

AIDS, Welfare, and Title II of the Americans with Disabilities Act

Armen H. Merjian†

INTRODUCTION

The Americans with Disabilities Act (ADA)¹ was enacted in 1990 to “provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.”² Among other things, the ADA seeks “to assure equality of opportunity, full participation, independent living and economic self-sufficiency for disabled people.”³ Both Human Immunodeficiency Virus (HIV)⁴ and Acquired Immune Deficiency Syndrome (AIDS)⁵ have been recognized as “disabilities”⁶ within the meaning of the ADA in the regulations that implement the act as well as in numerous cases brought under the statute.⁷ Indeed, HIV and AIDS were both among the disabilities Congress had in

† Member, New York and Connecticut Bars. B.A., Yale University, 1986; J.D., Columbia University, 1990. The author is the senior staff attorney at Housing Works, Inc. in New York and a former associate at the firm of Winthrop, Stimson, Putnam & Roberts in New York. The author thanks Ricardo Castro, Karen Dine, Brendan Hickey, Michael Kink, Susan Kohlmann, Teresa McGovern, June Scarlett, and Virginia Shubert, who lent considerable assistance in the formulation and writing of this Article. The author also acknowledges the support that Winthrop, Stimson, Putnam, & Roberts provided in the preparation of this Article.

1. 42 U.S.C. §§ 12101-12213 (1994).

2. 42 U.S.C. § 12101 (1994).

3. ADA COMPLIANCE GUIDE ¶ 100 (Thompson Publ'g Group, Inc., 1990 & Supp. Dec. 1992).

4. HIV is the virus that causes AIDS. See LYN R. FRUMKIN & JOHN M. LEONARD, QUESTIONS AND ANSWERS ON AIDS 1, 5-6 (3d ed. 1997); see also Ray v. School Dist., 666 F. Supp. 1524, 1529 (M.D. Fla. 1987) (“Current medical researchers have concluded that AIDS is caused by infection with human immuno-deficiency virus (HIV).”); Janine Sisak, *Confidentiality, Counseling, and Care: When Others Need to Know What Clients Need to Disclose*, 65 FORD. L. REV. 2747, 2747 n.1 (1997) (“HIV is a virus that damages the body's immune system, leaving it vulnerable to a wide variety of opportunistic infections and malignancies, which in turn produce an array of symptoms known as [AIDS].”); discussion *infra* Section I.A.

5. See discussion *infra* Section I.A.

6. For an excellent discussion of the evolving terminology used to describe disabilities, see Robert L. Burgdorf, Jr., *The Americans with Disabilities Act: Analysis and Implications of a Second-Generation Civil Rights Statute*, 1991 HARV. C.R.-C.L. L. REV. 413, 414 n.7. As Burgdorf explains, “[p]hraseology is a significant issue with regard to disabilities.” *Id.* This Article will use the currently-preferred terminology, as described by Burgdorf, except when quoting original materials.

7. See discussion *infra* Section III.A.

mind when it passed the ADA.⁸

Since 1990, numerous cases have been brought by persons living with HIV disease and AIDS under Title I of the Act, which addresses discrimination in employment.⁹ By contrast, an extremely small number of cases have been brought under Title II of the Act, which "generally prohibits a public entity from excluding a qualified individual with a disability from services, programs, or activities of the public entity."¹⁰ Persons with HIV and AIDS nonetheless continue to face discrimination on a daily basis from governmental bodies throughout the United States. This Article examines one such form of discrimination: unequal provision of social welfare benefits and services.

Undoubtedly, this discrimination is often unintentional, the result of oversight and disregard rather than discriminatory animus.¹¹ This does not mean, however, that its effects are any less pernicious. Regardless of intent, a city museum that opens its doors to all but provides no ramp effectively discriminates against those who cannot climb its stairs. The same is true of providers of social welfare benefits and services. Owing to the unique nature of the disease, persons living with AIDS require special accommodations—a "ramp," as it were—to access and maintain the social welfare benefits and services to which they are entitled. As discussed below, these special accommodations include home and hospital visits, specialized training of case workers, and low case worker-to-client ratios to ensure that the complex and rapidly-changing needs of clients are met. By failing to provide that ramp, governmental entities throughout the United States¹² are effectively discriminating against those in dire need of these benefits and services.¹³

8. See discussion *infra* notes 80-89 and accompanying text.

9. Title I prohibits discrimination on the basis of disability by any employer of more than 15 employees. See 42 U.S.C. §§ 12111-12117 (1994). Title III prohibits public accommodations, including hotels, restaurants, and retail stores, from denying persons with disabilities equal access to their services. See 42 U.S.C. §§ 12181-12201 (1994).

10. *Tyler v. City of Manhattan*, 857 F. Supp. 800, 817 (D. Kan. 1994).

11. See, e.g., Nancy Lee Jones, *Overview and Essential Requirements of the Americans with Disabilities Act*, 64 TEMP. L. REV. 471, 476 (1991) ("[U]nlike discrimination based on race, sex, or national origin, discrimination against disabled persons more often stems from thoughtlessness or ignorance of their abilities than from ill will.").

12. At the end of 1997, the cities of Albany, New York; Atlanta, Georgia; Cleveland, Ohio; Little Rock, Arkansas; Omaha, Nebraska; and New Haven, Connecticut—to name but a random few—did not provide specialized assistance or make reasonable modifications to policies, practices, and procedures to ensure persons with AIDS meaningful and equal access to social welfare benefits and services.

13. "According to the Federal Centers for Disease Control and Prevention, 750,000 Americans are infected with HIV, and fewer than 1 in 5 of them have private health insurance. Roughly half are insured by Medicaid or other government programs, but 29 percent have no insurance at all." Sheryl Gay Stolberg, *AIDS Drugs Elude the Grasp of Many of the Poor*, N.Y. TIMES, Oct. 14, 1997, at A21. Of the individuals with HIV, an estimated 259,000 were living with AIDS as of July 1997. See National Institute of Allergy and Infectious Diseases

In enacting the ADA, Congress sought to eradicate this sort of "unintentional" discrimination. As the Third Circuit has observed, "the ADA attempts to eliminate the effects of . . . 'benign neglect,' 'apathy,' and 'indifference.'"¹⁴ Accordingly, "[t]he prohibition of Title II applies to action that carries a discriminatory effect, regardless of the [government's] motive or intent."¹⁵ The ADA requires, moreover, that public entities "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability."¹⁶ The Act "stress[es] the concept of equal opportunity, not merely equal treatment, to eliminate discrimination."¹⁷ The ADA thus serves as a potent and, in many ways, novel weapon in the struggle against the "unintentional" discrimination that unfortunately plagues many of the nation's social service providers.¹⁸ The ADA can provide a means of redress, particularly in those municipalities where persons with AIDS lack the political power to secure legislation to accommodate their special needs.¹⁹

In this Article, I argue that public entities that fail reasonably to accommodate persons with AIDS in providing social welfare benefits and services are in clear violation of Title II of the ADA. Part I of this Article provides a layperson's guide to the unique characteristics of AIDS. This section, while brief, is vital to understanding the need for reasonable modifications in public policies, practices, and procedures to avoid discriminating against persons with AIDS, as mandated under Title II of the Act. Section I.A describes the nature of the disease, while Section I.B demonstrates how the disease affects the ability of persons with AIDS to access and maintain social welfare benefits and services.

Part II provides a brief introduction to Title II of the ADA. Section II.A demonstrates that Title II is a powerful and comprehensive civil rights law that was created, in part, to combat the discrimination ad-

[hereinafter NIAID], *HIV AIDS Statistics* (visited Nov. 7, 1997) <<http://www.niaid.nih.gov/factsheets/aidsstat.htm>>.

14. *Helen L. v. DiDario*, 46 F.3d 325, 335 (3d Cir. 1995).

15. *Tyler*, 857 F. Supp. at 817; see also H.R. REP. NO. 101-485(II), at 29 (1990), *reprinted in* 1990 U.S.C.A.N. 303, 310 ("Discrimination against people with disabilities results from actions or inactions that discriminate by effect as well as by intent or design."); *infra* note 56.

16. 28 C.F.R. § 35.130(b)(7) (1997).

17. ADA COMPLIANCE GUIDE, *supra* note 3, ¶ 804 (Supp. Dec. 1991).

18. In passing the ADA, Congress was well aware of the discrimination suffered by the disabled in social service programs. For example, Representative Levine specifically noted that nonfederally-funded social service programs offered by state and local governments "have often been out of reach to disabled persons." 136 CONG. REC. H2633 (daily ed. May 22, 1990) (statement of Rep. Levine).

19. As the discussion in Subsection III.C.2. indicates, a New York federal district court recently confirmed the right of persons with AIDS to reasonable modifications in the provision of social welfare benefits under the ADA. See *Henrietta D. v. Giuliani*, No. 95-CV-0641, 1996 WL 633382 (E.D.N.Y. Oct. 25, 1996).

dressed in this Article. Section II.B establishes the requirements for stating an ADA claim. Part III presents the legal argument for applying Title II to the provision of social welfare benefits and services to persons with AIDS, asserting that the requirements for a claim under Title II are easily met under the circumstances. The Article concludes by noting that the changing demographics of HIV disease only heighten the need to extend the protections afforded by Title II to persons with AIDS who are seeking social welfare benefits and services.

I. BACKGROUND

Gloria M. was a 44-year-old woman residing in Brooklyn, New York, who learned that she was HIV positive in 1987. In 1992, she began to develop HIV-related symptoms. In the same year, Gloria stopped working and was accepted for public assistance. She began to suffer numerous HIV-related symptoms, including severe weight loss, constant fatigue and nausea, and bouts of thrush, herpes, and neuropathy. In 1994, Gloria was admitted to a local hospital for what her doctor believed to be pneumonia. Knowing that she had a public assistance recertification appointment scheduled, she asked the hospital social worker to contact her public assistance case worker and inform the case worker that she was hospitalized and unable to make the appointment. The case worker did not visit Gloria in the hospital or postpone the appointment. Instead, Gloria's public assistance case was closed, leaving her with no income to pay for utilities, rent, phone bills, or food. When Gloria called her case worker to complain, she was informed that her case would remain closed until she attended a face-to-face recertification appointment.

After being diagnosed with tuberculosis, Gloria was discharged from the hospital. Although she was extremely ill and desperately in need of financial assistance, her case worker refused to accommodate her, insisting on a face-to-face meeting at the case worker's office three weeks later. Despite her doctor's strict order to rest, Gloria, who walked with a cane due to weakness and severe neuropathy in her legs, was forced to travel a significant distance for the appointment. She took two subways and walked six blocks in the cold to get to the office. When she arrived, her case worker informed her that she needed numerous additional documents before her public assistance case could be reopened. She had not received food stamps, rent, or cash assistance in two months.²⁰

Sadly, the case of Gloria M. is by no means atypical for persons with

20. I am indebted to Cynthia Schneider, Esq. for this story, which is based upon an actual case that she handled.

AIDS.²¹ In cities throughout the United States, no such accommodations are even attempted, leaving individuals such as Gloria M. helpless to negotiate the Byzantine series of agencies upon which they depend for their livelihood.²²

The following discussion provides a short introduction to HIV disease and the unique challenges that persons with AIDS face. Section I.A briefly describes the nature of HIV disease and the unique physical limitations and medical problems that persons with AIDS face. Section I.B examines why persons with AIDS require reasonable modifications of benefit system policies, practices, and procedures meaningfully to access social welfare benefits and services.

A. *The Nature of the Disease*

HIV disease is characterized by the progressive deterioration of the immune system.²³ In particular, "crucial immune cells called CD4+ T-cells are disabled and killed during the typical course of infection."²⁴ These cells, commonly referred to as "T-cells," play a critical role in fighting infections, "signalling other cells in the immune system to perform their special functions."²⁵ As the number of T-cells drops, persons with HIV become "particularly vulnerable to the opportunistic infections and cancers that typify AIDS, the end stage of HIV disease."²⁶ The term AIDS thus refers to the most advanced stage of HIV infection.²⁷ The United States Centers for Disease Control and Prevention (CDC), which is re-

21. Indeed, New York is one of the few American cities with a specialized Division of AIDS Services, established by Mayor Edward Koch in 1985 to accommodate the special needs of this community in accessing public benefits and services. See *infra* Subsection III.C.2.

22. See *supra* note 12.

23. See National Institute of Allergy and Infectious Diseases [hereinafter NIAID], *How HIV Causes AIDS* (visited Nov. 7, 1997) <<http://www.aegis.com/topics/hiiivandaids.html>>. For a general discussion of HIV/AIDS disease, see FRUMKIN & LEONARD, *supra* note 4.

24. NIAID, *supra* note 23; see also FRUMKIN & LEONARD, *supra* note 4, at 7 ("In HIV infection, a subset of T lymphocytes called CD4 lymphocytes are infected and killed by the HIV.").

25. NIAID, *supra* note 23; see also Ray v. School Dist., 666 F. Supp. 1524, 1529 (M.D. Fla. 1987) ("[T]he disease destroys, and generates qualitative abnormalities, in the victim's T-helper/inducer cells, which enable other components of the immune system to function. The virus thereby weakens the victim's immune system."); FRUMKIN & LEONARD, *supra* note 4, at 9 ("The subset of T cells called the CD4 lymphocyte or T-helper cells are critically important for coordinating and carrying out much of the immune response to tumors, viruses, fungi, and other types of microorganisms.").

26. NIAID, *supra* note 23; see also Deborah Dalrymple-Blackburn, Note, *AIDS, Prisoners, and the Americans with Disabilities Act*, 1995 UTAH L. REV. 839, 842 ("[O]nce active, the virus reproduces rapidly, depleting T-4 cells and compromising the infected individual's ability to fight infections or unusual cancers.") (citation omitted).

27. See, e.g., Benjamin R. v. Orkin Exterminating Co., 390 S.E.2d 814, 814 (W. Va. 1990) (defining AIDS as "the last phase of the incurable HIV disease"); FRUMKIN & LEONARD, *supra* note 4, at 29 ("AIDS is the final stage of HIV infection . . .").

sponsible for tracking the spread of AIDS in the United States, has developed official criteria for defining AIDS. Included in this definition are all HIV-infected individuals with fewer than 200 T-cells or any one of 26 clinical conditions that afflict individuals with advanced HIV disease.²⁸

Persons with AIDS are susceptible to diseases that normally do not cause illness in healthy people. "In people with AIDS, however, these infections are often severe and sometimes fatal because the immune system is so ravaged by HIV that the body cannot fight off certain bacteria, viruses and other microbes."²⁹ These opportunistic infections cause such symptoms as coughing, shortness of breath, seizures, dementia, severe and persistent diarrhea, fever, vision loss, severe headaches, wasting, extreme fatigue, nausea, vomiting, lack of coordination, coma, abdominal cramps, and difficult or painful swallowing.³⁰ Persons with AIDS are also prone to developing rare diseases such as *Pneumocystis carinii* pneumonia (PCP) and a form of skin cancer called Kaposi's sarcoma.³¹ These diseases are typically more aggressive and more difficult to treat in persons with AIDS.³² There is no known cure for AIDS.³³ Current medications only delay the onset of AIDS, mitigate the symptoms, treat the oppor-

28. The Centers for Disease Control defines AIDS as including all human immunodeficiency virus (HIV)-infected adolescents and adults aged 13 years or older who have either a) less than 200 CD4+ T-lymphocytes/ μ L; b) a CD4+ T-lymphocyte percentage of total lymphocytes of less than 14%; or c) or any one of 26 clinical conditions, including invasive cervical cancer, pulmonary tuberculosis, and recurrent pneumonia. See Centers for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults*, 41 MORBIDITY & MORTALITY WKLY. REP. No. RR-17, at 1 (Dec. 18, 1992). In children under 13 years of age, the definition of AIDS is similar except that lymphoid interstitial pneumonitis and recurrent bacterial infections are included in the list of clinical conditions. See Centers for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Classification System for Human Immunodeficiency Virus (HIV) Infection in Children Under 13 Years of Age*, 36 MORBIDITY & MORTALITY WKLY. REP. No. 15, at 224 (Apr. 24, 1987). See generally FRUMKIN & LEONARD, *supra* note 4, at 17-19 (setting forth the CDC definition).

29. National Institute of Allergy and Infectious Diseases [hereinafter NIAID], *HIV Infection and AIDS* (visited Nov. 7, 1997) <<http://www.aegis.com/topics/whataidsis/html>>; see also *Estate of William Behringer v. Medical Ctr.*, 592 A.2d 1251, 1267 (N.J. Super. Ct. Law Div. 1991) (noting that, with AIDS, "the body is unable to withstand infections it would normally suppress") (quoting *Doe v. Barrington*, 729 F. Supp. 376, 380 (D.N.J. 1990)).

30. See NIAID, *supra* note 29; FRUMKIN & LEONARD, *supra* note 4, at 30.

31. See, e.g., *Benjamin R.*, 390 S.E.2d at 815 n.2; JOHN G. BARTLETT & ANN K. FINKBEINER, *THE GUIDE TO LIVING WITH HIV INFECTION* 72-75 (3d ed. 1996); FRUMKIN & LEONARD, *supra* note 4, at 33-36.

32. See NIAID, *supra* note 29; see also Dalrymple-Blackburn, *supra* note 26, at 842 n.25 ("AIDS Dementia Complex, a neurological disorder which causes cognitive motor, and behavioral dysfunction, may afflict individuals in either early or advanced stages of infection.") (citing Leon D. Prockop, *AIDS Dementia Complex*, 9 J. LEGAL MED. 509, 512 (1988)).

33. See Lawrence O. Gostin, *The Resurgent Tuberculosis Epidemic in the Era of AIDS: Reflections on Public Health, Law, and Society*, 54 MD. L. REV. 1, 8 (1995) ("[T]here are no biological methods to render persons infected with HIV non-infectious, and pharmacological preventions and treatments are neither fully preventive nor curative.").

tunistic infections, and possibly delay death.³⁴

B. The Need for Reasonable Modifications

The unique characteristics of AIDS make it extremely difficult or impossible for persons with AIDS to access benefit systems with onerous application processes; ongoing documentation requirements; constant, mandatory office appointments; infection-ridden waiting rooms and shelters; and understaffed offices whose employees are not trained to understand or to accommodate the needs of persons with AIDS.³⁵ Accordingly, persons with AIDS require reasonable modifications of such policies, practices, and procedures to assure not only equal but meaningful access to social welfare benefits and services.

Quite simply, persons with AIDS have special needs. "The opportunistic infections and chronic conditions that result from a weakened immune system limit the HIV-infected person's ability to engage in usual activities of daily life such as traveling, standing in line, attending scheduled appointments, completing paper work, and otherwise negotiating medical and social-service bureaucracies."³⁶ These individuals often experience a rapid deterioration in health requiring several categories of assistance at once. Constant need for medical attention disrupts the ability of persons with AIDS to fulfill application and reporting requirements.³⁷ Frequent and extended hospitalization makes it difficult or impossible to attend required appointments with case workers.³⁸ Due to the stigma attached to HIV disease, moreover, these individuals are often estranged from family and friends and thus cannot enlist the assistance of others.³⁹

34. See Dalrymple-Blackburn, *supra* note 26, at 843.

35. In many areas, one is required to be at the welfare office by 8:00 A.M. in order to make application, but then [may] be required to wait until 3:30 P.M. to see anyone. [She] then may be treated like just another number in an overburdened system, being told that certain forms are not complete (which may mean doing the process again after a week's delay), and being informed that there is no assistance available If welfare is available, there is often a delay of six weeks before it begins.

Jack Hamilton & Vicki L. Morris, *The Psychological Aspects of AIDS*, in *THE AIDS CAREGIVER'S HANDBOOK* 81, 88 (Ted Eidson ed., 1988).

36. Affidavit of Dr. Gabriel Torres, dated Feb. 14, 1995, ¶ 6, *Henrietta D. v. Giuliani*, No. 95-CV-0641 (S.D.N.Y.) (on file with the *Yale Law & Policy Review*).

37. See BARTLETT & FINKBEINER, *supra* note 31, at 202-03 ("People with HIV infection are in extraordinary need of help with work, home life, medical care, medical insurance, legal issues, finances, and psychological problems. Furthermore, people with HIV infection are subject to so many sudden changes in health that planning becomes difficult.")

38. "The precipitous changes in physical and emotional health status throughout the trajectory of the disease and the concomitant psychosocial and physiological problems present a challenging complexity of healthcare needs of persons with HIV/AIDS." R.A. Berk & J.P. Nanda, *Prediction of the Healthcare Needs of Persons with HIV/AIDS from Preliminary Health Assessment Information*, 9 AIDS CARE 143, 143 (1997).

39. See, e.g., William A. Bradford, Jr., *Rendering Legal Aid to People with AIDS*, PRAC. LAW., June 1991, at 23, 25-26 ("Many in the PWA [Persons With AIDS] community have been

Meanwhile, case workers with exorbitant client caseloads find it difficult or impossible to assist clients fully with such substantial needs.⁴⁰

The severe and recurrent nature of the disease⁴¹ makes it impossible to maintain open entitlement cases and thus leads to the closure of worthy and desperately important cases. In addition, the requirement that persons with AIDS travel to and wait in infection-ridden public waiting rooms is not only dangerous but life-threatening for these individuals with severely weakened immune systems.⁴² For example, persons with AIDS are highly susceptible to tuberculosis (TB)⁴³ and other infectious diseases. For this reason, persons with AIDS also require medically-appropriate transitional and permanent housing.⁴⁴

To assure the effectiveness of TB medications and new "drug cock-

shunned, vilified, and discriminated against by both the public and private sector, and have lost friends and family because of the stigma associated with the disease. . . . The health care community, the social welfare community, and the religious community have too often lacked compassion when dealing with infected individuals."); Rhonda R. Rivera, *Lawyers, Clients, and AIDS: Some Notes from the Trenches*, 49 OHIO ST. L.J. 883, 895 (1989) ("Many persons with ARC (AIDS-related complex) or AIDS have no biological family upon whom they can either rely or in whom they can trust.").

40. See Bradford, *supra* note 39, at 27-28 ("In addition to the complicated regulations, problems in [the area of public entitlements] come from dealing with a bureaucracy that is sometimes lethargic and even hostile to PWAs."); THOMAS P. MCCORMICK, *THE AIDS BENEFITS HANDBOOK* 5 (1990) ("Workers are often rushed and overworked. Bureaucratic jargon, application forms, and notices to applicants can be well-nigh incomprehensible.").

41. See NIAID, *supra* note 29 ("Many people are so debilitated by the symptoms of AIDS that they are unable to hold steady employment or do household chores. Other people with AIDS may experience phases of intense life-threatening illness followed by phases of normal functioning.").

42. "Beyond the obvious impairment on the ability to procreate, even an asymptomatic HIV-positive individual can not travel freely. Such an individual must always be mindful of exposure to bacterial infection and fungi or even places requiring vaccinations." *Anderson v. Gus Mayer Boston Store*, 924 F. Supp. 763, 777 n.37 (E.D. Tex. 1996).

43. For an excellent and exhaustive discussion of the interplay between tuberculosis and HIV disease, see Gostin, *supra* note 33. Gostin explains:

The rate of new tuberculosis cases among persons with AIDS is almost 500 times that of the general population. This astonishing rate is most likely explained by the damage that the HIV disease does to the immune system. Many clinicians have long believed that persons with HIV infection are at increased risk of contracting [*Mycobacterium tuberculosis*] infection following exposure, and recent investigations of tuberculosis outbreaks in congregate settings have strongly supported this clinical perception.

Id. at 31-32 (citations omitted). Gostin also points out, *inter alia*, that the clinical course of tuberculosis is dramatically different in individuals with HIV disease, and that such individuals are more likely to be infected with drug-resistant strains of tuberculosis. See *id.* at 32, 33; see also Peter A. Selwyn, *Tuberculosis and AIDS: Epidemiologic, Clinical, and Social Dimensions*, 21 J.L. MED. & ETHICS 279, 280 (1993) ("[P]ersons with HIV infection and latent tuberculosis infection have a risk for development of active tuberculosis disease which is over 100 times increased compared to people not infected with HIV.").

44. See *Mixon v. Grinker*, 595 N.Y.S.2d 876, 878 (Sup. Ct. 1993) (challenging New York City's policy of placing persons with HIV disease in non-segregated shelters on the grounds that "placing HIV infected persons, whose immune systems are severely weakened, in a shelter where many residents have infectious diseases endangers the lives of the HIV infected individuals"), *aff'd in part and modified in part*, 627 N.Y.S.2d 668 (App. Div. 1995), *rev'd*, 669 N.E.2d 819 (N.Y. 1996).

tails" and protease inhibitors⁴⁵ now available to treat HIV disease, moreover, it is vital that persons with AIDS retain their Medicaid benefits. When these individuals lose their benefits, they are no longer able to secure medication. Individuals whose benefits are terminated also find it difficult or impossible to maintain treatment regimens while seeking to reactivate their benefits.⁴⁶ The consequences can be disastrous, since "[e]ven missing a few doses can ruin the treatment."⁴⁷ Failure to complete the treatment regimen results in grave danger and harm not only for the individuals in question, but also for society at large, since it is believed that uncompleted treatment regimens may generate more virulent strains of HIV⁴⁸ and the TB virus.⁴⁹

45. The latest development in the fight against HIV disease is the prescription of so-called "drug cocktails," which consist of two older AIDS drugs, such as AZT and 3TC, and the latest anti-viral drug, protease inhibitors. See, e.g., Elizabeth Kastor, *The New "Miracle" AIDS Drugs: A Dose of Hope and Hard Reality; Researchers Caution That Treatment Has Mixed Results*, WASH. POST, Sept. 5, 1996, at A1. When used in combination, these drugs have been found to reduce the levels of the HIV virus in some individuals to below detectable levels. See *id.*; see also Lawrence K. Altman, *Hope vs. Hype*, N.Y. TIMES, Jan. 19, 1997, § 1, at 1 ("There are several combinations, many that include the new protease inhibitors, or antiviral drugs. All can drive the amount of H.I.V., the AIDS virus, below the levels of detection in the blood for up to 18 months, which is as long as testing has been done."); Nigel Hawkes, *New Drugs Cut Level of HIV*, TIMES (London), July 8, 1996 (Home News Section) ("[A] triple-drug combination which included one of the protease inhibitors reduced the virus below detectable levels.").

46. Indeed, "[j]ust taking the combination therapy is a difficult regimen." *New Treatments Fail to Stop AIDS*, DETROIT NEWS, Sept. 30, 1997, at A1. This therapy includes "taking up to 20 pills a day in a rigid regimen that even the most compulsive person could find difficult." Lawrence K. Altman, *AIDS Meeting: Signs of Hope, and Obstacles*, N.Y. TIMES, July 7, 1996, § 1, at 1; see also Kastor, *supra* note 45 ("The drugs must be taken several times a day, some on an empty stomach, others with a high-fat meal. For those who suffer from HIV 'wasting syndrome' or other intestinal problems, managing to eat what they need is difficult enough without adding new complexities. And as AIDS increasingly becomes a disease of the poor and the drug-addicted, the complexities of such lives will only make treatment regimens more daunting.") (emphasis added).

47. *New Treatments Fail to Stop AIDS*, *supra* note 46; see also Altman, *supra* note 45 (noting that "skipping just a few doses can be a fatal step").

48. See Wendy E. Parmet & Daniel J. Jackson, *No Longer Disabled: The Legal Impact of the New Social Construction of HIV*, 23 AM. J.L. & MED. 7, 40-41 (1997):

In the campaign against tuberculosis, public health officials learned the importance of individuals adhering to and completing a drug therapy to prevent drug resistance. It is likely that similar vigilance in taking medication will be required in the case of the new protease inhibitors For society at large the result may be the development of drug-resistant strains of HIV that can later be communicated to other individuals. Thus, as is always true with an infectious disease, the fate of one individual affects the fate of others.

Id. (citations omitted); see also FRUMKIN & LEONARD, *supra* note 4, at 147-48 (noting that HIV may develop resistance to antiviral drugs); Altman, *supra* note 46 ("Drug-resistant strains of the virus might emerge among individuals who do not take the drugs according to schedule or who stop taking them because they feel better. Under such circumstances, resistant strains could be transmitted to others."); Denise Grady, *New Studies Offer Hope and Caution on AIDS Therapies*, N.Y. TIMES, Nov. 14, 1997, at A1 ("Failing to comply with the regimen can ultimately be fatal, with the development of resistant strains of the virus.").

49. See Gostin, *supra* note 33, at 15-16 ("If persons with tuberculosis take their medication in an incomplete or sporadic fashion, or if they receive suboptimal dosage or an insufficient number of drugs in the regimen, then the hardy bacilli survive and can go on to multiply and

Finally, the new drugs themselves create additional complications for persons with AIDS: "The most common side effects associated with protease inhibitors include nausea, diarrhea and other gastrointestinal symptoms. In addition, protease inhibitors can interact with other drugs resulting in serious side effects."⁵⁰ The requirement that many of the new drugs be refrigerated further complicates matters.⁵¹ Individuals taking the new drugs find it impossible to spend the significant time required to travel to and wait in social welfare offices lest they miss their scheduled dosages.

Reasonable modifications for persons with AIDS should include, among other things, hospital and home visits by social service case workers; low client-to-case worker ratios to ensure that case workers will be available to meet the considerable needs of persons living with AIDS; relaxation or waiver of office appointments, face-to-face recertification, and ongoing documentation requirements; access to all social welfare benefits and services through a single case worker in a single office; medically-appropriate transitional and permanent housing with refrigerated food and medicine storage; and a grace period for noncompliance with any requirements, during which a reasonable good faith search is conducted before benefits and services are terminated.⁵²

Finally, specialized training in the needs of clients with AIDS is essential to ensure meaningful and equal access to benefits and services and to avoid the misunderstanding and prejudice that persist against those with AIDS.⁵³ Training is also necessary to ensure that HIV-related informa-

produce drug-resistant active tuberculosis within months."). The result is disastrous not only for society—multi-drug-resistant tuberculosis has increased significantly since the mid-1980s—but, of course, for the individuals themselves, since "the outcome of treatment for persons with multidrug-resistant tuberculosis and the HIV infection is dire." *Id.* at 17.

50. NIAID, *supra* note 29; see also Parmet & Jackson, *supra* note 48, at 8 ("In fact, the new medications are extremely cumbersome to take, can produce horrible side-effects and do not work for many individuals."); Grady, *supra* note 48 ("And even following the regimen exactly can be difficult—side effects of the drugs can include chronic vomiting and diarrhea.").

51. Altman, *supra* note 45 (noting that "some drugs must be refrigerated").

52. The City Council for New York City recently amended the city's administrative code to mandate all of the modifications set forth in this paragraph in the provision of benefits and services to eligible persons with clinical/symptomatic HIV illness or AIDS. See N.Y. CITY ADMIN. CODE §§ 21-126 to -128 (approved July 11, 1997). For a discussion of the ADA litigation that helped to prompt the passage of this law, see discussion *infra* Subsection III.C.2.

53. See, e.g., Anonymous Fireman v. City of Willoughby, 779 F. Supp. 402, 413 (N.D. Ohio 1991) ("Failure to maintain confidentiality [regarding] HIV status creates a likelihood of discrimination . . ."); Doe v. Borough of Barrington, 729 F. Supp. 376, 384 (D.N.J. 1990) (noting the "stigma and harassment that comes with public knowledge of one's affliction with AIDS"); Sisak, *supra* note 4, at 2755 n.40 ("Significant harm can result from a breach of confidentiality. The stigma associated with the disease fosters hostility toward people with HIV, often resulting in ostracism and discrimination."); see also Karen L. Lovitch, *Additional Article: State AIDS-Related Legislation in the 1990s: Adopting a Language of Hope Which Affirms Life*, 20 NOVA L. REV. 1187, 1227-28 (1996) ("State governments must set an example for private employers by educating their own workers to encourage more compassionate responses to people living with

tion remains confidential, in compliance with numerous state laws.⁵⁴

As the following analysis demonstrates, these or similar modifications are not discretionary; they are mandated by the ADA.

II. STATUTORY BACKGROUND

A. Title II of the ADA: A Powerful Weapon

Together with Section 504 of the Rehabilitation Act,⁵⁵ Title II of the ADA is a powerful weapon in the battle against discrimination by state and local governments. Perhaps the chief virtue of the Act, noted above, is that it applies to actions that have a discriminatory effect, regardless of motive.⁵⁶ As one court recently observed:

It is important to keep in mind that lawmakers made clear that the ADA was *norm-changing legislation*, akin to the legislative turning points in this country's struggle to overcome racial discrimination. President Bush referred to the Act as an "*historic new civil rights Act*." Senator Tom Harkin, the champion of the Act, announced it to be the "*20th century Emancipation Proclamation* for all persons with disabilities," while Senator Dole called it "*the most comprehensive civil rights legislation our Nation has ever seen*." Unlike other legislation designed to settle narrow issues of law, the ADA has a comprehensive reach and should be interpreted with this goal in mind."⁵⁷

HIV disease and to prevent further transmission.").

54. See, e.g., CAL. HEALTH & SAFETY CODE § 120980 (West 1996); CONN. GEN. STAT. ANN. § 19a-583 (West 1997) ("No person who obtains confidential HIV-related information may disclose or be compelled to disclose such information . . ."); FLA. STAT. ANN. § 381.004(3)(G) (West 1993 & Supp. 1998) ("No person to whom the results of a [HIV] test have been disclosed may disclose the test results to another person except as authorized by this subsection . . ."); N.Y. PUB. HEALTH LAW § 2782(1) (McKinney 1993) ("No person who obtains confidential HIV related information in the course of providing any health or social service or pursuant to a release of confidential HIV related information may disclose or be compelled to disclose such information . . .").

55. 29 U.S.C. § 794 (1994). Enacted in 1973, Section 504 of the Rehabilitation Act "generally prohibits discrimination against the handicapped in any program or activity receiving federal financial assistance." Council for the Hearing Impaired Long Island, Inc. v. Ambach, 610 F. Supp. 1051, 1057 (E.D.N.Y. 1985).

56. See *Helen L. v. DiDario*, 46 F.3d 325, 335 (3d Cir. 1995) ("Because the ADA evolved from an attempt to remedy the effects of 'benign neglect' resulting from the 'invisibility' of the disabled, Congress could not have intended to limit the Act's protections and prohibitions to circumstances involving deliberate discrimination."); *Anderson v. Gus Mayer Boston Store*, 924 F. Supp. 763, 773 (E.D. Tex. 1996) ("One can also violate the ADA by omission."); *Tyler v. City of Manhattan*, 857 F. Supp. 800, 817 (D. Kan. 1994); *Concerned Parents to Save Dreher Park Ctr. v. City of W. Palm Beach*, 846 F. Supp. 986, 991 (S.D. Fla. 1994) ("[A]ctions that have the effect of discriminating against individuals with disabilities . . . violate the ADA."); *supra* notes 14-18 and accompanying text.

57. *Anderson*, 924 F. Supp. at 771 (citations omitted); see also Burgdorf, *supra* note 6, at 414-15 ("The [ADA], while certainly inspired by, and having many of the same ultimate goals of, prior civil rights legislation, has introduced some innovative approaches and may provide a somewhat different model for framing a nondiscrimination statute. The ADA constitutes a second-generation civil rights statute that goes beyond the 'naked framework' of earlier statutes and adds much flesh and refinement to traditional nondiscrimination law.").

Title II benefits, moreover, from an established body of case law that favorably interprets analogous provisions of Section 504 of the Rehabilitation Act. This law is applicable to Title II of the ADA.⁵⁸ Accordingly, relevant Rehabilitation Act case law and provisions shall be cited concomitantly with ADA case law and provisions throughout this analysis.

Finally, the ADA benefits from the clear and forceful regulations issued by the United States Department of Justice (DOJ). Congress expressly authorized the DOJ to "promulgate regulations in an accessible format that implement [Title II]."⁵⁹ Accordingly, "these regulations must be given 'legislative and hence controlling weight unless they are arbitrary, capricious, or clearly contrary to the statute.'"⁶⁰ As we shall see, the regulations unequivocally establish the rights of the disabled to *meaningful and equal access* to public benefits, services, and programs.

B. *The Requirements of an ADA Claim*

Title II of the ADA broadly provides:

Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public

58. As the Department of Justice (DOJ) has explained, "the standards adopted by Title II of the ADA for State and local government services are generally the same as those required under section 504 for federally assisted programs and activities." 28 C.F.R. pt. 35, app. A, at 467 (1997). In addition, the DOJ regulations provide that Title II of the ADA "shall not be construed to apply a lesser standard than the standards applied under title V of the Rehabilitation Act of 1973 (29 U.S.C. 791) or the regulations issued by Federal agencies pursuant to that title." 28 C.F.R. § 35.103(a) (1997); *see also* ADA COMPLIANCE GUIDE, *supra* note 3, ¶ 122 (Supp. Feb. 1992) ("The ADA does not reduce the scope of coverage or apply a lesser standard than is required by section 504."). Case law is in accord. *See, e.g., Helen L.*, 46 F.3d at 330 n.7 ("The law developed under section 504 of the Rehabilitation Act is applicable to Title II of the ADA."); *Hope v. Cortines*, 872 F. Supp. 14, 21 (E.D.N.Y.) ("The regulations implementing title II of the ADA likewise confirm the uniformity of interpretation between the ADA and the Rehabilitation Act . . ."), *aff'd*, 69 F.3d 687 (2d Cir. 1995); *Tugg v. Towey*, 864 F. Supp. 1201, 1205 n.4 (S.D. Fla. 1994) ("Based upon the close relationship between the two acts, cases interpreting the Rehabilitation Act are considered persuasive authority for interpreting the ADA.").

59. 42 U.S.C. § 12134 (1994); *see Ellen S. v. Florida Bd. of Bar Exam'rs*, 859 F. Supp. 1489, 1493 n.6 (S.D. Fla. 1994) ("Rather than outline the specific obligations of public entities under [Title II], the ADA directed the Department of Justice ('DOJ') to promulgate regulations . . .") (quoting *Kinney v. Yerusolim*, 812 F. Supp. 547, 548 (E.D. Pa.), *aff'd*, 9 F.3d 1067 (3d Cir. 1993)).

60. *Does 1-5 v. Chandler*, 83 F.3d 1150, 1153 (9th Cir. 1996) (quoting *United States v. Morton*, 467 U.S. 822, 834 (1984)); *see also Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984) ("[C]onsiderable weight should be accorded to an executive department's constructions of a statutory scheme it is entrusted to administer."); *Helen L.*, 46 F.3d at 331 ("Because Title II was enacted with broad language and directed the Department of Justice to promulgate regulations . . ., the regulations which the Department of Justice promulgated are entitled to substantial deference."); *Doe v. Kohn Nast & Graf, P.C.*, 862 F. Supp. 1310, 1319 (E.D. Pa. 1994) ("In interpreting the meaning of a statute, substantial deference is due the interpretation given its provisions by the agency charged with administering that statute.") (citing *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504 (1994)).

Americans With Disabilities Act

entity, or be subjected to discrimination by any such entity.⁶¹

It is now well established that to state a claim under Title II of the ADA, a plaintiff must demonstrate (1) that he or she is, or he or she represents the interests of, “a qualified individual with a disability”; (2) that the defendant is subject to the ADA; and (3) that the plaintiff, by reason of his or her disability, was denied the opportunity to participate in or benefit from some public entity’s services, programs, or activities, or was otherwise discriminated against by the public entity.⁶²

Each of these requirements is examined below. As the discussion indicates, persons with AIDS who are denied meaningful and equal access to social welfare benefits and services easily satisfy these requirements.

III. LEGAL ANALYSIS

This Part examines each of the three requirements for a claim under Title II of the ADA. Section III.A. demonstrates that a person with AIDS can be classified as a “qualified individual with a disability” under two independently dispositive tests. Section III.B. succinctly explains that the ADA is clearly applicable to the provision of social welfare benefits and services by all state and local governments and their instrumentalities. Finally, Section III.C. is divided into two parts. Subsection III.C.1 analyzes the relevant DOJ regulations, which are exceedingly helpful in establishing the all-important third prong of an ADA claim; Subsection III.C.2 reviews the relevant supporting case law, including *Henrietta D. v. Giuliani*,⁶³ a case directly on point.

A. “Qualified Individual with a Disability” Under Title II

Section 12131 of the ADA defines the term “qualified individual with a disability” as

an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.⁶⁴

61. 42 U.S.C. § 12132 (1994). The analogous provision in the Rehabilitation Act provides: “No otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . .” 29 U.S.C.A. § 794(a) (West Supp. 1997).

62. See *Sandison v. Michigan High Sch. Athletic Ass’n*, 863 F. Supp. 483, 488 (E.D. Mich. 1994); *Tyler v. City of Manhattan*, 857 F. Supp. 800, 817 (D. Kan. 1994); *Concerned Parents to Save Dreher Park Ctr. v. City of W. Palm Beach*, 846 F. Supp. 986, 990 (S.D. Fla. 1994).

63. No. 95-CV-0641, 1996 WL 633382 (E.D.N.Y. Oct. 25, 1996).

64. 42 U.S.C. § 12131 (1994).

This definition is further clarified by the DOJ regulations, which establish three alternative meanings for the term "disability" under Title II: "*Disability* means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment."⁶⁵ Persons with AIDS plainly meet at least the first of these definitions, and possibly the third as well, and thus they are "individuals with disabilities" under Title II. This analysis only applies, moreover, to qualified individuals with AIDS, i.e., those who "meet[] the essential eligibility requirements"⁶⁶ for the benefits and services at issue.

1. *HIV disease is a disability under the ADA*

HIV disease, and particularly symptomatic HIV disease and AIDS, is a disability under the ADA. This appears to be an uncontroversial proposition in light of the unequivocal legislative history and explicit regulations that the DOJ has promulgated. Additionally, no court has ever held that symptomatic HIV disease or AIDS is not a disability under the ADA.⁶⁷ There are warning signs, however. In *Ennis v. National Association of Business and Education Radio, Inc.*,⁶⁸ the Fourth Circuit held in dicta that HIV-positive status is not a disability per se within the meaning of the ADA.⁶⁹ Instead, the court ruled that "the plain language of the provision requires that a finding of disability be made on an individual-by-individual basis."⁷⁰ The Fourth Circuit recently affirmed this ruling en banc in *Runnebaum v. Nationsbank of Maryland, N.A.*⁷¹

The *Ennis* and *Runnebaum* decisions do not alter the analysis of this Article.⁷² In those cases, the Fourth Circuit examined the question

65. 28 C.F.R. § 35.104 (1997). "If an individual meets any one of these three tests, he or she is considered to be an individual with a disability for purposes of coverage under the Americans with Disabilities Act." 28 C.F.R. pt. 35, app. A, at 468 (1997).

66. 42 U.S.C. § 12131 (1994); see, e.g., *Rothschild v. Grottenthaler*, 716 F. Supp. 796, 799 (S.D.N.Y. 1989).

67. Search of LEXIS, Genfed Library, Courts File (Feb. 23, 1998).

68. 53 F.3d 55 (4th Cir. 1995).

69. See *id.* at 59-60.

70. *Id.* at 59.

71. 123 F.3d 156 (4th Cir. 1997) (en banc).

72. It is accordingly beyond the scope of this Article fully to analyze the *Ennis* and *Runnebaum* decisions. Others, however, have offered an outstanding critique of *Ennis* and its progeny (including, by implication, *Runnebaum*). See, e.g., *Parment & Jackson, supra* note 48, at 32-39. The authors explain, inter alia:

[W]hat is most remarkable about many of the recent cases that have questioned the disability status of asymptomatic HIV-positive plaintiffs is their blatant disregard of the legislative history of the ADA. While purporting to be faithful to the statutory edict, these courts ignore a legislative history that is as clear as any. And, in doing so, they ignore the critical public health imperatives that led Congress to seek to protect

whether *asymptomatic* HIV infection is a disability under Title I of the ADA.⁷³ The Fourth Circuit certainly did not rule that symptomatic HIV disease or AIDS is not a disability under the Act. No court has ever done so.⁷⁴ Further, unlike the DOJ regulations enacting Title II (set forth below), the Equal Employment Opportunity Commission's regulations defining the term "impairment" under Title I of the ADA do not specifically mention HIV.⁷⁵ Nevertheless, it is important briefly to reiterate that HIV disease, and certainly symptomatic HIV disease and AIDS, is clearly a disability under Title II of the ADA.⁷⁶

The DOJ regulations expressly establish HIV disease as a disability under Title II of the ADA: "The phrase *physical or mental impairment* includes . . . such contagious and noncontagious diseases and conditions as . . . *HIV disease (whether symptomatic or asymptomatic)*, tuberculosis, drug addiction, and alcoholism."⁷⁷ Again, these regulations must be given

HIV-positive individuals in the first place.

Id. at 41 (citations omitted). Indeed, the discussion *infra* notes 80-89 and accompanying text demonstrates that the Fourth Circuit is simply wrong; the legislative history and the DOJ regulations expressly and unequivocally establish HIV disease—whether symptomatic or asymptomatic—as a disability under the ADA.

73. For the argument in favor of finding asymptomatic HIV infection a disability under the ADA, see the dissent in *Runnebaum*, 123 F.3d at 176 (Michael, J., dissenting); Parmet & Jackson, *supra* note 48; and Robert A. Kushen, Note, *Asymptomatic Infection with the AIDS Virus as a Handicap Under the Rehabilitation Act of 1973*, 88 COLUM. L. REV. 563 (1988).

74. See *supra* note 67.

75. See 29 C.F.R. § 1630.2(h)(1) (1997).

76. In light of the Fourth Circuit's rulings and recent advancements—real or perceived—in the fight against HIV disease (which may well have influenced the Fourth Circuit's reasoning), it cannot be considered unduly pessimistic to establish, rather than assume, that symptomatic HIV disease and AIDS are protected disabilities under the ADA:

[A]s medicine brings cause for optimism, developments in the law create cause for alarm. Driven on the one hand by the apparent imperatives of legal reasoning and the "plain language" of the statute, and on the other hand, by changing perceptions of what it means to be "HIV-positive," these cases have undermined the legal protections against HIV discrimination. The implications of these developments are ominous.

Parmet & Jackson, *supra* note 48, at 39.

77. 28 C.F.R. § 35.104(1)(ii) (1997) (emphasis added). The DOJ analysis further emphasizes this point:

In *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987), a case involving an individual with tuberculosis, the Supreme Court held that people with contagious diseases are entitled to the protections afforded by section 504. Following the *Arline* decision, this Department's Office of Legal Counsel issued a legal opinion that concluded that symptomatic HIV disease is an impairment that substantially limits a major life activity; therefore it has been included in the definition of disability under this part. The opinion also concluded that asymptomatic HIV disease is an impairment that substantially limits a major life activity, either because of its actual effect on the individual with HIV disease or because the reactions of other people to individuals with HIV disease cause such individuals to be treated as though they are disabled.

28 C.F.R. pt. 35, app. A, at 469 (1997); see also ADA COMPLIANCE GUIDE, *supra* note 3, ¶¶ 231, 240, 242 (Supp. Mar. 1992) (discussing the inclusion of people infected with AIDS or the HIV virus within the protective scope of the ADA); *id.* ¶ 710 (Supp. Oct. 1992) ("[M]any states have recently revised their codes to expressly include people with AIDS in their definition of disability.").

"legislative and hence controlling weight," since they are not arbitrary, capricious, or clearly contrary to the statute,⁷⁸ as the legislative history of the statute makes clear.⁷⁹

In fact, courts⁸⁰ and commentators⁸¹ have noted that the legislative history of the ADA specifically mentions HIV disease as being included in the ADA's definition of "disability." For example, the House Report explains that "[t]he need for omnibus civil rights legislation was also one of the major recommendations of the Presidential Commission on the HIV Epidemic."⁸² The House Report then quotes with favor a portion of the Presidential Commission's Report that states, *inter alia*: "All persons with symptomatic or asymptomatic HIV infection should be clearly included as persons with disabilities who are covered by the anti-discrimination protections of this legislation."⁸³ The House Report explains that it was not possible to list all of the specific conditions that would constitute physical or mental impairments, but adds: "The term includes, however, such conditions, diseases, and infections as . . . infection with the Human Immunodeficiency Virus"⁸⁴ The Senate report is in accord.⁸⁵ These committee reports are "the authoritative source for finding the Legislature's intent" and decisively establish that HIV disease is an impairment under the Act.⁸⁶

78. *United States v. Morton*, 467 U.S. 822, 834 (1984) ("Because Congress explicitly delegated authority to construe the statute by regulation, in this case we must give the regulations legislative and hence controlling weight unless they are arbitrary, capricious, or plainly contrary to the statute."); *see supra* notes 59-60.

79. *See* discussion *infra* notes 80-89 and accompanying text; *see also supra* note 60.

80. *See, e.g., Abbott v. Bragdon*, 107 F.3d 934, 942-43 (1st Cir. 1997); *Support Ministries for Persons with AIDS, Inc. v. Village of Waterford*, 808 F. Supp. 120, 130 (N.D.N.Y. 1992) (noting that the ADA's legislative history "specifically mentions that infection with HIV is included in the ADA's definition of 'disability,' which is virtually identical to the definition of 'handicap' contained in the FHA and the Rehabilitation Act.").

81. *See, e.g., ADA COMPLIANCE GUIDE, supra* note 3, ¶ 231 (Supp. Mar. 1992) (noting that S. REP. NO. 101-116 (1989), the Senate report that accompanied the bill in Congress, "specifically includes infection with the human immunodeficiency virus (HIV)"); HENRY H. PERRITT, JR., *AMERICANS WITH DISABILITIES ACT HANDBOOK*, § 3.2, at 25 (2d ed. 1991) (noting that the Senate and House committee reports specifically mention HIV as an "impairment"); *Parment & Jackson, supra* note 48, at 21 ("[T]he legislative history of the ADA demonstrates conclusively the consensus within Congress that AIDS, as well as asymptomatic HIV, would be a protected disability under the new law."); *Dalrymple-Blackburn, supra* note 26, at 856 ("[T]he legislative history of the ADA specifically identifies HIV infection and AIDS as disabling impairments.").

82. H.R. REP. NO. 101-485(II), at 48 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 330.

83. *Id.* (quoting REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY EPIDEMIC 123 (1988)).

84. *Id.* at 333; *see also* S. REP. NO. 101-116, at 22 (1989) ("The term includes . . . infection with the Human Immunodeficiency Virus"). For a more detailed discussion of the legislative history of the term "impairment" as it relates to HIV disease, *see* the dissent in *Runnebaum v. Nationsbank of Maryland, N.A.*, 123 F.3d 156, 176 (4th Cir. 1997) (*en banc*) (Michael, J., dissenting).

85. *See* S. REP. NO. 101-116, at 22 (1989).

86. *See Garcia v. United States*, 469 U.S. 70, 76 (1984).

As the First Circuit recently pointed out, moreover,

[T]he ADA's precursor, the Rehabilitation Act, had been construed by the Department of Justice (DOJ) to protect persons infected with HIV from discrimination; in enacting the ADA, Congress endorsed the DOJ's view, noting that "a person infected with [HIV] is covered under the first prong of the definition of the term 'disability' because of a substantial limitation to procreation and intimate sexual relationships."⁸⁷

Had Congress chosen to eliminate HIV from coverage under the Act, it would have done so; instead, however, it did precisely the opposite and endorsed the DOJ's existing interpretation of the term disability to include HIV.⁸⁸ Accordingly, the ADA regulation should have the force of law.⁸⁹

Not surprisingly, then, courts outside of the Fourth Circuit have consistently ruled that HIV disease—including asymptomatic HIV disease—is a disability under the ADA (and a handicap under the analogous provision⁹⁰ in the Rehabilitation Act).⁹¹ Exhaustive research, moreover, has

87. *Abbott v. Bragdon*, 107 F.3d 934, 943 (1st Cir. 1997) (quoting H.R. REP. NO. 101-485(II), at 52 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 334).

88. Even opponents of the ADA understood that HIV would be a covered disability under the Act. *See* Parmet & Jackson, *supra* note 48, at 21 ("For example, Senator Jesse Helms, one of the Act's chief critics, expressed on the Senate floor his clear belief that discrimination against even asymptomatic HIV-positive persons would be covered by the Act.") (citing 135 CONG. REC. S10765-01 (daily ed. Sept. 6, 1989) (statement of Sen. Helms)).

89. As the Third Circuit explained while examining another ADA regulation patterned after a Section 504 regulation:

[B]ecause Congress mandated that the ADA regulations be patterned after the section 504 coordination regulations, the former regulations have the force of law. When Congress re-enacts a statute and voices its approval of an administrative interpretation of that statute, that interpretation acquires the force of law and courts are bound by the regulation. *United States v. Board of Comm'rs of Sheffield, Alabama*, 435 U.S. 110, 134 (1978). The same is true when Congress agrees with an administrative interpretation of a statute which Congress is re-enacting. *See Don E. Williams Co. v. Commissioner*, 429 U.S. 569, 574-77 (1977). Although Title II of the ADA is not a re-enactment of section 504, it does extend section 504's anti-discrimination principles to public entities. Furthermore, the legislative history of the ADA shows that Congress agreed with the coordination regulations promulgated under section 504. . . . [Section 35.130(d)] is almost identical to the section 504 integration regulation which has been in effect since 1981. As Congress has voiced its approval of that coordination regulation, 28 C.F.R. § 35.130(d) has the force of law.

Helen L. v. DiDario, 46 F.3d 325, 332 (3d Cir. 1995) (citations omitted). The same is true of the ADA and Rehabilitation Act regulations governing "disability" and "handicap." *See, e.g.,* *Support Ministries for Persons with AIDS, Inc. v. Village of Waterford*, 808 F. Supp. 120, 130 (N.D.N.Y. 1992) ("[T]he ADA's definition of 'disability' . . . is virtually identical to the definition of 'handicap' contained in the . . . Rehabilitation Act.") (citation omitted). Therefore, 28 C.F.R. section 35.104(1)(ii) (1997) also has the force of law.

90. The definition of "disabled" in the ADA is the same as that of "handicap" under the Rehabilitation Act, "with the exception of the exclusion of current illegal users of drugs and the exclusion of certain other individuals." Chai Feldblum, *Medical Examinations and Inquiries Under the Americans with Disabilities Act: A View from the Inside*, 64 TEMP. L. REV. 521, 522 n.10 (1991); *see also* *Collings v. Longview Fibre Co.*, 63 F.3d 828, 832 n.3 (9th Cir. 1995) ("The ADA defines a disability in substantially the same terms as the Rehabilitation Act defined a handicap (now disability). . . . The legislative history of the ADA indicates that Congress in-

failed to uncover a single case in which either symptomatic HIV disease or AIDS was held not to be a disability under either the ADA or the Rehabilitation Act.⁹² In addition, HIV disease is an established disability under the Fair Housing Act, which contains a "virtually identical" definition of "handicap" or "disability" as that included in the ADA and the Rehabilitation Act,⁹³ in several other agency interpretations of "impairment,"⁹⁴ and in numerous state disability laws.⁹⁵ Hence, persons

tended judicial interpretation of the Rehabilitation Act be incorporated by reference when interpreting the ADA.") (citation omitted), *cert. denied*, 116 S. Ct. 711 (1996); *Bolton v. Scrivner, Inc.*, 36 F.3d 939, 943 (10th Cir. 1994); *PERRITT, supra* note 81, § 3.2, at 24 (noting that the definition of the term "disability" under the ADA "is comparable to the definition of the term 'individual with handicap' in . . . the Rehabilitation Act").

91. See, e.g., *Abbot*, 107 F.3d at 939 ("We hold unhesitatingly that HIV-positive status, simpliciter, whether symptomatic or asymptomatic, comprises a physical impairment under the ADA."); *Gates v. Rowland*, 39 F.3d 1439, 1446 (9th Cir. 1994) ("[A] person infected with the HIV virus is an individual with a disability within the meaning of the [Rehabilitation] Act."); *Doe v. Garrett*, 903 F.2d 1455, 1459 (11th Cir. 1990) ("[W]e note that it is well established that infection with AIDS constitutes a handicap for purposes of the Act."); *John Doe v. Montgomery Hosp.*, No. CIV.A. 95-3168, 1996 WL 745524, at *5 (E.D. Pa. Dec. 23, 1996) (finding asymptomatic plaintiff disabled within the meaning of the ADA); *Anderson v. Gus Mayer Boston Store*, 924 F. Supp. 763, 774-75 (E.D. Tex. 1996); *Hoepfl v. Barlow*, 906 F. Supp. 317, 319 n.7 (E.D. Va. 1995) ("It is now settled law that HIV-positive individuals are 'disabled' within the meaning of the ADA."); *D.B. v. Bloom*, 896 F. Supp. 166, 170 (D.N.J. 1995); *Howe v. Hull*, 873 F. Supp. 72, 78 (N.D. Ohio 1994) ("AIDS and HIV infection are both disabilities within the meaning of ADA."); *Gonzales v. Garner Food Servs., Inc.*, 855 F. Supp. 371, 374 n.5 (N.D. Ga. 1994), *aff'd*, 89 F.3d 1523 (11th Cir. 1996); *United States v. Morvant*, 843 F. Supp. 1092, 1093-94 (E.D. La. 1994); *Doe v. District of Columbia*, 796 F. Supp. 559, 567 n.10 (D.D.C. 1992) ("[T]he Reagan Administration took the position that HIV-infected persons are handicapped within the meaning of the [Rehabilitation] Act."); *Casey v. Lewis*, 773 F. Supp. 1365, 1370 (D. Ariz. 1991); *Leckelt v. Board of Comm'rs of Hosp. Dist. No. 1*, 714 F. Supp. 1377, 1385 n.4 (E.D. La. 1989), *aff'd*, 909 F. 2d 820 (5th Cir. 1990); *Local 1812, Am. Fed'n of Gov't Employees v. United States Dep't of State*, 662 F. Supp. 50, 54 (D.D.C. 1987) (holding that both symptomatic and asymptomatic HIV disease are impairments under the Act). *But see Runnebaum v. Nationsbank of Md.*, 95 F.3d 1285 (4th Cir. 1996) (examining plaintiff's claim under Title I, not Title II, of the ADA); *Ennis v. National Ass'n of Bus. & Educ. Radio, Inc.*, 53 F.3d 55, 60 (4th Cir. 1995) (concluding that HIV-positive status does not necessarily qualify as a disability and suggesting that the asymptomatic plaintiff was probably *not* disabled within the meaning of the ADA).

92. Even if a court were to find that AIDS is not a disability *per se* under the ADA (i.e., disregarding the clear legislative history, the explicit DOJ regulations, and the weighty judicial precedent), it would be absurd to rule that AIDS or symptomatic HIV disease is not "a physical or mental impairment that substantially limits one or more of the major life activities of such individual." 28 U.S.C. § 35.104 (1994).

93. *Support Ministries*, 808 F. Supp. at 129 (finding HIV-positive plaintiffs "handicapped" under the Fair Housing Act and expressing disbelief that defendants could suggest otherwise).

94. See, e.g., 5 C.F.R. § 1636.103 (1997) (Federal Retirement Thrift Investment Board); 7 C.F.R. § 15e.103 (1997) (Department of Agriculture); 22 C.F.R. § 1701.103 (1997) (Institute of Peace); 29 C.F.R. § 34.2 (1997) (Department of Labor); 34 C.F.R. § 1200.103 (1997) (National Council on Disability); 45 C.F.R. § 2301.103 (1997) (Arctic Research Commission).

95. "[M]any states have recently revised their codes to expressly include people with AIDS in their definition of disability." ADA COMPLIANCE GUIDE, *supra* note 3, ¶ 710 (Supp. Oct. 1992); see, e.g., FLA. STAT. ANN. § 760.50(2) (Harrison Supp. 1996); KY. REV. STAT. ANN. § 207.135(1) (Michie 1995); WASH. REV. CODE ANN. § 49.60.174(1) (West Supp. 1998). In addition, all fifty states provide disability discrimination protection in some form. See Lovitch, *supra* note 53, at 1196. In many states, these laws have been specifically interpreted to cover persons with HIV and AIDS. See, e.g., *Prilliman v. United Air Lines Inc.*, 62 Cal. Rptr. 2d 142, 147 (Ct. App. 1997) ("AIDS is a physical handicap within the meaning of Government Code former sec-

with AIDS who are eligible for social welfare benefits and services are qualified "individuals with disabilities" under Title II.

2. *Persons with AIDS may be regarded as having a disability*

Title II also provides that individuals who are "regarded as having [a defined physical or mental] impairment" are disabled under the Act. This includes individuals who are "treated by a public entity as having such [a physical or mental] impairment."⁹⁶ Accordingly, if a public entity already treats persons with AIDS differently—e.g., by providing them with separate shelter or special nutritional supplements—these individuals may qualify as disabled regardless of whether they are in fact disabled.⁹⁷

tion 12926, subdivision (h), as defined by judicial decision. . . . [Inasmuch as case law reveals a general consistency between the current and former versions of section 12926, it is a relatively simple matter to harmonize [them] in their definitions of disability and handicap.]") (citations omitted); *Ann Howard's Apricots Restaurant Inc. v. Commission on Hum. Rts. & Opportunities*, 676 A.2d 844, 847 (Conn. 1996) (implying that AIDS is a physical disability for which discrimination is prohibited); *Joel Truitt Mgmt., Inc. v. District of Columbia Comm'n on Hum. Rts.*, 646 A.2d 1007, 1009 (D.C. 1994) (concluding that AIDS "is a condition falling within the definition of 'physical handicap'"); *Raintree Health Care Ctr. v. Illinois Human Rights Comm'n*, 672 N.E.2d 1136, 1141 (Ill. 1996); *Cronan v. New England Tel. Co.*, 41 Fair Empl. Prac. Cas. (BNA) 1273, 1276 (Mass. Super. Ct. 1986) ("[C]ommentators who have addressed this issue agree that AIDS is a qualifying handicap under the Rehabilitation Act . . ."); *Sanchez v. Lagoudakis*, 486 N.W.2d 657, 660 (Mich. 1992) ("We are persuaded that a person with AIDS can be found to be handicapped."); *Minnesota v. Clausen*, 491 N.W.2d 662, 666 (Minn. Ct. App. 1992); *Poff v. Caro*, 549 A.2d 900, 903 (N.J. Super. Ct. Law Div. 1987) ("[A] person suffering from AIDS has a disability caused by injury or illness and, therefore, is protected by the Law Against Discrimination."); *Hill v. Community of Damien of Molokai*, 911 P.2d 861, 868 (N.M. 1996); *Petri v. Bank of N.Y. Co.*, 582 N.Y.S.2d 608, 610-11 (Sup. Ct. 1992) (establishing AIDS as a disability under N.Y. State Human Rights Law); *Doe v. Denny's, Inc.*, 931 P.2d 816, 818 (Or. Ct. App. 1997) ("Plaintiff is physically impaired in that she is HIV positive."); *Benjamin R. v. Orkin Exterminating Co.*, 390 S.E.2d 814, 819 (W. Va. 1990) ("[T]his Court holds that a person at any stage of infection with the human immunodeficiency virus, including a person who has tested positive for the antibodies to such virus but who is asymptomatic, is a person with a 'handicap' within the meaning of *W.Va. Code*, 5-11-3(t) [1981]."); *Racine Unified Sch. Dist. v. Labor & Indus. Rev. Comm'n*, 476 N.W.2d 707, 721 (Wis. 1991) (finding that AIDS/ARC constitutes an actual impairment within the meaning of the state disability statute).

96. 28 C.F.R. § 35.104 (1997) (emphasis omitted). The House Judiciary Committee's ADA report explains:

This test is intended to cover persons who are treated by a covered entity as having a physical or mental impairment that substantially limits a major life activity. It applies whether or not a person has an impairment, if that person was treated as if he or she had an impairment that substantially limits a major life activity.

H.R. REP. NO. 101-485(III), at 29 (1990), *reprinted in* 1990 U.S.C.A.N. 445, 452.

97. *See, e.g., Dean v. Knowles*, 912 F. Supp. 519, 521 (S.D. Fla. 1996) ("This Court need not address the issue of whether a person who is HIV positive but asymptomatic is disabled per se under the ADA. The Eleventh Circuit held . . . that HIV seropositivity was a handicap under the Rehabilitation Act . . . because the correctional system treated inmates as if they were handicapped.") (citation omitted); *Local 1812, Am. Fed'n of Gov't Employees v. United States Dep't of State*, 662 F. Supp. 50, 54 (D.D.C. 1987) ("Persons who carry HIV may be deemed handicapped in one or both of two ways. It is enough if they are perceived to be handicapped.").

B. Covered Entities

Title II of the ADA expressly applies to public entities.⁹⁸ Under the Act, the term "public entity" is defined, in relevant part, as "any State or local government" or "any department, agency, special purpose district, or other instrumentality of a State or States or local government."⁹⁹ Title II applies, moreover, "to all services, programs, and activities provided or made available by public entities."¹⁰⁰ As the DOJ analysis indicates:

Title II of the ADA extends th[e] prohibition of discrimination to include all services, programs, and activities provided or made available by state and local governments or any of their instrumentalities or agencies, regardless of the receipt of Federal financial assistance.¹⁰¹

By contrast, the Rehabilitation Act applies only to programs or activities that "receiv[e] Federal financial assistance."¹⁰²

The ADA is thus plainly applicable to the provision of social welfare benefits by all state and local governments and their instrumentalities. Because these entities invariably receive federal financial assistance, the Rehabilitation Act is generally applicable as well.

C. The Third Prong: Access Alone Is Insufficient

"It is not enough to open the door for the handicapped," the Second Circuit has observed, "a ramp must be built so the door can be reached."¹⁰³ Both the DOJ regulations¹⁰⁴ and relevant case law¹⁰⁵ establish that public entities must not only provide access, but meaningful and equal access to benefits and services, even if that means making reason-

98. Neither Title II of the ADA nor the Rehabilitation Act requires claimants to exhaust administrative remedies prior to bringing a federal court action. See *Tyler v. City of Manhattan*, 857 F. Supp. 800, 812 (D. Kan. 1994); *Peterson v. University of Wis. Bd. of Regents*, 818 F. Supp. 1276, 1277 (W.D. Wis. 1993); 28 C.F.R. pt. 35, app. A, at 489-90 (1997) ("As with section 504, there is also a private right of action for persons with disabilities . . . [and] it is not the Committee's intent that persons with disabilities need to exhaust Federal administrative remedies before exercising their private right of action."). Similarly, state notice-of-claim provisions do not apply to ADA or Rehabilitation Act claims. See *Finley v. Giacobbe*, 827 F. Supp. 215, 219 (S.D.N.Y. 1993).

99. 42 U.S.C. § 12131(1) (1994).

100. 28 C.F.R. § 35.102(a) (1997).

101. 28 C.F.R. pt. 35, app. A, at 465 (1997); see also *Wolford v. Lewis*, 860 F. Supp. 1123, 1134 (S.D. W. Va. 1994) ("Title II of the ADA broadens the protection extended to individuals with disabilities by prohibiting discriminatory treatment from public entities, including state departments and agencies, without regard to the receipt of federal financial assistance."); *Coleman v. Zatechka*, 824 F. Supp. 1360, 1367 (D. Neb. 1993) ("[T]he ADA is not limited to programs receiving federal funding, but rather applies to *all* public entities").

102. 29 U.S.C. § 794(a) (1997).

103. *Dopico v. Goldschmidt*, 687 F.2d 644, 652 (2d Cir. 1982) (quoting Brief for Appellants at 120-21).

104. See discussion *infra* Subsection III.C.1.

105. See discussion *infra* Subsection III.C.2.

able modifications to policies, practices, and procedures to avoid discrimination. By failing to accommodate the special needs of persons with AIDS in the provision of social welfare benefits and services, numerous municipalities in the United States are in blatant violation of the ADA. The following discussion establishes the statutory support for this argument and demonstrates that relevant case law further supports this conclusion.

1. The DOJ regulations: strong medicine

In Title II of the ADA, Congress did not specify the types of actions included in the term “discrimination,” as it did in the employment and public accommodations sections of the Act.¹⁰⁶ Consequently, one must look to the DOJ regulations that implement Title II to find “the general principles for analyzing whether any particular action of the public entity violates [Title II’s] mandate.”¹⁰⁷ These regulations are exceedingly helpful to the ADA plaintiff because they explicitly address the passive, “unintentional” discrimination that has historically proven so difficult to combat. As noted, the regulations prohibit practices that have a discriminatory effect irrespective of the entity’s motive.

By effectively barring persons with AIDS from meaningful and equal access to social welfare benefits and services, public entities throughout the United States are in violation of at least three of these regulations.

First, Section 35.130(b)(1) of the regulations establishes that a public entity may not “provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others”¹⁰⁸ As the dis-

106. See ADA COMPLIANCE GUIDE, *supra* note 3, ¶ 222 (Supp. Mar. 1992).

However, the committee reports that accompanied the ADA in Congress reflect its intent that the forms of discrimination set out in other sections of the ADA (§§ 102(b)-(c) and § 302(b)) be incorporated into the regulations implementing title II, and that they be consistent with the regulations issued under section 504 [of the Rehabilitation Act].

Id.

107. 28 C.F.R. pt. 35, app. A, at 475 (1997). Similarly, the regulations promulgated by the Department of Health and Human Services (HHS) pursuant to section 504 of the Rehabilitation Act contain general prohibitions against discrimination. See 45 C.F.R. § 84.1 (1997).

108. 28 C.F.R. §35.130(b)(1)(iii) (1997); see also ADA COMPLIANCE GUIDE, *supra* note 3, ¶ 814 (Supp. Dec. 1991) (“Aids, services or benefits provided to disabled people must be equally effective in achieving the intended results of the program or activity.”); H.R. REP. NO. 101-485(II), at 29 (1990), reprinted in 1990 U.S.C.C.A.N. 303, 310 (“Discrimination against people with disabilities includes . . . denial of benefits, services, or opportunities to people with disabilities that are as effective and meaningful as those provided to others.”). The HHS regulations establish that recipients of HHS assistance, including Medicaid providers, may not “[p]rovide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others. . . .” 45 C.F.R. § 84.4(b)(1)(iii) (1997). Additionally, recipients may

cussion in Part I above indicates, because of the unique characteristics of AIDS, merely opening the doors to various social welfare offices is not "as effective in affording" those with AIDS "equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others." These individuals face numerous hurdles, many of which—such as frequent and extended hospital stays—are insurmountable without special assistance.

Second, Section 35.130(b)(3) of the regulations provides that a public entity may not "utilize criteria or methods of administration . . . [t]hat have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability"¹⁰⁹ or "[t]hat have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities . . ."¹¹⁰ The numerous ongoing documentation requirements and frequent, mandatory office appointments typical of so many social welfare agencies throughout the United States are clear examples of "criteria or methods of administration" that effectively discriminate against persons with AIDS. Obviously, food stamps and housing supplements cannot achieve their objectives if these benefits are terminated while clients are hospitalized.

Third, Section 35.130(b)(7) provides: "A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity."¹¹¹ The modifications required by persons with AIDS—e.g., home and hospital visits by case workers, low client-to-case worker ratios, and relaxation or waiver of office appointments and ongoing documentation requirements¹¹²—are both reasonable and necessary to avoid discriminating against persons with AIDS.

not "[o]therwise limit a qualified handicapped person in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service." *Id.* § 84.4(b)(1)(vii). The HHS regulations further provide:

For purposes of this part, aids, benefits, and services, to be equally effective, are not required to produce the identical result or level of achievement for handicapped and nonhandicapped persons, but must afford handicapped persons equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement, in the most integrated setting appropriate to the person's needs.

45 C.F.R. § 84.4(b)(2) (1997).

109. 28 C.F.R. § 35.130(b)(3)(i) (1997).

110. 28 C.F.R. § 35.130(b)(3)(ii) (1997). The HHS regulations provide that recipients may not "utilize criteria or methods of administration . . . that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program . . ." 45 C.F.R. § 84.4(b)(4) (1997).

111. 28 C.F.R. § 35.130(b)(7) (1997).

112. See discussion *supra* Section I.B.

In fact, these modifications are wholly consistent with an example of a reasonable modification provided by the DOJ itself.¹¹³ They are also consistent with the reasonable modifications set forth in Subpart D of the DOJ regulations, which govern program accessibility. These modifications include “assignment of aides to beneficiaries, home visits, [and] delivery of services at alternate accessible sites.”¹¹⁴ Making these modifications, moreover, would not in any way “fundamentally alter the nature of” the social welfare benefits and services.¹¹⁵ Persons with AIDS would not receive different or enhanced food stamps, Medicaid, or public assistance, but rather equal and meaningful access to the *same* benefits.¹¹⁶ This is precisely what Title II of the ADA was enacted to achieve. As the following discussion demonstrates, moreover, relevant case law interpreting these regulations firmly supports this conclusion.

2. Relevant Case Law

A recent, unreported decision by the District Court for the Eastern District of New York in *Henrietta D. v. Giuliani*,¹¹⁷ the only case to ex-

113. DOJ provided the following example of a reasonable modification:

A county general relief program provides emergency food, shelter, and cash grants to individuals who can demonstrate their eligibility. The application process, however, is extremely lengthy and complex. When many individuals with mental disabilities apply for benefits, they are unable to complete the application process successfully. As a result, they are effectively denied benefits to which they are otherwise entitled. In this case, the county has an obligation to make reasonable modifications to its application process to ensure that otherwise eligible individuals are not denied needed benefits. Modifications to the relief program might include simplifying the application process or providing applicants who have mental disabilities with individualized assistance to complete the process.

U.S. DEP'T OF JUSTICE, THE AMERICANS WITH DISABILITIES ACT TITLE II TECHNICAL ASSISTANCE MANUAL § II-3.6100, at 13 (1992). Individuals with AIDS face different but wholly analogous hurdles and thus require similar modifications.

114. 28 C.F.R. §35.150(b)(1) (1997). Training case workers in the special needs of persons with AIDS, and in the need to maintain confidentiality, is also consistent with Congress' intent. See H.R. REP. NO. 101-485(III), at 50 (1990), reprinted in 1990 U.S.C.C.A.N. 445, 473 (“In order to comply with the non-discrimination mandate, it is often necessary to provide training to public employees about disability.”).

115. 28 C.F.R. § 35.130(b)(7) (1997).

116. A leading commentator on the ADA offers further guidance:

To assist in clarifying the judicial conceptualization of “fundamental alteration,” commentators have proposed the following definition: “(1) a substantial change in the primary purpose or benefit of a program or activity; or (2) a substantial impairment of necessary or essential components required to achieve a program or activity's primary purpose or benefit.”

Robert L. Burgdorf, Jr., “*Equal Members of the Community*”: *The Public Accommodations Provisions of the Americans with Disabilities Act*, 64 TEMP. L. REV. 551, 561 (1991) (quoting Burgdorf & Bell, *Eliminating Discrimination Against Physically and Mentally Handicapped Persons: A Statutory Blueprint*, 8 MENTAL & PHYSICAL DISABILITIES L. REP. 64, 70 (Jan./Feb. 1984)). The reasonable modifications required by persons with AIDS would not constitute a fundamental alteration under either of these definitions.

117. *Henrietta D. v. Giuliani*, No. 95-CV-0641, 1996 WL 633382, at *8 (E.D.N.Y. Oct. 25, 1996).

amine this issue, fully supports the argument that reasonable modifications in the provision of social welfare benefits and services are required to avoid discriminating against persons with AIDS. *Henrietta D.*, however, is not without support. Courts examining similar circumstances have established that public entities must affirmatively act to ensure persons with disabilities equal and meaningful access to the benefits and services they provide. Specifically, as long as those benefits and services would not be fundamentally altered, entities must make reasonable modifications to their programs, policies, and procedures to avoid even unintentional discrimination. Following a discussion and analysis of the *Henrietta D.* decision, these supporting precedents shall be briefly examined below.

The plaintiffs in *Henrietta D.*, a class of New York City residents with AIDS and HIV-related disease,¹¹⁸ filed suit against Mayor Rudolph Giuliani and the New York City and State Departments of Social Services challenging significant cuts to New York City's Division of AIDS Services (DAS). DAS was created by the City of New York in 1985 to assist persons with AIDS and HIV-related disease in applying for and receiving social welfare benefits and services.¹¹⁹ DAS was established as a "case management system, with each DAS client assigned to a specific case manager who serves as the client's contact person for all social services and who helps to process the client's applications for various forms of aid and social services."¹²⁰ Among other things, DAS clients receive expedited services, cash supplements, and home visits from case managers.¹²¹ Persons are eligible for DAS if they demonstrate that they are residents of New York City, that they have AIDS or HIV-related disease, and that they are eligible for the benefits and services administered by the City of New York.¹²²

Plaintiffs alleged that, owing to significant budget cuts, "DAS systematically operates with 'widespread, protracted delays, errors, and unjustified denials of crucial subsistence benefits.'"¹²³ Plaintiffs further alleged that "DAS is meant to fulfill the requirements that are mandated by the ADA and Rehabilitation Act because without a properly functioning

118. The New York State Department of Health's AIDS Institute defines HIV-related disease as including AIDS, as defined by the CDC, "along with clinical conditions that are substantially affected by their association with HIV infection and represent evidence of clinical disease. These additional conditions include cardiologic, gynecologic, and neoplastic manifestations, as well as syphilis." Informational Letter from the N.Y. State Dep't of Social Services to Commissioners of Social Services 2 (Sept. 4, 1992) (on file with the *Yale Law & Policy Review*).

119. *Henrietta D.*, 1996 WL 633382, at *2

120. *Id.*

121. *See id.* at *3.

122. *See id.* at *1.

123. *Id.* at *2 (quoting Plaintiffs' Memorandum at 6).

DAS, they are unable to access the basic public assistance for which they are eligible.”¹²⁴ In other words, plaintiffs alleged that defendants were denying them “meaningful access” and “reasonable accommodations” or “modifications” in violation of the ADA and the Rehabilitation Act.¹²⁵

In considering plaintiffs’ motion for a preliminary injunction and defendants’ motion to dismiss, the court first noted the unique physical difficulties that plaintiffs faced in accessing social welfare benefits and services.¹²⁶

People with HIV infection develop numerous illnesses and physical conditions not found in the general population, and experience manifestations of common illnesses that are much more aggressive, recurrent, and difficult to treat. Infections and cancers spread more rapidly in a person whose immune system has been compromised, and . . . [i]llnesses not lethal to the general population can kill an HIV-infected person. For all these reasons, persons with AIDS and HIV-related disease experience serious functional limitations that make it extremely difficult, if not in some cases impossible, to negotiate the complicated City social service system on their own.¹²⁷

In denying their motion to dismiss, the court rejected defendants’ argument that neither the ADA nor the Rehabilitation Act requires defendants to make affirmative efforts to accommodate plaintiffs’ disabilities:

Defendants are incorrect to the extent that their argument is based on the presumption that they need not make *any* affirmative efforts to assist plaintiffs in getting their benefits and that DAS is therefore entirely legally gratuitous. The Second Circuit stated over ten years ago that the Rehabilitation Act “requires some degree of positive effort” and “at least ‘modest, affirmative steps’ to accommodate the handicapped.”¹²⁸

Accordingly, the court established that public entities must modify the manner in which they provide social welfare benefits and services to persons with AIDS:

Public assistance is generally provided to eligible New Yorkers when they meet their periodic appointment schedules and verify their status in other ways. Frequently this means waiting in long lines, and if they receive more than one type of benefit, it means doing so at several different locations. Given plaintiffs’ disability and, in particular, the ease with which even minor infections can profoundly threaten their health, it is clear that defendants must provide Food Stamps, Home Relief, and other public assistance benefits in some modified fashion to these plaintiffs.¹²⁹

124. *Id.* at *8.

125. *Id.*

126. Defendants conceded that plaintiffs were individuals with disabilities or handicaps “within the meaning of the ADA and the Rehabilitation Act.” *Id.* at *7.

127. *Id.* at *2 (citations omitted).

128. *Id.* at *8 (emphasis added) (quoting *Dopico v. Goldschmidt*, 687 F.2d 644, 652, 653 n.6 (2d Cir. 1982)).

129. *Id.* at *9.

Equally important, the court held that such modifications are not fundamental alterations but reasonable modifications, as required by Section 35.130(b)(7) of the DOJ regulations:

[D]efendants' effort to present DAS as *entirely* discretionary and simply a service provided out of the kindness of their hearts is inaccurate, if not insincere. The goal of DAS, at least in part, is to facilitate HIV-positive clients who are ill through the complex maze of social services that provide the variety of public assistance benefits to which plaintiffs are entitled. At a minimum, in its most basic, facilitory [sic] efforts, DAS is a necessary modification to, and not a fundamental alteration of, the public assistance services that the City provides to all eligible New Yorkers.¹³⁰

Ultimately, the court denied plaintiffs' motion for a preliminary injunction on factual rather than legal grounds. Quite simply, the court ruled that plaintiffs were unlikely to succeed in proving that "DAS is or will be debilitated to such a degree that it no longer acts or will act as the required reasonable modification to New York City's public assistance programs for AIDS and HIV-positive clients."¹³¹ The court ruled that DAS "does appear to serve as a reasonable modification" and "to assist plaintiffs in meaningfully accessing welfare benefits," and that a proposed restructuring plan would likely "address the bureaucratic problems" of DAS.¹³²

Though refusing to grant a preliminary injunction on factual grounds, the court unequivocally upheld the rights of persons with AIDS to precisely the sort of modifications advocated in this Article. Indeed, the court referred to New York's DAS as a "necessary modification"¹³³ and a "required reasonable modification to ensure meaningful access."¹³⁴ The decision clearly indicates, then, that cities throughout the United States that have failed to implement equivalent modifications are in violation of the Act.¹³⁵

130. *Id.* at *9 (emphasis added). Section 35.130(b)(7) requires such reasonable modifications "unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7) (1997); see *supra* text accompanying note 111.

131. *Id.* at *10.

132. *Id.*

133. *Id.* at *9.

134. *Id.* at *9; see also *id.* at *10 ("[I]t seems true that some form of DAS or an agency like it must exist to facilitate and assist plaintiffs in their accessing of public assistance . . .").

135. Following the court's decision in *Henrietta D.*, in July 1997, the City Council of New York City amended the City's administrative code to mandate the reasonable modifications sought by plaintiffs in that lawsuit. A number of those modifications have already been set forth. See *supra* Section I.B. Among the modifications for clients with AIDS and HIV-related disease mandated by the new law are the adoption of an "intensive case management" system "with an overall average ratio for all cases which shall not exceed one case-worker or supervisor

This conclusion is supported by other relevant ADA and Rehabilitation Act case law. Any analysis of the relevant law must begin with the Supreme Court's decision in *Alexander v. Choate*.¹³⁶ Indeed, "[i]n the legislative history of title II, the congressional committees held out Choate as the definitive interpretation of section 504 [of the Rehabilitation Act] that it intended title II to copy."¹³⁷ The standards that the DOJ adopted in Title II are therefore consistent with, and reflective of, the Supreme Court's interpretation of Section 504 of the Rehabilitation Act in *Choate*.¹³⁸

The plaintiffs in *Choate*, a group of disabled state Medicaid recipients, challenged Tennessee's proposal to reduce from twenty to fourteen the number of days that state Medicaid would pay hospitals on behalf of Medicaid recipients. Although the limitation was neutral on its face, plaintiffs argued that it would disproportionately affect people with disabilities in violation of the Rehabilitation Act. In oft-quoted language, the Court first established that, under the Rehabilitation Act,

an otherwise qualified handicapped individual must be provided with meaningful access to the benefit that the grantee offers [T]o assure meaningful access, reasonable accommodations in the grantee's program or benefit may have to be made.¹³⁹

The Court ruled, however, that plaintiffs sought more than mere equal or meaningful access; rather, they wanted "to alter th[e] definition of the benefit being offered."¹⁴⁰ Because the disabled had "meaningful and equal access" to the same benefit provided to others, the Court concluded that Tennessee was not obligated to reinstate its twenty-day rule or to provide greater coverage for the disabled.¹⁴¹

The plaintiffs in *Choate* challenged a facially-neutral reduction in benefits to all recipients, seeking greater benefits for themselves. By con-

to thirty-four cases," N.Y. CITY ADMIN. CODE § 21-127 (approved July 11, 1997), and "a home or hospital visit for the purpose of establishing eligibility and applying for benefits and services," *id.* § 21-128(b).

136. 469 U.S. 287 (1985).

137. Mark C. Weber, *Disability Discrimination by State and Local Government: The Relationship Between Section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act*, 36 WM. & MARY L. REV. 1089, 1115 (1995).

138. See 28 C.F.R. pt. 35, app. A, at 477 (1997); PERRITT, *supra* note 81, § 9.4, at 166 ("Section 35.130(b)(3) incorporates the United States Supreme Court's interpretation in *Alexander v. Choate* of certain Rehabilitation Act § 504 requirements.").

139. *Choate*, 469 U.S. 287, 301 (1985). The Court noted that "much of the conduct that Congress sought to alter in passing the Rehabilitation Act would be difficult if not impossible to reach were the Act construed to proscribe only conduct fueled by a discriminatory intent." *Id.* at 296-97; see also *Wilder v. City of New York*, 568 F. Supp. 1132, 1136 (E.D.N.Y. 1983) ("Section 504 differs from Title VI in that discriminatory intent is not essential to a violation of the Rehabilitation Act."); 28 C.F.R. pt. 35, app. A, at 477 (1997) (citing *Choate*).

140. *Choate*, 469 U.S. at 303.

141. See *id.* at 306.

trast, persons with AIDS seeking redress under the ADA would not require any enhancement of the benefits and services provided to others. Rather, these individuals require meaningful and equal access to the very same benefits and services. Also unlike the plaintiffs in *Choate*, persons with AIDS have been and will continue to be denied meaningful and equal access without reasonable modifications to existing programs. Under the Supreme Court's reasoning in *Choate*, public entities that fail to make those reasonable modifications are thus in violation of both the ADA and the Rehabilitation Act.

In *Concerned Parents to Save Dreher Park Center v. City of West Palm Beach*¹⁴² (*Dreher Park*), the District Court for the Southern District of Florida addressed facts similar to those at issue in this Article. In *Dreher Park*, plaintiffs moved for an injunction under Title II of the ADA to compel the defendant to restore municipal recreational programs designed for people with physical disabilities that were eliminated "as a result of budget constraints."¹⁴³ In granting the injunction, the court found that the elimination of the programs had "the effect of denying persons with disabilities the benefits of the City's recreational programs."¹⁴⁴ The court explained:

The City emphasizes that none of the City's recreational programs are closed to individuals with disabilities, and in this round-about way the City seems to be arguing that because no discriminatory animus exists, there is no Title II violation. Certainly intentional discrimination is banned by Title II. But further, actions that have the effect of discriminating against individuals with disabilities likewise violate the ADA.¹⁴⁵

The court's reasoning in *Dreher Park* can be applied to the issue in contention here. Although public entities may well argue, as in *Dreher Park*, that their failure to accommodate persons with AIDS lacks "discriminatory intent," persons with AIDS "are without a meaningful access to the benefits of the City's . . . programs. It is this effective denial of equal benefit that violates the ADA."¹⁴⁶ If anything, the plight of persons with AIDS is more compelling, since the services and benefits at issue for these individuals provide the food, shelter, medical care, and in-

142. 846 F. Supp. 986 (S.D. Fla. 1994).

143. *Id.* at 989.

144. *Id.* at 991. The court observed that these programs "were needed to give equal benefits of recreation to persons with disabilities. When these programs were eliminated, Plaintiffs were denied the benefits of the City's leisure services in contravention of Title II." *Id.* at 992.

145. *Id.* at 991; see also *supra* note 56 (listing cases supporting the assertion that the ADA is not limited to circumstances involving deliberate discrimination). The court noted that its interpretation was consistent with the Supreme Court's decision in *Choate*. See *Dreher Park*, 846 F. Supp. at 991 n.12.

146. *Id.* at 992 n.14.

come necessary for their survival.¹⁴⁷

In the subsequent *Concerned Parents to Save Dreher Park Center v. City of West Palm Beach*¹⁴⁸ (*Dreher Park II*), the District Court for the Southern District of Florida explained that the City's denial of equal access to the benefits or programs offered to non-disabled individuals constituted discrimination "by reason of" plaintiffs' disabilities:

[P]laintiffs could not participate in the programs offered to the non-disabled populations and required special services, none of which were available after the elimination of the Dreher Park Center programs. The City, therefore, denied the benefits of the City's leisure services program to the plaintiffs by reason of the plaintiffs' disabilities. Such a denial violated the ADA. Therefore, the City is liable to the plaintiffs.¹⁴⁹

Analogously, persons with AIDS have a disability that prevents them from meaningfully participating in the programs offered to non-disabled individuals, and they require reasonable modifications that are unavailable in numerous municipalities throughout the United States. These municipalities, therefore, have denied persons with AIDS the benefit of programs and services by reason of their disabilities. As in *Dreher Park II*, this denial violates the ADA.¹⁵⁰

The Second Circuit's decision in *Dopico v. Goldschmidt*¹⁵¹ proves similarly instructive. In *Dopico*, the plaintiffs brought a class action against local and federal defendants under the Rehabilitation Act for failing to make public transportation accessible to the disabled. In granting plaintiffs' request for declaratory and injunctive relief, the court emphasized that "plaintiffs do not seek fundamental changes in the nature of a program by means of alterations in its standards."¹⁵² In such instances, the court explained, "where the relief requested did not modify

147. See *Goldberg v. Kelly*, 397 U.S. 254, 264 (1970) ("[The termination of benefits] may deprive an *eligible* recipient of the very means by which to live while he waits. Since he lacks independent resources, his situation becomes immediately desperate. His need to concentrate upon finding the means for daily subsistence, in turn, adversely affects his ability to seek redress from the welfare bureaucracy."); *Willis v. Lascaris*, 499 F. Supp. 749, 760 (N.D.N.Y. 1980) ("[T]he consequence of those mistakes in the social service arena, are more harmful than if they are made in other governmental programs because the ability of people to survive may be jeopardized.").

148. 853 F. Supp. 424 (S.D. Fla. 1994) (entering consent judgment).

149. *Id.* at 426.

150. As the court explained in *Dreher Park*, "while Title II does not require any particular level of services for persons with disabilities in an absolute sense, it does require that any benefits provided to non-disabled persons must be equally made available for disabled persons." 846 F. Supp. at 992. In *Civic Association of the Deaf of New York City v. Giuliani*, 915 F. Supp. 622 (S.D.N.Y. 1996), the court enjoined the removal from city streets of alarm boxes that deaf plaintiffs use to report fires. See *id.* at 637 ("[W]ere Defendants proposing to eliminate fire services in their entirety, no claim would arise under the ADA. But for as long as a service, program, or activity remains in existence, as here, the ADA requires that it be accessible to the disabled.").

151. 687 F.2d 644 (2d Cir. 1982).

152. *Id.* at 653.

some integral aspect of a defendant's program, courts have ruled that section 504 does require efforts to make the program available to otherwise qualified handicapped persons."¹⁵³ The court therefore concluded that "section 504 does require at least 'modest, affirmative steps' to accommodate the handicapped,"¹⁵⁴ or "some degree of positive effort to expand the availability of federally funded programs to handicapped persons otherwise qualified to benefit from them."¹⁵⁵

Persons with AIDS similarly do not require "fundamental changes in the nature of a program by means of alterations in its standards."¹⁵⁶ They do, however, require "modest, affirmative steps"¹⁵⁷ and "some degree of positive effort."¹⁵⁸ Therefore, under *Dopico*, public entities should be required to expand the availability of services, programs, and benefits to individuals with AIDS who are otherwise qualified to benefit from them.¹⁵⁹

In *Shapiro v. Cadman Towers, Inc.*,¹⁶⁰ the Second Circuit affirmed the issuance of a preliminary injunction under the Fair Housing Amendments Act (FHAA).¹⁶¹ The plaintiff in *Shapiro*, a woman with multiple sclerosis, sought a preliminary injunction ordering her cooperative apartment complex and its board of directors to provide her with an indoor parking space ahead of others on a waiting list, thus modifying the cooperative's first come, first served policy as a reasonable accommodation of her disability. The district court granted the injunction, and the apartment complex appealed.

The Second Circuit upheld the district court's finding that, without the injunction, the plaintiff would likely suffer irreparable physical and

153. *Id.* at 653 n.6.

154. *Id.* at 652.

155. *Id.* at 653 n.6; see also *Henrietta D. v. Giuliani*, No. 95-CV-0641, 1996 WL 633382, at *8 (E.D.N.Y. Oct. 25, 1996) (stating that city and state officials were required to make affirmative efforts to assist eligible city residents with AIDS or HIV in getting their benefits); *Marisol A. v. Giuliani*, 929 F. Supp. 660, 685 (S.D.N.Y. 1996) ("[A] disabled individual is entitled to meaningful access to the benefits and services provided by a public agency or an agency receiving federal funds. *Access alone . . . is insufficient. Rather, a court may require an agency, under certain circumstances, to take affirmative steps to ensure that the access is meaningful.*") (citations omitted and emphasis added), *aff'd*, 126 F.3d 372 (2d Cir. 1997).

156. *Dopico*, 687 F.2d at 653.

157. *Id.* at 652.

158. *Id.* at 653 n.6.

159. See *Alexander v. Choate*, 469 U.S. 287, 301 (1985) ("[T]o assure meaningful access, reasonable accommodations in the grantee's program or benefit may have to be made."); 45 C.F.R. pt. 84, app. A, at 336 (1997) ("[I]n order to meet the individual needs of handicapped persons to the same extent that the corresponding needs of nonhandicapped persons are met, adjustments to regular programs or the provision of different programs may sometimes be necessary.").

160. 51 F.3d 328 (2d Cir. 1995).

161. As the Second Circuit noted, the FHAA was based on the standard of reasonable accommodation developed under the Rehabilitation Act. See *id.* at 334.

emotional harm because she “was subject to risk of injury, infection, and humiliation in the absence of a parking space in her building.”¹⁶² The injuries suffered by persons with AIDS who are effectively denied access to social welfare benefits and services—months without adequate cash, food stamps, and necessary home care—are far more severe and life-threatening than those faced by the plaintiff in *Shapiro* and plainly support the issuance of relief under the ADA.

Finally, in *Dees v. Austin Travis County Mental Health and Mental Retardation*,¹⁶³ plaintiffs alleged that defendant’s board of trustees violated the ADA by holding meetings at a time that made it impossible for plaintiffs, who suffered drowsiness from medication for mental illness, to attend. The court ruled that the board’s policy of holding regular board meetings at 7:00 a.m. effectively excluded plaintiffs from exercising their right to participate in these public meetings.¹⁶⁴ The court found, moreover, that the defendant had failed to demonstrate that changing the time of the regular meetings to 9:00 a.m. or later would “fundamentally alter the nature of the board because it is comprised of volunteers with other commitments.”¹⁶⁵ Accordingly, the court ordered that regular board meetings be held sometime between 9:30 a.m. and 6:00 p.m.¹⁶⁶

All of these cases “stress the concept of equal opportunity, not merely equal treatment, to eliminate discrimination,”¹⁶⁷ as Congress intended.¹⁶⁸ All demonstrate, moreover, that a finding of discriminatory animus is not necessary to succeed on an ADA claim; action or inaction that has the effect of discriminating against the disabled violates the ADA.¹⁶⁹ Accordingly, all of these cases amply support the legal requirement to provide reasonable modifications to persons with AIDS in the provision of social welfare benefits and services.

IV. CONCLUSION

In municipalities throughout the United States, public entities offer persons with AIDS no modifications or accommodations in the provision

162. *Id.* at 332. Similar to persons with AIDS, the plaintiff in *Shapiro* suffered from “an incurable disease that gradually and progressively sap[ped] her strength and interfere[d] with her balance and bodily functions.” *Id.* (citing *Shapiro v. Cadman Towers, Inc.*, 844 F. Supp. 116, 122 (E.D.N.Y. 1994)).

163. 860 F. Supp. 1186 (W.D. Tex. 1994).

164. *See id.* at 1190.

165. *Id.*; *cf.* *State ex rel. Nelson v. Fuerst*, 607 N.E.2d 836, 840 (Ohio 1993) (Douglas, J., dissenting) (suggesting that a state agency’s refusal to make public records available to individuals who are physically unable to travel to the location of the records may violate the ADA).

166. *See Dees*, 860 F. Supp. at 1192.

167. ADA COMPLIANCE GUIDE, *supra* note 3, ¶ 804 (Supp. Dec. 1991).

168. *See supra* notes 80-89 and accompanying text.

169. *See supra* Section II.A.

of social welfare benefits and services. As a result, these individuals are deprived of meaningful access to vitally important benefits and services to which they are entitled. This deprivation is life-threatening for persons with AIDS, who depend upon these benefits and services for their survival. The inability of persons with AIDS to obtain and maintain the benefits and services to which they are entitled affects their short- and long-term health and, ultimately, their life expectancy.¹⁷⁰

As the demographics of AIDS continue to change, and as AIDS continues to increase disproportionately among the less advantaged—people of color, women, and children—this problem will only worsen.¹⁷¹ The poorer¹⁷² and less powerful the persons with AIDS, the greater their need for meaningful access to life-sustaining benefits and services and the more critical the protections of the ADA become. Indeed, where other civil rights acts have failed these communities for lack of proof of animus, the ADA may well succeed, since it explicitly recognizes that “access alone . . . is insufficient.”¹⁷³

New York City has taken the lead in enacting legislation that seeks to ensure the reasonable accommodations that persons with AIDS require.

170. See, e.g., *Haskins v. Stanton*, 794 F.2d 1273, 1276-77 (7th Cir. 1986) (“[T]he deprivation of food ‘is extremely serious and is quite likely to impose lingering, if not irreversible, hardships upon recipients.’”) (quoting *Haskins v. Stanton*, 621 F. Supp. 622, 627-28 (N.D. Ind. 1985)); *Bizjak v. Blum*, 490 F. Supp. 1297, 1303 (N.D.N.Y. 1980) (“As has often been recognized by the Courts in public assistance cases, recipients of such benefits are generally completely reliant upon the continued receipt of them for their very survival.”). These observations ring even more true when describing individuals living with AIDS.

171. See FRUMKIN & LEONARD, *supra* note 4, at 128-29 (“During the 1990s, Blacks have had a greater proportional increase in rates of HIV infection as compared with Whites. . . . Women of childbearing age constitute a growing population of HIV-infected persons, and perinatal transmission of HIV is increasing at an alarming rate.”); Lovitch, *supra* note 53, at 1213 (“As more women, children, and people of color contract the virus, the need to reform the [health care] system in response to HIV disease will become even more urgent.”); Parmet & Jackson, *supra* note 49, at 29 (“By the late 1980s, . . . intravenous drug users and heterosexual people of color increasingly contracted the disease. As they did, the connections between HIV patients and mainstream American began to unravel. AIDS was becoming even more and more a problem of socially outcast groups.”); Sheryl Gay Stolberg, *Women & AIDS: The Better Half Got the Worse End*, N.Y. TIMES, July 20, 1997, § 4, at 1 (“The trends are particularly troubling for women, who account for 20 percent of the AIDS population and are joining the nation’s roster of cases faster than men. Most infected women are also minorities, and most are poor and uneducated.”); Mediconsult.com, *Pediatric AIDS* (visited Nov. 7, 1997) <<http://www.mediconsult.com/noframes/aids/shareware/aids/17.html>> (“6,209 children in the United States have developed AIDS through Dec. 31, 1994.”); NIAID, *supra* note 29 (“The epidemic is growing most rapidly among minority populations and is a leading killer of African-American males. According to the U.S. Centers for Disease Control and Prevention (CDC), the prevalence of AIDS is six times higher in African-Americans and three times higher among Hispanics than among whites.”).

172. See, e.g., David D. Ho, *Preface* to FRUMKIN & LEONARD, *supra* note 4, at xvii (“In the United States, the epidemic has shifted from the male homosexual population into the urban poor.”); Lovitch, *supra* note 53, at 1218 (noting that “HIV disease often strikes those in areas pervaded by drug use and poverty”).

173. *Marisol A. v. Giuliani*, 929 F. Supp. 662, 685 (S.D.N.Y. 1996).

Americans With Disabilities Act

In municipalities where persons with AIDS lack the numbers and clout of the New York City community, the ADA can fulfill the same role. Persons with AIDS and their advocates can and should file suit under the ADA to compel public entities to comply with their legal obligation to provide equal and *meaningful* access to crucial benefits and services. Such relief does not invade the decision-making provinces of state and local executive and legislative officials, but merely requires that those officials comply with the law.¹⁷⁴ Eight years after the passage of the ADA, this relief is already long overdue.

174. In one case, for example, a district court granted granting relief to plaintiffs who claimed that city defendants regularly failed to provide timely benefits as a result of inadequate staffing. *See Morel v. Giuliani*, 927 F. Supp. 622, 632 (S.D.N.Y. 1995) ("This relief does not invade the decision-making provinces of State and City executive and legislative officials, but would require City Defendants to resolve their fiscal difficulties in a fashion that complies with the Constitution and the law."); *see also Hurley v. Toia*, 432 F. Supp. 1170, 1176 (S.D.N.Y. 1977) ("Although the Court is well aware of the fiscal crises facing the governmental entities responsible for funding the Home Relief program, this kind of economic hardship pales before the 'brutal need' of the recipient for continued public assistance benefits.").

