BEFORE THE MONTANA DEPARTMENT
OF LABOR AND INDUSTRY

IN THE MATTER OF HUMAN RIGHTS BUREAU CASE NO. 0065011637:

MARLENE MCGILLIVRAY,	) Case No. 1942-2006
	)
Charging Party,	)
	)
vs.	)
	)
MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES, HELENA, MONTANA,	)
	)
Respondent.	)

IN THE MATTER OF HUMAN RIGHTS BUREAU CASE NO. 0065011638:

MARLENE MCGILLIVRAY,	) Case No. 1944-2006
	)
Charging Party,	)
	)
vs.	)
	)
MEDICAID SERVICES DIVISION OF THE MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES, HELENA, MONTANA,	)
	)
Respondent.	)

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FINAL AGENCY DECISION

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I. PROCEDURE AND PRELIMINARY MATTERS

On August 17, 2005, charging party Marlene McGillivray filed a complaint with the Montana Department of Labor and Industry ("department") alleging that respondent, Montana Department of Public Health and Human Services (DPHHS) discriminated against McGillivray because of her disability (morbid obesity) by denying her (in accord with administrative rules adopted by DPHHS) any services for treatment, control or reduction of her disability. The

department, acting through its Human Rights Bureau, divided the complaint into two complaints for investigation, and on March 22, 2006, referred both complaints, as separate complaints, to the Hearings Bureau for contested case hearing proceedings. Terry Spear, the presiding hearing examiner herein, consolidated the two complaints, and ultimately scheduled the hearing for the consolidated cases.

On August 7-8, 2006, hearing examiner Terry Spear held a contested case hearing in Helena, Montana, where the alleged discrimination took place. Beth Brenneman, Montana Advocacy Program, represented McGillivray. Geralyn Driscoll and Eli Clarkson, DPHHS Office of Legal Affairs, represented DPHHS, (the respondent in both cases), which attended the hearing through its designated representative, Mary Dalton. Terry Smith, Marlene McGillivray, Tammy Lowry, Dan Peterson, Duane Phreshinger, Roger Citron, Steven Helgerson, M.D., Denise Brunette, Scott Sim and Nancy Clark testified in person. The hearing examiner admitted Exhibits 1 through 3, 5 (Exhibit 5 is the abstract of an article appearing in Exhibit NN), 8, 16, 17, 37, A, C, D-G, J-K, N-Q (Exhibit P is duplicative of Exhibit 1), T, V through Y (Exhibit Y is admitted as proof that its contents were stated, not that its contents are true), AA, BB, DD, FF through II (Exhibit II is duplicative of Exhibit 3) and MM through PP into evidence during hearing. Exhibits 8, A and T have been redacted to protect privacy (see Post Hearing Final Sealing Order). After the hearing, McGillivray timely objected to Exhibits QQ and RR. The hearing examiner now takes judicial notice that publication of research in any medical journal provides sufficient guarantees of trustworthiness, in that at least a segment of the medical community considers the information in the article reliable and potentially authoritative, to justify admission of Exhibit QQ when the article addresses issues of medical care relevant to this case. Therefore, Exhibit QQ is admitted. The hearing examiner refuses Exhibit RR, sustaining the objection to untimely disclosure. A final sealing order accompanies this decision.

The parties submitted their post hearing proposed decisions and briefs, and the matter was submitted for decision. A copy of the Hearings Bureau docket for this file accompanies this decision.

DPHHS challenged jurisdiction, arguing that it had the discretion to make coverage decisions within the applicable public health and human services statutes and that McGillivray's failure to seek judicial review of the decision of the Montana Board of Public Assistance (***see*** Finding of Fact No. 16, ***infra***) barred McGillivray's complaint. DPHHS's discretion does not include violating Montana anti-discrimination laws in making its coverage decisions, and the Board of Public Assistance has no power to decide discrimination charges. McGillivray's complaint containing such charges invokes the Department of Labor and Industry's exclusive jurisdiction under the Montana Human Rights Act. Mont. Code Ann. § 49-2-509(7).

II. ISSUES

The determinative issue for this case is whether DPHHS violated Montana's anti-discrimination laws by denying coverage of the services detailed in the original complaint. A full statement of the issues appears in the final prehearing statement.

III. FINDINGS OF FACT

1. The Montana Department of Public Health and Human Services (DPHHS) is and has been the agency of state government statutorily charged with implementing the Montana Medicaid Program (MMP). The unit within DPHHS that is responsible for administering MMP is part of DPHHS and there is no reason for separate designation of that unit in this case.

2. When there is not enough funding to provide all needed medical assistance under MMP to all eligible persons, DPHHS has the authority to set priorities that cut the amount, scope or duration of medical services covered under the program. There was never a time pertinent to this case when MMP had sufficient funding to cover all of the medical assistance its eligible recipients needed.

3. In administering MMP, DPHHS balances what services are covered and what access to services will exist at the rates MMP pays to providers. MMP relies upon a network of providers who accept Medicaid patients and provide medically necessary care at the MMP rates.

4. Effective February 1, 2003, DPHHS adopted changes in MMP coverages, as well as other programs, for cost saving reasons. DPHHS had previously made a number of cost cutting decisions in 1991 and 2002, but in the 2002/2003 biennium, Montana state government revenue sources fell short of projections and actual program costs exceeded legislative appropriation. DPHHS projected substantial budget deficits in MMP (as well as other programs) for State Fiscal Year 2003.

5. In 2003 DPHHS made reimbursement and coverage reductions in MMP, with the goal of maintaining its statewide network for providing medically necessary services to all persons eligible for and receiving MMP assistance while keeping the costs of covered services within the available funding.

6. Two of the changes addressed coverage of medical needs that often related to MMP clients with morbid obesity. DPHHS terminated MMP coverage for future prescriptions of weight loss medications. DPHHS also eliminated MMP coverage for gastric by-pass surgeries. These were two of many procedures and pharmaceuticals eliminated from coverage, at the same time as the uniform reduction in provider reimbursement rates.

7. DPHHS made the two pertinent changes in coverage (elimination of coverage for new weight loss medication recipients and of gastric by-pass surgery) in accord with recommendations from a Drug Utilization Review Board (for the weight loss medication) and an advisory panel regarding medical coverage issues (for the gastric by-pass surgery). Both the board and the panel were composed of qualified Montana health care professionals willing to consult with DPHHS about coverage.

8. In 2003 and at the time of this hearing, there were medical authorities and studies supporting the use of prescription weight loss medication and gastric by-pass surgeries to treat morbid obesity. There were also medical authorities and studies questioning whether the benefits were sufficient to justify the amount of use of both courses of treatment. The evidence adduced in this case does not establish whether or not the two courses of treatment were being overused, only that some questions existed and still exist about their cost-effectiveness. In other words, it was reasonable to stop covering the two courses of treatment to save money, and it would have been reasonable to continue coverage of the two courses of treatment had there not been a shortage of money.

9. In making the February 1, 2003, changes, DPHHS did not act out of any discriminatory animus toward morbidly obese individuals. DPHHS was facing a shortage of funding for the current and projected level of MMP covered costs. As a result, DPHHS was attempting to cut MMP costs by identifying and eliminating MMP coverages with *less certain* utility and/or excessive cost, compared to the probable discernible long-term benefits for the involved individuals. A DPHHS witness agreed that this kind of cost cutting decision-making is "triage," sorting and allocating aid on the basis of need for or likely benefit from, in this instance, medical treatment, when there is not enough aid to meet all the need ("bang for the buck").

10. DPHHS went through the Montana Administrative Procedures Act administrative rules process and, after public hearing, properly adopted rules addressing its policy decisions, including elimination of coverage for bariatric surgery and weight loss pharmaceuticals.

11. Charging Party Marlene McGillivray has extreme or morbid obesity. She is 5 feet

and 2 ½ inches in height. From July 2004 to December 2005, her weight has ranged between 458 and 395 pounds, which equates to a Body Mass Index of 82 to 70. A Body Mass Index of 40 or above is considered morbidly obese. As the label suggests, morbid obesity substantially increases health risks for the sufferer.

12. McGillivray suffers from hypertension, asthma, sleep apnea, chronic back pain, high cholesterol, diabetes and congestive heart failure. The conditions are all "co-morbidities" that often appear in tandem with morbid obesity. These and other "co-morbidities" can result in part from morbid obesity and also will complicate the sufferer's medical treatment for both the "co-morbidities" and the morbid obesity. McGillivray also has hypothyroidism, an endocrine condition causing weight gain.

13. McGillivray has been overweight since she was 6 years old and has been morbidly obese the majority of her adult life. She has tried at least ten different diets over many years to lose weight. Although she has consistently complied with a low calorie diet and has periodically reduced her weight, she has been unable to maintain sufficient long-term weight reduction to recover from her morbid obesity. McGillivray, relying upon her own voluntary choices and behavior, has not recovered from her morbid obesity. It is not a temporary condition which she has been able to control and from which she has been reasonably able to recover.

14. Due to her multiple physical conditions, McGillivray has been and is substantially limited in the performance of multiple major life activities including walking, working, taking care of herself, sleeping, driving and shopping. She has been unable to work because of her overall physical condition since 2001. Her morbid obesity is a proximate cause (albeit not the only proximate cause) of her substantial limitations in performance of major life activities.

15. McGillivray is not currently an MMP client. In July 2004 through December 2005, she was eligible for and receiving Medicaid benefits from MMP.

16. In July 2004, McGillivray's treating physician, Dr. Terry Smith, prescribed the weight loss medication, phentermine. McGillivray applied for MMP coverage of phentermine. DPHHS denied the request pursuant to then-current MMP policy. She appealed that decision through MMP's internal procedures to the Montana Board of Public Assistance (MBPA). A hearing was held in Superior, Montana. A hearing officer for the MBPA heard the matter and issued a proposed decision on November 10, 2004, affirming the denial. (Attachment B of McGillivray's Complaint.) McGillivray appealed the proposed decision to the full Board, which issued an Order on March 11, 2005, upholding the decision. The period for seeking judicial review of that decision expired on April 11, 2005.

17. McGillivray and/or her treating Medicaid provider never sought prior authorization from MMP for bariatric surgery. Under then-current MMP policy, such authorization would have been withheld.

18. MMP provides a health care plan to indigent and needy Montana residents. It does not deny health plan eligibility based on any disability, including obesity. MMP covers provider visits related to treatment of obesity. MMP pays for some medical services related to treatment of obesity and its co-morbidities, including but not limited to treatment for diabetes, high blood pressure and orthopedic and arthritis related conditions. MMP paid claims for medical providers' covered treatment of McGillivray related to her morbid obesity and its co-morbidities after the changes in coverage, during July 2004 through December 2005..

19. In 2006 DPHHS again consulted its panel of practicing Montana physicians concerning Medicaid coverage issues. Gastric by-pass surgery was again one of the procedures considered, and the panel again advised that MMP should not cover the procedure.

20. If DPHHS had covered both use of weight loss pharmaceuticals and gastric by-pass surgery in July 2004 through December 2005, when McGillivray was eligible for and receiving Medicaid benefits from MMP, and if she had received both treatments, it is possible, but neither certain nor more likely than not, that her condition (morbid obesity) may have been ameliorated (***i.e.***, she may have lost some or a substantial amount of weight and maintained that weight loss). It is certain that, as a result of the 2003 coverage decisions, McGillivray (and any others similarly situated) lost the opportunity to attempt recovery from morbid obesity through prescription weight loss medication and gastric by-pass surgeries.

21. If DPHHS had chosen to maintain coverage of weight loss medication and gastric by-pass surgery for morbidly obese persons eligible and receiving MMP assistance beginning in 2003, MMP necessarily would have had less money to fund other kinds of assistance to its clients. DPHHS would then have been required to make cost reductions for other services.

IV. DISCUSSION[1]

A. McGillivray Proved Her *Prima Facie* Case

Montana law prohibits discrimination by the state in the provision of services because of disability. Mont. Code Ann. §§ 49-2-308(1)(a) and 49-3-205(1). To establish a *prima facie* case of disability discrimination in public services, McGillivray had to prove that (1) she had a disability; (2) she was as well qualified for, in this instance, the assistance of DPHHS in treatment of her disability as others receiving MMP assistance and (3) because of her disability, the state denied her the services. *Reeves v. Dairy Queen, Inc.*, ¶ 21, 1998 MT 13, 287 Mont. 196, 953 P.2d 703; *Hafner v. Conoco, Inc.* (1994), 268 Mont. 396, 886 P.2d 947, 950; ***see also*** *McDonnell Douglas Corp. v. Green* (1973), 411 U.S. 792.[2]

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[1] Statements of fact in this opinion are hereby incorporated by reference to supplement the fact findings. *Coffman v. Niece* (1940), 110 Mont. 541, 105 P.2d 661.

[2] These are not public services disability discrimination cases, but the same elements apply.

A disability is a physical or mental impairment substantially limiting one or more of a person's major life activities. Mont. Code Ann. § 49-2-101(19)(a). McGillivray is a person with a disability if she has an impairment that substantially limited one or more of her major life activities or a record of such an impairment or a condition regarded as such an impairment. ***Id.*** Work, for an applicable example, is a major life activity. *Martinell v. Montana Power Co.* (1994), 268 Mont. 292, 886 P.2d 421, 428. Clearly, on this record, McGillivray's morbid obesity does substantially limit several major life activities, including working, although her other medical conditions also contribute to her limitations.

Obesity that limits major life activities may sometimes develop and remain because of voluntary individual choices regarding diet, exercise, and so on. Such obesity may be a "temporary" condition which typically is not a disability under the law. *Adamson v. Pondera County*, ¶ 23, 2004 MT 27, 319 Mont. 378, 84 P.3d 1048, ***quoting*** EEOC Interpretive Guidelines to 29 C.F.R. § 1630.2:

> On the other hand, temporary, non-chronic impairments of short duration, with little or no long term or permanent impact, are usually not disabilities. Such impairments may include, but are not limited to, broken limbs, sprained joints, concussions, appendicitis, and influenza.

In the same section quoted in *Adamson*, the guidelines also cite obesity as a temporary condition, not as a disability: "Similarly, except in rare circumstances, obesity is not considered a disabling impairment."[3] Obesity resulting from personal choices and not from physical or mental abnormalities perhaps would be temporary and voluntary, and thus not a legal disability. Federal disability law applies reasoning like this in finding that drug addicts in recovery, but not current illegal drug users, can seek protection from disability discrimination laws. ***See***, ***e.g.***, *Davis v. Bucher* (E.D.Pa. 1978), 451 F. Supp. 791; ***see also***, 42 U.S.C. § 12210.

The federal guidelines' interpretative comments about when an impairment is substantially limiting explain the "rare circumstances" in which obesity is a disability:

> Part 1630 notes several factors that should be considered in making the determination of whether an impairment is substantially limiting. These factors are (1) the nature and severity of the impairment, (2) the duration or expected duration of the impairment, and (3) the permanent or long term impact, or the expected permanent or long term impact of, or resulting from, the impairment. The term "duration," as used in this context, refers to the length of time an impairment persists, while the term "impact" refers to the residual effects of an impairment. Thus, for example, a broken leg that takes eight weeks to heal is an impairment of fairly brief duration. However, if the broken leg heals improperly, the "impact" of the impairment would be the resulting

[3] ***Cf.***, *Soliz v. Continental Oil Co.* (H.R.C., 1978) No. RHE6-147 (***dicta***).

permanent limp. Likewise, the effect on cognitive functions resulting from traumatic head injury would be the "impact" of that impairment.

29 C.F.R., Part 1630 App., "Subtitle B--Regulations Relating to Labor, Chapter XIV--Equal Employment Opportunity Commission, Part 1630--Regulations to Implement the Equal Employment Provisions of the Americans with Disabilities Act" §1630.2(j).

McGillivray has a severe impairment due to her morbid obesity, a condition which has lasted for years and continues. The impact of her morbid obesity, which continues, is substantially limiting upon several major life activities, including working, as already noted. It strains reason beyond the breaking point to call a condition which has such a long and devastating impact "temporary and voluntary" without clear evidence that the condition is either. McGillivray has an actual legal disability proximately caused by morbid obesity, as well as her other medical conditions. She proved the first element of her *prima facie* case.

This decision emphatically does not find that McGillivray is doomed to be morbidly obese for life. One person suffering from a chronic, potentially fatal condition will progress through that condition to the bitter end. Another person, in seemingly identical circumstances, will find a way (medical, pharmaceutical, psychiatric, behavioral, etc.) to control and to improve the condition, even though the person was powerless to achieve that result in the past. There simply is no evidence that McGillivray could have controlled her obesity from her sixth birthday through 2005, but chose not to exercise that control. Her condition is neither "voluntary" nor "temporary," but it may still be remediable, even if use of weight control drugs and gastric by-pass surgery are foreclosed by cost.

McGillivray also proved the second element of her *prima facie* case. She was qualified for MMP assistance from July 2004 through December 2005, and was as qualified for that assistance as the other recipients of it.

McGillivray also proved that DPHHS eliminated two covered services, prescription of weight control drugs and gastric by-pass surgery, that are treatments for morbid obesity. Elimination of these treatments had an adverse impact upon morbidly obese persons, which was not felt by the more general population of MMP recipients. At the level of the third element of McGillivray's *prima facie* case, she proved that she was denied the coverage because she was morbidly obese; had she not been morbidly obese, she would not have needed the treatments.

B. DPHHS Has Shown a Legitimate Non-discriminatory Reason for its Action

McGillivray's *prima facie* case raises a legal inference that DPHHS's adverse action resulted from McGillivray's protected class status. This shifts the burden to DPHHS to "articulate some legitimate, nondiscriminatory reason" for its action. *McDonnell Douglas*, 411 U.S. ***at*** 802. This is the second tier of proof under *McDonnell Douglas*, imposed on DPHHS for two reasons:

> [It] meet[s] the plaintiff's prima facie case by presenting a legitimate reason for the action and . . . frame[s] the factual issue with sufficient clarity so that the plaintiff will have a full and fair opportunity to demonstrate pretext.

Texas Dept. of Comm. Affairs v. Burdine (1981), 450 U.S. 248, 255-56. DPHHS must clearly and specifically articulate a legitimate reason for its decision to end coverage of the two treatments. *Johnson v. Bozeman School Dist.* (Mont. 1987), 226 Mont. 134, 734 P.2d 209, 212.

Mont. Code Ann. § 53-6-101(12) states:

> If available funds are not sufficient to provide medical assistance for all eligible persons, the department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical services made available under the Montana medicaid program after taking into consideration the funding principles set forth in subsection (2) [of 53-6-101].

Mont. Code Ann. § 53-6-101(2) states:

> The department and the legislature shall consider the following funding principles when considering changes in medicaid policy that either increase or reduce services:
>
> > (a) protecting those persons who are most vulnerable and most in need, as defined by a combination of economic, social, and medical circumstances;
> > (b) giving preference to the elimination or restoration of an entire medicaid program or service, rather than sacrifice or augment the quality of care for several programs or services through dilution of funding; and
> > (c) giving priority to services that employ the science of prevention to reduce disability and illness, services that treat life-threatening conditions, and services that support independent or assisted living, including pain management, to reduce the need for acute inpatient or residential care.

DPHHS had a legitimate nondiscriminatory reason for ceasing to cover the treatments. It faced a financial crunch that required reduction in the amount it was spending in the MMP program, as well as in other programs. In choosing where to reduce its spending, DPHHS, relying upon health care professionals, assigned a lower priority to a number of services needed by MMP recipients for treatment of their conditions, because of cost-benefit analysis factors. Unable to cover everything, DPHHS made informed decisions about what coverages to end or diminish, in accord with its statutory mandates, without any discriminatory animus toward the persons (old, young, disabled in particular ways, etc.) who needed those covered services.

Every such decision necessarily allocates suffering. Those who bear the brunt of the coverage cuts often will deny that their needs should have received a lower priority than the needs of others, but coverage cuts inevitably cause some persons in need to suffer. Deciding which persons will suffer from a reduction in funding poses a fundamental human dilemma. In

crude form, it is the dilemma faced in a lifeboat containing more people than it can support for the likely time it will be at sea. The law does not require that such decisions be based on perfect reasons, or even that such decisions be based upon what a reviewing tribunal might consider the best possible reasons. What the law requires is that such decisions be "based on reasonable grounds." Mont. Code Ann. § 49-2-308(a).

At every policy making level, from the top of the legislative and executive branches of federal and state government to the government employees and health care professionals making recommendations, spending decisions regularly involve insufficient funds to cover the costs of all of the legitimate needs. DPHHS and virtually every other agency at every level will always be making "triage" decisions. DPHHS showed that it was motivated, in making this particular "triage" decision, by legitimate and nondiscriminatory factors rather than by animus against McGillivray or morbidly obese people generally.

C. McGillivray Did Not Establish Pretext

Once DPHHS produced a legitimate reason supporting its adverse action, McGillivray had the burden of showing that DPHHS's reason was in fact a pretext. *McDonnell Douglas* ***at*** 802; *Martinez v. Yellowstone County Welfare Dept.* (1981), 192 Mont. 42, 626 P.2d 242, 246. This is the third and last tier of proof required in *McDonnell Douglas*. Proof of the pretextual nature of DPHHS's proffered reason may be either direct or indirect: "She may succeed in this either directly by persuading the court that a discriminatory reason more likely motivated [DPHHS] or indirectly by showing that [DPHHS] 's proffered explanation is unworthy of credence" *Burdine*, 450 U.S. ***at*** 256.

Ultimately, McGillivray must persuade the fact finder, by a preponderance of the evidence, that DPHHS intentionally discriminated against her. *Johnson* ***at*** 213; ***see also*** , *Crockett v. City of Billings* (1988), 234 Mont. 87, 761 P.2d 813, 817-18. She did not.

McGillivray argued that DPHHS eliminated coverage of all treatments, beyond office visits, for morbid obesity (except continuation of coverage for persons already using prescribed weight loss medications), to accomplish minimal cost reductions. She argued that the impact upon her health (and perhaps that of others) was far too great to reject for such a small cost cut.

Her proof was not as strong as her argument. The evidence at hearing showed that DPHHS could project costs based upon past expenses, but could not be entirely accurate, since it could not predict how many people eligible for coverage would be prescribed the particular treatment. The number of eligible people in Montana who might need treatment for morbid obesity could only be estimated. The number of such people whose doctors would decide to prescribe these particular treatments was uncertain. The degree to which new medical literature might encourage or discourage medical decisions to prescribe these treatments was uncertain. The lengths of time particular patients would be prescribed weight loss medicine and prospective changes in the costs of the medicine, were uncertain. The likelihood that gastric by-pass surgeries would lead to the need for other treatments (suggested in part by some of

medical information) was uncertain. In short, the projected costs of coverage of these treatments could only be estimated, with no guarantees. What costs would be saved by these cuts (as well what benefits would be lost for the patients) was also uncertain.

DPHHS could have made other cuts instead of eliminating coverage of weight loss medication and gastric by-pass surgery, such as cutting coverage for medicine to assist smokers to stop. DPHHS did not have to prove that its decision was the only possible cut, aside from the other actual cuts. It did not have to prove that cutting coverage of weight loss medication and gastric by-pass surgery was "better" than any other possible cut. DPHHS had to prove, and did, that it acted upon a reasonable non-discriminatory basis, which McGillivray did not prove was pretextual.

The department does not substitute its judgment for that of DPHHS regarding a particular coverage decision, but only inquires whether the legitimate reason DPHHS proffered was a pretext. Each of the cost cutting decisions in 2003 could be seen (taken alone) as "not as good as" some other cut. Nevertheless, there were legitimate questions about the cost-effectiveness of the treatments targeted, and there were savings that, together with all the other cuts, allowed the programs to anticipate costs that appeared to be within their reduced budgets. The preponderance of the evidence supported the legitimate business reason in this case, rather than persuading the fact finder that the justifications were pretextual efforts to conceal discriminatory animus toward morbidly obese persons, such as McGillivray. As a small part of larger cost cuts, in the face of a budgetary crisis, these decisions were based upon legitimate and nondiscriminatory factors.

V. CONCLUSIONS OF LAW

1. The department has jurisdiction. Mont. Code Ann. § 49-2-509(7).

2. The Department of Public Health and Human Services did not illegally discriminate against Marlene McGillivray, because of disability, in its decisions regarding coverage of costs for prescription weight loss medication and gastric by-pass surgery. Mont. Code Ann. §§ 49-2-308(1)(a) and 49-3-205(1). The complaint must be dismissed. Mont. Code Ann. § 49-2-507.

VI. ORDER

1. Judgment is granted in favor of respondent Montana Department of Public Health and Human Services and its Medicaid Services Division and against charging party, Marlene McGillivray, on her complaint of illegal disability discrimination.

2. The complaint is dismissed.

DATED: May 8, 2007.

/s/ TERRY SPEAR
Terry Spear, Hearing Examiner
Hearings Bureau, Montana Department of Labor and Industry

* * * * * * * * * * *

CERTIFICATE OF MAILING

True and correct copies of this decision were served today by depositing them in the U.S. Mail, postage prepaid, addressed as follows:

BETH BRENNEMAN
MONTANA ADVOCACY PROGRAM
PO BOX 1681
HELENA MT 59624-1681

True and correct copies of this decision were served today by means of the State of Montana's Interdepartmental mail service, upon:

GERALYN DRISCOLL AND ELI CLARKSON
DPHHS - OFFICE OF LEGAL AFFAIRS
111 NORTH SANDERS
HELENA MT 59620

DATED this 8th day of May, 2007.

/s/ SANDRA PREBIL

Marlene McGillivray FAD tsp