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COVID-19 and Public Accommodations Under the Americans with Disabilities Act:

Getting Americans Safely Back to Restaurants, Theaters, Hotels and “Normal”

By Frank Griffin, M.D., J.D.*

I. Introduction

COVID-19 permanently changed the legal landscape for public accommodations—like restaurants, retail stores, theaters, gyms, hospitals, and many other private entities—under Title III of the Americans with Disabilities Act (ADA) by adding novel new obligations of which covered entities must be cognizant to avoid discrimination against people with newly definable disabilities.¹ According to the CDC and researchers, COVID-19 is likely to become endemic to the United States (US) population, so these new legal obligations are unlikely to go away for the foreseeable future.²

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¹ 42 U.S.C. § 12101.

² Ruiyun Li, et al., *Substantial undocumented infection facilitates the rapid dissemination of the novel coronavirus (SARS-CoV-2)*, 368 *SCIENCE* 489, 492 (2020), available at <https://science.sciencemag.org/content/sci/368/6490/489.full.pdf> (noting that prior to COVID-19 there were already “four endemic coronavirus strains circulating in the human populations,” and “[i]f the novel coronavirus follows the pattern of 2009 H1N1 pandemic influenza, it will also spread globally and become a fifth endemic coronavirus within the human population.”); CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), *Principles of Epidemiology in Public Health Practice, Third Edition: An Introduction to Applied Epidemiology and Biostatistics*, available at <https://www.cdc.gov/csels/dsepd/ss1978/lesson1/section11.html> (last visited May 25, 2020) (defining “endemic” as the constant presence and/or usual prevalence of a disease or infectious agent in a population within a geographic area”); BLOOMBERG NEWS, *Virus likely to keep coming back each year, say top Chinese scientists*, (April 27, 2020), available at https://www.bloomberg.com/news/articles/2020-04-28/virus-is-here-to-stay-and-likely-seasonal-say-china-scientists?utm_campaign=news&utm_medium=bd&utm_source=applenews (noting that it is “unlikely the new virus will disappear” because “it infects some people without causing obvious symptoms like fever” creating a group of “asymptomatic carriers” who

Historically, “society has tended to isolate and segregate individuals with disabilities,” which created a “serious and pervasive social problem.”³ The ADA was enacted in 1990 to “remedy widespread discrimination against disabled individuals” including “outright intentional exclusion as well as the failure to make modifications to existing facilities and practices.”⁴ The ADA was also intended to integrate people with disabilities into “the economic and social mainstream of American life” —including popular public accommodations like restaurants, movie theaters, arenas, museums, and other public venues.⁵

According to the Supreme Court, allowing discrimination based on the contagiousness of a disease is “inconsistent with the basic purpose” of the ADA of ensuring that people with disabilities are “not denied . . . benefits because of the prejudiced attitudes or the ignorance of others.”⁶ In finding that a person with tuberculosis can be a protected person with a disability, the Court noted that contagiousness gives rise to an unusually high level of “fear and apprehension” in society leading to “myths and fears about . . . disease [that] are as handicapping as the physical limitations” caused by the disease.⁷ Similarly, AIDS and even asymptomatic HIV infections have been found to be protected disabilities under the ADA.⁸

can “spread the virus undetected,” and stating that this is “very likely to be an epidemic that co-exists with humans for a long time”).

³ *PGA Tour, Inc. v. Martin*, 532 U.S. 661, 674-75 (2001).

⁴ *Id.* at 675.

⁵ *Id.*; see also *Staron v. McDonald's Corp.*, 51 F.3d 353, 355 (2d Cir. 1995) (quoting 42 U.S.C. § 12101(b)(1)–(2)) (stating that the ADA was adopted “to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities,” and to establish “clear, strong, consistent, enforceable standards’ for scrutinizing such discrimination”).

⁶ *Sch. Bd. of Nassau Cty., Fla. v. Arline*, 480 U.S. 273, 284 (1987) (the court here refers to § 504 of the Rehabilitation Act, which Congress has made clear applies to the ADA, which adopted the Rehabilitation Act’s definitions).

⁷ *Id.* at 284.

⁸ 28 C.F.R. Pt. 36, App. C, § 36.104 (stating, symptomatic HIV disease is an impairment that substantially limits a major life activity; therefore it has been included in the definition of disability under this part. . . . [and] asymptomatic HIV disease is an impairment that substantially limits a major life activity, either because of its actual effect on the individual with HIV disease or because the

The endemic presence of COVID-19 creates several populations of individuals that may face potential disability-related discrimination, including, but not limited to (1) individuals hospitalized or severely ill with COVID-19, (2) people with mild symptoms of COVID-19, (3) people who have tested positive for COVID-19 but are asymptomatic, (4) individuals who have been exposed to COVID-19, and (5) people who are vulnerable to COVID-19-related morbidity or mortality due to other disabilities. In some situations, affected individuals will be considered “direct threats,” not disabled, or otherwise not covered by the ADA. But in other cases, the public accommodation will have to make reasonable modifications to their practices, policies, procedures, or structural barriers to avoid discrimination as defined by the ADA.

This paper explores disability and discrimination under the ADA with regard to customers and clients of public accommodations, along with new obligations for reasonable modifications (including controversial measures like fever checkpoints, mandatory masking, and social distancing requirements) to accommodate this evolving group of newly defined individuals and to avoid COVID-19-related discriminatory practices.

II. Who must comply, what is prohibited, and who is protected under Title III of the ADA?

Title III of the ADA applies to places of public accommodation (i.e., “covered entities”) and states the general rule that “[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation.”⁹ To establish a *prima facie* case of discrimination under Title III of the ADA, the plaintiff must show that (1) defendants own or operate a “*place of public*

reactions of other people to individuals with HIV disease cause such individuals to be treated as though they are disabled.); see also *Bragdon v. Abbott*, 524 U.S. 624, 647 (1998) (holding that asymptomatic HIV infection to be a disability under the ADA).

⁹ 42 U.S.C. § 12182(a).

accommodation,” (2) defendants *discriminated* against him “on the basis of his disability,” and (3) he has a “*disability*.”¹⁰

A. Places of Public Accommodations

“Places of public accommodation” or “covered entities” under Title III of the ADA generally include private entities affecting commerce included in any of twelve categories including (1) places of lodging, (2) establishments serving food or drink, (3) places of exhibition or entertainment, (4) places of public gathering, (5) sales or rental establishments, (6) service establishments, (7) specified places of public transportation, (8) places of public display or collection, (9) places of recreation, (10) private places of education, (11) social service centers, and (12) places of exercise or recreation.¹¹

¹⁰ See, e.g., *Doe v. Deer Mountain Day Camp, Inc.*, 682 F. Supp. 2d 324, 340–41 (S.D.N.Y. 2010) (explaining, “In order to establish a *prima facie* case” under Title III of the ADA, the plaintiff must “establish that: (a) he has a “disability”; (b) Defendants are owners or operators of a place of “public accommodation”; and (c) Defendants discriminated against him, on the basis of his disability.”).

¹¹ 42 U.S.C.A. § 12181 (listing the 12 categories of public accommodations including (A) an inn, hotel, motel, or other place of lodging, except for an establishment located within a building that contains not more than five rooms for rent or hire and that is actually occupied by the proprietor of such establishment as the residence of such proprietor; (B) a restaurant, bar, or other establishment serving food or drink; (C) a motion picture house, theater, concert hall, stadium, or other place of exhibition or entertainment; (D) an auditorium, convention center, lecture hall, or other place of public gathering; (E) a bakery, grocery store, clothing store, hardware store, shopping center, or other sales or rental establishment; (F) a laundromat, dry-cleaner, bank, barber shop, beauty shop, travel service, shoe repair service, funeral parlor, gas station, office of an accountant or lawyer, pharmacy, insurance office, professional office of a health care provider, hospital, or other service establishment; (G) a terminal, depot, or other station used for specified public transportation; (H) a museum, library, gallery, or other place of public display or collection; (I) a park, zoo, amusement park, or other place of recreation; (J) a nursery, elementary, secondary, undergraduate, or postgraduate private school, or other place of education; (K) a day care center, senior citizen center, homeless shelter, food bank, adoption agency, or other social service center establishment; and (L) a gymnasium, health spa, bowling alley, golf course, or other place of exercise or recreation).

These twelve categories are “construed liberally to afford people with disabilities equal access to a wide variety of establishments available to the nondisabled.”¹² More specifically, public accommodations include many important mainstream American businesses and industries that accommodate countless customers and clients annually like hotels, restaurants, bars, movie theaters, sports stadiums, convention centers, grocery stores, shopping centers, beauty shops, professional offices (like doctors’ and lawyers’ offices), hospitals, public transportation stations, museums, libraries, zoos, amusement parks, private schools, day cares, food banks, gyms, and golf courses—just to name a few.¹³

B. Discrimination

Title III of the ADA “provides that [n]o individual shall be *discriminated against on the basis of disability* in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation.”¹⁴ Title III’s divides prohibited behavior defined as “discrimination” into three COVID-19-related categories.¹⁵ Note that causation (i.e., “on the basis of disability”) is required in the definition of discrimination.

First, discrimination includes “the imposition or application of *eligibility criteria* that screen out or tend to screen out an individual with a disability . . . from fully and equally enjoying any goods, services, facilities, privileges, advantages, or accommodations, *unless* such criteria can be shown to *be necessary*.”¹⁶ A few examples discussed below of possible eligibility criteria relevant to COVID-19 discrimination analysis include denying entry to individuals based upon criteria related to COVID-19 (e.g., positive tests, other disabilities, symptoms) or requiring some type of documentation to allow entry (e.g., certificates of health, “COVID-19 passports”) or rationing advanced health services like

¹² PGA Tour, Inc. v. Martin, 532 U.S. 661, 676–77 (2001) (finding that “golf tours” were places of public accommodation).

¹³ 42 U.S.C. § 12181.

¹⁴ Staron v. McDonald's Corp., 51 F.3d 353, 355 (2d Cir. 1995) (citing 42 U.S.C. § 12182(a)).

¹⁵ 42 U.S.C. § 12182(2).

¹⁶ *Id.*

mechanical ventilation to people with pre-existing disabilities or with low quality of life scores.

Second, discrimination includes “a failure to make *reasonable modifications* in policies, practices, or procedures, when such modifications are *necessary* . . . , *unless* the entity can demonstrate that making such modifications would *fundamentally alter* the nature of [the business].”¹⁷ Some examples of COVID-19-related potential “reasonable modifications” of policies, practices, or procedures discussed below include alteration in operating hours, cleaning procedures, employee testing, restriction of visitors to hospitals and nursing homes, and requiring face masks, among others.

Third, discrimination includes “a failure to remove [*structural architectural barriers* . . . where such removal is *readily achievable*” or “where . . . the removal of a barrier . . . is not readily achievable, a failure to [use] . . . *alternative methods if such methods are readily achievable.*”¹⁸ Structural barriers related to COVID-19 may include lack of barriers between employees and customers in checkout lines or other places where a prolonged encounter is possible, requiring entry (failing to provide curbside checkout), and requiring entry through turnstiles or door handles where contamination is possible, among others.

Further, places of public accommodation have an affirmative duty to provide goods and services to people with disabilities in the “most integrated setting appropriate to the needs of the individual” and should not deny individuals with disabilities “the opportunity to participate in such programs or activities that are not separate or different.”¹⁹ In addition, associational discriminatory behavior includes excluding or otherwise denying opportunities to “an individual or entity because of the known disability of an individual with whom the individual or entity is

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ 42 U.S.C. § 12182 (stating, “Goods, services, facilities, privileges, advantages, and accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual.”).

known to have a relationship or association” — for example, someone who has been exposed to a COVID-19 patient.²⁰

C. Disability

The ADA defines “disability” with respect to an individual as (1) “a physical or mental *impairment* that *substantially limits* one or more *major life activities* of such individual,” (2) “a *record* of such an impairment,” OR (3) “being *regarded as* having such an impairment.”²¹ To be considered as an individual with a disability under the ADA, at least one of these three “prongs” — referred to as the (1) “actual impairment prong,” (2) “record of prong,” or (3) “regarded as prong,” respectively — must be fulfilled.²² The statute specifically states that the definition of disability, including the individual terms, “shall be construed in favor of *broad coverage* . . . to the *maximum extent permitted* under this chapter.”²³

Under the first two prongs, the terms “substantially limit” and “major life activity” must be fulfilled. The term “substantially limits” is not specifically defined, but Congress emphasized in the ADA Amendments Act of 2008 (ADAAA) (after a series of court misinterpretations)²⁴ that “substantially limits” is “to be construed in favor of broad coverage” — like the rest of the statutory definition of “disability.”²⁵ Congress emphasized that “the primary object of attention” should be whether covered entities have complied with their obligations, and the question of whether an individual's impairment is a disability under the ADA “should not demand extensive analysis.”²⁶ The regulations indicate that an “impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.”²⁷

²⁰ *Id.*

²¹ 42 U.S.C. § 12102(1).

²² 42 U.S.C. § 12102(1) (as denoted by the “or” connector in the definition, an individual must only satisfy one prong to qualify as person with a “disability”).

²³ 42 U.S.C. § 12102(4).

²⁴ *Sutton v. United Airlines, Inc.*, 527 U.S. 471 (1999); ADA AMENDMENTS ACT OF 2008, PL 110–325, September 25, 2008, 122 Stat 3553.

²⁵ ADA AMENDMENTS ACT OF 2008, PL 110–325, September 25, 2008, 122 Stat 3553.

²⁶ *Id.*

²⁷ 42 U.S.C. § 12102(4).

The statute includes a nonexclusive list of “major life activities” that could be limited by an impairment.²⁸ Severe cases of COVID-19 most commonly affect the “major life activity” of “breathing,” but COVID-19 may also limit other major life activities like “caring for oneself, performing manual tasks, . . . eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.”²⁹ A nonexclusive list of “major bodily functions” is also included in the definition of “major life activities.”³⁰ COVID-19 affects most commonly the major bodily function of the “respiratory system,” but also could affect the other listed systems, “including but not limited to, functions of the immune system, . . . digestive, bowel, . . . [and] circulatory . . . functions.”³¹ Importantly, an individual vulnerable to COVID-19 complications or death may also have a “disability” defined by these terms, and therefore, be covered by the ADA.

The “regarded as” prong does not require the individual to establish a substantial limitation of any major life activities. Instead,

[a]n individual meets the requirement of “being regarded as having such an impairment” if the individual establishes that he or she has been subjected to an action prohibited under this chapter because of an *actual or perceived physical or mental impairment* whether or not the impairment limits or is perceived to limit a major life activity.³²

The “regarded as” prong is Congress’ way of “acknowledg[ing] that society’s accumulated myths and fears about disability and disease are as handicapping as the physical limitations that flow from actual impairment.”³³ The statute includes a “transitory and minor” exception for the “regarded as” prong stating it “shall not apply to impairments that

²⁸ 42 U.S.C. § 12102(2).

²⁹ *Id.*

³⁰ *Id.*

³¹ Wei-jie Guan, et al., *Clinical characteristics of coronavirus disease 2019 in China*, 382 NEW ENGLAND JOURNAL OF MEDICINE 1708, , 1708, 1716 (Table 3) (April 30, 2020), available at <https://www.nejm.org/doi/full/10.1056/NEJMoa2002032>.

³² 42 U.S.C. § 12102(3).

³³ Sch. Bd. of Nassau Cty., Fla. v. Arline, 480 U.S. 273, 284 (1987).

are transitory and minor.”³⁴ A transitory impairment is defined in the statute as “an impairment with an actual or expected duration of 6 months or less.”³⁵ This exception does not apply to the other prongs.

III. Evolving ADA Definitions and Requirements Related to COVID-19

COVID-19-related considerations are used here to divide the population into COVID-19-related groups and to evaluate accommodation and discrimination avoidance requirements based on COVID-19 status.

A. COVID-19-Related Disability Grouping of the Population

Disabled “clients or customers” of public accommodations are protected by Title III of the ADA.³⁶ To facilitate a discussion of the ADA’s COVID-19-related requirements, these clients and customers can be divided into groups related to their COVID-19 status. For purposes of evaluation, this paper examines the following groups: (1) COVID-19 contagious or potentially contagious individuals, (2) COVID-19 survivors with negative tests, (3) otherwise disabled individuals at high risk for COVID-19 complications if they become infected, and (4) healthy, non-disabled individuals who are asymptomatic.³⁷

1. COVID-19 Contagious or Potentially Contagious Individuals

Similar to individuals with other communicable diseases (e.g., HIV, tuberculosis), individuals with active, confirmed COVID-19 and those

³⁴ 42 U.S.C. § 12102(3).

³⁵ *Id.*

³⁶ 42 U.S.C. § 12182; see also Frank Griffin, *COVID-19 and the Americans with Disabilities Act: Balancing Fear, Safety, and Risk as America Goes Back to Work*, 51 SETON HALL LAW REVIEW --- (forthcoming November 2020) (discussing ADA obligations to employees—including those of public accommodations—under Title I of the ADA).

³⁷ Harvey Fineberg, *Ten weeks to crush the curve*, 382 NEW ENGLAND JOURNAL OF MEDICINE e37 (April 23, 2020) available at <https://www.nejm.org/doi/full/10.1056/NEJMe2007263> (providing an example of population grouping based upon COVID-19 status by differentiating everyone into five groups for health purposes including people with: (1) active COVID-19 infections, (2) signs and symptoms of COVID-19 and therefore, presumptively infected, but with negative tests (the tests have high numbers of false negatives)(source: white house test), (3) known exposure to COVID-19, (4) no history of COVID-19 exposure or infection, and (5) recovery from COVID-19 and possibly immune).).

potentially contagious (e.g., people with symptoms or with known exposure to COVID-19) will require an individualized assessment under the ADA to determine whether they qualify for disability protection.³⁸ Here, the following subgroups of potentially COVID-19 contagious individuals will be considered: (1) individuals with severe confirmed COVID-19, (2) individuals with mild or asymptomatic cases of COVID-19 and those only exposed to COVID-19 or feared to have COVID-19 based on symptoms, and (3) travelers to COVID-19 “hotspots.” In addition, the concept of a “direct threat” in the context of these groups will be explored, along with its implications on the disability rights under the ADA.

First, approximately 19% of COVID-19 patients in one study of 70,000 Chinese patients were classified as severe (14%) or critical (5%).³⁹ Individuals with severe or critical cases of COVID-19 requiring hospitalization or significant medical care qualify as individuals with a disability under the “actual impairment” prong while they are severely ill because during that time they have a “physical or mental impairment that substantially limits one or more major life activities.”⁴⁰ Major life activities often limited in severe cases of COVID-19 include “breathing” and the “respiratory system” demonstrated by symptoms including labored breathing, severe coughing, pneumonia, and sometimes even respiratory failure requiring invasive mechanical ventilation.⁴¹ Other major bodily functions under the ADA are also frequently substantially limited in

³⁸ CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), *Reducing Stigma*, available at <https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/reducing-stigma.html> (hereinafter CDC Stigma) (warning that communicable diseases, like COVID-19, often expose society’s greatest myths, fears, and negative reactions leading to “[s]tigmatization,” which is “especially common in disease outbreaks” and results in “stigmatized groups [being] subjected to social avoidance or rejection,” among other things).

³⁹ Zonyou Wu and Jennifer McGoogan, *Characteristics of and Important Lessons From the Coronavirus Disease 2019 (COVID-19) Outbreak in China: Summary of a Report of 72 314 Cases From the Chinese Center for Disease Control and Prevention*, J AMERICAN MEDICAL ASSOCIATION E1, E1 (February 24, 2020), https://jamanetwork.com/journals/jama/fullarticle/2762130?utm_campaign=articlePDF%26utm_medium%3darticlePDFlink%26utm_source%3darticlePDF%26utm_content%3djam.a.2020.3204.

⁴⁰ 42 U.S.C. § 12102(1).

⁴¹ Wu, *supra* note 39, at E1 (reporting respiratory symptoms including coughing, pneumonia, dyspnea, and respiratory failure).

severe COVID-19 cases including the immune system (e.g., 83.2% incidence of lymphocytopenia in one study), digestive system, circulatory system, among others that can all substantially limit major life activities like “caring for oneself, performing manual tasks, . . . eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working” due to issues like severe fatigue, malaise, fever, muscle pain, and other COVID-19 symptoms.⁴² For example, in *Arline*, the Supreme Court found that the teacher’s tuberculosis “affected her respiratory system” during her hospitalization, and therefore, “Arline thus had a physical impairment . . . affecting her respiratory system . . . serious enough to *require hospitalization, a fact more than sufficient* to establish that one or more of her major life activities were substantially limited by her impairment.”⁴³ A similar analysis will result for most COVID-19 patients with severe COVID-19 during hospitalization or acute medical care, even if they are only severely ill for relatively short periods of time because duration is “only one factor” used in the assessment.⁴⁴

Second, approximately 81% of individuals with COVID-19 infections in a study of 70,000 Chinese cases were mild and ranged from having no symptoms at all (i.e., asymptomatic) to having mild pneumonia or symptoms similar to the common cold.⁴⁵ Individuals with mild or asymptomatic COVID-19 and those who have only been exposed to COVID-19 will not qualify as an individual with a disability under the “actual impairment” or “record of” prongs of the ADA because they have no physical impairment that substantially limits a major life activity—similar to other mild injuries and diseases considered by courts. For example, “a record of recovery from a minor laceration or the common

⁴² 42 U.S.C. § 12102(2); Guan, *supra* note 31, at 1708, 1716 (Table 3).

⁴³ Sch. Bd. of Nassau Cty., Fla. v. Arline, 480 U.S. 273, 281 (1987). ⁴⁵ C.F.R. § 84.3(j)(2)(i) (1985).

⁴⁴ 76 FR 16978-01 *Regulations To Implement the Equal Employment Provisions of the Americans With Disabilities Act, as Amended* (citing Joint Hoyer-Sensenbrenner Statement on the Origins of the ADA Restoration Act of 2008, H.R. 3195 at 5) (explaining that the duration of the impairment is “only one factor in determining whether the impairment substantially limits a major life activity, and impairments that last only a short period of time may be covered if sufficiently severe”).

⁴⁵ Wu, *supra* note 39, at E1 (noting, “Most cases were classified as mild (81%; ie, nonpneumonia and mild pneumonia).”).

cold would not qualify for coverage under this definition.”⁴⁶ Likewise, broken bones and badly sprained joints typically heal in 6-12 weeks, but courts find them insufficient to qualify as an actual disability under the ADA.⁴⁷ Similarly, short term or intermittent low back pain treated with over-the-counter medications often fails to qualify as a disability with one court explaining that a “temporary non-chronic impairment of short duration is not a disability covered under the ADA.”⁴⁸

However, an individual with mild or asymptomatic COVID-19 or who has only been exposed to COVID-19 might qualify as an individual with a disability (assuming they are not “direct threats” – see discussion below) under the “regarded as” prong due to the associated stigma of COVID-19, depending upon how courts ultimately view COVID-19 under the “transitory and minor” exception to this prong. Under the “regarded as” prong, the individual must only establish “that he or she has been subjected to [a discriminatory action] because of [a] . . . perceived physical . . . impairment.”⁴⁹ The “regarded as” prong covers impairments that “might not diminish a person’s physical or mental capabilities, but could nevertheless substantially limit the person’s ability to work [or participate in public accommodations] as a result of the negative reaction of others to the impairment.”⁵⁰ For example, *Arline* involved a school teacher with a history of tuberculosis, an infectious disease, who was “regarded as”

⁴⁶ Karl Menninger, *Proof of “disability” under the Americans with Disabilities Act*, 33 AM. JUR. PROOF OF FACTS 3d 1 § 10 (March 2020 Update) (Originally published in 1995); *see, e.g.,* Corning v. LodgeNet Interactive Corp., 896 F. Supp. 2d 1138 (M.D. Fla. 2012) (finding that an individual could not establish a record of a disability without showing substantial limits of a major life activity; record of his FMLA leave and his supervisor’s knowledge of his kidney failure and chronic heart failure did not provide record of disability); Jenkins-Allen v. Powell Duffryn Terminals, Inc., 18 F. Supp. 2d 885 (N.D. Ill. 1998) (holding that seven months of workers’ compensation leave for surgery on both hands for carpal tunnel syndrome alone did not provide a record of disability); Maldonado v. Cooperativa De Ahorro, 685 F. Supp. 2d 264 (D.P.R. 2010) (explaining that a record of sleep apnea was not a record of impairment where it did not limit any major life activity).

⁴⁷ *See, e.g.,* Kruger v. Hamilton Manor Nursing Home, 10 F. Supp. 3d 385 (W.D. N.Y. 2014) (holding that a temporary broken arm was insufficient for finding a disability); *see also,* Spath v Berry Plastics Corp. (1995, ND Ohio) 900 F Supp 893, 13 ADD 1080, 4 AD Cas 1811 (finding a broken ankle insufficient).

⁴⁸ Macfarlan v. Ivy Hill SNF, LLC, 675 F.3d 266, 274 (3d Cir. 2012).

⁴⁹ 42 U.S.C. § 12102(3)(A).

⁵⁰ Sch. Bd. of Nassau Cty., Fla. v. Arline, 480 U.S. 273, 283 (1987).

having a disability by her school district because of her employer's unfounded fears.⁵¹

A "transitory and minor" exception is included in the "regarded as" prong stating it "shall not apply to impairments that are transitory and minor."⁵² A transitory impairment is defined in the statute as "an impairment with an actual or expected duration of 6 months or less."⁵³ COVID-19 has a median recovery time for individuals with mild cases of only 2 weeks.⁵⁴ So, the outcome of the individualized assessments will likely depend upon whether courts view COVID-19 as "minor." "Minor" is not defined in the statute. For employment cases, the regulations state that the "transitory and minor exception" "should be construed narrowly."⁵⁵

Swine flu was tested in the courts under the transitory and minor exception, where a Minnesota court found swine flu to be "minor" leaving the employee unprotected by the ADA when he was fired at the "height of . . . public hysteria" of the swine flu panic in 2009 because the employer mistakenly "feared [the employee] had contracted the swine flu" while traveling to attend his sister's funeral.⁵⁶ The Minnesota court ruled that whether an impairment is "transitory and minor" is determined objectively (i.e., "what matters is whether the impairment is, in fact, transitory and minor") and is not based upon what the defendant believed at the time.⁵⁷ The court compared swine flu morbidity and mortality numbers to those of the seasonal flu to determine whether it qualified as

⁵¹ *Id.* at 273.

⁵² 42 U.S.C. § 12102(3).

⁵³ *Id.*

⁵⁴ WORLD HEALTH ORGANIZATION, REPORT OF THE WHO-CHINA JOINT MISSION ON CORONAVIRUS DISEASE 2019 (COVID-19) 14 (February 2020), available at <https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf#:~:text=Using%20available%20preliminary%20data%2C,severe%20or%20critical%20disease> (hereinafter WHO Joint Mission).

⁵⁵ 29 C.F.R. § Pt. 1630, App., §1630.2(l).

⁵⁶ *Valdez v. Minnesota Quarries, Inc.*, No. 12-CV-0801 PJS/TNL, 2012 WL 6112846, at *1, *3(D. Minn. Dec. 10, 2012).

⁵⁷ *Id.* at *2-4 (citing 29 C.F.R. § 1630.15(f)).

“transitory and minor” because the “seasonal flu is undoubtedly transitory and minor for purposes of the ADA.”⁵⁸

In performing the comparison of swine flu to seasonal influenza, the court considered the fact that there were a “total of 274,000 hospitalizations and 12,470 deaths in the United States due to swine flu from April 2009 to April 2010” compared to CDC estimate of over 200,000 hospitalizations and up to 49,000 deaths annually from the seasonal flu in the United States.⁵⁹ Because the swine flu did not objectively result in considerably more hospitalizations and deaths than the seasonal flu, and because the seasonal flu is not to be considered a disability based on the ADA’s legislative history, the court concluded “from an objective standpoint, swine flu must be considered transitory and minor.”⁶⁰ Therefore, this court found that swine flu could not be considered a disability under the “regarded as” prong of the ADA’s disability definition according to the court—so the fired worker was not protected by the ADA in this case.⁶¹

If other courts follow the Minnesota court’s logic, the outcome of the “regarded as” analysis for individuals with mild or asymptomatic COVID-19 cases and those who have been exposed⁶² to COVID-19 may depend upon how the “final” COVID-19 morbidity and mortality numbers compare to those of seasonal influenza. According to some researchers, comparisons of COVID-19 to seasonal influenza is not a valid comparison.⁶³ Those researchers point out that by May 2020,

⁵⁸ *Id.*

⁵⁹ *Id.* at *3.

⁶⁰ *Id.* (relying on the fact that the swine flu “has a mortality and hospitalization profile similar to that of seasonal flu, and the legislative history cites seasonal flu as the paradigmatic example of a transitory and minor ailment.”).

⁶¹ *Valdez v. Minnesota Quarries, Inc.*, No. 12-CV-0801 PJS/TNL, 2012 WL 6112846, at *3, n3 (D. Minn. Dec. 10, 2012).

⁶² 42 U.S.C. § 12182 (Individuals who have been exposed may also be protected against associational discriminatory behavior includes excluding or otherwise denying opportunities to “an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.” However, this analysis is wrapped into the “direct threat” analysis below.).

⁶³ Jeremy Faust, et al., *Assessment of deaths from COVID-19 and from seasonal influenza*, JAMA INTERNAL MEDICINE E1, E1-E2 (May 14, 2020), available at <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2766121?guestAccess>

“approximately 65,000 people in the US had died of COVID-19,” which is deceptively “similar to the estimated number of seasonal influenza deaths reported annually by the CDC.”⁶⁴ However, the researcher pointed out that “[t]his apparent equivalence of deaths from COVID-19 and seasonal influenza does not match frontline clinical conditions, especially in some hot zones of the pandemic where ventilators have been in short supply and many hospitals have been stretched beyond their limits.”⁶⁵ The author points out that the “demand on hospital resources during the COVID-19 crisis has not occurred before in the US, even during the worst of influenza seasons.”⁶⁶ The researchers speculate that the “root of such incorrect comparisons may be a knowledge gap” related to how the data are reported, and point out that seasonal influenza morbidity and mortality are estimates based on hospital codes, but COVID-19 numbers are based on “raw counts.”⁶⁷ In other words, “COVID-19 fatalities are at present being counted and reported directly, not estimated” like seasonal influenza numbers.⁶⁸

Those researchers suggest that weekly comparisons between COVID-19 and seasonal influenza deaths are more valid. COVID-19 deaths during two weeks in April were 15,455 and 14,478 compared to the peak week of influenza season from 2013 to 2020 when deaths ranged from 351 in 2016 to 1626 in 2018 and the mean was 752.⁶⁹ The researchers observed that “[t]hese statistics on counted deaths suggest that the number of COVID-19 deaths during a possible peak week in 2020 were “9.5-fold to 44.1-fold greater than the peak week of counted influenza deaths during the past seven influenza seasons in the US, with a 20.5-fold mean increase.”⁷⁰ The reported deaths for the week ending April 11, 2020

[Key=cb171e02-ae9a-4f40-97d4-a69dc439a904&utm_source=For The Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfl&utm_term=051420.](#)

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ Faust, *supra* note 63, at E1-E2.

⁶⁹ *Id.*

⁷⁰ *Id.*

were “14.4-fold greater than influenza deaths during the apparent peak week of the current [2020 flu] season.”⁷¹

The researchers also noted that COVID-19 deaths “may be undercounted owing to ongoing limitations of test capacity or false-negative test results.”⁷² However, they acknowledge that “influenza counts may be less reliable because adult influenza deaths are not reportable to public health authorities, as are the case for COVID-19 deaths.”⁷³ The researchers also acknowledge that some cities, “such as New York City,” may include “some deaths that have been labeled as having been caused by COVID-19 [but] are not due to COVID-19.”⁷⁴

In addition, the authors state that “[c]ase fatality rates are another topic of confusion” because comparisons of COVID-19 and influenza are premature.⁷⁵ At the time the article was written, “[e]stimates of case fatality rates for COVID-19 ranged from less than 1% in some nations to approximately 15% in others” with the wide range reflecting “limitations in calculating case fatality rates” including testing differences and incomplete follow-up.⁷⁶

The CDC’s best estimate in late May 2020 is a case fatality rate of 0.4%, which is more in line with the researchers’ predictions in the above study when looking at a cruise ship.⁷⁷ The researchers in the above study note that the Diamond Princess cruise ship is “one of the few situations for which complete data are available, and the outbreak on that ship resulted in a case fatality rate of 1.8% (13 deaths of 712 cases) resulting in an “age adjusted” figure (to reflect the age of the general population) “closer to

⁷¹ *Id.*

⁷² *Id.*

⁷³ Faust, *supra* note 63, at E1-E2.

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), *COVID-19 Pandemic Planning Scenarios*, available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios-h.pdf> (hereinafter CDC Pandemic Planning); Arman Azad, *CDC estimates that 35% of coronavirus patients don’t have symptoms*, CNN Health (May 22, 2020), available at <https://www.cnn.com/2020/05/22/health/cdc-coronavirus-estimates-symptoms-deaths/index.html>.

0.5%.”⁷⁸ However, “0.5% would still be 5 times the commonly cited case fatality rate of adult seasonal influenza.”⁷⁹ The researchers conclude, “Although officials may say that SARS-CoV-2 is ‘just another flu,’ this is not true,” but how courts ultimately interpret the data is hard to predict.⁸⁰ Courts could possibly find that individuals with mild cases, asymptomatic cases, and those who have only been exposed to COVID-19 are entitled to ADA protections under the “regarded as” prong if COVID-19 is not considered “transitory and minor.” However, these individuals could still be disqualified for ADA protection under the “direct threat” exception discussed below.

Third, travelers to COVID-19 “hotspots” and high risk areas are not covered by the ADA based on a 2019 Eleventh Circuit decision where the court declined to “expand the ‘regarded as’ disabled definition in the ADA to cover cases . . . in which an employer perceives an employee to be presently healthy with only the potential to become disabled in the future due to voluntary conduct.”⁸¹ Presumably, similar logic would apply to a public accommodation who refused goods or services to an otherwise healthy recent traveler to a COVID-19 high risk area without intervening quarantine time because the traveler would not qualify as an individual with a disability under the ADA based on travel risk alone.

Finally, even if an individual has a disability defined by the ADA, public accommodations can defend discriminatory actions if the individual poses a “direct threat” to himself or others—as is sometimes the case for infectious diseases. Title III says that covered entities are *not* required “to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a *direct threat* to the health or safety of others.”⁸² “Direct threat” is defined as “a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or

⁷⁸ Faust, *supra* note 63, at E1-E2; *see also* Guan, *supra* note 31, at 1708 (finding a case fatality rate of 1.4%).

⁷⁹ Faust, *supra* note 63, at E1-E2.

⁸⁰ *Id.*

⁸¹ Equal Employment Opportunity Comm'n v. STME, LLC, 309 F. Supp. 3d 1207, 1212–13 (M.D. Fla. 2018), *aff'd*, 938 F.3d 1305 (11th Cir. 2019).

⁸² 42 U.S.C. § 12182(b)(3).

services.”⁸³ The ADA’s definition of “direct threat” is a codification of the Supreme Court’s articulated standard while holding that a person with a contagious disease, tuberculosis, can be a person with a disability under the law.⁸⁴

Public accommodations cannot make generalized stereotypical assumptions regarding contagious diseases and “direct threats.” The Supreme Court explained, “The fact that *some* persons who have contagious diseases may pose a serious health threat to others under certain circumstances does not justify excluding from the coverage of the Act *all* persons with actual or perceived contagious diseases.”⁸⁵ The Court observed, “Such exclusion would mean that those accused of being contagious would never have the opportunity to have their condition evaluated in light of medical evidence [r]ather, they would be vulnerable to discrimination on the basis of mythology – precisely the type of injury Congress sought to prevent.”⁸⁶ Paradoxically, the EEOC has done exactly that in one of its statements online, as discussed below.

To determine whether a particular individual poses a direct threat, public accommodations must make “an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: (1) the nature, duration, and severity of the risk; (2) the probability that the potential injury will actually occur; and (3) whether reasonable modifications of policies, practices, or procedures will mitigate the risk.”⁸⁷ Without an individualized assessment of these factors, any overly generalized policy based on COVID-19 stereotypes or generalizations will likely be found unlawful.⁸⁸ Preferred sources for “current medical knowledge” include

⁸³ *Id.*

⁸⁴ Sch. Bd. of Nassau Cty., Fla. v. Arline, 480 U.S. 273, 273 (1987).

⁸⁵ *Id.* at 285 (emphasis in original).

⁸⁶ *Id.*

⁸⁷ Anderson v. Little League Baseball, Inc., 794 F. Supp. 342, 345 (D. Ariz. 1992).

⁸⁸ *See, e.g., Id.* (citing Arline) (explaining that to protect “disabled individuals from discrimination based on prejudice, stereotypes, or unfounded fear,” the Supreme Court required an “individualized assessment” conforming to these requirements to insure that “the determination that a person poses a direct threat to the health or safety of others [is] not based on generalizations or stereotypes.”).

“public health authorities, such as the U.S. Public Health Service, the CDC, and the NIH.”⁸⁹

So, for people who are contagious or potentially contagious with COVID-19, the risks of the disease itself can first be assessed. In addition, the characteristic of the specific public accommodation will be considered—such as potential for distancing, likelihood of contact with other patrons, etc.

For COVID-19, research continues to emerge and evolve. The first factor includes the nature, duration and severity of the risk. The nature of the risk for COVID-19 spread is person-to-person contact mostly. The CDC says the virus is spread “between people who are in close contact with one another (within about 6 feet)” “through respiratory droplets produced when an infected person coughs, sneezes or talks.”⁹⁰ Researchers note that a “key factor in the transmissibility of COVID-19 is the high level of SARS-CoV-2 shedding in the upper respiratory tract, *even among pre-symptomatic patients.*”⁹¹ With regard to duration, researchers note that “public health authorities define a significant exposure to COVID-19 as face-to-face contact within 6 feet with a patient with symptomatic COVID-19 that is sustained for at least a few minutes (and some say more than 10 minutes or even 30 minutes)” and that the “chance

⁸⁹ *Bragdon v. Abbott*, 524 U.S. 624, 650 (1998) (stating, “In assessing the reasonableness of petitioner’s actions, the views of public health authorities, such as the U.S. Public Health Service, CDC, and the National Institutes of Health, are of special weight and authority.”).

⁹⁰ CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), *How COVID-19 spreads*, available at https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fprepare%2Ftransmission.html (hereinafter CDC How COVID-19 Spreads).

⁹¹ Monica Gandhi, et al., *Asymptomatic transmission, the Achilles’ heel of current strategies to control COVID-19*, 382 NEW ENGLAND JOURNAL OF MEDICINE 2158, 2158 (May 28, 2020), available at https://www.nejm.org/doi/full/10.1056/NEJMe2009758?query=recirc_curatedRelated_article?query=C19&cid=DM90829_NEJM_COVID-19_Newsletter&bid=188147264https://www.nejm.org/doi/full/10.1056/NEJMe2009758?query=recirc_curatedRelated_article?query=C19&cid=DM90829_NEJM_COVID-19_Newsletter&bid=188147264.

of catching COVID-19 from a passing interaction in a public space is therefore minimal.”⁹²

The severity of the risk, however, could be considered to be high because severe illness and death can result from infection. *Arline’s* language infers that “the significance of a risk is a product of the odds that transmission will occur and the severity of the consequences.”⁹³ “[I]t is the potential gravity of the harm that imbues certain odds of an event with significance.”⁹⁴ As noted above, in one of the few available situations with complete data, the case fatality rate aboard the Diamond Princess cruise ship was 1.8% with an estimated age-adjusted general population risk of 0.5% of death associated with COVID-19 infection, which means that around 1 in 200 people who get a COVID-19 infection will die.⁹⁵ As noted above, the CDC’s best estimate is 0.4% case fatality rate.⁹⁶ This is four to five times the risk associated with seasonal influenza. Since death is permanent, an argument can be made that the duration of the risk is permanent when viewed in this context.⁹⁷ The Eleventh Circuit specifically noted that “when the adverse event is the contraction of a fatal disease, the risk of transmission can be significant even if the probability of transmission is low: death itself makes the risk ‘significant.’”⁹⁸

The second factor in evaluating a direct threat is the “probability that the potential injury will actually occur,” which relates to the contagiousness of COVID-19.⁹⁹ As noted above, the Diamond Princess cruise ship was one of the few contained situations where complete data are available. On board that cruise ship were 3,711 people¹⁰⁰ and 712 were

⁹² Michael Klompas, et al., *Universal masking in hospitals in the COVID-19 era*, 382 NEW ENGLAND JOURNAL OF MEDICINE e63 (May 21, 2020), available at <https://www.nejm.org/doi/full/10.1056/NEJMp2006372?query=TOC>.

⁹³ *Onishea v. Hopper*, 171 F.3d 1289, 1297 (11th Cir. 1999).

⁹⁴ *Id.*

⁹⁵ Faust, *supra* note 63, at E1-E2.

⁹⁶ Azad, *supra* note 77; CDC Pandemic Planning, *supra* note 77.

⁹⁷ Faust, *supra* note 63, at E1-E2.

⁹⁸ *Onishea v. Hopper*, 171 F.3d 1289, 1297 (11th Cir. 1999).

⁹⁹ *Anderson v. Little League Baseball, Inc.*, 794 F. Supp. 342, 345 (D. Ariz. 1992).

¹⁰⁰ Tina Saey, *Cruise ship outbreak helps pin down how deadly the new coronavirus is*, ScienceNews (March 12, 2020), available at

COVID-19 positive,¹⁰¹ which means that roughly 19% became infected in the contained cruise ship environment over a few weeks. So, for cruise ships, the probability of infection is likely around 19%. Since only 3.4% of those infected will be hospitalized, the probability of hospitalization on a cruise ship is less than 0.7%.¹⁰² The CDC estimates the general populations' overall case fatality risk to be 0.4% for those infected with COVID-19, which means that the risk of COVID-19 death for the general population being on a cruise ship with a COVID-19 outbreak is less than 0.08%.¹⁰³ These risks may be even lower if new modifications to safety protocols are implemented once cruise ships resume business after the pandemic has abated.

A cruise ship is a contained environment for a prolonged period of time with the same group of people, unlike most encounters in other places of public accommodation; so, the probability would likely be much lower in most other places of public accommodation. In addition, with COVID-19 precautions and screening in place, the probabilities are likely to be significantly altered even on a cruise ship today. Overall, the probability that COVID-19 transmission will occur in a specific place of public accommodation depends upon issues like social distancing, close prolonged contact, location (outside versus inside), and the characteristics of the population (e.g., age, comorbidities).

The third factor in the direct threat analysis is “whether reasonable modifications of policies, practices, or procedures will mitigate the risk.”¹⁰⁴ The CDC recommends avoiding exposure to the virus and taking steps to slow the spread, including maintaining “good social distance (about 6 feet),” frequent hand washing, and regularly disinfecting surfaces.¹⁰⁵ Analysis of reasonable modifications to mitigate direct threats are specific to the public accommodation and an individualized assessment and are discussed in detail below. If the risk can be mitigated by reasonable

<https://www.sciencenews.org/article/coronavirus-outbreak-diamond-princess-cruise-ship-death-rate> (noting 3711 people on Diamond Princess).

¹⁰¹ Faust, *supra* note 63, at E2 (noting 712 positive COVID-19 cases on the Diamond Princess).

¹⁰² $19\% \times 0.034 = 0.646$.

¹⁰³ $19\% \text{ infected} \times 0.4\% \text{ chance of dying} = 0.076\%$.

¹⁰⁴ Anderson v. Little League Baseball, Inc., 794 F. Supp. 342, 345 (D. Ariz. 1992).

¹⁰⁵ CDC How COVID-19 Spreads, *supra* note 90.

modifications, then individual is no longer considered a “direct threat” under the ADA.

In summary, the direct threat analysis will be case and individual specific. In some venues, the analysis will be completely different from others. For example, in places where particularly vulnerable people gather—like nursing homes—the analysis will be completely different than places where mostly young people congregate—like playgrounds. Given some of the controversies over this pandemic, courts may even come to different conclusions under similar scenarios—so outcomes of early individual cases may be difficult to predict.

For example, HIV infection has resulted in variability in court opinions. “On one hand, the Fourth, Fifth, and Sixth Circuits have implicitly followed a cautious rule,” whereas the First Circuit ruled that “not only must the danger be theoretically justifiable, it must also have been realized in at least several cases.”¹⁰⁶ In the “cautious circuits” even small risks of HIV infection are significant where “a showing of a specific and theoretically sound means of possible transmission was enough to justify summary judgment against an HIV-positive plaintiff on the ground that the infection posed a “significant risk” to others in the workplace, even though reported incidents of transmission were few or nonexistent, and the odds of transmission were admittedly small.”¹⁰⁷ In contrast, the First Circuit noted that a dentist “is not entitled to demand absolute safety” in dealing with HIV positive patients and that “remote theoretical possibility of HIV transmission through tears, saliva, and urine” were not significant risks.¹⁰⁸ Similarly the Ninth Circuit said “it was an error to require that every theoretical possibility of harm be disproved.”¹⁰⁹ Courts may have similar difficulties discerning a consistent, clear path in early cases involving COVID-19.

2. *COVID-19 survivors with negative tests*

COVID-19 survivors’ ADA status changes after recovery from active infection from a medical and legal standpoint. From a medical

¹⁰⁶ *Onishea v. Hopper*, 171 F.3d 1289, 1298 (11th Cir. 1999).

¹⁰⁷ *Id.* at 1297.

¹⁰⁸ *Id.* at 1298.

¹⁰⁹ *Id.*

standpoint, they are no longer shedding the virus, so they are not contagious and therefore, are not a direct threat.¹¹⁰ In addition, they may possibly be immune to COVID-19 because the infection produces antibodies to COVID-19 that may be protective.¹¹¹ From a legal standpoint, the analysis also changes.

First, previously hospitalized and severely ill COVID-19 survivors will continue to qualify as individuals with disabilities under the “record of” prong of the ADA. People surviving severe or critical cases of COVID-19 requiring hospitalization typically recover within three to six weeks.¹¹² An individual who has fully recovered from COVID-19 and is no longer positive for the virus no longer qualifies as an individual with a disability under the “actual impairment” prong for their COVID-19 infection because they no longer have a physical impairment (unless they acquired a new disability during the infection).

However, the “record of” prong ensures that “people are not discriminated against because of a history of disability.”¹¹³ For example, the US military is considering excluding all applicants with a history of

¹¹⁰ CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), *When can you be around others after you had or likely had COVID-19*, available at <https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/end-home-isolation.html> (stating that it is safe for a person with known COVID 19 to be around others when they have been afebrile for 3 days, symptoms have improved, AND it has been 10 days since symptoms first appeared); see also

Fei Zhou, et al., *Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study*, 394 LANCET 1054, 1054 (2020), available at [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(20\)30566-3.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(20)30566-3.pdf) (stating, “Median duration of viral shedding was 20·0 days (IQR 17·0–24·0) in survivors, but SARS-CoV-2 was detectable until death in non-survivors. The longest observed duration of viral shedding in survivors was 37 days.”).

¹¹¹ Robert Kirkcaldy, et al., *COVID-19 and post-infection immunity*, JAMA Online (May 11, 2020), available at <https://jamanetwork.com/journals/jama/fullarticle/2766097> (stating, “In summary, existing limited data on antibody responses to SARS-CoV-2 and related coronaviruses, as well as one small animal model study, suggest that recovery from COVID-19 might confer immunity against reinfection, at least temporarily.”).

¹¹² WHO Joint Mission, *supra* note 54 (Reporting, “Using available preliminary data, the median time from onset to clinical recovery for mild cases is approximately 2 weeks and is 3-6 weeks for patients with severe or critical disease.”).

¹¹³ 29 C.F.R. § Pt. 1630, App.; 1630.2(k).

COVID-19.¹¹⁴ Public accommodations could face scrutiny under the ADA for any similar policy. To qualify under the “record of” prong, a record that might be used to demonstrate disability could include education, medical, or employment records, among others.¹¹⁵ For example, the Supreme Court found that a teacher’s “hospitalization for tuberculosis . . . suffices to establish that she has a ‘record of . . . impairment’ . . . and is therefore a handicapped individual.”¹¹⁶ Therefore, COVID-19 survivors who were hospitalized or otherwise received significant medical care with serious or critical illnesses can likely qualify for ADA protection under the “record of” a disability prong, since at the time of their hospitalization, COVID-19 substantially limited major life activities.

Second, survivors of mild COVID-19 cases, asymptomatic COVID-19 cases, and COVID-19 exposure cases could possibly be protected under the “regarded as” prong if public accommodations discriminate against them based on their prior COVID-19 history—as long as courts don’t determine that COVID-19 is subject to the “transitory and minor” exception discussed above. The “regarded as” prong helps fulfill the ADA’s goal of protecting people due to the stigma that can “occur after a person has been released from COVID-19 quarantine even though they are not considered a risk for spreading the virus to others.”¹¹⁷

3. Disabled individuals at high risk for COVID-19 complications if they become infected

Vulnerable individuals who are susceptible to COVID-19 complications including death may represent a new class of individuals with disabilities under Title III of the ADA because they cannot *fully and equally* enjoy the “goods, services, facilities, privileges, advantages, or

¹¹⁴ Meghann Myers, Coronavirus survivors banned from joining military, *Military Times* (May 6, 2020), available at <https://www.militarytimes.com/news/your-military/2020/05/06/coronavirus-survivors-banned-from-joining-the-military/> (circulating a memo from the pentagon stating that “a history of COVID-19, confirmed by either a laboratory test or clinician diagnosis, is permanently disqualifying”).

¹¹⁵ *Sch. Bd. of Nassau Cty., Fla. v. Arline*, 480 U.S. 273, 281 (1987).

¹¹⁶ *Id.*

¹¹⁷ CDC Stigma, *supra* note 38.

accommodations” of places of public accommodation if they must disproportionately risk their lives to participate.¹¹⁸

According to the CDC, people who are at “*high-risk* for severe illness from COVID-19” are people age “65 years and older,” “[p]eople living in a nursing home or long-term care facility,” and “people of all ages with underlying medical conditions, particularly if not well controlled.”¹¹⁹ “Underlying medical conditions” specifically mentioned by the CDC include chronic lung disease, moderate to severe asthma, serious heart conditions, immunocompromise caused by any health condition (such as “cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications”), severe obesity (BMI>40), diabetes, chronic kidney disease, and liver disease.¹²⁰ In a study of hospitalized patients in New York, COVID-19 was found to be particularly dangerous to people with older age, hypertension, obesity, and diabetes.¹²¹ In another study, the risk of death from COVID-19 for hospitalized patients was markedly higher for patients with these comorbidities than for younger, healthier patients.¹²²

The risk of COVID-19 infection to these vulnerable individuals substantially limit major life activities such as “caring for oneself” by going to the grocery store and other places of public accommodation due to the need to practice social distancing and “working” (especially for individuals who work in an environment that requires contact with the public).¹²³ Therefore, new populations of high risk individuals may now be considered to be disabled under the ADA because of the substantial

¹¹⁸ 42 U.S.C. § 12182(a) (emphasis added).

¹¹⁹ CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), *Frequently asked questions: Higher risk*, available at <https://www.cdc.gov/coronavirus/2019-ncov/faq.html#Higher-Risk> (hereinafter CDC Higher Risk).

¹²⁰ *Id.*

¹²¹ Safiya Richardson, et al., *Presenting characteristics, comorbidities, and outcomes among 5700 patients hospitalized with COVID-19 in the New York City area*, 323(20) JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 2052, 2052 (April 22, 2020), available at <https://jamanetwork.com/journals/jama/fullarticle/2765184>. (reporting the most common comorbidities were hypertension (56%), obesity (41.7%), and diabetes (33.8%)).

¹²² Zhou, *supra* note 110, at 1054 (noting older age and other comorbidities as a significant risk factors).

¹²³ 42 U.S.C. § 12102(2).

limits placed upon their major life activities by the presence and risks of COVID-19.

Specifically, for people at “higher risk of getting very sick from COVID-19,” the CDC advises them to “stock up on supplies,” “take everyday precautions to keep space between yourself and others,” “when you go out in public, keep away from others who are sick,” “limit close contact and wash your hands often,” and “avoid crowds, cruise travel, and non-essential travel.”¹²⁴ Further, the CDC says, “if there is an outbreak in your community, stay home as much as possible.”¹²⁵ If followed, these CDC recommendations will substantially limit the ability of vulnerable populations to participate in major life activities involving public accommodations where crowds may gather or the risk of COVID-19 exposure is significant. Therefore, many people previously not considered to be disabled under the ADA may now be considered disabled due to the restrictions related to their physical impairments that put them at high risk of morbidity and mortality related to COVID-19.

The Second Circuit has found that individuals with special susceptibilities—such as those vulnerable to COVID-19—are entitled to an individualized assessment under the ADA. In *Staron*, customers susceptible to cigarette smoke sought a total ban on smoking in McDonalds’ restaurants.¹²⁶ The Second Circuit held that a “fact-specific, case-by-case inquiry” was required by the ADA to determine whether this modification was necessary and that the smoke-sensitive customers stated a triable cause of action for ADA violation.¹²⁷ “Cases in which individuals claim under the ADA that allergies to smoke constitute a disability and require smoking restrictions are simply subject to the same general reasonableness analysis as are other cases under the Act,” including “the same case-by-case analysis that is applied to all other physical or mental impairments.”¹²⁸ The Second Circuit noted, “We see no

¹²⁴ CDC Higher Risk, *supra* note 119.

¹²⁵ *Id.*

¹²⁶ *Staron v. McDonald's Corp.*, 51 F.3d 353, 354 (2d Cir. 1995).

¹²⁷ *Id.* at 356.

¹²⁸ *Id.* at 357.

reason why, under the appropriate circumstances, a ban on smoking could not be a reasonable modification.”¹²⁹

Some groups with special vulnerabilities—like significantly increased risk of morbidity and mortality than the general population—to COVID-19 may be analyzed differently now with regard to requests for modifications to public accommodations to help protect them from COVID-19 infection. Under the ADA, reasonable modifications are required for individuals who qualify as having a disability either due to a “physical or mental *impairment* that *substantially limits* one or more *major life activities* of such individual” or due to “a *record* of such an impairment.”¹³⁰ A few more controversial COVID-19 vulnerable groups will be considered here as examples.

First, diabetes has been considered a “disability” and/or “impairment” meeting the ADA definition in some courts and not in others. For example, one court found that “[u]nder the ADA, qualified individual with a disability is defined broadly and *includes* diabetics.”¹³¹ Similarly, the First Circuit found, “Insulin-dependent diabetes [is] a physical impairment for purposes of determining whether plaintiff [is] disabled within meaning of ADA.”¹³² Likewise, ADA employment regulations state that “diabetes substantially limits endocrine function” as one example of “substantially limits,” which implies that diabetes is a disability.¹³³ Similarly, the Ninth Circuit found, “Diabetes is a physical impairment, which could qualify as a disability under the ADA, because it affects the digestive, hemic and endocrine systems, and eating is a major life activity.”¹³⁴ In contrast, other courts have found diabetes, in itself, is not a disability. For example, one court found, “Diabetes by itself does *not* constitute a disability under the ADA unless it impairs an individual's

¹²⁹ *Id.*

¹³⁰ 42 U.S.C. § 12102(1).

¹³¹ *Schreiner v. City of Gresham*, 681 F. Supp. 2d 1270 (D. Or. 2010).

¹³² *Carreras v. Sajo, Garcia & Partners*, 596 F.3d 25, 22 A.D. Cas. (BNA) 1601, 53 A.L.R. Fed. 2d 609 (1st Cir. 2010).

¹³³ 29 C.F.R. § 1630.2(j).

¹³⁴ *Rohr v. Salt River Project Agricultural Imp. and Power Dist.*, 555 F.3d 850, 21 A.D. Cas. (BNA) 964 (9th Cir. 2009).

ability to work or engage in other major life activities.”¹³⁵ Similarly, another court found that an “employee’s diabetic condition did *not* substantially limit his major life activity of eating and, thus, was *not* a disability under ADA.”¹³⁶

Second, hypertension, at one time, was not considered a disability if controlled on medications.¹³⁷ However, Congress subsequently modified the statute such that the “determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures such as . . . [anti-hypertensive] medication [and] medical supplies.”¹³⁸ The Sixth Circuit found that “the activities affected by Plaintiff’s hypertension [can] constitute ‘major life activities’ because of their significance in the human experience.”¹³⁹ People with diabetes and hypertension may justifiably substantially limit major life activities to comply with CDC recommendations outlined above; therefore, under the ADA, these impairments may be more likely to be classified as disabilities entitled to ADA protection in the post-COVID-19 era. Under the same logic, many other comorbidities like kidney disease, cancer, immunocompromise, etc. will also likely qualify as disabilities under the actual disability prong where they substantially limit a major life activity.

Third, even more controversially, severe obesity (BMI > 40) might arguably be classified as a disability related to COVID-19 risks. Typically, physical characteristics such as “height, weight, and muscle tone” are not considered “impairments” by courts unless they result from an “underlying physiological disorder.”¹⁴⁰ For example, the Eighth Circuit noted, “Taken as a whole, the relevant statutory and regulatory language makes it clear that for obesity to qualify as a physical impairment—and

¹³⁵ *Diaz Rivera v. Browning-Ferris Industries of Puerto Rico, Inc.*, 626 F. Supp. 2d 244, 15 Wage & Hour Cas. 2d (BNA) 1008 (D.P.R. 2009).

¹³⁶ *Griffin v. United Parcel Service, Inc.*, 661 F.3d 216, 25 A.D. Cas. (BNA) 551 (5th Cir. 2011).

¹³⁷ *Murphy v. United Parcel Serv., Inc.*, 527 U.S. 516, 521 (1999).

¹³⁸ 42 U.S.C.A. § 12102(4)(E) (West).

¹³⁹ *Williams v. Stark Cty. Bd. of Cty. Comm'rs.*, 7 F. App'x 441, 446 (6th Cir. 2001).

¹⁴⁰ *Morriss v. BNSF Ry. Co.*, 817 F.3d 1104, 1109–13 (8th Cir. 2016) (stating, “As with the physical characteristics of height, weight, and muscle tone, “other conditions” are not “impairments” unless they are the result of an underlying physiological disorder”).

thus a disability—under the ADA, it must result from an underlying physiological disorder or condition.”¹⁴¹ The Eighth Circuit concluded that “for obesity, even morbid obesity, to be considered a physical impairment [under the ADA], it must result from an underlying physiological disorder or condition.”¹⁴² Similarly, the Sixth Circuit stated, “We decline to extend ADA protection to all ‘abnormal’ (whatever that term may mean) physical characteristics.”¹⁴³ For employment purposes, EEOC guidance states that “weight is merely a physical characteristic—not a physical impairment—unless it is both outside the normal range *and* the result of an underlying physiological disorder.”¹⁴⁴ However, after COVID-19, an individualized assessment, as required, might lead to a different outcome today.

Finally, another controversial argument is that advanced age could be considered a disability given the COVID-19 risks based upon age alone documented by the CDC and studies noted above. “Advanced age, in and of itself, is . . . not [traditionally] an impairment” under the ADA, but “various medical conditions commonly associated with age” can “constitute impairments” within the meaning of the ADA’s disability definition.¹⁴⁵ However, the CDC and medical studies cited above report

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ *EEOC v. Watkins Motor Lines, Inc.*, 463 F.3d 436, 442–43 (6th Cir.2006) (the court continued, “To do so ‘would make the central purpose of the statutes, to protect the disabled, incidental to the operation of the “regarded as” prong, which would become a catch-all cause of action for discrimination based on appearance, size, and any number of other things far removed from the reasons the statutes were passed.”).

¹⁴⁴ *Morriss v. BNSF Ry. Co.*, 817 F.3d 1104, 1109–13 (8th Cir. 2016).

¹⁴⁵ 29 C.F.R. § Pt. 1630, App.; *see also* *N.A.A.C.P. v. Philadelphia Bd. of Elections*, No. CIV. A. 97-7085, 1998 WL 321253, at *4 (E.D. Pa. June 16, 1998) (“Being over the age of 65 is not in and of itself an impairment, although medical conditions associated with age, such as osteoporosis, can be. . . . The ADA requires reasonable modifications to accommodate only those actually disabled, which may or may not include the elderly.”); *Natarelli v. New York State Office of Vocational & Educ. Servs. for Individuals With Disabilities*, No. 607-CV-1130 GTS/GJD, 2009 WL 5204068, at *4 (N.D.N.Y. Dec. 21, 2009), *aff’d* sub nom. *Natarelli v. VESID Office*, 420 F. App’x 53 (2d Cir. 2011) (“Advanced age, in and of itself, is not an impairment [for purposes of the ADA].”); *Lee v. Se. Pennsylvania Transp. Auth.*, 418 F. Supp. 2d 675, 679 (E.D. Pa. 2005) (“Age alone, however, is not a disability for purposes of the ADA. Although many octogenarians do suffer from physical or mental impairments that limit one or more of their major life activities and are therefore “individuals with disabilities” as defined by the ADA, others remain physically and

age greater than 65 as being a significant risk factor for COVID-19, which could substantially limit multiple major life activities due to risks of infection. However, getting a court to recognize age alone as an “impairment” may be challenging. One exception may be elderly people who are nursing home residents who may qualify as individuals with disabilities simply because their presence in a nursing home portends substantial limitations in major life activities like “caring for oneself” and other activities required to live independently without assistance— regardless of age.

4. Healthy, non-disabled individuals who are asymptomatic

People who have no comorbidities that could be defined as disabilities and are having no symptoms of any illness are not covered under the ADA because they have no impairment.

B. COVID-19-Related Disability Accommodations and Avoidance of Discrimination

As discussed above, individuals with disabilities who are susceptible to COVID-19 complications, as well as people possibly contagious with COVID-19 are likely to be protected individuals with disabilities by the ADA under some circumstances. Potentially discriminatory practices against COVID-19-related disability groups includes implementation of eligibility criteria, failure to make reasonable modifications, and failure to remove structural barriers to allow these groups to fully and equally enjoy places of public accommodation.¹⁴⁶ People with disabilities are guaranteed “more than mere access to public facilities”; they are guaranteed “full and equal enjoyment,” not just what is “necessary.”¹⁴⁷ Specifically, “[p]ublic accommodations must start by

mentally healthy well into their ninth or tenth decade.”); *Lee v. Se. Pennsylvania Transp. Auth.*, 418 F. Supp. 2d 675, 679 (E.D. Pa. 2005) (“Age alone, however, is not a disability for purposes of the ADA.”); *Natarelli v. New York State Office of Vocational & Educ. Servs. for Individuals With Disabilities*, No. 607-CV-1130 GTS/GJD, 2009 WL 5204068, at *4 (N.D.N.Y. Dec. 21, 2009), *aff’d sub nom. Natarelli v. VESID Office*, 420 F. App’x 53 (2d Cir. 2011) (“the Court notes that advanced age, in and of itself, is not a recognized “disability” for purposes of Title II of the ADA.”).

¹⁴⁶ 42 U.S.C. § 12182(a).

¹⁴⁷ *Baughman v. Walt Disney World Co.*, 685 F.3d 1131, 1135 (9th Cir. 2012); 42 U.S.C. § 12182(a).

considering how their facilities are used by non-disabled guests and then take reasonable steps to provide disabled guests with a like experience.”¹⁴⁸ For example, a movie theater is required to provide companion seating for a person with a disability, not just the wheelchair seat—to provide an equal opportunity to enjoy a movie with a companion.¹⁴⁹

Public accommodations should consider enacting three types of changes to deal with COVID-19-related disabilities under the ADA including (1) addressing COVID-19-related “direct threats” in a non-discriminatory manner, (2) making reasonable modifications to policies, practices, and procedures to protect people with disabilities defined by COVID-19, and (3) removing structural barriers impacting people with COVID-19-related disabilities.

1. Addressing COVID-19-related “direct threats” in a non-discriminatory manner

Under Title III, covered entities are *not* required “to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a *direct threat* to the health or safety of others.”¹⁵⁰ The definition of an “individual with a disability” excludes “an individual who has a currently contagious disease or infection . . . and who, by reason of such disease or infection, would constitute a direct threat to the health or safety of other individuals.”¹⁵¹ However, places of public accommodation also have an affirmative duty to include people with disabilities in the “most integrated setting appropriate to the needs of the individual.”¹⁵² In addition, disability discrimination includes “the imposition or application of *eligibility criteria* that screen out or tend to screen out an individual with a disability . . . from fully and equally

¹⁴⁸ *Baughman v. Walt Disney World Co.*, 685 F.3d 1131, 1135 (9th Cir. 2012).

¹⁴⁹ *Id.* (the court also notes that movie theater wheelchair seating cannot simply be in uncomfortable positions like the front row because this does not provide “full and equal enjoyment”).

¹⁵⁰ 42 U.S.C. § 12182(b)(3).

¹⁵¹ *Onishea v. Hopper*, 171 F.3d 1289, 1296–97 (11th Cir. 1999).

¹⁵² 42 U.S.C. § 12182.

enjoying any goods, services, facilities, privileges, advantages, or accommodations, *unless* such criteria can be shown to *be necessary*.”¹⁵³

To identify and accommodate or deny access to individuals who pose direct threats, public accommodations are likely to rely on COVID-19-related eligibility criteria related to physical exam findings (e.g., fever checks with thermometers and with infrared scanning, visual inspection for outward signs of infection like coughing or sneezing) or related to medical inquiries (e.g., symptom inquiries, health attestation requirements, health “passports” or certificates, vaccination records). Safety requirements “must be based on actual risks and not on mere speculation, stereotypes, or generalizations about individuals with disabilities” — so the science behind some of these criteria will be briefly explored below.¹⁵⁴

Interestingly, in March 2020, the EEOC included the following statement on its website:

Based on guidance of the CDC and public health authorities as of March 2020, *the COVID-19 pandemic meets the direct threat standard*. The CDC and public health authorities have acknowledged community spread of COVID-19 in the United States and have issued precautions to slow the spread, such as significant restrictions on public gatherings. In addition, numerous state and local authorities have issued closure orders for businesses, entertainment and sport venues, and schools in order to avoid bringing people together in close quarters due to the risk of contagion. These facts manifestly support a *finding that a significant risk of substantial harm would be posed by having someone with COVID-19, or symptoms of it, present in the workplace at the current time*. At such time as the CDC and state/local public health authorities revise their assessment of the spread and severity

¹⁵³ 42 U.S.C.A. § 12182(2).

¹⁵⁴ *Baughman v. Walt Disney World Co.*, 685 F.3d 1131, 1137 (9th Cir. 2012).

of COVID-19, that could affect whether a direct threat still exists.¹⁵⁵

The EEOC regulations are not binding and appear to contradict the Supreme Court's "direct threat" analysis by classifying the disease itself as a "direct threat" rather than providing for an individualized assessment.¹⁵⁶

As the Supreme Court has explained, "The fact that some persons who have contagious diseases [like COVID-19] may pose a serious health threat to others under certain circumstances does not justify excluding from the coverage of the Act all persons with actual or perceived contagious diseases."¹⁵⁷ Yet, the EEOC regulations for COVID-19 lump everyone with the disease into the direct threat category regardless of circumstances. Instead, to protect "disabled individuals from discrimination based on prejudice, stereotypes, or unfounded fear," the Supreme Court requires an "individualized assessment" to insure that "the determination that a person poses a direct threat to the health or safety of others [is] not based on generalizations or stereotypes."¹⁵⁸ Just because a person has a contagious disease like COVID-19, HIV, or tuberculosis does not mean that person is a "direct threat" in all circumstances; for instance, a delivery service might safely deliver food using contactless delivery to a person with COVID-19 while in the hospital or inside their home without a direct threat occurring due to the reasonable modification of contactless delivery.

Courts will not define "COVID-19" the disease as a "direct threat," instead they will conduct an individualized assessment as to whether the specific individual with COVID-19 risk poses a "direct threat" based on reasonable judgment that relies on current medical knowledge and the

¹⁵⁵ U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION (EEOC), *Pandemic preparedness in the workplace and the Americans with Disabilities Act*, (Updated March 21, 2020), available at <https://www.eeoc.gov/laws/guidance/pandemic-preparedness-workplace-and-americans-disabilities-act>.

¹⁵⁶ *Id.* (the document notes: "The contents of this document do not have the force and effect of law and are not meant to bind the public in any way. This document is intended only to provide clarity to the public regarding existing requirements under the law or agency policies.").

¹⁵⁷ *Sch. Bd. of Nassau Cty., Fla. v. Arline*, 480 U.S. 273, 285 (1987) (emphasis in original).

¹⁵⁸ *Anderson v. Little League Baseball, Inc.*, 794 F. Supp. 342, 345 (D. Ariz. 1992).

best available fact-specific, objective evidence.¹⁵⁹ To make a determination, courts will consider: “(1) the nature, duration, and severity of the risk; (2) the probability that the potential injury will actually occur; and (3) whether reasonable modifications of policies, practices, or procedures will mitigate the risk.”¹⁶⁰ During the analysis, public health authorities, like the CDC, will be given “special weight and authority” for current medical knowledge and evaluating “reasonable medical judgments.”¹⁶¹ See Section III.A.1. above for more analysis of when COVID-19 constitutes a “direct threat.”

As noted above, physical examinations and medical inquiries may be employed by public accommodations as screening or eligibility criteria in response to COVID-19 risks. Title III offers no specific guidance regarding physical examinations and medical inquiries of customers and clients by public accommodations,¹⁶² so Title I of the ADA’s restrictions on employers may be instructive. The ADA prohibits employers from requiring medical examinations and making “disability-related inquiries” of their employees except under limited circumstances.¹⁶³ Medical examinations or inquiries for employees must be “job-related and consistent with business necessity.”¹⁶⁴ The EEOC defines a “medical examination” as a “procedure or test that seeks information about an individual’s physical or mental impairments or health.”¹⁶⁵

Medical exams and inquiries are “consistent with business necessity when an employer has a reasonable belief, based on *objective evidence*, that . . . an employee will pose a direct threat due to a medical condition.”¹⁶⁶ Similar regulations could be promulgated for inquiries by public accommodations, requiring a public accommodation to have a “reasonable belief” that the individual poses a “direct threat” to other

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ *Bragdon v. Abbott*, 524 U.S. 624, 650 (1998).

¹⁶² 42 U.S.C. § 12181.

¹⁶³ *EEOC*, *supra* note 155.

¹⁶⁴ *Id.*

¹⁶⁵ *Id.* (To determine whether or not something is a “medical examination,” factors like “whether the test involves the use of medical equipment” and “whether it is designed to reveal the existence of a physical or mental impairment” are relevant.)

¹⁶⁶ *Id.*

customers, clients, or its employees. Public accommodations performing medical examinations and inquiries will likely need to demonstrate these measures do not screen out protected individuals with disabilities, that they are a business necessity (e.g., to eliminate a direct threat), and that no reasonable modifications can be made to prevent the discrimination. The reliability of the “objective evidence” used to formulate a public accommodation’s “reasonable belief” that a person poses a direct threat will be important.

Fever checkpoints are one proposed medical examination or inquiry to identify COVID-19 direct threats and are examined here as an example of the analysis likely to apply to similar measures.¹⁶⁷ For example, the airlines and TSA are talking about “using airport security screeners to perform temperature checks on passengers before they board aircraft,” and some public accommodations are enacting similar measures.¹⁶⁸ In addition, infrared scanners may be used at large venues (like stadiums) where the crowd can be scanned to identify people with fevers.¹⁶⁹

Fevers are not diagnostic of COVID-19 and more often identify people with other disabilities or ailments than people actually infectious with COVID-19, so the use of fever checkpoints as “objective evidence” based on reasonable judgment relying on current medical evidence that a person is a “direct threat” is questionable.¹⁷⁰ One component of the analysis of direct threats is “the probability that the potential injury will actually occur,” and the probability that someone with a fever has COVID-19 is likely going to be quite small in most locations—unless the

¹⁶⁷ Alan Levine, et al., *Airport screeners may check for fever under plan being discussed*, Bloomberg (May 1, 2020), available at <https://www.bloomberg.com/news/articles/2020-05-01/airport-screeners-may-check-for-fever-under-plan-being-discussed>.

¹⁶⁸ *Id.*

¹⁶⁹ An Nguyen, et al., *Comparison of 3 infrared thermal detection systems and self-report for mass fever screening*, 16(11) *Emerging Infectious Diseases* 1710 (2010), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3294528/>; Eva Xiao, *COVID-19 raises demand for temperature scanners*, Wall Street Journal (May 21, 2020), available at <https://www.wsj.com/articles/coronavirus-raises-fever-for-infrared-skin-temperature-scanners-11590066006>.

¹⁷⁰ *Anderson v. Little League Baseball, Inc.*, 794 F. Supp. 342, 345 (D. Ariz. 1992).

location is experiencing a major COVID-19 outbreak.¹⁷¹ For example, roughly 0.1% of the US population may have been infected with COVID-19 during the week of May 25, 2020, which means that 99.9% did not have COVID-19—so if they had fever, it was likely from a different source.¹⁷²

Further, most people with COVID-19 do not have fevers. The CDC estimates that 35% of COVID-19 positive individuals have no symptoms at all.¹⁷³ Even in the COVID-19 patients that end up being hospitalized, less than half have fevers upon presentation to the hospital.¹⁷⁴ Therefore, of those 0.1% of Americans with active COVID-19 on May 25, 2020, the vast majority likely did not have a fever, and many likely had no symptoms whatsoever. So, any fever found at a fever checkpoint is unlikely to be related to COVID-19 in most scenarios.

Instead, the 99.9% of Americans without COVID-19 at the checkpoint will likely have another explanation for the fever—some of which may run afoul of the ADA. For example, around 17 million Americans (representing 5.2% of the US population) live with a history of cancer in the United States,¹⁷⁵ and many of those individuals face multiple

¹⁷¹ *Id.*; Klompas, *supra* note 92, at e63 (explaining that “public health authorities define a significant exposure to COVID-19 as face-to-face contact within 6 feet with a patient with symptomatic COVID-19 that is sustained for at least a few minutes (and some say more than 10 minutes or even 30 minutes)” and that the “chance of catching COVID-19 from a passing interaction in a public space is therefore minimal.”).

¹⁷² CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), *CDC COVID data tracker*, available at <https://www.cdc.gov/covid-data-tracker/> (For example, for the week ending May 25, 2020, there were 170,391 new cases of COVID-19 diagnosed); UNITED STATES CENSUS BUREAU, *U.S and world population clock*, available at <https://www.census.gov/popclock/>; The math: So, if the cases stay contagious for 3 weeks on average (conservative overestimate since CDC only recommends 14 days quarantine) and the same number of cases were diagnosed during the previous three weeks, a rough estimate of the total number of active cases of COVID-19 in the US on May 25, 2020 is around 511,173 active COVID-19 cases (170,391 x 3), which represents roughly 0.1% of the United States 329,701,500 people.

¹⁷³ CDC Pandemic Planning, *supra* note 77; Azad, *supra* note 77.

¹⁷⁴ Richardson, *supra* note 121, at 2052 (noting that fever was present in only 30.7% at the time of hospital admission); Guan, *supra* note 31, at 1708 (finding 43.8% of the patients had fever on admission).

¹⁷⁵ Kimberly Miller, et al., *Cancer treatment and survivorship statistics 2019*, 69(5) AMERICAN CANCER SOCIETY CA: A CANCER JOURNAL FOR CLINICIANS 363, 363 (2019), available at <https://acsjournals.onlinelibrary.wiley.com/doi/10.3322/caac.21565> (noting that “more than 16.9 million Americans with a history of cancer were alive on January 1, 2019)

different causes of fever ranging from the cancer itself, to chemotherapy, to immunocompromise, to fevers of unknown origin.¹⁷⁶ These individuals surviving cancer generally pose no direct threat to others—so policies and procedures that function as *eligibility criteria* that tend to screen out people with cancer will likely be found to constitute disability discrimination in violation of the ADA.¹⁷⁷

In addition, other causes of fever that are more common than COVID-19 undermine the use of fever checkpoints to categorize people as direct threats—even though the person with a fever may not qualify for protection under the ADA. For example, adults experience an average of two to four “common colds” per year, which can sometimes be accompanied by fevers.¹⁷⁸ In addition, seasonal influenza affects between 3 and 11% of the US population each year, which can also cause fevers.¹⁷⁹

In many ways, fever checkpoints treat everyone with a fever as though they are a direct threat in a way that stereotypes people just as the ADA is designed to prohibit. More research on the prevalence of COVID-19 in febrile populations and the effectiveness of fever checkpoints in eliminating direct threats is needed to justify their widespread adoption. Similar considerations will come into play when evaluating other types of medical examinations and inquiries used by public accommodations to identify and segregate individuals who may be “direct threats” under the ADA.

2. Making reasonable modification to policies, practices, and procedures to protect people with disabilities defined by COVID-19

As noted above, many COVID-19 vulnerable individuals could qualify for protection under the ADA at places of public accommodation.

¹⁷⁶ AMERICAN CANCER SOCIETY, *Fever*, available at <https://www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/low-blood-counts/fever.html> (discussing multiple causes of fever in cancer patients).

¹⁷⁷ 42 U.S.C. § 12182(2).

¹⁷⁸ Carol DerSarkissian, *How often do adults get the common cold and who is at most risk*, WebMD (February 28, 2018), available at <https://www.webmd.com/cold-and-flu/qa/how-often-do-adults-get-the-common-cold-and-who-is-most-at-risk>

¹⁷⁹ Jerome Tokars, et al., *Seasonal incidence of symptomatic influenza in the United States*, 66(10) CLIN. INFECT. DIS. 1511, 1511 (May 2, 2018), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5934309/>.

Disability discrimination includes “a failure to make *reasonable modifications* in policies, practices, or procedures, when such modifications are *necessary* . . . , *unless* the entity can demonstrate that making such modifications would *fundamentally alter* the nature of [the business].”¹⁸⁰ The CDC recommends that vulnerable people at “higher risk of getting very sick from COVID-19” practice social distancing, stay away from people who are sick, limit close contact with other people, wash their hands frequently, avoid crowds, avoid non-essential travel, and to “stay home as much as possible,” among other recommendations.¹⁸¹ Public accommodations should make reasonable modifications to their policies, practices, and procedures to help facilitate this protected populations’ attempts to follow the CDC guidelines. Failure to make reasonable modifications that do not fundamentally alter the business to protect vulnerable individuals with disabilities could be found to be discriminatory under the ADA by effectively denying services to those populations by making the public accommodation inaccessible without too high of a risk for serious injury.

Whether a particular modification is reasonable “involves a fact-specific, case-by-case inquiry that considers, among other factors, the effectiveness of the modification in light of the nature of the disability in question and the cost to the organization that would implement it.”¹⁸² Potentially “reasonable modifications” of policies, practices, or procedures may include implementing face mask requirements, altering operating hours (including special times exclusively for vulnerable populations), health screening and testing of employees, implementing special cleaning procedures, restriction of visitors to places where vulnerable populations are known to congregate (e.g., nursing homes, hospitals), among others. The need for these types of modifications will depend upon the recommendations of public health authorities and on scientific evidence of effectiveness proving the proposed modification is reasonable and “necessary” under the statute.

¹⁸⁰ 42 U.S.C.A. § 12182(2).

¹⁸¹ CDC Higher Risk, *supra* note 119.

¹⁸² *Staron v. McDonald's Corp.*, 51 F.3d 353, 356 (2d Cir. 1995); *see also* *Baughman v. Walt Disney World Co.*, 685 F.3d 1131, 1135 (9th Cir. 2012) (explaining that facilities “need only make accommodations that are reasonable,” which can include an analysis of the “costs of such accommodations, disruptions of their business and safety”).

For an example of the analysis, face mask requirements are being adopted by many public accommodations. Under the ADA, a face mask requirement needs to be “reasonable,” “necessary,” and not “fundamentally alter” the nature of the public accommodation to be required.

Several factors make face mask requirements seem “reasonable.” First, the CDC recommends that people “[c]over [their] mouth[s] and nose[s] with a cloth covering when around others, including when [they] have to go out in public, for example to the grocery store” to assist with social distancing recommendations.¹⁸³ Second, some large businesses are already adopting masking policies; for example, the large airlines “all adopted policies requiring that passengers wear face masks during flights.”¹⁸⁴ Third, at least one state governor has issued an executive order stating that “[a]ll patrons in the Commonwealth [of Virginia] aged ten and over shall when . . . spending time inside [buildings] cover their mouth and nose with a face covering.”¹⁸⁵ Fourth, universal masking might arguably help prevent asymptomatic spread, which has been described as an “Achilles heel” in containment strategies and may be particularly important in places where vulnerable people congregate.¹⁸⁶ Fifth, masks

¹⁸³ CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), *Social distancing*, available at <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html> (hereinafter CDC Social Distancing) (stating, However, “[c]loth face coverings should NOT be placed on children under age 2, anyone who has trouble breathing, or is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.”).

¹⁸⁴ Alan Levine, et al., *Airport screeners may check for fever under plan being discussed*, Bloomberg (May 1, 2020), available at <https://www.bloomberg.com/news/articles/2020-05-01/airport-screeners-may-check-for-fever-under-plan-being-discussed>.

¹⁸⁵ COMMONWEALTH OF VIRGINIA, OFFICE OF THE GOVERNOR, *Executive Order Number 63 (2020), Requirement to wear face covering while inside buildings*, (Effective May 29, 2020), available at <https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-63-and-Order-Of-Public-Health-Emergency-Five---Requirement-To-Wear-Face-Covering-While-Inside-Buildings.pdf>.

¹⁸⁶ Gandhi, *supra* note 91, at 2158 (noting that 71% of “presymptomatic persons had viable viruse by culture 1 to 6 days before development of symptoms”); Melissa Arons, et al., *Presymptomatic SARS-CoV-2 infections and transmissions in a skilled nursing facility*, 382 NEW ENGLAND JOURNAL OF MEDICINE 2081, 2081 (May 28, 2020), available at <https://www.nejm.org/doi/full/10.1056/NEJMoa2008457> (showing rapid spread in a nursing home population to 64% of residents within 23 days of the first positive test); *but see*, Ruiyun, *supra* note 2, at 492 (noting that the “transmission rate of undocumented

serve as “visible reminders of an otherwise invisible yet widely prevalent pathogen and may remind people of the importance of social distancing and other infection-control measures.”¹⁸⁷ Finally, masks are “talismans that may help increase . . . perceived sense of safety, well-being, and trust. . . [Even if,] such reactions may not be strictly logical.”¹⁸⁸

In contrast, whether or not face masks are “necessary” is much more controversial. The effectiveness of masks outside of a health care environment where workers are in direct contact with known COVID-19 positive patients is questionable at best. One group of researchers states, “We know that wearing a mask outside health care facilities offers *little, if any, protection* from infection.”¹⁸⁹ The researchers explain that the “chance of catching COVID-19 from a passing interaction in a public space is . . . minimal” because a significant exposure to COVID-19 requires “face-to-face contact within 6 feet with a patient with symptomatic COVID-19” for possibly 10 to 30 minutes according to some “public health authorities.”¹⁹⁰ These researchers note that universal masking and overuse may actually be harmful by leading “to more transmission of COVID-19 if it diverts attention from implementing more fundamental infection-control measures” and by causing a “future risk of running out of masks and thereby exposing [front-line] clinicians to the much greater risk of caring for symptomatic patients without a mask.”¹⁹¹ Further, at least one randomized control study found that cloth masks may actually increase infection rates stating “the results [of their study] caution against the use of cloth masks” with the “increased risk of infection” associated with cloth masks due to “[m]oisture retention, reuse, . . . and poor filtration.”¹⁹²

infections per person was 55% the transmission rate of documented infections, yet, because of their greater numbers, undocumented infections were the source of 79% of the documented cases.”); Klompas, *supra* note 92, at e63 (noting that the risks posed by asymptomatic individuals is mitigated somewhat by the fact that the “transmission risk from [asymptomatic infected people] is likely to be lower than the risk of spread from symptomatic patients”).

¹⁸⁷ Klompas, *supra* note 92, at e63.

¹⁸⁸ *Id.*

¹⁸⁹ *Id.*

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

¹⁹² C. Raina MacIntyre, et al., *A cluster randomized trial of cloth masks compared with medical masks in healthcare workers*, 5 *BMJ Open* e006577 (2015), available at <https://bmjopen.bmj.com/content/5/4/e006577> (The researchers concluded that “as a

However, a different study found that as a public health control measure, if universal masking was adopted so that 80-90% of people wore masks in public, then COVID-19 could be eliminated completely.¹⁹³ These scientists acknowledge that more research into the effectiveness of masking is needed and will likely be performed.¹⁹⁴

Face mask design likely plays a role in the effectiveness of any masking recommendations. “Turbulent gas cloud dynamics [see discussion below under distancing measures] should influence the design and recommended use of surgical and other masks,” which “can be used both for source control (i.e., reducing spread from an infected person) and for protection of the wearer (i.e., preventing spread to an unaffected person).”¹⁹⁵ For example, the “protective efficacy of N95 masks depends on their ability to filter incoming air from aerosolized droplet nuclei,” but “these masks are only designed for a certain range of environmental and local conditions and a limited duration of usage,” which may not be effective under certain circumstances—including many of those advocated in public accommodations.¹⁹⁶

At present, without more research, a court would likely be hard pressed to find that mandatory masking in most public accommodations is “necessary” as an ADA requirement—although given the surprising politization of the issue, legal challenge outcomes are likely to be unpredictable and variable.

Finally, public accommodations might argue that masks fundamentally alter the nature of their business. Although masking is common in some cultures, it is not commonly practiced in the United States and may make some patrons uncomfortable or unwilling to participate in the public accommodation’s business—costing the business customers and clients, especially in areas where masking has been

precautionary measure, cloth masks should not be recommended for health care workers, particularly in high-risk situations, and guidelines need to be updated.”).

¹⁹³ De Kai, et al., *Universal masking is urgent in the COVID-19 pandemic*, (submitted April 22, 2020), available at <https://arxiv.org/pdf/2004.13553.pdf>.

¹⁹⁴ *Id.*

¹⁹⁵ Lydia Bourouiba, *Turbulent gas clouds and respiratory pathogen emissions: Potential implications for reducing transmission of COVID-19*, 323(18) JAMA 1837 (May 12, 2020), available at <https://jamanetwork.com/journals/jama/fullarticle/2763852>.

¹⁹⁶ *Id.*

politicized. Further, masking may cause some people anxiety as a reminder of the pandemic and widespread fear surrounding them, just as seeing people without masks causes others anxiety about possible contagion (reasonable or not). One group of researchers viewed “the desire for widespread masking” to be a “reflexive reaction to anxiety over the pandemic.”¹⁹⁷ Anxiety is likely present on both sides of this issue, so the presence of masks might be seen as a fundamental alteration in places of public accommodation in locations where the support for mandatory masking is minimal.

Some special places of public accommodation involving health care may be required by the ADA to adopt masking protocols since there is more agreement on their effectiveness in these environments. One such population is the 1.3 million Americans residing in nursing homes where “symptom ascertainment may be unreliable in a group in which more than half the residents [have] cognitive impairment,” so that they may be less likely to report more subtle symptoms like sore throat, among others.¹⁹⁸ “Rapid and widespread transmission” of COVID-19 has been demonstrated in skilled nursing facilities, and the case fatality rate in one facility was 26%.¹⁹⁹ Surgical masking of all nursing home staff and visitors may also be an important measure according to some researchers.

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In short, courts will likely decide whether requested modifications under the ADA to policies, practices, or procedures—like mandatory face masking—are reasonable and necessary using an individualized assessment of the plaintiff and the public accommodation based on emerging scientific evidence regarding the effectiveness of the requested modification. Public accommodations would be well advised to follow guidelines established by public health authorities like the CDC that do not fundamentally alter their businesses, although their failure to do so may or may not ultimately run afoul of the ADA.

¹⁹⁷ Klompas, *supra* note 92, at e63.

¹⁹⁸ Gandhi, *supra* note 91, at 2158.

¹⁹⁹ Arons, *supra* note 185, at 2081.

²⁰⁰ Gandhi, *supra* note 91, at 2158.

3. Removing structural barriers impacting people with COVID-19-related disabilities

Public accommodations have an obligation to protect vulnerable people with disabilities by making reasonable structural modifications to allow protected individuals with disabilities the opportunity to practice social distancing and follow other CDC recommendations while enjoying their amenities. Public accommodations also have an obligation to provide services to people with disabilities who may be contagious with COVID-19 where doing so can be done safely.

Under Title III of the ADA, disability discrimination includes “a failure to remove [structural] architectural barriers . . . where such removal is readily achievable” or “where . . . the removal of a barrier . . . is not readily achievable, a failure to [use] . . . alternative methods if such methods are readily achievable.”²⁰¹ “Readily achievable” modifications are those defined as “easily accomplishable and able to be carried out without much difficulty or expense.”²⁰² “Difficulty” is not further defined, but the Supreme Court has noted that the language of the statute “indicates that it extends to considerations in addition to cost” and the determination should “take into account the impact upon the operation of the facility.”²⁰³

The regulations provide a nonexclusive list of examples of barrier removal and include some that may be related to protecting people who are vulnerable to COVID-19 like “[r]earranging tables, chairs, vending machines, display racks, and other furniture [e.g., to allow for “social distancing”]; . . . [i]nstalling flashing alarm lights [e.g., for overcrowded areas]; . . . [e]liminating a turnstile or providing an alternative accessible

²⁰¹ 42 U.S.C. § 12182(2).

²⁰² 42 U.S.C. § 12181(9); 42 U.S.C. § 12182(b)(2)(A)(iv).

²⁰³ *Spector v. Norwegian Cruise Line Ltd.*, 545 U.S. 119 (2005); 42 U.S.C. § 12181(9) (In determining whether an action is readily achievable, factors to be considered include (1) the “nature and cost” of the action needed, (2) “the overall financial resources of the facility . . . ; the number of persons employed . . . ; the effect on expenses and resources, or the impact otherwise . . .” (3) “the overall financial resources of the covered entity; the overall size of the business of a covered entity with respect to the number of its employees; the number, type, and location of its facilities,” and (4) “the type of operation or operations of the covered entity, including the composition, structure, and functions of the workforce of such entity; the geographic separateness, administrative or fiscal relationship of the facility or facilities in question to the covered entity.”).

path [e.g., to provide contactless entry]; . . . [and] [i]nstalling accessible door hardware [e.g., to provide touchless entry and exit].”²⁰⁴ Other similar COVID-19-related measures include installing barriers between customers and employees, installing traffic flow arrows/signage and other types of barriers to minimize contact between customers, installing markers in areas where lines may accumulate to mark 6 feet intervals between patrons, setting up entry points at stores that count and limit the capacity of buildings to allow enough space for social distancing (e.g., limited number of customers per square foot), placing hand sanitizer in strategic locations, and providing curbside and/or contactless delivery (e.g., to allow COVID-19 contagious individuals with disabilities to participate safely). Public accommodations should be attentive to structural barriers to physical distancing between patrons throughout their businesses, including areas that might be neglected like elevators and shuttle buses. Elevators may require special signage and may require a designated employee to ensure one family/related group at a time to avoid prolonged close contact between unrelated patrons

Most of the structural modifications noted above are designed to allow vulnerable individuals to follow social distancing guidelines, and ultimately, the legal analysis of the reasonableness of social distancing rules and any ADA requirements will likely come down to their science. The CDC recommends that people practice “social distancing,” which includes “keeping space between yourself and other people outside of your home” and “[l]imiting face-to-face contact with others.”²⁰⁵ The CDC’s specific recommendations for social distancing include (1) staying at least 6 feet from other people, (2) not gathering in groups, and (3) staying out of crowded places, and (4) avoiding mass gatherings.”²⁰⁶ Public accommodations can make some of the structural modifications noted above to help facilitate the CDC’s social distancing recommendations, which the CDC says is “especially important for people who are at higher risk for severe illness from COVID-19” in the vulnerable population discussed above and protected by the ADA.²⁰⁷

²⁰⁴ 28 C.F.R. § 36.304.

²⁰⁵ CDC Social Distancing, *supra* note 182.

²⁰⁶ *Id.*

²⁰⁷ *Id.*

In contrast, the World Health Organization (WHO) takes a slightly different stance with regard to social distancing than the CDC.²⁰⁸ WHO says, “You can reduce your chances of being infected or spreading COVID-19 by [m]aintain[ing] at least 1 meter (3 feet) distance between yourself and others.”²⁰⁹ WHO explains that “[w]hen someone coughs, sneezes, or speaks they spray small liquid droplets from their nose or mouth which may contain virus,” and “[i]f you are too close, you can breathe in the droplets, including the COVID-19 virus if the person has the disease.”²¹⁰ WHO also recommends “[a]void[ing] going to crowded places” to allow you to maintain their 3 feet rule.²¹¹

The science behind these social distancing rules seems a little less certain than the specific guidelines and will likely play a role in any ADA requirements by courts. According to medical researchers, the CDC and WHO recommendations are based on our “current understanding of the routes of host-to-host transmission in respiratory infectious diseases [that] are predicated on a model of disease transmission developed in the 1930s that, by modern standards, seems overly simplified.”²¹² In the 1930s, William F. Wells studied tuberculosis transmission and “dichotomized respiratory droplet emissions into “large” and “small” droplets” (or aerosols), which “mediate transmission of respiratory disease.”²¹³ Subsequent “[i]nfection control strategies were then developed based on whether a respiratory infectious disease is primarily transmitted via the large or the small droplet route.”²¹⁴ Today, this dichotomy of large versus small droplets developed in the 1930s “remains at the core of the classification systems of routes of respiratory disease transmission adopted by the WHO . . . and . . . the CDC” with “arbitrary droplet diameter cutoffs, from 5 to 10 micrometers” used to “categorize host-to-

²⁰⁸ WORLD HEALTH ORGANIZATION, *Coronavirus disease (COVID-19) advice for the public*, available at <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public>.

²⁰⁹ *Id.*

²¹⁰ *Id.*

²¹¹ *Id.*

²¹² Bourouiba, *supra* note 194, at 1837 (explaining that “[i]mplementing public health recommendations based on these older models [from the 1930s] may limit the effectiveness of the proposed interventions.”).

²¹³ *Id.*

²¹⁴ *Id.*

host transmission as droplets or aerosol routes.”²¹⁵ These classifications “continue to underly current risk management, major recommendations, and allocation of resources for response management association with infection control” for COVID-19.²¹⁶ The rapid international spread of COVID-19 “even when maximum containment policies were enforced” “suggests that using arbitrary droplet size cutoffs may not accurately reflect what actually occurs with respiratory emissions, possibly contributing to the ineffectiveness of some procedures used to limit the spread of respiratory disease.”²¹⁷

One new model for respiratory emissions shows that sneezes, coughs, and exhalations “are primarily made of a multiphase turbulent gas (a puff) cloud that entrains ambient air and traps and carries within it clusters of droplets with a continuum of droplet sizes,” instead of only “mucosalivary droplets following short-rang semiballistic emission trajectories.”²¹⁸ In this new model, the “locally moist and warm atmosphere within the turbulent gas cloud allows contained droplets to evade evaporation for much longer than occurs with isolated droplets,” which extends “the lifetime of a droplet” by up to a factor of 1000, “from a fraction of a second to minutes.”²¹⁹ In addition, the forward momentum of the cloud allows “pathogen-bearing droplets” of all sizes trapped in the turbulent hot and moist gas cloud to be carried up to 23 to 27 feet (7-8 meters) depending upon environmental conditions in the ambient air like temperature, humidity, and airflow.²²⁰ After the cloud evaporates (which is “poorly understood”), some “residues or droplet nuclei” may “stay suspended in the air for hours, following airflow patterns imposed by ventilation or climate-control systems.”²²¹ A report from China “demonstrated that [COVID-19] virus particles could be found in the ventilation systems in hospital rooms of patients with COVID-19 (5),” which is “more consistent with the turbulent gas cloud hypothesis of disease transmission than the dichotomous model [from the 1930s]

²¹⁵ *Id.*

²¹⁶ *Id.*

²¹⁷ Bourouiba, *supra* note 194, at 1837.

²¹⁸ *Id.*

²¹⁹ *Id.*

²²⁰ *Id.*

²²¹ *Id.*

because it explains how viable virus particles can travel long distances from patients.”²²² The clinical implications of these finding is unknown.²²³

The WHO (3 feet) and CDC (6 feet) distance recommendations for social distancing do not take into account “the possible presence of a high-momentum cloud carrying the droplets long distances” and the 3 to 6 feet recommendations likely “underestimate the distance, timescale, and persistence over which the cloud and its pathogenic payload travel, thus generating an underappreciated potential exposure range.”²²⁴

Therefore, under the scrutiny of expert testimony in a court proceeding, a requested structural modification may or may not be determined to be objectively reasonable and necessary regardless of the recommendations of public health authorities—although public accommodations would be wise to make reasonable modifications where readily achievable to accommodate the CDC’s recommendations. In addition, public accommodations should find ways to remove barriers to service of COVID-19 contagious individuals with disabilities safely where possible.²²⁵

V. Conclusion

COVID-19 has permanently changed the way public accommodations like restaurants, theaters, medical facilities, sports arenas, gyms, and many other proprietors of mainstream American activities must operate in order to accommodate people with COVID-19-related disabilities under the Americans with Disabilities Act. The required modifications will affect all clients, customers, and employees of these establishments by changing the way that activities are conducted in these venues.

²²² Bourouiba, *supra* note 194, at 1837.

²²³ *Id.*

²²⁴ *Id.*

²²⁵ *Onishea v. Hopper*, 171 F.3d 1289, 1298 (11th Cir. 1999) (explaining that a dentist “is not entitled to demand absolute safety” in dealing with HIV positive patients and that “remote theoretical possibility of HIV transmission through tears, saliva, and urine” were not significant risks—similar analysis will likely apply to COVID-19 regarding requiring “absolute safety”).

Newly defined COVID-19-related disability groups are emerging under the ADA. The biggest and most diverse group of newly defined individuals with disabilities includes vulnerable individuals who are susceptible to COVID-19 complications and death due to underlying medical conditions like diabetes, hypertension, moderate to severe asthma, immunocompromise, severe obesity, old age, among others.²²⁶ In addition, individuals actually impaired by severe cases of COVID-19, survivors of severe cases of COVID-19, and individuals stigmatized due to COVID-19 will be due special attention under the ADA by public accommodations.

As discussed in depth above, public accommodations will need to affirmatively take actions to allow people with ADA-defined disabilities related to COVID-19 to fully and equally enjoy their goods and services by implementing carefully thought out eligibility criteria necessary to eliminate direct threats; by reasonably modifying policies, practices, and procedures that do not fundamentally alter the nature of their businesses; and by removing structural barriers where readily achievable. Continued attention to emerging scientific and epidemiologic data will be important for public accommodations to successfully navigate the complex and controversial requirements potentially placed upon them by this latest contagion. Measures like fever checks, mandatory face masking, and required social distancing will continue to be scrutinized by scientists, public opinion, and the legal community. Courts will likely struggle and disagree in early evaluations of COVID-19-related requirements as highlighted in this article—just as they have in the past with regard to measures related to other contagious diseases like HIV and tuberculosis.

²²⁶ CDC Higher Risk, *supra* note 119; Richardson, *supra* note 121, at 2052.