



## **Demonstrating Coverage Under the ADA Amendments Act of 2008 for People with Diabetes**

### **Introduction**

The Americans with Disabilities Act Amendments Act of 2008 (“ADAAA”), Pub. L. No. 110-325, along with regulations adopted in 2011 to implement its provisions, has dramatically altered how courts consider which individuals with disabilities are protected by the Americans with Disabilities Act (ADA). For those with diabetes, the statutory provisions and regulations establish that the condition will virtually always be a disability under the ADA. This paper discusses the legal provisions that establish coverage under the new framework, and shows lawyers how to present evidence about diabetes and to respond to claims from employers that individuals with diabetes are not disabled.

The ADAAA was passed in September 2008 to counter nearly two decades of narrow judicial construction of the ADA, which had excluded many people, including some with diabetes, from coverage under the Act. Congress, in debating and passing the ADAAA, made clear repeatedly that it intended people with diabetes to be covered under the law.<sup>1</sup>

Under the ADA, coverage is established by showing that the individual has a disability, and the Act, at 42 U.S.C. § 12102(1), defines the term disability, with respect to an individual as

- (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 discussed more fully below, the ADAAA makes a number of changes with regard to the application of these coverage provisions.<sup>2</sup> Most significantly, the ADAAA:

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<sup>1</sup> The changes made by the ADAAA took effect on January 1, 2009, and the new standards apply to conduct on or after that date. The law does not apply retroactively, and cases based on conduct arising before 2009 continue to be governed by the old judicial interpretations of the ADA. *See, e.g., Shin v. Univ. of Md. Med. Sys. Corp.*, 369 Fed. Appx. 472, 479 n. 14 (4<sup>th</sup> Cir. 2010); *Thornton v. United Parcel Serv.*, 587 F.3d 27, 34 n.3 (1<sup>st</sup> Cir. 2009). Attorneys working on cases involving pre-2009 conduct should contact [legaladvocate@diabetes.org](mailto:legaladvocate@diabetes.org) for resources on properly addressing these older standards.

<sup>2</sup> The ADAAA incorporates corresponding amendments into the anti-discrimination provisions of the Rehabilitation Act, 29 U.S.C. § 791 *et seq.*, which apply to the federal government and entities contracting with the federal government or receiving federal financial assistance. *See* 29 U.S.C. §§ 705(9)(B),

1. Expressly states that its coverage provisions are to be construed broadly, and explicitly rejects specific Supreme Court interpretations setting far more demanding standards
2. Expands the “regarded as” category of disability, so that a condition need not “substantially” limit a major life activity to be the basis for a regarded as claim (however, the individual will not be entitled to a reasonable accommodation).
3. Adds the operation of major bodily functions, including the functioning of the endocrine system, to the list of covered major life activities; and
4. Requires that the ameliorative effects of mitigating measures such as medication not be considered when determining the presence of a disability.<sup>3</sup>

The EEOC amended its ADA regulations to implement the ADAAA, effective May 24, 2011.<sup>4</sup> The regulations should put to rest any doubt that diabetes is covered as a disability. Indeed, the regulations include diabetes on a list of conditions “which will, in virtually all cases, result in a determination of coverage.”<sup>5</sup>

This list, which appears under the regulatory heading “predictable assessments,” found at 29 C.F.R. § 1630.2(j)(3). The list includes such conditions as deafness, blindness, intellectual disability, missing limbs or mobility impairments requiring the use of a wheelchair, autism and cancer.<sup>6</sup> The regulations clarify that:

Given their inherent nature, these types of impairments will, as a factual matter, *virtually always* be found to impose a substantial limitation on a major life activity. Therefore, with respect to these types of impairments, the necessary individualized assessment should be particularly simple and straightforward.<sup>7</sup>

And in the next subparagraph, the regulations state:

For example, applying the [rules of construction set out in the regulations concerning the substantial limitation determination], **it should easily be concluded** that the following types of impairments will, at a minimum, substantially limit the major life activities indicated: ... diabetes substantially limits endocrine function[.]<sup>8</sup>

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705(20)(B). While the rest of this document discusses claims under the ADA, the same conclusions apply related to coverage under the Rehabilitation Act.

<sup>3</sup> The ADAAA also specifies that an impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active. While this provision has applicability to diabetes, as discussed near the end of this paper (*see* section on a Road Map for Establishing Coverage), it should be used very sparingly for purposes of establishing coverage, for the reasons discussed below.

<sup>4</sup> *See* 76 Fed. Reg. 16978 (codified at 29 C.F.R. Part 1630). These regulations have been found to be persuasive authority regarding conduct that happened before they took effect. *See Willoughby v. Connecticut Container Corp.*, 2013 U.S. Dist. Lexis 168457, \*27 n. 4 (D. Conn. Nov. 27, 2013); 490.

*Szarawara v. County of Montgomery*, 2013 U.S. Dist. Lexis 90386, \*8 (E.D. Pa. June 27, 2013).

<sup>5</sup> 29 C.F.R. § 1630.2(j)(3)(ii).

<sup>6</sup> 29 C.F.R. § 1630(j)(3)(iii).

<sup>7</sup> 29 C.F.R. § 1630.2(j)(3)(ii) (emphasis added).

<sup>8</sup> 29 C.F.R. § 1630.2(j)(3)(iii) (emphasis added).

## **The Science and Medicine of Diabetes and its Management**

Although the ADA has always been interpreted as requiring an individualized assessment to demonstrate coverage, and the amended EEOC regulations continue to recognize this requirement under the ADAAA,<sup>9</sup> as noted above, those regulations clarify that for diabetes (and other conditions on list of conditions that will almost always be disabilities in 29 C.F.R. § 1630.2(j)(3)) this assessment should be simple and straightforward.<sup>10</sup> Accordingly, while plaintiff's counsel in some cases will need to submit affidavits or other evidence from medical professionals regarding the impact of diabetes, such evidence can be simple and to the point. As discussed below, the evidence should focus on the impact of the individual's diabetes on endocrine system functioning. Further, as also discussed below, it will be useful, at least in early ADAAA cases, to also point out the impact of diabetes on other major life activities without mitigating measures. This section includes background information on diabetes that will be useful for attorneys in making these showings.

### Effect of diabetes on the endocrine system

Diabetes is a chronic disease that substantially limits the functioning of the endocrine system. It affects over 29 million Americans<sup>11</sup> and is characterized by high blood glucose (sugar) levels resulting from defects in insulin secretion, insulin action or both.<sup>12</sup> The endocrine system is a series of glands that produce and secrete hormones, which are released into the bloodstream and regulate many of the body's functions. The pancreas, one of the major glands of the endocrine system, is an organ responsible for making and secreting insulin, a hormone that is used to regulate the level of glucose in the blood. Producing insulin is a critical function of the endocrine system, because insulin is necessary for the body to convert glucose (sugar) into energy. Without insulin, the body's cells literally starve to death. Therefore, any deficiency in the way the body produces or uses insulin seriously impairs the endocrine system and renders it unable to do its job as effectively. Thus, it clearly represents a substantial limitation in endocrine function.

In people without diabetes, the pancreas produces insulin throughout the day and matches the amount of insulin released to the needs of the body. Glucose is extracted from food when it is being digested (or released from the liver when needed at other times). The blood then carries this glucose to cells throughout the body. There, insulin enables the glucose to enter the cells, where it is converted into quick energy for the cells to use or

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<sup>9</sup> See 29 C.F.R. § 1630.2(j)(1)(iv) and the corresponding section of the regulations' Appendix.

<sup>10</sup> 29 C.F.R. § 1630.2(j)(3)(ii).

<sup>11</sup> *National Diabetes Statistics Report 2014*. Atlanta, GA, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2014, available at <http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf>.

<sup>12</sup> Insulin resistance, common among people with diabetes, is also a disorder of the endocrine function.

store for future needs. This process of turning food into energy is crucial, because the body depends on this energy for every action, from pumping blood and thinking to running and jumping.

In diabetes, this process of turning food into energy cannot function properly. While glucose continues to enter the bloodstream from food, the insulin that allows cells to use that glucose either is not available in sufficient amounts or cannot do its job. As a result, too much glucose accumulates in the bloodstream.

There are three main types of diabetes: type 1 diabetes, type 2 diabetes, and gestational diabetes.<sup>13</sup> In type 1 diabetes, the pancreas stops making insulin or makes only a tiny amount. Type 1 develops when the body's immune system destroys the insulin-producing cells in the pancreas. Thus, the body is no longer able to produce significant amounts of insulin, and a person with type 1 diabetes must receive insulin from an outside source (injections or use of an insulin pump) in order to survive.

In type 2 diabetes, the body retains the ability to make insulin, but cannot make enough to meet its needs. The body's cells cannot recognize insulin or use it as effectively as in people without diabetes (a condition known as insulin resistance). This causes the body to need more insulin to process the same amount of glucose. While the pancreas may be able to produce some additional insulin for a while (thus minimizing the harmful effects of the disease), generally over time the pancreas's ability to produce insulin decreases and causes blood glucose levels to rise. Some people with type 2 (particularly in the early stages of the disease) can control their diabetes through diet and exercise.<sup>14</sup> Others must take various types of medications, while still others use insulin much as those with type 1 do.

Gestational diabetes develops during pregnancy (usually during the second or third trimesters) as a result of the body's inability to produce sufficient insulin to respond to insulin resistance, which is a natural part of pregnancy. This form of diabetes is treated much like type 2; treatment can begin with diet and exercise but also can include insulin if necessary (oral medications are not used because of risk of harm to the baby). After pregnancy, gestational diabetes generally disappears, although women who have had it are much more likely to develop type 2 diabetes later in life.

When insulin is absent or not efficiently used by the body, excess glucose in the bloodstream cannot be used by the cells to make energy. Instead, glucose collects in the blood, leading to the high glucose levels or "hyperglycemia" that is the defining characteristic of untreated diabetes.<sup>15</sup> The symptoms of hyperglycemia can include

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<sup>13</sup> Type 1 diabetes is sometimes still referred to as "juvenile diabetes" or "insulin-dependent diabetes," while type 2 diabetes is sometimes referred to as "adult-onset diabetes" or "non-insulin dependent diabetes." However, these alternative terms are no longer favored by the diabetes health care community and should be avoided because they are ambiguous.

<sup>14</sup> Diet and exercise are part of the treatment regimen for all people with diabetes, but for some people with type 2 diabetes it is the only way they manage their condition.

<sup>15</sup> Hyperglycemia can result from an imbalance between food, activity and medication and may also be caused by illness, infection or stress.

frequent urination, thirst, headache, weight loss, fatigue, and blurry vision. Hyperglycemia and inadequate insulin action may lead to *diabetic ketoacidosis*, or *hyperosmolar hyperglycemic syndrome*, life-threatening complications that are discussed below. In addition to these short-term consequences of acute hyperglycemia, high blood glucose levels cause a number of very serious long-term complications. Some of the more important long-term complications include:<sup>16</sup>

- *Retinopathy*: 28.5 % of people with diabetes have diabetic retinopathy, and 4.4 % have advanced retinopathy that can lead to severe vision loss;
- *Kidney disease*: diabetes is the leading cause of kidney failure, accounting for 44% of new cases in 2011;
- *Cardiovascular disease*: in 2010, death rates from cardiovascular disease are 1.7 times higher for adults with than those not without diabetes, and hospitalization rates for heart attacks were 1.8 times higher for those with diabetes;
- *Cerebrovascular disease*: hospitalization rates for stroke were 1.5 times higher among people with diabetes;
- *Hypertension*: about 71% of adults with diabetes have high blood pressure; and
- *Amputations*: about 60% of nontraumatic lower-limb amputations occur in people with diabetes, and in 2010 about 73,000 such amputations were performed on people with diabetes.

In addition, people with diabetes are at risk for complications during pregnancy, and are susceptible to infections and other illnesses. Diabetes also increases the risk of prolonged illness and death from other illnesses, including pneumonia, heart attack, and stroke.

### Diabetes management

The goal of diabetes management is to try to balance the blood glucose level within a safe range, minimizing very low and very high glucose levels. As noted above, type 1 diabetes must be treated with insulin, while type 2 can be treated with insulin, other medications, and/or diet and exercise depending upon the impact of diabetes on the individual.

Proper diabetes treatment depends on knowing and responding to the current blood glucose level. Checking blood glucose involves pricking the skin with a lancet at the fingertip, forearm, or other test site to obtain a drop of blood and placing the drop on a special test strip that is inserted in a glucose meter. The frequency of blood glucose checks can vary from person to person, and checks may be done both at scheduled times (such as before meals) and unscheduled times (such as when a person senses their blood glucose levels are too high or too low).

Insulin can be self-administered through injections or by wearing an insulin pump (a device that administers small, steady doses throughout the day and can be programmed to

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<sup>16</sup> U.S. Department of Health and Human Services, Centers for Disease Control and Prevention: *National Diabetes Fact Sheet: National Estimates and General Information on Diabetes and Prediabetes in the U.S.* (2011).

give extra insulin to cover food intake). When people are diagnosed with type 2 diabetes they often treat the disease with oral medications taken once or twice a day. Over time, the disease progresses and most people must increase the amount of medication, and change to insulin or a combination of insulin and oral medications to manage blood glucose levels. However, insulin and medication regimens vary from person to person based on a number of factors.

Treatments such as insulin and oral medications do not cure diabetes. In addition, insulin and some medications can lower blood glucose levels too much, leading to a dangerous condition known as hypoglycemia (low blood glucose levels). All types of insulin and certain classes of oral medications (sulfonylureas) can cause hypoglycemia – insulin because it lowers the body’s blood glucose level, and sulfonylureas because they stimulate the pancreas to produce and release more insulin. Other oral medications, unless taken in conjunction with sulfonylureas, do not cause hypoglycemia because they do not act to increase insulin levels. Hypoglycemia symptoms include anxiety, hunger, tremors, palpitations and sweating, confusion, drowsiness, mood changes, unresponsiveness, unconsciousness, convulsions, and, if untreated, death.

Hazardous short-term side effects associated with low blood glucose levels occur more quickly and more frequently than do the short-term effects of high blood glucose levels. In addition, people with diabetes, no matter how carefully the disease is managed, will still experience some high blood glucose levels. Even with the best treatment regimen, a person with diabetes cannot obtain glucose control that is comparable to – or as effective as – what the body does naturally in the person without diabetes, because the normally functioning pancreatic endocrine system releases small amounts of insulin directly into the liver in minute-to-minute response to the body’s needs.

### Untreated diabetes

Diabetes is treated in a variety of ways depending upon the individual’s situation. Because insulin is necessary to life, all people with type 1 diabetes must receive insulin every day through injections or an insulin pump. People with type 2 diabetes may be able to treat the condition with changes to their diet and exercise, or may require insulin and/or various oral medications to control high blood glucose levels. Without the use of mitigating measures such as insulin or oral medications, individuals with diabetes will experience the complications of hyperglycemia discussed above.

If a person with type 1 diabetes does not have insulin, glucose will build up in the blood, accompanied by fat breakdown toxins called “ketoacids.” Elevated blood glucose levels will cause increased urination and result in dehydration. The person will become fatigued, and, as ketoacids increase, may experience loss of appetite, followed by nausea and vomiting. This condition is called “diabetic ketoacidosis” (DKA). DKA can progress from nausea and vomiting to coma, shock, and death if left untreated.

A person with type 2 diabetes who requires insulin or oral medications will also experience hyperglycemia if he or she does not have medication. People with type 2

diabetes usually have a reserve of native insulin, but, in most cases, depend upon medication to maintain adequate control of their blood glucose levels. Without medication (oral agents or insulin), they will lose glucose control. The insulin they do produce will be less effective if medications to reduce insulin resistance are removed, causing glucose levels to rise. A person with type 2 diabetes who manages the disease through diet and exercise also suffers consequences if the diet and exercise are stopped or are ineffective. The person's blood glucose will rise to a level requiring medication to be brought back into a safe range.

The high blood glucose levels that mark untreated type 2 diabetes are often present before a person is diagnosed with diabetes, and can be as high as 600-1,000 mg/dl<sup>17</sup> (five to ten times the normal blood glucose level, which is between 70 and 140 mg/dl). As a result of the high blood glucose levels, the person will exhibit excessive thirst and frequent urination because of the overflow of glucose into the urine. Left untreated, this increased urination will lead to severe dehydration. Although DKA is extremely rare in people with type 2 diabetes, they are susceptible to extreme dehydration, leading to another life-threatening condition called hyperosmolar hyperglycemic syndrome (HHS). HHS develops over days or weeks, but can lead to confusion, hypotension (low blood pressure), shock, and eventually, to coma and death. HHS may be fatal in as many as 50% of those who develop it.

If a person with diabetes does not receive necessary medication, he or she is likely to suffer consequences as described above. This is because many of the complications of diabetes are caused by having too much glucose in the blood, and excess glucose damages the small blood vessels that carry blood throughout the body. Blood can't get where it needs to be, and causes problems with circulation that lead to retinopathy and nephropathy (kidney damage). Too much glucose also speeds up the normal hardening of the arteries (atherosclerosis), decreasing blood flow to the heart and to the brain, causing heart attack and stroke. Likewise, too much glucose damages nerve cells and affects the electrical messages that nerve cells send throughout the body, especially to the feet. Because diabetes is a relentlessly progressive disease, the consequences of unmitigated diabetes will change over time and the rate at which these complications develop in a person with untreated diabetes will vary.

### **“Regarded As”: The Simplest Path to Coverage**

The ADAAs provides several easy ways to show that a person with diabetes is covered. Early in the case, attorneys should evaluate the strategies discussed in this paper to determine which (alone or in combination) are best for their particular set of facts and claims. Making this choice carefully and wisely will maximize the chances of victory on this issue while minimizing the need for extensive discovery and medical evidence.

At the outset, a critical question is whether there is, or could be, a claim that the individual with diabetes requires a reasonable accommodation in order to perform the

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<sup>17</sup> American Diabetes Association: *American Diabetes Association Complete Guide to Diabetes* at 98. 5<sup>th</sup> ed. Alexandria, VA, American Diabetes Association, 2011.

essential functions of the job. If no such accommodation is needed, then the ADA’s “regarded as” prong provides the best route to coverage.<sup>18</sup>

Under the ADA, an individual is covered if he or she has an actual disability, a record of a disability,<sup>19</sup> or is regarded as having a disability. The ADAAA significantly expanded the availability of “regarded as” claims. According to the statute, “[a]n individual meets the requirement of ‘being regarded as having [a disabling] impairment’ if the individual establishes that he or she has been subjected to an action prohibited under this Act 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.” 42 U.S.C. § 12102(3)(A).<sup>20</sup> This eliminates from the analysis one of the key questions debated by courts since the ADA was passed: does the impairment that the individual has substantially limit a major life activity? That question need not even be asked here, because the mere existence of an impairment establishes coverage under the regarded as prong, provided the individual has been subjected to a prohibited action under the ADA.

Previously, the “regarded as” inquiry focused on whether the employer subjectively believed that the employee’s impairment was substantially limiting. Now, however, there is no need to demonstrate any limitation at all from the impairment, and the employer’s beliefs about the condition are irrelevant. *See Hilton v. Wright*, 673 F.3d 120, 129 (2<sup>nd</sup> Cir. 2012) (plaintiff is “not required to present evidence of how or to what degree [the employer] believed the impairment affected him.”) For this reason, standards applicable to the prior “regarded as” provision should not be applied to post-ADAAA cases. *See Brown v. City of Jacksonville*, 711 F.3d 883, 889 (8<sup>th</sup> Cir. 2013) (district court improperly analyzed plaintiff’s claims using pre-ADAAA standards and regulations). Pre-ADAAA case law is therefore irrelevant under the ADAAA, and attorneys should resist any efforts by employers to rely on such case law. *See Gaus v. Norfolk Southern Railway Co.*, 2011 U.S. Dist. Lexis 111089, \*55 (W.D. Pa. Sept. 28, 2011) (rejecting attempt to rely on pre-ADAAA “regarded as” cases); *Dube v. Texas Health & Human Svcs. Comm’n.*, 2011 U.S. Dist. Lexis 99680, \*11 (W.D. Tex. Sept. 6, 2011) (same); *but see Quarles v. Md.*

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<sup>18</sup> As explained in the regulations at section 1630.2(g)(3):

Where an individual is not challenging a covered entity's failure to make reasonable accommodations and does not require a reasonable accommodation, it is generally unnecessary to proceed under the “actual disability” or “record of” prongs, which require a showing of an impairment that substantially limits a major life activity or a record of such an impairment. In these cases, the evaluation of coverage can be made solely under the “regarded as” prong of the definition of disability, which does not require a showing of an impairment that substantially limits a major life activity or a record of such an impairment.

<sup>19</sup> “Record of” claims focus on situations where an individual has a history of or has been misclassified as having a substantially limiting impairment. 29 C.F.R. § 1630.2(k). Because the condition is generally not curable (and thus, once contracted, continues, without periods of “remission”) and is an actual disability, “record of” claims are not usually raised in diabetes cases.

<sup>20</sup> The regulations provide further that “an individual is ‘regarded as having [a substantially limiting] impairment under these circumstances ‘even if the entity asserts, or may or does ultimately establish, a defense to such action.’ 29 C.F.R. § 1630.2(l)(2). The ADAAA provides a defense to a regarded as claim where the employer can show that the impairment is both transitory and minor. 29 C.F.R. § 1630.15(f). Of course, as discussed above, diabetes is neither transitory nor minor.

*Dep't of Human Resources*, 2014 U.S. Dist. LEXIS 168483, \*12 (D. Md. Dec. 5, 2014) (although court analyzed plaintiff's actual disability claim under the ADAAA standards, it cited pre-ADAAA case law and standards in holding that plaintiff had failed to allege any facts showing that she was regarded as disabled due to her diabetes, and seemed unaware of the changes to the standard made by the ADAAA).

Numerous courts have acknowledged that diabetes is a physical impairment. *See, e.g., Gonzales v. City of New Braunfels*, 176 F.3d 834, 837 (5<sup>th</sup> Cir. 1999) (describing diabetes as a "serious impairment"); *Fraser v. Goodale*, 342 F. 3d 1032, 1038 (9<sup>th</sup> Cir. 2003); *Lawson v. CSX Transp., Inc.*, 245 F.3d 916, 923 (7<sup>th</sup> Cir. 2001). So, by definition, a diagnosis of diabetes will (or should) be enough to bring an employee within the scope of the "regarded as" prong.

But the ADA now makes clear that an individual who qualifies under this standard alone has no right to reasonable accommodations (an issue on which the circuits were previously split). 42 U.S.C. § 12201(h); 29 C.F.R. § 1630.2(o)(4). Where accommodations are needed (and especially where a form of disability discrimination alleged is failure to or refusal to accommodate), an actual disability or record of a disability must be shown. Attorneys should plead a "regarded as" claim whenever possible, and in many cases will not need to allege an actual disability. As explained in the EEOC regulations' interpretative guidance, this approach may be used where "the need for a reasonable accommodation is not at issue—for example, where there is no question that the individual is 'qualified' without a reasonable accommodation and is not seeking or has not sought a reasonable accommodation." 29 C.F.R. pt. 1630 app., § 1630.2(i).

Relying solely on this provision has special benefits in cases involving safety concerns, because it eliminates the need to introduce evidence about the limitations of the disease that might raise unfounded concerns in the court or jury about the fitness of the individual to perform the job. However, it is critical to consider whether there is any possible accommodation claim that may need to be raised, or that may be useful to counter arguments that are made by the defense. For example, if the employer is likely to assert that it fired the employee for poor job performance, and the employer failed to provide adequate breaks for diabetes management which would have enabled the employee to perform the job successfully, it may be useful to raise this failure to accommodate claim to rebut the employer's justification for the firing.

To see the benefits of this approach, consider a claim by a police department that it fired an officer with diabetes because he posed a safety risk. Since it thereby regarded the officer as disabled by firing him due to his diabetes, there is no need to claim that the officer had an actual disability, or introduce any evidence about the actual or potential effects of the individual's diabetes in order to establish coverage which could later be used by the defense to raise questions about whether the officer is qualified. "Regarded as" is the easiest way to prove coverage under the new law, and should be used whenever possible. However, because the need for an accommodation claim cannot always be foreseen, it is a good idea to also plead actual disability coverage, even while focusing

the court's attention on the regarded as prong, except in cases where, because of the concerns noted above, the attorney wishes to avoid introducing evidence of actual limitations.

### **Proving that Diabetes is an Actual Disability**

Even when the present or potential need for reasonable accommodations requires that the plaintiff demonstrate an actual disability, the new law makes showing that diabetes is a disability easy. Where possible accommodations are involved, the key question is whether diabetes substantially limits a major life activity. Most of the litigation about the definition of disability prior to the passage of the ADAAA centered around the question of whether the limitations in one or more "major life activities" caused by an impairment are substantial. Many courts had narrowly construed these terms to set a high standard of eligibility. However, the ADAAA and its legislative history make clear that Congress has rejected these heightened legal standards.

#### The Mandate for Broad Coverage

The Congressional record of the ADAAA's passage is filled with references to problems caused by narrow court interpretations of the definition of disability under the ADA for people with diabetes.<sup>21</sup> *See* Senate Managers' Statement, 154 Cong. Rec. S8840-S8841 (Sept. 16, 2008) ("[W]e are faced with a situation in which physical or mental impairments that would previously have been found to constitute disabilities are not considered disabilities under the Supreme Court's narrower standard. These can include individuals with impairments such as ... diabetes .... The resulting court decisions contribute to a legal environment in which individuals must demonstrate an inappropriately high degree of functional limitation in order to be protected from discrimination under the ADA.") Congress made clear that in passing the ADA in 1990 it intended diabetes to be covered as a disability, and the ADAAA is meant to restore this original intent. *See* H. Comm. on the Judiciary, ADA Amendments Act of 2008, H. Rep. No. 110-730 pt. 2, at 7 (June 23, 2008) ("In enacting the ADA, Congress issued extensive reports expressing its intent and expectation that the definition it adopted from the Rehabilitation Act would continue to be interpreted broadly. ... Likewise, persons with impairments, such as epilepsy or diabetes, which substantially limit a major life activity are covered under the first prong of the definition of disability, even if the effects of the impairment are controlled by medication.")

The ADA now states that "[t]he definition of disability in this Act shall be construed in favor of broad coverage of individuals under this Act, to the maximum extent permitted by the terms of this Act." 42 U.S.C. § 12102(4)(A); *see also* 29 C.F.R. §§ 1630.1(c)(4), 1630.2(j)(1)(i); *Summers v. Altarum Institute, Corp.*, 740 F.3d 325, 330 (4<sup>th</sup> Cir. 2014). The ADA also is to be interpreted consistent with the findings and purposes of the ADAAA, including Congressional belief that Supreme Court decisions have "created an

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<sup>21</sup> Georgetown University Law Center's ArchiveADA provides convenient access to the general legislative history of the ADAAA, including the documents cited here, at <http://www.law.georgetown.edu/archiveada/>.

inappropriately high level of limitation necessary to obtain coverage under the ADA,” 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 “the question of whether an individual’s impairment is a disability under the ADA should not demand extensive analysis.” 42 U.S.C. § 12102(4)(B); ADAAA § 2(b)(5). The implementing regulations contain similar language. 29 C.F.R. § 1630.2(j)(1)(iii). *See also Mazzeo v. Color Resolutions Intern., LLC*, 746 F.3d 1264, 1268 and n.2 (11<sup>th</sup> Cir. 2014) (“Congress intended ‘that the establishment of coverage under the ADA should not be overly complex nor difficult, and expect[ed] that the [ADAAA] will lessen the standard of establishing whether an individual has a disability for purposes of coverage under the ADA.’”) Because of the expansion in coverage, many, if not most, cases decided under the old ADA standards on coverage will not be applicable under the new law. *See Summers v. Altarum Institute, Corp.*, 740 F.3d 325, 330, 331 (4<sup>th</sup> Cir. 2014) (defendant and district court had improperly relied on pre-ADAAA cases).

The expansion of coverage also means that the kind of extensive medical evidence often needed before the passage of the ADAAA may no longer be needed in most cases. The regulations’ rules of construction for determining whether an impairment is substantially limiting state that a medical analysis is not necessary: “The comparison of an individual’s performance of a major life activity to the performance of the same major life activity by most people in the general population usually will not require scientific, medical, or statistical analysis.” 29 C.F.R. § 1630.2(j)(1)(v). In *Willoughby, supra*, the court rejected the defendant’s argument that plaintiff had failed to introduce adequate medical evidence of his diabetes-related limitations, finding that Congressional intent and the above-quoted regulatory language meant such evidence was not required. 2013 U.S. Dist. Lexis 168457 at \*25 n. 2. *See also Lema v. Comfort Inn*, 2013 U.S. Dist. Lexis 48408, \*25 (E.D. Cal. Apr. 3, 2013) (“comparative or medical evidence is not required”); *Mercer v. Arbor E & T, LLC*, 2013 U.S. Dist. Lexis 5723, \*36-37 (S.D. Tex. Jan. 15, 2013) (plaintiff’s own testimony about decreased concentration he experienced was sufficient to show possible substantial limitation, even without medical evidence). Nonetheless, as discussed further below, it is a good practice to include medical evidence about the limitations caused by diabetes, both because it will make proving coverage easier and because medical testimony will very often be required to prove other aspects of the case.[Kravtsov]

Thus, it is clear that coverage is to be much broader under the amended ADA, and doubts are to be construed in favor of coverage. These general principles are very helpful for people with diabetes. Although the courts have not yet issued a ruling directly addressing coverage of diabetes, some early cases under the ADAAA involving other conditions suggest that courts may find coverage based on these general principles alone, without demanding an extensive factual showing.<sup>22</sup> However, it is not necessary to rely solely on

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<sup>22</sup> *See Medvic v. Compass Sign Co., LLC*, 2011 U.S. Dist. LEXIS 89275 (E.D. Pa. Aug. 10, 2011) (argument that stuttering that caused difficulty communicating was not a disability was contrary to the spirit and purpose of the ADAAA); *Lowe v. American Eurocopter*, 2010 U.S. Dist. Lexis 133343, \*22 (N.D. Miss. 2010) (citing the expansion in coverage under the ADAAA to hold that pro se plaintiff who claimed her obesity substantially limited her ability to walk could survive a motion to dismiss).

general principles; the ADAAA makes a number of specific changes to the law that establish coverage for people with diabetes.

### The New Major Life Activity of Endocrine Function

The most important change for people with diabetes in the ADAAA is the statute's expansion of the concept of "major life activities" to include the operation of internal body systems like the endocrine system (which, as explained above, is severely affected by diabetes). In the past, major life activities were often seen as limited to external physical activities (such as walking or standing) or mental processes with clear external effects (such as thinking or concentrating). However, the ADAAA introduces a new category of major life activity relating to the body's internal processes. The Act at 42 U.S.C. § 12102(2)(B) provides:

[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.

This new provision means that plaintiffs with diabetes have a disability under the ADA because diabetes substantially limits endocrine function. The purpose of the endocrine system, as described above, is to produce and secrete needed hormones so they can be distributed throughout the body. Diabetes renders the body unable to produce adequate supplies of insulin, a critical hormone produced by the endocrine system. It can also cause cells to be resistant to recognizing and using insulin (insulin resistance), requiring the endocrine system to produce more insulin to do the same work and putting strains on the system that over time will damage its ability to function and produce insulin. The EEOC regulations also provide that "[t]he operation of a major bodily function includes the operation of an individual organ within a body system." 29 C.F.R. § 1630.2(i)(1)(ii). Since the pancreas is an organ within the endocrine system,<sup>23</sup> and its ability to produce insulin is lost or reduced in people with diabetes, this is another way to show that the endocrine system is substantially limited. Because diabetes, by definition, impairs the functioning of the endocrine system in significant ways, it should be straightforward to easily prove that the disease causes substantial limitation in endocrine function, with minimal medical evidence.<sup>24</sup>

The regulatory appendix to the new EEOC regulations reinforces this conclusion. "The link between particular impairments and various major bodily functions should not be difficult to identify. Because impairments, by definition, affect the functioning of body systems, they will generally affect major bodily functions. For example, ... diabetes

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<sup>23</sup> The appendix to the regulations specifically notes that the pancreas is an organ whose function can be substantially limited under this provision. 29 C.F.R. pt. 1630 app., § 1630.2(i).

<sup>24</sup> Diabetes also limits cell function because it deprives cells of the energy they derive from glucose. In addition, complications of diabetes may affect other bodily functions, including the circulatory and digestive systems. See, e.g., *Rohr v. Salt River Project Agric. Improvement and Power Dist.*, 555 F. 3d 850, 858 (9<sup>th</sup> Cir. 2009) (diabetes affects the digestive, hemic and endocrine systems). As discussed below, however, it should not be necessary to raise these claims.

affects the operation of the pancreas and also the function of the endocrine system.” 29 C.F.R. pt. 1630 app., § 1630.2(i). This strong regulatory language will be very helpful to plaintiffs attempting to show that their diabetes is a disability.

However, as noted at the outset of this paper, the regulations go even further. The regulations specify that the individualized assessment of diabetes and other conditions set out on the list of conditions that will almost always be disabilities in 29 C.F.R. § 1630.2(j)(3) will in virtually all cases result in a determination of coverage, because such conditions virtually always impose a substantial limitation on a major life activity.<sup>25</sup> See *Szarawara v. County of Montgomery*, 2013 U.S. Dist. Lexis 90386, \*9 (E.D. Pa. June 27, 2013) (in case involving type 2 diabetes, defendant presented the court with no evidence suggesting that the conclusion of the EEOC’s regulations was not applicable to plaintiff).

Thus, it is clear that, under EEOC’s view, diabetes will nearly always substantially limit endocrine function, and will therefore be found as a matter of course to be a disability. The kinds of factual evidence normally used to prove disability, such as facts about the condition, manner and duration of an impairment, are not necessary for the impairments on this list. 29 C.F.R. § 1630.2(j)(4)(iv). The EEOC emphasizes that although the list contained in this section is not a list of “per se” disabilities that will automatically, without more, qualify for coverage under the ADAAA, because of the broad scope of coverage and the inherent nature of these conditions “the necessary individualized assessment should be particularly simple and straightforward.” 29 C.F.R. pt. 1630 app., § 1630.2(j)(3). This language is extremely helpful in showing that diabetes is in fact a disability. Accordingly, under the EEOC’s view, only a diagnosis and a brief explanation regarding how diabetes substantially limits the individual’s endocrine function should be necessary to make this showing.

Several cases has found, relying on these regulations, that type 2 diabetes qualifies as a disability. *Willoughby, supra*, 2013 US. Dist. Lexis 168457 at \*26 (“Plaintiff – who suffers these symptoms due to diabetes, which is by definition a disease which impacts the functioning of the endocrine system – could indeed easily be found by a jury to be an individual who has ‘a physical impairment that substantially limits one or more major life activities of such individual’ and, accordingly, has a disability under the ADA.”) And in *Bellofatto v. Red Robin Int’l.*, 2014 U.S. Dist. Lexis 177341 (W.D. Va. Dec. 24, 2014), the court rejected the defendant’s argument that plaintiff’s type 1 diabetes did not constitute a disability, stating:

In this case, Bellofatto has presented sworn testimony and medical documentation demonstrating that she suffers from Type 1 diabetes, which impacts the functioning of the endocrine system, and that she is required to take insulin multiple times a day to regulate her blood sugar levels. Bellofatto's evidence from her treating physician also indicates that she ‘runs the risk of impaired ability to think coherently, loss of cognitive ability, or unconsciousness’ if her blood sugar levels fall too low. In light of such evidence, the court concludes that a reasonable jury could easily

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<sup>25</sup> 29 C.F.R. § 1630.2(j)(3)(ii), (iii).

find that Bellofatto has a physical impairment that substantially limits one or more major life activities of such individual,' and, thus, is disabled for purposes of the ADA.

*Id.* at \*27 (internal citations omitted). See also *Tadder v. Bd. of Regents of Univ. of Wisconsin Sys.*, 15 F. Supp. 3d 868, 884 n.9 (W.D. Wis. 2014) (in pre-ADAAA case involving individual with type 2 diabetes using insulin, court noted that under the ADAAA standards, the presence of the new major life activity of endocrine function “would appear to generally establish diabetes as an impairment imposing a substantial limitation on a major life activity.”); *Ray v. North American Stainless, Inc.*, 2014 U.S. Dist. Lexis 34737, \*12 (E.D. Ky. Mar. 18, 2014) (plaintiff with type 1 diabetes survived motion to dismiss by pleading that diabetes was an impairment that substantially limited endocrine function, and rejecting defendant’s argument that plaintiff needed to allege limitations in other major life activities).

Other courts have addressed different conditions and body systems, using arguments analogous to those that can be made for diabetes and endocrine function. Several cases have denied summary judgment to employers because the activity of normal cell growth is substantially limited by cancer. See *Meinelt v. P.F. Chang’s China Bistro*, 787 F. Supp. 2d 643, 651 (S.D. Tex. 2011) (defendant made no cogent argument refuting the conclusion that a brain tumor which required surgery affects normal cell growth and therefore should be found to constitute a disability); *Norton v. Assisted Living Concepts, LLC*, 786 F. Supp. 2d 1173, 1185 (E.D. Tex. 2011) (renal cancer substantially limits normal cell growth even when in remission); *Katz v. Adecco USA, Inc.*, 2012 U.S. Dist. Lexis 2893, \*19 (S.D.N.Y. Jan. 10, 2012) (same). Cases involving other conditions are similar. See *Scavetta v. King Soopers, Inc.*, 2013 U.S. Dist. Lexis 10944, \*6 (D. Colo. Jan. 28, 2013) (rheumatoid arthritis could substantially affect musculoskeletal function); *Coker v. Enhanced Senior Living, Inc.*, 897 F. Supp. 2d 1366, 1375–1376 (N.D. Ga. 2012) (plaintiff granted summary judgment based in part on doctor’s affidavit that non-cancerous breast disease resulted from abnormal cell growth and abnormal endocrine and reproductive function).

The changes made by the ADAAA, however, have not turned diabetes into an automatic disability or removed standard pleading requirements, and attorneys must still properly plead that the plaintiff has a disability. In *Quarles, supra*, 2014 U.S. Dist. LEXIS 168483 at \*12, the court granted the defendant’s motion to dismiss plaintiff’s claim that her diabetes constituted an actual disability. The only allegations plaintiff made about her diabetes were that it limited her ability to “move freely, walk steps, and travel from building to building.” The court specifically noted that plaintiff failed to allege any limitation of the functioning of her endocrine system, acknowledging that this limitation is often used by individuals with diabetes to demonstrate coverage. As to the activities plaintiff did allege, the court found that plaintiff had only alleged that these activities were “limited”, rather than being “substantially limited”, and plaintiff had alleged no specific facts about her diabetes that might have supported a determination that it substantially limited any activity. This case demonstrates the need to plead disability coverage correctly even under the new and more expansive ADAAA standards.

Because of the medical consensus about the effects of diabetes, and the strong position taken by the EEOC regulations, all attorneys attempting to prove that diabetes is an actual disability should argue that the disease substantially limits the endocrine function of their client, and should utilize the EEOC's listing of diabetes as a condition that will nearly always be a disability. Even if other methods are also used for proving disability, the substantial limitation in endocrine function argument should be the first one made (assuming a regarded as claim is not available because a reasonable accommodation is needed), as it is the simplest and easiest to understand and requires the least evidence to prove. Lawyers handling diabetes discrimination cases under the ADAAA should consult with the Association for assistance in compiling medical evidence and expert testimony.

### No Consideration of Mitigating Measures

Another key provision of the ADAAA overturns Supreme Court precedent and makes clear that, in determining whether an individual is covered by the ADA, employers and courts may not consider that individual's use of "mitigating measures," such as medication, to control the condition. The law states:

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.

42 U.S.C. § 12102(4)(E)(i); 29 C.F.R. § 1630.2(j)(1)(vi). ("In effect, these provisions [regarding mitigating measures] require courts to look at a plaintiff's impairment in a hypothetical state where it remains untreated." *Harty v. City of Sanford*, 2012 U.S. Dist. Lexis 111121, \*12 (M.D. Fla. Aug. 8, 2012). For individuals with diabetes, this means that the beneficial effects of insulin, oral medications, diet<sup>26</sup> and exercise in treating the disease may not be considered in determining the existence of a disability.<sup>27</sup> Instead, the

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<sup>26</sup> Cf. *Kravtsov v. Town of Greenburgh*, 2012 U.S. Dist. Lexis 94819, \*20 (S.D.N.Y. July 9, 2012) (meal planning was a mitigating measure whose effects could not be considered).

<sup>27</sup> The negative effects of such measures may still be considered. 42 U.S.C. § 12102(E)(i); 29 C.F.R. § 1630.2(j)(1)(vi). Thus, the hypoglycemia that can result from taking too much insulin could be used to

focus must be on the condition as it exists in its unmedicated state. *See Rohr, supra*, 555 F. 3d at 862 (“Impairments are to be evaluated in their *unmitigated* state, so that, for example, diabetes will be assessed in terms of its limitations on major life activities when the diabetic does *not* take insulin injections or medicine”) (emphasis in original).<sup>28</sup> Likewise, the effects of any complications the individual experiences due to diabetes, such as vision loss or neuropathy, must be considered without regard to any medication or treatment employed, as well as any devices or technology the individual uses such as a prosthesis or screen reader software.<sup>29</sup>

Diabetes in its unmitigated state will substantially limit many major life activities. Type 1 diabetes, without insulin, will cause sickness within hours and death within days or weeks, thus limiting all major life activities.<sup>30</sup> Type 2 diabetes also will cause severe health problems if not treated, although these complications will develop over a longer period of time. Either way, the effects of untreated diabetes, as discussed above, are well established and can be easily shown through a report or affidavit from a physician.

### **A Road Map for Establishing Coverage**

As the above discussion makes clear, it is now simple and straightforward to show that diabetes is a disability under the ADA. However, successfully making this showing depends on framing arguments correctly and on knowing what evidence to present about diabetes. This section presents some practical advice on these issues.

#### Choosing the Best Path to Coverage

At the outset of a case, the attorney will need to decide what arguments to use to show that diabetes is a disability. There are multiple ways to make that showing, based on the various new statutory rules of construction that the ADAAA provides as well as how diabetes impacts the plaintiff. While there is nothing wrong with making arguments in the alternative and presenting evidence on multiple fronts, those arguments should be

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show that diabetes substantially limits major life activities. 76 Fed. Reg. 16978, *See Willoughby, supra*, 2013 U.S. Dist. Lexis 168457 at \*26 (plaintiff with type 2 diabetes was experiencing symptoms of hyperglycemia and passed out at work, thus supporting the conclusion that he had a disability). 16982. However, this approach is not recommended because it may raise questions about the individual’s ability to safely do the job.

<sup>28</sup> *See Gogos v. AMS Mechanical Systems, Inc.*, 737 F.3d 1170, 1173 (7<sup>th</sup> Cir. 2013) (unmitigated hypertension could substantially limit circulatory and cardiovascular function); *Suggs v. Central Oil of Baton Rouge*, 2014 U.S. Dist. Lexis 90825, \*14-\*15 (M.D. La. Jul. 3, 2014) (plaintiff’s carotid artery disease substantially limited circulatory function when analyzed without the use of blood thinner and cholesterol medication).

<sup>29</sup> Whether an individual actually takes advantage of mitigating measures is irrelevant to consideration of whether that individual has a disability. 29 C.F.R. pt. 1630, app., § 1630.2(j)(1)(vi). Thus, for example, the fact that a person with diabetes failed to comply fully with diet and exercise recommendations or failed to take all prescribed medication is irrelevant in the analysis of coverage under the ADA.

<sup>30</sup> One court recently noted, in an ERISA case involving an individual with type 1 diabetes arising just before the effective date of the ADAAA, that the amended language prohibiting consideration of mitigating measures “clearly impacts plaintiffs suffering from diabetes. . . . Plaintiff could have raised a strong case for disability on his ERISA claims by analogy, had the ADAAA become effective earlier.” *Rhodes v. Principal Fin. Group, Inc.*, 2011 U.S. Dist. Lexis 150011 (M.D. Pa. Dec. 30, 2011).

prioritized to focus the attention of the defendants and the court on the one that provides the clearest path to coverage. Asserting too many different bases for coverage can confuse and distract the court, so it is best to start with a primary argument and add others in the alternative if appropriate.

*Regarded As Claims.* For cases involving discriminatory treatment of an individual based on diabetes in hiring, firing or another term or condition of employment, rather than a failure to provide reasonable accommodations, the argument should be that the individual was regarded as disabled. Since coverage under the “regarded as” prong is based on the existence of an impairment that is neither minor nor transitory, rather than limitations on major life activities, all that need be alleged in these cases is that the individual has diabetes, that diabetes is an impairment, and the individual was subjected to discrimination because of that condition. If there is a chance that the individual may need reasonable accommodations on the job or that this inquiry might be relevant to the case, attorneys should also claim, in the alternative, that the employee has a disability because of a substantial limitation on endocrine function (and perhaps for other reasons, as discussed below). But the focus should remain on “regarded as,” as this is the easiest way to address coverage in these cases.

*Substantial Limitation in Endocrine Function.* Where reasonable accommodations are at issue, the focus should first be on showing that the plaintiff’s diabetes substantially limits the major life activity of endocrine function. As discussed above, diabetes by its very nature substantially limits endocrine function, and the EEOC’s implementing regulations recognize this fact by declaring that it will nearly always be a disability.

*Endocrine Function “Plus.”* Since few courts have construed the new “major bodily functions” category of major life activities created by the ADAAA, in early cases it may be advisable to also plead other theories of coverage, but endocrine function should be the primary argument.<sup>31</sup> A good alternative argument, especially for individuals with type 1 diabetes, is that the disease in its unmitigated state substantially limits a range of major life activities, since it will cause severe health problems (and death) within days or weeks if not treated with insulin. Diabetes in its unmitigated state will also substantially limit those with type 2 diabetes, though somewhat more medical evidence may be required to make this showing.

While in certain cases it may be useful to argue other theories, including that the negative effects of insulin therapy (particularly hypoglycemia) are substantially limiting, or that diabetes is an episodic condition which is substantially limiting when the individual is

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<sup>31</sup> According to the EEOC, “[I]n many instances it will not be necessary to consider the non-ameliorative effects of mitigating measures to determine that an impairment is substantially limiting. For example, whether diabetes is substantially limiting will most often be analyzed by considering its effects on endocrine functions in the absence of mitigating measures such as medications or insulin, rather than by considering the measures someone must undertake to keep the condition under control (such as frequent blood sugar and insulin monitoring and rigid adherence to dietary restrictions).” 76 Fed. Reg. 16978, 16982.

experiencing hypoglycemia or hyperglycemia,<sup>32</sup> great care should be taken with these arguments. They will be unnecessary if the above arguments are pursued with appropriate evidence, and they will be risky in some (and possibly most) cases, particularly where safety sensitive jobs are at issue, because they require putting in evidence about the negative health effects and complications that the individual will face because of diabetes. Generally, such evidence is not needed in the coverage analysis. Also, such evidence may reinforce unfounded fears and stereotypes about including people with diabetes in the workplace.

### Proper Medical Evidence

Another important question in these cases is what and how much evidence to introduce about diabetes and its effects. As noted above, in “regarded as” cases, a diagnosis of diabetes should be sufficient, as diabetes is clearly a physical impairment that is neither transitory nor minor. However, in order to prove actual disability, the way diabetes substantially limits endocrine function or another major life activity must be shown. This proof need not be extensive or elaborate, but it is important in early cases to put in sufficient evidence of limitations, rather than simply relying on a diagnosis. This evidence should take the form of an affidavit or report from a physician describing diabetes and how it impacts the functioning of the endocrine system, and giving any details about the individual’s condition or treatment that are relevant. The physician need not be an endocrinologist, and can be the individual’s treating physician, but must have enough knowledge of diabetes to explain the condition clearly in a report (and to the jury if necessary). If the attorney is also asserting that diabetes in its unmitigated state limits other major life activities of the individual, the report should also address the consequences that he or she would face absent current treatment. The medical information earlier in this paper could be used as a guide in drafting such a report.

### Procedural Issues

The goal of the ADAAA is to remove coverage issues from their central place in ADA litigation. As such, in litigating these cases every effort should be made to resolve the issue of coverage early in the case and with minimal discovery and use of court resources, so that effort can be focused on the real issues in the case, such as whether the individual is qualified for the position, whether he or she poses a genuine and material safety risk, or what accommodations would be reasonable. Accordingly, attorneys should seek a stipulation from defendants that the plaintiff is disabled as early as possible. Given the overwhelming evidence of legislative intent that diabetes is a covered disability and the clear guidance on this issue contained in the EEOC regulations, the hope is that many defendants will agree to such a stipulation. For those that will not, attorneys should consider filing an early motion for partial summary judgment on this issue or establishing this fact under Fed. R. Civ. P. 56(g). Since little, if any, discovery from the defendants

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<sup>32</sup> The ADAAA provides: “An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.” 42 U.S.C. § 12102(4)(D); 29 C.F.R. § 1630.2(j)(1)(vii). See 29 C.F.R. Pt. 1630 app., § 1630.2(j)(1)(vii) (including diabetes among a list of conditions whose effects can be episodic and thus disabling).

will be needed to make the showing that the plaintiff's diabetes is a disability, such a motion could be prepared and filed quickly. The main focus in discovery will be the appropriate report or affidavit from a physician, as described above. Presenting such a report will encourage defendants to stipulate on the issue and, if they will not, provides the foundation for summary judgment at an early stage.

### **Conclusion**

The intent and promise of the ADA is to turn the question of eligibility under the ADA from the most frequently debated and litigated legal issue to a threshold question of minor importance that will not serve as a barrier to people with chronic diseases and medical conditions such as diabetes. As described above, it accomplishes this goal through several provisions designed to overturn narrow interpretations by the courts and by providing new ways to establish coverage. Advocates should thus feel confident that they can establish coverage for people with diabetes under the ADA.

The American Diabetes Association stands ready to assist attorneys bringing these pioneering cases. The Association provides extensive resources on this and other aspects of diabetes discrimination litigation on its website at <http://www.diabetes.org/attorneymaterials>. This site includes case lists, articles like this one discussing relevant legal issues, and pleadings and other materials from key cases that have successfully addressed these issues. The Association also provides assistance to attorneys bringing diabetes discrimination cases, including assistance in shaping arguments and drafting briefs. Lawyers with questions about a specific case are encouraged to e-mail [legaladvocate@diabetes.org](mailto:legaladvocate@diabetes.org).

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## Resources on Diabetes

### Website and Pamphlets

The American Diabetes Association (Association) has a great deal of information about diabetes, its complications and its treatment on its web site, <http://www.diabetes.org>. In the “All About Diabetes” section are pages on numerous topics that can be useful as background for attorneys who have clients with diabetes. In addition, pamphlets describing diabetes and its treatment and care can be obtained by calling 1-800-DIABETES.

The Association’s website has extensive information for lawyers litigating diabetes discrimination cases under the ADA. Of particular interest are a comprehensive list of diabetes cases (including pre-*Sutton* decisions considering diabetes in its unmitigated state) and briefs and other litigation materials from numerous cases. These resources can be accessed at <http://www.diabetes.org/attorneymaterials>. Individual questions should be referred to [legaladvocate@diabetes.org](mailto:legaladvocate@diabetes.org)

### American Diabetes Association’s Clinical Practice Recommendations

The Association’s Clinical Practice Recommendations are the most authoritative and widely-followed guidelines for the treatment of diabetes. They represent the official opinion of the Association as denoted by formal review and approval by the Professional Practice Committee and the Executive Committee of the Board of Directors. They are published each January as a supplement to *Diabetes Care*, the Association’s peer-reviewed journal for diabetes health care professionals. The Introduction to these Recommendations further explains their origins. The current Clinical Practice Recommendations can be found online at: [http://care.diabetesjournals.org/content/34/Supplement\\_1](http://care.diabetesjournals.org/content/34/Supplement_1).

Some of the more broadly applicable Recommendations that address the functional limitations issues are: Standards of Medical Care for Patients with Diabetes Mellitus; Diabetes and Employment; and Diagnosis and Classification of Diabetes Mellitus.

### Books

Numerous Association books provide more detailed explanations of the issues discussed above. *The American Diabetes Association Complete Guide to Diabetes* (5<sup>th</sup> ed., 2011) is intended for a lay audience. *Medical Management of Type 1 Diabetes* (5<sup>th</sup> ed. 2008), *Medical Management of Type 2 Diabetes* (6<sup>th</sup> ed. 2008), and *Therapy for Diabetes Mellitus and Related Disorders* (5<sup>th</sup> ed. 2009) are geared toward a health care professional audience. These books can be obtained by calling 1-800-DIABETES or through the Association’s website at <http://shopdiabetes.org/>.

