

# Chapter 1

## Introduction

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### A. Overview

#### [1] The People and Their Stories

Bill Carney was in his twenties when he became quadriplegic as a result of a jeep accident. Before the accident, he had had custody of his seven- and five-year old sons for four years since separating from his wife, Ellen. She had not visited them once during that time, and her other contact was limited to an occasional phone call or letter. After the accident, however, Ellen Carney sought custody of the boys because she thought that Bill could not be a good father. See *Carney v. Carney*, 24 Cal. 3d 725, 598 P.2d 36, 157 Cal. Rptr. 383 (1979).

Judith Gurmankin became blind at age twelve. After outstanding academic achievement in public high school in Philadelphia and completion of a Bachelor of Science degree at Temple University, she wanted to teach high school in the regular public schools in Philadelphia. Although she was academically qualified to do so, she was rejected because it was thought that a blind teacher would not be competent to teach sighted students. See *Gurmankin v. Costanzo*, 411 F. Supp. 982 (E.D. Pa. 1976), *aff'd*, 556 F.2d 184 (3d Cir. 1977), *cert. denied*, 450 U.S. 923 (1981).

Trina Hairston's disability was spina bifida, which resulted in incontinence and a limp, but she had no other conditions that would impede her attendance at public kindergarten in West Virginia. Her attendance in the regular classroom, however, was made contingent on her mother's presence at school to attend to Trina's needs—primarily diapering. Her mother needed to be home to take phone orders for coal deliveries and to attend to the needs of Trina's terminally-ill grandmother. See *Hairston v. Drosick*, 423 F. Supp. 180 (S.D. W. Va. 1976).

Rick Duran had a history of epilepsy, but had been seizure-free for over fifteen years when he applied to be a policeman in Tampa, Florida. He was successful in passing the oral and written tests, but when his history of epilepsy was noted in the physical exam, he was told he would be excluded automatically from consideration. See *Duran v. City of Tampa*, 430 F. Supp. 75 (M.D. Fla. 1977).

Catherine McDermott wanted to be a computer programmer. Although her technical skills were acceptable, she was denied the job because of her obesity—not because the condition would affect her work, but because she was a risk to the company's insurance benefit programs. See *State Div. of Human Rights ex rel. McDermott v. Xerox Corp.*, 65 N.Y.2d 213, 480 N.E.2d 695 (1985).

A California fifth grader, Andrew Adams was average in intelligence, but his dyslexia prevented him from benefiting from the education being provided at public schools. Because the school was so slow in obtaining an appropriate placement, Mrs. Adams enrolled her son in a special private school. See *Adams v. Hansen*, 632 F. Supp. 858 (N.D. Cal. 1985).

Ryan White got AIDS from a blood transfusion necessitated by his hemophilia. A pleasant teenager, who just wanted to go to school with other kids, he was repeatedly excluded from attending by court orders based on the fear of contagion—in spite of overwhelming evidence that one cannot get AIDS by casual contact. See DAVID L. KIRP, *LEARNING BY HEART* 26–64 (1989).

Michael Bunjer could not order his food through the speaker system at a fast food restaurant

because of his hearing impairment. When he tried to order using a paper and pencil, he was initially refused, later laughed at, and then given the wrong change and warm water instead of a soda. When he refused to leave the restaurant after complaining, he was arrested. See *Bunjer v. Edwards*, 985 F. Supp. 165 (D.D.C. 1997).

When the tenant of a mobile home installed a ramp with her own funds to accommodate her post polio syndrome and other disabilities, the mobile home park told her that she should consider moving to a “handicapped facility.” See *Elliott v. Sherwood Manor Mobile Home Park*, 947 F. Supp. 1574 (M.D. Fla. 1996).

Kathy Adams had always wanted to work for the Foreign Service. After passing all the tests, she found out that she had early stage breast cancer. She was treated with a mastectomy and later had her ovaries and fallopian tubes removed, but the State Department revoked her medical clearance and did not assign her a position because it believed that not all posts to which she could be assigned would have proper follow-up medical care for her. See *Adams v. Rice*, 531 F.3d 936 (D.C. Cir. 2008).

Charles Littleton was a 29-year-old man with an intellectual disability. He lived with his mother and received social security benefits because of his disability. He applied for a job with Wal-Mart as a cart-pusher. He asked to have his job coach accompany him for the interview. Wal-Mart refused, and, because the interview did not go well, did not hire Charles. See *Littleton v. Wal-Mart Stores*, 231 Fed. Appx. 874 (11th Cir. 2007).

There are other people with other stories, and there are other kinds of problems. These individuals are intellectually disabled, they are deaf, they have cystic fibrosis, and they have cancer. They have problems climbing the steps to get on the bus. They are deinstitutionalized and given bus fare to the next city because there is no community program available in the city where the institution is located. Often there is no program at the other end of the bus ride. In those cases where there is a community program available, there are often problems of neighbors using zoning laws and private deed restrictions to exclude group homes for individuals with intellectual disabilities.

What all of these people have in common is that because of some physical or mental impairment (or a record of such an impairment or a perception that they have an impairment)—they face unique problems functioning in the everyday world. Sometimes these problems result from thoughtless planning of the environment, with no malice to the person with a disability. Sometimes these problems are the result of clear prejudice about conditions, such as epilepsy. And sometimes the problems result simply from misplaced assumptions about the inabilities and abilities of individuals with disabilities. Sometimes the problems occur because of a lack of training by supervisory personnel or because there is a lack of knowledge about available accommodations.

What these individuals also generally have in common is that they have similar goals in life—they want to go to school, to work, to play, to travel, to obtain health care, to live, and to participate in the community and other activities, just like everyone else.

For some of them, their disabilities have been with them from birth. For others, like Bill Carney, an accident suddenly changed their lives. For still others, the impairment occurred gradually, such as blindness resulting from diabetes. Those who became disabled before age 21 are considered to be developmentally disabled, because the disability has affected them during the time when many important basic skills are normally developed. For some, the disability is not obvious to the casual observer: the individual who has epilepsy, is HIV-positive, or is an alcoholic. These individuals are said to have “hidden disabilities.”

What they also have in common is that they now receive protection from a variety of laws—protection that was largely unavailable until the early 1970s. Beginning in 1973 with the passage of amendments to the Vocational Rehabilitation Act and continuing to 1990 when the most comprehensive disability rights statute, the Americans with Disabilities Act (ADA) was passed, there has been an increase in the legal rights available to people with disabilities. In examining these

statutes and applying them to a particular situation, care must be taken in evaluating whether the condition in question is treated as a handicap or disability under applicable law. And that individual must be otherwise qualified to carry out the essential requirements of the program taking into account reasonable accommodations. In addition, the party whose conduct is in question must be subject to the statute in question. Even if these criteria exist, there still may be other procedural and substantive obstacles to protection or application.

As is evident from the brief descriptions of the individuals mentioned previously, there are many types of disabilities. Unlike most other groups who are given statutory protection against discrimination, a person can become a member of the class at any moment—merely by being involved in an accident and becoming paralyzed or becoming visually impaired from an illness. The members of this class are of all ages, all incomes, all religions, all ethnic groups, both sexes, and from all kinds of backgrounds. The problems they face in many cases are not unlike discrimination problems of other protected classes: they face challenges obtaining employment, they have problems obtaining housing, and they are excluded from education. But unlike the other groups protected from discrimination, the problems are frequently not the result of prejudicial attitudes or even institutionalized discrimination. The problems arise because much of the world has been designed for the average able-bodied person, with little thought of the person with limited mobility, limited vision, health problems, or other disabilities.

There is much debate over appropriate terminology—whether “impairment,” “disability,” or “handicap” is the most appropriate word. Federal statutes use both “disability” and “handicap,” although most statutes currently use “disability.” At present, “disability” is generally the preferred term, and these materials will use the term “disability,” except when describing a statute that still uses the term “handicap.” Many of the reported judicial decisions that are included in the materials use terminology that existed before amendments to change the language. This book has not changed the courts' terminology. It is generally accepted to use “people first” language when discussing individuals with disabilities, and this book follows that practice. For example, an individual is not a “disabled person,” but rather a “person with a disability.” She is not “mentally ill” or “blind,” but rather a “person with mental illness” or a “person who is blind.” The idea is that the individual with a disability is a person first and is not wholly defined by his or her disability. The term “nothing about us without us” is a slogan that persons with disabilities use that means that no decisions or changes in policy should be adopted without the presence of persons with disabilities. Within the deaf community there is some difference of opinion about this issue.

<http://www.wsd.wa.gov/documents/dcqwdocs/dcqw02-27-2012.pdf>.

This book provides legal materials covering issues involving people with physical and mental impairments. In most cases, the statutes apply to both groups—employment laws and education laws, for example. Some laws relate primarily to persons with physical impairments (mobility and sensory), i.e., architectural barrier laws, transportation laws, etc. Other laws relate primarily to individuals whose impairments are mental—who are either intellectually disabled or mentally ill—i.e., guardianship, institutionalization, and sterilization. Some apply to a broad range that might include those with learning disabilities—i.e., education.

## **[2] Chapter Goals**

The cases in the materials have been selected for a range of reasons. Most major Supreme Court decisions are excerpted or at least referenced. Lower court cases have been selected because they were early decisions interpreting a law, they represent an unsettled area, or they provide interesting or unique fact patterns. The Note cases provide greater context for many of the issues highlighted in the excerpts. The cases were also selected because they represent an array of conditions.

In addition to federal laws, there are a number of state laws that apply to these issues. For the most

part, federal law does not preempt existing state law. Both laws apply. Local requirements, such as nondiscrimination ordinances and building codes, are applicable as well. It is useful to be aware of state and local requirements, but because of the differing coverage in each jurisdiction, state and local materials are not included in this text except as examples of interesting fact settings or interpretations.

While constitutional theories may be applicable in situations where there is a governmental action involved, disability discrimination protection is primarily sought through statutory means, and federal statutes are generally the avenue of redress. This is because of the limitation on the parties where state action applies and the much more comprehensive protections of federal laws in terms of substantive and procedural protection and the remedies available. For that reason, state law is rarely addressed, although consideration of applicable state laws would be relevant to the practicing lawyer representing a client.

The overarching goals for each of the chapters are the following:

- To provide the basic framework and history for the policies implemented through statutory protections
- To provide the key substantive provisions under the applicable federal statutes
- Where more than one statute might apply, to clarify the relationship between and among statutes
- To provide the key regulations and other agency guidance on major issues
- To provide judicial interpretation of applicable statutes, including whether the decision provides clear precedent or represents one of several judicial viewpoints
- To provide some general understanding of procedural requirements and remedies
- To practice applying all of this in the context of hypotheticals and unsettled questions
- To assess some of the strategic decisions involved in advocacy on behalf of individuals with disabilities:

Is advocacy for an individual most effective?

Is more comprehensive advocacy such as a class action better?

Is advocacy other than client representation more likely to effect a desirable outcome?

- To sensitize students to what life is like for individuals with various types of disabilities and the societal impact on others:

What does it mean to the individual in a wheelchair that she cannot use public transportation to go to work?

What does it mean to the regular classroom teacher that students with serious behavior problems may be mainstreamed into the classroom?

Why are neighbors afraid of having a group of individuals with intellectual disabilities living next door?

What is the impact on health insurance coverage for someone with HIV who is terminated from employment?

What is the impact on the family when a seriously ill infant is born into that family? What is the impact of these infants on hospital resources or on the nurse in charge of the neonatal intensive care unit?

When groups of individuals with intellectual disabilities are taken to a baseball game by a well-meaning civic group, are they really being exposed to the mainstream of society? How does someone with a hearing impairment enjoy a television program?

- To provide an understanding of the overall policy implications applicable to individuals with disabilities including whether policies should be changed
- If policy change is required, should it be legislative, regulatory, judicial or institutional?

## B. How Many People Have Disabilities?

Precise statistics on the number of Americans with disabilities are very difficult to obtain. There are several reasons for this. First, the definition of handicap or disability varies depending on whether it is a Social Security benefit, employment, or education that is in question. (This is discussed in [Chapter 2](#).) In many settings the individual is not required to self-identify. In other cases, an individual may not consider himself/herself to be disabled. In some instances, individuals may over-identify, such as people who have correctable conditions (e.g., near-sightedness). In some cases, access to financial resources to provide documentation (e.g., learning disabilities) can disparately benefit individuals based on income status.

About one in five Americans has some disability as of 2010, the same percentage as existed at the time of the enactment of the 1990 Americans with Disabilities Act. About half of that group have a severe disability. The total number of individuals with disabilities (56.7 million) increased from the previous census, but the overall percentage has remained the same. There are relationships of disability to age, race, education, income and where one lives, but the causal connections, if there are any, are unclear.

Technology has had an impact on disabilities. Today, low-birthweight infants are surviving as a result of technology, and in many cases these infants have severe disabilities. Individuals with spinal cord injuries are surviving at very high rates today as a result of technology developed during the Viet Nam conflict to save wounded soldiers. In addition, computers and microchips and other technology have improved the functioning ability of many people with disabilities. For example, voice synthesizers, reading machines, and adapted automobiles have made a great deal of difference for many individuals. On the other hand, computers can be a barrier for individuals with visual impairments or mobility impairments who cannot see computer graphics and/or cannot use a mouse. Computer program design can limit who is able to use this technology. The increase in the incidence of HIV had a significant impact on the number of individuals with disabilities at one point, but the work to treat, decrease, and prevent HIV has lessened that impact. The increase in Alzheimer's disease and dementia is also significant.

The following are statistics of interest from various sources describing the incidence of disability.

### AMERICANS WITH DISABILITIES IN 2010

Have trouble walking (including those in need of a wheelchair, cane, crutches or walker)	30.6 million
Visual impairments (including 2 million blind or unable to see printed words)	8.1 million
Hearing impairments (including 1.1 million deaf or unable to hear conversations at all; with 5.6 million using a hearing aid)	7.6 million

Source: United States Census Bureau, Washington, DC 2012, <http://www.census.gov/prod2012pubs/p70-131.pdf>. See also press release about this report at <https://www.census.gov/newsroom/releases/archives/miscellaneous/cb12-134.html> (applying a broad definition of disability)

The 2012 report based on the 2010 census also notes the following information that informs policy and legal discussions about individuals with disabilities.

Approximately 9.4 million people in the noninstitutionalized population have difficulty with at least one daily life activity, and of that group about 5 million require assistance of others to perform

these activities.

Approximately 2.4 million Americans have Alzheimer's disease, senility, or dementia.

Being frequently depressed or anxious to the degree of interfering with ordinary activities affects about 7 million adults.

The number is much higher if the following “other” disabilities are counted. The following are general statistics from recent years.

Hypertension	75 million <sup>1</sup>
Cardiovascular Disease	85.6 million <sup>2</sup>
Cancer (all types)	14.1 <sup>3</sup>
Bi-Polar Disorder	5.7 million <sup>4</sup>
Schizophrenia	2.4 million <sup>5</sup>
Diabetes	29.1 million <sup>6</sup>
Polycystic Kidney Disease	600,000 <sup>7</sup>
Alzheimer's Disease, senility or dementia	5.4 million <sup>8</sup>
Multiple Sclerosis	400,000 <sup>9</sup>

U.S. Census data about individuals with disabilities indicates that in 2010, approximately 19 percent of Americans (56.7 million) had some degree of disability. The definition of disability for these purposes, however, does not mean that all of these individuals meet the definition of disability within the ADA.

The impact of disability on personal life is documented by a 1986 ICD Survey of Disabled Americans called *Bringing Disabled Americans into the Mainstream*. A comparison of adults with disabilities and all others indicates that while 87 percent of all others shop in a grocery store at least once a week, only 62 percent of adults with disabilities do so. While 78 percent of all others attended a movie last year, only 36 percent of adults with disabilities did. This demonstrates the importance of the ADA in reaching everyday activities in addition to the workplace, educational settings, housing, and social service providers.

## C. The Laws and How They Developed

Until the late 1960s, the philosophy towards Americans with disabilities was a combination of paternalism and fear—the result was usually segregation. Originally, the child with a disability was completely removed from the classroom to alleviate the stress on the teacher and other children, although in more recent years the child was placed in a special classroom setting where no stress could be placed on the child with the disability—the child was being taught diluted academic skills or manual activities. See Max L. Hutt & Robert Gwyn Gibby, *THE MENTALLY RETARDED CHILD* (2d ed. 1982).

For the adult, the philosophy was to provide disability benefits—financial support so the individual could exist, but with little attempt to move the individual back into the mainstream of society. Edward D. Berkowitz, in his 1987 book, *Disabled Policy*, describes from the perspective of a historian how disability policy began as financial support for the retirement of individuals with disabilities. Disability policy began in the early part of the 20th century with income-maintenance programs (Workers' Compensation (in 1911) and Social Security Disability Insurance (in 1935)). “Vocational rehabilitation” as policy began in 1920. The philosophy of this program was “corrective.” The intent was to rehabilitate the individual for the workplace, the attitude being one of making the individual fit

into the world as it was, rather than adapting the world to the needs of the individual with a disability.

Because of these policies most individuals with disabilities remained in their homes, in institutions, or otherwise outside the mainstream of society. There was, therefore, little reason to consider the needs of these individuals in the design of our environment. People in wheelchairs did not go to work—so subways and office buildings were not designed to accommodate them. Children with intellectual disabilities were thought to be incapable of functioning in society, so little attempt was made to teach them skills needed to work and manage their lives.

In the 1960s, a change in attitude began to occur. The philosophy became one of recognizing the worth and potential of all persons. The attitude included the idea that this potential could be realized only if persons with disabilities were allowed to participate in the mainstream of everyday life. *Brown v. Board of Ed.*, 347 U.S. 483 (1954), had already established that separation was inherently unequal in the context of race. This change in attitude resulted in a number of important changes in the law. These changes were initially found in judicial opinions. But, as is often the case when significant case law is made, Congress and state lawmakers recognized the need to clarify and codify many of the concepts from these early decisions.

The changes in the area of education occurred beginning in 1971 and 1972 with two separate but related lower court decisions approving consent decrees involving education of children with disabilities. These cases involved Fourteenth Amendment constitutional theories of equal protection and due process. See *Pennsylvania Ass'n for Retarded Children (PARC) v. Pennsylvania*, 334 F. Supp. 1257 (E.D. Pa. 1971); 343 F. Supp. 279 (E.D. Pa. 1972), and *Mills v. Board of Ed.*, 348 F. Supp. 866 (D.D.C. 1972). These decisions established that where a state undertakes to provide education at public expense, it must do so on an equal basis for *all* children and it must provide procedural safeguards before there is exclusion or differing treatment. Because of the potential for similar holdings in other pending cases and in recognition of the cost of providing special education, Congress passed the Education for All Handicapped Children Act (now known as the Individuals with Disabilities Education Act (IDEA)) in 1975, 20 U.S.C. §1400 et seq. This statute incorporated the basic principles and requirements from the *PARC* and *Mills* cases.

The IDEA is essentially a hybrid statute, funding states to provide education for students with disabilities within a framework of substantive and procedural protection, while also creating enforceable rights and individual remedies. The underlying premise of the IDEA is that *all* children are educable, and that they should receive public education in the *least restrictive appropriate* placement at *no cost*, that their educational program should be *individualized*, and that they should be provided *procedural protections*. There have been several significant amendments to the IDEA—providing for attorneys' fees, implementing preschool programming, eliminating governmental immunity, adding some substantive programming, and expanding on the definition of who is protected—but the basic premise of the IDEA is the same as it was in 1975. There have been hundreds of judicial decisions, including several Supreme Court cases, that have clarified some of the questions arising under this statute.

The Rehabilitation Act was passed in 1973, and until 1990 was the only other major federal statute providing for nondiscrimination on the basis of disability. The 1973 Rehabilitation Act was actually an amendment to a much older law providing for vocational rehabilitation—the focus of the older law being solely on employment. Early vocational rehabilitation legislation was passed after World War I as a response to the number of veterans with disabilities. See 1973 U.S. Code Cong. & Ad. News 2076. The 1973 Act provided that the federal government (under Section 501), federal contractors (under Section 503), and recipients of federal financial assistance (under Section 504) should not discriminate on the basis of handicap against otherwise qualified individuals. See 29 U.S.C. §§791, 793, 794. Amendments in 1992 included changing the terminology to use “disability” instead of “handicap” throughout the statute. The most significant substantive section of the Rehabilitation Act



is Section 504, which reaches not only employment, but also institutions such as public schools, welfare providers, hospitals, federally supported transportation, and so forth. Most of the private sector, however, was not covered by federal law. Reliance on state laws, which were inconsistent and often provided little enforcement power, was necessary for individuals with disabilities who wanted to bring discrimination claims.

Most early litigation under the Rehabilitation Act focused on procedural issues, such as whether the recipient was covered, whether there was a private right of action, and whether one must exhaust administrative remedies. Subsequent judicial opinion has addressed more substantive issues such as whether the particular person is within the protected class, whether the individual is otherwise qualified, whether discriminatory action actually occurred, whether reasonable accommodations are required, and whether defenses such as undue burden apply. Like the IDEA, there are many cases interpreting the Rehabilitation Act. This judicial interpretation is important not only for understanding the Rehabilitation Act, but also because it was incorporated into the language of the Americans with Disabilities Act (ADA), 42 U.S.C. §12101 et seq. The Rehabilitation Act has been amended to more clearly define coverage for individuals with contagious and infectious diseases, to define coverage applicable to individuals who are drug and alcohol users, and to provide that states and state agencies are not immune from suit under the statute.

Until the Americans with Disabilities Act was passed in 1990, there were several other federal statutes providing a patchwork of protection for individuals with disabilities. The Architectural Barriers Act of 1968, 42 U.S.C. §§4151–4157, requires newly constructed federal government buildings to be accessible. The Federal Aid Highway Act of 1972, 23 U.S.C. §142, mandates accessibility in federally assisted transportation programs and on federal highways. The Air Carrier Access Act of 1986, 49 U.S.C. §1374, prohibits discrimination against people with disabilities by providers of air transportation. In 1988 the Fair Housing Act, 42 U.S.C. §3601 et seq., was amended to provide protection against discrimination on the basis of disability in housing and to require barrier-free design for certain multi-unit dwelling construction. Other federal statutes relate to voter accessibility, telecommunications access, and a variety of other areas.

Comprehensive coverage was not a reality, however, until the passage of the Americans with Disabilities Act. The ADA prohibits discrimination on the basis of disability in both public and private employment (Title I), in public services provided by state and local governmental authorities (Title II), and in programs of public accommodation provided by private parties (Title III). Improvement in access to telecommunications (Title IV) is a significant part of the statute, as well. Miscellaneous provisions (Title V) relate to coverage of Congress and access in wilderness areas. As a result of the ADA, most schools (public and private), most places of business open to the public, most governmental services, most transportation services, and most employers must take steps to ensure reasonable accommodation in addition to the nondiscrimination mandates. As was noted previously, the ADA is intended to be interpreted consistently with the Rehabilitation Act in most situations. For that reason, there was a significant body of case law that applied to the ADA as soon as it was enacted.

Common to most of these statutes are concepts of nondiscrimination, reasonable accommodation, and least restrictive environment (sometimes referred to as mainstreaming). Individualized assessment is also a key principle. Depending on the activity, more than one of these statutes might apply. In the chapters that follow, the application of these various laws to particular life experiences such as employment or education is clarified in greater detail.

To be entitled to protection under any of the federal statutes, one must meet the definition of disability or handicap, must be otherwise qualified to carry out the fundamental requirements of the program with or without reasonable accommodation, must bring an action within the appropriate statute of limitations, must prove discrimination, and must have been discriminated against by an



entity that is covered by the statute in question. As the following chapters will illustrate, these issues can be quite complex. In 2008, in response to 1999 and 2002 Supreme Court rulings narrowing the interpretation of the ADA definition of disability, Congress amended the ADA to expand and clarify coverage and to address a number of issues.

One other major area of legal development applicable to the study of disability rights should be noted. This area relates to issues affecting individuals with mental disabilities. Issues such as commitment, deinstitutionalization, right to treatment, right to refuse treatment, right to treatment in the least restrictive environment, competency, and sterilization continue to be the subject of substantial judicial debate and uncertainty. One major case, *Halderman v. Pennhurst State Sch. & Hosp.*, 451 U.S. 1 (1981), involved many of these issues and applied constitutional principles as well as state mental health law, the Rehabilitation Act, and the Developmental Disabilities Assistance and Bill of Rights Act. Unfortunately, the *Pennhurst* case and other similar cases continue to leave many questions unanswered. A comprehensive discussion of these issues is found in MICHAEL J. PERLIN, *MENTAL DISABILITY AND LAW: CIVIL AND CRIMINAL*, Vol. 2 (LEXIS 2d ed. 1998), Vol. 3 (2000) Vol. 4 (2001).

Advocates are beginning to use traditional discrimination theories as an avenue to obtain more community services and access to independent living. While the discrimination statutes afford some opportunity for redress, the major problem is that the benefits and services needed in the communities, such as supervised housing and access to mental health treatment, are not available because of funding deficiencies. For example, using the Fair Housing Act has been quite successful as a means of challenging exclusionary zoning that is used to keep out group homes for individuals with intellectual disabilities, HIV, and other disabilities. The major obstacle to independent living is the lack of funding to provide this type housing and related supportive services and staffing in the first place.

The Constitution has been the basis of some of the litigation in the area of disability discrimination law. Major constitutionally based judicial decisions will be included in appropriate chapters. For the most part, however, disability rights law has developed in response to statutory requirements and judicial interpretations of those requirements.

One of the earliest Supreme Court decisions to address issues arising under a disability discrimination statute focused on whether intentional discrimination was the only prohibited discrimination on the basis of disability. Although the case arises in the context of the provision of certain health benefits, the reasoning is applicable to most other areas of disability discrimination law. A 2015 Supreme Court decision in a housing discrimination case held that disparate impact can be the basis for demonstrating impermissible discrimination, at least in that context. The following decision also highlights that issue generally. It continues to be an important analysis in light of the Affordable Care Act and other federal funding of programs and their application by state agencies that affect health of individuals with disabilities.

### **Alexander v. Choate**

469 U.S. 287 (1985)

JUSTICE MARSHALL delivered the opinion for a unanimous Court:

In 1980, Tennessee proposed reducing the number of annual days of inpatient hospital care covered by its state Medicaid program. The question presented is whether the effect upon the handicapped that this reduction will have is cognizable under §504 of the Rehabilitation Act of 1973 or its implementing regulations. We hold that it is not.

#### **I.**

Faced in 1980–1981 with projected state Medicaid costs of \$42 million more than the State's

Medicaid budget of \$388 million, the directors of the Tennessee Medicaid program decided to institute a variety of cost-saving measures. Among these changes was a reduction from 20 to 14 in the number of inpatient hospital days per fiscal year that Tennessee Medicaid would pay hospitals on behalf of a Medicaid recipient. Before the new measures took effect, respondents, Tennessee Medicaid recipients, brought a class action for declaratory and injunctive relief in which they alleged, *inter alia*, that the proposed 14-day limitation on inpatient coverage would have a discriminatory effect on the handicapped. Statistical evidence, which petitioners do not dispute, indicated that in the 1979–1980 fiscal year, 27.4% of all handicapped users of hospital services who received Medicaid required more than 14 days of care, while only 7.8% of “nonhandicapped” users required more than 14 days of inpatient care.

Based on this evidence, respondents asserted that the reduction would violate §504 of the Rehabilitation Act of 1973, 29 U.S.C. §794, and its implementing regulations. Section 504 provides:

“No otherwise qualified handicapped individual ... shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance....”

Respondents' position was twofold. First, they argued that the change from 20 to 14 days of coverage would have a disproportionate effect on the handicapped and hence was discriminatory.<sup>1</sup> The second, and major, thrust of respondents' attack was directed at the use of any annual limitation on the number of inpatient days covered, for respondents acknowledged that, given the special needs of the handicapped for medical care, any such limitation was likely to disadvantage the handicapped disproportionately. Respondents noted, however, that federal law does not require States to impose any annual durational limitation on inpatient coverage, and that the Medicaid programs of only 10 States impose such restrictions.<sup>2</sup> Respondents therefore suggested that Tennessee follow these other States and do away with any limitation on the number of annual inpatient days covered. Instead, argued respondents, the State could limit the number of days of hospital coverage on a per-stay basis, with the number of covered days to vary depending on the recipient's illness (for example, fixing the number of days covered for an appendectomy); the period to be covered for each illness could then be set at a level that would keep Tennessee's Medicaid program as a whole within its budget. The State's refusal to adopt this plan was said to result in the imposition of gratuitous costs on the handicapped and thus to constitute discrimination under §504.

## II.

The first question the parties urge on the Court is whether proof of discriminatory animus is always required to establish a violation of §504 and its implementing regulations, or whether federal law also reaches action by a recipient of federal funding that discriminates against the handicapped by effect rather than by design. The State of Tennessee argues that §504 reaches only purposeful discrimination against the handicapped. As support for this position, the State relies heavily on our recent decision in *Guardians Assn. v. Civil Service Commission of New York City*, 463 U.S. 582 (1983).

In *Guardians*, we confronted the question whether Title VI of the Civil Rights Act of 1964, 42 U.S.C. §2000d et seq., which prohibits discrimination against racial and ethnic minorities in programs receiving federal aid, reaches both intentional and disparate-impact discrimination. No opinion commanded a majority in *Guardians*, and Members of the Court offered widely varying interpretations of Title VI. Nonetheless, a two-pronged holding on the nature of the discrimination proscribed by Title VI emerged in that case. First, the Court held that Title VI itself directly reached only instances of intentional discrimination. Second, the Court held that actions having an unjustifiable disparate impact on minorities could be redressed through agency regulations designed to implement the purposes of Title VI. In essence, then, we held that Title VI had delegated to the agencies in the first instance the complex determination of what sorts of disparate impacts upon

minorities constituted sufficiently significant social problems, and were readily enough remediable, to warrant altering the practices of the federal grantees that had produced those impacts. The premise of the State's reliance on *Guardians* is that §504 was modeled in part on Title VI, and that the evolution of Title VI regulatory and judicial law is therefore relevant to ascertaining the intended scope of §504. Nonetheless, as we point out *infra*, too facile an assimilation of Title VI law to §504 must be resisted.

*Guardians*, therefore, does not support petitioners' blanket proposition that federal law proscribes only intentional discrimination against the handicapped. Indeed, to the extent our holding in *Guardians* is relevant to the interpretation of §504, *Guardians* suggests that the regulations implementing §504, upon which respondents in part rely, could make actionable the disparate impact challenged in this case. Moreover, there are reasons to pause before too quickly extending even the first prong of *Guardians* to §504.

Discrimination against the handicapped was perceived by Congress to be most often the product, not of invidious animus, but rather of thoughtlessness and indifference—of benign neglect. Thus, Representative Vanik, introducing the predecessor to §504 in the House, described the treatment of the handicapped as one of the country's "shameful oversights," which caused the handicapped to live among society "shunted aside, hidden, and ignored." Similarly, Senator Humphrey, who introduced a companion measure in the Senate, asserted that "we can no longer tolerate the invisibility of the handicapped in America...." And Senator Cranston, the Acting Chairman of the Subcommittee that drafted §504, described the Act as a response to "previous societal neglect." Federal agencies and commentators on the plight of the handicapped similarly have found that discrimination against the handicapped is primarily the result of apathetic attitudes rather than affirmative animus.

In addition, much of the conduct that Congress sought to alter in passing the Rehabilitation Act would be difficult if not impossible to reach were the Act construed to proscribe only conduct fueled by a discriminatory intent. For example, elimination of architectural barriers was one of the central aims of the Act, yet such barriers were clearly not erected with the aim or intent of excluding the handicapped. Similarly, Senator Williams, the chairman of the Labor and Public Welfare Committee that reported out §504, asserted that the handicapped were the victims of "[discrimination] in access to public transportation" and "[discrimination] because they do not have the simplest forms of special educational and rehabilitation services they need...." And Senator Humphrey, again in introducing the proposal that later became §504, listed, among the instances of discrimination that the section would prohibit, the use of "transportation and architectural [sic] barriers," the "discriminatory effect of job qualification ... procedures," and the denial of "special educational assistance" for handicapped children. These statements would ring hollow if the resulting legislation could not rectify the harms resulting from action that discriminated by effect as well as by design.

At the same time, the position urged by respondents—that we interpret §504 to reach all action disparately affecting the handicapped—is also troubling. Because the handicapped typically are not similarly situated to the nonhandicapped, respondents' position would in essence require each recipient of federal funds first to evaluate the effect on the handicapped of every proposed action that might touch the interests of the handicapped, and then to consider alternatives for achieving the same objectives with less severe disadvantage to the handicapped. The formalization and policing of this process could lead to a wholly unwieldy administrative and adjudicative burden. Had Congress intended §504 to be a National Environmental Policy Act for the handicapped, requiring the preparation of "Handicapped Impact Statements" before any action was taken by a grantee that affected the handicapped, we would expect some indication of that purpose in the statute or its legislative history. Yet there is nothing to suggest that such was Congress' purpose. Thus, just as there is reason to question whether Congress intended §504 to reach only intentional discrimination, there is similarly reason to question whether Congress intended §504 to embrace all claims of disparate-impact discrimination.

Any interpretation of §504 must therefore be responsive to two powerful but countervailing considerations—the need to give effect to the statutory objectives and the desire to keep §504 within manageable bounds. Given the legitimacy of both of these goals and the tension between them, we decline the parties' invitation to decide today that one of these goals so overshadows the other as to eclipse it. While we reject the boundless notion that all disparate-impact showings constitute prima facie cases under §504, we assume without deciding that §504 reaches at least some conduct that has an unjustifiable disparate impact upon the handicapped. On that assumption, we must then determine whether the disparate effect of which respondents complain is the sort of disparate impact that federal law might recognize.

### III.

To determine which disparate impacts §504 might make actionable, the proper starting point is *Southeastern Community College v. Davis*, 442 U.S. 397 (1979), our major previous attempt to define the scope of §504. *Davis* involved a plaintiff with a major hearing disability who sought admission to a college to be trained as a registered nurse, but who would not be capable of safely performing as a registered nurse even with full-time personal supervision. We stated that, under some circumstances, a “refusal to modify an existing program might become unreasonable and discriminatory. Identification of those instances where a refusal to accommodate the needs of a disabled person amounts to discrimination against the handicapped [is] an important responsibility of HEW.” We held that the college was not required to admit Davis because it appeared unlikely that she could benefit from any modifications that the relevant HEW regulations required, and because the further modifications Davis sought—full-time, personal supervision whenever she attended patients and elimination of all clinical courses—would have compromised the essential nature of the college's nursing program. Such a “fundamental alteration in the nature of a program” was far more than the reasonable modifications the statute or regulations required. *Davis* thus struck a balance between the statutory rights of the handicapped to be integrated into society and the legitimate interests of federal grantees in preserving the integrity of their programs: while a grantee need not be required to make “fundamental” or “substantial” modifications to accommodate the handicapped, it may be required to make “reasonable” ones.<sup>5</sup>

The balance struck in *Davis* requires that an otherwise qualified handicapped individual must be provided with meaningful access to the benefit that the grantee offers. The benefit itself, of course, cannot be defined in a way that effectively denies otherwise qualified handicapped individuals the meaningful access to which they are entitled; to assure meaningful access, reasonable accommodations in the grantee's program or benefit may have to be made. In this case, respondents argue that the 14-day rule, or any annual durational limitation, denies meaningful access to Medicaid services in Tennessee. We examine each of these arguments in turn.

#### A.

The 14-day limitation will not deny respondents meaningful access to Tennessee Medicaid services or exclude them from those services. The new limitation does not invoke criteria that have a particular exclusionary effect on the handicapped; the reduction, neutral on its face, does not distinguish between those whose coverage will be reduced and those whose coverage will not on the basis of any test, judgment, or trait that the handicapped as a class are less capable of meeting or less likely of having. Moreover, it cannot be argued that “meaningful access” to state Medicaid services will be denied by the 14-day limitation on inpatient coverage; nothing in the record suggests that the handicapped in Tennessee will be unable to benefit meaningfully from the coverage they will receive under the 14-day rule.<sup>6</sup> The reduction in inpatient coverage will leave both handicapped and nonhandicapped Medicaid users with identical and effective hospital services fully available for their use, with both classes of users subject to the same durational limitation. The 14-day limitation,

therefore, does not exclude the handicapped from or deny them the benefits of the 14 days of care the State has chosen to provide. To the extent respondents further suggest that their greater need for prolonged inpatient care means that, to provide meaningful access to Medicaid services, Tennessee must single out the handicapped for more than 14 days of coverage, the suggestion is simply unsound. At base, such a suggestion must rest on the notion that the benefit provided through state Medicaid programs is the amorphous objective of “adequate health care.” But Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services, such as 14 days of inpatient coverage. That package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered—not “adequate health care.”

The federal Medicaid Act makes this point clear. The Act gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in “the best interests of the recipients.” 42 U.S.C. §1396a(a)(19). The District Court found that the 14-day limitation would fully serve 95% of even handicapped individuals eligible for Tennessee Medicaid, and both lower courts concluded that Tennessee's proposed Medicaid plan would meet the “best interests” standard. That unchallenged conclusion indicates that Tennessee is free, as a matter of the Medicaid Act, to choose to define the benefit it will be providing as 14 days of inpatient coverage.

Section 504 does not require the State to alter this definition of the benefit being offered simply to meet the reality that the handicapped have greater medical needs. To conclude otherwise would be to find that the Rehabilitation Act requires States to view certain illnesses, i.e., those particularly affecting the handicapped, as more important than others and more worthy of cure through government subsidization. Nothing in the legislative history of the Act supports such a conclusion. Section 504 seeks to assure evenhanded treatment and the opportunity for handicapped individuals to participate in and benefit from programs receiving federal assistance. The Act does not, however, guarantee the handicapped equal results from the provision of state Medicaid, even assuming some measure of equality of health could be constructed.

Regulations promulgated by the Department of Health and Human Services (HHS) pursuant to the Act further support this conclusion.<sup>7</sup> These regulations state that recipients of federal funds who provide health services cannot “provide a qualified handicapped person with benefits or services that are not as effective as the benefits or services provided to others.” The regulations also prohibit a recipient of federal funding from adopting “criteria or methods of administration that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program with respect to the handicapped.” 45 CFR §84.4(b)(4)(ii) (1984).

While these regulations, read in isolation, could be taken to suggest that a state Medicaid program must make the handicapped as healthy as the nonhandicapped, other regulations reveal that HHS does not contemplate imposing such a requirement. Title 45 CFR §84.4(b)(2) (1984), referred to in the regulations quoted above, makes clear that

“[for] purposes of this part, aids, benefits, and services, to be equally effective, are not required to produce the identical result or level of achievement for handicapped and nonhandicapped persons, but must afford handicapped persons equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement....”

This regulation, while indicating that adjustments to existing programs are contemplated, also makes clear that Tennessee is not required to assure that its handicapped Medicaid users will be as healthy as its nonhandicapped users. Thus, to the extent respondents are seeking a distinct durational limitation for the handicapped, Tennessee is entitled to respond by asserting that the relevant benefit is 14 days of coverage. Because the handicapped have meaningful and equal access to that benefit,



Tennessee is not obligated to reinstate its 20-day rule or to provide the handicapped with more than 14 days of inpatient coverage.

## B.

We turn next to respondents' alternative contention, a contention directed not at the 14-day rule itself but rather at Tennessee's Medicaid plan as a whole. Respondents argue that the inclusion of any annual durational limitation on inpatient coverage in a state Medicaid plan violates §504. The thrust of this challenge is that all annual durational limitations discriminate against the handicapped because (1) the effect of such limitations falls most heavily on the handicapped and because (2) this harm could be avoided by the choice of other Medicaid plans that would meet the State's budgetary constraints without disproportionately disadvantaging the handicapped. Viewed in this light, Tennessee's current plan is said to inflict a gratuitous harm on the handicapped that denies them meaningful access to Medicaid services.

Whatever the merits of this conception of meaningful access, it is clear that §504 does not require the changes respondents seek. In enacting the Rehabilitation Act and in subsequent amendments,<sup>9</sup> Congress did focus on several substantive areas—employment, education, and the elimination of physical barriers to access—in which it considered the societal and personal costs of refusals to provide meaningful access to the handicapped to be particularly high. But nothing in the pre- or post-1973 legislative discussion of §504 suggests that Congress desired to make major inroads on the States' longstanding discretion to choose the proper mix of amount, scope, and duration limitations on services covered by state Medicaid. And, more generally, we have already stated, that §504 does not impose a general NEPA-like requirement on federal grantees.

The costs of such a requirement would be far from minimal, and thus Tennessee's refusal to pursue this course does not, as respondents suggest, inflict a “gratuitous” harm on the handicapped. On the contrary, to require that the sort of broad-based distributive decision at issue in this case always be made in the way most favorable, or least disadvantageous, to the handicapped, even when the same benefit is meaningfully and equally offered to them, would be to impose a virtually unworkable requirement on state Medicaid administrators. Before taking any across-the-board action affecting Medicaid recipients, an analysis of the effect of the proposed change on the handicapped would have to be prepared. Presumably, that analysis would have to be further broken down by class of handicap—the change at issue here, for example, might be significantly less harmful to the blind, who use inpatient services only minimally, than to other subclasses of handicapped Medicaid recipients; the State would then have to balance the harms and benefits to various groups to determine, on balance, the extent to which the action disparately impacts the handicapped. In addition, respondents offer no reason that similar treatment would not have to be accorded other groups protected by statute or regulation from disparate-impact discrimination.

It should be obvious that administrative costs of implementing such a regime would be well beyond the accommodations that are required under *Davis*. As a result, Tennessee need not redefine its Medicaid program to eliminate durational limitations on inpatient coverage, even if in doing so the State could achieve its immediate fiscal objectives in a way less harmful to the handicapped.

## IV.

The 14-day rule challenged in this case is neutral on its face, is not alleged to rest on a discriminatory motive, and does not deny the handicapped access to or exclude them from the particular package of Medicaid services Tennessee has chosen to provide. The State has made the same benefit—14 days of coverage—equally accessible to both handicapped and nonhandicapped persons, and the State is not required to assure the handicapped “adequate health care” by providing them with more coverage than the nonhandicapped. In addition, the State is not obligated to modify its Medicaid program by abandoning reliance on annual durational limitations on inpatient coverage.

Assuming, then, that §504 or its implementing regulations reach some claims of disparate-impact discrimination, the effect of Tennessee's reduction in annual inpatient coverage is not among them. For that reason, the Court of Appeals erred in holding that respondents had established a prima facie violation of §504. The judgment below is accordingly reversed.

### *Notes*

**1. *Legislative History of the Rehabilitation Act:*** The history of Section 504 of the Rehabilitation Act was summarized briefly in the 1985 Supreme Court decision in *Alexander v. Choate*, 469 U.S. 287 (1985), *supra*. What is not obvious from the opinion, however, is what politically led up to the passage of the Rehabilitation Act and the promulgation of the regulations. See RICHARD K. SCOTCH, *FROM GOOD WILL TO CIVIL RIGHTS: TRANSFORMING FEDERAL DISABILITY POLICY* (1984), describing the evolution of Section 504 of the Rehabilitation Act. The research the author conducted from the perspective of a sociologist involved contacts and interviews with more than one hundred individuals involved in the development of Section 504 and its subsequent regulations. Signed by President Nixon, in 1973, Section 504 was patterned after other civil rights legislation as a “routine inclusion” in the reauthorization of the Vocational Rehabilitation Act. *Id.* at 5. It is surprising to know that the social reform found in the 1973 amendments was not the result of the activism of disability rights advocates or any other strong political activism by federal legislators. “Rather, the adoption and development of a nondiscrimination policy was carried out by individuals working at the subpolitical, or staff, level.” *Id.* at 148. Initially, the reauthorization did not include Section 504. It was “conceived by Senate committee staff members and added to the bill at a relatively late point in the legislative process.” *Id.* at 49. “It appears that most members of Congress either were unaware that Section 504 was included in the act or saw the section as little more than a platitude, a statement of a desired goal with little potential for causing institutional change.” *Id.* at 54. There was little discussion or debate of Section 504 in either committees or on the floor of either the House or Senate. The promulgation of the regulations also has an unusual political history, as is further described in Scotch's fascinating book.

**2. *Legislative History of the Americans with Disabilities Act:*** Unlike Section 504 of the Rehabilitation Act, which did not result from lengthy debate and discussion, the Americans with Disabilities Act (ADA) went through extensive Congressional committee discussion and floor debate. Major efforts to pass a comprehensive antidiscrimination statute began in 1988. The ADA was almost passed in 1989, but concerns from several constituencies, such as small business, resulted in going back to the drawing board for another year of discussion. After considerable discussion by several Congressional Committees, and a potential eleventh-hour derailment on the issue of employees with AIDS in the food industry, the ADA was passed by Congress and signed by President Bush in July of 1990. For a detailed overview of the ADA, its history and its major provisions, see THE AMERICANS WITH DISABILITIES ACT: FROM POLICY TO PRACTICE (Jane West ed. 1991). See also BARNARD D. REAMS, PETER J. MCGOVERN & JON S. SCHULTZ, *DISABILITY LAW IN THE UNITED STATES: A LEGISLATIVE HISTORY OF THE AMERICANS WITH DISABILITIES ACT OF 1990* (1992). For a more recent overview of how the ADA was enacted, see LENNARD J. DAVID, *ENABLING ACTS: THE HIDDEN STORY OF HOW THE AMERICANS WITH DISABILITIES ACT GAVE THE LARGEST US MINORITY ITS RIGHTS* (BEACON PRESS 2015).

Unlike the nondiscrimination mandates in the Rehabilitation Act, which are relatively short in terminology, the ADA is a lengthy statute incorporating directly into the statute many of the issues that are covered by the Rehabilitation Act through its regulations and through case law interpretation. The ADA is truly a descendant of the Rehabilitation Act, and it specifically refers to the Rehabilitation Act judicial interpretation as precedent for the ADA. It is thus incorrect to state, as many ADA opponents did, that the ADA is unclear in its mandates. It is true that in some areas, particularly public accommodations, there was little guidance from the Rehabilitation Act



interpretation. In other areas, however, such as employment, higher education, and health services, there was a substantial and growing body of case law to draw upon.

The ADA and Rehabilitation Act were amended by the ADA Amendments Act of 2008, which took effect on January 1, 2009. As subsequent chapters will demonstrate, Congress passed the amendments to overturn a number of United States Supreme Court opinions interpreting the ADA and their application by the lower federal courts that had the effect of significantly narrowing the definition of individuals with disabilities. Some of these opinions concluded that persons with serious impairments such as intellectual disabilities, deafness, diabetes and cancer were not individuals with disabilities and were therefore not protected by the Act from discrimination.

A 1995 circuit court opinion provides a useful summary and outline of the history of the ADA in the context of the Rehabilitation Act history. The following is the portion of that opinion with the historical information.

**Helen L. v. Didario**

46 F.3d 325 (3d Cir. 1995)

MCKEE, CIRCUIT JUDGE:

In order to appreciate the scope of the ADA and its attendant regulations, it is necessary to examine the circumstances leading to its enactment. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794, was the first broad federal statute aimed at eradicating discrimination against individuals with disabilities. “Section 504 of the Rehabilitation Act of 1973, [is] commonly known as the civil rights bill of the disabled.” Section 504 now reads in relevant part:

No otherwise qualified individual with a disability ... shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance....

29 U.S.C. §794.<sup>11</sup>

Section 504's sponsors described it as a response to “‘previous societal neglect’” and introduced it to rectify “‘the country's ‘shameful oversights’ which caused the handicapped to live among society ‘shunted aside, hidden and ignored.’” *Alexander v. Choate*, 469 U.S. 287, 296 (1985).

As originally enacted, section 504 referred to a “handicapped” individual being discriminated against solely by reason of a “handicap.” The change in nomenclature from “handicap” to “disability” reflects Congress' awareness that individuals with disabilities find the term “handicapped” objectionable. Burgdorf, *The Americans with Disabilities Act Analysis and Implication of a Second-Generation Civil Rights Statute*, 26 Harv. C.R.-C.L. L.Rev. 413, 522 n. 7 (1991).

On April 26, 1976 then-President Gerald Ford signed Executive Order No. 11914, 3 C.F.R. §117 (1977), which authorized the Department of Health, Education and Welfare to coordinate enforcement of section 504 and which required the Secretary of HEW to promulgate regulations for enforcement.<sup>12</sup> Subsequently, HEW's section 504 rulemaking and enforcement authority was transferred to the Department of Health and Human Services (“HHS”). See 20 U.S.C. §3508.

On November 2, 1980, President Carter signed Executive Order No. 12250, 45 Fed. Reg. 72995, entitled “Leadership and Coordination of Nondiscrimination Laws.” That Executive Order transferred HHS's coordination and enforcement authority to the Attorney General. Section 1-105 of that Executive Order provided that the HHS guidelines “shall be deemed to have been issued by the Attorney General pursuant to this Order and shall continue in effect until revoked or modified by the Attorney General.” Thereafter, the Department of Justice adopted the HHS coordination and enforcement regulations and transferred them from 45 C.F.R. part 84 to 28 C.F.R. part 41, 46 Fed. Reg. 40686 (the “coordination regulations”). The section 504 coordination regulations begin by

stating that the purpose of 28 C.F.R. part 41 is to “implement Executive Order 12250, which requires the Department of Justice to coordinate the implementation of section 504 of the Rehabilitation Act 1973.” 28 C.F.R. §41.1. A subsequent section requires all federal agencies to issue regulations “to implement section 504 with respect to programs and activities to which it provides assistance.” 28 C.F.R. §41.4. The coordination regulations contain a separate section which lists a number of general prohibitions against disability-based discrimination. 28 C.F.R. §41.51. That section mandates that all recipients of federal financial assistance “shall administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons.” 28 C.F.R. §41.51(d). Although Section 504 has been called “the cornerstone of the civil rights movement of the mobility-impaired,” its shortcomings and deficiencies quickly became apparent. See, e.g., Cook, *The Americans with Disabilities Act: The Move to Integration*, 64 Temp. L. Rev. 393, 394–408 (1991) (The Rehabilitation Act and its regulations have been practically a dead letter as a remedy for segregated public services). One commentator has written that the weaknesses of section 504 arise from its statutory language, the limited extent of its coverage, inadequate enforcement mechanisms and erratic judicial interpretations. Burgdorf, *The Americans with Disabilities Act: Analysis and Implications of a Second-Generation Civil Rights Statute*, 26 Harv. C.R.-C.L. L. Rev. 413, 431 (1991).

Toward the end of the 1980's the United States Senate and the House of Representatives both recognized that then current laws were “inadequate” to combat “the pervasive problems of discrimination that people with disabilities are facing.” The Senate recognized the need for “omnibus civil rights legislation” for the disabled. Similarly, the House addressed the need for legislation that “will finally set in place the necessary civil rights protections for people with disabilities.” Both branches of Congress concluded:

There is a compelling need to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities and for the integration of persons with disabilities into the economic and social mainstream of American life. Further, there is a need to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities.

It was against this backdrop that the ADA was enacted.<sup>13</sup>

[B]ecause Congress mandated that the ADA regulations be patterned after the section 504 coordination regulations, the former regulations have the force of law. When Congress re-enacts a statute and voices its approval of an administrative interpretation of that statute, that interpretation acquires the force of law and courts are bound by the regulation. The same is true when Congress agrees with an administrative interpretation of a statute which Congress is re-enacting.

In enacting the ADA, Congress found that “historically, society has tended to isolate and segregate individuals with disabilities, and ... such forms of discrimination ... continue to be a serious and pervasive social problem.” 42 U.S.C. §12101(a)(2). Congress also concluded that “individuals with disabilities continually encounter various forms of discrimination, including ... segregation....” 42 U.S.C. §12101(a)(5).

In furtherance of the objective of eliminating discrimination against the disabled, Congress stated that “the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals[.]” 42 U.S.C. §12101(a)(8). Similarly, in response to its mandate, the Department of Justice stated “integration is fundamental to the purposes of the Americans with Disabilities Act.” 28 C.F.R. Part 35, App. A. §35.130.<sup>14</sup> Thus, the ADA and its attendant regulations clearly define unnecessary segregation as a form of illegal discrimination against the disabled.<sup>15</sup>

*Judicial Decisions as the Basis for New Legislation and Amendments to Existing Federal Legislation:* Although neither the Rehabilitation Act nondiscrimination mandates nor the ADA were a direct result of any specific judicial activity, other major legislation has been. The passage of the Education for All Handicapped Children Act (now the Individuals with Disabilities Education Act) was a direct result of the judicial settlements in the *PARC* and *Mills* decisions. Amendments to the IDEA also have been the direct result of judicial activity. In 1986, the EAHCA/IDEA was amended by the Handicapped Children's Protection Act to provide for attorneys' fees in special education cases. This amendment was a direct result of a Supreme Court decision that these fees could not be implied in the EAHCA/IDEA. See *Smith v. Robinson*, 468 U.S. 992 (1984). The EAHCA/IDEA was amended again in 1990 as a response to the decision in *Dellmuth v. Muth*, 491 U.S. 223 (1989), in which the Supreme Court held that states and state agencies are immune from suits under the EAHCA/IDEA.

The Air Carrier Access Act, which is an amendment to the Federal Aviation Act, was the direct result of a Supreme Court decision, *Department of Transp. v. Paralyzed Veterans of Am.*, 477 U.S. 597 (1986), which had held that commercial airlines are not recipients of federal financial assistance and, thus, were not subject to Section 504 of the Rehabilitation Act.

Although the ADA was not a direct result of judicial activity, it is probable that the mass transit portions of the ADA were, at least in part, a response to the confusion surrounding what was required for mass transit by the various federal laws (including Section 504 of the Rehabilitation Act, the Federal Aid Highway Act, and the Urban Mass Transportation Act), that became apparent as a result of several lower court cases interpreting these statutes.

### ***History of the ADA Amendments Act of 2008***

Although in passing the ADA Congress had an intent to provide broad protection to individuals with disabilities, Supreme Court and lower court opinions interpreted the definition of disability under the ADA narrowly, finding that many persons with severe impairments were not covered by the Act primarily in employment cases. Defendants prevailed in an extremely high percentage of cases brought under the ADA (some say as high as 97%), with many of plaintiffs' cases defeated because the courts concluded that the plaintiff was not an individual with a disability. See Chai R. Feldblum, et al., *The ADA Amendments Act of 2008*, 13 TEX. J. ON C.L. & C.R. 187, 202–03 (2008). Disability activists were disappointed that the courts had not interpreted the ADA of 1990 broadly to prohibit discrimination against persons with mental and physical disabilities. They had expected broad coverage, because the ADA definition of disability was the same as that in Section 504 of the Rehabilitation Act, whose definition had been interpreted broadly for years, and because of the more extensive legislative history of the ADA which indicated the Congressional intent to define disability broadly. See *id.* at 187, 203–04. The cases, in which the defendants often prevailed on motions for summary judgment, led to the ADA Amendments Act of 2008 (“ADAAA”) which overturned a number of Supreme Court decisions and expressly directed courts to construe the definition of disability in favor of broad coverage of individuals. The changed definition applies to both the ADA and the Rehabilitation Act. This text will incorporate the amendments in light of court interpretation of the definition of disability in subsequent chapters.

## **D. Framework for Analyzing Problems and Issues**

Throughout the textbook, each chapter includes one or more hypothetical problems as a fact pattern to consider the application of the statutes, regulations, and case precedents that might be relevant. In analyzing the problems in this book, the following considerations should be taken into account where relevant:

1. What additional **information** is needed?

Where can that information be obtained?

What documents are needed—medical reports, copies of correspondence, work evaluations, school records?

What limitations apply to obtaining records—confidentiality, cost?

When did the discrimination, denial of benefits, or exclusion take place (for statute of limitations purposes)?

**2. What laws** have been violated?

Is there a constitutional issue? Is there requisite state action?

If there is state action, what test applies—strict scrutiny, rational basis, or some other test?

Is the party carrying out the conduct in question covered by applicable law? Is the party a program receiving federal financial assistance, a federal contractor, or is it covered by state law?

Is the party claiming discrimination disabled or handicapped within the applicable definition?

Is the party claiming discrimination otherwise qualified, within the applicable definition?

Is there a private right of action; is exhaustion of administrative remedies required?

**3. What questions** should be asked of the client who brings a problem forward and how should the client be advised about the costs and benefits of various avenues to remedy the problem, i.e., what are considerations for client interviewing and counseling?

**4. What are the best means** of pursuing the problem, i.e., what **tactics**—negotiation, litigation (in which court?), administrative action?

**5. What procedures** need to be understood in order to represent the client?

**6. What remedy** is sought—damages, injunction, debarment, etc.?

What is most appropriate?

What is provided for by statute?

If damages, what kind of damages?

What about attorneys' fees and costs?

**7. What kind of defenses** might bar the action—statute of limitations, mootness, immunity, lack of jurisdiction, undue administrative or financial burden, direct threat to health and safety of others?

## E. Summary

This chapter highlights the wide variety of issues that are involved in studying discrimination on the basis of disability. The issues vary because of the differing types of disabilities (mobility, sensory, mental, health, learning, etc.) and the wide range of settings (education, employment, housing, accessing public services, accessing public accommodations, etc.). The focus of the textbook is primarily on rights, not benefits. Topics such as access to social security benefits, workers' compensation benefits, and similar benefits is addressed occasionally and indirectly. The only two exceptions are in the area of special education (where its major statute confers both rights and benefits) and health care (because of the complex interrelationship of health insurance and access to health care).

This chapter starts with examples of individual stories to frame these issues. The statistics about how many individuals are affected in various ways highlight the critical importance of protection from discrimination not only for the 20 percent of Americans with disabilities, but also for their family members and society generally. How the evolving laws protect those individuals is summarized in the history of discrimination policy. Finally, a framework for analyzing individual

cases is presented for consideration.

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1. [http://www.cdc.gov/dhds/data\\_statistics/fact\\_sheets/fs\\_bloodpressure.htm](http://www.cdc.gov/dhds/data_statistics/fact_sheets/fs_bloodpressure.htm).

2. This is the number of Americans with coronary heart disease or living with the aftereffects of strokes. “Heart Disease and Stroke Statistics at a Glance,” American Heart Association and American Stroke Association (2015) [https://www.heart.org/idc/groups/ahamh-public/@wcm/@sop/@smd/documents/downloadable/ucm\\_470704.pdf](https://www.heart.org/idc/groups/ahamh-public/@wcm/@sop/@smd/documents/downloadable/ucm_470704.pdf) retrieved June 26, 2016.

3. As of 2013, this is the number of individuals in the United States living with cancer. See SEER Fact Stat Sheets, <http://seer.cancer.gov/statfacts/html/all.html>, retrieved June 24, 2016.

4. Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 2005 June; 62(6):617–27.

5. Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The de facto mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*. 1993 Feb; 50(2):85–94.

6. As of 2014. <http://www.alz.org/facts/>.

7. “Polycystic Kidney Disease,” National Kidney Foundation (2003).

8. As of 2016. See <http://www.alz.org/facts/>, retrieved June 23, 2016.

9. <http://www.alz.org/facts/>, retrieved June 23, 2016.

1. The evidence indicated that, if 19 days of coverage were provided, 16.9% of the handicapped, as compared to 4.2% of the nonhandicapped, would not have their needs for inpatient care met.

2. As of 1980 the average ceiling in those States was 37.6 days. Six States also limit the number of reimbursable days per admission, per spell of illness, or per benefit period.

5. In *Davis*, we stated that §504 does not impose an “affirmative-action obligation on all recipients of federal funds.” Our use of the term “affirmative action” in this context has been severely criticized for failing to appreciate the difference between affirmative action and reasonable accommodation; the former is said to refer to a remedial policy for the victims of past discrimination, while the latter relates to the elimination of existing obstacles against the handicapped. Regardless of the aptness of our choice of words in *Davis*, it is clear from the context of *Davis* that the term “affirmative action” referred to those “changes,” “adjustments,” or “modifications” to existing programs that would be “substantial,” or that would constitute “fundamental [alterations] in the nature of a program...,” rather than to those changes that would be reasonable accommodations.

6. The record does not contain any suggestion that the illnesses uniquely associated with the handicapped or occurring with greater frequency among them cannot be effectively treated, at least in part, with fewer than 14 days’ coverage. In addition, the durational limitation does not apply to only particular handicapped conditions and takes effect regardless of the particular cause of hospitalization.

7. We have previously recognized these regulations as an important source of guidance on the meaning of §504.

9. The year after the Rehabilitation Act was passed, Congress returned to it with important amendments that clarified the scope of §504. While these amendments and their history cannot substitute for a clear expression of legislative intent at the time of enactment, as virtually contemporaneous and more specific elaborations of the general norm that Congress had enacted into law the previous year, the amendments and their history do shed significant light on the intent with which §504 was enacted. We have previously relied on the post-1973 legislative actions to interpret §504.

11. The general prohibition against disability-based discrimination contained in §504 was first proposed in the 92nd Congress as an amendment to Title VI of the Civil Rights Act of 1964, 42 U.S.C. §2000d et seq. Although it was ultimately enacted by the 93rd Congress as part of a pending Vocational Rehabilitation Act, its language was patterned after other civil rights statutes. *Alexander v. Choate*, 469 U.S. 287, 296 n. 13 (1985). The language of section 504 is virtually identical to that of section 601 of Title VI of the Civil Rights Act of 1964 that bars discrimination based upon race, color or national origin in federally-assisted programs.

12. The Rehabilitation Act did not mandate that any regulations be promulgated. Accordingly the

Department of Health, Education and Welfare (now the Department of Health and Human Services), did not promulgate any regulations to implement that Act. *Southeastern Community College v. Davis*, 442 U.S. 397, 404 n. 4 (1979).

13. For a concise history of the ADA's “tortuous legislative journey”, see Nancy Lee Jones, *Overview and Essential Requirements of the Americans with Disabilities Act*, 64 Temp. L. Rev. 471, 472–475 (1991).

14. We note that this is consistent with the Fair Housing Act of 1988, 52 U.S.C. §3604(f), another predecessor of the ADA. In enacting that Act, the House Judiciary Committee stated “the Fair Housing Amendments Act, like Section 504 of the Rehabilitation Act of 1973, as amended, is a clear pronouncement of a national commitment to end the unnecessary exclusion of persons with handicaps from the American mainstream.” H. Rep. No. 711, 100th Cong., 2d Sess., 18 (1988).

15. Even if it could be argued that the Act and its regulations are ambiguous on this point, the heading of the regulation at issue here, and the legislative history of the ADA confirm that Congress intended to define unnecessary segregation of the disabled as a form of illegal discrimination.