COMMENTS

"MEANINGFUL ACCESS" TO HEALTH CARE AND THE REMEDIES AVAILABLE TO MEDICAID MANAGED CARE RECIPIENTS UNDER THE ADA AND THE REHABILITATION ACT

ALEXANDER ABBE[†]

INTRODUCTION

In recent years, financial and political pressures have induced legislators to adopt forms of managed care for Medicaid programs. Rising health care costs,¹ the unpopularity of the Medicaid entitlement to both taxpayers

[†] B.A. 1994, Swarthmore College; J.D. Candidate 1999, University of Pennsylvania. I would like to thank Cheryl Roth Herzfeld, Adrienne Brown, Robert Fitzgerald, and the Associate Editors of the *University of Pennsylvania Law Review* for their many hours of hard work editing this Comment. I would also like to thank Professor Seth Kreimer for his guidance and suggestions and Robin Resnick of the Disabilities Law Project for her insight. Finally, I would like to thank my parents, Elizabeth and Earl Abbe, and my brother, Kenneth Abbe, for the unqualified and unlimited support that has helped me accomplish so much. Any errors or omissions are my own.

¹ A multitude of factors have contributed to the dramatic increase in the cost of health care in recent years, including technological advances, a much greater population of elderly persons as the baby boom generation ages, and new diseases such as AIDS. See Laurel Campbell, *Health Care—Rising Costs of 7-10% Will Put Squeeze on Employers*, COM. APPEAL (Memphis, Tenn.), Feb. 28, 1999, at J5, available in 1999 WL 4139175 (stating that health care costs rose 3.7% nationwide in 1998 and forecasting a 7-10% rise in costs in 1999, and citing "rising drug costs, an aging population and a proliferation of health care legislation as factors"); *Employers Expect Health-Care Costs to Rise 9 Percent in '99 Mercer Study Says*, ST. LOUIS BUS. J., Feb. 1, 1999, at 9, available in 1999 WL 8434004 (citing a survey conducted by William M. Mercer Inc. which indicated that prescription drug costs rose 13.8% in 1998); *Health Care Costs: At Rest or on the Rise?*, FIN. EXECUTIVE, Mar.-Apr. 1997, at 8, 8 (quoting a benefits manager as saying that "'it's not a matter of if costs go up, but when'"); Michael Prince, *Health Care Costs on the Rise Again*, BUS. INS., Dec. 21, 1998, at 24, available in 1998 WL 23211994 (explaining that prescription drug costs have skyrocketed "as new, more-expensive drugs have hit the market and as consumers demand those drugs because of the influence of pharmaceutical industry advertising"); Julie Sneider, *Health Care Costs Rise with Demand for Information*, BUS. J. (Milwaukee, Wis.), Nov. 7, 1997, at 1, available in 1997 WL 16162789 (asserting that "the demand for outcomes measurements, health care report cards and other quality initiatives is one reason employers may be paying more for health care and health insurance this year and next"); Chris van Weel & Joop Michels, *Dying, Not Old Age, to Blame for Costs of Health Care*, 350 LANCET 1159, 1159 (1997) (suggesting that the major increases in health care costs are a result of dying, not aging, because "[t]he last period of life (any life, at any age) is usually marked, by definition, by ill-

and state governments,² and shrinking budgets³ have made the move to managed care all but unavoidable. As one commentator puts it: "In short, rationing of health care is inevitable."⁴ Given this reality, legislators and courts are finding themselves in the difficult position of deciding between the health care needs of the disabled and the financial demands of the voters, and consistently they are concluding that managed care is the only option.⁵ In the U.S. Congress, this has led to the explicit endorsement of managed care for Medicaid under section 4701 of the Balanced Budget Act of 1997.⁶ In Pennsylvania, this has resulted in the development of "HealthChoices," a program under which all Medicaid recipients will be mandatorily enrolled in managed care organizations ("MCOs") by 2000.⁷ With this

ness that cannot be cured or controlled despite strenuous medical efforts"); *All Things Considered: Health Inflation* (NPR radio broadcast, Dec. 28, 1998), available in 1998 WL 3647721 (explaining that health care costs have risen for three decades and that the dramatic slowdown in growth in spending between 1993 and 1997 is a result of the movement into managed care, and forecasting double-digit rates of increase in the future).

² See Ed Sparer, *Gordian Knots: The Situation of Health Care Advocacy for the Poor Today*, 15 CLEARINGHOUSE REV. 1, 3-4 (1981) (tracing the political resistance to Medicaid expenditures since Medicaid's creation in 1969, and noting that although "[t]he large majority of the poor and low-income people, in addition to working-class and lower-middle-class persons generally, are excluded from Medicaid," they bear a disproportionate burden of the cost); see also Richard Himelfarb, Book Review, 91 AM. POL. SCI. REV. 734, 735 (1997) (reviewing THE PROBLEM THAT WON'T GO AWAY: REFORMING U.S. HEALTH CARE FINANCING (Henry J. Aaron ed., 1996)) (suggesting that President Clinton's proposed health care reform plan failed as a result of "the public's increasing hostility toward big government and increased taxes"). But see Glenn R. Pascall, *Health-Care Debate About More than Rising Costs*, PUGET SOUND BUS. J., Apr. 25, 1997, at 11, available in 1997 WL 7329650 (reporting that 81% of residents in the State of Washington "believe state government is not spending enough on health care").

³ Recent efforts to reduce spending at every level of government have had a significant impact on health care. See, e.g., John George, *Cuts in Federal Spending Bode Increased Pressure*, PHILA. BUS. J., Jan. 2, 1998, at 24 (noting that "tough decisions about resource allocations will again confront health-care executives" as health care funding decreases).

⁴ David Orentlicher, *Destructuring Disability: Rationing of Health Care and Unfair Discrimination Against the Sick*, 31 HARV. C.R.-C.L. L. REV. 49, 49 (1996). Orentlicher also notes that "we cannot afford all medically beneficial care. . . . Elimination of waste . . . would not free up enough resources to cover all potentially useful medical services." *Id.*

⁵ See Mary Crossley, *Medicaid Managed Care and Disability Discrimination Issues*, 65 TENN. L. REV. 419, 421 (1998) ("States hope that their Medicaid programs will enjoy the same cost savings attributed to the growth of managed care in the private sector, and that Medicaid recipients enrolled in a managed care plan will receive higher quality and more consistent care.").

⁶ See 42 U.S.C. § 1396u-2(a)(1)(A)(i) (Supp. IV 1998) ("[A state] may require an individual who is eligible for medical assistance under [Medicaid] to enroll with a managed care entity as a condition of receiving such assistance . . .").

⁷ See Barnett Wright, *Mandatory Managed Health Care Program for the Poor*, PHILA. TRIB., Oct. 22, 1996, at 4E (describing the HealthChoices program and its implementation in the five-county Philadelphia area); see also *infra* Part I.

"inevitable" rationing, MCOs eventually will deny care to Medicaid patients in many circumstances. This Comment explores the potential remedies that those patients have available to them under the Americans with Disabilities Act of 1990⁸ (the "ADA" or the "Act") and the Rehabilitation Act of 1973.⁹

Medicaid¹⁰ funding has been the target of budget cuts almost since its inception.¹¹ Although the program has never been comprehensive, given the large number of persons ineligible for Medicaid,¹² one should not underestimate its importance to those who do receive assistance, particularly those with disabilities. For instance, "between half and three-quarters of all prescriptions for antiretrovirals are paid for by Medicaid or through state

⁸ 42 U.S.C. §§ 12101-12213 (1994).

⁹ 29 U.S.C. §§ 701-794e (1994).

¹⁰ Medicaid is a program that was established by Congress in 1965 to aid low-income persons with health care costs. The program is jointly administered by the states and the federal government. See 42 U.S.C. § 1396. At the time, it was heralded as "the beginning of a new era in medical care for low-income families, [with] its ultimate goal [being] the assurance of complete, continuous, family-centered medical care of high quality to persons who are unable to pay for it themselves." Sparer, *supra* note 2, at 3 (quoting FEDERAL HANDBOOK OF PUBLIC ASSISTANCE 5140 (Supp. D 1967)). Under Medicaid, millions of very poor Americans receive care that would otherwise be unavailable to them. In 1995, more than 36 million persons received health care services through Medicaid. See *Overview of the Medicare and Medicaid Programs*, HEALTH CARE FINANCING REV., Jan. 1, 1997, available in 1997 WL 18242940.

The federal and state governments, however, abandoned this ideal of comprehensive care for the poor long ago. As mentioned before, the program is jointly funded by the federal and state governments, and by 1969, Congress was responding to state governments' complaints about the financial burdens that the program imposed. The government has repeatedly cut the program back since then, prompting one commentator to note in 1981 that "anti-poverty lawyers engaged in health care litigation . . . spend their time trying to stop things from getting worse; . . . they have abandoned efforts to make the program better" Sparer, *supra* note 2, at 3. The Medicaid statute only requires that states provide services to the very poor, who are defined as including recipients of Aid to Families with Dependent Children ("AFDC") or Supplemental Security Income ("SSI"), pregnant women and infants less than one year old whose family income is at least 185% below the poverty level, children aged one to six years who are 133% below the poverty level, and other children who are 100% below the poverty level. See 42 U.S.C. §§ 1396a(a)(10), (f)(2) (1994).

Congress enacted Medicaid simultaneously with Medicare, which provides health care assistance to the elderly, end-stage renal disease patients, and certain disabled persons. See 42 U.S.C. §§ 1395ggg (1994 & Supp. IV 1998). This Comment focuses primarily on Medicaid.

¹¹ See Sparer, *supra* note 2, at 3 (noting that Congress has been under pressure from state governments to reduce Medicaid expenditures almost since the inception of the program).

¹² See *id.* at 4 (listing those who are excluded from Medicaid, including "approximately one third of the people officially defined as 'poor' by the federal government; a majority of the people with incomes below the federal Bureau of Labor Statistics 'lower living level'; [and] the large majority of working-class Americans, many of whom cannot afford . . . insurance").

AIDS programs.”¹³ Nevertheless, “[i]t may be difficult for middle- and upper-class Americans to appreciate that poor people still die in the United States because medical care is refused them.”¹⁴ Many welfare advocates fear that a move to managed care¹⁵ will bring about exactly this result.¹⁶

Although the benefits provided to Medicaid recipients have been shrinking, the legal rights of disabled persons have expanded, especially with the enactment of the ADA in 1990. Building on the ground broken by the Rehabilitation Act of 1973, the ADA prohibits discrimination against the disabled in the arenas of employment, public services, and public accommodations.¹⁷ Recognizing the historical and continuing isolation and segregation of persons with disabilities,¹⁸ and the potentially devastating

¹³ Susan H. McBride, *The AIDS Cocktail*, MANAGED HEALTHCARE, Nov. 1997, at 39.

¹⁴ Sparer, *supra* note 2, at 10 (detailing numerous stories of deaths resulting from lack of medical assistance).

¹⁵ Managed care, in contrast to traditional fee-for-service insurance, places extensive limits on both the doctors and services available to the patient. See generally Jane Bennett Clark, *A Doctor's-Eye View of Managed Care*, KIPLINGER'S PERS. FIN. MAG., June 1, 1997, at 87, 88 (stating that the “simple” premise behind MCOs is that “[i]n exchange for either a salary or a prepaid fee for every patient (called a capitated rate), doctors deliver routine and preventive services and manage access to specialists—hence the term ‘managed care’”). Although some doctors find the arrangement “equitable,” others complain that “per-patient rates barely pay for the basics.” *Id.* at 88. Further, critics question the incentive structure, in which MCOs allocate a lump sum to doctors, out of which the doctors themselves pay specialists when their patients require specialized care—“a pretty horrible system that presents the potential for huge conflicts of interest.” *Id.* (internal quotations omitted). On the other hand, to state governments facing seemingly insurmountable Medicaid expenses, managed care is an attractive solution because MCOs “accept financial risk for the health care they sell.” Sara Rosenbaum et al., *Medicaid Managed Care and the Family Planning Free-Choice Exemption: Beyond the Freedom to Choose*, 22 J. HEALTH POL. POL'Y & L. 1191, 1192 (1997).

¹⁶ See Orentlicher, *supra* note 4, at 51-52 (suggesting that the “rationing of health care” will impact “who shall live and who shall die,” and that “[i]n other cases, rationing can have profound effects on a person's quality of life”).

¹⁷ See 42 U.S.C. §§ 12111-12112 (1994) (prohibiting employment discrimination against disabled persons); *id.* §§ 12131-12132 (prohibiting discrimination against disabled persons with respect to access to public services); *id.* §§ 12181-12182 (prohibiting discrimination against disabled persons with respect to public accommodations).

¹⁸ See *id.* § 12101(a) (discussing the discrimination that disabled Americans have historically faced, and that 43,000,000 disabled Americans continue to face today); see also Mark C. Weber, *Disability Discrimination by State and Local Government: The Relationship Between Section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act*, 36 WM. & MARY L. REV. 1089, 1090 (1995) (observing that “[t]wo-thirds of [disabled] persons . . . who are old enough to work are not working; of that group, two-thirds want work,” and that “[p]ersons with disabilities leave home to eat, view movies, or participate in public events much less frequently than other members of the general population” (footnotes omitted)).

"benign neglect" of the disabled that saturates American culture,¹⁹ Congress promulgated this broad-reaching statute.

With this expansion of rights on the one hand, and narrowing of benefits on the other, a significant amount of litigation has begun to appear, brought by patients challenging decisions made by state Medicaid agencies or Medicaid MCOs under the ADA and the Rehabilitation Act. As one commentator put it, "[s]ince its enactment, the ADA is already responsible for a crippling case-load."²⁰ For Medicaid recipients, the relevant provisions of the Act are Title II (public services)²¹ and Title III (public accommodations).²² Under Title II, a state or local government and its instrumentalities cannot exclude from participation in a program or deny services to a person with a disability.²³ Under Title III, a public accommodation cannot discriminate against a disabled person in the full and equal enjoyment of goods and services of the accommodation.²⁴ Predictably, however, there are a multitude of additional requirements and exceptions affecting whether a state or MCO is responsible when it denies care. A "safe harbor" provision in the ADA blocks suits against insurance companies under Title III, as long as the insurer makes its risk assessment based on sound actuarial principles, and not as a subterfuge to defeat the other purposes of the ADA.²⁵ A number of courts have held that the public accommodations title applies only to physical accommodations, and because most insured persons never actually visit their insurance company's office, the insurance company does not fall within that ambit.²⁶ And most significantly, a Medicaid beneficiary can recover for a denial of services only when he or she has been deprived of

¹⁹ *Alexander v. Choate*, 469 U.S. 287, 295 (1985) (observing that Congress enacted legislation preceding the ADA to confront discrimination against the disabled that was "most often the product, not of invidious animus, but rather of thoughtlessness and indifference—of benign neglect").

²⁰ Matthew W. Daus, *Mediating ADA Claims*, NAT'L L.J., Nov. 18, 1996, at D1.

²¹ See 42 U.S.C. § 12132 (prohibiting the exclusion of disabled persons from participation in public services by reason of their disability).

²² See *id.* § 12182 (prohibiting the denial of equal access to public accommodations).

²³ See *id.* § 12131-12132 (prohibiting discrimination against disabled persons with respect to access to public services and defining the term "public entity").

²⁴ See *id.* § 12182(a) (providing 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 accommodations of any place of public accommodation").

²⁵ See *id.* § 12201(c) (stating that the Act "shall not be construed to prohibit or restrict" insurers "from underwriting risks, classifying risks, or administering such risks").

²⁶ See *infra* Part III.B (discussing case law on the issue of whether insurance companies are "public accommodations").

"meaningful access" to that benefit.²⁷ Not all restrictions on access to public services and accommodations are actionable.

The issue of whether "meaningful access" to health care exists became the crucial inquiry in determining whether a state agency had discriminated against the disabled plaintiffs in *Alexander v. Choate*.²⁸ This widely cited case involved a challenge that Medicaid recipients brought against Tennessee's decision to reduce the yearly cap on reimbursed hospital days from twenty to fourteen. In rejecting the plaintiffs' claim, the court cited three relevant factors: the limitation did not "have a particular exclusionary effect" on the disabled, the reduction decision was not based on a standard that the disabled were less capable of meeting, and "nothing in the record suggest[ed] that the handicapped will be unable to benefit meaningfully from the coverage they will receive under the 14-day rule."²⁹ Outside the particular facts of *Choate*, however, it is uncertain what constitutes "meaningful access," and as a result the federal courts have issued a wide spectrum of decisions.³⁰ Some courts have gone so far as to conclude that if a recipient of a benefit has *any* access to the benefit, then that access is meaningful.³¹ Other courts suggest a more detailed inquiry into the circumstances, examining whether the defendant has taken modest, affirmative steps toward accommodation,³² or even whether the access provided is adequate.³³

Given these conflicting interests, the question remains: When disabled Medicaid managed care patients are denied care, what remedies are available to them under the ADA and the Rehabilitation Act? This Comment explores the potential causes of action a disabled Medicaid managed care patient has under the ADA or the Rehabilitation Act and whether a denial of care, under recent federal court interpretations, constitutes a lack of meaningful access. Part I looks at the problems presented by Medicaid managed care and the HealthChoices program in Pennsylvania. Part II discusses the stated purposes of the ADA and the Rehabilitation Act and whether the two acts even contemplate such a suit. Part III explores the specific titles of the

²⁷ See *infra* Parts IV-V (discussing the requirement that a plaintiff show a deprivation of meaningful access in order to have an actionable claim, and the multitude of court opinions interpreting "meaningful access").

²⁸ 469 U.S. 287, 301 (1985) (holding that health benefits "cannot be defined in a way that effectively denies otherwise qualified handicapped individuals the meaningful access to which they are entitled").

²⁹ *Id.* at 302.

³⁰ See *infra* Part V.A.

³¹ See *infra* Part V.A.1.

³² See *infra* Part V.A.3.

³³ See *infra* Part V.A.7.

ADA and the Rehabilitation Act and the potential suits that Medicaid patients could bring under each. Part IV analyzes *Alexander v. Choate* and the establishment of the "meaningful access" test. Part V investigates recent federal court rulings for interpretations of "meaningful access" in both the health care arena and other contexts. Finally, Part VI argues for a more expansive reading of the ADA and the Rehabilitation Act, the abandonment of numerous threshold barriers to bringing suit, and a more workable definition of meaningful access in light of the goals of the ADA.

I. THE PROBLEM PRESENTED BY MCOs AND "HEALTHCHOICES"

At the same time that Congress has responded to demands for increasing rights for the disabled, the government has been under increasing pressure to reduce health care costs. Rising health care costs resulting from technological advances, an aging population, and new diseases, combined with the unpopularity of the Medicaid entitlement, have prompted both the federal and state governments to adopt Medicaid managed care programs.³⁴ In Pennsylvania, this has resulted in the implementation of the "HealthChoices" program for Medicaid recipients.³⁵ Originally established as a trial program, 540,000 Medicaid recipients in southeastern Pennsylvania were required to choose one of four MCOs beginning on February 1, 1997.³⁶ The program expanded to include the ten-county southwestern part of the state on January 1, 1999,³⁷ and the Pennsylvania Department of Public Welfare (the "DPW") anticipates completing statewide enrollment in the next two years.³⁸ One provision of the Medicaid statute requires that recipients have the ability to choose their physicians.³⁹ Because MCOs typically

³⁴ See *supra* notes 1-7 and accompanying text (discussing the origins of managed care programs).

³⁵ See Wright, *supra* note 7, at 4E (providing an overview of HealthChoices). An analysis of the different forms of Medicaid managed care programs in other states is beyond the scope of this Comment, but for an overview, see Crossley, *supra* note 5, at 432-34.

³⁶ See *Pa. Delays HealthChoices Start-Up*, MANAGED MEDICARE & MEDICAID, Dec. 16, 1996, available in 1996 WL 15558245.

³⁷ See Peg Dumbaugh, *Medical Aid Moves to Managed Care*, PITTSBURGH POST-GAZETTE, Jan. 6, 1999, at N8, available in 1999 WL 5250461.

³⁸ See Department of Public Welfare, Commonwealth of Pennsylvania, *Statewide Mandatory Medicaid Managed Care Expansion Discussion Paper*, Dec. 1996 (last modified Jan. 22, 1997) <http://www.state.pa.us/PA_Exec/Public_Welfare/mancare.pdf>.

³⁹ See 42 U.S.C. § 1396a(a)(23) (1994) (mandating that a Medicaid program's enrollment of a patient in a health system "shall not restrict the choice of the qualified person from whom the individual may receive services").

restrict care to doctors in their individual networks,⁴⁰ in order to implement HealthChoices, Pennsylvania had to obtain a waiver of this provision.⁴¹

The implementation of HealthChoices in Pennsylvania has not been smooth. For example, the reimbursement rates HealthChoices MCOs pay for prescriptions to pharmacies are so low that two of the Philadelphia area's largest chains, CVS and Eckerd, will not fill HealthChoices prescriptions, and almost half of the independent pharmacies in the area have been forced to close since the implementation of HealthChoices.⁴² Also, patients in rural counties may be unable to see their primary care physicians, because some areas lack transportation for doctors in other counties, and there is a dearth of doctors in outlying counties participating in particular MCO plans.⁴³ Further, there are problems with MCOs assigning non-English-speaking patients to doctors who only speak English.

The main problem that managed care programs like HealthChoices present, of course, is that in their mission to cut costs, they inevitably cut the amount and quality of services, and this significantly affects the disabled. Not only do MCOs give physicians a financial incentive to restrict the care they provide,⁴⁴ but MCOs themselves attempt to discourage enrollment of persons with serious illnesses.⁴⁵ The motivation for this is clear: "[A]l-

⁴⁰ State-sponsored MCOs generally do not offer flexible "point-of-service" programs. See Rosenbaum et al., *supra* note 15, at 1195 ("State Medicaid programs do not have the resources to purchase 'point-of-service' products, which are more costly; furthermore, even if such products were made available, Medicaid enrollees do not, as a general rule, have the resources to make the higher copayments that such plan options demand of them.").

⁴¹ Under section 1915(b) of the Social Security Act, a state may request a "freedom of choice waiver" from the Department of Health and Human Services in order to "mandate beneficiary enrollment in managed care as a condition of coverage." *Id.* at 1193-94 (citing 42 U.S.C. § 1396n(b) (1994)); see also 42 U.S.C. § 1396n(b) (permitting waivers of the freedom of choice of provider provision if the Secretary of Health and Human Services "finds it to be cost-effective and efficient"); *HCFA Ties Pa. Medicaid Waiver to Pledges on Chronic Care*, MANAGED CARE WK., Jan. 13, 1997, available in 1997 WL 9048249 (noting Pennsylvania's receipt of the section 1915(b) freedom of choice waiver).

⁴² See Jeff Gelles, *Pennsylvania Pharmacists Sue State over Medicaid Reimbursement Rates*, KNIGHT-RIDDER TRIB. BUS. NEWS, Feb. 28, 1999, available in 1999 WL 12749318 (describing the difficulties that HealthChoices's low reimbursement rates have caused for independent pharmacists).

⁴³ See Christopher Snowbeck, *Rural Medicaid Recipients at Gravest Risk, Forum Told*, PITTSBURGH POST-GAZETTE, Nov. 6, 1998, at B4, available in 1998 WL 14509481 (describing the problems that HealthChoices would create for rural patients).

⁴⁴ Besides the pressure to reduce the amount of care, physicians report that managed care has negatively impacted "clinical independence . . . , the amount of paperwork required . . . , the amount of time spent justifying clinical decisions . . . and the patient-physician relationship" *Taking Pulse of Profession, Public*, AM. MED. NEWS, Oct. 13, 1997, at 7.

⁴⁵ The problem of improper incentives has not gone unnoticed by state legislatures. See *id.* (observing a "flurry of anti-managed-care bills passed recently by legislatures across the

though persons with disabilities make up only fifteen percent of Medicaid beneficiaries, forty percent of Medicaid spending is attributable to that group.⁴⁶ In a traditional managed care program, an insurer can contain its costs by keeping patients healthy through preventative health care. This strategy fails, however, when the patients have preexisting, chronic medical needs.⁴⁷ The role of the primary care physician as a “gatekeeper”—to limit access to expensive, specialized care—is also incompatible with the treatment of the disabled, because the disabled have greater need for specialists than the general population.⁴⁸

HealthChoices has a particularly significant effect on persons with severe disabilities such as AIDS, who often must leave their HIV-experienced doctors to receive care from a doctor in the HealthChoices program.⁴⁹ In more rural areas, where there might not even be one HIV-experienced doctor that is a member of a HealthChoices MCO, a person with AIDS could face a life-threatening lack of care.

Two lawsuits recently filed against the Pennsylvania DPW further illustrate the limitations on care imposed by HealthChoices. In the first of these cases, *Anderson v. Department of Public Welfare*, a group of HealthChoices patients with mobility and visual impairments brought a class action suit under the ADA.⁵⁰ One of the *Anderson* plaintiffs was a wheelchair-bound Medicaid recipient whose HealthChoices MCO assigned him to a dentist’s office that was inaccessible to the physically impaired.⁵¹ Another plaintiff in the suit challenged the failure of the HealthChoices MCOs to

nation”). Fortunately, the MCOs taking over state Medicaid programs do not generally have the option of rejecting patients.

⁴⁶ Crossley, *supra* note 5, at 426.

⁴⁷ See *id.* at 427 (noting that the principle of cost containment through preventative health care “is largely inapplicable to a population that includes many individuals with pre-established, long-term medical needs”).

⁴⁸ See *id.* at 428 (observing that “many persons with disabilities or chronic conditions have greater than average needs for specialist referrals”).

⁴⁹ Although it is almost a matter of common sense to consider AIDS as a disability, there is also a plethora of case law in support of this proposition. See, e.g., *Bragdon v. Abbott*, 118 S. Ct. 2196, 2204-07 (1998) (noting that “HIV infection satisfies the statutory and regulatory definition of a physical impairment during every stage of the disease” and concluding that even asymptomatic HIV can be a disability, given that it substantially limits the ability of a person to reproduce); *Anderson v. Gus Mayer Boston Store*, 924 F. Supp. 763, 774-75 (E.D. Tex. 1996) (“Conditions such as AIDS [and] HIV . . . have been determined by the courts to be *per se* disabilities.” (footnotes omitted)).

⁵⁰ 1 F. Supp. 2d 456, 459 (E.D. Pa. 1998).

⁵¹ See *id.* at 459-60. The plaintiffs also faulted the DPW for failing to mandate that the MCOs list in their directories any providers (other than primary care physicians) who were accessible to the disabled. See Memorandum of Law in Support of Plaintiffs’ Motion for Summary Judgment for Plaintiff at 2, 9-12, *Anderson* (No. 97-CV-3808).

supply provider directories and member handbooks in Braille, large print, or audiotape for the visually impaired.⁵² In ruling on the parties' cross motions for summary judgment, the court concluded as a matter of law that for mobility-impaired patients, the HealthChoices program "does not comply with the minimum program accessibility regulations promulgated under Title II and Section 504 [of the Rehabilitation Act]."⁵³ The court declined to rule on the claims of the visually impaired plaintiffs.⁵⁴

The court also denied the DPW's cross-motion for summary judgment in its entirety, which argued that the ADA cannot be used in cases of unintentional discrimination.⁵⁵ Although the DPW did not dispute Congress's intent to provide for a disparate impact cause of action, the DPW asserted that Congress exceeded its constitutional authority in enacting the disparate impact elements of the ADA.⁵⁶ The court specifically rejected these claims, recognizing that the "ADA is a congruent and proportionate response to unconstitutional discrimination against disabled individuals."⁵⁷ In June 1998, the parties reached a settlement agreement in which the DPW agreed to hire an organization to evaluate all HealthChoices providers for their accessibility to the disabled, and based on the results of the study, the DPW would ensure that the providers removed the barriers or the DPW would discontinue the use of the provider.⁵⁸ In addition, the DPW agreed to furnish provider directories and member handbooks in all three of the formats that the plaintiffs requested, although the DPW could limit the directory by zip code.⁵⁹

In another suit, *Metts v. Houstoun*, the plaintiffs alleged that the HealthChoices HMOs failed to provide adequate notice for reductions or denials of care.⁶⁰ Rather than receiving written notices explaining the rea-

⁵² The MCOs provided member handbooks in some of the alternative formats, depending on the MCO, but not all three. None of the MCOs offered provider directories in any alternative format. See *Anderson*, 1 F. Supp.2d at 460; Memorandum of Law at 1, 13-16, *Anderson* (No. 97-CV-3808).

⁵³ *Anderson*, 1 F. Supp. 2d at 463. The court also required that HealthChoices MCOs ensure that doctors' offices are accessible to the mobility impaired, with some exceptions for smaller, older facilities, which could refer the patients to other caregivers. See *id.* at 462-65.

⁵⁴ See *id.* at 466.

⁵⁵ See *id.* at 467-69 (rejecting the defendant's challenges that Congress lacked the authority to prohibit unintentional discrimination).

⁵⁶ See *id.* at 467 ("Defendants argue that the ADA, when directed at unintentional discrimination, is not 'appropriate legislation' within Congress' Section Five power . . .").

⁵⁷ *Id.* at 468.

⁵⁸ Telephone Interview with Robin Resnick, Esq., Disabilities Law Project (one of the attorneys for the *Anderson* plaintiffs) (Mar. 10, 1999).

⁵⁹ See *id.*

⁶⁰ No. 97-CV-4123, 1997 U.S. Dist. LEXIS 16737, at *2-3 (E.D. Pa. Oct. 24, 1997). Unlike *Anderson*, the plaintiffs in *Metts* brought the suit under the Due Process Clause of the

sons for the reductions or denials and the process for appealing these decisions, the plaintiffs received only oral notifications, perfunctory written notifications, or no notice whatsoever.⁶¹ As a result, Medicaid recipients were unaware that if they appealed the decision within ten days, they would still be able to receive benefits, pending the outcome of the appeal. Even if they were aware of their ability to appeal, without knowing the grounds for the denials, they did not know what to argue.

Metts also brings to light another incompatibility between managed care and care for the disabled. The plaintiffs in *Metts* challenged the HealthChoices MCOs' practice of denying care for services that the MCOs deemed "custodial"—that is, continual care for persons with chronic disabilities.⁶² The MCOs denied care to some Medicaid patients on the ground that the patients' conditions would not improve with treatment, despite the fact that treatment was needed just to maintain their conditions.⁶³ This is not an uncommon practice among MCOs—often, "MCOs' definitions of medical necessity . . . focus on whether the service will improve or restore function . . . [and] is biased toward providing curative care, rather than meeting the maintenance or developmental needs of many persons with disabilities."⁶⁴

Another practice that the *Metts* plaintiffs challenged was HealthChoices MCOs basing some of their decisions to deny care on general statistics, rather than on an individualized determination of each patient's needs. If a patient did not improve to the extent that someone with the patient's condition typically did, the MCO was apt to discontinue treatment.⁶⁵

As in *Anderson*, the parties in *Metts* were eventually able to come to a settlement; the DPW agreed to improve its notice system, to revise its criteria for making coverage determinations, and to evaluate patients' needs on a more individualized basis.⁶⁶ As long as the financial incentives exist for

Constitution and Title XIX of the Social Security Act. See U.S. CONST. amend. XIV; Social Security Act of 1965, tit. XIX, Pub. L. No. 89-97, 79 Stat. 343 (codified as amended at 42 U.S.C. §§ 1396-1396v (1994 & Supp. IV 1998)). Once a state voluntarily chooses to participate in Medicaid, the state must comply with the requirements of Title XIX and the applicable regulations. See *Harris v. McRae*, 448 U.S. 297, 301 (1980) ("Although participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the requirements of Title XIX.").

⁶¹ See *Metts*, 1997 U.S. Dist. LEXIS 16737, at *2-3.

⁶² Telephone Interview with Robin Resnick, *supra* note 58.

⁶³ *Id.*

⁶⁴ Crossley, *supra* note 5, at 429.

⁶⁵ Telephone Interview with Robin Resnick, *supra* note 58.

⁶⁶ *Id.*; see also *HealthChoices SE News—June 1998* (last modified Oct. 30, 1998) <<http://www.cilp.org/~phlp/JUNSE98E.HTM>> (summarizing important terms of the *Metts* settlement).

MCOs to limit care, however, new methods of limitation will likely arise, and the need for legal remedies will persist.

These examples point to one simple conclusion: Managed care programs cause deficiencies in care for disabled persons. Perhaps tautologically, the pressure to reduce funding will result in less care, and thus, those who will be the most greatly affected are the disabled. The question then becomes what remedy the ADA or the Rehabilitation Act provides.

II. PURPOSES OF THE ADA AND THE REHABILITATION ACT

The stated purposes of the acts themselves serve as a relevant starting point. The ADA purports to "provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."⁶⁷ The ADA is a much-needed remedy for persons with disabilities, and it is a powerful remedy when blatant, malicious discrimination occurs in the workplace, government services, or public accommodations.⁶⁸ Congress enacted the ADA in 1990 partly to combat some of the deficiencies of its predecessor, section 504 of the Rehabilitation Act of 1973.⁶⁹ The Rehabilitation Act prohibits discrimination against the disabled by organizations receiving federal funding. Its mandate consists of a single sentence: "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"⁷⁰ Discrimination against disabled persons occurs in vastly broader circumstances than these, however, and section 504 has been ineffectively enforced by many government agencies charged with its enforcement.⁷¹ As a result, Congress recognized in the late 1980s that the Rehabilitation Act was "inadequate to combat the pervasive problems of discrimination that people with disabilities are facing."⁷² Congress proceeded to draft the

⁶⁷ 42 U.S.C. § 12101(b)(1) (1994).

⁶⁸ For instance, Congress specifically recognized the pervasiveness of discrimination against persons with HIV and AIDS. See H.R. REP. NO. 101-485, pt. 2, at 31 (1990) ("[D]iscrimination against individuals with HIV infection is widespread and has serious repercussions for both the individual who experiences it and for this nation's efforts to control the epidemic.").

⁶⁹ 29 U.S.C. § 794 (1994).

⁷⁰ *Id.*

⁷¹ See *Kathleen S. v. Department of Pub. Welfare*, 10 F. Supp. 2d 460, 467 (E.D. Pa. 1998) (noting the reasons that "section 504 did not achieve its purpose of ending disabilities-based discrimination").

⁷² *Helen L. v. DiDario*, 46 F.3d 325, 331 (3d Cir. 1995) (quoting S. REP. NO. 101-116, at 18 (1989)) (internal quotations omitted).

ADA, finally enacting it on July 26, 1990.⁷³ Of particular import to Medicaid recipients is the fact that the ADA specifically addresses discrimination in health care. "It makes no sense to bar discrimination against people with disabilities in theaters, restaurants, or places of entertainment but not in regard to such important things as doctor's offices."⁷⁴

The two acts are more comprehensive than this, however. In passing these acts, Congress recognized that disabled individuals face not only discrimination motivated by invidious intent, but also discrimination that has a disparate impact on disabled persons. As a House of Representatives report recognized: "Discrimination often results from false presumptions, generalizations, misperceptions, patronizing attitudes, ignorance, irrational fears, and pernicious mythologies."⁷⁵ The two acts contain provisions that specifically address this form of discrimination. The regulations implementing the Rehabilitation Act, for instance, state that a recipient of federal funds

may not . . . utilize criteria or methods of administration (i) that have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap [or] (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program with respect to handicapped persons.⁷⁶

Similarly, the ADA prohibits "the imposition or application of eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any goods, services, facilities, privileges, advantages, or accommodations."⁷⁷ Discrimination that is not motivated by animosity is still discrimination, and these provisions clearly attempt to reduce its effect.

Nevertheless, the acts cannot eliminate all discrimination, nor can they guarantee that disabled persons will always receive the same result as the nondisabled. As a House of Representatives report recognized: "'Full and equal enjoyment' does not encompass the notion that persons with disabili-

⁷³ In enacting the ADA, Congress specifically envisioned that it be implemented following the standards of the Rehabilitation Act. "[N]othing in this chapter shall be construed to apply a lesser standard than the standards applied under . . . the Rehabilitation Act of 1973 . . . or the regulations issued by Federal agencies pursuant to such title." 42 U.S.C. § 12201(a) (1994). Accordingly, courts have followed case law interpreting the Rehabilitation Act when making rulings under the ADA. *See, e.g., Vande Zande v. State of Wis. Dep't of Admin.*, 44 F.3d 538, 542 (7th Cir. 1995) ("[T]he employment provisions of the [ADA] merely generalize to the economy as a whole the duties . . . that the regulations under the Rehabilitation Act imposed on federal agencies and federal contractors."). Accordingly, this Comment examines several cases that arise under the Rehabilitation Act.

⁷⁴ H.R. REP. NO. 101-485, pt. 2, at 35 (1990) (testimony of Robert Burgdorf, Jr.).

⁷⁵ *Id.* at 30.

⁷⁶ 45 C.F.R. § 84.4(b)(4) (1998).

⁷⁷ 42 U.S.C. § 12182(b)(2)(A)(i).

ties must achieve the identical result or level of achievement of nondisabled persons"⁷⁸ The question remains where to draw the line, between prohibiting all disparate impact discrimination and prohibiting only invidious discrimination.

The courts have wrestled with this issue and have not reached a consensus. For example, in *Helen L. v. DiDario*, the Third Circuit recognized that

[b]ecause the ADA evolved from an attempt to remedy the effects of "benign neglect" resulting from the "invisibility" of the disabled, Congress could not have intended to limit the Act's protections and prohibitions to circumstances involving deliberate discrimination. . . . Rather, the ADA attempts to eliminate the effects of that "benign neglect," "apathy," and "indifference."⁷⁹

In contrast, in *DeBord v. Board of Education*, the Eighth Circuit upheld a regulation on the ground that "[t]he policy is neutral; it applies to all students regardless of disability,"⁸⁰ despite the fact that the regulation primarily affected disabled students.

This Comment argues that courts should expand their recognition of disparate impact claims in the Medicaid managed care context.⁸¹ Congress recognized that "[t]he discriminatory nature of policies and practices that exclude and segregate disabled people has been obscured by the unchallenged equation of disability with incapacity and by the gloss of 'good intentions.'"⁸² Upholding discriminatory, yet facially neutral, health care regulations will only legitimate the gloss of good intentions.

III. CONSTRUCTION OF A SUIT UNDER THE ADA OR THE REHABILITATION ACT

Given this fundamental conflict between the needs of persons with disabilities and the move toward economizing health care, particularly Medicaid, the question remains regarding what remedies are available to disabled

⁷⁸ H.R. REP. NO. 101-485, pt. 2, at 101.

⁷⁹ 46 F.3d 325, 335 (3d Cir. 1995); see also *Crowder v. Kitagawa*, 81 F.3d 1480, 1483 (9th Cir. 1996) ("Congress intended to prohibit outright discrimination, as well as those forms of discrimination which deny disabled persons public services disproportionately due to their disability."); Weber, *supra* note 18, at 1118 (observing that under the ADA, "[p]rohibitions extend to intentional discrimination as well as practices that have an unintended negative impact on persons with disabilities" (citing 42 U.S.C. § 12112(b)(1), (3), (6)-(7))).

⁸⁰ 126 F.3d 1102, 1105 (8th Cir. 1997), *cert. denied*, 118 S. Ct. 1514 (1998); see also *infra* notes 137-57 and accompanying text (discussing *Alexander v. Choate*, 469 U.S. 287 (1985), and observing that the Supreme Court has not been receptive to disparate impact claims in the health care context).

⁸¹ See *infra* Part VI.

⁸² H.R. REP. NO. 101-485, pt. 2, at 41 (testimony of Arlene Mayerson, Disability Rights Education and Defense Fund).

persons who are denied care. For instance, HIV-positive patients depend on the latest treatments in order to remain alive. An MCO, however, may decide that the scientific community has not yet proven a new treatment to be sufficiently "effective" or that a treatment is still too experimental to permit reimbursement. Given the potentially life-extending benefits that a new class of AIDS drugs could have, would any part of the ADA provide a cause of action for these plaintiffs? This will depend, of course, on who the defendants are. The patients potentially could sue either the state, as administrators of the Medicaid program, or the MCO, as the provider refusing to give the care. Title II of the ADA applies to public services, namely state and local governments and their departments, agencies, and instrumentalities.⁸³ A suit against a state agency administering Medicaid benefits would fall under Title II. A suit against an MCO, in contrast, could potentially fall under Title II of the ADA (regarding public entities), Title III of the ADA (regarding public accommodations),⁸⁴ or section 504 of the Rehabilitation Act (regarding the recipients of federal funding).⁸⁵ Courts have construed Title I of the ADA, which applies to employers,⁸⁶ to apply to MCOs in very few cases.⁸⁷

One initial threshold problem in bringing a suit against an MCO is the ADA's "safe harbor" provision. According to section 501(c) of the ADA, Titles I, II, and III are not meant to prohibit or restrict insurers from carrying

⁸³ See 42 U.S.C. § 12131(1) (1994) (defining "public entity").

⁸⁴ See *id.* § 12181(7) (defining public accommodations to include, inter alia, restaurants, bars, grocery stores, inns, terminals, and laundromats).

⁸⁵ See 29 U.S.C. § 794(a) (1994) (indicating that no otherwise qualified person with a disability shall be denied the benefits of any program or activity receiving federal assistance).

⁸⁶ See 42 U.S.C. § 12111(4), (8) (defining terms such as "employee" and "qualified individual with disability").

⁸⁷ One commentator suggests that courts should consider MCOs to be employers because employers are "covered entities" under the ADA and because the statute prohibits discrimination by "an organization providing fringe benefits to an employee of a covered entity." David Manoogian, *With Suits Mounting, Courts Face the Question of Whether a Managed Care Organization Can Be an Employer Under the Americans with Disabilities Act*, NAT'L L.J., Mar. 17, 1997, at B6 (quoting 42 U.S.C. § 12112(b)(2)). Further, covered entities cannot discriminate by "participating in a contractual or other arrangement or relationship." *Id.* (citing 42 U.S.C. § 12112(b)(2)). Nevertheless, the case law in support of this proposition is sparse. Compare *Carparts Distributing Ctr., Inc. v. Automotive Wholesaler's Ass'n*, 37 F.3d 12, 17 (1st Cir. 1994) (concluding that an "employer" is "any party who significantly affects access of any individual to employment opportunities" (citation omitted)), with *Pappas v. Bethesda Hosp. Ass'n*, 861 F. Supp. 616, 619 (S.D. Ohio 1994) (finding that an MCO is not an "employer" under Title I), and *Dodd v. Blue Cross & Blue Shield Assn.*, 835 F. Supp. 888, 891-92 (E.D. Va. 1993) (granting an insurance company's motion for summary judgment in a Title I ADA suit based on the court's conclusion that an insurance company is not a covered entity under the ADA).

out traditional risk classification practices.⁸⁸ Under the strictest interpretation of this provision, some courts have held that insurance companies cannot be sued under the ADA.⁸⁹ On the other hand, an additional clause in Title IV provides that the safe harbor provision "shall not be used as a subterfuge to evade the purposes of subchapter I and III of this chapter."⁹⁰ Taken to an extreme, this provision appears to state that insurance companies will not be held liable for violating the ADA unless they actually attempt to do so. The ambiguity of this section has been interpreted by the Sixth Circuit as being "purposefully vague in order to satisfy contending interest groups."⁹¹ With the exception of Title II cases, discussed below in Part III.A, the safe harbor provision consequently has not proven itself to be an effective bar to suits against insurance companies.

Part of the confusion arising from the safe harbor provision is the meaning of the term "subterfuge." Although the ADA appears to permit some degree of latitude for insurers to make risk assessments, it is uncertain exactly where the line is drawn between valid risk assessment and invalid subterfuge. Clearly, an insurer cannot completely deny health care to a person with a disability on the basis of "risk assessment." As one court put it, the safe harbor provision "does not apply to situations where an individual with a disability has been totally denied coverage of any kind."⁹² Beyond this extreme, however, courts are in disagreement. In *Conner v. Colony Lake Lure*, for instance, a district court placed a heavy burden on the plaintiff to prove that an insurance plan was a subterfuge.⁹³ "[A] benefit plan cannot be a 'subterfuge' unless the employer intended by virtue of the plan to discriminate in a non-fringe-benefit-related aspect of the employment relation."⁹⁴ In contrast, in *Anderson v. Gus Mayer Boston Store*, a district court placed a "very heavy" burden on the insurer to prove that the insurer-

⁸⁸ See ADA § 501(c), 42 U.S.C. § 12201(c) (1994) (listing what should not be prohibited or restricted).

⁸⁹ See, e.g., *Attar v. Unum Life Ins. Co. of Am.*, 1997 WL 446439, at *12 (N.D. Tex. July 19, 1997) (finding that insurance companies are protected from suit under the Title IV safe harbor provision).

⁹⁰ 42 U.S.C. § 12201(c). Oddly enough, Congress did not apply the "subterfuge" exception to Title II, regarding public services, despite some indication in the congressional record that Congress intended to do so. See H.R. REP. NO. 101-485, pt. 2, at 136 (1990).

⁹¹ *Parker v. Metropolitan Life Ins. Co.*, 99 F.3d 181, 190 (6th Cir. 1996), *vacated en banc*, 107 F.3d 359 (6th Cir. 1997), *cert. denied*, 118 S. Ct. 871 (1998).

⁹² *Anderson v. Gus Mayer Boston Store*, 924 F. Supp. 763, 780 (E.D. Tex. 1996).

⁹³ CIV. NO. 4:97CV01, 1997 U.S. Dist. LEXIS 15938, at *1-2 (W.D.N.C. Sept. 4, 1997) (dismissing a plaintiff's claim that her employer fired her after learning of her son's disability in order to avoid paying his medical costs).

⁹⁴ *Id.* at *27 (citing *Public Employees Retirement Sys. v. Betts*, 492 U.S. 158, 166 (1989)).

ance plan was *not* a subterfuge, and the court asserted that a specific showing of intent was not necessary to demonstrate subterfuge.⁹⁵ "The term subterfuge 'simply[] denote[s] a means of evading the purposes of the ADA It does not mean that there must be some malicious intent to evade the ADA on the part of the insurance company'"⁹⁶ As a result, the safe harbor provision predictably "has been the source of a lot of confusion."⁹⁷

The unpredictable nature of the safe harbor provision makes a plaintiff's potential suit against a Medicaid MCO uncertain. If the plaintiff is in a jurisdiction that construes the safe harbor provision so as to block Title II suits against MCOs, she may want to abandon suing the MCO altogether and sue the state instead. Each of the potential causes of action under the different titles of the ADA and section 504 of the Rehabilitation Act are discussed below.

*A. Title II of the ADA and Section 504 of the Rehabilitation Act:
Public Entities*

A Medicaid recipient's ability to bring suit against the state under section 504 of the Rehabilitation Act or Title II of the ADA perhaps presents the greatest promise for success. In *Helen L. v. DiDario*, for instance, the Third Circuit recognized a Title II suit against the Pennsylvania Department of Public Welfare when the department required that the plaintiffs receive care in a nursing home rather than in their own homes.⁹⁸ One of the regulations implementing the ADA requires that a public entity provide services

⁹⁵ 924 F. Supp. at 769-70, 779, 781 (finding that absent the defense of undue hardship, an employer violated the ADA by switching from a high-premium health plan that covered an HIV-positive employee to a low-premium health plan that excluded the employee, and asserting that "[t]he ADA puts the burden on those actors classifying risks to show both their rationality and permissibility").

⁹⁶ *Id.* at 780 n.53 (quoting Neville M. Bilimoria, *No Relief in Sight: The Impact of the Americans with Disabilities Act on AIDS Discrimination in Employee Medical Plans*, 1994 DET. C.L. REV. 1053, 1080).

⁹⁷ *Id.* at 779 n.50.

⁹⁸ 46 F.3d 325, 338 (3d Cir. 1995) ("[The] DPW can not rely upon a funding mechanism of the General Assembly to justify administering its attendant care program in a manner that discriminates and then argue that it can not comply with the ADA without fundamentally altering its program."); see also *Kathleen S. v. Department of Pub. Welfare*, 10 F. Supp. 2d 460, 469 (E.D. Pa. 1998) ("There is no doubt that [the] DPW is a public entity subject to the requirements of Title II."); *Anderson v. Department of Pub. Welfare*, 1 F. Supp. 2d 456, 463, 468 (E.D. Pa. 1998) (recognizing a Title II suit against the DPW and noting that Title II was a valid exercise of the Fourteenth Amendment); cf. *Henrietta D. v. Giuliani*, No. 95 CV 0641(SJ), 1996 WL 633382, at *4-6 (E.D.N.Y. Oct. 25, 1996) (recognizing a Title II suit brought by Medicaid recipients with AIDS against the New York Division of AIDS Services but expressing skepticism as to the plaintiffs' ultimate success on the merits).

for a disabled person in the most integrated setting that is appropriate to her needs.⁹⁹ Because the DPW could have provided the disabled plaintiff with care in her own home through an attendant care program, the Third Circuit held that the DPW violated the ADA by requiring her to stay in a nursing home.¹⁰⁰ Similarly, in *L.C. ex rel. Zimring v. Olmstead*, the Eleventh Circuit found that psychiatric patients could challenge the state's refusal to place them in an integrated setting under Title II, because "[t]he State's failure to place [the plaintiffs] in the community . . . [fell] squarely within the ADA's ban on disability-based discrimination."¹⁰¹ A suit under Title II, unlike those under Titles I and III, has the added advantage of not requiring the exhaustion of administrative remedies.¹⁰² As a result, a plaintiff is less likely to run afoul of procedural problems with the state's administrative appeals process and will potentially receive faster relief.

In addition, courts have held that the state itself cannot escape responsibility just by delegating its authority. For instance, the District Court of Arizona asserted that "[i]t is patently unreasonable to presume that Congress would permit a state to disclaim federal responsibilities by contracting away its obligations to a private entity."¹⁰³

Although the state itself can be held liable, the question whether an MCO with whom the state has contracted can be held responsible under the Rehabilitation Act or Title II of the ADA is much less certain. An MCO implementing a Medicaid program is arguably an "instrumentality" of the state, which is specifically included in the definition of "public entity" in

⁹⁹ See 28 C.F.R. § 35.130(d) (1998) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.").

¹⁰⁰ *Helen L.*, 46 F.3d at 327.

¹⁰¹ 138 F.3d 893, 901 (11th Cir.), cert. granted, 119 S. Ct. 617 (1998). The Supreme Court's decision to grant certiorari in *Olmstead* is troubling. The Court will consider whether the ADA should not apply to state-provided services of long-term care. Should the Court conclude that Title II does not apply to long-term care, Title II likely will become largely inapplicable for disabled Medicaid recipients challenging denials of care. The Eleventh Circuit concluded that Title II is clearly applicable, given the "overwhelming authority in the plain language of Title II of the ADA, its legislative history, the Attorney General's Title II regulations, and the Justice Department's consistent interpretation of those regulations . . ." *Id.* at 896. Hopefully, the Supreme Court will be similarly persuaded.

¹⁰² See *Wagner v. Texas A & M Univ.*, 939 F. Supp. 1297, 1308 (S.D. Tex. 1996) ("Title II adopts the 'the [sic] remedies, procedures and rights' as set forth in the Rehabilitation Act of 1973[which] . . . 'does not require the exhaustion of administrative remedies.'" (citations omitted)).

¹⁰³ *J.K. v. Dillenberg*, 836 F. Supp. 694, 699 (D. Ariz. 1993) (citations omitted).

Title II.¹⁰⁴ Very few courts have addressed this specific issue, and those that have addressed the issue have dismissed the plaintiffs' claims. In *McDonald v. Massachusetts*, for instance, the District Court of Massachusetts rejected the plaintiff's assertion that an insurance company was an instrumentality of the state.¹⁰⁵ The grounds for the dismissal, however, were that the plaintiff had "set forth absolutely no underlying facts that would support the allegation[] . . . that [the insurance company] is an 'instrumentality' of the Commonwealth."¹⁰⁶ Given this rationale, it is uncertain whether the outcome would have been the same had the plaintiff provided more evidence. In another case, *Rodriguez v. City of Aurora*, the Northern District Court of Illinois also denied the plaintiff's claims against an insurer under the ADA's safe harbor provision.¹⁰⁷ Because the "subterfuge" exception does not apply in Title II cases, the court concluded that all suits against insurers were barred.¹⁰⁸ The court acknowledged that the legislative history supported the application of the subterfuge exception to Title II cases, but because the plain terms of the statute do not include Title II, the court dismissed the case.¹⁰⁹

One potential way to avoid the problem the safe harbor provision presents for Title II suits is to challenge an insurer's actions under section 504 of the Rehabilitation Act. Because Medicaid MCOs by definition receive federal funds, and the Rehabilitation Act applies to all federally funded programs and activities, an MCO could be responsible under the Rehabilitation Act.¹¹⁰ Alternatively, the plaintiffs could sue under Title III of the ADA, as discussed in the next Subpart.

¹⁰⁴ See 42 U.S.C. § 12131(1) (1994) ("The term 'public entity' means . . . any department, agency, special purpose district, or other instrumentality of a State or States or local government . . .").

¹⁰⁵ 901 F. Supp. 471, 479 (D. Mass. 1995) (dismissing the plaintiff's claim for workers' compensation benefits).

¹⁰⁶ *Id.* at 478.

¹⁰⁷ 887 F. Supp. 162, 163 & n.1, 164 (N.D. Ill. 1995) (dismissing the plaintiff's claim against a city police pension fund, where the plaintiff had been excluded from the fund because of a spinal problem and an abstract thinking difficulty, despite being an able police officer).

¹⁰⁸ See *id.* at 164 ("As is clear from the language of the statute, . . . the 'subterfuge' exception to the insurance exemption only applies to actions brought under subchapters I and III; it does not apply to actions, like *Rodriguez*, brought under subchapter II.").

¹⁰⁹ See *id.* ("Where [the statutory text] contains a phrase that is unambiguous . . . we do not permit it to be expanded or contracted by the statements of individual legislators or committees during the course of the enactment process." (citations and internal quotations omitted)).

¹¹⁰ See 29 U.S.C. § 794(b) (1994) (determining which programs and activities qualify as federally funded programs).

B. Title III of the ADA: Public Accommodations

A plaintiff's ability to bring a suit against a managed care organization under Title III of the ADA depends in large part on the court in which the plaintiff brings the case. On the one hand, Title III of the ADA establishes the broad mandate 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 accommodations of any place of public accommodation"¹¹¹ The House Reports accompanying the ADA assert that the purpose of Title III is "to bring individuals with disabilities into the economic and social mainstream of American life. . . in a clear, balanced, and reasonable manner."¹¹² Given this mandate and intention, it follows that a disabled individual should be able to challenge discriminatory practices of insurance companies that keep her out of the economic and social mainstream. On the other hand, several courts have been unwilling to interpret "public accommodation" to include insurance companies. Currently, the First Circuit is the only federal court of appeals that has accepted this interpretation.

In *Carparts Distribution Center, Inc. v. Automotive Wholesaler's Ass'n*, the First Circuit reversed a district court's dismissal of a suit against a health plan.¹¹³ The suit challenged the health plan's lifetime cap on benefits for persons with AIDS.¹¹⁴ The court rejected both the district court's view that a "public accommodation" must be a *physical* structure and the argument that because patients dealing with insurance companies typically did so over the phone, insurance companies were not public accommodations.¹¹⁵ Instead, the court reasoned that the terms of Title III itself did not require physical structures, and that the example of "travel service" among Title III's list of accommodations indicated that Congress contemplated non-physical structures. "It would be irrational to conclude that persons who enter an office to purchase services are protected by the ADA, but persons who purchase the same services over the telephone or by mail are not. Congress could not have intended such an absurd result."¹¹⁶

¹¹¹ 42 U.S.C. § 12182(a) (1994).

¹¹² H.R. REP. NO. 101-485, pt. 2, at 99 (1990).

¹¹³ 37 F.3d 12, 21 (1st Cir. 1994).

¹¹⁴ See *id.* at 14 (discussing challenges to the validity of a \$25,000 lifetime benefits cap for AIDS-related illnesses).

¹¹⁵ See *id.* at 19 (holding that establishments of "public accommodation" are not "limited to actual physical structures").

¹¹⁶ *Id.*

To exclude this broad category of businesses from the reach of Title III and limit the application of Title III to physical structures which persons must enter to obtain goods and services would run afoul of the purposes of the ADA and would severely

Nevertheless, numerous courts have reached just that result. In *Pappas v. Bethesda Hospital Ass'n*, for example, an employee brought suit under Title III against a hospital association after she was denied health coverage for her family.¹¹⁷ The court rejected the plaintiff's assertion that the hospital association fell under Title III, reasoning that "the references throughout Title III make it clear that its scope is limited to discrimination in the provisions of goods, services, facilities, privileges, advantages or accommodations based on a disabled person's physical ability to make use of those goods, services, etc."¹¹⁸ The court also rejected the Department of Justice's interpretation of the statute, which suggested that the discriminatory sale of insurance contracts falls under Title III, on the grounds that the Department of Justice opinion was only suggestive authority.¹¹⁹ Instead, given the lack of case law on the subject, the court reasoned that it must construe the terms of the ADA narrowly—"based on the 'ordinary, common meaning of the words in the statute.'"¹²⁰ The court concluded that the most ordinary meaning of "public accommodation" is a physical location.¹²¹

The Sixth Circuit initially followed *Carparts* in *Parker v. Metropolitan Life Insurance Co.* ("*Parker I*"), concluding that because Title III covered "goods" and "services," a person did not have to enter a structure in order to use a public accommodation.¹²² The Sixth Circuit, however, later reversed the opinion en banc ("*Parker II*") on the grounds that "[a] benefit plan offered by an employer is not a good offered by a place of public accommodation."¹²³ Because Parker obtained her benefits from her employer, rather than seeking out an insurance office on her own, there was no "nexus" to a

frustrate Congress's intent that individuals with disabilities fully enjoy the goods, services, privileges and advantages, available indiscriminately to other members of the general public.

Id. at 20.

¹¹⁷ 861 F. Supp. 616, 617 (S.D. Ohio 1994) (noting that the defendant refused to provide health care to both the plaintiff's husband, who had hypertension and hyperlipidemia, and to the plaintiff's son, who was a paraplegic confined to a wheelchair).

¹¹⁸ *Id.* at 620.

¹¹⁹ *See id.* (citing 28 C.F.R. pt. 36, app. B, at 600 (1993)).

¹²⁰ *Id.* (quoting *United States v. Ransbottom*, 914 F.2d 743, 745 (6th Cir. 1990)).

¹²¹ *See id.* (noting that all the examples of public accommodations in the statute "are 'places' within the plain meaning of that word").

¹²² 99 F.3d 181, 188 (6th Cir. 1996) [hereinafter *Parker I*] ("[P]laintiff argues that the plain meaning of these [ADA] provisions covers 'insurance products,' because insurance products are 'goods' or 'services' provided by a 'person' who owns a 'public accommodation.' We agree."), *rev'd en banc*, 121 F.3d 1006 (6th Cir. 1997) [hereinafter *Parker II*].

¹²³ *Parker II*, 121 F.3d at 1010.

physical place, hence no public accommodation.¹²⁴ The *Parker II* court construed the ADA narrowly, reasoning that it was bound to such an interpretation under the doctrine *noscitur a sociis*,¹²⁵ which directs that "a . . . term is interpreted within the context of the accompanying words to avoid the giving of unintended breadth to the Acts of Congress."¹²⁶

This "narrow" reading of the ADA is in direct contrast to the *Parker I* court's finding that because the ADA is a remedial statute, its terms should be "interpreted broadly, in a manner consistent with their stated goal."¹²⁷ Some courts have reached the same conclusion as the *Parker I* court, however, reasoning that "[u]nlike other legislation designed to settle narrow issues of law, the ADA has a comprehensive reach and should be interpreted with this goal in mind."¹²⁸ Under this broader reading, in *Baker v. Hartford Life Insurance Co.*, a district court asserted that "the ADA does not require a plaintiff to be physically present at the place of public accommodation to be entitled to non-discriminatory treatment."¹²⁹ A child brought suit in *Baker* against an insurance company when it refused to cover him because he suffered from a seizure disorder.¹³⁰ In denying the defendant's motion for dismissal, the court observed that "discrimination can occur . . . when a plaintiff is not physically present at the place of public accommodation and only has contact with that place . . . by telephone and correspondence."¹³¹

Similarly, the U.S. District Court for the Central District of California faced this issue in *Kotev v. First Colony Life Insurance Co.*, and reading all of the previous interpretations of the statute, concluded that Title III does apply to insurance companies.¹³² In *Kotev*, a life insurance applicant sued a life insurance company that refused to insure him because his wife was HIV-positive, though he himself was HIV-negative. The *Kotev* court raised

¹²⁴ See *id.* at 1011. The requirement of a "nexus" to a physical location was also raised by the *Pappas* court. See *Pappas*, 861 F. Supp. at 620 ("[T]here is no nexus whatsoever between the alleged discrimination and any public accommodation.").

¹²⁵ *Noscitur a sociis* is a doctrine where "the meaning of questionable or doubtful words or phrases in a statute may be ascertained by reference to the meaning of other words or phrases associated with it." BLACK'S LAW DICTIONARY 1060 (6th ed. 1990).

¹²⁶ *Parker II*, 121 F.3d at 1014 (citations and internal quotations omitted).

¹²⁷ *Parker I*, 99 F.3d at 188 (citation omitted). "[W]e are bound to interpret statutory language in such a way as to avoid rendering terms superfluous. . . . To say that the Disabilities Act prohibits discrimination only as to 'physical access' to places of 'public accommodation' would write the terms 'goods' and 'services' out of the statute." *Id.* (citation omitted).

¹²⁸ *Anderson v. Gus Mayer Boston Store*, 924 F. Supp. 763, 771 (E.D. Tex. 1996).

¹²⁹ No. 94 C 4416, 1995 WL 573430, at *3 (N.D. Ill. Sept. 28, 1995).

¹³⁰ See *id.* at *1.

¹³¹ *Id.* at *3.

¹³² 927 F. Supp. 1316, 1321 (C.D. Cal. 1996) ("[T]he plain language of Title III . . . demonstrates that Title III is not limited to prohibiting only the denial of physical access to persons with disabilities.").

perhaps the clearest reason to permit a suit against an insurance company under Title III: insurance companies would not need the safe harbor provision under Title III if the Title was inapplicable to insurance companies.¹³³ Further, the court asserted that even under the "narrow" readings of the ADA, which the courts in *Parker II* and *Pappas* espoused, the plain language of the ADA simply does not mandate that only physical accommodations are covered. Given the broad-ranging purposes of the ADA to end "discrimination faced day-to-day by people with disabilities," it would make little sense to remove such a large portion of the discrimination from the scope of the ADA.¹³⁴ Further, because the ADA protects not only the disabled, but also those with a record of a disability and those who are perceived as disabled, Title III would have little meaning for these groups if it applied only to physical places.¹³⁵

The issue of the applicability of Title III to insurance companies is still unsettled, but two subsequent cases have followed *Kotev*,¹³⁶ increasing the possibility that the *Pappas* and *Parker II* opinions will eventually lose their authority.

IV. *ALEXANDER V. CHOATE* AND "MEANINGFUL ACCESS"

The main obstacle to using the ADA or the Rehabilitation Act to challenge a state or managed care organization's limitation on Medicaid benefits is a 1985 Supreme Court case, *Alexander v. Choate*.¹³⁷ In *Choate*, disabled Medicaid recipients challenged a reduction in the maximum annual hospital days that the State of Tennessee would reimburse. The state reduced the number of annual inpatient hospital days for which Medicaid would pay hospitals from twenty to fourteen.¹³⁸ The plaintiffs argued that this policy change had a disproportionate effect on the disabled, in violation of, among

¹³³ See *id.* at 1322 ("First Colony has not explained why insurers would need this 'safe harbor' provision under Title III if insurers could never be liable under Title III for conduct such as the discriminatory denial of insurance coverage.").

¹³⁴ See *id.* at 1321 (citing 42 U.S.C. § 12101(b)(4) (1994)).

¹³⁵ See *id.* at 1321-22 (asserting that the plain language of the law cannot support such a restrictive interpretation).

¹³⁶ See *World Ins. Co. v. Branch*, 966 F. Supp. 1203, 1207 (N.D. Ga. 1997) (concluding, in a challenge to a health insurer's \$5000 lifetime cap on AIDS benefits, that "Title III's scope extends beyond the mere denial of physical access to places of public accommodation" (citation omitted)); *Cloutier v. Prudential Ins. Co.*, 964 F. Supp. 299, 302 (N.D. Cal. 1997) (citing *Kotev* for the conclusion that the plaintiff could sue an insurance company under Title III when it denied his application for life insurance because his partner was HIV-positive).

¹³⁷ 469 U.S. 287 (1985).

¹³⁸ See *id.* at 289 & n.2 (discussing the proposed 14-day limitation on inpatient coverage and other cost-saving changes that the state proposed to its Medicaid program).

other things, the Rehabilitation Act.¹³⁹ The Court recognized the problem of noninvidious discrimination against the disabled, and stated that "much of the conduct that Congress sought to alter in passing the Rehabilitation Act would be difficult if not impossible to reach were the Act construed to proscribe only conduct fueled by a discriminatory intent."¹⁴⁰ Nevertheless, the Court, when balancing the medical needs of the disabled with the financial burdens of the state, found that the cap on hospital inpatient days did not violate the Rehabilitation Act.¹⁴¹ The decisive element in the balancing test, according to the Court, was that the plaintiffs were not deprived of "meaningful access."¹⁴²

The establishment of a "meaningful access" analysis is the crucial element of the *Choate* opinion. In its attempt to balance the needs of the state against the needs of the plaintiffs, the Court asserted that the existence or lack of meaningful access was the relevant inquiry, although neither this standard nor this terminology appears in the Rehabilitation Act itself. "[A]n otherwise qualified handicapped individual must be provided with meaningful access to the benefit that the grantee offers. . . . [T]o assure meaningful access, reasonable accommodations in the grantee's program or benefit may have to be made."¹⁴³ In finding that the plaintiffs had meaningful access to health care, the Court cited three relevant factors: first, the fourteen-day limitation did not "invoke criteria that have a particular exclusionary effect" on the disabled; second, the cap was "neutral on its face," because it did not base the determination of who would be covered on any test that the disabled were less capable of meeting; and third, "nothing in the record suggest[ed] that the handicapped . . . [would] be unable to benefit meaningfully from the coverage they [would] receive under the 14-day rule."¹⁴⁴

The lack of a "particular exclusionary effect" that the Court referred to was the district court's finding that 95% of the disabled plaintiffs on Medi-

¹³⁹ See *id.* at 290.

¹⁴⁰ *Id.* at 296-97. "Discrimination against the handicapped was perceived by Congress to be most often the product, not of invidious animus, but rather of thoughtlessness and indifference—of benign neglect." *Id.* at 295; see also *supra* notes 75-82 and accompanying text (discussing Congress's recognition, in its enactment of the ADA and the Rehabilitation Act, of disparate impact discrimination against the disabled).

¹⁴¹ See *Choate*, 469 U.S. at 300 (asserting that the appropriate inquiry is a balancing test "between the statutory rights of the handicapped to be integrated into society and the legitimate interests of federal grantees in preserving the integrity of their programs," and explaining that "while a grantee need not be required to make 'fundamental' or 'substantial' modifications to accommodate the handicapped, it may be required to make 'reasonable' ones").

¹⁴² *Id.* at 301.

¹⁴³ *Id.* at 301.

¹⁴⁴ *Id.* at 302.

caid probably would be covered fully under the fourteen-day plan.¹⁴⁵ Yet, the record also contained data suggesting that in a recent year, 27% of the disabled patients using inpatient services needed more than fourteen days of care, while only 8% of the nondisabled that required hospitalization needed more than fourteen days.¹⁴⁶ That is, disabled hospital patients were more than three times as likely to be affected by the reduction in care than the nondisabled hospital patients. A finding of whether there is an "exclusionary effect" may therefore depend upon which statistics a court uses in its analysis. At any rate, all that one can glean from this particular part of the analysis is that when only 5% of a group of plaintiffs are affected by a regulation, the exclusionary effect may be insufficient to constitute a lack of meaningful access.

The Court's examination of the "facial neutrality" of the regulation is troublesome, because the plaintiffs brought the suit as a disparate impact cause of action.¹⁴⁷ That is, the plaintiffs recognized that there was no invidious provision in the regulation that singled out the disabled, but alleged that its disparate effect on them produced an actionable claim. The Court initially recognized that facially neutral regulations could have a disparate impact on the disabled.¹⁴⁸ Given that a per se rule against disparate impact discrimination "could lead to a wholly unwieldy administrative and adjudicative burden," however, the Court reasoned that some limit would have to be imposed.¹⁴⁹ As a result, the Court concluded that only "conduct that has an *unjustifiable* disparate impact upon the handicapped" constitutes a violation of the Rehabilitation Act.¹⁵⁰ In order to determine whether there is an "unjustifiable disparate impact," the relevant inquiry is whether "the reduction, *neutral on its face*, . . . distinguish[es] between those whose coverage will be reduced and those whose coverage will not on the basis of any" classification based on disability.¹⁵¹ Put simply, a facially neutral regulation is justifiable if it is facially neutral. This tautology has not helped the lower

¹⁴⁵ See *id.* at 303.

¹⁴⁶ See *id.* at 289-90.

¹⁴⁷ See *Choate*, 469 U.S. at 289 (noting that the plaintiffs alleged that the regulations would have a "discriminatory effect on the handicapped"); see also *supra* notes 75-82 and accompanying text (discussing disparate impact).

¹⁴⁸ See *Choate*, 469 U.S. at 295-97 (describing how actions that lack a discriminatory intent may nonetheless have an inadvertent discriminatory result).

¹⁴⁹ *Id.* at 298.

¹⁵⁰ *Id.* at 299 (emphasis added). The Court "assumed" rather than "decided" this interpretation of the law. See *id.* ("[W]e assume without deciding that § 504 reaches at least some conduct that has a unjustifiable disparate impact upon the handicapped.").

¹⁵¹ *Id.* at 302 (emphasis added).

courts to produce consistent decisions, and some have gone so far as to find that meaningful access exists when a regulation is facially neutral.¹⁵²

The Court's reasoning that nothing in the record suggested that the plaintiffs would not "benefit meaningfully" is also a bit problematic, because the term "meaningful" is used to explain the term "meaningful."¹⁵³ This factor does suggest that a plaintiff must have a strong evidentiary showing of a deprivation of access to succeed. Many lower courts, perhaps because of this ground for the decision, have held that unless there is a total deprivation of a benefit, a plaintiff still has meaningful access.¹⁵⁴

From the facts of *Choate*, it is clear that when 95% of beneficiaries have access to a program, and the regulation does not specifically single out a protected group, meaningful access exists.¹⁵⁵ Outside these particular facts, however, courts have resolved the question of the definition of "meaningful access" inconsistently. Given the circular reasoning in the Court's analysis, the three elements of the meaningful access analysis are virtually impossible to apply to other circumstances. Some courts have based their analyses on whether the challenged policy is facially neutral.¹⁵⁶ Others have examined whether the challenged policy results in a particular exclusionary effect.¹⁵⁷ But for the majority of lower court decisions, the determination whether "meaningful access" exists is at the judge's discretion. The next Part explores the many different interpretations that courts have expounded.

V. WHAT CONSTITUTES MEANINGFUL ACCESS?

The question regarding what constitutes meaningful access to health care under the ADA has not been resolved in the lower courts. The case law addressing the issue is not overly extensive because the ADA took full ef-

¹⁵² See *infra* Part V (discussing the spectrum of decisions on meaningful access for the disabled).

¹⁵³ See *Choate*, 496 U.S. at 302 (explaining that a patient would not have "meaningful access" if he were "unable to benefit meaningfully from the coverage").

¹⁵⁴ See *infra* Part V.A.1, for a discussion of cases interpreting "meaningful access" in this way.

¹⁵⁵ Despite some subsequent expansions of the *Choate* holding, this aspect of *Choate* remains firm: A blanket restriction on the amount of funds expended on health care does not constitute a denial of meaningful access. For instance, in *Moddero v. King*, the D.C. Circuit held that a \$75,000 lifetime maximum on mental health benefits for Foreign Service Benefit Plan recipients still provided meaningful access. See 82 F.3d 1059, 1062 n.2 (D.C. Cir. 1996) ("A \$75,000 lifetime maximum would . . . surely satisfy [*Choate*]'s requirement that the disabled benefit meaningfully from the coverage they will receive." (internal quotations omitted)).

¹⁵⁶ See *infra* Part V.B.2.

¹⁵⁷ See *infra* Part V.A.5.

fect only in 1992. Moreover, early cases interpreting the Rehabilitation Act construed it narrowly, thereby discouraging subsequent suits.¹⁵⁸ The following Subpart examines the district court decisions that address the issue of meaningful access and attempts to position them on a spectrum between the extremes of "any access" and "adequate access." The second Subpart discusses some of the ways that courts, recognizing the ambiguous state of the law, have attempted to avoid the question altogether.

A. *The Spectrum of Decisions on Meaningful Access for Disabled Persons*

The lack of a more specific holding in *Choate* has resulted in a series of district court opinions in substantial disarray. Recall that the Court in *Alexander v. Choate* cited three factors in its determination of meaningful access: (1) whether the challenged regulation had a particular exclusionary effect on the disabled; (2) whether the regulation was neutral on its face; and (3) whether anything suggested that the disabled would be unable to benefit meaningfully.¹⁵⁹ Courts occasionally have cited the first factor, but given that one cannot discern from *Choate* how much of an exclusionary effect is necessary to have a deprivation of meaningful access, the first factor is not particularly illuminating. The second factor is problematic because, as discussed earlier, when a plaintiff alleges that noninvidious, disparate impact discrimination has taken place, one would expect the regulation to be facially neutral. The third factor is clearly circular and provides no guidance. As a result, district courts have produced a variety of opinions.

The holding of *Choate*, that a state is not required to provide "adequate health care,"¹⁶⁰ remains good law. As a result, many courts have construed "meaningful access" to mean *any* access. That is, if a recipient receives any benefit whatsoever, the access is meaningful. Under this analysis, a court could conclude that a Medicaid recipient had "meaningful access" just by receiving Medicaid. Some courts have backed away from this absolutist approach, however, and have found violations of meaningful access in situations ranging from when a benefit is "effectively unavailable" to when access is "difficult or extremely inadequate," and even just "inadequate," potentially conflicting with *Choate*.

¹⁵⁸ See Orentlicher, *supra* note 4, at 58 (noting that the narrow interpretation of the Rehabilitation Act by federal appellate courts could have discouraged later claims).

¹⁵⁹ See *Alexander v. Choate*, 469 U.S. 287, 302 (1985); *supra* Part IV (discussing the Supreme Court's decision in *Choate* and its establishment of the "meaningful access" analysis).

¹⁶⁰ *Choate*, 469 U.S. at 303.

1. Meaningful Access as Any Access

At the far end of the spectrum are several holdings that suggest that there must be a total deprivation of access before meaningful access is compromised. In *Frances J. v. Bradley*, for instance, a district court found no violation of the Rehabilitation Act when the State declined to fund home care for mentally disabled elderly plaintiffs.¹⁶¹ Instead, the plaintiffs received care at a facility. Reasoning that the plaintiffs were "not being absolutely excluded from the program," the court found that they were "not being deprived of meaningful access to these benefits."¹⁶² The Eleventh Circuit took a similar approach, but found for the plaintiffs, in *United States v. Board of Trustees for the University of Alabama*.¹⁶³ In that case, the court found that when the University of Alabama refused to provide sign language interpreters for its deaf students, the students were deprived of meaningful access under the Rehabilitation Act.¹⁶⁴ "In the case of a deaf student, . . . all access to the benefit of some courses is eliminated when no sign-language interpreter is present."¹⁶⁵ Since total lack of access is not meaningful access, the court held that the University was in violation of the Rehabilitation Act.

Carried to its extreme, the absolutist approach can have some troubling results. In *Slager v. Duncan*, for instance, the plaintiff sued the county in which he lived under the ADA, seeking an injunction to block the installation of speed bumps his street.¹⁶⁶ The plaintiff suffered from a spinal injury that made driving over speed bumps very painful. Nevertheless, reasoning that the bumps "do not totally bar his use of the roads or leave him entirely 'unable to benefit meaningfully' from the streets, . . . he has not been denied 'meaningful access.'"¹⁶⁷ Thus, even though the "access" caused the plaintiff severe pain, painful access is still "meaningful."

¹⁶¹ No. 92C5190, 1992 WL 390875, at *2 (N.D. Ill. Dec. 15, 1992) (mem.).

¹⁶² *Id.* at *7.

¹⁶³ 908 F.2d 740 (11th Cir. 1990).

¹⁶⁴ *See id.* at 748.

¹⁶⁵ *Id.* The court went on to explain that "[i]n the context of a discussion class held on the third floor of a building without elevators, a deaf student with no interpreter is as effectively denied meaningful access to the class as is a wheelchair bound student." *Id.*

¹⁶⁶ No. AW-97-1598, 1997 WL 715033, at *1 (D. Md. Aug. 5, 1997), *aff'd*, 162 F.3d 1155, No. 97-2301, 1998 WL 558764 (4th Cir. 1998) (unpublished table decision).

¹⁶⁷ *Id.* at *2.

2. The Extreme Approach, but with Recognition of the Need for Effective Treatment

In another case, a district court also took an absolutist approach, but expressed some hesitation in using such a strict definition. In *Concerned Parents to Save Dreher Park Center v. City of West Palm Beach*, parents of disabled persons sued after the city chose to terminate recreational programs for the disabled.¹⁶⁸ In the wake of budget cuts, the city completely eliminated the programs for disabled persons, but continued numerous programs for the general population.¹⁶⁹ Recognizing that a complete absence of access was a deprivation of meaningful access, the court found that the city violated the ADA.¹⁷⁰ The court also recognized that the city did not have to provide services to anyone, but that if it provided programs for the general population, it had to make provisions for the disabled.¹⁷¹

The difference between this case and the other absolutist cases cited is that this court recognized that sometimes different or separate benefits must be provided in order to have the same effect. "[T]he ADA contemplates that different or separate benefits or services be provided if they are 'necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others.'"¹⁷² That is, the court implicitly suggested that there might be a deprivation of meaningful access when a regulation does not provide services that are *as effective* as those provided to the general population. "Ineffective" is closely related to "inadequate," which the *Choate* court rejected as a determination of meaningful access. The *Concerned Parents* court also specifically stated, however, that "adequate" recreational programs were not required under the ADA,¹⁷³ and took the absolutist approach in its holding.

¹⁶⁸ 846 F. Supp. 986, 988 (S.D. Fla. 1994).

¹⁶⁹ See *id.* at 989.

¹⁷⁰ See *id.* at 992 ("When these programs were eliminated, Plaintiffs were denied the benefits of the City's leisure services in contravention of Title II.").

¹⁷¹ See *id.* at 990 n.11 ("[T]he ADA does not require that persons with disabilities be given 'adequate recreational programs' or, for that matter, *any* recreational programs. However, the ADA does require that persons with disabilities be given *equal* access to whatever benefits the City offers to persons without disabilities." (citing *Alexander v. Choate*, 469 U.S. 287, 303 (1985))).

¹⁷² *Id.* at 991 (quoting 28 C.F.R. § 35.130(b)(1)(iv) (1993)).

¹⁷³ See *id.* at 990 n.11 ("[T]he ADA does not require that persons with disabilities be given 'adequate recreational programs' or . . . *any* recreational programs.").

3. Meaningful Access as Requiring Modest, Affirmative Steps toward Accommodation

Moving away from the extreme, two federal district courts have suggested that plaintiffs lack meaningful access to health care when the State has not considered their needs in establishing its regulations. This technically does not help one reach a clearer definition of "meaningful access," because the inquiry inappropriately revolves around what the caregiver provides, rather than what the patient receives. Nonetheless, some courts have focused on the caregiver's actions to make their determination on meaningful access. In *Marisol A. v. Giuliani*, children under the care of the New York City Administration for Children's Services sued the city for placing the children in group homes that were not equipped to deal with the children's medical problems.¹⁷⁴ The court denied the defendant's motion to dismiss, asserting that "a court may require an agency, under certain circumstances, to take affirmative steps to ensure that the access is meaningful."¹⁷⁵ The state placed two particular children, one with HIV and the other with neurological problems, in homes that lacked the medical staffs necessary to treat their conditions properly.¹⁷⁶ As a result, even though the children were receiving some care, the court did not deem it to be meaningful.

Similarly, in *Henrietta D. v. Giuliani*,¹⁷⁷ disabled persons with HIV and AIDS sued the city of New York because the Division of AIDS Services (the "DAS") provided benefits only after substantial delays and with considerable inconvenience to the recipients.¹⁷⁸ For instance, the plaintiffs had to travel long distances to receive benefits, "standing in line for long periods of time[, which] may be both painful and, more significantly, may expose them to infections which healthy people may not even notice, but which may prove deadly for them."¹⁷⁹ Rejecting the city's claim that the existence of the DAS program itself was "meaningful access," the court found that the Rehabilitation Act "requires some degree of positive effort and at least modest, affirmative steps to accommodate the handicapped."¹⁸⁰ Depending on the plaintiffs' conditions, the court reasoned that the city might have to

¹⁷⁴ 929 F. Supp. 662, 669-72 (S.D.N.Y. 1996).

¹⁷⁵ *Id.* at 685.

¹⁷⁶ *See id.*

¹⁷⁷ No. 95-CV0641-SJ, 1996 WL 633382, at *1 (E.D.N.Y. Oct. 25, 1996).

¹⁷⁸ *See id.* at *2 (describing the plaintiffs' claims in detail).

¹⁷⁹ *Id.* at *8.

¹⁸⁰ *Id.* (internal quotations omitted) (citing *Dopico v. Goldschmidt*, 687 F.2d 644, 652, 653 n.6 (2d Cir. 1982)); *see also id.* at *9 ("Given plaintiffs' disability and, in particular, the ease with which even minor infections can profoundly threaten their health, it is clear that defendants must provide Food Stamps, Home Relief, and other public assistance benefits in some modified fashion to these plaintiffs.").

make adjustments to its program—that the plaintiffs received some benefits, or that the city imposed delays on all Medicaid recipients alike, could not justify the delays.

Nevertheless, the *Henrietta D.* court was skeptical of the plaintiffs' ultimate success in proving a lack of meaningful access. Although the court recognized the potentially life-threatening problems with the policies of the DAS, the court also found that the DAS attempted to expedite the claims of some plaintiffs, provided cash supplements unavailable to persons without HIV, and required fewer visits to the city welfare offices.¹⁸¹ As a result, the court found that "plaintiffs are not likely to succeed in proving that DAS . . . does not or will not . . . [provide] beneficiaries [with] meaningful and equal access . . ."¹⁸² Thus, despite its recognition of an affirmative obligation to accommodate special needs, the court appeared to indicate that meaningful access exists when the state has made modest affirmative steps at accommodation, even if those steps are inadequate. Because the court was ruling only on a motion to dismiss for failure to state a claim upon which relief could be granted, however, the court denied the defendants' motion.¹⁸³

4. Meaningful Access as Readily Accessible

Beyond the absolutist and individualized inquiry standards, the Eastern District of Pennsylvania has suggested a "readily accessible" standard for determining whether there is meaningful access. In *Peoples v. Nix*, a blind attorney challenged Rule 120 of the Municipal Court of Philadelphia, which required a party to appear in court to obtain a default judgment even when the other party failed to appear.¹⁸⁴ The court recognized the ambiguity in the definition of "meaningful access," examining definitions such as "a right to use that has function or purpose," "[a] service that is readily accessible [and] promptly and easily obtained," and something that is "convenient or conducive" to performing a job.¹⁸⁵ Without settling on one particular definition, the court concluded that a determination regarding whether Rule 120 deprived blind persons of meaningful access to the courts would require a complete factual record and denied the defendant's motion to dismiss.¹⁸⁶

¹⁸¹ See *id.* at *10 (describing the way in which the DAS assisted some of its clients).

¹⁸² *Id.* at *11.

¹⁸³ See *id.* at *12.

¹⁸⁴ No. CIV.A. 93-5892, 1994 WL 423856, at *2 (E.D. Pa. Aug. 11, 1994) (citing PHILA. MUN. CT. R. CIV. P. 120).

¹⁸⁵ *Id.* at *3 (citations and internal quotations omitted).

¹⁸⁶ See *id.* at *4.

Nevertheless, the court at least implicitly recognized that meaningful access requires more than the mere presence of access.

Another district court reached a similar conclusion in *Oconomowoc Residential Programs, Inc. v. City of Greenfield*.¹⁸⁷ In *Oconomowoc*, developmentally disabled persons seeking to live in group homes claimed that a zoning ordinance prohibiting the location of two group homes within 2500 feet of each other violated the ADA.¹⁸⁸ The Court agreed, reasoning that as a remedial law, the ADA should be "construed broadly to ensure that disabled people are not denied meaningful access to housing or to public services or accommodations."¹⁸⁹ Despite the fact that the disabled persons could have stayed in homes that were more spread out, the court found that the "spacing requirement substantially limits meaningful access to housing."¹⁹⁰ Nevertheless, *Oconomowoc* is a little ambiguous in its use of the term "meaningful access." The court held that the restriction limited meaningful access, rather than just "access," but the court found a violation of the ADA when access clearly would have been less readily available to the disabled, suggesting a standard similar to that put forth in *Nix*.

5. Meaningful Access if No Particular Exclusionary Effect

The clearest part of the *Alexander v. Choate* meaningful access analysis, whether the challenged regulation results in a particular exclusionary effect, is used occasionally by courts to make their determinations of meaningful access. In *Thrope v. Ohio*, for instance, a district court considered a challenge to a \$5.00 fee that the state charged for handicapped parking windshield placards.¹⁹¹ The court granted summary judgment for the plaintiffs, concluding that the fee was "an illegal surcharge under the ADA."¹⁹² The State argued that the fee was permissible, because disabled persons had the option of getting a handicapped license plate instead, at no cost.¹⁹³ The court rejected this argument because in order to obtain special license plates, one would have to own or lease a vehicle, and not all disabled drivers owned or leased cars. "The license plate 'option' alone provides

¹⁸⁷ 23 F. Supp. 2d 941 (E.D. Wis. 1998).

¹⁸⁸ See *id.* at 943 (describing the plaintiffs' cause of action). The plaintiffs also brought a claim under the Federal Fair Housing Amendment Act. See 42 U.S.C. § 3604(f)(1)-(f)(3)(B) (1994) (forbidding discrimination in housing against disabled persons).

¹⁸⁹ *Oconomowoc*, 23 F. Supp.2d at 954.

¹⁹⁰ *Id.*

¹⁹¹ 19 F. Supp.2d 816, 818 (S.D. Ohio 1998).

¹⁹² *Id.* at 824.

¹⁹³ See *id.* (citing the State's contention that the placards are "only one alternative available to disabled Ohio drivers to permit them to utilize-handicapped-reserved parking spaces").

meaningful access to only a subset of disabled Ohioans (those who drive their own cars 100% of the time), and is thus at odds with the ADA.”¹⁹⁴

The *Thrope* analysis is notable because it, unlike the majority of other meaningful access analyses discussed in this Subpart, utilized one of the factors cited by the *Choate* Court—a particular exclusionary effect on the disabled. In *Choate*, the Supreme Court concluded that when 95% of the disabled Medicaid patients would probably be fully covered under the state’s revised health care plan, there was no particular exclusionary effect.¹⁹⁵ But, the *Choate* Court failed to provide guidelines that were any more specific—where 95% of the plaintiffs are covered, there is meaningful access, but what about 94% or 93%? Unfortunately, *Thrope* did not help to clear up this ambiguity. The court cites no statistics as to how many disabled persons neither owned nor leased cars but still needed handicapped placards. If one assumes that the percentage is small, the *Thrope* holding becomes stronger, as a deprivation of access to a small portion of the group would constitute a lack of meaningful access.

6. Lack of Meaningful Access for Difficulty or Extreme Inadequacy

Moving even further along the spectrum from “readily accessible,” another court has suggested that there is a deprivation of meaningful access when the benefit in question is too difficult to obtain or extremely inadequate. In *Bonner v. Lewis*, a deaf and mute inmate at the Arizona state prison sued under the Rehabilitation Act when the prison failed to provide him with a sign language interpreter.¹⁹⁶ As a result, he found it extremely hard to communicate in counseling sessions, in administrative and disciplinary hearings, and while receiving medical treatment.¹⁹⁷ The prison provided a telecommunication device so that the prison officials could communicate with the plaintiff, and some of the other inmates had a limited knowledge of sign language.¹⁹⁸ Nevertheless, the Ninth Circuit found that the factual question whether the communication was “extremely difficult and inadequate” was sufficient to raise a genuine issue of material fact, and reversed the district court’s summary judgment decision for the defendant.¹⁹⁹ This suggests a significantly more probing analysis of meaningful access than in the prior cases.

¹⁹⁴ *Id.* at 825.

¹⁹⁵ See *Alexander v. Choate*, 469 U.S. 287, 303 (1985).

¹⁹⁶ 857 F.2d 559, 560-61 (9th Cir. 1988).

¹⁹⁷ See *id.*

¹⁹⁸ See *id.*

¹⁹⁹ See *id.* at 563-64.

7. Meaningful Access as Adequate Access

At the far end of the spectrum is *World Insurance Co. v. Branch*, where the Northern District of Georgia implicitly suggested that there was a violation of meaningful access when access was inadequate.²⁰⁰ In *Branch*, Ralph Branch, a person with AIDS, challenged his health insurance company's \$5000 lifetime cap on AIDS benefits. In granting summary judgment for Branch, the court reasoned that "[b]ecause access to adequate health care is often integral to a disabled individual's ability to participate in society, the court cannot imagine that an insurer could arbitrarily cap the benefits payable with respect to a particular disability without running afoul of this stated purpose."²⁰¹ The court did not specifically state that in order to have meaningful access, one must have adequate access; rather, it used the fact that there was inadequate access to explain why the safe harbor provision did not apply.²⁰² Nevertheless, the court granted summary judgment for Branch, so there must have been a violation of meaningful access. It would make little sense to assert that an insurance company could not provide "inadequate" access under the safe harbor provision, but then to reason that it could under the meaningful access test. Such a reading, however, flies in the face of *Choate*, and this case remains isolated.

B. *Methods Courts Have Used to Avoid the Question Altogether*

Beyond the considerable ambiguity in the term "meaningful access," courts have added to the complexity of the determination by deciding cases on other grounds. In addition to the threshold problems in bringing a cause of action addressed in Part III, federal courts have declined to permit suits in cases where the benefits at issue are "special" programs or where the challenged regulation is facially neutral. Facial neutrality is not included in the above discussion of interpretations of meaningful access, despite being a factor in the *Choate* court's analysis, because when courts have addressed it as an issue, they have used it to avoid examining whether meaningful access in fact exists.

²⁰⁰ 966 F. Supp. 1203, 1208 (N.D. Ga. 1997), *aff'd in part, vacated in part*, 156 F.3d 1142 (11th Cir. 1998). Subsequent to the district court's decision, the health insurer rescinded its policy, so the Eleventh Circuit vacated the portion of the opinion dealing with its validity under the ADA as moot. *See* 156 F.3d at 1143.

²⁰¹ *Branch*, 966 F. Supp. at 1208.

²⁰² *See id.* at 1209 ("[T]here is no evidence explaining the purpose for which plaintiff caps an insured's lifetime benefits for AIDS at \$5000.").

1. "Special" Programs

When courts have found that a benefit program provided by the state is a "special" program, not available to the general public, they have generally declined to permit suits under the ADA and Rehabilitation Act. For instance, in *Lincoln CERCPAC v. Health & Hospital Corp.*, a district court granted a motion to dismiss a suit brought by disabled children when the State closed the New York rehabilitation clinic that they attended.²⁰³ The clinic provided specialized services for developmentally disabled children, and after its closing, no equivalent facility was available to provide these services.²⁰⁴ Citing *Choate's* holding that the state was not required to provide "adequate health care,"²⁰⁵ the court concluded that the clinic's programs were "specialized services to disabled individuals and not the public at large," and thus, there was no requirement under the Rehabilitation Act or the ADA to continue them.²⁰⁶ Exactly what made these services "specialized," however, is unclear. Under this same rationale, a court could preclude Medicaid patients from ever bringing suit because the government does not provide Medicaid to the public at large, but rather a very small subset. Nevertheless, the Second Circuit affirmed the district court's holding.²⁰⁷

A similar argument arose in the context of retirement benefits in *Felde v. City of San Jose*.²⁰⁸ In *Felde*, a disabled firefighter challenged the city's retirement policy, which awarded a 100% payment for accrued sick leave time to those retiring on a regular-service basis, but only 80% to those retiring on the basis of a disability.²⁰⁹ The court found no ADA violation, because the plaintiff could have chosen the normal retirement provisions, if he

²⁰³ 977 F. Supp. 274, 277 (S.D.N.Y. 1997), *aff'd*, 147 F.3d 165 (2d Cir. 1998).

²⁰⁴ See *id.* at 277-78 (detailing the plaintiff's allegations that there are no alternative healthcare providers in the area who provide "the same quality and quantity of services").

²⁰⁵ *Id.* at 279 (citing *Alexander v. Choate*, 469 U.S. 287, 309 (1984)) (internal quotation omitted).

²⁰⁶ *Id.* at 279-80.

²⁰⁷ See 147 F.3d at 168. Notably, the Second Circuit did not hold that the district court was correct in its finding that the state had no obligation to provide specialized programs. Instead, the court rested its decision on the plaintiffs' failure to raise the allegation that they were entitled to special services which the State denied them. See *id.* ("We need not decide whether, in some circumstances, a reasonable accommodation in the provision of medical care to a disabled person equal to that provided to a nondisabled person might have to include medical services that could be characterized as 'specialized.'").

²⁰⁸ 839 F. Supp. 708 (N.D. Cal. 1994), *aff'd*, 66 F.3d 335, No. 94-15272, 1995 WL 547698 (9th Cir. 1995) (unpublished table decision).

²⁰⁹ See *id.* at 709 ("It is undisputed that...[the] plaintiff received a proportionally smaller payout for unused sick leave when he retired on a disability basis than similarly-situated individuals who did not retire on a disability basis.").

had given up tax deductions provided for disabled persons. Instead, the court reasoned that allowing the firefighter to retire as "disabled" was a specialized service, and so the ADA provided no protection: "In reality, plaintiff is seeking special rather than simply nondiscriminatory treatment. The City's failure to provide him with such special treatment does not violate the ADA."²¹⁰ By concluding that the plaintiff's ability to claim eligibility for tax benefits was special treatment by the city, the court never had to reach the issue regarding whether the city had deprived him of meaningful access.

Recently, however, the Eleventh Circuit reached a different conclusion about "special" services. In *L.C. ex rel. Zimring v. Olmstead*, the circuit court found that the state could not confine a disabled person in a state-run institution where the plaintiff could be more appropriately treated in an integrated community setting.²¹¹ The plaintiff had been confined in a state psychiatric hospital where persons with mental disabilities were "cared for in a segregated environment."²¹² In ruling that the state violated the ADA by keeping the plaintiff in the segregated setting, the court recognized:

The fact that L.C. . . . seek[s] community-based treatment services that only disabled persons need does not foreclose [her] claim that [she was] unnecessarily segregated. . . . Underlying the ADA's prohibitions is the notion that individuals with disabilities must be accorded reasonable accommodations *not* offered to other persons in order to ensure that individuals with disabilities enjoy "equality of opportunity, full participation, independent living, and economic self-sufficiency."²¹³

Under this reasoning, the "special" services exception ceases to be an issue. The Eleventh Circuit decided *Olmstead* on April 8, 1998. It remains to be seen whether other jurisdictions will follow its example.

2. Facially Neutral Regulations

Another threshold inquiry that courts conduct is whether a regulation is "facially neutral." As discussed in Part IV, this analysis is problematic because the *Choate* Court itself conducted a somewhat circular analysis.²¹⁴ The test is also troublesome because under the ADA, disparate impact causes of action should allow for relief even when a regulation is facially

²¹⁰ *Id.* at 711.

²¹¹ 138 F.3d 893, 895 (11th Cir.), *cert. granted*, 119 S. Ct. 633 (1998); *see also supra* note 101 (discussing the Supreme Court's decision to grant certiorari in *Olmstead*).

²¹² *Id.*

²¹³ *Id.* at 899 (quoting 42 U.S.C. § 12101(a)(8) (1994)).

²¹⁴ *See supra* notes 148-51 and accompanying text (describing the *Choate* Court's analysis).

neutral.²¹⁵ Nevertheless, several courts have dismissed claims challenging facially neutral regulations. For instance, in *DeBord v. Board of Education*, the Eighth Circuit found that a school board did not deprive a student of meaningful access when its policy was facially neutral.²¹⁶ In *DeBord*, the school board refused to administer a prescription drug to a student with attention deficit hyperactivity disorder because the amount the doctor prescribed exceeded the recommended dosage in the *Physicians' Desk Reference*.²¹⁷ Despite the facts that the student's prescription was medically necessary and that the refusal by the school board to administer the prescription likely would mean that the student would have to leave school early in order to get the medication at home, the court found that there was no violation of the ADA or the Rehabilitation Act.²¹⁸ Instead, because the regulation applied to all students, whether disabled or not, the court found the regulation to be nondiscriminatory.²¹⁹ The court looked to the form of the regulation, rather than to the effect, and thus never reached the issue of meaningful access.

Fortunately, other courts have refrained from employing this type of circular reasoning. For instance, in *Peoples v. Nix*, a blind plaintiff made a challenge to the Pennsylvania state court rule requiring attorneys to appear for all proceedings although the rule appeared reasonable "on its face."²²⁰ The court reasoned that under a disparate impact analysis, the plaintiff may have had a viable challenge to the state's policies based on the effect of the regulation.²²¹

²¹⁵ See *supra* notes 75-82 and accompanying text (noting that Congress intended a disparate impact cause of action without envisioning a requirement of complete equality of outcome).

²¹⁶ 126 F.3d 1102, 1106 (8th Cir. 1997).

²¹⁷ See *id.* at 1104.

²¹⁸ See *id.* at 1106.

²¹⁹ See *id.* at 1105 ("There is no evidence that the school district had disabilities in mind when formulating or implementing its policy. . . . The policy is neutral; it applies to all students regardless of disability. A student's excess prescription, not the student's disability, prevents the student from receiving medication from the school nurse.").

²²⁰ No. CIV. A. 93-5892, 1994 WL 423856 (E.D. Pa. Aug. 11, 1994); see also *supra* notes 184-86 and accompanying text (discussing the court's construction of "meaningful access" in *Peoples v. Nix*).

²²¹ See *Nix*, 1994 WL 423856, at *3 ("A showing of discriminatory intent is not necessary to sustain a claim of violation of the ADA.").

VI. SUGGESTION FOR AN IMPROVED DEFINITION OF "MEANINGFUL ACCESS" AND A BROADER APPLICATION OF THE ADA AND THE REHABILITATION ACT

Given the current political drive to reduce government spending and its resulting limitations on Medicaid,²²² without a corresponding expansive reading of the ADA and the Rehabilitation Act and a true requirement of the provision of "meaningful access" to health care, disabled persons will face denials of care and have little recourse.²²³ Both the movement toward Medicaid managed care and the drive to cut Medicaid spending limit the potential of the political process to redress the harms that disabled persons suffer. Programs like HealthChoices in Pennsylvania will have severe consequences as patients lose their choice of doctors and their health will be compromised as they are denied care in order to meet a budget. Judicial interpretations of the disability statutes must be expansive enough to provide a solution.

If one of the purposes of the ADA is legitimately "to bring individuals with disabilities into the economic and social mainstream of American life,"²²⁴ then courts must employ a definition of "meaningful access" that approaches adequate access. It may be that most courts will be reluctant to go as far as the *Branch* court,²²⁵ but even a "readily accessible" standard, such as the *Peoples v. Nix*²²⁶ and *Oconomowoc Residential Programs, Inc. v. City of Greenfield*²²⁷ courts utilized, would provide more protection to the disabled. Cases like *Anderson v. Department of Public Welfare*²²⁸ demonstrate the need for a legal remedy; for an MCO to assign a patient in a wheelchair to a dentist on the second floor of a building without elevators is

²²² See Sparer, *supra* note 2, at 3 (describing Medicaid and the opposition that has formed against it).

²²³ This is not to say that the disabled have *no* recourse; for instance, states must also comply with the requirements of the Social Security Act. See *Harris v. McRae*, 448 U.S. 297, 301 (1980) (stating that once a state elects to participate in the Medicaid program, it must comply with the requirements of the Social Security Act). The ADA, however, is the more comprehensive statute for the disabled, as it was enacted specifically for the sake of the disabled.

²²⁴ H.R. REP. NO. 101-485, pt. 2, at 99 (1990).

²²⁵ *World Ins. Co. v. Branch*, 966 F. Supp. 1203, 1208 (N.D. Ga. 1997) (suggesting implicitly that absent adequate access, there is a lack of meaningful access), *aff'd in part, vacated in part*, 156 F.3d 1142 (11th Cir. 1998); see also *supra* notes 200-02 and accompanying text.

²²⁶ 1994 WL 423856, at *2 (E.D. Pa. Aug. 11, 1994); see also *supra* notes 184-86 and accompanying text.

²²⁷ 23 F. Supp. 2d 941 (E.D. Wis. 1998); see also *supra* notes 187-90 and accompanying text.

²²⁸ 1 F. Supp. 2d 456 (E.D. Pa. 1998).

unconscionable. But even less extreme cases require redress, and a broader requirement of meaningful access under the ADA could provide that redress.

Courts also must consistently recognize a disparate impact cause of action; otherwise the ADA and the Rehabilitation Act will become toothless in the health care context. Although invidious discrimination against the disabled remains an unfortunate reality of American culture, particularly among persons with HIV and AIDS, a far more pervasive problem is the "benign neglect" caused by regulations that have a disparate impact on the disabled. The *Choate* Court recognized the harm caused by disparate impact discrimination, but then issued a holding that did nothing to combat the problem. If, as the Court asserted, section 504 of the Rehabilitation Act "make[s] actionable the disparate impact challenged in this case," and if it was Congress's intent to combat discrimination that was "the product, not of invidious animus, but rather of thoughtlessness and indifference—of benign neglect,"²²⁹ then the inescapable conclusion is that the courts should interpret the statutes to prohibit disparate impact discrimination to the fullest extent possible.

A more consistent recognition of a disparate impact cause of action will help satisfy the mandate of the ADA. There are obviously situations where disparate impact is not actionable, such as when criteria are used that "are necessary for the operation of the program."²³⁰ On the other hand, not every classification will be vital to Medicaid's continued existence, and the ADA itself proscribes discrimination that "tend[s] to screen out an individual with a disability."²³¹ As one commentator notes, "[d]isparate impact discrimination occurs when a policy that is facially neutral with respect to a particular group nevertheless affects members of that group differently from others."²³² It is completely circular reasoning, then, to assert that a policy is nondiscriminatory *because* it is facially neutral, as the *Choate* Court does.

As it stands, the holding of *Choate* provides little guidance for a court evaluating an ADA or Rehabilitation Act claim. Although its balancing test provides a logical starting point, the lack of guidance on the definition of "meaningful access" permits courts to arrive at virtually any conclusion in Medicaid cases. The wide spectrum of holdings on meaningful access demonstrates this clearly. In order for the law to have any consistency, courts should employ a uniform standard of meaningful access that is more in line with the goals of the two acts.

²²⁹ Alexander v. Choate, 469 U.S. 287, 294-95 (1985).

²³⁰ Orentlicher, *supra* note 4, at 58 (citing 42 U.S.C. § 12182(b)(2)(A)(i) (Supp. 1993)).

²³¹ 42 U.S.C. § 12182(b)(2)(A)(i) (1994).

²³² Orentlicher, *supra* note 4, at 57 n.44.

Medicaid is an expensive program, and significant political forces have tried to cut it back since its inception.²³³ This is not, however, a justification for discrimination against the disabled. As the Eleventh Circuit recently noted, "[I]nadequate state appropriations do not excuse noncompliance with federal law. Having chosen to provide services to individuals with disabilities, the State . . . must act in a manner that comports with the requirements of the ADA."²³⁴ Given the recognition that much of the discrimination against disabled individuals is noninvidious, financial motives for discrimination cannot be discounted. When a building owner renovates but does not want to install a ramp, chances are it is not because of any deeply felt hatred for persons in wheelchairs; it is because the ramp will cost the building owner thousands of dollars. Nevertheless, the ADA requires that she install the ramp.²³⁵ Similarly, the financial justifications of health care providers, even where legitimate, cannot exclude them per se from compliance with the ADA. A political commitment to place disabled persons in the economic and social mainstream of American life requires a financial commitment as well.

Further, given that one of the ADA's purposes is "to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities,"²³⁶ courts should not interpret the ADA to enact further barriers at the threshold. The holdings of the *Parker II* and *Pappas* courts, concluding that insurance companies are not "public accommodations," are needlessly narrow readings of the statute.²³⁷ As the *Carparts* court reasoned, if a travel agency is a public accommodation, then how is an

²³³ See *supra* notes 1-16 and accompanying text.

²³⁴ *L.C. ex rel. Zimring v. Olmstead*, 138 F.3d 893, 904 (11th Cir. 1998) (citations and internal quotations omitted), *cert. granted*, 119 S. Ct. 633 (1998); see also *Doe v. Chiles*, 136 F.3d 709, 722 (11th Cir. 1998) (stating that inadequate state appropriations do not excuse noncompliance with the Medicaid Act); *Tallahassee Mem'l Reg'l Med. Ctr. v. Cook*, 109 F.3d 693, 704 (11th Cir. 1997) (stating that budgetary constraints may be a factor to be considered by a state when amending or implementing a plan, but that budgetary complaints alone can never be a sufficient reason for noncompliance); *Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388, 396 (5th Cir. 1980) (holding that once a state has voluntarily elected to participate in the Medicaid program the state must comply with federal standards).

²³⁵ See 42 U.S.C. § 12183(a)(2) (1994) (requiring that public accommodations which conduct renovations make the property "readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs").

²³⁶ *Id.* § 12101(b)(2).

²³⁷ *Parker II*, 121 F.3d 1006, 1011 (6th Cir. 1997) (en banc) (concluding that when there is no "nexus" to a physical place, there is no public accommodation); *Pappas v. Bethesda Hosp. Ass'n*, 861 F. Supp. 616, 620 (S.D. Ohio 1994) (holding that Title III of the ADA applies only to the physical use of a place); see also *supra* notes 117-21 and accompanying text (discussing *Pappas*); *supra* notes 122-27 and accompanying text (discussing the *Parker* decisions).

insurance company not one as well?²³⁸ Likewise, if the ADA covers “goods and services” of a public accommodation, why is physical entry onto the premises necessary?²³⁹ And, as the *Kotev* court observed, why would insurance companies need the safe harbor provision under Title III if the Title was inapplicable to insurance companies?²⁴⁰ Similarly, the state should not be able to escape responsibility for discriminatory practices against the disabled by contracting out its health care responsibilities,²⁴¹ or Title II would become a meaningless provision.²⁴²

The “specialized programs” arguments that the courts adopted in *Lincoln CERCPAC*²⁴³ and *Felde*²⁴⁴ contravene the purposes of the ADA and the Rehabilitation Act and should be abandoned. It is certainly not the case that all programs must be continued, but the discontinuance of the program in *Lincoln CERCPAC* singled out a specific group of disabilities for non-coverage, when no alternative programs were available. The *Felde* decision, in turn, presented an absurd concept of “choice.” If the plaintiff had “chosen” to accept the normal retirement provisions, he would have been ineligible for tax benefits—benefits that the government deemed necessary for disabled persons in order to put them on more equal footing in comparison to the nondisabled.²⁴⁵ Mandating that he “choose” to give up his tax

²³⁸ See *Carparts Distribution Ctr., Inc. v. Automotive Wholesaler's Ass'n*, 37 F.3d 12, 19 (1st Cir. 1994) (concluding that the inclusion of travel agencies as “public accommodations” suggests that “Congress clearly contemplated that ‘service establishments’ include providers of services which do not require a person to physically enter an actual physical structure”); see also *supra* notes 113-16 and accompanying text (discussing the *Carparts* court's rejection of the physical structure requirement and conclusion that a health plan is a public accommodation).

²³⁹ See *Parker I*, 99 F.3d 181, 188 (6th Cir. 1996) (“To say that the [ADA] prohibits discrimination only as to ‘physical access’ to places of ‘public accommodation’ would write the terms ‘goods’ and ‘services’ out of the statute.”), *rev'd en banc*, *Parker II*, 121 F.3d 1006 (6th Cir. 1997), *cert. denied*, 118 S. Ct. 871 (1998).

²⁴⁰ See *Kotev v. First Colony Life Ins. Co.*, 927 F. Supp. 1316, 1322 (C.D. Cal. 1996); *supra* notes 132-35 and accompanying text (discussing *Kotev*).

²⁴¹ See *supra* note 103 and accompanying text (citing *J.K. v. Dillenberg*, 836 F. Supp. 694, 699 (D. Ariz. 1993), which held that a state cannot disclaim liability by contracting away its obligations).

²⁴² See *supra* Part III.A (tracing the requirements of Title II of the ADA).

²⁴³ *Lincoln CERCPAC v. Health & Hosp. Corp.*, 977 F. Supp. 274 (S.D.N.Y.) (holding that the transfer of disabled children after the closing of a specialized hospital did not state a claim for violation of the Rehabilitation Act), *aff'd*, 147 F.3d 165 (2d Cir. 1997); see also *supra* notes 203-07 and accompanying text.

²⁴⁴ *Felde v. City of San Jose*, 839 F. Supp. 708 (N.D. Cal. 1994), *aff'd*, 66 F.3d 335 (9th Cir. 1995) (holding that a city's policy of paying only part of accrued sick time to firefighters who retired on a disabled basis, but paying in full to firefighters who retired on a nondisabled basis, did not violate the ADA); see also *supra* notes 208-10 and accompanying text.

²⁴⁵ See *supra* notes 208-10 and accompanying text.

deductions in order to receive full retirement benefits is like asking a blind person to choose to give up a seeing eye dog.

The ADA and the Rehabilitation Act have the potential to safeguard the rights and improve the quality of life of thousands of disabled persons. A narrow interpretation, however, will mean that this potential remains only a potential. *Choate's* basic holding, that a blanket cap on health care is not a deprivation of meaningful access, has been repeatedly upheld by courts,²⁴⁶ but this holding overlooks the fact that treating the disabled and nondisabled exactly alike will not result in the same benefits for the two groups; otherwise, there would be no need for a Rehabilitation Act or an ADA. As David Orentlicher observed, "If we treat people in exactly the same way there will be greater hardship on some persons than on others."²⁴⁷ Yet even if a blanket cap on benefits is not redressable, the unsettled nature of the definition of "meaningful access" leaves open the possibility of employing the two acts to redress some of the harms that managed care causes Medicaid recipients. If Congress truly enacted the ADA to combat the deficiencies of the Rehabilitation Act, as the Senate and the Third Circuit have noted, then courts should be able to expand on the holding of *Choate*.²⁴⁸ A broad reading of meaningful access would accomplish this.

²⁴⁶ See, e.g., *Parker II*, 121 F.3d 1006, 1008 (6th Cir. 1997) (en banc) (holding that an employer did not violate the ADA by providing a long-term disability plan that contained longer benefits for employees who became disabled due to physical illness than for those who became disabled due to mental illness); *EEOC v. CNA Ins. Cos.*, 96 F.3d 1039, 1043 (7th Cir. 1996) (holding that a two-year limit on mental health benefits in a long-term disability plan did not violate the ADA); *Moddermo v. King*, 82 F.3d 1059, 1063 (D.C. Cir. 1996) (upholding a lifetime cap on mental health benefits under the Foreign Service Health Plan); see also *supra* note 155 (discussing *King*).

²⁴⁷ Orentlicher, *supra* note 4, at 77. Orentlicher further explains:

As the Supreme Court has observed, "[s]ometimes the greatest discrimination can lie in treating things that are different as though they were exactly the same." For example, if all persons are denied leave for pregnancy, women suffer greater harm than men.

Consider another example involving two patients with appendicitis. One patient is otherwise healthy and will be ready for discharge from the hospital within five days of the appendectomy. The second patient has a coexisting medical problem (for example, diabetes) that causes recovery from the surgery to take ten days. If a health plan limited reimbursement across the board to seven days of hospitalization after surgery, the people with coexisting medical problems would be disadvantaged.

Sometimes we need to take people's differences into account when deciding how to treat them. To ensure that people are treated as equals, it is often necessary to treat people differently.

Id. at 77-78 (footnotes omitted).

²⁴⁸ See *supra* notes 72-73 and accompanying text (discussing the shortcomings of the Rehabilitation Act and Congress's intent to solve them with the ADA). Admittedly, this argument is more difficult to make with Title II, since Congress specifically chose to follow *Choate's* holding. "In the legislative history of [T]itle II, the congressional committees held

CONCLUSION

In recent years, the nationwide move to managed care has put the health of Medicaid recipients in the hands of companies that make every effort to reduce the amount of medical care. Programs like HealthChoices in Pennsylvania have resulted in, and continue to result in, reductions in quality and quantity of care. This has a disproportionate effect on the disabled.

The ADA and the Rehabilitation Act offer much needed protection for the rights of the disabled, particularly in the context of Medicaid managed care. The ADA, in particular, has as its stated purposes the elimination of discrimination against the disabled and the placement of the disabled in the political and economic mainstream of American life. As a means for addressing discrimination in health care, Medicaid managed care recipients have potential remedies under either Title II of the ADA or section 504 of the Rehabilitation Act (both dealing with public services), or Title III of the ADA (public accommodations).

In promulgating these two acts, Congress recognized that much of the discrimination faced by the disabled is not just from invidious intent, but from benign neglect. In *Alexander v. Choate*, the Supreme Court established the analysis regarding whether "meaningful access" to a benefit exists as the central inquiry in noninvidious discrimination cases. How to make that determination, however, is unclear, and courts have produced a wide spectrum of cases interpreting meaningful access, ranging from any access to adequate access.

The broad range of decisions on meaningful access is indicative of the need for judicial recognition that the ADA requires the provision of meaningful access, where "meaningful" signifies more than just "basic" or "rudimentary" access and approaches something closer to "adequate" access. Particularly in light of the need for experimental treatments for persons with AIDS and HIV, a less firm resolve will have disastrous consequences. And, if only the most basic, rudimentary access is mandated, how does the ADA or the Rehabilitation Act put the disabled in the economic mainstream of society?

Reducing disparate impact discrimination is vital to providing meaningful access to health care to the disabled and is a stated goal of the ADA and the Rehabilitation Act. Courts should properly enforce the acts.

out *Choate* as the definitive interpretation of section 504 [of the Rehabilitation Act] that it intended [T]itle II to copy." Weber, *supra* note 18, at 1115 (citing H.R. REP. NO. 101-485, pt. 2, at 84 (1990)). Nevertheless, given that *Choate* has not produced a coherent set of guidelines, it is not unreasonable to suggest that courts employ a consistent definition of "meaningful access" that is more in line with the purposes of the ADA.

* * * * *