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Protecting the Rights and Wellbeing of People with Disabilities during the COVID-19 Pandemic

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SUMMARY. The COVID-19 pandemic has exposed and exacerbated significant inequities experienced by people with disabilities. It has also emphasized the value of legal protections against discrimination based on disability. The Americans with Disabilities Act was enacted 30 years ago to eliminate discrimination against people with disabilities and ensure equal opportunity across major areas of American life (ADA, 2008). Together with an earlier law, the Rehabilitation Act of 1973 (Rehabilitation Act, 2012), this landmark civil rights law impacts a broad range of issues raised by the COVID-19 pandemic and protects a large and growing number of Americans. This Chapter focuses on application of these laws to health care and employment during the pandemic. These laws are powerful tools to protect the rights and well-being of people with disabilities, but they require robust enforcement. Enforcing agencies have provided COVID-19-specific guidance on the application of the laws to health care and employment. Further action is needed, as unresolved legal questions, gaps in protections, lack of knowledge of and noncompliance with disability rights laws, and a lack of data limit the impact of these laws. Recommendations for policymakers to ensure COVID-19 responses respects the rights and wellbeing of people with disabilities include: robust enforcement of the laws; clear and current agency guidance on how to comply with the laws; education about the requirements of the laws, especially in health care settings; and improved data collection and reporting.

Introduction

One in four Americans — a diverse group of 61 million people — experience some form of disability (Okoro et al., 2018). Disability is diverse, and certain racial and ethnic populations have much higher rates of disability than others. As a group, people with disabilities experience significant disparities in education, employment, poverty, access to health care, food security, housing, transportation, and exposure to crime and domestic violence (Pendo & Iezzoni, 2020). Intersections with race, ethnicity, gender, LGBTQ status, and other characteristics may intensify certain inequities. For example, members of underserved racial and ethnic groups with disabilities experience greater disparities in health status and access to health care (Yee et al., 2019).

The pandemic has increased unemployment and economic insecurity for people with disabilities and tested the scope of the ADA's protections in the workplace. It has also worsened health disparities experienced by people with disabilities and highlighted well-founded concerns of discrimination and unequal treatment

if they do seek health care services (Pendo & Iezzoni, 2020). The initial wave of the pandemic brought attention to two actions taken by employers to reduce the threat of COVID-19 infection in the workplace: COVID-19 screening and testing programs, and expanded remote work policies. In health care settings, COVID-19 highlighted policies regarding allocation of scarce medical resources and crisis standards of care. For more information on the application of the ADA to these early developments, please see Chapter 34 in *Assessing Legal Responses to COVID-19: Volume I*. This Chapter will focus on emerging issues as employees' return to the workplace, and legal strategies to address disability health disparities and the lack of disability data.

The Americans with Disabilities Act

The ADA was enacted 30 years ago to eliminate disability discrimination and ensure equal opportunity across major areas of American life. It expands the protections of an earlier law, the Rehabilitation Act, that prohibits disability discrimination in programs and activities that receive federal financial assistance

and in federal employment (Rehabilitation Act, 2012). The requirements of the ADA are illustrated in Table 34.1.

Although this Chapter focuses on the ADA, there are federal laws that prohibit discrimination based on disability in telecommunications, housing, air travel, voting, and education (Department of Justice Civil Rights Division, 2009). States and local governments may also have laws that prohibit disability discrimination.

The ADA impacts a broad range of issues raised by the COVID-19 pandemic. Title I applies to disability accommodations such as remote work, as well as COVID-19 screening, testing and vaccination policies. Together, ADA Titles II and III and the Rehabilitation Act apply to policies and practices of public hospitals and clinical practices, including allocation of scarce medical resources and crisis standards of care. These laws also apply to state, local, and private public health measures, such as physical distancing and mask-wearing requirements (Pendo et al., 2020).

The ADA protects a large and growing number of Americans. The ADA protects any individual who has a physical or mental impairment that substantially limits one or more major life activities, a record of impairment, or is regarded as impaired (ADA, 2008). This definition is meant to be construed in favor of broad coverage of individuals. For example, “major life activities” includes a long, non-exclusive list of both activities and bodily functions.

At the beginning of the pandemic, the focus was on disability protections for the millions of Americans with underlying health conditions that put them at greater risk of severe illness from COVID-19. ADA regulations provide that conditions such as cancer, lung disease, serious heart conditions, immune-suppressing conditions, and diabetes are considered disabilities in virtually all cases. COVID-19 has the potential to increase the number of people who meet this definition. For example, high blood pressure also puts individuals at greater risk of severe illness from COVID-19. This very common condition can be a disability, even when mitigated by medication. The impact of COVID-19 on mental health is also significant (see Chapter 19). New and preexisting mental health conditions can be ADA disabilities.

Although some uncertainty exists, COVID-19 infection itself may meet the definition of disability. Infection affects the immune system and normal cell growth even absent clinical symptoms and can substantially limit the major life activity or operation of one or more bodily systems or organs. COVID-19 infection can also be transmitted to others even absent clinical symptoms, which limits the ability to safely interact with others. Long-term mental and physical effects of COVID-19 infection and disease may also qualify as disabilities.

Workplace Protections COVID-19 Vaccination Policies

Title I of the ADA permits accurate and reliable methods of COVID-19 screening and testing of employees because the virus poses a direct threat to health and safety. It also limits

Table 36.1. Summary of ADA Requirements by Title

TITLE	COVERED ENTITIES AND REQUIREMENTS
Title I (Employment)	Requires equal access to employment opportunities, and that employers provide reasonable accommodations for applicants and employees with disabilities. Limits employer collection of medical and disability-related information from all applicants and employees.
Title II (Public Entities)	Prohibits discrimination against people with disability in any services, programs, and activities offered by states and local governments, and requires reasonable modifications when necessary.
Title III (Public Accommodation)	Prohibits discrimination by private places of public accommodation, such as restaurants, retail establishments, private clinical practices, and other businesses open to the public against people with disabilities.
Title IV (Telecommunications)	Requires telephone and internet companies provide accessible means of communication for people with disability as well as closed captioning of federally funded public service announcements
Title V (Miscellaneous Provisions)	Includes miscellaneous provisions that apply to the ADA as a whole including the responsibility of certain federal agencies for disseminating information and providing technical assistance for those seeking protection under the law.

the collection of medical and disability-related information in the workplace (see Chapter 34 in *Assessing Legal Responses to COVID-19: Volume I*).

The availability of COVID-19 vaccinations raises new questions about the ADA’s protections. Employers generally have the authority to impose vaccination requirements (Yang et al., 2020). Health care institutions, for example, often require employees receive vaccinations for contagious diseases such as influenza, measles, and rubella (Yang et al., 2020.). According to new guidance from the Equal Employment Opportunity Commission (EEOC), the ADA permits employers to encourage COVID-19 vaccination through voluntary programs. The ADA also permits employers to require COVID-19 vaccinations so long as they

consider reasonable accommodations for disability and religious reasons under the ADA and related laws (EEOC, 2020). But there are other unresolved legal questions about COVID-19 vaccine mandates because the vaccine was granted Emergency Use Authorization (EUA) (see Chapter 23), which requires recipients receive information about the option to accept or refuse the vaccine (EEOC, 2020).

COVID-19 and Remote Work as Accommodation

The ADA requires employers to make reasonable accommodations for employees with disabilities, which are affirmative steps that enable employees with disabilities to do their jobs. Accommodation decisions are made on a case-by-case basis and should be the product of an interactive process between the employer and employee. Employers are not required to provide the specific accommodation requested by the employee, so long as the alternative it offers adequately addresses the employee's needs and reasonably accommodates the disability.

Employers do not have to provide accommodations that pose an undue hardship (involving significant difficulty or expense) or a direct threat (a significant risk of substantial harm to the health or safety of the employee or others, which cannot be eliminated or reduced by a reasonable accommodation). For example, an employer can require an employee to stay home if the employee tests positive for COVID-19 or has COVID-19 symptoms. However, the employer should consider whether the direct threat can be minimized through a reasonable accommodation that allows the employee to stay on the job, such as working remotely. Employers must also consider reasonable accommodations for individuals who are at increased risk of COVID-19 due to underlying health conditions that meet the ADA definition of disability.

One-third to one-half of U.S. workers report working from home during the pandemic (Dingel & Neiman, 2020). We may see more conflicts as employers seek to bring employees back to the workplace. For example, an office worker may request to work from home to accommodate a medical condition that puts them at greater risk of serious COVID-19 disease. The employer might refuse that request because it has instituted protective measures such as temperature screenings, mask requirements, enhanced cleaning, and physical distancing requirements. If so, the employer must show its protective measures adequately address the threat of infection to the employee and others in the workplace based on an individualized assessment of the risk using the best available objective medical evidence (EEOC, 2020). The employer would also need to address any arguments by the worker that the measures are inadequate, such as lack of enforcement of the mask requirement, or impracticality of physical distancing given the office layout.

Employers do not have to provide accommodations that eliminate an essential part of the job. If a job has been done successfully from home during the pandemic, it may be more difficult for the employer to argue that physical presence in the workplace is essential.

Expanded remote work policies may greatly benefit workers with disabilities, among others. But expanded remote work may heighten workplace inequities. First, not everyone is entitled to remote work as an accommodation. Employers are not required to provide ADA accommodations to employees who are at increased risk of COVID-19 due to a reason other than disability (such as age or ordinary pregnancy) or to employees with family members who are at risk. (EEOC, 2020). Second, not all jobs can be done remotely. Educators, managers, and professionals in technology, business, and law are most likely to be able to work remotely, while many employees in food service, construction, maintenance and repair, and production are unable to perform their jobs off-site (Dingel & Neiman, 2020).

Health and Health Care Issues

The ADA prohibits exclusion of or discrimination against people with disabilities in health care in state policies and health care services offered by public hospitals (Title II), and in private physician's offices and private hospitals (Title III). Section 1557 of the Patient Protection and Affordable Care Act (ACA) amends the Rehabilitation Act to provide additional protections against discrimination in health care. These laws require equal access to health care services for individuals with disability, subject to some limitations. Equal access includes: no exclusion of patients with disabilities; physical access to health care services and facilities, including accessible spaces and the removal of barriers; effective communication, including auxiliary aids and services such as the provision of sign language interpreters or materials in alternative formats; and a general duty to make reasonable modifications of health care policies, practices, and procedures when necessary to accommodate individual needs.

The initial wave of the pandemic brought attention to policies regarding allocation of scarce medical resources and crisis standards of care developed by states and health care facilities (Chapter 24). The U.S. Dept. of Health and Human Services (HHS) Office for Civil Rights (OCR) has made clear that policies may not explicitly or implicitly discriminate on the basis of disability (see Chapter 34 in *Assessing Legal Responses to COVID-19: Volume I*). An equitable approach requires considering past and present health inequities experienced by people with disabilities and others that may be intensified by these policies. These policies should also be publicly adopted and created with meaningful input from people with disabilities and others likely to be disadvantaged by these policies.

Disparities and Discrimination before COVID-19

People with disabilities experience significant disparities in health status, access to health care, and other social determinants of health (Pendo & Iezzoni, 2020). Intersections with other disadvantaged groups may compound these disparities. As mentioned in the introduction, members of underserved racial and ethnic groups with disabilities experience greater disparities in health status and access to health care (Yee, et al., 2019). Emerging evidence suggests LGBTQ individuals with disabilities are especially vulnerable to many of these disadvantages (Pendo & Iezzoni, 2020).

People with disabilities are at higher risk for COVID-19 infection and serious disease because of pre-existing disparities. A recent series of reports published by the National Council on Disability underscore how persistent devaluation of the lives of people with disabilities by the medical community, legislators, researchers, and others, perpetuates inequities in health and access to health care, including life-saving care (National Council on Disability, 2019). People with disabilities also have well-founded concerns about disability bias and discrimination if they do seek care, as these problems persist 30 years after the enactment of the ADA (Pendo & Iezzoni, 2020). It is clear that robust enforcement of nondiscrimination laws must be coupled with education and training.

Lack of Disability Data

We lack data related to COVID-19 testing, infections, and outcomes for people with disabilities. As with other disproportionately impacted groups, data is needed to assess risks for people with disabilities, to develop health protection measures, and to identify and address important disparities. Disaggregated data related to disability would also provide information about the intersection of disability with race, ethnicity, gender, sexual orientation, and other groups for which data is collected (Yee et al., 2019). There has been long overdue attention to individuals in nursing homes and long-term care facilities during the pandemic (see Chapter 20). We also need data related to home and community-based services and providers which are critical to people with disabilities who live in the community. There are data collection standards for disability status that could be used for federal, state, and local collection and reporting of COVID-19 data. Section 4302 of the ACA already requires all federally conducted or supported health care and public health programs to collect data on disability status using, at a minimum, the six disability questions in the American Community Survey used to gauge disability among the U.S. population (Pendo & Iezzoni, 2020).

More broadly, collecting better disability data at the federal, state, and local levels is needed to identify and address critical issues of health disparities and health equity experienced by people with disabilities. For example, the ACA directs HHS to identify locations where individuals with disabilities access different types of care and to determine the number of providers with accessible facilities and accessible medical and diagnostic equipment and the number of employees trained in disability awareness and in caring for patients with disabilities. However, this data has not been collected (Pendo & Iezzoni, 2020). 🦠

Recommendations for Action

Federal government:

- To assure COVID-19 response respects the rights and well-being of people with disabilities, federal agencies should provide clear, ongoing legal guidance. Specifically:
 - o The OCR should continue to enforce and provide COVID-specific guidance on the requirements of the ADA, Rehabilitation Act, and Section 1557 of the ACA for health care providers, institutions, and systems regarding medical allocation policies, hospital visitor policies, and other policies that impact care for people with disabilities.
 - o Following the example of the EEOC's guidance for private employers, the DOJ should provide similar guidance on the requirements of the ADA and Rehabilitation Act in COVID-related policies adopted by state, local, and retail and other business entities, including mask-wearing policies.
 - o The EEOC should provide clear guidance on when COVID-19 infection, disease, and lasting physical and mental effects are ADA disabilities.
- Congress should fund and require HHS to collect and publicly report standardized data using, at a minimum, the data collection standards for disability that have been developed under the ACA in three areas:
 - o COVID-19 testing, infections, treatment, and outcomes;
 - o Home and community-based services necessary to people with disabilities who live in the community during COVID-19;
 - o As required by the ACA, identification of locations where individuals with disabilities access care, their accessibility, and the number of employees trained in disability awareness and in caring for patients with disabilities in those locations.

State governments:

- Governors should instruct public health officials to incorporate equity considerations and address the needs of people with disabilities in all COVID-19 orders, policies and programs, including provision of high-quality personal protective equipment (PPE) to providers of home and community-based services and other caregivers for people with disabilities living in the community.
- To assure COVID-19 response respects the rights and wellbeing of people with disabilities, state agencies should:
 - o Actively enforce and provide COVID-specific guidance on the requirements of state laws that prohibit discrimination based on disability.
 - o Provide clear guidance on when COVID-19 infection, disease, and lasting physical and mental effects are protected as disabilities under state anti-discrimination laws (see, e.g., NYC Human Rights, 2021).
 - o Review and revise state and local policies related to COVID-19, including medical allocation policies, hospital visitor policies, and mask-wearing policies, to ensure they comply with requirements of federal and state disability rights law.
- Pursuant to federal direction or on their own initiative, states should collect and publicly report standardized data using, at a minimum, the data collection standards for disability that have been developed under the ACA in the three areas identified for federal data collection above.
- States should adopt policies that encourage employers to:
 - o Allow all employees to work remotely where possible, regardless of disability.

- o Encourage employer adoption of voluntary COVID-19 vaccination policies when possible and ensure mandatory COVID-19 policies comply with requirements of federal and state disability rights law.

Local governments:

- To assure COVID-19 response respects the rights and wellbeing of people with disabilities, local agencies should take the same steps to enforce, review and revise local laws and policies as recommended for State agencies in connection with state laws above.
- Pursuant to federal or state direction or on their own initiative, local governments should require the collection and public reporting of standardized data using, at a minimum, the data collection standards for disability that have been developed under the ACA in the three areas identified for federal data collection above.
- As recommended for state governments above, local governments should adopt policies that encourage employers to broadly allow remote work and to adopt vaccination policies that comply with federal and state disability rights law.

About the Author

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