



A member of the ADA National Network

Access to Healthcare and the ADA¹

A. Introduction

While healthcare is important to everyone, it is well documented that access to healthcare is especially critical for people with disabilities, who frequently face barriers when seeking healthcare.² The Americans with Disabilities Act (“ADA”) is an important legal tool to remove barriers people with disabilities face, including barriers to healthcare. It is a violation of Titles II and III of the ADA for state and local government entities and places of public accommodation (private businesses open to the public) to discriminate on the basis of disability.³ Depending on whether they are public or private, hospitals, doctor’s offices, and other healthcare facilities are either entities of state or local government (and thereby covered by Title II), or places of public accommodations under the ADA (and thereby covered by Title III).⁴

This legal brief will review how the courts are interpreting critical issues for people with disabilities under the ADA. Before focusing on the substantive issues, the brief will examine the legal challenges of ADA coverage, including whether a particular healthcare provider is a place of public accommodation and how courts have interpreted whether people have legal standing when they have brought litigation against healthcare providers under the ADA. Then, the legal brief will discuss how the ADA’s requirement of effective communication has been interpreted in the healthcare context. The brief will then focus on ADA healthcare cases involving two common plaintiffs, people living with HIV/AIDS and people who use service animals. The brief will next examine ADA litigation brought against healthcare providers in which there are physical barriers to their facilities and medical equipment. The brief will then review how the courts have handled ADA challenges to disability differences in insurance coverage. Finally, the brief will focus on recent ADA cases involving medication management of children.

B. Are Healthcare Facilities Considered Places of Public Accommodation?

With respect to Title III of the ADA, disputes sometimes arise as to which services and facilities actually qualify as places of public accommodation for purposes of Title III coverage. While most private healthcare providers do not contest they are covered by the ADA, there have been a few health-related entities that have challenged ADA coverage. For example, the Tenth Circuit analyzed this question in the case of *Levorsen v. Octapharma Plasma*, involving a Title III discrimination claim brought by an individual with borderline schizophrenia against a plasma donation center.⁵ Defendant’s business involved drawing and processing blood from donors, then separating and reserving the plasma, and returning the blood to the respective donors. Defendant paid donors for their blood, and sold the plasma to pharmaceutical companies.⁶ Though plaintiff had donated his blood at defendant’s facility many times previously, on one occasion, an employee who learned of plaintiff’s psychiatric disability refused him the opportunity to donate on that basis alone, which in turn prompted plaintiff to file a discrimination claim under Title III of the ADA.⁷ The Tenth Circuit found for the plaintiff, reversing the district court’s ruling that defendant did not qualify as a place of public

accommodation.⁸ Reviewing the relevant ADA language, the court found defendant to be a place of public accommodation insofar as it was a “service establishment” in the ordinary meaning of the word. Specifically, the court noted that defendant was a place of business whose work benefited or assisted others, even though it produced no tangible goods in the course of its operations.⁹ The court expressly rejected defendant’s argument that it was not a service establishment because it received no direct payment from its donor customers, finding nothing in the ADA language to support such an interpretation.¹⁰

C. What’s Required to Bring Suit Against a Healthcare Facility?

Another issue specific to Title III coverage is that of legal standing. Article III of the U.S. Constitution limits federal court jurisdiction to actual cases or controversies.¹¹ Courts have fleshed out this constitutional phrase and interpreted it as requiring that every plaintiff have legal standing to bring a claim before federal court. Standing is a doctrine requiring that the plaintiff have a personalized stake in the outcome.¹² It requires the plaintiff to demonstrate three components.¹³ First, the plaintiff must suffer a personalized and concrete injury-in-fact of a legally cognizable interest.¹⁴ Second, the injury must be fairly traceable to the defendant’s conduct. Finally, it must be likely, as opposed to speculative, that the injury is able to be addressed through a favorable court decision.¹⁵

Applying these legal standing concepts to ADA cases brought under Title III, courts typically require plaintiffs to Plaintiff must show: 1) harm from lack of ADA compliance, 2) accessibility issues must relate to the plaintiff’s disability, and 3) must show a likelihood of future harm. It is this third factor, likelihood of future harm, that is at issue in Title III litigation. Courts have adopted a four factor test when determining whether there is a likelihood of future harm:

- Proximity of the business to the plaintiff’s home;
- Plaintiff’s past patronage of the defendant’s business;
- Definiteness of the plaintiff’s plans to return; and
- Frequency of travel near the business.¹⁶

Establishing legal standing has frequently been an insurmountable barrier for people with disabilities seeking relief under Title III of the ADA.¹⁷ In the healthcare context, courts have applied this analysis in assessing whether a given plaintiff has standing to seek injunctive (non-monetary) relief under Title III, especially in consideration of whether a plaintiff is likely to incur specific harm in the future due to barriers in accessing a given healthcare provider.

In *Hollinger v. Reading Health Sys.*, a man had been admitted to the hospital for alcohol-related seizures.¹⁸ Due to alcohol withdrawals, he “began screaming obscenities at hospital staff and refusing to answer their questions.”¹⁹ Ten days into his stay, he slapped a nurse and was charged with aggravated assault. He subsequently brought a claim under Title III of the ADA, asserting that he had suffered discrimination because of his alcoholism. His case was dismissed for lack of standing. The court outlined two theories by which a plaintiff can prove standing under Title III: (1) the intent to return method, and (2) the deterrent effect doctrine. Under the intent to return method, the plaintiff must prove that (a) defendant engaged in past discriminatory conduct in violation of the ADA; (b) it is reasonable to infer that the discrimination will continue; and (c) it is reasonable to infer that the plaintiff will return to the place in the future.²⁰ According to

evidence, the plaintiff had a fifty percent chance of returning to the hospital, he had never been to the hospital before, and there was a different emergency room closer to his home.²¹ Plaintiff failed under the first test. Under the deterrent effect test, the plaintiff must show that he is “deterred from patronizing a public accommodation because of accessibility barriers.”²² To do so, he must (1) have actual knowledge of the barriers; and (2) show a reasonable likelihood that he would use the facility in the future if not for its inaccessibility. According to evidence, the first element was not met because the hospital has a policy of discharging violent patients into police custody, regardless of their disability. The second element also failed because the plaintiff was unlikely to return to the hospital.²³

However, in *Perez v. Doctors Hosp. at Renaissance, Ltd.*, the Fifth Circuit considered whether the deaf parents of an infant who had received treatment for a brain tumor had standing to request injunctive relief under Title III.²⁴ Plaintiffs had made numerous hospital visits with their child over several years. During their initial visits, the hospital repeatedly failed to provide an American Sign Language (“ASL”) interpreter for plaintiffs. Eventually in later visits, the hospital began providing video remote interpreting (“VRI”) services, but the VRI equipment sometimes malfunctioned and hospital nurses sometime did not know how to operate it. The pivotal issue was whether plaintiffs faced a “real and immediate threat” of future harm, and it was upon this question that plaintiffs’ standing to seek injunctive relief depended.²⁵ The hospital argued that because the family experienced no problems with communication during several of their many visits over the years, there was no threat of future harm. The Fifth Circuit disagreed, finding that the hospital’s failure to train its staff and revise its ADA compliance policy demonstrated a clear possibility that plaintiffs would incur harm during future visits.²⁶

In *Alexander v. Kujok*, deaf plaintiffs in search of a new primary care physician sought care from six different offices within one healthcare network, and were denied ASL interpreters by each office.²⁷ All six offices were named as defendants. Because they were unable to find a healthcare provider within the network, plaintiffs found an out-of-network provider willing to provide adequate accommodations. Based on this fact, all defendants moved to dismiss for lack of standing, arguing that the plaintiffs would not return to their offices in the future since they had secured a provider. Plaintiffs argued that although they had temporarily found an out-of-network provider, the higher costs would eventually compel them to once again seek care from an in-network provider.²⁸ The court found that this was sufficient evidence to prove that plaintiffs were likely to seek services in the future. The court also noted that although plaintiffs must prove future harm, they “need not engage in the futile gesture of attempting to return to the physician if the plaintiff already knows that reasonable accommodations will not be provided.”²⁹

D. Effective Communication in the Healthcare Setting

A public accommodation must provide auxiliary aids and services when necessary to ensure effective communication.³⁰ Auxiliary aids and services include equipment or services a person needs to access and understand aural information and to engage in effective communication. This can include qualified sign language interpreters, where the interpreter enables a person who is deaf or hard of hearing to communicate and thus access the services offered by a public accommodation.³¹

The United States Department of Justice (“DOJ”) has settled numerous complaints in which it has affirmed the need for places of public accommodation, and of healthcare providers in particular, to provide reasonable accommodations in order to ensure effective communication. Many of these settlement agreements have included “primary consideration” language, lending particular deference to the preference expressed by the affected individual for a particular auxiliary aid or service.³² DOJ has reiterated the obligation of doctor’s offices in particular to provide sign language interpreters or other auxiliary aides and services that maybe appropriate to facilitate communication for individuals who are deaf or hard of hearing.³³

In addition to actions by the DOJ, private parties have been successful in reaching agreements with healthcare providers to undertake efforts to identify and provide preferred communication accommodations.³⁴

1. Sign Language Interpreters

When a person who is deaf or hard of hearing seeks medical services from a healthcare provider, there may be different means available by which the provider can effectively communicate with that individual. When the individual in question communicates using sign language, there are some circumstances in which live sign language interpretation is the only appropriate communication method. However, alternative methods of communication may suffice in other situations. In some cases, it may be sufficient for a provider to communicate with the individual simply by means of typed or handwritten notes. For example, written notes may suffice in cases involving simple and routine procedures wherein conversation is minimal, such as with routine lab tests or regular allergy shots. However, sign language interpreters should be used for communications that are more complex, such as discussions of medical history, diagnoses, procedures, treatment decisions, or communications regarding in-home care.³⁵

In assessing the question of when sign language interpreters are required in the healthcare setting, federal courts have reached different conclusions. Indeed, in some rare cases, courts have found healthcare providers to be under no obligation to provide sign language interpreters at all. For example, in *Martin v. Halifax Healthcare Systems*, the Eleventh Circuit reviewed the claims of several plaintiffs who were deaf and who had at various times been treated at defendant hospital.³⁶ Defendant had afforded plaintiffs a range of accommodations for their various visits, including at different times live sign language interpreters, VRI, and even written notes. On one occasion, one of the plaintiffs visited defendant’s emergency room with what was described as simply a “bump on the head.” On this occasion, he was not provided with sign language interpreting, but rather received all communications from hospital staff by way of written notes. In response to plaintiff’s Title III discrimination claim based on defendant’s alleged failure to facilitate effective communication, the court affirmed summary judgment in favor of defendant. In its ruling, the court noted that an interpreter had not been necessary in these circumstances, because plaintiff had received typed instructions, which he clearly indicated he was able to understand, and thus, the ADA’s requirement for effective communication had been achieved.³⁷

However, the Eleventh Circuit has separately ruled that when an individual who is deaf and typically uses ASL and is communicating with a healthcare professional about a complicated medical procedure, especially a surgery, the exchange of written notes is inadequate to achieve effective communication. In *Liese v. Indian River County Hospital District*, the court

considered a discrimination claim brought by two plaintiffs, a husband and wife, who were both deaf, after one of them was undergoing an emergency procedure to remove her gallbladder through laparoscopic surgery.³⁸ Despite plaintiffs' requests for a live sign language interpreter, hospital personnel had communicated with plaintiffs only by mouthing words, writing notes, and pantomiming.³⁹ In this case, finding sufficient evidence that the limited auxiliary aids that defendant had provided were ineffective, the court ruled in favor of plaintiffs, reversing the district court's decision to grant summary judgment. The appellate court noted that "under circumstances in which a patient must decide whether to undergo immediate surgery involving the removal of an organ under a general anesthetic, an understanding of the necessity, risks, and procedures surrounding the surgery is paramount."⁴⁰ The court determined that the aforementioned communication methods utilized by defendant were neither appropriate nor adequate for the circumstances, and may have deprived plaintiffs of the full benefits of the services provided.⁴¹

Additionally, in some cases, the use of written notes by healthcare providers to communicate with individuals who are deaf may not only be ineffective, but may simply be insensitive and socially inappropriate. In *Shaika v. Gnaden Huetten Memorial Hosp.*, a Pennsylvania federal district court reviewed a claim brought for negligent infliction of emotional distress against a hospital by a woman who was deaf, and whose daughter had died at the hospital after being rushed there for emergency treatment as a result of a heroin overdose.⁴² When plaintiff arrived at the hospital, she requested a sign language interpreter, which the hospital did not provide her. As the hospital's video remote interpreting system was out of order, hospital staff resorted to communicating with plaintiff through written notes, which was how plaintiff learned that her daughter had died.⁴³ Beyond that, it was very difficult for plaintiff to receive any further information from the hospital regarding the circumstances or cause of her daughter's passing. The court denied defendant's motion to dismiss plaintiff's claim that defendant had acted with deliberate indifference to plaintiff's right to effective communication.⁴⁴

Both the DOJ and private parties negotiating settlements for claims arising under the Titles II and III have included terms outlining specific circumstances in which in-person sign language interpreters must be provided, as well as ensuring an ongoing assessment of the efficacy of alternatives provided.⁴⁵ For example, an in-person sign language interpreter will generally be required where the patient has limited movement in their head, arms, or hands; where a patient has vision issues; where a patient has cognitive issues or is under the influence of drugs or alcohol; where a patient is in significant pain, including labor; where the medical issue is complex; if there are space limitations in the treatment facility; or at any time it is clear that the alternative method of communication is no longer effective.⁴⁶

2. Video Remote Interpreting ("VRI") v. In-Person Sign Language Interpreting

VRI connects the user with an off-site interpreter through the use of a video conferencing system in order to facilitate communication. For VRI to function effectively, there must be a high-speed, wide-bandwidth video connection available in order to prevent low-quality video images, and staff must be properly trained in order to set up and operate the VRI system efficiently.⁴⁷ VRI offers some potential advantages, including cost savings for short appointments and the fact that it may be used for patients in rural areas where sign language interpreters may not be readily

available, or in emergency situations where interpreters are not available on site. However, VRI is not the most appropriate communication tool for all circumstances, and has certain inherent limitations.

For example, DOJ has expressed concerns regarding the use of VRI to communicate with individuals who may have difficulty accessing the screen because they have limited vision, or because of their positioning due to injury.⁴⁸ Likewise, the National Association of the Deaf (“NAD”) has voiced its own concerns that providers may rely too heavily on VRI at the exclusion of more appropriate methods of communications, and that VRI can be ineffective where systems experience technical issues or where provider staff are not properly trained in its use.⁴⁹

Turning again to case law from the Eleventh Circuit, that court acknowledged many of these concerns regarding VRI in its ruling in *Silva v. Baptist Health South Florida*.⁵⁰ In that case, plaintiffs were hard of hearing, and sued the defendant hospital system for its alleged failure to provide them with effective communication over the course of their many medical visits. Defendant had not accommodated their requests for live sign language interpreters, and had instead persistently relied upon VRI to communicate with plaintiffs during their visits.⁵¹ Plaintiffs alleged that defendant’s use of VRI violated their rights under both Title III and the Rehabilitation Act, due to chronic technical difficulties and practical limitations incurred during use of defendant’s VRI system. Specifically, plaintiffs asserted that the VRI machine was often inoperable or unusable, that the picture on the monitor was commonly blocked, frozen or degraded, and that hospital staff frequently did not know how to use the equipment or to resolve technical problems.⁵²

The district court ruled in favor of defendants, finding that it had provided plaintiffs with effective communication. In its ruling, the court noted that plaintiffs had presented no evidence that defendants had ever misdiagnosed them or given them improper medical treatment, and that plaintiffs had not identified any particular information that defendants had communicated, but that plaintiffs had not understood.⁵³ Accordingly, the court found that plaintiffs lacked standing to seek injunctive relief, and granted defendants’ motion for summary judgment.⁵⁴

On appeal,⁵⁵ the Eleventh Circuit reversed, and remanded the case for further proceedings. The court found that the lower court had applied the incorrect standard in its review, and that ADA and Rehabilitation Act claims are not to be evaluated by the same criteria as those applied to medical malpractice claims.⁵⁶ Specifically, the court noted that the proper focus should be upon the nature of the communication itself, not the consequences of the failed communication. The court considered the question of whether any of the plaintiffs had experienced a real hindrance due to their disability, affecting their ability to exchange material medical information with their health care professionals.⁵⁷ Here, Plaintiffs provided evidence that they were hindered due to the difficulties using VRI, and the absence of live interpreters. Furthermore, the court noted that plaintiffs had no duty to identify exactly what information they were unable to understand or convey.⁵⁸ As a point of reference, the court cited DOJ regulations regarding the appropriate use of and training for VRI.⁵⁹ Finally, the court found that plaintiffs did in fact have standing, as they regularly used the defendant hospital, lived nearby and were likely to return in the future.⁶⁰

Additionally, DOJ has entered into settlement agreements regarding the use of VRI by healthcare providers. In one indicative settlement, *Morales v. Saint Barnabas Medical Center*, a hospital that used VRI committed to satisfy DOJ regulatory requirements going forward, including an assurance that its VRI equipment would only be used so long as it projected a clear and high-quality image.⁶¹ Furthermore, the hospital promised never to use VRI in circumstances where it was not effective or appropriate, such as where a patient cannot readily see or understand it, where the information exchanged is highly complex, where hospital staff cannot activate or operate the equipment expeditiously, or where no designated high speed Internet line is available. The hospital further agreed to provide a live interpreter whenever VRI is not effective, or where a patient indicates that it is not meeting his or her needs.⁶² As a matter of course, DOJ and private settlements have included language regarding the use of VRI and the necessary conditions to be maintained by healthcare providers in cases regarding communication barriers to healthcare.⁶³

3. Companion Communication

It is well-settled that the ADA's effective communication obligations extend to companions with disabilities. For purposes of the ADA, a "companion" is defined as "a family member, friend, or associate of an individual" accessing either the public entity or place of public accommodation, "who, along with such individual, is an appropriate person with whom the [public entity or public accommodation] should communicate."⁶⁴ To date, there has not been significant litigation disputing whether an individual qualifies as a companion, perhaps because of the broad definition of the term "companion" provided in the regulations. Instead, most cases involving companions simply accept that the individual is a companion, and then determine whether the communication provided was effective.

DOJ addressed the issue of companion communication in a settlement that it reached with a nursing home facility, stemming from a complaint filed by the daughter and granddaughter of one of the facility's residents.⁶⁵ Complainants were both hard of hearing and had requested that the facility provide them with a sign language interpreter to aid in their communications with staff regarding the resident's status and care. When the facility denied this request, complainants asserted that this was a violation of their right to effective communication.

DOJ maintained that the nursing facility had an obligation to provide auxiliary aids and services to both Complainants as "legally cognizable companions." It noted that the daughter was listed as the patient's emergency contact and next of kin, thus should have had an interpreter for various communications, including communications with staff regarding care issues, treatment options, and discharge planning. Instead, the facility relied on an unqualified staff member who lacked the requisite skills to interpret for complainants. In the settlement, the facility agreed to amend its policies to provide appropriate auxiliary aids and services to both patients and their companions going forward.

Courts have also considered whether a non-disabled family member may bring a claim for discrimination under the ADA for association discrimination. For example, in *Loeffler v. Staten Island University Hosp.*, the Second Circuit reviewed a case involving a hospital patient and his wife, both of whom were deaf and required sign language interpreters for effective communication.⁶⁶ Because the hospital failed to provide either interpreters or any viable

alternative means of communication during the patient's stay, his adolescent children were forced to provide interpretation, at least to the best of their abilities.⁶⁷ The court found that the children had suffered an independent injury, causally related to the hospital's failure to provide auxiliary aids and services to their parents. As it was, the children had been required to fill the gap left by the hospital's indifference and ADA violations.⁶⁸ The court noted that the children were required to miss school because they had to be on-call to provide interpretation, and that they were "needlessly and involuntarily exposed to their father's condition," placing them at risk of emotional trauma due to their young age.⁶⁹

However, the Eleventh Circuit subsequently reached a different conclusion in a case involving facts that were in many ways similar to those in *Loeffler*. The case, *McCullum v. Orlando Regional Healthcare Systems*, referenced above regarding standing, involved a lawsuit brought on behalf of a fourteen year-old patient who was deaf, along with his sister, by the children's parents, alleging that defendant hospital had failed to facilitate effective communication because it had not provided sign language interpreters, instead relying on the sister and parents for that purpose.⁷⁰ In this case, the court affirmed the lower court's decision to dismiss the claims brought by the patient's sister and parents, finding that "[N]on-disabled persons are [not] denied benefits when a hospital relies on them to help interpret for a deaf patient," even though as a general matter patients with disabilities are entitled to appropriate accommodations.⁷¹ The court explicitly distinguished the facts of this case from those in *Loeffler*, noting that here, the family never requested an interpreter, nor was there evidence that any of the patient's family members had suffered independent injury, such as by having to miss work or school.⁷²

It may be reasonable to ask whether the *McCullum* decision would turn out differently if it were issued today, in light of updated federal regulations regarding companion and association communication. Under the existing regulations, a provider may not rely on an adult to interpret or facilitate communication, except in an "emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available," or where an individual specifically requests that an accompanying adult provide the interpretation, the adult agrees, and the reliance is appropriate.⁷³ Additionally, a provider may not use a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public, where there is no interpreter available.⁷⁴

However, the reliance on a deaf person's hearing companion to communicate certain information, outside of the above exceptions, may not require a finding that the healthcare provider acted with deliberate indifference to their need for accommodation.⁷⁵ For example, in *Viera v. City of New York*, a plaintiff, who was deaf, claimed that a hospital acted with deliberate indifference to her rights by failing to provide an ASL interpreter when she was seeking medical treatment for her injured infant.⁷⁶ However, the court found that the hospital and its staff, despite being made aware plaintiff's need for accommodation, did not act with deliberate indifference because plaintiff did not specifically request an interpreter and she was seen communicating via text message and limited ASL with her companion, the child's father, who was not fluent in ASL.⁷⁷

4. “Talking” Prescription Containers

For many people, prescription medications are an important component of managing their medical condition and of maintaining good health. But for people with disabilities, and those with visual disabilities especially, it can be difficult to access the information printed on prescription medication containers, which in turn can make it difficult to follow prescription instructions. This can be another challenge particular to people with disabilities in managing their own health, and can put people at risk of taking their medications improperly. Fortunately, “talking” prescription containers are a recent and welcome innovation that can accommodate the needs of many prescription-holders with disabilities. This typically involves a device that attaches to the label on a prescription container and can read its printed information aloud, as well as emitting an audible alarm to remind the prescription-holder that it is time to take the medication, all of which can be especially helpful for people who are blind or have low vision. This is an excellent example of the various types of auxiliary aids and services that can lead to effective communication, especially with the advance of new technologies.

Attorney Lainey Feingold has had great success over many years in utilizing structured negotiation to improve accessibility for people with disabilities. Structured negotiation is a collaborative and solution-driven advocacy and dispute resolution method conducted without litigation. Many of the aforementioned successes have come through negotiations with medical facilities and providers of healthcare services, including with leading pharmacy corporations in order to make talking prescription containers widely available.⁷⁸

5. Website Accessibility

The accessibility and effective communication requirements of the ADA are applicable not only to the physical facilities of healthcare providers and direct personal interactions with their representatives, but to all their digital properties as well. Among the many barriers encountered by people with disabilities seeking quality and timely healthcare services, issues of digital accessibility can be among the thorniest. These barriers often arise from the individual’s initial interaction with the provider’s website. When a person with a disability cannot readily access a provider’s digital resources in order to retrieve basic information, book an appointment, or take advantage of any of the electronic conveniences enjoyed by nondisabled members of the public, this can substantially inhibit the individual’s ability to access the provider’s services, and more generally can make it more difficult for the individual to manage his or her own healthcare.

Different types of disabilities present different challenges with regard to accessing digital material, and in many cases people with disabilities may utilize adaptive technologies in order to do so. For example, people who are blind may use screen-reading technology in order to access the content of websites or of electronic documents. Thus, it is essential that digital resources be developed to include alternative text for images, as otherwise those users will be excluded from information that is available to everyone else. Additionally, some people have disabilities that impact manual dexterity and thus can make it difficult to control a mouse. Those people may find it exceptionally difficult to navigate a website featuring links and buttons that are not spaced and ordered thoughtfully on the page. Healthcare providers that utilize videos on their websites must ensure that these videos are captioned so that people who are deaf and hard of hearing have meaningful access to that content.

Though the ADA does not specify website accessibility per se, this does not relieve healthcare providers of the legal duty to make their digital resources accessible to people with disabilities. Should providers fail to make their digital resources comply with the technical requirements of the Web Content Accessibility Guidelines (“WCAG”) 2.0, those resources may very well be inaccessible to at least some individuals with disabilities. As such, providers may in fact be in violation of the ADA requirements for accessibility, and may thus be exposed to liability.

As with talking prescription containers, structured negotiation has provided an effective medium for obtaining website modification, and ensuring ongoing accessibility of healthcare providers’ online materials.⁷⁹ Additionally, while not specifically within the context of healthcare providers, the DOJ has required public accommodations to implement website accessibility measures as a part of settlement agreements, and presumably will do so in the healthcare setting.⁸⁰

E. Access to Healthcare for People Living with HIV/AIDS

Historically, people living with HIV/AIDS have faced significant stigma and discrimination, including in the healthcare context.⁸¹ When people living with HIV bring claims for discrimination under the ADA against healthcare providers, providers have typically asserted the defense of direct threat to justify denying services to patients or prospective patients with HIV.

By way of background, the U.S. Supreme Court explored the question of direct threat in the first ADA case that it ever heard, one which coincidentally involved a plaintiff with HIV. *Bragdon v. Abbott*, involved a dentist who had denied treatment to an HIV-positive patient, citing the direct threat to his own safety that he alleged treating this patient would pose.⁸² In its ruling for the plaintiff, the Court reiterated the duty of a defendant provider to make an individualized inquiry as to the circumstances of the particular plaintiff, and noted “that courts should assess the objective reasonableness of the views of health care professionals without deferring to their individual judgments.”⁸³

More recently, in *United States v. Asare*, a New York federal district court reviewed a Title III claim brought by three plaintiffs who had HIV, all of whom had sought male breast reduction surgery from defendant doctor.⁸⁴ Defendant refused to perform the procedure on any of the plaintiffs, citing his blanket policy against operating upon HIV-positive patients who were also taking antiretroviral medications, as plaintiffs all were. The court granted summary judgment in favor of plaintiffs, finding that defendant had failed to meet his duty, established by the U.S. Supreme Court in *Arline*, to conduct an individualized inquiry with regard to each plaintiff, instead relying on a blanket policy to deny service to a defined class of patients.⁸⁵ As defendant had produced no evidence that this blanket policy was necessary for his safety or his business, the policy did not withstand Title III scrutiny.⁸⁶ Furthermore, the court noted that, even if defendant had established that plaintiffs did pose safety risks, he had still failed to offer any reasonable accommodations, or to consider any of those which plaintiffs had themselves proposed.⁸⁷ Nor could defendant claim that such accommodations would constitute a fundamental alteration to his workplace, as he had failed to even investigate any such accommodations by way of the interactive process.⁸⁸

While many assume that HIV discrimination is less common today, DOJ has recently entered into settlement agreements with a number of healthcare providers and facilities after pursuing

claims against them for discriminating against individuals with HIV. Typical of such an agreement is a pledge by the provider to adopt and implement a non-discrimination policy, to submit to ongoing monitoring by DOJ, and to provide Title III training for staff and administrators. Many agreements also include financial settlements for the aggrieved parties involved.⁸⁹

F. Access to Healthcare for People with Disabilities Using Service Animals

Many people with disabilities rely upon service animals, including when seeking access to healthcare. While many healthcare providers are welcoming of service animals, there have been numerous situations in which people with disabilities have been denied access to healthcare with their service animals.

DOJ's ADA regulations define a service animal under Titles II and III as "[A]ny dog that is *individually trained to do work or perform tasks* for the benefit of an individual with a disability."⁹⁰ Service animals may be trained to perform any of a wide assortment of tasks, including, but not limited to, guiding an individual who is blind, retrieving or carrying items, pulling a wheelchair, assisting an individual with balance and stability, alerting an individual to certain sounds or allergens, and reminding an individual to take medication.⁹¹ The regulations further specify that all places of public accommodation are required to "modify policies, practices, or procedures to permit the use of a service animal by an individual with a disability."⁹²

DOJ has specifically referenced the unique issues arising in the healthcare environment when providing guidance about providing access to people with disabilities using service animals. Specifically, DOJ has said that "under the ADA, State and local governments, businesses, and nonprofit organizations that serve the public generally must allow service animals to accompany people with disabilities in all areas of the facility where the public is normally allowed to go. For example, in a hospital it would be inappropriate to exclude a service animal from areas such as patient rooms, clinics, cafeterias, or examination rooms. However, it may be appropriate to exclude a service animal from operating rooms or burn units where the animal's presence may compromise a sterile environment."⁹³ Furthermore, providers may not impose blanket bans against service animals, even if justifying those bans with arguments regarding safety and/or fundamental alteration, without engaging in the interactive process in an earnest effort to identify potential reasonable accommodations.⁹⁴

Enforcement of these requirements in the healthcare setting has also been undertaken by private litigants; generally, in order to require a healthcare provider to adopt an effective service animal policy and train staff on its implementation.⁹⁵ For example, in a recent settlement, based on a claim that the hospital system had unreasonably excluded a service animal, a California hospital system, Adventist Healthcare West, agreed to update and adopt a formal policy regarding the admission of service animals in all areas of their hospital open to patients.⁹⁶ However, the hospital system's policy included maintaining the right to exclude service animals where they posed a direct threat to the safety or welfare of the hospital's patients or staff.⁹⁷

In the context of service animals, the issue generally is whether the healthcare provider has sufficiently particularized reasoning for excluding a service animal; they must point to risks that

are not merely speculative. For example, in *Tamara v. El Camino Hospital* a hospital argued that allowing a service animal to accompany the plaintiff in a psychiatric unit would pose a direct threat because the harness could be used as a weapon and the presence of the animal might upset some of the other patients.⁹⁸ There, the district court ruled that these potential risks were merely speculative, and there was no evidence provided that the hospital had engaged in an individualized analysis of whether the particular patient and her accompanying service animal actually posed these threats.⁹⁹ Furthermore, the court noted that even if these risks were genuine, the hospital had failed to assess whether any accommodations could be made that would ameliorate the threats, as they were required to do.¹⁰⁰

However, where a healthcare facility, implementing its service animal policy, is able to show specific, individualized, and actual analysis that determines the presence of a threat to the safety or welfare of other patients and/or staff even with the use of accommodations it will not be liable under Title II or III of the ADA.¹⁰¹ In *Roe v. Providence Health System-Oregon*, a plaintiff was a patient on and off over a period of several years and she required the presence of a service animal.¹⁰² Despite several incidents, including one in which the animal growled at a nurse that was attempting to care for the patient, and a physician's concern regarding the animal's skin infection that might spread to the other patients, the hospital never sought to entirely exclude the animal.¹⁰³ The plaintiff nonetheless brought an action seeking injunctive relief based on the hospital's interactions with the animal and herself, and the defendant hospital counter moved to exclude the animal and plaintiff.¹⁰⁴ The court found that the dog posed a direct threat on the basis of its conduct, and the skin infection.¹⁰⁵ Furthermore, because plaintiff had failed to acquiesce to any of the hospital's proposed accommodations attempting to address these risks, the court found that the hospital had adequately engaged in a particularized analysis of the circumstances.¹⁰⁶

G. Accessible Medical Facilities and Equipment

In accordance with the accessibility requirements of Titles II and III, hospitals, doctor's offices and other healthcare providers have a general obligation to make their facilities accessible to people with disabilities wherever possible, including to remove physical access barriers and to purchase and maintain medical equipment that accommodates the needs of patients with disabilities. In July 2010, DOJ issued guidance in a fact sheet pertaining to these requirements with regard to people with mobility disabilities.¹⁰⁷

This document reiterates the duty of medical facilities to provide:

- full and equal access to their health care services and facilities; and
- reasonable modifications to policies, practices, and procedures when necessary to make health care services fully available to individuals with disabilities, unless such modifications would fundamentally alter the nature of the services.

In July 2010, DOJ also issued a Advanced Notice of Proposed Rulemaking (ANPRM) with respect to Nondiscrimination on the Basis of Disability by State and Local Governments and Places of Public Accommodation for Equipment and Furniture.¹⁰⁸ The ANPRM indicated that DOJ was considering possible changes to requirements under titles II and III of the Americans with Disabilities Act (ADA) to ensure that equipment and furniture used in programs and

services provided by public entities and public accommodations are accessible to individuals with disabilities. However, no changes were made under the Obama administration. A year after the Trump administration was in place, DOJ announced that it was withdrawing four ANPRMs, including the NPRM for equipment and furniture. In its withdrawal, DOJ stated that it was “reevaluating whether regulation of the accessibility of non-fixed equipment and furniture is necessary and appropriate.”¹⁰⁹

In January 2017, the U.S. Access Board issued Standards for Accessible Medical Equipment. Under these Standards, healthcare providers also have an obligation to purchase and maintain accessible medical equipment. Just a few examples of such equipment include wheelchair accessible scales, adjustable exam tables and accessible mammography equipment.¹¹⁰ It should be noted that Standards published by the Access Board do not have the force of law until a federal agency adopts its own regulations, but until that happens, the Standards can serve as important guidance for healthcare providers on how to make equipment and furniture accessible.

In recent years, DOJ has reached comprehensive agreements with healthcare facilities that are resulting in systemic change. These agreements typically require the facility to increase the accessibility of exam rooms and medical equipment, patient rooms, bathrooms, as well as to conduct staff training, revise accessibility policies and procedures and hire someone to oversee the remediation efforts set forth in the agreement.¹¹¹

In addition to DOJ’s efforts, there have been several systemic agreements to make healthcare facilities and equipment accessible through structured negotiations.¹¹² Also, numerous private suits have been brought against healthcare providers for failing to provide accessible facilities and medical equipment. In *Metzler v. Kaiser*,¹¹³ people with mobility impairments filed litigation alleging that Kaiser fails to full and equal access to its healthcare facilities across the state of California. Subsequently, the case settled and is one of the first comprehensive settlements with major healthcare provider. Settlement terms include: 1) hiring an Access Coordinator who has expertise in ensuring accessible healthcare for people with disabilities; 2) establishing an Access Plan to identify and remedy access barriers in Kaiser facilities statewide; and surveying medical equipment for accessibility and developing a procurement plan for acquisition of accessible equipment.¹¹⁴

In *Luna v. America’s Best Contacts and Eyeglasses, Inc.*,¹¹⁵ a class action was brought by three wheelchair users who were unable to receive an eye exam because inaccessible examination rooms and equipment at 337 stores. After the class was certified, the parties entered into a comprehensive settlement, which included the defendant agreeing to 1) retain an ADA Consultant to perform accessibility surveys and monitor remediation efforts; 2) secure ADA training for all personnel; 3) update policies and procedures for treating people with disabilities; and 4) each store must have: a chair glide, accessible eyeglass and contacts fitting locations, and accessible exam room.¹¹⁶

H. Insurance and the ADA

Insurance is a critical component for access to healthcare. However, many people with disabilities have encountered barriers when seeking insurance. One of the most common barriers people with disabilities have faced arises when insurance policies have limits or caps on

particular disabilities. The most commonly seen caps in insurance policies are for coverage of care for mental health and HIV/AIDS. More recently, insurance policies have begun to cap coverage of care for people on the autism spectrum.

Historically, most courts have rejected ADA challenges to discriminatory insurance policies. Typically, the difficulties facing people with disabilities in ADA-related challenges to insurance have focused on two issues – either the plaintiff loses because an insurance policy is deemed to not be a “place” of public accommodation as required by Title III of the ADA, or courts have held that the ADA does not cover the content of insurance policies, only discrimination in accessing the policy overall.

With respect to the first barrier, some courts have taken a very literal interpretation of Title III’s language “place” of public accommodation¹¹⁷ and required that there be an actual physical space involved for the ADA to apply. For instance, in *Parker v. Metro. Life Ins. Co.*,¹¹⁸ an employee’s long-term disability insurance policy provided for coverage for physical impairments until the employee turned sixty-five. However, coverage of mental health was limited to twenty-four months. She brought suit under the ADA under Title III against the employer alleging that treating one disability differently was discriminatory. The Sixth Circuit Court of Appeals upheld the lower court’s dismissal of the ADA claim against the insurance company on the basis that the insurance policy was not obtained through a physical space, such as an insurance office. Instead, it was secured through her employer. Without the physical space, the court found that Title III was not implicated and no challenge to the cap on mental health benefits could proceed. A number of other courts have agreed with the Sixth Circuit.¹¹⁹ However, a number of other courts have not required a physical space for Title III claims to proceed.¹²⁰ This split in the courts will likely continue until either the United States Department of Justice issues regulations clarifying whether nexus to a physical space is required for Title III, or the United States Supreme Court agrees to review an ADA case raising this issue.

The other legal argument that has been used successfully to limit ADA litigation against insurance companies is that the ADA does not regulate the content of the goods or services offered by the public accommodation. For example, in *Doe v. Mutual of Omaha Ins. Co.*,¹²¹ an insurance company capped HIV-related benefits at \$100,000, but all other disabilities had a cap of \$1 million. The plaintiff sued alleging this violated Title III of the ADA. The Seventh Circuit Court of Appeals found in favor of the defendant, despite the insurance company conceding that it had no actuarial basis for capping HIV-related benefits differently than all other impairments. The court ruled that while excluding a person from an insurance policy based on HIV alone could be an ADA violation. Here, the plaintiff had access to the policy so there was no ADA violation. Challenging the capping of benefits for one impairment was beyond the reach of the ADA.

While the vast majority of cases have held that the ADA does not cover the content of insurance policies, a small number of cases have concluded otherwise. For instance, in *Reid v. BCBSM, Inc.*,¹²² an insurance policy excluded coverage of behavioral therapy for people with Autism Spectrum Disorder (ASD). A mom filed suit on behalf of herself and her son to challenge this exclusion under Title III of the ADA. Blue Cross filed a motion to dismiss arguing that people with ASD weren’t excluded from the policy, and as long as people had access to the policy there was no ADA violation. The court denied the motion to dismiss. Because the exclusion of a

specific behavioral treatment only affected people with ASD, the court found it was discriminatory under the ADA. The court noted that plaintiff had sufficiently alleged that Blue Cross provided intensive behavioral therapy for other conditions, and that differential treatment and the singling out of ASD meant that plaintiff had stated a cause of action that Blue Cross was in violation of Title III of the ADA.

I. Inclusion of children with disabilities through administration of medication

In recent years, DOJ has undertaken numerous enforcement actions on behalf of children with insulin-dependent diabetes and other disabilities to help ensure that those children enjoy equal access to places of public accommodation. All too commonly, children with insulin-dependent diabetes have found themselves effectively excluded by institutions that were unwilling to modify their policies in order to provide basic diabetes management care. The needs of children with diabetes differ, but these children generally need assistance with blood glucose monitoring and with the administration of insulin and emergency medication.

For example, in 2018 DOJ announced a settlement with one of the nation's largest for-profit child care providers, whereby the corporation and its subsidiaries agreed to provide reasonable accommodations for attendee children with insulin-dependent diabetes, as well as financial settlements with the parties who initially alerted DOJ of the corporation's discriminatory practices.¹²³ Also, in 2015 DOJ settled with a day camp in New Jersey which had refused to provide the accommodations necessary for a prospective camper with diabetes to attend its program. In the settlement agreement, the camp pledged to develop an ADA/diabetes policy, to henceforth Individually assess the needs of each camper and prospective camper with diabetes, to assist all such campers and to make reasonable efforts to comply with their diabetes medical management plans ("DMMPs"), and to provide training for camp staff by a qualified professional, including instruction on the administration of insulin and emergency medication (glucagon).¹²⁴ DOJ reached a similar agreement in September 2018 with Kindercare, which operates approximately 1,800 facilities across the country.¹²⁵

Additionally, beginning in 2016, DOJ entered into settlement agreements with a number of local YMCAs, in order to ensure inclusion of children with diabetes at those facilities as well. Under these agreements the individual YMCAs have generally committed to modifying their existing policies, including by adopting DMMPs, to training staff regarding basic diabetes management, monitoring, and the administration of insulin and glucagon, to promoting general awareness of Title III nondiscrimination principles, and to ongoing oversight by DOJ.¹²⁶

In 2015, DOJ opened an investigation for a camp that refused to admit camper with epilepsy who required emergency medication (Diastat) for seizures. DOJ and the camp reached a settlement in which the camp agreed it would train staff to administer Diastat. The camp also agreed to adopt a Seizure Emergency Action Plan and Physician's Order for the administration of Diastat so that it has individual instructions. In the agreement, DOJ stated "it is the United States' position that it generally will be a reasonable modification by title III of the ADA for certain public accommodations, such as camps and child care service providers, to train laypersons to administer Diastat."¹²⁷ However, in a case with similar facts that went to trial, a judge found that

it was not a reasonable accommodation for a special education recreational program to administer Diastat to a child with epilepsy.¹²⁸ It is anticipated that this issue will continue to be one in which stakeholders disagree and more ADA litigation will be filed.

J. Conclusion

The ADA plays an indispensable role in ensuring the rights and opportunities of people with disabilities to access healthcare and medical services. In view of the many challenges with which this population still must contend, regular quality medical care remains especially critical for most people with disabilities in maintaining their health, and for many is the determining factor in the ability to live independently in the community. This brief outlines many of the ways in which the ADA helps to make reliable healthcare a reality for so many in the disability community, and the extent to which the DOJ and many courts have recognized this important connection. Many of the regulatory and litigation trends herein are still very much evolving, and interested parties will continue to monitor them for future developments. Those developments may carry ramifications with regard to healthcare that may resonate within the disability community long into the future

¹ This legal brief was written by Barry C. Taylor, Rachel Weisberg and Andrew Webb at Equip for Equality, the Illinois Protection and Advocacy Agency, with original funding provided by the Great Lakes ADA Center.

² See, *Disability Healthcare Access Brief*, Disability Rights Education and Defense Fund, April 2007, https://dredf.org/healthcare/Access_Brief.pdf

³ 42 U.S.C. § 12182 *et seq.* Note that, while this brief focuses largely upon the requirements of ADA Titles III, the requirements of Title II (which apply to state and local government entities) are very much similar to those of Title III. However, whereas Title III sets accessibility requirements that every place of public accommodation is expected to meet individually, Title II is intended more to ensure overall program access for programs and services provided by state and local governments. This brief does not focus on the ADA and healthcare workers with disabilities. For more information on that subject, go to: www.equipforequality.org/wp-content/uploads/2018/09/ADA-and-Healthcare-Workers-with-Disabilities.pdf

⁴ 42 U.S.C. 12181(F); 28 C.F.R. 36.104. In addition to the ADA, healthcare providers that receive federal financial assistance must comply with Section 504 of the Rehabilitation Act of 1973, which states that no individual with a disability shall “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(a).

⁵ *Levorsen v. Octapharma Plasma, Inc.*, 828 F.3d 1227 (10th Cir. 2016).

⁶ *Id.* at 1229.

⁷ *Id.* at 1229-30.

⁸ *Id.* at 1229.

⁹ *Id.* at 1234.

¹⁰ *Id.* at 1232-33.

¹¹ *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 559 (1992).

¹² *Id.*

¹³ *Id.* at 560.

¹⁴ *Id.*

¹⁵ *Id.* at 561.

¹⁶ See, e.g., *Vogel v. Rite Aid Corp.*, 992 F.Supp.2d 998, 1008 (C.D. Cal. 2014)

¹⁷ For a recent case demonstrating this challenge for people with disabilities, see *Longhini v. Infinite 9035, LLC*, 2018 WL 2857224 at 2-3 (M.D. Fla. June 11, 2018).

¹⁸ *Hollinger v. Reading Health Sys.*, 2017 WL 429804, at *1 (E.D. Pa. Jan. 31, 2017).

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.* at *5.

²² *Id.* at *4.

²³ See also, *McInnis-Misenor v. Me. Med. Ctr.*, 319 F.3d 63 (1st Cir. 2003)(woman seeking to get pregnant didn't have standing to contest the inaccessibility of a hospital's after birth recovery room.)

²⁴ *Perez v. Doctors Hosp. at Renaissance, Ltd.*, 624 Fed. Appx. 180, 182 (5th Cir. 2015).

²⁵ *Id.* at 183.

²⁶ *Id.* at 184.

²⁷ *Alexander v. Kujok*, 158 F.Supp.3d 1012 (E.D. Ca. 2016).

²⁸ *Id.* at 1019.

²⁹ *Id.*

³⁰ 42 U.S.C. §§ 12182(a), 12182(b)(1)(A)(ii), 12182(b)(2)(A)(iii); 28 C.F.R. §§ 36.201(a), 36.202, 36.303.

³¹ 28 C.F.R. 36.303(b)(1).

³² See, e.g., Settlement Agreement between the United States of America and Dekalb Regional Crisis Center, available online at www.ada.gov/dekalb_crisis_ctr_sa.html, whereby the provider revised its effective communication policy, henceforth conducting a communication assessment, which includes the relevant facts and circumstances, the individual's communication skills and knowledge, the nature and complexity of the communication at issue, and by an individual."

³³ See, e.g., Settlement Agreement between the United States of America and Baupinder S. Mangat, M.D. and Seminole Neurology Associates, P.A, December 1, 2017, www.ada.gov/mangat_sna_sa.html; Settlement Agreement between the United States of America and Grady Memorial Hospital, February 9, 2016, www.ada.gov/grady_sa.html; Settlement Agreement between the United States of America and Promedica Toledo Hospital, January 28, 2016, www.ada.gov/promedica_toledo_hospital_sa.html; Settlement Agreement between the United States of America and Srivinas Mukkamala, M.D., July 17, 2015, www.ada.gov/mukkamala_sa.html; Settlement Agreement Between the United States of America and Arshad Pervez, M.D., July 17, 2015, www.ada.gov/pervez_sa.html; Settlement Agreement between the United States of America and Fairfax Nursing Center, Inc., July 10, 2015, www.ada.gov/fairfax_nursing_ctr_sa.html; Resolution Agreement between the United States of America and St. Francis Hospital and Medical Center, March 23, 2015, www.ada.gov/fairfax_nursing_ctr_sa.html.

³⁴ See, e.g., Consent Order between Susanna and Thomas Paulay and WSNCHS North, Inc., St. Joseph Hospital, October 14, 2016.

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

³⁶ *Martin v. Halifax Healthcare Systems, Inc.*, 621 Fed. App'x 594, 2015 WL 4591796 (11th Cir. July 31, 2015)

³⁷ Separately, it should be noted that American Sign Language ("ASL") and English are not the same, thus some people who are deaf may be fluent in ASL, but unable to read English, making passing notes ineffective even for simple communications.

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

³⁹ *Id.* at 340-41.

⁴⁰ *Id.* at 343.

⁴¹ *Id.*

⁴² *Shaika v. Gnaden Huetten Memorial Hosp.*, 2015 WL 4092390 (M.D. Pa. July 7, 2015).

⁴³ *Id.*

⁴⁴ *Id.* at *10.

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

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

⁴⁷ For VRI performance standards applicable to Title III, see 28 C.F.R. § 36.303(f); for Title II standards, see 28 C.F.R. § 35.160(d).

⁴⁸ For further DOJ guidance and comments, see “ADA Requirements: Effective Communication,” available online at www.ada.gov/effective-comm.htm.

⁴⁹ *See*, “Minimum Standards for Video Remote Interpreting Services in Medical Settings,” available online at www.nad.org/issues/technology/vri/position-statement-hospitals.

⁵⁰ *Silva v. Baptist Health South Florida*, 856 F.3d 824 (11th Cir. 2017).

⁵¹ *Id.* at 830.

⁵² *Id.* at 837-38.

⁵³ *Id.* at 833-34.

⁵⁴ *Id.* at 829.

⁵⁵ *See*, DOJ amicus brief filed in support of this appeal, available online at www.justice.gov/crt/file/870846/download.

⁵⁶ *Silva*, 856 F.3d at 834.

⁵⁷ *Id.* at 835, 840.

⁵⁸ *Id.* at 835.

⁵⁹ *Id.* At 837; *see* footnote 8.

⁶⁰ *Id.* at 832-33.

⁶¹ *Morales v. Saint Barnabas Medical Center*, 13-cv-06363 (D.N.J. Consent Order, Feb. 14, 2017).

-
- ⁶² See also, *Moss v. Newark Beth Israel Med. Ctr.*, 13-cv-4360 (D.N.J. Consent Order, Feb. 16, 2017), available online at www.equipforequality.org/news-item/health-care-consent-orders
- ⁶³ See, e.g., Settlement Agreement between the United States of America and Highline Medical Center, August 22, 2017; see also Consent Order between Susanna and Thomas Paulay and WSNCHS North, Inc., St. Joseph Hospital, October 14, 2016.
- ⁶⁴ 28 C.F.R. § 35.160(a)(1) (Title II); 28 C.F.R. § 36.303(c)(1)(i)(Title III).
- ⁶⁵ Settlement Agreement between the United States of America and Fairfax Nursing Center, Inc., available online at www.ada.gov/fairfax_nursing_ctr_sa.html
- ⁶⁶ *Loeffler v. Staten Island University Hosp.*, 582 F.3d 268 (2nd Cir. 2009)
- ⁶⁷ *Id.* at 272-73.
- ⁶⁸ *Id.* at 280-81.
- ⁶⁹ *Id.*
- ⁷⁰ *McCullum v. Orlando Regional Healthcare Systems, Inc.*, 768 F.3d 1135 (11th Cir. 2014).
- ⁷¹ *Id.* at 1144.
- ⁷² *Id.* at 1145.
- ⁷³ 28 C.F.R. § 36.303(c)(3); see also Statement of Interest of the United States of America, U.S. Attorney's Office for the Southern District of New York, 15-civ-5430 (August 10, 2016), available at <https://www.ada.gov/usao-agreements.htm>
- ⁷⁴ 28 C.F.R. § 36.303(c)(4) (Title III); 28 C.F.R. § 35.160(c) (Title II). *But see, Durand v. Fairview Health Servs.*, 230 F.Supp.3d 959 (D. Minn 2017), appeal docketed, No. 17-1374 (8th Cir. Feb. 17, 2017). In *Durand*, an adult patient with an end-of-life directive was admitted to the ICU and died three days later. His deaf parents requested a sign language interpreter. An interpreter was made available for a few conversations between the parents and physicians. When the interpreter was not present, the patient's sister, who could not interpret in sign language fluently, facilitated communication between hospital staff and the parents. Due to some miscommunication, the father was not at the hospital when his son died, and the family filed suit. The court ruled that because the parents "played no role in their son's health care," the hospital had no duty to ensure that they "receive certain information." The court also ruled against the sister's claim of discrimination by association.
- ⁷⁵ *Viera v. City of New York*, 2017 WL 3130332 at 15-18 (S.D.N.Y. July 21, 2017).
- ⁷⁶ *Id.* at 1-13.
- ⁷⁷ *Id.* at 15-17.
- ⁷⁸ For example, see "Walgreens Now Offers Talking Prescription Labels," available online at www.lflegal.com/2014/06/walgreens-talking, as well as "CVS/Pharmacy Now Offers 'Talking' Prescription Labels for Individuals with Vision Impairments Through Online Pharmacy," available online at <http://acb.org/content/cvspharmacy-now-offers-talking-prescription-labels-individuals-vision-impairments-through>. See also information regarding the settlement with CVS MinuteClinic, which agreed to take additional steps to ensure that individuals with visual impairments receive treatment and other important information in accessible formats, and to arrange for sign language interpreters at the request of individuals who are deaf, available online at www.cvshhealth.com/content/minuteclinic-enhance-accessibility-patients-disabilities; Agreement Between American Council for the Blind and Rite Aid, February 18, 2016, available online at www.lflegal.com/2016/02/rite-aid-press/; Agreement Between American Council for the Blind and Humana Inc., September 30, 2015, available online at www.lflegal.com/2015/09/humana-press/
- ⁷⁹ See, e.g., Agreement between Mass. Eye and Ear and Bay State Council of the Blind, January 26, 2017, available online at <http://www.lflegal.com/2017/01/mceei-agt/>; WellPoint Accessible Information Agreement, February 12, 2014, available online at <http://www.lflegal.com/2014/02/wellpoint-agreement/>; American Cancer Society Accessible Website and Alternative Formats Agreement, February 23, 2011, available online at
-

www.lflegal.com/2011/02/acs-agreement/; Settlement Agreement with Rite-Aid.com, March 31, 2008, available online at www.lflegal.com/2008/04/rite-aid-web-agreement/

⁸⁰ See, e.g., Settlement Agreement between the United States of America and the City of Milwaukee, Wisconsin, June 9, 2016, available online at https://www.ada.gov/milwaukee_pca/milwaukee_sa.html

⁸¹ See for example, HIV Stigma and Discrimination, Avert - <https://www.avert.org/professionals/hiv-social-issues/stigma-discrimination>

⁸² *Bragdon v. Abbott*, 524 U.S. 624 (1998).

⁸³ *Id.* at 650.

⁸⁴ *United States v. Asare*, 2017 WL 6547900 (S.D.N.Y. Dec. 20, 2017).

⁸⁵ *Id.* at *5.

⁸⁶ *Id.*

⁸⁷ *Id.* at *6.

⁸⁸ *Id.*

⁸⁹ See Settlement Agreement between the United States of America and Advanced Plastic Surgery Solutions (December 11, 2017), available online at www.ada.gov/adv_plastic_surgery_sa.html, (involving a medical clinic that refused to accept a prospective patient because she had HIV); Settlement Agreement between the United States of America and Pain Management Care, P.C. (April 12, 2016), available online at https://www.ada.gov/pmc/pain_mgmt_care_cd.html, (regarding denial of medical treatment by a pain management doctor for a patient who had HIV); Settlement Agreement between the United States of America and North Florida OB-GYN Associates, P.A. (January 19, 2016), available online at www.ada.gov/north_florida_sa.html (involving a gynecologist who refused to perform a tubal ligation procedure on a patient because she had HIV); Settlement Agreement between the United States of America and Mercy Suburban Hospital (November 18, 2015), available online at www.ada.gov/mercy_hospital_sa.html, (involving a hospital which had declined to provide bariatric services for a patient who had HIV); Settlement Agreement between the United States of America and Dentex Dental Mobile, Inc. (March 13, 2015), available online at www.ada.gov/dentex_sa.htm, (involving a dental clinic which discriminated against an individual with HIV by refusing to provide treatment); Settlement Agreement between the United States of America and Genesis Healthcare System (January 15, 2015), available online at www.ada.gov/genesis_healthcare_sa.htm (involving a physician who had discriminated against a patient by failing to provide treatment and by improperly referring the patient elsewhere).

⁹⁰ 28 C.F.R. 36.104.

⁹¹ *Id.*

⁹² 28 C.F.R. 36.302(c)(1).

⁹³ See, *DOJ Guidelines*, available at www.ada.gov/service_animals_2010.htm. Healthcare providers must be prepared to accommodate individuals using service animals without inquiring about the nature or extent of the individual's disabilities. 28 C.F.R. 36.302(c)(6).

⁹⁴ See, e.g., *Tamara v. El Camino Hospital*, 964 F.Supp.3d 1077 (N.D. Cal. 2013). DOJ has also undertaken enforcement activities with regard to healthcare providers in order to ensure equal access for individuals with disabilities who use service animals. For example, see Settlement Agreement between the United States of America and Dr. Bruce Berenson, M.D., P.A. (August 7, 2012), available online at www.ada.gov/berenson_settle.htm.

⁹⁵ Consent Decree between Tracy and Stan Rousseau and Adventist Healthcare West, 4:17-cv-02985, (N.D. Cal. March 13, 2018), available upon request from author.

⁹⁶ Exhibit A in Consent Decree Between Tracy and Stan Rousseau and Adventist Healthcare West, 4:17-cv-02985, (N.D. Cal. March 13, 2018), available upon request from author.

⁹⁷ *Id.*

⁹⁸ *Tamara v. El Camino Hospital*, 964 F. Supp. 2d 1077, 1085-86 (N.D. Cal. 2013).

⁹⁹ *Id.*

¹⁰⁰ *Id.* at 1086.

¹⁰¹ *Roe v. Providence Health System-Oregon*, 655 F. Supp. 2d 1164, (D. Ore. 2009).

¹⁰² *Id.* at 1166.

¹⁰³ *Id.* at 1167.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.* at 1168.

¹⁰⁶ *Id.*

¹⁰⁷ See, “Access to Medical Care for Individuals with Mobility Disabilities,” available online at https://www.ada.gov/medicare_mobility_ta/medicare_ta.htm

¹⁰⁸ https://www.ada.gov/anprm2010/equipment_anprm_2010.htm

¹⁰⁹ <https://www.adatitleiii.com/wp-content/uploads/sites/121/2017/12/ada-rule-withdrawal.pdf>

¹¹⁰ For accessibility standards for medical diagnostic equipment, see the guidelines provided by the United States Access Board, available online at www.access-board.gov/guidelines-and-standards/health-care/about-this-rulemaking.

¹¹¹ See, e.g., settlement agreements between the United States and Washington Hospital Center (accessible online at www.ada.gov/whc.htm), Beth Israel Deaconess Medical Center (available online at www.ada.gov/bidmsa.htm), and Dr. Robia Ashfaq (available online at www.justice.gov/crt/settlement-agreement-between-united-states-america-and-dr-robila-ashfaq)

¹¹² See e.g., Settlement Agreement with UCSF Medical Center, reached September 21, 2008, available online at www.lflegal.com/2008/09/ucsf-settlement-agreement/; Settlement Agreement with Massachusetts General Hospital and Brigham and Women’s Hospital, reached June 26, 2009, available online at www.lflegal.com/2009/06/boston-press/.

¹¹³ Case No. 829265-2 (Sup. Ct. for the State of Cal., Alameda Co.)

¹¹⁴ The settlement is available online at www.equipforequality.org/wp-content/uploads/2018/09/Kaiser-Settlement.pdf

¹¹⁵ 1:11-cv-01783 (N.D. Ill. Complaint filed Mar. 15, 2011) Settlement agreement available online at www.equipforequality.org/wp-content/uploads/2018/09/Americas-Best-Stipulation-and-Class-Settlement-Agreement.pdf

¹¹⁶ See also, *Montano v. Bonnie Brae Convalescent Hosp., Inc.*, 79 F. Supp. 3d 1120 (C.D. Cal. 2015)(nursing home violated Title III of the ADA by failing to modify the room and bathroom used by a resident with quadriplegia); *Judy v. Lee Mem. Health Sys.*, 2008 WL 897705 (M.D. Fla. Mar. 31, 2008)(hospital’s decision to exclude valet parking for patients who use cars with hand controls was a violation of Title III of the ADA).

¹¹⁷ No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of **any place of public accommodation** by any person who owns, leases (or leases to), or operates a place of public accommodation.” 42 U.S.C. § 12182(a)(emphasis added)

¹¹⁸ 121 F.3d 1006 (6th Cir. 1997).

¹¹⁹ See, e.g., *James v. GEICO Ins. Co.*, 2016 WL 9776068 (E.D. Pa. Nov. 16, 2016); *Ross v. Hartford Life & Accident Ins. Co.*, 2015 WL 5680329 (D. Mass. Sept. 25, 2015); and *Ford v. Schering-Plough Corp.*, 145 F.3d 601 (3d Cir. 1998).

¹²⁰ See, e.g., *Carparts Distribution Ctr. v. Automotive Wholesaler's Ass'n.*, 37 F.3d 12 (1st Cir. 1994), *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557 (7th Cir. 1999).

¹²¹ 179 F.3d 557 (7th Cir. 1999).

¹²² 984 F. Supp. 2d 949, 955 (D. Minn. 2013).

¹²³ See, "Justice Department Reaches Settlement with Learning Care Group to Resolve ADA Violations" (March 20, 2018), available online at www.justice.gov/opa/pr/justice-department-reaches-settlement-learning-care-group-inc-resolve-ada-violations.

¹²⁴ See, Winnewald Day Camp Settlement Agreement (June 2015), available online at www.justice.gov/usao-nj/file/765696/download; see also "Summer Camps and the ADA," U.S. Department of Justice Bulletin, available online at www.justice.gov/file/campadaflyerpdf/download.

¹²⁵ https://www.ada.gov/kinder_care_sa.html

¹²⁶ See, e.g., Settlement Agreement between the United States of America and Arlington-Mansfield Area YMCA (February 24, 2016), available online at www.ada.gov/arlington_ymca.html, (agreement also included a cash settlement for complainant; Settlement Agreement between the United States and Philadelphia Freedom Valley YMCA (May 19, 2016), available online at www.ada.gov/rocky_run-sa.html; Settlement Agreement between the United States of America and YMCA of the Triangle (July 27, 2016), available online at www.ada.gov/ymca_triangle_sa.html; Settlement Agreement between the United States of America and YMCA of Metro Chicago (December 21, 2016), available online at www.justice.gov/usao-ndil/pr/united-states-announces-settlement-ymca-metro-chicago-ensure-compliance-americans.

¹²⁷ Settlement Agreement between the United State of America and Camp Bravo (June 24, 2015), available online at www.ada.gov/camp_bravo_sa.html

¹²⁸ *U.S. v. NISRA*, 168 F.Supp.3d 1082 (N.D. Ill. 2016).