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THE COURT AT THE EPICENTER OF A NEW CIVIL RIGHTS STRUGGLE: HIV/AIDS IN THE NEW YORK COURT OF APPEALS

ARMEN H. MERJIAN†

"Very often, ordinary people found that the policies put in force during an epidemic—the quick burial of corpses in lime in mass graves, confiscation of the property of the dead, closings of markets, establishment of quarantining—posed far greater threats to their world of lived experience and expectation than the disease itself."

—Sheldon Watts

INTRODUCTION

When the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) first emerged on the American scene in the early 1980s, little was known about the disease except that it was incurable, fatal, and transmissible. The specter of such a horrifying new "plague," whose routes of

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1 SHELDON WATTS, EPIDEMICS AND HISTORY xv (1997).
3 Science first identified AIDS in 1981, when the CDC reported the appearance of a handful of unexplained cases of PCP and Kaposi's sarcoma among gay men in New York and California. See CENTERS FOR DISEASE CONTROL AND PREVENTION, Pneumocystic Pneumonia—Los Angeles, 30 MORBIDITY AND MORTALITY WKLY REP. 250 (June 5, 1981); CENTERS FOR DISEASE CONTROL AND PREVENTION, Kaposi's Sarcoma and Pneumocystic Pneumonia Among Homosexual Men—New York City and California, 30 MORBIDITY AND MORTALITY WKLY REP. 305 (July 4, 1981). HIV, the causative agent for AIDS, was not discovered until mid-1984. See RONALD BAYER, PRIVATE ACTS, SOCIAL CONSEQUENCES 2 (1991).
4 Susan Sontag has written perhaps the definitive work on the
transmission were largely misunderstood or unknown, \textsuperscript{5} imbued the disease with the power instantly to stigmatize those living with the virus. \textsuperscript{6} By a disastrous twist of fate, moreover, AIDS disproportionately struck first in communities already laboring under the weight of society's prejudices: the gay community, intravenous drug users, and communities of color. \textsuperscript{7} As one early commentator explained: "It is one of the cruellest ironies of the epidemic that its impact is greatest among those already stigmatized: gay men and intravenous drug users (many of
whom are black or brown).”

AIDS thus created, almost overnight, a new class of individuals subject to widespread and often virulent prejudice and discrimination:

Since the first cases of AIDS identified in the 1980s were overwhelmingly among gay men, people of color, and intravenous drug users, AIDS got off to a bad start. The bigotry of many people, and even of some religious leaders, found new opportunities in AIDS issues to fight unpopular groups. Additionally, when the alarming objective medical characteristics of AIDS (that it is incurable, fatal, and transmissible) were thrown into the mix, more people were swept up in the hostility toward AIDS and toward those it infected.9

Individuals living with HIV and AIDS have experienced discrimination in every facet of life, including such areas as housing, education, employment, health care, and insurance.10

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8 David I. Schulman, AIDS Discrimination: Its Nature, Meaning and Function, 12 NOVA L. REV. 1113, 1115 (1988); accord Jonsen & Stryker, supra note 4, at 9 (“At its outset, HIV disease settled among socially disvalued groups, and as the epidemic has progressed, AIDS has increasingly been an affliction of people who have little economic, political, and social power. In this sense, AIDS is an undemocratic affliction.”); Goldstein, supra note 6, at 84 (“Many illnesses transform their victims into a stigmatized class, but AIDS is the first epidemic to take stigmatized classes and make them victims.”); Barry Sullivan, AIDS: Law, Public Policy, and the Work of the American Bar Association, 21 TOLEDO L. REV. 1, 4 (1989) (“[T]he fullest fury of the HIV epidemic has thus far been felt by communities which already are targets of distrust or discrimination.”).

9 Michael L. Closen, HIV/AIDS in the 1990s, 27 J. MARSHALL L. REV. 239, 240 (1994); see also Allan M. Brandt, AIDS: From Social History to Social Policy, in AIDS: THE BURDENS OF HISTORY 147, 153 (Elizabeth Fee & Daniel M. Fox eds., 1988) (“Because of the considerable fear the AIDS epidemic has engendered, and the fact that the disease has principally affected two already marginal social groups (gays and intravenous drug users), its victims have been further victimized by stigmatization and discrimination.”).

10 It is beyond the scope of this Article to review the myriad ways in which people living with HIV and AIDS have been discriminated against in this country. See, e.g., AMERICAN CIVIL LIBERTIES UNION, EPIDEMIC OF FEAR (1990); NEW YORK COMMISSION ON HUMAN RIGHTS, REPORT ON DISCRIMINATION AGAINST PEOPLE WITH AIDS (1987); Robert J. Blendon & Karen Donelan, Discrimination Against People with AIDS: The Public’s Perspective, 319 NEW ENG. J. MED. 1022 (1988); Scott Burris, Dental Discrimination Against the HIV-Infected: Empirical Data, Law and Public Policy, 13 YALE J. ON REG. 1 (1996); Closen, supra note 9; Mary C. Dunlap, AIDS and Discrimination in the United States: Reflections on the Nature of Prejudice in a Virus, 34 VILL. L. REV. 909 (1989); Lawrence O. Gostin, The AIDS Litigation Project: A National Review of Court and Human Rights Commission Decisions, Part I: The Social Impact of AIDS, 263 JAMA 1961 (1990); Lawrence O.
People with AIDS, suspected of having AIDS, and sometimes even suspected of being at heightened risk for AIDS were fired from their jobs, denied access to public school classrooms, deprived of custody and visitation with their children, refused services of a variety of kinds, derided and defamed throughout society, and otherwise discriminated against. Violent physical attacks on people with AIDS including school children, gays, prisoners, and others were not uncommon.\textsuperscript{11}

Opinion polls have consistently revealed widespread and profound prejudice against individuals living with HIV and AIDS. A December 1985 poll taken by the \textit{Los Angeles Times} revealed, for example, that “most Americans favor some sort of legal discrimination against homosexuals as a result of AIDS.”\textsuperscript{12} In that same poll, 51\% favored banning people with AIDS from having sex; 51\% favored quarantine for people living with AIDS; 48\% wanted people living with AIDS to carry special identification cards; and 15\% favored tattooing people living with AIDS.\textsuperscript{13} In a survey of 53 opinion polls conducted between 1983 and 1988, Harvard School of Public Health researchers reported that 29\% favored tattooing people living with HIV and AIDS; 25\% would refuse to work near someone living with AIDS and believed that employers should have the right to fire someone for

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\textsuperscript{11} Closen, \textit{supra} note 9, at 239–40; accord \textit{South Fla. Blood Serv. v. Rasmussen}, 467 So. 2d 798, 800 (Fla. Dist. App. Ct. 1985) (“Reported accounts indicate that victims of AIDS have been faced with social censure, embarrassment and discrimination in nearly every phase of their lives, including jobs, education and housing.”); \textit{Sheila Taub, Doctors, AIDS, and Confidentiality in the 1990s, 27 J. MARSHALL L. REV. 331, 331 (1994)} (“Because AIDS made its first appearance mainly among male homosexuals and intravenous drug abusers, and because the disease was rapidly and uniformly fatal, persons with AIDS encountered widespread discrimination in housing, education, employment, medical treatment, insurance, and other areas.”); \textit{AFRAIDS: Protecting School Children, THE NEW REPUBLIC, Oct. 14, 1985, at 7} (“The AIDS issue has now spawned a second epidemic—a wave of hysteria whose symptoms include ostracism, discrimination, and violence.”).  

\textsuperscript{12} \textit{E.R. Shipp, Physical Suffering Is Not the Only Pain That AIDS Can Inflict, N.Y. TIMES, Feb. 17, 1986, at A8.} In a Gallup poll taken one month earlier, more than one-third of Americans said that they “have a less favorable attitude toward homosexuals because of AIDS.” \textit{Id.}  

\textsuperscript{13} \textit{See id.}
\end{flushright}
this reason alone; and 17% said that those with AIDS should be treated as those with leprosy once were—by being sent to "far-off islands."

Tragically, this ignorance and discrimination continues. In a recent survey conducted by the Centers for Disease Control, nearly one in five Americans polled felt that people living with HIV "have gotten what they deserve." Forty percent of those polled believed that HIV transmission could occur through sharing the same drinking glass and 41% believed that transmission could occur from being coughed or sneezed on by a person living with HIV.

Thus a new civil rights battle—the battle against HIV/AIDS discrimination—was born of the epidemic, one that would sorely test the ability of courts to protect the interests of those with multiple stigmas—including people of color, gay individuals, prisoners, intravenous drug users, and a combination of one or more of these categories. Unfortunately, the United States Supreme Court refused to hear a case involving HIV or AIDS for more than a decade after the first petition for certiorari in such a case was filed in 1987. Consequently, the Supreme Court did not decide its first case involving HIV/AIDS until 1998, fully 17 years after AIDS was first identified in this country. "On more than twenty-five occasions since 1987," one commentator explains, "the Supreme Court refused to grant writs of certiorari in HIV-AIDS cases," doing "absolutely nothing directly to curb the human rights abuses that have attended the HIV-AIDS epidemic." Additionally, many of the initiatives taken by state and local authorities are not subject to federal claims, leaving the rights of those affected to be determined in state court. State supreme courts have thus served as the ultimate arbiters of the rights of people living with HIV and AIDS. It appears, however,

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14 Stein, supra note 5.
16 Id.
17 See David Schulman, AIDS and Civil Rights, 10 WHITTIER L. REV. 397, 398 (1988) ("AIDS and civil rights interrelate as a new challenge to the old impulses to stigmatize and victimize.").
20 Closen, supra note 18, at 900–01.
21 Id. at 900.
that no one has attempted an analysis of state supreme court jurisprudence regarding HIV and AIDS to determine how this new class has fared in our courts.

Rather than attempt an unwieldy examination of all 50 state supreme courts, this article examines the jurisprudence of the court at the epicenter of the AIDS epidemic: the New York Court of Appeals (the "Court").\textsuperscript{22} From the beginning of the AIDS epidemic, New York has led all states with both the highest number of reported AIDS cases and the highest AIDS incidence rates.\textsuperscript{23} New York reported 139,248 AIDS cases through June 2000, which is more than 19% of the 728,694 AIDS cases confirmed in the United States from the inception of the epidemic.\textsuperscript{24}

This Article concludes that, with some notable exceptions, the Court has failed to exercise the careful scrutiny that this new struggle demands, with some regrettable consequences. The discussion reveals, for example, that the Court upheld a decision denying prisoners with HIV the right to visit not only with spouses but also with parents or siblings, despite common medical knowledge at the time that HIV could not be spread through casual contact.\textsuperscript{25} Further, the Court accepted unfounded contentions that failure to impose HIV tests would bankrupt the insurance industry, notwithstanding contemporary wisdom that HIV would not bankrupt the insurance industry, and that HIV could not be distinguished in a principled manner.

\textsuperscript{22} See BAYER, supra note 3, at 104–05 ("N.Y., the epicenter of the American AIDS epidemic . . . "); AIDS Grant Program Initiated, AIDS WKLY, March 6, 2000 ("In the U.S., New York City is considered to be the epicenter of the HIV/AIDS epidemic . . . ").

\textsuperscript{23} See, e.g., CENTER FOR DISEASE CONTROL, HIV/AIDS Surveillance Report, AIDS Cases and Annual Rates per 100,000 Population, by Area and Age Group, Reported Through June 2000, United States, (Dec. 27, 2000), available at <www.cdc.gov/hiv/stats/hasr1201/table2.htm> [hereinafter Surveillance Report]. This was also the case, for example, when the Court heard its first case in 1987. See Jo-Ann Moriarty, Untitled, STATES NEW SERVICE, June 5, 1987 ("New York and California currently lead the country with the greatest number of reported AIDS cases, with numbers at 10,726 and 8,027 logged since June 1, 1981 . . . ").

\textsuperscript{24} See Surveillance Report, supra note 23 (showing New York State with the leading number of cases and the highest annual rates); see also STATE OF NEW YORK, DEPT OF HEALTH, AIDS IN NEW YORK STATE 56 (1998-99) ("More than 122,500 AIDS cases were confirmed in New York State through the end of 1997. New York State continues to lead the country in annual and cumulative AIDS incidence; cases diagnosed in New York State accounted for more than 19 percent of the 641,086 AIDS cases confirmed in the United States through December 1997.").

\textsuperscript{25} See infra notes 97–101 and accompanying text.
from equally expensive conditions for which no test was imposed.\textsuperscript{26}

The Court has also been greatly inconsistent in its deference to State authorities dealing with HIV and AIDS. In \textit{Doe v. Coughlin,}\textsuperscript{27} for example, the Court showed great deference to prison authorities ostensibly acting to protect the public health of the nonprison community, a matter outside of their area of expertise and authority.\textsuperscript{28} In \textit{Health Insurance Ass'n. of America v. Corcoran,}\textsuperscript{29} by contrast, the Court refused to defer to both the Superintendent of Insurance and the Commissioner of Health on matters squarely within their areas of expertise and authority, even accusing them, without support, of effecting their own personal objectives in implementing non-coercive measures to combat the spread of HIV.\textsuperscript{30} One year later, the Court unanimously upheld the Commissioner of Health's decision to implement virtually the same non-coercive measures, failing to distinguish or even discuss its prior ruling.\textsuperscript{31}

There have been some good decisions, including the Court's most recent in \textit{Hernandez v. Barrios-Paoli.}\textsuperscript{32} As the discussion reveals, however, these have been sandwiched between poor, even dreadful decisions, from \textit{Doe} in 1987 to \textit{Mixon v. Grinker}\textsuperscript{33} in 1996. All told, this Article reveals a disturbing failure to scrutinize sweeping assertions of necessity in the face of crisis. In particular, this Article reveals a failure to firmly protect the civil rights and civil liberties of multiple-stigmatized individuals against the unfounded claims of public officials, who shroud their actions in the garb of official sanction.\textsuperscript{34} It is precisely at

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\item \textsuperscript{26} See infra notes 170–91 and accompanying text.
\item \textsuperscript{27} 518 N.E.2d 536 (N.Y. 1987).
\item \textsuperscript{28} See infra notes 77–96 and accompanying text.
\item \textsuperscript{29} 565 N.E.2d 1264 (N.Y. 1990).
\item \textsuperscript{30} See infra notes 212–16 and accompanying text.
\item \textsuperscript{31} See N.Y. State Soc'y of Surgeons v. Axelrod, 572 N.E.2d 605 (N.Y. 1991); see also infra notes 227–70 and accompanying text.
\item \textsuperscript{32} 720 N.E.2d 866 (N.Y. 1999) (holding that eligibility verification review cannot be part of the required process to determine eligibility for the Division of AIDS Services and Income Support).
\item \textsuperscript{33} 669 N.E.2d 819 (N.Y. 1996) (holding that HIV infected homeless are not constitutionally or statutorily entitled to medically appropriate housing).
\item \textsuperscript{34} If nothing else, the AIDS crisis has revealed the inherent fallibility of public officials, whose proposals for dealing with the HIV epidemic have ranged from the ill-conceived to the downright invidious. In 1987, for example, the year that the Supreme Court first denied certiorari in a case involving HIV/AIDS, and the year of the New York Court of Appeals' first decision on HIV/AIDS, Senator Jesse Helms
times of crisis that the fairness of our judicial system is tested. As Justice Marshall warned: "History teaches that grave threats to liberty often come in time of urgency, when constitutional rights seem too extravagant to endure." The Court at the epicenter of the AIDS crisis, has fared poorly on this test.

This Article examines a total of eight cases involving HIV and AIDS in chronological order. Each of these cases is assessed in the context in which it was decided, i.e., utilizing medical and public health information available to the Court at the time of the decision. In addition, wherever possible, the cases are compared and contrasted to identify consistencies or inconsistencies in the Court's reasoning. A brief conclusion follows.

I. **DOE v. COUGHLIN (1987)**

A. **Background**

Appellants John and Jane Doe were married in June of 1985. At the time, John Doe was an inmate at the Auburn Correctional Facility serving a sentence of 5.5 to 11 years. In October of 1985, Mr. Doe qualified for the prison's Family Reunion Program (the "Program"), and the Does were granted a two-day conjugal visit in a trailer located on prison grounds.

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36 Although HIV and AIDS played a part in other cases reaching the Court, these eight have been selected because of the centrality of HIV and AIDS to the decisions.


38 The Program permits selected inmates to spend a period of days with their spouses and certain relatives in a private trailer located on the prison complex. The stated purpose of the Program was to "preserve, enhance and strengthen family ties that have been disrupted as a result of incarceration," in order to help inmates
Participation in the Program was governed by regulations issued by the New York State Department of Correctional Services. These regulations established a list of 15 factors to be considered in determining whether to grant a prisoner access to the Program, including whether the prisoner had received a "diagnosis as having a communicable disease."\(^3\)

In December of 1985, Mr. Doe was diagnosed with AIDS, and respondents, various corrections officials ("Respondents"), denied the Does any further conjugal visits on the grounds that Mr. Doe had been diagnosed "as having a communicable disease."\(^4\) The Does then filed suit alleging, inter alia, that Respondents' decision to revoke their right to conjugal visits violated their state and federal constitutional rights.\(^4\) In a 4-3 decision written by Judge Simons, a plurality affirmed the lower court rulings dismissing the Does' petition. The decision was extremely close, however, with Judges Bellacosa and Wachtler issuing concurrences and Judges Alexander, Hancock, Jr., and Kaye, issuing a forceful dissent.\(^4\)

### B. The Decision

The Does advanced two independent constitutional claims: violation of their right to privacy and violation of the equal protection clause of the Fourteenth Amendment. Examining

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\(^{39}\) *Coughlin*, 518 N.E.2d at 541 n.1 (citing N.Y. COMP. CODES R. & REGS. tit. 7, § 220.3 (a)-(c) (1995)). The fifteen factors are the prisoner's (1) length of time in incarceration; (2) degree of institutional adjustment; (3) eligibility for temporary release; (4) security classification; (5) assignment to a special housing unit; (6) pattern of disruptive behavior; (7) prior violations of Family Reunion Program regulations; (8) designation as a central monitoring case; (9) outstanding warrants; (10) nature of conviction; (11) parole violation status; (12) protective custody status; (13) participation in some other special program; (14) assignment to a mental hygiene unit; and (15) diagnosis as having a communicable disease. See *id*.

\(^{40}\) *Id.* at 538.

\(^{41}\) The Does also alleged that Respondents' decision was arbitrary and capricious, and unlawfully discriminated against Mr. Doe on the basis of his disability, in violation of the Federal Rehabilitation Act of 1973. For the sake of brevity, this Article examines only the Does' constitutional claims.

\(^{42}\) The New York Law Journal noted that the case "produced a highly unusual division of the court, which [had] been unanimous in more than 90% of the cases decided by it in the last two years." E.J. McMahon, *Ban Upheld on Conjugal Visits to State Prisoners with AIDS*, N.Y. L.J., Nov. 25, 1987, at 1, col. 3.; accord Jeffrey Schmalz, *New York Court Upholds Conjugal-Visit Ban for Inmate with AIDS*, N.Y. TIMES, Nov. 25, 1987, at B11 ("The court was unusually sharply divided.").
each of these claims in turn, Judge Simons first noted that although "[a]n individual does not automatically forfeit all constitutional rights upon conviction of a crime,"\footnote{Coughlin, 518 N.E.2d at 539.} he does lose his liberty upon imprisonment, and "his rights are necessarily limited by the realities of confinement and by the legitimate goals and policies of the correctional system."\footnote{Id. ("[A]n inmate retains only those rights which 'are not inconsistent with his status as a prisoner or with the legitimate penological objectives of the correctional system.'").} In particular, courts have uniformly held that neither a prisoner nor his spouse has a right to conjugal relations or visitation.\footnote{See id. at 540.} Accordingly, Judge Simons concluded, the Does' privacy claim must fail, for, "although prisoners retain some rights to privacy, the right to conjugal relations has not been included among them."\footnote{Id. at 548.} Judge Simons' conceptualization of the Does' privacy claim as a claim for the right to conjugal visitation or relations was critical to his perfunctory rejection of their claim. If, as Judge Simons saw it, the Does were seeking to establish a right to conjugal visitation, their claim must fail, because courts had consistently refused to establish such a right. Notably, however, the majority of judges disagreed with this limited conceptualization. Both of the concurrences and the dissent—a total of five judges—recognized that far more was at stake than the right to conjugal visitation.

Indeed, contrary to Judge Simons' characterization, the general right to conjugal visitation was never at issue in Doe. As the dissent explained, "Petitioners neither assert that respondent is required to establish a conjugal visitation program, nor do they argue that respondent must affirmatively provide all inmates access to the Family Reunion Program at facilities where it is instituted."\footnote{Id. at 548.} Rather, the Does claimed that Respondents' decision was based exclusively upon the concern that the Does would engage in sexual relations, thus implicating a more fundamental marital right. "[I]t must be recognized," Judge Wachtler explained in his concurrence, "that the decision at issue here was not based, for example, upon the Commissioner's dispassionate assessment of the extent of prison resources. Instead, his decision was based upon a calculated risk
that, if left alone, the inmate and his wife as a married couple would engage in sexual relations."48 What was at stake, then, was not the right to conjugal visitation, but the right of married couples to engage in sexual relations. Both the concurrences and the dissent emphasized this point.49

Addressing both the concurrences and the dissent, Judge Simons responded that, "rather than restrict a right, [Respondents] regulated a benefit available to those qualified."50 This is, however, tautological: it was Respondents' determination that the Does were not qualified for the Program that required closer scrutiny, and it required such scrutiny because it directly implicated the exercise of a fundamental constitutional right, not merely a request for a "benefit." The Does argued that they were, in fact, qualified, and that Respondents' determination that they were not qualified was constitutionally insufficient. The implication that the Does were not "qualified" for the "benefit," then, was doubly misleading.

Judge Simons' rejection of the Does' privacy claim led, inevitably, to his rejection of their equal protection claim. If, as Judge Simons found, the Does' claim did not implicate fundamental constitutional rights, then Respondents' decision needed only to survive a rational basis test. "Because the entitlement of selected inmates to conjugal visits is not a matter of constitutional right," Judge Simons explained, "petitioners' equal protection claim must be rejected if the Correction Department's ruling bears a rational relationship to a legitimate

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48 Id. at 545. The dissent similarly observed that the Does were denied the benefits of the Program "solely because of the manner in which they may choose to exercise their marital right." Id. at 549; accord id. at 546 (identifying basis of Commissioner's decision "to shield petitioner wife from infection should the two decide to engage in sexual relations").

49 Although a prisoner may have no liberty interest in participating in the Program, Judge Wachtler observed, "[A] higher standard of scrutiny is required because the decision to disallow participation is based upon how the inmate will exercise other, constitutionally protected rights." Coughlin, 518 N.E.2d at 545 (Wachtler, J., concurring). Judge Bellacosa agreed with Judge Wachtler, expressly acknowledging the existence of "other facets of inmates' rights to privacy which might implicate fundamental constitutional protections." Id. at 544 (Bellacosa, J., concurring). Similarly, Judge Alexander observed that "[t]he basis for this determination, in effect, invades a part of the fundamental marital right—the area of personal intimate decision-making between husband and wife—that survives incarceration." Id. at 549 (Alexander, J., dissenting).

50 Id. at 543 (emphasis added).
Once again, Judge Simons simply ignored the judgment of the majority of justices that the gravamen of the Does' privacy claim was not entitlement to conjugal visitation but the fundamental constitutional right to marital intimacy.\footnote{Id. at 542.} Applying the rational basis test, Judge Simons first underscored "the recognized danger of AIDS."\footnote{Id. at 542.} He then noted that the New York Correction Law expressly directs that Respondents give "due regard to . . . the safety and security of the community."\footnote{Id. at 543 (quoting N.Y. CORRECT. LAW § 70(2)(a) (McKinney 1987)).} Citing no authority, Judge Simons explained that "[p]reventing the spread of communicable diseases to those outside the prison comes within the statutory direction."\footnote{Id.} Given the recognized danger of AIDS, and "the fact that respondents cannot guarantee the disease would not be spread to a nonprisoner if petitioners are afforded conjugal visits," Judge Simons concluded that Respondents had a rational basis for excluding the Does from the Program.\footnote{Id. at 542.} That the Does might abstain from having sex, or that they might reduce the danger of transmission through safe sexual practices, did not alter this conclusion. "The possibility remains that permitting petitioners' participation in the conjugal visit program may result in the spread of a serious communicable disease."\footnote{Id.}

The question of harm to members of the prison community was never at issue in \textit{Doe}. Likewise, the potential spread of the HIV virus to Mrs. Doe was irrelevant to Judge Simon's decision.\footnote{Judge Simons was careful to note that Respondents' decision was not based upon the risk of harm to Ms. Doe. See \textit{id.} at 542 n.3 ("[R]espondents' concern manifestly extends beyond assumption of the risk involved to her personally.").} The decision was based solely upon the threat posed to the "community" outside of the prison. In a footnote, Judge Simons explained the basis of this threat.\footnote{See \textit{id.}} Mrs. Doe could possibly contract the HIV virus from Mr. Doe during a conjugal visit. Subsequently, "Jane Doe may become pregnant and transmit the disease to her child or . . . she may become single in the future, either by divorce or widowhood."\footnote{See \textit{id.}} Accordingly,
Judge Simons explained, Respondents' decision "bore a rational relationship to the proper and successful operation of the program and particularly to the spread of communicable diseases to nonprisoners."61 To buttress his argument, Judge Simons added that "[t]he courts traditionally have deferred to the discretion of correction officials on matters relating to the administration of prison facilities and rehabilitation programs."62

There are two critical problems with the plurality's decision, both of which bespeak an unwillingness to carefully scrutinize the actions of public officials in responding to this new and misunderstood "plague."63 First, Judge Simons applied the wrong test—minimal, "rational basis" scrutiny—to the Does' equal protection claim.64 Accordingly, Judge Simons failed to closely examine the extremely tenuous and speculative grounds upon which Respondents based their decision to exclude the Does. Second, and relatedly, Judge Simons accorded great deference to correction officials with regard to a matter not within the officials' area of superior knowledge and expertise. This undue deference led the plurality blindly to accept Respondents' argument that their decision was justified by the statutory obligation to consider "the safety and security of the community" outside of the prison. Each of these problems is addressed below.

In Turner v. Safley,65 the Supreme Court articulated the standard by which constitutional challenges to prison restrictions should be judged. The Supreme Court ruled that "when a prison regulation impinges on inmates' constitutional

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61 Id. at 544.
62 Id. at 543.
63 See supra note 4.
64 The majority of judges actually argued for a more heightened scrutiny to be applied to the Does' constitutional claims than the rational basis test that Judge Simons applied. See id. at 544 (Bellacosa, J., concurring) ("[A] higher test than rational basis would be necessary to pass constitutional challenge . . . ."); see id. at 545 (Wachtler, J., concurring) ("[A] higher standard of scrutiny is required because the decision to disallow participation is based upon how the inmate will exercise other, constitutionally protected rights."); see id. at 546 (Alexander, J., dissenting) ("[A] higher level of scrutiny is required . . . ."); see also Kozlowski v. Coughlin, 711 F. Supp. 83, 87 (S.D.N.Y. 1988), aff'd, 871 F.2d 241 (2d Cir. 1989) ("Although the plurality found that the inmate had no constitutional right to marital privacy, a majority of the court, including Chief Judge Wachtler in his concurring opinion, concluded that such a right existed and that its infringement should be subject to a heightened level of scrutiny.") (citation omitted).
rights, the regulation is valid if it is reasonably related to legitimate penological interests." As Judge Alexander explained, although this standard does not compel strict scrutiny of the regulation, "neither is it satisfied upon the finding of a mere 'rational basis' related to a general interest." Under both the federal and state constitutions, what is "central" to the court's approach, "is a weighing or balancing of the nature and importance of the right asserted against the purposes advanced for the prison regulation or practice. And, critical to either analysis is that the interest advanced by the prison relate to the purposes or administration of correction facilities."

Judge Simons never weighed the rights of the Does against the purposes advanced by Respondents, and his application of the rational basis test precluded any searching inquiry into the legitimacy of the authorities' ostensible justification. In fact, as we shall discuss, matters concerning the health of the nonprisoner community were not within the discretionary powers of Respondents. Not only was the basis of Respondents' authority tenuous, but the decision itself was based entirely upon a highly speculative potential threat:

Any connection between respondent's policy and the asserted interest...is tenuous. Respondent's determination, at bottom, is based on a series of speculations and unwarranted

66 Id. at 89; accord O'Lone v. Estate of Shabazz, 482 U.S. 342, 350 (1987) ("First, a regulation must have a logical connection to legitimate governmental interests invoked to justify it.").

67 For the argument that the Doe Court should have applied strict scrutiny to the Does' claim, see Simeon Goldstein, Note, Prisoners with AIDS: Constitutional and Statutory Rights Implicated in Family Visitation Programs, 31 B.C. L. REV. 967, 1008 (1990) ("The Doe court should have employed strict scrutiny as the standard of review for conjugal visit regulations."). For the argument that courts should apply a more demanding standard than the rational basis test to cases involving HIV, see Sean Doyle, Note, HIV-Positive, Equal Protection Negative, 81 GEO. L.J. 375 (1992). Doyle urges courts to closely "examine the medical reality behind the policymaker's assertions to expose what motivated their choice of means." Id. at 407.

68 Coughlin, 518 N.E.2d at 549 (Alexander, J., dissenting).

69 See id. at 550. Again both Judge Wachtler and Judge Bellacosa, in their concurrences, agreed that the higher standard should have been applied. Both were persuaded, however, that the authorities met this higher standard. See id. at 544 (Bellacosa, J., concurring); Id. at 545 (Wachtler, J., concurring) ("I agree with the result reached by the plurality, however, because I believe that under the higher scrutiny required by the implication of a constitutional right the Commissioner's decision has a sufficient basis.") (citations omitted).

70 See discussion infra notes 76–96 and accompanying text.
presumptions: that petitioners necessarily will use their private
time together to engage in sexual relations, that they
necessarily will disregard the advice of their professional health
counselors and not employ “safe sex” techniques, that
petitioner wife necessarily will contract AIDS from her
husband, and that petitioner wife necessarily will engage in
adulterous sexual activities with others—without the use of
prophylactics—and thereby transmit the virus to the
population at large.\footnote{Coughlin, 518 N.E.2d at 551 (Alexander, J., dissenting); see also Turner v.
Safley, 482 U.S. 78, 101 n. 1 (1987) (Stevens, J., concurring in part and dissenting in part) (warning that the majority’s “rather open-ended ‘reasonableness’ standard makes it much too easy to uphold restrictions on prisoners’ First Amendment rights on the basis of administrative concerns and \textit{speculation about possible security risks} rather than on the basis of evidence that the restrictions are needed to further an important governmental interest.”) (emphasis added).}

Responding to this assertion, Judge Simons noted that Ms.
Doe could also transmit the virus to her child through pregnancy
or she could become single in the future, “either by divorce or
widowhood.”\footnote{Perinatal transmission is by no means certain. See, \textit{e.g.}, Bragdon v. Abbot,
524 U.S. 624, 640 (1998) (“Petitioner concedes that women infected with HIV face about a 25% risk of transmitting the virus to their children. Published reports available in 1994 confirm the accuracy of this statistic.”) (citations omitted); Leonardo Renna, Note, \textit{New York State’s Proposal to Unblind HIV Testing for Newborns: A Necessary Step in Addressing a Critical Problem}, 60 BROOK. L. REV.
407, 412 (1994) (“Studies have shown that the rate of perinatal transmission is approximately one-in-three, with estimates ranging from 15 to 39\%.”).}

Judge Simons’ additional hypotheticals, however, made the plurality’s decision no less tenuous.

\textit{First}, with respect to potential perinatal transmission, the
decision was still based upon the assumptions articulated by the
dissent, and, in addition, the assumption that the virus would be
transmitted to the fetus,\footnote{See discussion \textit{supra} note 54 and accompanying text.} and that the as yet unconceived fetus
was a member of the “community.” This last point, never raised
by the dissent, is perhaps the most important of all.

Respondents’ justification for precluding the Does from the
Program was based entirely upon the statutory requirement that
Respondents give due regard to the “community.”\footnote{Because abortion is a legal option in this country, moreover, Respondent’s
decision must also have been based upon the assumption that the Does would}
Second, with respect to Ms. Doe's potentially becoming single in the future, the decision was likewise based upon the assumptions articulated by the dissent, and, in addition, the following assumptions: that after contracting the virus, Ms. Doe would divorce Mr. Doe or become widowed; that Ms. Doe would then engage in unprotected sex with another person; and that the third party would thereby contract the virus from Ms. Doe.\(^7^6\)

Judge Simons not only utilized an insufficient test in examining the "State purpose" of excluding the Does, but he erroneously deemed that purpose "penological":

The establishment of such [conjugal visitation] programs comes within the authority delegated to correction officials to exercise general responsibility for care and confinement of criminals and for instituting programs for their treatment and rehabilitation. The fulfillment of those penological objectives requires administrative regulations consistent not only with the safety and health of those within the prison facility, but also with the safety of society generally.\(^7^7\)

Judge Simons was correct in observing that the establishment of visitation programs comes "within the authority delegated to correction officials to exercise general responsibility for care and confinement of criminals and for instituting programs for their treatment and rehabilitation."\(^7^8\) He then, however, baldly linked these "penological objectives" with the discretionary authority to protect "the safety of society generally."\(^7^9\)

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\(^7^6\) There is, of course, a further assumption built in to this hypothetical: that Ms. Doe, upon becoming single, would continue to reside in the "community," and that the third party to whom she passed the virus would also reside in the "community." Under the plain meaning of the statute, Respondents are not cloaked with the authority to consider the safety of the entire country, or the world, for that matter. Rather, if the safety of those outside of the prison community fall within this term at all, it must refer merely to those in the community surrounding the prison. Arguably, then, if Ms. Doe moved to Florida following her divorce of Mr. Doe, her actions would be beyond the discretionary consideration of Respondents.

\(^7^7\) Coughlin, 518 N.E.2d at 543; see also id. at 543 (Inmates "forfeit this right [to privacy] upon incarceration for the most basic and legitimate penological reasons, punishment, security and deterrence.") (emphasis added).

\(^7^8\) Id. at 543.

\(^7^9\) Id.; see also Goldstein, supra note 67, at 1008 ("[P]rison regulations should address matters of institutional security, not public health, particularly when statutory references to community safety and security have focused on the escape or presence of dangerous criminals, not the containment of sexually transmitted
Judge Simons simply did not, and could not, demonstrate how the safety of society generally falls within the traditional responsibilities for the "care and confinement of criminals" or for "their treatment and rehabilitation."80 As Judge Alexander ably pointed out: "Respondent does not articulate any concern for institutional security, does not identify any interest in the safety of petitioner husband or the prison employees, and does not advance a single interest that would further a penological purpose or facilitate prison administration."81

The traditional justification for the Court's exercise of judicial restraint in prison cases was plainly lacking in Doe. In a series of prison cases preceding Doe, the United States Supreme Court explained the rationale for exercising judicial restraint when reviewing prison regulations and policies, and, concomitantly, for according deference to the decisions and judgments of prison authorities. In Preiser v. Rodriguez,82 the Court explained that "internal problems of state prisons involve issues . . . peculiarly within the state authority and expertise."83 One year later, in Procunier v. Martinez,84 the Court announced that "courts are ill-equipped to deal with the increasingly urgent problems of prison administration and reform."85 In Block v. Rutherford,86 the Court "refused to "substitute our judgment on. . . difficult and sensitive matters of institutional administration."87 Finally, in Turner v. Safely, decided just months before Doe, the Court announced: "Prison administration

diseases.").

80 Coughlin, 518 N.E.2d at 543.

81 Id. at 551 (Alexander, J., dissenting). Judge Alexander reiterated this point throughout the dissent: "Respondent has not shown how its policy bears any relationship to the traditional purposes of incarceration, or how it addresses concerns for institutional security and administration." Id. at 551 (Alexander, J., dissenting); see also id. at 546 (Alexander, J., dissenting) ("[R]espondent advances neither an institutional concern nor a penological purpose in support of his determination."); id. at 551 (Alexander, J., dissenting) ("Respondent's determination has no impact on the prison community. The asserted interest is not a penological one."); id. at 554 (Alexander, J., dissenting) ("[R]espondent has not proffered an institutional or penological purpose for classifying petitioner husband differently.").


83 Id. at 492.


85 Id. at 405; see also Pell v. Procunier, 417 U.S. 817, 827 (1974) (noting the "measure of judicial deference owed to correction officials").


87 Id. at 588.
is . . . a task that has been committed to the responsibility of those [executive and legislative branches], and separation of powers concerns counsel a policy of judicial restraint.”

The public health matter at issue in *Doe*, by contrast, was not an “internal problem[] of state prisons”; it did not “involve issues . . . peculiarly within the state authority and expertise”; and it did not involve “prison administration and reform” or “institutional administration.” Most important of all, protecting against a potential threat to public health was not “a task . . . committed to the responsibility of [Respondents].” As the dissent pointed out, “[T]he Legislature has not delegated to the Department of Correctional Services the authority to regulate in matters relating to public health.” That authority was delegated to the Public Health Council. Accordingly, the plurality in *Doe* should not have deferred to Respondents in an area that they were ill-equipped to handle.

In fact, Respondents’ actions evidenced a disturbing lack of expertise and sensitivity in handling the public health matter at issue. For example, after Mr. Doe was diagnosed with AIDS, Mrs. Doe was forced to visit him in the prison hospital, under deplorable conditions. Mr. Doe was forced to sit in a chair in the doorway of the hospital’s isolation room while Mrs. Doe was forced to sit in the hospital’s main corridor, “with a table placed between them and a correction officer in close proximity.” The Does were thus denied not only sexual intimacy, but also any privacy or human contact, forced to endure a dehumanizing and wholly unnecessary separation during their visits. Indeed, even at the time of Respondents’ decision, it was known that the HIV virus could not be spread through casual contact. A similar

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90 Id.
93 Turner, 482 U.S. at 85.
95 See N.Y. PUB. HEALTH LAW § 225 (McKinney 1990).
96 See Goldstein, supra note 67, at 1024 (“When such officials act outside the realm of their expertise and knowledge, traditional judicial deference is no longer appropriate.”).
97 Coughlin, 518 N.E.2d at 550 (Alexander, J., dissenting).
98 Judge Alexander noted that Mr. Doe could not transmit the virus to other family members “according to the medical evidence in the record.” Doe, 518 N.E.2d
ignorance and insensitivity lead Respondents to deny Mr. Doe's petition to visit privately with other family members as permitted under the Program. There was simply no penological basis, and certainly no medical basis, for this decision.

Finally, the decision to deny the Does the right to participate was itself medically unsound. As both the New York

99 See Coughlin, 518 N.E.2d at 551 (Alexander, J., dissenting). Respondents' decision to bar visits even with other family members was quite significant, since the majority, or 60% of family reunion visits under the Program were with parents or siblings. See McMahon, supra note 42.

100 In Turner v. Safely, the Supreme Court explained that courts should consider the impact that accommodating the inmate's request would have on guards and other inmates, and on the allocation of prison resources generally. 482 U.S. 78, 90 (1987); accord O'Leary v. Estate of Shabazz, 482 U.S. 342 (1987). The Supreme Court explained that "[w]hen accommodation of an asserted right will have a significant 'ripple effect' on fellow inmates or prison staff, courts should be particularly deferential to the informed discretion of corrections officials." 482 U.S. at 90. The decision to accommodate Mr. Doe would not have taxed prison resources or otherwise negatively affected other inmates or on prison guards. If anything, Respondents' decision to preclude the Does would have the "ripple effect" of deterring other inmates from taking an HIV test, thereby increasing the likelihood of transmission through conjugal visits with untested inmates living with HIV. See discussion infra notes 102-06 and accompanying text.

101 See Goldstein, supra note 67, at 1010-11 ("Given that family members were at no risk of contracting the virus through casual contact with their AIDS-infected relative, the prohibition of conjugal visits by prison officials was merely a pretext for discriminating against John Doe.").
State Commissioner of Health and the State Superintendent of Insurance knew, and, ironically, as the New York Court of Appeals would affirm four years after Doe, penalizing individuals who test positive for the HIV virus serves as a strong deterrent to testing. If individuals do not test for HIV, they cannot learn of their status, leading to the unwitting spread of the disease from untested individuals to their spouses. This may well have happened in New York. In reversing the ill-conceived policy four years after Doe, Commissioner Coughlin himself acknowledged that Respondents' policy had served as a strong deterrent to HIV testing among married prisoners. "[Commissioner Coughlin] said he believed that several thousand married prisoners had been refusing to take the test in recent years for fear that a positive result could cut them off

102 See Doe v. Coughlin, 509 N.Y.S.2d 209, 211 (3d Dep't 1986) ("Petitioners challenge respondents' findings that AIDS is a communicable disease on the ground that the Department of Health, which has the expertise in matters of disease classification while the Department of Correctional Services does not, has not classified AIDS as a communicable disease, but, rather, as a 'reportable' disease.") (citation omitted).

103 See discussion infra notes 227-70 and accompanying text.

104 Three years after Doe, the New York State AIDS Advisory Council's Ad Hoc Committee on AIDS in Correctional Facilities would recommend allowing conjugal visits based upon this very principle: "Prohibiting conjugal and family visits is a counter-productive policy because it will discourage prisoner from being tested for HIV infection. . . . Discriminating against those who acquire knowledge about their HIV status is a chilling punishment for decent and responsible behavior." Nancy Neveloff Dubler et al., Management of HIV Infection in New York State Prisons, 21 COLUM. HUM. RTS. L. REV. 363, 398 (1990).

105 "Because [New York] state law forbids mandatory testing for AIDS, the state has had no way of barring visits from spouses of untested prisoners even if those prisoners do have the disease." Sam Howe Verhovek, Spouse Visits for Inmates with HIV, N.Y. TIMES, August 5, 1991, at B1. According to an official prison estimate, in 1991, about 8,500, or 15% of the State's prisoners were believed to be living with HIV, but because most inmates refused testing, "only about 2,500 [were] known by the state to have the virus." Id. In Bullock v. Gomez, 929 F. Supp. 1299 (C.D. Cal. 1996), a California district court examined a similar challenge to California's prohibition of spousal conjugal visits for prisoners living with HIV. In denying defendants' summary judgment motion, the court rejected defendants' argument that their policy was based upon legitimate penological concerns. Among other things, the court questioned whether the policy was crafted to prevent the transmission of HIV considering the fact that, without mandatory testing in the prison, "[o]nly one-third of the inmates estimated to be HIV positive are identified as such," and that "it is general knowledge that unidentified HIV positive inmates use the overnight visiting areas for conjugal visits." Id. at 1907. The court cited expert testimony indicating that "one of the reasons that a significant number of HIV positive prisoners have not tested for HIV is that there are disincentives, the prohibition on conjugal visits being one such disincentive." Id. (citations omitted).
The great irony, or tragedy, of the decision to uphold Respondents' policy is that it was far more likely to result in the spread of the HIV virus in the "community," by unwitting, untested individuals, than permitting conjugal visits among individuals living with HIV who had received safe sex counseling, such as the Does. This was the price of deferring to authorities who lacked the expertise to draft policies best-suited to protect the public health of the community. As we shall see, public health authorities, in stark contrast, intentionally eschewed adopting measures that would deter testing among individuals at risk of contracting HIV illness. If the plurality had not been so intent on blindly adhering to the

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106 Verhovek, supra note 105.

107 For an alternative public health argument in favor of permitting prisoners living with HIV to participate in conjugal visits, see Thomas M. Bates, Rethinking Conjugal Visitation in Light of the 'AIDS' Crisis, 15 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT, 121-45 (1989). Bates argues that conjugal visits reduce gay sexual activity in prison, thereby reducing the spread of the virus. See Victoria P. Pappas, Note, In Prison with AIDS: The Constitutionality of Mass Screening and Segregation Policies, 1988 U. ILL. L. REV. 151, 172 n.177 (1988) ("Still other correctional experts recommend allowing inmates conjugal visits as a step toward reducing the spread of AIDS. These experts believe such visits would serve to satisfy inmates' sexual needs, thus decreasing inmates' desires to engage in consensual and/or nonconsensual homosexual relations.").

108 One of the factors that the Supreme Court determined to be relevant in determining the reasonableness of a prison regulation or decision is the presence or absence of "ready alternatives." Turner v. Safely, 482 U.S. 78, 90 (1987). The existence of alternatives, the Court has held, "may be evidence that the regulation is not reasonable, but is an 'exaggerated response' to prison concerns." Id.; accord Pell v. Procunier, 417 U.S. 817, 827 (1974). Hence, "if an inmate claimant can point to an alternative that fully accommodates the prisoner's rights at de minimis cost to valid penological interests, a court may consider that as evidence that the regulation does not satisfy the reasonable relationship standard." Turner, 482 U.S. at 91. Respondents' decision in Doe was an "exaggerated response" to the HIV/AIDS epidemic. The greatest evidence of this is, of course, Respondents' subsequent decision to reverse themselves and allow for conjugal visits provided that the couples receive [counseling on safe sex techniques]. See supra note 107 and accompanying text. This alternative carried no "cost to valid penological interests" and was actually an epidemiologically preferable alternative. Turner, 482 U.S. at 91. The manner in which the Does were forced to conduct their hospital visits, and Respondents' decision to deny even other family members the right to visit privately with Mr. Doe, certainly underscore the exaggerated nature of Respondents' response. It is noteworthy, in this regard, that at the time, Connecticut officials permitted inmates living with HIV to participate in conjugal visits provided that they and their families first met with the prison's medical director to discuss the risks of transmission. See Goldstein, supra note 67, at 994 n.239.

109 See infra notes 257-64 and accompanying text.
principle of judicial restraint, in an area where it was wholly
unwarranted, they might have agreed with the dissent that
Respondents' decision was "unjustifiable," and certainly
insufficient to trump the Does' fundamental constitutional
rights. Instead, prisoners living with HIV and their families
were forced to wait four more years until Respondents
themselves acknowledged, and reversed, the error of their ways.

II. WARE V. VALLEY STREAM HIGH SCHOOL DISTRICT
(1989)

Above all else, Ware v. Valley Stream High School District is a First Amendment decision, and an unusual one at that. Nonetheless, the regulations in question were promulgated to control the spread of HIV/AIDS, a recurrent theme in several of the Court's decisions regarding HIV/AIDS. The Court's treatment of the issue thus warrants a brief examination.

A. Background

In Ware, members of a religious group known as the
Plymouth Brethren (the "Brethren") challenged regulations
promulgated by the Commissioner of Education (the
"Commissioner") requiring all primary and secondary school
students to receive instruction about AIDS as violative of their
First Amendment right freely to exercise their religious
beliefs. The Brethren is a devoutly religious group dedicated
to strict adherence to Biblical teachings and separation from all
things they consider "evil." The regulations in question, promulgated pursuant to the Commissioner's statutory authority
and with the approval of the New York State Board of Regents, required that all primary and secondary students


\[112\] For a critique of Ware under the First Amendment, see Donna Marie
Werner, Ware v. Valley Stream High School District: At What Expense Should

\[113\] The First Amendment provides: "Congress shall make no law respecting an
establishment of religion, or prohibiting the free exercise thereof; or abridging the
freedom of speech, or of the press; or the right of the people peaceably to assemble,
and to petition the Government for a redress of grievances." U.S. CONST. amend. I.

\[114\] Ware, 550 N.E.2d at 422.

\[115\] See Ware v. Valley Stream High Sch. Dist., 545 N.Y.S.2d 316, 318 (2d Dep't 1989).
receive appropriate instruction concerning AIDS, including information "concerning the nature of the disease, methods of transmission, and methods of prevention,... stress[ing] abstinence as the most appropriate and effective premarital protection against AIDS." The regulations further provided that parents could request an exemption from AIDS-prevention lessons from any school principal upon assurance that they would provide suitable home instruction.

In November 1988, plaintiffs requested that the Valley Stream High School District exempt their children from the entire AIDS curriculum. The District denied plaintiffs' request but did exempt Brethren children from those portions of the curriculum dealing with "Prevention," which covered abstinence from illegal intravenous drug use and sexual activity to prevent transmission of HIV. In February 1989, plaintiffs filed suit, alleging that the AIDS curriculum conflicted with their strict religious belief "that followers not engage in sexual relations outside of marriage and not be exposed to instruction concerning sexuality or morality other than that which is imparted in the community." Plaintiffs also alleged that an exemption would not endanger the public in light of the improbability that their children would participate in activities that transmit HIV. The trial court granted defendants' motion for summary judgment and dismissed the complaint. The Appellate Division, Second Department affirmed.

B. The Decision

Writing for the majority, Judge Kaye noted that both the Commissioner and local officials "are vested with wide discretion in the management of school affairs." Judge Kaye

116 Id. at 316 (quoting N.Y. COMP. CODES R. & REGS. tit. 8, §§ 135.3(b)(2), (c)(2) (1995)).
117 Ware, 550 N.E.2d at 422 (citing N.Y. COMP. CODES R. & REGS. tit. 8, §§ 135.3(b)(2), (c)(2) (1995)).
118 Id. at 422.
119 Id. at 423.
120 Id.
121 Ware, 545 N.Y.S.2d 316, 321.
122 Ware, 550 N.E.2d at 425 (citations omitted).
added that "[d]eference to the education decisions of State and local officials—particularly in matters of curriculum—embodies several important concerns," and that "the judiciary should not lightly intrude in the resolution of school conflicts, which usually are best left to the education authorities." The regulations in question implicated basic constitutional rights under the First Amendment, however, warranting the Court's strict scrutiny. The Court proceeded to analyze plaintiffs' claim utilizing a two-part test, under which (1) plaintiffs must show a "sincerely held religious belief that is burdened by a State requirement," and (2) the State must demonstrate that the requirement nevertheless serves a compelling governmental purpose, and that an exemption would "substantially impede fulfillment of that goal." Addressing the first part of the test, the Court explained that "mere exposure to ideas that contradict religious beliefs does not impermissibly burden the free exercise of religion." Further, the First Amendment does not guarantee that school curriculum will not offend any religious group, and plaintiffs have no right to demand public school programs tailored to their individual preferences.

The Court ruled, however, that plaintiffs fit within the narrow, "mere exposure" exception that the Supreme Court recognized in Wisconsin v. Yoder. In Yoder, a group of Amish plaintiffs successfully asserted that a state law mandating school attendance until the age of 16 compelled them, "under threat of criminal sanction, to perform acts undeniably at odds with fundamental tenets of their religious beliefs," thus violating the Free Exercise Clause of the First Amendment. The Yoder plaintiffs alleged, in short, that compulsory school attendance

123 Id. (citations omitted).
124 Id. at 426.
125 Id. (citation omitted).
126 Id. at 427.
127 Id.
128 See, e.g., Lisa M. Sperry, Commercialism in New York Public Schools: State Versus Local Control, 5 ALB. L.J. SCI. & TECH. 339, 361 (1996) ("The exception to the general prohibition against protection from exposure to objectionable ideas is narrow. Exposure to ideas which are not merely offensive, but are abhorrent to the plaintiff's central and entrenched religious beliefs may be grounds for a violation of the Free Exercise Clause."). But see Werner, supra note 112, at 355–56 (arguing that no such exception exists).
130 Id. at 218.
threatened the continuing existence of the Amish community.\textsuperscript{131}

The \textit{Ware} plaintiffs similarly alleged that the mandatory AIDS curriculum “could alone destroy the foundations of their faith and ’jeopardize their place in the holy fellowship of God’s Son.’”\textsuperscript{132} The Court therefore concluded that, under \textit{Yoder}, plaintiffs might be able to demonstrate that they were impermissibly burdened by the regulations. The record was insufficient, however, to determine whether the AIDS curriculum was contrary to the Brethren’s beliefs or potentially destructive of the community as a whole. The Court accordingly remanded the case for further factual development on the questions whether “the free exercise of sincerely held religious beliefs is burdened by compulsory AIDS education, how great such a burden might be, and what if any further accommodation should be made.”\textsuperscript{133}

On the issue of compelling interest, the appellate division’s ruling was clear: citing the Court’s decision in \textit{Doe v. Coughlin}, the appellate division held that “the State’s interest in AIDS education on its face was so compelling that it necessarily would override plaintiffs’ free exercise rights.”\textsuperscript{134} The appellate division rejected plaintiffs’ argument that they could properly instruct their children at home, observing that “uncontradicted religious indoctrination which denies the existence of undeniable health crises does not provide a suitable alternative to education.”\textsuperscript{135} Finally, the appellate division rejected plaintiffs’ argument that an exemption would not endanger the public health given the unlikelihood that Brethren children would contract or pass the virus:

Significantly, the Brethren’s doctrine contemplates that some of its adherents may stray from its rigorous precepts and provides that “[sodomites], fornicators and adulterers [will be] withdrawn from” and may be cast out of the community. Such

\textsuperscript{131} See \textit{id.} at 212 (Plaintiffs’ expert testified that compulsory high school attendance would “ultimately result in the destruction of the Old Order Amish church community as it exists in the United States today.”).

\textsuperscript{132} \textit{Ware}, 550 N.E.2d at 430.

\textsuperscript{133} \textit{Id.} at 428.

\textsuperscript{134} \textit{Id.} at 429; see \textit{Ware v. Valley Stream High Sch. Dist.}, 545 N.Y.S.2d 316, 317 (2d Dep’t 1989) (“[W]e conclude that there are compelling and dominant State interests underlying the limited health education curriculum to which the appellants’ children will be exposed, and, accordingly, hold in favor of the respondents.”).

\textsuperscript{135} \textit{Ware}, 545 N.Y.S.2d at 321.
individuals, who would then be integrated into society-at-large, ignorant of AIDS and its methods of transmission and prevention, will surely be at risk and will, undeniably, if infected, constitute a potentially grave risk to all with whom they come into intimate contact.\textsuperscript{136}

The Court did not see it so clearly. Judge Kaye acknowledged that the State had a “compelling interest in controlling AIDS, which presents a public health concern of the highest order.”\textsuperscript{137} She also acknowledged that the State had a compelling interest in educating its youth about AIDS, and that “[e]ducation regarding the means by which AIDS is communicated is a powerful weapon against the spread of the disease and clearly an essential component of our nationwide struggle to combat it.”\textsuperscript{138} Nonetheless, Judge Kaye cautioned that “constitutional protections do not readily yield to blanket assertions of exigency,” and that “the threat of AIDS cannot summarily obliterate this Nation’s fundamental values.”\textsuperscript{139}

The state’s compelling interest, Judge Kaye explained, “does not, in and of itself, end all inquiry as to whether 35 Brethren children must be denied an exemption.”\textsuperscript{140} Specifically, the question whether the state’s interest would be substantially impeded by granting plaintiffs an exemption hinged upon two disputed factual issues. First, defendants’ allegation that some Brethren children might go astray, leave the community, or be cast out was, as plaintiffs insisted, “pure speculation; there is no evidence either way as to defections among the New York State Brethren.”\textsuperscript{141} Even if these events occurred, moreover, plaintiffs disputed that the education they provided left their children ill-equipped to cope with the dangers of HIV. The latter point was, in fact, what the Court identified as the second contested fact: if plaintiffs could show that their instruction was the functional equivalent of the AIDS curriculum, then the state “might well be required to accommodate their beliefs.”\textsuperscript{142} The Court remanded

\begin{thebibliography}{1}
\bibitem{136} Id.
\bibitem{137} Ware, 550 N.E.2d at 429.
\bibitem{138} Id.
\bibitem{139} Id. at 429. Judge Kaye later reiterated this caution: “[W]hile the spread of AIDS heightens and intensifies the public interest in education, it does not overturn other cherished values that may not require sacrifice.” Id. at 430.
\bibitem{140} Id. at 429.
\bibitem{141} Id. at 430.
\bibitem{142} Id.
\end{thebibliography}
Like Yoder, the Court's decision in Ware was based on discreet and highly unusual circumstances. Indeed, in Yoder, the Supreme Court explained that plaintiffs' demonstration of burden was one "probably few other religious groups or sects could make." In his dissent in Ware, Judge Bellacosa described Yoder as "an extraordinarily exceptional dispensation from the primacy of a universal public educational curriculum." The majority in Ware similarly acknowledged that "the reach of Yoder is plainly limited," and emphasized that the Brethren are a longstanding, highly individual—if not unique—religious group. Like Yoder, then, the precedential value of Ware is questionable. Yet the court's treatment of the issue of AIDS prevention is elucidating, particularly in comparison with Doe, decided two years earlier.

There are many parallels between Ware and Doe: both involved regulations promulgated by a State official granted wide discretion, in an area in which the Court was loathe to intervene, and both involved constitutional challenges to regulations drafted to combat the spread of HIV. The differences

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143 Judge Titone questioned whether such issues could be resolved through further factual inquiry. See id. at 433 (Titone, J., dissenting) ("[A] serious question would exist as to what kind of further proof defendants could conceivably muster.").

144 406 U.S. 205, 236 (1972).

145 Ware, 550 N.E.2d at 436.

146 Id. at 427. The Ware Court acknowledged, "Commentators have speculated that 'few future free exercise claimants are likely to match the testimony of extreme injury relied upon by the Supreme Court in Yoder.' " Id. (quoting Stephen Pepper, Reynolds, Yoder, and Beyond: Alternatives for the Free Exercise Clause, 1981 UTAH L. REV. 309, 338 (1981)) (other citations omitted).

147 Id. at 430 (emphasis added).

148 See Jay S. Bybee, Substantive Due Process and Free Exercise of Religion: Meyer, Pierce and the Origins of Wisconsin v. Yoder, 25 CAP. U. L. REV. 887, 931 (1996) ("In the end analysis, Yoder yields little law."); Stephen L. Carter, Does the First Amendment Protect More Than Free Speech?, 33 WM. & MARY L. REV. 871, 882 (1992) ("No group other than the Amish has been given so broad an exemption from generally applicable laws, and were the Yoder case to arise today, it is not at all clear that the outcome would be the same."); Frederick Mark Gedicks, Toward a Constitutional Jurisprudence of Religious Group Rights, 1989 WIS. L. REV. 99, 130 ("Yoder, although an interesting case, is not thought to be doctrinally significant . . ."); Karl J. Sanders, Kids and Condoms: Constitutional Challenges to the Distribution of Condoms in Public Schools, 61 U. CIN. L. REV. 1479, 1486 (1993) ("[T]he precedential weight of Ware is arguably minimal, limited to the minority of plaintiffs who can classify themselves as a truly unique religious group.").
in the Court's reasoning, however, are apparent—differences that the Court could not fairly justify. In *Ware*, the Court was cautious not to abrogate the constitutional rights of a minority in the name of controlling the spread of HIV. Applying strict scrutiny, the Court refused to accept defendant's sweeping assertions that the regulations were necessary to prevent the spread of HIV. Instead, the Court remanded the case for further proceedings to determine, inter alia, whether the state's goal could be achieved through less burdensome means.

In *Doe*, although the majority of justices urged the Court to apply a stricter scrutiny than mere rational basis to protect fundamental constitutional rights, the Court failed to do so. The Court upheld Respondents' decision without a searching inquiry—let alone a remand, as in *Ware*—to determine whether Respondents' decision was necessary, or whether less burdensome alternatives existed through which to achieve the same goals. The *Doe* Court blindly accepted the highly speculative argument that the Does might somehow spread the virus to the community; the *Ware* Court refused to accept defendant's "pure speculation" that some Brethren children might leave the community and remanded for further discovery on this issue.

The *Ware* Court strongly warned against trampling constitutional protections in the face of "blanket assertions of exigency." Yet, in *Doe*, the Court did precisely that, unjustifiably—and appallingly—denying a prisoner the right to visit with family members merely because he was living with

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149 *Ware*, 550 N.E.2d at 430.

150 Ironically, had the Court desired simply to uphold the regulation, *Yoder* would have provided ample authority. In *Yoder*, the Supreme Court expressly noted that no "harm to the physical or mental health of the child or to the public safety... had been demonstrated or may be properly inferred." 406 U.S. 205, 230 (1972). The State's interest was thus less than compelling. In *Ware*, by contrast, the State was acting to prevent harm to both the child and the public, both compelling interests under *Yoder*. No amount of evidence on remand could prove that the threat of such harm did not exist.

151 *Ware*, 505 N.E.2d at 429. In summarily rejecting the Does' claims, Judge Lawrence E. Kahn of the New York Supreme Court expressly recognized the fear and anxiety over the spread of HIV and AIDS. In light of the public hysteria over AIDS, Judge Kahn observed that "it is incumbent upon the courts to render determinations on the basis of sound legal principles with guidance from the latest medical and scientific research available." Doe v. Coughlin, 505 N.Y.S.2d 534, 556 (Sup. Ct. Albany County 1986). Unfortunately, however, neither Judge Kahn nor the majority of appellate judges followed this advice.
HIV. One year after Ware, moreover, the Court would again credit blanket assertions of exigency, effectively denying persons living with HIV access to private medical insurance.

III. HEALTH INSURANCE ASS’N. OF AMERICA v. CORCORAN (1990)

A. Background

In Health Insurance Ass’n of America v. Corcoran, various insurance companies and associations (“Petitioners”) challenged a 1987 regulation promulgated by the State Superintendent of Insurance (the “Superintendent”) regarding the use of HIV tests in insurance. The regulation (“Regulation”), which applied only to individual and small group health insurance policies, banned such insurers from: (1) considering HIV test results in determining an applicant’s insurability; (2) requesting an applicant to submit to an HIV test; and (3) inquiring whether an applicant had previously taken an HIV test, or inquiring as to the results of any such test. The Regulation was issued following notice and an opportunity for public comment at an “extensive hearing,” and after the Commissioner of Health had certified that the prohibited practices were “contrary to the health care needs of the public.”

Petitioners argued, inter alia, that the Superintendent exceeded his delegated statutory authority in promulgating the Regulation, and that the Regulation violated provisions of the

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152 When asked about the Doe decision some years later, Judge Alexander replied:

I think the driving force was a consideration of the larger community. Of course, my view was there was no demonstrated danger to the large community and it was a presumption to think that the wife would contract AIDS and then go out and violate her marriage vows. I thought we should have focused on the rights of the prisoners.


154 The regulation was promulgated as N.Y. COMP. CODES R. & REGS. tit. 11, § 52.27 (1999).

155 Corcoran, 551 N.Y.S.2d at 616. These constituted 10 to 15% of all health insurance policies issued in the State of New York. See id.

156 Id. at 616.

157 Id.

158 Id. (quoting N.Y. INS. LAW § 3217(b)(4) (McKinney 1985)).
New York State Insurance Law which permitted insurers to solicit relevant information from an applicant to determine the actuarial risks of insuring the applicant and to disclaim coverage for preexisting conditions.\textsuperscript{159} Affirming the lower court, the Appellate Division, Third Department agreed with Petitioners, unanimously declaring the regulation invalid. In a unanimous decision, the court of appeals affirmed, adopting the Third Department’s decision rather than issuing its own decision.\textsuperscript{160} We must therefore analyze the Third Department’s decision.

B. The Decision

The Superintendent based his authority to issue the Regulation on three specific statutory provisions empowering him to supervise the insurance industry and to issue regulations. These included the authority to disapprove insurance policy forms;\textsuperscript{161} a provision prohibiting an insurer from discriminating “between individuals of the same class . . . in any of the terms or conditions [of any health insurance policy] or in any other manner whatsoever”;\textsuperscript{162} and the authority to issue regulations to establish minimum standards for the form, content, and sale of health insurance policies.\textsuperscript{163} Of these, the Superintendent relied most heavily upon the third provision, which, as we shall see, expressly authorized the Superintendent to consider “the health care needs of the public.”\textsuperscript{164}

1. Fairness, Equity, and Nondiscrimination

Addressing the first two of these provisions, the Third Department explained that the Superintendent’s power to disapprove policy forms “is appropriate for provisions ‘likely to mislead the public *** [or be] prejudicial to the interests of the policyholders.’”\textsuperscript{165} The use of an HIV test, the court ruled, was neither misleading nor prejudicial. Instead, it was a valid underwriting tool, a “means of identifying a class substantially

\textsuperscript{159} See N.Y. INS. LAW § 3105 (McKinney 2000).
\textsuperscript{160} Health Ins. Ass’n of Am. v. Corcoran, 565 N.E.2d 1264 (N.Y. 1990).
\textsuperscript{161} See N.Y. INS. LAW § 3201 (McKinney 2000).
\textsuperscript{162} Id. § 4224(b)(1).
\textsuperscript{163} See id. § 3217.
\textsuperscript{164} See infra notes 207–08 and accompanying text.
\textsuperscript{165} Health Ins. Ass’n of Am. v. Corcoran, 551 N.Y.S.2d 615, 618 (3d Dep’t 1990), aff’d, 565 N.E.2d 1264 (N.Y. 1990) (quoting Massachusetts Mut. Life Ins. Co. v. Thacher, 222 N.Y.S.2d 339 (1st Dep’t 1961), aff’d, 83 N.E.2d 79 (N.Y. 1942)).
more prone to AIDS than the general population.”^{166} Such underwriting practices, the court observed, promote fairness to policyholders by not requiring them to bear in premiums the costs of insuring other individuals in higher risk categories.^{167}

The court similarly dismissed the Insurance Law’s antidiscrimination provision as a basis for promulgating the Regulation. The court explained that the prohibition against discrimination “ha[s] been authoritatively construed not to apply when differential treatment has a proper underwriting basis.”^{168} Hence, sections 3201 and 4224 of the Insurance Law did not authorize the Superintendent to promulgate the Regulation because “HIV testing, as a sound underwriting practice, is not unfair, inequitable, discriminatory or deceptive.”^{169}

In finding the use of HIV tests neither unfair, inequitable, nor discriminatory, the court relied heavily upon what it perceived as the catastrophic costs that the AIDS epidemic threatened to impose upon the industry, implicating the very “solventy of the insurer[s].”^{170} Indeed, the court virtually took judicial notice of this proposition, announcing that “[i]t can hardly be denied” that AIDS “represents a formidable financial threat of disastrous proportions to health insurers.”^{171}

But was this true? The court noted that nothing in the record cast doubt upon “this fact”,^{172} at the same time, however, the court failed to cite a single authority for this finding. In truth, AIDS did not pose an unprecedented or disastrous threat to the insurance industry, and the singling out of HIV and AIDS for exclusion from coverage supported a finding of unfairness, inequity, and/or discrimination.

Although the Superintendent may not have emphasized this issue, one of the commentators whom the court expressly cited and discussed made this very argument three years before *Corcoran* was decided:

[Industry claims that HIV antibody testing is compelled by economic necessity do not withstand scrutiny. In the first place, insurers have greatly exaggerated the cost of AIDS. A

\[^{166}\textit{Id. at 620.}\]
\[^{167}\textit{Id. at 618–19.}\]
\[^{168}\textit{Id. at 619.}\]
\[^{169}\textit{Id. at 620.}\]
\[^{170}\textit{Id. at 619.}\]
\[^{171}\textit{Id. (emphasis added).}\]
\[^{172}\textit{Id. (emphasis added).}\]
study commissioned by the CDC estimates the cost of treating people with AIDS to be only 0.2% of the nation's total personal health care expenditures in 1985, with a projected rise to 1.4% by 1991. The same authors estimate the average cost of treating people with AIDS in 1986 to be $60,000 to $75,000 per person, far less than many other illnesses.\textsuperscript{173}

The author, Benjamin Schatz, was not alone. The following year, another author explained that "[i]n comparison with other health care costs, the cost of AIDS represents a relatively small, but growing portion of total personal health care expenditures . . . ."\textsuperscript{174} In a more comprehensive article, a commentator writing in 1989 explained, after careful analysis:

AIDS is not an unusually important cause of death, nor is its exclusion necessary to prevent the destruction of the insurance market. It is, therefore, inappropriate to exclude coverage for costs attributable to AIDS from either group or individual health or life insurance policies unless all of the higher risk losses are also excluded. In addition, it would be inappropriate to exclude all HIV positive individuals from coverage. While HIV seropositivity does correlate with the occurrence of AIDS, there are equivalent factors which correlate with the more frequent causes of premature death.\textsuperscript{175}

Yet another article that year noted that "losses from AIDS are not significantly different than those from other catastrophic illnesses and may, in fact, be lower."\textsuperscript{176} Furthermore, in February of 1989, in a front-page article, the \textit{New York Times} explained that "[e]arlier forecasts that AIDS would bankrupt insurance companies, hospitals and governments have not materialized."\textsuperscript{177}

Thus, evidence directly contradicting the court's pronouncement of AIDS as a financial disaster for the insurance

\textsuperscript{173} Benjamin Schatz, \textit{The AIDS Insurance Crisis: Underwriting or Overreaching?}, 100 Harv. L. Rev. 1782, 1794–95 (1987); see also Corcoran, 551 N.Y.S.2d at 622 (citing and discussing this article).


industry was available to the court; indeed it was conspicuously discussed in the Schatz article, which the court quoted.\textsuperscript{178} The court persisted, however, in advancing its outdated,\textsuperscript{179} unfounded, and dispositive prediction of potential insolvency for the industry. As one author explained:

In the early 1980s . . . some insurance companies and hospitals, facing an increasing number of HIV patients with long hospital stays and potential labor-intensive care, claimed that the enormous costs of AIDS threatened to drive them into insolvency. The earliest studies on the potential cost of the epidemic indicated that the health care industry's costs would be extraordinary and in a different class than that of other serious illnesses. However, in 1986 and 1987, the studies of other respected institutions tempered some of the high numbers that were initially reported and estimated costs from diagnosis to death that were well below previous figures.\textsuperscript{180}

These figures, the author explained, demonstrated that the costs of treating HIV and AIDS were "no more disastrous than

\textsuperscript{178} In addition to the passage quoted above, the author added: "The fact that the HIV antibody test is not crucial to insurance company survival has been borne out by industry spokespersons, who have conceded that insurers have been able to operate without disruption in states that ban use of the test." Schatz, supra note 173, at 1795.

\textsuperscript{179} See Daniel M. Fox and Emily H. Thomas, The Cost of AIDS: Exaggeration, Entitlement, and Economics, in AIDS AND THE HEALTH CARE SYSTEM 197, 205 (Lawrence O. Gostin, ed., 1990) ("By the summer of 1986, then, the general consensus among experts on health care costs was that AIDS was expensive to treat, but not as costly as had earlier been feared.").

\textsuperscript{180} William A. Bradford, Jr. et al., The AIDS Epidemic and Health Care Reform, 27 J. MARSHALL L. REV. 279, 299 (1994). Writing in 1990, the year Corcoran was decided, two other commentators similarly explained:

Between 1983 and 1985, executives of hospitals and health insurance firms attracted the most attention by claiming that the costs were enormous and unprecedented and posed a threat to the solvency of their organizations. The earliest published data seemed to confirm this foreboding. Systematic studies begun in 1985 and completed over the next two years challenged this view, however. They presented AIDS as being about as expensive as other fatal illnesses, but with a dramatically increasing incidence, particularly among the poor.

Fox and Thomas, supra note 179, at 198; accord Michael T. Isbell, HEALTH CARE REFORM: LESSONS FROM THE HIV EPIDEMIC 1, 69 (1993) ("[T]he commercial insurance industry embarked in the 1980s on a barely disguised campaign to avoid paying its fair share of HIV-related medical costs."); Daniel M. Fox, AIDS and the American Health Polity: The History and Prospects of a Crisis Authority, in AIDS: THE BURDENS OF HISTORY at 316, 331 (Elizabeth Fee & Daniel M. Fox eds., 1988) ("Many insurance executives embraced the highest estimates, perhaps because they wanted the states or the federal government to assume the burden of payment.").
for other serious illnesses.” Nonetheless, the early, doomsday estimates “created the perception that AIDS-related illnesses are uniquely costly to the health care and insurance industries.”

Commentators throughout the 1990s have confirmed that AIDS did not, and does not, represent a threat of disastrous proportions to the insurance industry. Perhaps more importantly, numerous commentators have demonstrated that the cost of treating HIV and AIDS is not significantly greater, and is often considerably less, than that of treating other illnesses that insurers continue to cover. Schatz made this

181 Bradford, supra note 180, at 299.
182 Id. at 300; accord Michael T. Isbell, AIDS and Access to Care: Lessons for Health Care Reformers, 3 CORNELL J.L. & PUB. POLY 7, 14 n.48 (1993) (“The commercial insurance industry’s own financial data demonstrate the absurdity of claims that HIV threatened the viability of private insurers.”); Robert A. Padgug et al., AIDS and Private Health Insurance: A Crisis of Risk Sharing, 3 CORNELL J.L. & PUB. POLY 55, 56 (1993) (“Commercial insurers, as well as the public, were persuaded by early cost estimates which inaccurately calculated the costs of treating AIDS and firmly established AIDS as a disease with unacceptably high costs.”).
183 See, e.g., Bradford, supra note 180, at 300 (“Spending for AIDS is less than one percent of the total amount of medical spending in the United States, and the National Commission on AIDS has predicted that it is likely that this amount will never rise above two percent.”); James R. Bruner, AIDS and ERISA Preemption: The Double Threat, 41 DUKE. L.J. 1115, 1125 (1992) (“The financial predictions standing alone fail to provide persuasive justification for employers’ and the insurance industry’s efforts to exclude AIDS patients.”); Isbell, supra note 182, at 13 (“During the early years of the AIDS epidemic, commentators feared that AIDS would bankrupt the health care system. Experience, however, has revealed such fears to be baseless. Medical spending on people with HIV currently accounts for roughly 1 percent of health care spending in the United States.”); Li, supra note 10, at 483 (“Results of the [1996 survey by the Health Insurance Association of America and the American Council of Life Insurance] provide evidence that AIDS-related claims do not pose a justifiable threat to the financial well-being of commercial insurance companies. Therefore, the private insurance industry does not have any foundation for the fear that the AIDS epidemic would financially destroy the business.”); Samuel A. Marcosson, Who Is “Us” and Who Is “Them”—Common Threads and the Discriminatory Cut-Off of Health Care Benefits for AIDS Under ERISA and the Americans with Disabilities Act, 44 AM. U. L. REV. 361 (1994) (extensively discussing this topic); Padgug, supra note 182, at 59 (“The reports of the health insurance industry’s impending death were greatly exaggerated.”).
184 See, e.g., Randall R. Bovbjerg, AIDS and Insurance: How Private Health Coverage Relates to HIV/AIDS Infection and to Public Programs, 77 IOWA L. REV. 1561, 1574 (1992) (“AIDS spending looks less extreme relative to other expensive areas, a number of which cost more per case or in overall spending.”); Bradford, supra note 180, at 299 (“While the costs of HIV and AIDS medical care are great, they are not vastly different than for other serious medical conditions.”); Bruner, supra note 183, at 1125 n.48 (“AIDS is no more costly to treat than many other life-threatening illnesses.”); Marcosson, supra note 183, at 391 (“AIDS treatment does
very point in his 1987 article, as did other contemporaneous commentators. One commentator noted, for example, that “AIDS is comparable to cancer as a cause of premature death in this age and sex group [of men aged 25 to 44]: there are 39,500 years of potential life lost to cancer and only 32,300 to AIDS.”

To take but a few examples, the “[l]ifetime medical costs for a person with AIDS range between $75,000 and $85,000, as compared with liver transplants at about $235,000, heart transplants at $148,000, end-stage renal disease at $158,000 and cancer at $29,000 for only the last six months of life.” Heart disease treatment, moreover, cost $101.3 billion in health care expenditures in 1990 (the year in which the court of appeals decided Corcoran), which was 20 times the amount required for AIDS-related care in 1991. And the annual cost of medical care for AIDS was actually less than the cost of a year’s supply of clotting factor for a hemophiliac. In the year before Corcoran was decided, finally, reported deaths attributed to HIV illness accounted for only 1% of all deaths in the United States, whereas the proportion of deaths due to cancer rose to 23%.

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185 Schatz, supra note 173, at 1794–95.
186 See Berman, supra note 176, at 1070; Perkins, supra note 174, at 278; Vogel, supra note 175, at 991.
187 Vogel, supra note 175, at 991. Years of potential life lost constitutes the number of years below 65 that a person dies. Id. at 991 n.125.
189 See Bradford, supra note 180, at 300 n.158.
190 See ISBELL, supra note 180, at 68.
191 See Widiss, supra note 184, at 1639 n.92.
While the costs to the insurance company would not be catastrophic, the costs to persons living with HIV were. Owing to the tremendous gaps and inadequacies in the U.S. health care system, persons living with HIV were forced to become fully destitute before they could qualify for medical assistance through Medicaid, as the Commissioner noted in his certification to the Superintendent. Additionally, among other things, Medicaid covered only persons diagnosed with AIDS, not merely HIV. As a consequence, uninsured persons living with HIV were unable to obtain crucial, early medical assistance until diagnosed with full-blown AIDS. Without private medical insurance, then, many individuals living with HIV were left with no coverage of any kind. As one commentator observed:

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192 See Bovbjerg, supra note 184, at 1603 (“Ordinarily, people must lose their jobs, their private health insurance, and most of their income and assets to qualify for Medicaid.”); Isbell, supra note 182, at 15 (“Upon loss of coverage, persons with HIV move to ‘self-pay,’ depleting personal resources in order to finance medical care. After becoming sufficiently pauperized and/or ill to qualify for public assistance, patients generally look to Medicaid for health coverage.”). For an excellent discussion of this issue see Bradford, supra note 180.

193 See infra note 211 and accompanying text.

194 See, e.g., Bradford, supra note 180, at 310 (“A person with full-blown AIDS is considered ‘disabled’ under the guidelines, but seropositive people with mild symptoms or those who are being treated only prophylactically (e.g., AZT maintenance) may have trouble gaining eligibility to the program.”); Linda C. Fentinan, Symposium: What Lessons Have We Learned from the AIDS Pandemic?: AIDS as a Chronic Illness: A Cautionary Tale for the End of the Twentieth Century, 61 ALB. L. REV. 989, 1005 (1998) (noting that Medicaid and drug reimbursement programs “cover only persons who have been diagnosed with AIDS, rather than the larger group of those who have tested HIV positive.”); Isbell, supra note 182, at 32–33 (“Medicaid eligibility is thus normally impossible until a person with HIV exhibits an official AIDS indicator disease.”). As one commentator noted, “As a result of these rules, poor people with HIV infection experience needless illness, have a poorer quality of life, and die sooner than more affluent HIV-positive patients.” ISBELL, supra note 180, at 104.

195 See Bradford, supra note 180, at 284 (“Their limited economic means prevent them from developing an ongoing relationship with a physician; many receive little, if any, preventive care. Often, their only encounter with a medical provider is in the emergency room of a public hospital.”); Isbell, supra note 182, at 33 (“The restrictive requirements for Medicaid eligibility harm persons with HIV by eliminating their ability to receive early care.”); Lambert, supra note 177 (“Many typically show up in emergency rooms with little time left to live.”).

196 “AIDS has shown that Medicaid is shallow and inadequate,” Congressman Henry Waxman announced in 1989. “Many middle-class Americans are learning the hard way that, in most states, you can qualify only if you are totally disabled and have less than $1,500 to your name.” Henry A. Waxman, Symposium: Current Legal Issues in AIDS: Introduction to Symposium on AIDS, 49 OHIO ST. L.J. 877, 878 (1989); see also ISBELL, supra note 180, at ii (“One quarter of all people with
"While AIDS represents only a minor threat to insurance, the insurance system represents a mortal threat to persons with AIDS."¹⁹⁷

If HIV and AIDS did not threaten disaster for the insurance industry, and if the costs of treating HIV and AIDS were no greater than, and in some cases less than, other covered illnesses, then the conclusion is inevitable that individuals living with HIV and AIDS were being singled out for unfair, inequitable, and discriminatory treatment. As one commentator has explained:

The unfairness stems from the lack of monetary justification for treating the HIV disease differently from other conditions. HIV disease costs far less to treat than most individuals, employers and insurance companies often assume, and comparatively less than the treatment of other conditions. Thus, the question is not whether it would save an insurance plan money not to treat AIDS, because of course it would, but whether the analysis is done fairly in comparison to the treatment of other conditions. If treating AIDS does not cost more than other conditions, then the surprise of a new AIDS-only coverage limitation is an unfair one and therefore unconscionable.¹⁹⁸

Many commentators have posited that HIV and AIDS were AIDS, and an even larger percentage of the HIV-infected, lack any form of health coverage."; Widiss, supra note 184, at 1734 ("The absence of insurance or other health care plans for thousands of individuals who are afflicted with AIDS has again made the gaps in the nation's health care system all too conspicuous.").

¹⁹⁷ Pagdug, supra note 182, at 60; see also ISBELL, supra note 180, at 103 ("Untold thousands of working Americans have fallen into poverty as a direct result of their HIV infection. Dependant on Medicaid, public hospitals and community clinics for their medical care, the individuals have experienced first-hand the nation's neglect of the health care needs of the indigent.").

¹⁹⁸ Marc E. Elovitz, Combating AIDS Discrimination in Health Insurance, 10 ST. JOHN'S J. LEGAL COMMENT. 537, 539 (1995). Several commentators, in fact, have observed that persons living with AIDS have been singled out for unfair treatment by insurers. "Providing adequate AIDS coverage presents fundamentally the same dilemma as with all other costly medical conditions: high health care costs and insufficient dollars to meet them. AIDS is singled out, however, for cuts in benefits not made for other diseases." Marcossen, supra note 183, at 392 n.154; accord Li, supra note 10, at 495–96 ("Although other serious diseases lead to higher medical care expenses and related costs than AIDS, the insurance industry has not taken an active role in screening out people suspected of having an increased chance of contracting or developing such diseases."); Slivinska, supra note 188, at 342 ("The only real differences between AIDS and diabetes or MD lie in the mode of transmission and people affected. People with AIDS have been stigmatized largely because the disease is usually transmitted through sexual contact. Not suprisingly, the people affected are often perceived as being at fault or somehow 'deserving it.'").
targeted for discriminatory treatment because of prejudice against gay men. The fact that HIV/AIDS was considered a gay male disease not only engendered antipathy, but it also fostered apathy in the general public as well, since the majority of the population considered themselves somehow immune from the disease. This apathy or indifference, perhaps more than outright hostility and phobia, may explain the public tolerance for the insurance industry's use of HIV testing to exclude people with aids (PWA) from coverage. As one author, writing in the early 1990s, explained:

Cancer cannot be excluded, because so many people believe themselves at risk that the policy would be unattractive, even at a lower cost, if those benefits were unavailable. But AIDS is different: the so called "good risks" may drop out rather than pay the higher cost of a policy with full AIDS coverage. In addition, the public tolerance of depriving people with cancer of medical insurance is quite different from the attitude towards leaving PWAs with little or no coverage. That is, because it is acceptable to treat PWAs as "them," insurers can do so with little cost in adverse publicity or public outrage.

199 "It is likely that the exclusion of coverage for PWAs by employers and insurance companies is motivated by prejudice against gay men." Bruner, supra note 183, at 1125; accord Isbell, supra note 182, at 16 ("[T]he private health insurance industry has singled out HIV disease for discriminatory treatment and has 'attempt[ed] to impose a kind of moral judgment in the determination of coverage and payment of benefits for HIV related charges.' " (quoting REPORT TO THE COMMISSION FROM THE TASK FORCE ON HIV/AIDS INSURANCE ISSUES 4 (1992)); Marcosson, supra note 183, at 368 n.38 ("Because the public still perceives AIDS as a 'gay' disease, decisions to treat PWAs differently from people suffering from cancer or heart disease may reflect anti-gay animus."); Eric C. Sohlgren, Group Health Benefits Discrimination Against AIDS Victims: Falling Through the Gaps of Federal Law—ERISA, the Rehabilitation Act and the Americans with Disabilities Act, 24 LOY. L. REV. 1247, 1259 (1991) (positing a "strong implication that the AIDS coverage limitation has been motivated by reasons other than reducing expenses").

200 Writing in the [early] 1990s, one author explained: "Many heterosexual Americans think they are at no significant risk of contracting AIDS. They see AIDS as a self-inflicted condition and attribute the blame to the PWA. Viewing it as 'somebody else's problem,' they oppose spreading the cost for AIDS as is done for medical care generally." Bruner, supra note 183, at 1126–27; accord ISBELL, supra note 180, at 2 ("Americans often viewed AIDS as an unfortunate, albeit intractable, problem which had little relevance to their own lives.").

201 Marcosson, supra note 183, at 430; see also Michele Zavos, AIDS and Insurance: No Guarantees, 20 HUM. RTS. Q. 18, 19 (1993) ("People with AIDS and HIV have been singled out for adverse action because their illness is socially unacceptable, and employers have counted on the fact that other employees would not object to the reduction of benefits for someone with AIDS.").
Regardless of the underlying reasons and motivations, the court in Corcoran had ample grounds to determine that the use of HIV tests to exclude coverage was unfair, inequitable, and/or discriminatory, and thus to uphold the Regulation under sections 3201 and 4224(b)(1) of the Insurance Law. Instead, based on the court's own unsubstantiated predictions of impending financial doom, the court found insurers "unquestionably justified" in attempting to screen for individuals living with HIV.

2. The Health Care Needs of the Public

Section 3217 of the Insurance Law empowers the Superintendent to issue regulations establishing "minimum standards, including standards of full and fair disclosure, for the form, content and sale of accident and health insurance policies." Section 3217(b) establishes five "purposes of such minimum standards." Four of the five purposes, the court

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202 See Berman, supra note 176, at 1065 ("Denying the large group of seropositive individuals access to health insurance on the basis that a small number of those individuals may suffer from AIDS or ARC is inequitable."); Elovitz, supra note 198, at 542 ("Offering plans with AIDS-only limitations has no actuarial basis and therefore contravenes any notion of fairness."); see also Slivinska, supra note 188, at 342 ("The limitation of benefits for AIDS-related claims is nothing more than a hysterical reaction to a largely unjustified fear.").

203 Health Ins. Ass'n of Am. v. Corcoran, 551 N.Y.S.2d 615, 619 (3d Dep't 1990), aff'd, 565 N.E.2d 1264 (N.Y. 1990). The court observed that neither the Superintendent nor the Commissioner had "any special technical expertise in deciding the fundamental question of how the potentially enormous financial and human costs of the AIDS crisis should be borne within society." Id. at 622 (citation omitted). The decision to promulgate the Regulation, the court explained, "necessarily involved" weighing "the substantial increase in health care costs to insurers and... health insurance costs to non-HIV-infected insureds... as against the serious financial and human costs to seropositive persons and the financial costs to the State if testing is permitted." Id. at 621–22. It was clearly foreseeable, however, that a weighing of competing interests and costs would be involved any time the Superintendent eliminated, in the interest of public health, a measure adopted by the insurance industry. Yet nowhere in the statute is such a weighing of costs mentioned, let alone mandated. Similarly, the legislature provided no exception for those cases in which the Superintendent's decision would result in an increase in costs to the insurance industry, or to insureds. Instead, the statute empowers the Superintendent to eliminate measures that are contrary to the health care needs of the public, without regard to cost, when the Commissioner of Health so certifies. See N.Y. INS. LAW § 3217(b)(4) (McKinney 1985).

204 N.Y. INS. LAW § 3217(a) (McKinney 1985).

205 Id. § 3217(b) (McKinney 1985).
observed, "can be fairly characterized as consumer protective in orientation." As the court acknowledged, however, section 3217(b)(4) "is couched in broader terms," establishing as one purpose the "elimination of provisions which may be contrary to the health care needs of the public, as certified to the superintendent by the commissioner of health." Nothing in the language of this provision, or its legislative history, limits the Superintendent’s power merely to matters involving consumer protection.

Prior to the Superintendent’s promulgation of the Regulation in 1987, the Commissioner of Health (the "Commissioner") duly certified to the Superintendent that the use of HIV tests in screening applicants for insurance coverage was contrary to the health care needs of the public. The Commissioner of Health cited five independent reasons for this conclusion: (1) HIV tests only identify individuals as seropositive, and it was not definitively known at the time how many of those individuals would ultimately progress to AIDS; thus, "[t]he tests are, at best, limited predictors of morbidity and mortality"; (2) "there are serious social and psychological impacts upon those denied insurance for testing HIV positive, who may never contract AIDS or ARC, discouraging them from seeking treatment for regular medical care and forcing them to become impoverished so as to become eligible for Medicaid payment of their costs of health care"; (3) the threat of insurance disqualification would deter voluntary testing and submission to counseling, "the only currently effective means of AIDS control"; (4) increased HIV testing by insurers would endanger confidentiality, producing emotional and economic hardships for seropositive persons whose status is disclosed; and (5) there were accurate tests for diagnosing applicants living with AIDS, making testing for HIV seropositivity unnecessary.

Despite the fact that the Superintendent was acting pursuant to explicit statutory authority in promulgating the

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206 Corcoran, 551 N.Y.S.2d at 621.
207 Id.
208 N.Y. INS. LAW § 3217(b)(4) (McKinney 1985).
209 See Corcoran, 551 N.Y.S.2d at 621 ("Nowhere in the legislative history is this provision specifically explained.").
210 The reliability of the HIV tests for purposes of diagnosis improved vastly in the years after Corcoran was decided. See, e.g., Widiss, supra note 184, at 1731.
211 Corcoran, 551 N.Y.S.2d at 617.
Regulation, and although the Commissioner duly certified that the use of HIV tests was contrary to the health care needs of the public on five different grounds, the court declared the Regulation invalid. To uphold the Regulation, the court explained, would be to give the Superintendent and the Commissioner "carte blanche to drastically disturb longstanding principles of accepted insurer underwriting practices in order to further the Commissioner of Health's own objectives in public health."\(^{212}\) This characterization of the Commissioner's certification as merely reflecting his "own objectives" was manifestly unfair, and unfounded. There was no indication that the Commissioner was acting other than in his official capacity as the State's top health expert and official in submitting the certification. He advanced no fewer than five independent justifications for declaring the policy of HIV testing by insurers contrary to the health care needs of the public. The court articulated no principled basis, moreover, upon which to distinguish this particular certification as reflecting the Commissioner's own objectives, rather than the valid objectives of New York State as determined by its top health official—objectives that the Court would unanimously uphold one year later in *Axelrod*.\(^{213}\) Under the court's reasoning, then, any certification with which the court disagrees could be deemed invalid upon this basis.

The court simply abrogated, through judicial fiat, an unambiguous provision of the law that, according to the court, granted these officials too much power. As Judge Bellacosa observed three years earlier, under similar circumstances:

> While the court admits the difficulty under the high separation of powers standard of articulating the basis for drawing, and even finding, some line limiting [respondent's] conceded exercise of authority, it nevertheless goes ahead and does so. Its line is no line, but rather an arbitrary judgment call of its own. It is this judicial branch intrusion which constitutes the truly egregious separation of powers breach into the exercise of prerogative of the Legislature and of the executive.\(^{214}\)

To make matters worse, the court later contradicted itself, characterizing the Regulation as reflecting the Superintendent's

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\(^{212}\) *Id.* at 621 (emphasis added).

\(^{213}\) See *infra* notes 227–70 and accompanying text.

personal objectives, rather than the Health Commissioner's: "[R]espondent exceeds his authority when, by regulation, he 'effect[s] [his own] vision of societal policy choices . . . .'"215 The Superintendent unequivocally did not effect "his own vision" of policy choices; instead, he relied upon the state's top health official to guide his decision, as the statute expressly empowered him to do.216

The contrasts between Corcoran and the Court's decision in Doe are apparent and striking. The court in Corcoran acknowledged that, like Respondents in Doe, the Superintendent "has wide authority to prescribe regulations and in doing so may exercise broad power to interpret and implement legislative policy."217 In addition, the Superintendent was explicitly empowered to protect "the health care needs of the public,"218 rather than merely to consider the "safety" of the "community."219 Unlike Respondents in Doe, moreover, the Superintendent received explicit guidance from the New York State Commissioner of Health in formulating his policy with respect to HIV. His policy was therefore in keeping with, rather than contrary to, sound public health policy. Hence, while the issue at bar in Corcoran was similar to that in Doe, the Superintendent's Regulation was supported by clear statutory authority and the state's highest authority on public health. Under Doe, then, one would have expected the court of appeals (and the Third Department) to uphold the Superintendent's Regulation; however, they did not, neither by distinguishing nor

215 Corcoran, 551 N.Y.S.2d at 622.
216 For this reason, Corcoran can be distinguished from Life Insurance Ass'n of Massachusetts v. Commissioner of Insurance, in which the Massachusetts Supreme Court invalidated similar regulations promulgated by the Massachusetts commissioner of insurance. See 530 N.E.2d 168 (Mass. 1988). In that case, the court found that the commissioner "had no authority, express or implied, to adopt the regulations in question." Id. at 170. The Massachusetts commissioner was not statutorily empowered to protect the health care needs of the public, and there was no indication that the commissioner relied upon the express findings of state health officials in promulgating his regulations. Not surprisingly, then, the court in Corcoran did not even cite Life Insurance Ass'n in support of its decision.
217 Corcoran, 551 N.Y.S.2d at 617 (citing Ostrer v. Schenck, 364 N.E.2d 1107, 1108 (N.Y. 1977)).
218 N.Y. INS. LAW § 3217(b)(4) (McKinney 1985) (emphasis added).
219 N.Y. CORRECT. LAW § 70(2)(a)(McKinney 1987); see also Doe v. Coughlin, 518 N.E.2d 536, 553 (N.Y. 1987) (Alexander, J., dissenting) ("[T]he Legislature has not delegated to the Department of Correctional Services the authority to regulate in matters relating to public health.").
The Court ruled, finally, that the Regulation "drastically disturb[s] longstanding principles of accepted insurer underwriting practices," practices which were "previously sanctioned and encouraged under basic principles of insurance law and regulation." This was simply untrue. The assessment of actuarial risk is, generally, an accepted underwriting practice. The specific practice of screening applicants through the use of an HIV test, however, was certainly not "sanctioned and encouraged" in the law. Indeed, as the court acknowledged, the Legislature displayed "indecisiveness on the policy issue."

The fact that assessment of actuarial risk is generally accepted, moreover, does not insulate the practice when applied in such a way as to threaten the health care needs of the public, or when applied in a discriminatory manner. Indeed, there is ample precedent for invalidating "longstanding principles of accepted insurer underwriting practices" in this country:

For example, federal law forbids classification by race, color, religion, sex, or national origin in employer sponsored insurance plans. Many state statutes go beyond the federal law and proscribe classification based on physical or mental impairments or on a specific genetic trait. Such regulations and statutes recognize that "actuarial justification does not operate without limit" and that societal values may outweigh statistical validity.

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220 Coughlin, 518 N.E.2d at 621.
221 Id. at 622.
222 See, e.g., Widiss, supra note 184, at 1642 ("Distinguishing among applicants, in order to decide whether to issue coverage and the amount to be charged, is the very essence of insurance underwriting. In general, the discrimination insurers exercise in making such decisions is viewed as both necessary and acceptable.").
224 Berman, supra note 176, at 1073; accord Bruner, supra note 183, at 1117 n.17 ("Regulations in all 50 states place limits upon discrimination among insureds, and limits on insurance contracts evince a strong policy presumption against allowing complete freedom of contract in the field of health insurance."); Joyce Nixson Hoffman and Elizabeth Zieser Kincaid, AIDS: The Challenge to Life and Health Insurers' Freedom of Contract, 35 DRACKE L. REV. 709, 720 (1986-87) ("The ability of insurers to classify risks has also been limited in some states by laws and regulations which prohibit unfair discrimination solely on the bases of sex, sexual preference, marital status, physical and mental handicap, and certain genetic traits."); Schatz, supra note 173, at 1798 ("[G]enetic traits for sickle cell anemia and Tay-Sachs, like AIDS, are popularly associated with . . . groups that have long been the targets of discrimination. The ban on the use of predictive tests for these
Hence, while the use of traditional actuarial principles is generally permitted, it is unacceptable where doing so would threaten public health. It is also “invidious to do so if no rational basis can be articulated for choosing AIDS as the one risk whose cost we will not spread.”

In the face of new challenges presented by an epidemic such as AIDS, courts must closely scrutinize “longstanding principles” to assure that they do not jeopardize the health and the civil rights of citizens. This is particularly true when the epidemic is associated with groups traditionally subject to discrimination. In this case, the executive branch took that lead; the judiciary was sadly unwilling to face the challenge.

IV. NEW YORK STATE SOCIETY OF SURGEONS v. AXELROD (1991)

A. Background

In New York State Society of Surgeons v. Axelrod, four medical associations (“Petitioners”) filed suit challenging the New York State Commissioner of Health’s (the “Commissioner”) refusal to designate HIV as a communicable disease and a sexually transmissible disease pursuant to New York Public Health Law sections 225(5)(h) and 2311. Such a designation would have triggered the operation of statutes mandating

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225 Marcosson, supra note 183, at 397.

isolation and quarantine, name reporting, testing, and contact tracing.²²⁹ Although Petitioners conceded that isolation and quarantine were inappropriate for HIV illness,²³⁰ they contended that name reporting, mandatory testing, and contact tracing were “crucial in controlling spread of HIV infection and necessary to allow them to determine whether patients are infected with the disease so that they [could] take appropriate precautions during treatment.”²³¹ Petitioners alleged that the Commissioner was mandated under law to designate HIV as a communicable and sexually transmissible disease, and, in the alternative, that his failure to do so was arbitrary and capricious. An impressive group of public health experts (“Amici”) joined the Commissioner in opposing this lawsuit, including, among others, the American College Health Association, the American Medical Students Association, the American Nurses Association, the American Public Health Association, the American Red Cross, and the Public Health Association of New York City.²³²

The supreme court dismissed the case, a decision that the Third Department voted to affirm by a margin of 3-2. The court of appeals unanimously affirmed.

B. The Decision

The Court acknowledged that “HIV infection is a communicable disease,” and that it can be spread through sexual contact.²³³ The Court rejected Petitioners’ assertion, however, that the Public Health Laws required the Commissioner to designate HIV as a communicable disease and a sexually transmissible disease. Section 225(5)(h), the Court explained, merely provides that the “sanitary code may * * * designate the communicable diseases which are dangerous to the public health.”²³⁴ Nothing in the statute compelled the Commissioner to list all communicable diseases, and “[t]he Legislature’s use of the permissive word ‘may’... supports the conclusion that the

²²⁹ Axelrod, 572 N.E.2d at 609.
²³⁰ Id. at 609; see infra note 242.
²³¹ Id. at 608–09.
²³³ Axelrod, 572 N.E.2d at 607.
²³⁴ Id. (quoting N.Y. PUB. HEALTH LAW § 225(5)(h) (McKinney 1990)).
designation is left to the discretion of [the Commissioner]."\textsuperscript{235}

The Commissioner is vested with similar discretion under section 2311 of the Public Health Law, which provides:

The commissioner shall promulgate a list of [STDs], such as gonorrhea and syphilis, for the purposes of this article. The commissioner, in determining the diseases to be included in such list, shall consider those conditions principally transmitted by sexual contact and the impact of particular diseases on individual morbidity and the health of newborns.\textsuperscript{236}

This statute merely directs the Commissioner to “consider” conditions transmitted by sexual contact, the Court observed, providing the Commissioner with “the discretion to ‘determin[e] the diseases to be included in such list.’”\textsuperscript{237} This discretion is appropriate, the Court explained, because designation of the disease would trigger provisions for isolation and quarantine, name reporting, mandatory testing, and contact tracing, “provisions which, for public health reasons, may not be appropriate in dealing with every type of communicable or sexually transmissible disease.”\textsuperscript{238} The Commissioner had determined, for example, that the public health would not be served by placing influenza, a communicable disease, or chlamydia, a sexually transmissible disease, on the list.\textsuperscript{239}

Turning to Petitioners’ argument that the Commissioner’s decision was arbitrary and capricious, the Court explained: “We cannot substitute our judgment for that of qualified experts in the field of public health unless their judgment is ‘without justification.’”\textsuperscript{240} Accordingly, the Court’s review was “limited to whether respondents’ determination is rationally based, i.e., whether it is unreasonable, arbitrary or capricious.”\textsuperscript{241}

As noted, Petitioners conceded that isolation and quarantine were inappropriate for dealing with HIV and AIDS.\textsuperscript{242} State
officials already had access to reported cases of HIV infection,\textsuperscript{243} moreover, narrowing the question on appeal to whether the determination to forego contact tracing and mandatory testing was rational. On this question, the Court credited the Commissioner’s conclusion:

\begin{quote}
[As a practical matter, mandatory testing and contact tracing will not lead to control and prevention because many persons infected with HIV are not tested until their symptoms become apparent and symptoms may not develop for many years. In the interim, between infection and the appearance of symptoms, an individual may have multiple needle sharing, sexual contacts or both. These factors would make contact tracing, without the voluntary cooperation of the infected individuals, an almost impossible task. Moreover, HIV antibodies may take months to develop and infected individuals who have not yet developed antibodies may be capable of carrying and transmitting the disease. Thus, while contact tracing has historically been a useful public health tool in stemming epidemics of readily discoverable communicable diseases which have a short incubation period, that is not the nature of HIV infections.\textsuperscript{244}

The Court also credited the Commissioner’s conclusion, firmly supported by the Amici, that “mandatory testing and contact tracing would prevent individuals with HIV infection from cooperating with public health officials,”\textsuperscript{245} because individuals living with···HIV “have strong reasons to avoid...
\end{quote}

\textsuperscript{243} See Axelrod, 572 N.E.2d at 609.
\textsuperscript{244} See id.
\textsuperscript{245} Id.
disclosing that they have AIDS or HIV infection."246 Disclosure for such individuals "can result in discrimination in housing, employment and health care."247 Accordingly, the Commissioner determined that "counseling and voluntary cooperation are essential to alter private sexual and drug abuse practices which spread HIV infection," and cooperation and counseling will only occur if persons living with AIDS "are assured that testing will not be coerced and that their test results will remain confidential."248

The Court also explained that the Commissioner's approach was "in accord with the State policy underlying article 27-F of the Public Health Law, a statute enacted to promote voluntary testing for HIV infection."249 As Governor Cuomo emphasized in signing the new law:

By enacting this bill, New York rejects coercive measures. As experience in other states has shown, mandatory testing of broad population groups is neither effective nor desirable.250 Experience in other states has also shown that without effective assurances of confidentiality, voluntary testing efforts fail. The fight against AIDS can be won only with the voluntary cooperation of all our citizens, especially those most at risk.251

246 Id.
247 Id. The Amici pointed out, for example, that "New York City's Human Rights Commission has received more than 4,000 AIDS-related complaints of discrimination since 1983." Amici, supra note 232, at 21 (citation omitted).
248 Axelrod, 572 N.E.2d at 609.
249 Id. at 610; see N.Y. PUB. HEALTH LAW § 2780 (McKinney 1990).
250 Id. In California, for example, the Prevent AIDS Now Initiative Committee ("PANIC"), a political arm of Lyndon LaRouche, attempted in 1986 to implement mandatory procedures similar to those proposed by the Petitioners in Axelrod. See BAYER, supra note 3, at 147-153. Proposition 64, the LaRouche referendum, required that AIDS be defined as an "infectious, contagious and communicable disease," and that the condition of living with HIV be defined as an infectious, contagious, and communicable condition. Id. at 147-48. In addition, both HIV and AIDS were to be listed by the Department of Health Services as reportable diseases. Id. at 148. The proposition was opposed by "the entire medical establishment," the deans of four California schools of public health, the state's major newspapers, and a broad spectrum of social service organizations, and several mainstream politicians, and was soundly defeated. See id. at 149-50; Dennis Altman, Legitimation Through Disaster: AIDS and the Gay Movement, in AIDS: THE BURDENS OF HISTORY 301, 307 (Elizabeth Fee & Daniel M. Fox eds., 1988) ("[I]n California's November 1986 elections a group associated with Lyndon LaRouche proposed a measure to quarantine those who test antibody positive; it was defeated after gay and medical groups mounted a major campaign against it—supported by almost all mainstream politicians.").
251 Bill Jacket, L. 1988, ch. 584, Governor's Memorandum in approval, dated
Article 27-F, passed in 1988, requires written, informed consent prior to administering an HIV test: "[N]o person shall order the performance of an HIV related test without first receiving the written, informed consent of the subject of the test . . . ." In addition, Article 27-F places strict limitations on contact tracing, provides for anonymous testing, and assures the confidentiality of test results and HIV status. "No comparable protections are provided to an individual once the disease has been listed as communicable or sexually transmissible." Thus, Petitioners' desire for mandatory testing and contact tracing was clearly at odds with the Legislature's goal of expanding voluntary testing through the assurance of anonymous testing and confidentiality.

The Court noted, finally, that the Commissioner's approach was supported by leading health authorities, including the United States Centers for Disease Control and the Institute of Medicine, National Academy of Science. Both of these respected organizations had concluded, like the Commissioner, that mandatory testing and contact tracing were inappropriate to stem the spread of the HIV virus. The Commissioner thus had ample justification for his conclusion that the provisions triggered by designation of HIV were "ineffective and impractical..."
in dealing with [the illness]."

The Court's decision in *Axelrod* was firmly based on the prevailing public health consensus. "Voluntarist at its core," Ronald Bayer explained, "it was a consensus marked by an appreciation of the gravity of the AIDS epidemic and a recognition of the very limited role that coercive public health measures could play in the years ahead." As the Court recognized, the experts concluded that coercive measures could deter individuals at risk from testing or seeking counseling, thereby "subverting the prospects for the broad scale modification of private behavior so central to any effective campaign against AIDS." It was thus with little exaggeration

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260 Id. at 609.

261 For a comprehensive, contemporaneous discussion of this issue, see Bayer, supra note 3; see also William Curran, AIDS: Legal and Regulatory Policy (1988); Allan M. Brandt, AIDS: From Social History to Social Policy, in AIDS: The Burdens of History 147, 160 (Elizabeth Fee et al. eds., 1988) ("Mandatory screening could therefore have the effect of creating an underground epidemic in which infected individuals, fearing discrimination, isolation, or quarantine, refuse to cooperate with public health officials. Hidden infection is the nemesis of any effective campaign to halt an epidemic disease."); Scott Burris, "Testing, Disclosure, and the Right to Privacy," in Scott Burris et al., AIDS Law Today 115, 121 (1993).

The public health consensus in support of privacy protections against coercion led a majority of states to adopt measures in the late 1980s governing HIV testing and confidentiality. By the end of 1991, thirty-six states had enacted legislation requiring informed consent for HIV testing, and virtually every state provided some degree of protection for the confidentiality of HIV information. Id.; Mary E. Clark, AIDS Prevention: Legislative Options, 16 Am. J. L. & Med. 107, 134 (1990) ("Mandatory reporting of positive HIV antibody test results will not necessarily provide a more fully developed epidemiological picture of the population of individuals with HIV infection than is currently available. The decision to undergo HIV antibody testing is generally a voluntary one, and should remain so."); Michael L. Closen, HIV-AIDS in the 1990s, 27 J. Marshall L. Rev. 239, 240–41 (1994) ("Medical care experts roundly view mandatory HIV-testing statutes as contrary to sound health care goals"); Lawrence O. Gostin et al., The Case Against Compulsory Casefinding in Controlling AIDS, 12 Am. J.L. & Med. 8, 53 (1986) ("In the absence of evidence that compulsory testing, screening, and reporting alters behavior more effectively than voluntary education and counseling programs, federal and state public health authorities should design their strategies and devote their resources toward voluntary services for groups vulnerable to HIV."); Gostin, supra note 242, at 1019 ("Public health authorities have resisted political and public pressure for the use of coercive powers.").

262 Bayer, supra note 3, at 134. Dr. Bayer was a signatory to the brief of the Amici in *Axelrod*. See Amici, supra note 232, at 1, 4.

263 Bayer, supra note 3, at 134. Several contemporaneous studies had reported, for example, that mandatory measures would deter testing for HIV. See, e.g., Laura
that the Amici informed the Court: "Virtually all public health experts recommend voluntary HIV testing programs like the one the Commissioner has implemented in New York State." 264

The Commissioner's strategy was expressly endorsed by the New York State Legislature, moreover, which articulated the purpose of Article 27-F in the preamble of the Act:

By providing additional protection of the confidentiality of HIV related information, the legislature intends to encourage the expansion of voluntary confidential testing for the human immunodeficiency virus (HIV) so that individuals may come forward, learn their health status, make decisions regarding the appropriate treatment, and change the behavior that puts them and other at risk of infection. 265

The Commissioner's strategy was thus the very antithesis of arbitrary or "without justification," 266 his strategy was carefully constructed and consonant with both prevailing public health wisdom and the express intent of the New York State Legislature.

Notably, however, in two previous lawsuits, appellants had asked the Court to recognize the wisdom of the Commissioner's voluntary strategy. And in both decisions, Doe in 1987 and Corcoran in 1990, the Court had refused. In Doe, the Court rejected appellants' argument that the decision to classify AIDS

Fehrs et al; Trial of Anonymous Versus Confidential Human Immunodeficiency Virus Testing, 2 LANCET 379, 381 (1988) (citing an Oregon study finding that "the option of anonymity seem[ed] to have increased testing by 50% overall and by 125% among gay men"); E. Fordyce et al., Mandatory Reporting of Human Immunodeficiency Virus Testing Would Deter Blacks and Hispanics from Being Tested, 262 J.A.M.A. 349 (1989); Susan M. Kegles et al., Mandatory Reporting of HIV Testing Would Deter Gay Men from Being Tested, 261 JAMA 1246, 1275 (1989); Rose Weitz, Anonymity in Testing for HIV Antibodies: Desired Option, 81 AM. J. PUB. HEALTH 1212, 1213 (1991) ("The most common reason given for not getting tested (mentioned by 50% of untested persons) was not wanting the state to learn if they tested positive. In addition, 36% mentioned fear of discrimination if others learned they had been tested.").

264 Amici, supra note 232, at 18; accord Doe v. Roe, 526 N.Y.S.2d 718, 724 (N.Y. Sup. Ct. 1988) ("Existing regulations and laws, as well as the stated policy of responsible Health Departments and health officials demonstrate a public policy ... unalterably opposed to judicially coerced non-voluntary testing."); S. REP. NO. 101-116, at 8 (1989) ("As long as discrimination occurs, and no strong national policy with rapid and effective remedies against discrimination is established, individuals who are infected with HIV will be reluctant to come forward for testing, counseling and care.").

265 N.Y. PUB. HEALTH LAW § 2780 et seq. (McKinney 1998).

266 See supra note 240 and accompanying text.
as a communicable disease was arbitrary and capricious. "Regardless of the Health Department’s regulations," the Court ruled, "it is agreed that AIDS can be transmitted from person to person by direct exposure to blood, semen or breast milk. That being so, AIDS is routinely viewed as a communicable disease." The plurality proceeded to uphold the prison authorities’ compulsory and punitive policy, deferring to public authorities with no expert basis. As we have seen, that policy was antithetical to the Commissioner’s well-founded public health strategy.

In Corcoran, the Court even more explicitly rejected the Commissioner’s voluntary strategy. Just one year before the Court would unanimously decide Axelrod, the Court unanimously rejected the Commissioner’s conclusion that the use of mandatory HIV testing in insurance contracts was contrary to the health care needs of the public. In fact, the Court adopted the Third Department’s decision, which harshly dismissed the Commissioner’s voluntary strategy as merely “further[ing] the Commissioner of Health’s own objectives in public health.”

It is ironic, then, that just one year later, the Court would acknowledge in Axelrod that the Commissioner’s strategy was rational and supported both by the consensus of public health experts and the New York State Legislature. The soundness of the Axelrod decision merely highlights the errors of the Court in Doe and Corcoran.

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268 See supra notes 102–09 and accompanying text.
270 Although New York continues to eschew mandatory testing, in 1998, the New York State Senate enacted a name reporting and partner notification law, amending Article 21 of the Public Health Law. See N.Y. PUB. HEALTH LAW § 2130 (McKinney 1999); see also Sonia Bhatnager, HIV Name Reporting and Partner Notification in New York State, 26 FORD Urb. L.J. 1457 (1999). The law continues to allow individuals to opt for anonymous testing. See N.Y. PUB. HEALTH LAW § 2138 (McKinney 1999). The move to name reporting and partner notification has been attributed, inter alia, to advances in AIDS medication. See, e.g., AMERICAN CIVIL LIBERTIES UNION, HIV Surveillance and Name Reporting: A Public Health Case for Protecting Civil Liberties (Oct. 1997), available at http://www.aclu.org/issues/aids/namereport.html (“Renewed calls for HIV surveillance are at least partly the result of new developments in the AIDS epidemic, primarily the emergence of promising new medical treatments.”); Bhatnager, supra note 270, at 1460.
V. NORTH SHORE UNIVERSITY HOSPITAL v. ROSA (1995)

A. Background

In North Shore University Hospital v. Rosa,271 patient David Martell ("Martell") was subjected to heightened precautionary measures by the North Shore University Hospital dental clinic ("North Shore") because he was thought to be gay, and thus thought to be at greater risk of transmitting the HIV virus.272 On three occasions in 1985, Martell visited North Shore. On the first visit, Martell was treated without incident. During Martell’s second visit, Martell was questioned about his sexual orientation, any history of intravenous drug use, and infection with HIV or other illnesses. Martell became upset with these questions and left without receiving treatment. Martell returned for a third time in 1985, however, and was treated in accordance with North Shore’s "strict isolation techniques." The physicians treating Martell wore two sets of gloves, masks, goggles, full-body disposable gowns, and caps.273 In addition, some of the equipment was draped in plastic, and an orange “x”274 was taped over the “isolated room,”275 at the end of a dark hallway,276 in which Martell was treated. The Court noted that the quality of service provided to Martell was otherwise "no different from that given other patients."277

In December of 1985, Martell filed a complaint with the New York State Division of Human Rights (DHR) alleging that he was denied equal privileges at a public accommodation because he was perceived as being a member of a high-risk group and thus perceived as having a disability (Martell maintained that he was neither gay nor living with HIV).278 A hearing was conducted before an Administrative Law Judge (ALJ), who

272 Id.
273 Id. at 484.
274 The Court omitted to mention that the “x” was orange, stating only that it was “small.” Id. at 483. The color of the “x” is described in the appellate division decision. N. Shore Univ. Hosp. v. Rosa, 600 N.Y.S.2d 90, 91 (2d Dep’t 1993).
275 Rosa, 657 N.E.2d at 485.
276 Id. Judge Smith did not mention the fact that Martell was treated “at the end of a dark hallway” in his initial recitation of the facts; he mentioned it later, in describing Martell’s complaint. Id. at 484.
277 Id. at 483.
278 Id. at 485.
determined that North Shore discriminated against Martell because of his perceived disability; that the "isolation treatment" caused Martell unnecessary embarrassment and humiliation; and that North Shore's infectious disease protocol constituted an illegal discriminatory practice.\textsuperscript{279} Adopting a number of the ALJ's findings, the Commissioner of DHR ordered North Shore, inter alia, to cease using a dental protocol based upon a patient's perceived disability; to pay Martell $25,000 in compensation for his mental anguish; to educate its staff on the transmission of HIV/AIDS; and to utilize universal infection precautions for all patients.\textsuperscript{280} Both the appellate division and court of appeals voted unanimously to annul the Commissioner's determination.

B. The Decision

Judge Smith began this 1995 opinion by noting, "In 1985, the knowledge of medical professionals regarding the contraction and transmission of AIDS was by all accounts limited."\textsuperscript{281} In the early to mid-1980s, Judge Smith explained, "[T]he perception was that simply being a member of specific groups or classes was a tell-tale sign that an individual was at a greater risk of contracting and transmitting the disease."\textsuperscript{282} North Shore developed its protocol "some time around 1983," prior to the release of the Centers for Disease Control's (CDC) "Recommended Infection Control Practices for Dentistry" in April 1986.\textsuperscript{283} North Shore did, however, consult sources from the CDC and the American Dental Association.\textsuperscript{284} Pursuant to North Shore's protocol, "strict isolation techniques" were utilized for persons testing positive for HIV or hepatitis B, intravenous drug users, patients who had received multiple blood transfusions, hemodialysis patients, persons suffering from mononucleosis or tuberculosis, homosexual men, and prostitutes.\textsuperscript{285}

\textsuperscript{279} Id. at 484.
\textsuperscript{280} Id. at 485.
\textsuperscript{281} Id. at 484.
\textsuperscript{282} Id. at 484.
\textsuperscript{283} Id. (citing CENTERS FOR DISEASE CONTROL AND PREVENTION, Recommended Infection-Control Practices for Dentistry, 35 MORBIDITY & MORTALITY WKLY. REP. 237 (April 18, 1986)); see infra notes 302–04 and accompanying text.
\textsuperscript{284} Rosa, 657 N.E.2d at 484.
\textsuperscript{285} Id. at 483.
Judge Smith explained that Martell established a prima facie case of discrimination. The burden then shifted to North Shore to rebut the presumption of discrimination by showing a legitimate, nondiscriminatory reason for the differential treatment. The Court ruled that North Shore did this “by showing that at the relevant time, its protocol was reasonable, medically warranted and consistent with its desire to protect patients and staff from the spread of infectious diseases.”

Quite simply, North Shore demonstrated that its protocol was based upon “prevailing medical perceptions at the time,” and was not merely a pretext for discrimination. Indeed, “the evidence shows that infection control practices similar to [North Shore’s] were widespread in dental offices in the early 1980s.” Accordingly, the Commissioner’s finding “was not supported by substantial evidence,” and was correctly annulled by the Appellate Division.

At first blush, the decision to observe heightened precautions in the age of AIDS appears both reasonable and medically appropriate. The problem is that the Court sweepingly included, under the same broad brush, practices that were “based upon prevailing medical knowledge” and those that not were not medically justified and thus objectionable. Specifically, the Court cited no medical justification for North Shore’s practice of treating suspected at-risk patients “in an isolated room located at the end of a dark hallway,” or for placing a conspicuous orange “x” over the door of the isolated room. Indeed, in 1983, when North Shore developed its protocol, the CDC issued guidelines for clinical personnel who work with patients known or suspected to be living with HIV. The CDC recommended the use of gloves, masks, and protective eyewear when performing dental or oral surgical procedures; conspicuously absent was any recommendation concerning isolation or blatant identification, such as North Shore

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286 Id. at 485.
287 Id.
288 Id. at 486.
289 Id.
290 Id. at 485.
291 Id.
utilized. North Shore's unnecessary practices not only unfairly stigmatized patients, but the practice of identifying selected patients with an orange "Scarlett letter" over the treating room door threatened wrongfully to identify such patient as potentially living with HIV.

Under established New York law, the standard for reviewing an administrative determination such as the Commissioner's is (and was at the time) quite low. The determination must be upheld "[w]hen a rational basis for the conclusion approved by the division is found." As the Court has emphasized, moreover, "[T]he division's expertise in evaluating discrimination claims and formulating appropriate remedies may not be lightly disregarded in view of its wide discretion, legislatively endowed, to weigh and assess the conduct of the parties and to reach conclusions based on what is fairly inferable from the facts." Hence, "where there is room for choice, neither the weight which might be accorded nor the choice which might be made by a court are germane upon an analysis for the presence of substantial evidence before the commissioner." Under these governing standards, the unnecessary stigmatization caused by North Shore's selective use of "strict isolation techniques," and of the orange "x," provided ample grounds for upholding the Commissioner's finding.

A companion case decided by the Court on the very same day as the North Shore decision, underscores the uniquely objectionable nature of North Shore's practices. In Syracuse Community Health Center v. Wendi A., petitioner complained of the dental staff's use of protective gear and the draping of exposed surfaces in the treatment room. In annulling the

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293 Id.
297 See Howe v. Hull, 873 F. Supp. 72, 78 (N.D. Ohio 1994) ("Discrimination in public accommodation can take the form of the denial of the opportunity to receive medical treatment, segregation unnecessary for the provision of effective medical treatment, unnecessary screening or eligibility requirements for treatment, or provision of unequal medical benefits based upon the disability.") (emphasis added) (citations omitted).
Commissioner's finding of discrimination, the appellate division emphasized that "the treatment rooms are not visible from the waiting area, that the doors to the treatment rooms are kept closed except when staff members go in and out, and that no one but the patient and clinic staff members were aware that the precaution of draping had been utilized." The court expressly stated that respondent's actions were not discriminatory because they were taken "in the privacy of the treatment room in the case of an identified HIV positive patient." This is fundamentally different, and less onerous, than the practices utilized by North Shore.

A more difficult issue is the Court's acceptance of North Shore's argument that, in light of the prevailing medical consensus in 1985, it was permissible to subject only certain classes of patients for heightened precautions. Had the events in question occurred just one year later, there would have been no question that North Shore's practices were contrary to the prevailing medical consensus. As the Court noted, in the CDC's April 1986 "Recommended Infection-Control Practices for Dentistry," the CDC advised dentists to utilize universal precautions for all patients in light of the fact that "all infected patients cannot be identified by history, physical examination, or readily available laboratory tests." The Surgeon General of the United States repeated this advice in a 1987 report, also

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300 Id.
301 N. Shore Univ. Hosp. v. Rosa, 657 N.E.2d 483, 484 (N.Y. 1995). The Court explained:

[In the early to mid 1980s, the perception was that simply being a member of specific groups or classes was a tell-tale sign that an individual was at a greater risk of contracting and transmitting the disease. Subsequent research, however, revealed that life-style and behavior patterns played a substantial role in an individual's contracting the AIDS disease.]

Id.

302 See supra note 283 and accompanying text.
303 Under "universal precautions," the blood and certain body fluids of all patients are considered potentially infectious for the HIV virus, hepatitis B virus, and other bloodborne pathogens. Universal precautions are intended to prevent exposure to these pathogens. See CENTERS FOR DISEASE CONTROL AND PREVENTION, Perspectives in Disease Prevention and Health Promotion Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health-Care Settings, 37 MORBIDITY & MORTALITY WKLY. REP. 377 (June 24, 1988).
304 Id.
cited by the Court, as did the CDC in its uncited "Recommendations for Prevention of HIV Transmission in Health-Care Settings," which advised: "Since medical history and examination cannot reliably identify all patients infected with HIV or other blood-borne pathogens, blood and body-fluid precautions should be consistently used for ALL patients."

The Court concluded that in 1985, before these documents were issued, North Shore simply could not have been required, under prevailing medical standards, to utilize universal precautions, i.e., to treat all patients with the same precautionary measures. As the Court itself noted, however, "the American Dental Association issued guidelines regarding infection control recommending universal precautions as early as 1977." This would have removed the stigma that North Shore reserved for those even suspected of living with HIV, or of being gay, among other things. Additionally, of course, it would have reduced the potential for unwitting transmission of HIV, hepatitis B, and other bloodborne pathogens. In a 1985 report cited in passing by the Court, moreover, the U.S. Department of Health and Human Services (DOH) also recommended utilizing "routine" precautions to prevent the

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305 Rosa, 657 N.E.2d at 484 (citing U.S. DEPT OF HEALTH AND HUMAN SERVICES, SURGEON GENERAL'S REPORT ON AIDS (1987)).
307 Id.
308 Rosa, 657 N.E.2d at 484 (emphasis added).
309 See World News Tonight with Peter Jennings (ABC television broadcast, March 8, 1990) ("Universal precautions takes the pressure off health care workers to treat patients differently. That means no single patient is the object of medical discrimination and that all patients are handled with healthy and appropriate caution."). In Syracuse Community Health Center, in contrast to North Shore, the dental staff "took universal precautions with all patients," and draped exposed surfaces only "[w]hen the staff knew that a patient was HIV positive . . . ." Syracuse Cmty. Health Ctr. v. Wendi A., 604 N.Y.S.2d 406, 406 (4th Dep't 1993).
310 See John H. Lewis, Protect All Hospital Workers from AIDS, WASHINGTON POST, Sept. 27, 1988, at A20 ("Universal precautions protect workers from all blood-borne diseases, especially Hepatitis B, which causes significantly more deaths among health care workers annually than AIDS.").
311 See Scott Burris, Dental Discrimination Against the HIV-Infected: Empirical Data, Law and Public Policy, 13 YALE J. ON REG. 1, 8 (1996) ("[L]ong-standing guidelines have established a system of universal precautions applicable to all patients regardless of HIV status. Widely adopted by dentists, these precautions have dramatically reduced occupational exposures to patient blood.").
spread of HIV, herpes, and hepatitis, explaining that "[b]ecause not all infected patients can be identified by history, examination, or readily available laboratory tests, the following precautions are best adopted routinely." Nonetheless, the Court decided that the ADA and DOH guidelines did not reflect the prevailing wisdom, and thus that North Shore's practices were grounded in the existing consensus.

Under the Court's decision in Elaine W. v. Joint Diseases North General Hospital, Inc., however, the question whether North Shore's protocol was medically justified should have been decided by a finder of fact. In Elaine W., the Court established that "[a] factfinder will have to resolve whether [respondent's] policy is justified by sound medical opinion." The Court also noted that "[t]he mere proffering of a medical explanation, when disputed by other evidence, does not validate [respondent's] . . . policy." Under Elaine W., then, the Court should have remanded the case to the Commissioner, as the finder of fact, for a more exacting determination whether the specific procedures utilized by North Shore were medically justified. A remand would have revealed, at the very least, that North Shore's isolation techniques were unjustified and thus discriminatory. Like Doe and Corcoran, however, and in stark contrast to Ware, the Court assumed on its own the role of factfinder to invalidate a decision taken on behalf of persons living with, or suspected of living with, HIV. The Court not only failed to defer to the Commissioner, as it did in Doe, but it failed even to remand for further factual findings, as in Ware.

Finally, North Shore underscores the need for sexual orientation protection in New York State. The policy of singling out gay patients for strict isolation techniques was blatantly discriminatory; there was certainly no proof in the record that Martell was HIV positive. North Shore's only grounds for singling out Martell was the suspicion that he was

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312 U.S. DEPT OF HEALTH & HUMAN SVCS., Preventing the Transmission of Hepatitis B, AIDS, and Herpes in Dentistry 1, 7 (1985). The Report also noted, inter alia: "In some cases, the carriers of viruses associated with these diseases cannot clearly be identified by dental personnel who may unknowingly be exposed to AIDS, herpes, and hepatitis B." Id. at 1.


314 Id. at 525.

315 Id. at 524.

The mere fact that such practices may have been “widespread,” The case of Doe v. District of Columbia Commission on Human Rights is elucidating on this point. In Washington, D.C., where discrimination based upon sexual orientation is expressly prohibited, medical staff unlawfully drew and tested petitioner’s blood on the suspicion that he was gay. In addition, hospital staff utilized “blood and body fluid precautions” in light of the fact that petitioner “had a history of sexually transmitted diseases and suffered from hepatitis.” Because the use of heightened precautions was “based upon petitioner’s medical history,” the D.C. Court of Appeals (D.C.’s highest court) concluded that “the hospital implemented blood and body precautions based on valid medical concerns, rather than on petitioner’s sexual orientation.” In a concurrence, Associate Judge Ferren commented:

I want to emphasize that nothing in the majority opinion should be understood to support an argument that sexual orientation, without a medical history of sexually transmitted diseases, can serve as a proper basis for any discriminatory treatment. Nor, as I see it, can sexual orientation properly be considered even a high risk factor absent such a medical history. Any reference to homosexuality in this case as a high risk factor, therefore, is relevant only because of the history of sexually transmitted diseases.

Although the events in Doe v. District occurred in 1987, this principle is equally applicable to North Shore. In a just society, mere membership in a group alleged to disproportionately exhibit a trait cannot, without more, justify disparate treatment

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317 Bruner, supra note 183, at 1126 n.55; see Schatz, supra note 173, at 1783 (“AIDS is not a ‘gay disease.’ According to current projections, the vast majority of gay and bisexual men will not develop AIDS.”); Li, supra note 10, at 477–78.
321 Doe, 624 A.D.2d at 445.
322 Id.
323 Id. at 446.
324 Id. at 448 (Ferren, J., concurring).
of individuals from that group. As the Court observed in Elaine W., "[A] generalization may not serve to validate prohibited discrimination." This is particularly the case when the group in question is, like gay Americans, a group subjected to widespread societal prejudice.

VI. CAHILL v. ROSA (1996)

A. Background

In Cahill v. Rosa, the Court examined the question whether private dental offices are "place[s] of public accommodation" under the New York State Human Rights Law. In two separate cases, consolidated on appeal, complainants alleged that defendants discriminated against them, in violation of the Human Rights Law, by refusing to treat them because they were known or suspected to be living with HIV. In each case, following administrative proceedings, an Administrative Law Judge sustained the complainant's charges and awarded compensatory damages for mental anguish. The Commissioner of the New York State Division of Human Rights (the "Commissioner") adopted these findings. The Appellate Division, Second Department (the "Second Department"), voted unanimously to annul each of the Commissioner's rulings.

Nor can the cost of treating such individuals justify disparate treatment. In a 1993 decision, the Seventh Circuit explained that the cost of implementing universal precautions "can hardly be thought so great as to imperil dentistry. Annualized, these costs are estimated to be equal to less than one-third of one percent of the industry's annual revenues." Am. Dental Ass'n v. Martin, 984 F.2d 823, 829 (7th Cir. 1993); see also Martha A. Field, Testing for AIDS: Uses and Abuses, 16 AM J.L. & MED. 34, 63 (1990) ("From a point of view of medical safety as well as from a civil liberties viewpoint, society is better served by adopting universalist solutions and preventive measures for everyone to follow to avoid infection.").

Elaine W. v. Joint Diseases N. General Hosp., Inc., 613 N.E.2d 523, 526 n.2 (N.Y. 1993); see also id. at 526 ("As the Supreme Court has said: 'even a true generalization about the class is an insufficient reason for disqualifying an individual to whom the generalization does not apply.' ") (alteration in original) (quoting L. A. Dep't of Water v. Manhart, 435 U.S. 702, 708 (1978)).

Cahill, 674 N.E.2d at 274 (N.Y. 1996).


Cahill, 674 N.E.2d at 274.


See Cahill, 632 N.Y.S.2d at 614; Lasser, 634 N.Y.S.2d at 189.
a sharply divided 4-3 decision, the Court reversed the Second Department's decisions.

B. The Decision

Under the Human Rights Law, it is "an unlawful discriminatory practice for any person, being the owner, lessee, proprietor, manager, superintendent, agent or employee of any place of public accommodation... because of the... disability... of any person... to refuse, withhold from or deny to such person any of the accommodations, advantages, facilities or privileges thereof." The term "place of public accommodation" is specifically defined in section 292(9) of the law, which lists places that are and are not included in the definition. Among the places included in the definition are "wholesale and retail stores and establishments dealing with goods or services of any kind."

Defendants raised two main points to support their argument that dental offices are not places of public accommodation under the statute. First, they asserted that dental offices are not included in the statutory list of public accommodations; hence, under the doctrine of *expressio unius est exclusio alterius*, the Legislature did not intend to include dental offices within the statutory definition. Second, they contended that the statutory phrase "wholesale and retail" modifies the phrase "stores and establishments dealing with goods or services of any kind," and because dental offices are not wholesale or retail establishments, they are not covered by the

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333 Section 292(9) states:
The term "place of public accommodation, resort or amusement" shall include, except as hereinafter specified, all places included in the meaning of such terms as: inns, taverns, road houses, hotels, motels...; buffets, saloons, barrooms...; wholesale and retail stores and establishments dealing with goods or services of any kind, dispensaries, clinics, hospitals, bath-houses, swimming pools, laundries... Such term shall not include public libraries, kindergartens, primary and secondary schools, high schools, academies, colleges and universities...; or any institution, club or place of accommodation which proves that it is in its nature distinctly private.
334 Id.
335 *See* BLACK'S LAW DICTIONARY 581 (6th ed. 1990)
Tellingly, the Court announced that “[a]nalysis starts by recognizing that the provisions of the Human Rights Law must be liberally construed to accomplish the purposes of the statute.” In North Shore, the Court neither began its analysis with this statutory maxim nor even cited the maxim in its decision. Addressing defendants’ first argument, the Court observed that the statute utilizes “broad and inclusive language” in setting forth the list of included places. “The prefatory sentence [to the Human Rights Law],” the Court observed, “states that ‘[t]he term ‘place of public accommodation, resort or amusement’ shall include, except as hereinafter specified, all places included in the meaning of such terms as.’” The list that follows this broad language, moreover, “is illustrative, not specific.” The omission of dental offices from the illustrative list of places included was thus in no way dispositive.

The omission of dental offices from the narrow list of exempted places was, by contrast, significant. As the Court explained, the “narrow and restrictive language identifying [places exempted] stands in stark contrast to the expansive language identifying those included within the definition of a ‘place of public accommodation.’” This indicates that the Legislature intended that the inclusive list be broadly construed, and the exemptions narrowly construed. The omission of dental offices from the list of places exempted therefore suggests that the Legislature did not intend their exemption.

Similarly, because the Court was called upon to determine whether dental offices were “included in the meaning” of the enumerated places, the doctrine of expressio unius was inapplicable. The Legislative History supports this liberal interpretation. As the Court explained, the Legislature has repeatedly amended the statute to expand its scope, and in 1960, it deleted a limiting phrase from the statute. Hence, “the

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338 Id. at 276 (quoting N.Y. EXEC. LAW § 292(9) (McKinney 1993 and Supp. 2000)).
339 Id.
340 Id. at 277 (quoting N.Y. EXEC. LAW § 292(9) (McKinney 1993 and Supp. 2000)).
Legislature used the phrase place of public accommodation in the broad sense of providing conveniences and services to the public,341 and it "intended that the definition of place of accommodation should be interpreted liberally."342

Turning to defendants' second argument, the Court concluded that "[t]he language of the statute is ambiguous at best and the ambiguity is unresolved by legislative history."343 The Court had previously ruled, however, that "the statute generally applies to 'establishments' of any kind, implicitly interpreting that phrase as separate from and not modified or limited by the phrase 'wholesale and retail.' "344 The Court adopted this interpretation in Cahill.

The only remaining question, then, was whether dental offices are covered in the meaning of the term "establishments dealing with goods or services of any kind." Because dental offices "provide services to the public," the Court concluded, they are places of public accommodation.345 The fact that such offices are located on private premises, or that clients are generally seen by appointment, did not alter the Court's conclusion. Dentists draw clients through advertisements, telephone listings, referrals, and, in the case of one of the defendants, by a signs displayed on the premises.346 Significantly, defendants did not claim that their practices were limited in any way. Neither of the defendants "offered evidence that his patient roster was selective or exclusive, or that his practice was not generally held open to the public."347 Indeed, in one of the cases before the Court, the complainant "walked into the office as a new patient without an appointment and originally was accepted for treatment."348 Accordingly, the Court found that dental offices "are generally open to all comers" and are thus places of public accommodation.349 The Court noted, finally, that the decision would not result in any hardship to dentists, because "all licensed health care workers in this State are required to use

341 Id. at 276 (internal quotations omitted).
342 Id. (citing U.S. Power Squadrons, 452 N.E.2d. at 1203).
343 Id. at 276.
344 Id. at 277 (citing U.S. Power Squadrons, 452 N.E.2d at 1204).
345 Id. at 276.
346 Id. at 277.
347 Id.
348 Id.
349 Id.
‘universal precautions’ in all situations in which there is potential for the transmission of virus[es].”

The Court’s reasoning in Cahill was sound. The statute was indeed ambiguous, like so many state public accommodation statutes. The simple use of a comma to convey an expansive reading (“wholesale and retail stores, and establishments dealing with goods or services of any kind”) or a virgule to convey a restrictive reading (“wholesale and retail stores/establishments dealing with goods or services of any kind”) would have clarified the Legislature’s intent. The Legislature provided neither, leaving it to the courts to divine the scope of the statute. The courts were not, however, without guidance. Under established New York law, remedial statutes such as the Human Rights Law must be construed broadly to effectuate their purpose. Significantly, in the Human Rights Law, the Legislature codified this general principle in the statute itself; expressly mandating that “[t]he provisions of this article shall be construed liberally for the accomplishment of the purposes thereof.” More specifically, over a decade before Cahill, the Court concluded that the statute “defines ‘place of public accommodation, resort or amusement’ inclusively and illustratively, and sets forth an extensive list of examples of places within the statute.” The Legislature, moreover, expanded this definition over the years, “a clear indication that the Legislature intended that the definition of place of accommodation should be interpreted broadly.”

Thus, in several cases leading up to Cahill, the Court refused to construe the public accommodations language narrowly. As the Court explained, “[I]t is the duty of courts to

350 Id. at 278 (citation omitted).
352 See, e.g., Braschi v. Stahl Assoc. Co., 543 N.E.2d 49 (N.Y. 1989); Sanders v. Winship, 442 N.E.2d 1231, 1233 (N.Y. 1982) (“Our analysis may well start with the obvious fact that the statute, expressive of fundamental State policy and expressly purposed to combat the specific discrimination quoted above, is to be regarded as remedial in nature and, therefore, liberally construed.”) (citations omitted).
354 U.S. Power Squadrons, 452 N.E.2d at 1202–03.
355 Id. at 1203.
make sure that the Human Rights Law works and that the intent of the Legislature is not thwarted by a combination of strict construction of the statute and a battle with semantics. The Court refused "to assume that, in framing such a statute, the Legislature did not act with a consciousness that anti-discrimination edicts all too commonly are circumvented unless they are comprehensive in their application." After all, the general purpose of the statute "is a more important aid to the meaning than any rule which grammar or formal logic may lay down."

Finally, it is also established under New York law that where there is doubt as to the meaning of terms, and a choice between two constructions is afforded, courts will adopt the construction that avoids injustice, hardship, or other objectionable results. Given the Legislature’s express directive that the statute be liberally construed, the broad and inclusive language of the subsection in question, and the established principles of statutory construction favoring a liberal construction, the Court’s inclusive reading of the statute was wholly appropriate. As the Court eloquently explained:

To hold otherwise would impute to the Legislature approval of legal discrimination by dentists (and other health care providers) on the basis of disability, race, gender, or any other protected classifications. Finding a categorical exemption in this context would signify that the Legislature intended that persons with disabilities should be free from discrimination in such places as ice cream parlors and skating rinks, but that dental and medical providers could lawfully deny health care to them solely on the basis of their disability, a result wholly

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357 Sanders, 442 N.E.2d at 1233 (N.Y. 1982)
359 See, e.g., In re Jacob, 660 N.E.2d 397, 405 (N.Y. 1995); Braschi, 543 N.E.2d at 51.
360 See Quinnipiac Council, Boy Scouts of Am. v. Comm’n on Human Rights and Opportunities, 528 A.2d 352, 358 (Conn. 1987) (examining a public accommodations law deemed ambiguous on the point at issue). The court found that "the unconditional language of the statute, the history of its steadily expanded coverage, and the compelling interest in eliminating discriminatory public accommodation practices persuade us that the physical situs is not today an essential element of our public accommodation law." Id.
inconsistent with the purposes of the Human Rights Law.\textsuperscript{361}

The dissent made no mention of the general purpose of the Human Rights Law. Likewise, the dissent did not begin its analysis by acknowledging that the Court must construe the statute liberally to effectuate its remedial purpose. Instead, in its opening sentence, the dissent complained that the Court's construction "will result in an explosive increase in the jurisdiction of the State Division of Human Rights."\textsuperscript{362} The question whether the Court's interpretation would increase jurisdiction—and thus litigation—was irrelevant, however, to the question whether dental offices are covered under the statute.

In addition, if the Legislature had intended to restrict the jurisdiction of the Division of Human Rights, it would not have included explicit language mandating a liberal, rather than restrictive, reading of the statute. The Legislature plainly intended an expansive jurisdiction to eradicate the cancer of discrimination\textsuperscript{363} throughout the State of New York, save in narrowly enumerated circumstances. Indeed, as noted, even without this explicit language, courts must construe statutes such as the Human Rights Law liberally to effectuate their overarching, and noble, purpose.\textsuperscript{364} Hence, it is neither an argument against a liberal interpretation nor a proper subject of lamentation that the Court's ruling will expand the protections against discrimination in New York State. Rather, it is cause for celebration when the Court can strike down discriminatory practices such as those at issue in \textit{Cahill} while in no way abrogating—indeed while furthering—the Legislature's intent and purpose. In any event, if the Court had been mistaken in its interpretation, the Legislature could have amended the statute to clarify its intent.\textsuperscript{365} It did not.

\textsuperscript{361} Cahill v. Rosa, 674 N.E.2d 274, 277–78 (N.Y. 1996).
\textsuperscript{362} Id. at 278–79 (Levine, J., dissenting).
\textsuperscript{363} See Carusone, \textit{supra} note 351, at 864 ("the goal of public accommodation statutes is to eradicate the invidious 'cancer of discrimination'") (quoting Fuchilla v. Layman, 537 A.2d 652, 660 (N.J. 1988)).
\textsuperscript{364} See \textit{supra} note 337 and accompanying text.
Finally, the Cahill decision simply brought New York in accord with the contemporary view of dental offices as places of public accommodation. The Americans with Disabilities Act, enacted by Congress in 1990, expressly includes, as a place of public accommodation, "a professional office of a health care provider, hospital, or other service establishment." This includes dental offices. The dissent, concerned with the "traditional uses of the phrase," failed to grasp this fact, arguing that a dental office "traditionally lacks that openness of access by the general public that has been an essential characteristic of a place of public accommodation." The facts in Cahill demonstrate that if this was traditionally the case, it is no longer. As one commentator explained, "Rigidly enforcing outdated conceptions of what constitutes a 'place of public accommodation' might have the effect of enshrining public policies that are outdated and have been repudiated by later legislation." Fortunately, the majority in Cahill refused to do so.

VII. MIXON v. GRINKER (1996)

A. Background

In Mixon v. Grinker, petitioners challenged the adequacy of New York City's program to provide emergency housing for homeless persons living with HIV illness but not AIDS, as defined by the CDC. Petitioners asserted that placing individuals living with HIV illness in the city's barracks-style shelters, where many residents have infectious diseases, endangered the lives of such severely immuno-compromised individuals. Petitioners argued that the city was required to provide them with "medically appropriate housing which

369 Id. at 280 (emphasis added).
370 See supra notes 346–49 and accompanying text.
371 Singer, supra note 365, at 1423.
includes, at a minimum, a private sleeping area and sanitary facilities.\textsuperscript{373}

After petitioners filed suit, the city devised a Comprehensive Care Program (CCP), under which homeless persons living with HIV illness or in frail condition were placed in "dormitory" style rooms, with up to twelve persons in a room.\textsuperscript{374} Residents shared common eating and bathroom facilities and received enhanced nutrition and on-site medical coverage.\textsuperscript{375} Individuals seeking admission to this housing were required to submit to a skin test and an X-ray to detect tuberculosis (TB). Those with infectious TB would not be admitted but would instead be referred to a hospital.\textsuperscript{376} As the trial court explained, however:

\begin{quote}
[I]t was established at trial that the skin test and X-ray cannot always determine the existence of active TB in a person with an HIV infection because of the manner in which the body's immune system is damaged. This is especially so with respect to persons with multiple drug resistant TB, a condition prevalent among many homeless persons who have failed to complete a prior prescribed regimen of drug treatment for TB. Tests to determine whether a person has multiple drug resistant TB can take several months.\textsuperscript{377}
\end{quote}

The city argued that the CCP was nonetheless a "rational means of allocating scarce resources among the many homeless persons seeking public assistance."\textsuperscript{378}

Judge Edward H. Lehner of the New York Supreme Court explained that the city's regulation "must, unless irrational, be upheld by the courts which should not determine which of conflicting medical opinions is correct."\textsuperscript{379} Judge Lehner found, however, that "a program that can place as many as 12 persons with weakened immune systems in a single room lacks a rational basis."\textsuperscript{380} Judge Lehner emphasized that the city could not reliably determine whether a person was suffering from multiple drug resistant TB,\textsuperscript{381} a disease that had "reached nearly

\textsuperscript{373} Mixon v. Grinker, 595 N.Y.S.2d 876, 878 (Sup. Ct. N.Y. County 1993).
\textsuperscript{374} Id. at 879.
\textsuperscript{375} Mixon, 669 N.E.2d at 820.
\textsuperscript{376} Mixon, 595 N.Y.S.2d at 879.
\textsuperscript{377} Id. at 879.
\textsuperscript{378} Id.
\textsuperscript{379} Id. at 880.
\textsuperscript{380} Id.
\textsuperscript{381} For a discussion and scientific explanation of multi-drug resistant tuberculosis, see Lawrence O. Gostin, \textit{The Resurgent Tuberculosis Epidemic in the}
epidemic proportions among the homeless who are HIV infected."\textsuperscript{382} This could lead to individuals spreading the illness throughout the program for months before being detected, a danger also posed by "other infectious diseases."\textsuperscript{383}

Based on the extensive testimony proffered at trial, Judge Lehner found that there were "'emergency circumstances' presented by the unfortunate fate of the plaintiffs who have no home and face an uncertain future as a result of being infected with an illness that regrettably still is not fully understood."\textsuperscript{384} And while he refused to order the city to provide petitioners with housing in private rooms, as provided to persons living with AIDS, Judge Lehner ruled that, "under the circumstances it would be irrational to place more than four persons of the plaintiff class in one room."\textsuperscript{385} Judge Lehner specified that beds in the facilities should be no closer than eight feet apart; that rooms should be properly ventilated; and that residents should be given the option to eat and use bathroom facilities separate from the general population of the facilities.\textsuperscript{386}

On appeal from both parties, the Appellate Division, First Department ("First Department"), quoting \textit{McCain v. Koch},\textsuperscript{387} ruled that when the government undertakes to provide emergency housing for the homeless, "it must do so in a way 'which satisfies minimum standards of sanitation, safety and decency.'"\textsuperscript{388} Indeed, citing a string of cases, the First Department explained that "the judiciary has consistently acted to guarantee minimum health and safety standards for emergency housing."\textsuperscript{389} The voluminous record in \textit{Mixon}\textsuperscript{390} supported the trial court's finding that the CCP's tests failed reliably to detect multiple drug resistant TB, a disease of "near epidemic proportions among the homeless who are HIV

\textsuperscript{382} \textit{Id.} at 880.
\textsuperscript{383} \textit{Id.}
\textsuperscript{384} \textit{Id.} at 880–81.
\textsuperscript{385} \textit{Id.} at 881.
\textsuperscript{386} \textit{Id.}
\textsuperscript{387} 511 N.E.2d 62 (N.Y. 1987).
\textsuperscript{388} \textit{Mixon v. Grinker}, 627 N.Y.S.2d 668, 672 (1st Dep't 1995).
\textsuperscript{389} \textit{Id.} at 674.
\textsuperscript{390} The First Department noted that the record consisted of "ten bound volumes." \textit{Id.} at 675.
infected." Thus, because the city's housing "fail[ed] to sufficiently protect [petitioners] against the dangers of tuberculosis," the CCP did not meet the minimum standards required under *McCain*.

Because the trial court's plan would not improve the CCP, the First Department vacated the plan and remanded the case for a hearing as to the modifications required to make the City's housing "minimally habitable." The ultimate plan, the First Department observed, "must present more than an illusion of protecting the HIV-ill from exposure to tuberculosis." The First Department agreed with the trial court that there is no constitutional or statutory requirement "per se" that the city provide petitioners with the same housing provided to homeless persons living with AIDS. The court noted, however, that the Supreme Court may well conclude that the only manner to provide "minimally habitable" emergency housing to petitioners is through the use of one or more forms of housing offered to homeless persons living with AIDS.

In a unanimous decision, the Court reversed.

B. The Decision

After setting forth the facts, the Court explained its reasoning in two short paragraphs, in which the Court merely distinguished *Mixon* from the Court's decision in *McCain*. The Court explained that the First Department's reliance upon *McCain* "as authority for their judicial scrutiny of the CCP was misplaced." The Court's equitable authority to fashion minimal standards of habitability "is an extraordinary judicial task reserved for a situation when no departmental guidelines exist." Indeed, in *McCain*, the Court emphasized that "[i]t was because of the absence of any departmental regulation that it was necessary for the court to establish its own minimum standards."

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391 *Id.*
392 *Id.*
393 *Id.* (quoting *McCain v. Koch*, 511 N.E.2d 62, 66 (N.Y. 1987)).
394 *Id.*
395 *Id.* at 675.
396 *Id.*
398 *Id.*
399 *Id.*
Once the government “adopted regulations establishing standards of minimal habitability,” however, “so long as the regulations are in effect, no question can exist concerning the minimum standards for the accommodations to be provided.” In Mixon, in contrast to McCain, the city formulated “a comprehensive program,... with input from public health experts including the director of the AIDS Institute, for housing HIV-ill and other medically frail individuals.”

Under such circumstances, the Court ruled, “McCain does not confer upon plaintiffs the rights to plenary judicial review of the merits of the special medical needs housing program embodied in departmental guidelines.”

After eight years of litigation, with a lengthy trial, “voluminous exhibits,” and an appellate record of “ten bound volumes,” the Court refused even to consider the facts, or petitioners’ legal claims. The Court’s deference to the city was not merely substantial; it was absolute. Indeed, unlike the lower courts, the Court did not review the CCP with even minimal, “rational basis” scrutiny. Instead, the Court imposed no standard at all, perfunctorily declaring that petitioners had no right to challenge the city’s plan on any basis. Most troubling of all, the Court did so despite the findings of two lower courts, including the trier of fact, that the city’s plan created “emergency circumstances,” exposing petitioners to illnesses that “endanger the health and safety of individuals who are among the most vulnerable.” The Court thus violated a well-established principle of appellate review: “A trial court’s finding of fact, if affirmed by the Appellate Division, is beyond the review powers of this Court [of Appeals] provided the finding is supported by evidence on the record.”

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400 Id.
401 Id. at 821.
402 Id. (citing N.Y. State Soc’y of Surgeons v. Axelrod, 572 N.E.2d 605 (N.Y. 1991)).
403 Mixon v. Grinker, 627 N.Y.S.2d 668, 675 (1st Dep’t 1995).
404 Id.
407 Mixon, 627 N.Y.S.2d at 674.
In support of its decision, the Court cited only two cases: *McCain* and *Axelrod*. Ironically, however, both of these cases unequivocally established petitioners' right to judicial review of the city's plan under a rational basis analysis. The Court relied heavily upon a passage in *McCain* stating that "so long as the regulations are in effect, no question can exist concerning the minimum standards for the accommodations to be provided."\(^{409}\)

The *McCain* Court directed this language not at petitioners, however, but at the government. The government had challenged the right of petitioners to demand minimum standards of habitability in the shelters. The Court pointed out that, while the litigation was pending, the city’s obligation to provide minimum standards of habitability had been codified in departmental regulations. So long as those regulations remained in effect, the city could not challenge its obligation to meet the minimum standards established, because "they [were] commanded by statute to do so."\(^{410}\) The Court was certainly not seeking to establish, wholly without precedent, that petitioners could never challenge a plan adopted by the city on any grounds. Indeed, the Court in *McCain* confirmed that petitioners could challenge the city's regulation, albeit on limited grounds: "The regulation, reflecting the choice made by the department,... is beyond our power to disturb unless it is 'so lacking in reason for its promulgation that it is essentially arbitrary.' "\(^{411}\)

In *Axelrod*, the Court confirmed the right of petitioners to challenge the determinations of public health experts. There, the Court explained: "Our review is limited to whether respondents' determination is rationally based, i.e., whether it is unreasonable, arbitrary or capricious."\(^{412}\) The right to challenge governmental actions or decisions as unreasonable, irrational, or arbitrary and capricious is, in fact, well established in New York law.\(^{413}\) Consequently, even the city in *Mixon* urged that the

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\(^{409}\) 669 N.E.2d at 820 (quoting McCain v. Koch, 511 N.E.2d 62, 66 (N.Y. 1987)).

\(^{410}\) *McCain*, 511 N.E.2d at 67 (citations omitted).

\(^{411}\) *McCain*, 511 N.E.2d at 66 (quoting Marburg v. Cole, 36 N.E.2d 113 (N.Y. 1941)).


Court apply rational basis scrutiny to their plan.414

There was simply no basis, in *McCain, Axelrod*, or otherwise, upon which to deny petitioners the right to judicial review of the city's plan. The Court's complete refusal to examine petitioners' claims was an unprecedented abdication of the Court's duties. What is worse, it was an abdication in the face of life-threatening, "emergency circumstances." The 1990s witnessed a resurgence in TB, which disproportionately affected both the homeless and people living with HIV.415 TB has long been a significant problem in the homeless community, and studies have confirmed that, "in many inner cities, the level of [TB] among the homeless ranges from eighteen to seventy-nine percent."416 To make matters far worse, persons living with HIV are particularly susceptible to TB. "HIV-infected persons are the most likely to contract TB because HIV severely weakens their immune systems, thereby making them unable to extinguish the TB infection."417 Persons living with AIDS, for example, experience rates of TB 500 times greater than the general population.418 And persons living with HIV are 40 times more likely to progress to active tuberculosis following infection than persons who are not living with HIV.419

The resurgence in TB was also characterized by a high

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414 Mixon v. Grinker, 627 N.Y.S.2d 668, 673 (1st Dep't 1995).
415 See, e.g., ISBELL, supra note 180, at 57; Peter F. Barnes & Susan A. Barrows, *Tuberculosis in the 1990s*, 119 ANNALS INTERNAL MED. 400 (1993); Gostin, supra note 381, at 30–31 ("The HIV epidemic has fueled the resurgence of tuberculosis in major urban areas such as New York . . . .").
417 Bradford, supra note 180, at 289; accord Gostin, supra note 381, at 31–32 ("Many clinicians have long believed that persons with HIV infection are at increased risk of contracting [tuberculosis] infection following exposure, and recent investigations of tuberculosis outbreaks in congregate settings have strongly supported this clinical perception."); Karen H. Rothenberg and Elizabeth C. Lovoy, *Something Old, Something New: The Challenge of Tuberculosis Control in the Age of AIDS*, 42 BUFF. L. REV. 715, 724 (1994) ("The recent rise in TB is especially alarming for HIV-infected individuals, who are particularly susceptible to the disease.").
418 John F. Jewett & Frederick M. Hecht, *Preventive Health Care for Adults with HIV Infection*, 269 JAMA 1144, 1147 (March 3, 1993) ("The incidence of tuberculosis (TB) is substantially increased in HIV-infected individuals, occurring 500 times more commonly in patients with AIDS than in the general population.").
419 See Gostin, supra note 381, at 32.
incidence of multiple drug resistant TB,\textsuperscript{420} which, as the lower courts in \textit{Mixon} explained, had "reached near epidemic proportions among the homeless who are HIV infected."\textsuperscript{421} Multiple drug resistant TB was (and is) devastating for people living with HIV. In one CDC study conducted in the early 1990s, the mortality rate for multiple drug resistant TB in persons living with HIV ranged from 72 to 89 percent, and the median time between diagnosis and death was four to sixteen weeks.\textsuperscript{422}

Finally, as petitioners in \textit{Mixon} demonstrated, congregate shelters are extremely conducive to the spread of tuberculosis, particularly among the immunocompromised. As Lawrence Gostin explains:

If a person were to set out to design facilities that efficiently transmit airborne diseases, then that person might well emulate the physical conditions found in congregate settings in America, such as . . . homeless shelters . . . . In many of these settings, residents live, eat, and sleep in small enclosed spaces; beds are inches or feet apart; and buildings are dark and poorly ventilated. Moreover, the residents of many of these congregate facilities are impoverished, malnourished, and overrepresented in populations that have disproportionately high rates of communicable disease, and in populations that have significantly impeded access to health care services.\textsuperscript{423}

Because TB tests fail accurately to screen for multiple drug resistant TB,\textsuperscript{424} the city’s plan of housing up to 12 individuals in a room placed petitioners at imminent risk of contracting a profoundly lethal illness—TB. As the trial court pointed out, this was also true of other infectious diseases.\textsuperscript{425} There is

\textsuperscript{420} See ISBEL, \textit{supra} note 180, at 57.
\textsuperscript{421} Mixon v. Grinker, 595 N.Y.S.2d 876, 880 (Sup. Ct. N.Y. County 1993).
\textsuperscript{422} See Gostin, \textit{supra} note 381, at 33; Rothenberg, \textit{supra} note 417, at 726.
\textsuperscript{423} See Gostin, \textit{supra} note 381, at 49.
\textsuperscript{424} See Mixon v. Grinker, 627 N.Y.S.2d 668, 675 (1st Dep't 1995); see also Gostin, \textit{supra} note 381, at 35 ("[T]he damage to the immune system caused by HIV makes the tuberculin skin test unreliable."); Jewett & Hecht, \textit{supra} note 418, at 1147 ("The accuracy of tuberculin testing is diminished by anergy in HIV-infected individuals."); Rothenberg and Lovoy, \textit{supra} note 417, at 725 ("Because HIV infection can depress the body's immune response to infection, approximately ten to eighty percent of HIV-infected individuals with TB produce a negative TB skin test.").
\textsuperscript{425} See Mixon, 595 N.Y.S.2d at 880. As one commentator explains:
The HIV-ill are in great danger of developing full-blown AIDS when placed in shelters where the incidence of infectious diseases is very high. Alternatively, the HIV-ill who stay away from shelters because of violence
nothing rational about a plan that places countless individuals at imminent risk of illness and death.

Ironically, perhaps the keenest criticism of Mixon is contained in the First Department's decision. Rejecting the city's argument that the court should refrain from critically assessing the plan, the First Department explained:

While we are cognizant of our role in a tripartite system of government, we decline to adopt the defendants' narrow view which would, in essence, convert the courts into a rubber stamp for any policy developed by municipal and state agencies. If, as here, contradictory evidence has been proffered at a non-jury trial, the court not only has the power, but, in fact, has an affirmative duty to weigh, assess, and evaluate such evidence. In doing so, the court may consider those factors ordinarily considered by a finder of fact in assessing credibility and it need not turn a blind and uncritical eye to the testimony of witnesses who, as authors and proponents of a given policy, have a vested interest in its being upheld. Indeed, when, as here, there is compelling evidence which undermines the purported rationale of an agency's decision or proposal, a court should not fail to act simply out of deference to an agency's proposal, particularly when such a failure would endanger the health and safety of individuals who are among the most vulnerable and least able to obtain redress through the other branches of government.426

In this passage, the First Department has succinctly conveyed the impropriety of absolute deference to a governmental body, particularly in the face of compelling evidence and life-threatening circumstances. Ignoring these critical points, the Court in Mixon assumed, without further examination, an infallible government incapable of abridging the rights of its citizens. The facts in Mixon, however, make it abundantly clear that the government is eminently fallible. On the rationale that the relief petitioners sought would be "financially burdensome or inconvenient," the city refused to alter a plan that both the trier of fact and the First Department concluded, upon a voluminous record, "fail[ed] to sufficiently

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or poor conditions live in alleys, under bridges, in subways, and on benches. They encounter formidable obstacles in obtaining showers, adequate rest, and nutritional meals, which also puts them in great danger of developing full-blown AIDS.

Phillips, supra note 416, at 578.

426 Mixon, 627 N.Y.S.2d at 674 (emphasis added).
protect [petitioners] against the dangers of tuberculosis." \footnote{427} \footnote{Id. at 675.} Tragically, "[b]ecause of the overall political impotence and powerlessness of today's homeless population, homeless [persons living with AIDS] lack the requisite constituency . . . to effect majoritarian reform." \footnote{428} \footnote{Phillips, supra note 416, at 570 (citations and internal quotations omitted).} The Court's refusal to examine the substantial evidence on appeal ensured that the most disenfranchised of citizens—indigent, homeless individuals living with HIV illness—would find no forum in which to obtain relief from the mortal threat of congregate shelter.

VIII. HERNANDEZ v. BARRIOS-PAOLI (1999)

A. Background

In Hernandez v. Barrios-Paoli, \footnote{429} \footnote{720 N.E.2d 866 (N.Y. 1999).} the Court considered the appeal of Daniel Hernandez ("Mr. Hernandez"), a poor person living with clinical/symptomatic HIV illness or AIDS and a client of the New York City Human Resources Administration's (HRA) Division of AIDS Services Income Support (DASIS) (collectively, "Respondents"). As the Court explained, "DASIS is an agency within the Department of Social Services established administratively by HRA in 1985 to assist persons with clinical/symptomatic HIV illness or AIDS in securing vital public benefits and services." \footnote{430} \footnote{See Merjian, supra note 2, at 379–83 (describing the problems faced by persons living with AIDS in obtaining social welfare benefits and the adoption of the DASIS Law to codify basic protections and modifications on their behalf).} Mr. Hernandez brought suit under recently-enacted provisions of the New York City Administrative Code (the "DASIS Law") \footnote{431} \footnote{N.Y. CITY ADMIN CODE §§ 21-126 to 21-128 (Lenz & Riecker, Inc. 2001). The DASIS Law was signed into law in 1997; see Hernandez, 720 N.E.2d at 867.} that, he claimed, eliminated Respondents' Eligibility Verification Review (EVR) for clients of DASIS.

The administration of Mayor Rudolph Giuliani implemented the EVR requirement in 1995 ostensibly to verify clients' eligibility for public assistance and to ferret out fraud. \footnote{432} \footnote{See Hernandez, 720 N.E.2d at 867; see infra notes 455–58 and accompanying text.} The EVR program, administered by staff of HRA's Office of Revenue
and Investigation and not by staff of DASIS, required all clients to travel to Brooklyn, New York for an investigatory interview, followed by a mandatory home visit. Clients who failed to comply with the EVR requirement could be denied benefits on that basis, and benefits would not be provided until clients completed the entire process. The Court noted, for example, that Respondents informed Mr. Hernandez that "without an EVR interview, he would not receive public assistance." The EVR requirement merely duplicated, however, the verification process undertaken in all cases by DASIS staff, who conduct eligibility interviews and home visits to determine eligibility.

"In recognition of the severe limitations and chronic health problems that persons with AIDS face," Mr. Hernandez argued that "the New York City Council enacted the DASIS Law in July of 1997 to facilitate DASIS clients' access to crucial benefits and services, to eliminate unnecessary bureaucratic hurdles, and to decrease the chance that DASIS clients will have vital benefits unnecessarily delayed, interrupted, or terminated." Specifically, Mr. Hernandez argued that three independently dispositive provisions of the DASIS law eliminated the EVR requirement for clients of DASIS, in recognition of their special needs, that the DASIS Law requires that DASIS clients be assisted to "establish any and all elements of eligibility" for benefits and services by "staff of" DASIS, and "at a single location," and that the law prohibits the imposition of

433 See Hernandez, 720 N.E.2d at 868.
434 Id.
435 Id. at 867.
436 See id. at 868 ("The DASIS staff member conducts a field visit and a public assistance interview to establish eligibility for publicly subsidized benefits.").
437 Br. for Appellant at 1, Hernandez v. Barrios-Paoli, 720 N.E.2d 866 (N.Y. 1999) [hereinafter Appellant's Brief]. As the DASIS Law states, the purpose of DASIS is to "provide access to benefits and services" to every New Yorker with clinical/symptomatic HIV illness or with AIDS. N.Y. CITY ADMIN. CODE § 21-127 (Lenz & Riecker, Inc. 2001).
438 Both of these requirements are contained in Section 21-128(a)(1) of the DASIS Law, which provides, in relevant part:
Access to benefits and services shall mean the provision of assistance by staff of the division to a person with clinical/symptomatic HIV illness or with AIDS at a single location in order to apply for publicly subsidized benefits and services, to establish any and all elements of eligibility including, but not limited to, those elements required to be established for financial benefits, and to maintain such eligibility . . . .

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“requirements with respect to... eligibility for benefits and services” that are “more restrictive than those requirements mandated by state or federal statute, law, regulation or rule.”

Mr. Hernandez argued that because EVR is conducted by persons who are not “staff of” DASIS, because the EVR process violates the requirement that eligibility be established “at a single location,” and because EVR is an additional eligibility requirement imposed by the city that is not required under state or federal law, it is expressly prohibited by the DASIS Law.

The supreme court agreed with Mr. Hernandez, ruling that the DASIS Law plainly and expressly eliminates the EVR requirement for DASIS clients. The Appellate Division, First Department (“First Department”), unanimously reversed. The Court granted permission to appeal and unanimously reversed, reinstating the supreme court’s injunction eliminating EVR for DASIS clients.

B. The Decision

The Court began its analysis by examining the plain meaning of the DASIS Law, followed by analysis of the spirit and purpose of the statute and the objectives that the Legislature sought to accomplish. “Indeed,” the Court explained, “the general spirit and purpose of the statute is an important aid in understanding the meaning of its words.” The EVR requirement, the Court found, violated the plain meaning of the DASIS law and contravened its purpose.

The DASIS Law “makes clear that DASIS staff, rather than EVR investigators, must provide and ensure access to benefits and services,” the Court ruled, including “establishing any and all elements of eligibility * * * including those elements required to be established for financial benefits, and to maintain such


439 N.Y. CITY ADMIN. CODE § 21-128(b) (Lenz & Riecker, Inc. 2001).

440 See Appellant’s Brief, supra note 437, at 1.


443 See Hernandez, 720 N.E.2d at 868 (“[W]e begin our analysis with the familiar maxim that statutory interpretation requires courts to first look to the plain meaning of the words of a statute.”).

444 Id.
eligibility.’” In addition, section 21-128(b) expressly states: “The requirements with respect to such access to and eligibility for benefits and services shall not be more restrictive than those requirements mandated by state or federal statute, law, regulation or rule.” Although State statutes and regulations may authorize the EVR requirement, the Court ruled, that “they do not mandate it.” Hence, because EVR was not conducted by DASIS staff, and because the EVR requirement was not mandated by State law or regulation, it was prohibited under the plain meaning of the DASIS Law.

The Court found that the spirit and purpose of the DASIS Law also compelled the Court’s decision. The DASIS Law was unquestionably “enacted to facilitate access to necessary public benefits and services for individuals suffering from clinical/symptomatic HIV illness and AIDS in New York City.” The Court’s decision to eliminate the EVR requirement for DASIS clients was “consistent with the explicit intent of city

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445 Id. In unanimously reversing the supreme court, the First Department made a new and wholly erroneous finding of fact essentially to abrogate this provision. Specifically, the First Department found that “DASIS staff are not intended to make eligibility determinations, but only to provide the necessary assistance in securing benefits.” Hernandez, 677 N.Y.S.2d at 536. Hence, “the use of non-DASIS staff for the EVR process does not violate Local Law 49.” Id. The First Department’s reasoning appears to have been that, since DASIS does not establish eligibility, the City Council could not have meant what it expressly said when it required that only DASIS staff assist DASIS clients in establishing any and all elements of eligibility. As we have seen, however, DASIS staff indeed establish eligibility for all DASIS clients, making the EVR requirement duplicative. See supra note 436 and accompanying text.

446 Hernandez, 720 N.E.2d at 869 (quoting N.Y. CITY ADMIN. CODE § 21-128(b) (Lenz & Riecker, Inc. 2001)) (emphasis added by the Court).

447 Id.

448 The Court rejected Respondents' argument that EVR was a “process” rather than a requirement, noting, inter alia, that “the very notice sent by EVR investigators to an applicant who fails to complete an EVR interview states that ‘compliance with the EVR review is an eligibility requirement.’” Hernandez, 720 N.E.2d at 868.

449 The Court did not address Mr. Hernandez’s contention that the EVR requirement also violated the requirement that all elements of eligibility be established at a single location, and argument which the Supreme Court fully credited: “The Code plainly requires that persons with HIV/AIDS be provided assistance and be permitted to satisfy any and all eligibility elements at a single location. The Administrative Code does not then require home visits and neither shall the Court.” Hernandez v. Barrios-Paoli, 669 N.Y.S.2d 195, 197 (Sup. Ct. N.Y. County 1998), rev’d, 677 N.Y.S.2d 535 (1st Dep’t 1998), rev’d, 720 N.E.2d 866 (N.Y. 1999).

450 Hernandez, 720 N.E.2d at 870.
lawmakers to streamline eligibility determination procedures and requirements for this unique group of public assistance applicants, as evidenced by the words of the statute and the legislative history. The Court rejected Respondent's argument that if the City Council had intended to eliminate EVR, then they would have mentioned it by name.

As the Court itself pointed out, the conclusion was "manifest." The plain meaning of the DASIS Law clearly eliminated the EVR requirement for DASIS clients. As the trial court observed:

The approximately 18,000 New York City public assistance recipients living with HIV and AIDS face unique challenges in accessing public benefits and services, including greater susceptibility to infection and the fear of HIV-related discrimination. The DASIS law sensitively and sensibly requires that such persons be provided access to public benefits at a single location by staff trained to deal specifically with the issues faced by persons living with HIV/AIDS.

The Court's reading was also wholly in keeping with the spirit and purpose of the DASIS Law, and with the City Council's manifest intent in enacting the law: "to ease unnecessary administrative burdens for public assistance applicants suffering from clinical/symptomatic HIV illness or AIDS in New York City."

The EVR requirement is indeed a profound burden. The Giuliani administration implemented EVR as part of an unabashed attempt to reduce benefits to more than 100,000 New York City residents within one year. As one commentator

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451 Id. at 870.
452 Id. at 869–70.
453 Hernandez, 669 N.Y.S.2d at 198
454 Hernandez, 720 N.E.2d at 870. That the DASIS Law seeks, wherever possible, to ease the burdens of individuals with clinical/symptomatic HIV disease and AIDS in accessing and maintaining publicly-subsidized benefits and services is apparent on the face of the statute. In addition to the provisions at issue in Hernandez, the DASIS Law contains such provisions as "intensive case management" for DASIS clients, with comparatively small case worker-to-client ratios. See N.Y. CITY ADMIN. CODE § 21-127 (Lenz & Riecker, Inc. 2001). The DASIS law also provides for the establishment of a "bill of rights for persons with clinical/symptomatic HIV illness or with AIDS," id. § 21-128(h), strict limitations on the termination of benefits and services for DASIS clients, id. § 21-128(i), and "quality assurance measurements" for DASIS, id. § 21-128(i).
455 See David Firestone, 100,000 New Yorkers May Be Cut Off Welfare in Crackdown, N.Y. TIMES, Aug. 8, 1995, at B1, col. 2.
explained, the motive for EVR was clear: "[T]he City sought to impose administrative hoops and hurdles to reduce the number of individuals on welfare." In so doing, the city set the stage for tragic error and abuse:

Cases were frequently closed simply because there was nobody at home to answer the questions, or because the forms slipped under the door by EVR investigators failed to give instructions in any language but English. In one incident, an individual's case was closed because she was not present when the EVR investigators dropped by her house; she was out at the work program assigned to her by the very same welfare agency.

Indeed, a 1997 report by the nonpartisan Citizens Budget Committee concluded that the vast majority of public welfare recipients whose cases were closed had not committed fraud and were entitled to the benefits and services that the city had terminated.

The burdens of EVR were only exacerbated for persons living with AIDS. One city official reported, for example, that some DASIS clients' public assistance cases were closed for missing appointments even when they were prevented from showing up by hospitalization. As Mr. Hernandez pointed out:

EVR home visits are not conducted in a manner that is sensitive or responsive to issues faced by persons with clinical/symptomatic HIV illness or AIDS. Visits are not scheduled for specific dates and times. Clients therefore become virtual prisoners in their homes until a visit is completed. In addition, the requirement to remain at home often conflicts with medical appointments, attendance at adult


457 Kennedy, supra note 456, at 246.

458 See CITIZENS BUDGET COMMISSION, The State of Municipal Services in the 1990s: Social Services in New York City, Aug. 11, 1997; see also Lynette Holloway, Report Says Errors, Not Fraud, Are the Biggest Reason New York City Cuts Off Welfare, N.Y. TIMES Aug. 12, 1997, at B3 ("The commission estimated that a vast majority were dropped because of administrative errors or other reasons that had nothing to do with fraud.").

day treatment programs, and other important obligations. Yet, if the client is not home for some reason when the EVR investigator visits, his or her application for public assistance, rental assistance, food stamps, Medicaid, or other vital benefits may be denied, delayed, or interrupted.\footnote{Appellant's Brief, \textit{supra} note 437, at 4–5. Indeed, although Mr. Hernandez had completed his application for Food Stamps and rent enhancement, and although his application had in fact been approved, Respondents refused to release his food stamps and the rent checks necessary to secure his new apartment—and to end his homelessness—until and unless he completed the EVR requirement. Respondents failed, however, to identify any necessary information or documentation that Mr. Hernandez had not already provided to DASIS (and its eligibility specialists). \textit{Id.} at 6. As appellant explained: "Mr. Hernandez has no savings and no place to go, and faces the very real prospect of homelessness, which will likely aggravate his illness and might very well result in his death. The respondents' failure to apply the DASIS law as written threatens Mr. Hernandez's health, and potentially his life." \textit{Id.} at 6.}

Elimination of the EVR requirement in no way prejudiced Respondents, because they were certainly not prohibited from ferreting out fraud as they always had—through the DASIS eligibility specialists. The Court's decision thus had the virtue of removing an onerous and unnecessary hurdle for this severely immunocompromised population while in no way preventing Respondents from complying with their obligations under the law.

CONCLUSION

In his dissent in \textit{O'Lone v. Estate of Shabazz},\footnote{\textit{Id.} at 355 (Brennan, J., dissenting).} Justice Brennan eloquently warned of the need vigilantly to guard the rights of the imprisoned against the actions of prison officials:

Prisons may exist on the margins of [our] society, but no act of will can sever them from the body politic. When prisoners emerge from the shadows to press a constitutional claim, they invoke no alien set of principles drawn from a distant culture. Rather, they speak the language of the charter upon which all of us rely to hold official power accountable. They ask us to acknowledge that power exercised in the shadows must be restrained at least as diligently as power that acts in the sunlight.\footnote{\textit{See, e.g.}, Note, \textit{Discrimination Against Prisoners with AIDS—Equal}

Justice Brennan's admonition is particularly applicable to the case of prisoners living with HIV and AIDS.\footnote{463} Such
prisoners are doubly, even triply marginalized in our society: they are living with a dreaded disease, they are incarcerated, and, owing to the demographics of the disease, they are often either persons of color, or present or former drug users.\textsuperscript{464} As one commentator has observed, "Deference to the legislative and executive branches, which are by definition more prone to the prejudices and panic of the electorate, has led to hasty decision making that results in the use of the most extreme responses to the AIDS epidemic in the prison setting."\textsuperscript{465} The Court's decision in Doe is a tragic example of this.

The unique characteristics of the AIDS epidemic render Justice Brennan's words equally applicable to the decisions of other public officials. In the face of the widespread panic and prejudice engendered by an epidemic such as AIDS, courts must carefully assess, rather than rubber stamp, the purported justifications invoked by public officials to defend their actions. Given the relative powerlessness of people living with HIV and AIDS, the courts may well represent the only source of refuge,

\textit{Protection and Due Process Claims Arising from Segregation and Denial of Conjugal Visits}, 6 N.Y.L. SCH. J. HUM. RTS. 99, 99–100 (1988) ("Scapegoated throughout society, incarcerated people are most likely to be punished for AIDS and the least likely to get assistance.") (citation and internal quotations omitted).

\textsuperscript{464} See, e.g., Deborah Dalrymple-Blackburn, \textit{AIDS, Prisoners, and the Americans with Disabilities Act}, 1995 UTAH L. REV. 839, 839–40 (1995) (citing the "overrepresentation of intravenous drug users and minority groups in prison populations"). The author notes that, among New York state inmates, 95% of the AIDS cases reported through 1992 were attributed to injected drug use. Id. at 839–40 n.7; see also Wendy E. Parmet & Daniel J. Jackson, \textit{No Longer Disabled: The Legal Impact of the New Social Construction of HIV}, 23 AM. J.L. & MED. 7, 29 ("By the late 1980s . . . intravenous drug users and heterosexual people of color increasingly contracted the disease. As they did, the connections between HIV patients and mainstream America began to unravel. AIDS was becoming even more and more a problem of socially outcast groups.").

\textsuperscript{465} Irene Lambrou, Comment, \textit{AIDS Behind Bars: Prison Responses and Judicial Deference}, 62 TEMP. L. REV. 327, 328 (1989); accord id. at 353 ("Judicial deference to the activities of prison administrators has certainly cleared the way for a panicked, misinformed public to mandate unjustified measures that often unduly restrict the rights of prison inmates who have had the tragic misfortune to contract a deadly, incurable disease."). Just months before the Court decided Doe, to take but one example, United States Attorney General Edwin Meese suggested that some prisoners carrying the HIV virus should not be paroled like other prisoners. See Robert Pear, \textit{AIDS Tests Ordered for U.S. Prisoners and Immigration; Meese Details Plan}, N.Y. TIMES, June 9, 1987, at A1. Education Secretary William Bennett echoed this sentiment. See Bennett Would Detain Some Carriers of AIDS, N.Y. TIMES, June 15, 1987, at A13.
Likewise, courts must not allow unfounded and outdated claims of exigency to govern their decisions. As one New York judge has observed, "It is incumbent upon the courts to render determinations on the basis of sound legal principles with guidance from the latest medical and scientific research available." Too often, although not in all cases, the New York Court of Appeals at the epicenter of the AIDS epidemic has failed to do so.

In *Hernandez*, the Court showed great concern to protect the rights of persons living with HIV and AIDS. Indeed, the Court agreed to hear the appeal of a poor person living with AIDS against State and city officials, and then proceeded unanimously to reverse a unanimous appellate court ruling against the appellant. As we enter the third decade of the AIDS crisis, let us hope that this decision signals a greater awareness of and sensitivity to the inherently fallible nature of "official" HIV and AIDS policies.

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466 As one commentator has explained:
Policymakers are tempted to confront AIDS primarily as a public health matter while treating the liberty rights of HIV-positive individuals as incidental. This temptation magnifies the historic counter-majoritarian role of the judiciary in protecting the rights of individuals who—like the HIV-positive—are viewed by a majority of the population as undesirable, unpopular, and even dangerous.
