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The AIDS Epidemic and Health Care Reform, 27 J. Marshall L. Rev. 279 (1994)

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THE AIDS EPIDEMIC AND HEALTH CARE REFORM

WILLIAM A. BRADFORD, JR., MICHELE A. ZAVOS, AND THE AMERICAN BAR ASSOCIATION AIDS COORDINATING COMMITTEE*

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The views expressed in this Article are solely those of the ABA AIDS Coordinating Committee. This Article has not been reviewed or approved by the House of Delegates or the Board of Governors of the American Bar Association. Viewpoints expressed herein do not necessarily represent the official position or policies of the American Bar Association, unless expressly stated.

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I. INTRODUCTION

The spread of Human Immunodeficiency Virus infection (HIV), as well as the changing epidemiological nature of Acquired Immunodeficiency Disease (AIDS), created a variety of legal issues. This paper is a survey of the issues associated with providing access to health care for people with AIDS. The paper begins with an analysis of the demographic trends among HIV-infected persons and persons with AIDS (PWAs). Next, the paper discusses the issues arising from the impediments PWAs confront in obtaining access to health care, including an analysis of protections afforded by the recently-enacted Americans with Disabilities Act. The paper then examines the issues of access to health care in the context of private insurance coverage and self-insured employers. Finally, the paper analyzes the problem of uninsured persons with HIV and the resultant burden on Medicaid and public financing.

This paper was prepared by the AIDS Coordinating Committee of the American Bar Association (ABA). The Coordinating Committee, formed in 1987, has among its members representatives of various relevant sections of the ABA and of analogous organizations such as the National Bar Association and the New York State Bar Association. The AIDS Coordinating Committee drafted and co-sponsored the wide-ranging ABA Policy on AIDS, which the House of Delegates adopted in August 1989. This ABA Policy on AIDS will be noted throughout this paper.

HIV, the cause of AIDS, attacks the body's immune system and leaves the host susceptible to a variety of cancers and infections.¹ AIDS is the term adopted by the Centers for Disease Control and Prevention (CDC) for the condition that occurs in the later stages of HIV disease when the immune system is the most damaged.² It is estimated that HIV-infection develops into full-blown AIDS approximately ten years after infection.³ Generally, PWAs live approximately two years after full-blown AIDS is diagnosed.⁴

In this country, the CDC is responsible for defining what diseases constitute AIDS. Before 1993, the CDC's definition of AIDS

1. Helena Brett-Smith & Gerald H. Friedland, *Transmission and Treatment in AIDS* LAW TODAY: A NEW GUIDE FOR THE PUBLIC 21-23 (Scott Buris et al. eds., 1993). See also Kenneth G. Castro et al., *1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults*, 40 MORBIDITY AND MORTALITY WKLY. REP., Dec. 18, 1992, at 1.

2. Smith & Friedland, *supra* note 1, at 35.

3. *Id.*

4. See *id.* at 37 (discussing the increasing life expectancy of persons with full blown AIDS).

included anyone who had one of twenty diseases.⁵ However, the CDC revised and expanded the definition in 1993 after criticism that it was based on the medical condition of homosexual men and did not include the experience of women, drug users, and poor people.⁶ The expanded AIDS definition includes any HIV-infected person with severe immunosuppression, pulmonary tuberculosis, recurrent pneumonia, or invasive cervical cancer.⁷ The CDC intended for the revised definition to aid in more accurate current and future health-care evaluations by including diseases afflicting persons of all classes.⁸

By the end of 1992, more than 170,000 Americans had died of AIDS.⁹ In the early 1980s, six cities reported over three-fourths of all reported AIDS cases, but by 1991 thirty-one metropolitan areas and twenty-five states each reported over one thousand AIDS cases.¹⁰ In the early years of the epidemic in the United States, homosexual men comprised almost sixty percent of reported AIDS cases, with intravenous drug users making up the second largest group.¹¹ However, drug users and their partners, have become the significant demographic groups affected by AIDS in the 1990s.¹² Although no population group is insusceptible to AIDS and HIV, poor people with no health insurance coverage are more likely to contract AIDS than insured, economically-stable persons;¹³ African-Americans and Hispanics are also disproportionately represented.¹⁴ The disease is similarly becoming increasingly associated

5. *Id.* at 35-36. The CDC included Kaposi's Sarcoma, pneumocystis carinii pneumonia, and toxoplasmosis of the brain, among other serious diseases, in its definition. *Id.*

6. MICHAEL T. ISBELL, HEALTH CARE REFORM LESSONS FROM THE HIV EPIDEMIC; 50-51 (1993) [hereinafter HEALTH CARE REFORM] (citing Anastos & Marte, *Women—The Missing Persons in the AIDS Epidemic*, THE AIDS READER 190 (1990)); Michele A. Zavos, *Legal Considerations*, in UNTIL THE CURE: CARING FOR WOMEN WITH HIV 125 (Ann. Kurth, ed., 1993).

7. Castro, *supra* note 1, at 4. Severe immunosuppression is defined as a CD4+ lymphocyte count of less than 200/mm³ or a CD4+ percent of total lymphocyte count of less than 200/mm³ or a CD4+ percent of total lymphocytes less than fourteen when it is not possible to get an absolute count. *Id.*

8. *Id.* at 5-6, 8, 9.

9. CENTERS FOR DISEASE CONTROL, HIV/AIDS SURVEILLANCE, YEAR-END EDITION, Feb. 1993, tbl. 13.

10. REPORT OF THE NAT'L. COMM'N ON ACQUIRED IMMUNE DEFICIENCY SYNDROME, AMERICA LIVING WITH AIDS (Linda C. Humphrey ed. 1991) 11 [hereinafter 1991 NAT'L COMM'N REP.].

11. HEALTH CARE REFORM, *supra* note 6, at 47. Blood transfusions were also responsible for many cases during the early 1980s. *Id.* at 48.

12. *Id.*

13. *Id.* at 49.

14. National Health Law Program, *Health Benefits: How the System is Responding to AIDS*, 22 CLEARINGHOUSE REV. 724, 725 (1988) [hereinafter CLEARINGHOUSE REV.]. African-Americans and Hispanics comprise 41% of AIDS cases generally, and over 75% among children. *Id.*

with the inner city and the impoverished.¹⁵ Even these figures are deceiving; the CDC estimates that reported AIDS cases consist of only ten to fifteen percent of the actual number of HIV-infected persons¹⁶ and do not include those individuals who have died of HIV-related conditions which do not meet the CDC definition of AIDS.

II. THE CHANGING NATURE OF COMMUNITIES AT RISK

The demographics of the AIDS epidemic have undergone substantial changes in recent years.¹⁷ What was once considered a disease primarily affecting homosexual males¹⁸ has now become an epidemic among the heterosexual population particularly impacting women and people of color who reside in impoverished, urban areas.¹⁹ Rather than being evenly distributed throughout the population, the AIDS epidemic has generally manifested itself in distinct population groups, comprised of individuals lacking access to health care and other resources.²⁰ As these specific populations become disproportionately affected by AIDS and HIV-infection, epidemiologists have observed a gradual decline in AIDS among male homosexuals.²¹

The shift in demographics of the AIDS/HIV epidemic partially resulted from the initiation of AIDS educational programs within the homosexual community in the 1980s. Alternatively, minimal programs existed in the localities and population groups currently experiencing a dramatic upsurge in AIDS cases.²² Therefore, to counter the shifting demographics of PWAs, the United States health care reform package should contain educational and treatment programs designed specifically for the concentrated populations heavily affected by AIDS and HIV.²³

15. See 1991 NAT'L COMM'N REP., *supra* note 10, at 13-14.

16. *Id.* at 12-13 ("[The] CDC estimates that, at present, approximately one adult male in 100 in the United States is HIV positive and one adult female in 600 is similarly infected.").

17. See HEALTH CARE REFORM, *supra* note 6, at 48.

18. *Id.*

19. See PANEL ON MONITORING THE SOCIAL IMPACT OF THE AIDS EPIDEMIC, NAT'L RESEARCH COUNCIL, THE SOCIAL IMPACT OF AIDS IN THE UNITED STATES 7, 247-53, 257 (Albert R. Jonsen & Jeff Stryker eds., 1993).

20. *Id.* at 7-9.

21. HEALTH CARE REFORM, *supra* note 6 at 48.

22. See Nan D. Hunter, *Complications of Gender: Women and HIV Disease*, in AIDS AGENDA: EMERGING ISSUES IN CIVIL RIGHTS 7-9 (Nan D. Hunter & William B. Rubenstein eds., 1992).

23. American Bar Assoc., *American Bar Association Policy and Report on AIDS*, 21 U. TOL. L. REV. 9, § O.1, at 18 (1989), [hereinafter *ABA Pol'y and Rep. on AIDS*] "Accurate, effective education of the public regarding HIV, consistent with generally accepted public health recommendations, should be supported by public and private entities as essential to any informed response to legal issues arising from the HIV epidemic." *Id.* "Public and private entities should expeditiously develop and implement HIV-related programs targeted to serve minority communities." *Id.* § D.4, at 12.

A. *The Disproportionate Impact of AIDS on the Disenfranchised*

Persons of low socio-economic status residing in urban areas comprise the population group experiencing the most rapid increase in reported HIV/AIDS cases.²⁴ The results of a case study on the shifting demographics of HIV and AIDS in New York City illustrate the recent population changes experienced in metropolitan areas throughout the country.²⁵ The study confirmed that the number of HIV-positive individuals and PWAs in impoverished, urban areas far exceeded the number of such persons in more affluent suburban areas. The 1992 study revealed that ninety-five percent of New York City's PWAs resided in the inner-city boroughs, while the remaining five percent inhabited the four surrounding suburban counties.²⁶

In March of 1992, the CDC reported that New York City had experienced 37,952 AIDS cases, as compared with 26,336 cases in December of 1989.²⁷ The study concluded that the disproportionate number of HIV/AIDS cases in low income, urban areas resulted from the existence of certain kinds of "social interactions" in these communities, such as intravenous drug use, high-risk sexual activity, joblessness, homelessness, limited access to health care, and overcrowding.²⁸ Educational and treatment programs could arguably lessen HIV transmission in low income urban communities.²⁹ In fact, the ABA has recommended the development of distinct programs designed to confront the problem of widespread HIV transmission among drug users.³⁰

24. See PANEL ON MONITORING THE SOCIAL IMPACT OF THE AIDS EPIDEMIC, *supra* note 19, at 7-8, 243-44.

25. See *id.* at 243-44, 247. The Panel indicated its belief that the changing demographics observed in the New York study are representative of that in other urban communities. *Id.* at 243-44. The Panel concluded that "the New York City study, as it stands, offers a vivid portrait of the epidemic in a particular place and illustrates with particular force the principal conclusions of [the Panel]: namely, the epidemic is not spreading uniformly throughout the population but is highly localized, and the epidemic is now progressing in such a way that a convergence of social ills creates a nidus in which it can flourish." *Id.* However, the Panel acknowledged that the conclusions reached in the New York City study cannot be generalized to the United States as a whole. *Id.* at 296. Similar patterns will likely occur elsewhere, but studies in other locales are needed. *Id.* at 243, 245, 296.

26. *Id.* at 245.

27. *Id.* at 245-46. However, the Panel characterized this figure as an "underestimation of the numbers of actual AIDS cases," due to reporting problems, such as "lags" and "undercounting." *Id.* at 246.

28. PANEL ON MONITORING THE SOCIAL IMPACT OF THE AIDS EPIDEMIC, *supra* note 19, at 244.

29. See ABA *Pol'y and Rep. on AIDS*, *supra* note 23, § O.1, at 18.

30. ABA *Pol'y and Rep. on AIDS*, *supra* note 23, § M.1, at 17-18. "States and localities should address the HIV epidemic among drug abusers and their partners as a significant public health problem and should support appropriate public health education and medical interventions." *Id.*

Low-income persons with HIV or AIDS encounter great difficulty in obtaining access to health care. Such persons either are impoverished prior to the onset of their HIV-infection or become poverty-stricken as a result of financing their own treatment and owe.³¹ Moreover, once an individual with HIV disease enters the phase of "full-blown" AIDS, he or she generally becomes unable to remain gainfully employed. Lack of employment may cause the individual to become impoverished, entirely uninsured, and reliant on Medicaid.³² However, the access to health care for PWAs on Medicaid remains limited because the current Medicaid system provides only minimal coverage for PWAs.³³

In addition to the treatment barriers, many low income PWAs are not even diagnosed as HIV-positive until the disease has progressed to such an acute stage that death is imminent.³⁴ Their limited economic means prevent them from developing an ongoing relationship with a physician; many receive little, if any, preventive care. Often, their only encounter with a medical provider is in the emergency room of a public hospital.³⁵

Even when impoverished persons receive treatment at public hospitals, they are unlikely to receive an HIV test due to the costs associated with such tests.³⁶ In 1988, the average cost of treating an AIDS in-patient was \$630 per day, yet the average hospital receives only \$500 per day in Medicaid reimbursements.³⁷

Low income PWAs on Medicaid confront yet another significant obstacle to medical treatment. Under the combined federal and state Medicaid program, only ten states permit Medicaid reimbursement for alternative care treatments, such as out-patient care, hospice care, and community-based health care.³⁸ Even though alternative forms of care cost less and provide more efficient

31. See Daniel Shacknai, *Wealth = Health: The Public Financing of AIDS Care*, in AIDS AGENDA: EMERGING ISSUES IN CIVIL RIGHTS, 181-82, 187.

32. *Id.* at 181, 185, 187. To become eligible for Medicaid, a person must meet a threshold poverty level and must be deemed "disabled" under the Social Security Administration's definition. *Id.* at 183-84. A person with CDC-defined AIDS is considered presumptively disabled, and therefore entitled to Medicaid, subject to later consideration. See *infra* Part V.B (delineating the general requirements for Medicaid coverage).

33. Shacknai, *supra* note 31, at 189-91.

34. *Id.* at 185.

35. See HEALTH CARE REFORM, *supra* note 6, at 10.

36. See *id.*

37. Shacknai, *supra* note 31, at 190 (citing REPORT OF THE PRESIDENTIAL COMMISSION ON IMMUNODEFICIENCY VIRUS EPIDEMIC 143 (1988)). In some Southern states, the hospital reimbursement figure is only \$282. *Id.* Medicaid provides only \$8.00 in reimbursement for each outpatient treatment provided by New York City hospitals, although the treatment costs the hospitals approximately \$80.00 per visit. *Id.* (citing Proceedings of New York City Mayor's Conference on AIDS (Feb. 1990)).

38. *Id.*

treatment, the remainder of the state's Medicaid programs only cover in-patient care.³⁹ Further expansion of alternative care treatments has not occurred because of the complicated and time-consuming federal waiver which each state must receive before implementing a new Medicaid procedure.⁴⁰ Therefore, in order to effectively treat low-income PWAs, state governments should permit Medicaid reimbursements for less costly alternative treatments.⁴¹

B. Disenfranchised Women: The Newest At-Risk Population

During the 1980's men comprised approximately nine out of ten PWAs.⁴² However, women presently represent the group most at risk of acquiring HIV.⁴³ According to the National Institute of Health's 1992 report, women, who comprise 51.3 percent of the total population, accounted for 11.4 percent of newly reported AIDS cases.⁴⁴ In 1993, women comprised nearly 26,000 of the nation's approximately 240,000 AIDS cases.⁴⁵ Most women with HIV contracted the infection through intravenous drug use or through sexual contact with an HIV-positive man who contracted HIV through intravenous drug use.⁴⁶ During heterosexual contact in which one party is HIV-positive, women are twenty times more likely to contract HIV from men than men are likely to contract HIV from women.⁴⁷ Epidemiologists estimate that 75,000 women will be diagnosed with AIDS by 1995,⁴⁸ and that by 1994 in New York State, more women than homosexual men will be diagnosed with AIDS.⁴⁹ Worldwide, experts predict that by the year 2000 the number of women with AIDS will equal the number of men with AIDS.⁵⁰

However, medical providers generally do not consider HIV-infection in women as a likely possibility and, thus, often fail to diag-

39. *See id.*

40. American Bar Assoc., *Report of the AIDS Coordinating Committee*, 21 U. TOL. L. REV. 19, 54 (1989).

41. *See ABA Pol'y and Rep. on AIDS*, *supra* note 23, § D.3, at 12. The ABA adopted the following policy concerning alternative forms of treatment for Medicaid recipients: "Government programs that cover HIV-related health care should incorporate flexible mechanisms for payment, including expediting the Medicaid waiver review process, to allow more treatment alternatives for HIV." *Id.*

42. HEALTH CARE REFORM, *supra* note 6, at 48.

43. NAT'L COMM'N ON AIDS, THE CHALLENGE OF HIV/AIDS IN COMMUNITIES OF COLOR 19 (1992) (citations omitted).

44. HEALTH CARE REFORM, *supra* note 6, at 48.

45. *Id.*

46. *See id.*; Zavos, *supra* note 6, at 125.

47. HEALTH CARE REFORM, *supra* note 6, at 48.

48. *Id.*

49. Hunter, *supra* note 22, at 5 (citing Catherine Woodard, *In the Future, AIDS Hits Women Worst*, *NEWSDAY*, Oct. 25, 1990, at 4).

50. *Id.* (citing Daniel Pearl, *AIDS Spreads More Rapidly Among Women*, *WALL ST. J.*, Nov. 30, 1990, at B1).

nose women with HIV or AIDS until their illness has progressed to an acute stage.⁵¹ Studies show that physicians often misdiagnose their women patients' gynecological symptoms as mere isolated conditions, even though gynecological infections may be the most frequent initial symptom of HIV in women.⁵² Another reason for physicians' failure to diagnose women as HIV-infected is that a severe deficit in medical research exists regarding women and HIV/AIDS.⁵³ As a result some medical practitioners may lack the requisite medical knowledge to recognize the symptoms associated with these diseases.⁵⁴

Even where physicians correctly diagnose gynecological symptoms as initial manifestations of HIV, women confront the additional impediment that the CDC's most recent AIDS definition still excludes many gynecological manifestations.⁵⁵ Thus, low income women who experience gynecological conditions which are indicative of AIDS are ineligible for Supplemental Security Income (SSI); that ineligibility, in turn, normally prohibits them from receiving Medicaid.⁵⁶

Despite the absence of gynecological symptoms from the AIDS definition, the CDC revised its definition in 1993 to include a new indicator that broadens the official designation to include persons

51. Hunter, *supra* note 22, at 10. "[Misdiagnosis of women] has occurred because the perception that HIV is a male disease has been widespread among health care providers" *Id.* "Delay in an accurate diagnosis leads to delay in treatment and missed opportunities for medical intervention early enough in the course of the disease to significantly prolong life." *Id.*

52. *Id.* at 10 (citing Safrin & Dattel, et al., *Seroprevalence and Epidemiologic Correlates of Human Immunodeficiency Virus Infection in Women with Acute Pelvic Inflammatory Disease*, 75 *OBSTETRICS & GYNECOLOGY* 666 (1990)).

53. *Id.* at 11.

54. *Id.* at 9-12. Women's groups advocate for increased testing of women with HIV; see Zavos, *supra* note 6, at 125. In 1992, Congresswoman Morella (D-Md.) introduced two bills, "Women and AIDS Research Initiative" (H.R. 1073) and "Women and AIDS Outreach and Prevention Act" (H.R. 1072), to authorize additional spending for research regarding women and AIDS and specifically earmark federal funds for educational programs for women, respectively. *Id.* Although both bills were referred to committee, neither became law. To date, no member of the 103rd Congress has reintroduced either bill. Telephone Interview with Legislative Dep't, United States House of Representatives (June 7, 1993).

55. Hunter, *supra* note 22, at 10. Gynecological illnesses, such as chronic pelvic internal organ or body cavity abscesses, chronic genital ulcers and recurrent herpes have been excluded from CDC's enumeration of symptoms that warrant an official AIDS diagnosis. See Zavos, *Women with HIV*, *supra* note 6, at 7; *supra* Part I for discussion of CDC defined AIDS.

56. Hunter, *supra* note 22, at 10-11. Ultimately, a women's ineligibility for SSI or Medicaid results in a denial of meaningful health care. See *id.* at 9, 11; *supra* Part V (discussing Medicaid coverage generally). However, the CDC has cautioned organizations and agencies against using the CDC classification and definition system as a basis for providing benefits or entitlements. Castro, *supra* note 1, at 8.

with T-cell counts below 200 per cubic millimeters of blood.⁵⁷ This new indicator may help alleviate the difficulty HIV-infected women with gynecological conditions confronted in the past because many of these women have T-cell counts below 200, which would bring them within the revised AIDS definition.⁵⁸

In addition to the problems associated with diagnosis delays, some researchers attribute the growing population of women with AIDS/HIV to the fact that a disproportionate number of such women are people of color and reside in impoverished urban areas that lack access to health care.⁵⁹ In 1990, African-American women comprised 52.1% of women with AIDS in New York, and 29.8% of AIDS cases in that State were Hispanic women.⁶⁰

Another important explanation for the growing population of women with AIDS stems from the lack of state, local and private educational programs geared toward women at risk of contracting HIV.⁶¹ Most educational programs and media portrayals focus almost exclusively on the risks to male homosexuals, without informing at-risk populations of the widespread phenomenon of females with HIV-infection and AIDS.⁶²

Since most women with AIDS are low-income, single-parent mothers, the adverse impact that their inevitable incapacitation and death has on the lives of the orphaned children they leave behind presents serious challenges to the social infrastructure of the United States.⁶³ Low income persons are unlikely to possess a tes-

57. Zavos, *supra* note 6, at 125. The CDC proposed this change in August of 1991, but it did not become effective until January 1, 1993. *Id.* at 5.

58. See Hunter, *supra* note 22, at 11. However, the new indicator does not entirely resolve this problem because a woman will only obtain a T-cell reading of 200 or below if her physician construes her gynecological symptoms as possible indicators of HIV-infection, and recommends that she submit to an HIV test, a course of conduct which medical providers often overlook. See *id.* (citations omitted).

In addition, women who lack access to health care will not receive a CDC defined AIDS diagnosis. See *id.* at 12.

59. Hunter, *supra* note 22, at 6.

60. *Id.* Some recent studies attribute the rise in AIDS cases among women to the fact that more women are addicted to crack cocaine than men. See PANEL ON MONITORING THE SOCIAL IMPACT OF THE AIDS EPIDEMIC, *supra* note 19, at 271 (noting that impoverished women addicts have been known to contract HIV while engaging in risky sexual behaviors in exchange for the illicit drug).

61. See Hunter, *supra* note 22, at 6-7 (discussing the lack of HIV educational programs for women).

62. See *id.*; see ABA Pol'y and Rep. on AIDS, *supra* note 23, § 0.1, at 18. The lack of educational programs geared to women at risk of contracting HIV indicates the necessity for public and private entities to adhere to the American Bar Association's Policy of ensuring that "[a]ccurate, effective education of the public regarding HIV, consistent with generally accepted public health recommendations . . . be supported by public and private entities as essential to any informed response to legal issues arising from the HIV epidemic." *Id.*

63. See Elizabeth B. Cooper, *HIV-Infected Parents and the Law: Issues of Custody, Visitation and Guardianship*, in AIDS AGENDA: EMERGING ISSUES IN

tamentary instrument specifying a guardian for their children upon their death; therefore the state must step in and assume responsibility for the minor children, either by placing the children with foster parents or finding an adoptive parent for the child.⁶⁴ Parentless children not only pose challenges to government entities charged with caring for them, but the orphaned children obviously endure emotional distress as a consequence of their permanent separation from their parent.⁶⁵ Furthermore, although the foster care system provides children with shelter and financial support, it is an imperfect system, shown to have deleterious effects on some participants.⁶⁶

The foregoing problems are exacerbated by the fact that most of these children will be perpetually impoverished. To provide a caregiver for orphaned children upon their parents' death or incapacitation, some experts suggest the institution of legal methods, such as a "springing guardianship," that would take effect whenever the parent's disease rendered him/her unable to care for the child, but would then reinstate custody to the natural parent if the parent's illness entered remission.⁶⁷ Under the "springing guardianship" system, ultimate custody would be placed in the guardian upon the parent's death. Thus, given the important issues confronting children with AIDS and HIV, the health care reform package should contain social programs designed to alleviate the stresses confronted by children with AIDS/HIV-infected parents.⁶⁸

C. *The Disproportionate Impact of AIDS on People of Color*

The AIDS epidemic has disproportionately affected people of color.⁶⁹ Although African-Americans comprise only twelve percent of the United States population, they account for thirty percent of the nations AIDS cases.⁷⁰ Furthermore, Hispanics comprise seventeen percent of PWAs, although they account for only nine percent of the population.⁷¹ In 1989, the "age-adjusted HIV-related death

CIVIL RIGHTS, *supra* note 22, at 70, 86-88 (noting that often the courts must decide where to place a child after the parent dies).

64. *See id.*

65. *See id.* at 88.

66. *Id.* at 78, 88. Children with a parent with AIDS often feel "stigmatized or shunned as the result of having a parent with HIV disease." *Id.* at 78. "[P]arents who have placed their children in foster care . . . may be confronted with myriad problems primarily involving the foster care agency's intrusion into and oversight of the family's situation." *Id.* at 88.

67. *See id.* at 92-94; Zavos, *supra* note 6, at 125.

68. *See ABA Pol'y and Rep. on AIDS, supra* note 23, §§ K.3-K.4, at 16. "Foster care and adoption agencies should provide HIV-related services to children under their jurisdiction consistent with the goal of providing appropriate services in the least restrictive setting." *Id.* § K.3.

69. HEALTH CARE REFORM, *supra* note 6, at 49.

70. *Id.* (citations omitted).

71. *Id.*

rate" among African-American men was three times that of Caucasian males.⁷² Persons of color, who reside in poverty and lack access to health care, account for most of the AIDS cases in this population group.⁷³

Studies attribute the prevalence of the AIDS epidemic in poor, minority communities to the lack of access to health care in such communities as well as to behavior and situational patterns (i.e., drug abuse, homelessness, joblessness, overcrowding) that are conducive to the transmission of the HIV-infection and other ailments.⁷⁴ Thus, the health care reform package should provide these minority communities with increased access to health care and educational programs geared to their special needs.⁷⁵

*D. Tuberculosis and HIV Among the Impoverished:
A Lethal Combination*

The growing population of impoverished persons with Tuberculosis (TB) presents novel challenges to health care providers. Although the overall number of reported TB cases in the United States has remained constant in recent years, the rate of such cases in low income, impoverished communities has reached epidemic proportions.⁷⁶ For instance, in 1982 in New York City, 22 persons per every 100,000 were TB infected, while in 1991, that number had grown to 50 persons per every 100,000.⁷⁷

Persons most susceptible to TB disease live in low-income, urban and overcrowded areas, in which widespread HIV-infection and other ailments exist.⁷⁸ Within this population group, HIV-infected persons are the most likely to contract TB because HIV severely weakens their immune systems, thereby making them unable to extinguish the TB infection.⁷⁹ Unlike HIV, which can be transmitted

72. *Id.*

73. *Id.* at 8. "[L]ow income and poor health are strongly linked The association of poverty, underdeveloped community structures, and disease is well demonstrated by the impact of the HIV epidemic in communities of color." *Id.*; see HEALTH CARE REFORM, *supra* note 6, at 49.

74. See NAT'L COMM'N ON AIDS, *supra* note 43, at 8-14; HEALTH CARE REFORM, *supra* note 6, at 49.

75. ABA Pol'y and Rep. on AIDS, *supra* note 23, § D.4, at 12. The ABA policy directs that "[p]ublic and private entities should expeditiously develop and implement HIV-related programs targeted to serve minority communities." *Id.*

76. UNITED HOSP. FUND OF N.Y., THE TUBERCULOSIS REVIVAL: INDIVIDUAL RIGHTS AND SOCIETAL OBLIGATIONS IN A TIME OF AIDS 8-9 (1992).

77. *Id.* at 10.

78. *Id.* at 8-12.

79. *Id.* at 10. The TB infection, if not inactivated or encapsulated by one's immune system, develops into TB disease. *Id.* at 9; see also Edward P. Richards & Katharine C. Rathbun, *Tuberculosis: An Introduction for Health Care Attorneys*, 6 HEALTH LAW 11 (1993) (describing that tuberculosis is "inextricably linked to HIV infection").

only via the exchange of bodily fluids, TB can be readily transmitted by casual contact. TB is most commonly transmitted when a person with TB-disease emits, by the act of coughing, "airborne droplets" that come in contact with another.⁸⁰ Persons possessing intact immune systems, however, are generally able to inactivate the TB organism. Persons with damaged immune systems, however, normally cannot terminate the infection. Thus, after an incubation period, they develop full-fledged TB disease.⁸¹ Generally, the appropriate drug regimen effectively cures a person with drug sensitive TB.⁸²

The most alarming issue surrounding the increasing incidence of TB concerns the emergence of a lethal strain of the disease, designated multi-drug resistant TB.⁸³ Multi-drug resistant TB occurs in two circumstances. First, TB may become drug-resistant when a person infected with drug sensitive TB fails to remain on drug therapy for the specified time period required for a cure.⁸⁴ When TB becomes drug-resistant, the disease often recurs and subsequently becomes resistive to drug treatment.⁸⁵ Some reports suggest that impoverished persons are more likely to terminate their drug treatment before they are fully cured, thereby causing them to develop multi-drug resistant TB.⁸⁶ Second, multi-drug resistant TB develops in situations where a person with an impaired immune system acquires the drug-repellent strain of TB through exposure to a person with this hazardous form of TB.⁸⁷

Hospitals themselves may spread, rather than cure, TB. A 1991 study of New York City's multi-drug resistant TB cases revealed that eighty-two percent of persons with multi-drug resistant TB contracted the disease in public hospitals.⁸⁸ Furthermore, the study reported that approximately eighty-five percent of those per-

80. See UNITED HOSP. FUND OF N.Y., *supra* note 76, at 9.

81. *Id.*

82. *Id.* at 11-12.

83. See Richards & Rathbun, *supra* note 79, at 13; NAT'L LEADERSHIP COALITION ON AIDS, MANAGING TUBERCULOSIS AND HIV INFECTION IN TODAY'S GENERAL WORKPLACE 52 (1992); see also UNITED HOSP. FUND, *supra* note 76, at 11-12.

84. UNITED HOSP. FUND OF N.Y., *supra* note 76, at 11; NAT'L LEADERSHIP COALITION ON AIDS, *supra* note 83, at 1.

85. UNITED HOSP. FUND OF N.Y., *supra* note 76, at 11-12.

86. See *id.* at 6. According to the Centers for Disease Control, 44 percent of persons in New York City who received prior treatment for TB later developed a form of drug-resistant TB, whereby they became insensitive to one or more drug treatments. *Id.* at 12. "Poor patient compliance, . . . is the consequence of an inadequate medical and social infrastructure in New York City." *Id.* (other citations omitted).

87. *Id.*

88. *Id.* at 12. (citing Centers for Disease Control, *Nosocomial Transmission of Multi-Drug Resistant Tuberculosis Among HIV-Infected Persons—Florida and New York, 1988-1991*, 266 JAMA, 1483-85 (1991)).

sons with multi-drug resistant TB were HIV-positive.⁸⁹ Because drug resistant TB is highly contagious, some facilities deny admission to TB infected persons in order to prevent transmission of the disease to others.⁹⁰

The serious health risks that result from multi-drug resistant TB justify the creation of medical programs which address this specific problem. The United Hospital Fund of New York advocates the creation of programs designed to ensure that persons with drug-sensitive TB comply with their prescribed drug therapy to prevent the development of drug-resistant TB.⁹¹ Other experts advocate the development and spread of a five-pronged tuberculosis control program to minimize the rapid influx of the disease among at-risk population groups in the United States.⁹²

III. WITHHOLDING MEDICAL CARE AND CONFIDENTIALITY BREACHES: IMPEDIMENTS TO TREATMENT AND EARLY DETECTION

A. *The Treatment Impediment*

In addition to the difficulty PWAs face in obtaining financial assistance for medical services,⁹³ other impediments also hinder their access to health care. PWAs are often denied treatment by health care providers.⁹⁴ Some health care providers refuse to treat HIV-infected individuals due to their concerns about contracting HIV, even though the risk of contracting the disease from providing

89. *Id.*

90. *See, e.g.,* *Mixon v. Grinker*, 595 N.Y.S.2d 876, 879 (N.Y. Sup. Ct. 1993) (discussing in part homeless shelter's practice of denying admission to TB infected persons so as to prevent contagion among other residents). Upon denying admission to TB infected persons, the shelter referred such persons to an appropriate hospital. *Id.*

91. UNITED HOSP. FUND OF N.Y., *supra* note 76, at 21, 23.

92. Richards & Rathbun, *supra* note 79, at 14. The authors enumerate the five components of an effective TB control program:

(1) Diagnosis of disease in infected individuals;

(2) Reporting of infected individuals to the health authorities;

(3) Tracing of contacts of infected individuals to identify other infected persons;

(4) Treatment of infected persons; and

(5) Isolation of infected persons who have active disease until they are no longer infectious. *Id.*

93. *See infra* Parts IV and V discussing the problems persons with HIV/AIDS face in securing insurance.

94. HEALTH CARE REFORM, *supra* note 6, at 141. "[A] considerable number of physicians are refusing to treat persons with AIDS or HIV infection, or threatening to refuse." *Id.* (citing Fox, *The Politics of Physicians' Responsibility in Epidemics: A Note on History*, Hastings Center Rep. 98 (April-May 1988)); *see also* PANEL ON MONITORING THE SOCIAL IMPACT OF THE AIDS EPIDEMIC, *supra* note 19, at 74; Wendy E. Parmet, *An Antidiscrimination Law: Necessary But Not Sufficient*, in AIDS AND THE HEALTH CARE SYSTEM, 85 (Lawrence O. Gostin ed., 1990).

health care to infected individuals is minimal.⁹⁵ Studies indicate that persons of color with HIV confront the greatest challenge in obtaining medical treatment.⁹⁶ As the number of reported AIDS cases continues to increase annually, obtaining health care for HIV-infected individuals and PWAs has also become increasingly difficult.⁹⁷

According to a 1991 study, almost one-third of practicing physicians in the United States believe that they should not be required to treat patients with HIV or AIDS.⁹⁸ Additionally, fifty percent of the medical practitioners who participated in the study indicated that, if permitted, they would decline to provide medical care to infected patients.⁹⁹ Twenty-two percent of the 560 hospitals surveyed in a 1990 study reported at least one instance in which a medical provider had denied treatment to a person with AIDS.¹⁰⁰ Moreover, other studies indicate that, upon disclosure that a patient has AIDS or HIV-infection, some physicians refer such patients to other medical providers.¹⁰¹

B. *Statutory Prohibitions Against the Denial of Treatment to HIV-Infected Individuals*

Two federal statutes, section 504 of the Rehabilitation Act of 1973,¹⁰² and the recent Americans with Disabilities Act (ADA),¹⁰³ as well as many comparable state statutes, generally protect persons with AIDS and HIV from being denied access to health care.

95. HEALTH CARE REFORM, *supra* note 6, at 143-44. "In reality, the provision of health care to a patient infected with HIV presents only a minimal risk of HIV transmission to the provider. Careful adherence to CDC's universal precautions protocol for infection control virtually eliminates this small risk." *Id.* The fact that misconceptions exist regarding the transmission of HIV/AIDS from patient to health care provider reinforces the need for additional public and private programs designed to educate health care workers about these medical conditions. See *ABA Pol'y and Rep. on AIDS, supra* note 23, § 0.1, at 18 (emphasizing the need to educate the public about the HIV epidemic).

96. HEALTH CARE REFORM, *supra* note 6, at 141.

97. *Id.*; see PANEL ON MONITORING THE SOCIAL IMPACT OF THE AIDS EPIDEMIC, *supra* note 19, at 12-13. The Panel expressed its concern that, in the wake of the AIDS epidemic, young doctors might become reluctant to specialize in internal medicine, and may elect to avoid practicing medicine in areas inhabited by large numbers of HIV-infected persons. *Id.* at 12. The Panel acknowledged that a shortage of nurses exists in public hospitals, but remains uncertain as to whether the deficiency is the result of the increasing numbers of AIDS cases in the United States. *Id.*

98. HEALTH CARE REFORM, *supra* note 6, at 142 (citing Gerbert et al., *Primary Care Physicians and AIDS: Attitudinal and Structural Barriers to Care*, 266 JAMA 2837 (1991)).

99. *Id.*

100. *Id.*

101. *Id.*

102. The Rehabilitation Act of 1973, § 504, 29 U.S.C. § 794 (1988).

103. The Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101-12213 (Supp. III 1991).

Guidelines promulgated by the American Medical Association, the American Bar Association, and the National Commission on Acquired Immune Deficiency Syndrome state that physicians may not ethically withhold treatment from individuals based solely on their HIV status.¹⁰⁴

Section 504 of the Rehabilitation Act provides in pertinent part: "No otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance"¹⁰⁵ The statute defines persons with "disabilities" as individuals whose "physical or mental impairment substantially limits one or more major life activities"; persons with a prior record of such impairment; and individuals who lack an impairment, yet whom others perceive as disabled.¹⁰⁶

The statute defines an "otherwise qualified" individual as any individual who possesses the essential qualifications for the program even if "reasonable accommodation" is necessary, and does not present a "direct threat" to others.¹⁰⁷ If it is determined that a person poses a "direct threat" to others, the Act imposes the additional requirement that, prior to excluding such person, the program must determine whether it can make reasonable accommodations to minimize the potential risks.¹⁰⁸

104. PANEL ON MONITORING THE SOCIAL IMPACT OF THE AIDS EPIDEMIC, *supra* note 19, at 73 n.9 (citations omitted). In 1987, the American Medical Association adopted a policy in direct response to the AIDS epidemic which stated in pertinent part:

A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive Neither those who have the disease [AIDS] nor those who have been infected with the virus should be subjected to discrimination based on fear or prejudice least of all by members of the health care community.

Id. (quoting 1987 JAMA 1360 (1987)); see also HEALTH CARE REFORM, *supra* note 6 at 143; ABA Pol'y & Rep. on AIDS, *supra* note 23, § D.1, at 12. "Health Care providers should not refuse to treat or limit treatment of an individual, because of the individual's actual or perceived HIV status." *Id.* "Public and private entities should take appropriate steps to ensure that people in minority communities receive equal access to HIV-related treatment, prevention and research programs." *Id.* § 1.2, at 15. "The [National] Commission [on Acquired Immune Deficiency Syndrome] believes that health care practitioners have an ethical responsibility to provide care to those with HIV disease." 1991 NAT'L COMM'N REP., *supra* note 10, at 50.

105. 29 U.S.C. § 794 (1988 & Supp. IV 1992).

106. *Id.* § 706(8)(B).

107. *Id.*

108. For example, in the employment context 45 C.F.R. § 84.3(k)(1)(1992) defines a "qualified handicapped person" . . . [as] a handicapped person who, with reasonable accommodation, can perform the essential functions of the job in question."

Although neither the Rehabilitation Act nor the ADA explicitly covers persons with contagious diseases, the Supreme Court has interpreted the definition of "disabilities" to include such individuals.¹⁰⁹ In the influential *Nassau County v. Arline* decision,¹¹⁰ that would later serve as the framework for the tests set forth in the ADA, the Court held that an elementary school teacher with a prior record of a contagious disease, tuberculosis, qualified as "handicapped" under section 504 of the Rehabilitation Act.¹¹¹ The Court explained that an infectious disease substantially limits one or more major life activities of the infected individual, thereby constituting a handicap within the meaning of the Act.¹¹² Furthermore, the *Arline* Court articulated a four-pronged test for determining whether a person with disabilities is "otherwise qualified."¹¹³

Drawing from the principles enunciated in *Arline*, courts have held that section 504 covers HIV-infected individuals.¹¹⁴ In *Glanz v. Vernick*,¹¹⁵ an HIV-positive patient brought suit against a doctor and a federally funded clinic, alleging that their refusal to provide him with ear surgery violated section 504.¹¹⁶ After holding that section 504 applies to HIV-infected individuals,¹¹⁷ the court remanded the matter to determine whether, under the *Arline* test, the plaintiff was "otherwise qualified" for surgery.¹¹⁸

109. See *infra* note 124 and accompanying text for a discussion of the classification of PWAs as disabled.

110. 480 U.S. 273 (1987).

111. *Id.* at 280-81.

112. *Id.*

113. *Id.* at 288. The four-part test comprises the following:

(a) the nature of the risk (how the disease is transmitted),

(b) the duration of the risk (how long is the carrier infectious),

(c) the severity of the risk (what is the potential harm to third parties), and

(d) the probabilities the disease will be transmitted and will cause varying degrees of harm. *Id.* (quoting *Brief for Am. Med. Ass'n* at 19).

114. See, e.g., *Doe v. Centinela Hosp.*, No. CIV.A.87-2514 PAR, 1988 WL 81776 (D. Cal. June 30, 1988) (holding that § 504's coverage extends to an HIV-infected individual who was denied admission to federally-funded rehabilitation program). The court remanded the matter to determine whether the plaintiff was "otherwise qualified" and whether the defendant-hospital's alternative program qualified as a "reasonable accommodation." *Id.* at 2044. The Justice Department issued an advisory opinion in which it stipulated that § 504 covers HIV-infected persons. See *Parmet*, *supra* note 94, at 87 (citations omitted).

Although persons with HIV and AIDS have sought protection under the Rehabilitation Act from the denial of access to health care, most cases brought under § 504 of the Act involve challenges to work place exclusions. See *generally* *Shuttleworth v. Broward Co.*, 639 F. Supp. 654 (S.D. Fla. 1986).

115. 756 F. Supp. 632 (Mass. Dist. Ct. 1991).

116. *Id.* at 634.

117. *Id.* at 635.

118. *Id.* at 638-39. In assessing the plaintiff's qualifications for surgery, the court determined that the *Arline* standard permits an inquiry into the potential risks posed to both the patient and health care providers who treat HIV infected individuals. *Id.* at 638.

Although section 504 has afforded HIV-infected individuals protections from treatment exclusions, it provides only limited coverage. Section 504 covers only entities of the federal government, groups contracting with the federal government and recipients of federal funds.¹¹⁹ It applies to all public hospitals, as well as to private hospitals that receive Medicare and/or Medicaid payments.¹²⁰ However, private health care facilities, such as private medical and dental practices operating without federal funds, are not covered by section 504.¹²¹

In response to the limited coverage provided to persons with disabilities in the Rehabilitation Act, all fifty states and the District of Columbia have promulgated legislation, modeled after section 504, to grant more comprehensive protections.¹²² Moreover, two-thirds of the states have mandated, either in statutory language, judicial or administrative decisions or policies, that their statutes apply to persons with HIV-infection and AIDS.¹²³ Courts have enforced such statutes against health care providers who withhold treatment to PWAs or HIV-infected persons.¹²⁴ However, state statutes differ markedly in their content and application.¹²⁵ Thus, prior to the passage of the Americans with Disabilities Act, no uniform legislation existed to provide comprehensive protections to persons with disabilities in both the public and private sectors.

To afford increased protections for persons with disabilities and to remedy the coverage gaps of section 504, Congress passed the Americans with Disabilities Act (ADA) in 1990, which became effective on December 26, 1991.¹²⁶ The ADA consists of four titles which prohibit discrimination against persons with disabilities in the areas of employment, public services, public accommodations, and public transportation. Title III of the ADA, the public accommodations title, mandates that "[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommo-

119. 29 U.S.C. § 794(b).

120. Parmet, *supra* note 94, at 88.

121. *Id.*

122. See, e.g., *Sanchez v. Lagoudakis*, 486 N.W.2d 657 (Mich. 1993) (extending coverage under "Michigan Handicappers' Civil Rights Act" to person perceived by her private employer as having AIDS); Michele A. Zavos, *Right to Work: Job Protections for People with HIV*, TRIAL, July 1993, at 41; LISA BOWLEG, INTERGOVERNMENTAL HEALTH POLICY PROJECT, A SUMMARY OF HIV/AIDS LAWS FROM THE 1991 STATE LEGISLATIVE SESSIONS (1992).

123. See Zavos, *supra* note 122 (noting the applicability of these statutes to PWAs).

124. *ABA Pol'y & Rep. on AIDS*, *supra* note 23, at 143. See, e.g., *Minnesota v. Clausen*, 491 N.W.2d 662 (Minn. Ct. App. 1992) (defining dental patient with HIV as "disabled" under Minnesota statute prohibiting persons with disabilities from exclusion from public and private services).

125. See *id.*; BOWLEG, *supra* note 122.

126. 42 U.S.C. §§ 12101-12213 (1988 & Supp. III 1991).

dations of any place of public accommodation"¹²⁷

In addition to satisfying the public accommodation requirement, entities must "affect commerce," under the extremely broad definition set forth in the statute, to be covered by the ADA's anti-discrimination prohibitions.¹²⁸ Embracing the principles in Section 504, the ADA's protections extend only to persons with disabilities who do not present a "direct threat" to others. The ADA defines a "direct threat" as "a significant risk to the health or safety of others" that cannot be eliminated by reasonable accommodation of "policies, practices, or procedures."¹²⁹

The ADA covers a broader range of individuals than section 504 because the ADA does not limit the prohibition on discrimination merely to programs receiving federal financial assistance.¹³⁰ Rather, the ADA proscribes discrimination in "any place of public accommodation."¹³¹ Under the statute's broad definition of "public accommodations," the ADA forbids discrimination by private health care providers,¹³² entities which could not be reached under section 504 since many private health care providers typically do not receive "federal financial assistance."¹³³

Considering section 504's broad definition of "handicap,"¹³⁴ and

127. *Id.* § 12182(a). The Justice Department's regulations for Title III emphasize that a place of "public accommodation" must be a "private entity" that provides services to the public, as defined by one of the fourteen facilities specified in the statute. See *Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities*, 28 C.F.R. § 36.104 (1992) (defining commercial facilities). Some of the facilities that qualify as public accommodations include hotels, restaurants, bars, theaters, stadiums, grocery stores, shopping centers and offices of "health care provider[s]." 42 U.S.C. § 12181(7)(A-L).

128. 42 U.S.C. § 12181(1). The statute defines the term "commerce" broadly to include "travel, trade, traffic, commerce, transportation, or communication" among the United States or among states and foreign countries. *Id.*

129. *Id.* § 12182(3). The regulations specify that entities must utilize the four-pronged, *Arline* standard to ascertain whether an individual presents a "direct threat" or "significant risk", and whether any potential risks can be reasonably accommodated. See 28 C.F.R. pt. 36, App. B (1992). A covered entity must make reasonable accommodation, "unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the . . . service . . . or would result in an undue burden." 42 U.S.C. § 12182(b)(2)(A)(iii).

130. Compare 29 U.S.C. § 794 (1988) (limiting coverage only to recipients of federal financial assistance) with 42 U.S.C. § 12182 (Supp. 1991) (extending coverage to all places of public accommodation).

131. 42 U.S.C. § 12182(a); see *Parmet*, *supra* note 94, at 88-89 (explaining that the ADA was enacted to "fill many of the gaps" left open by § 504).

132. 42 U.S.C. § 12181(7)(F). "The following private entities are considered public accommodations for purposes of this subchapter, if the operations of such entities affect commerce: (F) a professional office of a health care provider, hospital, or other service establishment" *Id.*

133. 29 U.S.C. § 794(a) (1988). See *supra* text accompanying note 127 for a discussion of § 504's coverage of only those private health care providers receiving Medicare or Medicaid payments.

134. 29 U.S.C. § 706(8)(B)(i) to (iii) (1988).

the Supreme Court's liberal interpretation of "handicap,"¹³⁵ a court could construe the ADA's definition of "disability" to extend coverage to PWAs, as well as to individuals perceived as having AIDS or HIV.¹³⁶ Furthermore, a brief examination of the legislative history of the ADA reveals a congressional intent to include PWAs within the scope of ADA coverage.¹³⁷

Because the ADA became law only recently,¹³⁸ there has been little reported litigation concerning the issue of whether the ADA is applicable to PWAs.¹³⁹ If the courts interpret the ADA to extend to PWAs, the effect will be a major increase in access to health care services for HIV-infected persons.¹⁴⁰ Since the ADA does not exempt private health care providers from its coverage, inclusion of PWAs with the ADA's definition of disability will help remove many of the treatment impediments that PWAs confront in obtaining suitable health care.¹⁴¹ Health care reform efforts should be consistent with the provisions of the ADA.

C. Breaches of Confidentiality: Barriers to Testing

Many individuals fail to take an HIV test because they fear potential breaches in confidentiality.¹⁴² These individuals are con-

135. *Nassau County v. Arline*, 480 U.S. 273, 280-81 (1987). For a discussion of the *Arline* decision, see *supra* notes 110-118 and accompanying text.

136. For a discussion of § 504's definition of "handicap," see *supra* notes 105-18 and accompanying text.

137. See Chai R. Feldblum, *Workplace Issues: HIV and Discrimination*, in AIDS AGENDA: EMERGING ISSUES IN CIVIL RIGHTS, *supra* note 22, at 293 n.34 (citing *Report on the House Committee on Education and Labor*, H.R. REP. NO. 101-485, 101st Cong., 2d Sess., pt. 2, at 52 (1990)). Among the various legislative materials, Professor Feldblum emphasized the committee's following remark: "a person infected with the Human Immunodeficiency Virus is covered under . . . the definition of the term 'disability' because of a substantial limitation to procreation and intimate sexual relations." *Id.*

138. 42 U.S.C. § 12181 (effective Dec. 26, 1991).

139. See, e.g., *Downtown Hosp. v. Sarris*, 588 N.Y.S.2d 748, 752 (N.Y. Civ. Ct. 1992) (asserting that the ADA might extend coverage to persons with AIDS); see also *Doe v. Mercy Health Corp.*, 150 F.R.D. 83 (E.D. Pa. 1993) (denying defendant's motion for summary judgment on procedural grounds and permitting the parties to proceed with discovery in an action brought by an HIV-infected surgeon claiming that his placement on restricted duty by Mercy Catholic Hospital violated the ADA).

140. See Zavos, *supra* note 122, at 43. An extension of coverage under the ADA to people with AIDS would comport with the American Bar Association's policy that "[h]ealth care providers should not refuse to treat or limit treatment of an individual because, of the individual's actual or perceived HIV status." *ABA Pol'y & Rep. on AIDS*, *supra* note 23, § D.1, at 12.

141. Zavos, *supra* note 122, at 43.

142. See *ABA Pol'y & Rep. on AIDS*, *supra* note 23, at 36. "Rigorous maintenance of confidentiality is considered critical to the success of the public health endeavor to prevent the transmission and spread of HIV infection." *Id.* at 35 (citing REP. OF THE PRESIDENTIAL COMM'N ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC at 127 (1988)). "Health care provider's duty to preserve confidentiality of medical information is both an ethical and a legal obligation." *Id.* at 35.

cerned with the effects which might ensue if their test results were made public; such effects may include losing a job or housing and being subject to ridicule.¹⁴³ Persons who suspect that they are HIV-infected have been known to delay early detection and treatment to avoid the potential negative consequences which flow from confidentiality breaches.¹⁴⁴ However, delays in testing result in missed opportunities for treatment which could have prolonged the life span of an HIV-infected individual or prevented the infection of others.¹⁴⁵

There is a developing line of case law in which HIV-infected persons, who suffered breaches of confidentiality, have sued health care providers for unlawfully disclosing their HIV status to others.¹⁴⁶ Thus, as advocated by both the ABA and the Presidential Commission on AIDS, health care reform should include methods of insuring compliance with existing confidentiality laws,¹⁴⁷ and it should include uniform confidentiality laws.¹⁴⁸ Some uniform confidentiality laws have already been proposed.¹⁴⁹ Uniform laws would permit nationwide education on the rights and obligations of confidentiality and would eliminate the incentive to "forum

143. See HEALTH CARE REFORM, *supra* note 6, at 144-46.

144. See *id.* at 145-46.

145. See Hunter, *supra* note 22, at 10.

146. See, e.g., *Doe v. Shady Grove Adventist Hosp.*, 598 A.2d 507 (Md. 1991) (characterizing hospital's act of disclosing patient's HIV/AIDS status as a breach of confidentiality); *Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991) (holding that defendant-medical center breached its duty of confidentiality, under New Jersey's anti-discrimination statute, by disclosing surgeon's HIV/AIDS status).

147. Although there are no uniform federal law governing confidentiality in HIV testing, some states have enacted their own state confidentiality laws. Among the most comprehensive of such laws is New York State's confidentiality statute. See N.Y. PUB. HEALTH LAW § 2782 (McKinney 1992). However, New York's statute only applies to employees in the state's correctional facilities and parole and probation divisions; the statute's protections do not extend to personnel of the state court system and law enforcement agencies. N.Y.S. BAR ASS'N., REPORT OF THE SPECIAL COMMITTEE ON AIDS AND THE LAW 35 (1992).

148. ABA *Pol'y & Rep. on AIDS*, *supra* note 23, § B.1, at 9. "[S]pecific confidentiality protections should be afforded to HIV-related information under state and federal statutes and judicial and administrative procedures." *Id.* "The Presidential Commission has identified the lack of uniform confidentiality protections as a significant obstacle to HIV prevention efforts, and has called both for the enactment of a federal law and for the development of model state confidentiality legislation which would enunciate a general confidentiality rule . . ." *Id.* at 37 (citing REP. OF THE PRESIDENTIAL COMM'N ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC, at 120 (1988)).

149. ABA *Pol'y & Rep. on AIDS*, *supra* note 23, at 37-38 (citing Comment, *Protecting Confidentiality in the Effort to Control AIDS*, 24 HARV. J. ON LEGIS. 315, 345 (1987)). Furthermore, the Intergovernmental Health Policy Project is devising a report regarding existing informed consent and state confidentiality laws. *Id.*; see also Sharon Rennert, *AIDS/HIV and Confidentiality*, MODEL POL'Y AND PROCEDURES (ABA AIDS and Developmental Disabilities Project) 1991.

shop" for a venue which offers the greatest confidentiality in HIV-testing.

IV. AIDS AND PRIVATE PAYORS

A. *The Comparative Cost of AIDS Care*

AIDS and HIV-related medical conditions are among the most litigated and controversial diseases in the history of the United States.¹⁵⁰ While the costs of HIV and AIDS medical care are great, they are not vastly different than for other serious medical conditions.¹⁵¹ In the early 1980s, however, some insurance companies and hospitals, facing an increasing number of HIV patients with long hospital stays and potential labor-intensive care, claimed that the enormous costs of AIDS threatened to drive them into insolvency.¹⁵² The earliest studies on the potential cost of the epidemic indicated that the health care industry's costs would be extraordinary and in a different class than that of other serious illnesses.¹⁵³ However, in 1986 and 1987, the studies of other respected institutions tempered some of the high numbers that were initially reported and estimated costs from diagnosis to death that were well below previous figures.¹⁵⁴ In 1992 the lifetime costs of treatment for a person with HIV/AIDS illnesses were estimated at \$102,000.¹⁵⁵ Although comparative cost studies are still viewed as relatively incomplete,¹⁵⁶ the costs of treating HIV and AIDS illnesses are no more disastrous than for other serious illnesses. For example, patients who need liver transplants have lifetime medical costs that are three to four times that of a person with AIDS.¹⁵⁷ Medical expenses for other chronic illnesses yield a similar compar-

150. See NATIONAL RESEARCH COUNCIL, *THE SOCIAL IMPACT OF AIDS IN THE UNITED STATES* 61-63 (Albert R. Honsen & Jeff Stryker eds., 1983) (discussing the litigation that has arisen out to the transmission of the HIV-infection within the health care industry).

151. See *id.* at 71 (stating that "the current costs for care of AIDS patients has . . . a noticable, but not an overwhelming impact on health care financing").

152. Daniel M. Fox & Emily H. Thomas, *The Cost of AIDS: Exaggeration, Entitlement, and Economics*, in *AIDS AND THE HEALTH CARE SYSTEM* 198 (Lawrence O. Gostin ed., 1990).

153. *Id.* at 202-03. A CDC study was among the first and most publicized analyses of health care costs and claimed a \$147,000 hospitalization expense for persons with AIDS from diagnosis to death. *Id.* at 202.

154. *Id.* at 203-05 (estimating cost from diagnosis to death in a range from \$27,500 to \$59,000).

155. HEALTH CARE REFORM, *supra* note 6, at 67 (citing Hellinger, *Assessing the Medical Care Costs of the HIV Epidemic in the United States: 1992-95*, Abstract No. WeC1033 (VIII Int'l Conf. on AIDS, July 19-24, 1992)).

156. See Fox and Thomas, *supra* note 152, at 209. ("Methods for studying the costs of routine care for patients with different diseases in particular hospitals remain inadequate, particularly in an era of reimbursement systems based on diagnosis.").

157. *Harvey v. Fineberg*, *The Social Dimensions of AIDS*, *Sci. Am.*, Oct. 1989, at 128, 133.

ison.¹⁵⁸ In fact, studies of actual insurance claims indicate that AIDS-related costs have not had nearly the dramatic effect originally perceived.¹⁵⁹ Spending for AIDS is less than one percent of the total amount of medical spending in the United States,¹⁶⁰ and the National Commission on AIDS has predicted that it is likely that this amount will never rise above two percent.¹⁶¹ Despite these figures, the early estimates of health care expenses for AIDS have created the perception that AIDS-related illnesses are uniquely costly to the health care and insurance industries.¹⁶²

At present, The National Commission on AIDS estimates that twenty to twenty-five percent of HIV-infected persons have no form of medical coverage.¹⁶³ One survey found that only seven percent of public hospital admissions with AIDS in 1985 were covered by private insurance.¹⁶⁴ Studies also show that persons with HIV/AIDS are eight times as likely to have completely lost health care coverage as persons without the disease.¹⁶⁵ Medicaid takes over much of the burden; forty percent of AIDS patients are covered by this program, which is over four times the rate of coverage of the general population.¹⁶⁶ Although Medicaid funds eleven percent of all medical costs in general, it provides for ninety percent of medical costs of children with AIDS and twenty-five percent of the national total for AIDS-related medical expenses. For the fiscal year 1992, Medicaid and Medicare together spent \$1.3 billion in federal funds

158. Heart disease treatment cost \$101.3 billion in 1990 health care expenditures, which was 20 times that of the amount required for AIDS-related care in 1991. Paraplegia resulting from automobile accidents, myocardial infarction, and breast cancer also have similar lifetime costs as that of persons with AIDS. The annual medical costs of a person with AIDS is actually less than the cost of a heart transplant or a year's supply of clotting factor for a hemophiliac. HEALTH CARE REFORM, *supra* note 6, at 67-68 (outlining several medical conditions which have been more costly to treat than HIV/AIDS related illnesses).

159. *Id.* at 70 (citing studies).

160. *Id.* at 67.

161. *Id.* (citing 1991 report by the National Commission on AIDS).

162. See Lawrence Bartlett, *Financing Health Care For Persons With AIDS: Balancing Public and Private Responsibilities*, in AIDS AND THE HEALTH CARE SYSTEM, *supra* note 152, at 211, 211. On the other hand, as one commentator has observed, AIDS "magnifies the deficiencies in financing of health care . . . [and] may show society in starkest form the hardship and despair of a system that does not guarantee health care for all citizens." Lawrence O. Gostin, *preface to AIDS AND THE HEALTH CARE SYSTEM*, *supra* note 152, at 3, 10.

163. HEALTH CARE REFORM, *supra* note 6, at 69 (citing the NAT'L COMM'N ON AIDS study).

164. Bartlett, *supra* note 162, at 213.

165. HEALTH CARE REFORM, *supra* note 6, at 69 (citing Kass et. al., *Loss of Private Health Insurance Among Homosexual Men with AIDS*, 28 INQUIRY 249 (1991)). When they are able to maintain private coverage, PWAs generally pay higher premiums than those without the disease. *Id.*

166. Fineberg, *supra* note 157, at 314.

for AIDS care.¹⁶⁷

B. Limitations in Private Health Insurance

The high cost of AIDS medical care, the perception that it is even costlier than it is in fact, and the certainty that HIV-infection leads to AIDS, all have made problematic securing third-party payment of health costs for HIV-infected persons.¹⁶⁸ The overwhelming majority of private insurers consider persons with AIDS or AIDS-related conditions to be "uninsurable."¹⁶⁹ As a result, a variety of methods have been employed to exclude PWAs from private coverage. The past ten years have shown a dramatic decline in coverage of people with HIV.¹⁷⁰ One effective underwriting method has been to require a test for the HIV antibody. By 1987, most insurance companies had imposed HIV-testing on insurance applicants.¹⁷¹ Some jurisdictions, including Washington, D.C., Massachusetts and New York, responded by prohibiting this practice.¹⁷² However, these laws have been widely challenged and many have been overturned.¹⁷³

167. HEALTH CARE REFORM, *supra* note 6, at 70-72. Commentators predict that the federal government in 1993 will spend \$1.6 billion and the states will spend \$1.2 billion to provide AIDS health care to Medicaid beneficiaries. *Id.*

168. The ABA contends that "[a]ll health insurance policies and health plans that cover a comprehensive range of medical conditions should cover AIDS, ARC, and HIV to the same extent as other serious medical conditions." *ABA Pol'y & Rep. on AIDS*, *supra* note 23, § F.10, at 13. The ABA also asserts that "[i]nsurers should not cancel or refuse to renew . . . polic[ies] because of the individual's HIV-related claims or a change in health status related to HIV." *Id.* § F.14, at 14. See Michele Zavos, ABA, *AIDS and Insurance: No Guarantees*, HUM. RTS., Winter 1993, at 18, 19 [hereinafter Zavos, *AIDS and Insurance*] (discussing the insurance industry's attempt to reduce coverage to individuals with AIDS related medical claims, and the litigation surrounding this issue).

169. CLEARINGHOUSE REV., *supra* note 14, at 736-37. A 1987 survey by the Health Insurance Association of America found that 91 percent of HIV-infected persons were considered uninsurable and all persons diagnosed with full-blown AIDS were unable to get policies from insurance companies. HEALTH CARE REFORM, *supra* note 6, at 80 (citing INTERGOVERNMENTAL HEALTH POLICY PROJECT, INTERGOVERNMENTAL AIDS REPORTS, March/April 1990, at 6).

170. HEALTH CARE REFORM, *supra* note 8, at 73.

171. See Peter Hiam, *Insurers, Consumers, and Testing: The AIDS Experience*, 15 LAW, MEDICINE, AND HEALTH CARE, Winter 1987/88, at 212, 212.

172. CLEARINGHOUSE REV., *supra* note 14, at 737-38. The ABA urges that HIV tests conducted for underwriting purposes should conform to "generally accepted public health protocols." *ABA Pol'y & Rep. on AIDS*, *supra* note 23, § F.5, at 13.

173. CLEARINGHOUSE REV., *supra* note 14, at 738; HEALTH CARE REFORM, *supra* note 6, at 80; see, e.g., *Health Ins. Ass'n of America v. Corcoran*, 551 N.Y.S.2d 615 (N.Y. App. Div. 1990) (holding that use of HIV test results was a valid underwriting practice under state law), *aff'd*, 565 N.E.2d 1264 (N.Y. 1990); *Life Ins. Ass'n of Mass. v. Commissioner of Ins.*, 530 N.E.2d 168 (1988). The insurance industry's response to the law in Washington, D.C., was to refuse to write policies in the district. Bartlett, *supra* note 162, at 215. The D.C. City Council subsequently rescinded the ban. *Id.*

Some insurance companies have been accused of using other underwriting factors as proxies for HIV and AIDS diagnoses. For example, an applicant's residence, occupation, or perceived sexual orientation may have been used to screen out individuals considered to be at risk for HIV-infection. The National Association of Insurance Commissioners, with the assistance of gay rights advocates and representatives of the insurance industry, has issued model guidelines that prohibit these practices. These guidelines have been officially adopted in some states, and are used to provide guidance in others.

Even when a person has obtained a policy, there are other ways in which coverage of PWAs can be limited.¹⁷⁴ Many policies impose waiting periods or fail to reimburse the costs of preexisting conditions. A preexisting condition triggers an average nine month waiting period, although some plans have a longer term.¹⁷⁵ State law also allows insurers to rescind policies upon the discovery of a materially false or misleading statement or omission on an application, and HIV-positive policy holders may lose coverage on such bases.¹⁷⁶ The applicant typically must fill out a comprehensive medical history questionnaire with a variety of HIV-related questions (e.g., past symptoms), and misstatements in response to these questions can support a policy rescission even if the alleged misstatements are not related to claims.¹⁷⁷

In addition, the scope of insurance coverage is often inadequate for indicated treatment of persons with HIV and AIDS. Most private policies do not cover reimbursement for prescription drugs.¹⁷⁸ This is especially significant to HIV-infected individuals and PWAs because of the importance of drugs in their treatment¹⁷⁹ and the

174. See CLEARINGHOUSE REV., *supra* note 14, at 738. The ABA's policy is that "[i]nsurers should not cancel or refuse to renew or increase premiums on an individual insurance policy because of the individual's HIV-related claims or a change in health status related to HIV." *ABA Pol'y & Rep. on AIDS*, *supra* note 23, § F.14, at 14.

175. HEALTH CARE REFORM, *supra* note 6, at 82-83. Although HIV-infection alone, as a latent condition, may not be accurately classified as a preexisting condition according to standard use, many insurers treat it as one for claim purposes anyway. *Id.*

176. See HEALTH CARE REFORM, *supra* note 6, at 84-85. *Cf.* *Waxse v. Reserve Life Ins. Co.*, 809 P.2d 533 (Kan. 1991) (holding that insurance company did not have grounds to rescind a contract with an HIV-infected person who answered negatively on an application question asking if he had "blood disorders" absent a specific inquiry to AIDS or the HIV virus) (cited in HEALTH CARE REFORM, *supra* note 6, at 85).

177. HEALTH CARE REFORM, *supra* note 6, at 84 (citations omitted). The ABA policy states that "an insurer should be prohibited from asking an applicant whether they have taken an HIV test or sought counseling regarding HIV." *ABA Pol'y & Rep. on AIDS*, *supra* note 23, § F.6, at 13.

178. HEALTH CARE REFORM, *supra* note 6, at 86.

179. "Prescription drugs dominate HIV care, which is chiefly delivered in outpatient settings rather than in hospitals. . . . Prescription drugs consume as

high cost of drugs that treat HIV-infection.¹⁸⁰ Insurance policies usually do not cover experimental treatments and require FDA approval if drugs are to be covered.¹⁸¹ As the National Commission on AIDS has observed, however, "[t]reatments that are technically experimental may be the standard of care for HIV disease."¹⁸² Insurance policies also often exclude coverage for long-term and preventive care.¹⁸³ Preventive care, particularly testing and counseling, is increasingly recognized as the means with the most potential for curbing the spread of HIV.¹⁸⁴ Similarly, long-term care has become more important as the life expectancy of PWAs rises.¹⁸⁵ Finally, private insurance companies may simply write policies that explicitly limit or exclude AIDS-related benefits even though such practices are prohibited by state insurance regulations.¹⁸⁶

On another front, self-insurers are also exploring means to lessen the covered expense of PWA treatment. Two out of three Americans use employment-based plans for their health coverage, making it the largest source of health care financing in the country.¹⁸⁷ Of this number, approximately sixty percent are covered by self-insured plans.¹⁸⁸ Because smaller employers have increasingly eliminated health benefits for their employees, the number of privately insured Americans has decreased in the past several years.¹⁸⁹

Employers are also concerned about the cost of medical treatment for PWAs and those with HIV. Self-insured employers, how-

much as 92% of the average \$10,000 price tag for early intervention services." *Id.* (citing Davis et al., FINANCING HEALTH CARE FOR PERSONS WITH HIV DISEASE: POLICY OPTIONS—TECHNICAL REPORT PREPARED FOR THE NATIONAL COMMISSION ON AIDS 13 (1991)).

180. AZT cost approximately \$10,000 per year when it first became available in 1987. *Id.* at 88. Foscarnet has an annual expense of \$20,000 and other drugs range from \$2,000 to \$8,000 for a year's supply. *Id.* at 89-90.

181. CLEARINGHOUSE REV., *supra* note 14, at 738; *see also* HEALTH CARE REFORM, *supra* note 8, at 91-95. The ABA suggests that "[i]nsurers should be encouraged to include coverage of drugs which have been approved by the FDA under a 'Treatment IND' mechanism." *ABA Pol'y & Rep. on AIDS, supra* note 23, § F.12, at 14.

182. 1991 NAT'L COMM'N REP., *supra* note 10, at 72.

183. HEALTH CARE REFORM, *supra* note 6, at 97. When cost-effective, the ABA encourages insurers to cover treatments in nursing homes, hospices, and outpatient facilities. *ABA Pol'y & Rep. on AIDS, supra* note 23, § F.10, at 13. The ABA also recommends case management techniques. *Id.* § F.11, at 14.

184. 1991 NAT'L COMM'N REP., *supra* note 10, at 54.

185. HEALTH CARE REFORM, *supra* note 6, at 97.

186. *See* NATIONAL ACADEMY OF SCIENCES, CONFRONTING AIDS: UPDATE 1988, at 113 (1988) [hereinafter CONFRONTING AIDS].

187. HEALTH CARE REFORM, *supra* note 6, at 10 (citing Rockefeller, *A Call for Action: The Pepper Commission's Blueprint for Health Care Reform*, 265 JAMA 2507, 2508 (May 15, 1991)).

188. Zavos, *AIDS and Insurance, supra* note 168, at 20. Eighty percent of large employers self-insure their workers. HEALTH CARE REFORM, *supra* note 6, at 14.

189. *See* HEALTH CARE REFORM, *supra* note 6, at 10 (citation omitted).

ever, may be able to avoid full coverage of AIDS and HIV more easily than insurance companies because they are regulated by the Employment Retirement Income Security Act (ERISA) rather than individual states.¹⁹⁰ The Supreme Court has held that this federal action preempts state regulation of self-insured benefit plans.¹⁹¹ ERISA, however, has placed few restraints on the efforts of self-insured employers to escape HIV-related liability.

One of the most publicized of these efforts was upheld by the Fifth Circuit in *McGann v. H & H Music Co.*¹⁹² In that case, a self-insured employer reduced its employees' lifetime \$1 million maximum health insurance coverage for all medical claims to a \$5,000 ceiling for AIDS-related claims. McGann, an employee with AIDS, sued the employer under Section 510 of ERISA when his benefits reached their limit.¹⁹³ The court held that ERISA did not prohibit a self-insured employer from imposing insurance caps under the theory that an employer may terminate or amend a plan at any time, and that the availability of the \$1 million maximum was not a "right" protected by Section 510.¹⁹⁴ This was the case even though McGann was the only employee adversely affected by the plan.¹⁹⁵ Although the ABA, among other groups including the American Medical Association and the National Governors' Association, urged the Solicitor General to support the plaintiff's petition for a writ of certiorari,¹⁹⁶ the Supreme Court denied the petition in 1992 and allowed the lower court decision to stand.¹⁹⁷ Another recent case on similar facts has also held that "defendant's unilateral modification of an existing plan cannot support a [Section] 510 claim."¹⁹⁸

190. See 29 U.S.C. §§ 1001-1461 (1988) (ERISA).

191. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990); see HEALTH CARE REFORM, *supra* note 6, at 13.

192. 946 F.2d 401 (5th Cir. 1991), *cert. denied* 113 S. Ct. 482 (1992); see also *Owens v. Storehouse*, 773 F. Supp. 416 (N.D. Ga. 1991), *aff'd*, 984 F.2d 394 (11th Cir. 1993).

192.5 *McGann*, 946 F.2d at 402.

193. *Id.* at 403. Section 510 of ERISA provides in relevant part:

It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan, . . . or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan

29 U.S.C. § 1140 (1988).

194. *McGann*, 946 F.2d at 405 (stating that "McGann's allegations show no promised benefit, for there is nothing to indicate that defendants ever promised that the \$1,000,000 coverage limit was permanent").

195. *Id.* at 406-08.

196. See Zavos, *AIDS and Insurance*, *supra* note 168, at 19.

197. *Greenberg v. H & H Music Co.*, 113 S. Ct. 482 (1992).

198. *Owens v. Storehouse*, 773 F. Supp. 416, 419 (N.D. Ga. 1991), *aff'd*, 984 F.2d 394 (11th Cir. 1993). One of the collateral effects of the uninsurability of persons with serious medical conditions is that they are forced to stay in a job if they are fortunate enough to get some coverage for fear of not being able to reinsure. This phenomena, known as "job lock," reflects the importance of

The current state of the law allowing limits to previously established health benefits is certainly not restricted to people with HIV/AIDS. In limiting coverage, however, employers may be counting on the stigma of HIV/AIDS and on the assumption that other employees will not object to the reduction of benefits to PWAs.¹⁹⁹ In addition, the National Association of Attorneys General has observed that "ERISA has become a tool for employers who wish to avoid their obligations under state law."²⁰⁰

C. *Confronting the Gaps in Private Insurance*

Other employees are challenging the same type of insurance practices used in *McGann* under the Americans with Disabilities Act.²⁰¹ Section 102(a) of the Act,²⁰² which now applies to employers with twenty-five or more employees, prohibits discrimination based on a disability in the terms, conditions, and privileges of employment.²⁰³ However, the crucial provision in this context will likely be Section 501(c).²⁰⁴ This section states that the ADA is not intended to restrict employers in the operation of bona fide benefit plans based on the underwriting, classification, or administration of risks that are consistent with state law. In addition, the ADA is not intended to prohibit bona fide benefit plans not subject to state law.²⁰⁵ Benefit practices, however, will not be protected if they are "a subterfuge used to evade the purposes" of the Act.²⁰⁶ Because there is no statutory definition of this provision in the Act, courts may look at analogous provisions in other anti-discrimination statutes to determine its meaning. For example, the Supreme Court interpreted similar language in the Age Discrimination in Employment Act (ADEA)²⁰⁷ in deciding whether a plan that limited benefits to those under age sixty constituted a subterfuge to evade the purposes of that Act.²⁰⁸ The court took a narrow approach and held that there was no subterfuge unless the plan was adopted for the purpose of discriminating against an individual on the basis of age

health plan portability for people with HIV. See HEALTH CARE REFORM, *supra* note 6, at 14 (citations omitted).

199. See Zavos, *AIDS and Insurance*, *supra* note 168, at 19.

200. HEALTH CARE REFORM, *supra* note 6, at 13-14 (citing N. Y. TIMES, Mar. 29, 1992).

201. 42 U.S.C. §§ 12101-12213 (Supp. III 1991).

202. *Id.* § 12112(a).

203. On July 26, 1994, § 102 will apply to employers with 15 or more employees. The Act also reaches indirect discrimination by prohibiting the employer's participation in contracts or other arrangements that have the effect of discriminating against employees with a disability. *Id.* § 12112(b).

204. *Id.* § 12201(c).

205. *Id.*

206. 42 U.S.C. § 12201(c) (Supp. III 1991).

207. See 29 U.S.C. § 623(f)(2) (1988).

208. Public Employees Retirement Sys. v. Betts, 492 U.S. 158 (1989).

in a non-benefit aspect of the employment relationship.²⁰⁹

The Equal Employment Opportunity Commission (EEOC) recently issued interim guidelines for the application of the ADA to employer provided health insurance.²¹⁰ These guidelines provide that once a disability-based distinction is found in an employer's health insurance plan, the employer has the burden of proving that the distinction comes within the protective ambit of Section 501(c).²¹¹ The EEOC also defines subterfuge in the guidelines as "disability-based disparate treatment that is not justified by the risks or costs associated with the disability."²¹²

In 1993, the EEOC found that a union health plan which excluded HIV or AIDS from its coverage violated the ADA on its face.²¹³ The Commission found that the employer had no "viable defense" under the Act. The issue is now pending in the United States District Court in New York.²¹⁴ In another case, *Kadinger v. IBEW Local 110*, the estate of a union member challenged a cap on AIDS-related benefits set by the member's union and its health insurer.²¹⁵ This may be the first case to deal with this issue.²¹⁶

209. *Id.* at 181.

210. See EEOC Interim Guidance on Application of ADA to Health Insurance (issued June 8, 1993) [hereinafter Interim Guidance]; see also *Disability Bias in Health Insurance Barred*, WASH. POST, June 9, 1993, at A14.

211. See Interim Guidance, *supra* note 210, § III. "[I]t is the respondent employer who has control of the risk assessment, actuarial, and/or claims data relied upon in adopting the challenged disability-based distinction." *Id.*

212. *Id.* The guidelines also set forth a "non-exclusive" list of potential business/insurance justifications available to the employer. For example, the employer may prove that the disparate treatment is justified by legitimate actuarial data and that comparable conditions are treated similarly, or that the distinction is necessitated by the requirements of "fiscal soundness." *Id.*

213. *Donaghey v. Mason Tenders Dist. Council Trust Fund*, EEOC Charge No. 160-93-0419 (Jan. 28, 1993) (ruling from New York District office); see *AIDS Activists Applaud Jan. 27 EEOC Ruling That Insurance Caps Are a Violation of ADA*, 8 AIDS POL'Y AND LAW, Feb. 19, 1993, at 1, 7. The Philadelphia district office of the EEOC has since issued a decision in accord with *Donaghey*. See *Doe v. Laborers' District Council*, EEOC Charge No. 170-93-0899 (Sept. 9, 1993) (ruling that a \$10,000 lifetime cap on payment for HIV-related medical treatment in a union health plan violates the ADA).

214. *Donaghey*, EEOC Charge No. 160-93-0419. See *Mason Tenders District Council Welfare Fund v. Donaghey*, 93-CIV-1154 (S.D.N.Y. filed Mar. 1, 1993); *EEOC v. Mason Tenders District Council Welfare Fund*, 93-CIV 3865 (S.D.N.Y. filed June 9, 1993). On November 19, 1993, the district court denied *Mason Tenders'* motion for summary judgment, holding both that the union insurance fund is a covered entity under the ADA and that ERISA does not exempt it from the ADA's anti-discrimination provisions. See *Mason Tenders Welfare Fund Not Exempt From ADA Provisions*, U.S. Judge Says, 8 AIDS POL'Y & LAW, Nov. 28, 1993, at 1, 7.

215. CV No. 2-93-159 (D.C. N. Minn. filed Mar. 17, 1993). The case settled when the union welfare fund agreed, *inter alia*, to the entry of a Consent Decree removing the cap on AIDS-related benefits. See Milt Freudenheim, *In Minnesota, Settlement Is First For AIDS Bias by Health Insurer*, New York Times, Dec. 22, 1993, at A19.

216. To date there are no court decisions on this issue.

In addition, legislative efforts are being made to prevent the outcome upheld in *McGann*.²¹⁷ Representative William Hughes (D.-N.J.), introduced the Group Health Plan Nondiscrimination Act of 1992, HR 6147 (introduced to the House on October 5, 1992). The bill would amend Title I of ERISA to prohibit a limitation or elimination of benefits in self-insured policies which occur after the employee has submitted his claim for reimbursement.²¹⁸

There are other methods currently in use that also serve to extend private insurance coverage. Thirty-six states have conversion requirements that enable individuals previously covered under employment-based policies to switch to an individual policy within a certain amount of time.²¹⁹ These individual policies, however, often provide for coverage that is significantly inferior to that under the group plans.²²⁰ In 1985, the Consolidated Omnibus Reconciliation Act (COBRA) established a continuation requirement for employers of twenty or more workers mandating that employers provide eighteen months of benefit coverage for workers after they leave their jobs.²²¹ COBRA, however, may have limited potential for HIV-infected people. Many persons with HIV work for smaller employers than those covered by COBRA.²²² Furthermore, although the premiums are limited by law, they are often high enough to preclude individuals from paying them, particularly with the drop in income that accompanies the loss of a job.²²³ Some states have addressed this issue by publicly funding COBRA premiums, which is usually less expensive for the states' Medicaid programs.²²⁴ However, to the extent that the COBRA premiums do not cover the true cost of insuring these individuals the cost is shifted from the state to the private sector.

217. See *Fight Against Greenberg Decision; Legislation to Amend ERISA Planned for 1993*, 7 AIDS POL'Y & LAW, Nov. 27, 1992, at 1, 2; Zavos, *AIDS and Insurance*, *supra* note 168, at 19.

218. See Zavos, *AIDS and Insurance*, *supra* note 168, at 19. Senator Boxer (D.-Ca.) has introduced a companion bill in the Senate.

219. Bartlett, *supra* note 162, at 216 (discussing conversion requirements for previous members of employee based group policies).

220. HEALTH CARE REFORM, *supra* note 6, at 96. In addition, these state requirements do not affect self-insurers covered by ERISA. *Id.*

221. HEALTH CARE REFORM, *supra* note 6, at 95. When a worker leaves employment due to a disability and qualifies for SSDI, the continuation term is extended to 29 months. HEALTH CARE REFORM, *supra* note 6, at 95. Thirty-five states also have their own continuation requirements. Bartlett, *supra* note 162, at 216 (discussing affordability of coverage required under conversion and continuation agreements).

222. HEALTH CARE REFORM, *supra* note 6, at 96 (discussing limitations of COBRA insurance coverage).

223. *Id.*; Bartlett, *supra* note 162, at 216 (discussing how most unemployed people can not afford COBRA coverage).

224. See HEALTH CARE REFORM, *supra* note 6, at 122 (discussing how states attempt to assist HIV patients not capable of affording COBRA).

A third method by which states shore up private coverage is to establish risk pools. A risk pool requires insurers in the state to share the underwriting responsibilities for otherwise uninsurable persons.²²⁵ The purpose of these programs is to guarantee the opportunity to purchase health insurance to all persons, regardless of their medical condition.²²⁶ The biggest barrier to effectiveness, however, is once again cost. Even though state law imposes price caps, risk pool premiums are generally 125-200 percent higher than standard private insurance rates.²²⁷ Moreover, Wisconsin and Maine are the only states to establish a subsidy program for indigents' premiums.²²⁸ A related problem is that because ERISA preempts state regulation of self-insurers, these employers cannot be required to contribute to state risk pools. The costs associated with these plans are thus carried by a much smaller base of insurers.²²⁹ Consequently, risk pools are unable to provide a comprehensive solution to the health care problem of uninsureds who are not poor, but who might become so when confronted with significant medical costs.

However, many young people, the indigent, and IV drug users are not, and never have been, candidates for private health insurance, with or without HIV-infection. The issue of medical coverage for these individuals is a problem that cannot be solved through the private insurance system or employee benefits coverage. If the present trend in demographics of HIV-infection continues, health insurance underwriting restriction, limits on rate increases, COBRA continuation rights, ERISA preemption limits, the ADA, and the availability of risk pools will become increasingly irrelevant to the discussion of medical coverage for individuals with HIV infection.

225. Bartlett, *supra* note 162, at 216-17. By 1991, 24 states had provided for risk pools. HEALTH CARE REFORM, *supra* note 6, at 138 (discussing how 24 states have created major risk pools in order to provide insurance for people uninsurable due to their medical conditions).

226. AARON K. TRIPPLER, COMPREHENSIVE HEALTH INSURANCE FOR HIGH-RISK INDIVIDUALS: A STATE-BY-STATE ANALYSIS 4 (4th ed. 1990). Maximum lifetime benefits, if any, range between \$250,000-1,000,000. *Id.* at 23-24.

227. TRIPPLER, *supra* note 226, at 4; CLEARINGHOUSE REV., *supra* note 14, at 735.

228. CLEARINGHOUSE REV., *supra* note 14, at 735. As a result the participation in risk pools has been much lower than anticipated. *Id.*

229. CONFRONTING AIDS, *supra* note 186, at 279-80. In addition, all of the risk pools have waiting periods lasting from six months to a year that prohibit coverage of preexisting conditions. TRIPPLER, *supra* note 226, at 29-30; *see* Bartlett, *supra* note 168, at 217 (stating how costs associated with risk pools are borne only by the parties purchasing traditional health insurance coverage).

V. THE UNINSURED AND PUBLIC FINANCING

A. *The Burden on Public Financing*

The exclusion of persons with AIDS and HIV from private coverage as described above necessarily means that a large number of these individuals will be forced to rely on public programs for the financing of their medical care. In essence, AIDS confronts a health care system that is designed around the concept that long-term, expensive illnesses occur primarily in old age.²³⁰ This shift from a private health care system to the public financing of AIDS care will only continue as the demographics of persons with AIDS change from homosexuals to drug-users and their sexual partners.²³¹

Uninsured persons are generally poor, young, unmarried, uneducated, rural, of color, part-time or self-employed workers.²³² The lack of health coverage predictably leads to inadequate medical care. Even though they are typically in worse health than insured people, the uninsured are less likely to receive any medical care, see a doctor, or receive in-patient medical care. Persons with chronic ailments who have no insurance are about fifty percent as likely to see a doctor and are discharged sooner than those with insurance.²³³ Other studies have found that babies born to uninsured parents are thirty percent more likely to be sick or die than those of insured parents. The uninsured are thirty-nine percent less likely to have coronary angiograms and 29 percent less probable to have bypass surgery.²³⁴ In addition, as will be discussed, the public financing of medical treatment contains other problems for uninsured HIV-infected persons.

B. *Problems of Access in Medicare and Medicaid Coverage*

1. *Medicaid*

In general, Medicaid has two separate eligibility requirements

230. Fox & Thomas, *supra* note 152, at 205, 208 (discussing how the major diseases resulting in death usually occur in old age).

231. Bartlett, *supra* note 162, at 213 ("Members of this latter population are less likely to hold jobs that provide employment-related health benefits or, because they are often low income, to have purchased individual insurance coverage prior to their infection."). The National Commission on AIDS has suggested that the "Medicaidization" of AIDS health care stems from two sources: the spread of the virus among low-income persons and the simultaneous contraction of private health insurance coverage. 1991 NAT'L COMM'N REP., *supra* note 10, at 72-73.

The ABA advocates a shared responsibility between public and private groups for persons who are medically uninsurable. *ABA Pol'y & Rep. on AIDS*, *supra* note 23, § F.15, at 14.

232. HEALTH CARE REFORM, *supra* note 6, at 8-9 (discussing the categories of people who fall into the group of uninsured).

233. *Id.* at 9-10.

234. Zavos, *AIDS and Insurance*, *supra* note 168, at 20-21 (stating the increased health insurance risk factors facing the uninsured).

that must be met to qualify for coverage.²³⁵ First, the applicant must satisfy the appropriate means test. In most states, this is tied to the Supplemental Security Income (SSI) program's monthly income limits.²³⁶ Second, to receive Medicaid benefits, the applicant must be a member of one of the covered groups. Thus, an otherwise financially eligible person must be "disabled" as determined by the Social Security Administration (SSA), a member of a family receiving Aid to Families with Dependent Children (AFDC), blind, pregnant, under the age of seven, or over sixty-five.²³⁷ The majority of states allow persons who meet SSI's disability requirements (disabled and unable to work) to qualify automatically for Medicaid. Other states, however, have established their own disability requirements which are stricter than that of SSI.²³⁸

Most persons with AIDS qualify for Medicaid on the basis of disability, although low-income women and children can also become eligible for Aid to Families with Dependent Children (AFDC). To expedite the process, PWAs are presumptively considered to be disabled under the SSI rules, subject to a later review.²³⁹ Individuals who would otherwise be eligible for Medicaid based on disability or AFDC, but whose income exceeds the SSI limit, may still qualify in most states for coverage as "medically needy" if their income dips below a certain level after they "spend down" in paying for medical expenses. In many states, this amount is calculated every six months, so that Medicaid will only be available to reimburse the amount below the spend-down level after the costs have been incurred.²⁴⁰

The eligibility requirements of Medicaid create special problems of access for persons with AIDS. A person with full-blown AIDS is considered "disabled" under the guidelines, but seropositive people with mild symptoms or those who are being treated only prophylactically (e.g., AZT maintenance) may have trouble gaining eligibility to the program.²⁴¹ Thus, applicants without an AIDS diagnosis do not get the benefit of a presumption and must show that they should qualify as disabled. This problem is even more acute for women and children who have the most difficulty in gaining ac-

235. See Shacknai, *supra* note 31, at 183-84 (discussing that requirements of "financial" and "categorical" must be meant to qualify for Medicaid).

236. *Id.* at 184 (stating that SSI's monthly income limit is \$386, although this may be higher in some states).

237. *Id.* at 184 (stating the "categorical" requirements one needs to qualify for Medicaid).

238. CLEARINGHOUSE REV., *supra* note 14, at 727-28.

239. Bartlett, *supra* note 162, at 219. This presumption is based on the CDC definition of AIDS. Bartlett, *supra* note 162, at 219. See also *supra* notes 5-8 and accompanying text.

240. CLEARINGHOUSE REV., *supra* note 14, at 728-29.

241. Shacknai, *supra* note 31, at 184-85 (discussing that the severity of the diagnosis of a person who is HIV-infected may determine Medicaid eligibility).

cess to health care.²⁴² Qualifying as disabled requires the use of expensive tests that may be difficult to obtain in public hospitals.²⁴³ Moreover, although CDC estimates that sixty percent of all persons with HIV would benefit by early intervention, Medicaid withholds this type of treatment through its strict disability rules. Consequently, low-income HIV-infected persons dependent on Medicaid are deprived of valuable and life-prolonging medical care and may die sooner than wealthier patients.²⁴⁴

The financial requirements create similar problems of access to people with HIV. Thirteen states have no "spend-down" provisions for the medically needy,²⁴⁵ requiring applicants to effectively impoverish themselves before they become eligible for Medicaid funds.²⁴⁶ In addition, once applicants do qualify for Medicaid, they can easily rise above the required income level and disqualify themselves. Thus, even though HIV-infected persons may be able to work, Medicaid discourages employment by requiring those eligible for aid to remain poor.²⁴⁷ In addition, in the states that have no provisions for the medically needy, Medicaid eligibility may be forfeited upon an individual's qualification for Social Security benefits after losing his or her job. These persons are effectively in "limbo" because they are precluded from obtaining private insurance and are placed out of Medicaid coverage.²⁴⁸

242. *Id.* at 185. For a discussion of HIV-infected women and problems with access to health care, see *supra* notes 46-67 and accompanying text. The variation in eligibility requirements also raises issues of fairness as HIV-infected patients in more affluent states can receive more coverage. For example, a 1987 study found that 54 percent of patients with AIDS were eligible for Medicare in the Northeast, compared to 18 percent in the South. HEALTH CARE REFORM, *supra* note 6, at 105 (citing National Commission on Aids report).

The ABA believes it important that both "[p]ublic and private entities . . . expeditiously develop and implement HIV-related programs targeted to serve minority communities." *ABA Pol'y & Rep. on AIDS*, *supra* note 23, § D.4, at 12.

243. Shacknai, *supra* note 31, at 185 (discussing how hospitals do not always render official AIDS diagnoses because doing so would trigger state requirements of those diagnosed with AIDS to be hospitalized regardless of ability to pay).

244. HEALTH CARE REFORM, *supra* note 6, at 103-04 (citations omitted). In fact, studies show that early intervention saves the government money by delaying expensive end-stage care into the future. Patients who have received early intervention also require less expensive hospitalization in the latter stages of the disease. *Id.* (citations omitted).

245. See *supra* note 244 and accompanying text for a discussion of cost saving benefits of early medical intervention.

246. Shacknai, *supra* note 31, at 187 (discussing how states with no "spend down" provisions require people to pay for health care out-of-pocket until they attain poverty); see also HEALTH CARE REFORM, *supra* note 6, at 106-07 (discussing how states without "spend down" provisions require patients to pay for health care out-of-pocket until they are impoverished).

247. Shacknai, *supra* note 31, at 188 (discussing how "categorical" and "financial" requirements for Medicaid eligibility require impoverishment).

248. Bartlett, *supra* note 162, at 219 (discussing how the receiving of social security can terminate medical coverage).

The various types of Medicaid coverage and service adversely affect persons with AIDS and HIV as well.²⁴⁹ Some services, such as in-patient hospital care, outpatient care, and laboratory services are required to be covered under federal mandate. Other services, including prescription drugs, hospice care, case management, and intermediate care facility services are optional.²⁵⁰ Currently, however, only ten states provide for home- and community-based services, which are increasingly recognized as more effective than in-patient care for many HIV-infected persons. Hospice services are part of the Medicaid program in only about half the states.²⁵¹

It is also common for state Medicaid plans to place limits on whatever services they do offer. These limits restrict the effectiveness of health care available for low-income PWAs and may increase government expense in the long run.²⁵² For example, Medicaid agencies may limit the number of hospital days, doctor visits, or types of specific services that they will cover.²⁵³ In addition, when Medicaid covers a service, it often has a low rate of reimbursement.²⁵⁴ This discourages health care providers from treating HIV-infected persons and forces these patients into busy public hospitals and clinics.²⁵⁵ Although all jurisdictions cover the optional service of prescription drugs, some states limit the number of refills or place cost limits on reimbursement.²⁵⁶ Every state currently reimburses for AZT, but other drugs, such as aerosolized pentamidine and fansidar, may be excluded or limited.²⁵⁷ In addi-

249. The ABA advocates "flexible mechanisms for payment, including expediting the Medicaid waiver review process, to allow more treatment alternatives for HIV." *ABA Pol'y & Rep. on AIDS*, *supra* note 23, § D.3, at 12.

250. CLEARINGHOUSE REV., *supra* note 14, at 730.

251. Shacknai, *supra* note 31, at 190. In addition to their effectiveness, these alternatives are less costly than full hospitalization, the most expensive health care option. *Id.* at 194.

Home-based and community-based care may be provided if a state first obtains a "section 2176 waiver." Congress has authorized states to focus on certain groups, such as persons with AIDS, in providing services like private nursing and hospice care. See 42 U.S.C. § 1396(n) (1988); CLEARINGHOUSE REV., *supra* note 14, at 733. There are limits, however. The waivers cannot be used to provide services otherwise provided by the state and cannot include vocational or educational activities. *Id.* at 733.

252. HEALTH CARE REFORM, *supra* note 6, at 108 (discussing how Medicaid restrictions on prescription drugs for HIV patients results in increased costs due to unnecessary illness in the future).

253. CLEARINGHOUSE REV., *supra* note 14, at 730-31. For example, Arkansas limits recipients to twelve covered days of inpatient care per year and Louisiana provides for only ten. Bartlett, *supra* note 162, at 219.

254. See Shacknai, *supra* note 31, at 190 (discussing how Medicaid reimbursement falls far below costs for HIV patients).

255. HEALTH CARE REFORM, *supra* note 6, at 107 (discussing how limitations on Medicaid reimbursement results in inferior care for HIV patients).

256. Shacknai, *supra* note 31, at 191 (discussing how Medicaid fails to provide adequate coverage for prescription drugs).

257. *Id.*

tion, low-income persons may be unable to take advantage of the recent liberalization in the availability of experimental drugs because most state Medicaid programs require full approval from the Food and Drug Administration for reimbursed treatments.²⁵⁸

Limitations on Medicaid services have been challenged in several states and jurisdictions have been split in their responses.²⁵⁹ Federal rules require that the extent of covered Medicaid services must be "sufficient in amount, duration, and scope to reasonably achieve its purpose."²⁶⁰ For example, the Fourth Circuit, citing the flexibility of states under Medicaid, has upheld limitations on the number of covered days of in-patient and outpatient hospital services.²⁶¹ California courts, on the other hand, have struck down a state rule that arbitrarily restricted the drugs the program would reimburse.²⁶² The Supreme Court has also held that a state's reduction in Medicaid coverage of hospital days does not violate the Federal Rehabilitation Act.²⁶³

2. Medicare

In general, Medicare covers citizens over age sixty-five and persons with a disability who meet certain work history requirements. Medicare pays for only one percent of the AIDS health care expenses.²⁶⁴ Medicare is tied to Social Security Disability Insurance employment history requirements, and thus individuals with an inadequate past work record may be ineligible for benefits.²⁶⁵ Even more significantly, an otherwise eligible participant must have received SSDI checks for two years — making this program essen-

258. See HEALTH CARE REFORM, *supra* note 6, at 110-111; Shacknai, *supra* note 31, at 191. Activists pressured the FDA to broaden the availability of investigational new drugs (INDs) for HIV-infected people. Medicaid, however, does not cover these INDs until there is complete FDA approval. Shacknai, *supra* note 31, at 191.

259. See HEALTH CARE REFORM, *supra* note 6, at 108-09. In general, state limitations must comport with federal regulations requiring the services to be adequate in amount, duration, and scope, and to cover all "medically necessary" services. See CLEARINGHOUSE REV., *supra* note 14, at 731.

260. 42 C.F.R. § 440.230(b) (1992).

261. Charleston Memorial Hosp. v. Conrad, 693 F.2d 324, 330 (4th Cir. 1982) (cited in HEALTH CARE REFORM, *supra* note 6, at 109 n.168; see also, e.g., Ellis v. Patterson, 859 F.2d 52, 55 (8th Cir. 1988); Curtis v. Taylor, 625 F.2d 645, 652 (5th Cir. 1980); Stan Dorn et al., *Maximizing Coverage for Medicaid Clients*, 20 CLEARINGHOUSE REV. 411, 411-414 (1986).

262. Jeneski v. Myers, 163 Cal. App. 3d 18, 209 Cal. Rptr. 178, 188-89 (Cal Ct. App. 1984), *cert den'd sub nom* Kizer v. Jeneski, 471 U.S. 1136 (1985) (cited in HEALTH CARE REFORM, *supra* note 6, at 109).

263. Alexander v. Choate, 469 U.S. 287, 302 (1985). The court expressly noted that it was not addressing federal Medicaid requirements. *Id.* at 304 n.23.

264. Bartlett, *supra* note 162, at 218 (discussing how a person has to have contributed sufficient funds to SSDI in order to qualify for Medicare).

265. HEALTH CARE REFORM, *supra* note 6, at 128.

tially irrelevant to many PWAs who never live long enough to take advantage of it.²⁶⁶ Although there has been support for eliminating this waiting period,²⁶⁷ this change may be prohibited by cost considerations.²⁶⁸

The primary advantage of Medicare is that it reimburses at a higher level than Medicaid, thereby increasing the options of patients looking for doctors and hospitals.²⁶⁹ However, Medicare's emphasis on in-patient hospital care may exclude some treatments that are important to persons with HIV and AIDS. For instance, prescription drugs and long-term health care facilities are both left out of Medicare coverage.²⁷⁰

VI. CONCLUSION

From the basketball court to the courthouse, the AIDS epidemic has reached almost every facet of American life. In the context of access to health care, HIV-infection is in many respects no different than other catastrophic and chronic illnesses that have historically affected large population groups. On the other hand, HIV and AIDS present somewhat unique problems that pose special challenges, many of them legal, to any comprehensive plan for health reform: the demographic trends which portray a disease that is increasingly becoming one of the inner city; the discrimination associated with AIDS due to its means of transmission and the social stigma that has accompanied its growth; the efforts of the private insurance industry to limit coverage for AIDS-related treatment; and the resulting burden on public finance and programs that appear inadequate to help many persons with HIV.

Some of these issues have only recently emerged and are becoming the objects of research and scholarship. What is clear, however, is that no successful modification of health care access for Americans can occur without confronting the effect that the AIDS virus has on almost every aspect of the American health care system. At the same time, the concerns raised by the AIDS epidemic in the last decade have made apparent the need for thoughtful and

266. See CLEARINGHOUSE REV., *supra* note 14, at 725 (citations omitted).

267. See, e.g., CONFRONTING AIDS, *supra* note 186, at 280; Shacknai, *supra* note 31, at 197 (discussing how reduction in the Medicare waiting period would do away with the need of some Medicaid reforms).

268. It has been estimated that the elimination of the two year delay for persons with AIDS would cost the federal government \$2-8 billion over five years. Of course, persons with other disabilities would also demand a waiver, leading to even higher expense. Removal of the waiting period for all terminally ill Medicare participants is estimated at \$6-15 billion. Bartlett, *supra* note 162, at 218-19 (citations omitted).

269. Shacknai, *supra* note 31, at 197 (discussing the advantages of Medicare over Medicaid).

270. *Id.* at 189; HEALTH CARE REFORM, *supra* note 6, at 128 (discussing how the bulk of HIV treatment is delivered outside the hospital setting).

significant changes in the way health care is provided in the United States.

