical Assistance Manual 9 (Nov.1993); Response to Congressman Sonny Callahan, 5 Nat. Disability L. Rep. (LRP) ¶360, p. 1167 (Feb. 9, 1994); Response to A. Laurence Field, 5 Nat. Disability L. Rep. (LRP) ¶21, p. 80 (Sept. 10, 1993). Any other conclusion, the Department reasoned, would contradict Congress' affirmative ratification of the administrative interpretations given previous versions of the same definition. 28 CFR pt. 36, App. B, pp. 609, 610 (1997) (citing the OLC opinion and HUD regulations); 56 Fed.Reg. 7455, 7456 (1991) (same) (notice of proposed rulemaking).

***647** We also draw guidance from the views of the agencies authorized to administer other sections of the ADA. See 42 U.S.C. § 12116 (authorizing EEOC to issue regulations implementing Title I); § 12134(a) (authorizing the Attorney General to issue regulations implementing the public services provisions of Title II, subtitle A); §§ 12149, 12164, 12186 (authorizing the Secretary of Transportation to issue regulations implementing the transportation-related provisions of Titles II and III); § 12206(c) (authorizing the same agencies to offer technical assistance for the provisions they administer). These agencies, too, concluded that HIV infection is a physical impairment under the ADA. 28 CFR § 35.104(1)(iii) (1997); 49 CFR §§ 37.3, 38.3 (1997); 56 Fed.Reg. 13858 (1991); U.S. Dept. of Justice, Civil Rights Division, The Americans with Disabilities Act: Title II Technical Assistance Manual 4 (Nov. 1993); EEOC, A Technical Assistance Manual on the Employment Provisions (Title I) of the Americans with Disabilities Act II-3 (Jan.1992) (hereinafter EEOC Technical Assistance Manual); EEOC Interpretive Manual § 902.2(d), pp. 902-13 to 902-14 (reissued Mar. 14, 1995) (hereinafter EEOC Interpretive Manual), reprinted in 2 BNA EEOC Compliance Manual 902:0013 (1998). Most categorical of all is EEOC's conclusion that "an individual who has HIV infection (including asymptomatic HIV infection) is an individual with a disability." EEOC Interpretive Manual § 902.4(c)(1), p. 902-21; accord, *id.*, § 902.2(d), p. 902-14, n. 18. In the EEOC's view, "impairments ... such as HIV infection, are inherently substantially limiting." 29 CFR pt. 1630, App., p. 350 (1997); EEOC Technical Assistance Manual II-4; EEOC Interpretive Manual § 902.4(c)(1), p. 902-21.

The regulatory authorities we cite are consistent with our holding that HIV infection, even in the so-called asymptomatic phase, is an impairment which substantially limits the major life activity of reproduction.

***648** III

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

"3. When deciding under title III of the ADA whether a private health care provider must perform invasive procedures on an infectious patient in his office, should courts defer to the health care provider's professional judgment, as long as it is reasonable****2210** in light of then-current medical knowledge?

"4. What is the proper standard of judicial review under title III of the ADA of a private health care provider's judgment that the performance of certain invasive procedures in his office would pose a direct threat to the health or safety of others?

"5. Did petitioner, Randon Bragdon, D. M. D., raise a genuine issue of fact for trial as to whether he was warranted in his judgment that the performance of certain invasive procedures on a patient in his office would have posed a direct threat to the health or safety of others?" Pet. for Cert. i.

Of these, we granted certiorari only on question three. The question is phrased in an awkward way, for it conflates two separate inquiries. In asking

whether it is appropriate to defer to petitioner's judgment, it assumes that petitioner's assessment of the objective facts was reasonable. The central premise of the question and the assumption on which it is based merit separate consideration.

Again, we begin with the statute. Notwithstanding the protection given respondent by the ADA's definition of disability, petitioner could have refused to treat her if her infectious condition "pose[d] a direct threat to the health or safety of others." 42 U.S.C. § 12182(b)(3). The ADA defines a direct threat to be "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids ***649** or services." *Ibid.* Parallel provisions appear in the employment provisions of Title I. §§ 12111(3), 12113(b).

The ADA's direct threat provision stems from the recognition in *School Bd. of Nassau Cty. v. Arline,* 480 U.S. 273, 287, 107 S.Ct. 1123, 1130-1131, 94 L.Ed.2d 307 (1987), of the importance of prohibiting discrimination against individuals with disabilities while protecting others from significant health and safety risks, resulting, for instance, from a contagious disease. In *Arline,* the Court reconciled these objectives by construing the Rehabilitation Act not to require the hiring of a person who posed "a significant risk of communicating an infectious disease to others." *Id.,* at 287, n. 16, 107 S.Ct., at 1131, n. 16. Congress amended the Rehabilitation Act and the Fair Housing Act to incorporate the language. See 29 U.S.C. § 706(8)(D) (excluding individuals who "would constitute a direct threat to the health or safety of other individuals"); 42 U.S.C. § 3604(f)(9) (same). It later relied on the same language in enacting the ADA. See 28 CFR pt. 36, App. B, p. 626 (1997) (ADA's direct threat provision codifies *Arline*). Because few, if any, activities in life are risk free, *Arline* and the ADA do not ask whether a risk exists, but whether it is significant. *Arline, supra,* at 287, and n. 16, 107 S.Ct., at 1131, and n. 16; 42 U.S.C. § 12182(b)(3).

[12] The existence, or nonexistence, of a significant risk must be determined from the standpoint of the person who refuses the treatment or accommodation, and the risk assessment must be based on medical or other objective evidence. *Arline, supra,* at 288, 107 S.Ct., at 1131; 28 CFR § 36.208(c) (1997); *id.,* pt. 36, App. B, p. 626. As a health care professional, petitioner had the duty to assess the risk of infection based on the objective, scientific information available to him and others in his profession. His belief that a significant risk existed, even if maintained in good faith, would not relieve him from liability. To use the words of the question presented, petitioner receives no special deference simply because he is a health care professional. It is true that *Arline* reserved "the question whether courts should also defer to the reasonable medical ***650** judgments of private physicians on which an employer has relied." 480 U.S., at 288, n. 18, 107 S.Ct., at 1131, n. 18. At most, this statement reserved the possibility that employers could consult with individual physicians as objective third-party experts. It did not suggest that an individual physician's state of mind could excuse discrimination without regard to the objective reasonableness of his actions.

Our conclusion that courts should assess the objective reasonableness of the views of health care professionals without deferring to their individual judgments does not answer ****2211** the implicit assumption in the question presented, whether petitioner's actions were reasonable in light of the available medical evidence. In assessing the reasonableness of petitioner's actions, the views of public health authorities, such as the U.S. Public Health Service, CDC, and the National Institutes of Health, are of special weight and authority. *Arline, supra,* at 288, 107 S.Ct., at 1130-1131; 28 CFR pt. 36, App. B, p. 626 (1997). The views of these organizations are not conclusive, however. A health care professional who disagrees with the prevailing medical consensus may refute it by citing a credible scientific basis for deviating from the accepted norm. See W. Keeton, D. Dobbs, R. Keeton, & D. Owen, Prosser and Keeton on Law of Torts § 32, p.

187 (5th ed.1984).

We have reviewed so much of the record as necessary to illustrate the application of the rule to the facts of this case. For the most part, the Court of Appeals followed the proper standard in evaluating petitioner's position and conducted a thorough review of the evidence. Its rejection of the District Court's reliance on the Marianos affidavits was a correct application of the principle that petitioner's actions must be evaluated in light of the available, objective evidence. The record did not show that CDC had published the conclusion set out in the affidavits at the time petitioner refused to treat respondent. 107 F.3d, at 946, n. 7.

A further illustration of a correct application of the objective standard is the Court of Appeals' refusal to give weight ***651** to petitioner's offer to treat respondent in a hospital. *Id.*, at 943, n. 4. Petitioner testified that he believed hospitals had safety measures, such as air filtration, ultraviolet lights, and respirators, which would reduce the risk of HIV transmission. App. 151. Petitioner made no showing, however, that any area hospital had these safeguards or even that he had hospital privileges. *Id.*, at 31. His expert also admitted the lack of any scientific basis for the conclusion that these measures would lower the risk of transmission. *Id.*, at 209. Petitioner failed to present any objective, medical evidence showing that treating respondent in a hospital would be safer or more efficient in preventing HIV transmission than treatment in a well-equipped dental office.

We are concerned, however, that the Court of Appeals might have placed mistaken reliance upon two other sources. In ruling no triable issue of fact existed on this point, the Court of Appeals relied on the 1993 CDC Dentistry Guidelines and the 1991 American Dental Association Policy on HIV. 107 F.3d, at 945-946. This evidence is not definitive. As noted earlier, the CDC Guidelines recommended certain universal precautions which, in CDC's view, "should reduce the risk of disease transmission in the dental environment." U.S. Dept. of Health and Human Services, Public Health Service, CDC, Recommended Infection-Control Practices for Dentistry, 41 Morbidity and Mortality Weekly Rep. No. RR-8, p. 1 (May 28, 1993). The Court of Appeals determined that, "[w]hile the guidelines do not state explicitly that no further risk-reduction measures are desirable or that routine dental care for HIV-positive individuals is safe, those two conclusions seem to be implicit in the guidelines' detailed delineation of procedures for office treatment of HIV-positive patients." 107 F.3d, at 946. In our view, the Guidelines do not necessarily contain implicit assumptions conclusive of the point to be decided. The Guidelines set out CDC's recommendation that the universal precautions are the best way ***652** to combat the risk of HIV transmission. They do not assess the level of risk.

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

"Current scientific and epidemiologic evidence indicates that there is little risk of transmission of infectious diseases through dental treatment if recommended infection control procedures are routinely followed. Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed. Such infection control procedures****2212** provide protection both for patients and dental personnel." App. 225.

We note, however, that the Association is a professional organization, which, although a respected source of information on the dental profession, is not a public health authority. It is not clear the extent to which the Policy was based on the Association's assessment of dentists' ethical and professional duties in addition to its scientific assessment of the risk to which the ADA refers. Efforts to clarify dentists' ethical obligations and to encourage

dentists to treat patients with HIV infection with compassion may be commendable, but the question under the statute is one of statistical likelihood, not professional responsibility. Without more information on the manner in which the American Dental Association formulated this Policy, we are unable to determine the Policy's value in evaluating whether petitioner's assessment of the risks was reasonable as a matter of law.

The court considered materials submitted by both parties on the cross-motions for summary judgment. The petitioner was required to establish that there existed a genuine ***653** issue of material fact. Evidence which was merely colorable or not significantly probative would not have been sufficient. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249-250, 106 S.Ct. 2505, 2510-2511, 91 L.Ed.2d 202 (1986).

We acknowledge the presence of other evidence in the record before the Court of Appeals which, subject to further arguments and examination, might support affirmance of the trial court's ruling. For instance, the record contains substantial testimony from numerous health experts indicating that it is safe to treat patients infected with HIV in dental offices. App. 66-68, 88-90, 264-266, 268. We are unable to determine the import of this evidence, however. The record does not disclose whether the expert testimony submitted by respondent turned on evidence available in September 1994. See *id.*, at 69-70 (expert testimony relied in part on materials published after September 1994).

There are reasons to doubt whether petitioner advanced evidence sufficient to raise a triable issue of fact on the significance of the risk. Petitioner relied on two principal points: First, he asserted that the use of high-speed drills and surface cooling with water created a risk of airborne HIV transmission. The study on which petitioner relied was inconclusive, however, determining only that "[f]urther work is required to determine whether such a risk exists." Johnson & Robinson, Human Immunodeficiency Virus-1 (HIV-1) in the Vapors of Surgical Power Instruments, 33 J. of Medical Virology 47 (1991). Petitioner's expert witness conceded, moreover, that no evidence suggested the spray could transmit HIV. His opinion on airborne risk was based on the absence of contrary evidence, not on positive data. App. 166. Scientific evidence and expert testimony must have a traceable, analytical basis in objective fact before it may be considered on summary judgment. See *General Electric Co. v. Joiner*, 522 U.S. 136, 144-145, 146, 118 S.Ct. 512, 518, 519, 139 L.Ed.2d 508 (1997).

Second, petitioner argues that, as of September 1994, CDC had identified seven dental workers with possible occupational***654** transmission of HIV. See U.S. Dept. of Health and Human Services, Public Health Service, CDC, HIV/AIDS Surveillance Report, vol. 6, no. 1, p. 15, tbl. 11 (Mid-year ed. June 1994). These dental workers were exposed to HIV in the course of their employment, but CDC could not determine whether HIV infection had resulted from this exposure. *Id.*, at 15, n. 3. It is now known that CDC could not ascertain how the seven dental workers contracted the disease because they did not present themselves for HIV testing at an appropriate time after this occupational exposure. Gooch et al., Percutaneous Exposures to HIV-Infected Blood Among Dental Workers Enrolled in the CDC Needlestick Study, 126 J. American Dental Assn. 1237, 1239 (1995). It is not clear on this record, however, whether this information was available to petitioner in September 1994. If not, the seven cases might have provided some, albeit not necessarily sufficient, support for petitioner's position. Standing alone, we doubt it would meet the ****2213** objective, scientific basis for finding a significant risk to the petitioner.

Our evaluation of the evidence is constrained by the fact that on these and other points we have not had briefs and arguments directed to the entire record. In accepting the case for review, we declined to grant certiorari on question five, which asked whether petitioner raised a genuine issue of fact for trial. Pet. for Cert. i. As a result, the briefs and ar-

guments presented to us did not concentrate on the question of sufficiency in light all of the submissions in the summary judgment proceeding. "When attention has been focused on other issues, or when the court from which a case comes has expressed no views on a controlling question, it may be appropriate to remand the case rather than deal with the merits of that question in this Court." *Dandridge v. Williams*, 397 U.S. 471, 476, n. 6, 90 S.Ct. 1153, 1157, n. 6, 25 L.Ed.2d 491 (1970). This consideration carries particular force where, as here, full briefing directed at the issue would help place a complex factual record in proper perspective. Resolution of the issue will be of importance ***655** to health care workers not just for the result but also for the precision and comprehensiveness of the reasons given for the decision.

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

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

It is so ordered.

Justice STEVENS, with whom Justice BREYER joins, concurring.

The Court's opinion demonstrates that respondent's HIV infection easily falls within the statute's definition of "disability." Moreover, the Court's discussion in Part III of the relevant evidence has persuaded me that the judgment of the Court of Appeals should be affirmed. I do not believe petitioner has sustained his burden of adducing evidence sufficient to raise a triable issue of fact on the significance of the risk posed by treating respondent in his office. The Court of Appeals reached that conclusion after a careful and extensive study of the record; its analysis on this question was perfectly consistent with the legal reasoning in Justice KENNEDY's opinion for the Court; and the latter opinion itself explains that petitioner relied on data that were inconclusive and speculative at best, see *ante*, at 2212-2213. Cf. *General Electric Co. v. Joiner*, 522 U.S. 136, 118 S.Ct. 512, 139 L.Ed.2d 508 (1997).

***656** There are not, however, five Justices who agree that the judgment should be affirmed. Nor does it appear that there are five Justices who favor a remand for further proceedings consistent with the views expressed in either Justice KENNEDY's opinion for the Court or the opinion of THE CHIEF JUSTICE. Because I am in agreement with the legal analysis in Justice KENNEDY's opinion, in order to provide a judgment supported by a majority, I join that opinion even though I would prefer an outright affirmance. Cf. *Screws v. United States*, 325 U.S. 91, 134, 65 S.Ct. 1031, 1051, 89 L.Ed. 1495 (1945) (Rutledge, J., concurring in result).

Justice GINSBURG, concurring.

Human Immunodeficiency Virus (HIV) infection, as the description set out in the Court's opinion documents, *ante*, at 2203-2205, has been regarded as a disease limiting life itself. See Brief for American Medical Association as *Amicus Curiae* 20. The disease inevitably pervades life's choices: education, employment, family and financial undertakings. It affects the need for and, as this case shows, the ability to obtain health care because of the reaction of others to the impairment. No rational legislator, it seems to me apparent, would require nondiscrimination once symptoms become visible but ****2214** permit discrimination when the disease, though present, is not yet visible. I am therefore satisfied that the statutory and regulatory definitions are well met. HIV infection is "a physical ... impairment that substantially limits ... major life activities," or is so perceived, 42 U.S.C. §§ 12102(2)(A)-(C), including the afflicted individual's family relations, employ-

756 F.Supp. 632, 3 NDLR P 123
(Cite as: 756 F.Supp. 632)

United States District Court,
D. Massachusetts.

Rosalie GLANZ, executrix of the estate of Raymond Vadnais, Plaintiff,
v.
Dr. David M. VERNICK, Dr. Michael Miller, Beth Israel Corporation, and Beth Israel Hospital, Defendants.
Civ. A. No. 89-0748-MA.

Feb. 5, 1991.

Patient brought action against physician and clinic alleging discrimination for refusal to perform elective ear surgery on him because he had tested positive for human immunodeficiency virus. After patient's death, his estate was substituted as party plaintiff. Physician and clinic moved for summary judgment. The District Court, Mazzone, J., held that: (1) clinic was federally funded program subject to provisions of Rehabilitation Act; (2) material issue of fact as to whether clinic was vicariously liable for actions of physician precluded summary judgment; (3) by choosing the work for federally funded clinic, physician did not become personally liable under Rehabilitation Act; (4) material issue of fact as to whether patient was "otherwise qualified" for ear surgery precluded summary judgment; and (5) pendent state law claims unrelated to federal law claims would be dismissed without prejudice.

Summary judgment denied in part and allowed in part.

West Headnotes

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(Cite as: 756 F.Supp. 632)

***634** Harvey A. Schwartz,Schwartz, Shaw & Griffith, Boston, Mass., for plaintiff.

Claudia Hunter, Bloom and Buell, Boston, Mass., for defendants.

MEMORANDUM AND ORDER

MAZZONE, District Judge.

In April, 1989, plaintiff's decedent, Raymond Vadnais, brought this suit alleging discrimination in violation of § 504 of the Rehabilitation Act of 1973 (the "Act"), 29 U.S.C. § 794, along with two state-law claims. Mr. Vadnais claimed that defendant Dr. Vernick, a staff member at Beth Israel Hospital, refused to perform elective ear surgery on him because Mr. Vadnais had tested positive for Human Immunodeficiency Virus (HIV), associated with Acquired Immune Deficiency Syndrome (AIDS).

Mr. Vadnais claimed to have suffered severe pain in his right ear, which pain was prolonged because of the defendants' failure to perform surgery and disappeared only when surgery was performed elsewhere.

On March 14, 1990, Mr. Vadnais died of AIDS-related illnesses. The motion of plaintiff, executor of the estate of Mr. Vadnais, to be substituted as a party plaintiff pursuant to Fed.R.Civ.P. 25(a)(1) was allowed. Prior to Mr. Vadnais's death, defendants had filed motions for summary judgment. Those motions were stayed to allow defendants to file a motion to dismiss on the ground that the federal cause of action abated with Mr. Vadnais's death. That motion was denied in part, and the executor was allowed to maintain this suit to seek compensatory, but not punitive, damages. *Glanz v. Vernick,* 750 F.Supp. 39 (D.Mass.1990). The case is now before me on the summary judgment motions.

I

The allegations in the complaint can be briefly summarized as follows. In December, 1986, defendant Dr. Vernick saw Mr. Vadnais at the Ear, Nose, and Throat Clinic (the "ENT Clinic") at Beth Israel Hospital and treated him for severe pain in the right ear, at first by prescribing antibiotics and ear drops. In January, 1987, Dr. Vernick diagnosed a perforation in Mr. Vadnais's right ear and, at Mr. Vadnais's third visit, recommended surgery to repair the perforation. After Mr. Vadnais agreed to undergo surgery, Dr. Vernick learned that Mr. Vadnais was infected with HIV and in March, 1987, informed Mr. Vadnais that he would not perform the operation. The ear condition persisted, causing severe pain and discomfort, while Mr. Vadnais continued the ineffective use of antibiotics and ear drops.

In August, 1988, Dr. Yale Berry, unaware of Mr. Vadnais's HIV status, performed the surgery, curing Mr. Vadnais's ear problem. Subsequently, Mr. Vadnais brought this lawsuit seeking to enjoin defendants from denying him any further surgical procedures. Mr. Vadnais also sought compensatory damages for the pain and suffering and emotional distress caused by the delay in receiving corrective surgery, along with punitive damages and attorney's fees. As mentioned above, only the action for compensatory damages survived Mr. Vadnais's death.

II

Count I of the complaint charges that Dr. Vernick, Beth Israel Hospital, and Beth ***635** Israel Corporation (the latter two hereinafter referred to collectively as "Beth Israel"), by refusing to perform surgery, unlawfully discriminated against Mr. Vadnais because of his handicap, HIV seropositivity, in violation of § 504 of the Rehabilitation Act. Count II alleges a separate violation of § 504 against the Beth Israel defendants for failure "to adequately educate, train and supervise" staff regarding HIV and AIDS infection. Amended Complaint ¶ 88.

Section 504 states in pertinent part that "[n]o otherwise qualified handicapped individual in the United States ... shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance...." 29 U.S.C. § 794.

[1][2] The defendants do not dispute that HIV-positive status is a "handicap" within the meaning of the Act. In fact, several district courts and the Department of Justice have found that it does qualify. *See Leckelt v. Board of Comm'rs of Hosp. Dist. No. 1,* 714 F.Supp. 1377, 1385 n. 4 (E.D.La.1989), *aff'd,* 909 F.2d 820 (5th Cir.1990). Nor do defendants contest that a private cause of action for compensatory damages is available under § 504. While the First Circuit has never squarely addressed the issue, *see Hurry v. Jones,* 734 F.2d 879, 886 (1st Cir.1984) (finding no need to reach the question); *Ciampa v. Massachusetts Rehabilitation Comm'n,* 718 F.2d 1 (1st Cir.1983) (assuming without decid-

ing that damages are available under § 504), there is ample authority for the conclusion that compensatory damages are available. *See Miener v. Missouri*, 673 F.2d 969, 973-74 (8th Cir.) (collecting cases finding an implied right of action under § 504), *cert. denied*, 459 U.S. 909, 103 S.Ct. 215, 74 L.Ed.2d 171 (1982); *see also Gelman v. Department of Educ.*, 544 F.Supp. 651 (D.Colo.1982) (concluding that compensatory damages, but not punitive damages, are available under § 504).

Rather, the defendants argue that summary judgment is appropriate for several other reasons. Dr. Vernick argues that summary judgment should be allowed in his favor because Mr. Vadnais was not "otherwise qualified" for surgery, as required by § 504, and because Dr. Vernick does not "receiv[e] Federal financial assistance." The Beth Israel defendants argue as to Count I that they never treated the patient, had no control over Dr. Vernick's medical decisions, and cannot be held vicariously liable for his actions. As to Count II, they argue that there is no liability under § 504 for failure to train.

Summary judgment may be granted to a moving party if there is "no *genuine* issue of *material* fact." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48, 106 S.Ct. 2505, 2509-10, 91 L.Ed.2d 202 (1986). The facts must be viewed in the light most favorable to the non-moving party. *Griggs-Ryan v. Smith*, 904 F.2d 112, 115 (1st Cir.1990). Summary judgment cannot be issued if there exist any factual issues that need to be decided before the legal issues can be. *Rossy v. Roche Prods., Inc.*, 880 F.2d 621, 624 (1st Cir.1989).

A. *"Receiving Federal Financial Assistance"*

[3][4] Plaintiff contends that Beth Israel is a "program or activity receiving Federal financial assistance" within the meaning of § 504 by virtue of the fact that it receives Medicare and Medicaid payments. The Act defines "program or activity" as "an entire corporation, partnership, or other private organization, or entire sole proprietorship- ... (ii) which is principally engaged in the business of providing ... health care...." 29 U.S.C. § 794(b)(3)(A). Beth Israel's ENT Clinic is clearly a "program or activity" as defined in this provision. Whether such a program qualifies as "receiving Federal financial assistance" within the meaning of § 504 solely because its medical services are paid for by Medicaid presents a pure question of law. The parties cite only once case that has met this issue head on. In *United States v. Baylor Univ. Medical Center*, 736 F.2d 1039 (5th Cir.1984), *cert. denied*, 469 U.S. 1189, 105 S.Ct. 958, 83 L.Ed.2d 964 (1985), ***636** the Fifth Circuit held that the receipt of Medicare and Medicaid payments by a hospital triggered the coverage of § 504. The Fifth Circuit found that legislative history establishes conclusively that Medicare and Medicaid were intended to constitute federal financial assistance for the purposes of Title VI, and that the scope and effect of § 504 were intended to be identical to those of Title VI. *Id.* at 1042-45. The Fifth Circuit also noted that this result accords with longstanding Department of Health and Human Services interpretation of § 504, *id.* at 1047, and is equally compelled by the Supreme Court's decision in *Grove City College v. Bell*, 465 U.S. 555, 104 S.Ct. 1211, 79 L.Ed.2d 516 (1984). *Baylor Univ.*, 736 F.2d at 1046 . I agree with the Fifth Circuit's reasoning and hold that a hospital's receipt of Medicare or Medicaid payments for its services qualifies as receiving federal financial assistance within the meaning of § 504.

[5] It is undisputed that Mr. Vadnais presented himself to the ENT Clinic and that the Clinic referred him to Dr. Vernick, a staff physician. Beth Israel, not Dr. Vernick, billed Mr. Vadnais for the services provided at the ENT Clinic, and Beth Israel received Medicaid reimbursement for those services. Thus, summary judgment for the defendants cannot be granted on the ground that the alleged discrimination did not occur in a program receiving federal assistance.

[6] Defendants also assert that the alleged discrim-

ination did not occur in a federally funded program because the procedure that Mr. Vadnais underwent was an elective procedure, and elective surgery is not covered by Medicaid. Whether the particular procedure is covered, however, is irrelevant. If the ENT Clinic is a program or activity for the purposes of § 504, then it cannot discriminate against any handicapped individuals, regardless of whether they receive Medicaid benefits or not. *Grove City College*, 465 U.S. at 571 n. 21, 104 S.Ct. at 1220 n. 21; *Baylor Univ.*, 736 F.2d at 1047-48.

[7][8] Beth Israel further argues that, despite the fact that Mr. Vadnais was a patient of the hospital, that the hospital billed him, and that it received Medicaid payments for the treatment he received at the ENT Clinic, Mr. Vadnais was Dr. Vernick's patient, not Beth Israel's. Beth Israel cites Massachusetts case law for the proposition that a hospital cannot be held liable for the actions of its doctors. The cited cases, however, establish that a hospital can be vicariously liable for the actions of its doctors-the question of liability is simply decided under the principles of agency law. The test for vicarious liability is whether the hospital exercised any power or control over the professional conduct of the treating physician. *Kelley v. Rossi*, 395 Mass. 659, 662, 481 N.E.2d 1340, 1342-43 (1985); *Kapp v. Ballantine*, 380 Mass. 186, 195, 402 N.E.2d 463, 469 (1980).

The plaintiff has presented evidence that, with regard to treatment of HIV-positive and AIDS patients, the hospital does exercise control over its physicians. The hospital employs an "AIDS coordinator," Dr. Cotton, who testified in her deposition that the hospital staff has "very clear directives" not to refuse care to AIDS patients. Once alerted to Mr. Vadnais's medical record, Dr. Cotton in fact contacted Dr. Vernick to determine whether he had improperly refused treatment to Mr. Vadnais. Moreover, the facts that the hospital does the billing and that Dr. Vernick receives a salary from the hospital for resident teaching tend to reinforce the conclusion that he was a hospital employee, rather than an independent contractor, at least for the purposes of treating Mr. Vadnais. This factual evidence is enough to preclude summary judgment on the ground that the hospital is not liable for Dr. Vernick's actions.

[9] Moreover, the courts that have considered the question have determined that vicarious liability is appropriate in an action brought under § 504. *Bonner v. Lewis*, 857 F.2d 559, 566-67 (9th Cir.1988); *Patton v. Dumpson*, 498 F.Supp. 933, 942-44 (S.D.N.Y.1980). In addition to noting that *respondeat superior* is consistent with the regulations promulgated under § 504, the district court in *Patton* enunciated strong ***637** policy reasons for its decision to permit vicarious liability:

> The application of *respondeat superior* to § 504 suits would be entirely consistent with the policy of that statute, which is to eliminate discrimination against the handicapped. The justification for imposing vicarious liability on employers for the acts of their employees is well-known. It creates an incentive for the employer to exercise special care in the selection, instruction and supervision of his employees, thereby reducing the risk of accidents. In the absence of a Congressional directive to the contrary, this court can assume only that Congress intended the judiciary to use every available tool to eliminate discrimination against the handicapped in federally funded programs.

Id. at 943. Thus, it is appropriate to hold Beth Israel responsible for the actions of its medical staff in complying with the Rehabilitation Act, even without a finding of power or control.

[10] The question still remains whether Dr. Vernick himself can be held liable for allegedly discriminating against Mr. Vadnais in Beth Israel's federally funded program. The plaintiff argues that the doctor should be held liable because he conducts a personal medical practice in which he treats Medicare and Medicaid patients-sometimes at Beth Israel Hospital-and bills them through his personal Medicare provider number.

The Supreme Court's decision in *Grove City College* indicates that application of the anti-discrimination provisions of civil rights legislation for programs receiving federal financial assistance must be program-specific. In *Grove City College* the Court held that because of its participation in the BEOG program, the college's financial aid program-but not the entire institution-was subject to the provisions of Title IX. The application of § 504 in this case must thus be limited to the relevant program receiving federal funds in the form of Medicare or Medicaid payments. Dr. Vernick participates in at least two distinct "programs": his private medical practice, in which he personally receives federal funds for treating some patients, and Beth Israel's ENT Clinic, in which he is employed in a resident teaching capacity. The latter is the relevant program in the case at bar.

If Dr. Vernick is to be held personally liable in this case, then, it must be solely on the basis of his participation in Beth Israel's federally funded program. Dr. Vernick relies on *United States Dep't of Transp. v. Paralyzed Veterans of Am.*, 477 U.S. 597, 106 S.Ct. 2705, 91 L.Ed.2d 494 (1986), for the proposition that § 504 applies only to those who actually "receive" federal funds, whether directly or indirectly, rather than those who are merely intended beneficiaries. *Id.* at 606-07, 106 S.Ct. at 2711. In distinguishing between airport operators, which receive federal assistance, and commercial airlines, which merely benefit from the effects of such assistance, the Court in *Paralyzed Veterans* stressed the contractual nature of the Rehabilitation Act: "By limiting coverage to recipients, Congress imposes the obligations of § 504 upon those who are in a position to accept or reject those obligations as part of the decision whether or not to 'receive' federal funds." *Id.* at 606, 106 S.Ct. at 2711.

In his resident teaching position at Beth Israel, Dr. Vernick clearly is not in a position to accept or reject federal assistance. While it can be argued that Dr. Vernick can elect not to work at Beth Israel, he cannot be held to the requirements of § 504 for choosing to work at a federally funded hospital any more than a commercial airline can be subjected to its provisions for choosing to operate out of federally funded airports. Accordingly, Dr. Vernick cannot be held liable under the Act for his participation in Beth Israel's federally funded program.

[11] As to Count II of the complaint, Beth Israel is correct to assert that nothing in the Rehabilitation Act indicates that § 504 imposes liability for "failure to train," and the plaintiff has produced no authority to the contrary. Moreover, given my decision that Beth Israel can be held ***638** directly liable under § 504 for the acts of its employees, liability for failure to train them is superfluous.

B. *"Otherwise Qualified"*

[12] The defendants also base their motion for summary judgment on the ground that Mr. Vadnais was not "otherwise qualified" for elective ear surgery. They argue that it is proper for a doctor to consider a patient's handicap in determining whether a patient is qualified for surgery. On the basis of this argument, they conclude that Mr. Vadnais was not "otherwise qualified" for surgery because his HIV disease increased his risk of infection, and, furthermore, that the court should defer to the doctor's determination that it was in his patient's best interest to postpone surgery.

[13] The defendants cannot be faulted for considering Mr. Vadnais's handicap in determining whether he was "otherwise qualified" for surgery. In *School Bd. v. Arline*, 480 U.S. 273, 287-89, 107 S.Ct. 1123, 1130-31, 94 L.Ed.2d 307 (1987), the Supreme Court held that the defendant school board could consider the risks posed by the plaintiff's contagious disease (tuberculosis) in determining whether she was otherwise qualified to teach school. It follows that, in the present case, the defendants can take into account the risks imposed-both on the patient and on themselves-by the prospect of surgery on an HIV-positive patient. Of course, if they properly conclude that there are

risks, they must also consider whether it is possible to make reasonable accommodations to enable the patient to undergo surgery despite those risks. *See Id.* at 287-88 & n. 17, 107 S.Ct. at 1130-31 & n. 17.

[14] As the Court made clear in *Arline*, the "otherwise qualified" determination requires an individualized inquiry and appropriate findings of fact. *Id.* at 287, 107 S.Ct. at 1130. With respect to the defendants' assertions about the risks of surgery, the facts are in dispute. The defendants contend that surgery was postponed because Dr. Vernick thought that Mr. Vadnais was "AIDS positive," because the proposed ear surgery was elective, and because it would pose significant risks to the patient. In addition, they offer Dr. Berry's statement in his deposition that he would not have performed the surgery had he known that Mr. Vadnais had AIDS. The plaintiff offers the contradicting evidence that Mr. Vadnais was HIV-positive and had not yet been diagnosed as having AIDS when surgery was refused. Moreover, Dr. Vernick in answers to interrogatories and Dr. Berry in his deposition stated that they do not consider HIV seropositivity alone as a disqualifying factor for surgery. Based on the evidence that the plaintiff has produced, facts are certainly available to warrant the conclusion that Mr. Vadnais was "otherwise qualified" for surgery. Moreover, the defendants have not produced any evidence that reasonable accommodations could not have been made.

[15] There is some merit to the argument that the court should defer to a doctor's medical judgment. *Cf. Arline*, 480 U.S. at 288, 107 S.Ct. at 1131 ("courts normally should defer to the reasonable medical judgments of public health officials" when conducting "otherwise qualified" inquiry). Accepting this argument at face value, however, would completely eviscerate § 504's function of preventing discrimination against the disabled in the health-care context. A strict rule of deference would enable doctors to offer merely pretextual medical opinions to cover up discriminatory decisions. The evidentiary approach to § 504 cases discussed in *Pushkin v. Regents of the Univ. of Colo.*, 658 F.2d 1372 (10th Cir.1981), properly balances deference to sound medical opinions with the need to detect discriminatory motives. The plaintiff must first make out a *prima facie* case that he was otherwise qualified for surgery, and only then does the burden shift to the defendant to show that the plaintiff's handicap made him unqualified. *Id.* at 1387; *Leckelt*, 714 F.Supp. at 1385. The plaintiff, however, must still be given an opportunity "to prove either that the reason given by defendants is a pretext or that the reason ... 'encompasses *unjustified* consideration of the handicap itself.' " ***639** *Id.* at 1385 (citing *Pushkin*, 658 F.2d at 1387) (emphasis added).

In sum, because the receipt of Medicare and Medicaid payments brings Beth Israel's ENT Clinic within the scope of § 504, and because there are genuine issues of material fact surrounding the "otherwise qualified" inquiry, summary judgment on the § 504 claim is inappropriate.

III

Count III of the complaint alleges a violation of the Massachusetts Civil Rights Act, Mass.Gen.Laws ch. 12, § 11I, against Dr. Michael Miller, another Beth Israel doctor, who treated Mr. Vadnais for his HIV illness. The plaintiff alleges that, when told that Mr. Vadnais had scheduled ear surgery at the Massachusetts Eye and Ear Infirmary, Dr. Miller threatened to disclose Mr. Vadnais's HIV-positive status to the prospective surgeon. In Massachusetts, health-care providers are prohibited from disclosing patients' HIV status without first obtaining specific consent from the patient for *each* requested release. Mass.Gen.Laws ch. 111, § 70F. Plaintiff seeks money damages under the Civil Rights Act for Dr. Miller's alleged interference with Mr. Vadnais's "right not to reveal his HIV status." Amended Complaint ¶ 92. Count IV presses a cause of action against the Beth Israel defendants directly under ch. 111, § 70F, for permitting unauthorized disclosure of decedent's medical records.

[16][17] The only basis for this court's entertaining these state-law claims is its power to assume pendent jurisdiction over claims that "derive from a common nucleus of operative fact" with the federal claims that are properly before the court. *United Mine Workers v. Gibbs*, 383 U.S. 715, 725, 86 S.Ct. 1130, 1138, 16 L.Ed.2d 218 (1966). Of course, the fact that judicial power to hear state-law claims exists does not require the court to exercise jurisdiction. While the defendants have not objected to this court's assumption of jurisdiction, on the facts and issues before me, I find that there are more reasons than not to refrain from the exercise of that power.

First, the state-law claims at issue here present novel questions of state law on which the state courts have not yet had much opportunity to comment. Rather than speculate on how the Massachusetts courts would likely treat the relationship of the HIV confidentiality statute to the Civil Rights Act, it would be preferable to permit the state courts to decide these issues in the first instance.

Second, while the facts giving rise to the state-law claims are related to those giving rise to the federal claim, the two incidents were separate and would not appear to involve much, if any, overlapping testimony. Thus, the interests in judicial economy, convenience, and fairness to the litigants that often justify pendent jurisdiction are not strongly implicated here.

Third, Dr. Miller, the principal defendant in these state-law claims, is not named in any claim that is independently cognizable in federal court. To decide the claim against him would require the court to assume pendent-*party* jurisdiction. Recent Supreme Court decisions indicate that assumption of pendent-party jurisdiction requires a searching analysis of the jurisdictional statute on which the case is based, and that for this purpose, jurisdictional statutes are to be narrowly construed. *See Finley v. United States*, 490 U.S. 545, 549-50, 109 S.Ct. 2003, 2006-07, 104 L.Ed.2d 593 (1989).

Finally, the dismissal of these state-law claims would not prejudice the plaintiff, as the statute of limitations has not yet run on either claim. The events that are the alleged basis for liability took place in January, 1988. The statute of limitations for civil rights claims is three years, Mass.Gen.Laws ch. 260, § 5B, while the applicable limitation for a suit commenced under the confidentiality statute is four years. *Id.* § 5A. Neither had elapsed when Mr. Vadnais died in March, 1990; thus, the plaintiff executrix has until March, 1992, to commence this action for the benefit of the decedent's estate. *Id.* § 10.

For the reasons stated above, I will dismiss these state-law claims without prejudice***640** so that they can be brought in the more appropriate forum.

ORDER

The summary judgment motion of Beth Israel Hospital and Beth Israel Corporation is DENIED with respect to Count I and ALLOWED with respect to Count II. Defendant Dr. Vernick's motion for summary judgment is ALLOWED. Counts III and IV are DISMISSED without prejudice.

Because there is no longer any just reason to retain him as a party in this case, Fed.R.Civ.P. 54(b), judgment is entered in favor of defendant Dr. Miller. This dismissal is without prejudice to the plaintiff's state-law claims.

D.Mass.,1991.
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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

ARTHUR McELROY, Plaintiff, v. PATIENT SELECTION COMMITTEE OF THE NEBRASKA MEDICAL CENTER; JAMES H. SORRELL; HOLLY SHOEMAKER; and SUE MILLER, Defendants.	)	4:06CV3162 **MEMORANDUM AND ORDER**

The plaintiff, Arthur McElroy, who appears pro se, is requesting the court to overturn a decision made by the Patient Selection Committee of the Nebraska Medical Center to refuse kidney transplantation services to McElroy because of his mental condition. This action is brought pursuant to Title III of the Americans with Disabilities Act, 42 U.S.C. § 12182, against the Nebraska Medical Center (NMC) and two nurses employed by NMC who are members of the Patient Selection Committee, Holly Shoemaker and Sue Miller, and also against James H. Sorrell, M.D., who, while not employed by NMC, serves as a psychiatrist for the Committee. McElroy alleges that the defendants violated the ADA by administering a "fraudulent" psychiatric examination and rejecting his application for a kidney transplant based on protocols that discriminate against persons who are mentally ill.

The defendants have moved for summary judgment, claiming that the decision not to offer NMC's kidney transplantation services to McElroy was purely a medical decision that was based upon reasoned medical analysis and judgment, including an individualized inquiry into McElroy's condition. The individual defendants also claim that they are not subject to suit under Title III of the ADA. Upon careful consideration of the pleadings, affidavits, and briefs, the court concludes that the defendants' motions for summary judgment should be granted in all respects.

I. Factual Background

Pursuant to our local rules, the defendants in their briefs have set forth statements of material facts with appropriate references to the pleadings and affidavits. *See* NECivR 56.1(a). Because McElroy has not controverted these statements,[1] they are deemed admitted. *See* NECivR 56.1(b)(1) ("Properly referenced material facts in the movant's statement will be deemed admitted unless controverted by the opposing party's response.") (emphasis in original). Condensed, the material facts are as follows.

The Nebraska Medical Center is an entity that operates both University Hospital and Clarkson Hospital in Omaha, Nebraska. The Patient Selection Committee for Kidney and Pancreas Transplantation is part of the transplantation services offered by NMC. The Committee is comprised of surgeons, physicians, psychiatrists, nurses, social workers and other healthcare and wellness professionals who meet and confer to determine whether it is in each applicant's best interest to be placed on the kidney transplant list at NMC. The Committee is responsible for determining who will be offered the kidney transplantation services of NMC.

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[1] McElroy has filed a "motion" to deny the defendants' motions for summary judgment, in which he contends that the pleadings show the existence of genuine issues of material fact. This opposing "motion" (filing 45) is not a proper filing under our local rules, *see* NECivR 7.1(b)(1)(A), but it will be treated as part of McElroy's accompanying brief (filing 46). It is McElroy's contention that a factual dispute must exist because the defendants have denied his conclusory allegations that they violated the ADA. There is no merit to this contention. Federal Rule of Civil Procedure 56(e) provides that, when a properly supported motion for summary judgment is made, the adverse party "must set forth specific facts showing that there is a genuine issue for trial." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986). Rule 56(e) therefore requires the nonmoving party to go beyond the pleadings and by his own affidavits, or by the "depositions, answers to interrogatories, and admissions on file," designate "specific facts showing that there is a genuine issue for trial." *Celotex Corp. v. Catrett*, 477 U.S. 317, 324 (1986). McElroy has failed to do this.

Holly Shoemaker works as a transplant coordinator for NMC, and Sue Miller works as a manager of the Kidney/Pancreas Transplant Office for NMC. Both are members of the Patient Selection Committee.

McElroy has been institutionalized at the Lincoln Regional Center since 1992. He applied for kidney transplantation services at NMC, and his application was discussed by the Patient Selection Committee on October 14, 2004, February 2, 2006, February 16, 2006, May 4, 2006, May 25, 2006, June 1, 2006 and June 8, 2006.

Miller attended all of these meetings except the meeting of February 2, 2006, and Shoemaker attending all but the meeting of February 16, 2006. Miller and Shoemaker both had several communications with McElroy regarding his application.

The Patient Selection Committee follows a specific set of protocols in determining whether an applicant should be offered NMC's kidney transplantation services. These protocols list a "history of psychiatric illness" as a relative contraindication for kidney transplantation services. A "major ongoing psychiatric illness" is listed as an absolute contraindication for kidney transplantation services.

The Patient Selection Committee considered McElroy's medical and psychiatric history, which included a diagnosis of delusional disorder, persecutory type with a previous diagnosis paranoid schizophrenia. As part of the selection process, the Committee asked Dr. James Sorrell, a psychiatrist, to evaluate McElroy.

On April 11, 2006, Dr. Sorrell performed a psychiatric evaluation of McElroy and received information regarding his condition from McElroy himself and from records provided by the Lincoln Regional Center. It is Dr. Sorrell's medical opinion that McElroy suffers from delusional disorder, persecutory type. Dr. Sorrell found, to a reasonable degree of medical certainty, that a kidney transplant for McElroy is absolutely contraindicated in light of his particular condition and would not be in McElroy's best interests or in the best interests of NMC or those who would be

treating McElroy. Dr. Sorrell also found that it would be a disservice to McEloy to offer him a kidney transplant. Dr Sorrell states that "[t]he procedure is complex and intrusive and requires long-standing adherence to immunosuppressive agents and cooperation with the various different people who treat a patient recovering from a kidney transplant. Adherence to immunosuppressive agents and cooperation with his medical team is highly doubtful in light of his history and his chronic psychotic illness for which he has yet to establish complete and autonomous control." (Filing 43, ¶ 12.)

Dr. Sorrell denies that he was asked to provide a "fraudulent" psychiatric evaluation, and states that his findings were based solely upon his education, training, and experience, and upon his examination of McElroy and McEloy's history. Dr. Sorrell denies that his findings were based upon any stereotypes of persons with mental illness.

Pursuant to the discussions of the Patient Selection Committee, the protocols followed by the Committee for selection of patients for kidney transplantation, and the medical opinions of Dr. Sorrell, the Committee came to the consensus that NMC could not ethically offer kidney transplantation services to McElroy, and that it would not be in McElroy's best interests to undergo the kidney transplantation process at NMC.

While Miller and Shoemaker are members of the Patient Selection Committee, neither has the power or authority on their own to accept McElroy for transplantation services at NMC, or to overturn or go against any decision made by the Committee regarding whether a particular applicant should be accepted for transplantation services. Neither has the power or authority to amend or enact policies or procedures of NMC as they relate to any standards or protocols for the acceptance or denial of candidates for transplantation services at NMC. Neither Miller nor Shoemaker owns, leases, leases to, or operates NMC or the Patient Selection Committee.

Dr. Sorrell is not an employee of NMC and he does not have the power or authority to accept McElroy for transplantation services at NMC or to overturn or go against any decision made by the Committee regarding whether a particular applicant should be accepted for transplantation services. Just like Miller and Shoemaker, Dr. Sorrell does not have the power or authority to amend or enact policies or procedures of NMC as they relate to any standards or protocols for the acceptance or denial of candidates for transplantation services at NMC. Similarly, he does not own, lease, lease to, or operate NMC or the Patient Selection Committee

II. Legal Analysis

Summary judgment should be granted only "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). *See also Egan v. Wells Fargo Alarm Servs.*, 23 F.3d 1444, 1446 (8th Cir.1994). It is not the court's function to weigh evidence in the summary judgment record to determine the truth of any factual issue. *Bell v. Conopco, Inc.*, 186 F.3d 1099, 1101 (8th Cir. 1999). In passing upon a motion for summary judgment, the district court must view the facts in the light most favorable to the party opposing the motion. *Dancy v. Hyster Co.*, 127 F.3d 649, 652 (8th Cir. 1997).

In order to withstand a motion for summary judgment, the nonmoving party must substantiate their allegations with "'sufficient probative evidence [that] would permit a finding in [their] favor on more than mere speculation, conjecture, or fantasy.'" *Moody v. St. Charles County*, 23 F.3d 1410, 1412 (8th Cir. 1994) (quoting *Gregory v. City of Rogers*, 974 F.2d 1006, 1010 (8th Cir. 1992)). Essentially the test is "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 251-52 (1986).

> [T]he plain language of Rule 56(c) mandates the entry of summary judgment, after adequate time for discovery and upon motion, against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial. In such a situation, there can be "no genuine issue as to any material fact," since a complete failure of proof concerning an essential element of the nonmoving party's case necessarily renders all other facts immaterial. The moving party is "entitled to a judgment as a matter of law" because the nonmoving party has failed to make a sufficient showing on an essential element of her case with respect to which she has the burden of proof.

Celotex Corp. v. Catrett, 477 U.S. 317, 322-23 (1986).

A. Liability of Individual Defendants

Title III of the ADA prohibits discrimination against the disabled in the full and equal enjoyment of public accommodations by prohibiting any "person who owns, leases, or operates a place of public accommodation from discriminating against an individual on the basis of that individual's disability." *Amir v. St. Louis Univ.*, 184 F.3d 1017, 1027 (8th Cir.1999) (citing 42 U.S.C. § 12182(a)). "It is established case law in the Eighth Circuit that, in the absence of a claim that an individual owns, leases, or operates a place of public accommodation, 'there is no colorable claim under Title III of the ADA.'" *White v. Creighton University*, No. 8:06CV536, 2006 WL 3419782, *3 (D.Neb. Nov. 27, 2006) (quoting *Valder v. City of Grand Forks*, 217 F.R.D. 491, 494 (D.N.D. 2003)). McElroy's complaint thus fails to state a claim upon which relief can be granted against Miller, Shoemaker, or Sorrell. *See Pona v. Cecil Whittaker's, Inc.*, 155 F.3d 1034, 1036 (8th Cir.1998) ("[The claimant's] Title III claim against the St. Louis police officers . . . is even more obviously infirm, because there is not a colorable claim that the officers owned, leased, or operated the pizzeria in question. The claim therefore necessarily fails on its face.")).

Even if the complaint were to allege that the individual defendants "operate" NMC or the Patient Selection Committee, there is no evidence to support such a claim. Indeed, the evidence shows that the individual defendants have no authority to grant McElroy access to NMC's transplantation services or to overturn the decision that was made by the Patient Selection Committee. Miller, Shoemaker, and Sorrell are therefore entitled to the entry of summary judgment in their favor. *See Emerson v. Thiel College*, 296 F.3d 184, 189 (3rd Cir. 2002) (construing "operate" in accordance with its ordinary meaning, including "to control or direct the functioning of" and "to conduct the affairs of," and finding that college administrators did not individually "operate" the college).

B. Liability of the Nebraska Medical Center

"A person alleging discrimination under Title III must show (1) that he is disabled within the meaning of the ADA, (2) that the defendant is a private entity that owns, leases, or operates a place of public accommodation, (3) that the defendant took adverse action against the plaintiff that was based upon the plaintiff's disability, and (4) that the defendant failed to make reasonable modifications that would accommodate the plaintiff's disability without fundamentally altering the nature of the public accommodation." *Amir*, 184 F.3d at 1027 (citing 42 U.S.C. § 12182(a) and (b)(2)(A)(ii)). NMC focuses solely on the third factor, and argues that a medical decision cannot provide the basis for an ADA claim. The Eighth Circuit has so held. *See Burger v. Bloomberg*, 418 F.3d 882, 883 (8th Cir. 2005) ("Having conducted a de novo review of the record, . . . we agree with two other circuits that have recently concluded a lawsuit under the Rehab Act or the Americans with Disabilities Act (ADA) cannot be based on medical treatment decisions, *see, e.g., Schiavo ex rel. Schindler v. Schiavo*, 403 F.3d 1289, 1294 (11th Cir. 2005) (Rehab Act, like ADA, was never intended to apply to decisions involving medical treatment); *Fitzgerald v. Corr. Corp. of Am.*, 403 F.3d 1134, 1144 (10th Cir. 2005) (inmate's claims under Rehab Act and ADA were properly dismissed for failure to state claim as they were based on medical treatment decisions).").

Because the evidence conclusively shows that McElroy's application for a kidney transplant was rejected by the Patient Selection Committee for legitimate medical reasons, he cannot maintain an action under the Americans with Disabilities Act. Summary judgment will therefore be entered in favor of NMC.

IT IS ORDERED that:

1. Defendants' motions for summary judgment (filings 39, 42) are granted, and Plaintiff's action is dismissed with prejudice.

2. The clerk of the court shall rename Plaintiff's "motion" to deny Defendants' motions for summary judgment (filing 45) as a "brief".

3. Final judgment shall be entered by separate document.

November 21, 2007.

BY THE COURT:

s/ *Richard G. Kopf*
United States District Judge

United States Court of Appeals
For the Eighth Circuit

No. 17-1374

Roger Durand; Linda Durand; Priscilla Durand

Plaintiffs - Appellants

v.

Fairview Health Services

Defendant - Appellee

Minnesota Hospital Association

Amicus on Behalf of Appellee(s)

Appeal from United States District Court
for the District of Minnesota - Minneapolis

Submitted: May 15, 2018
Filed: September 4, 2018

Before SHEPHERD, MELLOY, and GRASZ, Circuit Judges.

MELLOY, Circuit Judge.

Linda and Roger Durand, both of whom are hearing-impaired, and their hearing-abled daughter, Priscilla Durand (collectively, "Appellants"), allege Fairview Ridges Hospital ("Fairview") failed to provide "meaningful access" to "auxiliary aids and services," in the form of American Sign Language (ASL) interpreters and a teletypewriter (TTY), during the course of their adult son Shaun Durand's terminal hospital stay, in violation of Title III of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12101, *et seq.*; Section 504 of the Rehabilitation Act (RA), 29 U.S.C. § 794; and the Minnesota Human Rights Act (MHRA), Minn. Stat. § 363A.01, *et seq*. Additionally, Priscilla alleges an injury independent of her parents' claim and asserts associational standing under the same statutes. The district court[1] granted Fairview's motion for summary judgment as to both issues. We affirm.

I. Background

Linda and Roger are a married couple with six adult children. Although Linda and Roger are hearing-impaired, none of their children are deaf. The Durand children communicate with Linda and Roger through a combination of methods, including ASL, lip reading, finger spelling, speaking, and writing. Linda and Roger assert they "do not pick up on all the information their children communicate to them." Linda and Roger also assert they "do not always indicate when they don't understanding something."

Shaun is Linda and Roger's oldest child. When Shaun was seven years old he was diagnosed with Marfan syndrome, a genetic disorder affecting his heart. Over the course of the next several years, Shaun underwent multiple heart surgeries. Appellants assert "Shaun had long believed that he would not live past the age of 30, and had declined to pursue a heart transplant or a left ventricular assist device." In

[1]The Honorable Richard H. Kyle, United States Judge for the District of Minnesota.

May 2013, when he was thirty-one years old, Shaun passed away at Fairview Ridges Hospital.

Priscilla, Shaun's sister and Linda and Roger's daughter, played an active role in Shaun's health care and management. In October 2012, Shaun executed an Authorization to Discuss Protected Health Information, designating Priscilla and three other siblings as individuals with whom his medical information could be shared. Neither Roger nor Linda were included in the authorization.

In November 2012, Priscilla and Shaun met with a Fairview social worker to discuss a transition to hospice care. Shortly thereafter, Priscilla, Shaun, and Fairview's hospice director convened a meeting with the Durand family, including Linda and Roger. Fairview provided an interpreter for the meeting.

In December 2012, Shaun and a Fairview doctor executed a Provider Orders for Life Sustaining Treatment (POLST) wherein Shaun requested doctors not attempt to intubate or resuscitate.

In February 2013, Shaun executed a health care directive designating Priscilla as his sole health care agent. The directive also referred to his POLST and requested Fairview not attempt resuscitation.

In April 2013, Shaun was admitted to Fairview with renal failure. Amy Klopp, an Advanced Practice Nurse, held a palliative "care conference." Fairview asserts care conferences allow "everybody who holds a stake in a person's life to weigh in and feel comfortable and understand the decisions that have been made." Linda and Roger attended the conference. Fairview provided an interpreter for the meeting.

On May 7, 2013, Shaun was admitted to the Fairview intensive care unit for renal failure. He was accompanied by Priscilla and one of his brothers. At the time Shaun was admitted he was "confused" and had a "decreased level of consciousness."

On the morning of May 8, 2013, Priscilla met with Nurse Klopp to discuss key medical decisions, including the decision to move Shaun to end-of-life comfort care and remove his respirator. Nurse Klopp and Priscilla also planned an afternoon care conference with the Durand family, including Linda and Roger. Around noon, Shaun's siblings notified Linda and Roger of Shaun's hospitalization.

Although Fairview requested an interpreter for the afternoon care conference, the interpreter did not arrive until after the conference started. Nurse Klopp then updated Linda and Roger through the interpreter, and Linda and Roger had an opportunity to ask Nurse Klopp questions through the interpreter. Around 5:00 p.m., Shaun's physician held a meeting, with an interpreter present, for an unspecified period of time. According to Fairview's records, an interpreter was dispatched by a third-party vendor to Fairview at 2:52 p.m., arrived at the hospital at 3:44 p.m., and departed the hospital at 6:00 p.m.

During the evening of May 8 and on the morning of May 9, 2013, nurses and doctors were in and out of Shaun's room as a part of their hospital rounds. Interpreters were not present during these visits. At times, Priscilla or a sibling interpreted or shared updates regarding Shaun's condition with Linda and Roger.

On May 9, 2013, Nurse Klopp convened a second care conference. Nurse Klopp updated the conference attendees, including Linda and Roger through the aid of an interpreter.

According to Linda and Roger, at that point they understood the end of Shaun's life was near but believed the timeline to be a matter of days. Linda and Roger

returned home, and Roger proceeded to work his typical overnight shift that night. Linda and Roger devised a plan where Linda would use Fairview's TTY device to contact the voicemail box of Roger's employer in the event there was a change in Shaun's condition. No one had previously attempted to reach Roger at work. Roger asked his supervisor to frequently check the voicemail box.

Later in the evening, after learning Shaun would likely pass away in a matter of hours, Linda requested a TTY machine from the hospital. An administrator initially denied her request. Approximately one hour later, the administrator provided Linda with a TTY machine. Linda declined the administrator's offer of assistance in setting up the device. Linda was ultimately unable to use the TTY machine. Priscilla and one of her siblings attempted to call Roger's work number, but they did not leave voicemail messages. The police eventually notified Roger, while Roger was at work, that his son had passed away.

Linda, Roger, and Priscilla filed suit against Fairview, requesting a series of declaratory judgments, injunctive relief requiring Fairview to provide "appropriate auxiliary aids and services" to hearing-impaired individuals, as well as compensatory, treble, and punitive damages and attorneys' fees. After extensive discovery, Fairview filed a motion for summary judgment, and Appellants filed a motion for partial summary judgment. The district court granted Fairview's motion. Appellants filed a timely appeal.

II. Standard of Review

We review de novo the district court's grant of Fairview's motion for summary judgment, "viewing all evidence and reasonable inferences in the light most favorable to the nonmoving party." Barstad v. Murray Cty., 420 F.3d 880, 883 (8th Cir. 2005). "Summary judgment is appropriate only if no genuine dispute exists as to any

material fact and the movant is entitled to a judgment as a matter of law." Argenyi v. Creighton Univ., 703 F.3d 441, 446 (8th Cir. 2013) (citation omitted).

III. Discussion

"Title III of the ADA proscribes discrimination in places of public accommodation against persons with disabilities." Steger v. Franco, Inc., 228 F.3d 889, 892 (8th Cir. 2000); see 42 U.S.C. § 12182(a). Discrimination is defined by the ADA as "a failure to take such steps as may be necessary to ensure that no individual with a disability is . . . treated differently than other individuals because of the absence of auxiliary aids and services." 42 U.S.C. § 12182(b)(2)(A)(iii). Similarly, Section 504 of the RA provides, "[n]o otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 29 U.S.C. § 794; see also Alexander v. Choate, 469 U.S. 287, 295 (1985) (noting the type of discrimination Congress sought to remedy with the RA was the type resulting from "thoughtlessness and indifference—of benign neglect" rather than "invidious animus"). Minnesota law also provides people with a disability similar protections against discrimination, through the MHSA. See Minn. Stat. § 363A.11.

Although there are differences between the ADA and the RA, including the RA's aforementioned federal funding requirement, the case law interpreting the two statutes is generally used interchangeably. Loye v. Cty. of Dakota, 625 F.3d 494, 496 (8th Cir. 2010); see also Gorman v. Bartch, 152 F.3d 907, 912 (8th Cir. 1998) (noting the substantive similarities between the ADA and RA such that the "cases interpreting either are applicable and interchangeable" (citation omitted)). Additionally, "[i]n general, the ADA and MHRA are also construed the same." Loye, 625 F.3d at 496 n.2 (citing Somers v. City of Minneapolis, 245 F.3d 782, 788 (8th Cir. 2001)).

Importantly, for present purposes, neither party articulates a difference between the MHRA and the ADA and RA.

1. "Meaningful Access"

In order to establish a discrimination claim, Linda and Roger must demonstrate: (1) they were qualifying individuals with disabilities; (2) Fairview was a "place of public accommodation (for ADA purposes) and received federal funding (for Rehabilitation Act purposes)"; and (3) Fairview "failed to make reasonable modifications that would accommodate [their] disability." Mershon v. St. Louis Univ., 442 F.3d 1069, 1076–77 (8th Cir. 2006). The parties agree (1) Linda and Roger are individuals with a qualified disability, and (2) Fairview is a place of public accommodation receiving federal funding. The remaining question, therefore, is whether there are facts in dispute as to whether Fairview provided Linda and Roger with the necessary aids and services, such as access to an interpreter and a TTY device, during Shaun's hospitalization.

Linda and Roger argue Fairview discriminated against them by failing to provide statutorily required aids and services in the form of sufficient access to interpreters and a TTY device. As a result, Linda and Roger claim they "did not understand crucial aspects of Shaun's prognosis or the decisions that had been made regarding his care." We disagree with Linda and Roger's interpretation of what is statutorily required under the ADA, RA, and MHRA. Although the hospital could have improved upon the services provided, the services Fairview *did* provide allowed Linda and Roger to gain access to the same information and related services as similarly situated, hearing-abled individuals.

Generally, the ADA and RA require "responsible parties to provide 'necessary' auxiliary aids and services." Argenyi, 703 F.3d at 448. Still, while "[b]oth the ADA and [RA] are intentionally broad in scope, . . . they do not require institutions to

provide *all* requested auxiliary aids and services." Id. (emphasis added). A reasonable denial of a request for an auxiliary aid or service does not necessarily create a statutory liability. See id. As such, in order to determine whether the responsible party or parties meet the "necessary" requirement, we apply the "meaningful access" standard. See id. at 449; see also Alexander, 469 U.S. at 301 (citing Section 504 of the RA and noting "an otherwise qualified . . . individual must be provided with meaningful access to the benefit that the grantee offers").

The meaningful access standard requires entities to provide hearing-impaired individuals with "an equal opportunity to gain the same benefit" as their hearing-abled peers. Argenyi, 703 F.3d at 449; see also id. at 448 (noting the ADA aimed "to remedy 'the discriminatory effects of . . . communication barriers' for individuals with hearing disabilities" (quoting 42 U.S.C. § 12101(a)(5))); Liese v. Indian River Cty. Hosp. Dist., 701 F.3d 334, 343 (11th Cir. 2012) (holding the "proper inquiry" regarding "necessary" auxiliary aids and services was whether the aids "gave that patient an equal opportunity to benefit from the hospital's treatment"); Loye, 625 F.3d at 500 (noting the "the legal standard is effective communication that results in meaningful access"). Accordingly, the meaningful access standard necessitates a fact-intensive inquiry and is largely context-dependent. Argenyi, 703 F.3d at 449; Liese, 701 F.3d at 342–43. As such, courts must identify the hearing-abled peer group, as well as the context of the hospital visit, in order to determine whether the hearing-impaired individuals were provided an equal opportunity to access the same benefits.

As Shaun's parents, Linda and Roger are naturally considered to be a part of the group of stakeholders interested in his condition. However, as the district court noted, Linda and Roger did not seek the hospital's aids and auxiliary services as patients or as a patient's designated decisionmaker. In fact, in the years leading up to his final hospitalization, Shaun specifically elected not to include Linda or Roger as parties authorized to receive his medical information. Nor did he designate Linda

or Roger as his health care agents. Thus, when Linda and Roger visited the hospital in May 2013, they did so as family visitors: related, interested, non-patient parties with limited authority to receive certain medical information and no formal decisionmaking agency.

Second, it is undisputed that, over the course of Shaun's final hospitalization, his condition developed into an urgent, emergency situation. While the November 2012 hospice conference and April 2013 palliative care conference helped prepare Linda, Roger, Priscilla, and Shaun's medical team for the ultimate outcome, the timing and course of events were largely unknown. As such, during Shaun's final hospitalization, Priscilla and Shaun's medical team had to make immediate, time-sensitive decisions. In these types of situations, we expect Fairview to prioritize conversations with critical parties who have decisionmaking authority over conversations with family visitors, regardless of their disability status.

Finally, family visitors and similarly situated stakeholders are entitled to effective communication. This includes participation in certain conversations, access to certain information, and, ultimately, effective communication of that information. See 28 C.F.R. § 36.303(c) (requiring hospitals to "furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities"). Here, Linda and Roger argue they were not able to fully comprehend the severity of Shaun's condition. The evidence, however, shows Fairview provided Linda and Roger with access to information, through interpreters, before and during Shaun's final hospitalization and provided ample opportunities for Linda and Roger to ask questions that may have clarified their understanding of Shaun's condition. On these facts, we cannot conclude Fairview failed to discharge its duty to provide effective communication. See Loye, 625 F.3d at 500.

Next, turning to the TTY device, it is not disputed that Fairview provided a TTY device. There is also no dispute Linda refused the hospital administrator's

assistance in setting up the TTY device. These facts alone are sufficient to establish Fairview provided Linda and Roger with the requested auxiliary aid and offered assistance, which was declined, in setting up the device. Here, the district court also discussed a series of complications with Linda's plan to use the TTY device that were outside the scope of Fairview's control. For example, this was the first time Linda, or anyone else, had attempted to reach Roger at his place of work. And, even though Priscilla and another sibling called Roger at work, they did not leave a voicemail message. As the district court noted, "on these facts, the Court discerns no violation of the law." We agree.

Overall, based on the record, the district court determined there was no factual dispute as to whether Fairview provided a legally sufficient amount of aids and services during the course of Shaun's hospitalization. We agree. As such, Fairview is entitled to summary judgment as a matter of law.

2. Associational Standing

The second issue on appeal is whether Priscilla has associational standing to bring a claim against Fairview independent of her parents' claims. Priscilla alleges she was unable to "fully concentrate on her own needs" because she was required to interpret for her deaf parents during the course of Shaun's hospitalization.

Generally, courts have "widely accepted . . . under both the RA and the ADA [that] non-disabled individuals have standing to bring claims when they are injured because of their association with a disabled person." McCullum v. Orlando Reg'l Healthcare Sys., Inc., 768 F.3d 1135, 1142 (11th Cir. 2014) (citing Addiction Specialists, Inc. v. Twp. of Hampton, 411 F.3d 399, 405–09 (3d Cir. 2005) (discussing standing of a non-disabled party under the ADA and RA)). Specifically, the ADA states,"It shall be discriminatory to exclude or otherwise deny equal goods, services, facilities, privileges, advantages, accommodations, or other opportunities

to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association." 42 U.S.C. § 12182(b)(1)(E). Although the RA does not have a similar provision, courts have read part of the statute—"[t]he remedies, procedures, and rights set forth in title VI of the Civil Rights Act of 1964 . . . shall be available to any person aggrieved by any act or failure to act"—as establishing associational standing. 29 U.S.C. § 794a(a)(2); Loeffler v. Staten Island Univ. Hosp., 582 F.3d 268, 280 (2d Cir. 2009).

However, there is a circuit split as to the scope of associational standing under the ADA and RA. Compare Loeffler, 582 F.3d at 277–79 with McCullum v. Orlando Reg'l Healthcare Sys., Inc., 768 F.3d 1135, 1142 (11th Cir. 2014). In Loeffler, the Second Circuit determined under the ADA and RA, "non-disabled parties bringing associational discrimination claims need only prove an independent injury causally related to the denial of federally required services to the disabled persons with whom the non-disabled plaintiffs are associated." 582 F.3d at 279. The majority in Loeffler concluded that, because a hospital did not provide federally-required services to a deaf patient, and because his two minor and hearing-abled children were required to act as on-call interpreters for their father, forcing the kids to miss school and be "involuntar[il]y expos[ed] to their father's suffering," the children had associational standing. Id. But see id. at 287 (Jacobs, C.J., dissenting) (noting that because Congress intended the standard under the ADA and RA to require non-disabled individuals to be excluded or denied services *because of their association,* and the non-disabled children had not been excluded from or denied services based on their association with their deaf father, the children did not have associational standing under either statute).

In McCullum, the Eleventh Circuit held "a non-disabled individual has standing to bring suit under the ADA [and RA] only if she was personally discriminated against or denied some benefit because of her association with a disabled person." 768 F.3d at 1142. The Eleventh Circuit cited Chief Judge Jacobs'

dissent in Loeffler and shared his concern at the possibility that "non-disabled individuals may seek relief under the RA and ADA for injuries other than exclusion, denial of benefits, or discrimination that they themselves suffer." Id. at 1143–44. The court noted, "If that contention were correct, it would mean that Congress granted non-disabled persons more rights under the ADA and RA than it granted to disabled persons, who can recover only if they are personally excluded, denied benefits, or discriminated against based on their disability." Id. Although the ADA and RA may not intend to grant *more* rights to non-disabled individuals, the statutes do grant *different* rights to disabled and non-disabled individuals.

Here, given the undisputed facts, Priscilla does not qualify for associational standing under either Loeffler or McCullum. As discussed above, Linda and Roger were not denied statutorily required services under the ADA, RA, or MHRA. Priscilla's injury, therefore, cannot be "causally related to the denial of federally required services to the disabled persons with whom the non-disabled plaintiffs are associated," as required in Loeffler. 582 F.3d at 279. Additionally, Priscilla does not claim "she was personally discriminated against or denied some benefit because of her association with a disabled person," as required by McCullum. 768 F.3d at 1142. We conclude Priscilla does not have associational standing. We leave for another day the broader, more general question of when an injured, non-disabled individual may establish associational standing. As such, Fairview is entitled to summary judgment as a matter of law.

III. Conclusion

For the reasons stated above, we affirm the judgment of the district court.

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Hospitals: Patients Who Don't Speak English Have Rights Too

By Mary Anne Pazanowski

Aug. 28, 2018 12:40PM

- *Houston man sues hospital that sent him home with English-only discharge instructions*
- *About 20 million people in U.S. don't speak English well, increasing odds providers will be sued for failing to accommodate their language needs*

Song Xie left a Houston hospital a few days after Christmas 2015. He had a stroke less than a week later caused, he says, by inadequate discharge instructions.

The instructions were written in English—a language the son providing Song Xie's post-discharge care couldn't read, he says. Song Xie sued Memorial Hermann Health System in a Texas state court, saying the hospital violated the Affordable Care Act's prohibition on national origin discrimination when it didn't translate the instructions into the son's native language.

Providers should be prepared for this new type of litigation, which could cost them hundreds of thousands of dollars in fines and civil damages. About 20 million people in the U.S. don't speak or understand much English, according to government data. An Associated Press-NORC Center for Public Affairs Research survey released in late July found that nearly six out of 10 Hispanic adults, for example, have difficulty communicating with health-care providers.

The ACA's Section 1557 bars providers from discriminating against people on any basis prohibited by federal law, including national origin. A failure to address language barriers is a form of such discrimination.

Iceberg's Tip

Song Xie's suit appears to be the only Section 1557 language barrier case against a provider so far, according to two attorneys who counsel hospitals and health systems on compliance matters. It may be only the tip of the iceberg.

There might be other cases involving patients with limited English proficiency (LEP) that settled before a complaint was filed, Toby K.L. Morgan, an attorney and director of compliance at

Atlanta's Emory Healthcare, told Bloomberg Law. She and Andrew Stevens, a health-care litigation associate at Atlanta's Arnall Golden Gregory LLP, predict there will be more.

Section 1557 is relatively new, Morgan said. Many people aren't yet aware the law gives them a right to sue providers. This will become a "more significant cause of action over time," she said.

Song Xie's lawsuit still has a long way to go. Memorial Hermann Aug. 14 asked the court to dismiss his claims, based on Texas medical malpractice pleading rules. Song Xie's attorney, Marc Bozeman, of the Bozeman Law Firm in Houston, told Bloomberg Law he will argue in a response due Sept. 11 that those rules don't apply to the Section 1557 claim.

Memorial Hermann's attorney, Frank N. Luccia, of Luccia + Evans, Houston, declined to comment.

Work-Around for Civil Rights Law

Section 1557 is "a work-around" for Title VI of the Civil Rights Act of 1964, Stevens told Bloomberg Law. Title VI forbids national origin discrimination, and is enforced by the Health and Human Services Department's Office for Civil Rights.

Individual remedies under Title VI, however, are limited. LEP patients can sue providers only for intentional discrimination.

Section 1557 allows LEP patients to sue providers for unintentional, or "disparate impact," discrimination, the HHS says. That is, a seemingly benign policy that has a greater impact on one group, could be unlawful.

All but one court, so far, has followed the HHS's interpretation of Section 1557 in the context of sex discrimination claims, Stevens said.

Analogous Problem

Providers can review legal requirements for effectively communicating with deaf patients for guidance on how to accommodate LEP patients. The two concerns are "very similar in nature," Morgan said.

Deaf patients' rights are set out in the Americans With Disabilities Act and the Rehabilitation Act. The HHS OCR has fined providers between $20,000 and $200,000 for violations, Morgan said. Providers can expect similar fines for failing to provide LEP patients with translators or interpreters, she said.

Private plaintiffs normally seek an order requiring providers to stop discriminating and adopt effective communications policies. Damages are available when a plaintiff proves a provider was deliberately indifferent to his or her needs. LEP patients' remedies likely will be similar, Stevens said.

Medical errors attributable to language barriers pose a more expensive threat, he said.

Compliance Needed

Providers can try to avoid costly litigation by complying with federal requirements for LEP patients. The HHS’s guidance on the issue is very specific.

Interpreters must be available for almost every interaction with LEP patients, except in emergencies, and must be “qualified” medical interpreters, Morgan said. Clinical personnel, who speak a patient’s language and think they don’t need an interpreter, could be a problem, she said.

Providers must accommodate all languages, Morgan said. The HHS has identified the 10 to 15 most popular languages spoken in the U.S., and has guidelines for determining the most frequently spoken languages in a provider’s geographic area, she said.

Interpreting services are expensive, so it probably pays to have full-time staff interpreters for the most popular languages, Morgan said. For less-commonly spoken languages, providers can use video or telephonic interpreting services, she said.

All written communications—informed consent forms, discharge instructions, and lab test results, for example—also must be translated into patients’ native languages. This was the danger area for Memorial Hermann, which is alleged to have sent Song Xie home with discharge instructions written only in English.

Creating an “action plan” to address LEP concerns is a good start for ensuring compliance with federal laws, Stevens said. Morgan also suggested providers appoint Section 1557 “coordinators” to develop policies and practices, assess staff capabilities, train and educate staff, and ensure important documents are translated.

To contact the reporter on this story: Mary Anne Pazanowski in Washington at mpazanowski@bloomberglaw.com

To contact the editor responsible for this story: Peyton M. Sturges at psturges@bloomberglaw.com

Section 1557: Frequently Asked Questions

1. **What is Section 1557?**

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in health programs or activities that receive Federal financial assistance or are administered by an Executive agency or any entity established under Title I of the ACA. Section 1557 has been in effect since enactment of the ACA.

2. **In what ways does Section 1557 protect consumers?**

Section 1557 makes it unlawful for any health care provider that receives funding from the Federal government to refuse to treat an individual – or to otherwise discriminate against the individual – based on race, color, national origin, sex, age or disability. Section 1557 imposes similar requirements on health insurance issuers that receive federal financial assistance. Health care providers and insurers are barred, among other things, from excluding or adversely treating an individual on any of these prohibited bases. The Section 1557 final rule applies to recipients of financial assistance from the Department of Health and Human Services (HHS), the Health Insurance Marketplaces and health programs administered by HHS.

3. **How is the final rule under Section 1557 different from rules under the other civil rights laws the Office for Civil Rights already enforces?**

The final rule is consistent with existing, well-established Federal civil rights laws and clarifies the standards HHS will apply in implementing Section 1557 of the ACA. These standards provide that individuals cannot be denied access to health care or health coverage or otherwise be subject to discrimination because of race, color, national origin, sex, age, or disability.

Building on long-standing and familiar civil rights principles, the final rule is an important step toward eliminating unlawful discrimination in federally funded programs and HHS programs. Section 1557 is the first Federal civil rights law to broadly prohibit discrimination on the basis of sex in all federally funded health care programs. The final rule extends nondiscrimination protections to individuals enrolled in coverage through the Health Insurance Marketplaces and certain other health coverage. It also applies to HHS's own health programs.

4. **Is Section 1557 currently being enforced?**

Section 1557 has been in effect since the enactment of the ACA in 2010. Since that time, the Office for Civil Rights (OCR) has been receiving and investigating discrimination complaints under Section 1557.

5. **What is the effective date for the final rule?**

The final rule is effective 60 days after publication in the Federal Register. There are three situations in which covered entities have additional time to comply with the rule's requirements: posting notices of consumer rights and taglines; accessibility standards for buildings not previously covered by the Americans with Disabilities Act; and design changes to health coverage.

6. What can I do if I believe my civil rights under Section 1557 have been violated?

If you feel that you have been subject to discrimination in health care or health coverage, you may file a complaint of discrimination under Section 1557. Please visit OCR's website at www.hhs.gov/ocr to file a complaint or to request a complaint package, or call OCR's toll free number at (800) 368-1019 or (800) 537-7697 (TDD) to speak with someone who can answer your questions and guide you through the process. OCR's complaint forms are available in a variety of languages. Individuals can also file lawsuits under Section 1557.

7. Why is OCR issuing a final rule addressing Section 1557?

OCR is issuing this final rule to educate consumers about their rights and to help covered entities understand their legal obligations under Section 1557. The final rule builds on the standards of the four Federal civil rights laws referenced in Section 1557 and their implementing regulations: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. Among other things, the final rule implements prohibitions against sex discrimination in federally funded health care programs and establishes standards that apply to the Health Insurance Marketplaces and health programs administered by HHS.

8. Who does the final rule apply to?

The final rule applies to every health program or activity that receives HHS funding, every health program or activity administered by HHS, such as the Medicare Part D program, and the Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces. Covered entities may include hospitals, health clinics, health insurance issuers, state Medicaid agencies, community health centers, physician's practices and home health care agencies.

While the final rule applies only to HHS and the health programs and activities it funds, the Section 1557 statute applies more broadly to health programs and activities that receive financial assistance from any Federal department or agency.

9. Does the final rule apply to the Marketplaces?

Yes, both the Federally-facilitated Marketplaces and the State-based Marketplaces are covered by Section 1557.

10. How are covered entities supposed to let consumers know about their rights?

The final rule requires all covered entities to post a notice of consumer civil rights; covered entities with 15 or more employees are also required to have a civil rights grievance procedure and an employee designated to coordinate compliance. Under a new requirement, covered entities are required to post information telling consumers about their rights and telling consumers with disabilities and consumers with limited English proficiency (LEP) about the right to receive communication assistance. They are also required to post taglines in the top 15 languages spoken by individuals with LEP in the states in which the covered entity operates, advising consumers of the availability of free language assistance services.

To minimize burden on covered entities, OCR has prepared a model notice and model nondiscrimination statement that covered entities can use if they choose to do so; covered entities are free to create their own notices or statements if they wish. For more information

about translated notices and taglines, visit www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html.

11. What does the final rule require for individuals with limited English proficiency (LEP)?

The final rule adopts the longstanding civil rights principle that covered entities must take reasonable steps to provide meaningful access to each individual with LEP. The standards incorporated into the final rule are flexible and context-specific, taking into account factors such as the nature and importance of the health program and the communication at issue and other relevant considerations, such as whether an entity has developed and implemented an effective language access plan appropriate to its circumstances.

12. What does the final rule require concerning individuals with disabilities?

The final rule is consistent with existing directives implementing the requirements under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973. It requires effective communication, including through the provision of auxiliary aids and services; establishes standards for accessibility of buildings and facilities; requires that health programs provided through electronic and information technology be accessible; and requires covered entities to make reasonable modifications to their policies, procedures, and practices to provide individuals with disabilities access to a covered entity's health programs and activities.

13. What types of discrimination constitute discrimination on the basis of sex?

Under the final rule, sex discrimination includes, but is not limited to, discrimination on the basis of pregnancy.

Pursuant to court order, OCR is enjoined from enforcing the Section 1557 regulation's prohibitions against discrimination on the basis of gender identity and termination of pregnancy on a nationwide basis. For information about the court order, please see above.

14. Why did OCR choose to include provisions that specifically address equal program access on the basis of sex in health programs and activities?

Many of the provisions of the final rule incorporate long-standing principles and protections of civil rights law and thus will be familiar to entities governed by the final rule. The final rule provides additional guidance in areas for which application of these principles may not be as familiar. Because Section 1557 is the first Federal civil rights law that broadly prohibits sex discrimination in all federally funded health care programs and activities, the final rule contains provisions designed to educate consumers and covered entities specifically about sex discrimination in the health care context. OCR is also providing additional information about the application of nondiscrimination principles to health insurance and other health coverage.

15. What does the provision that specifically addresses equal program access on the basis of sex in health programs and activities require?

The final rule requires covered entities to provide individuals equal access to health programs and activities without discrimination on the basis of sex. This provision applies to all health programs and activities, including with regard to access to facilities, administered by the covered entity.

16. What does the provision regarding nondiscrimination in health insurance and other health coverage prohibit?

The final rule prohibits covered entities from discriminating on the basis of race, color, national origin, sex, age or disability when providing or administering health-related insurance or other health-related coverage. This prohibition applies to all health insurance issuers that are recipients of Federal financial assistance, which includes premium tax credits and cost sharing reductions associated with coverage offered through the Health Insurance Marketplaces or Medicare Parts A, C and D payments.

Under the final rule, a covered entity cannot: deny, cancel, limit, or refuse to issue or renew a health related insurance policy or other health-related coverage; deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions; or employ marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, age, or disability. The final rule does not require plans to cover any particular benefit or service or prohibit issuers from determining whether a particular health service is medically necessary, but a covered entity cannot have a coverage policy that operates in a discriminatory manner.

Pursuant to court order, OCR is enjoined from enforcing the Section 1557 regulation's prohibitions against discrimination on the basis of gender identity and termination of pregnancy on a nationwide basis. For information about the court order, please see above.

17. Does the final rule cover employment discrimination?

The final rule provides limited coverage of employment discrimination. The final rule prohibits an employer that receives Federal financial assistance that is principally engaged in providing health care or health coverage, such as a hospital or nursing home, from discriminating in employee health benefits. The final rule also applies to employee health benefits offered by an entity that is not principally engaged in providing health care or health coverage if the entity receives Federal funding that is specifically for the employee health benefit program itself or for a particular health program. In the latter situation, however, only the employees who work for the health program would be covered by the rule. The final rule's treatment of employment discrimination under Section 1557 does not change the protections under Title VII of the Civil Rights Act, the Americans with Disabilities Act, the Age Discrimination in Employment Act, or the other civil rights statutes referenced in Section 1557.

18. Does the final rule include a religious exemption?

The final rule on Section 1557 does not include a religious exemption; however, the final rule does not displace existing protections for religious freedom and conscience.

19. Can I review the final regulation?

Yes. You can review a copy of the final regulation at www.federalregister.gov.

20. Can I get a copy of the regulation in large print, Braille, or some other alternative format?

Yes. To get a copy in an alternative format, please contact the Office for Civil Rights and provide the specifications for the format. To contact us, call our toll-free number at (800) 368-1019 or (800) 537-7697 (TDD) for assistance.

Section 1557: Ensuring Meaningful Access for Individuals with Limited English Proficiency

Section 1557 is the civil rights provision of the Affordable Care Act of 2010. Section 1557 prohibits discrimination on the grounds of race, color, national origin, sex, age, or disability in certain health programs and activities. The Section 1557 final rule applies to any health program or activity, any part of which receives funding from the Department of Health and Human Services (HHS), such as hospitals that accept Medicare or doctors who receive Medicaid payments; the Health Insurance Marketplaces and issuers that participate in those Marketplaces; and any health program that HHS itself administers.

Protections for Individuals with Limited English Proficiency

- Consistent with longstanding principles under civil rights laws, the final rule makes clear that the prohibition on national origin discrimination requires covered entities to take reasonable steps to provide meaningful access to each individual with limited English proficiency who is eligible to be served or likely to be encountered within the entities' health programs and activities.
    - An individual with limited English proficiency is a person whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.
    - Reasonable steps may include the provision of language assistance services, such as oral language assistance or written translation.
    - The standards in the final rule are flexible and context-specific, taking into account factors such as the nature and importance of the health program and the communication at issue, as well as other considerations, including whether an entity has developed and implemented an effective language access plan.

- Covered entities are required to post a notice of individuals' rights providing information about communication assistance for individuals with limited English proficiency, among other information.

- In each state, covered entities are required to post taglines in the top 15 languages spoken by individuals with limited English proficiency in that state that indicate the availability of language assistance.

- Covered entities are prohibited from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services.

- Covered entities are encouraged to develop and implement a language access plan to ensure they are prepared to take reasonable steps to provide meaningful access to each individual that may require assistance.

OCR has translated a sample notice of nondiscrimination and the taglines for use by covered entities into 64 languages. For translated materials, visit www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html.

For more information about Section 1557, visit www.hhs.gov/civil-rights/for-individuals/section-1557.

Section 1557: Ensuring Effective Communication with and Accessibility for Individuals with Disabilities

Section 1557 is the civil rights provision of the Affordable Care Act of 2010. Section 1557 prohibits discrimination on the ground of race, color, national origin, sex, age, or disability in certain health programs and activities. The Section 1557 final rule applies to any health program or activity, any part of which receives funding from the Department of Health and Human Services (HHS), such as hospitals that accept Medicare or doctors who receive Medicaid payments; the Health Insurance Marketplaces and issuers that participate in those Marketplaces; and any health program that HHS itself administers.

Protections for Individuals with Disabilities

- Consistent with existing requirements, Section 1557 requires covered entities to take appropriate steps to ensure that communications with individuals with disabilities are as effective as communication with others. Section 1557 also requires covered entities to provide appropriate auxiliary aids and services, such as alternative formats and sign language interpreters, where necessary for effective communication.

- Covered entities must post a notice of individuals' rights, providing information about communication assistance among other information.

- Covered entities are required to make all programs and activities provided through electronic and information technology accessible to individuals with disabilities, unless doing so would impose undue financial or administrative burdens or would result in a fundamental alteration in the nature of the covered entity's health program or activity.

- Section 1557 incorporates the 2010 Americans with Disabilities Act Standards for Accessible Design as the standards for physical accessibility of new construction or alteration of buildings and facilities. Almost all covered entities are already required to comply with these standards.

- Covered entities cannot use marketing practices or benefits designs that discriminate on the basis of disability.

- Covered entities must make reasonable changes to policies, practices and procedures where necessary to provide equal access for individuals with disabilities unless the covered entity can demonstrate that making the changes would fundamentally alter the nature of the health program or activity.

For more information about Section 1557, visit http://www.hhs.gov/civil-rights/for-individuals/section-1557.

Section 1557: Protecting Individuals Against Sex Discrimination

Section 1557 is the civil rights provision of the Affordable Care Act of 2010. Section 1557 prohibits discrimination on the grounds of race, color, national origin, sex, age, or disability in certain health programs and activities. The Section 1557 final rule applies to any health program or activity, any part of which receives funding from the Department of Health and Human Services (HHS), such as hospitals that accept Medicare or doctors who receive Medicaid payments; the Health Insurance Marketplaces and issuers that participate in those Marketplaces; and any health program that HHS itself administers.

The rule makes clear that sex discrimination prohibited under Section 1557 includes discrimination based on:

- An individual's sex
- Pregnancy, childbirth and related medical conditions

Protections against Sex Discrimination

- Individuals cannot be denied health care or health coverage based on their sex.
- Women must be treated equally with men in the health care they receive and the insurance they obtain.
- Sex-specific health programs or activities are permissible only if the entity can demonstrate an exceedingly persuasive justification. For example, that the sex-specific health program or activity is substantially related to the achievement of an important health-related or scientific objective.

For more information about Section 1557, visit www.hhs.gov/civil-rights/for-individuals/section-1557.