



Defending Liberty
Pursuing Justice

THE AMERICAN BAR ASSOCIATION
AIDS Coordinating Committee and
AIDS Coordination Project

HIV/AIDS Law and Practice 2004
From Nuts & Bolts to Cutting Edge

January 23-24, 2004
Loyola University
New Orleans, La.

*Presented in Cooperation with
AIDS Law of Louisiana and
Loyola Law School*

TABLE OF CONTENTS

About the ABA AIDS Coordinating Committee and AIDS Coordination Project **3**

Members of the ABA AIDS Coordinating Committee **4**

Conference Program and Room Assignments **5**

Professional Biographies of Moderators and Panelists **8**

Friday, January 23, 2004

Plenary Session (Panel): Major HIV/AIDS Litigation: Wins, Losses, and Cutting Edge Issues **15**

Plenary Session (Panel): The ADA and the Rehabilitation Act: Litigation Strategy **25**

HIV/AIDS in the South **41**

Social Security Practice **49**

Debtor/Creditor Issues **55**

Immigration **59**

Housing **68**

Sexual Health and Sex Education Issues **77**

Saturday, January 24, 2004

Plenary Session (Panel): Medical Privacy, Confidentiality, and Criminalization **89**

Government Health Insurance: Medicaid, Medicare, and ADAP **102**

HIV in Adult and Juvenile Correctional Facilities **118**

HIV/AIDS in Minority Communities **123**

Private Insurance **124**

Women's Health and Reproductive Rights **137**

Damages under Federal and State Anti-discrimination Laws **144**

PROGRAM EVALUATION FORM 149

ABA AIDS Coordinating Committee

Established in August 1987, the American Bar Association (ABA) AIDS Coordinating Committee is charged with organizing the ABA's HIV/AIDS-related activities, developing policy recommendations, and encouraging new ABA-sponsored HIV/AIDS-related programs. It is comprised of a Chair appointed by the President of the ABA, a Vice Chair, and representatives of over 15 sections, commissions, divisions, and other ABA-affiliated organizations and bar associations.

Of particular note have been the Committee's continued contributions in establishing education and awareness programs for legal professionals and furthering a wide range of HIV/AIDS policy initiatives through its support of and participation in HIV/AIDS-related policy programs at federal, state, and local levels. The Committee also has been instrumental in broadening the base of information available to legal professionals about the disease by the publication of a number of articles, position papers, and reports on current HIV/AIDS-related legal topics.

ABA AIDS Coordination Project

The AIDS Coordination Project, under the auspices of the ABA Section of Individual Rights and Responsibilities, provides staff support to the ABA AIDS Coordinating Committee and develops projects that address the complex issues that HIV and AIDS present to the legal community. Since its beginning in January 1988, the Project has been in contact with attorneys, pro bono coordinators, bar association staff, and others in almost every major city in the United States to gather information on HIV/AIDS-related *pro bono* efforts nationwide, acting as a resource center for pro bono programs serving people with HIV/AIDS.

A clearinghouse for dissemination of HIV/AIDS-related legal information, the Project organizes HIV/AIDS-related education programs for the bench and bar at national, state, and local conferences, including the ABA's Annual Meeting. It is available for consultation on planning HIV/AIDS-related legal workshops, identifying speakers for locally organized education programs, and assisting in the development of appropriate written materials. It also plays a substantial role in the HIV/AIDS policy community through service on advisory boards, participation in national HIV/AIDS-related policy programs and comment on HIV/AIDS-related policy issues on the federal and state levels. It has developed a number of the Committee's HIV/AIDS-related legal publications, the most recent of which are *Perspectives on Returning to Work: Changing Legal Issues and the HIV/AIDS Epidemic* and *Deregulation of Hypodermic Needles and Syringes as a Public Health Measure: A Report on Emerging Policy and Law in the United States*.

For more information about the Committee and the Project, please contact:

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AMERICAN BAR ASSOCIATION AIDS COORDINATING COMMITTEE (2003-04)

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New York Supreme Court
Appellate Division/First Department
New York, NY

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St. Louis, MO

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Philadelphia, PA
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Mark E. Wojcik

The John Marshall Law School
Chicago, IL
Criminal Justice Section



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Pursuing Justice**

AMERICAN BAR ASSOCIATION
AIDS COORDIN
ATION PROJECT

HIV/AIDS Law & Practice 2004
From Nuts & Bolts to Cutting Edge

Loyola University
Danna Center
6363 St. Charles Avenue
New Orleans, LA
(Dress Code: "Business casual")

PROGRAM

Friday, January 23, 2004

- 8:30 - 9:00 a.m. Welcome and Introductions
St. Charles Room
- 9:00 -10:15 a.m. **Plenary Session (Panel): Major HIV/AIDS Litigation: Wins, Losses, and Cutting
Edge Issues.** *Catherine Hanssens, Brooklyn, NY; Ben Klein, Gay & Lesbian Advocates & Defenders,
Boston, MA*
St. Charles Room
- 10:15-10:30 a.m. Break
- 10:30 a.m. - 12:00 p.m. **Plenary Session (Panel): The ADA and the Rehabilitation Act: Litigation Strategy**
St. Charles Room *Mark Wojcik (moderator), John Marshall Law School, Chicago, IL
Hayley Gorenberg, AIDS Project, Lambda LDEF, New York, NY
Mitchell Katine, Williams, Birnberg & Andersen, LLP, Houston, TX
James Passamano, Sufian & Passamano, LLP, Houston, TX*
- 12:00 - 1:45 p.m. **Luncheon Presentation: HIV/AIDS in the South**
St. Charles Room *Linton Carney, AIDS Law Louisiana, New Orleans, LA
Dr. Gene Copello, The AIDS Institute and University of South Florida College of
Medicine, Tampa, FL*
- Lunch provided courtesy of S&H Consulting, LLC*
- 1:45 - 3:15 p.m. **Concurrent Sessions**
- **Social Security Practice (Octavia Room)**
*Dirk Selland (moderator), Social Security Administration, Baltimore, MD
Hon. Mark R. Dawson, SSA Office of Hearings and Appeals, Metairie, LA
Ann H. Fisher, AIDS Legal Council of Chicago, Chicago, IL
Leslie Kline-Capelle, HIV & AIDS Legal Services Alliance, Los Angeles, CA*

- **Debtor/Creditor Issues (incl. Bankruptcy) (Audubon Room)**
Ross Lanzafame (moderator), Harter, Secrest & Emery, Rochester, NY
Bill Flynn, Gay Men's Health Crisis, New York, NY
Ronda Goldfein, AIDS Law Project of Pennsylvania, Philadelphia, PA
- **Immigration (Claiborne 1 & 2 Room)**
Jody Odell (moderator), Barnes & Thornburg, South Bend, IN
Victoria Neilson, Lesbian and Gay Immigration Rts. Task Force, New York, NY
Maribel Reynoso, HIV & AIDS Legal Services Alliance, Los Angeles, CA

3:15 - 3:30 p.m. Break

3:30 - 5:00 p.m. **Concurrent Sessions**

- **Housing (Octavia 1 Room)**
Martha Kegel (moderator), UNITY for the Homeless, New Orleans, La.
Michelle Gilbert, Legal Assistance Foundation of Metro. Chicago, Chicago, IL
Jeffrey P. May, Gtr. New Orleans Fair Housing Action Ctr., New Orleans, LA
Armen Merjian, Housing Works, New York, NY
- **Sexual Health and Sex Education Issues (Audubon Room)**
Shelley D. Hayes (moderator), S&H Consulting, LLC, Washington, DC
Catherine Hanssens, Brooklyn, NY
Bill Smith, Sexuality Information and Education Council of the U.S., Wash., DC
Mark Del Monte, AIDS Alliance for Children, Youth, and Families, Wash., DC

5:00 CONFERENCE ADJOURNS TO SATURDAY SESSION

6:00-8:00 p.m. **Reception**
 Louisiana State Bar Association
 601 St. Charles Avenue, New Orleans
 (800) 421-5722 • (504) 566-1600

Reception sponsored by Louisiana State Bar Association

Saturday, January 24, 2004

- 8:30 – 9:00 a.m. Continental Breakfast
- 9:00 - 10:15 a.m.
St. Charles Room **Plenary Session (Panel): Medical Privacy, Confidentiality, and Criminalization**
Daniel Bruner (moderator), Whitman-Walker Clinic Legal Services, Washington, DC
Catherine O'Neill, Legal Action Center, New York, NY
David Webber, Philadelphia, PA
- 10:15 - 10:30 a.m. Break
- 10:30 a.m. - 12:00 p.m. **Concurrent Sessions**
- **Government Health Insurance: Medicaid, Medicare, & ADAP (Octavia 1)** *Sidney Watson (moderator), St. Louis University School of Law, St. Louis, MO*
Randy Boyle, National Health Law Program, Los Angeles, CA
Jon Givner, LAMBDA Legal Defense and Education Fund, New York, NY
Ronda Goldfein, AIDS Law Project of Pennsylvania, Philadelphia, PA
 - **HIV in Adult and Juvenile Correctional Facilities (Audubon Room)**
Hon. Richard T. Andrias (moderator), New York Supreme Court, New York, NY
Gloria Browne-Marshall, John Jay College, New York, NY
Joshua Lipman, Southern Center for Human Rights, Atlanta, GA
Catherine O'Neill, Legal Action Center, New York, NY
- 12:00 - 1:45 p.m.
St. Charles Room **Luncheon Presentation: HIV/AIDS in Minority Communities**
Ronald Johnson, National Minority AIDS Council, Washington, DC
- Lunch provided courtesy of S&H Consulting, LLC*
- 1:45 - 3:15 p.m. **Concurrent Sessions**
- **Private Insurance (Octavia 1 Room)**
Seth Levy (moderator), Pillsbury Winthrop LLC, Los Angeles, CA
Howard Schwartz, Gay Men's Health Crisis, New York, NY
Debra Wolf, Gay Men's Health Crisis, New York, NY
 - **Women's Health and Reproductive Rights (Claiborne 1 & 2 Room)**
Dawn Siler-Nixon (moderator), Ford & Harrison LLP, Tampa, FL
Caya Lewis, National Family Planning and Reproductive Health Association, Washington, DC
Robin Runge, ABA Commission on Domestic Violence, Washington, DC
Lynne H. Solomon, AIDS Network, Madison, WI
- 3:15 - 3:30 p.m. Break
- 3:30 - 5:00 p.m.
St. Charles Room **Closing Plenary: Damages under Federal and State Anti-discrimination Laws**
Scott Burris (moderator), Temple University School of Law, Philadelphia, PA
Alan Koral, Vedder, Price, Kaufman & Kammholz, PC, New York, NY
Allison Nichol, Disability Rights Section, U.S. Department of Justice, Washington, DC
- 5:00 p.m. **CONFERENCE ADJOURNS**
- 5:30-6:30 p.m. **Kick-Back-and-Relax Reception**
Renaissance Arts Hotel
700 Tchoupitoulas Street, New Orleans
(504) 613-2330

Moderators and Panelists Professional Biographies

Hon. Richard T. Andrias, Chair of the ABA AIDS Coordinating Committee, is an Associate Justice of the New York Supreme Court, Appellate Division, First Department (Manhattan and Bronx). From February 1985 to December 1987, he was the Supervising Judge of the New York County (Manhattan) Criminal Court and a trial judge in the criminal and civil divisions of the New York Supreme Court from January 1988 to June 1997. Prior to being appointed to the Criminal Court in 1983, he was a trial lawyer for the Legal Aid Society's Criminal Defense Division and in private practice doing primarily corporate and commercial litigation for several years. A graduate of Columbia Law School, Judge Andrias was the Chair of the American Bar Association's Ad Hoc Committee on AIDS and the Criminal Justice System and Co-Chair of the Association of the Bar of the City of New York's Joint Committee on AIDS in the Criminal Justice System. In 1989-1990, he was a member of the Governor's Task Force on Rape and Sexual Violence.

Randolph T. Boyle is a staff attorney in the Los Angeles office of the National Health Law Program. Previously, he worked 6 ½ years as a staff attorney for California Rural Legal Assistance in California's Central Valley. Thereafter, he served as the Debtors' Rights Attorney and Outreach Attorney for AIDS Project Los Angeles. While at APLA, he also worked with a team of HIV health professionals from UCLA to provide trainings on HIV/AIDS issues to medical professionals in Mexico. He actively participated in the formation of the HIV and AIDS Legal Services Alliance (HALSA) and assisted clients of HALSA with Social Security, Medi-Cal, and other benefits issues. He also was the Executive Director of the Fair Housing Congress of Southern California.

Gloria Browne-Marshall is an Assistant Professor at John Jay College of Criminal Justice in New York City, where she teaches Constitutional Law and Evidence, and was an Adjunct Lecturer on "Race, Law and American Society" at Vassar College. She formerly was Senior Law Clerk to Hon. Herbert J. Hutton of the U.S District Court for the Eastern District of Pennsylvania, Staff Attorney at the Southern Poverty Law Center in Montgomery, Alabama, and Assistant Counsel to the NAACP Legal Defense and Educational Fund in New York. Among her many publications is a forthcoming book chapter entitled, "To Be Black, Infected, and Incarcerated: A Socio-Legal Perspective on Black Women Inmates Living with HIV/AIDS."

Daniel Bruner is Associate Director for Litigation and Advocacy at Whitman-Walker Clinic in Washington, DC. Whitman-Walker is a nonprofit, community-based agency providing medical care and other services to the HIV-infected and gay and lesbian communities in the Washington-metropolitan area, including the District of Columbia and surrounding counties in Maryland and Virginia. Whitman-Walker's Legal Services Department provides *pro bono* advice and representation for persons living with HIV and their caregivers and families. Prior to joining Whitman-Walker's Legal Services Department in 1995, Dan was a partner at the Washington, D.C. law firm of Spiegel & McDiarmid. While at Spiegel & McDiarmid, he was a Whitman-Walker volunteer attorney for five years and a member and chair of the Legal Services Operating Committee. He concentrates on discrimination in employment, health care, and public accommodations, on insurance and employee benefits, and on issues of confidentiality. Dan is also an Associate Adjunct Professor of Law American University's Washington College of Law, where he currently teaches public health law.

Scott Burris, a member of the ABA AIDS Coordinating Committee, is a professor at the Beasley School of Law of Temple University, and Associate Director of the Center for Law and the Public's Health based at the Johns Hopkins School of Public Health. His major research interests are public health law, drug policy and health, and disability discrimination. His publications include *AIDS Law Today: A New Guide for the Public* (Yale University Press, 1993), *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 Columbia L. Rev. 59 (1999), *Physician Prescription of Sterile Injection Equipment to Prevent HIV Infection: Time for Action*, 133 Ann. Int. Med. 218 (2000), *Different Paths to Justice: The ADA, Employment and Administrative Enforcement by the EEOC and FEPAs*, 17 Behavioral Sci. & L. 29 (1999), and *Reducing Sexual Transmission of HIV from Those Who Know They Are Infected: The Need for Personal and Collective Responsibility*, 13 AIDS 297 (1999).

Leslie F. Kline Capelle is the Public Benefits Staff Attorney at the HIV & AIDS Legal Services Alliance (HALSA). Representing members of the HIV and AIDS communities of Los Angeles County in state (MediCal/Medicaid) and federal (SSDI/SSI) disability determination appeals, she has achieved a success rate of over 95%. She is the author of the HIV and AIDS disability determination strategy chapter of Matthew Bender's Social Security Practice Guide and additional public benefits articles for AIDS Project Los Angeles' *Positive Living* monthly publication.

Linton Carney is the Executive Director of AIDS Law of Louisiana, Inc. After judicial clerkships at the Louisiana Supreme Court and the United States District Court for the Western District of Louisiana, he practiced law at Monroe & Lemann in New Orleans for 13 years, and specialized in commercial litigation and bankruptcy. He has been a volunteer for NO/AIDS Task Force, and

served on the AIDS Law board of directors for three years. Since 2000, he has been a member of the New Orleans Regional AIDS Planning Council, and presently serves as chair of the Nominating/Bylaws Committee. He is also a member of the Access to Justice Committee of the Louisiana State Bar Association. From 1999 to 2002, he was a participant in the VaxGen clinical trials, phase II, for an HIV vaccine.

Dr. Gene Copello is the Executive Director of The AIDS Institute (formerly Florida AIDS Action), based in Tampa, Florida; Assistant Professor and Director of the Center for Public Policy Research and Ethics Division of Infectious and Tropical Diseases at the University of South Florida College of Medicine; and a leader of the Southern AIDS Coalition. Among The AIDS Institute's aims is to develop the Center for Advocacy Training, which would assist regions of the United States heavily affected by HIV/AIDS through community mobilization and advocacy networks; implement the group's first education and advocacy program aimed at health care professionals; open a Washington, D.C., office to focus on expanding federal policy initiatives; and create the Center for Global Mobilization, which would focus on providing assistance to resource-poor nations.

Hon. Mark R. Dawson is the Hearing Office Chief Administrative Law Judge ("HOCALJ") of the Social Security Administration Office of Hearings and Appeals in Metairie, Louisiana, with hearing sites in Metairie, Baton Rouge, and Houma, Louisiana. He was appointed an ALJ in 1994 for Hattiesburg, Mississippi, and served as the HOCALJ in Lexington, Kentucky from 1996-2000. He was a Special Asst. U.S. Attorney in the Civil Division in San Diego from 1992-1994 subsequent to a 20-year career in the U.S. Navy Judge Advocate General's Corps, where he specialized in legal medicine and served three years as a General Court-Martial Judge. Judge Dawson received his B.A. from the University of California at Berkeley, his J.D. from the University of California Hastings College of the Law, and his LL.M. in legal medicine from the George Washington University National Law Center.

Mark Del Monte is the Director of Public Affairs for AIDS Alliance for Children, Youth and Families. AIDS Alliance represents the needs of women, children, youth and families infected and affected by HIV. Mark develops policy and directs AIDS Alliance's federal advocacy activities across the spectrum of HIV-related issues including HIV prevention, research, treatment and care. In addition, he directs an AIDS Alliance youth HIV prevention program and mother to child transmission reduction programs. Prior to moving to Washington he practiced law, providing free legal services to HIV-positive women, children and youth in northern California.

Ann H. Fisher, a member of the ABA AIDS Coordinating Committee, is the Executive Director of the AIDS Legal Council of Chicago, a community-based not-for-profit serving the legal needs of people with HIV in Cook County, Illinois. With offices in Chicago's loop and at Cook County Hospital, the Council serves more than 1,000 people with HIV annually. Prior to her work at the Council, Ann served as Senior Attorney of the Disability Law Project of the Legal Assistance Foundation of Chicago, and later as the Supervisory Attorney of the Foundation's HIV Law Project. She is a graduate of the University of Michigan and the Wayne State University College of Law and was a law clerk to Judge James Churchill of the U.S. District Court for the Eastern District of Michigan and Judge Thomas Fairchild of the U.S. Court of Appeals for the Seventh Circuit.

William Flynn is a Staff Attorney with the Legal Services and Advocacy Department of Gay Men's Health Crisis, Inc. (GMHC) in New York City, one of the oldest and most comprehensive HIV/AIDS organizations in the nation. He provides direct client representation to people living with HIV/AIDS in the area of Bankruptcy and Debt Management Issues. He conducts a twice-monthly seminar for clients and community based organizations entitled "HIV and Your Debts." He also represents clients who have experienced HIV-based discrimination in employment, housing, and public accommodations. He previously represented people living with mental disabilities for Westchester/Putman Legal Services.

Michelle Gilbert has been the Supervisory Attorney and Project Director of the HIV/AIDS Project of the Legal Assistance Foundation of Metropolitan Chicago since 2000. She was a Senior Staff Attorney in LAF's Central Intake Office for four years and staffed LAF's Policy Advocacy Project for six years until Congress prohibited legal services attorneys from engaging in lobbying. A 1986 graduate of the University of Illinois College of Law, she was briefly associated with the Chicago offices of Jenner & Block and Rivkin, Radler, Dunne & Bayh.

Jon Givner is a staff attorney in the AIDS Project of Lambda Legal. Through impact litigation, education and policy analysis, Lambda Legal's AIDS Project seeks to challenge HIV-based discrimination in employment, housing and health care, to secure fair access to sound health care, and to ensure that government policies relating to HIV are based on sound science. Before joining Lambda Legal's New York office, Jon was a Berkeley Law Foundation fellow and staff attorney at Legal Services of Northern California in Sacramento, where he provided civil legal services in housing, benefits and public education matters.

Ronda B. Goldfein is Executive Director of the AIDS Law Project of Pennsylvania, the nation's oldest and largest independent public-interest law firm dedicated to AIDS and HIV. Since joining the Philadelphia-based firm in 1992, she has successfully

represented individuals living with HIV in a broad range of issues, including access to health care through public and private insurance, employment law, confidentiality and privacy. She negotiated a landmark 1994 discrimination settlement in which the Philadelphia Fire Department agreed to provide AIDS education to more than 2,000 firefighters and emergency medical technicians—the first consent decree under the Americans with Disabilities Act. Her firm has risen to the defense of more than 20,000 Pennsylvanians free of charge, and has educated more than 24,000 others on AIDS-related legal issues. She chairs a Philadelphia research facility's Institutional Review Board and is responsible for protecting the legal and ethical rights of clinical trial participants.

Hayley Gorenberg is director of the AIDS Project for Lambda Legal Defense and Education Fund, where she manages the agency's HIV litigation and policy analysis work. The AIDS Project is active in cases addressing issues such as the right to fairness in health, disability and life insurance, the employment rights of health care workers and others with HIV, refusals to treat HIV positive persons, and a variety of other cases interpreting the Americans with Disabilities Act (ADA). Before joining Lambda Legal, she was Coordinating Attorney for HIV Advocacy at The Legal Support Unit of Legal Services for New York City, where she provided litigation support to lawyers and other advocates in civil legal cases affecting low-income, HIV-positive New Yorkers. She also designed continuing legal education programs on HIV-related legal issues, and chaired a city-wide legal task force on HIV and poverty law and the Special Committee on AIDS of the Association of the Bar of the City of New York.

Catherine Hanssens has been active in HIV legal and policy issues since 1984. During this time she has litigated cases affecting the rights of people with HIV on a broad range of issues in state and federal courts and has spearheaded legislative and policy initiatives such as standby guardianship laws and a current New York bill on sexual health and HIV prevention in prisons. As AIDS Project Director at Lambda Legal Defense and Education Fund for eight years, Hanssens led the development of Lambda's HIV litigation and policy work, and was lead attorney on all of Lambda's briefing on U.S. Supreme Court cases affecting the Americans with Disabilities Act and people with HIV. Prior to joining Lambda in 1994, Hanssens worked with the AIDS Law Project of Pennsylvania, where she created and managed a model on-site legal assistance program for mothers with AIDS in Philadelphia-area hospitals and clinics that brought together legal, medical, and social services. In an earlier position with the New Jersey Public Advocate, a state public interest law agency, she successfully litigated the state's first case addressing involuntary HIV testing, a system-wide challenge to segregation and treatment of prisoners with HIV, and the only federal appeals court decision recognizing the right of incarcerated women to funded elective abortions. More recently, she has been a visiting clinical professor at Rutgers University Law School-Newark, and currently is developing a new project on HIV law and policy.

Shelley D. Hayes of S&H Consulting, LLC, is Vice Chair of the ABA AIDS Coordinating Committee and has served since 1985 as a consultant to various federal agencies, including the Departments of Agriculture, Defense (Defense Mapping Service), Navy, and Interior, on issues related to federal sector employment discrimination complaints. Between 1987 and 1990, she served as an editor with the Research Institute of America, a business advisory service, where she was responsible for publications related to employment issues and to employee safety and health matters. In 1995 and 1996, she also served as a consultant to the United States Department of Labor on projects to re-write technical occupational safety and health (OSHA) regulations in plain English. Her current areas of specialization include employment and healthcare law.

Ronald Johnson is Public Affairs and Education Manager at the National Minority AIDS Council, where he is responsible for curricula development for all training conducted within the Government Relations and Public Policy Division. He also is responsible for the education of NMAC's constituents on issues related to HIV/AIDS for racial and ethnic minority communities. His projects include co-facilitation of the HIV/AIDS Stigma Project and leadership and advocacy training for the Gay Men of Color Policy Initiative. He has more than a decade of professional experience in the HIV/AIDS arena, including as an Early Intervention Consultant with the Florida Department of Health, where he was responsible for training and certifying all counselors conducting HIV testing in Broward County.

Mitchell Katine is a partner with the Houston law firm of Williams, Birnberg & Andersen L.L.P. He represents all types of clients in matters dealing with employment, real estate, insurance, and disability law, especially HIV and AIDS. He teaches HIV & The Law as an adjunct professor at the University of Houston Law Center and was local counsel and Lambda Legal's Houston Cooperating Attorney for John Lawrence and Tyrone Garner in the United States Supreme Court case that overruled *Bowers v. Hardwick* and removed all sodomy laws throughout America. He has helped create a gay and lesbian legal organization for Houston attorneys, the Texas Association of Lesbian and Gay Elected and Appointed Officials, and the State Bar of Texas Section on Sexual Orientation and Gender Identification issues (the first such section in the United States). In August 2003, he received the Uncommon Man Award from the Uncommon Legacy Foundation, and in October 2003, he received the Achievement Award from the Gay and Lesbian Medical Association.

Martha Kegel is Executive Director of UNITY for the Homeless in New Orleans, La. UNITY's mission is to increase the community's organized capacity to resolve the issues of homelessness through open, inclusive, and coordinated decision-making,

collaborative efforts, and funding. It's goals are to assist homeless persons to become self-sufficient and regain self-esteem; to engage in planning and policy evaluation efforts to maximize the use of existing resources; to allow for a systemic approach for tapping significant new funds and encouraging collaborative efforts; and to advocate for policy changes affecting homelessness.

Bennett Klein has been the AIDS Law Project Director at Gay & Lesbian Advocates & Defenders (GLAD) since 1994. Prior to joining GLAD, he was a litigation associate at the Boston law firms of Kotin, Crabtree & Strong (1990-94) and Gaston & Snow (1987-90). He has been involved in several Boston-area community organizations, including as a "buddy" for the AIDS Action Committee of Massachusetts, a Board member of the Massachusetts Lesbian and Gay Bar Association, and a founding member of the Boston Alliance of Gay and Lesbian Youth. He was lead counsel in *Bragdon v. Abbott*, the first HIV discrimination case to be heard by the United States Supreme Court (establishing nationwide protection against discrimination under the Americans With Disabilities Act for all people with HIV). More recently, he won a decision before the Division of Medical Assistance Board of Appeals ensuring equal access to liver transplants for HIV-positive individuals under the Commonwealth's MassHealth program.

Alan M. Koral is a shareholder at Vedder Price and a member of the firm's Labor Practice Area of the New York office. He represents and counsels corporations with respect to litigation matters, administrative hearings and investigations, as well as general employment law. He has written and lectured extensively on labor and employment law matters. In 1985, he was appointed by Governor Mario Cuomo to the New York State Human Rights Advisory Council, and was later appointed by Governor Pataki to the New York Human Rights 50th Anniversary Advisory Committee and previously served for many years as a member of the New York State Human Rights Advisory Council under Governor Cuomo. He also serves on the Management Education Advisory Board of the New York Chamber of Commerce and Industry, the Advisory Committee for labor and employment programs of the Practising Law Institute and the Editorial Advisory Board of the Employee Relations Law Journal. He is Co-Chairman of the Committee on Equal Employment Opportunity Law of the Labor and Employment Law Section of the New York State Bar Association and a member of the EEO Committee of the American Bar Association.

Ross P. Lanzafame, a member of the ABA AIDS Coordinating Committee, counsels long-term and acute health care providers and health care professionals with regard to business, corporate and government regulatory matters. He advises clients on federal and state regulations governing facility operation, financing, medical records and data confidentiality, patient accounts management, and reimbursement programs such as Medicare and Medicaid. He prepares and appeals certificate of need applications for hospitals and nursing homes and handles special matters such as AIDS in the health care workplace. He also develops corporate compliance plans and programs for facilities and professionals so as to assure compliance with regulatory and statutory mandates, in particular the fraud, anti-kickback and Stark provisions of federal and state law. In addition, Ross focuses on reimbursement issues affecting health care providers.

Seth D. Levy, a member of the ABA AIDS Coordinating Committee, is an associate in the Los Angeles office of the law firm of Pillsbury Winthrop, practicing intellectual property law in the areas of patents, copyrights, trademarks, and trade secrets. His practice focuses mainly on patent prosecution, technology licensing, and client counseling in the biotechnology and healthcare fields. (Medical devices, pharmaceuticals, gene therapies, and non-medical biological systems comprise the bulk of his patent practice.) He also is a volunteer attorney and Chairman of the Advisory Board for Legal Services at the Los Angeles Gay & Lesbian Center, where he supervises the ongoing development and implementation of a law student clinical program to better serve the needs of the more than 2,500 clients that the Center's Legal Clinic assists every year. Seth also coordinates a public service project for his law firm targeting school violence and hate crimes in conjunction with the ABA Young Lawyers Division and General Practice Section, by bringing diversity and tolerance training to third-grade classrooms.

Caya B. Lewis is a senior policy analyst at the National Family Planning and Reproductive Health Association (NFPRHA) where she assists in the development and implementation of programs and initiatives to heighten awareness and support for reproductive health rights among members, policymakers, media, and the public. Before joining NFPRHA, Ms. Lewis was the Director of the Health Division for the National Association for the Advancement of Colored People (NAACP) where she was responsible for advising the President/CEO on health issues and policy, designing health prevention and education initiatives, and building partnerships to support the NAACP's 2200 branches nationwide. She was appointed to the Presidential Advisory Council on HIV/AIDS in 2000 and is completing the last year of her term. Ms. Lewis graduated with honors from Spelman College and the University of Michigan School of Public Health with a Masters of Public Health. She has experience and training in adolescent health, community health, events planning and community organizing.

Joshua Lipman has worked extensively on investigating and researching prison rights and death penalty cases, including Foster v. Fulton County, involving inadequate medical treatment for HIV/AIDS prisoners at the Fulton County (Georgia) Jail. Currently, he is a Fellow for Prison Healthcare Issues at the Southern Center for Human Rights in Atlanta, Georgia, where the focus of his work

is the prosecution of a federal lawsuit, Leatherwood v. Campbell, involving inadequate medical treatment and living conditions for HIV/AIDS-affected male prisoners confined within the Alabama Department of Corrections system.

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Catherine O'Neill is a Senior Vice President and the Director of HIV/AIDS Projects at the Legal Action Center. The Center is a not-for-profit public interest law firm with offices in New York City and Washington, D.C., that specializes in legal and public policy issues relating to HIV/AIDS and addiction. In more than 20 years as a lawyer and litigator with the Legal Action Center, Kate has specialized in the laws prohibiting disability-based discrimination, especially as they apply to individuals with HIV/AIDS and those with histories of alcoholism or addiction, and in health care confidentiality issues.

James Passamano is a partner in the Houston law firm of Sufian & Passamano, L.L.P., which specializes in Healthcare, Social Security, Employee Benefits, and International Law. Before establishing the firm, James was a Senior Trial Attorney for the United States Equal Employment Opportunity Commission and served as a judicial clerk for the United States District Court for the Southern District of Texas in Houston. He also is an adjunct professor of law at South Texas College of Law, teaching the Americans with Disabilities Act. He has written several books and articles on legal topics, most recently: *Representing ADA Plaintiffs*, by James A. Passamano and Beth S. Sufian (James Publishing, Costa Mesa, California January 2003) and *A Clinician's Guide to the Legal Rights of People with Cystic Fibrosis*, by Beth Sufian, James Passamano and Suzanne Pattee (Cystic Fibrosis Foundation, September 2002).

Maribel Reynoso is the Immigration Staff Attorney at the HIV & AIDS Legal Services Alliance (HALSA). Prior to her employment with HALSA, she was employed by the Law Offices of Andres Z. Bustamante, where she practiced removal defense and post-conviction relief. She graduated from the University of Kansas School of Law in 2001 and is a member of the California Bar. She has filed successful asylum applications, HIV waivers, and disability waivers for naturalization applicants. She has been helping people with HIV and AIDS since 1992 and has volunteered at the UCLA C.A.R.E. Clinic, Tuesday Child, and Carl Bean House.

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Bill Smith is Director of Public Policy for the Sexuality Information and Education Council of the United States or SIECUS. In this capacity, he heads up SIECUS's public policy and advocacy efforts in the areas of sexual and reproductive health at the federal, state and local levels. Based in Washington, DC, Bill conducts policymaker education in the United States Congress and the Executive Branch and oversees a staff that does similar work in many states and communities. He also writes extensively and speaks on many issues related to politics and reproductive and sexual health policy. Prior to joining SIECUS in February 2000, he was Manager of the Religion and Public Values Program at The National Campaign to Prevent Teen Pregnancy, where he was responsible for launching an innovative community-based model to overcome conflict around teen sexuality and served as a member of the Campaign's field staff, providing consultation and technical assistance in dozens of communities across the country.

Lynne H. Solomon has served as the Director of Legal Services and Affirmative Action Officer at AIDS Network in Madison, Wisconsin since November of 1999. She is responsible for the overall operation of the Legal Services Program, advises clients living with HIV on their legal rights, and develops and delivers trainings on legal issues relating to HIV/AIDS and workplace discrimination. She planned two statewide conferences on disability law and drafted and coordinated the production of the handbook, *Your Rights in the Workplace: A Legal Guide for People Living with HIV in Wisconsin*. She is active in the State Bar of Wisconsin, serving on the Board of Directors for the Young Lawyers' Division and the Public Interest Law Section.

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David W. Webber is a Philadelphia lawyer who specializes in HIV/AIDS and other infectious disease legal issues. Currently, he limits his direct client representation to cases that present issues of precedential significance or involve important public health and public interest issues. He also serves part-time as the project director for the Pennsylvania Coalition to Save Lives Now Syringe Access Project. David received his B.A. degree from the University of Pennsylvania (1976) and his J.D. degree from Temple

University (1980). In 1988, he founded the AIDS Law Project of Pennsylvania, a nonprofit public interest law firm, serving as its Executive Director from 1988-92 and Director of Education and Policy from 1992-93. He has taught AIDS/HIV law at the Pennsylvania AIDS Education and Training Center, Cabrini College, and Villanova and Temple Universities. He was editor and contributing author to the third edition of *AIDS and the Law* (1997; cumulative supplement, August 2001), and, in 2000, was appointed Editor-in-Chief of the *AIDS & Public Policy Journal*.

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Debra J. Wolf is the Assistant Director of the Legal Services and Advocacy Department of the Gay Men's Health Crisis (GMHC) in New York City, one of the oldest and most comprehensive HIV/AIDS organizations. Founded in 1981 by volunteers, GMHC has a three fold mission: to reduce the spread of HIV disease; to help people with HIV maintain and improve their health and independence; and to keep the prevention, treatment and cure of HIV an urgent national priority. She provides direct client representation to people living with HIV/AIDS in the areas of employment discrimination, the Americans With Disabilities Act and long-term disability issues. She conducts a monthly seminar entitled "Your Rights and Responsibilities as an HIV+ Employee," and lectures often in the community on these issues. Debra has written numerous articles, including "Reintegrating Employees with HIV/AIDS into the Workplace," which was published in the Fall 2001 issue of *The Diversity Factor*.

**Major HIV/AIDS Litigation:
Wins, Losses, and Cutting Edge Issues**

Recent Wins & Losses, Current & Cutting Edge Issues

Catherine Hanssens

1. Recent HIV Litigation Wins & Losses, and Some Noteworthy Related Cases

1. HIV as a disability

Blanks v. Southwestern Bell, 310 F.3d 398 (5th Cir. 2003) -HIV+ employee returning from short-term disability leave for depression and work-related stress unable to secure acceptable reasonable accommodation, resigning after 2 weeks in a lower-paying position. Employee sued, claiming failure to accommodate and constructive discharge. District court's finding that Blanks is not a PWD under the ADA affirmed on basis that 1) nothing in record to support he is impaired in a major life activity; no impact on reproduction because wife had tubes tied; 2) not impaired in ability to work because only unable to perform narrow range of jobs; 3) no record of disability if the "record" doesn't satisfy prong 1 definition of disability; 4) not "regarded as" disabled because only viewed by employer as unable to work as a customer service rep, i.e., not regarded as substantially limited in a broad range of jobs.

2. 11th Amendment/Private Damages Actions Against State Discriminators

1. *Doe v. State of Nebraska*, 345 F.3d 593 (8th Cir. 2003) – Estate of woman with HIV and her adopted son filed damages suit against Nebraska, the Neb. Dep't of Health and Human Services and various state officials under the Rehabilitation Act for excluding her from foster care and adoption program. State defendants argued that they had not voluntarily waived their Eleventh Amendment immunity from suit because the financial inducement of federal funds was so great that they effectively had no choice but to waive their immunity in exchange for funding. Affirming in favor of Doe, the Eighth Circuit found that Nebraska knowingly waived its Eleventh Amendment immunity by accepting federal funds for its foster care and adoption programs.

2. See also *Garrett v. University of Alabama*, 344 F.3d 1288 (11th Cir. 2003)(*Garrett II*) – Vacating judgment of district court, court of appeals held that state agencies waived their Eleventh Amendment immunity to damages claims under Section 504 of the Rehabilitation Act when they continued to accept federal funds after enactment of statute conditioning receipt of federal funds on waiver of immunity to Section 504 claims.

3. See also *Savage v. Glendale Union High School*, 343 F.3d 1036 (9th Cir. 2003) – As school district is not agent of the state, it is not entitled to immunity under Eleventh Amendment.

4. But see *Pace v. Bogalusa City School Board, Louisiana State Board of Elementary and Secondary Education et als*, 325 F. 3d 609 (5th Cir. 2003), *rehearing en banc granted* 339 F.3d 348 (5th 2003) – Holding state defendants entitled to Eleventh Amendment immunity from Rehab Act claim. NB: The Fifth Circuit has not yet issued a decision following rehearing, and to date the First, Third, Fourth and Eighth Circuits explicitly have declined to follow *Pace*.

5. See also *Lane v. Tennessee*, 315 F. 3d 680 (6th Cir. 2003), *cert granted* 123 S.Ct. 2622 (2003) – In ADA action by individuals with disabilities against state challenging lack of accessibility to court facilities, court of appeals held on rehearing that state defendants did not have immunity to plaintiffs' ADA damages claim that their due process rights of access to courts were violated. This case bears a key distinction from *Garrett I*, where the Supreme Court barred damages actions in ADA Title I employment claims against state entities under the Eleventh Amendment sovereign immunity doctrine: in *Lane*, a Title II case, access to services and programs implicating protected constitutional rights are at issue.

2. Housing

Giebeler v. M & B Associates, 343 F.3d 1143 (9th Cir. 2003) – Because the Fair Housing Amendments Act (FHAA) imposes an affirmative duty on landlords to provide reasonable accommodations to those with disabilities with regard to both physical accommodations and to administrative policies governing rentals, landlord violated the FHAA when it refused to allow man with HIV, who was unable to work and had insufficient income to qualify for the apartment in question, to allow the apartment to be rented by the plaintiff's financially qualified mother as a cosigner.

3. Government Benefits

Henrietta D. v. Bloomberg, 331 F. 3d 261 (2nd Cir. 2003) – Affirming a district court decision in favor of plaintiff class of NYC residents who are Medicaid eligible and have AIDS or an HIV-related condition and a need for home care services, who claimed that DASIS, the city agency charged with assisting them in access to public benefits and services, was so ineffective in meeting its legal obligations that it violated the ADA, the Rehabilitation Act of 1973, NY state social services law and provisions of the NY and U.S. Constitution. The Second Circuit held that a) a plaintiff advancing a reasonable accommodation claim need not show that the challenged practice has a disparate impact on persons with disabilities; b) a plaintiff with a disability can show an exclusion violates the ADA or the Rehab Act "by reason of such disability," even if there are other causes for the exclusion, if they show that the disability was a substantial cause of the exclusion; c) injunctive relief is appropriate if it provides "meaningful access;" d) injunctive relief did not provide plaintiffs with benefits above and beyond those facially available to all qualifying individuals; e) States are liable under the ADA and the Rehab Act for their agents/delegates' violation of these acts; f) a state official sued in her official capacity is a "public entity" under the ADA; f) Congress did not intend in its enactment of the ADA and the Rehab Act to foreclose private remedies under the *Ex parte Young* doctrine.

4. Health Care/Medical Marijuana

1. *Raich v. Ashcroft*, 2003 WL 22962231 (9th Cir.(Cal.)– Issued in mid-December, 2003, the court of appeals reversed and remanded case in favor of plaintiffs, who are users and growers of marijuana for medical purposes pursuant to CA Compassionate Use Act and sought declaratory and injunctive relief from the federal Controlled Substances Act (CSA). The court held that plaintiffs were likely to succeed on their claim that CSA's application to them exceeded Congress' Commerce Clause authority; and that harm to users from enforcement of CSA against them outweighed gov't interests.

2. *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002) – Affirming permanent injunction for patient and physician class on their First Amendment claim against enforcement of federal policy to seek investigation and revocation of license of physician to prescribe controlled substances based solely on a physician's "recommendation" of the use of medical marijuana.

5. Public Accommodations

1. *Lorenzo Font v. Francisco*, 260 F.Supp.2d 394 (D.P.R. 2003) – Relatives of deceased lacked standing to bring ADA associational claim against funeral home that refused open casket request due to deceased's death from AIDS.

2. *Doe v. County of Centre*, 242 F.3d 437 (3rd Cir. 2001) – Challenge by foster parents of child with HIV, who sought to foster additional children, to County foster care agency's policy prohibiting placement of HIV seronegative children in home with HIV positive children. Court of Appeals found facial violation of the ADA and the Rehabilitation Act; material facts existed on whether some children could be placed in home without significant risk to themselves, reflecting County's failure to do an individualized assessment.

6. Employment

1. Employee's failure to disclose: *Gajda v. Manhattan and Bronx Surface Transit Operating Authority*, 2003 WL 22939123 (S.D.N.Y. Dec. 12, 2003) – Upholding termination of driver who refused to provide complete medical information about his HIV for purposes of assessing fitness for work and accommodation needs.

2. Employer's Unauthorized Disclosure: *Doe v. U.S. Postal Service*, 317 F.3d 339 (D.C. Cir. 2003) – Reversing summary judgment for the U.S.P.S. on Doe's Privacy Act and Rehabilitation Act claims, the court found issues of fact on whether supervisor told co-workers of Doe's HIV status, and that Doe's reference to his HIV status on FMLA form in as part of leave request did not constitute a voluntary disclosure by Doe, but rather was an employer inquiry subject to the confidentiality protections afforded employer-conducted medical examinations. (Note court's distinguishing of 11th Cir. case, *Cash v. Smith*, 231 F.3d 1301 (11th Cir. 2000), where appeals court rejected a confidentiality claim based on disclosure of information voluntarily provided by employee to a supervisor and unrelated to inquiry from employer).

3. Rescission of Job Offer After Applicant's Disclosure of HIV Status: *Solorio v. American Airlines, Inc.*, 2002 WL 485284 (S.D.Fla.) – Without ability to demonstrate that supervisor making decision to rescind job offer as flight attendant knew of his HIV status, plaintiff can not overcome nondiscriminatory explanation that plaintiff's doctor's indication of need for some travel restrictions made plaintiff a "less competitive" candidate and show that explanation was pretextual.

4. Direct Threat: *Chevron U.S.A., Inc. v. Echazabal*, 536 U.S. 73, 122 S. Ct. 2045 (2002) - Chevron defends its firing of long-time plant worker after diagnosis with Hepatitis C on basis that exposure to plant toxins posed a direct threat to himself. Reversing the Ninth Circuit decision, the Supreme Court determines that the EEOC's regulatory extension of the ADA's "job-related" & "business necessity" defense to include a requirement that an individual not pose a direct threat to himself was within the scope of its permissible rulemaking authority.

5. See also, on Direct Threat: *Kapche v. San Antonio*, 304 F.3d 493 (5th Cir. 2003) – (Also not an HIV case - insulin-treated diabetes, or ITDM), but noteworthy for court's acknowledgment that in earlier decisions concerning persons with ITDM it had "diverged somewhat" from the ADA's requirement that "direct threat" defenses be based on an *individualized assessment* of the employee's "present ability to safely perform the essential functions of the job." Having concluded in an earlier decision that medical science had progressed to the point where exclusions on a case by case basis are the only permissible procedure, the court remanded for a second time, directing a factual finding on whether Kapche was qualified based on an individualized assessment of his abilities to control his diabetes and perform the job's essential functions. The Supreme Court decisions in *Sutton v. United Airlines Inc.*, 527 U.S. 471, 119 S. Ct. 2139 (1999) and companion cases, which mandate an individualized assessment in determining whether a plaintiff has a disability, were central to the Fifth Circuit's analysis.

7. Confidentiality of HIV Status

Stokes v. Barnhart, 257 F. Supp. 288 (D.Me. 2003) – The HIV status of a hospitalized cancer patient was revealed by SSA worker to third party present in hospital room, who in turn revealed this to others. Court concludes that Maine HIV confidentiality law, prohibiting disclosure of "the results of an HIV test" unless certain exceptions are met, literally covers only test results and not HIV-related information conveyed verbally; and that federal disability and privacy laws have no applicability; but allows claim for intentional infliction of emotional distress to go to trial.

8. Prisons

Gibbs v. Martin, 2003 WL 21909780 (E.D. Mich. July 28, 2003) Dismissal of ADA and Rehabilitation Act claims by 3 prisoners confined to indefinite administrative segregation for "sexual misconduct." Plaintiffs argued that their long-term segregation violated the ADA and Rehab Act in that they are treated differently than non-HIV+ prisoners who engage in the same conduct, who are released after 30 days of punitive confinement into the general population

9. Criminal Law

State v. Ron Hill, CA Superior Court (San Francisco, 2003) – Superior Court judge found insufficient evidence to support an indictment of intentional transmission against a former health commissioner. The evidence included testimony of 2 men who testified they seroconverted after sex with Hill; that Hill had represented to his sexual partners that he was HIV-; that Hill regularly solicited sex on the internet. The trial judge concluded that even if Hill had lied about his HIV status, his deceit was insufficient to show specific intent to infect others under the law. The prosecutor indicated an intent to pursue amendment of the law to allow easier prosecutions.

3. Some Current and Cutting Edge Issues

1. Access to Courts – Several factors, including recent U.S. Supreme Court decisions on the right of Congress under the 11th Amendment to impose antidiscrimination remedies on the states, and federal policy decisions threatening to further restrict legal services for the poor could have a significant impact on the real ability to secure relief from discrimination in the courts.

1. Supreme Court restrictions on damages claims under the ADA.

2. Attack on bread and butter legal services through Ryan White Act restrictions – The problem of HIV funding for legal services increasingly being linked to clients' specific medical conditions. Federal authorities are placing more limits on the types of legal representation that it considers to be HIV-related. Legal services programs now are required to verify "that client advocacy services provided to Ryan White Title I eligible clients are necessary for the client to maintain access to HIV/AIDS medical and support services."

3. How can we respond? Can we enhance advocacy efforts through better resource consolidation and collaboration?

2. Direct Threat Defense: the continuing challenge of "innocent victims," medical procedures, and other scenarios where blood-to-blood contact can be visualized. What are the best cases, and the most workable approaches, for fostering an assessment of direct threat that shows that a refusal to admit or to treat is a discriminatory overreaction to a microcosmic but greatly feared risk?

3. Fundamentalist Attacks on Sexual Health and HIV Education: the need to develop state and federal law strategies for attacking "faith-based" sex education and denial of access to accurate health information, particularly for vulnerable youth. Some recent illustrations of the problem:

1. In Wake County, NC In mid-December, 2003, the Wake County, N.C., school board preliminarily approved a proposal that would prevent any school employee from encouraging or demonstrating the use of contraceptives. A board member also running for state superintendent of schools introduced the proposal, which would also require employees to discuss the legal status of "homosexual acts" in the state when talking about HIV transmission. The school board in November 2002 voted on sex education changes that would have allowed for the development of elective courses for students in grades 10 and 12 on topics such as condom use, homosexuality, the prevention of STDs and unintended pregnancy. The board also had voted earlier to give students in grades seven through nine more lessons on contraceptives, sexually transmitted diseases and the effects of teen pregnancy.

2. In late November, 2003, administrators at a public high school in Georgetown, Ky., asked an area HIV/AIDS service group at a health fair not to display four brochures that either contained information about "safe sex," were targeted at gay or lesbian teenagers, or that included the gay pride flag or information about "alternative lifestyles." The AIDS service group said that the safe sex brochure questioned was targeted at an adult audience and had been placed on the table by accident by a volunteer but later removed by staff when they realized the error. However, a teacher also removed brochures titled, "Young and Gay: Protect Yourself," "Lesbians and HIV: Are You at Risk?" and "Safer Sex, Better Too." Brochures on safe sex that were not specifically targeted at gay or lesbian teens were not removed from the table. (AP/Louisville *Courier-Journal*, 11/23).

4. The Aging of the PWH population: With some graying of the HIV population, are there issues we will be seeing or may be missing? Some of these issues could range from misdiagnosis of HIV in older patients to discrimination and stigma in nursing home admissions and treatment. What are the "HIV as a disability" issues for seniors under the ADA?

5. Access to the Standard of Care: Health Care and Prevention Services for Institutionalized Persons: Co-infection with Hepatitis C, drug resistance and toxicity is an increasingly critical problem, and the issue of approval for liver transplants is particularly challenging in this context. As to youth in foster care and detention facilities, sexual health and HIV education is largely non-existent while homophobia is largely ignored.

MAJOR HIV/AIDS LITIGATION: WINS, LOSSES AND CUTTING EDGE ISSUES

Bennett H. Klein

I. HIV AS DISABILITY AFTER BRAGDON AND THE SUTTON TRILOGY

Illustrative Cases

In Many Cases, Courts Are Reading *Bragdon* Broadly Or Defendants Are Not Contesting Disability:

1. Rivera v. Heyman, 157 F.3d 101 (2d Cir. 1998) (“The Supreme Court recently confirmed that HIV infection is a disability under the Americans with Disabilities Act of 1990.”).
2. Abbott v. Bragdon, 163 F.3d 87, 88 (1st Cir. 1998) (on remand from U.S. Supreme Court) (HIV is disability under ADA).
3. Holiday v. Chattanooga, 206 F.3d 637 (6th Cir. 2000) (city concedes that as an HIV-positive individual, plaintiff has statutory disability).
4. Pope v. Kaiser Foundation Health Plan, 1998 WL 865646 (E.D. Cal. 1998) (citing Bragdon as “recognizing HIV as a disability under the ADA”).
5. Wallengren v. Samuel French, Inc., 39 F. Supp.2d 343 (S.D.N.Y. 1999) (“In light of the substantially limiting effects of HIV and AIDS, as identified in Bragdon, on an individual’s ability to work,” plaintiff’s “AIDS condition” is disability”).
6. Clark v. North Central Management, Inc., 1999 WL 218557 (N.D. Ill. 1999) (citing Bragdon for proposition that “HIV infection is a disability within the meaning of the ADA”).
7. Jones v. Rehabilitation Hospital of Indiana, 2000 WL 1911884 (S.D. Ind.) (citing Ginsburg’s concurrence in Bragdon discussing multiple major life activities affected by HIV and the holding in Albertson’s v. Kirkingburg that some impairments are inherently substantially limiting to conclude that “HIV and AIDS are impairments that substantially limit a major life activity”; “both the agency interpretations of the ADA and the Act’s legislative history support the conclusion that Congress intended HIV infection to be a per se disability”).
8. Ihekwe v. City of Durham, 129 F. Supp.2d 870 (M..D.N.C. 2000) (HIV status qualifies as disability under ADA).
9. Roe v. Village of Westmont, 2003 WL 444508 (N.D. Ill.) (police officer who tested HIV-positive and then told not eligible for employment covered under “regarded as” prong of definition).

A Growing Number of Courts, However, Are Insisting On Individualized Inquiry As To Disability And Finding Plaintiffs Not Covered:

1. Blanks v. Southwestern Bell Communications, 310 F.3d 398 (5th Cir. 2002) (citing Bragdon’s reliance on substantial limitation to reproduction, court states that plaintiff failed to develop how any major life activity was impaired or how HIV affected his major life activity of reproduction; plaintiff raises no triable fact on disability issue because he does not want to have any more children and fails to identify other activity affected).

2. Waddell v. Valley Forge Dental Associates, 276 F.3d 1275 n.4 (11th Cir. 2001) (affirming summary judgment for defendants on other grounds, but noting in a long footnote that Bragdon did not decide whether HIV was a “per se” disability and that Sutton and Kirkingburg show Supreme Court’s insistence on individualized assessment of disability; repudiating statement in Doe v. De Kalb County School District, 145 F.3d 1441n. 5 (1998) immediately following Bragdon that “A person who is infected with HIV is “disabled” for purposes of the ADA”).
3. Solario v. American Airlines, Inc., 2002 WL 485284 (S.D. Fl.) (noting that when Bragdon is read together with Sutton’s individualized inquiry mandate, HIV status is not a per se disability).
4. Cruz Carillo v. AMR Eagle, Inc., 148 F.Supp.2d 142 (D.P.R. 2001) (even where plaintiff testified that his HIV status dictated his decision not to have children, plaintiff failed to meet burden because he did not introduce expert medical evidence as to how HIV substantially limits man’s ability to reproduce, and “statistical evidence” of significant risk of infection of female partners by men with HIV).
5. Gutwaks v. American Airlines, Inc., 1999 WL 1611328 (N.D. Tex.) (citing Bragdon and Sutton for individualized inquiry requirement and noting that plaintiff does not currently have or desire to father children so reproduction is not a major life activity for plaintiff).

II. VARIOUS LITIGATION ISSUES OF RISK OF HIV INFECTION TO OTHERS

1. Direct threat access to health care cases

A) Bragdon v. Abbott 524 U.S. 624 (1998) (in this case against a dentist with a written policy of refusing to treat patients with HIV based on the risk of patient-to-provider transmission, the Court reaffirmed several principles about the “direct threat” defense: (1) The ADA’s direct threat provision codifies the Arline standard. See 524 U.S. at 649; 42 U.S.C. § 12182(b)(3) (ADA definition of direct threat as a significant risk to health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures); 28 C.F.R. § 36.208(c) (Department of Justice regulation specifying same direct threat factors as Arline). (2) An assessment of a “direct threat” must be made based on the objective, scientific information available to the provider at the time of the discrimination. 524 U.S. at 649. Professional ethical guidelines are not objective, scientific evidence. Id. at 652. (3) A health care professional does not receive deference. The provider’s state of mind, even a good faith belief that a significant risk exists, does not relieve the provider from liability. Id. (4) The views of public health authorities, such as the CDC and NIH, are entitled to “special weight and authority.” Id. at 650.

B) Abbott v. Bragdon, 107 F.3d 934 (1997) (in case addressing dentist’s defense that treating patients with HIV was “direct threat,” Court found dentist’s evidence to be “too speculative or too tangential (or, in some instances, both) to create a genuine issue of material fact.”)

C) United States v. Morvant, 898 F.Supp. 1157, 1167-67 (E.D. La. 1995) (rejecting dentist’s direct threat defense argument and noting a “plethora of expert testimony” that the CDC recommendations for dental infection control mitigate any risk).

D) D.B. v. Bloom, 896 F.Supp. 166, 170 n. 6 (D. N.J. 1995) (“HIV-positive individual may be safely treated in private dental office which utilizes universal precautions” and “no medically justified reason existed” for discrimination).

E) Howe v. Hull, 874 F.Supp. 779 (N.D. Ohio 1994) (finding that emergency room doctor’s reason for transferring HIV-positive patient was pretextual, where doctor claimed patient had rare disorder but only had allergic drug reaction and doctor did not mention rare disorder in requesting transfer).

[But note: While “direct threat” cases have largely been favorable, courts are more reluctant to rule for a plaintiff when the claim of discrimination involves not a doctor’s fear of HIV transmission, but an allegation of discrimination based on the doctor’s decision about the proper medical treatment of the patient. See Lesley v. Chie 250 F.3d 47 (1st Cir. 2001) (in case involving HIV-positive woman referred elsewhere by ob-gyn, court reluctant too question whether doctor’s decision was “the best decision under the circumstances, or even whether it met the standard of care for the profession;” “patient may challenge her doctor’s decision to refer her elsewhere by showing the decision to be devoid of any reasonable medical support.”)].

2. Non-health-care related “direct threat” cases

a) Onishea v. Hopper, 171 F.3d 1289, 1299 (11th Cir. 1999) (in context of program segregation of HIV-positive inmates, courts state that “direct threat” exists whenever there is “evidence that the asserted risk of transmission has a sound theoretical basis,” regardless of scientific evidence regarding probability, because of fatal consequences.)

b) Gibbs v. Martin, 2003 WL 21909780 (E.D. Mich.) (summary judgment for prison in challenge to prison policy segregating indefinitely HIV-positive prisoners who have engaged in sexual misconduct when non-HIV positive prisoners who engage in sexual misconduct are released after 30 days into general population.)

c) Montalvo v. Radcliffe, 107 F.3d 873, 877-78 (4th Cir. 1999) (upholding dismissal of HIV-positive student from karate school even though transmission has never occurred in that or similar setting.)

d) Doe v. County of Centre, 242 F.3d 437 (3rd Cir. 2001) (successful challenge to policy precluding placement of non-HIV-positive children in foster home without disclosure overcoming “direct threat” defense.)

3. Health care worker cases

Theoretical base of transmission sufficient to create “direct threat” for health care workers where court finds some risk of blood-to-blood contact with patient. See Doe v. Washington University, 780 F.Supp. 628 (E.D. Mo. 1991); Bradley v. University of Texas, M.D. Anderson Cancer Ctr., 3 F.3d 922 (5th Cir. 1993); Doe v. University of Maryland Medical System Corp., 50 F.3d 1261 (4th Cir. 1995); Mauro v. Borgess Medical Center, 137 F.3d 398 (6th Cir. 1998); Waddell v. Valley Forge Dental Associates, 276 F.3d 1275 n.4 (11th Cir. 2001);

4. Non-health care worker employee direct threat cases

a) EEOC v. Prevo’s Family Market, 135 F.3d 1089 (6th Cir. 1998) (upholding requirement that produce clerk with HIV submit to medical exam and HIV test as “job-related are consistent with business necessity.”)

b) Chevron v. Echazabal, 536 U.S. 73 (2002) (upholding EEOC regulation authorizing refusal to hire individual whose job would endanger own health due to disability.)

c) Doe v. District of Columbia, 796 F.Supp. 559 (D. D.C. 1992) (found that the District of Columbia violated the Rehabilitation Act by withdrawing its offer of employment to a fire fighter on the basis of his HIV-positive status.)

d) Holiday v. Chattanooga, 206 F.3d 637 (6th Cir. 2000) (police officer could not be denied employment offer because of HIV status, when denial was based on unsubstantiated medical claims and when he is otherwise qualified for the job.)

5. Criminalization of HIV

a) 24 states have adopted statutes that criminalize exposure or transmission of HIV by at least some forms of behavior. See Zita Lazarini, Sarah Bray, and Scott Burris, "Evaluating the Impact of Criminal Laws on HIV Risk Behavior," 30 Journal of Law, Medicine and Ethics at 224-238 (2002). Other states use general criminal statutes.

b) Increasing number of prosecutions reported in press and cases, involving biting, spitting, throwing feces and other modes of HIV transmission. See Commonwealth v. Smith 790 N.E.2d 708 (Mass. 2003) (assault for intent to murder for biting and throwing feces) and State v. Bird 692 N.E.2d 1013 (Ohio 1998) (felonious assault conviction for spitting in police officer's face). See also Stephanie Simon, "AIDS Scare at Tiny South Dakota College Shakes Town," Los Angeles Times (Apr. 30, 2002) (college freshman charged with intentionally exposing his girlfriend to HIV through unprotected sexual intercourse); Associated Press, "Man Pleads Guilty to Using HIV as a Deadly Weapon," Laredo Morning Times (Apr. 15, 2001) (defendant plead guilty to aggravated assault with a deadly weapon for knowingly exposing at least five women to HIV through unprotected sexual intercourse).

6. Fear of AIDS cases

**The ADA and the Rehabilitation Act:
Litigation Strategy**

Pre-Litigation Preparation
Mitchell Katine

- I. “From this Moment On”** (see MMWR, Vol. 50, #RR-19; Nov. 9, 2001, p. 37)
1. Analysis of employment situation and existing benefits is essential from the moment of HIV infection.
 - A. Eligibility under the ADA, Rehabilitation Act, FMLA
 - B. Health insurance and COBRA continuation
 - C. LTD availability
 - D. Analysis of any preexisting condition, waiting periods, or other exclusionary provisions in employee benefits
 - E. Availability of continuation and conversion of benefits
 - F. Analysis of supervisory structure and treatment of employee by employer
 - G. Status of company policies and prior actions with other similarly situated employees
 2. Analysis of health status and anticipated future developments.
 - A. Status of HIV infection and test result indicators (i.e., Tcell count, viral load, opportunistic infections, hospitalizations, etc.)
 - B. HIV symptoms with possible work performance ramifications
 - C. Status of HIV medication and resulting side effects (also frequency of doctor visits)
 - D. Medical records and employment references in medical records
 3. Work performance issues.
 - A. Length of employment
 - B. Ability to perform essential job functions
 - C. Need for immediate or anticipated reasonable accommodations
 - D. Status of work performance documentation (i.e., evaluations, promotions, raises, warnings, etc.)
 4. HIV disclosure issues.
 - A. Status of HIV disclosure
In order to obtain “protected status” as an employee with a “disability” under the ADA and the Rehabilitation Act, the employee must show that the employer knew of employee’s physical or mental impairment and any limitations experienced by the employee as a result of that disability. The law does not require an employer to assume that an employee with a disability suffers from a limitation. *Taylor v. Principal Financial Group, Inc.*, 93 F.3d 155 (5th Cir. 1996); *Gammage v. West Jasper School Board of Education*, 179 F.3d 952 (5th Cir. 1999); *Cloutre v. Runyon*, 2003 WL 22955875 (5th Cir. 2003).
 - B. Planning necessary disclosure
 - C. Planning necessary request for reasonable accommodations
 - D. Reasonable suspicions of employer (i.e., rumors, etc.)
 - E. Status of sexual orientation disclosure
 5. Immediate evidentiary preparation.

- A. Log book or diary
- B. Written evaluations
- C. Tape recording
- D. Work assignment and/or performance documentation
- E. Credible live witnesses
- F. E-mail and documentary evidence of treatment and job performance

II. Disclosure of HIV/Disability Status

1. Determination of disability.

A. Substantial limitation of major life activities

Basic evidence to substantiate disability is vital. In *Carrillo v. AMR Eagle, Inc.*, 148 F.Supp.2d 142 (D. Puerto Rico, 2001), the court held that the employee did not meet his burden of proving his HIV was a substantial limitation on any major life activity by stating as follows:

“Cruz Carrillo has not met this burden. He failed to introduce into evidence any medical evidence from which a reasonable jury could find that HIV substantially limits a man’s ability to reproduce: there is no study, medical testimony, or statistical evidence in the record of a significant risk of infection of female partners by men with HIV; there is no evidence of whether an infected man’s sperm may carry and transmit the virus to his child at conception; there is no evidence in the record of any treatment available to lower the risk of infection.”

B. Doctor/medical support

C. Ability to perform essential job functions

2. Written disclosure.

A. Preparation of written notice

B. Generally, not from a lawyer

C. Hand delivered

D. Amicable tone

E. Reference any needed reasonable accommodations

F. Reference ability to perform essential job functions

G. Confidentiality issues

However, the ADA does not provide confidentiality protections to persons who disclose their HIV status in connection with requests for reasonable accommodations. *Ballard v. Healthsouth Corp.*, 147 F.Supp.2d 529 (N.D. Tex. 2001). However, there may be some state law protections such as § 81.103 of the Health & Safety Code in Texas.

H. No lawyer references or copies

3. Identify proper person for delivery of HIV/disability disclosure.

A. Anticipate chain of command disclosures

B. Select ultimate decision maker

C. Anticipate reaction in selection process

4. Request reasonable accommodations, if needed. Unless requested, no duty to provide reasonable accommodations, or engage in interactive process, arises. *Taylor v. Principal Financial Group, Inc.*, 93 F.3d 155 (5th Cir. 1996); 29 C.F.R. § 1630.9, App. (1995).
 - A. Request accommodation by both describing the limitation/need and requesting specific accommodation
 - B. Have request supported by medical professional
 - C. Request a reply
 - D. Request interactive process; as cited in *Carrillo*, FN9:

“Under the ADA the interactive process is a mandatory obligation triggered by an employee giving notice of the employee’s disability and desire for accommodation. Americans with Disabilities Act of 1990, § 102(b)(5)(A), 42 U.S.C. § 12112(b)(5)(A); 29 C.F.R. § 1630.2(o)(3).”
 - E. Request confidentiality (although not enforceable under ADA)
5. Actual disclosure process.
 - A. Do not do it alone (include credible witness)
 - B. Written disclosure with copy to be kept as evidence
 - C. Signed receipt not essential
 - D. Tape recording possibility
 - E. Log entry immediately after disclosure meeting (and thereafter of treatment)
 - F. HR/benefit issues may need to be addressed simultaneously

III. Post-Disclosure Discriminatory Treatment

1. Job performance is essential.
 - A. Continue to perform job as best possible
 - B. Refrain from conduct that would support legitimate termination of employment
 - C. Document job performance
 - D. Gather evidence and witnesses of job performance
 - E. Do not expect employer to accurately portray job performance
2. Do not quit.
 - A. Remain employed as long as possible
 - B. It is better to be fired than to quit
 - C. Anticipate employment termination and be prepared to document event
 - D. Send self-serving e-mails and/or letters, as appropriate
 - E. Telephone conversations hard to prove unless recorded
3. Employment termination.
 - A. Do not say or do anything that will be used against you (i.e., immature behavior or violent acts as a result of anger or obvious discrimination)
 - B. Request written confirmation of basis for employment termination
 - C. Do not sign anything until reviewed by attorney
 - D. Do not cash any “severance” money until situation reviewed by attorney

- E. Keep event confidential. Planned use of media is often more effective than spontaneous acts done out of anger
 - F. File for unemployment compensation and seek alternative employment to mitigate damages (unless planning to file for LTD)
 - G. Maintain documentation, evidence, witnesses, etc. to support claim of discrimination
4. Unemployment compensation.
- A. Meet privately with legal counsel, but do not alert former employer of use of legal counsel
 - B. Force employer to explain basis of employment termination
 - C. Allege discrimination as basis for employment termination on unemployment compensation claim forms
 - D. Appeal denial of unemployment compensation
 - E. Sworn statements of employee and employer are admissible in subsequent ADA or Rehabilitation Act litigation

IV. Pre-EEOC Complaint Filing

- 1. Demand letter to avoid EEOC claim.
 - A. Confidentiality as added benefit to employer.
 - B. Make demand reasonable, but strongly supported by evidentiary elements in letter
 - C. Reinstatement sometimes possible
 - D. Consistent positions vital
- 2. Pre-EEOC mediation.
 - A. Often preferred by both sides
 - B. Economical way to resolve dispute

V. EEOC Claim of Discrimination

- 1. Proper complaint.
 - A. Identify all parties
 - B. Identify all types of discrimination (i.e., don't forget retaliation)
 - C. Provide complete factual basis with witnesses
 - D. Request copies of responsive information
 - E. Consistent positions vital
- 2. EEOC discovery.
 - A. All communications from employee and employer will be available through open records procedure
 - B. Allow and assist EEOC to do free discovery
- 3. EEOC determination.
 - A. Favorable determination for employee strengthens case
EEOC determination is generally admissible evidence pursuant to Fed. R. Evid. 803(8)(c) unless proven by opponent to be untrustworthy. *Smith v. Universal Services, Inc.*, 454 F.2d 154 (5th Cir. 1972); *McClure v. Mexia Independent School District*, 750 F.2d 396, 400 (5th Cir. 1985).
 - B. Conciliation efforts by EEOC following favorable determination

The ADA and the Rehabilitation Act: Litigation Strategy

Hayley Gorenberg

A Bouquet of Litigation Concerns

I. Context

- a. Lessons from Lambda's Help Desk and EEOC materials.
- b. Rehabilitation Act Section 504 cases covered people with HIV, and *Bragdon v. Abbott* confirmed Section 504 as a floor (ADA must provide at least as much protection).
- c. Legal standard
 - i. Disabled ("substantial limitation of major life activity")
 - ii. Regarded as disabled
 - iii. History/record of a disability

II. HIV as a disability

- a. Post-*Bragdon*: landscape:
 - i. Three options for finding disability:
 1. HIV is a disability *per se*, based solely on *Bragdon* and cases relying on it;
 - a. Prior to *Bragdon*, courts nationwide found HIV/AIDS *per se* disabilities under the ADA, the Rehab Act and the Fair Housing Amendments Act. 24 pre-*Bragdon* cases stated that people with HIV or AIDS were *per se* disabled. Many cases made no distinction between HIV and AIDS.
 - b. In the aftermath of *Bragdon*, advocates developed a strategy to establish HIV as a *per se* disability. Though at least 15 federal courts have since accepted HIV or AIDS as a *per se* disability, none have done so in a convincing way, and most appear to simply use *Bragdon* in a manner that may be susceptible to attack.
 - c. Some courts (most notably the 11th Circuit in *Waddell v. Valley Forge Dental Assocs.*) have gone out of their way to note that HIV is probably not a *per se* disability, and the Fifth Circuit was the first post-*Bragdon* circuit court to hold that an HIV+ plaintiff was not disabled under the ADA. *Blanks v. Southwestern Bell Communications, Inc.*, 310 F.3d 398 (5th Cir. 2002).
 2. *per se* disability, based on more detailed argument regarding the effects of HIV, or
 3. individualized arguments
 - iii. Asymptomatic HIV¹: Since *Bragdon*, federal courts have disfavored finding asymptomatic HIV disabling on the basis of an individualized assessment of limitations of major life activities (MLA's). Only one court—before *Bragdon* or after—has found a gay man with asymptomatic HIV disabled on the basis of an individualized assessment (MLA of procreation after plaintiff testified that he had intended to have children).
- b. MLA's impaired by HIV (*Bragdon*: "Given the pervasive, and invariably fatal, course of the disease, its effect on major life activities of many sorts might have been relevant to our inquiry." Ginsburg concurrence: "The disease inevitably pervades life's choices: education, employment, family and financial undertakings.")
 - i. Generally, sex and reproduction may be some of the more straightforward MLA's. NB: More challenging absent intent to procreate, or where plaintiff is a youth or a child. Consider effects of reduced vertical transmission, assisted reproductive technologies, well-controlled HIV.
 - ii. Plaintiff's bare statement that s/he fears transmitting HIV to others (for example, during sex or reproduction) may not establish a substantial limitation without scientific evidence. See *Cruz Carrillo v. AMR Eagle, Inc.*, 148 F. Supp. 2d 142 (D.P.R. 2001) (plaintiff's testimony

¹ As the Supreme Court observed in *Bragdon*, "asymptomatic" HIV infection "is a misnomer, in some respects, for clinical features persist throughout, including lymphadenopathy [swollen lymph glands], dermatological disorders, oral lesions, and bacterial infections." 524 U.S. at 635, 118 S. Ct. at 2204. "[T]he general systemic disorders present during all stages of the disease [include] fever, weight loss, fatigue, lesions, nausea, and diarrhea" 524 U.S. at 636, 118 S. Ct. at 2204.

insufficient to establish substantial limitation in reproduction, absent scientific evidence regarding the likelihood of transmission of HIV from a man to a woman or future child during unprotected sex).

- iii. Survey of reproduction cases
 1. No post-*Bragdon* case using an individualized assessment has found a person with HIV to be disabled as a result of substantial limitation in reproduction.
 2. At least four post-*Bragdon* cases have held that plaintiffs with HCV are disabled because of substantial limitations in reproduction. All four plaintiffs either were married men or women with children.
 3. At least one pre-*Bragdon* and one post-*Bragdon* case stated or implied that actual intent to reproduce is *not* relevant to the question of whether a plaintiff is substantially limited in the major life activity of reproduction. Most courts reach the opposite conclusion.
 4. At least 12 post-*Bragdon* cases have found plaintiffs with impairments other than HIV to be *not* substantially limited in the major life activities of reproduction or sexual activity, and three other cases reached the same conclusion regarding HIV+ plaintiffs. The plaintiffs in these cases failed to satisfy the courts in a variety of ways, including:
 - a. Plaintiff wasn't substantially limited because decision not to have children was not a result of the impairment.
 - b. Plaintiff failed to establish with medical evidence that sex or reproduction presented a significant risk. Generally, a bare statement of the plaintiff's fears or concerns will not establish the substantial limitation. The plaintiff must submit medical evidence.
 - c. Plaintiff supported claim of disability with broad/vague statements insufficient to meet evidentiary burden.
 - d. Plaintiff's limitation in the ability to reproduce or have sex was temporary.
- iv. Sexual activity
 1. At least 11 post-*Bragdon* cases have found that sexual activity is a major life activity. Many of these courts spoke generally about sexual activity and reproduction together.
 2. Only one district court since *Bragdon* has held that sexual activity is not a major life activity, and that decision was poorly reasoned, failed even to cite *Bragdon*, and used the terms "sexual intercourse" and "reproduction" interchangeably.
 3. Only two post-*Bragdon* courts have explicitly concluded that a plaintiff is or might be disabled as a result of a substantial limitation in *non-procreative* sexual activity. (These cases did not involve HIV+ plaintiffs.)
 4. It remains unclear what constitutes a substantial limitation in sexual activity. Courts have provided some minimal guidance:
 - a. Two courts held that decrease in frequency of sexual activity does not establish a substantial limitation.
 - b. One court held that using condoms during sex does not substantially limit the major life activity.
 - c. One court found adverse impact of mastectomy on self-image may substantially limit woman in MLA of sex.
 - d. One court held that a woman's pain and loss of libido may substantially limit her sexual activity.
 - e. One court, discussing both sexual intimacy and reproduction, stated that low risk of transmission of HCV substantially limited a man's MLA of sexual intimacy with his wife.
- v. Parenting: PLWHIV arguably substantially limited in MLA of parenting, since major source of anxiety for HIV-positive parents is that they will become ill and unable to care for children. Note study that mothers typically put children's medical care before their own. Karen P. Beckerman, *Conception, Pregnancy and Parenthood: Maternal Health Care and the HIV*

- Epidemic*, in The Medical Management of AIDS 555, 571 (Merle A. Sande & Paul A. Volberding eds., 6th ed. 1999).
- vi. Health maintenance/self-care: Can be quite clear for symptomatic HIV, but more challenging for asymptomatic (no court has ever accepted insurance discrimination argument as impediment to self-care). Consider effects of adherence to treatment regimes, medication side-effects resulting in substantial limitations (*Sutton*, 527 U.S. at 484, 119 S. Ct. at 2147), long-term health consequences of toxic regimes (e.g. kidney and liver damage, abnormal fat redistribution, diabetes), challenge of maintaining mental health.
 - vii. Work: Unavailable as MLA in employment cases
 - viii. Interacting with others: Not always considered an MLA (consider that many individuals disclose HIV status to only a select few family members or friends because of the stigma and discrimination they face, or fear they will face, if they disclose their HIV status. Gregory M. Herek, *AIDS and Stigma*, 42 Am. Behavioral Sci. 1106, 1111 (1999); John G. Bartlett and Ann K. Finkbeiner, *The Guide to Living with HIV Infection Developed at the Johns Hopkins AIDS Clinic* 21 (4th ed. 1998)
- c. Work with clients to get them to understand and articulate *how* their life activities are substantially limited. Start early in the case, thinking about psychiatric experts, other witnesses who round out the picture of HIV's impact on client.
 - d. Seek stipulation/admission regarding disability: Prior to *Bragdon*, defendants commonly stipulated (in at least 10 cases) that plaintiffs with HIV or AIDS were disabled; after *Bragdon*, defendants remain willing to concede that HIV is a disability. In 7 post-*Bragdon* opinions, courts have noted that there was no dispute regarding the plaintiff's protected status. Notably, many of these courts cited *Bragdon* after stating that the parties did not dispute the issue. Defendants may stipulate because
 - i. They agree with your definition or with *Bragdon*
 - ii. Litigating the issue may be costly
 - iii. Litigating client's status less important if a parallel state claim is made under a law explicitly protecting PLWHIV
 - iii. Fighting the point—with specific attacks on plaintiff's explanation of impact on intimate aspects of her/his life-- may create sympathy for the plaintiff and potential animosity against defendant.
 - e. Press "regarded as" and "record of" coverage as well.
 - i. Prior to *Bragdon*, nine courts found plaintiffs to be protected either because they were "regarded as" disabled or because societal stigma substantially limited their abilities to engage in certain major life activities. Many of the "regarded as" cases discussed general societal stigma rather than the specific beliefs of the defendants.
 - ii. Since *Bragdon*, there has been very little jurisprudence concerning "regarded as" coverage for people with HIV. One post-*Bragdon* case held that general societal stigma is not enough to establish "regarded as" coverage.
 - iii. "Regarded as" (arguably "closest to the reality and to the real heart of the ADA in targeting disability-related discrimination"): *limited only because of attitudes of others to that impairment*. Conceptualize exclusion from public accommodation as a substantial limitation on the MLA of participating fully in society. See also Ginsburg concurrence: "[HIV] affects the need for and, as this case shows, the ability to obtain health care because of the reaction of others to the impairment...HIV infection is 'a physical...impairment that substantially limits...major life activities,' or is so perceived (citation omitted) including the afflicted individual's family relations, employment potential, and ability to care for herself (citations omitted)."] If being singled out for punitive treatment under the law is a factor, see www.hivcriminallaw.org (collecting HIV "criminalization" laws and cases) as reflective of the institutionalization of stigma.

III. Assess all cases for pretexts defendant may use.

- a. Defendants may seek statements susceptible to characterization as “lie” that would otherwise allow dismissal.
- b. Examine any other medical conditions diagnosed in client.

IV. “Griping about the ADA” (a pre-amendment game plan):

- a. Mental and Physical Disability Law Reporter, surveying Title I ADA cases for 2002 (<http://www.abanet.org/disability/reporter/feature.html>) concluded of 442 decisions last year, 309 were employer wins, and 18 were employee victories. The rest were decisions that failed to resolve the merits of the disability claim. As in the 2000 and 2001 surveys, employees won no victories at all in the 11th and D.C. Circuits. The majority of employee wins were in the 5th and 8th Circuits (employees prevailing more than 10% of the time). Constrictions have led many to conclusion that amendment is vital. Yet while wins are too uncommon, many cases settle well
- b. Public education: a tool to swing the balance: pressing cases, publicizing settlements
- c. Getting clients ready to proceed under true name
 - i. Review and include in retainer information regarding any education/media component of organization’s work, being explicit regarding disclosure of HIV status in media work.
 - ii. Advise the client that anyone who he/she wants to advise personally should be told before filing and press on the case.
 - iii. If client is currently employed, has client told his/her employer about HIV status?
 - iv. If employed, has client talked with current employer about pursuing legal action because of HIV-related discrimination? Client should discuss fact that he/she is proceeding under true name and work on plan with employer for how best to handle questions that might come up from colleagues or members of community; attorney also might talk with current employer where appropriate.
 - v. Identify appropriate resources to support client’s claim and, where relevant, current employer (e.g., if the case involves “direct threat” issue, identify public health officials who might be contacted, explore response they’d give, provide education (pressure, etc.) where needed)
 - vi. Criminal transmission concerns
 - 1. Review relevant state law on criminal law and/or specific HIV transmission statutes and advise client.
 - 2. Explore with client whether the laws raise potential concerns (alert client that issues related to intimate sexual activity may be relevant to making out a claim that he/she is a “qualified individual with a disability”)
 - vii. Additional considerations
 - 1. Review any reporting requirements relevant to this client (e.g., state law or employer requirements)
 - 2. Client has complied with those, or why client has not or will not comply (e.g., Illinois has a healthcare worker notification law that requires a physician/lab – not the individual – to report whether a test subject is a healthcare worker and the type of job activities he/she performs; may want to challenge employer-mandated requirement)
 - 3. Resources and experts
 - i. Lambda as a resource
 - ii. Legal department as resource, potential co-counsel
Education & Public Affairs: Communication Director Eric Ferrero
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**Defeating Motions to Dismiss by State Governments:
Eleventh Amendment Sovereign Immunity after *Garrett v. Alabama***

James A. Passamano

I. INTRODUCTION

Since the Supreme Court's decision in *University of Alabama v. Garrett*, 531 U.S. 356 (2001), state defendants have become ever more vigorous in their efforts to assert 11th Amendment immunity.

State attorneys general have made especially vigorous efforts to have courts apply the reasoning in *Garrett* (which was brought under Title I of the ADA regarding employment) to all claims under Title II of the ADA, which governs discrimination in state programs and activities.

This presentation addresses how to successfully defeat assertions of 11th Amendment State sovereign immunity.

II. UNDERSTANDING THE LIMITS OF THE RULING IN *GARRETT*.

State Defendants frequently contend that *Garrett* broadly stands for the proposition that States are immune from suit under the ADA. This is an over broad description of the holding in *Garrett* and of its affects on ADA claims. In defeating a motion to dismiss based on sovereign immunity, it is necessary to understand what *Garrett* held, as well as what it did not hold.

On its face, *Garrett* is limited to the issue of whether Congress properly abrogated the 11th Amendment with for the purposes of Title I of the ADA.

A. *Garrett* Does Not Apply to Title II.

The Court specifically reserved the question of whether Title II claims are subject to 11th Amendment immunity. The question of whether Congress property abrogated 11th Amendment immunity for Title II was not resolved in *Garrett*. The Court noted:

We are not disposed to decide the constitutional issue whether Title II, which has somewhat different remedial provisions from Title I, is appropriate legislation under clause 5 of the Fourteenth Amendment when the parties have not favored us with briefing on the statutory question.

Garrett, 531 U.S. at 374, n. 1.

B. Substantive Provisions of ADA Are Unaffected by *Garrett* and Still Binding on States.

Furthermore, the Court limited its decision in *Garrett* to whether the abrogation clause in the ADA was effective under Title I. It did not invalidate any of the substantive provisions of Title I or other Title of the ADA. The court acknowledged that:

Our holding here that Congress did not validly abrogate the States' sovereign immunity from suit by private individuals for money damages under Title I does not mean that persons with disabilities have no federal recourse against discrimination. Title I of the ADA still prescribes standards applicable to the States.

Garrett, 531 U.S. at 374, n. 9.

The effect of invalidating the abrogation clause as applied to Title I is to preclude claims for retrospective money damages against non-consenting states. The substantive provisions governing employment are still binding on the

states under Congress's commerce clause power. The Commerce Clause, however, is not a source of authority for Congress to override 11th Amendment immunity from claims for money damages. *Seminole Tribe*, 517 U.S. at 72-73 and *Kimel v. Florida Bd. of Regents*, 528 U.S. 62, 78-79 (2000).

Despite the lack of abrogation authority under the commerce clause, the substantive provisions of Title I are still enforceable in federal court against a state official under *ex Parte Young*. *Garrett*, 531 U.S. at 374, n. 9, and see also *Ex parte Young*, 209 U.S. 123 (1908). However, an *ex Parte Young* cause of action is limited to prospective equitable relief.

C. Public enforcement actions under Title I are not affected by Garrett.

Finally, Garrett has no effect on the public enforcement provisions of Title I of the ADA initiated by the United States. *Garrett*, 531 U.S. at 374, n. 9.

II. 11TH AMENDMENT IMMUNITY

AMENDMENT XI: The judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by citizens of another state, or by citizens or subjects of any foreign state.

A. Eleventh Amendment Is Broader Than its Language Suggests

The 11th Amendment by its text limits federal court jurisdiction by precluding suits in federal court against a state by a citizen of another state or of a foreign state. The Supreme Court in *Hans v. Louisiana*, 134 U.S. 1 (1890) held that the 11th amendment is significant not only for what it says but also for what it means and held that it also precludes suits against a state in federal court by a citizen of that state.

B. Exceptions to Eleventh Amendment Immunity

Eleventh Amendment immunity is not absolute. There are at least three exceptions. These are: (1) abrogation by the Congress under its 14th amendment powers; (2) waiver of immunity or consent to suit; and (3) proceeding under an *Ex Parte Young* cause of Action. *Verizon*, 122 S.Ct. at 1760; and *Coeur d'Alene*, 117 S.Ct. at 2046.

1. First Exception to Immunity: Fourteenth Amendment Abrogation

AMENDMENT XIV: Section 1. ... No state shall make or enforce any law which shall **abridge the privileges or immunities** of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without **due process** of law; nor deny to any person within its jurisdiction the **equal protection** of the laws. ...

Section 5. The Congress shall have power to enforce, by **appropriate legislation**, the provisions of this article.

U.S. CONST. AMEND. XIV (emphasis added).

a. Appropriate Legislation

Garrett addressed whether only whether Congress had properly abrogated 11th Amendment immunity under its 14th Amendment, Section 5 authority to enact "appropriate legislation" to assure the state provide equal protection and due process to all persons.

In previous holdings the Supreme court held that legislation is "appropriate" under the fourteenth amendment if: (1)

Congress has unambiguously expressed its intent to abrogate immunity; and (2) Congress must have acted pursuant to a valid exercise of 14th Amendment power. *Seminole Tribe of Florida v. Florida*, 517 U.S. 44 (1996). Where Congress seeks to enforce the Equal Protection Clause of the 14th Amendment, the Supreme Court has held that a valid exercise of Congressional power requires evidence of “widespread and persistent deprivations of constitutional rights” by the states. *City of Boerne v. Flores*, 521 U.S. 507, 526 (1997), and *Nevada Dep’t of Human Res. v. Hibbs*, ___ U.S. ___, 123 S.Ct. 1972 (2003).

(i) ADA Unambiguously Expressed Intent to Abrogate Immunity

Congress unambiguously expressed its intent to abrogate 11th Amendment Sovereign immunity in the ADA. In section 12202, it provides that:

A State shall not be immune under the eleventh amendment to the Constitution of the United States from an action in Federal or State court of competent jurisdiction for a violation of this chapter. In any action against a State for a violation of the requirements of this chapter, remedies (including remedies both at law and in equity) are available for such a violation to the same extent as such remedies are available for such a violation in an action against any public or private entity other than a State.

42 U.S.C. §12202.

(ii) Lack of Evidence of Widespread and Persistent Employment Discrimination by the States in *Garrett*

It was under this standard that the Supreme Court found in *Garrett* that Congress had not properly exercised its 14th Amendment powers. The legislative history of the ADA did not show evidence of a “widespread and persistent deprivations” of constitutional rights in *employment* by states. The ADA legislative history, however, did have substantial evidence of state discrimination against disabled person in accessing state programs and activities, both in terms of physical barriers to state programs and activities and in terms of state established policies, practices and procedures.

(iii.) Legislative History of ADA Does contain Evidence of Widespread and Persistent Discrimination by the States in Access to Government Programs

The legislative history of the ADA lists over 300 specific examples of states depriving disabled person to access of government services. See H. R. Rep. No. 101–485, pt. 2 p. 28 (1990) and *Garrett*, 531, U.S. 371, n. 7.

This opens an argument that *Garrett* is not applicable to claims under Title II because there is substantial evidence in the legislative history which can support a finding of widespread and persistent discrimination by the states in access to government programs. The Supreme Court has acknowledged that Title II of the ADA is predicated on a more substantial legislative history pertaining to discrimination by states in provision of public services and embodies a somewhat different remedial scheme than Title I. *Garrett*, 531, U.S. 371, n. 1 and 7.

b. Constitutional Difference Between Title I and Title II

Title I concerns employment actions by state and local governments, which implicates equal protection of persons. Within the equal protection analysis states have extraordinarily wide berth, bounded only by the limits of the equal protection clause which prohibits irrational employment decisions. See generally *Garrett*, 531 U.S. at 366-368 and *Hibbs*, 123 S.Ct. at 1981-1982. Also, employment is not an activity unique to government. Employment opportunities are available in greater numbers in the private sector.

Title II in contrast involves fundamental rights that are unique to government activity, such as petitioning government,

access to courts, voting, 4th and 8th Amendment protections, and substantive and procedural due process rights. Title II addresses unique government activity for which there is no counterpart in the private sector.

c. Complications of Coordinated State and Local Government Activities

Coordinated activities of state and local governments under Title II are also different in kind from state employment. Employment actions that were the subject of *Garrett* were solely the decisions of specific state departments or agencies.

However, governmental activities and programs covered by Title II are often a mix of state government and local government action. Typically, the state authority sets the policies and practices of coordinated state and local government activities. Yet, 11th Amendment sovereign immunity has no applicability to local governments. Where state and local governments act in coordinated activities, the local government would be subject to an ADA suit and the state agency would not be if Title II is not a valid exercise of Congresses 14th Amendment powers to abrogate the 11th Amendment.

d. Fundamental difference between Title I and Title II

At a more fundamental level, Title II deals with fundamental political rights. *Garrett* addressed equal employment opportunity, yet there is no constitutional right to be employed generally, and certainly no specific constitutional right to be employed by the state.

In contrast, Title II deals with fundamental rights that are constitutionally guaranteed to persons. The right to participate in governmental activities directly implicates the due process right to participate in activities such as voting, to access the courts to receive notice in an accessible format, to be confronted with accusers, to be heard in judicial proceedings. Exclusions from the exercise of these rights by a state because of disability status cannot pass the rationality standard.

e. Circuit Courts Divided

There are ample reasons to argue that *Garrett* is not applicable to Title II claims and that the decision in *Garrett under title I* is not automatically transferable to Title II. However, The 10th Circuit in *Thompson v. Colorado*, 278 F.3d 1020 (10th Cir. 2001) held that Title II is not a valid for the same reason articulated in *Garrett* . In *Popovich v. Cuyahoga Court of Common Pleas*, 276 F.3d 808 (6th Cir. 2002), *cert. denied*, 537 U.S. 812 (2002) the court held that Title II is different in kind from Title I, and therefore *Garrett* does not compel a finding that Title II is an improper exercise of 14th Amendment power. Under a separate analysis the Sixth Circuit Court of Appeals concluded that Title II is a proper exercise of 14th Amendment power by Congress and permitted civil actions under Title II against states.

On January 13, 2004, the Supreme Court held argument in *Tennessee v. Lane*, No. 02-1667, which squarely addresses the issue of whether Title II is an abrogation of 11th Amendment Immunity.

2. Second Exception to Immunity: Waiver of Immunity

a. Waiver of Immunity by Failure to Asset Immunity

States may be sued despite the 11th amendment if they waive immunity, consenting to suit. Consent or waiver may be accomplished in several ways. A state may simply decline to assert its immunity in a civil action, although this is most uncommon.

b. Waiver by State Statute

Typically, states waive immunity by statute in the form of at tort claims act or other form of waiver enacted by the legislature. Each specific state statute determines the details and scope of this type of waiver. In some states, there are

general tort claims statutes, and in addition there is a waiver of immunity for specific types of claims as part of a comprehensive remedial schemes for certain form of legislation. Typically these statutes permit claims against states for negligence, and do not encompass claims of discrimination because discrimination is an intentional wrong.

c. Spending Clause Waiver of Immunity

There is yet another form of waiver that is especially relevant to asserting federally protected civil rights against state defendants: waiving 11th amendment immunity as a condition of receiving federal financial assistance. Conditioning federal funds on a state's waiver of immunity is a Congressional power under the *spending clause*, which is a different source of Congressional power than that addressed in *Garrett*.

Conditions placed on the receipt of federal funds are different from 14th Amendment abrogation because the Congress is not taking immunity away from a state against the will of the state. Rather, the state is voluntarily relinquishing its immunity and consenting to suit as a condition to accepting federal funds. If the state wishes to preserve its immunity, it need simply forgo the offer of federal funds. If the state accepts the funds it also accepts the conditions attached.

(i) Waiver of Immunity by Accepting Federal Financial Assistance under the Rehabilitation Act

Congress has specifically provided in 42 U.S.C. §2000d-7(a) that:

(1) A State *shall not be immune* under the Eleventh Amendment of the Constitution of the United States from suit in Federal court for a *violation of section 504 of the Rehabilitation Act of 1973* (29 U.S.C. 794), title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), title VI of the Civil Rights Act of 1964 (42U.S.C. 2000d et seq.), or *the provisions of any other Federal statute prohibiting discrimination by recipients of Federal financial assistance*.

(2) In a suit against a State for a violation of a statute referred to in paragraph (1), remedies (including remedies both at law and in equity) are available for such a violation to the *same extent* as such remedies are available for such a violation in the suit *against any public or private entity other than a State*.

42 U.S.C. §2000d-7(a)(emphasis added).

Under its spending clause powers, Congress has set conditions on the acceptance of federal financial assistance. In §2000d-7(a) and (b), Congress requires that states accepting federal financial assistance waive their 11th amendment immunity for claims under the Rehabilitation Act, or any other federal statute prohibiting discrimination by recipients of federal financial assistance.

(ii) Section 2000d-7applies to other anti-discrimination statutes

Section 2000d-7 is not limited to discrimination alleged under the Rehabilitation Act, but broadly applies to “*the provisions of any other Federal statute prohibiting discrimination by recipients of Federal financial assistance*.” 42 U.S.C. §2000d-7(a)(1).

In *Barnes v. Goreman*, 122 S.Ct. 2097, 2100 (2002), the Supreme Court found that the Rehabilitation Act (and title VI of the Civil Rights Act of 1964 with which the Rehabilitation Act shares enforcement procedures and remedies) “invokes Congress’s power under the spending clause, U.S. Const. Art. I, § 8, cl. 1 to place conditions on the grant of federal funds. *Goreman*, 122 S.Ct. at 2100, *citing Daves v. Monroe Cty. Bd. of Educ.*, 526 U.S.C. 629, 119 S.Ct. 1661 (1999).

In *Gorman*, the Supreme Court held that private actions under §504 of the Rehabilitation Act and Title II of the ADA may be brought to recover compensatory damages. *Goreman*, 122 S.Ct. at 2100, *citing Franklin v. Gwinnett County Public Schools*, 112 S.Ct. 1028, 1036 (1992). The main issue in *Gorman* was whether punitive damages could also be recovered. Yet, the Court reasoned that whenever a governmental agency defined in the ADA or §504 accepts federal funds under a spending program, the entity receiving the funds is obligated to comply with all of the federal conditions imposed by the relevant federal law. *Gorman*, 122 S.Ct. at 2101. (citations omitted).

A recipient of federal funds can be held liable to the federal government or to *third party beneficiaries* for the violations of the terms of the relevant statute. *Gorman*, 122 S.Ct. at 2101. A recipient of federal funds is “on notice that it is subject not only to those remedies explicitly provided in the relevant legislation, but also to those remedies traditionally available in suits for breach of contract.” *Gorman*, 122 S.Ct. at 2101. Even where the relevant statute contains no express remedies, “a recipient of federal funds is nevertheless subject to suit for compensatory damages.” *Gorman*, 122 S.Ct. at 2101 (Citations omitted).

When a federal funds recipient violates the conditions of spending clause legislation, the wrong done is the failure to provide what it is obligated to provide, and therefore the recipient can be held accountable to the person harmed. *Gorman*, 122 S.Ct. at 2101. If a state or its agencies did not wish to relinquish their immunity, it could follow the simple expedient of not yielding to the offer of federal funding of Medicaid. *Id.*; *Oklahoma v. U.S. Civil Serv. Comm’n.*, 330 U.S. 127, 143-44 (1947).

(iii) Claims for Compensatory Damages Against State Agencies

In *Lovell v. Chandler*, 303 F.3d 1039 (9th Cir. 2002), eligible Medicaid beneficiaries alleged that the Hawaiian Medicaid agency failed to provide the coverage mandated by the federal Medicaid Act by imposing eligibility standards and categorical exclusions that were more restrictive than permitted by federal law. *Lovell*, 303 F.3d at 1045. This case not only involved the Rehabilitation Act and the ADA, but also a provision of the Medicaid Act that prohibits diagnosis basis discrimination in providing Medicaid services.

The Ninth Circuit in *Chandler* held that individuals are entitled to recover compensatory damages, attorneys fees and costs when a Medicaid agency violates the federal Medicaid Act. *Lovell*, 303 F.3d at 1056, *citing Guardian v. Civil Serv. Com. of City of New York*, 463 U.S. 582, 103 S.Ct. 3221 (1983). Significantly, the Ninth Circuit held that the plaintiffs were entitled to damages, fees and costs despite the State’s claims of sovereign immunity. *Id.* at 1056 and 1058. The Court held that the Congress had made waiver of 11th Amendment immunity a condition on accepting federal and that the State had waived immunity by accepting federal funds. *Id.* at 1051.

3. Third Exception to Immunity: *Ex parte Young*

The well-established exception to 11th Amendment state sovereign immunity doctrine is *Ex Parte Young*, which permits federal court jurisdiction over claims against state officials alleged to be violating federal law. *Ex Parte Young*, 209 U.S. 123, 159-160, 28 S.Ct. 441, 453-454 (1908). When a plaintiff alleges an ongoing violation of federal law, the federal court is entitled to exercise jurisdiction over the matter to the extent that plaintiff seeks prospective equitable relief. *Ex Parte Young*, 209 U.S. at 159-60, 28 S. Ct. at 453-454 (1908); *Will v. Michigan Dept. of State Police*, 491 U.S. 58, 71, 109 S.Ct. 2304, 2312, n. 10 (1989); *Pennhurst State School and Hospital v. Halderman*, 465 U.S. 89, 102, 104 S. Ct. 900, 908 (1984). The Supreme Court in *Will* reaffirmed the long established principal that:

a state official in his or her official capacity when sued for injunctive relief, would be a person under 1983 because ‘official capacity action for prospective relief are not treated as actions against the state.’

Will, 109 S. Ct. at 2312, n. 10, *citing Kentucky v. Graham*, 473 U.S. 159, 67, n. 14 (1985), and *Ex Parte Young*, 209 U.S. 123, 159-60, 28 S. Ct. 441, 453-454 (1908).

The Supreme Court in *Will* noted that the distinction between an action against state officials for *money damages* and state officials for *prospective relief* is commonplace in sovereign immunity doctrine. The federal Courts have jurisdiction to hear claims for prospective *relief* against state officials acting in their official capacity, despite the any immunity that the 11th Amendment might otherwise provide. Id.

a. State Officials Are Persons Liable under Ex Parte Young

State attorneys general typically argue that state officials enjoy the same immunity as the state because they are merely the agents of the state. However, the well-established law under *Ex parte Young* and its progeny is that a suit seeking prospective equitable relief against a state official who is engaged in a continuing violation of federal law is *not* deemed to be a suit against the State for purposes of state sovereign immunity. *Ex Parte Young*, 209 U.S. at 159-60, 28 S. Ct. at 453-54; *Will*, 109 S. Ct. at 2312, n. 10.

The Supreme Court has long observed that official capacity actions for prospective relief are not treated as actions against the State and therefore are not precluded by State sovereign immunity. Id. The reasoning is that a state official who is engaged in an ongoing violation of federal law cannot cloak himself in sovereign immunity to avoid responsibility to federal authority. Id. Neither the State nor its officials are immune from responsibility to the supreme authority of the United States. Id.

b. Ex Parte Young Actions Have Continued to Be Embraced as Essential to Preserving Federal Supremacy

The *Ex Parte Young* exception to sovereign immunity continues to be embraced by the Supreme Court as a necessary means of preserving federal supremacy. *See Idaho v. Coeur d'Alene Tribe*, 521 U.S. 261, 293, 117 S.Ct. 2028, 2045-46 (1997)(affirming the continued necessity and vitality of the *Ex Parte Young* Exception to 11th Amendment Sovereign Immunity).

Even in *Garrett*, the Supreme Court noted that:

Our holding here that Congress did not validly abrogate the States' sovereign immunity from suit by private individuals for money damages under Title I does not mean that persons with disabilities have no federal recourse against discrimination. Title I of the ADA still prescribes standards applicable to the States. Those standards can be enforced by the United States in actions for money damages, as well as by private individuals in actions for injunctive relief under *Ex parte Young*, 209 U.S. 123 (1908).

Garrett, 121 S.Ct. at 968, n. 9 (emphasis added).

If state officials could not be subject to federal judicial authority for violations of federal law, the states and their officials would enjoy supremacy over federal law. Id. As then Justice Rehnquist stated for the majority in *Green v. Mansour*, “the availability of prospective relief of the sort awarded in *Ex Parte Young* gives life to the Supremacy Clause,” as “[r]emedies designed to end a continuing violation of federal law are necessary to vindicate the federal interest in assuring the supremacy of that law.” *Green v. Mansour*, 474 U.S. 64, 68, 106 S.Ct. 423, 426 (1985).

HIV/AIDS in the South

HIV/AIDS in the South

Linton Carney

Particular laws affecting those infected with HIV

1. Intentional exposure statutes

Approximately half the states in the United States have some version of intentional exposure statutes.

- Alabama—Class C misdemeanor—Ala Code, Sec. 22-11A-14
- Arkansas—Class A felony—Ark. Code Ann., Sec. 5-14-123
Class A misdemeanor not to notify healthcare professional-- Ark. Code Ann. Sec. 20-15-903
- Florida—felony in the third degree—Fla. Stat., Sec. 384.24
- Georgia—felony—Ga. Code Ann., Sec. 16-5-60
- Louisiana—felony—La. R.S.14:43.5 (enhanced penalties if victim is police officer)
- Mississippi—no criminal statute; Mississippi Department of Health issues quarantine order requiring person with HIV to notify sexual partners; felony to violate order
- North Carolina—
- South Carolina—felony—S.C. Code Ann., Sec. 44-29-145
- Tennessee—Class C felony—Tenn. Code Ann., Sec. 39-13-109
- Texas—Class B misdemeanor to conceal HIV status from health authorities—Tex. Code Ann., Sec. 81-066; violations of control measure orders is a Class B misdemeanor—Tex. Code Ann., Sec. 81.087
- Virginia—Infected sexual battery Class 6 felony--Va. Code Ann., Sec. 18.2-67.4:1 (includes syphilis and hepatitis B)

HIV vs. AIDS REPORTING

All southern states report HIV, except Georgia.

CONFIDENTIALITY STATUTES

All States have testing and confidentiality laws for HIV.

- Alabama—Compulsory testing of people incarcerated for 30 days or more in county or state facilities.—Ala. Code, Sec. 22-11A-17.
- Arkansas—Authorizes Department of Corrections to “establish a program for intensive treatment of deviant sexual behavior of inmates” and to screen for STDs—Ark. Code Ann., Sec. 12-29-406
- Florida—medical facility personnel subject to disciplinary action for breaching testing and confidentiality statute—Fla. Stat., Sec. 381.004; no civil liability on practitioner for failing to inform partner-- Fla. Stat., Sec. 455.674
- Georgia—health department can seek court order for mandatory testing persons “suspected” of being infected—Ga. Code Ann., Sec. 31-17A-2.
- Louisiana—no private cause of action for breach of statute, narrow definition of HIV test results--La. R.S.40:1299
- Mississippi—mandatory testing of sex offenders—Miss. Code Ann., Sec. 99-19-203
- North Carolina—physicians to report to health department if they suspect a patient is infected —N.C. Gen. Stat. Se. 130A-135
- South Carolina—must notify school nurse and superintendent about infected minor in school--S.C. Code Ann., Sec. 44-29-135

- Tennessee—Class C felony—Tenn. Code Ann., Sec. 39-13-109
- Texas—convicted prostitutes tested, if positive can be prosecuted for aggravated prostitution--Tex. Code Ann., Sec. 39-13-521
- Virginia—Unauthorized disclosure made willfully or through gross negligence are subject to civil penalty by the court; subject of disclosure can recover actual damages, reasonable attorney's fees and court costs--Va. Code Ann., Sec. 32.1-36.1

DISCRIMINATION

No state in the South prohibits discrimination on the basis of sexual orientation. Anti-discrimination laws in a few localities.

HATE CRIMES

Arkansas, Tennessee and South Carolina do not have hate crime statutes. Hate crimes cover sexual orientation only in Florida and Louisiana.

STATE GOVERNMENT

Most states in the South depend disproportionately on sales taxes as opposed to property and/or income taxes.

Per capita taxes—USA average is \$1,966

- Alabama—\$1,510
- Arkansas—\$1,851
- Florida—\$1,523
- Georgia—\$1,709
- Louisiana—\$1,610
- Mississippi—\$1,661
- North Carolina—\$1,901
- South Carolina—\$1,579
- Tennessee—\$1,399
- Texas—\$1,377
- Virginia—\$1,818

(None above US average.)

Per capita expenditures—USA average is \$4,159

- Alabama—\$3,741
- Arkansas—\$3,932
- Florida—\$3,070
- Georgia—\$3,314
- Louisiana—\$3,671
- Mississippi—\$4,101
- North Carolina—\$3,854
- South Carolina—\$4,451
- Tennessee—\$3,198
- Texas—\$3,027
- Virginia—\$3,722

(Only South Carolina is above national average.)

EDUCATION

Per capita public school expenditures-- USA average is \$7,898

- Alabama—\$6,052
- Arkansas—\$5,942
- Florida—\$7,431
- Georgia—\$6,620
- Louisiana—\$6,553
- Mississippi—\$5,535
- North Carolina—\$6,824
- South Carolina—\$7,210
- Tennessee—\$6,108
- Texas—\$7,039
- Virginia—\$7,664

(None above US average.)

High School graduation rates—lowest in nation is South Carolina, 51%. Georgia, North Carolina, Louisiana, Alabama, Florida, Mississippi, and Tennessee all in bottom 10. Only Arkansas and Virginia above national average of 67.3%.

Drop-out rate is 4.8% nationally, 9.2% in Louisiana.

LABOR

All Southern states are right to work states; most provide exceptions to unemployment eligibility for labor disputes.

All southern states are at-will employment states.

Minimum wage is \$5.15; states either do not have own program or cap it at federal minimum.

Unemployment insurance: National average weekly payment in 2002 was \$256.76. But it was \$168.49 in Mississippi, \$167.44 in Alabama. Only North Carolina, Texas and Virginia exceeded national average, and North Carolina pays \$258.98, Texas \$258.68. Virginia's rate is \$311.27.

PUBLIC BENEFITS

TANF payments—national average is \$1,039.38 per family per month.

- Alabama—\$622.22
- Arkansas—\$484.24
- Florida—\$1,401.57
- Georgia—\$792.90
- Louisiana—\$844.53
- Mississippi—\$680.46
- North Carolina—\$916.20
- South Carolina—\$539.42

- Tennessee—\$411.46
- Texas—\$475.11
- Virginia—\$733.48

(Only Florida exceeds the national average.)

Food stamps—average monthly payment per recipient—US average is \$79.60

- Alabama—\$78.46
- Arkansas—\$77.65
- Florida—\$73.97
- Georgia—\$80.19
- Louisiana—\$83.14
- Mississippi—\$76.43
- North Carolina—\$77.83
- South Carolina—\$77.26
- Tennessee—\$76.85
- Texas—\$81.61
- Virginia—\$71.49

(Six of the top ten states for percentage of population receiving food stamps are in the South. 13.1% in Louisiana, 11.3% in Mississippi.)

SSI —average monthly payment per recipient—US average is \$405.71

- Alabama—\$363.40
- Arkansas—\$339.18
- Florida—\$378.37
- Georgia—\$350.64
- Louisiana—\$373.02
- Mississippi—\$345.64
- North Carolina—\$336.63
- South Carolina—\$350.39
- Tennessee—\$352.64
- Texas—\$339.16
- Virginia—\$353.10

DEBTOR/CREDITOR

Personal bankruptcy rate: national rate is 529/100,000.

- Alabama—925
- Arkansas—858
- Florida—541
- Georgia—869
- Louisiana—590
- Mississippi—769
- North Carolina—430
- South Carolina—379
- Tennessee—1078—highest in nation

- Texas—354
- Virginia—574

EXEMPTIONS FROM SEIZURE

- Alabama—\$5,000 in equity in home, \$3,000 in personal property; garnishment after \$154 weekly pay.
- Florida—exemption protects home and ½ acre in urban setting, 16 acres in unincorporated area; exemption for garnishment up to \$500 per week for “head of family.”
- Louisiana—\$25,000 homestead exemption
- Mississippi—\$75,000 homestead exemption

CRIME

- All Southern states are death penalty states.
- Top crime rates—Florida #2, Louisiana #4, Tennessee #6, Texas #7 and North Carolina #10.
- Violent crime: Florida #1, Tennessee #4, South Carolina #5, Louisiana #6.
- Murders: Louisiana #1, Mississippi #2, Alabama #3, Tennessee #8, Georgia #9.

Incarceration rate; national average 422/100,000.

- Louisiana #1, Mississippi #2, Texas #3, Alabama #5, Georgia #6, South Carolina #7.

48% of people on death row are in the South.

HIV/AIDS in the South

Dr. Gene Copello

SOUTHERN AIDS COALITION POLICY STATEMENT

There is an emergency underway in the southern states of the United States. The disparate impact of the HIV/AIDS epidemic on southern citizens in the South – especially within communities of color – must be addressed. The epidemic is changing; the face of HIV/AIDS is becoming increasingly rural, minority and poor. Neither federal nor state policy or funding are adequate to enable the South to successfully address this emergency.

- Whereas... Southern states account for a little more than 1/3 of the US population, but account for about 40% of the people estimated to be living with AIDS and 46% of the estimated number of new AIDS cases;
- Whereas... This difference in new AIDS cases between the South and other regions of the country is increasing. The percentage of new AIDS cases diagnosed in the South rose from 40% of the national total in 1996 to 46% of the national total in 2001;
- Whereas... Seven of the 10 states with the highest AIDS case rates are in the South;
- Whereas... Six of the metropolitan areas with the highest AIDS case rates are in the South;
- Whereas... Eight of the 10 states with the greatest percentage of the population living below the federal poverty level are in the South; and,
- Whereas... Almost 38% of the cumulative cases and almost 49% of the 2001 newly reported cases of AIDS have been within the African American population yet only 19% of the southern population (19 million out of a total of 100 million) are African American. The region with the next largest total of African Americans within their population is the Midwest, with about 6.5 million out of a total of 65 million (about 10%).

Therefore, be it Resolved, as a result of this emergency occurring in the South, the Southern AIDS Coalition has adopted the following policy positions and recommendations, and encourages the support of all in achieving these goals:

Prevention: The Southern AIDS Coalition believes that, in order to reduce the spread of HIV/AIDS and the diseases commonly associated with it such as sexually transmitted diseases and hepatitis, and to improve the health status of those already infected by these diseases, all persons living in the United States, regardless of their geographic location, must have access to culturally- and linguistically-appropriate community-based services, including: outreach and prevention services; testing and counseling opportunities; and linkages to healthcare. Therefore,

- (1) We call upon the Federal Government to develop program policies to ensure greater equity in the provision of comprehensive and appropriate HIV/AIDS prevention services within all states, and specifically within all areas of the South.
- (2) We call upon State and Local Governments within the South to increase human and financial resources directed to communities bearing a significant and disproportionate impact of HIV/AIDS as determined by epidemiological data and community assessments. Communities of color and men who have sex with men are disproportionately affected; addressing these disparities requires focused efforts and the dedication of special resources.

Care: The Southern AIDS Coalition believes that all persons living with HIV/AIDS across the United States, regardless of their geographic location or income, must have access to appropriately trained HIV-specific primary medical care providers, to services necessary to sustain medical care, and to a medication formularies consistent with United States Public Health Service guidelines. This goal is consistent with the vision of a compassionate society, and contributes to the prolongation and improvement of peoples' lives, facilitates their positive contributions to family and society and helps to reduce the further spread of this pandemic.

- (1) It is imperative that the Federal Government provides emergency funding to assure the availability of HIV-related medical care services and medications for persons living in the South. Federal policy must be modified/adopted to assure that funds are used to establish and support a basic "standard of care" for all states and territories. This "standard of care" must assure that all eligible individuals (i.e., those who are HIV+, whose income is at/below 300% of the federal poverty level and who have no other third party source to pay for these medications), have access to a basic HIV/AIDS medication formulary which includes all FDA-approved anti-retrovirals and an adequate selection of medications for the prevention and treatment of opportunistic infections and co-infections.
- (2) It is similarly imperative that the Federal Government support and fund the availability of safe, affordable and otherwise appropriate housing – consistently demonstrated to be one of the most critical support services to facilitate improved health status and successful health care outcomes – for all people living with HIV requiring such assistance.

The Southern AIDS Coalition supports these concepts for all regions of the country and also recognizes the need to maintain existing public health infrastructure nationwide. However, the HIV/AIDS epidemic in the South must be addressed by providing and targeting new federal, state and local resources to prevention and care services in the South. This must be done while holding harmless federal funding to all regions of the country.

In order to accomplish these policy and human goals, the Southern AIDS Coalition has determined that a special HIV/AIDS appropriation totaling \$121,806,000 be provided to Southern AIDS Coalition states in federal Fiscal Year 2005 and every year thereafter, within the following categories, until parity is reached.

• Prevention	\$ 25,548,000
• Care	\$ 34,564,000
• Essential Medications	\$ 48,619,000
• Housing	\$ 13,075,000

The Southern AIDS Coalition includes: Alabama, Arkansas, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

³ Note: The estimates of funding required for Prevention, Care and Housing were developed by determining the total federal (CDC Cooperative Agreement, HRSA Ryan White Title I/II [non-ADAP], and HOPWA) funds available/expended, and determining an average "\$ per capita" (i.e., \$ available/expended per person estimated to be living with AIDS). For the purpose of this analysis, Ryan White Title I (EMA formula and supplemental funding) and Title II (state base and emerging communities funding) were summed, and this new total was counted as received by the appropriate state. Similarly, CDC cooperative agreement funds going to states and cities were summed, as were HOPWA funds going to states and SMSAs. The amount a state would hypothetically "be entitled to" under this approach was calculated, and the difference between the amount a state (including their cities) actually received and would "be entitled to" receive if this approach was adopted was determined. The positive differences were summed, and the totals requested in each separate category represent the sum of these differences. For the Essential Medications component, an estimate was developed for what it would require to bring each SAC state to a funding level to assure access to the PHS-recommended formulary of medications for all HIV+ individuals at/below 300% of the federal poverty level. Finally, the amounts for each state were summed to calculate the amount needed for the entire region. Under this "special appropriation" approach, no state would actually lose any funding, since the additional funds would be part of the requested new special appropriation

Social Security Practice

SOCIAL SECURITY DISABILITY HEARINGS PRACTICE
HIV INFECTION CASES

Hon. Mark R. Dawson

1. Changes Expected This Year in Hearings Practice

- a. The advent of the electronic file and the video teleconference hearing (“VTC”)
- b. “Demonstration” projects described by Commissioner Barnhart
 - i. partial benefits for claimants who can work part-time
 - ii. medical benefits **ONLY** for claimants needing specific medications or treatments provided such benefits may reasonably result in improvement permitting return to the workplace
 - iii. The immediate award of 1 year's benefits for claimants with major trauma or surgery who are expected to return to work following recovery
- c. Expected substantial revision of 20 C.F.R. 404, App.1, Sec. 14.00D and Listing 14.08.

2. Practice Tips - The suggestions that follow are offered in the context of two guiding principles of HIV infection disability hearings - selling the worthiness of the claimant to the judge, and stressing the functional limitations of the claimant arising from impairments due to the consequences of the HIV infection. A representative may have to overcome a lingering prejudice that morality or blameworthy behavior is at issue.

- a. Meeting or medically equaling listings 14.08A-M (bacterial, fungal, protozoan or helminthic, viral, malignancies, dermatological, hematological, neurological, wasting syndrome, diarrhea, cardiomyopathy, nephropathy, or other serious infections) are ideally established with medical expert testimony citing the medical evidence of record, and resolved at the DDS level without the need for a formal hearing.
- b. 14.08N -the claimant's friend - a functional listing when the claimant neither meets nor medically equals any other listing -is by far the most common theory at the hearing level:

“Repeated manifestations of HIV infection resulting in significant, documented symptoms or signs (e.g., fatigue, fever, malaise, weight loss, pain, night sweats) and one of the following at the "marked" level: (1) restriction in activities of daily living; or (2) difficulties in maintaining social functioning; or (3) difficulties in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.”

- c. Establishing the 14.08N listing. Tell the judge before the hearing you plan to prove the claimant meets 14.08N. At the hearing, specifically cite the evidence of record establishing the requisite symptoms or signs, and use claimant or other witness testimony to establish the subjective requirements of the listing.
- d. Establish the claimant's credibility - this is crucial in HIV infection cases. Stressing educational accomplishments and/or creditable work history may be quite helpful.

If there is a criminal history documented in the record, stress good parole history. The claimant should be well dressed, well groomed, and respectful, to the extent feasible. The claimant should evince the desire to return to work should their impairments diminish in severity. The claimant's

general credibility is key to establishing the presence of subjective impairments, such as pain, fatigue, headaches, depression, and loss of sleep.

- e. Handling Drug/Alcohol Abuse (“DAA”) Issues - Proper presentation of histories of illegal or prescription drug abuse, and/or alcohol abuse is critical, both in terms of credibility and materiality. If the judge finds the claimant disabled, but also finds DAA, and that DAA is material to the finding of disability, the claimant is ineligible for benefits. This issue, if present, must be addressed directly.
- f. Do not overlook the effects of co-morbidities, i.e., other diseases or conditions, such as chronic back pain, causing functional impairments which may further diminish the claimant's residual functional capacity. Remember that functional impairments arise from mental conditions. The most common are depressive and anxiety disorders. Even if the claimant has not received mental health treatment other than a prescription for Prozac from his treating physician, relate any such problem to diminished functioning in the areas of the activities of daily living, social withdrawal, or the ability to concentrate for extended periods in a work-like setting. If the claimant's medications have sufficiently serious side effects such that they affect these functional domains, be sure the testimony is on the record.
- g. Utilization of community services. A particularly effective way to demonstrate the diminished ability of a claimant to perform the activities of daily living is to document or offer testimony of the nature and frequency of any public services or other assistance provided the claimant. This is also a good source for witness testimony.
- h. A senior judge in my office expressed the view that his biggest aggravation in HIV infection cases is a sense of entitlement on the part of the claimant's representative to the effect that HIV seropositivity itself, with mild to moderate symptoms, should be sufficient to merit benefits. To the extent possible, also advise the claimant of the probable adverse effects of an "attitude" at the hearing.
- i. Effect of retroviral regimen or other effective treatment - we have seen a major reduction in HIV infection cases apparently due to the efficacy of retrovirals in achieving remission of most serious infectious processes. This issue also must be addressed. If there is evidence of return of opportunistic infections despite medication, get a statement from a treating physician. A judge also will carefully note any evidence in the record suggesting the claimant has not been compliant with treatment, usually in the form of failure to consistently take medication as prescribed. Address the issue-minimize the risk the judge will assess the claim in light of the impression the claimant is partly to blame for the seriousness of his condition.
- j. Remember to stress loss of ability to do work-activities on a full-time sustained basis that has lasted for at least one year
- k. Don't overemphasize the importance of CD4 counts. It is misleading to assume that a low count is evidence of the seriousness of the infection. The key is to stress functionality. A claimant properly cannot say that he can't lift a 10-lb. bag of potatoes due to his low CD4 count.
- l. In a close case, suggesting to the judge that (s)he recommend the appointment of a representative payee may be a good tactic, creating the impression the claimant's impairments truly markedly reduce his ability to function independently. For public service representatives, ensure that the judge is aware that you are providing representation on a “fee waiver” basis. The inference is that you truly believe in the merits of the case.

SOCIAL SECURITY PROTECTIONS FOR BENEFICIARIES RETURNING TO WORK

Ann H. Fisher

I. Introduction

A. Resources

- i. Social Security “Redbook” of Work Incentives
<http://www.ssa.gov/work/ResourcesToolkit/redbook.html>
- ii. Summary of 1619(b) programs for extending Medicaid Eligibility
<http://www.ssa.gov/work/ResourcesToolkit/Health/1619b.html>
- iii. Social Security Work Site
<http://www.socialsecurity.gov/work/index.html>
- iv. T II C.A.N.N. “Returning to Work and Keeping Medicare and Medicaid”
October 2002 by T. McCormack
http://biotech.law.lsu.edu/cphl/HIV/working_medicare.pdf
- v. Medicaid Buy-in programs by state
<http://cms.hhs.gov/twwiia/ede.asp>
- vi. POMS on screening out HIV cases
<http://policy.ssa.gov/poms.nsf/lnx/0428003005>
- vii. AIDS Legal Council Return to Work Guide
<http://aidslegal.com/media/pdfs/returning.pdf>
 1. You may adapt for your state
- viii. List of benefits planning grantees in each state
<http://www.ssa.gov/work/ServiceProviders/BPAODirectory.html>

B. Considerations

- i. Financial improvement
- ii. Psychological improvement
- iii. Fear of re-applying
- iv. Access to health care

II. SSDI work incentives (aka employment supports)

A. Income

- i. 9 month trial work period, plus 39 months EPE
 1. Definition of trial work period
 - a. \$580 per month in 04
 - b. Need not be cumulative
 - c. Can keep entire income
- ii. Extended period of eligibility
 1. Loss SSDI if income over SGA of \$810 after deduction of impairment related work expenses (IWRE)
 2. Automatic reinstatement for any month income goes below \$810—REGARDLESS OF REASON INCOME IS LOST
- iii. After EPE, reapplication with “Expedited Reinstatement”
 1. But must prove disabled

2. Available for five years after termination of eligibility
- iv. Practical considerations
 1. Earn lots in early months
 2. Reduce earnings, or find IRWEs, to bring below SGA if just above that amount
 3. Not that this applies only to EARNINGS, not to other income claimants might receive (e.g. royalty payments, school grants).

B. Medical

- i. Medicare parts A and B both continue
 1. Part A no charge for 9 ½ years
 2. Part B will have to pay premium if no longer getting check
 - a. Okay to drop part B if work insurance available
 - b. Special enrollment period if work insurance ends so no need to wait for open enrollment
 - c. Dual coverage often gives piece of mind
 3. Obviously big issue will be pharmacy coverage
 - a. State ADAP situation and eligibility?
- ii. Medicaid –much more difficult
 1. Easier if dual beneficiary—see SSI info below
 2. Otherwise probably need a Medicaid buy-in program
 - a. 27 states had implemented as of October 2003, 4 more states have scheduled implementation dates
 - b. Always allow higher income (200+ percent of FPL) than Medicaid
 - c. Higher asset limit (often \$10,000)
 - d. Programs vary widely
 - i. Check your state
 - ii. Advocate for program if you don't have one already
 - e. Note that Medicaid Buy-in programs also often cover “working disabled” who have never been on SSDI or SSI

III. SSI work incentives

A. Income

- i. No trial work period
- ii. Immediate budgeting
 1. Disregard first \$65 then count 50% of what's left
 2. Invariable overpayments
 3. Same income disregards for impairment related work expenses
- iii. If make more than \$1200 after disregards, then will lose check
- iv. If no check for 12 months, then must reapply (bummer!)

B. Medical

- i. Keeping Medicaid under Section 1619(a)
 1. Must still be getting at least \$1 SSI
 2. Must be earning SGA (\$810)
 3. May need to educate your local Medicaid agency
- ii. Keeping Medicaid under Section 1619(b)
 1. Must be earning SGA
 2. Must be earning under the state 1619(b) limit

- a. Varies by state
 - i. \$18,719 in Alabama
 - ii. \$36,180 in New York
- b. Increases each year
- c. IRWEs can reduce income
3. Program greatly under-utilized
4. Probably will need to educate local Medicaid staff
5. Requires determination by SSA before eligibility established so start there and ask for 1619(b) determination

IV. Practical advice for clients

- A. No substitute for specific advice tied to specific job offer
 - i. Supposed to be available in each state
 - ii. Check out your local benefits planning grantee
 - iii. Be sure to tell clients to report. Computers talk in the night
- B. Legal advice will always be only part of the picture

Debtor/Creditor Issues

Debt Management: Resolving Tax and Housing Related Debts

Ronda B. Goldfein

I. Federal Tax Debt

Communicating with the IRS

1. The best way to contact the IRS to resolve an income tax debt is the 800 number listed on all the notices or, if provided, the phone number and contact name on the correspondence the taxpayer received from the IRS.
2. Prior to contacting the IRS you should have the taxpayer sign and date a Power of Attorney, Form 2848, for each tax year of concern. Once you have the representative on the phone, make sure to fax the completed form to the representative as well as to the central fax number for the region. This will place the form on file and you will not be asked to re-fax the form each time you speak to the IRS about a specific taxpayer.
3. Once there is a Form 2848 on file with the IRS you will be assigned a CAF (Centralized Authorization File) Number, which you will need to write on all future Power of Attorney forms you complete.

Options for Resolution

1. Uncollectible Status
 - a. While there are no fees associated with requesting a tax debt be placed in uncollectible status, the taxpayer must have filed all tax returns, regardless of the ability to pay the debt, in order to qualify for this option.
 - b. To apply for a debt to be placed in uncollectible status, the taxpayer must submit a statement of their income and expenses ⁴(e.g.: housing, transportation, utilities, medical, food) which show they are unable to pay anything towards the outstanding debt. When constructing this statement, the taxpayer may only include unallowable expenses such as credit cards, cable, and long distance phone service, if the taxpayer can show that the expense is medically necessary.
 - c. Once in uncollectible status the debt will continue to accrue interest and penalties. If the debt exceeds \$5,000, the IRS automatically imposes a lien for the debt amount, which will appear on the taxpayer's credit report. The debt will remain in uncollectible status until the taxpayer earns \$20,000 in gross annual income or the taxpayer incurs new tax debt. ⁵
2. Installment Agreements
 - a. An installment agreement can be set-up by the taxpayer's representative over the phone and requires a \$45 application fee.

⁴ The IRS has national standards for the expenses mentioned above, which can be found on the IRS website. If the taxpayer's expenses in a particular area exceed the national standard, the taxpayer must show why the IRS should use the taxpayer's figures as opposed to the national standards.

⁵ The Statute of Limitations for IRS debt is generally ten years after the tax has been assessed. Getting a taxpayer into uncollectible status can mean, depending on the circumstances of the taxpayer and the age of the debt, that the taxpayer can safely remain in uncollectible status until the Statute of Limitations expires and the debt is eliminated.

- b. The terms of the agreements are based on both the taxpayer's income taxpayer and the length of time the IRS will allow for repayment. These repayment plans are usually calculated to amortize the debt over 24 or 36 months.

3. Offer in Compromise (OIC), Form 656

- a. In addition to a \$150 fee, the taxpayer must have filed all tax returns, regardless of ability to pay the debt, in order to qualify for this option. The IRS may waive the fee for low-income taxpayers.
- b. The OIC request form is two parts. On the first part, the taxpayer must explain the circumstances as to why the debt cannot be paid. The second part, a financial statement, Form 433a (for individual taxpayers), verifies that there are no available resources and contains the offer amount. In calculating the offer amount you should refer to the detailed instructions on Form 656.
- c. Finally, the taxpayer can choose between three payment options for the OIC. The taxpayer can pay in cash within ninety day of the acceptance of the offer; pay a lump sum within ninety days and then pay the remaining balance in monthly installments over two years; or, the offer can be repaid in monthly installment lasting the remaining portion of the statutory period of the debt.

4. Bankruptcy

- a. Generally a taxpayer is not able to discharge a tax debt through a bankruptcy but, there are exceptions based on the age of the tax debt and the circumstances surrounding the debt.

II. State and Local Income Tax Debt

- A. State and local tax agencies generally have parallel remedies to those available to cure IRS debt. When facing this type of debt, contact the taxing entity directly to determine the options are available for the taxpayer.

Real Estate Taxes

- A. When attempting to resolve a real estate tax debt, a taxpayer has two options: (1) negotiate a repayment agreement with the municipality; or (2) fold the debt into a Chapter 13 bankruptcy and pay the arrears through the bankruptcy plan.
- B. To avoid future real estate tax debt, the taxpayer may want to negotiate with the mortgage company to include the real estate tax payments with the monthly mortgage payments.

IV. Housing Related Debt

Mortgage Debt

1. First, review federal and state laws governing the mortgages and fair lending practices to ensure no violations in the original mortgage documents or foreclosure notices.
2. If the mortgage and foreclosure actions comply with federal and state law, you should assess the client's ability to continue making payments on the house, by comparing the client's income and expenses. This type of analysis is necessary to advise the client on the most viable option for their financial situation.
3. A mortgagee has two available options to clear mortgage arrears. The first option is re-structure the mortgage, which allows the mortgagee to address the arrears without filing a Chapter 13 bankruptcy.

If the mortgage company is unwilling to offer a satisfactory restructuring plan, the mortgagee may file a Chapter 13 bankruptcy and pay back the arrears while keeping current with the monthly mortgage payment. When discussing this option, you should ensure that the mortgagee's income allows for these payments to continue for a period of three to five years. The Chapter 13 filing fee is approximately \$200, which can be paid in installments.

Landlord-Tenant – Public

A tenant facing eviction for non-payment of rent in public housing has several options to address the debt and prevent the eviction. First, the tenant can negotiate and enter into a repayment agreement with the landlord. Another option is to apply for DEFA (Direct Emergency Financial Assistance—federal Ryan White dollars administered through the local grantee) which will cover two months rent up to approximately \$1,000 for an individual per year and \$1,500 for a family per year. Additionally, the tenant can apply for state-based funds to assist in paying the overdue rents. Finally, since the courts have interpreted public housing tenancy as a protected interest, a public housing tenant may file a Chapter 13 bankruptcy to stay the eviction and pay the overdue rent.

Landlord-Tenant – Private

Private housing tenants have the same options to prevent eviction as public housing tenants with one exception. While a private housing tenant may file a Chapter 13 bankruptcy to stay an eviction, a private landlord will be able to obtain immediate relief from the stay.

Immigration

PREPARING HIV WAIVERS & DISABILITY WAIVERS

Maribel Reynoso

I. Overview of Immigration Law

A. Family-Sponsored Immigration and Preference Categories:

Immediate Relatives of U.S. Citizens: (no numerical limitation) have an immediate visa available. This includes spouses of U.S. citizens (USC), children of USC's and parent of USC (USC is 21 or more).

1. First preference: Unmarried sons & daughters of USC (over 21)

2. Second preference:

- 2A Spouses and children of lawful permanent residents (LPR's);
- 2B Unmarried adult sons and daughters of LPR's

3. Third Preference: Married sons and daughters of USC's

4. Fourth Preference: Brothers and sisters of USC's

B. Employment Based Immigration and Preferences: Section 203(b), 8 USC §1153(b)

1. First Preference Priority Workers

- Persons with Extraordinary Ability
- Outstanding Professors and Researchers
- Multinational Executives and Managers

2. Second Preference Priority Workers: Members of the professions holding advanced degrees or aliens of exceptional ability

3. Third Preference Priority Workers: skilled workers, professionals and other workers

4. Fourth Preference Priority Workers: Special Immigrants: i.e. religious workers, person seeking reacquisition of citizenship/and returning resident, foreign medical graduates etc.

5. Fifth Preference: Employment Creation (investors) \$1,000,000 in a new commercial enterprise that employs ten USC or authorized immigrant workers full time and manages the business on a day to day basis or through policy formation.

Note: Employment-based immigration with the exception of special immigrants, persons with extraordinary ability, national interest waivers and investors require a labor certification. Employer or perspective employer will file the petition. Labor Certification Requirement: not sufficient workers able, willing and qualified at the time and place of alien entry. Employment must not adversely affect wages and working conditions of U.S. workers.

II. Diversity Visas

A. Section 203(c) provides 50,000 visas each year. No visas will be issued to high admission region and states. The regions are (1) Africa; (2) Asia; (3) Europe; (4) North America (other than Mexico); (5) Oceania; and (6) South America, Mexico, Central America and the Caribbean. Visas will be divided between low admission

states and high admission regions with priority given to low admission regions. The selection is random in each fiscal year. Applicants may file only one petition.

The lottery is held every year in October. Requirements are as follows:

- High school diploma or its equivalent.
- Has within 5 years applying at least 2 years of work experience in any occupation requiring at least years 2 years training or experience. The occupation must require an SVP of 7.
- Family members are eligible. Spouse and children are eligible including spouses and children acquired subsequent to the DV entry submission.

C. Nicaraguan and Cuban Adjustment (Nicaraguan Adjustment And Central American Relief Act, Pub.L.No. 105-RA

Provides for Nicaraguans or Cubans physically present in the U.S. since Dec. 1, 1995 if he or she applies for adjustment of status before April 1, 2000.

D. Salvadorans, Guatemalans, and Eastern Europeans still eligible for Cancellation under the old Suspension Rules.

Under NACARA, Congress exempted certain Salvadorans, Guatemalans and Eastern Europeans from the harsh consequences by permitting them to apply for suspension of deportation or special rule cancellation of removal if they meet the “old” suspension of deportation requirements (7 years, good moral character, extreme hardship/or 10 years, good moral character, exceptional and extremely unusual hardship) under certain circumstances.

- **Salvadorans** eligible for cancellation under former suspension rules if not convicted of aggravated felony and
 1. not apprehended after Dec. 19, 1990 at the time of entry and first entered the U.S. on or before Sept. 19, 1990 and registered for benefits pursuant to the settlement agreement in *American Baptist Churches v. Thornburgh* (ABC), 760 F.Supp. 796 (N.D. Cal. 1991) on or before Oct. 31, 1991, or applied for TPS on or before Oct. 31, 1991;
 2. or filed an application for asylum with INS on or before April 1, 1990;
 3. spouse and children are covered and sons and daughters are covered if the son or daughter entered the U.S. on or before Oct. 1, 1990.
- **Guatemalans:** Same rules as Salvadoran except they had to have entered on or before Oct. 1, 1990 and register for benefit under ABC before Dec. 31, 1991.
- **Eastern Europeans:** entered the U.S. on or before Dec. 31, 1990; filed an application for asylum on or before Dec. 31, 1991; at the time of filing asylum was a national of the Soviet Union, Russia, any republic of the former Soviet Union, Latvia, Estonia, Lithuania, Poland, Czechoslovakia, Romania, Hungary, Bulgaria, Albania, East Germany, Yugoslavia, or any state of the former Yugoslavia; NOT convicted of an aggravated felony.

Note: Alien must be admissible at the time of entry or be granted a waiver in order to immigrate. Application will be denied if applicant is inadmissible and the waiver(s) is denied. Grounds of inadmissibility are in Section 212 of the INA. They include health related grounds, criminal, security, public charge, labor

*certification and qualifications for certain immigrants, illegal entrants and immigration violators. Please note that alien may be inadmissible for more than one ground and may need more than one waiver. ******

III. HIV Exclusion Section 212(a)(1)(A)(i) of the Immigration & Nationality Act

HIV is a ground of inadmissibility only. HIV is not a ground of removal. You cannot be deported for being HIV positive, but you can be denied entry.

Section 212(a)(1)(A)(i) of the INA states: any alien who is determined to have a communicable disease of public health significance, which shall include infection with the etiologic agent for acquired immune deficiency syndrome is inadmissible.

There is an HIV waiver under section 212(g) of the INA. **You must have a qualifying relative:** spouse, parent, or son/daughter who is a LPR or USC. If you do not have a qualifying relative, you do not qualify for the HIV waiver.

Refugee's, legalization and SAW applicants do not need a qualifying relative for the HIV waiver. These programs provide a discretionary waiver for humanitarian purposes, to assure family unity, or when it is otherwise in the public interest.

Registry, Suspension of Deportation/Cancellation of Removal, NACARA (nationals of El Salvador, Guatemala, and specified former Soviet bloc countries) do NOT require waiver.

You may be denied entry as an immigrant and as a non-immigrant. There is no blood test when you come in as a non-immigrant, however, there is a question on the application which asks whether you have a communicable disease of public health significance. There is a waiver for non-immigrants.

Adjusting your status to that of a lawful permanent resident (LPR), also known, as "green card" holder is an admission "entry". You must be an admissible alien in order to be admitted to the United States as a LPR. There is a blood test when you apply to become an LPR.

Note: it does not matter whether you were infected in the U.S. or abroad. It does not matter whether the virus is undetectable; you still need an HIV waiver. However, being undetectable may be helpful in the public charge determination. HIV is NOT a problem in naturalization cases.

A. Requirements for HIV Waiver under 212(g) of the INA

1. Must have a qualifying relative (spouse, parent, son or daughter of LPR or USC)
2. Must demonstrate that if admitted to the U.S. the danger to the public health of the United States created by his or her admission is minimal; the possibility of the spread of the infection created by his or her admission is minimal; and there will be no cost incurred by any level of government agency of the United States without prior consent of that agency. See INS Memorandum on HIV-Related Waivers, Sept. 6, 1995 HQ 212.3P.
3. Factors considered sufficient to meet the discretionary criteria include but are not limited to:
 - evidence that the applicant has arranged for medical treatment in the United States;
 - the applicant's awareness of the nature and severity of his or her medical condition;
 - the applicant's willingness to attend educational seminars and counseling sessions;
 - the applicant's knowledge of the modes of transmission of the disease; and
 - formal consent by a U.S. government agency to provide medical treatment to the applicant.

- In refugee cases, proof that a hospital, research organization or other types of facility will provide care at no cost to the U.S. government, or proof of private insurance is also acceptable. See INS Memorandum on HIV Related Waivers.
- Applicants found excludable under 212(a)(1)(A)(i) of the Act as having a communicable disease of public health significance (HIV) can also be excludable under the public charge provisions of section 212(a)(4) of the Act.
- A determination whether to grant an HIV waiver and determination for public charge must be separate. A separate determination must be made for each.
- If you are applying abroad, the consular makes the public charge determination

B. Public Charge §212(a)(4) of the Act

- Section 212(a)(4) of the Act provides that an alien is excludable if he or she is likely to become a public charge at any time.
- There is no waiver for public charge.
- Public charge provisions do NOT apply to refugees.
- When determining public charge factor to consider are:
 1. whether the applicant has an offer of employment in the United States;
 2. whether the applicant is able to undertake the offered employment, as evidenced by a physician's assessment of his or her current medical condition;
 3. the applicant's own financial resources;
 4. the financial resources of the applicant's family members, if the applicant depends on family for his or her medical insurance covering all or part of the HIV-related expenses;
 5. whether the applicant has or is able to obtain, at an affordable cost, medical insurance covering all or part of the HIV related expenses; and
 6. whether the applicant is able to meet the basic living expenses, in addition to those medical costs associated with HIV. See INS Memorandum on HIV Related Waivers.
- Publicly funded medical treatment for HIV infection does NOT automatically render applicant excludable under public charge provision. If the applicant has received or intends to receive HIV related treatment a government financed facility, the applicant must submit evidence that such treatment is available and that the appropriate government agency has consented to the treatment. See INS Memorandum on HIV Related Waivers.

C. Checklist for HIV Waiver

- Form I-601 & INS attachment to Form I-601 ("TO BE COMPLETED WITH HIV INFECTION")
- Evidence of Qualifying Relative (birth certificate/naturalization certificate, green card, marriage certificate, etc.)
- Evidence of Medical Insurance (covering applicant's HIV condition)
- Physician's Letter/Healthcare Provider
- Social Worker/Counselor/Psychologist Letter
- Declaration from Applicant
- Declaration from Qualifying Relative/hardship

D. Disability Waivers for Naturalization Exam

- Persons who are physically or developmentally disable or have a mental impairment. 62 Fed.Reg.12, 915-23 (Mar. 19, 1997). The English language and the history and government requirements are waived for persons who are unable to comply with both requirements because they possess a physical or developmental disability or mental impairment. 8 C.F.R. §312.2(b)(1).
- A medical certificate from a medical doctor, osteopath, or clinical psychologist “experienced in diagnosing” these disabilities must complete an N648 to be filed with the N400 application.
- The person must still meet the moral character, residence, and other requirements and must be capable of taking and understanding the oath. Policy Memorandum No. 47 Pearson, Ex. Assoc. Comm., Field Operations (HQ 70/33-P) (Apr. 7, 1999) reprinted in 76 Interpreter Releases 693-711 (May 3, 1999).
- Applicant needs to file Form N648. Applicant prepares Part I. Licensed medical doctor, doctor of osteopathy, or clinical psychologist prepares Part II of the application. It is very important that the doctor provide his or her medical diagnosis of applicant’s impairment(s) in terms a person without medical training could understand.
- Doctor MUST make it clear why the applicant’s impairment(s) prevent the applicant the applicant from learning and/or demonstrating knowledge of the English and/or U.S. history and civics. The connections between the impairment must be clear and specific to the client. Do not use terms such as may or could. The doctor needs to be specific and not speculate as to what could happen to people with that condition. It is very helpful if you provide the doctor with a sample of an approved disability waiver application.
- File N648 (disability waiver) and N400 (Naturalization Application) together. Officer will not review the N648 application prior to the interview. Be prepared. If the N648 waiver is granted, the applicant can have the interview in their native language. Please bring an interpreter. Attorneys cannot serve as interpreters.
- If N648 waiver is denied, Officer will give applicant opportunity to proceed in English and take the U.S. history and civics exam or permit the applicant to re-file the N648 at the rehearing/re-examining interview scheduled 90 days later. Unfortunately, there is no way of knowing whether disability waiver will be granted. Applicant should attempt to study for exam in case waiver is denied and applicant wants to proceed in English.

Resources

- Kurzban’s Immigration Law Sourcebook, Ira J. Kurzban.
- Immigration & HIV Waiver Manual. Barristers AIDS Legal Services Project in collaboration with the HIV & AIDS Legal Services Alliance, Inc. Continuing Legal Education, Los Angeles County Bar Association January 22, 2003.

HIV AND IMMIGRATION: THE “PROs” OF BEING HIV-POSITIVE

Victoria Neilson

I. Asylum

- A. Standard: well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. 8 U.S.C. § 1101(a)(42)(A)
 1. Defining “membership in a particular social group”
 - a. Members share “common immutable characteristic” that they either cannot change or should not be required to change because such characteristic is fundamental to their individual identities. *Matter of Kasinga* Int. Dec. 3278 (BIA 1996)
 2. Defining “persecution”
 - a. Persecution v. hardship
 - (1) Persecution = harm or suffering inflicted by the government or by persons or organizations the government is unwilling or unable to control, and must be country-wide
 - (2) Hardship asylum
 3. Application must be filed within one year of last entry into U.S. or there must be “changed” or “extraordinary” circumstances which prevented filing
 - a. Recent HIV diagnosis as “changed” circumstance
 - b. Effects of HIV/AIDS as “extraordinary” circumstance
 4. Applicant must merit a favorable exercise of discretion
 5. Can apply for adjustment of status to legal permanent resident one year after grant of asylum
- B. One “reported” case of HIV based asylum 78 No. 3 Interpreter Release 233 January 15, 2001
 - a. Applicant from India; Immigration Judge granted asylum b/c
 - (1) Applicant was in particular social group of “married women in India who have contracted HIV, who fear that their families will disown them or force them to get a divorce, and who wish to or need to be employed.”
 - (2) India Supreme Court prohibited people w/ AIDS from marrying and imprisons those who violate the law
 - (3) Extreme stigmatization and job loss b/c of HIV status
 - (4) INS argued lack of medical care to U.S. standard and possibility of social ostracism do not rise to persecution standard
- C. Related forms of relief

1. Withholding of removal 8 USC § 1231(b)(3)
 - a. Higher standard, “more likely than not” to suffer persecution
 - b. Mandatory, not discretionary
 - (1) No one year filing deadline
 - (2) Available in spite of criminal convictions (as long as they’re not “particularly serious” crimes)
 - c. No ability to adjust status to legal permanent resident (possibility of return to country if conditions change)
 2. Temporary Protected Status
 - a. Blanket, temporary designation for nationals of particular countries where there are natural disasters, civil wars, or other calamities temporarily preventing nationals from returning
 - b. HIV waiver required, but can be based on “humanitarian” grounds, i.e. no need for qualifying relative or supporting medical documentation
- D. Asylee adjustment of status
1. No requirement for qualifying immediate relative
 2. No requirement to prove unlikely to become a public charge
 - a. Haitian Refugee Immigration Fairness Act
 - b. Nicaragua and Cuban Adjustment Act

II. Convention against Torture Relief

- A. Standard: alien must be “more likely than not” to face torture by or with the acquiescence of the government; no necessity to be “on account of” HIV status
- B. Complies with international law – no denial for criminal activity
- C. At least one unreported case of relief granted based on HIV
 1. Applicant was legal permanent resident from Haiti
 2. Long criminal history (drugs; robbery; parole violations)
 3. Applicant was HIV positive for over 10 years, drug resistant, required experimental drug regimen
 4. Immigration Judge (“IJ”) found that since applicant would be detained by Haiti upon his return, would not receive clean food and water, would be at great risk for tuberculosis, and

would not receive life-sustaining medical treatment, his return would be a death sentence

5. IJ also noted that there are no special provisions made in prisons for people with HIV, “end result of detaining people in grossly substandard detention facilities with HIV/AIDS causes those people to suffer from a needlessly speedy and painful death.” “To return the Respondent to Haiti would inevitably result in him dying a torturous death in a detention center, where he would be denied medical treatment and even clean food and water. This Court has no doubt that such an act is torture.”

III. Cancellation of Removal

- A. Standard: physically present in U.S. for at least 10 years; good moral character for 10 years; no serious criminal convictions; must establish that alien’s removal would result in exceptional and extremely unusual hardship to their spouse, parent or child, who is a U.S. citizen or legal permanent resident. 8 USC 1229(b)(1)(D)
 1. Prior law – Suspension of Deportation
 - a. Standard: 7 years physical presence; good moral character for 7 years; extreme hardship to *self* or spouse, parent or child who is a U.S. citizen or legal permanent resident.

IV. Humanitarian Relief/Permanently Residing Under Color of Law (“PRUCOL”)

- A. Prior law – Pre-1996 Extended Voluntary Departure
 1. Standard: physically present for 2 years; good moral character; fatal illness
- B. Deferred Action
 1. No legal standard; entirely discretionary with District Director
 2. Factors to be considered include:
 - a. Likelihood of ultimately removing the alien;
 - b. Presence of sympathetic factors;
 - c. Likelihood of adverse publicity
 - d. Whether alien falls under high enforcement priority
- C. Prosecutorial Discretion

5. Useful Links

- www.lgirtf.org – provides information and technical assistance on HIV and immigration nationally
- <http://www.nationalimmigrationproject.org/HIV/HIV.htm> – valuable online manual on HIV and U.S. immigration law
- <http://www.worldpolicy.org/globalrights/gayindex.html> – report on treatment of sexual minorities and people with HIV in the Americas
- <http://www.asylumlaw.org> – great resource for asylum cases in general

Housing

The HOPWA Due Process Requirement

Michelle Gilbert

I. The Law

A. The Statute

In 1990, Congress created the AIDS Housing Opportunities Act, commonly called “HOPWA,” to provide states and localities with the resources and incentives to devise long-term comprehensive strategies for meeting the housing needs of persons with AIDS and their families. 42 U.S.C. § 12901, et seq.

B. Legislative History

The Senate Report accompanying the legislation recognized the special challenges of the often substance-involved, mentally ill and homeless people who would benefit from the housing assistance under HOPWA and related acts. The Report stated: “Recipients, especially with the assistance of their service providers, would be expected to do as much as possible to ensure that an individual’s assistance is terminated only in the most severe cases. The [Senate ...] Committee intends that reasonable efforts be made to intervene before terminating assistance... .” Senate Report 101-316, 1990 U.S. Code Cong. and Adm. News 5763, 5934.

Note that HOPWA and Shelter+Care, a similar statute that provides housing and supportive services to low income individuals, including people living with HIV/AIDS [42 U.S.C. § 11403, et seq.] were parts of the same legislation until near to the end of the legislative process. Legislative history and interpretation should be similar for both.

C. Regulations

The regulations provide that service providers may terminate HOPWA assistance for either of two reasons: that the grace period for a surviving family member of a HOPWA participant has elapsed and for the “violation of requirements.” 24 C.F.R. §§ 574.310(e)(1) and (2). The HOPWA regulations do not require that housing providers follow due process when terminating assistance because of the end of the grace period (24 C.F.R. § 574.310(e)(1)) but do require that housing providers follow due process when terminating assistance because of the “violation of requirements” (24 C.F.R. § 574.310(e)(2)). Specifically, the regulations provide that:

Violation of requirements -- (i) Basis. Assistance to participants who reside in housing programs assisted under this part may be terminated if the participant violates program requirements or conditions of occupancy. Grantees must ensure that supportive services are provided, so that a participant’s assistance is terminated only in the most severe cases.

(ii) Procedure. In terminating assistance to any program participant for violation of requirements, grantees must provide a formal process that recognizes the rights of individuals receiving assistance to due process of law. This process at minimum, must consist of:

(A) Serving the participant with a written notice containing a clear statement of the reasons for termination;

(B) Permitting the participant to have a review of the decision, in which the participant is given the opportunity to confront opposing witnesses, present written objections, and be

represented by their own counsel, before a person other than the person (or a subordinate of that person) who made or approved the termination decision; and

(C) Providing prompt written notification of the final decision to the participant.

24 C.F.R. § 574.310(e)(2) (emphasis added).

D. Regulatory History

HUD published the HOPWA regulations in this form and HUD's response to public comment at 57 Fed. Reg. 61736 (December 28, 1992).

II. Legal Arguments

We were unable to find any decision that examined the HOPWA due process requirement prior to the decision in our case, Cotton v. Alexian Bros. Bonaventure House, 2003 U.S. Dist. LEXIS 11721 (N.D. Ill. July 7, 2003)(described below). Plaintiff's arguments were based on opinions from other areas of housing law.

A. Private Right of Action

The judge mentioned but did not decide this issue in Cotton.

"A court's role in discerning whether personal rights exist in the § 1983 context should ... not differ from its role in discerning whether personal rights exist in the implied right of action context. ... Both inquiries simply require a determination as to whether or not Congress intended to confer individual rights upon a class of beneficiaries. ... For a statute to create such private rights, its text must be 'phrased in terms of the persons benefitted.'" Gonzaga University v. Doe, 536 U.S. 273, 284-85 (2002)

Gonzaga, which seemed to limit private rights of action and denied that one existed under the act at issue, did not overrule Wright v. Roanoke Redevelopment & Housing Authority, 479 U.S. 418 (U.S. 1987), which had found a private right of action to enforce the rent limitations in the U.S. Housing Act of 1937. The Gonzaga plaintiff had asserted a private rights of action based on the "individualized right to withhold consent and prevent the unauthorized release of personally identifiable information in education records by an educational institution that has a policy or practice of releasing, or providing access to, such information." The Court stated that this "is a far cry from the sort of individualized, concrete monetary entitlement found enforceable in ... Wright." Gonzaga, 536 U.S. at 284, n.4.

In Rolland v. Romney, 318 F.3d 42, 52-53 (1st Cir. 2003), the court found a private right of action to enforce the Nursing Home Reform Amendments to the Medicaid law, 42 U.S.C. § 1396r because that statute was written largely in terms of the persons intended to be benefitted. The court stated "'rights-creating language' can be characterized as language that 'explicitly confers a right directly on a class of persons that include the plaintiff.'" Cannon, 441 U.S. at 690 n.13. Rights-creating language has also been found in provisions that identify "'the class for whose especial benefit the statute was enacted.'" Id. at 688 n.9 (quoting Texas & Pacific Ry. Co. v. Rigsby, 241 U.S. 33, 39 (1916)). Statutory language that protects the general public, such as that customarily found in criminal statutes, or that is simply a ban on discriminatory conduct by recipients of federal funds, is far less likely to imply a private remedy than rights-creating language."

See also Wallace v. Chicago Housing Authority, 03 C 0491, 2003 U.S. Dist. LEXIS 23304 (N.D. Ill. December 23, 2003)(finding private right of action under Fair Housing Act, Quality Housing and

Work Responsibility Act, and Executive Orders 11063 and 12892) and Kapps v. Wing, 283 F. Supp. 2d 866, 880 (E.D.N.Y. 2003)(finding private right of action, enforceable through Section 1983, under Home Energy Assistance Program). Note also that “[a]dministrative regulations can create rights under § 1983, when they have the force of law and meet the Blessing criteria. The statute pursuant to which they have been enacted may or may not confer rights under Blessing. The phrase ‘laws’ in § 1983 refers to any valid source of federal law that creates rights. Langlois v. Abington Housing Authority, 234 F. Supp. 2d 33, 49 (D. Mass. 2002).

B. Inadequacy of Post-Deprivation Hearing

Cotton did not assert that Bonaventure House had committed a constitutional violation, but we relied on a variety of cases that considered due process.

The essence of due process is notice of a deprivation and an opportunity to be heard in order to prevent, if possible, a wrongful deprivation. “Parties whose rights are to be affected are entitled to be heard; and in order that they may enjoy that right they must first be notified.” Fuentes v. Shevin, 407 U.S. 67, 80 (1972); McKenzie v. City of Chicago, 973 F. Supp. 815, 817 (N.D. Ill. 1997); Kennedy v. Village of Oak Lawn, 99 C 7917, 2000 U.S. Dist. LEXIS 16783 (N.D. Ill. Nov. 14, 2000). The Supreme Court has excused a lack of pre-deprivation notice and hearing only when the deprivation is “random and unauthorized” and an adequate post-deprivation remedy exists. Parratt v. Taylor, 451 U.S. 527, 541 (1981); Hudson v. Palmer, 468 U.S. 517, 533 (1984). Post-deprivation remedies, however, are inadequate when: (1) the deprivation is foreseeable or predictable; (2) pre-deprivation process is possible and practicable; and (3) the conduct is not unauthorized. Zinermon v. Burch, 494 U.S. 113, 136 (1991).

Courts have determined that the need for pre-deprivation notice and hearing is particularly important when a tenant may be dispossessed from his or her home. “Courts, following the guidance of Goldberg [v. Kelly], 397 U.S. 254 (1970)], have held that in the case of public housing, as in the case of welfare benefits, a pre-termination hearing must be held before eviction from public housing projects. Improper denial of the benefit cannot be corrected easily at a later date, therefore, due process protection must be afforded.” Anast v. Commonwealth Apartments, 956 F. Supp. 792, 799 (N.D. Ill. 1997). See also Mananioba v. Fairmont Housing Authority, No. 90-3098, 1991 U.S. App. LEXIS 507 (4th Cir. 1991)(unpublished opinion)(applying Zinermon, the court held that due process required pre-deprivation notice and hearing to evict the family of a former tenant “because the risk of erroneous eviction...was foreseeable,...pre-deprivation process was possible, and ...the state had delegated to these defendants the power to effect the very deprivation complained of”).

Courts recognize that wrongfully depriving a poor person of housing is particularly serious because the person may not be able to afford any other decent housing. Caulder v. Durham Housing Authority, 433 F.2d 998, 1003 (4th Cir. 1970), cert. denied, 401 U.S. 1003 (1971). The Caulder court also noted that a post-deprivation hearing may be an inadequate remedy because the need for low income housing is so great that another resident may have moved into the property while the ousted tenant waited for the post-deprivation hearing. Id.

C. The Cotton case

In the fall of 2002, Bonaventure House, a HOPWA-funded agency that provides housing and other services to people living with AIDS, told their residents Gregory Cotton and Emory Bolden (in unrelated incidents) that they had to leave the premises that afternoon or it would call the Police. (In their lawsuits, Mr. Cotton and Mr. Bolden chose to proceed under their own names rather than fictitious names.) It did not provide the residents with pre-termination written notice or hearing and did not file an action in circuit court to get an eviction order. It did these things pursuant to its written

Involuntary Discharge Policy. Cotton, then Bolden, filed separate cases in federal court, which were later joined as related cases. The plaintiffs alleged that the actions against them and the Involuntary Discharge Policy violated HOPWA, the Illinois Supportive Residences Licensing Act, the Illinois Forcible Entry and Detainer Act and the Chicago Residential Landlord Tenant Ordinance and intentionally caused Plaintiffs emotional distress. The plaintiffs requested a declaratory judgment that the actions and the written Involuntary Discharge Policy violated these acts; a temporary and permanent injunction preventing Bonaventure from engaging in these actions or enforcing its Involuntary Discharge Policy and money damages for intentional infliction of emotional distress. Both plaintiffs secured temporary restraining orders that required Bonaventure House to reinstate their residency. The matter was briefed on cross-motions for summary judgment.

Bonaventure House conceded that it received HOPWA funds and was bound by the HOPWA regulations. It argued that (1) that the wording of the regulation meant that HUD required due process for terminations based on violations of requirements, but not conditions of occupancy and (2) its Involuntary Discharge Policy, and the specific applications of the Policy to Mr. Cotton and Mr. Bolden, comply with due process.

The court rejected Bonaventure House's argument that it had to provide due process for violation of requirements but not conditions of occupancy. The court stated that: "There is no basis to read the regulation's use of the two different terms-'requirements' and 'program requirements'-to mean the same thing." and "[i]f, as Bonaventure contends, a program participant's minimum due process rights under HOPWA were meant to depend on whether the participant is terminated for violating a "program requirement" as opposed to a "condition of occupancy," it is reasonable to believe that the regulation would have offered some guidance as to the kind of rules that fall in to each category. Otherwise, a HOPWA grantee like Bonaventure could avoid its due process obligations each time it discharged a participant by simply characterizing the basis for termination as a violation of a condition of occupancy rather than a program requirement.

The court refrained from holding that the Involuntary Discharge Policy violated due process as a matter of law. Specifically, the court was concerned that "in situations where a particular resident's behavior is alleged to pose an imminent threat to the safety of others, [Bonaventure House] has a legitimate interest in removing the dangerous resident immediately. Under such circumstances, it may be impracticable to provide the formal hearing contemplated by HOPWA's implementing regulations until after the resident has been removed from the premises."

Instead, the court held that "in determining the proper timing of the written notice and hearing guaranteed by HOPWA's implementing regulations, we should consider the extent to which HOPWA grantees require the flexibility to make quick decisions regarding their program participants, the general feasibility of providing pre-deprivation process, the consequences to program participants of losing their assistance, and the adequacy of a written notice and hearing after termination of a program participant's benefits." The court concluded that Bonaventure House had violated HOPWA's due process requirement by failing to provide written notice of termination, but withheld decision on whether it had violated the due process requirement by failing to hold a pre-termination hearing.

As discussed briefly below, the court initially rejected the plaintiffs' arguments that Bonaventure House had violated state and municipal law. Plaintiffs filed a motion for reconsideration and the court reversed that part of the decision. The parties settled by agreeing to a new discharge policy (attached to this outline) and a monetary settlement.

D. State Law Claims

The Plaintiffs also asserted violations of state and municipal anti-lockout laws. Before analyzing those statutes, however, the plaintiffs had to argue that federal law did not pre-empt the application of state and local law.

1. Preemption. Although state laws that are contrary to federal laws will not stand, courts apply a strong presumption against federal preemption of state and local laws. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645 (1995); Johnson v. Wing, 12 F. Supp. 2d 311, 317 (S.D.N.Y. 1998), aff'd, 178 F.3d 611 (2d Cir. 1999). This presumption is particularly strong in fields traditionally occupied by the states [New York State Conference, 514 U.S. at 654-55], such as landlord-tenant law. Rowe v. Pierce, 622 F. Supp. 1030, 1033 (D.D.C. 1985); Topa Equities, Ltd. v. City of Los Angeles, CV 00-10455, 2002 U.S. Dist. LEXIS 10194 (C.D. Cal. April 8, 2002)(holding that federal law concerning pre-payment of housing subsidy loan guarantees did not preempt City of Los Angeles rent stabilization ordinance). A federal law may preempt a state law by **express provision, implication** or “occupying the field” or **conflict** between the federal and state law

The HOPWA statute does not contain an express preemption provision. In fact, the HOPWA statute and regulations require grantees to follow certain local laws. HOPWA provides that any HOPWA-funded construction or improvements to community residences must comply with applicable State and local housing codes and licensing requirements. 42 U.S.C. § 12910(d)(1)(C). The HOPWA regulations further require that grantees must comply with State and local housing codes, licensing requirements and any other requirements in the jurisdiction “regarding the operation of the housing.” 24 C.F.R. § 574.310(b)(1)(emphasis added).

Federal legislation implicitly preempts state or local law when it so thoroughly occupies the field in a particular area that it is reasonable to assume that no state or local regulation is possible. HOPWA, specifically, is not “a case where a national administrator surveys the problem of varying state approaches and concludes a national policy is necessary.” Kargman v. Sullivan, 552 F.2d 2, 6 (1st Cir. 1977). HOPWA’s stated purpose “is to provide States and localities with the resources and incentives to devise long-term comprehensive strategies.” 42 U.S.C. § 21901. Thus, state and local governments enjoy the preeminent position of devising and implementing housing strategies while the federal role is financing those strategies.

Finally, requiring HOPWA grantees to follow state and local landlord tenant law creates no conflict with Congressional intent. Congress passed HOPWA to alleviate the problems caused by homelessness among people with HIV. See Statement of Member of Congress Nancy Pelosi, an original HOPWA co-sponsor (H.R. 3423, 1990), indicating that the AIDS housing provisions were designed to address the special housing needs of people with AIDS with programs to prevent homelessness and provide short-term and permanent housing to “enhance the quality of life for people with AIDS.” 136 Cong. Rec. 34136 (October 25, 1990).

2. Illinois Anti-Lockout Provisions. The Illinois Forcible Entry and Detainer Act provides the sole means for settling a dispute over the possession of real property when a person has peaceably entered the property. The Act requires prior written demand, service of process and an opportunity for a hearing in municipal court. See 735 ILCS 5/9-104, 9-108, 9-210; Illinois Supreme Court Rule 101(b); Gordon v. Degelmann, 29 F.3d 295, 300 (7th Cir. 1994)(“In Illinois a person residing in a dwelling under a claim of right is entitled to the judicial hearing afforded by the forcible entry and detainer statute before he may be removed as a trespasser”); Russell v. Howe, 688 N.E.2d 375, 379 (Ill. App. 1997); Quincy v. Daniels, 615 N.E.2d 839, 842 (Ill. App. 1993); People v. Evans, 516 N.E.2d 817 (Ill. App. 1987).

**AIDS AND HOMELESSNESS IN NEW YORK CITY:
THE RIGHT TO MEDICALLY APPROPRIATE EMERGENCY HOUSING**

Armen Merjian

I. HOMELESS LAW AND LITIGATION IN NEW YORK CITY

- A. City's duty to provide homeless New York City residents with emergency housing in general established through litigation. Specifically, in 1981, the City signed a consent decree agreeing to provide indigent, homeless New York City residents with emergency housing in the case of Callahan v. Carey (Sup. Ct., NY Co. Index No. 42582/79). See, e.g., Wilkins v. Perales, 128 Misc. 2d 265, 267 487 N.Y.S.2d 961, 963 (Sup. Ct., N.Y. Co. 1985) ("After two years of negotiations and with the aid of the court (Wallach, J.) a consent judgment was entered into by the representatives of the homeless, the city and the State. By its terms the judgment requires the city to provide shelter and board for each homeless man who applies for it.").
- B. Obligation later extended to homeless women and families. See Eldredge v. Koch, 98 AD2d 675, 469 N.Y.S.2d 744 (1st Dept 1983); McCain v. Koch, 70 NY2d 109, 517 N.Y.S.2d 918, 511 N.E.2d 62 (1987), Barnes v. Koch, 136 Misc 2d 96, 518 N.Y.S.2d 539 (Sup Ct, NY Co. 1987); Mixon v. Grinker, 212 A.D.2d 183, 627 N.Y.S.2d 668 (1st Dep't 1995), rev'd on other gds, 88 N.Y.2d 907, 646 N.Y.S.2d 661 (1996) (citations omitted).
- C. In 1997, the New York City Council passed Local Law 49, which mandates that the City must provide homeless residents who qualify for public assistance with medically-appropriate emergency housing. New York City Administrative Code § 21-126 to 21-128. Local Law 49 defines medically-appropriate "transitional" housing as "housing which is suitable for persons with severely compromised immune systems, and if necessary, accessible to persons with disabilities as defined in section 8-102 of this code. Such housing shall include, but not be limited to, individual refrigerated food and medicine storage and adequate bathroom facilities which shall, at a minimum, provide an effective locking mechanism and any other such measures as are necessary to ensure privacy." N.Y. City Admin. Code § 21-128(a)(4).
- D. The Right to Same-day Placement: Hanna v. Turner. In 1999, in an unpublished decision, the New York State Supreme Court (i.e. the trial court) established that homeless and indigent clients living with AIDS must be placed in medically-appropriate emergency housing on the same day that they request such housing. Hanna v. Turner, 98 Civ. 111105 (N.Y. Sup. Ct., Nov. 15, 1999). This obligation was later enforced through a contempt proceeding, upheld on appeal. Hanna v. Turner, 289 A.D.2d 182, 735 N.Y.S.2d 513 (1st Dep't 2001) (upholding contempt order against city officials for failing to provide same-day emergency housing to homeless individuals with AIDS).

II. WINDS V. TURNER: THE RIGHT TO MEDICALLY APPROPRIATE EMERGENCY HOUSING

- A. The Crisis
1. 1997 Report: A 1997 report, commissioned by the New York City Mayor's Office but only released in 1998, chronicled horrifying conditions in the single room occupancy hotels ("SROs") that the City utilizes to house homeless living with AIDS. These conditions included: grossly unsanitary conditions; lack of refrigerated food and medicine storage; and lack of access (non-ambulatory and semi-ambulatory residents were often given rooms on the middle and upper floors of the SROs).

2. The Comptroller's Report: an October 1998 report by the Office of the Comptroller of the City of New York similarly chronicled the hazardous conditions to which homeless residents living with AIDS were being subjected in the SROs.

B. Wright v. Giuliani, federal class action suit challenging these conditions filed in 1999.

1. Seven class plaintiffs alleged horrifying conditions.
2. Lawsuit based upon ADA/Rehab Act and local law.
3. Simple theory: severely immuno-compromised residents require reasonable accommodations/modifications to the housing program in order to ensure "meaningful access" and enjoyment, and use of those programs, including: individual refrigeration for AIDS medication and fresh food; elevator buildings or first-floor placements; clean linens and sheets weekly; rodent- and pest-free accommodations; properly-cleaned bathrooms, etc.

E. The impasse

1. District Court decision: Wright v. Giuliani, 99 Civ. 10091, 2000 U.S. Dist. LEXIS 8322 (S.D.N.Y. June 14, 2000). Court denies City's motion to dismiss but also denies preliminary injunction on the grounds that the plaintiffs must first proffer evidence comparing their housing to that provided to the "able-bodied" homeless in order to show discrimination, i.e. through disparate treatment claim. This is plainly wrong under established ADA/Rehab Act law. In any event, the district court did not reach, and in no way impeached, the merits of the Wright plaintiffs' claims under the federal disability statutes. As the Second Circuit explained: "There can be no suggestion that the district court has predetermined plaintiffs' merits case . . ." Wright, 230 F.2d 543, 549 n.1 (2d cir. 2000) (emphasis added).
2. Second Circuit decision: Instead of addressing the merits of the case, and the district court's erroneous insistence upon proof of disparate treatment, the Second Circuit remanded the case for evidence establishing that plaintiffs sought access to the same housing program provided to all in New York City, a fact never in dispute in the case. Wright v. Giuliani, 230 F.2d 543 (2d Cir. 2000).
3. The parties briefly suspended litigation pending a decision clarifying the ADA/Rehab Act standards in the analogous case of Henrietta D. v. Giuliani; when that litigation was postponed, and before the merits of the ADA and Rehab Act claims could be reached, on October 4, 2001, Plaintiffs withdrew the federal case (without prejudice) and refiled in state court under the local law.
4. Postscript re Henrietta D. v. Giuliani: in a landmark decision, the Second Circuit last year unanimously rejected the notion that plaintiffs suing under the ADA/Rehab Act must show disparate treatment, establishing that the failure to provide reasonable accommodations is itself a form of actionable discrimination. Henrietta D. v. Bloomberg, 331 F.3d 261 (2003). The district court decision is most elucidating: 119 F. Supp. 2d 181 (E.D.N.Y. 2000); see also 81 F.Supp. 2d 425 (E.D.N.Y. 2000).

C. Winds v. Turner filed in 2001

1. The facts: rodents, lack of access, filthy conditions, etc.
2. The claim: Local Law 49

3. The decision: On September 11, 2002, Judge Eileen Bransten of the New York State Supreme Court ruled in favor of the Plaintiffs. “Petitioners’ statements,” Judge Bransten ruled, “establish that their housing is not suitable for healthy individuals, much less for ‘persons with severely compromised immune systems.’” Judge Bransten explained that “housing that is not habitable because of vermin, filth, lack of furnishings and inaccessibility, certainly cannot be considered ‘suitable.’” Judge Bransten found the facilities provided to petitioners by HASA “deficient in several respects,” including “the presence of rodents and roaches”; “failure to provide minimal essential furnishings and amenities, such as mattresses, clean usable linens and ample toilet paper render[ing] the housing unsuitable”; placing clients “on high floors of non-elevator buildings for extended periods of time notwithstanding their medically-motivated requests for low-floor housing”; lack of “individual operating refrigerators” required by law for food and medicine storage; and “woefully inadequate” bathroom services.
4. Among other things, the Judge ordered the City to provide the petitioners “suitable and appropriate furnishings and amenities”; accessible rooms where non-elevator buildings are used; “usable” bathrooms that are “consistently maintained and cleaned”; “operational utility services”; placements that are “free of vermin;” and individual operating refrigerators, without which “there is a strong possibility – and in the summer months, a likelihood – that critical life-sustaining medications, nutritional supplements and food will spoil.”
5. As a result of the lawsuit, the City agency responsible for housing homeless clients living with AIDS has also hired and deployed inspectors to inspect conditions at the SROs utilized, and they have established a complaint hotline to respond to complaints and requests for emergency relocation.

Although Winds was brought under local law, it is persuasive authority regarding some of the minimum protections that PWAs require in emergency housing, and potentially of use for plaintiffs suing under the ADA/Rehabilitation Act.

Sexual Health and Sex Education Issues

A Brief History of Abstinence-Only-Until-Marriage Programs in the U.S.

Bill Smith

Abstinence-only-until-marriage education has been taught for over two decades and yet there is still no peer-reviewed research that proves it is effective. Government funding of abstinence-only-until-marriage programs is not new. In fact, the federal government has poured large sums of money into such programs for the past 20 years.

AFLA: The Birthplace of Abstinence-only Programs

The U.S. Office of Population Affairs began administering the Adolescent Family Life Act (AFLA) in 1981. This program was designed to prevent teen pregnancy by promoting chastity and self-discipline.[1] During its first year, AFLA received \$11 million in federal funds. In fiscal year 2000, AFLA received \$19 million.

AFLA's early programs taught abstinence as the only option for teens and often promoted specific religious values. As a result, the American Civil Liberties Union filed suit in 1983 charging that AFLA violated the separation of church and state as defined in the U.S. Constitution. In 1985, a U.S. district judge found AFLA unconstitutional. On appeal in 1988, the U.S. Supreme Court reversed that decision and remanded the case to a lower court.[2]

Finally, an out-of-court settlement in 1993 stipulated that AFLA-funded sexuality education programs must: (1) not include religious references, (2) be medically accurate, (3) respect the "principle of self-determination" regarding contraceptive referral for teenagers, and (4) not allow grantees to use church sanctuaries for their programs or to give presentations in parochial schools during school hours.[3] Within these limitations, AFLA continues to fund abstinence-only programs today.

Abstinence-only-until-marriage education as defined in AFLA has been taught for over two decades and yet there is still no peer-reviewed research that proves it is effective in changing adolescents' behavior. To the contrary, a meta-evaluation of AFLA program evaluations found them "barely adequate" to "completely inadequate." [4]

Congress Institutes Similar Programs through Doolittle Amendment

The first Congressional attempt to censor sexuality education using an abstinence-only provision came in 1994 during the reauthorization of the Elementary and Secondary Education Act. Representative John Doolittle (R-CA) introduced an amendment to limit the content of HIV-prevention and sexuality education in school-based programs.

Fortunately, four federal statutes required alterations to the Doolittle amendment. The Department of Education Organization Act (Section 103a), the Elementary and Secondary Education Act (Section 14512), Goals 2000 (Section 319 (b)), and the General Education Provisions Act (Section 438) all prohibited the federal government from prescribing state and local school curriculum standards.

Proponents of abstinence-only programs learned from this that even though they could not legally restrict state and local education programs that they could restrict and define the scope of state and local health policy and funding. They applied their new-found lesson in 1996.

Federal Entitlement Program Promotes Abstinence-only-until-marriage

That year, the federal government attached a provision to the popular welfare-reform law establishing a federal entitlement program for abstinence-only-until-marriage education.

This entitlement program, Section 510(b) of Title V of the Social Security Act, funneled \$50 million per year for five years into the states. Those states that choose to accept Section 510(b) funds are required to match every four federal dollars with three state-raised dollars and then disperse the funds for educational activities.[5]

Programs that use the funds are required to adhere to a strict eight-point definition, which, among other things, requires them to teach that "sexual activity outside of marriage is likely to have harmful psychological and physical effects."^[6] (The complete definition is on page 11.) The section 510(b) abstinence-only-until-marriage funds are up for reauthorization in 2001.

Other Federal Abstinence Legislation

Since inception, over a half billion tax dollars have been spent on abstinence-only-until-marriage programs. In November 1999, opponents of comprehensive sexuality education, family planning, and reproductive rights began a process that successfully secured an additional 50 million federal dollars for abstinence-only-until-marriage programs over the next two years. Although these funds are not part of Section 510(b), they are only available for programs that conform to the strict eight-point definition in 510(b).^[7]

These funds are awarded directly to state and local organizations by the Maternal and Child Health Bureau through a competitive grant process instead of through state block grants as is the case for 510(b) funds. Many viewed this decision as an attempt by conservative lawmakers to control the funding and prevent money from supporting media campaigns, youth development, and after-school programs that they saw as diluting the abstinence message.^[8]

[1] R. Saul, "Whatever Happened to the Adolescent Family Life Act?," The Guttmacher Report on Public Policy, vol. 1, no. 2, April 1998.

[2] Ibid.

[3] D. Daley, "Exclusive Purpose: Abstinence-Only Proponents Create Entitlement in Welfare Reform," SIECUS Report, April/May 1997.

[4] C. Bartels, et. Al., Adolescent Abstinence Promotion Programs: An Evaluation of Evaluations. (Paper presented at the Annual Meeting of the American Public Health Association, Nov. 18, 1996, New York, NY.)

[5] Daley, "Exclusive Purpose" SIECUS Report, April/May 1997.

[6] Section 510, Title V of the Social Security Act (Public Law 104-193).

[7] W. Smith, "Public Policy Update: More Federal Funds Targeted for Abstinence-Only-Until-Marriage Programs," SIECUS Report, June/July 2000.

[8] Ibid. How the money is spent: Currently, almost \$200 million federal dollars are spent each year on abstinence-only-until-marriage education. Below are some examples of what young people are being taught. All of the examples come from curricula that are in some way supported by federal funds.

- "The first player spins the cylinder, points the gun to his/her head, and pulls the trigger. He/she has only one in six chances of being killed. But if one continues to perform this act, the chamber with the bullet will ultimately fall into position under the hammer, and the game ends as one of the players dies. Relying on condoms is like playing Russian roulette." *Me, My World, My Future, revised HIV material, p. 258.*
- "Because they generally become aroused less easily, females are in a good position to help young men learn balance in relationships by keeping intimacy in perspective." *Sex Respect, Student Workbook, p.6.*
- "Is it fair to make the baby die because of a bad decision his or her parents made?" *Sex Respect, Student Workbook, p.25.*
- "Conception, also known as fertilization, occurs when one sperm unites with one egg in the upper third of the fallopian tube. This is when life begins...even though he or she was only the size and appearance of a pencil dot, the baby was a separate, genetically unique individual" *FACTS, Middle School, Teacher's Guide, p. 23.*
- "THERE IS NO WAY TO HAVE PREMARITAL SEX WITHOUT HURTING SOMEONE." *Sex Respect, Student Workbook, p.35*
- "A specific blood test for Chlamydia can detect the presence of the disease." *Sex Respect, Student Workbook, p. 44.* (Chlamydia is a bacterial infection of the cervix or penis. It cannot be detected through a blood test.)

- "At the least, the chances of getting pregnant with a condom are 1 out of 6." *Me, My World, My Future, revised HIV material, p. 257.* (When used consistently and correctly condoms are 98 percent effective in preventing pregnancy and up to 99 percent effective in preventing the transmission of HIV and other STDs.)
- "A young man's natural desire for sex is already strong due to testosterone...females are becoming culturally conditioned to fantasize about sex as well." *Sex Respect, Student Workbook, p. 6.*
- "A woman is stimulated more by touch and romantic words. She is far more attracted by a man's personality while a man is stimulated by sight. A man is usually less discriminating about those to whom he is physically attracted." *WAIT Training, Workshop Manual, p. 40.*
- "Watch what you wear, if you don't aim to please, don't aim to tease." *Sex Respect, Student Workbook, p. 82.*
- One of the best ways to avoid AIDS is to "avoid homosexual behavior." *Sex Respect, Student Workbook, p. 25.*
- "The liberation movement has produced some aggressive girls today, and one of the tough challenges for guys who say no will be the questioning of their manliness" *Sex Respect, Student Workbook, p. 85.*
- Choosing the Best states that there are over 100,000 new cases of syphilis reported to the Centers for Disease Control and Prevention(CDC) each year. (*Student Manual, p. 14*) Sex Respect says "infectious syphilis rates have more than doubled among teens since the mid-1980s." (*Student Workbook, p. 36*) According to the CDC, 6,657 cases of primary and secondary syphilis were reported in 1999, the lowest annual number of cases reported since 1957.
- "There is no such thing as 'safe' or 'safer' premarital sex." *FACTS, Middle School, Teacher's Guide, p. 9.*
- "For condoms to be used properly, over 10 specific steps must be followed every time. This tends to minimize the romance and spontaneity of the sex act." *Choosing the Best, Student Manual, p. 25.* "What if a girl came to school in a crop top, just barely covering her bra, and shorts starting three inches below her naval? What 'game' would she be playing?" *WAIT Training, Workshop Manual, p. 86.*
- "How can girls make guys feel esteemed and admired for choosing the wise course?" *Facing Reality, Student Manual, p. 30.*

For Further Information:

The Sexuality Information and Education Council of the United States (SIECUS)

Public Policy Office

1706 R St NW

Washington, DC 20009

202-265-2405 Voice

202-462-2340 Fax

www.siecus.org

www.nonewmoney.org

www.ncsse.org

Youth at Risk:
LGBTQ Students Legal and Policy Responses
Mark Del Monte

Introduction and Background

- More than half of all new HIV infections occur in young people under the age of 25.
- More than 130,000 young adults in the United States have developed AIDS in their twenties, meaning they were infected in their teens.
- At least half of the HIV infections reported among young men 13-24 resulted from exposure to the virus through sex with other men.
- In one nationwide survey, over 83 percent of GLBT students reported verbal harassment at school. Seventy-four percent of transgender students reported sexual harassment. Over 21 percent of all GLBT youth reported being punched, kicked, or injured with a weapon at school because of their sexual orientation.

Legal and Policy Responses

Federal and State Litigation

CASE: **Nabonzy v. Podlesny, 92 F.3d 446 (7th Cir. 1996)**

FACTS: Harassment and physical abuse because of sexual orientation and sex, mock rape in front of 20 students, urinated on, put in special education, beaten by 8 students causing internal bleeding

CLAIMS: Equal Protection Clause; Due Process Clause

RESOLUTION: Settlement

MONETARY: \$962,000

CASE: **Flores v. Morgan Hill Unified School District (N.D. Cal.)**

FACTS: Suit brought on behalf of 6 former MHUSD districts who were subjected to daily harassment and threats of physical violence and actual physical violence on the basis of their real or perceived sexual orientation and gender.

CLAIMS: Equal Protection Clause, Title IX, state law claims

RESOLUTION: settlement

MONETARY: over \$1,100,000

INJUNCTIVE:

- Amendment of existing nondiscrimination policy to include sexual orientation and gender
- Training for all administrators, teachers, counselors, and other employees who monitor student behavior on harassment and discrimination on the basis of sexual orientation or gender identity
- Mandatory training for seventh and ninth graders on preventing anti-lgbt harassment and

discrimination

- District policies and student handbooks will be revised so that they expressly state that harassment and discrimination based on actual or perceived sexual orientation and gender identity is expressly prohibited under district policies and state law
- The district must keep written records of any complaints made concerning anti-lgbt harassment or discrimination

State Law:

- Safe schools laws. Eight states and the District of Columbia have passed legislation prohibiting harassment and discrimination based on sexual orientation.
- Example Statute:

CALIFORNIA CODES
EDUCATION CODE

220. No person shall be subjected to discrimination on the basis of sex, ethnic group identification, race, national origin, religion, color, mental or physical disability, or any basis that is contained in the prohibition of hate crimes set forth in subdivision (a) of Section 422.6 of the Penal Code [*§422.6(a) race, color, religion, ancestry, national origin, disability, gender, or sexual orientation, or because he or she perceives that the other person has one or more of those characteristics*] in any program or activity conducted by an educational institution that receives, or benefits from, state financial assistance or enrolls pupils who receive state student financial aid.

- Massachusetts Safe Schools Program

Local Interventions:

- Individual school district policies
- Gay-straight alliances (GSA's)
 - **Equal Access Act. Colin v. Orange Unified Sch. Dist.**, 83 F. Supp. 2d 1135, 1148 (C.D. Cal. 2000). If a public high school allows any student group whose purpose is not directly related to the school's curriculum to meet on school grounds during lunch or after school, it may not deny other student groups the same access to the school because of the content of their proposed discussions

Resource Documents

Advocates for Youth (2003). *GLBTQ Youth: At Risk and Underserved*

Cianciotto, J., & Cahill, S. (2003). *Education policy: Issues affecting lesbian, gay, bisexual, and transgender youth*. New York: The National Gay and Lesbian Task Force Policy Institute.

National Center for Lesbian Rights (2004) *Fifteen Expensive Reasons Why Safe Schools Legislation is in Your States Best Interest*

Office of National AIDS Policy (2000). *Youth and HIV/AIDS 2000: A New American Agenda*. Washington, DC.

Useful Websites

www.AIDS-Alliance.org -- AIDS Alliance for Children, Youth & Families

www.SIECUS.org -- Sexuality Information Education Council of the United States

www.NGLTF.org -- National Gay and Lesbian Task Force

www.AdvocatesforYouth.org -- Advocates for Youth

www.guttmacher.org -- Alan Guttmacher Institute

www.NFPRHA.org -- National Family Planning and Reproductive Health Association

www.GLSEN.org -- Gay Lesbian Straight Education Network

<http://www.hivinsite.ucsf.edu/> -- HIV InSite

www.michigan.gov/safeschools -- Michigan state safe schools website

www.nclrights.org -- National Center for Lesbian Rights

<http://www.doe.mass.edu/hssss/program/ssch.html> -- Massachusetts Safe Schools Program

www.gsanetwork.org -- Gay Straight Alliance Network

Advocacy for Youth in Foster Care and Detention Facilities

Catherine Hanssens

I. The Scope of the Problem: Youth at Risk

A. Statistics on HIV and young men

1. CDC 2000 study on younger gay men (Linda A. Valleroy, PhD, et al., and the Young Men's Study Group)(284 JAMA 198-204 (July 12, 2000) – surveyed MSM aged 15 to 22 years) HIV infection prevalence was 7.2%, lower in Seattle and higher in New York; prevalence was higher among blacks, Hispanics, and those of mixed race; highest among transgendered persons HIV prevalence was higher among men who reported anal sex, injecting drugs, having had an STD, *or having run away from home* 41% of all the men reported unprotected anal sex during the past 6 months Report concludes that the study findings “signal a critical and widespread public health problem and underscore a need to evaluate and intensify prevention efforts for young MSM.”
2. CDC (in a study reported in MMWR, January 14, 2000) found that most gay men with AIDS are men of color (1998 reported cases: 52% of men infected through gay sex are people of color). The report strongly suggests that while social and economic factors are associated with higher rates of sexual risk-taking behavior, *the stigma of being gay is catalytic in the spread of HIV among African Americans and Latinos*. Several studies over the years have noted the intersection not only of homophobia and discrimination against those with HIV, but also a connection between homophobia and increased risks and rates of HIV transmission.

II. State Foster Care Systems' Treatment of Queer Youth and Those At Risk of HIV Infection

A. Review of State Child Welfare Policies

1. Few if any states have a written policy concerning the provision of sound, comprehensive HIV/AIDS education for children in foster or residential care, and some have policies that are affirmatively harmful.
2. Most states have a policy for HIV testing of adolescents in foster care. These policies deal with one or more of the following issues: when to test; consent to testing; mandatory testing; treatment; counseling; non-discrimination; placement of HIV+ or at risk children; and confidentiality. Some states (e.g., CT, DE, KY, MA, MD, NH) make specific provision for children in state care to consent to HIV testing themselves -- either children who are over a certain age (12 or 14) or children who are capable of giving informed consent to testing. States without written policies have varied ways of dealing with HIV testing and consent. In North Dakota and Pennsylvania, for example, officials maintain that policy matters are dealt with at the county level, rather than at the state level. In Montana, foster care is dealt with by private agencies and there are no relevant guidelines governing these agencies' approach to HIV testing.
3. Few have any policy on the placement of adolescents who identify as lesbian or gay. While some officials indicate that if a child's sexual orientation came to the attention of a case-worker then it would be taken into account in placement decisions on a case-by-case basis, this obviously leaves a great deal of discretion with the case-worker, from the decision to even consider a child's sexual orientation and related placement needs to the judgment as to the appropriate family environment for a GLBT adolescent.

B. Addressing the Needs of At-Risk Youth in State Care -- The Need, the Challenges, and Some Strategies for Change

1. Sexual health and HIV prevention programming must be ongoing and recognize accurately and without judgment the full range of sexual orientation and gender identification issues. HIV prevention for gay youth must take place in a supportive environment, and deal with issues such as coming out, substance use, and with the development of skills and strategies for coping socially. Addressing the lack of prevention in state-regulated youth care facilities also must include the challenging task of eliminating the institutionalization of sexphobia, homophobia and heterocentrism in that system. As the Child Welfare League of America recognized more than a decade ago, "Child welfare agencies and their staff members have often been handicapped in their ability to properly meet the needs of this [LGBT] client group due to societal stigmatization, a lack of information, misinformation, and fear, and a consequent lack of understanding."
2. Marshall the facts: Research supports the soundness of science-based, gay-friendly programs and environments in promoting health and safety.
 - a. See, e.g., Dailard, C., *Understanding 'Abstinence' : Implications for Individuals, Programs and Policies*, THE GUTTMACHER REPORT ON PUBLIC POLICY (Dec. 2003)("To date, no education program focusing exclusively on abstinence has shown success in delaying sexual activity."); *Sex Education: Needs, Programs and Policies*, The Alan Guttmacher Institute (2003)(http://www.agi-usa.org/pubs/ed_slides.html)
 - b. See, e.g., Blake, S.M., et als., *Preventing Sexual Risk Behaviors Among Gay, Lesbian, and Bisexual Adolescents: The Benefits of Gay-Sensitive HIV Instruction in Schools*, 91 AMERICAN J. OF PUB. HEALTH 940, 944 (June 2001)(Gay-supportive school environment can reduce self-endangering activity by LGBT youth). See also Mallon, G., *Let's Get This Straight: A Gay and Lesbian-Affirming Approach to Child Welfare*, (Columbia Univ. Press, 2000); Mallon, G., *We Don't Exactly Get the Welcome Wagon: The Experiences of Gay and Lesbian Adolescents in Child Welfare Systems* (1998).
 - c. The Alan Guttmacher Institute (www.agi-usa.org), the Kaiser Family Foundation (www.kff.org), and SIECUS (www.siecus.org) are very useful resources for studies and information.

III. Some Strategies for Legal Challenges to States' Failure to Provide for the Protection of the Health of At-Risk Youth in State Care

A. State Laws Governing Adolescents' Autonomy in Consenting to Certain Kinds of Health Care Services

1. Most states have laws which allow mature minors to consent to treatment of sexually-transmitted diseases without consent of or notice to parents or

guardians. Many of these statutes do, or can be read to, include HIV-related testing and (at least to some extent) treatment.

2. Examples of state statutes and ages of consent:

State	STD (includes HIV unless otherwise noted)
Alabama	12 for treatment/testing (Ala. Code 22-11A-19)
Alaska	any age for testing (Alaska Stat. 09.65.100 (4))
Arizona	any age for testing (Ariz. Rev. Stat. Ann. 44732.01)
Colorado	14 (Colo. Rev. Stat. 13-22-105)
Delaware	HIV 12 (16 Del.C. § 1202)
Florida	discretion of medical provider for testing (Fla. Stat. ch. 384.30)
Louisiana	any age for treatment (La. Rev. Stat. Ann. 40:1095)
Minnesota	any age for testing (Minn. Stat. Ann. 144.343)
Montana	any age for possible infection with STD/HIV (Mont. Code Anno., § 41-1-402 (c))
Nebraska	any age for testing (Neb. Rev. Stat. 71-504)
Montana	any age for possible infection with STD/HIV (Mont. Code Anno., § 41-1-402 (c))
Nebraska	any age for testing (Neb. Rev. Stat. 71-504)
North Carolina	any age (N.C. Gen. Stat. 130A-148)
Texas	any age for diagnosis of infectious, contagious, communicable diseases, including HIV/AIDS (Texas Family Code Sec. 32.003)
Vermont	12 (Vt. Stat. Ann. Tit. 18, 4226)
Washington	14 (Wash. Rev. Code Ann. 70.24.110)

See *Alfonso v. Fernandez*, 195 A.D. 2d 46, 606 N.Y.S.2d 259 (2d Dep't 1993)(upholding challenge to school condom availability plan as a "health service" requiring parental consent under NY Pub.Hlth Law § 2504(1), and a violation of plaintiffs' due process right to parent without state interference, but distinguishing condom program from "talk or literature on the subject of sexual behavior"); *Curtis v. School Committee of Falmouth*, 420 Mass. 749, 652 N.E.2d 580 (1995)(criticizing

Alfonso and upholding similar condom availability program); *Brown v. Hot, Sexy and Safer Productions, Inc.*, 68 F.3d 525 (1st Cir. 1995); *Parents United for Better Schools v. School District of Phila.*, 68 F.3d 525 (3rd Cir. 1998).

B. State and local laws prohibiting sexual orientation-based discrimination can be used to challenge the failure to address LGBT youth in sexual health and HIV prevention programming.

1. For example, New Jersey's Law Against Discrimination's prohibition of sexual orientation discrimination, N.J.S.A. 10:5-1 *et seq.*, might be used to challenge the state's failure to develop any policy that requires group foster homes to reflect the needs of LGBT youth. California, Connecticut and New York also prohibit sexual orientation discrimination by state service providers such as child welfare and youth detention facilities. In September, 2003, California adopted a law explicitly prohibiting sexual orientation discrimination in the foster care system, guaranteeing fair and equal access to all children in foster care, and requiring staff training to ensure equal access and treatment.
2. State sponsorship of religion through incorporation of religious content in sexual education programs raises First Amendment issues – *ACLU of Louisiana v. Governor Foster*, No. 02-1440 (for copy of settlement agreement, see:

<http://www.aclu.org/ReproductiveRights/ReproductiveRights.cfm?ID=11272&c=227>).

Under the agreement, recipients of abstinence program funds must submit monthly reporting forms to the governor's office certifying that "this month no activity, event or material created or supported in whole or in part with GPA funds has included religious content; that no GPA funds have been used to advocate or promote, through prayer or otherwise, religion or religious messages."

3. State and Federal equal protection guarantees require that all youth in state care have equal access to services that protect their health and welfare. See, e.g., *Nabozny v. Podlesny*, 92 F.3d 446 (7th Cir. 1996)(U.S. Constitution's guarantee of equal protection requires school officials to protect both gay and hetero students from harassment); *Stemler v. City of Florence*, 126 F.3d 856 (6th Cir. 1997)(discrimination based on perceived sexual orientation violates equal protection guarantees). Recent challenges to parental notification statutes, in which state courts have rejected distinctions in mandated parental involvement between pregnant minors seeking abortions and those choosing to carry to term as violative of equal protection, are helpful. See *American Academy of Pediatrics v. Lungren*, 16 Cal.4th 307, 66 Cal.Rptr.2d 210, 940 P.2d 797 (1997)(concluding that parental notification statute violates state equal protection guarantees because "no compelling state interest has been established to justify the classification of minors based upon their reproductive choices."); see also *State of Alaska v. Planned Parenthood of Alaska*, 35 P.3d 30(AS 2001).

4. Restrictions on the right of adolescents in state care to access information and services related to their sexual health and choices threaten constitutionally-protected privacy rights. See *North Florida Women's Health and Counseling Services, et al. v. State of Florida*, 2003 WL 21546546 (Fla)(finding that Florida's parental notification statute governing minors seeking abortions violates state constitutional right of privacy); *State of Alaska v. Planned Parenthood of Alaska*, 35 P.3d 30(AS 2001). Protected rights of privacy and due process also can be invoked to challenge disparate treatment of LGBT youth in provision of services, access to relevant, appropriate sexual health information, protection from harm, and in expression of sexual identity. See *Lawrence and Garner v. Texas*, 123 S. Ct. 2472 (2003)(invalidating Tex. sodomy law).
5. Support is available in some cases in the prison context recognizing that, in the area of health care, the rights of those in custody may require more, rather than less, investment of resources than afforded free people, see, e.g., *MCCI Inmates v. Lanzaro*, 834 F.2d 326 (3rd Cir. 1987)(finding county's refusal to afford access to and funding for elective abortions violated inmates' 8th and 14th Amendment rights, as inmates rely on jailor for basic care); and that the standard of care in the provision of health services does not hinge on who is paying for them or in what facility they are being provided, see, e.g., *In the Matter of Rules Adoption Regarding Inmate-Therapist Confidentiality*, 224 N.J.Super. 252, 540 A.2d 212 (App. Div.1988) (invalidating rules that created a standard for confidentiality at odds with professional standards and guidelines); *Gates v. Fordice*, 1999 WL 33537206 (N.D.Miss. Jul 19, 1999) (NO. CIV.A. 4:71CV6-JAD, CIV.A. 4:90CV125-JAD)(finding that HIV positive inmates are entitled, at a minimum, to the degree of care outlined in the guidelines of the National Institutes of Health;"simply because they are incarcerated should not subject these inmates to a level of care that will significantly lower their chances of surviving with the virus, especially since the treatment that will give maximum suppression is known.")

IV. Exploring Reform Without Lawsuits

1. Link policy reform to state licensing/certification requirements of group homes and foster parents; to accreditation standards that private and state funding and oversight agencies require of service providers; and to professional codes of ethics.
2. Improve and focus monitoring and investigation of physical and emotional abuse of queer youth in foster care and detention facilities.
3. Increase funding of housing and programmatic innovations that link LGBT foster youth to gay-supportive community resources.
4. Develop reform initiatives through collaborative coalitions representing a diverse range of disciplines and community agencies with ties to child welfare. State advocates for children in neglect and abuse proceedings are a potential, and underused, resource.

Medical Privacy, Confidentiality, and Criminalization

COMING TO GRIPS WITH THE PERSISTENCE AND RECENT INCREASE IN OTHER-ENDANGERING SEXUAL ACTIVITY

Daniel Bruner

The following reflects the thoughts and opinions of the author, and does not necessarily reflect the position of Whitman-Walker Clinic or the Whitman-Walker Clinic Legal Services Program.

I. Too many people who know they are HIV+ are continuing to expose their sex partners to HIV, often without disclosing their HIV infection to their partners.

A. There appears to be an increase over the past few years, at least among men who have sex with men (MSM), in sexual activity that poses a greater risk of transmission.

1. Reports on increased unprotected anal intercourse and other risk behavior by MSM:

Beryl A. Koblin et al., *High-Risk Behaviors Among Men Who Have Sex With Men in 6 US Cities: Baseline Data From the EXPLORE Study*, 93 Am. J. Pub. Health 926 (2003)

Sanny Y. Chen et al., *Continuing Increases in Sexual Risk Behavior and Sexually Transmitted Diseases Among Men who Have Sex With Men: San Francisco, Calif., 1999-2001*, 92 Am. J. Pub. Health 1387 (2002)

Mitchell H. Katz et al., *Impact of Highly Active Antiretroviral Treatment on HIV Seroincidence Among Men Who Have Sex with Men: San Francisco*, 92 Am. J. Pub. Health 388 (2002)

Richard J. Wolitski et al., *Are We Headed for a Resurgence of the HIV Epidemic Among Men Who Have Sex With Men?* 91 Am. J. Pub. Health 804 (2001)

G. Michael Crosby and Michael Grofe, *Study of HIV Sexual Risk Among Disenfranchised African American MSM*, U.C.F.F. Center for AIDS Prevention Studies, Science to Community Report, Prevention #8 (March 2001)
<http://www.caps.ucsf.edu/publications/TESS2C.pdf>

2. Increases in syphilis, rectal gonorrhea and other sexually transmitted infections in MSM, many of who are co-infected with HIV:

Centers for Disease Control and Prevention, *Primary and Secondary Syphilis – United States, 2002*, 52 M.M.W.R. 1118 (2003)

Whitman-Walker Clinic Press Release, *Increase in Syphilis Rates Among Gay and Bisexual Men Seen at Whitman-Walker Clinic* (Nov. 20, 2003)
<http://www.wwc.org/news/syphilisstats.htm>

Centers for Disease Control and Prevention, *Primary and Secondary Syphilis Among Men Who Have Sex With Men – New York City, 2001*, 51 M.M.W.R. 853 (2001)

Kimberley K. Fox et al., *Gonorrhea in the HIV Era: A Reversal in Trends Among Men Who Have Sex With Men*, 91 Am. J. Pub. Health 959 (2001)

Centers for Disease Control and Prevention, *Outbreak of Syphilis Among Men Who Have Sex With Men – Southern California, 2000*, 50 M.M.W.R. 117 (2001)

Centers for Disease Control and Prevention, *Resurgent Bacterial Sexually Transmitted Disease Among Men Who Have Sex with Men – King County, Washington, 1997-1999*, 48 M.M.W.R. 773 (1999)

B. Recent studies have found that disturbingly large percentages of persons who know they are HIV+ have sex, including higher-risk sex, often without disclosing their HIV infection to sex partners.

Megan E. O'Brien et al., *Prevalence and Correlates of HIV Serostatus Disclosure*, 30 Sexually Trans. Dis. 731 (2003) (survey of HIV+ individuals in New Orleans; 25% reported that they had not disclosed their HIV infection to their primary sex partners and 75% reported they had not disclosed to their casual sex partners)

Daniel H. Ciccarone et al., *Sex Without Disclosure of Positive HIV Serostatus in a US Probability Sample of Persons Receiving Medical Care for HIV Infection*, 93 Am. J. Pub. Health 949 (2003) (survey of HIV+ persons in the nationwide HIV Cost and Services Utilization Study; sex without disclosure of HIV status was reported by 42% of gay and bisexual men, 19% of heterosexual men, and 17% of women; unprotected anal or vaginal sex without disclosure was reported for 13% of serodiscordant partnerships, with no significant differences between groups)

Centers for Disease Control and Prevention, *Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States, 2003*, 52 M.M.W.R. 329, 330 (2003) (unpublished 2002 CDC study of HIV+ men and women; 4-22% reported not using a condom during their most recent anal or vaginal intercourse with a known HIV-negative partner, and 14-48% reported not using a condom with a partner of unknown serostatus)

Chen et al., *Continuing Increases in Sexual Risk Behavior and Sexually Transmitted Diseases Among Men who Have Sex With Men: San Francisco, Calif., 1999-2001* (among participants who said they were HIV+, the proportion who reported unprotected anal sex with two or more partners of unknown serostatus increased from 19% in 1999 to 25% in 2001; these percentages were higher than for participants who reported they were HIV-negative)

Crosby & Grofe, *Study of HIV Sexual Risk Among Disenfranchised African American MSM* <http://www.caps.ucsf.edu/publications/TESS2C.pdf>, at 3 (1999-2000 survey conducted in San Francisco's Tenderloin neighborhood; 56% of the men who reported being HIV+ also reported unprotected anal intercourse with a partner of unknown or serodiscordant status; this percentage was higher than for HIV-negative participants)

Gary Marks, Scott Burris, and Thomas A. Peterman, *Reducing Sexual Transmission of HIV From Those Who Know They Are Infected: The Need for Personal and Collective Responsibility*, 13 AIDS 297, 298-99 & Table 1 (1999) (reviewing earlier studies)

C. Apparently as a result of a resurgence in risky sexual behavior, HIV infection rates among MSM have begun to increase.

Centers for Disease Control and Prevention, *Increases in HIV Diagnosis – 29 States, 1999-2002*, 52 M.M.W.R. 1145 (2003) (data from states with HIV name reporting; from 1999 to 2002, new HIV diagnoses among MSM increased by 17%; increased diagnoses also reported among Hispanics and non-Hispanic whites generally)

Katz et al., *Impact of Highly Active Antiretroviral Treatment on HIV Seroincidence Among Men Who Have Sex with Men: San Francisco* (between 1997 and 1999, annual HIV incidence rate among MSM who sought anonymous HIV testing doubled, from 2.1% to 4.2%)

Koblin et al., *High-Risk Behaviors Among Men Who Have Sex With Men in 6 US Cities: Baseline Data From the EXPLORE Study*, 93 Am. J. Pub. Health at 926 (discussing other evidence of increases in HIV prevalence rates among MSM over the levels observed in the late 1980's and early 1990's)

II. Current HIV prevention strategies are not working for too many people; the “code of the condom” strategy adopted early in the epidemic is no longer adequate.

- A. The “code of the condom” prevention message is: assume that your sex partner is HIV+, and use a condom whenever you have (higher-risk) sex. The correlate message is: as long as you always use a condom, disclosure by sex partners of their HIV serostatus to one another is unnecessary. *E.g.*, David L. Chambers, *Gay Men, AIDS, and the Code of the Condom*, 29 Harv. C.R.-C.L. L. Rev. 353 (1993).
- B. The “use a condom every time” message has never been entirely successful; after dropping precipitously in the 1980's, the estimated rate of new HIV infections in the U.S. has remained 40,000 per year since the early 1990's.⁶ In recent years, a resurgence of more risky sexual behavior, by persons at higher risk of HIV and persons who know they are HIV+, may have resulted from a number of factors, including:
- “Safe sex fatigue” – persons who were willing to use condoms as a short-term measure, motivated by fear of HIV/AIDS, are finding it more difficult to adhere to this measure as the years progress
 - Desire for intimacy
 - Desire for enhanced sexual pleasure
 - Desire for the experience of sexual abandonment or surrender (“transcendence”)⁷
 - People living with HIV/AIDS are living longer and feeling better, and, therefore, are likely to have longer and more active sex lives
 - The (incorrect) belief (rationalization?) that HIV drug therapies render the person living with HIV/AIDS non-infectious
 - The (incorrect) belief (rationalization?) that HIV infection is no longer a grave, life-threatening disease

⁶ Centers for Disease Control and Prevention, *Incorporating HIV Prevention Into the Medical Care of Persons Living with HIV*, 52 M.M.W.R. RR-12, 1 (2003).

⁷ James I. Martin, *Transcendent Experience Among Gay Men: Implications for HIV Prevention*, manuscript submitted for publication.

Willi McFarland and Pamela DeCarlo, *What is the Effect of HIV Treatment on HIV Prevention?* U.C.S.F. Center for AIDS Prevention Studies, Fact Sheet #27ER (revised Sept. 2003) <http://www.caps.ucsf.edu/treatment.html>, at 2-3

Katz et al., *Impact of Highly Active Antiretroviral Treatment on HIV Seroincidence Among Men Who Have Sex with Men: San Francisco*, 92 Am. J. Pub. Health at 388, 392

Wolitski et al., *Are We Headed for a Resurgence of the HIV Epidemic Among Men Who Have Sex With Men?* 91 Am. J. Pub. Health at 805

James I. Martin and Josephine Knox Pryce, *The Role of Intimacy in HIV Prevention Among Gay Men*, 13 Nat'l Soc. Sci. J. 64 (1999)

Marks, Burris & Peterman, *Reducing Sexual Transmission of HIV From Those Who Know They Are Infected: The Need for Personal and Collective Responsibility*, 13 AIDS at 298, 300

In addition, a propensity to engage in unsafe sexual behavior, regardless of HIV serostatus, appears to be positively correlated with:

- Use of drugs (particularly use of multiple drugs) and (perhaps) alcohol
- Depression and lack of self-esteem
- A history of childhood or adult sexual or physical abuse

Gail Wyatt et al., *How Does Childhood Sexual Abuse Affect HIV Prevention?* U.C.S.F. Center for AIDS Prevention Studies, Fact Sheet #52E (Sept. 2003), <http://www.caps.ucsf.edu/CSA.html>

Ron Stall et al., *Association of Co-Occurring Psychosocial Health Problems and Increased Vulnerability to HIV/AIDS Among Urban Men Who Have Sex With Men*, 93 Am. J. Pub. Health 939 (2003)

Wolitski et al., *Are We Headed for a Resurgence of the HIV Epidemic Among Men Who Have Sex With Men?* 91 Am. J. Pub. Health at 805, 806

Crosby & Grofe, *Study of HIV Sexual Risk Among Disenfranchised African American MSM* <http://www.caps.ucsf.edu/publications/TESS2C.pdf>, at 3

James I. Martin & Josephine Knox, *Self-Esteem Instability and its Implications for HIV Prevention Among Gay Men*, 22 Health & Social Work 264 (1997)

It appears that the influence of these factors is highly variable between individuals.⁸ A very recent study of gay men concluded that sexual risk-taking was correlated with several personality traits, including whether one tends to react to threat, anxiety and/or depression by becoming more

⁸ E.g., Margaret A. Chesney et al., *An Individually Tailored Intervention for HIV Prevention: Baseline Data From the EXPLORE Study*, 93 Am. J. Pub. Health 933 (2003).

sexually aroused or less sexually aroused; whether one has a “sensation-seeking” personality; and whether one tends to use sex as a mood regulator.⁹

- C. In a very important article, Gary Marks, Scott Burris and Thomas Peterman highlight the importance of “ecological” or social conditions that affect how an individual responds to safer-sex messages and to an HIV diagnosis, initially and over time.¹⁰ HIV stigma and discrimination, homophobia and sexual orientation discrimination, racism, poverty, and lack of sexual power vis-à-vis one’s partner(s) may influence a person with HIV or at risk of HIV to engage in risky sexual behavior in a number of ways. Homophobia, HIV stigma, racism or other factors may corrode his self-esteem and incentive to care about his long-term health and the health of his partners; homophobia and legal discrimination against same-sex couples might make it more difficult for a gay man to form and maintain a long-term relationship; homophobia, racism or poverty might encourage use of drugs or impose stresses that cause or exacerbate mental illness. They advocate prevention strategies that not only focus on the HIV-positive individual, but also target social norms and practices and laws that encourage or facilitate unhealthy behavior.

III. Revitalized HIV prevention efforts will require a revival of *moral* discourse.

- A. Much public health and health promotion thinking is mired in simplistic, reductionistic models of human behavior. Public health promotion literature and initiatives tend to conceptualize their goal as simply reducing mortality and morbidity. Behavioral “risk factors” are identified and targeted with interventions designed to change the undesirable behavior by reducing positive reinforcements for that behavior and introducing or strengthening negative reinforcements. HIV prevention is no exception. Generally, the aim has been conceptualized as reducing certain undesirable (because relatively high-risk) behaviors, such as unprotected anal intercourse, and the focus has been on devising and marketing more effective safer-sex messages (messages that more effectively reinforce condom usage and stigmatize unprotected anal sex) and forms of prevention counseling that are more likely to induce greater condom usage.
- B. As argued by David Buchanan,¹¹ the “behaviorist” orientation of public health promotion thinking misses the fundamental point that people do not want just to live long and disease-free lives; they want to *live well and meaningfully*. What living well and meaningfully means to a particular individual is a matter of what she values – in other words, it is a *moral* matter.¹² A

9 John Bancroft et al., *Sexual Risk-Taking in Gay Men: The Relevance of Sexual Arousability, Mood, and Sensation Seeking*, 32 *Arch. Sexual Behav.* 555 (2003).

10 Gary Marks, Scott Burris, and Thomas A. Peterman, *Reducing Sexual Transmission of HIV From Those Who Know They Are Infected: The Need for Personal and Collective Responsibility*, 13 *AIDS* 297 (1999).

11 David R. Buchanan, *AN ETHIC FOR HEALTH PROMOTION: RETHINKING THE SOURCES OF HUMAN WELL-BEING* (2000).

12 I am using “morality” here in a broader sense than the term is often used. Morality or ethics is often thought of narrowly as having to do with one’s obligations towards others. Fundamentally, however, morality has to do with the kind of person one wants to be, with the ends or goals that one values, such as honesty, courage, caring, adventurousness, kindness, excellence in a profession or skill, or self-expression or self-fulfillment. Of course, how one believes one ought to behave towards others, or how one wants to behave towards others, may well be implicated by one’s values. See, e.g., Charles Taylor, *Philosophical Reflections on Caring Practices*, in *THE CRISIS OF CARE* 182-83 (Susan S. Phillips and Patricia Brenner eds., 1994). For a much more detailed

long life free of serious illness is, of course, something that most of us value almost without reflection, as a good in itself and as something that enables us to realize the other goods that we value. But a long life free of serious illness is not necessarily the most important thing to many people, particularly if such a life seems dull, painful or lacking in significance.

- C. When people engage in behavior that is destructive of their own health and of the health of others, they might simply have different values than we have and would like them to have. For instance, I might smoke cigarettes, or engage in sex that puts me or others at risk of contracting HIV or other STD's, because I value the pleasure that I get more than I worry about my future health or about the health of my sex partner(s). However, my judgments might be distorted. On reflection, I might realize that I smoke or engage in risky sex as a way of coping with stress or dissatisfaction in my life, or out of a sense of low self-esteem or hopelessness. I might reevaluate my behavior as short sighted and destructive of values that are more fundamental to me.

According to the philosopher Charles Taylor, a fundamental feature of being human is to engage in "strong evaluation" or "second-order evaluation" of our desires and values. We not only value a variety of things, but we also experience some of the things we value as deeper or more important or more fundamental than others, and we are capable of re-evaluating what it is we value in light of more fundamental values. I might love chicken but decide to stop eating it based on what I learn about the miserable conditions in which chickens are raised by the poultry industry. I might love fine red wines but be bothered by how much I'm drinking, and reduce how much wine I drink or even stop drinking it entirely. I might love gossiping with my friends or co-workers but come to see this activity as destructive and undignified. I might love extravagant shopping but come to be bothered by how much I'm spending on things that I come to view as frivolous. In such a case, I change my valuation of something in light of other values that more deeply implicate who I am or want to be.¹³

- D. In order to address sexual behavior that is destructive of one's own health and the health of others, we need to revive an *ethics of caring*. We must recognize the importance of *taking care or being mindful of* our own health and the health of those with whom we engage in sexual intimacy. HIV/AIDS activists and service providers – and, I submit, the gay male community – need to acknowledge that sexual conduct is an intensely moral or ethical matter. Much harm has been done, and many prejudices have been disseminated, in the name of "sexual morality," but the solution is not to divorce sexual life from morality, but to articulate ethical principles that express our deepest, most authentic values, including the goodness of sexual acts and relationships, including same-sex acts and relationships, based on mutual attraction, caring and respect. This ethic is deeper than what is conventionally thought of as "altruism" or treating others as one "ought" to treat them despite one's own desires and interests. An ethic of caring is based on a vision of myself as part of a community: I take responsibility for the health of my sex partners, just as I take responsibility for my own health. Such an ethic transcends the "atomism" or radical individualism of our consumer society: if I truly care for the my sex partners (whether I

exposition, see Charles Taylor, *SOURCES OF THE SELF: THE MAKING OF THE MODERN IDENTITY* 3-107 (1989), and *The Concept of a Person*, in *PHILOSOPHICAL PAPERS 1: HUMAN AGENCY AND LANGUAGE* 97-114 (1985).

13 Charles Taylor, *The Concept of a Person*, and *What is Human Agency?* in *PHILOSOPHICAL PAPERS 1: HUMAN AGENCY AND LANGUAGE* 15 (1985). See also Buchanan 102-18.

am monogamous or have several or many sex partners), then exposing them to a real risk of acquiring HIV or another STD from me, at least without their informed consent, is not something that I would experience as being in my interest.

Cultivating an ethic of caring may also help us transcend the dilemma that “negative” HIV prevention messages may be ineffective or even backfire. Blaming or condemning HIV+ people when they engage in higher-risk sex and/or do not disclose their HIV status may reinforce the stigma that persons living with HIV often suffer, and be resisted or even reinforce feelings of powerlessness or worthlessness that may actually contribute to more unsafe sexual activity.¹⁴ An ethic of caring communicates a much more “positive” message. Nevertheless, acts that subject others to a significant risk of acquiring HIV, without their fully informed consent, cannot be condoned.

- E. To address issues of sexual risk as posing moral questions – i.e., questions of value – may help us deal more effectively with obstacles to healthy sexual activity, such as drug and alcohol abuse, depression and other mental disorders, attraction to high-risk activity, lack of self esteem – and the fact that for many people, sex without condoms simply feels better, not only physically, but emotionally and even spiritually. Rather than treating these factors as lapses from rational judgment, and trying to counteract them with stronger messages to “always use a condom,” we can try to address them as conflicts of values, or confusions of moral judgment, and help those struggling with addictions and confusions to clarify what is really of greatest value to them and to put their basic values into practice. Many of the problems that drive people to engage in sexual activity that endangers themselves and their sex partners are problems of self-esteem and of identity – in other words, moral problems. On reflection and with practice, I might discover that my use of drugs, alcohol, or sex is an unsatisfactory attempt to deal with unresolved issues through self-medication. Or I might conclude that although crystal meth or unprotected anal sex with numerous partners gives me intense pleasure, it doesn’t square with other values that are more important to me, including caring for myself and the people with whom I share sex.
- F. Reinvigorating moral discourse on this issue, I believe, goes hand in hand with contesting the social forces that encourage riskier sexual behavior. As Marks, Burris and Peterman explain, healthy sexual behavior by persons living with HIV/AIDS is made more difficult by homophobia, discrimination against same-sex couples, HIV stigma, racism and other social injustices. Challenging these injustices is key to empowering ourselves as a community.¹⁵ We cannot effectively empower ourselves to contest and overcome homophobia, HIV stigma, racism and the other oppressive forces that cripple so many lives while knowingly or recklessly transmitting HIV to one another based on the “looking out for Number One” orientation that also cripples our society. Moreover, a philosophy that emphasizes sexual liberation of the individual, without attendant responsibilities of caring and honesty, harms those with less sexual power, such as women.¹⁶

14 Marks, Burris & Peterman, *Reducing Sexual Transmission of HIV From Those Who Know They Are Infected: The Need for Personal and Collective Responsibility*, 13 AIDS at 298-300.

15 *Id.* At 301-04 (discussing the need for all of us to assume collective responsibility for addressing the social injustices that facilitate HIV transmission). See also Richard G. Parker, *Empowerment, Community Mobilization and Social Change in the Face of HIV/AIDS*, 10 AIDS S27 (1996).

16 For a critique of HIV prevention policies based primarily on the privacy and civil rights of persons with

- G. We also need to re-think the “code of the condom” that has dominated HIV prevention thinking. In particular, I submit that we need to re-think the notion that disclosure of one’s HIV serostatus to one’s sex partners is not required so long as one uses condoms (or usually does so). Decisions about disclosure are complex and intensely painful for many people living with HIV/AIDS, in large part due to the continuing stigmatization of HIV. However, powerful arguments can be made that withholding one’s HIV infection from a sex partner is morally disrespectful, and treats the other as a means to one’s own end (pleasure or some other satisfaction, or avoidance of discomfort) rather than as an autonomous moral agent entitled to make his or her own decisions about sexual risk.¹⁷ A “don’t ask, don’t tell” approach to HIV serostatus can also facilitate misunderstanding, rationalization and self-deception in sexual encounters and even longer-term relationships.¹⁸ Moreover, the “code of the condom” is already not working in many instances, because many people, including many people living with HIV/AIDS, occasionally or even frequently have unprotected anal or vaginal intercourse without condoms. If the resurgence in unprotected sex is due, at least in part, to “safe sex fatigue” and the simple fact that unprotected sex is often more physically more enjoyable and emotionally more satisfying, then a moral norm and social norm favoring disclosure of HIV serostatus may be desirable in order to enable individuals to engage in negotiated safety with their sex partners.¹⁹
- H. Recent efforts to raise these issues and stimulate a moral dialog within the gay male and HIV/AIDS advocacy communities should be encouraged and expanded. For instance, a coalition in Seattle, the MSM HIV/STD Taskforce, recently issued a “Community Manifesto,” available at <http://www.metrokc.gov/health/apu/taskforce/manifesto.htm>, that in my view deserves a great deal of attention.

IV. Implications for us as lawyers advocating for persons living with HIV/AIDS

- A. Legal advocates for persons with HIV/AIDS should face up to the fact that sexual activity that knowingly or recklessly exposes others to HIV is a serious public health problem and a serious ethical problem. We should ask ourselves whether an exclusive focus on the rights of persons living with the virus, including their privacy rights at the expense of sex partners, reinforces the ethic of atomism or radical individualism that has corroded our society and may be subjecting us to a resurgence of HIV.
- B. Criminal law sanctions against nondisclosure of HIV serostatus and/or knowing exposure of another to HIV

HIV/AIDS and persons at high risk of HIV, see Nancy Scheper-Hughes, *AIDS and the Social Body*, 39 Soc. Sci. Med. 991 (1994). She argues that in Brazil, such policies have led to HIV infection of substantial numbers of women, homeless children and transgender people, who lack the sexual power of men in Brazilian society.

¹⁷ See Donald C. Ainslie, *AIDS and Sex: Is Warning a Moral Obligation?* 10 Health Care Analysis 49, 51-54 (2002); Marks, Burris & Peterman, *Reducing Sexual Transmission of HIV From Those Who Know They Are Infected: The Need for Personal and Collective Responsibility*, 13 AIDS at 298.

¹⁸ Ainslie, *AIDS and Sex: Is Warning a Moral Obligation?* 10 Health Care Analysis at 60.

¹⁹ Marks, Burris & Peterman, *Reducing Sexual Transmission of HIV From Those Who Know They Are Infected: The Need for Personal and Collective Responsibility*, 13 AIDS at 298.

1. One function of the criminal law is to express society's condemnation of certain behaviors that are viewed as particularly dangerous or morally reprehensible. That such actions – e.g., acts of violence against persons – may be explained by the perpetrator's family history, economic circumstances, history of substance abuse, or psychological circumstances does not necessarily mean that she should not be held responsible for her actions.
2. Existing criminal laws applicable to HIV exposure vary substantially as to what conduct is prohibited and what defenses are available. Some HIV exposure laws criminalize any exposure regardless of the other person's knowledge or consent; others criminalize exposure without informed consent. Some laws specifically define prohibited exposures in a manner consistent with medical knowledge; others define prohibited exposures vaguely, subjecting defendants to a greater risk of injustice at the hands of prejudiced and uninformed prosecutors, judges, and juries. Criminal laws of general applicability, such as laws against assault with a deadly weapon and reckless endangerment, have been used to convict arrestees and prisoners in situations posing no real possibility of HIV transmission, such as spitting cases. Many HIV/AIDS legal advocates have argued that HIV-specific criminal laws are counter-productive as public health measures, because they are stigmatizing and susceptible to abuse, and that criminal laws of general applicability provide sufficient tools for prosecutors in truly egregious cases. Would it be preferable to oppose the application of general criminal laws to higher-risk sexual activity, and to advocate instead for HIV-specific laws (or STD-specific laws) that clearly specify the conduct that needs to be proscribed, e.g., unprotected insertive anal or vaginal intercourse by a defendant who knows he is HIV-positive and has not informed his sex partner and obtained his or her informed consent?
3. It is sometimes argued that criminalization of higher-risk sex by persons who know they are HIV-positive creates an incentive not to be tested, when a state's laws provide for access by police and prosecutors to public health data. We need to consider whether such a disincentive actually exists, and how to balance any such disincentive against the social benefit – if any – of clearly identifying and condemning sexual conduct that endangers others.
4. If we continue to conclude that a criminal justice approach to knowing or reckless HIV exposures is unsound, then we need to ask ourselves what the appropriate response of society should be. Advocates for enacting or strengthening HIV-exposure criminal laws are motivated, at least in part, by moral outrage. If the HIV/AIDS advocacy community does not acknowledge that outrage and effectively address it, we will be ineffective.

C. Privacy rights of persons with HIV vs. the health and safety of sex partners

1. Legal advocates for persons living with HIV/AIDS often view partner notification initiatives by public health authorities with skepticism if not hostility. This opposition to partner notification may not be shared by many or most persons with HIV themselves.²⁰

²⁰ See, e.g., Matthew R. Golden et al., *Support Among Persons Infected With HIV for Routine Health Department Contact for HIV Partner Notification*, 32 J. Acquir. Immune Defic. Syndr. 196 (2003).

While it is important to ensure that partner notification schemes provide newly-diagnosed persons with the opportunity to notify their sex partners themselves, and to protect the confidentiality of the source individual whenever feasible (at least in cases of contacts that occurred in the past), it is important to remember that an appropriate, indeed vital, public health function is to ensure that past and present sexual contacts of an individual diagnosed with HIV receive prompt notice.

2. Frequently, lawyers advocating for persons with HIV/AIDS learn of situations in which health care providers, or mental health or social service professionals, disclose a client's HIV infection to third parties, without the client/patient's consent. All too often, such disclosures are completely unjustified, and reflect the ignorance or prejudice of the healthcare provider, mental health or social service professional – e.g., disclosures to employers or to family members with whom the client/patient has not had a sexual relationship. However, when a disclosure has been made to a sex partner or another third party who was subjected to a significant risk of HIV transmission, we should be cautious before vigorously pursuing invasion of privacy or breach of confidentiality causes of action. We should ask ourselves: Was the disclosure actually harmful in these circumstances? What would the consequences have been of nondisclosure?²¹ What social norm is implied by pursuing an invasion of privacy or breach of confidentiality claim in a given case?
- D. Finally, lawyers frequently have considerable influence with their clients as trusted advisors as well as vigorous advocates. Where appropriate, we should assist our clients in facing destructive behavior – by appropriate referrals if we do not feel competent to engage in counseling.

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**Government Health Insurance:
Medicaid, Medicare, and ADAP**

Work of the HIV Medicaid/Medicare Workgroup in Addressing Proposed Changes to Medicaid and Medicare

Randolph T. Boyle

I. Block Granting Proposal for Medicaid

- A. Bush Administration proposal in 2003
 - 1. States could maintain their current Medicaid programs or elect to turn Medicaid into a block grant and receive additional short-term fiscal relief.
 - 2. The proposal would have eliminated the entitlement status of Medicaid. The Administration says that the capped allotments are not block grants, but that is not true. It would have eliminated the counter-cyclical nature of the program, and states could have capped enrollment as well as spending.
 - 3. The deal would have been for ten years, with additional money in the first seven years, and the state would repay the federal government the advanced funds in the final three years.
 - 4. States would have “flexibility” to decide eligibility, services, cost sharing, and protections for groups currently covered under the optional eligibility categories. These would probably include most people on Medicaid due to AIDS-related disability.
 - 5. Over 66% of Medicaid spending on people with disabilities is “optional.”
- B. National Governors’ Association reaction
 - 1. NGA formed a committee with half Republicans, half Democrats. Support of the NGA would have been crucial for the proposal to move forward.
 - 2. The Republicans members sent a letter DHHS on 6/10/03 supporting the greater state flexibility and caps to the states’ obligations.
 - 3. The Democrats opposed the proposal. The NGA was unable to present a unified position.
 - 4. Important to note that in 1995, every Senator signed a letter opposing block granting Medicaid. In 1997 NGA issued a letter against block grants—Tommy Thompson was one of the signatories.
 - 5. The Working Group mobilized grassroots to contact governors to oppose the proposal.
- C. What to expect in 2004
 - 1. Will the same or a similar proposal come up?
 - 2. Will the Republicans use the successful strategy used for the Medicare drug bill that excluded most Democrats and rammed through the House to pull a similar stunt with Medicaid?
- D. **Resources:** The National Health Law Program Web site has an analysis of the Administration’s proposal as well as copies of the documents from 1995 and 1997.
<http://www.healthlaw.org/medicaid.shtml>

II. ETHA (Early Treatment for HIV Act) S.847

- A. Introduced in the Senate last year, similar bill to be introduced in House
- B. Advocate to get elected representatives to sign on. Currently 19 Senators as co-sponsors.
- C. Would allow states to elect to cover people who have HIV, but are not disabled as Medicaid defines it.
- D. **Resource:** An analysis of ETHA is available at:
<http://www.taepusa.org/pages/legislation.html>

III. Dual Eligibles under the Medicare Bill

- A. Dual eligibles: People with both full Medicaid and Medicare.
Wrap-around: Medicaid covers services and some expenses that Medicare does not. Medicaid may pay all or part (up to the Medicaid rate) of the service.
- B. Creation of the new Part D benefit.
 - 1. Drugs will be covered through private insurance plans. Until the Part D starts in 2006, Medicare beneficiaries will be able to use a drug discount card. § 1860D-31 of the Social Security Act. The discount cards must be available by early May and will only be effective until the end of 2005.
 - 2. Beneficiaries must have at least two plans to choose from in a region. § 1860D-3. If a dual eligible does not choose a plan, s/he will be put into a plan. The beneficiary thereafter can change plans or disenroll.
 - 3. If a dual eligible chooses a plan that is average or low-cost for that region, Medicare pays all of the deductibles and premiums. Of course, the lower cost plan may not cover some of the medications a beneficiary may need. The beneficiary may choose a more costly plan, but the beneficiary will have to pay the difference in the premium cost.
 - 4. Plans will have substantial leeway to determine what drugs will be covered.
 - 5. Plans must cover at least two drugs in a “therapeutic class.” Plans, not CMS, may each define “therapeutic class.”
 - 6. Mid- to higher-income beneficiaries will have a large deductible to satisfy before the benefits begin. At a certain point, there is no coverage—the “doughnut hole,” until drug expenses reach a higher monetary amount.
 - 7. Low-income (under 150% FPL) can obtain assistance to avoid paying premiums or co-payments. Low-income beneficiaries will not have a “doughnut hole.”
 - 8. Even if the drug plan will not pay anything for a covered drug (i.e. it’s part of the deductible or the beneficiary is in the doughnut hole), the beneficiary must be able to get the drug at the negotiated lower price that the drug plan can obtain the drug.
 - 9. Not clear that states will be able to process all dual eligibles on time for the January 2006 launch. The transition may require a lot of outreach.
 - 10. The federal government is expressly prohibited from using Medicare’s purchasing power to get lower drug prices for the Medicaid and Veterans Administration programs. § 1927.
- B. Elimination of the wrap around for prescription drugs
 - 1. Begins January 2006

2. States are prohibited from providing a wrap-around for dual eligibles using federal matching dollars. States may provide coverage for non-covered drugs, cost sharing, etc., but only with state-only money.
 3. States may not provide wrap-around to any dual eligibles who could get Part D, even if a beneficiary does not elect it.
 4. If the drug plan does not cover a drug, the beneficiary will have to pay 100% of the cost of that drug, unless a state decides to pick up this cost with state-only money.
- C. Co-payments
1. Dual eligibles in institutions will have no cost sharing.
 2. Dual eligibles with income below 100% of FPL will have co-payments of \$1 per generic drug and \$3 per brand name drug in 2006.
 3. Dual eligibles with income above 100% of the FPL will have co-payments of \$2 per generic drug and \$5 per name brand drug in 2006.
 4. The co-payments will increase annually because they are tied to the Consumer Price Index.
 5. Medicaid prohibits denying a prescription because a beneficiary cannot pay the co-payment. This prohibition will not apply in the new Part D.
 6. Most HIV/AIDS drugs are brand name, so our clients will usually pay the higher co-payments.
- D. The Working Group mobilized faxes and letter writing to Senators to attempt to stop the bill.
1. Senator Barbara Boxer (D-CA) read the letter on the Senate Floor
 2. Senator Dianne Feinstein (D-CA) obtained “reassurances” from the Secretary of Health and Human Services.
 3. The Work Group made visits to senators’ offices and numerous phone calls
- E. **Resources:** The Kaiser Commission on Medicaid and the Uninsured has several excellent articles on its Web site: <http://www.kff.org/about/kcmu.cfm>

IV. Developments in Managed Care

- A. Principles of managed care for people with disabilities
1. The principles were developed in anticipation that the California Medicaid program (Medi-Cal) would require people with disabilities to enroll in managed care plans.
 2. The State only seemed to be looking at potential cost savings, not quality of care.
 3. Copies of the Principles will be available at the conference. Suggestions for revisions/additions can be given to Randy Boyle
- B. New definition of HIV specialist in California
1. California passed legislation and issued regulations defining an “HIV Specialist” and requiring managed care plans to allow for standing referrals to HIV specialists. 28 Cal. Code of Regs. § 1300.67.60. Health & Safety Code § 1374.16.

2. The definition requires credentials from the American Academy of HIV Medicine or board certification or a Certificate of Added Qualification.
3. May also be board certified in the field of infectious diseases, but also has direct experience with HIV care.

V. Guiding Principles for Managed Care for People with Disabilities

The following principles should guide any dialogue about providing managed health care services for persons with disabilities.

1. Improved access to quality of care, not short-term cost savings, must be the driving force for moving beneficiaries with disabilities into Medi-Cal managed care.

Any cost savings that occur, whether short-term or long-term, should be captured and kept within the Medi-Cal system to improve the availability and quality of health care services for persons with disabilities.

2. Any efforts to move Medi-Cal beneficiaries from fee-for-service into managed care should take advantage of systems and services that would improve the quality of life for these beneficiaries.

Such systems and services include but are not limited to:

- *Employing health care providers whom the oversight agency has deemed significantly experienced in the provision of health care for people with disabilities.*
- *Adapting pre-existing programs, tailoring new programs, and creating specific programs when needed to meet the unique needs of people with disabilities. Health maintenance and wellness programs should be accessible to people with disabilities and relevant to their needs.*
- *Assuring that an adequate numbers of providers are available to serve this population.*
- *Emphasizing the power of coordinated care, when it focuses on the range of social and medical services a person needs to maximize his/her functional ability, to maximize resources and reduce costs.*
- *Assuring linkages with non-Medi-Cal services needed to serve this population.*
- *Assuring that new pharmaceuticals, related tests, and new treatment modalities will be accessible and available in the care delivery system.*
- *Emphasizing creativity and flexibility to assure responsiveness to individual needs in a timely manner.*

3. Changes in Medi-Cal service delivery should not reduce:

- Health benefits and services available to the recipient with a disability.
- Access to appropriate specialists.
- Timeliness of services.

4. Informed choice and empowerment of the Medi-Cal enrollee should underlie all program changes.

People with disabilities should not have to sacrifice control over healthcare decision-making.

5. Keeping people with disabilities healthy and able to function at home, at school, at work, and in the community must be the primary goal.

To this end, managed care services must include access to specialists (including using the specialist as case manager/care coordinator when appropriate), assistive technology, and community-based services, and must be designed to move away from an institutional bias (e.g., nursing home and other institutional placement).

6. Managed care organizations and participating providers should comply with all relevant requirements of the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and the Unruh Civil Rights Act as a basis for participation in the Medi-Cal program, with active monitoring of this requirement.

The state should describe how it will monitor compliance and respond to reports and evidence of disability discrimination. Managed care organizations must similarly monitor their contractors' compliance. The state should provide resources and technical support to enable small, safety-net Medi-Cal providers to comply with these laws. Compliance includes, but is not limited to, providing:

- *Consent forms, care instructions, medication labels and instructions, plan policies and changes in policy, payment information, grievance and appeals forms and any mailings in accessible formats for people with vision or other disabilities.*
- *Sign language interpreters and assistive listening technology for people from the deaf and hard-of-hearing communities.*
- *Accessibility of all facilities, medical equipment, services, and programs.*
- *Basic training of providers, medical groups, and staff in cross-disability awareness, accommodating and interacting with people with disabilities, and providing effective and appropriate treatment.*

7. Quality standards and monitoring of these standards must be developed specifically with respect to health care for persons with disabilities.

Standards and monitoring should:

- *Take advantage of lessons learned from other states' experience regarding transitioning people with disabilities into managed care.*
- *Be predicated on a study of the baseline of satisfaction and health status for people with disabilities prior to enrollment in managed care.*
- *Take advantage of care coordination as a mechanism for assuring identification of service needs, timely receipt of services, sharing of information within the care system, and efficient use of resources.*
- *Be developed and informed by ongoing meetings between all stakeholders, including Medi-Cal beneficiaries with disabilities or their representatives, and advocates from diverse disability communities.*

8. Reimbursement or capitation rates must cover the

real costs of providing medical care to people with disabilities and chronic health conditions.

Such rates also must recognize that serving some individuals with disabilities takes more time and resources than serving other populations, and that it may require high initial investment to produce long-term savings. The managed care organization must not have financial arrangements that create an incentive to withhold medically necessary care.

- 9. Development of models and contracts for Medi-Cal managed care, and development and implementation of state oversight of these models, should involve representatives of enrollees with disabilities in substantive, decision-making roles. -**

Disability representatives in this oversight group should include beneficiaries with disabilities, representatives of children with developmental and other disabilities, and qualified advocates with disabilities. Disability representatives should help develop standards for appropriate services for these populations and advise state agencies on innovative, cost-effective approaches to improving care for these communities. Diverse disabilities should be represented in the oversight group.

- 10. All health plans that accept Medi-Cal must provide medically necessary care, including services, equipment, and pharmaceutical supplies.**

The contractual definition of medically necessary care must assure the provision of all items and services needed to maximize the patient's functional ability and promote and preserve the patient's ability to live independently in the community.

The AIDS Drug Assistance Program Crisis

Jon Givner

I. ADAP: The Basics

- A. Authorized and funded under Title II of the Ryan White CARE Act, 42 U.S.C. § 300ff-11, et seq. Each state must “establish a program . . . to provide therapeutics to treat HIV disease or prevent the serious deterioration of health arising from HIV disease in eligible individuals, including measures for the prevention and treatment of opportunistic infections.” 42 U.S.C. § 300ff-26.
- B. Federal law creates minimal eligibility requirements: individuals must be (1) HIV-positive, and (2) be “a low-income individual, as defined by the State.”
- C. States have discretion to define medication formularies, financial eligibility criteria, clinical eligibility criteria. As a result, financial eligibility criteria range from 125% of FPL to 500%, and drug formularies range in size from about 20 to about 450. Nationally, about 80% of ADAP clients have incomes under 200% of FPL
- D. ADAP is not an entitlement program.

II. Where the Money Comes From

- A. Federal government awards ADAP funds to 57 states and territories based on an AIDS prevalence formula. Under the Ryan White CARE Act Amendments of 2000, 42 USCA § 300ff-28(a)(2)(I)(ii), three percent of federal ADAP funds are set aside for supplemental grants to states with demonstrated severe needs.
- B. Some states supplement federal dollars with state funds, but others rely exclusively on the federal grant. Title II money makes up about 71% of ADAP budgets nationwide.

III. The Current Financial Crisis

- A. The ADAP Working Group estimates that ADAPs need an additional \$214 million for FY 2004. In December, congressional conferees agreed to increase federal ADAP funding by only \$35 million.
- B. What’s causing this crisis? Several factors:
 - 1. The combination of steady new infection rates and decreasing HIV-related fatality rates have created significantly larger ADAP rolls. Approximately 600 people per month become newly eligible for ADAP.
 - 2. Medicaid cutbacks and restrictions.
 - 3. State budget crises & high unemployment.

4. Expensive new treatments, including medication to treat side effects and co-infections.
- C. The overall ADAP budget has increased more than four-fold since 1996, but the national shortfall has been increasing almost exponentially in the past four years. Advocacy groups estimate that new infections alone necessitate annual increases in ADAP funding of approximately \$100 million.

IV. What's Happening Now

- A. States have responded to the funding crisis by implementing various cuts: creating wait lists, capping program expenditures, removing medications from approved formularies, reducing financial eligibility requirements, and restricting medical eligibility requirements.
- B. As of August 2003, 17 of 57 ADAPs had implemented restrictions, including 13 with capped enrollment and/or wait lists and five with reduced formularies. Over 600 people are now on wait lists.

V. How ADAPs Can Save Money

- A. Paying for health insurance premiums: The CARE Act allows states to pay the costs of "purchasing or maintaining health insurance or plans whose coverage includes a full range of . . . therapeutics and appropriate primary services" if the cost of the premiums are less than the cost of purchasing medications directly. 42 U.S.C. § 300ff-26(e). The average cost of insurance premiums for an ADAP client is around \$3,500 per year, compared to approximately \$12,000 for HAART.

As of June 2002, ADAPs paid insurance premiums for only 7% of ADAP clients.

- B. Paying premiums to enroll clients in their spouses' or partners' employer-based health insurance: Because of the high cost of premiums, low-income workers often do not enroll dependent family members in available employer-based health plans. When the uninsured spouses and partners apply for ADAP, states should determine whether the applicant is insurable under a dependent policy. ADAPs may then reimburse the working spouse/partner for the cost of the premium.
- C. Pursuing Medicaid eligibility for ADAP clients:
1. ADAPs should take steps to fully screen clients for potential eligibility for Medicaid, rather than simply determining whether or not a client is already on Medicaid.
 2. The Breast and Cervical Cancer Prevention and Treatment Act of 2000, Pub. L. 106-354, offers Medicaid eligibility (in 49 participating states) to women under age 65 who receive screening and referral for treatment for breast or cervical cancers or pre-cancerous conditions through the CDC's National Breast and

Cervical Cancer Early Detection Program. (For more info, see <http://www.cdc.gov/cancer/nbccedp/law106-354.htm>.)

- D. Pursuing VA benefits for ADAP clients: ADAPs may encourage eligible clients to enroll for VA care.
- E. Counting ADAP-paid pharmaceutical bills toward Medicaid spend-down requirements?

VI. Possible Legal Challenges to Termination of ADAP Clients

A. “State-Created Danger” Constitutional Theory

1. In DeShaney v. Winnebago County Dept. of Social Svcs., 489 U.S. 189 (1989), the Supreme Court held that the Due Process Clause does not guarantee the safety of citizens, but the Court implied that a state actor may violate the Constitution if he/she creates a dangerous situation or renders a particular citizen more vulnerable to harm.
2. DeShaney did not explicitly adopt the “state-created danger theory”; it just implied the existence of the duty. Many courts have since adopted the theory, but others have not.
3. Appellate courts adopting the state-created danger theory have stated different tests. The elements of a claim in the Third Circuit, for instance, are: (1) foreseeable harm; (2) willful disregard of the plaintiff’s safety by a government actor; (3) a relationship between the plaintiff and defendant (ie, plaintiff was a foreseeable victim); and (4) the use of the defendant’s authority to create a danger that otherwise would not have existed or to make the plaintiff more vulnerable to danger than if the defendant had not intervened. See Kneipp v. Tedder, 95 F.3d 1199 (3d Cir. 1996).

Other circuits enunciate the test differently, requiring, for example, that the plaintiff be “a member of a limited and specifically definable group” or that the defendant act with deliberate indifference. See, e.g., Uhlrig v. Harder, 64 F.3d 567 (10th Cir. 1995); Wood v. Ostrander, 879 F.2d 573 (9th Cir. 1989).

4. Nutshell version of the state-created danger argument in the ADAP context: By offering ADAP coverage to otherwise uninsured individuals, the state has encouraged and allowed clients to begin HAART. When the state terminates a current client from the program, it creates direct and foreseeable harm to the client by contributing to possible drug resistance and failure. This may place the client in a worse position than had s/he not enrolled in the program at all. Because of the foreseeable nature and potential severity of the harm, one may conclude that the state decision makers have acted with deliberate indifference.
5. In correctional settings, courts have found short-term deprivation of medication to HIV-positive inmates can constitute deliberate indifference in light of the danger of drug resistance. See e.g., McNally v. Prison Health Services, 46 F.

Supp. 2d 49 (D. Me. 1999); Sullivan v. Pierce, 216 F.3d 1084, 2000 WL 432368 (9th Cir. 2000) (unpublished decision). See also Phillips v. Michigan Dept. of Corrections, 731 F. Supp. 792 (W.D. Mich. 1990) (similar argument on behalf of transgendered inmate denied continued estrogen therapy).

B. Equitable Estoppel

1. Equitable estoppel typically requires the following elements: (1) the party to be estopped must be aware of the facts; (2) that party must intend that its conduct will be acted upon; (3) the injured party must be ignorant of the true state of the facts; and (4) the injured party must rely upon the conduct to his/her detriment. When a party raises an estoppel claim against a government entity, s/he also typically must establish that (5) the injustice that would result from the court's failure to act would outweigh any negative effect on public interest or policy that would result from the court's action. See, e.g., City of Long Beach v. Mansell, 3 Cal.3d 462 (1970).
2. A government agency may be estopped from denying benefits to an individual if the agency has acted in such a way as to engender reasonable reliance by the individual. See, e.g., Stevens v. Dept. of Social Welfare, 159 Vt. 408 (1992); Kramarevsky v. Dept. of Social and Health Svcs., 122 Wash.2d 738 (1993). Note that these cases involved very different circumstances from those presented by ADAP cuts.
3. Nutshell version of the estoppel argument in the ADAP context: By inviting an individual to participate in ADAP, the state implicitly asserts that program participation will not be terminated arbitrarily, leaving the client in a worse position as a result of his/her participation in the program. Not knowing that benefits will later be terminated, clients rely on this implicit promise by joining the program. As a result of that reliance, clients will likely be harmed when terminated from the program, due to drug resistance and the effects of inconsistent adherence. The potentially drastic health consequences of drug resistance outweigh the financial benefit to the public of terminating individuals from the program.

VII. Additional Info and Data

- <http://hab.hrsa.gov/programs.htm>
- http://www.nastad.org/documents/public/pub_careandtreatment/2003613TheNationalADAPMonitoringProjectAnnualReport.pdf
- <http://www.tiicann.org>
- http://www.thebody.com/adapwg/pdfs/adap_funding.pdf
- http://www.thebody.com/aahivm/adap_funding.html

**Why is Ted Kennedy So Angry?: Medicare before and after the
Medicare Prescription Drug, Improvement and Modernization Act of 2003/22**

Ronda B. Goldfein

Overview

- A. Medicare is a federally funded health insurance program, available to certain people age 65 and older, or who are disabled, without regard to income or resources.
- B. Medicare eligibility is based upon an individual's or spouse's work record, as recorded through the Social Security, Civil Service or Railroad Retirement systems.
- C. In 2003, we saw the largest expansion of Medicare since its creation in 1965. While the new law held out the promise of expanded coverage and financial relief, in fact the law curtails coverage options and fails to truly alleviate the financial burden caused by the cost of prescription medication.
- D. The majority of the changes won't begin until 2006.
- E. The most notable change is the inclusion of the voluntary drug benefit administered through drug-only plans or integrated plans that provide a full set of Medicare benefits.
- F. For more information on Medicare, www.ssa.gov or call **1-800-772-1213**.

Eligibility

- A. Generally, the following people are eligible for Medicare:
 - 1. People receiving disability benefits from Social Security Disability Insurance (SSDI), Railroad Retirement or Civil Service Retirement systems.
 - a. Medicare benefits begin two years after the SSDI benefits begin or counting the five-month waiting period for SSDI, 29 months from the disability onset date.
 - b. If it has taken more than two years to get SSA approval, the beneficiary may be eligible for Medicare immediately.
 - 2. People age 65 or older and entitled to Social Security retirement or railroad retirement or civil service retirement benefits (even if still working and not getting retirement benefits).
 - 3. People suffering from end stage renal disease.
 - 4. People age 65 or older may be eligible for Medicare even if they are not eligible for Social Security or Railroad Retirement benefits. These people will have to pay for Part A coverage as well as for Part B.

- B. Individuals entitled to Part A or enrolled in Part B may enroll in Part D, a voluntary prescription drug benefit, offered by private plans.

Covered benefits

- A. Currently, Medicare has two parts.
- B. Part A pays for hospital care, psychiatric care, hospice, skilled nursing home care, and some home health care.
- C. Part B pays for doctor visits and other outpatient care, including x-rays, durable medical equipment, ambulances, physical therapy and some home health care.
- D. Effective, Spring 2004, Medicare beneficiaries will be offered the option to buy a Medicare drug discount card for \$30 per year. The discount card is expected to offer an average of about 13% off the cost of prescription drugs.
 - 1. Enrollees with household incomes below 135% of the poverty level will receive the card at no cost, with \$600 credit on it, if they do not have prescription coverage through Medicaid, or employee health plan.
 - 2. Enrollees, who are not enrolled in Medicaid, with income at or below 100% of the poverty level will be required to pay a 5% co-insurance rate for each prescription.
 - 3. Enrollees with income at or below 135% of the poverty level will be required to pay a 10% co-insurance rate for each prescription.
- E. Effective 2006, Medicare beneficiaries may buy into Part D.
 - 1. All Medicare Part D plans must offer at least the standard drug coverage or its actuarial equivalent. Deductible may not be more in an equivalent plan, but plan sponsors may offer separate plans with richer coverage.
 - 2. HMOs, PPOs, or private drug plans registered with the Medicare program will manage the various drug benefit programs offered as a result of the new legislation.
 - 3. Due to the fact that there will be many Medicare Part D providers, no two plans will be the same. The only requirement for creating the plan is that the total value of the plan is equal to that of the standard plan. While the companies are required to carry drugs in each “therapeutic class” the plans do not have to include all drugs in a particular class. Therefore, beneficiaries must make sure that they enroll in plans that cover the prescriptions they need.

Premiums

- A. Most Medicare beneficiaries do not have to pay for Part A, but they do pay a monthly premium for Part B (\$66.60 per month in 2004). The premium is deducted from their Social Security, civil service retirement, or railroad retirement checks each month.

- B. Premiums are not required for most low-income beneficiaries, also known as dual eligibles. See “Low-Income Beneficiaries” section below.
- C. The Part D standard coverage premium will be \$35 per month in 2006.
 - 1. May be paid directly to the plan, deducted from SSD or paid by electronic benefits transfer.
 - 2. Late enrollees will be charged a premium amount that is increased by the greater of an amount the Secretary determined is actuarially sound or 1% each month the individual did not have creditable coverage after the end of the individuals’ enrollment period.

Deductibles

- A. Part A annual deductible (\$876 in 2004) for hospitalization, The Part A deductible applies only to those enrolled in the original fee-for-service Medicare program. See “Medicare HMOs” below. Part A beneficiaries pay \$219 for the 61st through 90 day of hospitalization in a benefit period, and \$109.50 for the 21st through 100th day of extended care services in a skilled nursing facility.
- B. Part B deductible for outpatient services is \$100 with a co-payment of 20% of each bill.
- C. Part D deductible for 2006 will be \$250.

Co-pays

- A. Medicare provides 75% coverage for the first \$2250.
- B. No coverage for expenses between \$2250 and \$5100. This gap, euphemistically referred to as “the doughnut hole”, is equivalent to \$3600 in out-of-pocket spending.
- C. After \$5,100, the beneficiary pays the greater of \$2 for generic/\$5 for brand or 5% coinsurance.

Low-income beneficiaries

- A. Medicare beneficiaries enrolled in Medicaid are know as “dual eligibles.”
 - 1. State-based programs are available for those beneficiaries whose income falls at or below 100% of the poverty level, also know as “full dual eligibles,” which provide Medicaid coverage.
 - 2. Qualified Medicare Beneficiary (QMB) is a beneficiary whose income 100% of the federal poverty level plus a \$20 exclusion. The QMB gets a Medicaid card that covers the Medicare monthly premium, co-pays, and deductibles, but doesn’t pay for other items, such as prescriptions.

3. Special Low-Income Medicare Beneficiary (SLMB) is a beneficiary whose income is 120% of the federal poverty level, plus a \$20 exclusion. The SLMB doesn't get a Medicaid card. The state Medicaid agency pays the Medicare premiums. SLMB participants have to pay for their own Medicare co-pays and deductibles.
 4. Qualified Individual (QI). The QI program's income limit is 135% of the Federal Poverty Income Guidelines (or at state option up to 175%). The QI beneficiary doesn't get a Medicaid card. The state Medicaid agency pays all or part of Medicare monthly premiums.
- B. Effective January 1, 2006, drug coverage through Medicaid for dual eligibles ends. Instead, dual eligibles may enroll in Medicare part D plans.
1. Low-income beneficiaries are entitled to a premium subsidy.
 - a. Medicaid full benefit dual eligibles regardless of income and assets, and enrollees with income below 135% of poverty who meet an asset test (\$6,000 for individual /\$9,000 for couple) get a full premium subsidy.
 - b. Low-income beneficiaries not enrolled in Medicaid with income below 150% of poverty who meet asset test (\$10,000 for individual/\$20,000 for couple) get a sliding scale premium subsidy.
 - c. Most late enrollment penalties will be subsidized.
 2. Low-income beneficiaries are entitled to a cost-sharing subsidy.
 - a. Full benefit dual eligibles with income below 100% of poverty have no deductible.
 - i. Co-pays will be \$1 for generic/\$3 for brand, up to \$5,100.
 - ii. After \$5,100, no co-pay required.
 - b. Full benefit dual eligibles with income above 100% of poverty and beneficiaries not enrolled in Medicaid with income below 135% of poverty and meet asset test (\$6,000 for individual /\$9,000 for couple) have no deductible.
 - i. Co-pays will be \$2 for generic/\$5 for brand, up to \$5,100.
 - ii. After \$5,100, no co-pay required.
 - c. Beneficiaries not enrolled in Medicaid with income below 150% of poverty who meet asset test (\$10,000 for individual/\$20,000 for couple) will pay \$50 annual deductible.
 - i. Coinsurance payment of 15%, up to \$5,100.
 - ii. After \$5,100, co-pays of \$2 for generic/\$5 for brand are required.

- d. Institutionalized full benefit dual eligibles have no cost-sharing requirements.

VII. Medigap Policies

- A. Medigap insurance provides Medicare beneficiaries supplemental coverage to reduce their out-of-pocket medical costs by offering benefits such as limited prescription drug coverage, deductible assistance, hospital stays, and reduced co-pays.
- B. After January 1, 2006, no Medigap policies providing drug coverage may be sold, issued or renewed.
- C. Medicare beneficiaries enrolled in Medigap policies that provide prescription drug benefits at that time will have two options to keep their Medigap coverage:
 - 1. Current enrollees may keep their current policy, modified to remove any drug benefit; or
 - 2. Switch to a substitute guaranteed issue policy (with no preexisting condition exclusions), offered by the same issuer, without drug coverage.
- D. Medicare beneficiaries whose Medigap policies, with prescription drug coverage, renew after January 1, 2006 may keep their policies until expiration. However, the policy issuer must inform the beneficiary as to whether the policy provides creditable coverage. If the policy does not provide creditable coverage, the beneficiary will have to pay late enrollment fees if they enroll in Medicare part D after open enrollment closes.
- E. The legislation prohibits insurers from providing a supplemental policy that covers the gaps in coverage under Medicare Part D.

VIII. State Based Program Options

- A. States can opt to provide coverage for classes of drugs not covered under Medicare Part D and will receive matching funds from the federal government to support those programs.
- B. State Pharmacy Assistance Programs may provide supplemental drug coverage to Part D enrollees by purchasing extra benefits from a Part D plan or providing a supplemental benefit program.

IX. Medicare HMOs and Private Drug Plans

- A. Currently, Medicare beneficiaries may choose to receive their medical coverage through any HMO. Generally, HMOs do not require any premiums or deductibles and some offer very limited prescription coverage. In choosing this option, beneficiaries should be wary of available benefits and make sure their doctors accept the HMO.

HIV in Adult and Juvenile Correctional Facilities

HIV and AIDS in Adult Correctional Facilities

Joshua Lipman

1. Forum

- A. Federal Court – 8th Amendment and 14th Amendment¹ – constitutional claims brought under the Prison Litigation Reform Act (“PLRA”) and its limitations:
- Then under the PLRA limitations:
 - Federal court enforced consent decrees are subject to the strictures of the PLRA.
 - Court needs to find that the consent decree is narrowly tailored to and the least intrusive means to correct the violation.²
 - This has been interpreted to mean that the court needs to make the narrowly tailored finding of the consent decree -- provision-by-provision.³
- B. State Court – state statutory claims and constitutional theories
- C. Monetary damages and or injunctive relief.

GOAL: To remedy the conditions experienced by the HIV or AIDS infected prisoner.

2. Clients and developing communication

- A. Medical knowledge – important because it develops a relationship between you and the client. Should know about the types of medication (i.e., HAART medication and OI medication). Knowledge of these medications is very helpful. Should know about the various illnesses and infections that HIV infected patients can experience, and about the

¹The state has an “obligation to provide medical care for those whom it is punishing by incarceration.” Estelle v. Gamble, 429 US 97, 103 (1976)(“These elementary principles establish the government’s obligation to provide medical care for those whom it is punishing by incarceration.”); *see also* DeShaney v. Winnebago County Department of Social Services, 489 US 189, 200 (1989)(“The rationale for this principle is simple enough: when the State by the affirmative exercise of its power so restrains an individual’s liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs - e.g., food clothing, shelter, **medical care**, and reasonable safety - it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause.”)(emphasis added).

²*See* Ruiz v. U.S., 243 F.3d 941, 951 (5th Cir. 2001).

³*See* Cason v. Seckinger, 231 F.3d 777, 785 (11th Cir. 2000)(“We read § 3626(b)(3) as requiring particularized findings, on a provision-by-provision basis, that each requirement imposed by the consent decrees satisfies the need-narrowness-intrusiveness criteria, given the nature of the current and ongoing violation.”); Castillo v. Cameron County, Texas, 238 F.3d 339, 354 (5th Cir. 2001)(same); Ruiz, 243 F.3d 941, 950 (5th Cir. 2001)(same)

basic blood tests that HIV patients use to monitor the progress of their disease (i.e., viral load, CD4, and resistance testing).

- B. Need to find out about viral load and CD4 of the client. This determines the medical status of the client.
- C. Should develop an interview format (i.e., topics that need to be addressed in the interview). The format provides you with direction for the interview.
- D. Must discuss exhaustion of administrative remedies (PLRA requirement).⁴
 - o Filing complaint and grievances – whatever the facility utilizes for administrative remedies.
 - o Need copies of the grievances and complaints (should grieve with specificity)
- E. Retrieve correctional facility medical records of the client. This provides valuable insight into the healthcare delivery system at the correctional facility. Deficiencies in the healthcare delivery system can be glaring in the medical records (e.g., gaps in medication provision, untimely responses to medical complaints or grievances, etc.). Ninety percent of the problems in a medical facility system can be documented in the client’s medical records.

3. **Medical expert**

- A. Should be an HIV/AIDS specialist.
- B. Should have experience in the delivery of medical treatment in the correctional setting.
- C. Needs to have access to the client medical records.
- D. FRCP 35(a) physical examination of the clients:⁵

⁴See 42 U.S.C. §1997e(a) (“No action shall be brought with respect to prison conditions under section 1979 of the Revised Statutes of the United States (42 U.S.C. 1983), or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted; *see also* Leal v. Georgia Department of Corrections, 254 F.3d 1275, 1279 (11th Cir. 2001)(per curiam)(a prisoner is precluded from filing a lawsuit in federal court “until such administrative remedies as are available are exhausted.”); Miller v. Tanner, 196 F.3d 1190, 1993 (11th Cir. 1999)(same); Alexander v. Hawk, 159 F.3d 1321, 1324 (11th Cir. 1998)(Congress intended 42 U.S.C. §1997e(a) to “curtail ability of prisoners to bring frivolous and malicious lawsuits by forcing prisoners to exhaust all administrative remedies before bringing suit in federal court.”); Pozo v. McCaughtry, 286 F.3d 1022, 1024 (7th Cir. 2002)(same);

⁵See Fed. R. Civ. P. 35(a); *see also* Schlagenhauf v. Holder, 379 US 104 (1964)(addresses the requirements for a Fed. R. Civ. P. 35(a) physical examination); Hardy v. Riser, 309 F.Supp. 1234, 1241 (N.D. Miss. 1970)(“Its [Fed. R. Civ. P. 35(a)] purpose to inform the court and the parties of the true facts as to the physical condition of the party claiming injury, has largely been achieved.”)(changes to original); 8 Wigmore, John, Evidence, §2220(9)(i), 176(1961)(“The duty to bear witness to the truth, by whatever mode of expression may be appropriate, includes necessarily the duty to exhibit the *physical body* so far as the ascertainment of the truth requires it.”)

- Have the expert tour the living conditions of the clients – living conditions can have a significant impact upon the health of HIV/AIDS inmates (e.g., close proximity if there is overcrowding can lead to the spread of contagious diseases).
 - The expert should then conduct physical examinations of the clients. Need to have releases signed by the clients to be examined; the expert should have access to any medical records that pertain to the client being examined; and photograph the client medical condition. (Run this like an outside clinic).
 - Get a photographer/videographer inside the facility to photograph and preserve the condition of the housing and the physical condition of the clients.
- E. If there are HIV/AIDS-related inmate deaths, then the medical expert should have access to the deceased inmate medical records. The medical expert should reconstruct the cause of death of the inmates (e.g., medical system failures, what the cause the death was, and whether the death preventable).
- F. The Expert’s Report (FRCP 35(b))⁶

The medical experts report should include:

1. Observations addressing the living conditions of the HIV and AIDS inmates.
2. Observations addressing the FRCP 35(a) physical examination and delivery of medical care of current HIV and AIDS clients.
3. If there have been any HIV/AIDS-related inmate deaths at the facility, and the medical records of these inmates are able to be retrieved and provided to the medical expert, then the report should reconstruct the cause of death of these inmates and determine whether the deaths were preventable.
4. Recommendations by the expert in addressing and proposing a remedy for all constitutional and statutory violations.

4. **Discovery**

- A. Use discovery to piece together the delivery of the correctional facility’s medical system.
- B. This is accomplished by requesting certain documents:

⁶See Fed. R. Civ. P. 35(b)(1)(“ . . .the party causing the examination [Fed. R. Civ. P. 35(a) physical examination] to be made shall deliver to the requesting party a copy of the detailed written report of the examiner setting out the examiner’s findings, including results of the tests made, diagnosed and conclusions, together with like reports of all earlier examinations of the same condition.”)

1. Documents recording a Quality Improvement Program⁷
 - A CQI reviews the faults in the medical delivery system and suggests any changes that should be made to correct those faults.
2. Documents recording a Utilization Review⁸
3. Documents addressing sick call – this can be used to determine how often patients are seen during sick call.
4. Grievance and complaints that have been filed.
5. Continued access to medical records. (especially if inmates have died during the pendency of litigation).
6. If available, securing post-mortem autopsy reports.

⁷See Anno, B. Jaye, Correctional Health Care, Guidelines for the Management for an Adequate Delivery System, pg. 327 (2001)(the committee consists of a “process of ongoing monitoring and evaluation to assess adequacy and appropriateness of the care provided and to institute corrective action as needed.”)

⁸Id. at 327 (2001)(utilization reviews are designed to assess “[a]reas such as appropriate inpatient admissions, length-of-stay considerations, and use of ancillary services.”)

HIV/AIDS in Minority Communities

(Any materials for this session will be distributed during the session)

Private Insurance

Nuts & Bolts: Managed Health Care for PWLA/HIV

Howard L. Schwartz

OVERVIEW

1. Managed Health Care Defined

- General characteristics of managed care vs traditional indemnity
- HMO/POS/PPO
- Employer/Individual/Supplemental Plans/Catastrophic

2. Pre-Existing Condition Exclusions/Portability

- What is a condition?
- How to calculate time?
- Is the prior plan creditable? (ADAP, etc.)
- Plan variations (medigap, employer plans) – Read the Summary Plan Description
- Case Study

3. Medical necessity of treatment vs. experimental therapy

- Clinical trials
- Off Label Uses
- Complementary/Alternative therapies
- Cosmetic treatments –Lipodystrophy Badell v. Celtic Life Insurance Co., 159 F. Supp.2d 1186 (N.D. Cal 2001)

4. Prescription issues

- Formulary restrictions overview
- Tiered prescription plans
- Prior Authorization
- Serostim example
- Who's in charge:
Subcontractors providing pharmacy benefits, mail order pharmacies
- Advocating for clinical exceptions to formulary restrictions

5. Capitation of services

- Prescription caps
- Home care caps
- Total service caps, deductibles, service exclusion categories

6. COBRA and State's COBRA

- Statutory Overview and Pre-emption by State Plans
- Triggers
- Length of COBRA coverage and who is covered
- COBRA process time line
 - Knoll v Equinox Fitness Clubs, 2003 U.S. Dist. LEXIS 23086 (SDNY 2003). 30-day notice to employee, plus 14 additional days if employer is not the plan administrator. DOL proposed regulations endorses 14 additional days even if employer is the plan administrator, although some courts disagree.
- Extension of COBRA due to SSDI
- Grey areas—Divorce/Separation agreements
- Case study

7. Medical claims and Premium Payments

- Reading the fine print, reviewing with medical provider
- Primary versus secondary
- Collections
- Premium payments and grace periods
 - COBRA vs. Employer vs. Individuals
- Suspension of services due to non payment even during grace period: impact on medication regimens, surgery, medical care

ADVOCACY AND MANAGED CARE APPEALS

8. Managed Care Grievances and Review Mechanisms

- State Bill of Rights
- Utilization Review for medical necessity vs. grievance
 - Time lines, who will review etc. covered in plan description, physician involvement
- Internal appeals within the managed care plan
- External appeals if provided by State-prepare a “brief” or memorandum
- State oversight organizations, eg. State Attorney General, Dept. of Insurance, Legislative
- FDA and FTC oversight of certain medical fraud issues

9. Gathering Information to pursue a claim

- Requesting Summary Plan Description – 30 days, 29 U.S.C. 1024 (b)(4) and 1132 (c)
- US Dept. Of Labor enforcement call: 202-219-8771

- All claims, forms, correspondence from plan
- Denial reasons must be articulated to give a meaningful opportunity for review
29 CFR sec. 2560.503-1 (f)
- Obtain all medical charts and discuss with medical providers
- Client's own diary: medical conditions, day to day, and employer issues

10. The document battle and assessing your client's rights

- The Summary Plan Description governs or the underlying plan documents?
Heidgerd v. Olin Cor-Q., 906 F.2d 902 (2nd Cir.1990);
Hansen v. Continental Insurance Co., 940 F. 2d 971 (5th Cir. 1991)
- Oral representations and estoppel for misrepresentations
Kane v. Aetna Life Insurance, 893 F.2d 1283 (11th Cir. 1990)
- Discretion issues vs *De Novo* review
Firestone Tire & Rubber Co. v. Bruch, 489 US 101 (1989)
- Clear grant of discretion required
Wulf v Ouantum Chemical Corp., 26 F.3d 1368, 1373 (6th Cir. 1994) cert denied,
115 S.Ct. 667 (1994)

NEW ISSUE - HIPAA and MANAGED CARE

11. HIPAA Basics, 42 U.S.C. sec. 1320d *et seq.*

- Health Insurance Portability and Accountability Act of 1996
- Generally establishes a federal floor of safeguards to protect privacy of medical records and other "personal health information" by restricting use and disclosure
- Regulated by US Dept. of Health & Human Services. Final regulations effective April 14, 2003, 45 C.F.R. Parts 160 and 164

12. HIPAA applies to:

- Health information transmitted in electronic, written or oral form
- By covered entities: Health Care Providers, Plans, Clearinghouses IF they transmit health information electronically in connection with certain covered transactions
- Covered transactions: Processing Claims, payment and remittance, coordination of benefits, claim status, enrollment/disenrollment information, plan eligibility, premium payments, referral certifications and authorizations, first report of injury, health claim attachments

13. What information is protected?

- Created or received by a health care provider, health plan, public health authority, employer, school, life insurer, or health care clearinghouse, AND
- Is related to the past, present or future physical and mental health of an individual

14. HIPAA and State HIV confidentiality laws

- HIPAA pre-empts any “contrary” state law provision, except when, among other things:
 - the state law relates to privacy and is “more stringent” than the HIPAA provision
 - Stringency Test:
 - Gives an individual greater rights to access or amend health records
 - Provides more information to an individual regarding use, disclosure, or rights and remedies
 - Provides a narrower scope or duration or affords increased privacy protections
 - Provides for retention or reporting of more detailed information in an accounting of disclosures
 - Provides greater privacy protection for the individual who is the subject of the protected information
 - Or in special cases when the Secretary of HHS has determined that the state law is necessary: to prevent fraud/abuse related to provision of health care, or reporting of child abuse, or public health surveillance, etc. 45 C.F.R. Part 160.203

15. HIPAA and Consent Forms

- Cannot condition treatment on patient signing consent
- Must describe consequences if any of patients refusal to sign consent
- Must describe any exceptions to the patient’s right to revoke consent
- Patient’s rights explained- receive a notice of privacy policies, access records, request an amendment to records, receive an accounting, file a complaint, request restrictions on access

16. HIPAA and Health Insurance Records

- Right to Amend Records can be done by patient, parent/guardian
- 60 response time from date of request
- if amendment is accepted, identify affected record and append or link to correction
- if amendment denied, provide written denial explaining reasons and patient’s right to submit a written statement.
- Also provided: right to obtain an accounting of disclosures of personal health info

17. HIPAA Complaints and Sanctions

- Complaints concerning HIPAA policies and procedures can be made
- Sanctions are to be imposed against workforce for violations of privacy policies
- Designated staff member to be responsible for receipt of complaints (privacy officer)
- Document all complaints received and their disposition

18. HIPAA Enforcement

- No federal right to sue, but violations could be grounds for state tort actions
- Administrative complaints made to HHS for enforcement of violation against the covered entity
- Penalties include: \$100 civil fine per violation, \$50,000 max. criminal fine and one year imprisonment for knowingly wrongful disclosures and higher fines for intent to sell information, etc.

CASE STUDY: Pre-Existing Conditions
Howard L. Schwartz

SIMON'S DILEMMA

Simon has been on an employer group policy for last 5 years. About 2 months ago, Simon goes to his PCP who tests him for HIV; the results come back +. Simon does not seek any form of HIV treatment/lab work after the test.

Last month, Simon's employer went out of business. Simon was lucky enough to have some savings set aside. He uses part of his savings to buy an individual health plan at the end of the same month, which is effective on the first day of the following month. The plan description says it will not cover any pre-existing conditions.

During the first month of the new policy, Simon goes to an in-network Infectious Disease Specialist and has HIV-related lab work done.

- Can he be subject to a pre-existing condition wait period?
- What is the impact of getting HIV test results but not getting treatment or lab work?
- Would your answer to the above be different if he did the HIV test at an anonymous testing site?
- What would happen if he had the HIV test 8 months ago without any treatment or lab work since?
- What if he had not gone to an infectious disease specialist until after being on the new plan for six months? What if he waited until after a full year of being on the new plan?
- *Would it matter if instead of buying individual insurance, Simon found a new job a month after he left the old one, but the new job's insurance does not start until after completion of a 3 month probationary period?*

CASE STUDY: Managed Care-COBRA
Howard L. Schwartz

NADIRA'S DILEMMA

Nadira lost her job last month. There were about 70 employees and half of them were laid off. She is on unemployment and is trying to find a new job.

Nadira says she thinks her health insurance coverage ended on the day she was laid off. She needs to see her doctor and has medications that need to be refilled at the pharmacy.

- How can you help Nadira?
- Would your answer change if the employer went out of business?
- What would happen next year if the employer decides to change to a new health plan insurance?

**Private Long Term Disability Insurance:
Establishing New Claims and Administrative Appeals**

Debra J. Wolf

I. Establishing Claims

Refer client to treating physicians to discuss and review medical records and ensure physician will certify full disability.

Review policy: At an initial consultation, the client should bring all available plan or policy documents. If not already in the client's possession, the client should be instructed to immediately take steps to obtain such documents.

1. What Law Governs (State or Federal/ERISA)?

Individual Insurance Policies as Contracts

▪ State Law: In general, individually purchased disability insurance policies are considered contracts, governed by state insurance and contract law. Insurance law will typically prescribe mandatory benefits and provisions. Contract law will govern matters such as interpretation and rules of construction with regard to policy provisions, choice of law, etc. Insurance policies are often considered by state common law to constitute a special breed of contract, and thus may give rise to special rules or treatment not applicable to contracts generally.

Employer-Sponsored Plans

▪ ERISA. An "employee welfare benefit plan" is defined as "any plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services...." 29 U.S.C. § 1002(1). Is it an ERISA plan? 29 U.S.C. §1102(a)(1): "Every employee benefit plan shall be established and maintained pursuant to a written instrument." A "plan" is a "scheme decided upon in advance." Pegram v. Herdrich, 530 U.S. 211, 223 (2000). An ERISA-governed plan is established "if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits." Grimo v. Blue Cross/Blue Shield of Vermont, 34 F.3d 148, 151 (2nd Cir. 1994).

2. Definition of Disability

Most policies will contain a definition of "total disability" that falls into one of three broad categories -- own occupation, regular occupation and any occupation. It is not uncommon, particularly in employer-sponsored group plans, to see a definition of disability which starts as "own occupation" and then transitions to "any occupation" after a set period of time -- typically 12 to 36 months -- has elapsed.

a. Occupation: Where "total disability" is defined in a policy or plan as the "inability to perform the substantial and material duties of your occupation" or one's "own occupation," courts have

consistently held that the ability to engage in limited work duties -- whether dissimilar or even identical to the duties of the insured's own occupation -- does not preclude the insured from receiving benefits where he or she nonetheless remains unable to return to a full roster of duties approximating his or her pre-disability employment. See, e.g., Dixon v. Pacific Mut. Life Ins. Co., 268 F.2d 812 (2d Cir. 1959); Pittel v. Federal Home Life Ins. Co., N.Y.L.J., p. 26, col. 3 (Jul. 11, 1996, S.Ct. N.Y. Co.); Godesky v. First UNUM Life Ins. Co., N.Y.L.J., p. 33, col. 4 (Jun. 20, 1996, S.Ct. Duchess Co.); Matza v. Empire State Mut. Life Ins. Co., 50 A.D.2d 554, 375 N.Y.S.2d 578, 581 (1st Dept. 1975); 1C Appelman On Ins. 2d, §§671-74 (1981); Colonial Life and Accident Ins. Co. v. Whitley, 10 Ark App. 304, 664 S.W.2d 488, 490 (1984); Famularo v. Paul Revere Life Ins. Co., 378 So. 2d 531, 533-34 (La. Ct. of App., 4th Dept. 1979); Bowler v. Fidelity & Cas. Co. of New York, 53 N.J. 313, 250 A.2d 580 (N.J. S. Ct. 1969).

b. Regular Occupation: Courts that have addressed the meaning of “regular occupation” have determined that the term encompasses, at the very least, the broader defining attributes of the insured’s occupation, such as the employer’s size, location, and industry. In other words, while “regular occupation” does not necessarily include the anomalous and idiosyncratic responsibilities associated with an individual claimant’s job, it must include those particular responsibilities which typify or reflect the policyholder’s specialty and level of accomplishment. Kinstler v. First Reliance Standard Ins. Co., 181 F.3d 243 (2d Cir., 1999) (erroneous for insurance carrier to measure a plan participant’s occupational duties by a generic government-produced job description for “director of nursing,” holding that the carrier was required to evaluate disability based on that position as it was typically performed for employers of the same general size and structure); Mizzell v. Paul Revere Life Ins. Co., 118 F. Supp.2d 1016, (C.D.Cal. 2000) (improper for carrier to deny disability benefits under a regular occupation policy on the ground that the claimant was able to perform the sedentary activities associated with a general occupation description of a “vice president/general manager” published by the Department of Labor, when he was unable to perform the responsibilities of his “actual occupation,” which were “clearly not sedentary in that he was often required to travel up to two days a week”); Krisa v. Equitable Life Assur. Soc., 113 F. Supp.2d 694, 702 (M.D.Pa. 2000) (held that insured’s regular occupation was not a generic attorney, but specifically a trial attorney, and that his ability to continue some aspects of that work, such as office administration functions and solicitor work on behalf of several school districts, did not preclude him from qualifying for total disability benefits);

c. Any Occupation: This is the least generous of the “total disability” standards, though it would appear to be at least one qualitative step above Social Security’s “any substantial gainful activity” standard. Courts, moreover, have generally considered provisions employing language to the effect that a claimant must be unable to engage in any occupation “for which he or she is qualified by education, training, or experience” (the “QETE Standard”) to require some degree of comparability between the claimant’s prior work history and the occupations which the insurer or plan administrator argues he or she is able and qualified to perform.

d. Preexisting Condition exclusion: Review policy as well as state law. For example, New York Insurance Law Section 3234 (1) limits the pre-existing condition exclusion and a group policy cannot exclude coverage for a period in excess of twelve months following the effective date of coverage and (2) provides for portability of ERISA LTD plans under certain circumstances.

Note: State Law Has Some Concurrent Effect: State insurance laws setting forth generally required plan provisions will likely not be preempted (e.g., pre-existing condition definitions and limitations), unless they intrude on some of the core functions reserved to ERISA plan sponsors (e.g., setting the kind or amount of specific plan benefits required to be included in a plan) or required by ERISA law.

3. Mental health limitations: often limited to 24 months.
4. Timing of application: The disability must commence while the client is employed.

II. Administrative Appeals of the Denial or Termination of LTD Benefits

1. Administrative Appeal required to meet Exhaustion requirement

The Exhaustion Requirement: Although not specifically prescribed in ERISA, the Courts of Appeal have uniformly determined that the federal policy embodied in ERISA requires a plan participant to exhaust internal administrative procedures as a prerequisite to commencing a lawsuit to secure plan benefits. E.g., Kennedy v. Empire Blue Cross & Blue Shield, 989 F.2d 588, 594-95 (2nd Cir. 1993); Communications Workers of America v. AT&T, 40 F.3d 426 (D.C. Cir. 1994); Baxter v. C.A. Muer Corp., 941 F.2d 451 (6th Cir. 1991); Springer v. Wal-Mart Assocs. Group Health Plan, 908 F.2d 897 (11th Cir. 1990); Weldon v. Kraft, Inc., 896 F.2d 793 (3rd Cir. 1990).

There can be a number of levels of administrative appeals. If there is more information to supplement the established claim/appeal file, additional administrative appeals may be very useful.

Deadlines: ERISA provides a deadline of 180 days from receipt of denial of claim to appeal. Generally, can be extended for short period of time but agreement to extension should be confirmed in writing by insurer.

2. Obtaining Basic Documentation

a. Must be Made to the Plan Administrator. Moran v. Aetna Life Ins. Co., 872 F.2d 296, 299 (9th Cir. 1989); Vanderklok v. Provident Life and Acc. Ins. Co., 956 F.2d 610, 618 (6th Cir. 1992);

b. Request Complete Claim File / Satisfactory Denial Notice. See Sample Administrative Record Request Required by ERISA but request in individual policies as well; insurer often complies. Insured is entitled to E-mails, Telephone Diaries, Interoffice memoranda, correspondence Computerized Claim Tracking and Logs, Surveillance Tapes and Reports, Client Medical Documentation, Reports and CV's of reviewing physicians.

c. ERISA Penalties: "Any administrator . . . who fails or refuses to comply with a request for any information . . . within thirty days after such request may in the court's discretion be personally liable to such participant . . . in the amount of up to \$110 a day . . . , and the court may in its discretion order such other relief as it deems proper." 29 U.S.C. §1132(c)(1). See, e.g., Sunderlin v. First Reliance Standard Life Ins. Co., 235 F. Supp. 2d 222, 235 (W.D.N.Y. 2002) (\$15 per day fine); McConnell v. Costigan, 2002 U.S. Dist. LEXIS 15826 (S.D.N.Y., Aug. 23, 2002) (\$10 per day fine); Proujansky v. Blau, 2001 U.S. Dist. LEXIS 12694 (S.D.N.Y., Aug. 22, 2001) (\$20 per day fine); Scarso v. Briks, 909 F. Supp. 211, 214-15 (S.D.N.Y. 1996) (\$50 per day fine); Pagovich v. Moskowitz, 865 F. Supp. 130, 135-38 (S.D.N.Y. 1994) (\$75 per day fine); Kascewicz v. Citibank, N.A., 837 F. Supp. 1312, 1321-34 (S.D.N.Y. 1993), 738 (4th Cir. 1996).

III. Strategy for Establishing or Appealing a Claim

1. Claimant's Disabling Condition and Symptoms

Compile a detailed description of all claimant's illnesses and conditions, symptoms, medications (side effects), etc. These descriptions should be both qualitative and quantitative, and information as to how a particular symptom interferes with a particular job duty should be fully elaborated. For example, instead of just "fatigue," information should be elicited such as does the claimant require afternoon naps to be functional, does the claimant require lengthy amounts of sleep at night (and does this interfere with arriving at work in a punctual manner), how long can the claimant engage in a physical activity (mild, vigorous) before becoming exhausted and requiring a rest, etc.

2. Medical analysis

Review claim file and supplement with updated medicals and letters from treating physicians. Include updated Client Medical Records/IME Reports/Social Security Determinations/Other (labs, Karnovsky score, weight tracking). Ask doctor to include all helpful information. See sample letters provided.

3. Client Occupational Documentation

Many administrative records contain only a general vocational or labor assessment. Make sure you supply client's actual job description. Also consider statements from supervisors and/or co-employees regarding job duties and observations of insured's ability to do job.

4. Letter of Appeal: Key General Principles

a. More is Better. Supplement the administrative record or claim file with as much information as possible. Examples of such information to be regularly included are: physicians' statements, claimant job description, claimant symptom statement, claimant restrictions and limitations statements, co-worker statements, employer statements, work performance evaluations, attendance records, domestic partner statements, job advertisements and descriptions, vocational and labor market information, published medical information and studies, reports by medical, psychological, neuropsychological and vocational consultants. Remember that in ERISA cases, you may not be allowed to supplement the administrative record after a final determination has been rendered, so the submissions made during the appeal must fully and comprehensively establish your client's claim. While a claimant under an individually-purchased policy will be allowed to introduce new evidence in any legal proceeding, the comprehensive presentation of the claim prior to a lawsuit will help establish (i) the relative strength of the claim (and the probability of success in litigation), and (ii) your client's "good faith" and cooperative attitude. This, in turn, may facilitate resolution and/or settlement of the claim prior to commencement of a lawsuit.

b. Highlight Helpful Legal Precedents and Contractual Language such as definition of disability.

c. The Effect of Job Accommodations: A claimant's ability to perform an accommodated job should not be pertinent to the inquiry of whether the employee is disabled in his or her own or regular occupation. Donnelly v. Guarantee Mut. Life Co., 1999 U.S. App. LEXIS 8736 at *5, n. 1 (6th Cir., May 4, 1999) ("The issue is not, however, whether plaintiff could have been assigned different duties that he

would be able to accomplish in his partially-disabled state. Rather, the question is whether plaintiff was unable to complete the tasks inherent in his own job”) (not recommended for full text publication); Saffle v. Sierra Pacific Power Company Bargaining Unit Long Term Disability Income Plan, 85 F.3d 455, 459-60 (9th Cir. 1996) (arbitrary for plan administrator to interpret provision -- defining disability as “completely unable to perform each and every duty of [his/her] regular occupation” -- as precluding benefits where “accommodations could be made in the job to allow [claimant] to continue working”)

d. **Relevance of Social Security Disability Determination:** Although there is ample case law suggesting that an SSA disability determination is irrelevant to the determination of disability under an individual or ERISA group policy, there is other case law suggesting circumstances under which such a determination can be used to a claimant’s advantage. Thus, evidence of an SSA disability determination, particularly one reached after a full hearing, should always be submitted as supplemental evidence in support of your client’s claim. Kirwan v. Marriott Corp., 10 F.3d 784, at 790 n.32 (11th Cir. 1994). See also Riedl v. General American Life Ins. Co., 248 F.3d 753, 759 n.4 (8th Cir. 2001) (although not binding, a Social Security determination is “admissible evidence to support an ERISA claim for long-term disability benefits”); Edgerton v. CNA Ins. Co., 215 F. Supp. 2d 541, 549-50 (E.D. Pa. 2002) (“Although an SSA decision may not be dispositive in determining whether an ERISA administrator’s decision is arbitrary and capricious, it is a factor that should be considered”); Wilkes v. Unum Life Ins. Co., 2002 U.S. Dist. LEXIS 8763, at *27-30 (W.D. Wis., Jan. 29, 2002) (“Although determinations and decisions made by the Social Security Administration are not binding in ERISA actions ... this ... does not mean that ... Social Security determination(s) should be afforded no weight”); Saliamonas v. CNA, Inc., 127 F. Supp. 2d 997, 1000 (N.D. Ill., 2001) (“The fact that the Social Security Administration found [claimant] to be disabled under a stricter standard than [contained in the plan], while not conclusive, is certainly probative of disability”).

5. Discretionary Authority/Arbitrary and Capricious Standard

Discretionary Authority: Review policy for “discretionary language.” A denial of benefits is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.” Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). Where such authority is given, under traditional trust principles, a “deferential standard of review” is appropriate and the administrator’s decision “will not be disturbed if reasonable.” Firestone, 489 U.S. at 111. The burden of the claimant is that the administrator acted arbitrary and capricious (ignoring relevant factors, not based on substantial evidence). Some examples of findings of arbitrary and capricious:

a. A claim administrator acts arbitrarily when it ignores relevant factors or fails to base its decision on substantial evidence. Miller v. United Welfare Fund, 72 F.3d 1067, 1073-74 (2nd Cir. 1995);

b. **Sudden Deterioration Requirement:** It is arbitrary for a claim administrator to require a “sudden deterioration” in claimant’s condition to substantiate a disability claim, when the governing Plan contains no such requirement. Holzschuh v. Unum Life Ins. Co., 2002 U.S. Dist. LEXIS 13205, Civ. Action No. 02-13205 (E.D. Pa., July 17, 2002).

c. **Objective Evidence Requirement:** It is arbitrary for a claim administrator to require “objective” evidence when the Plan “nowhere provides that employees must submit objective medical evidence in support of their claims.” Durr v. Metropolitan Life Ins. Co., 15 F.Supp. 2d 205, 212 (D. Conn. 1998) It is error for a claim administrator to reject a claimant’s subjective complaints and

symptoms unless it references “specific, relevant evidence that would support not fully crediting” the claimant. Willis v. Baxter Int’l, Inc., 175 F. Supp. 2d 819, 833 (W.D.N.C. 2001)

d. Failure to Seek or Request Necessary Information: A claim administrator acts arbitrarily, in violation of ERISA, when it fails to obtain, or to otherwise request from the plan participant, particular kinds of evidence which the claim administrator requires to approve a claim. Juliano v. The Health Maintenance Organization of New Jersey, 221 F.3d 279, 287 (2nd Cir. 2000)

e. Failure to Base Decision on Appropriately Qualified Expert Opinions: It is arbitrary and capricious for a claim administrator to make conclusory medical or vocational determinations without the support of an appropriately qualified expert opinion, particularly once the plan participant has himself submitted such an expert opinion in support of his claim. 29 CFR 2560.503-1(h)(3)(iii) and (h)(4); Miller v. United Welfare Fund, 72 F.3d 1067, at 1073 (2d Cir. 1995); Levinson v. Reliance Standard Life Ins. Co., 245 F.3d 1321, at 1326 (11th Cir. 2001), rehearing and rehearing en banc denied, 260 F.3d 628 (11th Cir., 2001).

f. Failure to Give Holistic Consideration: (combined overall effects of long term HIV infection). It is arbitrary for a claim administrator to consider a claimant’s ailments individually, and not consider those ailments in combination when assessing his entitlement to disability benefits. Willis v. Baxter Int’l, Inc., 175 F. Supp. 2d 819, 832 (W.D.N.C. 2001).

g. Failure to Properly Credit Opinion of Treating Physician: Although the Supreme Court, in Black & Decker Disability Plan v. Nord, 538 U.S. ___, 123 S. Ct. 1965 (2003), held that Social Security’s “treating physician rule” is inapplicable in the ERISA context, this does not mean that a beneficiary is defenseless when facing a plan’s medical consultant. Nord prohibits only “routine deference” which “automatically ... accord[s] special weight to the opinions of a treating physician.” 123 S. Ct. at 1971-72. Indeed, the Court observed that “the assumption that the opinions of a treating physician warrant greater credit ... may make scant sense when, for example, the relationship between the claimant and the treating physician has been of short duration, or when a specialist engaged by the plan has expertise the treating physician lacks.” 123 S. Ct. at 1971. By implication, “greater credit” may be warranted where the treating physician does have superior expertise or a long-standing relationship with the claimant.

If the policy does not show a “clear grant of discretion”, plan decisions are subject to de novo review with greater opportunity to set forth common law arguments.

Women's Health and Reproductive Rights

Reproductive Rights and HIV/AIDS: A Policy Perspective on Current Issues

Caya B. Lewis

A. Introduction

In the current political environment, the policy fights on abortion and family planning are no longer isolated from HIV/AIDS policy. Attempts to establish fetal personhood, threaten a woman's right to privacy, and push abstinence-only policies are influencing domestic and global regulations and legislation on HIV prevention and care, especially for women.

1. Fetal Rights and Right to Privacy: SCHIP Regulations, UVVA legislation and Safe Abortion Procedures Ban
2. Abstinence-only Education Programs/ Disparaging Condoms: U.S. and Abroad
3. International Family Planning: UNFPA
4. International Family Planning: The Global Gag Rule and Global AIDS Bill
5. Center's for Disease Control Prevention Initiative

B. Fetal Rights and Right to Privacy: SCHIP Regulations, UVVA legislation and Safe Abortion Procedures Ban

1. State Children's Health Insurance Program (SCHIP) expansion

a. On October 2, 2002, the Centers for Medicare & Medicaid Services (CMS) released the final rule revising the definition of "child" under the SCHIP Program. Under the new rule, "an unborn child may be considered a 'targeted low-income child' by the State and is thus eligible for SCHIP if other applicable State eligibility requirements are met."

b. Has a harmful impact on women's health and undermines women's reproductive rights by recognizing a fetus as a "person."

c. CMS stated that family planning and sterilization could not be covered under a state's SCHIP benefit scheme (unless the mother were under age 19 and eligible for SCHIP in her own right), because such services are not being given to an eligible child. In response to the question of whether SCHIP funds could be used to treat injury or disease not related to a woman's pregnancy, such as broken bones or mental illness, CMS wrote that states would have "broad flexibility" to decide what services would be included under their SCHIP-funded plans, but also stated that "there must be a connection between the benefits provided and the health of the unborn child."

d. Harmful from a reproductive rights perspective because elevating the status of the fetus undermines *Roe v. Wade*, but the silver lining is that many states that have exercised this option are using it to provide health care to illegal immigrant women who would otherwise lack access.

2. Unborn Victims of Violence Act (H.R. 1997)

- a. Would create a separate criminal offense if an individual kills or injures an “unborn child” while committing a federal crime against a pregnant woman.
- b. Fails to address the very real need for strong, federal legislation to prevent and punish violence against women.
- c. Instead, under the guise of protecting women from violence, the bill creates a new cause of action on behalf of the unborn, thereby laying the groundwork for establishing fetal personhood and eroding the foundation of a woman’s right to choose.
- d. Definitions of “unborn child” in bill could call into question the legality of certain contraceptives or contraceptive research

3. Safe abortion procedures ban (S. 3 PL-): First-ever bill banning safe abortion procedures since *Roe v. Wade* was decided by the Supreme Court in 1973

- a. Signed into law on November 5, 2003
- b. Similar to *Stenberg v. Carhart* ruling struck down by the Supreme Court: no health exception, bans several pre-viability procedures
- c. Three challenges immediately filed and injunctions issued
- d. Recent Ohio ruling on December 17, 2003 very troubling

C. **Abstinence-only Education Programs/ Disparaging Condoms: U.S. and Abroad**

1. The domestic agenda

- a. Federal funding for abstinence-only vs. comprehensive sex-ed and family planning services
 - i. Three main sources of funding:
 1. A provision in the 1996 welfare reform law, Section 510(b) of Title V of the Social Security Act, authorized a \$50 million per year earmark in the Maternal and Child Health block grant.
 2. Another separate and distinct earmark within the MCH block grant (known as Special Projects of Regional and National Significance or SPRANS) for “community-based” abstinence programs” – funding that must comply with the most restrictive definition of abstinence-only.
 3. Adolescent Family Life Act (AFLA), which has been, administered by the Office of Population Affairs for more than 30 years. Derisively referred to as the “chastity” program during the Reagan years, many of

the pregnancy prevention services funded through AFLA have long advocated abstinence, although, only recently has the restrictive abstinence-until-marriage definition been applied

ii. Strict Eight-point Definition

--Established in welfare bill, requires, among other things, that programs teach that sex outside of marriage has harmful “psychological and physical effects.”

--Title V-funded programs are prohibited from discussing methods of contraception, including condoms, except in the context of failure rates

iii. Increased funding for abstinence-only

iv. Under-funding for family planning

b. Pushing the ABC's (Abstinence, Be Faithful, Use Condoms) on America

i. ABC in family planning program announcement

ii. Disparaging condoms as a way to promote abstinence-only

--NIH Condom Report

--HPV

2. The Global AIDS bill (P.L. 108-25) as a vehicle to export abstinence-only

a. Global AIDS Bill earmarks at least one-third of HIV/AIDS prevention funds in bill for "abstinence-until-marriage" programs

b. Anti- prostitution clauses

c. HPV survey

3. Fifth United Nations Asian and Pacific Population Conference in Bangkok

a. The Administration also sought to include “natural family planning” under areas of required research, as well as delete “consistent condom use” as a means to reduce vulnerability to HIV infection in the section on HIV/AIDS.

b. On December 16, Assistant Secretary of State Gene Dewey states, “the U.S. supports the sanctity of life from conception to natural death.” Dewey also asserted that “because condoms are simply not 100 percent effective... it is critical that we also promote abstinence for the unmarried and fidelity for those who are married.”

D. United Nation's Population Fund (UNFPA)

1. Historically, United States one of the largest contributors to UNFPA. UNFPA provides life-saving reproductive health services in over 150 poor countries around the world. UNFPA was founded shortly after the initiation of the global population program of the U.S. Agency for International Development (USAID)

2. Bush Administration has frozen US contribution approved by Congress for FY 2002 and FY 2003 based on Kemp-Kasten provision

a. The Kemp-Kasten amendment prohibits U.S. funding to any organization that "supports or participates in the management or a program of coercive abortion" or involuntary sterilization.

b. The Administration relied on unsupported allegations made by a small organization that vehemently opposes contraception that claimed that UNFPA was in violation of the Kemp-Kasten provision in U.S. law

c. Despite lack of evidence that UNFPA has violated the Kemp-Kasten amendment, President Bush cut off funding, asserting that UNFPA *unknowingly* and *indirectly* supports coercive abortion and involuntary sterilization in China

d. Attempts to clarify Kemp Kasten thwarted

--Amendments introduced by Representative. Joseph Crowley (D-NY) and Senator Patrick Leahy (D-VT) would have maintained the protections in Kemp-Kasten while clarifying its intent by prohibiting US funds from going to UNFPA only if it "*directly supports or participates in coercive abortion or sterilization.*"

e. International AIDS Consortium de-funded because of link to UNFPA

--In late August 2003 the State Department announced their decision to de-fund a small but well-regarded AIDS program for African and Asian refugees run by the Reproductive Health for Refugees Consortium. The State Department alleged that Marie Stopes International (MSI) was in violation of the Kemp-Kasten law although officials said they have no evidence to that MSI is directly involved in forced abortions and sterilization. MSI's partnership with UNFPA was cited as the basis for the funding decision.

E. Global Gag Policy

1. Originally implemented by President Ronald Reagan in 1984, this regulation prohibits non-U.S., non-governmental organizations to which USAID provides either direct or indirect funding for population assistance from using their own private, non-US dollars to provide, counsel, refer, or advocate for legal abortion.

2. Administration expanded gag rule to broader range of family planning programs

a. President Bush issued an executive order to expand the reach of the global gag rule on August 29, 2003

b. Expanded policy will broaden the impact to other voluntary family planning programs funded through the State Department

c. Full impact of the expansion is not yet clear; programs that could be affected serve HIV/AIDS patients, individuals who are victims of trafficking, and refugees

d. Administration did exempt programs funded through the President' Emergency Plan for AIDS Relief (PEPFAR); even if such groups provided abortion services, they could still receive funds under the initiative if they used them to treat people with HIV/AIDS

3. Earlier threat to expand the global gag rule to global AIDS funds

a. White House threatened to expand the global gag rule to global AIDS bill.

i. International organizations that use their own funds to provide, counsel, or refer for abortion services would be barred from receiving HIV/AIDS funds, as has already been the case for USAID family planning funds

ii. Apply not just to USAID, but also to the CDC and Department of Defense's HIV programs

b. This policy is counter to the well- held public health practice that integrated care is best—especially in resource poor settings like many of those in Africa and the Caribbean.

c. Because women represent half of the HIV case world- wide this policy is a particular assault on women's health and rights

F. Center's for Disease Control new prevention initiative: Advancing HIV Prevention: New Strategies for a Changing Epidemic (AHP)

1. AHP consists of four strategies:

- incorporating HIV testing into routine medical care;
- expanding use of rapid HIV tests to diagnose infections outside traditional medical settings;
- preventing new infections by reaching HIV-positive and their partners who are not receiving ongoing medical care;
- decreasing perinatal transmission through increased HIV testing of pregnant women, as well as routine screening of any infant whose mother was not screened

2. CDC Prenatal Testing Guidelines Report support voluntary testing

a. In 2000, 93 percent of women knew their HIV status before delivery

b. CDC estimates that about 300 HIV positive babies born in 2002, even though 6,000 to 7,000 HIV positive women will gave birth. This is down from a peak of 2,500 HIV positive babies born in 1992.

c. This dramatic decline reflects both advances in treatment for mothers and newborns and widespread adoption of the Public Health Service recommendations that health care workers offer HIV counseling and voluntary HIV testing for all pregnant women.

d. Gives support for voluntary testing

3. However, AHP focuses on decreasing perinatal transmission through more coercive testing policies

a. Currently three approaches to prenatal testing

i. Voluntary testing or “Opt-in:” Women must consent specifically to an HIV antibody test

ii. “Opt-out” testing: Women are notified that an HIV test will be included in a standard set of tests unless they opt out. No pre-test counseling is provided with this option.

iii. Mandatory newborn testing: Newborns are tested for HIV with or without the consent of the mother if the mother’s HIV status is unknown at delivery. A positive result in an infant indicates the HIV positive status of the mother.

b. States overwhelmingly require voluntary testing (“opt-in”) in accordance with CDC recommendations

c. AHP shifts the focus from primary prevention efforts aimed at educating the public about how to avoid HIV infection to “prevention for positives”, thus increased scrutiny on reproductive freedom for HIV+ women

**Damages under Federal and State
Anti-discrimination Laws**

Damages and Settlement Considerations in HIV/AIDS Cases

Alan M. Koral

I. **Damages Under the Americans With Disabilities Act and the Rehabilitation Act**

A. The availability and calculation of damages in HIV/AIDS cases under the ADA or Rehabilitation Act does not differ from other forms of disability discrimination brought under those federal statutes.

B. ADA

1. As part of the Civil Rights Act of 1991, congress made available capped compensatory and punitive damages for violations of the ADA, though only where “intentional discrimination” rather than “disparate impact” is alleged. 42 U.S.C. § 1981a(a)(2).
 - a. Compensatory damages include damages for “future pecuniary losses, emotional pain, suffering, inconvenience, mental anguish, loss of enjoyment of life, and other nonpecuniary losses.” 42 U.S.C. § 1981a(b)(3).
 - b. Punitive damages also may be awarded for discrimination “with malice or with reckless indifference” to the rights protected by the ADA. 42 U.S.C. § 1981a(a)(2) & (b)(1). The Supreme Court has explicitly rejected the notion that egregious conduct by the employer is a prerequisite to the award of such damages, holding instead that an employer need only “discriminate in the face of a perceived risk that its actions will violate federal law to be liable in punitive damages.” *Kolstad v. American Dental Ass’n*, 527 U.S. 526 (1999).
2. Where an ADA plaintiff seeks compensatory or punitive damages, either party may demand a jury trial. 42 U.S.C. § 1981a(c)(1).
3. The maximum potential damage award varies with the size of the employer, and no compensatory or punitive damages are available for failure to make reasonable accommodation where the employer “demonstrates good faith efforts” to make an effective accommodation in consultation with the individual with a disability. 42 U.S.C. § 1981a(b)(3) & (a)(3).
4. Attorney fees are routinely awarded to prevailing plaintiffs under the ADA.
5. Considerations specific to government employers
 - a. Under Title I of the ADA (the employment provisions), only *Ex Parte Young* actions for injunctive relief are available against state government actors.
 - b. Under Title II of the ADA, state defendants are not immune from damages claims founded in due process violations. *Lane v. Tennessee*, 315 F.3d 680 (6th Cir. 2003) (holding that failure to make a county courthouse accessible to the disabled, absent assistance, constituted a due process violation, for which damages were available against state defendants under Title II), *cert granted in part* 156 L.Ed.2d 626, 123 S.Ct. 2622, 2003 U.S. LEXIS 4818 (2003). The Court heard oral argument on this case earlier this month.

c. Title III of the ADA (the “public accommodations” provisions), affords no private right of action for damages; damages are available only when the Justice Department is a party.

C. Rehabilitation Act (Private Enforcement Against Recipients of Federal Financial Assistance and Federal Agencies under § 504)

1. In 1978, Congress amended the Rehabilitation Act to provide that any remedies set forth under Title VI shall also be available to any plaintiff bringing a suit under § 504.
2. The Supreme Court held in *Consolidated Rail Corp. v. Darrone* that back pay is available under § 504 as a remedy for intentional discrimination, but did not determine the availability of compensatory or punitive damages. 465 U.S. 624 (1984).
3. Some federal courts have held that § 504 does not permit the award of punitive damages. *See, e.g. Moreno v. Consolidated Rail Corp.*, 99 F.3d 782 (6th Cir. 1996)(en banc); *Winfrey v. City of Chicago*, 957 F.Supp. 1014 (N.D. Ill. 1997); *Doe v. Marshall*, 882 F.Supp. 1504 (E.D.Pa. 1995). However, the majority of courts have found that punitive damages are permitted against nonfederal defendants. *See, e.g. Hunt v. Meharry Medical College*, 2000 U.S. Dist. LEXIS 7804 (S.D.N.Y. June 6, 2000); *Falls v. Prince George’s Hosp. Ctr.*, 199 U.S. Dist. LEXIS 22551 (D.Md. Mar. 16, 1999); *Burns-Vlidak by Burns v. Chandler*, 980 F.Supp. 1144 (D.Haw. 1997).
4. The Rehabilitation Act expressly authorizes an award of reasonable attorney fees to prevailing parties, other than the United States, in actions brought to enforce § 504. 29 U.S.C. § 794a(b).

II. **Damages Under Selected State Statutes**

A. While a comprehensive treatment of state and local law would be unrealistic, it is important to recognize that state law remedies may be substantially broader than remedies under federal law.

1. While some states follow the original Title VII model by limiting remedies to injunctive relief, back pay and attorney fees, other states allow recovery for compensatory damages, which may include pain and suffering, and exemplary or punitive damages.
2. Others impose civil and even criminal penalties. *E.g.*, COLO. REV. STAT. ANN. §§ 24-34-801 -- 24-34-802 (violations are misdemeanors punishable by fine or imprisonment); VT. STAT. ANN. Tit. 9, § 4553(a)(7)(B) (\$10,000 civil penalty for each violation).
3. Some state statutes have been held to permit individual liability for violations. *E.g.*, N.Y. EXEC. LAW § 296; N.J. STAT. ANN. § 10:5-1 *et seq.*

B. Selected State Statutes

1. New York

- a. The New York State Human Rights Law, N.Y. EXEC. LAW § 296 *et seq.*, explicitly bars discrimination on the basis of disability. However, unlike the ADA, the NYSHRL does not require

accommodation of behaviors that do not meet the employer's workplace behavior standards, so long as the standards are consistently applied to all similarly situated employees. 9 N.Y.C.R.R. 466.11(g).

- b. Damages under the New York State Human Rights Law are not limited to back pay; they extend to compensatory relief, which could include damages for pain and suffering. However, the New York Court of Appeals has held that punitive damages are not available. *Thoreson v. Penthouse International, Ltd.*, 80 N.Y.2d 490, 591 N.Y.S.2d 978, 606 N.E.2d 1369 (1992).
- c. The New York State Human Rights Law has been held to impose individual liability under limited circumstances, upon both the basis of "aiding and abetting," and the basis of an ownership interest or possession of power to do more than carry out personnel decisions made by others. *See Patrowich v. Chemical Bank*, 63 N.Y.2d 541, 483 N.Y.S.2d 659, 473 N.E.2d 11 (1984).
- d. Additional damages considerations under the New York City Human Rights Law, N.Y.C. ADMIN. CODE § 8-101 *et seq*
 - (i) The New York City Human Rights Law makes explicit provision for direct individual liability. N.Y.C. ADMIN. CODE § 8-107(1).
 - (ii) Unlike the New York State Human Rights Law, the City Human Rights Law provides for attorney fees and punitive damages.
 - (iii) Unlike the ADA, the City Human Rights Law does not cap available damages.

2. New Jersey

- e. The New Jersey Law Against Discrimination, N.J. STAT. ANN. § 10:5-1 *et seq*, was made applicable to physically handicapped persons in 1972, and to non-physically handicapped persons in 1978.
- f. Back pay, compensatory damages (including front pay, and damages for emotional distress), and punitive damages are available under the New Jersey Law Against Discrimination.
- g. As in New York, individual liability for "aiding and abetting" may be imposed for violations of the New Jersey Law Against Discrimination. *See Tyson v. CIGNA Corp.*, 918 F.Supp. 836 (D.N.J. 1996).

3. California

- a. The California Fair Employment and Housing Act, CAL. GOV'T CODE § 12926 *et seq*, explicitly extends its protections to workers suffering from "chronic or episodic conditions such as HIV/AIDS."
- b. In private lawsuits brought under the FEHA, there is no limit on the amount of damages available for emotional distress and additional unlimited punitive damages may be awarded.

4. Illinois

The protections of the Illinois Human Rights Act, 775 ILL. COMP. STAT. 5/2-102, have been held to extend to individuals diagnosed with HIV/AIDS. *Raintree Health Care Ctr. v. Human Rights Comm'n*, 275 Ill. App. 3d 387, 211 Ill. Dec. 561, 655 N.E.2d 944 (1 Dist. 1995), *aff'd*, 173 Ill. 2d 469, 220 Ill. Dec. 124, 672 N.E.2d 1136 (1996). The HRA permits the recovery of “actual” compensatory damages, including those for emotional distress, as well as reasonable attorney fees.

C. Settlement Issues in Employment Situations

Remaining Employed

Job Modifications

Transfers

Flexible Hours

Leaves of Absence When FMLA Doesn't Apply

Salary Continuation During Leave

Ending Employment/Termination

Severance Pay

Annuity

Health Insurance/COBRA

Other Employee Benefits

Alternative Dispute Resolution

Section 513 of the ADA provides that where appropriate, and to the extent authorized by law, the use of alternative means of dispute resolution is encouraged to resolve disputes arising under the ADA. 42 U.S.C. § 12212.

Alternative Dispute Resolution Options

Mediation

The EEOC has never possessed the resources to properly investigate all of the cases brought before it, and has long struggled with many more cases than it can handle.

In an effort to make the most of its limited resources, the EEOC is making increased use of mediation.

Mediation was held in 26.9% of all ADA disability cases filed with the EEOC between January 1, 1999, and June 30, 2000, and closed as of September 30, 2000. Kathryn Moss, et al., *Mediation of Employment Discrimination Disputes Involving Persons With Psychiatric Disabilities*, PSYCHIATRIC SERVICES, August 2002, at 988.

Settlement was reached in 62.2% of the above. *Id.*

Voluntary Arbitration

Negotiation

HIV/AIDS Law and Practice 2004
From Nuts & Bolts to Cutting Edge

January 23-24, 2004
Loyola University
New Orleans, La.

PROGRAM EVALUATION FORM

Mandatory Continuing Legal Education (MCLE) state regulators require CLE program evaluations for CLE accreditation. We value your input and ask that you complete and return this form to either the Registration Desk before your departure from the conference, or by fax to Michael Pates, Director, ABA AIDS Coordination Project, 202/662-1032. Thank you.

Friday, January 23, 2004

9:00 -10:15 a.m. **Plenary Session (Panel): Major HIV/AIDS Litigation: Wins, Losses, and Cutting Edge Issues**

Rating: Excellent _____ Good _____ Fair _____ Poor _____ N/A _____

Comments: _____

10:30 - 12:00 **Plenary Session (Panel): The ADA and the Rehabilitation Act: Litigation Strategy**

Rating: Excellent _____ Good _____ Fair _____ Poor _____ N/A _____

Comments: _____

12:00 - 1:45 p.m. **Luncheon Presentation: HIV/AIDS in the South**

Rating: Excellent _____ Good _____ Fair _____ Poor _____ N/A _____

Comments: _____

1:45 - 3:15

Social Security Practice

Rating: Excellent _____ Good _____ Fair _____ Poor _____ N?A _____

Comments: _____

Debtor/Creditor Issues (incl. Bankruptcy)

Rating: Excellent _____ Good _____ Fair _____ Poor _____ N/A _____

Comments: _____

Immigration

Rating: Excellent _____ Good _____ Fair _____ Poor _____ N/A _____

Comments: _____

3:30 - 5:00

Housing

Rating: Excellent _____ Good _____ Fair _____ Poor _____ N?A _____

Comments: _____

Sexual Health and Sex Education Issues

Rating: Excellent _____ Good _____ Fair _____ Poor _____ N/A _____

Comments: _____

Saturday, January 24, 2004

9:00 - 10:15 a.m.

Plenary Session (Panel): Medical Privacy, Confidentiality, and Criminalization

Rating: Excellent _____ Good _____ Fair _____ Poor _____ N/A _____

Comments: _____

10:30-12:00

Government Health Insurance: Medicaid, Medicare, & ADAP

Rating: Excellent _____ Good _____ Fair _____ Poor _____ N/A _____

Comments: _____

HIV in Adult and Juvenile Correctional Facilities

Rating: Excellent _____ Good _____ Fair _____ Poor _____ N/A _____

Comments: _____

12:00-1:45

Luncheon Presentation: HIV/AIDS in Minority Communities

Rating: Excellent _____ Good _____ Fair _____ Poor _____ N/A _____

Comments: _____

1:45 - 3:15

Private Insurance

Rating: Excellent _____ Good _____ Fair _____ Poor _____ N/A _____

Comments: _____

Women's Health and Reproductive Rights

Rating: Excellent _____ Good _____ Fair _____ Poor _____ N/A _____

Comments: _____

3:00-5:00 **Closing Plenary (Panel): Damages under Federal and State Anti-discrimination Laws**

Rating: Excellent _____ Good _____ Fair _____ Poor _____ N/A _____

Comments: _____

Additional Comments: