Volume 30 | Issue 1
FALL 2020

LOYOLA UNIVERSITY CHICAGO
AD • MAJOREM • DEI • GLORIAM
1870
SCHOOL *of* LAW

BEAZLEY INSTITUTE FOR HEALTH LAW AND POLICY

# Annals OF Health Law

## ADVANCE DIRECTIVE

The Student Health Policy and Law Review of
LOYOLA UNIVERSITY CHICAGO SCHOOL *of* LAW

# ANNALS OF HEALTH LAW AND LIFE SCIENCES
## *Advance Directive*

**THE *STUDENT* HEALTH POLICY AND LAW REVIEW OF LOYOLA UNIVERSITY CHICAGO SCHOOL OF LAW**

**BRINGING YOU THE LATEST DEVELOPMENTS IN HEALTH LAW**

Beazley Institute for Health Law and Policy

VOLUME 30, STUDENT ISSUE 1 FALL 2020


## CONTENTS


**Editors' Note**
*Lauren Koch, Peggy Frazier, and Harte Brick*

ARTICLES

**Using the COVID-19 Pandemic to Reframe the Plausibility of Breastfeeding Through Telework**
Kiana Baharloo ..... 101

**Proposed Alternatives to Direct-to-Consumer Drug Advertising During a Global Pandemic**
Alida Beck ..... 115

**State Medicaid Reimbursement for Remote Patient Monitoring and Interactive Communication Will Help Reduce Health Care Gap Among Black and White People with Preexisting Conditions that Put them at Increased Risk of Severe Illness from COVID-19**
Victoria Bethel ..... 129

**Homelessness and Health Justice**
Edwin Caro ..... 143

**The Unequal Health Coverage Received by Rural Americans and How Mandatory Telehealth Coverage Can Help**
Luke Cummings ..... 157

**COVID-19 and College Athletics: Examining the Effects of Coronavirus on African American Student Athletes and the Future of Collegiate Sports**
Christian Fuller ..... 169

**Do I Have To?: Mandating a Vaccine in a Politicized Pandemic**
Madison N. Heckel ..... 183

**Compassionate Release During a Pandemic: Clearer Routes for Direct Advocacy of Prisoners to Avoid Harmful Delays to Medically Vulnerable Population**

Abby Higgins ..... 199

**Price Gouging & Health Justice: Passing Anti-Price Gouging Laws amid a Pandemic**
Joseph Nguyen Ho ..... 213

**Alternative Dispute Resolution as a Means for Health Justice**
Michael Kemel ..... 227

**OSHA & Addressing the Disparate Impact of COVID-19 Within Vulnerable Communities**
Liam Kenney ..... 243

**Chronic Disease Management among Low-Income Urban Populations Through the Use of Telehealth – Impact and Challenges**
Jundi Liang ..... 255

**Reasonable Accommodations for Parental Caregivers**
Hani Majeed ..... 267

**How a Pandemic Heightens Healthcare Issues for Individuals with Chronic Illnesses: A Case Against Excessive Cost-Sharing**
Meera Patel ..... 281

**Bridging the Digital Divide: How COVID-19's Telemedicine Expansion May Exacerbate Health Disparities for Low-Income, Urban, Black Patients**
Sarah Ryan ..... 295

**The Dichotomy of Social Isolation in a Global Pandemic When the Power to Protect Actually Harms**
Marina Saldaris ..... 313

**The Unconstitutionality of Access to Health Care in Prisons During COVID-19**
Nitika Suchdev ..... 329

ANNALS OF HEALTH LAW
*Advance Directive*

# Editors' Note

The *Annals of Health Law and Life Sciences* is proud to present the twenty-fifth issue of our online, student-written publication, Advance Directive. As in past publications, this Issue's articles coincide with the Beazley Institute for Health Law and Policy and *Annals of Health Law and Life Sciences*, Fourteenth Annual Health Law Symposium topic: "Viewing Health Justice Through the Lens of Public Health Crises."

The *Fall 2020 Advance Directive* Issue will dive into a broad spectrum of topics within the current conversation taking place in the United States surrounding public health crises, namely the COVID-19 pandemic. The COVID-19 pandemic has further illuminated the need for healthcare reform particularly addressing access and quality of care for vulnerable and low-income populations.

This Issue addresses the disparate impact of COVID-19 within vulnerable populations, such as incarcerated individuals, the elderly, and rural communities. The Issue also aims to evaluate the constitutionality of state and federal responses to current and future health crises. Further, the Issue advocates for broad healthcare reform as a result of the COVID-19 pandemic including expanding reimbursement and access to telehealth and Medicaid coverage. The range of topics covered in this Issue exemplifies the widespread failure of the United States healthcare system and the immediate need for health justice, brought to the forefront by the COVID-19 pandemic.

We would like to thank Karin Long, our Annals Editor-in-Chief, for her leadership and support. We would also like to thank and acknowledge our Annals Executive Board Members: Dan Duffy, Natasha Shukla, and Krystal Tysdal. The members of Annals deserve recognition for their hard work, dedication, and well-thought articles. Lastly, we must thank the Beazley Institute for Health Law and Policy and our faculty advisors, Professors Sawicki and Paradise and Kristin Finn for their guidance and support.

We hope you enjoy this Issue of *Advance Directive*.

Sincerely,

Harte Brick
Advance Directive Editor
*Annals of Health Law*
Loyola University Chicago
School of Law

Peggy Frazier
Advance Directive Editor
*Annals of Health Law*
Loyola University Chicago
School of Law

Lauren Koch
Advance Directive Editor
*Annals of Health Law*
Loyola University Chicago
School of Law

# Using the COVID-19 Pandemic to Reframe the Plausibility of Breastfeeding Through Telework

*Kiana Baharloo*

## INTRODUCTION

Breastfeeding is one of the most powerful and effective public health tools.[1] Breast milk is uniquely suited to infants' nutritional needs and has immunological and anti-inflammatory properties that protect both mothers and children from illnesses and diseases.[2] However, the well-known benefits of breastfeeding are contradictory to the current rates of breastfeeding in the United States ("U.S.") as well as current legislation.[3]

There are staggering numbers of infants in the U.S. who are not breastfed in accordance with federal and global guidelines.[4] The American Academy of Pediatrics recommends exclusive breastfeeding for the first six months of infants' lives and for at least one year while introducing complementary foods.[5] Although there are other social and physiological reasons mothers do not breastfeed, employment has been identified as the most influential factor.[6] In 2007, only eight percent of U.S. employees in the private sector

---

[1] *Breastfeeding Report Card*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 17, 2020) https://www.cdc.gov/breastfeeding/data/repreportc.htm.
[2] U.S. DEP'T HEALTH & HUM. SERVS., THE SURGEON GEN.'S CALL TO ACTION TO SUPPORT BREASTFEEDING 1 (2011).
[3] U.S. Dep't Health & Human Services, *Increase the Proportion of Infants who are Breastfed at 1 year — MICH-16*, HEALTH.GOV, https://health.gov/healthypeople/objectives-and-data/browse-objectives/infants/increase-proportion-infants-who-are-breastfed-1-year-mich-16 (last visited Oct. 17, 2020).
[4] Am. Acad. Pediatrics Work Group on Breastfeeding, *Breastfeeding and the Use of Human Milk*, 100 PEDIATRICS 1035,1036 (1997).
[5] *Breastfeeding Report Card*, *supra* note 1.
[6] Katharina Hauck et al., *Integrating Motherhood and Employment: A 22-year Analysis Investigating Impacts of US Workplace Breastfeeding Policy*, 11 SSM POPULATION HEALTH, 1, 1 (2020).

had access to paid family leave to take care of a newborn.[7] Yet, studies show that women who receive twelve or more weeks of paid maternity leave are 2.83 times more likely to initiate breastfeeding than those without paid work leave.[8] Work barriers are influenced by an array of factors, including both state and federal regulations.[9]

The large-scale shift of work environments and protocols due to the COVID-19 pandemic has created an opportunity to focus on the absence of protection that paid work leave offers new mothers. This paper explores legislation regarding maternity leave and its impact on breastfeeding, and how remote work ("telework"), is a plausible and sustainable supplement to maternity leave. Part I will discuss the importance of breastfeeding as a public health tool. Part II will examine legislation and policies relevant to breastfeeding. In Part III, the aforementioned policies will be critiqued. In Part IV, positive policy examples will be evaluated, and in Part V, policies will be reframed with telework as a necessity to increase breastfeeding rates in the U.S.

## THE IMPORTANCE OF BREASTFEEDING AS A PUBLIC HEALTH TOOL

Breastfed infants have a lower risk for many negative health outcomes including sudden infant death syndrome ("SIDS"), necrotizing enterocolitis, type two diabetes, asthma, and childhood obesity.[10] In addition, mothers who breastfeed are at a lower risk for ovarian and breast cancers[11] and have lower

[7] Rui Huang & Muzhe Yang, *Paid Maternity Leave and Breastfeeding Practice Before and After California's Implementation of the Nation's First Paid Family Leave Program*, 16 ECON. & HUMAN BIOLOGY 45, 56 (2015).
[8] Kelsey Mirkovic et al., *Paid Maternity Leave and Breastfeeding Outcomes*, 43 BIRTH 233, 233 (2016).
[9] Hauck et al., *supra* note 6, at 2.
[10] Mirkovic et al., *supra* note 8.
[11] *Id*.

reported incidence of endometrial and thyroid cancers.[12] Conversely, there are dangers of formula feeding. Infants who are fed formula at four months are over 250% more likely to be hospitalized for lower respiratory tract disease in the first year of life than breastfed infants.[13] Formula feeding can also lead to short-term infections such as diarrhea and ear infections.[14]

The benefits of breastfeeding are not only applicable to individuals' health, but also the economic health of the healthcare system. Low breastfeeding rates add an estimated $2.2 billion per year to direct medical costs in the U.S.[15] One study found that, if ninety percent of U.S. families followed breastfeeding guidelines, the U.S. would save $13 billion annually from reduced direct medical and indirect costs of premature death.[16] With ninety percent breastfeeding compliance, $4.7 billion would be saved just on costs relating SIDS and an additional $2.6 billion in costs relating to necrotizing enterocolitis.[17] Similarly, with an eighty percent breastfeeding compliance rate, $10.5 billion per year would be saved.[18] In addition to direct medical costs, other costs of noncompliance with breastfeeding guidelines include lower productivity in terms of less employee time off to take care of a sick child,[19] formula costs, and increased insurance costs.[20] Ninety percent compliance could also save $3.9 billion on infant formula.[21] In addition,

---

[12] Adetola Louis-Jacques & Alison Stuebe, *Enabling Breastfeeding to Support Lifelong Health for Mother and Child*, 47 OBSTETRICS & GYNECOLOGY CLINICS OF N. AM., 363, 364 (2020).
[13] U.S. DEP'T HEALTH & HUM. SERVS., *supra* note 2.
[14] *Id*.
[15] Mirkovic et al., *supra* note 8.
[16] U.S. DEP'T HEALTH & HUM. SERVS., *supra* note 2, at 3.
[17] Summer Sherburne Hawkins et al., *Breastfeeding and the Affordable Care Act*, 62 PEDIATR. CLIN N. AM. 1071, 1072-1073 (2015).
[18] U.S. DEP'T HEALTH & HUM. SERVS., *supra* note 2, at 3.
[19] *Id*.
[20] *Id*. (estimating that families who followed optimal breastfeeding practices could save more than $1,200–$1,500 in expenditures for infant formula in the first year alone).
[21] Hawkins et al., *supra* note 17, at 1073.

breast milk has no environmental footprint, whereas formulas require packaging, shipping, and fuel costs.[22] Although paid maternity leave will save money for individuals and the healthcare system, paid telework will have the same benefits with fewer economic drawbacks.

## CURRENT LEGISLATION AND POLICIES THAT IMPACT BREASTFEEDING

There is a clear relationship between economics and health that is currently neglected in U.S. maternity leave policies. The U.S. is the only advanced, industrialized nation without a federal law providing new mothers paid leave.[23] Employees in the U.S. primarily rely on employer policies to provide paid leave for family and medical reasons.[24] However, only fifteen percent of U.S. workers in 2017 had access to employer-sponsored paid family leave, according to the National Compensation Survey ("NCS"), which defines paid family leave as "leave to care for a newborn child, an adopted child, a sick child, or a sick adult relative."[25] Considering that most of the population does not receive employer-sponsored paid leave, effective legislation is crucial to improving breastfeeding rates. Federal legislation that influences breastfeeding include the Family and Medical Leave Act ("FMLA"), the Affordable Care Act ("ACA"), Medicaid, and the Special Supplemental Nutrition Program for Women, Infants, and Children ("WIC").[26]

---

[22] *Id*.
[23] BLS Staff, *How Paid Family Leave Affects Mothers in the Labor Force*, BLS.GOV (Mar. 2012) https://www.bls.gov/opub/mlr/2012/beyond-bls/how-paid-family-leave-affects-mothers-in-the-labor-force-the-chicken-or-the-egg-women-s-empowerment-and-economic-development.html.
[24] Ann Bartel et al., *Racial and Ethnic Disparities in Access to and use of Paid Family and Medical Leave: Evidence from four Nationally Representative Datasets*, BLS.GOV (Jan. 2019), https://www.bls.gov/opub/mlr/2019/article/racial-and-ethnic-disparities-in-access-to-and-use-of-paid-family-and-medical-leave.htm.
[25] *Id*.
[26] Hawkins et al., *supra* note 17, at 1072.

FMLA was enacted in 1993[27] and requires companies with fifty or more employees to provide twelve unpaid weeks of leave for various family matters, including parental leave.[28] However, this is an inequitable approach because lower wage, seasonal, and part-time workers are less likely to qualify for FMLA benefits[29] and those in lower paid jobs are more likely to return to work earlier.[30] The FMLA therefore likely benefits mothers who are of higher income and can afford to take unpaid time off, and does not benefit low-income mothers. In fact, a main reason why family leave is not taken is loss of income.[31] As a consequence, in 2012, twenty-three percent of working women returned to the workplace within only ten days of giving birth.[32]

The ACA has two provisions that influence breastfeeding.[33] In 2012, it was mandated that non-grandfathered, private health insurance must provide certain coverage for breastfeeding, including lactation support, counseling, and breastfeeding equipment.[34] Notably, these changes typically do not benefit low-income individuals insured under Medicaid, which is a government-funded entitlement program[35] for those who may not be able to afford health insurance. Further, there is a "Break Time for Nursing Mothers" law under the ACA, where employers must allow unpaid break time to express milk for one year after birth, in a private space that is not a

---

[27] Hauck et al., *supra* note 6, at 2.
[28] U.S. BUREAU OF LABOR STAT., EMPLOYEE BENEFITS SURVEY, BLS https://www.bls.gov/ncs/ebs/factsheet/family-leave-benefits-fact-sheet.htm (last updated Feb. 26, 2019).
[29] Bidisha Mandal et al., *The Differential Effects of Full-Time and Part-Time Work Status on Breastfeeding*, 97 HEALTH POL'Y,79, 84 (2010).
[30] Hauck et al., *supra* note 6, at 2.
[31] Huang & Yang, *supra* note 7, at 46.
[32] Louis-Jacques & Stuebe, *supra* note 12, at 376.
[33] Hawkins et al., *supra* note 17, at 1074-1075.
[34] Kandice Kapinos et al., *Lactation Support Services and Breastfeeding Initiation: Evidence from the Affordable Care Act*, 52 PEDIATR. CLIN. N. AM., 2175, 2176 (2017).
[35] Tami Gurley-Calvez et al., *Effect of the Affordable Care Act on Breastfeeding Outcomes*, 2 AM. J. OF PUB. HEALTH 277, 277 (2018).

bathroom.[36] However, this law does not significantly increase breastfeeding rates as sixty percent of women reported that they did not have the time or space to do so.[37] Overall, the ACA only increased breastfeeding initiation by 2.5%.[38] Only twenty-four states and Washington D.C. provide any breastfeeding protection beyond the minimum, and largely ineffectual, requirements under the ACA, rendering mothers in about half of the U.S. states reliant primarily on the ACA for breastfeeding protection.[39] Moreover, only twelve states and Washington D.C. have maternity leave beyond both the FMLA and ACA, however, only four of those states and Washington D.C. have any form of paid maternity leave.[40]

Lastly, WIC applies in relevant part to certain income-eligible breastfeeding women up to one year after delivery and to non-breastfeeding women up to six months after delivery.[41] In order to receive WIC benefits, a mother must demonstrate that she is a nutritional risk and income eligible–at or below 185% of the federal poverty level.[42] WIC promotes breastfeeding and provides information through counseling, educational materials, support through peer counselors, and all states contain a provision regarding access to breast pumps.[43]

Studies have shown that workplace breastfeeding policies save an average of three dollars for every one dollar invested, where savings reflect employee retention, satisfaction, and reduced absences due to illness.[44] Yet, few

---

[36] Louis-Jacques & Stuebe, *supra* note 12, at 376.
[37] *Id*.
[38] Hauck et al., *supra* note 6, at 6.
[39] Sara Neelon et al., *The Role of Equity in US States' Breastfeeding Policies*, 173 JAMA PEDIATRICS 908, 909 (2019).
[40] *Id*.
[41] SILVIE COLMAN ET AL., U.S. DEP'T OF AGRIC., FOOD AND NUTRITION SERV., OFF. OF RES. & ANALYSIS, EFFECTS OF THE SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC): A REVIEW OF RECENT RESEARCH, REPORT WIC-12-WM (Jan. 2012).
[42] *Id*.
[43] Hawkins et al., *supra* note 17, at 1084.
[44] WORLD HEALTH ORGANIZATION (WHO) & UNITED NATIONS CHILDREN'S FUND (UNICEF), GLOBAL BREASTFEEDING ADVOCACY BRIEF (2019).

women take advantage of the opportunity to breastfeed due to challenges associated with breastfeeding in the workplace, such as social stigma and practical difficulties.[45] Thus, telework may increase breastfeeding without additional investments.

## ISSUES WITH CURRENT LEGISLATION

Current legislation reflects and exacerbates racial and socioeconomic influences on breastfeeding rates. Women of color are less likely to breastfeed and infants of color are less likely to be breastfed, and therefore, do not benefit from the associated health outcomes.[46] African American mothers have the lowest breastfeeding rates at only 17.2%.[47] Notably, existing policies to support breastfeeding do not include language on race, ethnicity, income, or education.[48] Another important factor in considering maternity leave is the shift in the U.S. workforce that has occurred over the last several decades. In 2010, women with children under the age of eighteen in the workforce was 71.3%[49] compared to 47.5% in 1975.[50] This increase of women's employment has not been reflected by changes in paid leave.

An overarching issue of relevant policies is that they do not apply to all employees, which leaves mothers in lower paying occupations returning to work earlier.[51] National survey findings are consistent with evidence that the "FMLA has provided health benefits to infants of highly educated and married women," but not to infants of less advantaged mothers.[52] Similarly, the ACA presents a gap in coverage because Medicaid recipients are typically

[45] Hauck et al., *supra* note 6, at 1.
[46] Neelon et al, *supra* note 39, at 908.
[47] Hauck et al., *supra* note 6, at 2.
[48] Neelon et al, *supra* note 39, at 909.
[49] BLS Staff, *supra* note 23.
[50] *Id*.
[51] Hauck et al., *supra* note 6, at 2.
[52] Bartel et al., *supra* note 24.

excluded from ACA breastfeeding support[53] and Medicaid traditionally has not been required to provide lactation support.[54] Neither the Medicaid statute nor the Federal Medicaid regulations specifically mention lactation services, and state coverage varies widely,[55] where only fourteen states cover breastfeeding education, twelve states cover lactation consultations, and thirty-nine states include a provision of a breast pump.[56]

Medicaid also presents a disparity in coverage, where racial and ethnic minorities constitute forty-seven percent of eligible individuals, although they only constitute thirty-seven percent of the U.S. population.[57] Minorities' heightened reliance on Medicaid is problematic because, although the ACA offers limited benefits, Medicaid has no minimum required lactation benefits[58] and state variance in Medicaid services[59] is likely to have differential impacts on coverage of racial groups.[60] This issue is particularly complex because the increase of insured patients is typically believed to improve health outcomes, however, the absence of any breastfeeding protection under Medicaid may have contradictory results for those reliant on Medicaid, especially for minority groups.

Another issue with the ACA is that it tends to only cover hourly employees, not salaried employees.[61] Since the ACA employer health insurance mandate applies to individuals who work more than thirty hours a week,[62] yet another gap in coverage is created for those who do not work the minimum number of hours required to qualify for ACA benefits. When the

---

[53] Gurley-Calvez et al., *supra* note 35.
[54] Kapinos et al., *supra* note 34, at 2189.
[55] Hawkins et al., *supra* note 17, at 1078.
[56] *Id*. at 1082.
[57] Christina Andrews et al., *The Medicaid Expansion Gap and Racial and Ethnic Minorities with Substance Use Disorders* 105 AM. J. OF PUB. HEALTH S452, S452 (July 2015).
[58] Hawkins et al., *supra* note 17, at 1078.
[59] *Id*. at 1079.
[60] Andrews et al., *supra* note 57, at S454.
[61] Hawkins et al., *supra* note 17, at 1075.
[62] Aparna Mathur et al., *Has the Affordable Care Act Increased Part-Time Employment?*, 23 APPLIED ECON. LETTERS, 222, 222 (2016).

ACA is applicable, breastfeeding "support, supplies, and counseling" are not well defined, creating variation among insurance policies.[63] In considering issues of Medicaid and the ACA, it is crucial to note that the relationship between these policies leaves some mothers falling through the cracks between affording insurance and earning too much to qualify for Medicaid.[64] The lack of uniformity of access to ACA benefits presents an issue of utilizing the ACA, and as a result, Medicaid, to increase breastfeeding rates.

Although WIC has the most inclusive language of breastfeeding services, it is a grant-based program that relies on limited resources, which creates a need of prioritization.[65] Approximately seventeen percent of women may be eligible for WIC but are not enrolled,[66] which may mean a greater enrollment for WIC could lower access and quality of breastfeeding support without an increase of federal funds. Another consideration is a possible negative correlation between WIC participation and breastfeeding.[67] Although WIC encourages breastfeeding, it also provides packages for supplemental formula.[68] As formula is typically expensive, it has been theorized that this unintentionally incentivizes formula feeding by creating an image of a valuable product that one may not be able to afford without WIC.[69] Although not an established cause, studies have found a correlation with low rates of breastfeeding under WIC.[70]

---

[63] Hawkins et al., *supra* note 17, at 1075.
[64] *Id*. at 1087.
[65] *Id*. at 1080.
[66] *Id*.
[67] COLEMAN ET AL., *supra* note 41, at 29.
[68] *Id*. at 3.
[69] *Id*.
[70] *Id*. at 29.

EXAMPLES OF EFFECTIVE LEGISLATION

California was the first state to offer a partially paid family leave ("PFL") law in 2004.[71] As an extension of state disability insurance ("SDI"), employees covered with SDI also have PFL.[72] Although only partially paid, PFL increased overall maternity leave in California from three to six weeks, with large increases for non-college-educated, unmarried, Black, and Hispanic mothers.[73] After California enacted PFL, breastfeeding rates at six months increased by 17.4%.[74] This is a substantial increase given that many women, mostly young, non-white, less-educated, low-income, and those without employer paid leave, did not know about this law.[75] Therefore, this lack of knowledge may indicate that PFL likely had potential for even greater increased breastfeeding rates than what was observed if more mothers had known about it.

In 2020, Washington implemented the Paid Family and Medical Leave Program, which is a state-run insurance benefit.[76] This program allows most employees[77] to receive up to twelve weeks of paid leave for, among other circumstances, bonding after birth.[78] Unlike sick leave and accrued time off, the Paid Family and Medical Leave Program is not an employer provided benefit, but rather provided through the Employment Security Department, which creates no additional costs to employers.[79] Another benefit to this

[71] Huang & Yang, *supra* note 7.
[72] *Id*. at 47.
[73] *Id.* at 56.
[74] *Id*. at 51.
[75] Bartel et al., *supra* note 24.
[76] *Paid Family & Medical Leave*, WASH. ST. DEP'T LABOR & INDUSTRIES , https://lni.wa.gov/workers-rights/leave/paid-family-and-medical-leave (last visited Oct. 18, 2020).
[77] *Paid Family and Medical Leave*, ECON. OPPORTUNITY INST., http://www.opportunityinstitute.org/paidleave/ (last visited Oct. 18, 2020) (employees who worked 820 hours in the previous year, including different employers).
[78] *Paid Family & Medical Leave*, *supra* note 76.
[79] *Information on the Washington Paid Family and Medical Leave Program*, WASH. ST. NURSES ASS'N (Feb. 29, 2020). https://www.wsna.org/news/2020/information-on-the-washington-paid-family-and-medical-leave-program.

program is that both parents are eligible, and it can be taken at different times.[80] This program is also effective for business because it exempts businesses with less than fifty employees from paying premiums, which allows for competition and predictability.[81]

Notably, the ACA has been shown to benefit black, less educated, and unmarried mothers, showing that policy changes do in fact have the potential to help vulnerable populations.[82] But, because the ACA only requires coverage for those who work full-time,[83] part-time working mothers may not benefit from ACA mandated employer insurance. Crucial to note is that returning to work full-time decreases breastfeeding rates, yet part-time work does not.[84] This dichotomy presents a balance between insurance benefits of full-time employment and breastfeeding benefits of part-time employment.

## TELEWORK AS A NECESSARY COMPONENT OF WORK LEAVE POLICIES TO PROMOTE BREASTFEEDING

Part-time work presents higher rates of breastfeeding initiation and duration compared to full-time work.[85] Full-time working mothers utilizing telework, when compared to part-time work, likely would allow for the same space, time,[86] and comfort to breastfeed while working from home, while still allowing for health insurance coverage as a full-time employee. Telework appeals to both productivity and economic strength while providing mothers with the ability to breastfeed.

---

[80] *Paid Family & Medical Leave*, *supra* note 77.
[81] *Id*.
[82] Kapinos et al., *supra* note 34, at 2175.
[83] Mathur et al., *supra* note 62.
[84] Mandal et al., *supra* note 29.
[85] *Id*.
[86] Alan Ryan et al., *The Effect of Employment Status on Breastfeeding in the United States*, 16 WOMEN'S HEALTH ISSUES 243, 249 (2006) (explaining that obstacles in the workplace include space, time, and support from co-workers and employers).

Data from the U.S. Bureau of Labor Statistics ("BLS") indicates that forty-five percent of U.S. employees are in occupations in which telework is feasible.[87] However, a much lower percentage of employees, between twenty-two and twenty-five percent, actually worked from home prior to the COVID-19 pandemic.[88] Therefore, there are employees who may not have traditionally worked from home, but indeed have the ability to do so. Telework has proven to be successful in the U.S. through qualitative evidence from both employers and employees.[89] The forward-thinking and dynamic workplace ideologies implemented as a result of the COVID-19 pandemic should serve to reframe maternity leave legislation. Currently, there is no national quantitative data about productivity with remote work, however, the BLS is monitoring productivity and costs[90], and when data becomes available, this information can be used to further assess this proposition.

Similar to aforementioned critiques of other policies, telework is not an available option to all employees[91] and higher education is positively correlated to an ability to telework.[92] Therefore, mothers who are in lower paying jobs or have less education that are already excluded from paid leave policies[93] possibly would not have the ability to telework. Data also shows racial disparities in ability to telework, where there is close to a sixteen percent difference in the highest and lowest rates of access to telework between Hispanic, Black, and white employees.[94] Despite these drawbacks, data indicates that roughly forty-eight to fifty-one percent of women have the

---

[87] *Ability to Work From Home: Evidence From Two Surveys and Implications for the Labor Market in the COVID-19 Pandemic*, U.S. BUREAU LABOR STAT. (June 2020) https://www.bls.gov/opub/mlr/2020/article/ability-to-work-from-home.htm.
[88] *Id*.
[89] Adam Ozimek, *The Future of Remote Work*, SSRN.COM (May 27, 2020) https://ssrn.com/abstract=3638597.
[90] *Ability to Work From Home*, *supra* note 87.
[91] *Id*.
[92] *Id*.
[93] Hauck et al., *supra* note 6, at 2.
[94] *Ability to Work From Home*, *supra* note 87.

ability to telework.[95] Therefore, even though not all mothers will have access to telework, this option is potentially available to a large proportion of women, making this a solution that could impact many mothers. In addition, telework may become more widely utilized as the pandemic continues and even after, possibly increasing the proportion of women who have an ability to telework.

Integration of telework into legislation requires an examination of applicability and compatibility. Since the FMLA only provides unpaid leave rather than paid leave,[96] telework may not fall into this legislation. On the other hand, since the ACA is federally mandated, only with Medicaid and insurance exclusions,[97] it could make telework a far reaching candidate of lactation support under the broad definitions and language of the Act.[98] An integration of telework into state policies, like seen in California and Washington, likely would prove to be successful given the large increase in breastfeeding rates in California after enacting PFL.[99] However, adjustment of the ACA to include telework may be more effective, due to the advantage of federal laws over state laws in creating more uniform protection, rather than a patchwork commitment to breastfeeding.[100] Where the ACA does not cover, Medicaid, will require expansion in order to provide breastfeeding support, including telework. Telework as an option for maternity leave also requires a change in employer policies, considering that paid leave is typically controlled by employers.[101] Employers that support breastfeeding through policies benefit through reduced maternity leave and absenteeism,

---

[95] *Id*.
[96] Hauck et al., *supra* note 6, at 2.
[97] Hawkins et al., *supra* note 17, at 1078.
[98] Mathur et al., *supra* note 62.
[99] Huang & Yang, *supra* note 7, at 51.
[100] Hawkins et al., *supra* note 17, at 1078.
[101] Bartel et al., *supra* note 24.

higher productivity, and lower healthcare costs.[102] As a change in a positive direction, several companies have allowed some employees work from home indefinitely,[103] which supports the proposition of telework for breastfeeding as a long-term solution as opposed to a temporary circumstance.

## CONCLUSION

Legislation regarding telework as a form of paid leave for new mothers should follow the large shift to remote work as a result of the COVID-19 pandemic. This solution possesses possible benefits of increased breastfeeding rates, as seen in unemployed and part-time employment, coupled with productivity of full-time employees, appealing to economic arguments against paid maternity leave. The COVID-19 pandemic exemplified that it is possible for many Americans to telework, and this should be utilized to increase breastfeeding as a public health tool.

[102] Hauck et al., *supra* note 6, at 2.
[103] Joey Hadden et al., *20 Major Companies that have Announced Employees can work Remotely long-term*, BUS. INSIDER (Oct. 12, 2020,5:05 PM) https://www.businessinsider.com/companiec-asking-employees-to-work-from-home-due-to-coronavirus-2020.

# Proposed Alternatives to Direct-to-Consumer Drug Advertising During a Global Pandemic

*Alida Beck*

## INTRODUCTION

In 2005, the U.S. pharmaceutical industry spent upwards of $18 billion on marketing drugs and almost $30 billion in 2016.[1] It is neither a secret nor a surprise that pharmaceutical companies bring in substantial profits compared to other industries of comparable size.[2] Major earnings and profits aside, pharmaceutical companies are also notorious for spending a lot of money.[3] And while pharmaceutical research and development ("R & D") accounts for a large and dominant portion of pharmaceutical company budget and spending,[4] the U.S. pharmaceutical industry spends a significant amount of money on marketing its products as well.[5] Notably, the United States and New Zealand are the only countries in the world that legally permit direct-to-consumer pharmaceutical advertising.[6] As the COVID-19 pandemic continues, pharmaceutical companies around the globe race to create a vaccine, and the industry's level of spending and ability to directly market to consumers raises ethical questions.[7] Further, competition between pharmaceutical companies to create the first safe and widely distributable

[1] Lisa M. Schwartz & Stephen Woloshin, *Medical Marketing in the United States, 1997-2016*, 321 JAMA 80, 82 (2019).
[2] Fred D. Ledley et al., *Profitability of Large Pharmaceutical Companies Compared with Other Large Public Companies*, 323 JAMA 834, 842 (2020).
[3] Ezekiel J. Emanuel, *Big Pharma's Go-To Defense of Soaring Drug Prices Doesn't Add Up*, ATLANTIC (Mar. 23, 2019), https://www.theatlantic.com/health/archive/2019/03/drug-prices-high-cost-research-and-development/585253/.
[4] Ledley, et al., *supra* note 2.
[5] Emanuel, *supra* note 3.
[6] Schwartz & Woloshin, *supra* note 1, at 87.
[7] Jillian C. Kohler & Tim K. Mackey, *Why the COVID-19 Pandemic Should be a Call for Action to Advance Equitable Access to Medicines*, 18 BMC MED., June 2020, at 1.

vaccine has the potential to leave other necessary and sought-after drugs behind, delaying their development and subsequent patient access.[8]

Patient access, such as equitable and affordable access to drugs, is an ongoing health crisis.[9] Patients, both insured and uninsured, are seeing drug costs continue to rise and accessibility to drugs, either for chronic disease or occurrence of infection, is difficult and drugs can be expensive to come by.[10] In fact, pharmaceutical companies logged more than 800 price increases in 2020.[11] While the pharmaceutical companies continue to profit, individuals, especially those experiencing poverty and of other marginalized groups, are bearing the brunt of COVID-19.[12]

Pharmaceutical companies have continued to be on the frontier of innovation, developing new treatments, drugs, and vaccines.[13] As the numbers of available drugs increase, availability of advertisements of drugs has also increased.[14] Direct-to-consumer marketing of drugs, or Direct-to-Consumer Drug Advertising (DTCA), is an effort by pharmaceutical companies to promote their drugs right to patients.[15] These advertisements include television commercials, internet ads, billboards along the freeway, or pamphlets at a physician's office.[16]

This article will consider the impact of DTCA on access to drugs, which have become astronomically expensive thus creating a barrier for access and

---

[8] *Id.*
[9] *Id.*
[10] Saeed Ahmadiani & Shekoufeh Nikfar, *Challenges of Access to Medicine and the Responsibility of Pharmaceutical Companies: A Legal Perspective*, 24 DARU J. PHARMACEUTICAL SCI. 1, 19 (2016).
[11] Sarah Owermohle, *Drug Prices Steadily Rise Amid Pandemic, Data Shows*, POLITICO (Jul. 7, 2020), https://www.politico.com/news/2020/07/07/drug-prices-coronavirus-351729.
[12] Emily A. Benfer et al., *Health Justice Strategies to Combat COVID-19: Protecting Vulnerable Communities During a Pandemic*, HEALTH AFFS. (Mar. 19, 2020) https://www.healthaffairs.org/do/10.1377/hblog20200319.757883/full.
[13] Els Torreele et al., *UPDATE ON 2004 BACKGROUND PAPER, BP 6.9 NEGLECTED TROPICAL DISEASES*, 38, 32 (2004).
[14] Julie Donohue, *A History of Drug Advertising: The Evolving Roles of Consumers and Consumer Protection*, 84 MILBANK Q. 659, 659 (2006).
[15] *Id.* at 662.
[16] *Id.* at 671.

will propose a short-term change to direct-to-consumer drug advertising. First, the article will discuss the budget of direct-to-consumer drug advertising and how its prevalence impacts accessibility and cost. Second, the article will examine possible alternatives to direct-to-consumer drug advertising, how and when those alternatives could take effect, and the potential outcomes of a moratorium, a temporary prohibition, or change to direct-to-consumer drug advertising. Finally, this paper will present a possible moratorium, the constitutionality of a moratorium, and the pharmaceutical industry's duty during a global pandemic.

## THE COST OF DIRECT-TO-CONSUMER DRUG ADVERTISING FOR PHARMACEUTICAL COMPANIES

### *Pharmaceutical Company Marketing and Marketing Budgets*

Pharmaceutical companies apportion their budget to ensure that they can beneficially research, develop, and market their innovations.[17] Most of the marketing budget is specifically geared towards reaching those with prescribing privilege, such as doctors.[18] Direct-to-consumer marketing, however, also secures a large portion of marketing budgets, and focuses more on drugs that can be obtained over the counter ("OTC") and "common-ailment targeted prescription drugs."[19] Direct-to-consumer advertising can occur on the radio, on television, in magazines, and on the internet.[20] Direct-to-consumer advertising, in comparison with advertising to doctors, removes

[17] *Id.*
[18] Joan Buckley, *Pharmaceutical Marketing – Time for Change*, 9 ELECTRONIC J. BUS. ETHICS & ORG. STUDIES 4, 5 (2004).
[19] *Id.* at 5.
[20] *The Impact of Direct-to-Consumer Advertising*, FDA https://www.fda.gov/drugs/drug-information-consumers/impact-direct-consumer-advertising (last visited Sept. 24, 2020).

the middle-person communicator and places information in the hands of a consumer.[21]

In 2002, a study of pharmaceutical promotional material and advertising showed that over $19 billion are spent by pharmaceutical companies in the United States to promote treatments to doctors only.[22] This type of promotion or advertising can include visits from sale representatives, educational events, and targeted advertising; these account for the bulk of promotional budgets, but direct-to-consumer spending is also considerable.[23] While direct-to-consumer marketing budgets are actually smaller than the budgets used to market drugs to prescribing healthcare professionals, pharmaceutical companies are also investing large amounts of funds towards direct-to-consumer marketing.[24] For example, "in the first six months of 2009 alone, DTC expenditures exceeded $2.3 billion."[25]

*Impact Direct-to-Consumer Marketing on the Patient*

Taking into consideration the high spending on direct-to-consumer marketing, it is important and necessary to consider what impact this might have on the consumer who, in this case, is also the patient.[26] Direct-to-consumer television advertisements, for example, often have narrators listing off a checklist of symptoms, asking the consumer, or patient, to self-identify their symptoms.[27] These advertisements can seemingly empower the consumer, but also pose the risk of commercializing and setting a dangerous precedent for laypeople and non-medical professionals to self-diagnose.[28] A

[21] *Id.*
[22] Buckley, *supra* note 18, at 5.
[23] Mary Ebeling, *'Get with the Program!': Pharmaceutical Marketing, Symptom Checklists and Self-Diagnosis*, 73 SOC. SCI. & MED. 825, 826 (2011).
[24] *Id.*
[25] *Id.* at 826.
[26] *Id.*
[27] *Id.* at 828.
[28] *Id.* at 827.

study of DTCA's impact on patients and physician showed that DTCA could also lead to overprescribing of drugs by physicians to patients.[29] It is clear that while DTCA might seem to empower and inform the patient, it is not without its risks.[30]

Further, the impact is disparate and creates a barrier to access to individuals with lower levels of income[31] Currently, there is little to no incentive for pharmaceutical companies to make drugs more affordable or accessible to those who might struggle to afford or access them.[32] Private companies, like pharmaceutical companies, are non-state actors, and therefore are more difficult to instill in human rights conventions or promote health justice initiatives.[33] Pharmaceutical companies are currently incentivized by profit and possibly tax cuts, not by satisfying the needs of human rights.[34] To change the status quo would be to incentivize pharmaceutical companies to prioritize human rights and health justice by lowering prices, increasing access, and motivating these companies to focus on creating less expensive drugs.[35]

---

[29] Sara J. Becker et al, *Effects of Direct-to-Consume Advertising on Patient Prescription Requests and Physician Prescribing: A Systematic Review of Psychiatry-Relevant Studies*, J. CLINICAL PSYCHIATRY, Oct. 2016, at 8. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5293137/.
[30] *Id.*
[31] Ahmadiani & Nikfar, *supra* note 10, at 1.
[32] *Id*. at 5.
[33] *Id*. at 5-6.
[34] *Id.*
[35] *Id*. at 6.

### *The Direct-to-Consumer (DTCA) Price Tag: Economic and Non-Economic Cost of Direct-to-Consumer Advertising*

Drug prices are not usually featured in advertisements and advertisements can increase demand, driving the price of a drug up.[36] DTCA is often used for driving sales of new, more expensive drugs, thereby driving the price of drugs up.[37] In terms of non-economic costs, DTCA runs the risk of misinformation or providing information to laypeople consumers, those without formal medical training or years of experience in the medical field.[38] DTCA can cause confusion amongst patients and can possibly cause patients to stop taking their medication due to concerns for their safety after seeing warning messages via television advertising.[39] This confusion puts consumers at risk because the pharmaceutical company has more information about the drug than the consumer.[40]

## A PROPOSED CHANGE DIRECT-TO-CONSUMER DRUG ADVERTISING

### *2016 Moratorium Attempt: Responsibility in Drug Advertising Act*

In 2016, a moratorium of direct-to-consumer drug advertising was proposed by Congresswoman Rosa DeLauro.[41] The bill proposed a three-year moratorium on direct-to-consumer advertising, in an effort to better protect consumers and patients from misinformation and attempt to keep the discussion of symptoms, treatment, and the involvement of drugs between

---

[36] Chika Arakawa, Direct-to-Consumer Advertising of Alzheimer's Disease Drugs, (Apr. 2, 2012) (course paper, Harvard University) (on file with Harvard University's DASH repository) https://dash.harvard.edu/bitstream/handle/1/10985167/Arakawa_2012.pdf.
[37] *Id.*
[38] Hyla H. Polen, *Impact of Direct-to-Consumer (DTCA) on Patient Health-Related Behaviors and Issues. 26* HEALTH MARKETING Q. 42, 47 (2009).
[39] *Id.*
[40] *Id.*
[41] Press Release, Rosa DeLauro, *Delauro Introduces the Responsibility in Drug Advertising Act* (Feb. 22, 2016) https://delauro.house.gov/media-center/press-releases/delauro-introduces-responsibility-drug-advertising-act.

patients and healthcare professionals.[42] The Act was raised in an effort to confront the overall $374 billion spent by consumers in 2006 on prescription drugs alone and, ideally, decrease the costs to individuals and providers.[43] The bill argued that the ads did more harm than good, possibly hindering the physician-patient relationship in the United States, while counterparts in the European Union continued to opposed direct-to-consumer advertising.[44] The bill ultimately failed on issues of constitutionality.[45] There are two possible aspects that could have bolstered the argument to pass the bill: timing and framing.[46] Rep. DeLauro could have considered a shorter-term for a moratorium to not impede so strongly and for so long on pharmaceutical company's first amendment rights.[47] Additionally, and likely more importantly, is the framing of the issues that Rep. DeLauro presented, that misinformation by the pharmaceutical companies was the problem.[48] If, instead, the issue had been framed as changing *how* pharmaceutical companies advertised, or possibly a regulation on what can or cannot be advertised; that could have been an entirely different bill.[49] DTCA focuses on emotional advertising, playing to people's fears and feelings, as opposed to educational advertising, which empowers and informs patients.[50]

---

[42] *Id.*
[43] *Id.*
[44] Patricia Guthrie, *Direct-to-Consumer Advertising Debated in the United States and European Union*, 176 CMAJ 1404, 1404 (2007).
[45] *Id.*
[46] Janelle Applequist & Jennifer Gerard Ball, *An Updated Analysis of Direct-to-Consumer Television Advertisements for Prescription Drugs*, 16 ANNALS FAM. MED. 211, 211-16 (2018).
[47] *See* Press Release, Rosa DeLauro, *supra* note 41.
[48] *Id.*
[49] Applequist & Ball, *supra* note 46, at 211.
[50] *Id.*

*Constitutionality and the Central Hudson Test*

Moratoriums, like the aforementioned one proposed to Congress in 2016, have long been cited as unconstitutional, calling into question a pharmaceutical company's First Amendment right.[51] Critics of these moratoriums state that advertising falls under First Amendment rights and claim that any type of moratorium would violate a pharmaceutical company's freedom of speech to advertise their products at will.[52] However, it should be considered that, beyond freedom of speech, a moratorium could actually prevent further public health crises or issues, allowing for there to be a direct connection between healthcare professionals and patients, as opposed to allowing pharmaceutical companies play a role in these communications.[53] The occurrence of a global pandemic sheds new light on the question of constitutionality and provides an opportunity for a Supreme Court-approved test to be applied to a proposed moratorium or otherwise free speech-infringing action.[54]

The "Central Hudson Test," named for a 1980 SCOTUS decision in the case of *Central Hudson Gas & Electric v. Public Service Commission*, is a four-part test for whether governmental regulation of commercial free speech is constitutional.[55] For commercial free speech to be considered protected speech, the speech cannot be misleading and must concern only lawful activity.[56] If the commercial free speech passes this first part and is considered speech, a court will then use the following steps (steps 2-4) to decide if the regulation of the particular commercial free speech is

[51] Mark I. Schwartz, *To Ban or Not to Ban – That is the Question: The Constitutionality of a Moratorium on Consumer Drug Advertising*, 63 Food & Drug L.J. 1, 65 (2008).
[52] *Id.*
[53] Guthrie, *supra* note 44.
[54] *Id.*
[55] *Commercial Speech*, CORNELL LAW SCHOOL LEGAL INFORMATION INSTITUTE, https://www.law.cornell.edu/wex/commercial_speech (last visited Nov. 8, 2020).
[56] *Id.*

constitutional.[57] Second, the government interest in regulating, affecting, or changing such speech must be substantial.[58] Third, the government regulation must directly advance the governmental interest asserted.[59] Fourth and finally, the government regulation must not overreach or be more extensive than is necessary to serve the governmental interested expressed in the preceding step.[60]

During the ongoing COVID-19 pandemic, courts across the United States have placed moratoriums on a number of typical services or actions, such as debt collection, eviction, gatherings of groups, etc.[61] However, given a global pandemic and the public health and safety of Illinois residents in connection with the threat of spread of COVID-19 in gatherings, a "reasonable restriction of constitutional rights during a public health crisis in action" was enforced by the United States District Court.[62] For example, earlier this year in Illinois, the Governor issued an executive order prohibiting gatherings greater than fifty people.[63] Beginning in March, all gatherings of over fifty people were temporarily halted in an attempt to slow the spread.[64] In a more usual circumstance, this temporary ban would be seen as a blatant violation of freedom of speech and freedom to assemble.[65]

The executive order issued by Governor Pritzker in June 2020 passes the aforementioned Hudson constitutionality test for governmental regulation of gathering, or free speech.[66] The speech concerned gatherings of a certain

---

[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] *Id.*
[61] Illinois Republican Party v. Pritzker, 2020 WL 3604106 (N.D. Ill. July 2, 2020), *aff'd*, 973 F.3d 760 (7th Cir. 2020).
[62] *Id.*
[63] *Id.*
[64] *Id.*
[65] *Id.*
[66] *Id.*

number of people, which is lawful activity under the First Amendment, as is free speech.[67] The interest in regulating the gatherings was substantial, in that the Governor was concerned about the spread of a disease.[68] The regulation directly advanced the government interest asserted, as the Governor was attempting to limit groups of fifty or more.[69] Finally, the executive order was not more extensive than is necessary to serve the government interest; the order related to all gatherings equally and was, again, done in an attempt to slow the spread of COVID-19 during a global pandemic.[70] For the foregoing reasons, the executive orders, would be governmental regulation of speech (gatherings) deemed constitutional.[71] This executive order is similar to the presently discussed moratorium as both would typically be considered infringements of free speech, except that both actions are being done to improve public health and promote health justice during a global pandemic.

*A Moratorium During a Global Pandemic*

There should be an immediate and short-term moratorium on direct-to-consumer drug advertising while the world faces a global pandemic and attempts to create a safe and effective vaccine.[72] It is possible to enact this moratorium by writing a bill that could become law, an executive order from the federal or state government, or by agreed-upon internal industry regulation.[73] States must incentivize the pharmaceutical companies if states truly want to make changes that promote public health, health justice, and accessibility.[74] As our system operates now, there is too much room for

[67] *Id.*
[68] *Id.*
[69] *Id.*
[70] *Id.*
[71] *Id.*
[72] *Id.*
[73] *See* Press Release, Rosa DeLauro, *supra* note 41.
[74] Ahmadiani & Nikfar, *supra* note 10, at 6.

misinformation and errors in self-diagnosis due to the prevalence of direct-to-consumer advertising.[75] Further, the amount of money spent on marketing drugs to consumers could be better spent on public health initiatives or addressing the global pandemic.[76]

The pandemic plays a unique role in its effect of the application of the four-part Hudson test regarding commercial free speech and whether the government can regulate it.[77] Pharmaceutical advertising is commercial free speech as protected by the First Amendment; it concerns lawful activity and is likely not misleading.[78] It would not be misleading because the purpose of the moratorium would not be to deceive the public or spread information, but to instead either inform them of anti-COVID-19 measures or to otherwise promote public health initiatives. This would satisfy the first part of the four-part test.

Second, the government has asserted that the interest in regulating the speech must be substantial; in this case, it is self-evident that a global pandemic is substantial.[79] Third, utilizing the reach of pharmaceutical marketing and advertising would reach consumers, and directly advance the governmental interest asserted: to inform the public of the COVID-19 pandemic, public health alerts, and, eventually, treatments and vaccinations available to protected against COVID-19.[80] The governmental regulation could advance both public health and governmental interests amid a global pandemic. With the goal of providing truthful, accessible and educational

---

[75] Sara J. Becker et al, *Effects of Direct-to-Consume Advertising on Patient Prescription Requests and Physician Prescribing: A Systematic Review of Psychiatry-Relevant Studies*, J CLIN PSYCHIATRY, Oct. 2016, at 1.
[76] *Id.*
[77] *Commercial Speech*, *supra* note 55.
[78] *See* David Valdeck, *The Difficult Case of Direct-to-Consumer Drug Advertising*, 41 Loyola Los Angeles L. R. (forthcoming 2008) https://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1002&context=ois_papers.
[79] *Commercial Speech*, *supra* note 55.
[80] *Id.*

information regarding COVID-19, the government could use the same avenues typically used by pharmaceutical companies to access people.

Fourth and finally, a regulation that would impose a moratorium on advertising in the name of spending the advertising dollars either to inform the public of COVID-19 or spending the advertising dollars on finding a cure for COVID-19, would not be more extensive than is necessary to serve the interest expressed in the previous step.[81] The government must not overstep, but instead must attempt to serve health justice during a global pandemic and a world fraught with misinformation.[82] Meeting all four of the Hudson Test criterion, a moratorium on DTCA in the name of either using the marketing channels to inform the public of the COVID-19 pandemic and how to stay safe; or, using the marketing budget financing to develop a COVID-19 vaccine, would allow for constitutional governmental regulation of commercial free speech.[83]

*Commercial Duty During a Global Pandemic*

The pharmaceutical industry has a duty to provide affordable access to treatments as well as a duty to provide adequate and accurate information to the public.[84] COVID-19 has impacted the pharmaceutical industry, shifting rules and regulations as countries race to try and find a safe and effective vaccine for the virus.[85] Recently, short term rules and regulations have shifted to create a vaccine and pharmaceutical budgets have shifted to attempt to meet the demand for a vaccine for COVID-19.[86] However, in the long-

[81] *Id.*
[82] Jeffrey Kluger, *The Misinformation Age Has Exacerbated – and Been Exacerbated – by the Coronavirus*, TIME (July 23, 2020), https://time.com/5870464/coronavirus-pandemic-misinformation/.
[83] *See Commercial Speech*, *supra* note 55.
[84] *Id.*
[85] Ayati et al., *Short and Long Term Impacts of COVID-19 on the Pharmaceutical Sector*, DARU J. PHARMACEUTICAL SCI. 7, 4 (2020).
[86] *Id.*

term, there could potentially be ethical dilemmas, pattern changes within consumption, a slow-down in the pharmaceutical industry, a shifting pharmaceutical industry towards self-sufficiency, and approval delays for new drugs and new medical devices.[87] This requires an affirmation of industry accountability and a realization of the duty a pharmaceutical company has.[88]

The pharmaceutical industry should be held to its two assigned duties; one to its shareholders, and the other to the public to which it markets.[89] Generally, pharmaceutical companies, and the industry that these companies operate within, had a duty to supply communities with affordable and accessible drugs, but there is also a duty to provide reliable and legally sound information to these communities.[90] This accountability is upheld by legal duties to agencies, like regulatory bodies such as the Food and Drug Administration (FDA), but is also a "human rights principle."[91] In 2011, the Supreme Court held that, required by federal law, there is an imposed duty on pharmaceutical manufacturers to provide accurate and legally information to consumers.[92] Government regulations should encourage, at least in the short term, pharmaceutical companies to exercise their duty and responsibility to patients and to follow human rights principles in order to promote health justice during a global pandemic.[93]

---

[87] *Id.* at 4.
[88] Graham M N Dukes, *Accountability of the Pharmaceutical Industry*, 360 LANCET, 1682, 1682 (2002).
[89] *Id.*
[90] *Id.*
[91] *Id.*
[92] Pliva. Inc. v. Mensing, 131 S.Ct. 2567, 2570 (2011).
[93] *Id.*

## CONCLUSION

This article has reviewed the prevalence of pharmaceutical spending on direct-to-consumer advertising and the impact this has on marketing budgets and patients. Taking into consideration a global pandemic, this article proposes a short-term moratorium on direct-to-consumer advertising in an effort to promote public health efforts, focus funds and efforts on creating a safe and effective vaccine, an attempt to de-commercialize diagnosis and treatment for patients, in the name of the legal duty assumed by pharmaceutical company's role to uphold health justice during a public health crisis. This moratorium will allow for pharmaceutical companies to assume their assigned legal and human rights principled duty and responsibility to improve healthcare and provide innovation in a time of need, utilizing their vehicles of communication with communities, while also de-monetizing and reevaluating the ethics of marketing drugs directly to patients. While only a short-term solution, this governmental regulation of commercial free speech is likely to promote health justice during the COVID-19 global pandemic.

# State Medicaid Reimbursement for Remote Patient Monitoring and Interactive Communication Will Help Reduce Health Care Gap Among Black and White People with Preexisting Conditions that Put Them at Increased Risk of Severe Illness from COVID-19

*Victoria Bethel*

## INTRODUCTION

In the United States, black people with preexisting conditions are disproportionately facing the COVID-19 death sentence.[1] According to the Centers for Disease Control and Prevention, as of August 2020, black people have a 2.6 times higher contraction rate, 4.7 times higher hospitalization rate, and 2.1 times higher death rate from COVID-19 than white people.[2] The enduring racial disparities in health care contribute to COVID-19's disproportionate impact.[3]

Black people have a higher prevalence of the underlying medical conditions that increase a person's risk of severe illness from COVID-19, which include hypertension and diabetes.[4] From 2017 to 2018, the

[1] Don Tai et al., *The Disproportionate Impact of COVID-19 on Racial and Ethnic Minorities in the United States,* 2020 CLINICAL INFECTIOUS DISEASES 1, 1.
[2] *Hospitalization and Death by Race/Ethnicity*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html (last updated Aug. 18, 2020).
[3] Tai et al., *supra* note 1, at 1.
[4] *Id.*; *High Blood Pressure (Hypertension)*, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/symptoms-causes/syc-20373410 (last updated May 12, 2018) (discussing hypertension, which is another name for high blood pressure. "High blood pressure is a common condition in which the long-term force of the blood against your artery walls is high enough that it may eventually cause health problems, such as heart disease."); *Diabetes*, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/diabetes/symptoms-causes/syc-20371444 (last updated Oct. 30, 2020) (discussing diabetes, which refers to high blood glucose (sugar). "Glucose is vital to your health because it's an important source of energy for the cells that make up your muscles and tissues. It's also your brain's main source of fuel." However, "too much sugar in your blood can lead to serious health problems.").

prevalence of hypertension was higher among black adults (57.1%) than white adults (43.6%).[5] Black adults also develop hypertension at younger ages.[6] From 2013 to 2016, the prevalence of diagnosed diabetes was higher among black adults (13.9%) than white adults (8.5%).[7]

Social determinants of health ("SDOH"), which are the conditions in which people live, learn, work, and play that affect their health risks and outcomes, influence these disparities.[8] One domain of SDOH is economic stability.[9] Before the COVID-19 pandemic, the poverty rate was higher among black people (twenty-two percent) than white people (nine percent) and the annual income of white households was ten times that of black households.[10] Consequently, black people "have less financial capacity to make healthful decisions in the midst of the financial hardships that have accompanied the COVID-19 pandemic."[11] Another domain of SDOH is health care access and quality.[12] Black people have lower access to quality health care than white people as they "tend to live in areas where medical care is of poor quality or is underserved."[13] Thus, black people may receive poorer quality of care during the pandemic.[14]

The COVID-19 pandemic incited the unprecedented rise in the use of telehealth among healthcare providers and it will purportedly continue to rise

---

[5] YECHIAM OSTCHEGA ET AL., HYPERTENSION PREVALENCE AMONG ADULTS AGED 18 AND OVER: UNITED STATES, 2017-2018 2 (2020).
[6] Daniel T. Lackland, *Racial Differences in Hypertension: Implications for High Blood Pressure Management*, 348 AM. J. MED. SCI. 135, 135 (2014).
[7] NICHOLAS D. MENDOLA ET AL., PREVALENCE OF TOTAL, DIAGNOSED, AND UNDIAGNOSED DIABETES AMONG ADULTS: UNITED STATES, 2013-2016 3 (2018).
[8] Tai et al., *supra* note 1, at 1-2.
[9] *Social Determinants of Health*, OFF. DISEASE PREVENTION & HEALTH PROMOTION, https://health.gov/healthypeople/objectives-and-data/social-determinants-health (last visited Dec. 2, 2020).
[10] Tai et al., *supra* note 1, at 1-2.
[11] *Id.*
[12] OFF. DISEASE PREVENTION & HEALTH PROMOTION, *supra* note 9.
[13] Tai et al., *supra* note 1, at 1-2.
[14] *Id.*

post-pandemic.[15] Telehealth is the use of "two-way, real time interactive communication" between a health care practitioner and patient as a means for the practitioner to provide care while he or she and the patient are in separate locations.[16] In early March 2020, President Trump signed into law the Coronavirus Preparedness and Response Supplemental Appropriations Act, which includes provisions that temporarily broaden telehealth access for Medicare beneficiaries.[17] The Centers for Medicare & Medicaid Services ("CMS") is promoting remote patient monitoring ("RPM").[18] CMS has issued guidance and extended coverage to five new specific Current Procedure Terminology ("CPT") codes, which are codes physicians and health care professionals use to bill health insurance companies for their health care services.[19] As of September 2020, only twenty-three state Medicaid programs reimburse for RPM and their laws on coverage and reimbursement differ.[20]

RPM is a telehealth modality in which "digitally connected, non-invasive devices" are used to collect patients' physiological data (e.g. blood pressure) remotely.[21] Many RPM technologies are designed to integrate data from

---

[15] Emily Sokol, *Telehealth Will Continue to Grow After Coronavirus Pandemic*, MHEALTH INTELLIGENCE (June 12, 2020), https://mhealthintelligence.com/news/telehealth-will-continue-to-grow-after-coronavirus-pandemic.
[16] *Telemedicine*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html (last visited Dec. 3, 2020).
[17] CTRS. MEDICARE & MEDICAID SERVS, COVID-19 EMERGENCY DECLARATION BLANKET WAIVERS FOR HEALTH CARE PROVIDERS 22 (2020).
[18] Gloryanne Bryant, *CMS Guidance for Remote Patient Monitoring (RPM)*, ICD 10 MONITOR (July 21, 2020), https://www.icd10monitor.com/cms-guidance-for-remote-patient-monitoring-rpm.
[19] *Id.*; *CPT Overview and Code Approval*, AMA, https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval (last visited Dec. 2, 2020).
[20] CTR. FOR CONNECTED HEALTH POL'Y, STATE TELEHEALTH LAWS & REIMBURSEMENT POLICIES 13-14 (2020) (listing the state Medicaid programs that reimburse for RPM: Alabama, Alaska, Arizona, Arkansas, Colorado, Illinois, Indiana, Kansas, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Nebraska, New York, Oregon, South Carolina, Texas, Utah, Vermont, Virginia and Washington).
[21] Bryant, *supra* note 18.

RPM into electronic health records, giving providers fast and easy access to patient data, thereby allowing for better diagnosis and treatment.[22] According to one systematic review, one study pertained exclusively to RPM of hypertension and it had a positive health outcome.[23] In this systematic review, positive health outcomes from the implementation of RPM included improved self-management (e.g., taking blood pressure) and improved quality of life (e.g., initiating self-care behaviors).[24] Three studies within this systematic review pertained exclusively to RPM of diabetes—two had positive health outcomes and one had a neutral health outcome.[25] Four studies within this systematic review involved RPM of diabetes and hypertension and all had positive health outcomes.[26] Another systematic review found that RPM of diabetic patients, compared with usual care, produced a small but significant improvement in average blood glucose levels.[27] Essentially, multiple clinical studies have found that RPM is an effective "early symptom management tool."[28]

To alleviate COVID-19's disproportionate impact on black people with preexisting conditions, states should have some of their hospitals conduct community health assessments to determine whether a key need is helping black people control their chronic conditions and if so, state Medicaid

---

[22] AM. HEART ASSOC., USING REMOTE PATIENT MONITORING TECHNOLOGIES FOR BETTER CARDIOVASCULAR DISEASE OUTCOMES GUIDANCE 4 (2019).
[23] Ashok Vegesna et al., *Remote Patient Monitoring via Non-Invasive Digital Technologies: A Systematic Review*, 23 TELEMEDICINE & E-HEALTH 3, 7 (2017) (discussing the outcomes of various RPM studies; "Due to the descriptive nature of many of the included studies, health outcomes were categorized as positive, negative, or neutral (rather than individual measures of efficacy or effectiveness) to allow for an assessment of the overall trends in improving outcomes across all technologies.").
[24] *Id*. at 12.
[25] *Id.*at 7.
[26] *Id.*
[27] Puikwan A. Lee et al., *The Impact of Telehealth Remote Patient Monitoring on Glycemic Control in Type 2 Diabetes: A Systematic Review and Meta-Analysis of Systematic Reviews of Randomized Controlled Trials*, 18 BMC HEALTH SERVS. RSCH. 1, 7 (2018).
[28] Samantha McGrail, *88% of Providers Investing in Remote Patient Monitoring Tech*, MHEALTH INTELLIGENCE (Nov. 4, 2019), https://mhealthintelligence.com/news/88-of-providers-investing-in-remote-patient-monitoring-tech.

programs should reimburse providers for RPM. First, this article will discuss the use of a community health assessment process to determine which state Medicaid programs should cover RPM. Second, this article will discuss why hypertension and diabetes should be conditions eligible for RPM reimbursement and why interactive communication between the provider and patient should be required and reimbursed. Third, this article will discuss the benefits of RPM, especially for black patients.

## HOSPITALS SHOULD CONDUCT COMMUNITY HEALTH ASSESSMENTS TO IDENTIFY COMMUNITIES WITH BLACKS IN NEED OF HELP CONTROLLING CHRONIC CONDITIONS AND IF DATA REVEALS A KEY NEED, STATE MEDICAID SHOULD REIMBURSE FOR RPM

States should develop a funding program that provides funding, upon application, to hospitals that have served a large number of black patients with comorbidities who were hospitalized for, or died from, COVID-19, to conduct community health assessments ("CHAs"). CHAs identify "key health needs and issues through systematic, comprehensive data collection and analysis."[29] People with uncontrolled, chronic conditions such as hypertension and diabetes are at higher risk of developing severe illness from COVID-19 than those whose chronic conditions are well-managed.[30] CHAs may help identify whether uncontrolled hypertension and diabetes are contributing to the disproportionate prevalence of severe illness from COVID-19 among black patients.

---

[29] *What is a Community Health Assessment?*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/publichealthgateway/cha/plan.html (last updated July 24, 2018).
[30] William F. Marshall, *COVID-19 and High Blood Pressure: Am I at Risk?*, MAYO CLINIC (June 30, 2020), https://www.mayoclinic.org/diseases-conditions/coronavirus/expert-answers/coronavirus-high-blood-pressure/faq-20487663; *How COVID-19 Impacts People with Diabetes*, AM. DIABETES ASSOC., https://www.diabetes.org/coronavirus-covid-19/how-coronavirus-impacts-people-with-diabetes (last visited Dec. 2, 2020).

When conducting CHAs, hospitals typically collect and analyze both primary data they gathered themselves and secondary data from other sources.[31] Primary data can be collected via surveys and interviews.[32] The questions should accurately and directly address what is being measured.[33] In order to assess how well managed the patients' condition is, hospitals should ask questions regarding patients' self-management, such as physiologic data monitoring (e.g. blood pressure and glucose levels) and medication adherence. For secondary data, the electronic health record data offers a "unique window into the health needs of community members who have received care."[34] In gathering data from the patient's record, such as ventilator use and intensive care unit admission, the hospitals will be able to assess the severity of COVID-19's impact on the patient.

If various hospitals in a state determine that control of chronic conditions among black patients is a significant community health need, then that state's Medicaid program should provide reimbursement for RPM.[35] When deciding on strategies, to make an impact at the population level, hospitals can implement strategies that get at the root of the health need.[36] Clinical interventions that promote accountability and incentivize meaningful outcomes (e.g., blood pressure and blood glucose control) are essential to

---

[31] *Community Health Assessment Toolkit Step 4: Collect and Analyze Data*, AHA CMTY. HEALTH IMPROVEMENT, https://www.healthycommunities.org/resources/toolkit/files/step4-collect-analyze (last visited Nov. 14, 2020).
[32] *Data & Benchmarks*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/publichealthgateway/cha/data.html (last updated Aug. 30, 2017).
[33] AHA CMTY HEALTH IMPROVEMENT, *supra* note 31.
[34] *Id.*
[35] *Community Health Assessment Toolkit Step 7: Plan Implementation Strategies*, AHA CMTY. HEALTH IMPROVEMENT, https://www.healthycommunities.org/resources/toolkit/files/step7-plan-implementation (last visited Nov. 14, 2020) (describing key components of plan implementation strategies; One component is Level of intervention: Think critically about the level at which you are intervening and how your efforts can make the most impact. Will your strategy be clinically based, or will it take place in the community? Will you address the specific needs of individuals or the community as a whole?).
[36] *Id.*

improving uncontrolled chronic conditions.[37] RPM "can empower patients to better manage their health and participate in their health care," and thus would be a valuable intervention to implement in communities where black people are in need of help managing their chronic conditions.[38]

## REIMBURSEMENT SHOULD COVER RPM OF HYPERTENSION AND DIABETES AND REIMBURSE FOR INTERACTIVE COMMUNICATION WITH PATIENTS

State Medicaid should include hypertension and diabetes as reimbursable conditions for RPM. Focusing on the conditions that have a "high cost in terms of illness and death" helps to reduce racial healthcare disparities.[39] Poor control of hypertension increases the risk of heart disease, stroke, and kidney disease.[40] Black people have poorer control of their hypertension and consequently are two times more likely to die from strokes and five times more likely to develop kidney disease than white people.[41] Poor control of diabetes increases the risk of kidney disease, blindness, and lower limb amputations.[42] Black people have poorer control of their diabetes and consequently are more likely to develop these complications than white people.[43] Black people are also 2.3 times more likely to die from diabetes

---

[37] Thomas R. Frieden, *A Framework for Public Health Action: The Health Impact Pyramid*, 100 AM. J. PUB. HEALTH 590, 592 (2010).
[38] AM. HEART ASSOC., *supra* note 22, at 1.
[39] Martha Hostetter & Sarah Klein, *In Focus: Reducing Racial Disparities in Health Care by Confronting Racism*, COMMONWEALTH FUND (Sep. 27, 2018), https://www.commonwealthfund.org/publications/newsletter-article/2018/sep/focus-reducing-racial-disparities-health-care-confronting.
[40] Lackland, *supra* note 6.
[41] *Id.*
[42] MENDOLA ET AL., *supra* note 7, at 1; Elias Spanakis & Sherita Golden, *Race/Ethnic Differences in Diabetes and Diabetic Complications*, 13 CURRENT DIABETES REPS. 814, 817 (2013).
[43] *Id.*

than white people.[44] Thus, keeping blood pressure and blood sugar under control is extremely important.

State Medicaid programs should also require and reimburse for interactive communication between the patient and provider to provide feedback.[45] According to Dr. Winston Wong of the UCLA Kaiser Permanente Center for Health Equity, improving control of chronic conditions among minority patients "requires a continuous care relationship that builds around trust."[46] The methods of interactive communication should include videoconferences due to some of the telemedicine-related concerns black study participants have expressed.[47] For instance, some black people have concerns that if the physician is physically absent, they will be unable to look the physician in the eye and determine if he or she is telling them the truth.[48]

Interactive communication gives providers an opportunity to assess what patient-related perceptions cause their black patients' medication nonadherence. Culturally based perceptions of medication and illness significantly influence medication nonadherence among black people with chronic conditions.[49] According to a systematic review of black peoples' beliefs about hypertension and its treatment, some black people fear and or

---

[44] Spanakis & Golden, *supra* note 42, at 816.
[45] Bryant, *supra* note 18 (discussing CPT Code 99457: Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified healthcare professional time in a calendar month, requiring interactive communication with the patient/caregiver during the month; first 20 minutes; and CPT Code 99457: Each additional 20 minutes).
[46] Hostetter & Klein, *supra* note 39.
[47] Sheba M. George et al., *Pre-Experience Perceptions About Telemedicine Among African-Americans and Latinos in South Central Los Angeles*, 15 TELEMEDICINE J. & E-HEALTH 525, 528 (2009) (summarizing African-Americans' telemedicine-related concerns as three primary issues: (1) the physical absence of the physician specialist; (2) the ability to monitor the specialist's qualifications with telemedicine; and (3) the use of technology and resulting privacy/confidentiality issues).
[48] *Id.*
[49] Olayinka O. Shiyanbola, et al., *"I Did Not Want to Take That Medicine": African-Americans' Reasons for Diabetes Medication Nonadherence and Perceived Solutions for Enhancing Adherence*, 12 PATIENT PREFERENCE & ADHERENCE 409, 410 (2018).

distrust using medication.[50] Many black people only take medications when they believe they are experiencing symptoms of hypertension.[51] Although a hypertensive crisis may precipitate symptoms, hypertension generally has no symptoms.[52] Some black people use home remedies, commonly garlic, herbs, vitamins, Epsom salts, and prayer.[53] In a study about black peoples' reasons for nonadherence to diabetes medications, they expressed concerns about the medication's side effects, doubts of its safety and effectiveness, fear of taking medicines, and frustration over taking medications for a long time.[54] Some diabetic black people in urban areas do not realize how vital medications are for controlling their health.[55] Hypertensive and diabetic black people also report intentionally not taking their medications because they do not believe they have the diagnosis.[56] Essentially, black patients have varying perceptions of medication and illness which influence their medication nonadherence, of which providers should be cognizant.

Interactive communication can also give providers an opportunity to educate their black patients, which is vital because an educated and informed black patient will be better able to effectively use health care services.[57] When educating black patients, providers must take into consideration that forty percent of black people have poor reading skills, and consequently lack health literacy, the ability to understand basic health information.[58] People who lack health literacy also struggle to communicate with their providers

---

[50] Leo Buckley et al., *A Systematic Review of Beliefs About Hypertension and its Treatment Among African Americans*, 18 CURRENT HYPERTENSION REP. 1, 7 (2016).
[51] *Id.*
[52] *Id.* at 3.
[53] *Id.* at 3-4.
[54] Shiyanbola et al., *supra* note 49, at 412.
[55] *Id.* at 410.
[56] *Id.* at 410-413.
[57] Allan S. Noonan et al., *Improving the Health of African Americans in the USA: An Overdue Opportunity for Social Justice*, 37 PUB. HEALTH REVS. 1, 12 (2016).
[58] *Id.*

and read medication instructions.[59] Furthermore, in a study among black diabetics, a perceived solution for enhancing medication adherence was for health care providers to educate black patients about diabetes, specifically the importance of taking the medications and the consequences of not taking the medications.[60]

State Medicaid should also require provider training focused on increasing "cultural awareness, knowledge and skills," a common strategy used to improve the patient-provider interaction.[61] When interactively communicating with black patients, providers need to have cultural competence, "a foundational pillar for reducing disparities through culturally sensitive and unbiased quality care."[62] When trying to encourage black patients to be adherent with treatment, "strategies that are culturally appropriate and community competent and that consider the nuances of population, community, family, and individual differences have a vital role in reducing health disparities, promoting health equity, and improving population health."[63] In a study among black diabetics, a perceived solution for enhancing medication adherence was for providers to be educated about black people and the societal issues they face.[64] Three studies examining medication adherence among black hypertensive patients found that they were more likely to adhere when they felt that their provider was communicating with them in an empathetic manner.[65]

---

[59] *Id.*
[60] Shiyanbola et al., *supra* note 49, at 414.
[61] *Cultural Competence in Health Care: Is It Important for People with Chronic Conditions*, GEORGETOWN UNIV. HEALTH POL'Y INST., https://hpi.georgetown.edu/cultural/ (last visited Nov. 14, 2020).
[62] AGENCY FOR HEALTHCARE RSCH. & QUALITY, IMPROVING CULTURAL COMPETENCE TO REDUCE HEALTH DISPARITIES FOR PRIORITY POPULATIONS 1 (2014).
[63] Monica Hooper et al., *COVID-19 and Racial/Ethnic Disparities*, 323 JAMA 2466, 2467 (2020).
[64] Shiyanbola et al., *supra* note 49, at 414.
[65] Lisa M. Lewis et al., *Enhancing Adherence of Antihypertensive Regimens in Hypertensive African-Americans: Current and Future Prospects*, 10 EXPERT REV. CARDIOVASCULAR THERAPY 1375, 1377 (2012).

### RPM WILL BE BENEFICIAL TO BLACK PATIENTS BECAUSE IT WILL INCREASE PROVIDERS' VISIBILITY IN BLACK PATIENTS' HEALTH OVER TIME, ENABLE TIMELY INTERVENTION, AND FOSTER SELF-MANAGEMENT

RPM will be helpful for the black community as it can give providers insight into patients' treatment adherence and health over time and an opportunity to intervene before a "costly care episode," such as a COVID-related hospitalization.[66] Medication adherence, the degree to which a patient follows the medication regimen as prescribed, is a barrier that black people face in achieving optimal health care.[67] Hypertensive black people are approximately two to four times less likely to adhere to their medications than white people.[68] While diabetic black people are twenty-five percent less likely to adhere, even with equal access to medications.[69] Additionally, poor compliance with self-monitoring blood glucose is also an issue as studies have shown that black people with insulin-treated diabetes conducted their own daily blood glucose checks less frequently than white people.[70]

Furthermore, RPM may help empower black patients to better manage their hypertension and diabetes and participate in their health care, as self-management and shared decision making are also benefits of RPM.[71] Black patients report less participation in medical decision-making than white patients, which results in lower levels of patient satisfaction with care.[72]

---

[66] AM. HEART ASSOC., *supra* note 22, at 1.
[67] Daniel Hu et al., *Interventions to Increase Medication Adherence in African-American and Latino Populations: A Literature Review*, 73 HAW. J. MED. & PUB. HEALTH 11, 11 (2014).
[68] Antoinette M. Schoenthaler et al., *Predictors of Changes in Medication Adherence in Blacks with Hypertension: Moving Beyond Cross-Sectional Data*, 50 ANNALS BEHAVIORAL MED. 642, 642 (2017).
[69] Shiyanbola et al., *supra* note 49, at 410.
[70] Deborah A. Levine et al., *Disparities in Self-Monitoring of Blood Glucose Among Low-Income Ethnic Minority Populations with Diabetes, United States*, 19 ETHNICITY & DISEASE 97, 101 (2009).
[71] AM. HEART ASSOC., *supra* note 22, at 1.
[72] GEORGETOWN UNIV. HEALTH POL'Y INST., *supra* note 61.

There has been a shift in viewing RPM as mere "data collectors" to now viewing it as a "self-engaging and motivating system" as it facilitates meaningful patient-provider interactions.[73] Having the RPM data also makes some patients feel better equipped to engage with their healthcare services and like more of an equal partner in their care.[74] According to a systematic review of patients' experiences with using RPM for various chronic diseases, the results of seven studies revealed that RPM promoted confidence to self-manage.[75]

## CONCLUSION

Black people are disproportionately burdened with preexisting medical conditions, such as hypertension and diabetes, that put people at increased risk of severe illness from COVID-19.[76] People with poor control of these conditions face a higher susceptibility of severe illness than those whose conditions are well-managed.[77] Thus, states should help hospitals who have served large numbers of black patients with comorbidities and been hospitalized for or died from COVID-19 conduct CHAs. The CHAs can help determine whether poor condition management is a significant issue among black patients with hypertension and diabetes and if so, then the state's Medicaid program should reimburse for RPM of these conditions. Providers should be required to interactively communicate with the patient, as means to build their black patients' trust and educate them. Various studies have proven that RPM improves patients' health outcomes.[78] Thus, RPM would

---

[73] Mirza Baig et al., *A Systematic Review of Wearable Patient Monitoring Systems - Current Challenges and Opportunities for Clinical Adoption*, 41 J. MED. SYS. 1, 6 (2017).
[74] Rachael C. Walker et al., *Patient Expectations and Experiences of Remote Monitoring for Chronic Diseases: Systematic Review and Thematic Synthesis of Qualitative Studies*, 124 INT'L J. MED. INFORMATICS 78, 81 (2019).
[75] *Id.*
[76] Tai et al., *supra* note 1, at 1.
[77] Marshall, *supra* note 30; AM. DIABETES ASSOC., *supra* note 30.
[78] Vegesna et al., *supra* note 23; Lee et al., *supra* note 27.

be a useful intervention to implement in communities where black patients with uncontrolled comorbidities are being disproportionately impacted by COVID-19.

# Homelessness and Health Justice

*Edwin Caro*

## HOMELESSNESS: FORMATION OF A CRISIS

In response to the rapidly emerging public crisis of homelessness in the United States, Congress established a definition for homeless people in the 1980s to address the growing concerns of homelessness around the country.[1] The United States Code defines a homeless individual as one "who lacks a fixed, regular, and adequate nighttime residence," including individuals who sleep in public or private places not designed as a regular sleeping accommodation such as cars, abandoned buildings, and public spaces.[2] Rather than opting for creating supportive measures to aid the homeless, many jurisdictions across the U.S. have enacted legislation that criminalizes the actions homeless people undertake to survive.[3] These include laws and municipal ordinances which ban sitting, lying down, sleeping, or living in a vehicle.[4] In some jurisdictions, even feeding homeless people in public spaces has been outlawed.[5] These laws and ordinances present numerous problems for homeless individuals as well as the healthcare systems they rely on for their care in emergency situations, considering that nearly thirty three percent of all emergency department visits are made by homeless individuals.[6]

---

[1] 42 U.S.C. § 11302(a).
[2] *Id.*
[3] NAT'L L. CTR. ON HOMELESSNESS & POVERTY, HOUSING NOT HANDCUFFS 2019: ENDING THE CRIMINALIZATION OF HOMELESSNESS IN U.S. CITIES 37 (2019).
[4] Scott Clifford & Spencer Piston, *Explaining Public Support for Counterproductive Homelessness Policy: The Role of Disgust*, 39 POL. BEHAV. 503, 504 (2017).
[5] *Id.*
[6] Daniel G. Garrett, *The Business Case for Ending Homelessness: Having a Home Improves Health, Reduces Healthcare Utilization and Costs*, 5 AM. HEALTH & DRUG BENEFITS 17, 17 (2012).

In addition to the implementation of those laws, jurisdictions also impose severe punishments on the homeless by incarcerating them for failure to comply, or demanding payment of excessive fines that the individual cannot pay back.[7] For example, consider a Minnesota woman who had been incarcerated for sleeping in their vehicle, had her vehicle impounded while in jail, and cannot afford to pay the impound fees once released.[8] She has lost her only option for a covered shelter and now must brave the harsh winter elements subjecting her to preventable illnesses that a covered shelter would provide protection against.[9] These laws and policies which force the removal of the homeless population from visible areas within cities has come to be known as the "criminalization of homelessness."[10]

To make matters more difficult, the concurrent decline in housing and social service programs in the 1980s meant fewer homes would be available to those who were either ill and newly homeless or could only afford low-cost dwellings creating new barriers for homeless people to overcome.[11] With a lack of housing, many newly homeless individuals struggled with self-care, maintaining necessary medical treatment, and basic first aid.[12] These barriers erected in the wake of the shortage for affordable housing prompted the creation of the Housing First (HF) model as a solution to end homelessness while simultaneously addressing the health needs of impacted homeless individuals.[13] HF is a treatment model that reintegrates homeless individuals back into their communities at their own pace, providing shelter, health care, and community integration while giving their participants choice

---

[7] NAT'L L. CTR. ON HOMELESSNESS & POVERTY, *supra* note 3, at 37.
[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] Cheryl Zlotnick et al., *Health Care for the Homeless: What We Have Learned in the Past 30 Years and What's Next*, 103 AM. J. PUB. HEALTH S199, S199 (2013).
[12] COMM. ON HEALTH CARE FOR HOMELESS PEOPLE, HOMELESSNESS, HEALTH, AND HUMAN NEEDS 42 (National Academies Press (US), 1988).
[13] INGRID GOULD ELLEN & BRENDAN O'FLAHERTY, HOW TO HOUSE THE HOMELESS 43 (Russell Sage Foundation, 2010).

as to which decisions are to be made in terms of their housing and treatment.[14] Research on the HF model strongly suggests that the initiative is a convincing success with high housing retention rates and a decrease in overall costs when compared to other treatment programs.[15]

Another solution proposed to address the barriers homelessness imposes comes from the states of Rhode Island, Connecticut, and Illinois which have enacted legislation commonly referred to as a "Homeless Bill of Rights."[16] These laws prohibit discrimination based on housing status allowing homeless individuals the right to use public spaces like sidewalks, parks, and other public buildings and allowing these individuals to be given a reasonable expectation of privacy as if they were housed.[17] These policies provide an alternative solution to homelessness placing emphasis on the homeless individual's civil rights rather than penalizing their methods of survival.[18] These laws protect homeless people's limited options with the state of Connecticut, going so far as to explicitly prohibit law enforcement officers from harassing the homeless, giving them the chance to rest undisturbed.[19] Such polices are an effort to combat the rise in criminalization laws across the country and slow the spread of anti-homelessness measures, which results in the issue simply being moved from one area to another.[20]

A solution to the homelessness crisis in the United States should start with the enactment of a federal "Homeless Bill of Rights" that would stifle further attempts to criminalize many aspects of homelessness and incorporate housing as a basic human right—with increased funding for housing

---

[14] *Id.*
[15] ELLEN & O'FLAHERTY, *supra* note 13, at 48-49.
[16] Jonathan Sheffield, *A Homeless Bill of Rights: Step by Step from State to State*, 19 PUB. INT. L. REP. 8, 10-11 (2013).
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Id.* at 9-10.

programs. The United States already recognizes housing as a human right as a signatory to the International Covenant on Economic, Social and Cultural Rights ("ICESCR") of 1966.[21]

This article will examine the existing policies and practices that have contributed to the ongoing homelessness crisis and give insight towards potential solutions to curb the continuous rise in homelessness. Part I of this article provided the background on homelessness and its increasing prevalence as a public health crisis in the United States. Part II discusses the impact of homeless criminalization laws, their enforcement practices, and how those policies are both costly and ineffective. Subsequently, Part III examines the "Homeless Bill of Rights" legislation that has been introduced in several states as a method to reduce and prevent the enactment of laws and ordinances criminalizing acts the homeless commonly conduct. Finally, Part IV discusses the large savings of taxpayer money and reduction of costly emergency medical services that stems from housing homeless individuals in accordance with the Housing First model.

## CRIMINALIZATION AND ITS COSTS

The first piece to a potential solution to the homelessness crisis in the United States starts with understanding the costs incurred by enforcing laws which criminalize homeless acts. As cities across the United States continue to enact legislation designed to remove the visibly homeless from public spaces, the cities create additional costs associated with the new policies.[22] For example, the city of Los Angeles spends over 100 million dollars each year on patrolling, arresting, and providing mental health interventions to

---

[21] International Covenant on Economic, Social and Cultural Rights of 1966 art. 11, *opened for signature* Dec. 16, 1966, U.N.T.S. 993 (detailing that while the U.S. is a signatory party, it has yet to ratify the treaty).

[22] Gale Holland, *L.A. Spends $100 Million a Year on Homelessness, City Report Finds*, L.A. TIMES (Apr. 16, 2015), https://www.latimes.com/local/lanow/la-me-ln-homeless-cao-report-20150416-story.html.

homeless individuals.[23] Of that amount approximately thirty million dollars is spent on "sweeps" which evict homeless individuals with little or no notice out of homeless encampments, uprooting shelters and adding additional instability into their lives.[24] Often times these sweeps result in the destruction of the homeless individual's property—such as legal documents, medical devices, and clothing—leading to legal and medical issues increasing the costs associated with the enforcement of criminalization laws and subsequent lawsuits.[25]

Another example of criminalization and its costs comes from the city of Portland, Oregon which reported in 2017 that over half of all people arrested were individuals experiencing homelessness.[26] Considering that on average, the cost of incarcerating a single person for a year amounts to a staggering $47,057, these policies can quickly cost taxpayers extraordinary amounts of money which could be used to fund other programs.[27] Despite the massive costs associated with enforcing homeless criminalization laws, the National Law Center on Homelessness and Poverty reports that the efforts to continue criminalizing homelessness and put these laws on the books has increased in every category that the organization had measured nationwide and has been on the rise for the past thirteen years.[28]

As a result, research suggests that individuals who have experienced homelessness for over a year—the "chronically homelessness"—cost taxpayers approximately $83,000 per homeless person each year.[29] With criminalization showing increasing prevalence, it is logical that this figure

---

[23] *Id.*
[24] NAT'L L. CTR. ON HOMELESSNESS & POVERTY, *supra* note 3, at 40.
[25] *Id.*
[26] *Id.* at 71.
[27] *Id.*
[28] *Id.* at 11.
[29] *Id.* at 71.

stands to apply to more individuals as more cities ban sleeping, sitting, and living in a car in public spaces.[30] This notion is further supported by research which states that homeless individuals are incarcerated at a disproportionately higher rate—up to eleven times higher—than individuals who are housed.[31] The research demonstrates that with the increase in criminalization policies, comes the increase of homeless individuals arrested as a result of these policies, and the number of homeless individuals now incarcerated increases—each costing taxpayers $47,057.[32] This means that the overall costs associated with incarcerating unhoused individuals will continue to expand creating the need for more funds required to enforce these policies, more funds to increase jail capacity, and more taxpayer money funneled into this network of costly, punitive programs.[33]

Another consequence of these punitive policies is the growing health care costs for homeless populations.[34] In many cities where homeless encampment sweeps are regularly conducted, medical devices and prescriptions are thrown away or destroyed by law enforcement sent in to clear those areas of homeless people.[35] For instance, Boston, as part of its "Operation Clean Sweep" in August 2019, sent police officers into an encampment where the officers were witnessed seizing wheelchairs and having them crushed in the back of a garbage truck as the officers ordered the homeless individuals away from the Boston Medical Center.[36] For many homeless people the loss of these possessions is devastating especially since they lack the financial means to replace them, or must rely on public programs to replace them at a cost to taxpayers.[37]

---

[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] *Id.* at 40.
[35] *Id.*
[36] *Id.*
[37] *Id.*

Furthermore, since homeless encampments create a central location for homeless individuals to congregate, the U.S. Centers for Disease Control and Prevention ("CDC") recommends that these encampments cease to be cleared during the COVID-19 pandemic.[38] The CDC suggests this for the reason that forcing a mass exodus of homeless people who already face hygienic barriers would likely contribute to the spreading of the virus, resulting in more emergency room visits.[39] In Boston specifically, a study showed that homeless individuals used the emergency room nearly four times more than low-income residents and that sixteen million dollars each year had been spent on about 6,500 homeless people for emergency room care alone prior to the emergence of COVID-19.[40] In general, homeless individuals are five times more likely to be admitted to a hospital as a result of an emergency as well as require longer periods of hospitalization since many serious health conditions are exacerbated due to the fact that an individual lacks a fixed residence.[41]

## HOMELESS BILL OF RIGHTS

Ensuring civil protections for the homeless individuals impacted is necessary to combat homelessness. The introduction of a "Homeless Bill of Rights" was signed into law on June 20, 2012 in Rhode Island making it the first state-level law to protect the civil rights of homeless individuals.[42] A unique feature of the legislation was that the law provides several benefits to

---

[38] Blake v. City of Grants Pass, No. 1:18-CV-01823-CL, 2020 WL 4209227, at *15 (D. Or. July 22, 2020).
[39] *Id.*
[40] Seiji Hayashi, *How Health and Homelessness are Connected—Medically*, ATLANTIC (Jan. 25, 2016), https://www.theatlantic.com/politics/archive/2016/01/how-health-and-homelessness-are-connectedmedically/458871/.
[41] NAT'L L. CTR. ON HOMELESSNESS & POVERTY, *supra* note 3, at 73.
[42] Sheffield, *supra* note 16, at 11.

a prevailing plaintiff.[43] These benefits include "appropriate injunctive and declaratory relief, actual damages, and reasonable attorney's fees and costs."[44] This suggests that the law is not only judicially enforceable, but that an individual who has been discriminated against is more likely to file a claim when there is a potential for money damages as well as find legal representation more easily with the award of reasonable attorney's fees.[45] The same enforcement provision was included in the original bill for the state of Connecticut, but was omitted in the final version as lawmakers believed the provision would invite frivolous lawsuits within the state.[46] Nevertheless, the enactment of the bill in those three states shows the possibility of alternative solutions for how the nation approaches homelessness.[47]

Additional support for this approach comes from a joint report by the U.S. Interagency Council on Homelessness ("USICH") and the U.S. Department of Justice ("DOJ"), condemning the criminalization of the homeless and recommending the implementation of effective alternative practices and policies that would contribute to a reduction and prevention of homelessness.[48] That declaration was praised by U.N. human rights experts on extreme poverty, housing, water, and sanitation.[49] Those agencies' statements are but one small step towards the recognition of the criminalization of the homeless as a violation of the human rights of homeless people, since, in some cases, those criminalization efforts "amount to cruel, inhuman or degrading treatment."[50] That is why the enactment of a "Homeless Bill of Rights" should be a topic of federal legislation. It stands

---

[43] *Id.*
[44] *Id.*
[45] *Id.*
[46] *Id.* at 12.
[47] *Id.* at 11.
[48] U.N. Special Rapporteur, *USA: Moving Away from the Criminalization of Homelessness, A Step in the Right Direction*, HUM. RTS. TO WATER & SANITATION (Apr. 23, 2012), https://sr-watersanitation.ohchr.org/en/Pressrelease_usa_2.html.
[49] *Id.*
[50] *Id.*

to address the growing concerns of the inhumane treatment of homeless individuals across the United States.

Moreover, the Ninth Circuit Court of Appeals in the case of *Martin v. City of Boise* addressed the question of whether cities can enforce punitive measures against homeless people in cases where there is no reasonable alternative but to commit the criminalized act in public spaces.[51] The court held that Boise could not criminalize homeless people for sleeping on public property "on the false pretense [homeless persons] had a choice in the matter."[52] The false pretense in *Martin* was that, while shelter beds were available, religious requirements had to be met to attain a bed, and since those religious requirements presented a barrier to entry for homeless individuals of a different faith, those beds were not actually available.[53] Therefore, the court found that criminalizing homeless people for not sleeping in beds that were unavailable to them was deemed cruel and unusual punishment and a violation of their Eighth Amendment rights.[54] The Ninth Circuit is particularly relevant and well-suited to address this question since many of the Western States within the circuit are heavily impacted by homelessness.[55] Both this decision and the prevalence of successful legal challenges brought forth by homeless individuals asserting their rights against criminalization policies stands to show the importance of establishing a federal "Homeless Bill of Rights" to further civil protections for homeless individuals.[56]

---

[51] Sara K. Rankin, *Punishing Homelessness*, 22 NEW CRIM. L. REV. 99, 115-16 (2019).
[52] Martin v. City of Boise, 920 F.3d 584, 617 (9th Cir. 2019).
[53] *Id.* at 610.
[54] *Id.* at 618.
[55] *See* Rankin, *supra* note 51, at 116 n.91 (stating that the State of California alone has "nearly half of unsheltered people in the country." As well as growing homelessness in Washington, and high rates of unsheltered homeless individuals).
[56] NAT'L L. CTR. ON HOMELESSNESS & POVERTY, *supra* note 3, at 76-77.

HOUSING IS HEALTHCARE

The research surrounding homeless individuals who gain adequate housing is overwhelming positive, leading to better mental health, reduced substance use, and over improved health status across the United States.[57] The United States as a signatory party to the ICESCR understands and recognizes the need for adequate housing.[58] Unfortunately, the U.S. is not bound by the treaty since the U.S. has yet to ratify the document and set it as binding international law.[59] However, tides are shifting against criminalization of homelessness as USICH, DOJ, and the Department of Housing and Urban Development have all declared the crisis as a human rights issue and have begun the implementation of the United Nation's human rights bodies' recommendations to tackle the homelessness crisis issue.[60] Moreover, adequate housing promotes better health outcomes for homeless individuals by reducing the number of hospital visits, the duration of hospital stays, and the total number of admissions.[61] Furthermore, overall public system spending is reduced by nearly as much as is currently spent on housing, demonstrating a net decrease in costs when housing is a favored approach as a response to the homelessness crisis.[62]

One study conducted out of Seattle—which dealt specifically with a subset of chronically homeless individuals with severe alcohol problems—found that an HF approach led to significant cost savings and an overall high reduction in alcohol use for the participants in the program through the first

---

[57] Julia Paradise & Donna Cohen Ross, *Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples*, KAISER FAM. FOUND., Jan. 2017, at 2.
[58] Eric Tars, *Housing as a Human Right*, *in* 2018 ADVOCATES' GUIDE 1-13, 1-13 (Nat'l Low Income Hous. Coal., 2018).
[59] *Id.*
[60] *Id.* at 1-14.
[61] Mary F. Larimer et al., *Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems*, 301 J. AM. MED. ASS'N 1349, 1349 (2009).
[62] *Id.*

year.[63] The study pursued ninety-five individuals who had cost the state, prior to enrollment in the program, $42,964 per person per year.[64] That cost was driven down to $13,440 per person per year as a result of the housing program.[65] Additionally, the study discovered that the longer the individual was housed, the greater the reduction in costs and alcohol use.[66] This study points towards HF as being a highly approachable model for treatment when seeking reduction of homelessness, especially given that the HF model does not require its participants to abstain from drug use to participate following a harm reduction approach.[67] Harm reduction is the recognition that participants may be at different stages of recovery, and that interventions to try and deal with that abuse issue should be individually tailored to best serve that participant and get them on the right track.[68] What this means within the context of an HF program is that there is no threat to an individual losing their housing status as a result of their substance abuse issue.[69] That is because the point of HF is to demonstrate how simply housing individuals does far more good for society than allowing those who were formerly homeless to further deteriorate without a home.[70]

Programs like HF stand to reduce healthcare costs by fifty-nine percent, emergency department costs by sixty-one percent, and the overall number of general inpatient hospitalizations by a staggering seventy-seven percent—but the savings do not end there.[71] Shelter beds providing community services to aid homeless individuals in New York City can range between

---

[63] *Id.* at 1355.
[64] *Id.*
[65] *Id.*
[66] *Id.*
[67] *Id.*
[68] Sam Tsemberis & Maria Nakae, *Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis*, 94 AM. J. PUB. HEALTH 651, 652 (2004).
[69] *Id.*
[70] *Id.*
[71] Garrett, *supra* note 6, at 18.

$23,000 and $33,000 per person per year to maintain; add in emergency medical and incarceration costs and the numbers skyrocket.[72] The relationship between homelessness and incarceration is inextricably linked and shows a trend dating back to the deinstitutionalization that occurred in the 1980s.[73] That is a result of mentally ill patients with alternative housing options having to resort to living in the streets, and since their ability to function is impaired without proper medical attention, they find themselves in and out of the revolving door that is incarceration and homelessness.[74] Placing that same group of homeless individuals into an HF program—removing the individual from a position vulnerable to incarceration as a result of criminalization laws—and housing them, however, results in the combined rent and service costs for those individuals ranging between $17,000 and $24,000 while also including medical treatment and avoiding jails altogether for crimes related to homelessness.[75]

## CONCLUSION

Criminalization of the homeless is costly, ineffective, and often times illegal considering the many possible civil rights violations they pose, like in the case of *Martin v. City of Boise*. In order to combat the rise of this criminalization, the federal government should adopt national "Homeless Bill of Rights" legislation which includes both the right to adequate housing and an increase in funding for housing programs. Adequate housing through HF programs stand to save incredible amounts of taxpayer money, including savings for healthcare, while also contributing to the creation of a more stable, healthy population of individuals who were once homeless and are

[72] Ellen, *supra* note 13, at 49.
[73] *See generally* John M. Quigley & Steven Raphael, *The Economy of Homelessness: The Evidence From North America*, 1 EURO. J. HOUS. POL'Y 323, 326 (2001).
[74] *Id.*
[75] Ellen, *supra* note 13, at 49.

now on the path to recovery. An individual who is housed, is healthier than an individual who is not.

# The Unequal Health Coverage Received by Rural Americans and How Mandatory Telehealth Coverage Can Help

*Luke Cummings*

## INTRODUCTION

Telehealth can change the future of medicine in rural communities. The term "telehealth" describes the vast array of services that doctors are now able to provide remotely such as diagnosing, monitoring, and educating patients or physicians.[1] Relatedly, the term "telemedicine" is a more narrow term describing only the clinical aspects of doctoring.[2] This paper discusses telehealth as it is the more general term and covers more types of services patients may receive through the use of technology.[3] Telehealth laws vary widely at the state level.[4] Some states, including Minnesota, require practitioners to get a specialized telehealth license.[5] Other states, such as Maryland, require private insurers to cover telehealth services, while still other states like Alabama have no laws to stop private insurers from denying coverage of telehealth services.[6] This large disparity is problematic because it leads to residents of different states having unequal medical options available to them, which will lead to long lasting health disparities in populations.[7] This inconsistency between states exemplifies the need for a

[1] Jeremy Sherer & Amy Joseph, *Physician Law Evolving Trends and Hot Topics: Telehealth*, 32 HEALTH L. 20, 20 (2020).
[2] *Id*.
[3] *Id.*
[4] App. B-11. *Telemedicine Laws*, 3 HEALTH L. PRAC. GUIDE APPENDIX B APP. B-11 (2020).
[5] *Id.*
[6] *Id.*
[7] *Rural Health Disparities*, RURAL HEALTH INFO. HUB. (last reviewed Apr. 22, 2019), https://www.ruralhealthinfo.org/topics/rural-health-disparities.

federal law requiring telehealth services to be covered by insurers, especially in light of the COVID-19 pandemic.

The COVID-19 public health emergency has reignited discussions around telehealth services.[8] Public health emergencies involving contagious diseases highlight the benefits of telehealth practices, such as allowing patients to receive treatment while also social distancing to reduce the spreading of the aforementioned diseases.[9]

However, access to telehealth services is critical to ensuring adequate access to health care, even in the absence of a public health emergency, particularly for residents who live in rural communities—fifteen to twenty percent of the United States population.[10] A common theme throughout rural U.S. communities is substandard health.[11] For example, in 2014 more people died per capita from the five leading causes of death—heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke—in Nonmetropolitan areas compared to Metropolitan areas.[12] These rural health disparities can be compounded by other health inequalities, such as the disparities that exist for racial minorities.[13] For example, African Americans and American Indian/Alaskan Native adults are more likely to have multiple chronic health conditions compared to non-Hispanic white populations.[14]

Causes of rural health inequalities are numerous.[15] These areas often have higher rates of poverty and uninsured or underinsured.[16] Counties labeled as

---

[8] Anthony C. Smith et al., *Telehealth for Global Emergencies: Implications for Coronavirus Disease 2019 (COVID-19)*, 26.5 J. TELEMEDICINE & TELECARE 309, 309 (2020).
[9] *Id.*
[10] Robin Warshaw, *Health Disparities Affect Millions in Rural U.S. Communities*, ASS'N AM. MED. COLL. (Oct. 31, 2017), https://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities.
[11] *Id.*
[12] *Rural Health Disparities*, *supra* note 7, at Age-Adjusted Death Rates for the Five Leading Causes of Death per 100,000 Population: United States, 2014.
[13] *Rural Health Disparities*, *supra* note 7.
[14] *Id.*
[15] Barbara Ann Graves, *Telehealth for Communities: Toward Eliminating Rural Health Disparities*, 10.1 ONLINE J. RURAL NURSING & HEALTH CARE 4, 4 (2010).
[16] *Id.*

"completely rural" had a higher percentage of uninsured residents at 12.3% compared to 10.1% of people in "mostly urban" counties.[17] The people in rural areas also have less access to medical professionals; both through lack of appropriate professionals in their area, as well as inadequate public transportation.[18] These causes lead to a type of feedback loop for people in these areas; medical professionals are less likely to settle down for business in these higher poverty areas, which leads to more poverty and even worse health care options over time.[19]

Due to the alarming challenges faced by rural Americans in accessing health care, the United States needs to enact new laws to ensure that people in rural areas are able to get the necessary medical care they need to survive. This article argues a national law requiring telehealth services to be covered by insurance providers should be implemented to create better outcomes for those living in rural areas.[20] First, this article will address the benefits of telehealth coverage—both during and not during a public health emergency. Next, this article will dive into the distinct challenges faced in rural areas that leads to disproportionately negative health effects when telehealth is not covered. This article will also address some of the struggles of telehealth coverage, particularly in rural areas. Finally, this article will propose some solutions to overcoming these burdens and ultimately make the case that a federal law should be passed requiring telehealth services to be covered by insurers nationally.

---

[17] Jennifer Cheeseman Day, *Rates of Uninsured Fall in Rural Counties, Remain Higher Than Urban Counties*, U.S. CENSUS BUREAU (Apr. 9, 2019), https://www.census.gov/library/stories/2019/04/health-insurance-rural-america.html.
[18] Graves, *supra* note 15.
[19] *Id.*
[20] *See* Kiley Aycock, *Just a Phone Call Away: Should Texas Require Insurance Providers to Cover Telehealth Services?*, 19 TEX. TECH. ADMIN. L.J. 347, 350 (2018) ("Patients in rural areas can access higher quality of care when using telemedicine because of the greater and easier access to physicians. Telemedicine leads to a timely diagnosis and early treatment of a patient which will 'often result in improved outcomes and less expenses.'").

## BENEFITS AND OBSTACLES OF TELEHEALTH COVERAGE

Telehealth services have numerous benefits, the most important of which is the ability to increase access to health care and reduce costs—regardless of the existence of a public health emergency.[21] During a public health emergency involving infectious diseases, telehealth becomes an even more necessary tool because it allows patients to receive care without putting themselves or others at risk.[22] Though recent telehealth discussion has been centered on the COVID-19 pandemic, telehealth has also been used during natural disasters such as hurricanes.[23]

The previous benefits are applicable to exigent situations, but telehealth also provides advantages under normal circumstances. First, telehealth is extremely convenient; many people face frustrating travel times and wait times to access a physician.[24] Telehealth from home services remove all travel time. Second, telehealth can open up opportunities to see specialists that are not present in a region.[25] An individual's access to specialists varies drastically depending on location.[26] According to the National Rural Health Association, "there are only 30 specialists per 100,000 people in rural communities, compared to 263 specialists per 100,000 urban residents."[27] This is not solely a problem with highly unique forms of specialists.[28] The same disparity exists with primary care physicians as well—55.1 per 100,000 residents in rural areas and 79.3 per 100,000 in urban areas.[29] Additionally, a study in 2017 found that "54% of rural counties did not have a hospital with

---

[21] Ray E. Dorsey & Eric J. Topol, *State of Telehealth*, 375.2 NEW ENG. J MED. 154, 154 (2016).
[22] Smith, *supra* note 8.
[23] *Id.*
[24] Dorsey, *supra* note 21.
[25] Graves, *supra* note 15, at 5.
[26] Warshaw, *supra* note 10.
[27] *Id.*
[28] *Id.*
[29] *Id.*

obstetrics services."[30] These statistics emphasize the gap telehealth could fill, specifically for those who live in rural areas.

Another potential benefit of making telehealth a larger part of the medical industry is a reduction in costs.[31] Telehealth services have outcomes that equal or surpass traditional in-person care.[32] One study concluded that video telehealth was, "cost-effective for home care and access to on-call hospital specialists."[33] The study concluded that video telehealth services can be cost effective for "regional and rural health care," however, the technology being used and the clinical discipline could cause this to vary.[34] Telehealth services may not always be the most cost effective way to treat an illness, but evidence has shown it can be an efficient alternative.[35] More importantly, it may be the only way to get timely access to the type of care individuals need.[36]

## DISPROPORTIONATE EFFECTS ON RURAL COMMUNITIES

Rural areas have a different medical landscape compared to urban areas.[37] Telehealth is the first step to putting rural and urban areas on more equal footing in regard to health access and outcomes.[38] In particular, telehealth may create more benefits in rural areas than in urban settings.[39] This is a result of the unequal distribution of physicians and specialists in rural areas.[40] It is likely that those living in rural areas would have further to travel to

---

[30] *Id.*
[31] Victoria A. Wade et al., *A Systematic Review of Economic Analyses of Telehealth Services Using Real Time Video Communication,* 10 BMC HEALTH SERVICES RSCH. 1, 2 (2010).
[32] *Id.* at 11.
[33] *Id.* at 5-6 table 1 and 10-11.
[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] *See generally* Warshaw, *supra* note 10 (statistics on the variance between rural and urban health landscapes).
[38] Graves, *supra* note 15, at 4.
[39] *Id.*
[40] Warshaw, *supra* note 10.

receive the care they need, and thus would benefit more from using telehealth.[41]

Travel time may sound like a small inconvenience for some, however, rural areas usually have lower median incomes ($52,386 for rural households and $54,296 for urban households in 2015).[42] As a result, traveling long distances to see a doctor may require having to miss work, which is not an option for people living in paycheck to paycheck.[43] There is also the fear of follow up appointments; even if someone is able to miss work to visit a doctor once, some conditions may requires multiple visits, adding to the burden for rural populations.[44]

In addition to these inequalities in access to health care, rural health problems are aggravated by the pervasiveness of unhealthy behaviors in these areas.[45] Those living in rural areas are more likely to smoke, have abnormal body weight, fail to meet aerobic activity recommendations, and lack adequate sleep.[46] In particular, the youth smoking rate in rural areas (11%) is over double what it is in large central metropolitan areas (5%).[47] Opioid use is another problem that is harming rural areas.[48] Urban areas have greater access to opioid overdose and addiction facilities while opioid overdose deaths are forty-five percent higher in rural areas.[49]

In addition to the common unhealthy behaviors, it is important to acknowledge that each rural area may also face its own unique health

---

[41] *Id.*
[42] Warshaw, *supra* note 10; Alemayehu Bishaw & Kirby G. Posey, *A Comparison of Rural and Urban American: Household Income and Poverty*, U.S. CENSUS BUREAU (Dec. 8, 2016), https://www.census.gov/newsroom/blogs/random-samplings/2016/12/a_comparison_of_rura.html.
[43] Warshaw, supra note 10.
[44] *Id.*
[45] *Rural Health Disparities*, *supra* note 7.
[46] *Id.* at Prevalence of Health-Related Behaviors Among Adults, 2013.
[47] *Rural Health Disparities*, *supra* note 7.
[48] Warshaw, *supra* note 10.
[49] *Id.*

problems.[50] For example, residents in Appalachia face a frightening infant mortality rate that is sixteen percent higher than the rest of the US.[51] They also face a suicide rate that is seventeen percent higher than the national suicide rate.[52] Due to the lack of physicians, it is harder for rural communities to tackle these problems.[53] However, telehealth could be used to create greater access to care for these problems in rural areas.[54]

Telehealth has the opportunity to close this gap because lack of access to telehealth services disproportionately affects rural areas.[55] As discussed, there is a lack of physicians and specialists in these rural areas in particular.[56] Looking first at ambulatory care (services typically provided without being admitted to a hospital), telehealth has already been able to make a difference where it is available.[57] It has reduced travel times and expenses as expected, but it has also increased patient satisfaction in these areas.[58] The increased satisfaction suggests that there is little if any difference in quality of care received through telehealth compared to in person visits, which provides additional support for the implementation of telehealth in rural areas.[59]

Another less obvious use of telehealth is that it benefits not just the patient, but also the practitioners, through educating those delivering the care.[60] The doctors working in these areas can be provided the necessary continuing education for their career without the time, costs, or resources that would be

---

[50] *Rural Health Disparities*, *supra* note 7.
[51] *Id.*
[52] *Id.*
[53] Warshaw, *supra* note 10.
[54] James P. Marcin et al., *Addressing Health Disparities in Rural Communities Using Telehealth*, 79 PEDIATRIC RES. 169, 169 (2016).
[55] *Ambulatory Care Settings*, MEDPAC, http://www.medpac.gov/-research-areas-/ambulatory-care-settings (last visited Oct. 17, 2020); Marcin et al., *supra* note 54 at 174.
[56] Warshaw, *supra* note 10.
[57] Marcin et al., *supra* note 54, at 171; *Ambulatory Care Settings*, *supra* note 55.
[58] Marcin et al., *supra* note 54, at 171.
[59] *Id.*
[60] *Id.*

required for in person education.[61] There is a shortage of physicians in these areas and that shortage is expected to worsen over time.[62] The increased capacity to provide continuing education to these practitioners could act as an encouraging factor to get more medical professionals to practice in these areas.[63]

The number one obstacle to expanding telehealth in rural areas, and in the United States as a whole, is the lack of consistent telehealth laws.[64] Some states, such as Alabama and Alaska, simply do not have laws that require private insurers to cover telehealth services.[65] This lack of consistent laws makes it difficult to ensure that everyone has access to telehealth services as they prevent accessing telehealth at an affordable price. However, other laws may complicate issues as well.[66] While many states do require telehealth services to be covered by private insurers, there are differences in what procedures potential providers have to go through.[67] For example, while most states only require a physician to have a license to practice in the state, Georgia requires a separate telehealth license.[68] One federal law which makes coverage of telehealth services consistent throughout all the states would encourage expansion of the infrastructure necessary for telehealth services. It is a risk to invest in the expansion of telehealth services when state laws are inconsistent.[69] Telemedicine companies would feel safer investing into making telemedicine more accessible and efficient if they had one set of laws to follow instead of fifty.[70]

---

[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] *See generally Telemedicine Laws*, *supra* note 4 (providing comparison of laws that vary from state to state).
[65] *Id.*
[66] *Id.*
[67] *Id.*
[68] *Id.*
[69] *Id.*
[70] *Id.*

SOLUTIONS TO OVERCOMING TELEHEALTH OBSTACLES

The first major problem is the variance in state laws in regard to coverage of telehealth services.[71] The United States could solve this problem through the passage of federal laws requiring telehealth services be covered and reimbursed under private insurance plans. Besides just coverage, these laws should also loosen restrictions on licensing requirements. State laws may eventually align, but passage of a federal law would ensure things move in the right direction. Medicaid and Medicare could begin leading the way in this aspect. Licensing requirements are important to ensure that doctors are competent, but COVID-19 has shown that removing state specific licensing requirements can be effective.[72] Typically, a practitioner providing telehealth services to a patient in State A would require a license to practice in State A.[73] However, due to COVID-19, most states are allowing practitioners from other states to practice in their state through telehealth services.[74] This temporary waiver should be made permanent and incorporated into federal law. Those living in rural states would be able to take advantage of specialists that are not available in their state through telehealth services.

Another important aspect of a future telehealth law would be payment parity. Payment parity exists when services provided through telehealth are reimbursed at the same rate as if the service was provided in person.[75] Only a small minority of states required payment parity for telehealth services

---

[71] *Id.*
[72] Gabriela Weigel et al., *Telemedicine in the U.S. During the COVID-19 Emergency and Beyond*, KAISER FAM. FOUND. (May 11, 2020), https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/.
[73] *Id.*
[74] *Id.*
[75] *Id.*

before COVID-19.[76] More states have begun to require telehealth payment parity during the COVID-19 public health emergency.[77] Laws requiring payment parity for telehealth services encourages insurance providers to include these services in their plan.[78] This, in turn, increases access.[79]

In response to COVID-19, telehealth options covered by Medicare were expanded.[80] Before this expansion, Medicare only paid for telehealth if certain requirements were met.[81] One of these requirements was that the patient would have to receive the telehealth service at a clinic, hospital, or other type of medical facility.[82] Now, temporarily due to COVID-19, Medicare is covering office, hospital, and other types of visits conducted via telehealth, even if done from the patient's home.[83] Any new legislation expanding telehealth should allow patients to receive telehealth services from their home. As discussed, travel times can be a major deterrent to receiving care for those in rural areas.[84] Telehealth from home services eliminate all travel time.

Similarly, under Medicaid states decide whether or not to cover telehealth services.[85] "The general requirements of comparability, statewideness, and freedom of choice do not apply with regard to telemedicine services."[86] In regard to pricing, private insurers tend to follow Medicare's lead.[87] Medicare

---

[76] *Id.*
[77] *Id.*
[78] *Id.*
[79] *Id.*
[80] *Medicare Telemedicine Health Care Provider Fact Sheet*, CTRS. MEDICARE & MEDICAID SRVS. (Mar. 17, 2020), https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.
[81] *Id.*
[82] *Id.*
[83] *Id.*
[84] Dorsey, *supra* note 21.
[85] *Telemedicine*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html (Last visited Oct. 18, 2020).
[86] *Id.*
[87] *See* Jeffrey Clemens & Joshua D. Gottlieb, *In the Shadow of a Giant: Medicare's Influence on Private Physician Payments*, J. POL. ECON. 1, 1 (2016) (noting private prices increased by $1.16 when Medicare's fees increased by $1).

could possibly set the trend with regard to telehealth coverage.[88] Keeping these Medicare temporary changes permanent through enactment of federal law would be a good start to expanding telehealth coverage.

## CONCLUSION

Telehealth services are an increasingly important part of medical care, particularly during public health emergencies such as COVID-19. Telehealth services have a unique opportunity to help bridge the gap in health disparities between rural and urban areas.[89] Further, the expansion of telehealth services in the United States could increase medical access for everyone, not just those living in rural areas.[90] However, it is important to acknowledge the disparate impact the lack of telehealth coverage has on those living in rural areas due to the sparsity of physicians and specialists in these regions.[91] There are barriers to expanded telehealth coverage such as inconsistent state laws, but these barriers can be overcome.[92] The best way to overcome the barrier of state laws is to pass federal legislation requiring the coverage of telehealth services by insurance providers. Any new law should allow for the practice of telehealth across state lines to ensure that those in underserved areas are able to access the care they need. State by state licensing requirements for telehealth have temporarily went away in many states due to COVID-19 and it shows that such a change is feasible.[93] Any new law should also address

---

[88] *See generally id*. at 32 ("Medicare could exert sway through multiple channels. As a large market participant, it competes with private insurers for physician resources. Practitioners further emphasize that many private insurers' contracts are benchmarked directly to Medicare's menu.").
[89] *See generally Rural Health Disparities*, *supra* note 7 (stating disparities in rural and urban healthcare while partially attributing this to access to medical care, telehealth is a way of increasing access to medical care).
[90] Graves, *supra* note 15.
[91] *Id. See* Warshaw, *supra* note 10 (comparing the sparsity of physicians and specialists in rural areas).
[92] *Telemedicine Laws*, *supra* note 4; Weigel et al, *supra* note 72.
[93] Weigel et al., *supra* note 72.

payment parity for telehealth services. Payment parity for telehealth services would motivate providers to cover telehealth services and increase their availability.[94] Furthermore, these laws should require insurance providers to cover telehealth services done from home, not just those done at medical centers. Telehealth has the potential to close the gap in health disparities that exist in rural communities, but obstacles in the way of its expansion need to be removed.

[94] *Id.*

# COVID-19 and College Athletics: Examining the Effects of Coronavirus on African American Student Athletes and the Future of Collegiate Sports

*Christian Fuller*

## INTRODUCTION

The COVID-19 pandemic has caused one of the greatest disruptions in the twenty-first century. One industry in particular that has had a major setback is the college sports industry. Many colleges and universities have contemplated canceling their sports seasons entirely, thus leaving many African American athletes without proper protection from COVID-19.[1] While African American students account for the majority of football and basketball players[2], they are also more vulnerable to COVID-19. The mortality rate for the coronavirus has had a disproportionate impact on the African American community.[3] There are numerous factors that are likely contributing to this racial health disparity, such as lack of resources and pre-existing health conditions.[4] In addition, "micro-level factors shape racial health disparities including racial bias in medical treatment and the racial empathy gap in perceived pain tolerance."[5] Many individuals from racial and ethnic minority groups are more likely to contract and die from COVID-19

[1] Nancy Zimpher & Jonathan Mariner, *As Big Ten and Pac-12 Cancel Their Football Seasons Because of COVID-19, College Sports Programs are Facing a Financial Apocalypse*, MARKETWATCH (August 11, 2020), https://www.marketwatch.com/story/big-college-sports-programs-face-a-financial-apocalypse-if-the-football-season-is-cancelled-its-time-for-new-priorities-focused-on-the-athletes-11597154899.
[2] Shaun R. Harper, *Black Male Student-Athletes and Racial Inequities in NCAA Division I College Sports*, USC RACE & EQUITY CTR. 3, (2018).
[3] *See* Rashawn Ray, *Why are Blacks Dying at Higher Rates from COVID-19?*, BROOKINGS (April 9, 2020), https://www.brookings.edu/blog/fixgov/2020/04/09/why-are-blacks-dying-at-higher-rates-from-covid-19/ ("Blacks are 74% more likely to contract coronavirus than their percentage of the state").
[4] *Id.*
[5] *Id.*

due to systemic health and social inequities.[6] Thus, continuing with collegiate sports amid COVID-19 exposes African American athletes to a disproportionate risk of infection in comparison to other races.[7] Research has shown that social distancing and isolation are the best ways to reduce the spread of the virus.[8] However, there have been success stories of how to properly continue with sports while lowering the risk of infection.[9]

This article will discuss the proper measures and precautions university and conference leaders should implement to ensure the safety and wellbeing of African American athletes against COVID-19.[10] First, the article will discuss the health disparities that generally exist within the African American community. Second, it will examine the precautions that have been successfully implemented in professional sports. Lastly, the article will evaluate why collegiate sports should continue this season for the benefit of African American athletes.

At the collegiate level, The National Collegiate Athletic Association ("NCAA") is the member-led organization that is dedicated to the well-being and lifelong success of student athletes.[11] "The NCAA functions as a general legislative and administrative authority for men's and women's intercollegiate athletics. It formulates and enforces the rules of play for

---

[6] *Health Equity Considerations & Racial & Ethnic Minority Groups*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html (last updated July 24, 2020).
[7] Anya van Wagtendonk, *COVID-19 is Exposing Inequalities in College Sports. Now Athletes are Demanding Change*, VOX, (August 2, 2020), https://www.vox.com/2020/8/2/21351799/college-football-pac-12-coronavirus-demands.
[8] *Protect Yourself*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html (last updated September 11, 2020).
[9] Jasmyn Wimbish, *NBA Announces Zero Players Tested Positive for COVID-19 Inside Disney Bubble for Fifth Straight Week* (August 19, 2020), CBS SPORTS, https://www.cbssports.com/nba/news/nba-announces-zero-players-tested-positive-for-covid-19-inside-disney-bubble-for-fifth-straight-week/.
[10] Wagtendonk, *supra* note 7.
[11] *What is the NCAA?*, NAT'L COLLEGIATE ATHLETIC ASS'N, http://www.ncaa.org/about/resources/media-center/ncaa-101/what-ncaa (last visited September 15, 2020).

various sports and the eligibility criteria for student athletes."[12] Part of their mission is to keep student athletes safe, by working to protect them physically and mentally while ensuring they are receiving the best care for concussions, cardiac health, mental health, injury prevention, and an array of other issues.[13]

Since January 21, 2020, the COVID-19 virus has resulted in more than 13 million cases and more than 269,763 deaths in the United States.[14] While the African American, Latinx, and Native American communities face unique challenges they share the following barriers: they "[a]re disproportionately impacted by structural racism and socioeconomic factors[,] [a]re more likely to be uninsured[,] [e]xperience higher rates of pre-existing and underlying health conditions, and [a]re more likely to be low wage frontline workers."[15] These population groups are also more likely to be in frontline, low wage positions such as home-health care, grocery stores and food service, public service, and transportation.[16] The inability to social distance and the public interaction results in these essential workers having a greater risk for COVID-19.[17]

## DISPARITIES IN AFRICAN AMERICAN COMMUNITIES

For decades, redlining—which is "the discriminatory practice of denying services to residents of certain areas based on their race or ethnicity"—has

---

[12] Encyclopedia Britannica, (September 14, 2020), https://www.britannica.com/topic/National-Collegiate-Athletic-Association.
[13] *Well-Being*, NAT'L COLLEGIATE ATHLETIC ASS'N, http://www.ncaa.org/health-and-safety (last visited September 15, 2020).
[14] *CDC COVID Data Tracker*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://covid.cdc.gov/covid-data-tracker/#cases_casesinlast7days (last updated December 2, 2020).
[15] INFECTIOUS DISEASES SOC'Y AM., COVID-19 AND HEALTH DISPARITIES IN THE UNITED STATES 3 (June, 2020) https://www.idsociety.org/globalassets/idsa/public-health/covid-19/covid19-health-disparities.pdf.
[16] *Id.*
[17] *Id.*

been the root cause of racial health disparities that currently exist in the African American communities.[18] Numerous "inequities in social determinants of health that put racial and ethnic minority groups at increased risk of getting sick and dying from COVID-19 include[] discrimination; health[care] access and utilization; occupation; educational; income and wealth gaps; and housing."[19] In states with racial data available, African Americans almost always have higher contraction and death rates from COVID-19.[20] While African Americans only represent thirteen percent of the United States' population, they account for twenty-five percent of all COVID deaths.[21] Compared to white individuals, the mortality rate for African Americans who have contracted COVID-19 is 2.4 times higher.[22] Among other factors, African Americans are also more likely to reside in communities that lack healthy food options, green spaces, recreational facilities, lighting, and safety.[23] In addition, these areas tend to be more densely populated, thereby increasing contact with other individuals and making social distancing less achievable.[24] Communities with higher Black populations are more likely to be exposed to pollutants and toxins.[25] These factors, among others, are the reason for increased COVID-19 cases,

---

[18] Ray, *supra* note 3. *See also A 'Forgotten History' of How the U.S. Government Segregated America*, NPR, https://www.npr.org/2017/05/03/526655831/a-forgotten-history-of-how-the-u-s-government-segregated-america (May 3, 2017) ("The Federal Housing Administration furthered the segregation efforts by refusing to insure mortgages in and near African-American neighborhoods").
[19] Health Equity Considerations, *supra* note 6.
[20] Ray, *supra* note 3. *See US Blacks Three Times More Likely than Whites to get COVID-19*, CIDRAP, https://www.cidrap.umn.edu/news-perspective/2020/08/us-blacks-3-times-more-likely-whites-get-covid-19 (August 14, 2020) ("blacks are more likely to have preexisting conditions that predispose them to COVID-19 infection, less likely to have health insurance, and more likely to work in jobs that do not accommodate remote work.").
[21] Chris Horn, *COVID-19 Highlights Underlying Racial Health Disparities* (June, 2020), https://www.sc.edu/uofsc/posts/2020/06/covid_health_disparities.php#.X2W5Gi2ZPOR.
[22] INFECTIOUS DISEASES SOC'Y AM., *supra* note 15.
[23] Ray, *supra* note 3.
[24] *Id*.
[25] *Id*.

hospitalizations, and deaths in communities where minority groups work and reside.[26]

In regard to the U.S. workforce, African Americans are more likely to hold positions identified as COVID-19 frontline essential workers, therefore making them and their families over-exposed to COVID-19.[27] African Americans represent nearly thirty percent of bus drivers and nearly twenty percent of all food service workers, janitors, cashiers and stockers.[28] Thus, staying home during a quarantine is a privilege that many African Americans do not have.[29]

Moreover, African Americans are "less likely to have equitable healthcare access—meaning hospitals are farther away and pharmacies are subpar," which delays urgent prescriptions.[30] African American health problems result "not because [they] do not care for themselves, but because healthcare resources are criminally inadequate in their neighborhoods."[31]

In addition to structural conditions, micro-level barriers contribute to the racial health disparities that are experienced by African Americans, such as racial bias in medical treatment and pain assessment.[32] "Collectively, these structural conditions and micro-level outcomes equate to a major disadvantage for African Americans where the consequences are increased exposure, diagnosis, and death from the Coronavirus."[33] "Long-term, systemic changes are needed to promote economic stability, healthy

[26] Health Equity Considerations, *supra* note 6.
[27] Ray, *supra* note 3.
[28] *Id*.
[29] *Id*.
[30] *Id*.
[31] *Id*.
[32] *Id*.
[33] *Id*.

neighborhoods, education, food security, and access to culturally competent healthcare."[34]

Although efforts have been implemented to slow the spread of COVID-19, inadvertent problems like lost wages, reduced access to services, and increased stress, for some racial and ethnic minority groups may result.[35]

In regard to college sports, the NCAA conducted a Student-Athlete COVID-19 Well-being Survey that was administered online, from April 10, 2020 through May 1, 2020, to examine the impact of the COVID-19 pandemic on student-athletes' current physical and mental well-being.[36] The results showed many student-athletes reported experiencing high rates of mental distress.[37] Particularly, "mental health concerns were highest amongst respondents of color, especially those whose families are facing economic hardship and those living alone."[38]

## COVID-19 PRECAUTIONS IN PROFESSIONAL SPORTS

Without a COVID-19 vaccination, executing a safe return to sports poses many risks for professional athletes and team officials.[39] Athletes have been faced with the decision to either return for the 2020 season or limit their potential exposure to the virus by opting out of the season.[40] In consideration of players and staff that are more vulnerable to the virus, professional sports

---

[34] INFECTIOUS DISEASES SOC'Y AM., *supra* note 15.
[35] Health Equity Considerations, *supra* note 6.
[36] *NCAA Student-Athlete COVID-19 Well-being Survey*, NCAA, https://ncaaorg.s3.amazonaws.com/research/other/2020/2020RES_NCAASACOVID-19SurveyReport.pdf (last visited November 4, 2020).
[37] *Survey Shows Student-Athletes Grappling with Mental Health Issues*, NCAA, http://www.ncaa.org/about/resources/media-center/news/survey-shows-student-athletes-grappling-mental-health-issues (May, 2020).
[38] *Id*.
[39] James Wagner & Marc Stein, *As Sports Begin Reopening, Athletes Weight the Health Risks*, (May 23, 2020), https://www.nytimes.com/2020/05/23/sports/coronavirus-athletes.html.
[40] *Id.*

leagues have implemented specific precautions in their reopening policies.[41] For example, some professional leagues allowed teams to schedule voluntary, socially distanced practices and workouts for their athletes.[42]

To date the NBA's bubble model has proven to be the safest and most successful against COVID-19 prevention.[43] "Of the 341 players tested for COVID-19 on the NBA campus since test results were last announced on August 12, zero [had] returned confirmed positive tests."[44] The NBA's safety plan consisted of an array of precautions, including daily COVID-19 testing, no outside fans, limited team travel parties, and mandatory masks usage while indoors (except during games).[45] After four months of players, coaches and staff living in a bubble, the final game of the 2019-2020 NBA season concluded with no coronavirus cases reported.[46]

Similar to the NBA, the NHL has also detailed protocols for a successful return to play plan which consists of limited traveling parties for each team, regular COVID-19 testing, an immediate self-quarantine policy for those that experience symptoms and/or test positive, six foot social distancing when not actively playing, disinfecting of benches between game periods, and no sharing of water bottles or towels.[47] After nine-plus weeks of NHL

---

[41] *Id*.
[42] *Id*.
[43] Wimbish, *supra* note 9.
[44] *Id*.
[45] Brian Windhorst & Tim Bontemps, *Inside the NBA's 100-page Safety Plan: Big Questions and Key Details* (June 16, 2020), https://www.espn.com/nba/story/_/id/29320883/inside-nba-100-page-safety-plan-big-questions-key-details.
[46] *Lakers Win NBA Finals; No Coronavirus Cases Reported in Bubble*, NPR, https://www.npr.org/2020/10/12/923064484/lakers-win-nba-finals-no-coronavirus-cases-reported-in-bubble (October 12, 2020).
[47] Lia Assimakopoulos, *Life in the Bubble: NHL Details Protocols for Phase 4 of Return-to-Play Plan*, (July 6, 2020), https://www.nbcsports.com/washington/capitals/life-bubble-nhl-details-protocols-phase-4-return-play-plan.

employees living in a bubble, they successfully ended their season as well with no reports of coronavirus cases.[48]

## COLLEGE SPORTS AMID COVID-19

While there is no blueprint for how to successfully return to sports after quarantine, some schools, such as The University of Illinois, have allowed their student athletes to return in phases for voluntary workouts.[49] These workouts are comprised of small groups that practice social distancing.[50] Recently, the Big Ten voted unanimously to resume the football season.[51] They have implemented considerable medical practices that include "daily antigen testing, enhanced cardiac screening, and an enhanced data-driven approach when making decisions about practice/competition."[52] The daily antigen testing will be completed and recorded prior to each practice or game.[53] Students who test positive for COVID-19 through point of contact ("POC") daily testing will require a polymerase chain reaction test to confirm the result of the POC test. Following a positive diagnosis, the earliest a student-athlete can return to game competition is 21 days.[54] Additionally, the

---

[48] Samantha Pell, *The NHL Completed its Bubble Playoff Without One Coronavirus Case. It was no Small Feat.* (September 29, 2020), https://www.washingtonpost.com/sports/2020/09/29/nhl-stanley-cup-bubble-ends/.
[49] Shannon Ryan, *COVID-19 and Sports: From an Uptick in Injuries to Mental Health Issues, the Potential Risks for Athletes are Plentiful*, (July 1, 2020), https://www.chicagotribune.com/sports/ct-sports-return-medical-experts-coronavirus-20200701-tdrpbruvzrcyddrzmlhhhxpr4e-story.html.
[50] *Id*.
[51] *The Big Ten Conference Adopts Stringent Medical Protocols; Football Season to Resume October 23-24, 2020*, THE BIG TEN, https://bigten.org/news/2020/9/16/the-big-ten-conference-adopts-stringent-medical-protocols-football-season-to-resume-october-23-24-2020.aspx (September 16, 2020).
[52] *Id*.
[53] *Id*.
[54] *Id*. *See* Colten Bartholomew, *Sources: Badgers QB Chase Wolf tests positive for COVID-19; Graham Mertz out 21 days after second positive test*, WISCONSIN ST. J. (October 28, 2020), https://madison.com/wsj/sports/college/football/sources-badgers-qb-chase-wolf-tests-positive-for-covid-19-graham-mertz-out-21-days/article_9d8a5119-ffd4-574c-b25a-

Big Ten is working to create a cardiac registry with the intent of determining what the long-term impact COVID-19 has on student-athletes who test positive.[55] The collection of this data will allow experts to study the unknown cardiac effects COVID-19 has had on elite student athletes who test positive for the virus.[56]

Although the Big Ten is taking precautions to ensure the safety of all student-athletes and personnel, racial disparities for student athletes of color still exist; these students reported higher levels of racial disparities in housing and food stability and access to medical care, in comparison with white student-athletes.[57] For public policy reasons and to aide in the promotion of fairness and justice, the NCAA should allow for the unionization of college athletes to help reduce or eliminate these disparities. The NCAA should consider the potential that this legislation would have on student-athletes, especially African Americans, by allowing campus athletes to earn a free-market income.[58] "Treating college student athletes as "employees" would mean they would be protected by the National Labor Relations Act, and thus could unionize and bargain collectively with the schools, like any other employee."[59] Compensating players not only is the moral thing to do pursuant to Ethical Egoism, but the student-athletes would be treated equally as they would be compensated fairly for their work.[60]

---

be5690747024.html (Big Ten conference protocols state players who have a positive test confirmed must sit out of games for 21 days).

[55] *Id*.

[56] *Id*.

[57] Mental Health Issues, *supra* note 36.

[58] Patrick Hruby, *Four Years A Student-Athlete: The Racial Injustice of Big-Time College* Sports, VICE (April 4, 2016), https://www.vice.com/en/article/ezexjp/four-years-a-student-athlete-the-racial-injustice-of-big-time-college-sports.

[59] Frank J. Cavico, et al., *Unionization and College Athletics: An Emerging Legal, Ethical, and Practical Quandary*, 4 MGMT. & ADMIN. SCIS. R. 1 (2015).

[60] *Id*.

Annually, the NCAA generates approximately $700 million from broadcast rights to March Madness, while the merchandising and licensing revenue for college sports surpasses $4 billion.[61] Although African Americans are the predominate athletes that help generate the revenue, they only receive ten percent of the total revenue.[62] Several African American student-athletes have even reported that they send most of their cost-of-living stipend that is received from their scholarship back home to help their families, leaving them with a disparate lack of financial support.[63] Furthermore, these student-athletes encounter the same medical issues as professional athletes, but are not provided medical protection for injuries that can impair them for live.[64] Thus, the potential impact of allowing student-athletes to unionize and generate income from signing autographs, starring in commercials, or other endorsements, would allow African American student-athletes to have access to more resources and achieve the goal of decreasing the disproportionate impact between white and African American student-athletes.[65] African American students would be able to focus less on making ends meet since they would have access to more capital to support themselves, while also eliminating the need for find outside employment.[66] In addition, the extra income would relieve their families of providing direct financial support and even discourage the corruption in collegiate bribery.[67] To prevent calling into question the NCAA's racial integrity towards the population who has historically been affected the most and makes up the

[61] Hruby, *supra* note 58.
[62] *Id*.
[63] *Id*.
[64] Rose Eveleth, *College Football Players Push to Unionize for Medical Benefits*, SMITHSONIAN MAG. (January 29, 2014), https://www.smithsonianmag.com/smart-news/college-football-players-push-unionize-medical-benefits-180949531/.
[65] Hruby, *supra* note 58.
[66] Louise Gaille, *Should College Athletes Be Paid Pros and Cons*, VITTANA (July 29, 2018), https://vittana.org/14-should-college-athletes-be-paid-pros-and-cons.
[67] *Id*.

largest percentage of revenue-generating sports, they should implement changes that provide equal opportunities for all student-athletes across the board.

In summary, allowing students to play this season will result in many benefits for African American athletes such as: access to better health care, advancement in their sports careers, and increased finances, while also adding additional revenue to their schools.[68] Furthermore, the canceling of the collegiate sports season will lead to a decrease in game film that scouts use to evaluate prospects for a professional career in sports, thus decreasing a player's chances for professional recruitment.[69]

The NCAA supports student athletes in a variety of ways, such as providing additional funding that may be used to cover other expenses related to attending school, such as gas for transportation or childcare.[70] Students receive food beyond the traditional meals and snacks, and fueling stations are available at all hours and they also receive individualized nutrition plans.[71] Not only does the NCAA promote health and safety of student athletes, they fund an insurance policy that covers injuries while playing or practicing, up to $20 million in lifetime benefits.[72] In addition to covering medical needs, some Division I and II schools provide unlimited meals for student athletes, as well as access to nutritionists and other health professionals.[73]

---

[68] Scooby Axson, *College Football Means Big Money. Black Athletes Stand at the Intersection of Risk and Profit*, NBC NEWS (August 27, 2020), https://www.nbcnews.com/news/nbcblk/college-sports-mean-big-money-black-athletes-stand-intersection-risk-n1238450.
[69] *Id*.
[70] Kevin Allen, *Here are Some Benefits NCAA Athletes Already are Eligible for that You Might Not Know About*, USA TODAY (October 1, 2019), https://www.usatoday.com/story/sports/college/2019/10/01/ncaa-football-basketball-benefits-college-athletes-now-can-receive/2439120001/.
[71] *Id*.
[72] *How We Support College Athletes*, NAT'L COLLEGIATE ATHLETIC ASS'N, http://www.ncaa.org/about/resources/media-center/ncaa-101/what-ncaa (last visited December 1, 2020).
[73] *Id*.

Furthermore, NCAA provides tutoring services and academic advisors for student athletes and as a result the graduation rate of student athletes is higher than the student body.[74]

Moreover, many students and parents petitioned to reverse the Big Ten's initial decision to cancel the 2020 football season by supporting Ohio State University's junior quarterback Justin Fields #WeWantToPlay social media movement.[75] Many argued that cancelling the season will force players to be sent home where the likelihood of social distancing will be low, in turn increasing their exposure to the virus and putting their safety at a higher risk.[76] Not to mention the burden of medical care will be placed on the families if a player tests positive for COVID-19.[77]

## CONCLUSION

In summary, cancelling the collegiate sports season would bring more detriment than assistance to African American student athletes. Basketball and football are the top two revenue generating sports programs in the NCAA and are comprised of predominately African American student athletes. These students will not have access to most of the benefits that are provided to student athletes by the NCAA if the season is not continued. Conference leaders and schools should model after the NBA and NHL's approach to creating a safe return to play plan to proceed with the season while lowering the risk of infection.[78] If they use the proper measures and precautions

---

[74] *Id.*
[75] Ben Kercheval & Barrett Sallee, *Trevor Lawrence Sparks United #WeWantToPlay Movement, Players Association Goal as 2020 Seasons Hangs in Balance*, CBS SPORTS (August 10, 2020), https://www.cbssports.com/college-football/news/trevor-lawrence-sparks-united-wewanttoplay-movement-players-association-goal-as-2020-season-hangs-in-balance/.
[76] *Id.*
[77] *Id.*
[78] Wimbish, *supra* note 9.

implemented by the professional sports leagues, university and conference leaders will be able to ensure the safety and wellbeing of African American athletes against COVID-19.

# Do I Have To?: Mandating a Vaccine in a Politicized Pandemic

*Madison N. Heckel*

## INTRODUCTION

While COVID-19 has impacted everyone in some capacity, the pandemic has hit hardest to those who are economically disadvantaged.[1] The pandemic has led to significant job and wage loss, particularly for lower-income households, and many quickly ate through what little savings they had to get by.[2] An effective COVID-19 vaccine is essential to allowing Americans to get back to work without risking the lives of them or their loved ones.[3] However, there have been many uncertainties surrounding the vaccine, ranging from when the vaccine will become available, to how much the vaccine will cost Americans, and how the vaccine will be distributed.[4] And in the background, a larger question looms: will Americans take a COVID-

[1] Rebekah L. Rollson & Sandro Galea, *The Coronavirus Does Discriminate: How Social Conditions are Shaping the COVID-19 Pandemic*, CTR. PRIMARY CARE: HARV. MED. SCH. (May 5, 2020) http://info.primarycare.hms.harvard.edu/blog/social-conditions-shape-covid.
[2] Kim Parker et al., *About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19*, PEW RSCH. CTR. (Apr. 21, 2020), https://www.pewsocialtrends.org/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/.
[3] Molly Kinder & Martha Ross, *Reopening America: Low-Wage Workers Have Suffered Badly from COVID-19 So Policymakers Should Focus on Equity*, BROOKINGS (Jun. 23, 2020), https://www.brookings.edu/research/reopening-america-low-wage-workers-have-suffered-badly-from-covid-19-so-policymakers-should-focus-on-equity/.
[4] *See* Eileen Drage O'Reilly, *How the U.S. Might Distribute a Coronavirus Vaccine*, AXIOS (May 29, 2020), https://www.axios.com/coronavirus-vaccine-distribution-america-a12c4e95-df80-47f0-beec-d17d7e7657db.html (examining questions related to the vaccine). *See generally* Carl O'Donnell, *When Will a Coronavirus Vaccine Be Ready?*, REUTERS (Aug. 11, 2020), https://www.reuters.com/article/us-health-coronavirus-vaccines-explainer/when-will-a-coronavirus-vaccine-be-ready-idUSKCN2571H2 (answering often asked questions regarding a COVID-19 vaccine creation and distribution process); Sydney Lupkin, *Prices for COVID-19 Vaccines Are Starting To Come Into Focus*, NPR (Aug. 6, 2020), https://www.npr.org/sections/health-shots/2020/08/06/899869278/prices-for-covid-19-vaccines-are-starting-to-come-into-focus.

19 vaccine?[5] This question arises not only from the "anti-vax" community, but also from those who regularly get vaccinations but are skeptical of the rapid manufacture of a COVID-19 vaccine.[6] Both the speed of the creation of a vaccine and the lack of trust in President Trump have led many to wonder if a COVID-19 vaccine would be safe, and experts worry these fears could lead to too few Americans being vaccinated for the country to reach a safe level of immunity.[7]

This article will examine the constitutionality of a mandatory COVID-19 vaccine given the current socio-political climate. First, this article will discuss the legal history of vaccine mandates. Second, this article will consider the current plans for developing a COVID-19 vaccine, how the Trump administration presented these plans, and the public's concerns with these plans. Finally, this article will analyze how individuals' concerns balance against public health, and how these concerns could impact the constitutional issues that may arise if a mandated vaccination is deemed necessary.

## LEGAL HISTORY OF VACCINE MANDATES

The Supreme Court first heard a case on mandated vaccinations in *Jacobson v. Massachusetts* in 1905.[8] The case arose after Massachusetts passed a law granting individual cities and towns the authority to enforce

---

[5] Shannon Mullen O'Keefe, *One in Three Americans Would Not Get COVID-19 Vaccine,* GALLUP (Aug. 7, 2020), https://news.gallup.com/poll/317018/one-three-americans-not-covid-vaccine.aspx.

[6] Jared S. Hopkins, *A Covid-19 Vaccine Problem: People Who Are Afraid to Get One*, WALL ST. J. (Aug. 28, 2020), https://www.wsj.com/articles/covid-19-vaccine-hesitancy-is-a-growing-concern-for-researchers-health-officials-11598607002.

[7] Maggie Fox, *'Operation Warp Speed' is Fueling Vaccine Fears, Two Top Experts Worry*, CNN (Jun. 5, 2020), https://www.cnn.com/2020/06/05/health/warp-speed-coronavirus-vaccine-worries/index.html; Tom McCarthy, *Fear Mounts Trump May Pressure FDA to Rush Covid-19 Vaccine by Election*, GUARDIAN (Jun. 22, 2020), https://www.theguardian.com/us-news/2020/jun/22/trump-circle-pressure-fda-rush-covid-19-vaccine-election.

[8] Jacobson v. Massachusetts, 175 U.S. 11 (1905).

mandatory, free vaccinations for adults if the municipality determined it was necessary for the public health or safety of the community.[9] After the law was passed, the town of Cambridge faced a smallpox outbreak in 1902 and adopted a regulation requiring vaccinations for all of its inhabitants.[10] The plaintiff in the case, Jacobson, refused the vaccine, and was given a monetary fine as a result.[11] In the case, Jacobson argued that the vaccination mandate violated his Fourteenth Amendment rights under both the Equal Protection and Due Process Clauses and exceeded the state's power.[12]

The case was appealed to the Supreme Court, who determined that the mandatory vaccine law did not violate the Fourteenth Amendment and was a state's rightful usage of its police power.[13] Every society has the duty to conserve the safety of its members, the Court stated, and to do so, the society may enforce "reasonable regulations, as the safety of the general public may demand."[14] Thus, the Court held that mandatory vaccines are not arbitrary or oppressive, so long as they go no further than is reasonably required for the safety of the public.[15] The Court clearly stated that real liberty cannot exist if each person is granted complete liberty over themselves and their property "regardless of the injury that may be done to others."[16] This clarified the need to balance the possible individual harm by such a mandated vaccine with the public health benefits a vaccine would create.[17]

Seventeen years later, the Supreme Court was asked to determine if a school district could constitutionally exclude unvaccinated children from its

---

[9] *Id*. at 27.
[10] *Id*.
[11] *Id*. at 26.
[12] *Id*.
[13] *Id*. at 24-25.
[14] *Jacobson*, 175 U.S. at 29.
[15] *Id.* at 28.
[16] *Id*. at 26.
[17] *Id.*

district in *Zucht v. King*.[18] In contrast to *Jacobson*, there was no public health emergency at the time this school district required the vaccination.[19] The petitioner in *Zucht* argued that because of the lack of emergency, the school district deprived her of her liberty without due process by making the vaccination effectively mandatory.[20] The Court in *Zucht* noted that *Jacobson* had "settled that it is within the police power of a state to provide for compulsory vaccination."[21] As such, the Court determined that the ordinance was not an arbitrary use of power, but reflected the broad discretion needed to protect public health.[22]

## PUBLIC CONCERNS OVER A COVID-19 VACCINE MANDATE

In May of 2020, Operation Warp Speed was announced in response to the COVID-19 pandemic.[23] Operation Warp Speed was a government initiative by a number of agencies whose goal was delivering 300 million doses of a safe, effective COVID-19 vaccine by January 2021.[24] This initiative provided companies such as Johnson & Johnson, Moderna, and AstraZeneca funding ranging from $456 million to $1.2 billion to work to develop a potential vaccine.[25] It began with fourteen "promising candidates" for

[18] Zucht v. King, 260 U.S. 174 (1922).
[19] *Zucht*, 260 U.S. at 175.
[20] *Id.*
[21] *Id.* at 176.
[22] *Id.* at 177.
[23] *See Fact Sheet: Explaining Operation Warp Speed*, U.S. DEP'T HEALTH & HUMAN SERVS., https://www.hhs.gov/about/news/2020/06/16/fact-sheet-explaining-operation-warp-speed.html (last updated Nov. 13, 2020) [hereinafter *Explaining Operation Warp Speed*] (these agencies include the Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the National Institutes of Health (NIH), the Biomedical Advanced Research and Development Authority (BARDA), and the Department of Defense (DoD)).
[24] *Id.*
[25] *Id.*

vaccine development, and the task force ultimately narrowed the group down to the seven most promising vaccines.[26]

While Operation Warp Speed was meant to accelerate the vaccine developmental process in order to combat COVID-19, it still followed the same three-phase process of clinical development regulated by the Food & Drug Administration ("FDA").[27] During the first phase, small groups of people receive a trial vaccine.[28] The second phase then provides the trial vaccine to a larger group, expanding to include those COVID-19 may affect more such as older people and those with health issues.[29] Finally, during the third phase the trial vaccine is administered to thousands of people and tests for efficacy and safety.[30] Even after all three phases are completed, the FDA continues monitoring and tracking the vaccine to ensure it does not have significant side effects after being administered.[31] Often, the entire process of developing a vaccine lasts between ten and fifteen years.[32]

News regarding the COVID-19 pandemic has become politicized, with Democrats and Republicans generally having different opinions on the values of mask-wearing and social distancing, as well as the possible

---

[26] *Id.* (These seven vaccines were going to come from a variety of technological options that would then move into the early stages of clinical trials).
[27] *See Explaining Operation Warp Speed*, *supra* note 23 ("Rather than eliminating steps from traditional development timelines, steps will proceed simultaneously, such as starting manufacturing of the vaccine at industrial scale well before the demonstration of vaccine efficacy and safety as happens normally."). S*ee generally Vaccine Testing and the Approval Process*, CDC, https://www.cdc.gov/vaccines/basics/test-approve.html (last updated May 1, 2014) (explaining the CDC regulations of the vaccine approval process).
[28] *Vaccine Testing and the Approval Process*, CDC, https://www.cdc.gov/vaccines/basics/test-approve.html (last updated May 1, 2014).
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Vaccine Development, Testing, and Regulation*, HISTORY OF VACCINES (Jan. 17, 2018), https://www.historyofvaccines.org/content/articles/vaccine-development-testing-and-regulation.

treatments for COVID-19.[33] These political differences continued even after President Trump himself tested positive for the virus.[34] As of October 2020, one poll showed that a majority of Americans did not trust President Trump to provide accurate information regarding COVID-19.[35] This could be connected to Trump's endorsement of multiple treatments of COVID-19 that were never fully tested or approved by the FDA.[36]

The politization of the pandemic became a top priority for voters in the 2020 election, and distrust in the President did not bode well for his re-election.[37] Thus, when the Centers for Disease Control & Prevention ("CDC") began telling states in early September to prepare to distribute a COVID-19 vaccine by early November,[38] many wondered if the communication was due to pressure from the President himself to produce a

---

[33] Kristen de Groot, *Do Political Beliefs Affect Social Distancing?*, PENN TODAY (May 22, 2020), https://penntoday.upenn.edu/news/do-political-beliefs-affect-social-distancing; Lauren Aratani, *How Did Face Masks Become a Political Issue in America*?, GUARDIAN (Jun. 29, 2020), https://www.theguardian.com/world/2020/jun/29/face-masks-us-politics-coronavirus.

[34] Trip Gabriel, *Trump May Have COVID, But Many of His Supporters Still Scoff at Masks*, N.Y. TIMES (Oct. 6, 2020), https://www.nytimes.com/2020/10/06/us/politics/trump-voters-face-masks.html.

[35] *Trump COVID Diagnosis Does Little to Change Americans' Behavior Around the Virus,* IPSOS (Oct. 6, 2020), https://www.ipsos.com/en-us/news-polls/axios-ipsos-coronavirus-index (citing seventy percent of Americans as having little to no trust in President Trump to provide them with accurate information about the virus).

[36] *See generally* Katie Thomas, *Regeneron Asks F.D.C. for Emergency Approval for Drug That Trump Claimed Cured Him*, N.Y. TIMES (Oct. 7, 2020), https://www.nytimes.com/2020/10/07/health/trump-covid-regeneron.html (regarding Trump's claims that Regeneron "saved his life" when he was hospitalized with COVID-19); *see also* Benn Gittleson et al., *Trump Doubles Down on Defense of Hydroxychloroquine to Treat COVID-19 Despite Efficacy Concerns*, ABC NEWS (Jul. 28, 2020), https://abcnews.go.com/Politics/trump-doubles-defense-hydroxychloroquine-treat-covid-19-efficacy/story?id=72039824 (regarding Trump's vocal endorsement of both Regeneron and hydroxychloroquine).

[37] Josh Dawsey & Yasmeen Abutaleb, *Emboldened By His COVID-19 Recovery, Trump Pushes Return to Normalcy* (Oct. 14, 2020), https://www.washingtonpost.com/politics/trump-covid-campaign/2020/10/14/a5faf466-0da0-11eb-bfcf-b1893e2c51b4_story.html ("Recent polls show Trump trailing Biden by double digits, with the pandemic proving to be his biggest political vulnerability.").

[38] Sheila Kaplan et al., *C.D.C. Tells States How to Prepare for Covid-19 Vaccine by Early November*, N.Y. TIMES (Sep. 2, 2020), https://www.nytimes.com/2020/09/02/health/covid-19-vaccine-cdc-plans.html.

vaccine before election day.[39] Then vice presidential candidate Kamala Harris openly stated that she "would not trust Donald Trump" in connection with a COVID-19 vaccine without a "credible source of information that talks about the efficacy and the reliability" of the vaccine.[40] Many across the country share her sentiment, with a Politico/Morning Consult poll showing that only fourteen percent of voters would be more likely to take a COVID-19 vaccine if President Trump recommended it.[41] Further, most Americans on both sides of the aisle are under the impression that the COVID-19 vaccine approval process is being driven by politics rather than science.[42]

To reduce fear that a vaccine may be driven more by politics than science, scientific leaders involved in the development of a vaccine have taken steps to show the public how committed they are to ensuring the safety of the vaccine.[43] The chief scientific advisor for Operation Warp Speed said he would quit the position if there was political interference in the process of developing a vaccine.[44] A group of drug companies have pledged that they will not release any vaccines that do not meet efficacy and safety standards.[45]

---

[39] Lin Erdman, *Majority of Americans Believe Political Pressure Will Cause FDA to Rush a Coronavirus Vaccine, New Poll Finds*, CNN (Sep. 10, 2020), https://www.cnn.com/2020/09/10/politics/coronavirus-vaccine-political-pressure-poll/index.html.
[40] Tal Axelrod, *Harris On Getting Any COVID-19 Vaccine Before Election: 'I Would Not Trust Donald Trump',* HILL (Sep. 5, 2020), https://thehill.com/homenews/campaign/515266-harris-on-getting-any-covid-19-vaccine-before-election-i-would-not-trust.
[41] David Lim, *Poll: Voters Much More Likely to Trust Family, Fauci than Trump on Vaccine*, POLITICO (Aug. 5, 2020), https://www.politico.com/news/2020/08/05/coronavirus-vaccine-poll-fauci-trump-391494.
[42] Ed Silverman, *Poll: Most Americans Believe the COVID-19 Vaccine Approval Process is Driven by Politics, Not Science*, STAT (Aug. 31, 2020), https://www.statnews.com/pharmalot/2020/08/31/most-americans-believe-the-covid-19-vaccine-approval-process-is-driven-by-politics-not-science/.
[43] *Coronavirus: Pharma Firms Unveil Safety Pledge Over Vaccine*, BBC NEWS (Sep. 8, 2020), https://www.bbc.com/news/world-54046157.
[44] Kim Bellware et al., *Live Updates: Coronavirus Vaccine Project Chief Says He Would Quit If There Was Political Interference*, WASH. POST (Sep. 3, 2020), https://www.washingtonpost.com/nation/2020/09/03/coronavirus-covid-live-updates-us/.
[45] Jacqueline Howard & Naomi Thomas, *9 Vaccine Makers Sign Safety Pledge in Race for COVID-19 Vaccine*, CNN (Sep. 8, 2020), https://www.cnn.com/2020/09/08/health/covid-19-vaccine-pharmaceutical-companies-pledge-bn/index.html.

And while Trump has said his push for a vaccine was "not because of the election" but "because we want to save people,"[46] there is evidence to the contrary. In one stark example, Dr. Paul Offit, a member of the FDA's vaccine advisory committee, stated that numerous people "on the inside of this process" are concerned the administration will "reach their hand into the Warp Speed bucket, pull out one or two or three vaccines," and "roll it out."[47]

As scientists work toward creating, manufacturing, and eventually distributing a vaccine, the pandemic rages on. Congress passed the Coronavirus Aid, Relief, and Economic Security (CARES) Act on March 27th, 2020 in an attempt to reduce COVID-19's economic impact on Americans.[48] This economic relief package included one-time stimulus checks to those earning less than $75,000, an extra $600 a week in federal unemployment, and grant money for small businesses.[49] Much of the CARES Act aid, however, expires in December 2020, and the pandemic is expected to reach an all-time high as the country moves into winter.[50] The economic effects of this pandemic are being most felt by those in lower income households.[51] Almost half of lower income homes have had trouble

---

[46] Libby Cathey & Stephanie Ebbs, *Trump Administration Insists Politics Won't Play Into Timeline For Coronavirus Vaccine*, ABC NEWS (Sep. 5, 2020), https://abcnews.go.com/Politics/trump-administration-insists-politics-wont-play-timeline-coronavirus/story?id=72823404.

[47] *Id*.

[48] *The CARES Act Works for All Americans*, U.S. DEPT. TREASURY, https://home.treasury.gov/policy-issues/cares (last accessed Dec. 1, 2020).

[49] Kelsey Snell, *What's Inside the Senate's $2 Trillion Coronavirus Aid Package*, NPR (Mar. 26, 2020), https://www.npr.org/2020/03/26/821457551/whats-inside-the-senate-s-2-trillion-coronavirus-aid-package.

[50] Greg Iacurci, *14 Million Workers Face Losing Unemployment Benefits at the End of December*, CNBC (Nov. 25, 2020) https://www.cnbc.com/2020/11/25/14-million-workers-face-losing-unemployment-benefits-at-the-end-december.html; Steve Gorman, Daniel Trotta, *CDC Chief Warns Americans Face 'Rough' Winter from COVID-19 Surge*, REUTERS (Dec. 2, 2020), https://www.reuters.com/article/health-coronavirus-usa/cdc-chief-warns-americans-face-rough-winter-from-covid-19-surge-idUSKBN28C20R.

[51] Jonnelle Marte, *Lower-Income Workers Hit Harder By Coronavirus Job Losses, Fed Survey Finds*, REUTERS (May 14, 2020), https://www.reuters.com/article/us-usa-fed-

paying their bills and used money from their savings or retirement to pay their bills.[52] These hardships are most felt by Black and Hispanic Americans.[53] These issues will not be cured by a COVID-19 vaccine,[54] but it is a necessary step in ending this pandemic.[55]

## WHAT DOES THIS MEAN FOR A COVID-19 VACCINE MANDATE?

*Jacobson* is considered fairly settled law.[56] Accordingly, all fifty states have mandated vaccinations of some kind for childcare and school.[57] Under these mandates, all states allow for medical exemptions to children who would be harmed by a vaccination.[58] And while medical, religious, and "philosophical" exemptions exist, ideally these exemptions would only apply to a small portion of the population so as to maintain herd immunity.[59] Herd immunity protects those who are unable to get vaccines because a significant

---

jobs/lower-income-workers-hit-harder-by-coronavirus-job-losses-fed-survey-finds-idUSKBN22Q2QG.

[52] Kim Parker et al., *Economic Fallout from COVID-19 Continues to Hit Lower-Income Americans the Hardest*, PEW RSCH. CTR. (Sep. 24, 2020), https://www.pewsocialtrends.org/2020/09/24/economic-fallout-from-covid-19-continues-to-hit-lower-income-americans-the-hardest/.

[53] *Id.*

[54] Matt Egan, *A Vaccine Might Be Coming, but the COVID Economy Still Desperately Needs Stimulus*, CNN (Nov. 9, 2020), https://www.cnn.com/2020/11/09/business/coronavirus-vaccine-economy-stimulus/index.html.

[55] Sarah Boseley, *Vaccine Results Bring Us a Step Closer to Ending COVID, Says Oxford Scientist*, GUARDIAN (Nov. 23, 2020) https://www.theguardian.com/world/2020/nov/23/vaccine-brings-us-a-step-closer-to-ending-covid-says-oxford-scientist.

[56] James Colgrove & Ronald Bayer, *Manifold Restraints: Liberty, Public Health, and the Legacy of* Jacobson v. Massachusetts, 95 AM. J. PUB. HEALTH 571, 571 (2005); Erwin Chemerinsky, *Vaccines Protect Us. But Does the U.S. Constitution Protect Anti-Vaccine Parents?*, SACRAMENTO BEE (May 6, 2019), https://www.sacbee.com/opinion/california-forum/article229946704.html ("Every court to rule on the issue has held that the government may require that people be vaccinated against communicable diseases.").

[57] *States with Religious and Philosophical Exemptions from School Immunization Requirements*, NCSL, https://www.ncsl.org/research/health/school-immunization-exemption-state-laws.aspx (last updated June 26, 2020).

[58] *Id.*

[59] *Id.*; Herd Immunity and COVID-19 (Coronavirus): What You Need To Know, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/herd-immunity-and-coronavirus/art-20486808. (last updated Jun. 6, 2020).

percentage of the population has been immunized and thus will not catch and transfer the disease to those who are not immunized.[60] The more contagious a disease is, the higher the proportion of the population needs to be vaccinated in order to achieve herd immunity.[61] With a disease as contagious as COVID-19, a significant majority of the population would need to receive a vaccine in order to reach herd immunity.[62] Thus, schools, cities, or states may consider mandating a COVID-19 vaccine in order to protect their citizens and return to a level of normalcy the United States has not seen for the majority of 2020.[63]

Under *Jacobson*, a mandated COVID-19 vaccine would only be considered constitutional if the requirement goes no further in restricting individual liberties than is reasonably required for the safety of the public.[64] As of this writing, over 242,000 Americans have died of COVID-19 and the U.S. is averaging over 100,000 cases per day.[65] This may lead one to believe the public health interest for a COVID-19 vaccine is significantly higher than

---

[60] *Id*.
[61] *Id*.
[62] *See* Cynthia DeMarco, *COVID-19 Herd Immunity: 7 Questions, Answered*, U. TEXAS MD ANDERSON CANCER CTR. (Jul. 17, 2020), https://www.mdanderson.org/cancerwise/what-is-covid-19-coronavirus-herd-immunity-when-will-we-achieve-herd-immunity.h00-159383523.html ("There's actually a formula used to calculate [the percentage of the population needed to achieve herd immunity]. This formula includes the basic reproduction number or 'R-zero,' which indicates the average number of new people that a single infected individual can expose and infect. That figure for the flu is around 1.3. … Unfortunately, for the coronavirus, it's between 2 and 3. We probably need around seventy percent of the population to have developed antibodies in order to half community transmission of COVID-19.").
[63] *See generally* Travis Guillory, *Could a COVID-19 Vaccine Be Mandatory?*, KJRH, https://www.kjrh.com/news/local-news/could-a-covid-19-vaccine-be-mandatory (Sep. 14, 2020) (examining the possibility that a state could make a COVID-19 vaccine mandatory); Jillian Kramer, *COVID-19 Vaccines Could Become Mandatory. Here's How It Might Work*, NATIONAL GEOGRAPHIC (Aug. 19, 2020), https://www.nationalgeographic.com/science/2020/08/how-coronavirus-covid-vaccine-mandate-would-actually-work-cvd/.
[64] Jacobson v. Massachusetts, 197 U.S. 11, 28 (1905).
[65] *COVID in the U.S.: Latest Map and Case Count*, N.Y. TIMES, https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html (last updated Nov. 13, 2020).

the individual liberty of each citizen.[66] This belief, however, may not be the case.[67]

Fear of a COVID-19 vaccine being rushed through due to political pressure significantly decreases the value of a vaccine.[68] The petitioner in *Jacobson* relied on evidence against vaccine safety as a whole[69]—which has overall been disproven by science.[70] The Court in *Jacobson* stated that the evidence brought forward was inadequate and that the only "competent evidence" that could have been presented was that of medical experts.[71] Those arguing against a mandatory COVID-19 vaccine, however, have the public concerns of political and scientific leaders in the vaccine in question.[72] A possible challenger would be able to show significantly more evidence of experts questioning the value of the vaccine than was presented in *Jacobson*.[73] It is likely that voices from within the vaccine development task

---

[66] *Constitution Has Answers for Balancing Health and Liberties Amid COVID-19, UArizona Experts Say*, U. ARIZONA HEALTH SCI. (Jul. 30, 2020), https://uahs.arizona.edu/news/constitution-has-answers-balancing-health-and-liberties-amid-covid-19-uarizona-experts-say.

[67] *U.S. Justice Alito Says Pandemic Has Led to 'Unimaginable' Curbs on Liberty*, REUTERS (Nov. 13, 2020), https://www.reuters.com/article/us-health-coronavirus-usa-supremecourt/u-s-supreme-courts-alito-raised-concerns-over-individual-liberty-amid-covid-19-idUSKBN27T0LD ("The justice, who is seen as a conservative, told a meeting of the Federalist Society … he was not under playing the severity of the crisis … [b]ut he added: 'We have never before seen restrictions as severe, extensive and prolonged as those experienced for most of 2020.'").

[68] Felice J. Freyer, *Public Health Experts Fear Politics Will Taint COVID-19 Vaccine Approval*, BOS. GLOBE (Sep. 2, 2020), https://www.bostonglobe.com/2020/09/02/metro/public-health-experts-fear-politics-will-taint-vaccine-approval/.

[69] *Jacobson*, 197 U.S. at 23.

[70] *Vaccine Safety*, CDC, https://www.cdc.gov/vaccinesafety/index.html (last updated Aug. 27, 2020).

[71] *Jacobson*, 197 U.S. at 23.

[72] Alice Miranda Ollstein, *On Coronavirus Vaccines, Biden Says He'll Trust Scientists, Not Trump*, POLITICO (Sep. 16, 2020), https://www.politico.com/news/2020/09/16/joe-biden-coronavirus-vaccine-trump-416420 ("Democratic nominee Joe Biden sharply questioned the Trump administration's process for approving a coronavirus vaccine"); Dennis Pillion, *UAB Expert Says Rushed COVID Vaccine Is Pushing Scientists Into 'Data-Free Zone'*, AL.COM (Sep. 5, 2020), https://www.al.com/news/2020/09/uab-expert-says-rushed-covid-vaccine-is-pushing-scientists-into-data-free-zone.html.

[73] *See generally* Freyer, *supra* note 68; Silverman, *supra* note 42.

force questioning the safety of the vaccine would weigh heavily against the vaccine's value when compared to the opinions against the use of vaccines as a whole which were articulated in *Jacobson*.[74] Thus, while a working vaccine would have significant value to public health, this shared skepticism in the safety or effectiveness of a vaccine may lead a court to find that individual liberty outweighs the value of the vaccine to public safety.[75] And while science is non-partisan, the vaccine development process has been pushed into politics, which has caused many to doubt the truthfulness of the science the Trump Administration is trying to promote.[76]

Additionally, the speed at which scientists are working to develop a COVID-19 vaccine has many worried about the vaccine's effectiveness,[77] thus increasing the relative value of citizens' individual liberty interest. Operation Warp Speed was named as such because it was meant to speed up the vaccine development process as much as was safely possible.[78] This speed became publicly concerning when vaccine trials by AstraZeneca were halted in the U.K. due to a volunteer developing neurological issues.[79]

---

[74] *Jacobson*, 197 U.S. at 23.
[75] Jason Grant, *Lawyers, Professors Push Back Against Bar Group Call for 'Mandatory' COVID-19 Vaccinations*, N.Y. L. J. (Jun. 4, 2020), https://www.law.com/newyorklaw journal/2020/06/04/lawyers-professors-push-back-against-state-bar-group-call-for-mandatory-covid-19-vaccinations/.
[76] Erdman, *supra* note 39.
[77] Andrew Naughtie, *Scientists Fear Trump Could Rush Out Coronavirus Vaccine Before It's Ready*, INDEPENDENT (Aug. 4, 2020), https://www.independent.co.uk/news/world/americas/ump-coronavirus-vaccine-operation-warp-speed-safe-covid-a9653526.html.
[78] Fox, *supra* note 7. *See also* Stuart A. Thompson, *How Long Will a Vaccine Really Take?*, N.Y. TIMES (Apr. 30, 2020), https://www.nytimes.com/interactive/2020/04/30/opinion/coronavirus-covid-vaccine.html.
[79] Katherine J. Wu, *Safety Review Underway of AstraZeneca's Vaccine Trial*, N.Y. TIMES (Sep. 10, 2020), https://www.nytimes.com/2020/09/10/health/covid-astrazeneca-vaccine-trans.html. It was later determined that these symptoms were not related to the vaccine but instead were due to a rare spinal inflammatory disorder called transverse myelitis; Michael Holden, *AstraZeneca Resumes UK Trials of COVID-19 Vaccine Halted by Patient Illness*, REUTERS (Sep. 15, 2020), https://www.reuters.com/article/health-coronavirus-britain-vaccine/astrazeneca-resumes-uk-trials-of-covid-19-vaccine-halted-by-patient-illness-idUSKBN2630NY.

Further, by fast-tracking through the development process, long term risks and side effects will be less known when the vaccine is finally distributed to the public.[80] For example, Moderna's current Phase 3 trials includes 30,000 participants—8,500 less than needed to reliably identify a one in 10,000 adverse effect.[81] People of color and older Americans—both of which are groups that have been disproportionately impacted by the virus—have been less willing to participate in vaccine trials.[82] The risks of a vaccine cannot be fully understood if trial participants do not mirror the actual makeup of the U.S.[83] Forcing Americans to get a vaccine that is riskier than a slower-developed vaccine has a larger impact on individuals' personal liberty.[84] Many Americans want a COVID-19 vaccine but are not willing to take the risk themselves before knowing it is fully tested.[85]

A vaccine is absolutely necessary for the United States to recover from COVID-19.[86] The politics and speed behind a COVID-19 vaccine, however,

---

[80] Katrina Megget, *What Are the Risks of Fast-Tracking a COVID-19 Vaccine?*, ROYAL SOCIETY CHEMISTRY (Jul. 13, 2020), https://www.chemistryworld.com/news/what-are-the-risks-of-fast-tracking-a-covid-19-vaccine/4012130.article.
[81] *Id.*; *Moderna's Fully Enrolled Phase 3 COVE Study of mRNA-1273*, MODERNA, https://www.modernatx.com/cove-study (last updated Oct. 22, 2020).
[82] *See generally* Rachel Nania, *Older Adults, Minorities Underrepresented in COVID-19 Vaccine Trials*, AARP (Sep. 28, 2020), https://www.aarp.org/health/conditions-treatments/info-2020/range-of-subjects-in-vaccine-trials.html; Blake Farmer, *COVID Vaccine Trials Move at Warp Speed, But Recruiting Black Volunteers Takes Time*, KAISER HEALTH NEWS (Sep. 16, 2020), https://khn.org/news/covid-vaccine-trials-move-at-warp-speed-but-recruiting-black-volunteers-takes-time/ (discussing fears many Black Americans have of medical testing due to previous governmental wrongdoings to Black communities).
[83] Mary Chris Jaklevic, *Researchers Strive to Recruit Hard-Hit Minorities Into COVID-19 Vaccine Trials*, JAMA NETWORK (Aug. 13, 2020), https://jamanetwork.com/journals/jama/fullarticle/2769611.
[84] Doug Donovan, *Vaccine Opponents Unite Around a 'Civil Liberties' Argument on Social Media, Study Finds*, JOHN HOPKINS U. (Oct. 2, 2020), https://hub.jhu.edu/2020/10/02/anti-vaccine-movement-unites-around-civil-liberties-argument/.
[85] Lauren Aratani, *Majority of Americans Will Wait to Get Covid Vaccine, Poll Shows*, GUARDIAN (Sep. 22, 2020) https://www.theguardian.com/us-news/2020/sep/22/us-covid-vaccine-poll-wait (stating only thirteen percent of respondents would get a COVID vaccine immediately after it becoming available, sixteen percent saying they would wait a few weeks, and eighteen percent saying they would wait at least a year).
[86] James Gallagher, *Coronavirus Vaccine: When Will We Have One?*, BBC NEWS (Sept. 25, 2020), https://www.bbc.com/news/health-51665497.

have hindered a vaccine's public health value tremendously.[87] This has led to a distrust of a possible vaccine, and a mandate may be required for herd immunity to be achieved.[88] This distrust has increased the value of Americans' individual liberty, which may outweigh the diminished public health value of a COVID-19 vaccine, thus causing a mandated vaccine to fail the *Jacobson* balancing test.[89]

## CONCLUSION

On November 9, 2020, Pfizer and BioNTech announced data results from a phase 3 study that their vaccine candidate was found to be more than ninety percent effective in preventing COVID-19.[90] While Pfizer had been offered funding from Operation Warp Speed, they denied it and have worked to distance themselves from the Trump administration and Operation Warp Speed.[91] President Trump claimed, without evidence, that Pfizer had delayed announcing these results until after the election, continuing to connect the vaccine to politics.[92] While Pfizer's results look promising, the vaccine still has to go through the emergency authorization process before any public distribution can begin.[93] Discussions of a mandated vaccine, however, have

---

[87] Linda Marsa, *Why Americans Fear They're Playing Vaccine Roulette*, DISCOVER MAG. (Oct. 26, 2020), https://www.discovermagazine.com/health/why-americans-fear-theyre-playing-vaccine-roulette.
[88] Elizabeth Cohen, *Fauci Says COVID-19 Vaccine May Not Get US to Herd Immunity if Too Many People Refuse to Get It*, CNN (Jun. 28, 2020), https://www.cnn.com/2020/06/28/health/fauci-coronavirus-vaccine-contact-tracing-aspen/index.html.
[89] Grant, *supra* note 75.
[90] *Pfizer and Biontech Announce Vaccine Candidate Against COVID-19 Interim Analysis From Phase 3 Study*, PFIZER (Nov. 9, 2020), https://www.pfizer.com/news/press-release/press-release-detail/pfizer-and-biontech-announce-vaccine-candidate-against.
[91] Carl Zimmer & Katie Thomas, *Pfizer's Covid Vaccine: 11 Things You Need to Know*, N. Y. TIMES (Nov. 12, 2020) https://www.nytimes.com/live/2020/pfizer-covid-19-vaccine.
[92] Grace Dean & Andrew Dunn, *Donald Trump and His Son Donald Trump Jr., Without Evidence, Accuse Pfizer of Deliberately Waiting Until After Election Day to Release its COVID-19 Vaccine Trial Results*, BUSINESS INSIDER (Nov. 10, 2020), https://www.businessinsider.com/trump-pfizer-covid-19-vaccine-conspiracy-theory-delay-election-day-2020-11.
[93] Zimmer & Thomas, *supra* note 91.

already begun, as the New York State Bar Association passed a resolution urging the state to consider a state-wide mandate.[94] While President-elect Joe Biden has not made any mention of a mandated vaccine in his administration, the burden is now on him to help rebuild public trust in the vaccine for Americans to volunteer to take it.[95]

A COVID-19 vaccine is unquestionably needed for the United States to even consider going back to "business as usual."[96] A vaccine, however, will be useless if an insufficient number of Americans are willing to take a vaccine surrounded by so much political pressure.[97] If herd immunity cannot be achieved through voluntariness in taking a vaccine, then schools, cities, and states may turn to mandating the vaccine in order to protect their citizens.[98] This mandate, however, may not be able to withstand the balancing test developed in *Jacobson v. Commonwealth of Massachusetts* due to these same political pressures that caused fear in the vaccine.[99]

---

[94] Jason Grant, *State Bar Passes Mandatory COVID-19 Vaccination Recommendation*, N.Y. L. J. (Nov. 7, 2020), https://www.law.com/newyorklawjournal/2020/11/07/state-bar-passes-mandatory-covid-19-vaccination-recommendation/.
[95] Jamie Ducharme & Alice Park, *Biden's Real COVID-19 Challenge Is Restoring a Nation's Trust in Science*, TIME (Nov. 7, 2020), https://time.com/5907908/biden-administration-covid-19/.
[96] Gallagher, *supra* note 86.
[97] Cohen, *supra* note 88.
[98] Roy M. Anderson et al., *Challenges in Creating Herd Immunity to SARS-CoV-2 Infection By Mass Vaccination*, LANCET (Nov. 4, 2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32318-7/fulltext.
[99] Grant, *supra* note 94.

# Compassionate Release During a Pandemic: Clearer Routes for Direct Advocacy of Prisoners to Avoid Harmful Delays to Medically Vulnerable Population

*Abby Higgins*

## INTRODUCTION

The COVID-19 pandemic shed light on the variability in state and local responses to a public crisis.[1] With a lack of national guidance, and a focus on maintaining federalism principles, states have implemented policies that align with their own best path forward.[2] This creates glaring inconsistency across state action and programs to combat the virus, from lockdown procedures to reporting of case data.[3] Prison management is no exception to this inconsistency.[4] The Bureau of Prisons ("BOP") did provide guidance on how to update procedures regarding COVID-19, however their authority only extends to federal prisons.[5] Even with this guidance to all federal

[1] *See* Soumya Rangarajan, *COVID-19's Other Unnecessary Death Toll*, SCI. AM.: PUB. OP. (Sept. 15, 2020), https://www.scientificamerican.com/article/covid-19s-other-unnecessary-death-toll. (discussing the lack of national message and a variety of state responses).
[2] *See* Sarah H. Gordon et al., *What Federalism Means for the US Response to Coronavirus Disease 2019*, JAMA HEALTH FORUM (May 8, 2020), https://jamanetwork.com/channels/health-forum/fullarticle/2766033 ("Federalism, of the division of power between a national government and states, is a fundamental feature of US public health authority. In this pandemic, US public health federalism assures that the coronavirus response depends on zip code.").
[3] *See id*. (discussing state's individual response to federal messaging and their authority to take action); Laura Dyrda, *States are Reporting Inconsistent, Incomplete COVID-19 Data, Analysis Finds*, BECKER'S HOSP. REV. (July 24, 2020), https://www.beckershospitalreview.com/data-analytics/states-are-reporting-inconsistent-incomplete-covid-19-data-analysis-finds.html. *See generally* Jacob Gershman, *A Guide to State Coronavirus Reopenings and Lockdowns*, WALL ST. J. (last updated May 20, 2020), https://www.wsj.com/articles/a-state-by-state-guide-to-coronavirus-lockdowns-11584749351 (detailing state by state procedures for lockdowns and the reopening process).
[4] Emily Wirdra & Dylan Hayre, *Failing Grades: States' Responses to COVID-19 in Jails & Prisons*, PRISON POL'Y INITIATIVE (June 25, 2020), https://www.prisonpolicy.org/reports/failing_grades.html.
[5] *Covid-19 Updates*, BUREAU OF PRISONS, https://www.bop.gov/coronavirus/ (detailing measures and guidance on a variety of Covid-19 related topics like inmate movement, social

prisoners, the polices have been criticized for their incompleteness.[6] Additionally, due to the COVID-19 pandemic's disparate impact on high risk populations, there was considerable scrutiny given to the early release programs for medical vulnerabilities in prison populations to maintain safety measures.[7] This early release program, known as "compassionate release", is a sparingly authorized process used to release prisoners who qualify as particularly medically vulnerable to their homes, where they would seek care on their own.[8]

Compassionate release statutes and programs at the state level include different standards for who has the authority and opportunity to bring a claim for review; this can include a requirement for a terminally ill diagnosis, specific reapplication criteria, and categorical exclusions for release based on

visits, staff interaction, and volunteers). *See About Our Agency*, BUREAU OF PRISONS, https://www.bop.gov/about/agency/ ("We protect public safety by ensuring that federal offenders serve their sentences of imprisonment in facilities that are safe…".).

[6]Natalie Chwalisz, *The Federal Bureau of Prisons Response to the Coronavirus has been Disastrous and Deadly*, WASH. POST: LOCAL OP. (Aug. 7, 2020), https://www.washingtonpost.com/opinions/local-opinions/the-federal-bureau-of-prisons-response-to-the-coronavirus-has-been-disastrous-and-deadly/2020/08/06/3d30464c-d65b-11ea-aff6-220dd3a14741_story.html (discussing the unique position of DC prisons, due to sending all convicted residents to federal prisons, and the harm that has followed from lack of action by the BOP); Kim Bellware, *Prisoners and Guards Agree About Federal Coronavirus Response: 'We do not feel safe'*, WASH, POST (Aug. 24, 2020), https://www.washingtonpost.com/nation/2020/08/24/prisoners-guards-agree-about-federal-coronavirus-response-we-do-not-feel-safe/ (detailing an inmate's experience in being diagnosed for COVID-19 and after an appointment, the case had no movement for at least 24 days).

[7] *See* United States v. Haney, No. 19-cr-541, 2020 U.S. Dist. LEXIS 63971, *1 (S.D.N.Y. Apr. 13, 2020) (Rakoff, J.) ("The rapid spread of COVID-19 has caused a public health crisis and a national emergency that can best be reduced by the kind of social distancing not easily attained in an overcrowded federal prison facility, such as the Metropolitan Detention Center ("MDC") where Haney resides.").

[8] *Id.* (stating that in normal times a defendant's request for permanent compassionate release would be frivolous on its face). *See generally* Bill Rankin, *In Atlanta, Federal Lawyers Fight to Free Inmates amid Coronavirus*, AJC (September 7, 2020) https://www.ajc.com/news/atlanta-news/atlanta-lawyers-mission-amid-virus-compassionate-release-of-inmates/VTI6ZEZG7JFTTNW42AZNRY2YMM/ (covering a particular case that the Atlanta Federal Defender's office took up along with dozens of others under compassionate release).

type of crime.[9] In fact, many of these state statutes are focused on reactive release due to a terminally ill diagnosis.[10] Even if an inmate meets the criteria within the state statute, there is wide variance on who has the authority to bring the claim to the courts, ranging from the warden, to the secretary or director of corrections, to the sheriff, creating a complex and inconsistent process to follow.[11] Due in part to this complexity, there is a lack of education on the opportunities presented by compassionate release, with one study showing that nearly half of elderly respondents stated they lacked the knowledge to apply.[12]

On the other hand, the federal prison systems look to the BOP, which follows guidance pursuant to 18 USCA §3852.[13] This statute discusses that the authority to bring a claim for compassionate release lies within the BOP, as opposed to the inmate advocating for themselves in the vast majority of the cases.[14] To aid in the management of prisons during the pandemic, Attorney General William Barr published a statement on process adjustments due to COVID-19 and encouraged prisons to utilize their options to release prisoners to home confinement or other programs to get prisoners out of the

---

[9] *See generally* Mary Price, *Everywhere and Nowhere: Compassionate Release in the States*, FAMM (June 2018), https://famm.org/wp-content/uploads/Exec-Summary-Report.pdf. (reporting on the variability of state statutes describing early release programs for medical need).

[10] *Id*. at 16 ("Kansas is one of the extreme examples. To be eligible for Terminal Medical Release, a prisoner's death must be expected within 30 days.").

[11] *See generally* S.D. Codified Laws § 24-15A-56 ("The secretary of corrections may consider referrals for compassionate parole consideration from the inmate's health care provider or the warden"); Mich. Comp. Laws Ann. § 771.3h (West) ("A county sheriff may notify the court in writing that a prisoner may be eligible for compassionate release if the county sheriff has consulted with a physician and the physician determined that the prisoner has a life expectancy of not more than 6 months.").

[12] Stephanie Grace Post & Brie Williams, *Strategies to Optimize the Use of Compassionate Release from US Prisons*, 110 AM J PUB. HEALTH SUPPL 1 S25, S25 (2020) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6987939/pdf/AJPH.2019.305434.pdf.

[13] 18 U.S.C.A. §3582(c)(1)(A).

[14] *Id.*

confined space.[15] However, an inmate is only able to bring the claim on their own behalf once they have exhausted all administrative options after appealing to the BOP.[16] This exhaustion requirement has shown to be difficult to overcome for inmates, and federal courts have inconsistently applied the requirement while reviewing cases related to the COVID-19 pandemic, lowering the number of compassionate release cases brought to court.[17]

The lack of proper health care and specifically poor reactions to disease outbreaks within prisons is not unique to COVID-19.[18] The criticism on prison systems' lack of appropriate response to health crises has focused on the insufficiency of administration measures, cramped and crowded living situations, and the fact that the prison population generally has a higher percentage of illness.[19] The reality of healthcare in prisons is a lack of preparation for standard maintenance or preventative healthcare, and a nearly unsurmountable obstacle for providing care during any public health crisis.[20]

---

[15] William Barr, *Memorandum for the Director of Bureau Prisons*, OFF. ATT'Y GEN., 1 (March 26, 2020), https://www.bop.gov/coronavirus/docs/bop_memo_home_confinement.pdf.

[16] *Id.* ("upon motion of the defendant after the defendant has fully exhausted all administrative rights to appeal a failure of the Bureau of Prisons to bring a motion on the defendant's behalf or the lapse of 30 days from the receipt of such a request by the warden of the defendant's facility.").

[17] Madison Adler, *Virus Forces Judges Into Life or Death Calls on Inmate Releases*, BLOOMBERG L. (May 18, 2020), https://www.bloomberglaw.com/document/X1L7F1GO000000 ("Brooks did, however, note that the administrative exhaustion requirement 'presents a glaring roadblock foreclosing compassionate release at this point.'"); Jolene LaVigne-Albert, *Inmate Release Exhaustion Rule Should be Waived for COVID*, LAW360, (April 19, 2020), https://www.law360.com/articles/1264971/inmate-release-exhaustion-rule-should-be-waived-for-covid.

[18] *See* Scott Burns, *Prisons, Law and Public Health: The Case for a Coordinated Response to Epidemic Disease Behind Bars*, 47 U. MIAMI L. REV. 291, 307 (1992) (comparing the prison system response to HIV and tuberculosis epidemics to the ideal response).

[19] John Jacobi, *Prison Health, Public Health: Obligations and Opportunities*, 31 AM. J OF LAW & MED. 447, 447-478 (2005).

[20] *See generally* Eric Levenson, *Prison Inmates are Twice as Likely to Die of Covid-19 than Those on the Outside, New Report Finds*, CNN (Sept. 3, 2020), https://www.cnn.com/2020/09/02/us/prison-coronavirus-clusters-report/index.html (reviewing the impact to prison

This article will argue the need to provide a clearer distinction on when an inmate can advocate for their own early release regarding medical vulnerability at both federal and state levels. First, the article will discuss the federal courts' debate over their jurisdiction to hear claims despite the requirement to exhaust all administrative options as a result of the COVID-19 pandemic.[21] Second, the article will review the variability of state laws in regard to the ability to bring a claim regarding compassionate release or another authority being required.[22] Finally, this article will present a statutory adjustment at both a federal and a state level that creates a more equitable and appropriate authority for bringing medical release claims during a public health emergency.

## VARIABILITY WITHIN FEDERAL COURTS ON EXHAUSTION REQUIREMENT

In December of 2018, President Donald Trump signed the First Step Act into law.[23] The First Step Act expanded the ability to review claims from prisoners on a request for release based on medical need, effectively shortening the term.[24] Criteria for medical release include either a compelling reason, or the inmate's age being above seventy, with at least thirty years served.[25] In limited situations however, inmates are able to advocate directly for compassionate release.[26] This adjustment to the statute

populations including that the rate of Covid-19 infection, a prisoner is four times as likely to get the virus than the general population, citing crowding and inadequate resources).
[21] *See* Barr, *supra* note 15.
[22] Price, *supra* note 9, at 12.
[23] *See generally* Nathan James, *The First Step Act of 2018: An Overview*, CONG. RSCH. SERV. 18 (Mar. 4, 2019), https://crsreports.congress.gov/product/pdf/R/R45558 (analyzing the impact of the expansion to the compassionate release analysis by federal courts after the First Step Act's addition of a compelling reason.); *Compassionate Release and the First Step Act: Then and Now*, FAMM 3, https://famm.org/wp-content/uploads/Compassionate-Release-in-the-First-Step-Act-Explained-FAMM.pdf.
[24] 18 U.S.C.A. §3582(c)(1)(A).
[25] *Id.*
[26] *Id.*

to broaden the scope of who can bring a claim has unfortunately not adjusted the restrictive nature of the compassionate release process broadly.[27] The ability for direct advocacy is only available once all administrative options have been exhausted, or thirty days have passed and the BOP has failed to act on the claim.[28] The exhaustion principle has historically been very strictly followed, but recognizes exceptions including where the requirement would require undue delay that could cause "catastrophic health consequences."[29] During the pandemic, the analysis on administrative exhaustion carried out by courts has been inconsistent when accounting for effects of the COVID-19 virus.[30] For instance, in a normal environment thirty days is not that long to wait for a decision from the BOP, but due to the complexity of a rapidly spreading virus it becomes, very literally, a life or death situation.[31]

This confusion occurred even as the AG's guidance specifically encouraged the utilization of home confinement in some situations and specifically reiterated the need to review COVID-19 symptoms in order to provide a more effective environment to protect their health.[32] As AG Barr states, the BOP has options on releasing prisoners to home confinement, like

---

[27] Annie Wilt, *The Answer Can Be Yes: The First Step Act and Compassionate Release*, HARVARD CIVIL RIGHTS – CIVIL LIBERTIES L. REV. (Oct. 23, 2019), https://harvardcrcl.org/the-answer-can-be-yes-the-first-step-act-and-compassionate-release.
[28] LaVigne-Albert, *supra* note 17.
[29] *See* Washington v. Barr, 925 F.3d 109, 118 (2d Cir. 2019) (discussing the three exceptions to statute mandated exhaustion: "(1) where exhaustion would be futile, including where undue delay due to exhaustion may result in "catastrophic health consequences;" (2) where "the administrative process would be incapable of granting adequate relief;" and (3) where "pursuing agency review would subject plaintiffs to undue prejudice.").
[30] *Federal Prisoners and COVID-19: Background and Authorities to Grant Release*, CONG. RSCH. SERV. 10 (last updated: Apr. 23, 2020) https://crsreports.congress.gov/product/pdf/R/R46297 ("However, other lower federal courts have concluded that they have the discretion to waive the exhaustion requirement, indicating (among other things) that Congress could not 'have intended the 30-day waiting period of 3582(c)(1)(A) to rigidly apply in the highly unusual' circumstances of the COVID-19 pandemic.").
[31] *See* Adler, *supra* note 17.
[32] Barr, *supra* note 15, at 1.

modifying a sentence after reviewing particular circumstances.[33] If home confinement is rejected, the prisoner can appeal under the compassionate release statute.[34] The statute on its face seems to allow an opportunity for an inmate to advocate on behalf of themselves to the court.[35] However the administrative burden placed upon the inmate can delay the hearing to the point where the inmate may die waiting for their appeal to be heard.[36] With the goal of eliminating administrative burden to the courts, this requirement has laid more administrative duties on an overstrained BOP, and has caused fatal harms to compassionate-release eligible inmates.[37]

In practice, courts have been struggling with the balance of the statutory language and the reality of the pandemic when it comes to thirty-day delays, even with this more streamlined federal guidance. In April of 2020, the Third Circuit ruled on a case denying the inmate compassionate release because the thirty day period had not been met for the BOP to review, stating that "it presents a glaring roadblock foreclosing compassionate release at this point."[38] Conversely, that same month in an Iowa District Court, the court ruled that the inmate did not have to meet the exhaustion requirement in their appeal to be released early due to medical vulnerability, stating that the original party likely not looking at the application, the parties lacked an adversarial relationship.[39] This conflict creates more confusion, and courts have often discussed the impracticability of this rule during a public health

[33] *Id.*
[34] 18 U.S.C.A. §3582(c)(1)(A).
[35] *Id.*
[36] *See* Alder, *supra* note 17.
[37] *See* LaVigne-Albert, *supra* note 17
[38] United States v. Raia, 954 F.3d 594, 597 (3d Cir. 2020).
[39] United States v. Brown, No. 4:05-CR-00227-1, 2020 WL 2091802, at 4 (S.D. Iowa Apr. 29, 2020) ("Thus, precedent dictates it is inappropriate to require issue exhaustion. Defendant may raise new arguments, including a sudden, global pandemic, in his motion to the Court.").

emergency.[40] Clearer standards within and outside of a public health crisis would allow courts to evaluate the requirements more consistently.[41] Removing administrative timelines, like the thirty-day waiting period, during the pandemic allows courts to properly review all facts of the case and apply the compassionate release program to meet the need for which it was created.[42]

## STATE COMPASSIONATE RELEASE PROGRAMS

As opposed to the federal prisons, states have control over their own compassionate release programs within state prisons. There is a wide variety within the elements of the programs in regard to reporting, eligibility, authority, and if it is an option at all.[43] As many of these cases are either handled internally within the prison or are never reported if they do go to court, there is not a lot of public information available to review the differences pre and post COVID-19 on the volumes or approvals of compassionate release.[44] To respond in situations of public health crises, adjustments should be made to who has the authority to bring a compassionate release claim, and reporting should be encouraged to track progress.

---

[40] United States v. Delgado, No. 3:18-CR-17-(VAB)-1, 2020 WL 2464685, at *3 (D. Conn. Apr. 30, 2020) (discussing the difference in court decisions related to the exhaustion requirement during the Covid-19 pandemic).

[41] Brie A. Williams et al., *Balancing Punishment and Compassion for Seriously Ill Prisoners*, 155 ANN. INTERN. MED 122, 127 (2011) (discussing the need for clearer medical standards for compassionate release review due to the current standards causing confusion and a power imbalance).

[42] *See generally* Marjorie P. Russell, *Too Little, Too Late, Too Slow: Compassionate Release Of Terminally Ill Prisoners-Is The Cure Worse Than The Disease?*, 3 WIDENER J. PUB. L. 799 (1994) (detailing numerous administrative delays that cost individuals under review for compassionate release).

[43] *See* Price, *supra* note 9, at 27 (compiling all state medical paroles programs, and reporting that all states have a program except one, Iowa).

[44] *See id.* at 18 (discussing that less than half of states collect data on application for medical parole or the outcome).

Below is a review of two states laws and/or processes: Illinois, a state that does not have a codified process, and New York, a state with one of the most robust compassionate release statutes.[45]

Illinois does not have a defined law that outlines a process for compassionate release, however, there is a section in the Illinois Constitution that states that the Governor has the ability to commute a sentence.[46] In 2015, the Governor of Illinois commissioned a report on reducing prison population, whose result included a recommendation on making a defined process for compassionate release.[47] This report recommended reporting on cases regularly, and that identification of terminally ill patients is managed by the medical personnel rather than wardens or commissioners.[48] These two measures would shift the focus to a medical requirement rather than a procedural one.[49] This proposal would be an obvious improvement, however, it still does not allow for direct advocacy to the authority that adjusts the sentence but refers to setting up the process to be similar to successful state programs, like New York.[50]

New York does have a defined statute related to compassionate release proceedings, with eligibility for both terminally ill and seriously ill patients, and is recognized as one of the most complete programs in the nation.[51] For instance, this statute requires reporting of both requests for compassionate release and the outcome.[52] Importantly, there is also the ability of the inmate

---

[45] *Id.* at 27.
[46] Ill. Const. Art. V §12.
[47] *See* ILL. STATE COMM'N ON CRIMINAL JUSTICE & REFORM: FINAL REPORT 66 (Dec. 2016), http://www.icjia.state.il.us/cjreform2015/pdf/CJSR_Final_Report_Dec_2016.pdf (advocating for compassionate release programs that include both reporting and identification of medical experts to help advocate and educate eligible inmates).
[48] *Id.*
[49] *Id.*
[50] *Id.*
[51] N.Y. Exec. Law §259-s.
[52] N.Y. Exec. Law §259-s(2)(a).

to directly bring a claim, along with an option for family members to apply for compassionate release.[53] The reporting requirement provides the state with information on the efficiency and success of the program.[54] For example, in 2013 to 2015, 174 inmates died while their application was being processed.[55] This is lower compared to other states, but still a high amount of prisoners whose lives could have been saved if approved.[56] This analysis identifies the costly delay in the process, allowing management to act on them. Even though New York's program is one of the most complex, these results are indicative of the outstanding hindrances in getting through these parole requests.

## PROPOSAL TO UPDATE LANGUAGE FOR BRINGING COMPASSIONATE RELEASE CLAIMS DURING A PUBLIC HEALTH EMERGENCY

Many government agencies and systems have exceptions for public health emergencies, that either eliminate obstacles, or give flexibility to the managing bodies to create appropriate policies that last solely for the duration of the declared emergency.[57] This framework should be used to review compassionate release or medical parole for inmates when it comes to proactively avoiding contracting a disease or seeking treatment that goes

---

[53] *Id.*
[54] *See* Price, *supra* note 9, at 19.
[55] *See id.*
[56] *Parole and Early Release*, OPPAGA, 18 (Nov. 2019), https://oppaga.fl.gov/Documents/Reports/19-13.pdf (discussing that 38 inmates were released during fiscal year 2018-2019 while 288 died).
[57] *See generally Is the HIPAA Privacy Rule Suspended During a National or Public Health Emergency?*, HHS.GOV (July 26, 2013), https://www.hhs.gov/hipaa/for-professionals/faq/1068/is-hipaa-suspended-during-a-national-or-public-health-emergency/index.html (discussing the waiving rights of the secretary for privacy rules and regulations during a public health emergency). *See also Coronavirus Waivers & Flexibilities*, CMS.GOV, https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers (detailing information on regulation waivers during the Covid-19 pandemic across Medicaid, Medicare, and CHIP).

above and beyond the prison's current capabilities. Specifically, allowing for exceptions during a public health crisis would benefit early release programs and allow inmates to advocate on their own without waiting for administrative backlog. Under this framework inmates can directly bring claims, removing the need for the BOP and other prison faculty to review applications.[58] Additionally, states should be required to involve medical personnel in the process early on. Involving medical personnel further improves efficiency and navigability of this process, as these professionals can more clearly identify eligible patients and provide documentation based on their regular interactions with their patients.[59] Finally, there needs to be an expansion of education at both the federal and state level.

On the federal side, these recommendations can be accommodated through an update to 18 U.S.C.A. § 3582 to allow removal of the thirty-day time delay or expand the compelling reason criteria to include public health exceptions and allow inmates to bring cases directly to the courts. Courts have stated that this analysis is a burden.[60] This update would allow for an inmate to bring their case directly to the courts to review all factors that play a role in to their situation. This administrative efficiency is vital, especially when, as with COVID-19, viral spread is time-sensitive and removing vulnerable prisoners fast can reduce their exposure.

---

[58] *See* Tom McParland, *Former Cuomo Aide, Latest to Highlight BOP 'Confusion', Remains in Quarantine at NY Prison*, LAW.COM (May 5, 2020), https://www.law.com/newyorklaw journal/2020/05/05/former-cuomo-aide-latest-to-highlight-bop-confusion-remains-in-quarantine-at-ny-prison/.

[59] Andreas Mitchell & Brie Williams, *Compassionate Release Policy Reform: Physicians as Advocates for Human Dignity*, AMA J OF ETHICS 854, 854-61 (2017), (discussing the benefits of evidence-based advocacy).

[60] *See* United States v. Brown, 411 F. Supp. 3d 446, 449 (S.D. Iowa 2019), *order amended on reconsideration*, No. 4:05-CR-00227-1, 2020 WL 2091802 (S.D. Iowa Apr. 29, 2020) ("The Sentencing Commission never harmonized its policy statement with the FSA. Rather, the outdated policy statement still assumes compassionate release 'may be granted only upon motion by the Director of the Bureau of Prisons.' § 1B1.13cmt. n.4. This is no longer the law. This leaves district courts in a conundrum.").

The argument on the state side is much less clear due to variety in current state laws and the opinions on the programs in general. However, there are common successes among more efficient and effective compassionate release programs. Efficiency gains should be implemented: direct advocacy from inmates, medical professional review and recommendation, and educational processes for inmates and their families. States should be encouraged to implement direct advocacy for compassionate release, taking advantage of the added efficiency during a public health crisis as an exception.[61] As many states have wardens, directors of corrections, or governors that either review the claim first or directly appeal to the courts, this would remove that burden when a public health emergency has taken place.[62] This would lighten a heavy administrative load during an emergency, without sacrificing the health and well-being of a high-risk population. Looking to Illinois as an example of where a current process can be exacerbated by a public health crisis, as described earlier, the Governor is in charge of bringing claims.[63] During the COVID-19 pandemic, the Governor was in charge of decisions including, but certainly not limited to: lockdown procedures for business, education decisions, and mask mandates.[64] Adding on to this workload with an increasing number of compassionate release applications, makes it unlikely that the timely review needed is met. Allowing direct advocacy has the opportunity to speed up the program substantially and reduce the number of deaths of waiting applicants.[65]

---

[61] *See* H.R. REP. 115-699 at 22 (discussing the need to lean on the effectiveness and efficiency of the court as the background behind the First Step Act legislation).
[62] *See* Post & Williams, *supra* note 12.
[63] Ill. Const. Art. V §12.
[64] ILL DEPT. OF PUB. HEALTH, https://www.dph.illinois.gov/covid19/governor-pritzkers-executive-orders-and-rules (discussing all the Executive Orders issued by Governor JB Pritzker during the COVID-19 pandemic).
[65] N.Y. Exec. Law §259-s.

Involving medical personnel that provide recommendations and documentation for eligible inmates can further increase the efficiency of the process. This coordination should be integrated into standard medical care, especially as the expectation would be that prisoners would be under regular medical review during a public health crisis or normal operation. Incorporating advocacy of medical professionals has the added benefit of providing education to inmates, however, no matter the involvement of medical professionals all compassionate release programs should update their training and educational materials. Without knowledge of the programs or access to learn about options, no one is likely to bring the claim.[66] This could be either targeted education for vulnerable populations or regular updates on the process to inmates and their families. Either way, education and awareness lend itself to better advocacy and more complete applications, ultimately benefitting the efficiency of the program. Finally, in order to measure the effectiveness of the program and make updates, there is also a need to have consistent reporting so that effective updates can be tracked and implemented broadly.

These updates allow for alignment with federal government goals on effective home confinement and compassionate release programs.[67] This flexibility encourages appropriate release for those who are medically vulnerable, and the prison is unable to care for effectively. Both state and federal prisons have room to improve when it comes to compassionate release, and both can learn from the failures of the pandemic in regard to prison care. Allowing prisoners, or prisoners' families, to advocate directly to the decision-making body for the institution creates a more streamlined

[66] Price, *supra* note 9, at 21 (laying out specific recommendations on publicizing information on compassionate release).
[67] *See* James, *supra* note 23 (discussing the goals of the First Step Act in reducing prison population and recidivism).

process and reduces confusions and administrative burden. This is an efficiency gain across the system, but especially within a public health crisis when time is even more valuable.

## CONCLUSION

In areas where home confinement or medical home confinement is available and appropriate, prisoners are limited in their ability to advocate for their early release, even when they have met eligibility requirements. Within a public health crisis, time is even more valuable for those inmates who are suffering from a terminal illness or are high risk for infection. Removing the administrative requirements that separate the inmate from direct advocation, at either a level within the prison management or the court, and a higher level in light of delays, allows for quicker decisions when time is incredibly valuable in a public health emergency. Inmates should be allowed to advocate for themselves regarding compassionate release programs directly to the courts or decision maker to reduce these very costly time delays.

# Price Gouging & Health Justice: Passing Anti-Price Gouging Laws amid a Pandemic

*Joseph Nguyen Ho*

The Coronavirus Disease 2019 ("COVID-19") pandemic creates numerous healthcare problems for consumers. One, in particular, is the price gouging of health care supplies which causes access issues for consumers. A solution to this price gouging problem is to enact federal and state anti-price gouging statutes to promote health justice. The federal government and the thirteen states with no anti-price gouging statutes should take legislative action to enact these protective statutes.[1] Currently, thirty-seven states and the District of Columbia maintain anti-price gouging statutes.[2] States that do not have anti-price gouging statutes rely on executive orders or other consumer protection laws.[3] Similarly, while the federal government has relied on other federal acts and executive orders to prevent price gouging, there is no federal law aimed at prohibiting price gouging.[4] Consequently, Congress has proposed bills, but to no avail.[5] Notwithstanding, legislatures must enact anti-price gouging statutes.

Indeed, this legislative action addressing price gouging will promote health justice amid a pandemic. First, this paper examines the background of price gouging, federal anti-price gouging laws, and perhaps the largest area of divergence in price gouging laws: state-by-state variation. Next, this paper shifts to discuss the effects of price gouging on the general economy

---

[1] *COVID-19 Survey of Federal and State Price Gouging Laws*, KING & SPALDING, https://www.kslaw.com/pages/covid-19-survey-of-federal-and-state-price-gouging-laws (last visited Dec. 2, 2020) [hereinafter *Federal & State Price Gouging Survey*].
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] *Id.*

and antitrust law. Finally, the paper concludes with the posit that to promote health justice amid a pandemic, Congress and states with no anti-price gouging statutes must enact legislation.

## PRICE GOUGING

### *Defining Price Gouging*

The Department of Justice ("DOJ") defines "price gouging" as a term that lacks a formal definition—but typically refers to a significant and rapid price increase after a demand.[6] Often, price gouging is a situation where a retailer or a supplier takes advantage of increases in demand by "charging exorbitant prices for necessities after a natural disaster or other state emergency."[7]

### *State Anti-Price Gouging Laws*

An illustrative example of the difficulty of determining whether this increase in price is excessive or based on meeting market demands is *People ex rel. Spitzer v. Wever Petroleum*.[8] The New York Superior Court, or New York's appellate court, noted that the price increase was unconscionably excessive because the defendant's (Wever) price increase "far exceeded the needed increase for Wever to maintain a similar pre-hurricane profit or to generate the required revenue to purchase gasoline from ExxonMobile the

---

[6] U.S. DEP'T. JUST., DIRECTORATE FOR FINANCIAL AND ENTERPRISE AFFAIRS COMPETITION COMMITTEE 7 (Oct. 4, 2011), https://www.justice.gov/sites/default/files/atr/legacy/2014/05/30/278823.pdf.

[7] Heather Morton, *Price Gouging State Statutes*, NCSL (Mar. 30, 2020), https://www.ncsl.org/research/financial-services-and-commerce/price-gouging-state-statutes.aspx.

[8] *See People ex rel. Spitzer v. Wever Petroleum Inc.*, 14 Misc. 3d 491, 492-495 (Sup. Ct. Alb. Cty. 2006) (interpreting General Business Law § 396-r as "a showing of gross disparity in prices, coupled with proof that disparity is not attributable to supplier costs, raises a presumption that the merchant used the leverage provided by the market disruption to extract a higher price. The use of such leverage is what defines price gouging, not some arbitrarily drawn line of excessiveness.")

next business day."[9] While the New York judiciary relied in part on an anti-price gouging statute that dealt with fuel price-points, it illustrated how the court distinguishes a question of unconscionability.[10] While this example acts as an example of New York courts, the state-by-state variation of anti-price gouging laws is vast due to emergency orders and executive orders.[11] In fact, often, these emergencies trigger price gouging laws and statutes that prevent excessive pricing.[12] As mentioned, thirty-seven states and the District of Columbia have price-gouging statutes that prevent excessive pricing.[13] Approximately thirteen states either do not have protections or rely on other acts or executive orders.[14]

Additionally, while states vary between legislature enacted statutes and other types of laws, states also vary on what price increase constitutes illegal

---

[9] *Id.* at 495.
[10] *See generally id.* at 495 ("[T]his Court finds that the respondent's claims, even if true, that its increase in retail price was the result of a supplier increase, failed to rebut the inference that the price increases were attributable to respondents' use of the leverage provided by the market disruption and were therefore unconscionably excessive").
[11] *See generally Federal & State Price Gouging Survey*, *supra* note 1 (detailing a survey of the fifty states and the District of Columbia regarding each state's and the federal government's anti-price gouging law(s)).
[12] *Id.*
[13] *Id. See also Interactive State-by-State Price Gouging Map*, PROSKAUER (Nov. 1, 2020), https://www.proskauer.com/report/interactive-state-by-state-price-gouging-map (explaining all fifty states and the District of Columbia's price gouging laws).
[14] *See Federal & State Price Gouging Survey*, *supra* note 1 (explaining that among these thirteen states, five states rely on Consumer Protection Act(s) such as Washington's "RCW 19.86.010 *et seq,"* New Mexico's Unfair Practices Act – N.M. STAT. §57-12-3 *et seq*, Ohio's REV. CODE ANN. § 1345.03, New Hampshire's consumer protection laws, and Montana's MONT. CODE ANN. § 30-14-103. While other states have no particular state laws (South Dakota, North Dakota, & Wyoming). Others have miscellaneous reliance's but may fall under executive orders, such as Nevada (general fraud and antitrust laws) and Nebraska (Lincoln City ordinances). Finally, other states rely on executive orders during state trigged emergencies such as Delaware, Minnesota, Arizona (although Arizona's AG has stated it does not have the authority under its existing consumer protection laws to prosecute COVID-19 price gouging). It is worthy to note that along with IL, numerous other states which have different and broad price-gouging laws utilize executive orders to prohibit price increases on certain goods or services during COVID-19).

price gouging.[15] For example, while some states adopt California's ten percent price increase limitation during a declared emergency, other states either completely prohibit price increases or ambiguously prohibit "excessive" prices.[16] Other variations include what scope the statute covers, how state's statutes are triggered, and, in certain instances, how officials enforce each statute.[17] Illinois, for example, has Administrative Code: sections 465.10 through 465.30 which prohibit selling petroleum products for an "unconscionably high price."[18] However, Illinois' governor has since extended the executive order on October 16, 2020 for an additional 30 days to cover household products and medical supplies.[19] In contrast, states such as California, New York, and Missouri have specific, targeted coverages that prohibit a more comprehensive range of price gouging under their statutes.[20] Thus, the variations illustrate the urgency of enacting uniform anti-price gouging laws and wide-reaching laws that limit exorbitant prices increases, thereby creating access to medical supplies.[21]

---

[15] *Price Gouging In The Covid-19 Pandemic: Protecting Yourself And Your Business*, ROBINS KAPLAN (Apr. 14. 2020), https://www.robinskaplan.com/resources/publications/2020/04/price-gouging-in-the-covid19-pandemic-protecting-yourself-and-your-business. [hereinafter *Limits on Price Increases*].
[16] *Id.*
[17] Schill et al., *Avoiding Price-Gouging Pitfalls While Navigating Price Increases in the Era of COVID-19*, JONES DAY 1 (Aug. 2020), https://www.jonesday.com/en/insights/2020/08/avoiding-price-gouging-pitfalls-while-navigating-price-increases-in-the-era-of-covid19.
[18] Chris Hohn & Steve Shredl, *Retailers, Manufacturers, Wholesalers: Be Aware of Price Gouging Laws During COVID-19*, THOMPSON COBURN LLP (Mar. 25, 2020), https://www.thompsoncoburn.com/insights/publications/item/2020-03-25/retailers-manufacturers-wholesalers-be-aware-of-price-gouging-laws-during-covid-19.
[19] *Id. See also*, *Federal & State Price Gouging Survey*, *supra* note 1 (explaining Illinois' price gouging laws).
[20] Hohn & Shredl, *supra* note 18.
[21] Jack Nicas, *It's Bedlam in the Mask Market, as Profiteers Out-Hustle Good Samaritans*, N.Y. TIMES (May 7, 2020) https://www.nytimes.com/2020/04/03/technology/coronavirus-masks-shortage.html?smid=nytcore-ios-share.

*Federal Guidance on Price Gouging Laws*

Federally, there is no legislation prohibiting price gouging.[22] Instead, on March 23, 2020, President Trump invoked the Defense Production Act of 1950, 50 U.S.C. §4512, and issued Executive Order 13910, Preventing Hoarding of Health and Medical Resources, to respond to the spread of COVID-19.[23] The Executive Order delegated to the Secretary of Health and Human Services (HHS) the ability "to prevent hoarding of health and medical resources necessary to respond to the spread of COVID-19 within the United States […]."[24] The Attorney General also issued a memorandum that, under the order, the Secretary of HHS can protect scarce healthcare and medical items by designating particular items as protected, and once designated, the Defense Production Act "makes it a crime for any person to accumulate that item either (1) in excess of his or her reasonable needs or (2) for the purpose of selling it in excess of prevailing market prices."[25] Notwithstanding, the House and Senate have introduced bills that include provisions that target price gouging, but none have been signed into law.[26] For example, the House passed the Health and Economic Recovery Omnibus Emergency Solution (HEROES) Act.[27] A particular provision of the HEROES Act, "title I of Division M—known as the COVID-19 Price Gouging Prevention Act—would prohibit the '"unconscionably excessive"' sale of goods or services by

---

[22] Christopher E. Ondeck et al., *Federal Price Gouging Enforcement Update*, NAT'L. L. REV. (July 8, 2020), https://www.natlawreview.com/article/federal-price-gouging-enforcement-update.
[23] *Federal & State Price Gouging Survey*, *supra* note 1.
[24] *Id.*
[25] Memorandum from William Barr, Attorney Gen., U.S. Dep't of Justice., on Department of Justice COVID-19 Hoarding and Price Gouging Task Force (Mar. 24, 2020), https://www.justice.gov/file/1262776/download [hereinafter Department of Justice Memorandum].
[26] Ondeck et al., *supra* note 22.
[27] Zielinski et al. *Price Gouging Enforcement in the Wake of COVID-19: Where is the FTC?*, SUBJECT TO INQUIRY (May 27, 2020), https://www.subjecttoinquiry.com/uncategorized/price-gouging-enforcement-in-the-wake-of-covid-19-where-is-the-ftc/.

sellers who use the emergency to unreasonably increase prices for the duration of the public health emergency."[28] The Senate, however, has not yet passed the HEROES Act.[29]

## PRICE GOUGING: ECONOMICS, U.S. ANTITRUST LAWS, AND HEALTH JUSTICE

### *Viewing Antitrust and Price Gouging in the Economy through a Health Justice Lens*

Antitrust laws such as the Sherman Act and Clayton Act provide the ground rules for a market economy and is transsubstantive, meaning that these laws apply to all types of private market behavior such as COVID and non COVID markets.[30] Officials often investigate price gouging in the same manner as traditional antitrust laws.[31] In viewing price gouging through a federal antitrust lens, entities may, in contrast, set whatever price they choose because price gouging alone is not a violation of federal antitrust law.[32] Nevertheless, the risk of a potential investigation is similar between price-fixing and price gouging because in situations when there is an industry-wide price increase, the question shifts to whether the increase is due to antitrust price-fixing, price gouging, or other common response to market conditions.[33] In practice, generally, there is no distinction between price

---

[28] *Id.*
[29] The Heroes Act, H.R. 6800, 116th Cong. (2019-2020).
[30] *See* Spencer Weber Waller, *How Much of Health Care Antitrust Is Really Antitrust*, 48 LOY. U. CHI. L.J. 643, 643- 645 (2017) ("Antirust is intended to be transsubstantive, applying to all types of private market behavior.").
[31] Ondeck et al., *Pricing in an Emergency*: *Where Price Gouging Meets Antitrust*, NAT'L. L. REV. (May 21, 2020), https://www.natlawreview.com/article/pricing-emergency-where-price-gouging-meets-antitrust.
[32] Laurien Gilbert, *Price Gouging and the Pandemic*: *An Economic Perspective*, NAT'L. L. REV. (Aug. 3, 2020), https://www.natlawreview.com/article/price-gouging-and-pandemic-economic-perspective.
[33] Ondeck et al., *supra* note 31.

gouging and antitrust, as "antitrust regulators around the world have recently issued warnings against price gouging[…]."[34] Indeed, antitrust principles/laws incentivize competition to lower prices and improve service.[35] To illustrate this distinction, however, price-fixing is defined as "an agreement among competitors that raises, lowers, or stabilizes prices or competitive terms."[36] Therefore, while defined differently, it is clear that the purpose of antitrust and anti-price gouging laws is to promote consumer protection.[37] Amid a pandemic, creating access while complying with the traditional market mechanisms of antitrust and price gouging are covered by the umbrella of consumer protection.[38]

In practice, the result of hurricanes 'Katrina' and 'Rita' is instructive.[39] As a result of the hurricanes, U.S. consumer fuel prices increased and caused questions of whether this increase was normal in the circumstances.[40] In fact, this increase led Congress to direct the FTC to investigate whether the increases resulted from price gouging or market manipulation.[41] Based on the two FTC definitions of price gouging and market manipulation, the report stated that "a very small number of price gouging incidents, only one of which was not explained by local or regional market trends."[42] Former FTC Chairman Deborah Platt Majoras addressed this matter in front of the U.S. Senate Commerce Committee and stated:

> [A]ny price gouging statute should attempt to account for the market-clearing price. Holding prices too low for too long in the face of temporary

---

[34] *Antitrust Implications of COVID*-19, GIBSON DUNN (Mar. 12, 2020), https://www.gibsondunn.com/coronavirus-antitrust-implications-of-covid-19-response/.
[35] Ondeck et al., *supra* note 31.
[36] Lori Lustrin & Melissa C. Pallett-Vasquez, *Price Fixing in the Food Industry*, NAT'L. L. REV. (Oct. 26, 2018), https://www.natlawreview.com/article/price-fixing-food-industry.
[37] Ondeck et al., *supra* note 31.
[38] *See id.*
[39] U.S. DEP'T OF JUST., *supra* note 6, at 7.
[40] *Id.*
[41] *Id.* at 7.
[42] *Id* at 7-8.

> supply problems risks distorting the price signal that ultimately will ameliorate the problem. If supply responses and the market-clearing price are not considered, wholesalers, and retailers will run out of gasoline and consumers will be worse off.[43]

Indeed, the report referred to the difficultly of detecting price gouging, noting the challenges of distinguishing gougers from those reacting reasonably to the emergency.[44] Thus, the distinction is difficult for regulators, prompting the need for legislative activism to protect consumers.[45]

*Price Gouging and Economics through the Lens of Health Justice*

In addition to understanding the need for guidance on identifying price gouging, viewing anti-price gouging through an economic lens illustrates how a health justice approach not only clarifies another inherent problem with these laws but also protects consumers from anti-price gouging during a pandemic.[46] Health justice is a framework for using law and policy to reduce unjust disparities.[47] Specifically, health justice "demands affordable and equitable access to healthcare, including testing and treatment for COVID-19 as well as accommodations and supports for more routine, but equally life-threatening, physical, mental, and behavioral health needs."[48]

The debate of preventing price increases generally occurs when arguing between whether raising prices helps limit consumption, thereby preventing shortages of products or whether maintaining a price-point to ensure equitable allocation of goods to those with a priority need is more

---

[43] *Id* at 8-9.
[44] *Id* at 9.
[45] Ondeck et al., *supra* note 31.
[46] Gilbert, *supra* note 32.
[47] Emily A. Benfer & Lindsay F. Wiley, *Health Justice Strategies to Combat COVID-19: Protecting Vulnerable Communities During a Pandemic*, HEALTH AFFAIRS (Mar. 19, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200319.757883/full/.
[48] *Id.*

beneficial.[49] Theoretically, answering this question would require comparing competitors, but identifying price gouging simply through price comparisons is inherently difficult.[50] Notwithstanding, this analysis ignores viewing pricing through equitable allocation of goods because of income inequality.[51] Indeed, it is clear that income is strongly associated with morbidity and mortality because poverty is recognized to contribute to death and diseases.[52] In addition to this general prevailing view, the barrier to care appears to have become more difficult as food prices increased.[53] Amazon, a national retailer, also increased surgical masks and hand sanitizer up to fifty percent at the pandemic's outset..[54] These increases may disproportionately affect low-income individuals and therefore when arguing for viewing pricing through income inequality, contemplating this debate through a lens of access through health justice is economical.[55]

## ENACTING ANTI-PRICE GOUGING STATUTES TO IMPROVE HEALTH JUSTICE

### *State Legislature*

Price gouging began at the outset of the pandemic. In a widely reported story, two Tennessee brothers bought and hoarded 17,700 bottles of hand

[49] Gilbert, *supra* note 32.
[50] *Id.*
[51] *Id.*
[52] Dhruv Khullar & Dave A. Chokshi, *Health, Income, & Poverty: Where We Are & What Could Help*, HEALTH AFFS. (Oct. 4, 2018), https://www.healthaffairs.org/do/10.1377/hpb20180817.901935/full/.
[53] David Pitt, *US Food Prices See Historic Jump and are Likely to Stay High*, CHI. SUN TIMES (May 30, 2020), https://chicago.suntimes.com/news/2020/5/30/21275547/us-food-prices-see-historic-jump-and-are-likely-to-stay-high.
[54] *See* Kelly Tyko, *Coronavirus Price Gouging*: *Face Mask Prices Increased 166% on Amazon, Report Finds*, USA TODAY (Mar. 11, 2020), https://www.usatoday.com/story/money/2020/03/11/amazon-price-gouging-report-coronavirus-face-masks/5007990002/ (a box of 10 "N95 respirators" selling for 18.20 mid-January spiked to $199.99 in late February").
[55] *See* Gilbert, *supra* note 32 (explaining price gouging and the pandemic through an economic lens).

sanitizer and reportedly sold 300 bottles of hand sanitizer on Amazon for eight to seventy dollars each; a number multiple times higher than what they had paid.[56] This aptly highlights the problem price gouging creates at the onset of a pandemic and highlights the practicality of implementing federal and state anti-price gouging laws because these brothers bought all of the hand sanitizer (preventing others from purchasing it) and sold it at exorbitant prices (again preventing others from purchasing it, specifically people who do not have the money or people who do not have access to the internet). This issue also illustrates the need to shift from patchwork protections to uniform law during the onset and amid the pandemic's length. For example, Tennessee invoked its price gouging statute on March 12, 2020 by executive order, protecting emergency and medical supplies.[57] New York broadened its price gouging laws by amending its statute, Section 396-r, to include "essential goods or services" such as "essential medical supplies and services."[58] In contrast, states like Arizona and Minnesota relied on executive orders, and states like South and North Dakota essentially took no action.[59] The differences in state law depict the need for clarity in state anti-price gouging laws as the failure of clarity makes complying ostensible.[60]

---

[56] Neil Vigdor, *Tennessee Brothers Who Hoarded Hand Sanitizer Settle to Avoid Price-Gouging Fine*, N.Y. TIMES (June 22, 2020), https://www.nytimes.com/2020/04/22/us/hand-sanitizer-matt-colvin-noah-coronavirus.html.

[57] *See Federal & State Price Gouging Survey*, *supra* note 1 (surveying Tennessee's price gouging laws).

[58] Michael Vanunu, *Amended Law Increases Civil Penalties for Greed During Crisis*, RIVKIN RADLER (Jun. 9, 2020), https://www.rivkinradler.com/publications/amended-law-increases-civil-penalties-for-greed-during-crisis/.

[59] *See Federal & State Price Gouging Survey*, *supra* note 1 (explaining that the United States Attorney for South Dakota urged the public to report price gouging to the National Center for Disaster Fraud. North Dakota' Attorney General stated because there are no laws, the office would not be able to take complaints. Arizona's Executive Order is in regards to proactive measures to protect against COVID-19. While, generally, Minnesota's emergency Executive Order 20-10 prohibits price gouging during the emergency).

[60] *See* Christopher E. Ondeck & Jennifer Tarr, *Pandemic Price Gouging is a Huge Issue — But State Laws to Stop it are Creating More Problems than they Solve*, FORTUNE (Aug. 4, 2020), https://fortune.com/2020/08/04/price-gouging-laws-covid-coronavirus/ (explaining,

Therefore, states that do not have legislature enacted statutes should implement more precise price gouging statutes to promote health justice.

First, to sustain goods and services for consumers, legislatures must clarify what triggers a price gouging statute and the length of price gouging protections during an emergency. An example of the unclear framework is the length of Kentucky's price gouging laws.[61] While, Commentators stated that Kentucky' price gouging law expired on April 21, 2020, the Governor has stated that he will continue to extend the price gouging law through the duration of the state's emergency.[62] As of September 28, 2020, the Governor signed Executive Order 2020-822 prohibiting price gouging and extending previous orders for the emergencies duration and time.[63]

This analysis does not intend to address the legality of the extensions or conclude that emergency orders should not trigger price gouging protections. Instead, this paper argues that regardless of whether emergency orders trigger statutory protections, there needs to be clarity to protect suppliers, providers, and consumers. For example, fourteen states have undefined price gouging end dates; ten states' price gouging's end date is "not applicable;" and the remaining states' and the District of Columbia's end dates vary dramatically.[64] Thus, enacted statutes that outline the length or procedures to address price gouging are crucial amid a pandemic.

---

first there is a disruption in competition. Second, there is a disruption in companies' standard operations. Third, companies fear lawsuits).

[61] *See* Ondeck et. al, *When Will it End — Price Gouging Restrictions Remain in Place for Uncertain Period*, NAT'L. L. REV. (July 9, 2020), https://www.natlawreview.com/article/when-will-it-end-price-gouging-restrictions-remain-place-uncertain-period (explaining that some commenters believe, albeit potentially incorrectly, that certain price gouging laws expired).

[62] *Id.*

[63] *See Federal & State Price Gouging Survey*, *supra* note 1 (explaining Kentucky's price gouging laws).

[64] *Proskauer on Price Gouging*, PROSKAUER ROSE, 4-5 https://s3.amazonaws.com/assets.production.proskauer/uploads/445301a6fd476ce55051112a7a79d741.pdf (last visited Dec. 2, 2020).

Second, the nonuniformity and patchwork of coverage prevent access to goods amid a pandemic. As mentioned, California's enforcement triggers after a ten percent increase in prices, while other states prohibit all price increases or "excessive" price increases.[65] Furthermore, some states' anti-price gouging laws apply to "supply chain businesses," some only cover necessary materials, while others cover normal goods and services.[66] Commentators suggest that this patchwork discourages innovation and competition, disrupts businesses' standard operations, and promotes class action.[67] Unfortunately, these do not directly address the effect on health justice. States that model their prospective price gouging laws after states with these laws should be aware that failure to clarify price gouging terms could directly and negatively affect consumers' health. In other words, enacting legislation to reframe the message in the lens of health justice will promote a positive message and commitment to ethical change.

Third, while it is imperative states enact anti-price gouging statutes, it is a priority that these prospective statutes cover health necessities. For example, New York amended its price gouging statutes as a response to COVID-19.[68] While California's enacted price gouging statute, CAL. PENAL CODE § 396(b), applied to a wide range of products such as food items or goods, emergency supplies, and medical supplies, among others.[69] In contrast, an example of patchwork coverage is in Indiana, where its price gouging statute focuses on fuel prices, but the state has otherwise relied on executive orders.[70] Here, patchwork coverage is evident when comparing each state, and it is

---

[65] *Limits on Price Increases*, *supra note* 15.
[66] Ondeck & Tarr, *supra* note 60.
[67] *Id.*
[68] Vanunu, *supra* note 58.
[69] *See Federal & State Price Gouging Survey*, *supra* note 1 (explaining California's price gouging laws).
[70] *See id* (explaining Indiana's price gouging laws).

clear from these states' variations that the scope of coverage is noncomprehensive.[71] Therefore, explicitly codifying price protection of goods and other medical supplies in response to the pandemic and even in a post-pandemic environment to avoid price gouging situations seen in epinephrine pens is necessary to ensure equitable access as a matter of health justice.[72]

Finally, it is worthy to note that the Kentucky Attorney General brought a federal action to enforce the state's price gouging statute against Amazon suppliers.[73] The federal court held that Kentucky's price gouging statutes is not allowed to regulate prices charged outside of Kentucky due to Amazon's nationwide operation.[74] Accordingly, it reasoned that suppliers have limited control over prices and the difficulty complying with differing state price gouging laws.[75] This litigation aptly depicts state difficulty navigating and enforcing price gouging, and the need for a federal price gouging statute. This argument is bolstered by the views expressed by Professor Waller, "when the law in action does not match the law on the books, something has to give."[76]

---

[71] *See id* (examining all fifty states, the federal government, and the District of Columbia's anti-price gouging laws.).
[72] *See* Wolf Richter, *EpiPen is Getting Crushed by a $10 Copycat,* BUS. INSIDER (Mar. 8, 2017) https://www.businessinsider.com/after-years-of-price-gouging-mylans-epipen-gets-crushed-2017-3 (explaining that Mylan's EpiPen, the once center of the Big Pharma price gouging plunged from 95% to 71% in two months because of new competitors.).
[73] Andrew Cook & Robert McKenna, *Court of Appeals to Decide Whether Kentucky Price Gouging Statute Violates Commerce Clause*, JD SUPRA (Nov. 12, 2020), https://www.jdsupra.com/legalnews/court-of-appeals-to-decide-whether-72831/#_ftn6.
[74] *Id.*
[75] *Id.*
[76] Waller, *supra* note 30, at 666.

*Enacting a Federal Statute*

There is no federal anti-price gouging statute.[77] Instead, the federal government has relied on the Defense Production Act, invoking an executive order to prevent price gouging.[78] The executive order prevents hoarding and selling at an excessive price-point.[79] Despite the DPA, there is a clear need for a federal statute to create uniformity and to protect consumers in a dramatic time of health disparities because the DPA is limited to excessive hoarding and pricing, failing to explain what "excess" means.[80] This may inhibit encompassing enforcement and is notably seen in other states that vary in defining "excessive."[81] As a matter of policy, commentators believe a national wide price gouging law will prompt businesses to implement compliance policies which would also promote uniformity.[82]

## CONCLUSION

Currently, with patchwork at the state and federal level and noncomprehensive and unclear price gouging laws, enacting comprehensive and clear federal and state anti-price gouging laws creates equitable access to health care and promotes health justice. Therefore, the federal and state government must view price gouging, antitrust laws, and the economy through a health justice lens for the betterment of society.

---

[77] Kendra L. Berardi & Ian T. Clarke-Fisher, *Responding to Government Inquiries Related to Price Gouging During the COVID-19 Pandemic*, NAT'L. L. REV. (Mar. 30, 2020), https://www.natlawreview.com/article/responding-to-government-inquires-related-to-price-gouging-during-covid-19-pandemic.
[78] *See Federal & State Price Gouging Survey*, *supra* note 1 (explaining Federal Price Gouging laws).
[79] Department of Justice Memorandum, *supra* note 25, at 2.
[80] Christopher E. Ondeck et al., *Federal Price Gouging Enforcement Update*, Nat'l. L. Rev. (July 8, 2020), https://www.natlawreview.com/article/federal-price-gouging-enforcement-update.
[81] *Limits on Price Gouging Increases*, *supra* note 15.
[82] Ondeck & Tarr, *supra* note 60.

# Alternative Dispute Resolution as a Means for Health Justice

*Michael Kemel*

## INTRODUCTION

Medical errors are inevitable, in spite of the healthcare system's best efforts to avoid them.[1] Since the mid-19th century, when professional medical care became common in the United States, the remedy for a patient who suffers from such an error has been to bring a medical malpractice lawsuit.[2] Medical malpractice has its place but is often lacking for both healthcare providers and patients.[3] Utilizing alternative dispute resolution (ADR) in the medical industry will both reduce the risk of expensive lawsuits and increase patient safety.[4] In particular it will benefit patients of low socioeconomic status, who have the most to lose in the event of a medical error.[5]

---

[1] Martin A Makary & Martin Daniel, *Medical Error—the Third Leading Cause of Death in the US*, 8056 BMJ 353, (2016).
[2] James C. Mohr, *American Medical Malpractice Litigation in Historical Perspective*, 283 JAMA 1731, 1731-32 (2000).
[3] David M. Studdert et al., *Health Policy Report: Medical Malpractice*, 350 N. ENGL. J. MED. 283, 287 (2004) ("[T]rial attorneys believe that the threat of litigation makes doctors practice more safely, but the punitive, individualistic, adversarial approach of tort law is antithetical to the nonpunitive, systems-oriented, cooperative strategies promoted by leaders of the patient-safety movement.").
[4] David H. Sohn & B. Sonny Bal, *Medical Malpractice Reform: The Role of Alternative Dispute Resolution*, 470 CLIN ORTHOP. RELAT. RES. 1370, 1372 (2011). ("In Colorado, a physician-directed medical malpractice insurance carrier named COPIC instituted an early apology program in 2000 called the 3Rs—Recognize adverse events, Respond quickly, and Resolve issues. The program included both apology and early disclosure with a focus on preserving the physician–patient relationship. The result was a 50% reduction in malpractice filings, a decrease in settlement costs of 23%, and a startlingly low average settlement award of roughly $5000.").
[5] Gay Becker & Edwina Newsom, *Socioeconomic Status and Dissatisfaction with Health Care Among Chronically Ill African Americans*, 93 AM. J. PUB HEALTH 742, 742 (2003).

This article will discuss how implementing ADR effectively in the medical field will improve the general health and well-being of people of low socioeconomic status and argue that medical malpractice suits should be used only as a last resort. First, I will explain why individuals with low socioeconomic status are more vulnerable in the medical system. Then, I will compare and contrast lawsuits with ADR. Finally, I will explain why ADR will benefit all patients, but especially those of low socioeconomic status.

## THE INSECURE POSITION OF PATIENTS OF LOW SOCIOECONOMIC STATUS

Patient safety is defined by the National Academy of Medicine (formerly the Institute of Medicine or IOM) as "the prevention of harm to patients."[6] Patient safety has been a point of scrutiny ever since the National Academy of Medicine released the landmark paper "To Err is Human" in 1999.[7] It is a national concern, with an estimated 98,000 to 440,000 people dying annually from preventable errors in hospital.[8] However, many roadblocks to progress persist, some of which originate in the culture of medical organizations.[9]

Patient safety is of particular concern to people of lower socioeconomic status. Socioeconomic status is defined as "the social standing or class of an individual or group," and is most impacted by education, income, and

---

[6] PAMELA H. MITCHELL, PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES (Ronda G. Hughes ed., 2008).
[7] *20 Years After "To Err is Human", Leapfrog Hospital Safety Grades Prove Transparency Can Save Lives*, www.hospitalsafetygrade.org/about-us/newsroom/display/807485 (last visited Nov. 30, 2020); *10 Years After to Err Is Human: Are Hospitals Safer?*, www.healthleadersmedia.com/clinical-care/10-years-after-err-human-are-hospitals-safer (last visited Nov. 30, 2020).
[8] David Bornstein, *Hospitals Focus on Doing No Harm*, N.Y. TIMES (Feb. 2, 2016, 3:21AM), https://opinionator.blogs.nytimes.com/2016/02/02/how-hospitals-are-changing-to-become-safer.
[9] Lawrence Schlachter, *Medical Culture Encourages Doctors to Avoid Admitting Mistakes*, STAT (Jan. 13, 2017), www.statnews.com/2017/01/13/medical-errors-doctors/.

occupation.[10] Individuals within this group are more likely to have health problems and suffer from higher mortality rates and poorer health in general.[11] This can be attributed to disproportionate levels of exposure to pollutants, higher levels of chronic stress, fewer positive social relationships, poor education resulting in unhealthy choices, and lower quality healthcare.[12] In order for patients of lower socioeconomic status to have access to better medical care, the culture of healthcare organizations must shift. This must be done by prioritizing transparency and disclosure, as well as engaging with patients directly. Improving health justice requires equity, which means minimizing the disparity in health and life expectancy between those of lower and higher status.[13]

## LAWSUITS VERSUS ALTERNATIVE DISPUTE RESOLUTION

Medical malpractice suits have long been used to hold physicians liable, but these suits are the wrong means to achieving this end for many reasons.[14] Such suits have been found to be "a profoundly inaccurate mechanism for distributing compensation" as well as "tremendously inefficient."[15] The majority of bad outcomes are the result of accidents, with physicians showing genuine remorse.[16] Though tort suits are designed to make the victim whole

---

[10] *Socioeconomic Status*, APA, www.apa.org/topics/socioeconomic-status (last visited Nov. 30, 2020).
[11] Nancy E. Adler & Katherine Newman, *Socioeconomic Disparities in Health: Pathways and Policies*, 21 HEALTH AFFS. 60, 66-70 (2002).
[12] *Id*.
[13] Marmot et al., *Closing the Gap in a Generation Health Equity Through Action on the Social Determinants of Health*, 372 LANCET 1661, 1661-62 (2008) ("At all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health. If systematic differences in health for different groups of people are avoidable by reasonable action, their existence is, quite simply, unfair.").
[14] Studdert, *supra* note 3.
[15] *Id*. at 285-86.
[16] Thomas H. Gallagher et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors*, 289 JAMA 1001, 1006 (2003) ("Physicians also experienced powerful emotions following a medical error. Physicians felt upset and guilty about harming the

rather than punish the offender, [17] medical malpractice suits themselves punish physicians by causing them professional as well as financial distress.[18]

The combination of this punishment and an arduous legal process makes physicians highly risk-averse, leading to employ "defensive medicine."[19] Defensive medicine is "when a medical practitioner performs treatment or procedure to avoid exposure to malpractice litigation," which include positive and negative defensive medicine.[20] Positive defensive medicine refers to excessive medical procedures.[21] This is not only needlessly expensive or invasive but, ironically, "unnecessary invasive diagnostic tests are additional risks and costs to the patient."[22] On the other hand, negative defensive medicine consists of denying procedures to those who could benefit from them because they are risky and present a higher chance of litigation.[23] Overall, defensive medicine causes a noticeable increase in healthcare costs and risk to patients.[24]

Defensive medicine is particularly harmful to patients of low socioeconomic status, as they are less likely to have quality insurance, or even any at all.[25] In a 2003 study, out of all individuals with private

---

patient, disappointed about failing to practice medicine to their own high standards, fearful about a possible lawsuit, and anxious about the error's repercussions regarding their reputation.").

[17] John C. P. Goldberg, *Two Conceptions of Tort Damages: Fair v. Full Compensation*, 55 DEPAUL L. REV. 435, (2006) ("The point of tort damages is to compensate, to restore the status quo ante, to make the plaintiff whole.").

[18] Gallagher, *supra* note 16, at 1005.

[19] M. Sonal Sekhar & N. Vyas, *Defensive Medicine: A Bane to Healthcare*, 3 ANN. MED. HEALTH SCI. RES., 295, 295 (2013).

[20] *Id*.

[21] *Id*.

[22] Sekhar, *supra* note 19.

[23] *Id*.

[24] Laura D. Hermer & Howard Brody, *Defensive Medicine, Cost Containment, and Reform*, 25 J. GEN. INTERN. MED., 470, 471-72 (2010) ("Kessler and McClellan concluded that defensive medicine costs accounted for approximately 5-9% of total health care costs for patients with AMI.").

[25] Becker *supra* note 5, at 744.

insurance, 53.6% were businesspeople or professionals, while 21.4% were laborers.[26] This is compared to 7.1% and 71.4% of the same demographics without any insurance.[27] Education followed a similar pattern; 89.3% of those with private insurance had a college degree or higher, while 57.1% of those without any insurance had only a high school diploma or lower.[28] A lack of insurance among such patients means that they are more likely to suffer in the event of an error.

In addition to the risk created by defensive medicine, by medical malpractice suits create risk through their costliness. Malpractice suits are expensive, directly costing healthcare providers in 2009 alone approximately $35 billion, or 2% of total healthcare expenditures across the United States that year.[29] A majority of states have implemented caps on noneconomic damages in medical malpractice suits to minimize this economic risk.[30] Even with these caps, the noneconomic damages caps still typically start at $250,000, while total caps may be well over $1 million.[31] And even then, these caps can be subverted through patients pursuing higher economic damages, which are not capped.[32]

---

[26] *Id*.
[27] *Id*.
[28] *Id*.
[29] *National Medical Malpractice Statistics*, NOLO, www.medicalmalpractice.com/lander/national-medical-malpractice-facts (last visited Sept. 24, 2020).
[30] *Non-Economic Damages*, USLEGAL, https://definitions.uslegal.com/n/non-economic-damages/ (last visited Oct. 18, 2020) ("Non-economic damages are compensations claimed against intangible harms such as severe pain, physical and emotional distress and disfigurement, loss of the enjoyment of life for an injury has caused, including sterility, loss of sexual organs, physical impairment. Non-economic damages can be claimed by the family of victims who have died or injured severely. It is also known as quality-of-life damages. Non-economic damages caps are a reform to limit the amount of damages that can be recovered for torts.").
[31] *Medical Malpractice Damage Caps*, MED. MALPRACTICE CTR., https://malpracticecenter.com/legal/damage-caps/ (last visited Sept. 26, 2020).
[32] Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps*, 80 N.Y.U. L. REV. 391, 469 (2005), ("[W]hen controlling for the independent effects of severity of injury, as well as numerous additional litigant characteristics, state law, and county demographic variables, noneconomic damages caps have no statistically significant

Medical malpractice suits, due in no small part to their expense, have a major impact on medical culture.[33] Studies of malpractice have found that errors are often hidden due to a fear of retaliation.[34] The tremendous stress placed on physicians and healthcare organizations by malpractice suits encourages behavior like defensive medicine or possibly even fraud to avoid them.[35] Healthcare providers are therefore incentivized to hide evidence of minor, or even major, errors, typically by acting as a "spin doctor" and "describing the event in the most positive yet factually accurate light possible."[36] Studies suggest that a majority of doctors, while not necessarily willing to directly lie to patients, would be willing to obscure their role in medical errors, or even lie by omission.[37] In one such study, a cross-sectional survey posed two hypotheticals to more than three hundred primary care physicians, one a delayed diagnosis of cancer, the other a delayed response due to communication failure.[38] More than seventy percent of those surveyed said they would provide "only a limited or no apology, limited or no explanation, and limited or no information about the cause."[39]

Reducing transparency has been shown to make distrust among patients worse and increase litigation, perpetuating a vicious cycle.[40] The medical

---

effect on the size of overall compensatory damages, as reflected in either jury verdicts or final judgments.").

[33] Gallagher, *supra* note 16, at 1006.

[34] *Id*. at 1004.

[35] *The Emotional Cost of Medical Malpractice Claims Against Doctors, Part 1*, DOCTORS DIRECT INSURANCE, www.practiceprotection.com/physicians/the-emotional-cost-of-medical-malpractice-claims-against-doctors-part-1/ (last visited Nov. 30, 2020).

[36] Gallagher, *supra* note 16, at 1006.

[37] Schlachter, *supra* note 9 ("Most doctors would never tell a flagrant lie. But in my experience as a neurosurgeon and as an attorney, too many of them resort to half-truths and glaring omissions when it comes to errors.").

[38] *Id*.

[39] Schlachter, *supra* note 9.

[40] Ronald M. Stewart et al., *Transparent and Open Discussion of Errors Does Not Increase Malpractice Risk in Trauma Patients*, 243 ANN. SURG., 645, 647 (2006).

industry already has a poor record of being transparent.[41] Patients generally seek explanations, "not to affix blame but, rather, to understand what happened to them and to know that the institution and individuals involved had learned from the event."[42] Many patients also report filing suits in an effort to prevent such occurrences in the future.[43] Physicians generally agree in principal that patients should be made aware of harmful errors, and some claimed they would be willing to do so even if such errors were not harmful.[44] However, there is still apprehension towards disclosure in many situations, with physicians claiming they would not wish to disclose if errors were trivial or unknown, or citing fears that disclosure of actual errors would create distrust in patients.[45] Patients trusting healthcare providers is crucial, as lacking trust leads to adverse effects such as patients outright ignoring the advice of their physicians.[46] A major shift in medical culture will be required in order to root out these deeply held impulses.[47]

A lack of transparency has serious consequences for patients of low socioeconomic status. Individuals of low socioeconomic status already fare more poorly in the health system, as they have less access to healthcare, have access to poorer quality healthcare, and seek healthcare less frequently.[48] Low socioeconomic status is also tied to ethnicity and race, with groups like African Americans experiencing some of the worst deficiencies in

---

[41] Bornstein, *supra* note 8.
[42] Gallagher, *supra* note 16, at 1006.
[43] *Id*.
[44] *Id*. at 1003.
[45] *Id*. at 1003-04.
[46] John D. Piette et al., *The Role of Patient-Physician Trust in Moderating Medication Nonadherence Due to Cost Pressures*, 165 ARCH. INTERN. MED. 1749, 1752 (2005) ("Low income was a risk factor for cost-related underuse among low-trust patients but not among high-trust patients with similar incomes.").
[47] Gregory N. Stock et al., *Organizational Culture, Critical Success Factors, and the Reduction of Hospital Errors*, 106 INT. J. PROD. ECON., 368, 386 (2007).
[48] Becker, *supra* note 5, at 742.

healthcare.[49] Despite major improvements in healthcare and life expectancy, "African Americans continue to bear a higher burden of death, disease, and disability than Whites."[50]

The cultural history of groups like African Americans remain highly influential.[51] One such instance was the infamous Tuskegee Syphilis Experiment, which took place between 1932 and 1972, where syphilitic men were examined to study the course of the disease.[52] Though penicillin emerged as a treatment while the study was underway, treatment was not provided and in fact was actively hindered.[53] The Center for Disease Control even approved continuing the study in 1969, only for the Department of Health, Education, and Welfare to shut it down in 1972 after the initial findings were reported in the national press.[54] The impact of such events lingered, as studies have proven that individuals of low socioeconomic status remain more distrustful of healthcare providers.[55] While this pattern impacts African Americans, it has been found to occur across racial and ethnic boundaries.[56] Additionally, some studies suggest that those with worse health are most distrustful of the healthcare industry, possibly leading to a cycle of inadequate care.[57]

---

[49] *Id*.
[50] *Id*.
[51] *Id*.
[52] Allan M. Brandt, *Racism and Research: The Case of the Tuskegee Syphilis Study*, 8 HASTINGS CEN. REP. 21, 21 (1978).
[53] *Id*.
[54] *Id*.
[55] *Americans Mistrust Medical Profession, but Like Their Own Doctors*, (2014), www.hsph.harvard.edu/news/hsph-in-the-news/americans-mistrust-medical-profession-but-like-their-own-doctors/.
[56] Katrina Armstrong et al., *Racial/Ethnic Differences in Physician Distrust in the United States*, 97 AM. J. PUBLIC HEALTH, 1283, 1287 (2007).
[57] *See* Katrina Armstrong et al., *Distrust of the Health Care System and Self-Reported Health in the United States*, 21 J. GEN. INTERN. MED., 292, 294 (2006) (Those with worse self-reported health had greater distrust of the healthcare system, with a highly statistically significant p-value of .001.).

## ALTERNATIVE DISPUTE RESOLUTION IS NEEDED TO IMPROVE PATIENT SAFETY

Alternative dispute resolution (ADR) is needed to make considerable positive changes in patient safety. This alternative to lawsuits in resolving conflicts "refers to techniques used to resolve conflicts without going to the courtroom."[58] In other words, ADR is simply an alternative method to dispute resolution which avoids medical malpractice suits. ADR may take a variety of forms, which "can be thought of as a spectrum from informal to formal."[59] On the informal end of the spectrum is basic negotiation, where parties meet to discuss and resolve the conflict.[60] More formal proceedings are also available, including mediation, in which "a negotiation is facilitated by a neutral third-party mediator;"[61] arbitration, where parties are represented by attorneys before an arbiter or arbitration panel who issues binding decisions;[62] and pretrial screenings, "informal screenings before litigation by a neutral party to assess the relative strengths of each party's case and determine whether the trial merits going to trial."[63] These solutions do not rely on the courts, and are often quicker, simpler, cheaper, more flexible, and more effective than traditional suits.[64]

ADR must play a bigger role in healthcare in order for the medical industry to better protect itself from liability, prevent more mistakes, and provide equity to patients. Medical malpractice is an important last resort, as discussed in detail later, but it is overused in its current form.[65] One might

---

[58] Sohn, *supra* note 4, at 1370.
[59] *Id*. at 1371.
[60] *Id*.
[61] *Id*. at 1372.
[62] *Id*. at 1373.
[63] *Id*. at 1374.
[64] *Id*. at 1372.
[65] Studdert, *supra* note 3.

reasonably think that healthcare organizations would seek to avoid medical malpractice and other tort suits whenever possible, as healthcare organizations seem to dislike dealing with the fallout of adverse events, but this practice so far has led to such issues being hidden rather than addressed.[66]

While it is understandable that healthcare organizations wish to avoid confronting problems, this behavior is irresponsible and does not guarantee that the malpractice suits will go away. In fact, studies have demonstrated that no significant increase in the risk of suits occurs due to full and transparent disclosure of errors.[67] A study at the University of Texas Health Science Center at San Antonio was conducted to examine the effects of presenting trauma patient cases at a Weekly Morbidity and Mortality (M&M) conference.[68] M&M conferences are venues, open to all healthcare providers, that serve to discuss deaths, selected major complications, and adverse events.[69] Such conferences exist to foster a more transparent culture related to adverse events.[70] The study found that the rate of patients suing in total (4.25 per 100,000 patients/year), only those included in the M&M presentation (29.6 per 100,000 patients/year) and those who suffered complications (14 per 100,000 patients/year) had no statistical differences between them.[71] There was at worst no negative impact resulting from the presentation of cases.[72] The medical industry has no excuse to hide its errors. It would thus benefit all parties if the healthcare providers were to face its

[66] Schlachter, *supra* note 9, ("The culture of medicine frowns on admitting mistakes, usually on the pretense of fear of malpractice lawsuits. But what's really at risk are doctors' egos and the preservation of a system that lets physicians avoid accountability by ignoring problems or shifting blame to 'the system' or any culprit other than themselves.").
[67] Stewart, *supra* note 40, at 647.
[68] *Id*. at 645.
[69] *Id*. at 646.
[70] *Id*.
[71] *Id*. at 647.
[72] *Id*.

problems head on and provide venues outside the courtroom for issues to be resolved.

## CURBING MEDICAL MALPRACTICE IN FAVOR OF ALTERNATIVE DISPUTE RESOLUTION WILL ESPECIALLY BENEFIT THOSE OF LOW SOCIOECONOMIC STATUS

Among other benefits, ADR can reframe errors as learning opportunities rather than mistakes to be hidden. Most errors are the result of systemic problems, including fatigue, improper labeling of equipment, communication breakdowns, and staffing issues.[73] Medical malpractice suits may punish healthcare providers such for reasonable errors or errors beyond their control. This is a detrimental precedent, as it leads to aforementioned negative results, like defensive medicine and minimal transparency, which ignores many root causes of errors.[74] Undue punishment is not the way the medical field should proceed if it wishes to provide a safer environment for its patients. At best, it is blaming physicians for being human and making mistakes, at worst, it is blaming employees for systemic problems beyond their control, such as excessive work hours or communication failures due to shift changes.[75] If a safer patient environment is the goal, ADR must play a greater role relative to medical malpractice suits.

If institutions protect their employees and settle with patients in the event of medical errors, it will encourage more physicians, nurses, and others to speak out in the event of medical errors. There is significant evidence that physicians feel a wide range of negative emotions after discovering they

---

[73] Michael A. E. Ramsay, *Physician Fatigue*, 13 BAYLOR U. MED. CEN. PRO. 148, 148 (2000) ("The incidence of human error is increased by fatigue, sleep deprivation, and stress (2). As performance decreases, errors of omission occur with increasing frequency.").
[74] Sekhar, *supra* note 19; Gallagher, *supra* note 16, at 1006.
[75] Ramsay, *supra* note 73, at 148 ("However, as performance further deteriorates errors of commission occur: these are 'mistakes' where the planning process itself is flawed.").

committed a medical error.[76] Some physicians worry that they would make unwise decisions if it meant relieving themselves of the emotional burden.[77] Creating an environment more accepting of errors would also make it more likely that physicians reveal errors that were caused by more personal failings.

Medical malpractice suits are especially hard on the disadvantaged and poor because such suits are expensive and slow to provide financial compensation, if any.[78] People of low socioeconomic status, by definition, have limited financial resources and less wealth to get through traumatic events.[79] They are also less likely to have insurance.[80] These individuals need compensation immediately after the error in question to account for future medical bills and lost income. Because ADR can provide patients and their families with immediate access to settlement funds, it is the best course of action for individuals who need reimbursement faster than medical malpractice lawsuits can facilitate.[81]

Medical malpractice suits, as they currently exist, are already an incentive to come to the negotiating table. Only seven percent of medical malpractice suits make it to trial, with the remainder settled out of court.[82] The suits that do make it to trial are not typically won by plaintiffs, with only twenty-one percent of the cases tried ruling in their favor.[83] Thus, it is the settlement resulting from filing the suit, rather than the suit itself, that most frequently

---

[76] Gallagher, *supra* note 16, at 1005.
[77] *Id*.
[78] Studdert, *supra* note 3.
[79] APA, *supra* note 10.
[80] Becker, *supra* note 5.
[81] John S. Andrew, *Making or Breaking Alternative Dispute Resolution? Factors Influencing Its Success in Waste Management Conflicts*, 21 Envir. Impact Ass. Rev. 23, 31 (2001) ("[I]t was readily apparent that ADR had resolved the dispute much faster and at less expense than the conventional process would have, based on the typical duration and cost of the latter in similar circumstances.").
[82] National Medical Malpractice Statistics, *supra* note 29, at 1.
[83] *Id*.

compensates victims. Because out-of-court settlements provide compensation, healthcare providers appear to be in a prime position to offer or expand upon systems for compensating patients that are cheaper, more convenient, and less confrontational for both the patients and the providers.

This argument for ADR does not suggest that medical malpractice should be discarded. It is important that medical institutions be held liable. Medical malpractice suits rarely make it to trial anyway.[84] Ideally, tort litigation should remain an option, but the focus and efforts of healthcare providers should be shifted to ADR.

Increasing the use of ADR will not be easy for a variety of reasons. Though physicians generally voice approval for disclosure, many fear that disclosing errors could undermine patient trust.[85] However, studies have shown that increased transparency does not increase the risk of litigation, but instead increases trust and communication with patients.[86] As discussed, malpractice suits are painful for the patients as well, thus, alternatives should be pursued whenever possible for the benefit of both potential plaintiffs and defendants.

Providing ADR to patients will likely reduce the risk of medical malpractice suits being filed against healthcare providers, due to the availability of other remedies and increased trust and transparency.[87] A

---

[84] National Medical Malpractice Statistics, *supra* note 29, at 1.
[85] Gallagher, *supra* note 16, at 1003-04.
[86] Stewart, *supra* note 40, at 648 ("In matters of disclosure and reporting, transparency is a key initiative of the patient safety movement. To correct errors, one must be free to discuss them frankly and openly with all care providers in the system. Our data, in this and a previous study, lend direct support to the notion that internal transparency with respect to discussion of errors does not lead to increased risk of lawsuit.").
[87] *See* Stewart, *supra* note 40, at 647 (increasing transparency did not increase risk of litigation).

decreased risk of malpractice suits will likely make physicians less paranoid and ensure a positive feedback loop of increased trust and transparency.[88]

The implementation of ADR should be provider-driven. A system should be implemented that provides quick compensation rather than spurring injured parties to take unnecessary legal action. Healthcare organizations providing their own solutions for their mistakes may go a considerable way in improving transparency and building trust with patients. The amount of compensation is likely to be controversial, as seen with the amount of current legislation on tort damage caps.[89] For some, this might be preferable to no initial payment. For others, this is where medical malpractice suits could step in. As discussed, in this system, medical malpractice suits would not be replaced but would instead play a more limited role in keeping privately provided remedies accountable.

## CONCLUSION

ADR must play a bigger role in healthcare in order for the medical industry to better protect itself from liability, prevent more mistakes, and provide equity to patients. ADR would benefit patients of low socioeconomic status who suffer from medical errors and are seeking compensation. This is because it provides quicker access to settlement funds, is less emotionally taxing on healthcare providers and patients alike, improves patient safety, and increases trust. Many patients of low socioeconomic status are already distrustful of the healthcare system. A lack of transparency and lacking channels of communication will not help this fact. Medical malpractice suits have not adequately reduced medical errors, in part because a lack of

[88] Gallagher, *supra* note 16, at 1004 ("Many physicians said that a fear of litigation limited what they tell patients about errors.").
[89] National Medical Malpractice Statistics, *supra* note 29, at 1.

disclosure makes it easier for healthcare providers to simply ignore errors rather than rectify them. To adequately reduce medical errors, punishment of healthcare providers must be replaced with reflection and education. Further, opacity by healthcare providers in why and how medical errors occur, which is motivated by fear of medical malpractice lawsuits, must be replaced with transparency. And while ADR is a better form of dispute resolution, the medical malpractice lawsuit is still an important tool, and simply must be used in concert with less punishing alternatives. Finally, in order to further health justice, ADR must be more often utilized to provide better compensation and communication with patients of lower socioeconomic status.

# OSHA & Addressing the Disparate Impact of COVID-19 Within Vulnerable Communities

*Liam Kenney*

## INTRODUCTION

The last few decades have showcased drastic leaps toward a cohesive global community not only through relations between states in economics and technology, but also in healthcare policy.[1] In a world of increasing human connection and unprecedented access to global travel, a worldwide pandemic presents one of the most serious public health concerns.[2] Countries around the world have struggled to provide an appropriate response to the current coronavirus pandemic with both stories of inspirational success and utter failure.[3] The discrepancy between responses is likely due to the complexity of the pandemic, which includes a dizzying array of geographical and societal factors that can impact the spread and effect of a global virus.[4] Countries must work together in order to properly coordinate an international response while ensuring adequate measures are taken within their own borders. The potential for the rapid and widespread transmission of similar viruses in the future necessitates an updated federal baseline in the United

[1] *See* Dominique Vervoort et al., *COVID-19 Pandemic: A Time for Collaboration and a Unified Global Health Front*, INT'L J. FOR QUALITY HEALTH CARE (June 27, 2020) (citing, "The SARS and Ebola outbreaks in the past two decades have made countries around the world restructure emergency preparedness and disease surveillance programs to mitigate potential future epidemics.").
[2] CDC, *Why it Matters: The Pandemic Threat*, https://www.cdc.gov/globalhealth/health protection/fieldupdates/winter-2017/why-it-matters.html (last visited October 18, 2020).
[3] Pablo Gutiérrez & Seán Clark, *Coronavirus World Map: Which Countries Have the Most Covid Cases and Deaths?*, https://www.theguardian.com/world/2020/oct/16/coronavirus-world-map-which-countries-have-the-most-covid-cases-and-deaths (last visited October 18, 2020).
[4] CDC, *supra* note 2.

States which allows for a more uniform response to pandemics in order to protect public health.[5]

It is no secret that some communities within the U.S. are more vulnerable than others to the threat of public health concerns, such as a contagious virus.[6] For example, during the current crisis, Black or African American individuals are dying at a rate that is 2.4 times greater than that of Caucasian individuals.[7] At a time when many Americans are unemployed or working from home, those that are required to physically report to their workplace are often at the mercy of their employer when it comes to issues of sufficient and effective precautions stemming from a lack of federal guidance.[8] Socioeconomic and minority statuses are among the most important factors in calculating levels of vulnerability to a widespread health concern such as a pandemic.[9] The potential for a disparate impact within minority communities in the context of employment becomes apparent when looking at studies such as those conducted by the National Employment Law Project, which discovered roughly seventy-three percent of Black employees went to work outside of their homes during the current pandemic compared to less than half of white workers.[10] Employees who cannot work from home must

---

[5] Alexandra Kelley, *Fauci Calls for Uniform Pandemic Response to Replace Disjointed State-by-State Approach*, HILL, (November 17, 2020), https://thehill.com/changing-america/well-being/prevention-cures/526372-fauci-calls-for-uniform-pandemic-response-to.
[6] *The COVID Racial Data Tracker*, COVID TRACKING PROJECT, https://covidtracking.com/race (last visited Sept. 13, 2020).
[7] *Id.*
[8] The Editorial Board, *Why Is OSHA AWOL*, N.Y. TIMES, (June 21, 2020), https://www.nytimes.com/2020/06/21/opinion/coronavirus-osha-work-safety.html.
[9] *The COVID-19 Community Vulnerability Index*, SURGO FOUND., https://precisionforcovid.org/ccvi (last visited Sept. 13, 2020).
[10] Peter Dorman & Lawrence Mishel, *A Majority of Workers are Fearful of Coronavirus Infections at Work, Especially Black, Hispanic, and Low- and Middle-Income Workers*, ECON. POL'Y INST. (June 16, 2020), https://www.epi.org/publication/covid-risks-and-hazard-pay/.

hope that their employer complies with the constant stream of changing orders and guidance from state laws, executive orders, and local ordinances.[11]

The myriad of ever-changing responses to the pandemic at the state level requires federal intervention in order to sufficiently protect employees deemed to be essential workers.[12] This article argues that the Occupational Safety and Health Administration ("OSHA") must enact a general infectious disease standard in order to minimize the disparate impact of inadequate and ever-changing state actions upon vulnerable communities. First, the article will discuss how the current U.S. response to the pandemic is organized in the context of workplace safety and what OSHA's role has been thus far. Second, the article will discuss how federal intervention through OSHA could benefit the most at-risk communities. Finally, the feasibility of implementing OSHA regulations which address infectious diseases will be explored.

In order to advocate for changes that benefit vulnerable communities, it is critical to first understand what is included in the definition of the term vulnerable. The term "vulnerable" refers to communities that suffer from six health and social indicators as defined by the Centers for Disease Control and Prevention's ("CDC") social vulnerability index and specific COVID-19 vulnerability factors.[13] These indicators include socioeconomic status, household composition and disability, minority status and language, housing type and transportation, epidemiologic factors, and healthcare system factors.[14] Utilization of this data allows for a more refined definition of what constitutes a vulnerable community and how certain factors rank in

---

[11] Bruce Rolfsen, *States, Localities Filling Federal Void with Virus Safety Rules*, BLOOMBERG L., (Aug. 7, 2020), https://news.bloomberglaw.com/safety/states-localities-filling-federal-void-with-virus-safety-rules.
[12] *Id.*
[13] *The COVID-19 Community Vulnerability Index*, *supra* note 9.
[14] *Id.*

accounting for such vulnerability.[15] The combination of these indicators suggests the level at which a specific community is equipped to deal with a widespread health concern such as a pandemic.[16]

Although the current pandemic has yet to subside in the United States, there are prominent trends emerging as to what factors are the most important in determining risk factors for vulnerability.[17] Socioeconomic and minority status is heavily correlated with the level of overall community vulnerability—that is, these factors are tied with increased vulnerability to a pandemic such as COVID-19.[18] This disparity in vulnerability becomes more concerning when combined with data which clearly indicates that, throughout all stages of the pandemic, minorities are going into work at a higher rate than non-minorities.[19] With no sign that the coronavirus will subside any time soon in the United States,[20] a solution for implementing a uniform policy could be to establish a federal policy that can protect the country's most vulnerable populations.[21]

## PANDEMIC RESPONSE ORGANIZATION AND OSHA'S ROLE

The United States federal pandemic response is organized in a top-down manner with a variety of agencies assigned to different tasks.[22] In general,

---

[15] *Id*.
[16] *Id*.
[17] *Id*.
[18] *Id*.
[19] Catherine Thorbecke, *'Heroes or Hostages?': Communities of Color Bear the Burden of Essential Work in Coronavirus Crisis,* ABC NEWS, https://abcnews.go.com/Business/heroes-hostages-communities-color-bear-burden-essential-work/story?id=70662472 (last visited October 18, 2020).
[20] *COVID-19 Forecasts: Cases,* CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/forecasts-cases.html (last visited Sept. 13, 2020).
[21] Rolfsen, *supra* note 11.
[22]Lindsay Maizland, *U.S. Coronavirus Response: Who's In Charge of What?,* COUNCIL ON FOREIGN RELATIONS, (April 7, 2020), https://www.cfr.org/article/us-trump-coronavirus-response-covid19-agencies-in-charge.

the U.S. Department of Health and Human Services ("HHS") leads from the top through its management of the national stockpile of medical supplies, drugs, and personal protective equipment.[23] HHS is responsible for overseeing the general federal public health response which includes other agencies such as the CDC.[24] On the other hand, OSHA falls under the U.S. Department of Labor, and OSHA's administrator answers directly to the President's cabinet through the Secretary of Labor.[25] This structure seems to allow OSHA to operate outside of the general federal pandemic response, however, OSHA plays a vital role in providing guidance to employers on how to safely operate and protect the health of their employees where possible during the current pandemic.[26]

Since its creation in 1970, OSHA's mission has been to serve public health through its founding principle that employees "should not have to choose between their life and their job."[27] This dedication would appear to be true and apply during public health crises such as the current pandemic. However, OSHA has only published guidelines for workplaces concerning COVID-19 that do not hold any mandatory legal or regulatory power.[28] The absence of such concrete federal standards has negative consequences for essential workers who must physically report to work (many of whom are minorities).[29] Minority populations make up the bulk of essential worker demographics in places such as New York City where seventy-five percent of all essential workers are people of color.[30] This causes a disparate impact

---

[23] *Id*.
[24] *Id*.
[25] *About OSHA,* U.S. DEPT. OF LABOR: OSHA, https://www.osha.gov/aboutosha (last visited Sept. 13, 2020).
[26] OSHA, GUIDANCE ON PREPARING WORKPLACES FOR COVID-19, 3, (2020) [hereinafter OSHA COVID-19 GUIDANCE].
[27] OSHA, *ALL ABOUT OSHA*, 3, (2020).
[28] OSHA, COVID-19 GUIDANCE, *supra* note 26, at 3-4.
[29] Thorbecke, *supra* note 19.
[30] *Id*.

on vulnerable minority and low socioeconomic communities, as employers struggle to keep up with ever-changing local and state actions that attempt to patch the holes left open by OSHA's failure to issue to mandatory guidelines.[31]

Without the teeth that a proper regulation would provide, businesses have little incentive to comply with guidelines that are not backed by enforcement action from OSHA.[32] A lack of enforcement forces workers into the dangerous position of trusting their health to their employer's willingness to provide a workplace safe from potential exposure to the virus. As of October 2020, OSHA has received over 9,000 complaints directly related to Covid-19, yet has only given out about eighty-five citations to employers.[33] This failure to protect the health of workers during a global pandemic is the absolute antithesis of OSHA's mission.[34] In 2019, OSHA issued 28,934 citations in total, offering a much higher level of enforcement.[35] There does not appear to be a stated reason for the lack of enforcement during the current pandemic, putting vulnerable essential workers at risk.[36]

In the end, the failure to protect workers during the pandemic affects virtually everyone and has a significant disparate impact on vulnerable communities. OSHA is in the best position to enact, and enforce, meaningful

---

[31] Rolfsen, *supra* note 11.
[32] OSHA, COVID-19 GUIDANCE, *supra* note 26, at 3-4.
[33] *COVID-19 Response Summary*, OSHA https://www.osha.gov/enforcement/covid-19-data (last visited October 18, 2020).
[34] *See About OSHA*, *supra* note 25. (citing mission statement, "With the Occupational Safety and Health Act of 1970, Congress created the Occupational Safety and Health Administration (OSHA) to ensure safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education and assistance.").
[35] *Top 10 OSHA Violations of 2019: Citations Drop 18 Percent, but List Unchanged*, COMPLIANCE SIGNS, https://www.compliancesigns.com/blog/top-10-osha-violations-of-2019-citations-drop-18-percent-but-list-unchanged/ (last visited October 18, 2020).
[36] *Interim Enforcement Response Plan*, OSHA (April 13, 2020) https://www.osha.gov/memos/2020-04-13/interim-enforcement-response-plan-coronavirus-disease-2019-covid-19 (Reasoning behind lack of enforcement is absent).

regulations in the workplace to protect workers during a pandemic.[37] OSHA must enact and enforce a standard to protect workers. OSHA is responsible for prescribing remedies to the overwhelming amount of workplace complaints related to COVID-19 and should possess the power to remedy such complaints in a way that is best suited to the occupational hazards presented by the current pandemic.[38] Although the CDC excels in its role of providing general guidance and performing activities such as contact tracing and identification of hotspots, its scope is too broad and its resources too stretched to provide the support that employees need in their places of work.[39] OSHA has the specialized knowledge and experience required to create safer workplace conditions, thus, OSHA should enact and enforce standards that protect workers during a public health crises, such as the current pandemic.[40]

## THE BENEFITS OF FEDERAL INTERVENTION THROUGH OSHA

There are a number of positive effects that would result from workplace regulations created and enforced by OSHA.[41] A federal workplace standard would allow for clarity and consistency for both workers and employers.[42] Bloomberg Law, which has tracked state and local coronavirus-related regulations, reports that there are currently 439 such workplace regulations

---

[37] OSHA Act of 1970, Pub. L. No. 91-596, Introduction, 84. Stat. 1590, 1970 (As amended through Jan. 1, 2004) (citing purpose of Act as it pertains to worker occupational health and safety).
[38] *COVID-19 Response Summary*, *supra* note 33. (noting a major data point is removing workers from COVID-19 hazards).
[39] Lauren Hirsch & Yelena Dzhanova, *Coronavirus Response Hurt by Lack of Funding for Public Health Labs, CDC Director Tells Congress*, CNBC, https://www.cnbc.com/2020/03/10/coronavirus-testing-delays-caused-in-part-by-underfunding-cdc-director-says.html (last visited October 18, 2020).
[40] OSHA, *supra* note 27, at 3 (discussing OSHA's general mission and its role as an enforcer).
[41] *Id.*
[42] Rolfsen, *supra* note 11.

in place.[43] With a concrete federal standard, employers would know what rules they must follow and workers would know what to expect when it comes to workplace safety and their health.[44] Employers would not have to worry about violating grey areas of ever-changing orders and guidance from state and local officials.[45] Along with this, workers would know what to expect for workplace safety and would gain peace of mind that their health is not dependent on the whims of their employer.[46]

Another benefit of an established federal standard is the enforcement aspect of OSHA.[47] Businesses that do not take employee safety serious in general would have to face the potential of government penalties for failure to comply with workplace safety regulations.[48] Put simply, the cost of violations for non-compliance in general have risen exponentially and the cost to comply with regulations are now significantly less than penalties for violating relevant standards.[49] Such enforcement action in the form of fines for unsafe conditions would be crucial for protecting our most vulnerable communities.[50] A recent report by the Economic Policy Institute found that nearly seventy percent of current Hispanic and Black onsite employees feel that they face considerable risks of exposure to the coronavirus.[51] The report concluded that the most vulnerable workers with the least bargaining power (including Black, Hispanic, and low to middle-class employees) are not currently protected by established standards.[52] These employees fear for

---

[43] *Id.*
[44] *Id.*
[45] *Id*.
[46] Dorman & Mishel, *supra* note 10.
[47] OSHA, *supra* note 27, at 14.
[48] *Id*.
[49] Vivienne Wilson, *The Financial Impact of Non-Compliance on Businesses* https://spinbackup.com/blog/the-impact-of-non-compliance-on-businesses/ (last visited October 18, 2020).
[50] *Id*.
[51] Dorman & Mishel, *supra* note 10.
[52] *Id*.

their health and safety at jobs where they have little to no hazard pay or ability to negotiate benefits and improved working conditions.[53]

Many of these individuals from vulnerable communities are forced to continue working throughout the pandemic as they rely heavily on their positions in order to provide for themselves and their families.[54] Roughly half of essential workers believe that there is a moderate to large risk of contracting the coronavirus from doing their job.[55] Furthermore, nearly forty percent of employees have raised concerns directly with their employer over a lack of protection from COVID-19.[56] These concerns demonstrate a lack of faith in employers to properly implement safety measures and shows that the country's essential workers worry about their health at work.[57] By establishing standards, OSHA can help to calm the fears of health hazards and exposure to the virus by providing safer workplaces for those who need it most.[58] This can be accomplished by simply converting the current OSHA guidelines into proper regulations with the power of legal enforcement and penalties for employers who fail to comply.[59]

## FEASIBILITY OF AN OSHA WORKPLACE PANDEMIC STANDARD

Although addressing the disparity of the effects of the current pandemic within vulnerable communities may be possible through policy-making and intervention by OSHA, there are concerns with the feasibility of such a solution.[60] The courts have been of little help in relieving the struggles of

[53] *Id*.
[54] *Id.*
[55] *Id*.
[56] *Id*.
[57] *Id.*
[58] OSHA, *supra* note 27, at 3.
[59] *About OSHA*, *supra* note 25.
[60] The Editorial Board, *supra* note 8.

American workers during the current pandemic.[61] A major lawsuit brought by A.F.L.-C.I.O. against the Department of Labor and OSHA in the U.S. Court of Appeals for the District of Colombia that would have forced OSHA to mandate emergency standards for worker protection was dismissed in June.[62] The labor federation argued in the suit that OSHA has ignored calls to protect vulnerable workers by issuing necessary regulations concerning the pandemic.[63] The Court held that the agency is free to determine its own standards.[64] While this may be a sound legal decision as courts often grant great deference to federal agencies, it closes an avenue for compelling the agency to act in a time of crisis and perform the way it was intended to protect the most vulnerable members of our society.[65]

Congress has also failed to offer relief for both businesses and employees.[66] The second proposed stimulus package of 2020 includes language which requires OSHA to create and enforce an emergency standard that includes safety measures concerning the coronavirus.[67] However, the Senate has failed to vote on the package due to a move led by Senator Mitch McConnell and other members of the Senate to hold out on implementing legal protections for employers that might be sued for not providing safe workplaces.[68] While such a move is aimed at protecting business owners, it may further delay the protections necessary for the health and safety of workers around the country.

---

[61] *Id*.
[62] Harper Neidig, *Appeals Court Rejects AFL-CIO Lawsuit Over Lack of COVID-19 Labor Protections*, HILL (June 11, 2020), https://thehill.com/regulation/court-battles/502249-appeals-court-rejects-afl-cio-lawsuit-over-lack-of-covid-19-labor.
[63] *Id*.
[64] The Editorial Board, *supra* note 8.
[65] *Id*.
[66] *Id*.
[67] *Id*.
[68] *Id*.

To make matters worse, OSHA has been underfunded and understaffed during the Trump administration with even fewer inspectors nationwide than it had in the 1970s.[69] Data from the National Labor Employment Law Project suggests that OSHA has performed roughly 5,000 fewer inspections per year on average than it had during the last two presidential administrations and nearly half of the agencies leadership positions have yet to be filled by the Trump administration.[70] A lack of necessary leadership, employees, and inspections greatly cripples the power of the agency to perform its oversight and enforcement duties.[71] The current pandemic demonstrates that this lack of power is unacceptable and severely harms our most vulnerable who must report to work through times of public health crises.[72] While such feasibility issues may seem daunting, they are not impossible to overcome. Although a potential avenue through the court system has been denied, Congress can pass the currently debated bill with language compelling OSHA to act and the administration may increase the capabilities of the agency back to its more powerful stature by increasing funding and appointing agency leaders.[73] Although this may have to wait until 2021 as the administration nears its end. If Senators can come to an agreement on a balance between protecting workers and the businesses that employ them, OSHA may obtain the power necessary to enact and enforce proper levels of workplace safety.[74] With economic pressures and uncertainty surrounding COVID-19 rising, this

[69] *Id*.
[70] *Id*.
[71] *Id*.
[72] Dorman & Mishel, *supra* note 10 (discussing the fears and expectations that employees have surrounding COVID-19 and their workplace).
[73] The Editorial Board, *supra* note 8 (discussing a lack of necessary inspectors and issues within Congress).
[74] *Id*.

may be a likely scenario in the near future as calls for aid continue to increase.[75]

## CONCLUSION

As discussed, there are a variety of issues affecting the potency of OSHA's actions in its current state. However, the members of our most vulnerable communities are desperate for relief, especially those forced to work throughout the current crisis in order to provide for their families. OSHA has the power to make a significant positive impact in the daily lives of minority and low- and middle-income employees by ensuring their health and safety during this time. The high rates of onsite employment in these communities suggests that OSHA may be the perfect vehicle with which to swiftly minimize the disparate impact that this pandemic is having within vulnerable areas.

[75] David Altig et al., *Economic Uncertainty Before and During the COVID-19 Pandemic*, NBER Working Papers 27418, National Bureau of Economic Research, Inc. (2020), https://ideas.repec.org/p/nbr/nberwo/27418.html.

# Chronic Disease Management among Low-Income Urban Populations Through the Use of Telehealth – Impact and Challenges

*Jundi Liang*

## INTRODUCTION

Telehealth, or digital medicine, transfers traditional in-person care from hospitals and clinics to virtual visits on electronic devices at home.[1] Preliminary studies indicate the development of telehealth has the potential to decrease readmissions, avoid unnecessary testing and consultations, and lower costs for home care.[2] Telehealth also serves as a safety precaution for care providers and patients to avoid potential infectious exposures.[3] In rural areas, telehealth has reduced health disparities by adopting on-demand urgent care services to reach patients who live far away from caregivers.[4] However, people with lower socioeconomic status are not only more likely to live in urban areas with less access to health care, but are also more likely to lack health insurance.[5] These populations often have minimal access to preventive health care, routine health checkups, and emergency room services.[6] This paper will introduce how digital health may help to improve chronic diseases among the low-income urban population. Although telehealth has the potential to enhance physician support for patients

[1] E. Ray Dorsey & Eric J. Topol, *Telemedicine 2020 and the next decade*, 395 LANCET 859, 859 (2020).
[2] *Id*.
[3] *Using Telehealth to Expand Accesses to Essential Health Services During the COVID-19 Pandemic*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html (last visited Sep. 11, 2020).
[4] Saif Khairat et al., *Advancing Health Equity and Access Using Telemedicine: A Geospatial Assessment*, 26 J. AM. MED. INFORMATICS ASS'N 796, 804 (2019).
[5] *Urban Versus Rural Care*, UNITE FOR SIGHT, https://www.uniteforsight.org/global-health-university/urban-rural-health#_ftn7 (last visited Sep. 12, 2020).
[6] *Id*.

suffering from chronic diseases through remote monitoring, majority of the services are not yet patient-centered and lack personalized data analysis and treatment for wide adoption. Lastly, this paper will address what legal measures can be undertaken to overcome these challenges. Specifically, telehealth policies should require providers to use more accessible and personalized platforms and should incorporate mandatory physician trainings to address the needs of underserved populations.

## BACKGROUND

Chronic diseases like asthma, diabetes, and obstructive pulmonary disease commonly occur in urban environments.[7] Low-income populations are the among the most vulnerable to these diseases.[8] Unlike infectious disease controls or urgent care, chronic disease control requires long-term patient-clinician communication to achieve patients' adherence and behavior changes.[9] With the rapid increase of patients with chronic diseases, telehealth intervention is useful in stimulating patients' self-management.[10] Effective preventive management through telehealth alleviates the challenges for people with little access to in person appointments by integrating virtual and in-person care involving health workers from different social branches.[11]

An illustration of effective use of telehealth to improve patients' self-management can be found in a study from 2011 (Carter et al.).[12] A treatment

---

[7] Emily J. Flies et al., *Urban-Associated Diseases: Candidate Diseases, Environmental Risk Factors, and a Path Forward*, 133 ENV'T. INT'L. 3-8 (2019).
[8] *Id*.
9 Na Liu et al., *Telehealth for Noncritical Patients with Chronic Diseases During the COVID-19 Pandemic*, 22 J. MED. INTERNET RES. 2 (2020).
[10] Esther Talboom-Kamp et al., *From Chronic Disease Management to Person-Centered eHealth; A Review on the Necessity for Blended Care*, 1 CLINICAL EHEALTH 3 (2018).
[11] Dorsey & Topol *supra* note 1, at 1.
[12] *See* Ernest L. Carter et al., *A Patient-Centric, Provider-Assisted Diabetes Telehealth Self-Management Intervention for Urban Minorites*, 8 PERSP. IN HEALTH INFO. MGMT. (2011)

group of African Americans with diabetes from low-income urban areas with access to an online platform that combined a self-management module, a health education module, and a social networking module gained significant health improvements compared to a control group with no online access.[13] In this study, the self-management module included each patient's information exchange with the nurse through video conference, the nurse's transmission of the data into electronic health record (EHR) to the patient's provider, and the provider's update of treatment plans.[14] The health education module provided the patients with culturally and age-appropriate health education materials (videos, links, and information on health and wellness).[15] Further, the social networking module linked all patients allowing them to share coping strategies and healthy lifestyles.[16] Results indicated that patients not only gained greater access to health services, but also assumed more responsibility for their own health.[17]

A second case study used a multicomponent medical and behavioral interventional program to deliver care to children with asthma in central urban, economically disadvantage neighborhoods in a school-based setting.[18] The program consisted of video-based telehealth ("VBT") visits with asthma specialists, school-based self-management visits with an adherence psychologist, and study visits at school with the assistance of a nurse or

(study suggesting telehealth interventions can effectively promote chronic disease management in medically underserved communities).
[13] *Id*. at 1–6.
[14] *Id*. at 3-4.
[15] *Id*. at 4.
[16] *Id*.
[17] *Id*. at 5-6.
[18] Nancy Y. Lin et al., *Telehealth Delivery of Adherence and Medication Management System Improves Outcomes in Inner-City Children with Asthma*, 55 PEDIATRIC PULMONOLOGY 859-863 (2020) (study demonstrating that a multicomponent telehealth program delivered to a school-based setting can significantly improve asthma outcomes and care in a challenging population).

coordinator.[19] Results showed improved asthma control and medication adherence, establishing lifelong self-management skills among school children under telehealth intervention.[20]

While telehealth has increased treatment methods for chronic diseases, it also comes with certain drawbacks. On the one hand, implementing self-management requires complex and difficult routines, and cannot be achieved without close monitoring from care providers.[21] On the other hand, obstacles including time and competing priorities pose a big challenge for telehealth.[22] Patients have found it difficult to address their own concerns and reported that the distance made providers less attentive.[23] Some believed they had less control of the conversation because the doctor rushed through the visit due to time pressure, others felt unheard and neglected due to lack of eye contact from their providers.[24] Older, lower-income individuals in urban areas have also expressed strong preference to see their caregiver in person instead of utilizing telehealth.[25] This is most likely due to the importance of personal relationships between these individuals and their care providers as well as the hesitation regarding quality and reliability of exams performed through virtual appointments.[26] Such concerns pose potential barriers to the wider adoption of telehealth for chronic-disease management among low-income populations in urban areas. Due to the diversity of telehealth chronic diseases management, new platforms or technologies must incorporate personalized

---

[19] *Id*. at 859.
[20] *Id*. at 862.
[21] Talboom-Kamp et al., *supra* note 10, at 4.
[22] *Id*.
[23] Howard S. Gordon et al., *"I'm Not Feeling Like I'm Part of the Conversation" Patients' Perspectives on Communicating in Clinical Video Telehealth Visits*, 35 J. GEN. INTERN. MED. 1751, 1753 (2020).
[24] *Id*. at 1753-54.
[25] Rajeev S. Ramchandran et al., *Patient Perceived Value of Teleophthalmology in an Urban, Low Income US Population with Diabetes*, 15 PLOS ONE 1, 9 (2020).
[26] *Id*.

care and enhance collaboration with the urban health care system.[27] Telehealth technologies need to be personalized to each individual in order to encourage continued participation.[28]

## ANALYSIS

This article will now look at methods to institute a wide adoption of patient-centered telehealth platform with individualized treatment for chronic disease management. To successfully implement such patient-centered platform among urban low-income communities, it is important for telehealth regulations to incorporate mandatory measures to ensure each individual's access to telehealth technologies, customize their use of technology, give them direct control to the collected data, and improve the communication between patients and providers.

### *Encourage the Use of Telemedicine Among Patients*

In order to encourage telemedicine acceptance by low-income patients and address their above-mentioned concerns, a number of steps need to be taken. A first and necessary step would be to create incentives among the patients to use telehealth by informing them about the medical qualifications of the specialists and the level of diagnostic accuracy using telemedicine.[29] State medical regulatory boards must incorporate special requirements in clinic telemedicine policies and procedures to address the needs of low-income patients. These requirements should include developing educational materials to address misinformation and gaps in knowledge among older

---

[27] Birthe Dinesen et al., *Personalized Telehealth in the Future: A Global Research Agenda*, 42 J. MED. INTERNET RES. 5, 5-6 (2016).
[28] *Id.*
[29] Sheba George et al., *How Do Low-Income Urban African Americans and Latinos Feel about Telemedicine? A Diffusion of Innovation Analysis*, 2012 INT'L. J. TELEMEDICINE & APPLICATION 7, 7-8 (2012).

patients or urban low-income individuals.[30] Such materials need to highlight explicit benefits of telehealth, user instructions, as well as the identities of caregivers at the other end of a telehealth service to provide the same kind of trust during a face-to-face meeting.[31]

Technological availability also affects the implementation of telehealth. For low-income individuals living in urban areas who may not have access to personal devices or technology, telehealth regulations may require local governments to use a certain percentage of funding to loan mobile devices and provide internet hotspots for them to enable access.[32] Governments or insurers could also reimburse community-based health programs to provide them with communication services to maintain their outpatient care.[33] Alternatively, a telehealth wellness kiosk system could be implemented in a community setting for routine health monitoring, with staff on site to assist with device utilization.[34] Each user can get a personal card they insert to access personal health information whenever they use the kiosk.[35] For older individuals among these communities, regulatory guidelines should encourage the design of flexible computer interfaces and smooth navigations to ensure their consistent use of the system.[36]

In addition, the federal government recently finalized a rule allowing Medicare to cover telemedicine, incentivizing more physicians and patients

---

[30] *Id*.
[31] Qian Liu et al., *Securing Telehealth Applications in a Web-Based e-Health Portal*, 10 IEEE 3-7 (2008).
[32] June-Ho Kim et al., *How the Rapid Shift to Telehealth Leaves Many Community Health Centers Behind During The COVID-19 Pandemic*, HEALTH AFF. (Jun 2, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200529.449762/full/.
[33] *Id*.
[34] George Demiris et al., *Older Adults' Acceptance of a Community-Based Telehealth Wellness System*, 38 INFORMATICS FOR HEALTH & SOCIAL CARE 27–36, 27 (2013).
[35] *Id*. at 31.
[36] *Id*. at 33.

to adopt virtual visits.[37] Because wider adoption of telehealth requires involvement of workers from different social institutions as well as more digital devices, insurers should also reimburse the costs of assisting staff and cellular data to the low-income populations to ensure the affordability of care among low-income patients.[38] Furthermore, telehealth regulations should require that network provider agreements provide physicians using telehealth with 24/7 tech support to resolve technical problems, and impose mandatary telehealth usage training to hospitals and clinics that implement new telehealth technologies.[39]

*Personalize the Use of Technology*

Advocates for telehealth claim that this platform generates more touchpoints with patients with chronic diseases by offering more timely and convenient care than traditional methods.[40] However, the use of technology instead of in-person consultation requires that the platform accommodate each patient's culture, age, education level, physical capabilities, and computer literacy.[41] Chronic disease management for urban, low-income communities will not become more patient-centric unless telehealth regulations call for culturally approachable platforms be designed to match the patients' needs.

Telehealth can enhance culturally congruent care when culturally and linguistically appropriate information are incorporated into provider

---

[37] Ken Terry, *New Rule Provides Telemedicine Opportunity*, MED. ECON. (May 1, 2019), https://www.medicaleconomics.com/view/new-rule-provides-telemedicine-opportunity.
[38] Kim et al., *supra* note 32.
[39] Terrey L. Hatcher, *Understanding Telehealth Regulations and Requirements*, RELIAS (Jul 2, 2020), https://www.relias.com/blog/understanding-telehealth-regulations.
[40] *See* DELOITTE, EMPOWERING PATIENTS WITH TELEHEALTH 10 (2016) (demonstrating ways real-time telehealth platform can enable health care providers to enhance their support for patients with chronic diseases).
[41] Dinesen et al., *supra* note 2727, at 6.

agreements.[42] With respect to a patient's age, older patients with limited dexterity and poor vision need a simple and efficient user interface, while younger populations may be more attracted to platforms with immediate feedback and competition with other patients in attaining preset goals.[43] Telehealth policies must also consider the intrusive nature of the monitoring system and require that the system be designed around individual patient preferences.[44] Regulatory measures recognizing each patient's functional strengths and weaknesses and personalizing the care management strategies would ensure more accurate data collection and provide better insights into patients' health.[45]

Furthermore, low-income populations which include African Americans and Latinx immigrants make up the largest proportion of the populations who experience the most severe and concentrated types of health disparities in an urban setting.[46] Because these groups receive the lowest formal education of any race or ethnic group, culturally competent intervention content must be designed for them from the outset.[47] Regulations should require that Spanish language content for Latinx be written in universal Spanish at a sixth-grade literacy level, and that video and animation be incorporated into devices to overcome low literacy barriers.[48] Adherence among these groups can be achieved by reminders via mobile app, and a virtual classroom environment can be set up to reach participants in group-based training sessions.[49]

---

[42] Demiris et al., *supra* note 34, at 33.
[43] Dinesen et al., *supra* note 27, at 6.
[44] *Id*.
[45] *Id*.
[46] George et al., *supra* note 29. at 1.
[47] Rodriquez & Perez-Stable, *The Time Is Now for eHealth Research with Latinos*, 107 AM. J. PUB. HEALTH 1706-07 (2017).
[48] *Id*.
[49] *Id*. at 1706.

*Patient-Generated Data*

Allowing patients to monitor their own health leads to changes in their behavior and results in positive impact on their health.[50] One study showed that a combination of behavior change techniques tailored to patients' needs, self-monitoring with immediate feedback, shared decision-making, motivational interviewing, and personal support for health professionals can empower the patients' self-management skills.[51] However, with patient's information stored in the Electronic Health Record ("EHR") system, the current policies pertaining to EHR technology overly emphasize providers' access to information and sharing of information within the providers rather than focus on patients.[52] Healthcare providers tend to focus on diagnosis, treatment, and quality measures of data due to their busy agenda, while ignoring contextual and personal information about the patient's needs in managing chronic disease.[53]

Here, guidelines need to be made for physicians to undergo trainings on being cognizant of the communities they are working with and prioritizing these patient-generated data. Regulatory enforcement also needs to focus on the collaboration of communities of experts who develop the systems and those who work closely with the urban low-income populations.[54] Successful engagement of data collection and information review require patient-generated data become actionable information and be integrated into clinical

---

[50] Chris Salisbury et al., *Telehealth in Chronic Disease: Mixed-Methods Study to Develop the TECH Conceptual Model for Intervention Design and Evaluation*, 5 BMJ OPEN 1, 7 (2014).
[51] *Id.*
[52] Dinesen et al., *supra* note 27, at 7.
[53] Susan S. Woods et al., *Integrating Patient Voices into Health Information for Self-Care and Patient-Clinician Partnerships: Veterans Affairs Design Recommendations for Patient-Generated Data Applications*, 23 J. AM. MED. INFORMATICS ASS'N 491 (2016).
[54] Dinesen et al., *supra* note 27, at 9.

workflows.[55] State regulations need to require health systems to make changes to clinicians' schedules to perform virtual "desktop medicine" and deal with patient-generated data.[56] Further, these systems can personalize patient health record data by prioritizing patient-generated data integration strategies.[57] Nurses and non-physician staff who review and process patient data should also be allowed to contribute to the efficient design of data tools and workflow solutions.[58]

In the case of chronic disease management, healthcare institutions could be encouraged by law to use timely input of data from patients to accelerate progress in mobilizing evidence-based care, and design community or population-level interventions for health benefits.[59] Telehealth regulations should consider designs that allow patients to annotate and highlight abnormal data or exceptional events in order for providers to read into additional contextual information of the patient.[60] Within low-income communities, providers and social workers may also want to diligently communicate with patients to clarify the intended uses of the data by each party to avoid miscommunication and set goals for patient tracking practices.[61] Such collaboration guarantees efficiency in communication and matches the proper telehealth system within the intended outcomes.[62]

---

[55] Woods et al., *supra* note 53, at 491.
[56] *Id*. at 493.
[57] *Id*.
[58] *Id*. at 494.
[59] Dinesen et al., *supra* note 27, at 7.
[60] Chia-Fang Chung et al., *Boundary Negotiating Artifacts in Personal Informatics: Patient-Provider Collaboration with Patient-Generated Data*, CSCW '16: PROCEEDINGS 19TH ACM CONFERENCE ON COMPUTER-SUPPORTED COOPERATIVE WORK & SOCIAL COMPUTING 18 (2016).
[61] *Id*. at 21.
[62] Dinesen et al., *supra* note 27, at 9.

*Physicians' Communication Competency*

The lack of patient-centered interaction can also be found in a lack of adequate inter-physician communication.[63] Because most utilization of telehealth does not require communication skill training,[64] poor provider-patient communications have resulted in patients feeling less involved in the virtual visit.[65] Virtual visits require sharpened attention and communication from both the physician and the patient, and the absence of guidance on how to best utilize the platform can result in the omission of critical details.[66] Therefore, mandatory trainings to increase physicians' remote consultation competencies should be incorporated into medical education to enhance the efficacy and safety of treatments.[67] Such training in virtual care should be required for all medical staff and should cover data capture, communication skills, and patient background education.[68] An example of this could include helping patients prepare for telehealth visits, encouraging patients to speak up, communicating by responding empathically, and setting goals according to patients' preferences and abilities to achieve the goal.[69] Literature indicates initial in-person meeting may help populations such as African Americans establish trust with physicians and prepare the patient for future virtual visits.[70] Patients from underserved communities find it more difficult to communicate effectively with their providers due to distrust, privacy

[63] L.S. van Galen et al., *Telehealth Requires Expansion of Physicians' Communication Competencies Training*, 41 MED. TEACHER 714 (2018).
[64] *Id*.
[65] Gordon et al., *supra* note 23, at 1753.
[66] Galen et al., *supra* note 63, at 714.
[67] *Id*.
[68] Elizabeth Varinga, *Training Clinicians with Telehealth*, HEALTH RECOVERY SOLUTIONS, https://www.healthrecoverysolutions.com/blog/training-clinicians-with-telehealth (last visited Oct 18, 2020).
[69] Gordon et al., *supra* note 23, at 1755.
[70] George et al., *supra* note 29, at 7.

concerns, or fear of deportation.[71] A physician needs to be trained in how to engage in interpersonal conversations before presenting the problems to establish trust and show deference to the patient's cultural values.[72] Active listening also helps physicians better perceive the patients' words and enhances empathic understanding.[73]

## CONCLUSION

With the emergence of telehealth, patients facing inequities due to lack of resources in low-income urban areas now have more opportunities to access health care providers through real-time virtual consultations and appointments. Although the current telehealth system is not yet patient-centric enough to provide personalized treatment and engagement, there is promise of a more inclusive future by utilizing the current policy framework. An opportunity for further research could include addressing the cost-benefit analyses and the reimbursement policies of telehealth adoption.

---

[71] *Telehealth Treatment Engagement with Latinx Populations During the COVID-19 Pandemic*, LANCET (Oct 8, 2020), https://www.thelancet.com/action/showPdf?pii=S2215-0366%2820%2930419-3.
[72] *Id.*
[73] *Id.*

# Reasonable Accommodations for Parental Caregivers

*Hani Majeed*

## INTRODUCTION

The COVID-19 pandemic has highlighted the need for employers to provide reasonable accommodations for parents and guardians of young children with bona-fide childcare needs.[1] Since COVID-19 is highly contagious, its outbreak has led to an overnight closure of our society.[2] Overnight, millions of parents found themselves working remotely from their homes as their employers closed their physical workplaces.[3] Upon recommendations from Center for Disease Control (CDC) and government orders, daycares and schools ceased in-person instruction.[4] Domestic workers and nannies accordingly became cautious about leaving their homes.[5] Conversely, "essential worker" parents which constitute about forty percent of working Americans, were still required to go into work despite their children's schools and daycares being closed.[6] This hodgepodge situation created a bona-fide childcare dilemma for most American parents of young children, particularly those between the ages of birth to five.[7]

Whether working remotely or going into work, parents and guardians of young children became physically or mentally limited because of their bona-

[1] David E. Gottlieb, *Childcare Accommodations and Legal Ramifications During COVID-19*, N.Y. L. J., 2 (March 19, 2020).
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] Olga Khazan & Adam Harris, *What Are Parents Supposed to Do With Their Kids?* ATLANTIC (Sept 3, 2020), https://www.theatlantic.com/politics/archive/2020/09/limited-child-care-options-essential-workers/615931/.
[7] Cody Uhing, *National Poll Finds Essential Workers, Families Struggling with Child Care During Crisis*, FIRST FIVE YEARS FUND (Apr 22, 2020), https://www.ffyf.org/national-poll-finds-essential-workers-families-struggling-with-child-care-during-crisis/.

fide childcare needs.[8] For example, a mother was fired from her job because she could not keep her kids quiet while on business calls.[9] Despite asking for accommodations to avoid calls while she was putting her kids down for a nap, the calls continued to be scheduled without taking her situation into account.[10] Even though she met all her deadlines, her employer told her to "take care of the kid situation," and terminated her.[11] In another case, a single mother, who served as an airline's director of revenue management, was terminated after she repeatedly requested to take two hours a day off for her child's education needs.[12] She was bluntly told that it "was not in the interest of the company or yourself."[13] She was fired soon after.[14]

Realizing the emergency of the situation, the federal government passed the Families First Coronavirus Response Act (FFCRA).[15] This act required certain employers to provide their eligible employees with two weeks of paid sick leave and ten weeks of expanded family and medical leave if the employee is caring for a child whose school or place of care is closed for reasons related to COVID-19.[16] Since the leave offered a limited number of days, many parents used up their protected leave in the spring and summer

---

[8]Legal Information Institute, *Bona Fide*, CORNELL L. SCH., https://www.law.cornell.edu/wex/bona_fide (last visited Oct. 31, 2020) ("Bona fide is a Latin term meaning 'good faith.' This refers to an individual's position under the law that is based in good faith without notice of fraud with regards to a particular transaction or with regards to the authenticity of a particular document.").

[9] Kylie Ore Lobell, *Accommodating Working Parents During the COVID-19 Pandemic* (July 30, 2020), https://www.shrm.org/resourcesandtools/hr-topics/employee-relations/pages/accommodating-working-parents-during-the-covid-19-pandemic.aspx.

[10] *Id.*

[11] *Id.*

[12] Erin Mulvaney, *Motherhood Penalty' May Fuel Workplace Lawsuits in Pandemic (1)*, BLOOMBERG L. (Apr. 29, 2020, 5:21 AM), https://news.bloomberglaw.com/daily-labor-report/motherhood-penalty-may-fuel-workplace-lawsuits-in-pandemic.

[13] *Id.*

[14] *Id.*

[15] *Families First Coronavirus Response Act: Employee Paid Leave Rights*, DEP'T LABOR, https://www.dol.gov/agencies/whd/pandemic/ffcra-employee-paid-leave (Nov. 15, 2020).

[16] *Id.* (The act applies to employers of more than 50 employees, but less than 500 employees. Exemptions for other employers may also apply).

months, and found themselves struggling again as school districts announced their hybrid or all on-line schedules for fall.[17] This significantly reduced or eliminated kids' supervised time in school, while teaching and caretaking obligations continued to rest on parents.[18]

This article argues that when compared to fathers, mothers' employment is disproportionately affected by the pandemic, hence, legislation needs to be enacted to ensure that mothers do not have to choose between employment and caregiving responsibilities.[19] First, the article examines how mothers are disproportionately affected by school closures during the pandemic. Next, it explains why current legislation does not offer enough protection. Finally, the article recommends a policy requiring employers to provide reasonable accommodation for bona-fide childcare needs. This policy should be modeled after American Disabilities Association (ADA), while borrowing concepts from the Canadian Human Rights Commission, to ensure equity for mothers. Throughout this article, the term "parents" encompasses both parents and guardians, and the term "mother" refers to the maternal figure in a heterosexual relationship.

## MOTHERHOOD PENALTY

The "motherhood penalty" is a phrase coined by sociologists to describe persistent gender disparities that working mothers encounter in the workplace.[20] It is the phenomenon by which women's pay and opportunities decrease once they become mothers.[21] This pandemic has exacerbated the

---

[17] Khazan & Harris, *supra* note 6.
[18] Lobell, *supra* note 9.
[19] Caitlin Collins, et al., *COVID-19 and the Gender Gap in Work Hours*, GENDER WORK ORG., July 2020, at 11-12 https://onlinelibrary.wiley.com/doi/pdf/10.1111/gwao.12506.
[20] Mulvaney, *supra* note 12.
[21] *The Motherhood Penalty*, AAUW, https://www.aauw.org/issues/equity/motherhood/ (last visited Nov 15, 2020).

motherhood penalty.[22] Furthermore, it has induced discrimination in hiring, firing, pay, and promotions.[23] Unless employers offer flexible working condition for both parents, there is a risk that the motherhood penalty will drastically increase in the coming months and years.[24]

Mothers, when compared to fathers, continue to burden a larger share of caregiving obligations for young children during this pandemic.[25] Professor Caitlyn Collins, co-author of a study by Washington University in St. Louis, suggests, "Even among households in which both parents are able to work from home and are directly exposed to childcare and housework demands, mothers are scaling back to meet these responsibilities to a greater extent that fathers."[26] Although the reason for this is unclear, data indicates that since the beginning of the pandemic, on an average, mothers have scaled back their work hours by about five percent or two hours per week, whereas fathers' work hours have essentially stayed the same.[27]

This also creates a long-term problem for mothers as employers look for ways to save money, and are more likely to lay off or discriminate against those who have already weakened their labor market attachment by scaling back their hours.[28] The Center for Work Life Law at the University of California's Hastings College of the Law notes that they have received over one thousand calls in the past six months by parents, pregnant employees and other caregivers who need assistance with mistreatment at work or issues

---

[22] Collins, *supra* note 19.
[23] Mulvaney, *supra* note 12. *See also,* David Yaffe-Belaney, *Pandemic Firings Lead to Wave of Bias Claims from Parents,* PRESS HERALD, https://www.pressherald.com/2020/11/11/pandemic-firings-lead-to-wave-of-bias-claims-from-parents/.
[24] Sarah Savat, *Mothers' Paid Work Suffers During Pandemic Study Finds*, SOURCE, (July 13, 2020), https://source.wustl.edu/2020/07/mothers-paid-work-suffers-during-pandemic-study-finds.
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.*

involving parental leave.[29] Their data also indicates that working parents, especially women are filing a record number of lawsuits against their employers.[30] Most of these suits are filed under Family First Coronavirus Act.[31] Furthermore, they note that women are leaving their careers in record numbers this year.[32]

Legislation requiring employers to reasonably accommodate parent's requests can curb the motherhood penalty. As Professor Collins notes, "By easing work demands and allowing flexibility where possible in the coming months, employers can prevent long-term losses in women's labor force participation."[33] However, at this time, there is no duty upon employers to offer this flexibility.[34] The remaining of this article argues that such a duty would fill the gaps in the statutory framework, and could protect parental caregivers, who are mostly mothers, from leaving the workforce entirely.

## CURRENT LAW AND ITS INSUFFICIENCY

There is no duty on American employers to provide accommodations to their employees for ordinary, non-healthcare, caregiving needs.[35] Except for the temporary FFCRA, there is no explicit federal law that protects parental caregivers from discrimination.[36] However, parents often bring in parental caregiver discrimination lawsuits under the Family and Medical Leave Act (FMLA) of 1993 and Title VII of the Civil Rights Act of 1964.[37]

---

[29] Yaffe-Bellany, *supra* note 2312, at 23.
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] Savat, *supra* note 24.
[34] Debbie Kaminer, *The Work-Family Conflict: Developing a Model of Parental Accommodations in the Workplace*, 54 AM. U. L. REV. 305, 322 (Aug. 2005).
[35] *Id.*
[36] Mulvaney, *supra* note 12.
[37] Kaminer, *supra* note 34, at 334.

Family and Medical Leave Act (FMLA) of 1993 was the first federal statute to address the issue of parental leave.[38] The essence of FMLA, as posed in the preamble, lies in the importance of parenting, especially in the early stages of childrearing.[39] Without protections in place to allow for accommodations, working parents must "choose between job security and parenting."[40] However, the FMLA fails to meet the promises of its preamble.[41] It does not mandate paid family leave, and since taking twelve weeks of unpaid leave may not be an economically feasible option, most parents are unable to incur any benefit from it.[42] Ultimately, FMLA serves as a symbolic act, which fails to protect the "vast percentage of American employees"[43] It duplicated what the market was already providing– unpaid leave.[44]

Whereas FMLA focusses on unpaid leave, Title VII of the Civil Rights Act, provides protections against employment discrimination based on race, color, national origin, religion, and sex.[45] Title VII is insufficient as it focuses on employer's presumptions about mothers as caregivers, not their actual needs.[46] It requires for men and women to be treated equally.[47] It focuses on formal equality between the sexes, not equal impact, thereby limiting the equitable solution to discriminatory issues in the workplace.[48]

---

[38] *Id.*
[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] Allison A. Reuter, *Subtle but Pervasive: Discrimination Against Mothers in Workplace*, 33 FORDHAM L. J. 101, 112 (Feb. 3, 2011), https://ir.lawnet.fordham.edu/cgi/viewcontent.cgi?article=2252&context=ulj.
[43] *Id.*
[44] *Id.*
[45] 42 U.S.C. §§ 2000e-2000e-17 (1964).
[46] Kaminer, *supra* note 34, at 322.
[47] *Id.*
[48] *Id.*

Courts have made it clear that Title VII prohibits employers from presuming that mothers will be poor employees because of caregiving responsibilities;[49] however, under the current laws, employers have no duty to accommodate a parent's caregiving requests.[50] In *Guglietta v. Meredith Corp.,* the plaintiff alleged that she was discriminated by her employer for being a "woman with a child", but the court disagreed and thought a better characterization was "a woman with childcare difficulties."[51] The court held that she would not qualify under a Title VII claim because whereas a "woman cannot be discriminated against for having a child," she can be denied shorter hours because of her childcare needs.[52] The employer has no duty to accommodate.[53]

Similarly, in another case, *Gingras v. Milwaukee County*, the court emphasized that the distinction "between illegal stereotyping and actual adverse effects on performance" is the key in Title VII claims.[54] It is not for the courts to decide whether an employer's behavior towards the employee is "kind, a good business practice, or anything of the like."[55] The court leaves the question for accommodation to "the legislature or for individual employers themselves."[56] Since leaving the problem to individual employers creates a risk for exasperating the motherhood penalty (during and after the pandemic), it is time for the legislature to address this problem with the intent to offer equity and fairness for mothers.

---

[49] *Id.*
[50] *Id.*
[51] Guglietta v. Meredith Corp., 301 F. Supp. 2d 209, 217 (D. Conn. 2004). *See also*, Reuter, *supra* note 42, at 137.
[52] Reuter, *supra* note 42, at 137.
[53] *Id*
[54] Gingras v. Milwaukee County, 127 F. Supp. 3d 964, 979 (E.D. Wis. 2015).
[55] *Id.*
[56] *Id.*

The probability of an exasperated motherhood penalty is too high of a risk for the legislature to ignore the problem.[57] Title VII focuses on presumptions, stereotypes, and formal equality that doesn't account for equity.[58] FMLA focuses on offering unpaid leave for taking care of a new born child or a child with serious health conditions.[59] Even the temporary Families First Coronavirus Response Act (FFCRA) focuses on definite time off in an indefinite situation for school closures.[60] As discussed above, none of these acts meet the demands of parenting while working during this pandemic. An effective anti-discrimination parental caregiver law would focus on reducing discrimination by putting the duty on businesses to accommodate parents for bona-fide caregiving requests.

Such laws permanently exist in many developed countries, including Canada, Great Britain, New Zealand and Australia.[61] They require employers to set up a process to negotiate flexible work arrangements, and allow employers to refuse accommodations only for certain business reasons.[62] Canadian Human Rights Commission places the duty to accommodate caregivers on employers.[63] They note that the "duty to

---

[57] Rasheed Malik et al., *The Coronavirus Will Make Child Care Deserts Worse and Exacerbate Inequality*, CTR. FOR AM. PROGRESS (June 22, 2020, 6:30 AM), https://www.americanprogress.org/issues/early-childhood/reports/2020/06/22/486433/coronavirus-will-make-child-care-deserts-worse-exacerbate-inequality/.
[58] Kaminer, *supra* note 34.
[59] *Id.*
[60] *Families First Coronavirus Response Act: Employee Paid Leave Rights*, DEP'T LABOR, https://www.dol.gov/agencies/whd/pandemic/ffcra-employee-paid-leave (last visited Nov 15, 2020).
[61] Joan C. William et al., *Protecting Family Caregivers from Employment Discrimination*, AARP POL'Y INSTIT. 10 (last visited Nov 15. 2020) https://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/protecting-caregivers-employment-discrimination-insight-AARP-ppi-ltc.pdf.
[62] *Id.*
[63] *What is the Duty to Accommodate*, CANADIAN HUM. RTS. COMM'N, https://www.chrc-ccdp.gc.ca/eng/content/what-duty-accommodate.

accommodate means that sometimes it is necessary to treat someone differently in order to prevent or reduce discrimination."[64] The duty to accommodate means that sometimes alternative arrangements must be made to secure full participation by certain individuals or groups.[65]

The United States uses a similar framework for people with disabilities through the Americans with Disabilities Act of 1990.[66] The ADA prohibits an "employer from discriminating against an individual with a disability who, with reasonable accommodation, can perform the essential functions of a job, unless the employer can demonstrate that the accommodation would impose an undue hardship on the operation of the employer's business."[67] A reasonable accommodation amounts to a change an employer has to make to "ensure that a qualified individual with a disability can perform the essential functions of the job and enjoy equal employment opportunities."[68] This change may involve the application process, the hiring process, the job itself, the way the job is done, and the work environment.[69] The accommodations are deemed reasonable if they do not create "undue hardship" or a "direct threat" to the employer.[70] ADA also requires an interactive process between the employer and employee.[71] The interactive process is a tool that

---

[64] *Id*.
[65] *Id*.
[66] *American Disabilities Act*, 42 USCS 12101 et seq., in 42 USCS 12112.
[67] US Airways, Inc. v. Barnett, 535 U.S. 391, 393 (2002).
[68] *What Is Considered a Reasonable Accommodation Under the Americans With Disabilities Act in 2020?*, DISABLED PERSON, https://www.disabledperson.com/blog/posts/what-is-considered-a-reasonable-accommodation-under-the-americans-with-disabilities-act-in-2020 (last visited Oct. 31, 2020).
[69] *Id.*
[70] *Id. See generally*: US Airways, Inc. v. Barnett, 535 U.S. 391, 393 (2002) ("A plaintiff/employee…need only show that an 'accommodation' seems reasonable on its face, i.e., ordinarily or in the run of cases. The defendant/employer then must show special (typically case-specific) circumstances demonstrating undue hardship in the particular circumstances.").
[71] Grant T. Collins & Penelope J. Phillips, *Overview of Reasonable Accommodation and the Shifting Emphasis from Who Is Disabled to Who Can Work*, 34 HAMLINE L. REV. 469, 484 (2011).

employers and employees use to "determine whether there is an accommodation that will allow a particular individual with disabilities to perform the essential functions of a particular job."[72]

Similarly, the federal government can prevent the exasperation of the motherhood penalty during this pandemic (and after) by enacting a legislation that places the duty to accommodate a bona-fide parental caregiving need on employers. Like the ADA which requires an interactive process between the employer and employee, this legislation would require a dialogue between parental caregivers and employers. The parental caregiver must first demonstrate a bona-fide caregiving need and suggest a reasonable accommodation that would enable him or her to perform well at work. A reasonable accommodation may be flexible scheduling, an intermittent leave of absence, or an access to alternative work arrangements. The employer must then assess whether the accommodation would still allow the worker to perform the essential functions of a particular job. This would apply to mothers, fathers, or any other family members who provide caregiving for young children. If it places an "undue hardship" or there is a "legitimate business reason" for denying the accommodation, the employer may refuse the accommodation request. However, the burden would fall upon the employer to show that the accommodation would not be suitable for their business reasons.

The United States should adopt the Canadian definition of bona-fide caregiving needs. In Canada, courts have held that a bona-fide caregiving need requires parent to demonstrate that he or she has "made reasonable efforts to meet childcare obligations through reasonable alternative solutions, and is unable to reconcile competing family and work obligations."[73] If the

---

[72] *Id.*

[73] *Johnstone Decision Underlines Need for More Flexible and Inclusive Workplaces,* WOMEN'S LEGAL EDUC. & ACTION FUND, https://myemail.constantcontact.com/Where-a-

childcare demand is beyond "trivial or insubstantial," the employer's duty to accommodate would arise.[74] However, the employee does not have to prove she or he has done "everything within his or her power" to arrange childcare.[75]

The duty to accommodate is not a one-size-fit-all legislation. The appeal of this legislation is in its ability to recognize that parents have unique needs depending on their individual circumstances during the pandemic. With unprecedented barriers to other caregivers, parents need flexibility in their schedules: some need to work remotely, some need to work less, and some need to take a few hours off during the day and work in the evenings to meet their children's needs. The requirement of an interactive dialogue would ensure that employers are not terminating employees without taking the parents' bona-fide childcare needs into consideration. Since the legislation would have a balancing approach, it would ensure that any cost to employers is not overly burdensome.

## CRITICISM OF REASONABLE ACCOMMODATION

Since businesses are already struggling during the COVID-19 economy, a criticism may present itself in the form of a legitimate concern for business owners. Some may feel that this legislation would limit the growth of our economy. That is why this legislation requires the balance of reasonable accommodation with the needs of a business, without burdening it with undue hardship. The Equal Employment Opportunity Commission defines an undue hardship under ADA as an accommodation that would be "unduly

workplace-rule-results-in-a-bona-fide-childcare-problem--the-workplace-must-accommodate--Federal-Court-of-Appeal-rules.html?soid=1100520459480&aid=1NNAVVIJ_U0 (last visited Nov 15, 2020).

[74] *Id.*

[75] *Id.*

costly, extensive, substantial or disruptive, or would fundamentally alter the nature or operation of the business."[76] Certain factors are considered before an accommodation is provided.[77] These factors include "the cost of the accommodation, the employer's size, financial resources and the nature and structure of its operation."[78] Legislation for caregivers must take a similar approach and allow for businesses to deny accommodation, but only if it presents an undue hardship.

Another criticism of reasonable accommodations emphasizes choice. People choose to have kids, hence, they should not ask for better treatment. During this pandemic, this argument is moot because parents are not choosing for their childcare options to be closed. Even after this pandemic though, the choice reasoning "ignores the fact that the choices given to the primary caretaker, who is usually the mother, are fundamentally unfair choices."[79] A woman should not be given a choice for a biological need (for many but not all) and a need to earn money. Joan C. Williams, the director and professor at UC Hastings' Work Life Law Department explains, "[i]n the work/family context, the rhetoric of choice masks a gender system that defines childrearing and the accepted avenues of adult advancement as inconsistent and then allocates the resulting costs of childrearing to mothers."[80] Furthermore, single and divorced women, or women who do not have a high-wage earning spouse cannot simply choose not to work, but rather must work to provide the necessities for their families.[81] Hence, the choice dichotomy fails during the pandemic and after it.

---

[76] *The ADA: Your Responsibilities as an Employer*, EEOC, https://www.eeoc.gov/publications/ada-your-responsibilities-employer (last visited Nov. 15, 2020).
[77] *Id.*
[78] *Id.*
[79] Kaminer, *supra* note 34, at 335.
[80] Joan C. Williams, *Gender Wars: Selfless Women in the Republic of Choice*, 66 N.Y.U. L. REV. 1559, 1596.
[81] Kaminer, *supra* note 34, at 345.

## CONCLUSION

The COVID-19 pandemic has created a disincentive for employers to keep caregiving parents on their payroll. Most caregiving parents in the country are mothers, and hence, this phenomenon exasperates the motherhood penalty and expands the gender pay gap. To curtail this problem and to ensure equity in the workplace, the government should pass legislation requiring employers to provide reasonable accommodations for parents with bona-fide childcare needs. This legislation may model the Americans with Disabilities Act which requires a balance between the employee's needs and the employer's business needs, while borrowing the definition of bona-fide caregiving needs from the Canadian Human Rights Commission. It must also require an interactive dialogue before employers can terminate parents due to their childcare obstacles. Although a duty for reasonable accommodation cannot resolve all the problems associated with the motherhood penalty, enacting a federal statute during this pandemic signals to the employers that they must take this unprecedented childcare situation into account before discriminating against caregivers, who happen to be mostly mothers.

# How a Pandemic Heightens Healthcare Issues for Individuals with Chronic Illnesses: A Case Against Excessive Cost-Sharing

*Meera Patel*

## INTRODUCTION

Cost-sharing is a way for both insurers and patients to split medical costs, making healthcare more affordable for the individual.[1] Cost-sharing generally implies a burden on both insurance companies and individuals.[2] However, the focus of this article will be on cost-sharing burdens on individuals.[3] This method of payment has been increasingly used by state Medicaid programs to promote financial responsibility and transition individuals to private insurance plans.[4] At the same time, cost-sharing comes with many setbacks for vulnerable populations, specifically individuals with chronic illnesses.[5] The definition of a chronic illness is when someone has a condition that has "lasted or was expected to last twelve or more months and resulted in functional limitations and/or the need for ongoing medical care."[6] The most expensive chronic illnesses include cardiovascular diseases, diabetes, cancer, obesity, arthritis, and asthma.[7]

---

[1] Elizabeth David, *An Overview of Health Insurance Cost-Sharing*, VERYWELL HEALTH (Aug. 29, 2020, 6:45 PM), https://www.verywellhealth.com/what-is-cost-sharing-1738709.
[2] *Id*.
[3] *Id*.
[4] LEIGHTON KU & VICTORIA WACHINO, THE EFFECT OF INCREASED COST-SHARING IN MEDICAID: A SUMMARY OF RESEARCH FINDINGS 2 (2005).
[5] *Framework to Address High Cost Burden for People with Serious Chronic Conditions*, PARTNERSHIP TO FIGHT CHRONIC DISEASE (Sept. 12, 2020, 1:10 PM), https://www.fightchronicdisease.org/resources/framework-address-high-cost-burden-people-serious-chronic-conditions [hereinafter *High Cost Burden*].
[6] Wenke Hwang et al., *Out-Of-Pocket Medical Spending for Care Of Chronic Conditions*, 20 HEALTH AFF. 266, 268 (2020).
[7] *See generally* Thomas Beaten, *Top 10 Most Expensive Chronic Diseases for Healthcare Payers*, HEALTH PAYER INTELLIGENCE (Sept. 12, 2020, 1:50 PM), https://healthpayer intelligence.com/news/top-10-most-expensive-chronic-diseases-for-healthcare-payers

Regardless of insurance coverage, chronic illnesses require more medical care, which in turn increases the cost-sharing burden for these individuals.[8] Because of their greater need for medical care, chronically ill individuals pay a higher percentage of their medical costs than individuals without chronic illnesses.[9] In fact, a 2001 study showed that an individual without a chronic illness spent only $249 in 1996 for medical expenses, compared to $1,134 for an individual with three or more chronic illnesses.[10] Cost-sharing burdens on individuals were reduced under the Affordable Care Act ("ACA") since insurance companies pay a greater percentage than before the ACA, but the amount of reduction depends on the patient's health and health plan.[11] While more individuals with chronic illnesses have health care coverage compared to before the ACA, their poor health causes cost-sharing burdens to remain high, creating ongoing challenges for this vulnerable population.[12]

During the COVID-19 pandemic, measures were taken to lighten cost-sharing burdens on individuals, and similar measures should be taken post COVID-19 for individuals with chronic illnesses. This article starts by exploring the negative impacts of high cost-sharing on chronically ill individuals. Next, this article will focus on the changes made in response to high cost-sharing. Along with previous policy changes, this article will explore suggestions to help reduce high cost-sharing for chronically ill individuals. Additionally, this article will discuss the impacts of a pandemic

---

(stating the top 10 most expensive chronic diseases are cardiovascular diseases, smoking-related health issues, alcohol-related health issues, diabetes, Alzheimer's disease, cancer, obesity, arthritis, asthma, and stroke).

[8] Hwang et al., *supra* note 6, at 275.

[9] *Id*. at 274.

[10] *Id.* at 270.

[11] Sarah R. Collins et al., *How Will the Affordable Care Act's Cost Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?*, COMMONWEALTH FUND 1, 6–7 (Mar. 2016).

[12] Les Masterson, *ACA Plans Expanded Coverage for Chronic Conditions*, HEALTHCARE DIVE (Sept. 12, 2020, 2:30 PM), https://www.healthcaredive.com/news/aca-plans-expanded-coverage-for-chronic-conditions/520407/.

on chronically ill individuals and how there is still a great amount of financial burden on this vulnerable population after government aid. Finally, this article will analyze past changes and suggestions, impacts of a pandemic, and provide suggestions to help reduce cost-sharing for individuals with chronic illnesses post COVID-19.

## HIGH COST-SHARING HAD AND CONTINUES TO HAVE NEGATIVE IMPACTS ON CHRONICALLY ILL INDIVIDUALS

While healthcare expenses tend to increase overtime, the increasing cost burdens on individuals receiving medical care, especially chronically ill patients, have many grave implications.[13] In general, high cost-sharing leads to an increased burden of health care costs, which directly leads to a substantial economic burden on patients, particularly those with chronic illnesses.[14] As cost-sharing burdens on individuals increase, the utilization of health care services decreases for both necessary and unnecessary services.[15] This in turn forces patients to ration what health care services they use.[16] In this process, due to the lack of sensitivity to serious symptoms, individuals with chronic illnesses may not be able to differentiate between what is a necessary or unnecessary health care service.[17] Chronically ill individuals not being able to tell this difference can result in patients not

---

[13] *See generally* Melinda C. Haren, et al., *Increased Patient Cost-Sharing, Weak US Economy, and Poor Health Habits: Implications for Employers and Insurers*, 2 AM. HEALTH & DRUG BENEFITS 134 (Apr-May 2009) (noting that grave implications include reducing utilization of necessary services, individuals forgoing medically necessary care, decrease in optimal care-seeking behavior).
[14] *Summary: The Burden of Health Care Costs for Working Class Families, a State-Level Analysis*, PENN LDI 1, 2 (Apr. 2016), https://ldi.upenn.edu/sites/default/files/Penn%20LDI%20and%20US%20of%20Care%20Cost%20Burden%20Summary_Final.pdf.
[15] Haren, *supra* note 13, at 135.
[16] Mitchell D. Wong et al., *Effects of Cost Sharing on Care Seeking and Health Status: Results From the Medical Outcomes Study*, 91 AM. J. PUB. HEALTH 1889, 1891–93 (2001).
[17] *Id.*

being willing to use preventative care, ultimately leading to poor health outcomes.[18]

Consequently, reducing the utilization of preventative health care services leads to higher-cost health care services as reactionary measures.[19] For example, higher cost-sharing for medications can lead to patients filling less prescriptions, eventually causing hospitalization or even death.[20] Where less initiation of health care services can be harmful, the inability to continue using health care services can be even more detrimental.[21] Specifically, individuals with chronic illnesses face severe medical complications when there is an interruption in a necessary health care service compared to those without a chronic illness.[22] The treatment for chronic illnesses requires more expensive medications and health care services, therefore, without proper access to care because of high cost-sharing, individuals with chronic illnesses will suffer.[23]

## CHANGES AND SUGGESTIONS WERE MADE TO AID CHRONICALLY ILL INDIVIDUALS EVEN BEFORE COVID-19

Before the COVID-19 pandemic, changes and suggestions were made to help improve high cost-sharing for vulnerable populations, like individuals with chronic illnesses. One of these changes uses cost-sharing reductions ("CSR"), which lowers cost-sharing to the individual if he or she qualifies for the reduction.[24] These subsidies lower out-of-pocket maximums and

---

[18] *Id.*
[19] KU & WACHINO, *supra* note 4, at 5.
[20] *Id.*
[21] PAN FOUNDATION, COST SHARING AND ACCESS TO PRESCRIPTION MEDICATIONS 4 (2016).
[22] Alan R. Weil, *Chronic Care, Prescription Drugs, And More*, 37 HEALTH AFF. 1023 (2018), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0790.
[23] KU & WACHINO, *supra* note 4, at 6-7.
[24] *Cost Sharing Reductions (CSR)*, HEALTHCARE.GOV (Sept. 12, 2020, 2:50 PM), https://www.healthcare.gov/glossary/cost-sharing-reduction/.

cost-sharing amounts and are available for families that earn under 250% of the Federal Poverty Line ("FPL").[25] When the ACA was first enacted, these subsidies were funded by the federal government, whereas now they are funded by individual insurers.[26] Even though patients with chronic illnesses may not be directly affected by this change of funding source, this population will be indirectly affected if/when insurers increase health plan costs to cover the subsidies.[27] Another change under the ACA was the implementation of advance premium tax credits, which provide tax credits for individuals earning 400% or less of the FPL.[28] This exclusive premium tax credit can be applied in advance to lower monthly premium costs, decreasing the burden of health care costs for qualifying chronically ill individuals.[29]

Aside from subsidies, many individuals seek alternatives to health insurance such as, concierge medicine, cost-sharing programs, and medical discount cards.[30] However, these alternatives can have setbacks for chronically ill patients. In concierge medicine services, upon receiving a pre-determined fixed fee, physicians provide direct access to health care services.[31] These types of efficient concierge services can be beneficial for individuals with chronic illnesses due to the fact that a physician will always

---

[25] *Health Insurance Subsides 2019: Are They Still Available?*, EHEALTHINSURANCE (Sept. 12, 2020, 3:00 PM), https://www.ehealthinsurance.com/resources/affordable-care-act/health-insurance-subsides-2019-are-they-still-available [hereinafter *Health Insurance Subsides*].
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] Amanda Capritto, *5 Ways to Save Money on Healthcare if You Don't Have Health Insurance*, CNET (Nov. 14, 2020, 4:50 PM), https://www.cnet.com/health/alternatives-to-traditional-health-insurance/.
[31] Hallie Levine, *What to Know About Concierge Medicine*, AARP (Sept. 12, 2020, 3:10 PM), https://www.aarp.org/health/conditions-treatments/info-2019/what-to-know-about-concierge-medicine.html.

be available to manage periodical specialty visits.[32] However, insurance may not be billed for these services, increasing costs of health care services for the individual.[33] Additionally, cost-sharing programs, like Medi-Share, involve a community of people who agree to cover each other's health care costs.[34] Looking to the nature of these programs, they can be exclusive to certain groups of people, unfairly limiting access for others.[35] Finally, medical discount cards can help chronically ill patients reduce out-of-pocket expenses with benefit plans.[36] However, especially for individuals with chronic illnesses, these plans may not cover or provide discounts for specific, necessary treatments.[37] While these alternative options can help some chronically ill individuals, they are not addressing the needs of all chronically ill individuals, which shows that there needs to be additional measures to help lessen financial burdens on this vulnerable population.[38]

Along with federal policy and cost-sharing programs, experts in public policy have made suggestions to help reduce high cost-sharing.[39] One of these suggestions is cost caps, which will limit how much certain individuals have to pay for out-of-pocket health care costs.[40] There are many different types of suggested caps, however the ones that are most relevant to

---

[32] Gabby Marquez, *Why Concierge Medicine Isn't Just for Patients with Chronic Conditions*, ELATION HEALTH (Sept. 12, 2020, 3:15 PM), https://www.elationhealth.com/direct-care-blog/why-concierge/.
[33] Levine, *supra* note 31.
[34] MEDI-SHARE, https://www.medishare.com (last visited Sept. 12, 2020).
[35] *Id.*
[36] *Medical Discount Cards*, ACS, https://www.acs.org/content/acs/en/membership/member-benefits/personal-discounts/medical-discount-cards.html (last visited Sept. 12, 2020).
[37] *See generally id.* (stating prescription drugs, dental care, vision care, hearing aids, chiropractic care, 24-hour nurse helpline, telemedicine, diabetes care, vitamins & mineral supplements, complementary/alternative medicine, podiatry plan, and online wellness improvement plan are only services that can be covered).
[38] Levine, *supra* note 31; MEDI-SHARE, *supra* note 34; *Medical Discount Cards*, *supra* note 36.
[39] DAVID KENDALL ET AL., THIRD WAY, COST CAPS AND COVERAGE FOR ALL: HOW TO MAKE HEALTH CARE UNIVERSALLY AFFORDABLE 1 (2019).
[40] *Id.* at 6. (noting out-of-pocket costs include premiums and deductibles).

chronically ill patients are cost caps for ACA exchanges, Medicaid, and Medicare.[41] Cost caps for ACA exchanges reduce premium caps for low-income individuals and increase premium caps for the middle class.[42] Even though the ACA already caps premium charges for certain individuals, this suggestion would expand the coverage and help end the current abrupt cut-offs for cost caps.[43] Under Medicaid and Medicare, cost caps would further protect low-income individuals from high out-of-pocket medical costs.[44] This is necessary because low-income individuals with chronic illnesses have more financial hardships compared to middle class individuals with chronic illnesses.[45] Changes and suggestions were prevalent to help decrease cost-sharing before the pandemic, and even more necessary during the pandemic and after when chronically ill individuals will face the consequences of the pandemic.[46]

## COVID-19 HAS EXACERBATED THE DIFFICULTIES FOR CHRONICALLY ILL INDIVIDUALS TO NAVIGATE THE HEALTHCARE SYSTEM

The current public health crisis has heightened difficulties for vulnerable populations, especially chronically ill individuals.[47] Along with causing cancellations of appointments with specialists, the pandemic has caused many equipment used for treatment of chronic illnesses to be deemed

---

[41] *See id.* (noting suggested caps include cost caps for ACA exchanges, employment-based coverage, Medicaid, and Medicare).
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] *See* WHO, PART TWO. THE URGENT NEED FOR ACTION 13 ("The chronic disease burden is concentrated among the poor.").
[46] *Cost Sharing Reductions*, *supra* note 24; Capritto, *supra* note 30; KENDALL ET AL., *supra* note 39.
[47] Rachel Charlton-Dailey, *We Cannot Neglect the Health Needs of Chronically Ill and Disabled People During the Pandemic*, ROOTED RIGHTS (Sept. 12, 2020, 4:00 PM), https://rootedinrights.org/we-cannot-neglect-the-health-needs-of-chronically-ill-and-disabled-people-during-the-pandemic/.

unnecessary if there is no medical emergency, due to the need of limiting the spread of COVID-19.[48] Additionally, the possibility of exposure to COVID-19 has steered chronically ill patients away from health care facilities because of their higher risk of negative health outcomes from the virus.[49] The immediate care that chronically ill patients had before the pandemic is lacking, which will cause many of these individuals to suffer from detrimental and more severe health outcomes later.[50]

Not only has COVID-19 impacted health outcomes and availability of health care services for chronically ill patients, it has also led to temporary changes in cost-sharing.[51] Generally, this national emergency has caused there to be more changes through waivers and federal acts.[52] Individual states can submit requests to waive certain Medicaid requirements under section 1135 of the Social Security Act to later submit a Disaster Relief State Plan Amendment ("SPA").[53] These SPAs can waive anything related to COVID-19 services that would directly or indirectly benefit providers and beneficiaries.[54]

---

[48] *Id.*
[49] Joe Caruso, & Christopher Gaeta, *How COVID-19 May Lead to a Wave of Chronic Illness Exacerbations*, EMS WORLD (Sept. 12, 2020, 4:10 PM), https://www.emsworld.com/article/1224593/how-covid-19-may-lead-wave-chronic-illness-exacerbations.
[50] *Id.*
[51] MEDICAID, MEDICAID DISASTER RELIEF FOR THE COVID-19 NATIONAL EMERGENCY STATE PLAN AMENDMENT INSTRUCTIONS 1 (2020). ("Through this state plan amendment (SPA) template, states (including the District of Columbia and territories) can request approval of specific changes related to the national emergency declared due to the COVID-19 outbreak.").
[52] *Id.* ("The COVID-19 disaster relief SPA allows states to establish time-limited changes to their state plan to address access and coverage issues during the COVID-19 national emergency.").
[53] *Id.* ("A state may submit a request under section 1135 of the Social Security Act (the Act) to waive, or modify, certain requirements that would otherwise be applicable to this SPA submission. These waivers are limited to SPAs that provide or increase beneficiary access to items and services related to COVID-19 (such as cost sharing waivers, payment rate increases, or amendments to Alternative Benefit Plans (ABPs) to add services or providers) and that would not restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.").
[54] *Id.*

Furthermore, under the Families First Coronavirus Response Act, COVID-19 testing itself is covered by many insurers,[55] as are health care services that are related to COVID-19 testing.[56] This means that there are no cost-sharing expenses for individuals with most private insurance plans, Medicare, and Medicaid.[57] Even chronically ill patients who are uninsured may have COVID-19 testing costs waived depending on state policy.[58] This act benefits individuals with chronic illnesses by eliminating the burden of cost-sharing for COVID-19 tests.[59] This benefit can be carried over to other necessary healthcare services for chronically ill patients if insurance companies build cost-sharing expenses into their coverage. For instance, insurance companies can waive the costs of necessary prescription medications or waive deductibles for common procedures in order to lessen cost-sharing burdens on individuals.

Even though certain costs related to the pandemic are covered by insurance, there are still out-of-pocket costs.[60] While COVID-19 testing is covered under most insurance plans, alternative diagnoses may not be.[61] In order for these alternative diagnoses to be covered, COVID-19 testing must be ordered during the visit.[62] However, in this case, physicians may not always order COVID-19 tests due to the limited access to tests.[63] Also, COVID-19 tests may not be ordered for patients with mild symptoms.[64]

---

[55] Kao-Ping Chua & Rena M. Conti, *Despite The Families First Coronavirus Response Act, COVID-19 Evaluation Is Not Necessarily Free*, HEALTH AFF. (Aug 29, 2020, 6:10 PM), https://www.healthaffairs.org/do/10.1377/hblog20200413.783118/full/.
[56] Nisha Kurani et al., *COVID-19 Test Prices and Payment Policy*, HEALTH SYSTEM TRACKER (Sept. 12, 2020, 5:10 PM), https://www.healthsystemtracker.org/brief/covid-19-test-prices-and-payment-policy/.
[57] *Id.*
[58] Chua & Conti, *supra* note 55.
[59] *Id.*
[60] *Id.*
[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] *Id.*

Instead, tests for other diagnoses may only be ordered, which would not be considered a covered health care service under the Families First Coronavirus Response Act.[65] This difference shows that even going to see a physician for COVID-19 symptoms may not always be a covered health care service.[66] This makes it especially difficult for chronically ill patients, who visit their physicians for symptoms similar to COVID-19, but end up having symptoms caused by their illness.[67] A visit for another diagnosis can have high cost-sharing burdens on the individual and if this virus did not exist, these patients would most likely not have visited a physician for those same symptoms, and saved money on health care costs.[68] Despite financial protections during a pandemic, unfortunately, there are still cost-sharing burdens on individuals, especially for chronically ill individuals.[69]

Aside from non-covered alternative diagnoses, individuals may be receiving delayed coverage for their health care services.[70] Federal law prohibits cost-sharing even for out-of-network COVID-19 tests and providers usually directly bill insurance companies for patients.[71] However, in some circumstances, patients are required to pay up front when they seek out-of-network health care services and later submit reimbursement claims to their insurance companies.[72] This can be highly problematic for chronically ill individuals who are focusing on their health and may be too sick to submit these claims, since not submitting claims can lead to out-of-

---

[65] *Id.*
[66] *Id.*
[67] *Id* (noting that even with the FFCRA, patients still have financial liability for alternative diagnoses).
[68] *Id.*
[69] *Id* (discussing cost sharing burdens on individuals even with recent legislation to provide financial relief).
[70] Kurani et al., *supra* note 56.
[71] *Id.*
[72] *Id.*

pocket costs for COVID-19 testing, which is an additional financial burden on top of payment for these patients' chronic illnesses.[73]

Finally, a major setback in cost-sharing is that even though COVID-19 testing is covered, treatment is not covered.[74] Once an individual tests "positive" for the virus, hospitalization may be required to monitor and control symptoms of the disease.[75] Depending on the type of insurance one has, cost-sharing can be steep.[76] Especially for chronically ill patients, who are at a higher risk of developing severe symptoms, complications are more common, leading to required hospitalization for a longer period of time.[77] While some insurers have waived all or some treatment costs, many have not, which places the financial burden on patients, with a greater burden on those with chronic illnesses, since chronically ill patients may need to pay for more treatment due to their underlying conditions.[78] Even with cost-sharing assistance for COVID-19 testing, the pandemic has highlighted many other cost-sharing complications for individuals, especially those with chronic illnesses, which can lead to unnecessary cost-sharing burdens.[79]

## MODIFICATIONS TO COST-SHARING MUST BE MADE POST COVID-19

Excessive cost-sharing was a tremendous financial burden before the pandemic and continues to be a burden during the pandemic for individuals

---

[73] *Id.*
[74] Rachel Fehr et al., *Five Things to Know about the Cost of COVID-19 Testing and Treatment*, KFF (Sept.13, 2020, 9:30 AM), https://www.kff.org/coronavirus-covid-19/issue-brief/five-things-to-know-about-the-cost-of-covid-19-testing-and-treatment/.
[75] *Id.*
[76] *Id.*
[77] *Navigating COVID-19 with a Chronic Condition*, WEILL CORNELL MED. (Sept.13, 2020, 10:00 AM), https://weillcornell.org/news/navigating-covid-19-with-a-chronic-condition [hereinafter *Navigating COVID-19*].
[78] Fehr et al., *supra* note 74 (noting that treatment costs may be higher for chronically ill patients due to higher chances of complications).
[79] *Id.*

with chronic illnesses.[80] After the initial impact of COVID-19 has been mitigated, the healthcare industry must navigate how to most effectively move forward post COVID-19. Changes to reduce cost-sharing burdens on patients before the pandemic involved the government providing aid to patients, and later insurance companies taking over that aid.[81] Currently, insurance companies are receiving less help from the government.[82] Instead of independently providing relief for individuals, it may be beneficial to implement a way for multiple systems to work together to provide reduced cost-sharing rates.[83] This could mean that the government provides financial incentives to insurance companies for implementing reduced cost-sharing rates for individuals with chronic illnesses. If the government and insurance companies are able to work together to create a system of reduced cost-sharing rates, chronically ill individuals may be able to receive proper treatments for their conditions and not be hindered by excessive cost-sharing, leading to better health outcomes.

Other changes for limiting cost-sharing, like concierge services, cost-sharing programs, medical discount cards, can be very helpful for individuals with chronic illnesses.[84] However, these programs can be difficult to access and even when accessed, may not provide the best financial services for chronically ill individuals.[85] Chronic illnesses are diverse and require various degrees of medical care, which makes it difficult to implement a cost-sharing

---

[80] *See* Haren et al., *supra* note 13 (noting implications include reducing utilization of necessary services, individuals forgoing medically necessary care, decrease in optimal care-seeking behavior).
[81] *Health Insurance Subsides*, *supra* note 25.
[82] *Id.*
[83] *Id* (discussing how only the insurance companies are legally required to pay for CSR subsidies).
[84] *See generally* Capritto, *supra* note 30.
[85] MEDI-SHARE, *supra* note 34 (providing an overview of a cost-sharing program); ACS, *supra* note 37 (providing an overview of a medical discount card program).

program with strict guidelines.[86] For instance, treatment options of chronic illnesses may include medications, surgery, physical therapy, or a combination.[87] Similar to how cost-sharing reductions are for COVID-19 testing only and not treatment, many established cost-sharing programs are exclusive to what is covered.[88] For example, the Chronic Illness Support Program covers usual health care costs for select chronic conditions.[89] This program neglects treatments for exacerbated symptoms of some chronic conditions and basic care of others.[90] Instead, there should be looser guidelines for receiving reduced cost-sharing for individuals with chronic illnesses, similar to how most insurance companies waive all COVID-19 tests, in order to increase access to health care services and decrease financial burdens on individuals.

## CONCLUSION

Even though cost-sharing has been used to promote financial responsibility and transition individuals to private insurance plans, excessive cost-sharing for chronically ill individuals can have grave implications.[91] After the implementation of the ACA to decrease cost-sharing and programs to help reduce cost-sharing, chronically ill individuals still face tremendous

---

[86] Adem Sav et al., *Burden of Treatment for Chronic Illness: A Concept Analysis and Review of the Literature*, 18 HEALTH EXPECTATIONS 312, 313 (2013).
[87] *Id.*
[88] *Dedicated Plans for Chronic Conditions*, CMTY. HEALTH OPTIONS (Sept.13, 2020, 10:15 AM), https://www.healthoptions.org/members/dedicated-plans-for-chronic-conditions/.
[89] *See generally id.* (stating covered chronic conditions only includes Asthma, Coronary Artery Disease, Diabetes, Chronic Obstructive Pulmonary Disease, Hypertension, Emphysema*).*
[90] *Id.*
[91] KU & WACHINO, *supra* note 4; *High Cost Burden*, *supra* note 5 ("High out-of-pocket costs serve as a significant deterrent to obtaining care needed to maintain health. These cost-shifting policies ignore the challenging reality that people with serious chronic illnesses already face the highest medical spending. The people with the least flexibility and most at risk are being called upon to make trade-offs and bear the burden both economically and physically.").

difficulties with cost-sharing.[92] Excessive cost-sharing for chronically ill individuals created many barriers before the pandemic, which have only worsened lately.[93] Initiatives by the government to provide incentives to health insurance companies and health care providers, and programs focused on all chronic illnesses will help reduce cost-sharing rates, leading to better health outcomes for individuals with chronic illnesses.

[92] Masterson, *supra* note 12 (discussing how the ACA attempted to reduce cost sharing by expanding coverage for individuals with chronic illnesses); Haren et al., *supra* note 13 (stating implications include reducing utilization of necessary services, individuals forgoing medically necessary care, decrease in optimal care-seeking behavior).

[93] Rachel Charlton-Dailey, *supra* note 47; Kao-Ping Chua & Rena M. Conti, *supra* note 55; Nisha Kurani et al., *supra* note 56; *Navigating COVID-19*, *supra* note 77 (finding barriers include appointment cancellations, cost-sharing elimination only when COVID-19 tests are ordered or rendered services related to COVID-19, higher risks for serious complications).

# Bridging the Digital Divide: How COVID-19's Telemedicine Expansion May Exacerbate Health Disparities for Low-Income, Urban, Black Patients

*Sarah Ryan*

## INTRODUCTION

According to the World Health Organization, "the social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."[1] Interactions between the social determinants of health are responsible for vast health disparities among different populations.[2] The National Institutes of Health defines health disparities as "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States."[3] People who have systematically experienced greater obstacles to health based on discrimination are adversely affected by health disparities.[4] Characteristics that contribute to a person's ability to achieve good health outcomes include race, ethnicity, sexual identity, age, socioeconomic status, and geography.[5] However, outcomes are not the only aspect of health in which these disparities exist; disparities are also present in access to quality health care.[6]

---

[1] *About Social Determinants of Health*, WORLD HEALTH ORG., https://www.who.int/gender-equity-rights/understanding/sdh-definition/en/ (last visited September 12, 2020).
[2] *Id*.
[3] NAT'L INSTS. HEALTH, STRATEGIC RESEARCH PLAN AND BUDGET TO REDUCE AND ULTIMATELY ELIMINATE HEALTH DISPARITIES VOLUME I FISCAL YEARS 2002-2006 4-5 (2002).
[4] SECRETARY'S ADVISORY COMM. ON NAT'L HEALTH PROMOTION & DISEASE PREVENTION OBJECTIVES FOR 2020, U.S. DEP'T OF HEALTH & HUMAN SERVS., PHASE I REPORT: RECOMMENDATIONS FOR THE FRAMEWORK AND FORMAT OF HEALTHY PEOPLE 2020 28 (2008).
[5] *Disparities*, HEALTHY PEOPLE 2030, https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities (last visited September 12, 2020).
[6] *See About Social Determinants of Health*, *supra* note 1; *About Health Disparities*, NAT'L HEART LUNG & BLOOD INST., https://www.nhlbi.nih.gov/health/educational/healthdisp/

The COVID-19 pandemic has exposed inequalities in access to quality health care. For example, data from New York suggests that patients at underfunded community hospitals with fewer staff, worse equipment, and less access to advanced treatments were three times more likely to die as patients at well-financed academic medical centers in the wealthiest parts of the city.[7] Similarly, geographical distance and a shortage of providers also contribute to disparities in access to timely, quality health care.[8] In 2019, seventy-seven million people in the United States ("U.S.") lived in "health professional shortage areas," which are designated as such due to geographic-, population-, or facility-based provider shortages in primary care, dental health, or mental health services.[9]

One tool being used to overcome the foregoing barriers to quality healthcare is "telehealth," or "the use of medical information exchanged from one site to another through electronic communications to improve a patient's health."[10] Within the umbrella of telehealth exists "telemedicine," which the Centers for Medicare and Medicaid Services define as real-time interactive communication between a patient and practitioner using two-way interactive electronic communications equipment.[11] The COVID-19 pandemic catapulted telemedicine to the forefront of patient care due to stay-at-home orders and social-distancing measures enacted to minimize contact between

about-health-disparities.htm (last visited September 11, 2020) (discussing why health disparities exist and the aspects of health they manifest in).

[7] Brian M. Rosenthal et al., *Why Surviving the Virus Might Come Down to Which Hospital Admits You*, N.Y. TIMES, (Updated July 31, 2020), https://www.nytimes.com/2020/07/01/nyregion/Coronavirus-hospitals.html.

[8] Samantha Kleindienst Robler et al., *Telehealth: The Great Equalizer*, AUDIOLOGY TODAY, (Apr. 2020), https://www.audiology.org/audiology-today-marchapril-2020/telehealth-great-equalizer.

[9] *See id*. (citing to the Health Resources and Services Administration, 2019); *Health Professional Shortage Areas (HPSAs)*, HEALTH RSCH. SERVS. ADMIN. HEALTH WORKFORCE, (last reviewed May 2020) https://bhw.hrsa.gov/shortage-designation/hpsas.

[10] *See* Kleindienst, *supra* note 8 (citing the Am. Telemedicine Ass'n.).

[11] *Telemedicine*, MEDICAID, https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html, (last visited September 13, 2020).

people to reduce the spread of the coronavirus.[12] With the pandemic's end nowhere in sight, and the extent to which telemedicine has become the go-to method of care, telemedicine will become a normalized fixture in the healthcare system.[13] While telemedicine has the potential to increase access to quality health care, and thereby reduce health disparities, if implemented irresponsibly it could make the disparities worse.[14] This exacerbation of the disparities is due to the "digital divide," which describes the gap between those who have and do not have access to new forms of information technology such as computers and their communication networks.[15] While telemedicine can be used to potentially reduce health disparities, it should be implemented with care, accounting for the digital divide so that it does not inadvertently exacerbate those disparities.

First, this paper will address existing healthcare disparities that low-income, Black patients in urban communities face, as well as describe the concept of the digital divide as it relates to these disparities. Next, this paper will argue that, although telemedicine has the potential to address traditional barriers to health care, it might paradoxically exacerbate the health disparities that low-income Black patients in urban communities face. Finally, this paper will recommend methods that should be used to promote equitable telemedicine access *while* it expands to prevent the digital divide from becoming a social determinant of health.

---

[12] Holly Secon, *An Interactive Map of the US Cities and States Still Under Lockdown — And Those That are Reopening*, BUS. INSIDER, (June 3, 2020), https://www.businessinsider.com/us-map-stay-at-home-orders-lockdowns-2020-3.

[13] Mina Bakhtiar et al., Notes & Comments, *The Digital Divide: How COVID-19's Telemedicine Expansion Could Exacerbate Disparities*, J. AM. ACAD. DERMATOLOGY, e1-2 (2020).

[14] Jenna Becker, *How Telehealth Can Reduce Disparities*, BILL OF HEALTH: BLOG, (September 11, 2020), https://blog.petrieflom.law.harvard.edu/2020/09/11/telehealth-disparities-health-equity-covid19.

[15] Jan A.G.M. van Dijk, *Digital Divide Research, Achievements and Shortcomings*, 34 POETICS 221, 222 (2006).

## EXISTING HEALTH DISPARITIES FACED BY LOW-INCOME, URBAN, BLACK PATIENTS

Disparities in health outcomes are the result of interactions between the social determinants of health.[16] Cities strapped with limited resources struggle to distribute those resources among rapidly growing populations.[17] The imbalance between resources and people manifests as poverty, overcrowding, poor housing conditions, housing and food insecurity, increased risks of violence, inadequate urban infrastructure such as reliable transportation, and a lack of educational opportunities.[18] Even where cities do possess adequate resources, those resources are often utilized by a small portion of the population, systematically excluding millions of others.[19] Within cities, individual status such as race, gender, age, and wealth also escalate inequalities.[20] These inequalities appear as differences in not only health experiences, but also in health outcomes.[21]

Black patients experience health disparities at high rates, especially when compared with the health of non-Hispanic white patients.[22] For example, the rates for all major causes of death (including heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide) are

---

[16] *Global Report on Urban Health: Equitable, Healthier Cities for Sustainable Development*, Preface, WORLD HEALTH ORG., 1, 7 (2016) (noting that urban health outcomes are impacted by "the inextricable and inter-dependent links between health, economic productivity, social stability and inclusion, climate change and healthy environments, and an enabling built environment and governance.").
[17] *Id*. at 17.
[18] *Id*. at 17-19.
[19] *Id*. at 20.
[20] *Id*. at 21.
[21] *See* Ruben Castenada, *How Being Black in America is Bad for Your Health*, U.S. NEWS WORLD REP., (July 26, 2018), https://health.usnews.com/wellness/articles/2018-07-26/how-being-black-in-america-is-bad-for-your-health (explaining that poor Black Americans have worse health outcomes than whites, and that disparities exist even for Black Americans who earn six figures).
[22] *See* Sofia Carratala & Connor Maxwell, *Health Disparities by Race and Ethnicity Fact Sheet*, 1-6 (2020) (discussing health disparities by race and ethnicity).

generally higher for Black patients than white patients.[23] In fact, Black patients have the lowest life expectancy compared with any other racial or ethnic group and have the highest mortality rate for all cancers combined.[24] Further, Black patients experience a greater prevalence of asthma and higher infant mortality rates, as well as being less likely to be insured and vaccinated.[25] Intersections with gender are also important to consider when examining the health disparities that affect Black patients.[26] According to the U.S. Department of Health and Human Services Office of Minority Health, eighty percent of Black women are overweight or obese compared to 64.8% of non-Hispanic white women.[27] The prevalence of obesity in Black women is especially striking since people who are overweight are much more likely to suffer from chronic diseases such as high blood pressure, diabetes, and high cholesterol, which are all risk factors for heart disease and stroke.[28]

These disparities grow more conspicuous when considering the effects of income on race and health. The 2018 real median income of Black households was $41,361, only 58.6% of the $70,642 income of non-Hispanic white households[29] The 2013 CDC Health Disparities and Inequalities Report revealed that unemployment was more prevalent among Black adults

---

[23] *Profile: Black/African Americans*, OFF. MINORITY HEALTH, https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=61 (last visited September 10, 2020).
[24] Sofia Carratala & Connor Maxwell, *supra* note 22, at 2.
[25] Nat'l Ctr. Health Stat., *Health, United States 2018*, Highlights, 1-4, 18, (2019).
[26] *See generally Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage*, OFF. MINORITY HEALTH, April 2020, (describing the quality of health care received in 2018 by Medicare beneficiaries enrolled in Medicare Advantage plans nationwide, highlighting racial differences in health care experiences and clinical care, comparing quality of care for women and men, and looking at racial and ethnic differences in quality of care among women and men separately).
[27] *Obesity and African Americans*, OFF. MINORITY HEALTH, https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=25 (last visited September 10, 2020).
[28] *The Health Effects of Overweight and Obesity*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/healthyweight/effects/index.html (last visited September 10, 2020).
[29] JESSICA SEMEGA ET AL., CURRENT POPULATIONS REPORTS, INCOME AND POVERTY IN THE UNITED STATES: 2018, U.S. CENSUS BUREAU (2020).

than whites, and that unemployed adults were less likely than employed adults to report their health as being "excellent" or "very good."[30] Additionally, Black adults were among the highest percentage of adults with incomes below the federal poverty line.[31] According to the same report, preventable hospitalizations occurred at higher rates for residents of lower income neighborhoods compared with higher income neighborhoods and were more frequent for Black patients than white patients.[32] Income differences might explain why in 2017, only 55.5% of Black adults had private health insurance as compared to 75.4% of white adults.[33] Furthermore, in 2017, about ten percent more Black patients relied on Medicaid or public health insurance than their white counterparts.[34] Finally, twice the percentage of Black patients were uninsured.[35]

Acknowledging that factors like race, gender, age, and wealth status intensify disparities is important because it means they have significant implications for shaping the future of health care. Rather than merely focusing on acute physical ailments, health care should account for the broader challenges faced by urban, low-income Black patients.[36] Such challenges include stress from dealing with racial discrimination and barriers to living a healthy lifestyle such as access to healthy and affordable food options and safe environments for exercise and travel.[37]

---

[30] *See* CDC HEALTH DISPARITIES & INEQUALITIES REPORT—U.S. 2013, CTR. SURVEILLANCE, EPIDEMIOLOGY, LAB'Y SERV., 16 (2013) (Table 3: 'Percentage of Adults with Incomes less than the federal poverty level, by selected characteristics, in 2009 and 2011;' In 2011, the Black, non-Hispanic group made up the second highest percentage of adults with incomes less than the federal poverty level (16.4%), trailing the American Indian/Alaska Native group (18.9%)).
[31] *Id*.
[32] *Id*. at 140-41.
[33] *Profile: Black/African Americans, supra* note 23.
[34] *Id.*
[35] *Id.*
[36] Castenada, *supra* note 21.
[37] *Id*.

THE DIGITAL DIVIDE

It is essential to consider how proposed solutions to the above interact with existing health care disparities. For example, as the expansion of telehealth continues, it is important to consider that telehealth's potential benefits will not be realized without addressing the digital divide.[38] Historically, the same populations that encounter disparities in healthcare coverage, access, and outcomes are also harmed by the digital divide.[39] While nine in ten American adults use the Internet, people's digital lives appear noticeably different when considering factors such as race and income.[40] For example, forty-four percent of adults with household incomes below $30,000 per year do not have home broadband services[41] and forty-six percent do not own a traditional computer.[42] In contrast, use of these technologies is nearly ubiquitous among higher-income Americans, who are also more likely to have multiple internet-enabled devices within one household.[43]

In addition to device ownership, Internet and broadband usage also varies across demographic groups. For instance, Black adults are much less likely to have Internet and broadband services at home and are almost twice as

---

[38] Jeff Wurzburg, *CMS Telehealth Policy Can Benefit Vulnerable Communities*, LAW360 (July 20, 2020), https://www.law360.com/articles/1293035/cms-telehealth-policy-can-benefit-vulnerable-communities.

[39] *See id*. (citing to *NTIA Data Reveal Shifts in Technology Use, Persistent Digital Divide*, NAT'L TELECOMM. INFO. ADMIN., (June 10, 2020), https://www.ntia.gov/blog/2020/ntia-data-reveal-shifts-technology-use-persistent-digital-divide); Dana Floberg, *The Racial Digital Divide Persists*, FREE PRESS, (Dec. 13, 2018), https://www.freepress.net/our-response/expert-analysis/insights-opinions/racial-digital-divide-persists.

[40] *Internet/Broadband Fact Sheet*, PEW RSCH. CTR., https://www.pewresearch.org/internet/fact-sheet/internet-broadband/ (2019).

[41] *See Types of Broadband Connections*, FCC, (Updated June 23, 2014), https://www.fcc.gov/general/types-broadband-connections. (explaining that the term broadband commonly refers to high-speed Internet access that is always on and faster than the traditional dial-up access).

[42] Monica Anderson & Madhumitha Kumar, *Digital Divide Persists Even as Lower-income Americans Make Gains in Tech Adoption*, PEW RSCH. CTR. (2019).

[43] *Id*.

likely as white adults to rely on their smartphones for online access.[44] Similarly, adults with lower annual incomes (<$30,000) are more than five times as likely to be dependent on their smartphones for online access compared to those with higher incomes ($75,000+).[45] This statistic is striking when considering that twenty-nine percent of adults with household incomes below $30,000 per year do not own a smartphone.[46] This leaves almost thirty percent of adults in that income range potentially without Internet access, a significant realization in the COVID-19 era, where peoples' education, work, and health care are increasingly taking place online.

Studies of the digital divide have widely lent themselves to researching disparities between rural and urban communities, while largely ignoring how race factors into the analysis.[47] It is important to include race in such analyses, especially considering America's history of racial injustice. For example, research suggests that the "racial digital divide" for wired broadband is much larger than for mobile access.[48] This gap could be explained by the mobile market's lower-cost plans, lack of credit checks, and marketing strategies specifically targeted at low-income Black and Hispanic families.[49] On the other hand, wired-broadband includes higher capacity and faster speed options, but on the condition of passing a credit check.[50] Black people have historically been the target of predatory loans, and are consequently more likely to have damaged credit, thus rendering them

[44] *Internet/Broadband Fact Sheet*, *supra* note 40.
[45] *Id*.
[46] Anderson & Kumar, *supra* note 42.
[47] Dana Floberg, *The Racial Digital Divide Persists*, FREE PRESS, (Dec. 13, 2018), https://www.freepress.net/our-response/expert-analysis/insights-opinions/racial-digital-divide-persists.
[48] *Id*.
[49] *Id.*
[50] *Id*.

ineligible for wired-broadband services.[51] So far, policymakers have done little to address problems like the credit check barrier, which can systematically bar already-vulnerable populations from adopting broadband, and therefore exacerbate the digital divide.[52] This example demonstrates the digital disparities that exist for urban Black communities, and highlights the importance of eliminating them, especially as COVID-19 relegates most facets of life to the screen.

## TELEMEDICINE EXPANSION MAY MAKE DIGITAL DISPARITIES A SOCIAL DETERMINANT OF HEALTH

The rapid adoption of, and investment in, telehealth has transformed telemedicine into the baseline method of health care.[53] According to a U.S. Department of Health and Human Services report, by April 2020, telehealth was the mechanism used to provide nearly half (43.5%) of Medicare-funded primary care visits in February 2020, before COVID-19's classification as a public health emergency.[54] Reports from private insurers corroborate telemedicine's accelerated acceptance with telehealth claims increasing to sixteen million in June 2020, compared to about 500,000 in June 2019.[55]

---

[51] Sarah Ludwig, *Credit Scores in America Perpetuate Racial Injustice. Here's How*, GUARDIAN, (October 13, 2015), https://www.theguardian.com/commentisfree/2015/oct/13/your-credit-score-is-racist-heres-why.
[52] Floberg, *supra* note 47.
[53] Mandy Roth, *3 Ways COVID-19 Transformed Healthcare Delivery Through Telehealth*, HEALTHLEADERS MAGAZINE (2020), https://www.healthleadersmedia.com/innovation/3-ways-covid-19-transformed-healthcare-delivery-through-telehealth.
[54] Joanna Pearlstein, *Access to Telemedicine is Hardest for Those Who Need it Most*, WIRED, (September 3, 2020), https://www.wired.com/story/access-telemedicine-is-hardest-those-who-need-it-most (citing to HHS Issues New Report Highlighting Dramatic Trends in Medicare Beneficiary Telehealth Utilization amid COVID-19, Press Release, U.S. DEP'T OF HEALTH AND HUMAN SERVS., (July 28, 2020), https://www.hhs.gov/about/news/2020/07/28/hhs-issues-new-report-highlighting-dramatic-trends-in-medicare-beneficiary-telehealth-utilization-amid-covid-19.html.
[55] *Id.*

Telemedicine's easy expansion was facilitated by both the closure of nonessential outpatient practices and the Centers for Medicare and Medicaid Services ("CMS") easing of regulations regarding reimbursement for digital services.[56] Legislators and healthcare regulators view the adoption and incorporation of telemedicine as a necessary step in expanding access to health care to medically-underserved and low-income populations, especially during the coronavirus pandemic.[57] Colorado Governor Jared Polis recently voiced this sentiment stating, "[i]t's more convenient, it's safer because you don't have to put people at risk of contracting COVID-19 by going out, and it saves money on health care."[58] Telemedicine not only has the potential to reduce healthcare costs but also to effectively address other traditional barriers to quality care for vulnerable populations, such as limited transportation and restricted availability of subspecialty providers.[59] Mina Bahktiar, of the University of Pennsylvania Perelman School of Medicine, notes that the advancement of telemedicine intuitively seems to expand access to health care, "given its convenience, cost effectiveness, and triage capabilities."[60]

Despite the increasing acceptance of telemedicine, it is important to consider how the increased use of telemedicine practices might unexpectedly exacerbate already-existing health disparities.[61] As previously noted, disparities in healthcare access and health outcomes already exist for Black patients and especially for those with low income.[62] Also, patient access to the equipment needed for telemedicine (e.g. smartphones, tablets, computers,

---

[56] Bakhtiar et al., *supra* note 13.
[57] Wurzburg, *supra* note 38.
[58] *See id*. (citing to Tripp Baltz, *Telehealth Barriers Smoothed Under New Colorado Law*, BL, July 6, 2020).
[59] *Id*.
[60] Bakhtiar et al., *supra* note 13.
[61] *Id.*
[62] Castenada, *supra* note 21.

broadband and reliable internet connection) varies widely based on race and income.[63] While the wealth of articles analyzing the digital divide in the rural context may give people the impression that this is solely a rural problem, digital infrastructure barriers also affect urban settings.[64] For example, almost half of households living in poverty in New York City do not have broadband in the home.[65] Further, more than 1.5 million New Yorkers do not have the internet connections they need to make full use of the Internet.[66] Likewise, in Chicago, an estimated 100,000 middle- and high-school age students lack access to high-speed Internet, and while 85.8% of Chicago households have a computer, only 75.9% have a broadband Internet subscription.[67] The limitations posed by poor digital infrastructure are compounded by characteristics of the U.S. healthcare system, which drive up the costs of service and dominate physicians' actions.[68]

Early evidence raises concerns that the use of technology for maintaining health care may intensify healthcare inequities for certain populations.[69] The results of one outpatient cardiovascular care study done during the Coronavirus pandemic suggested that health disparities might be aggravated

---

[63] Floberg, *supra* note 47.
[64] *Id. See also De Blasio Administration Releases Internet Master Plan for City's Broadband Future*, OFF. WEBSITE CITY N.Y., (2020), https://www1.nyc.gov/office-of-the-mayor/news/010-20/de-blasio-administration-releases-internet-master-plan-city-s-broadband-future.
[65] *Id*.
[66] *Id*.
[67] *Providing Stable High-Speed Internet Access to Students who Need it the Most*, CHI. PUB. SCHS., (2020) https://www.cps.edu/strategic-initiatives/chicago-connected/; *QuickFacts: Chicago, IL*, UNITED STATES CENSUS BUREAU, (July 1, 2019), https://www.census.gov/quickfacts/fact/table/chicagocityillinois/INT100218#INT100218.
[68] *See Seven Factors Driving Up Your Healthcare* Costs, PBS NEWS HOUR: HEALTH, (Oct. 24, 2012), https://www.pbs.org/newshour/health/seven-factors-driving-your-health-care-costs (explaining how most insurers pay medical providers under a fee-for-service system that reimburses for each service rendered and describing how demand for new medical advances that are usually more expensive than the products and treatments they replace).
[69] Lauren A. Eberly, *Telemedicine Outpatient Cardiovascular Care During the COVID-19 Pandemic*, 142 AM. HEART ASS'N. 510.512, (June 2020), https://www.ahajournals.org/doi/epub/10.1161/CIRCULATIONAHA.120.048185.

even among patients seeking routine outpatient services due to inequitable access to telemedical care, especially for poorer patients.[70] The study showed that households with annual incomes less than $50,000 were more likely to use audio only for telemedicine appointments instead of using video.[71] As mentioned above, thirty percent of those making less than $30,000 a year do not have a smartphone, and thus, do not have the technological capability to use video during a telemedicine appointment.[72] Patients who are limited to audio-only visits may not receive the same quality of care via telemedicine than their video and internet-equipped counterparts. This disparity is because video visits are more like traditional, face-to-face visits and allow opportunities to use real time images for evaluation.[73]

Medicare and some private insurers have promised to reimburse video calls at the same rate they would pay for office visits.[74] The result being that video calls are favored over telephonic health "visits," which were often not been reimbursed in the past and have gained acceptance more slowly.[75] Such policies may unintentionally penalize providers with poorer patients who can only complete telehealth visits by telephone.[76] On the other hand, there are cases where people are billed for phone conversations that used to be free because the fragmented shift to telemedicine has induced providers to bill up front for services due to uncertainty regarding reimbursements.[77]

---

[70] *Id*.
[71] *Id*.
[72] *See Internet/Broadband Fact Sheet*, s*upra* note 40 (containing statistics of broadband/internet usage analyzed by race). *See also* Anderson & Kumar, *supra* note 42 (explaining technology device ownership and usage).
[73] Eberly, *supra* note 69; Bakhtiar et al., *supra* note 13.
[74] Jay Hancock, *Patients Are Being Billed For Some Phone Chats With Doctors That Used To Be Free*, NPR, (April 27, 2020), https://www.npr.org/sections/health-shots/2020/04/27/843475097/patients-are-being-billed-for-some-phone-chats-with-doctors-that-used-to-be-free.
[75] *Id.*
[76] Eberly, *supra* note 69.
[77] Hancock, *supra* note 74.

Beyond Internet accessibility, traditional barriers to equitable health care compounded with other factors may result in telemedicine becoming an additional hurdle rather than a help for Black, urban patients.[78] Winkle et al. notes that the transition to digital health care is widening the gap between individuals who are or are not "connected," or "those who can access *and* use technology services and tools that rely on internet or wireless connectivity."[79] Digital literacy, or "e-literacy," remains a barrier to digital health solutions for both providers and patients, who have various levels of technological proficiency.[80] Likewise, while telehealth is often lauded as a solution to the obstacles posed by unreliable transportation and geographically distant healthcare facilities, such gains may be nullified by heightened pressures to fill any time saved on commuting with hours working.[81] The recession following the coronavirus outbreak sharply increased unemployment among all groups of workers, and many low-income patients likely remain unable to take any time off from work to focus on their health, even if it takes form as telemedicine.[82]

Another possible reason that digital health solutions may increase, rather than abate, systemic inequities is that the designers behind technological health solutions tend to overlook those who could most benefit from their

---

[78] Anita Ramsetty & Cristin Adams, *Impact of the Digital Divide in the Age of COVID-19*, 27 J. AM. MED. INFO. ASS'N. 1147, 1147 (July 2020).
[79] Brian Van Winkle et al., *Why Aren't Our Digital Solutions Working for Everyone?*, 19 AMA J. ETHICS 1116, 1116–24. (Nov. 2011).
[80] *See id*. at 1117 (describing e-literacy as a measure of one's level of technological competency; can be improved through methods like digital skills training, simplified and adapted technology and equipment, and community support).
[81] *See* Rakesh Kochhar, *Unemployment Rose Higher in Three Months of COVID-19 Than it did in Two Years of the Great Recession*, PEW RSCH. CTR., (2020), https://www.pewresearch.org/fact-tank/2020/06/11/unemployment-rose-higher-in-three-months-of-covid-19-than-it-did-in-two-years-of-the-great-recession/ (explaining the effects of the COVID-19 pandemic on unemployment rates in the U.S.).
[82] *Id*.

use.[83] Further, healthcare systems, providers, researchers, and engineers are not incentivized to focus their innovations on the most vulnerable patients.[84] Physicians are incentivized to attract and care for privately insured patients as opposed to those who are uninsured or dependent on federal and state medical insurance programs.[85] Healthcare providers stipulate that excessive administrative burdens and miniscule and delayed monetary reimbursement associated with programs like Medicaid accounted for this preference.[86]

The significance of such information becomes apparent when considering that pertinent data shows that most uninsured people are in low-income families, and that people of color are at higher risk of being uninsured than non-Hispanic whites.[87] Moreover, uninsured people often lack access to care and are less likely to receive "preventive care and services for major health conditions and chronic diseases," thereby often going without necessary medical attention.[88] Thus, put into context with existing social determinants of health, it follows that the digital divide could become yet another factor that determines someone's health outcomes. If digital health solutions are not advanced equitably, disparities in healthcare access and outcomes will continue to increase for low-income, Black patients, who already constitute a large part of those who are most vulnerable in times of crises.[89]

---

[83] Winkle et al., *supra* note 77 at 1117.
[84] *Id*.
[85] *See generally* Edward C. Wang et al., *Inequality of Access to Surgical Specialty Health Care: Why Children with Government-Funded Insurance Have Less Access Than Those With Private Insurance in Southern California*, 114 PEDIATRICS e584, e588 (November 2004), https://pediatrics.aappublications.org/content/pediatrics/114/5/e584.full.pdf.
[86] *Id*.
[87] Jennifer Tolbert et al., *Key Facts About the Uninsured Population*, KAISER FAM. FOUND., (Dec. 13, 2019), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.
[88] *Id*.
[89] Ramsetty & Adams, *supra* note 78, at 1148.

## BRIDGING THE DIVIDE BY PROMOTING EQUITABLE TELEMEDICINE ACCESS DURING EXPANSION

In order to prevent telemedicine from becoming yet another factor that contributes to the health disparities suffered by low-income, Black patients in urban areas, it is important to promote digital equity while the telemedicine expansion occurs. If telemedicine is likely to transform the future of clinical medicine, it is critical to anticipate and address disparities before they grow.[90] Winkle et al. offer helpful solutions such as utilizing tech-enabled healthcare workers by integrating them into existing community programs,[91] incentivizing healthcare providers to play a greater role in such innovations through funding and community collaboration,[92] and connecting patients with customized resources.[93] Physicians and other medical professionals should embrace educational training on telemedicine and digital literacy, as well as support their patients in these capacities.[94] Further, in order to ensure that new technologies meet the low-income Black population's needs and are designed to accommodate their digital skill level, patients from these communities should be included in these collaboration efforts.[95]

Another proposed method to bridging the digital divide is increased use of store-and-forward technologies, which require lesser bandwidth compared to video visits.[96] This method uses secure e-mail communications for the electronic transmission of medical information such as digital images,

[90] *Id*.
[91] Winkle et al., *supra* note 79, at 1119.
[92] *Id.* at 1121.
[93] *Id.* at 1120.
[94] Bakhtiar et al., *supra* note 13.
[95] Winkle et al., *supra* note 79, at 1121.
[96] Bakhtiar et al., *supra* note 13.

documents, and pre-recorded videos.[97] Store-and-forward technology is asynchronous, meaning that the information is used to provide services outside of real-time.[98] This solution removes the need for coordinating schedules, since the provider, any specialist, and patient can all participate in the process when it is convenient for them.[99] Aside from increasing efficiency, proponents applaud this process as being able to overcome language and cultural barriers because it eliminates the need for real-time translation services.[100]

Another solution is forging city and nonprofit partnerships like those that are taking place in the sphere of public education to provide needed access to technological devices and Internet access.[101] One such effort is Chicago Connected, which aims to narrow the digital divide for Chicago Public Schools ("CPS") families by providing up to four years of high-speed internet for CPS families most in need.[102] The Federal Communications Commission ("FCC") has also undertaken efforts to advance the adoption and accessibility of "broadband-enabled health care solutions and advanced technologies."[103] In 2017, the American Medical Informatics Association ("AMIA") responded to these efforts with a letter containing "opportunities to address the digital divide's impact on health" within the FCC's efforts.[104] The AMIA suggested that the FCC and other government and local partners

---

[97] *Store-and-Forward (Asynchronous)*, CTR. CONNECTED HEALTH POL'Y, (last visited September 15, 2020), https://www.cchpca.org/about/about-telehealth/store-and-forward-asynchronous.
[98] *Id*.
[99] *Id*.
[100] *Id*.
[101] Bakhtiar et al., *supra* note 13.
[102] *Providing Stable High-Speed Internet Access*, *supra* note 67.
[103] Douglas B. Fridsma, Response, *AMIA Response to FCC Notice on Accelerating Broadband Health Tech Availability*, 1,1 (May 24, 2017), https://www.amia.org/sites/default/files/AMIA-Response-to-FCC-Notice-on-Accelerating-Broadband-Health-Tech-Availability.pdf.
[104] *Id*. at 1.

be willing to steer leadership and funding efforts should private-sector actors fail to adequately address the issue.[105] Another proposal included the FCC's consideration of policies that promote "disadvantaged populations" having access to specific health applications for mobile use and maintenance of personal health records without incurring network data charges.[106] The AMIA emphasized that the government should be willing to protect the public good considering "evidence suggesting that broadband access is a social determinant of health."[107] As lawmakers respond to these concerns with new legislation,[108] they must be reminded that cities suffer from digital inequities too.

## CONCLUSION

The COVID-19 pandemic has illuminated the healthcare disparities that Black, low-income patients in urban communities face. The "digital divide" should be considered among the other social determinants of health that contribute to these disparities. Considering this knowledge, lawmakers and healthcare providers should be wary of relying on telemedicine to the extent that it might further exacerbate health disparities for the urban, Black, low-income population. Utilizing community resources and strategic private and public collaboration to ensure innovative and accessible technology and patient support should be considered to advance equitable telemedicine

---

[105] *Id.* at 3.
[106] *Id.*
[107] *Id.*
[108] Press Release, *Trump Administration Proposes to Expand Telehealth Benefits Permanently for Medicare Beneficiaries Beyond the COVID-19 Public Health Emergency and Advances Access to Care in Rural Areas*, CTRS. MEDICARE MEDICAID SERVS.: NEWSROOM (August 3, 2020) https://www.cms.gov/newsroom/press-releases/trump-administration-proposes-expand-telehealth-benefits-permanently-medicare-beneficiaries-beyond (last visited September 15, 2020).

development and prevent the digital divide from exacerbating health disparities during and after the COVID-19 pandemic.

# The Dichotomy of Social Isolation in a Global Pandemic When the Power to Protect Actually Harms

*Marina Saldaris*

## INTRODUCTION

The COVID-19 pandemic is a global public health crisis.[1] As of December 1, 2020, there have been over sixty-three million cases worldwide, with more than 1.4 million deaths directly related to COVID-19.[2] The United States has suffered more than thirteen million cases and over 270,000 deaths thus far.[3] To mitigate the spread of the virus, governors across the United States issued various executive orders mandating stay-at-home quarantines.[4] Many of these executive orders have been renewed or extended repeatedly as the pandemic continues.[5] Although isolation does decrease the spread of the virus, it also causes an accelerated decline in the mental and physical health of elderly nursing home residents.[6] This topic is relevant because more than fifty-four million United States citizens are aged 65 and older.[7] Furthermore, over forty percent of the all COVID-19 related United States deaths have occurred in nursing home residents.[8]

---

[1] CDC, *Coronavirus Disease, Global COVID-19* (July 28, 2020), https://www.cdc.gov/coronavirus/2019-ncov/global-covid-19/index.html.
[2] *Coronavirus Resource Ctr.*, JOHNS HOPKINS UNIV. & MED. (Sept. 28, 2020), https://coronavirus.jhu.edu/.
[3] *Id*.
[4] Council of State Governments, *Covid-19 Resources for State Leaders*, Executive Orders, CSG (Oct 10, 2020), https://web.csg.org/covid19/executive-orders/.
[5] *Id*.
[6] Emily Paulin, *Is Extended Isolation Killing Older Adults in Long-Term Care?* AARP (Sept. 3, 2020), https://www.aarp.org/caregiving/health/info-2020/covid-isolation-killing-nursing-home-residents.html.
[7] U.S. Census Bureau, *Quick Facts* (2020), ttps://www.census.gov/quickfacts/fact/table/US/PST045219.
[8] Health Affairs, *In New York State Unionized Nursing Homes, Lower COVID-19 Mortality*, HEALTH AFF. BLOG (Sept. 10, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200910.227190/full/.

There is no question that the government orders which mandated stay-at-home provisions, forced mask-wearing, prohibited travel, and suspension of all non-essential businesses and public gatherings, were essential in containing the spread of COVID-19.[9] However, on first impression, social distancing focuses too narrowly on controlling viral spread rather than considering the effects on vulnerable populations, such as the elderly in nursing homes.[10] The draconian nature of quarantine has resulted in collateral damage in the form of an accelerated decline in nursing home resident's mental and physical health.[11] While the purpose of these restrictions may have been to prevent viral spread to this vulnerable population, the isolation has also caused a disproportionate impact on marginalized populations, such as the elderly.[12]

Nine months since the emergence of the COVID-19 virus and the pandemic shows no sign of abating, with a reported average of more than one hundred forty thousand new COVID-19 cases daily and an increase of seventy-six percent from the previous two weeks.[13] Social distancing and isolation remain first-line measures to thwart the viral spread and the resulting loneliness so common among the elderly continues to predict poor prognosis for their overall health.[14] Furthermore, the COVID-19 pandemic

---

[9] Ill. Exec. Order No. 2020-32 (Apr. 30, 2020), https://www2.illinois.gov/Pages/Executive-Orders/ExecutiveOrder2020-32.aspx.
[10] Sandro Galea & Katherine Keyes, *Understanding the COVID-19 Pandemic Through the Lens of Population Health Science*, 00 AM. J. EPIDEMIOLOGY 2, 1-6, (July 6, 2020), https://doi.org/10.1093/aje/kwaa142.
[11] Paulin, *supra* note 6.
[12] Jade Conner et al., *Health Risks and Outcomes that Disproportionately Affect Women During the COVID-19 Pandemic: A Review*, 266 SOC. SCI. & MED. 1, 1-7 (2020), https://pubmed.ncbi.nlm.nih.gov/32950924.
[13] *Covid in the U.S.: Latest Map and Case Count*, N.Y. TIMES (Nov. 14, 2020), https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html.
[14] A.H. Jansson et.al., *Loneliness in Nursing Homes and Assisted Living Facilities: Prevalence, Associated Factors and Prognosis*, 3 J. NURSING HOME RES. 43, 43-49 (2017), https://www.jnursinghomeresearch.com/919-loneliness-in-nursing-homes-and-assisted-living-facilities-prevalence-associated-factors-and-prognosis.html.

will continue to compound the usual risks for elderly loneliness, with the added risk of virus-related morbidity and mortality, related to the all too common comorbidities associated with the elderly.[15]

This article will argue that unless governors take a dimensional approach to combat public health crises, like pandemics, they will continue to cause collateral damage and casualties.[16] Although focusing on the number of cases and death rates may seem like the best approach, it limits the ability to understand and mitigate the consequences of these actions.[17] The causes of the global pandemic are far more remote than the COVID-19 virus merely infecting the body.[18] The course of the pandemic was predetermined by many factors such as politics, nationwide mistrust in government, and chronic underfunding for public health resources.[19] Addressing the chronic underfunding for public health could have curtailed the viral spread from the beginning.[20] The "viral suppression at all costs" mentality came at the expense of vulnerable populations, like the elderly.[21]

Governors should employ an age-risk stratification which strives to balance the goal of reducing risk of viral morbidity and mortality while preserving the overall health in the most vulnerable populations, like elderly nursing home residents.[22] To accomplish this, executive orders must include failure to thrive ("FTT") provisions, which permit an exception to the visitation ban, allowing for a permanently designated family member to be the sole visitor for a nursing home resident and not only at end-of-life

---

[15] *CMS Announces New Measures to Protect Nursing Home Residents from COVID-19*, CTR. FOR MEDICARE & MEDICAID SERVS. (Mar, 13, 2020), https://www.cms.gov/newsroom/press-releases/cms-announces-new-measures-protect-nursing-home-residents-covid-19.
[16] Galea & Keyes, *supra* note 10, at 2.
[17] *Id*.
[18] *Id*. at 3.
[19] *Id.*
[20] *Id*.
[21] *Id*. at 4.
[22] *Id*. at 2.

situations.[23] Furthermore, executive orders must include face-to-face contact ("FTFC") requirements, which provides for in-person contact between nursing home residents and their family members including outdoor visits, window visits, vehicle parades, limited indoor visits, and personal visitors for failure to thrive.[24]

This article will discuss the collateral damage caused by executive orders on nursing home residents. First, this article discusses the effects of isolation on the accelerated decline in nursing home residents and examines the disproportionate effect of healthcare on the elderly. Next, this article analyzes how executive orders have essentially turned nursing homes into golden prisons for their residents. Third, it addresses how access to FTFC enabled by technology can be used to aid and promote nursing home residents' health. Lastly, this article proposes that governors should be required to include FTT clauses in any executive order that mandates extreme social isolation for the elderly. Additionally, executive orders should require nursing homes to provide their residents with a minimum amount of FTFC with others each day.

## EFFECTS OF ISOLATION ON ACCELERATED DECLINE IN ELDERLY HEALTH

By and large, people are social by nature and maintaining healthy social relationships can help them live longer, high-quality lives.[25] However,

---

[23] Sarah R. Champagne, *The Crushing Isolation of Nursing Homes During The Pandemic*, TEX. TRIB. (Aug. 14, 2020), https://www.keranews.org/news/2020-08-14/the-crushing-isolation-of-nursing-homes-during-the-pandemic.

[24] TEX. STAT. tit. 26 TAC, § 551.47. (Aug. 14, 2020), https://www.sos.texas.gov/texreg/archive/August282020/Emergency%20Rules/26.HEALTH%20AND%20HUMAN%20SERVICES.html.

[25] *See* CDC, *Loneliness and Social Isolation Linked to Serious Health Conditions*, Alzheimer's Disease and Healthy Aging (Oct. 10, 2020), https://www.cdc.gov/aging/publications/features/lonely-older-adults.html (explaining that humans are social by nature; that high-quality social relationships can enable them to live longer, healthier lives; the health risks of loneliness, the populations most at risk for loneliness, the link between

evidence has shown that older adults are at increased risk for loneliness and social isolation because they are more likely to face circumstances such as loss of family or friends, solitary living, hearing loss, and chronic illness.[26] Nearly twenty-five percent of adults older than 65 suffer from social isolation.[27] Social isolation coupled with loneliness puts them in jeopardy of developing dementia and other serious medical conditions.[28] Furthermore, the effects of social isolation rival those of high blood pressure, obesity, cigarette smoking, and physical immobility.[29]

Studies have found that social isolation significantly increases a person's risk of early death from all causes; a risk that may surpass those of smoking, obesity, and physical inactivity.[30] Social isolation and lack of meaningful relationships has been linked to a fifty percent increased risk of dementia, a thirty-two percent increased risk of stroke, and a twenty-nine percent increased risk of heart disease.[31] In patients with a history of heart failure, loneliness is linked to a fifty-seven percent increased risk of emergency room visits, a sixty-eight percent increased risk of hospitalization, and a near

loneliness and social isolation with serious health conditions in older adults, and a list of information and resources available).

[26] *Id*.

[27] *Id*.

[28] *Id*.

[29] *See* NAT'L ACAD. SCI., ENG'G, & MED., SOCIAL ISOLATION AND LONELINESS IN OLDER ADULTS: OPPORTUNITIES FOR THE HEALTH CARE SYSTEM, 42 (2020), https://www.nap.edu/read/25663/chapter/1 (explaining that humans are social by nature and that high-quality social relationships are vital for their health and well-being. Also, this report provides a comprehensive review of risk factors for social isolation and loneliness, mechanisms by which social isolation and loneliness impact mortality, morbidity, and health, factors that affect those mechanisms, and ways to measure social isolation and loneliness. Furthermore, this report discusses the role of the health care system in addressing all these issues, which clinical interventions show the most promising outcomes, and ways to better educate and train the health care workforce).

[30] CDC, *supra* note 25.

[31] *Id*.

quadruple increased risk of death.[32] Furthermore, loneliness has also been linked to higher rates of depression, anxiety, and suicide.[33]

There are 1.3 million nursing home residents in the United States.[34] Prior to the COVID-19 pandemic, the prevalence of social isolation and loneliness were already considered a "public health crisis," with forty-three percent of United States adults over age sixty having described feeling lonely.[35] A large proportion of nursing home residents have experienced an increase in anxiety, depression, irritability, and dementia-related behaviors.[36] The severe confinement measures seem to be making this crisis in long-term care facilities worse.[37] Thousands of nursing home residents have been confined to their buildings and in some cases, their rooms since March 2020.[38] Although some states recently eased their COVID-19 restrictions, allowing limited family visitations; more states are reimplementing shelter-in-place orders due to the third COVID-19 surge across the United States.[39] Also, many states still restrict *all* visitors except during end-of-life compassionate care situations.[40]

Failure to thrive ("FTT") in the elderly population is not a distinct disease, but rather a multifactorial syndrome manifesting in a progressive decline in

---

[32] *Id*.
[33] *Id*.
[34] Ashley Abramson, *Protecting Nursing Home Residents During COVID-19. Nursing Homes Have Become Hotbeds for COVID-19 — As Well as for Loneliness, Fear, and Stress for Residents, Their Families and Staff*., AM. PSYCHOL. ASS'N. (Apr. 30, 2020), https://www.apa.org/topics/covid-19/nursing-home-residents.
[35] Paulin, *supra* note 6.
[36] *Id*.
[37] *Id*.
[38] Jack Healy et al., *'A Slow Killer': Nursing Home Residents Wither in Isolation Forced by the Virus*, N.Y. TIMES (October 30, 2020), https://www.nytimes.com/2020/10/30/us/nursing-homes-isolation-virus.html.
[39] *Coronavirus Reopening, Map of COVID-19 Case Trends, Reopening Status and Mobility*, USA TODAY (Nov. 15, 2020), https://www.usatoday.com/storytelling/coronavirus-reopening-america-map/#restrictions.
[40] Andrew Soergel, *Track the Status of Nursing Home Visits in Your State*, AARP (Nov. 9, 2020), https://www.aarp.org/caregiving/health/info-2020/nursing-home-visits-by-state.html.

vitality, progressive apathy, and a loss of willingness to eat and drink that culminates in death.[41] The incidence of FTT increases as people age and affects twenty-five to forty percent of nursing home residents.[42] It manifests as decreased appetite, inactivity, poor nutrition, and a significant weight loss of more than five percent of baseline.[43] FTT is not a normal corollary of aging, an indicator of dementia, an expected consequence of chronic disease, or a standard indicator of the late stage of terminal illnesses.[44] Rather, the syndrome correlates with an underlying mental, physical, or psychosocial condition.[45]

## WHEN EXECUTIVE ORDERS TURN NURSING HOMES INTO GOLDEN PRISONS

The effects of COVID-19 are not proportionate throughout the United States.[46] The pandemic has affected different populations differently and exposed the United States' health system inequalities.[47] The nation's chronic underfunding of public health infrastructure and overall indifference to the

---

[41] Russell Robertson & Marcos Montagnini, *Geriatric Failure to Thrive*, 70 AM. FAM. PHYS 343, 343 (July 14, 2004), https://www.aafp.org/afp/2004/0715/p343.html.
[42] *Id.*
[43] Nadia Ali, *Failure to Thrive in Elderly*, MEDSCAPE (Aug. 28, 2020), https://emedicine.medscape.com/ article/2096163-overview.
[44] Robertson & Montagnini, *supra* note 41.
[45] Ali, *supra* note 43.
[46] Aaron van Dorn et al., *Covid-19 Exacerbating Inequalities in the US*, 395 LANCET 1243, 1243-1244 (Apr. 18, 2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30893-X/fulltext.
[47] *See* van Dorn, *supra* note 46 (explaining that African American and other communities of color having been especially affected by the COVID-10 pandemic; that across the country, COVID-19 deaths are disproportionately high among African Americans compared with the overall population (i.e. in Milwaukee, three quarters of all COVID-19 related deaths are African American, and in St Louis, all but three people who have died from COVID-19 were African American); that pre-existing racial and health inequalities already present in US society are being exacerbated by the pandemic; that existing structural factors prevent communities of color from practicing social distancing; that minority populations in the US disproportionally make up "essential workers" such as retail grocery workers, public transit employees, and health-care workers and custodial staff. Therefore, these front-line workers, disproportionately black and brown, are typically not afforded the privilege of 'staying at home', leading to increased exposure, morbidity and mortality).

welfare of congregate populations has left the elderly trapped in their long-term care facility, in a place that was supposed to keep them safe.[48] Governors should have taken into account that nursing home residents, predisposed to chronic comorbidities, were at even greater risk because they were unable to physically distance, because they had nowhere to go.[49] These residents were left to fend off the virus as best they could.[50] However, they could not, as evidenced by the forty-two percent of overall COVID-19 deaths attributed to nursing home residents.[51]

The COVID-19 pandemic has compounded the typical risks of loneliness with an increased risk for virus-related complications in the elderly, due to their tendency to have multiple health problems.[52] Aggressive recommendations from the Centers for Disease Control and Prevention ("CDC") called for the immediate cancellation of all group activities, communal dining, and the restriction of *all* visitors, with an exception only provided for end-of-life situations.[53] Nursing homes have been presented with the dichotomy of protecting their medically-fragile residents from the virus at the expense of isolating them from FTFC with others.[54]

Without daily social stimulation, like communal meals and group activities, nursing home residents lose their connections and feel like they are in a prison.[55] The United Nations ("UN") defines solitary confinement as

---

[48] Galea & Keyes, *supra* note 10, at 4.
[49] *Id*. at 3.
[50] *Id*.
[51] Gregg Girvan, *Nursing Home & Assisted Living Facilities Account for 42% of COVID-19 Deaths*, FOUND. RSCH. ON EQUAL OPPORTUNITY (FREOPP) (May 7, 2020), https://freopp.org/the-covid-19-nursing-home-crisis-by-the-numbers-3a47433c3f70.
[52] CMS, *supra* note 15.
[53] *Id*.
[54] Paulin, *supra* note 6.
[55] *Id*.

isolation from others, except for guards, for at least twenty-two hours a day.[56] Likewise, a nursing home resident in quarantine may only experience FTFC when a staff member delivers meals or comes to take their temperature.[57] According to the UN, indefinite and prolonged solitary confinement in excess of fifteen days is considered torture.[58] The UN further reported that after only a few days of social isolation, long-term mental damage is caused.[59]

The only similarity that solitary confinement should share with a stay-at-home order is the physical separation from other people.[60] The minimum size requirement for a government nursing home residential room is 150 square feet, barely twelve feet by twelve feet.[61] This is hardly bigger than a typical nine feet by twelve feet jail cell found in any United States prison.[62] Additionally, prisons are required to ensure that inmates spend no more than ten continuous hours in their small space.[63] However, some nursing home residents are confined to their rooms all day, every day.[64] Even solitary

---

[56] UN, *Solitary Confinement Should be Banned in Most Cases, UN Expert Says*, UN NEWS (Oct. 18, 2011), https://news.un.org/en/story/2011/10/392012-solitary-confinement-should-be-banned-most-cases-un-expert-says.
[57] Rachel Chason & Rebecca Tan, *Isolated and at Risk. Twelve Nursing Home and Assisted-Living Residents Share What Life has Been Like Since the Pandemic Began.* WASH. POST (May 28, 2020), https://www.washingtonpost.com/graphics/2020/local/social-issues/coronavirus/nursing-homes-patients-voices-covid-19/.
[58] UN, *supra* note 56.
[59] *Id*.
[60] David H. Cloud et al., *Medical Isolation and Solitary Confinement: Balancing Health and Humanity in US Jails and Prisons During COVID-19*, 35 J. GEN. INTERNAL MED. 2738, 2739 (2020).
[61] 38 C.R.F. § 59.140 (2012).
[62] U.S. General Accounting Office (GAO), *Federal Prisons, Revised Design Standards Could Save Expansion Funds*, Report to Congressional Requesters 3, 1-18 (Mar. 1991), https://www.gao.gov/products/GGD-91-54.
[63] *Id*.
[64] Abramson, *supra* note 34.

confinement inmates are allowed one to two hours each day of fresh air and the ability to walk outdoors.[65]

By way of comparison, the "Stay-at-Home" Order issued in Mid-March, by Texas Governor, Greg Abbott, remained in effect for an astounding 145 days.[66] However, the State of Texas understood that prolonged isolation can lead to mental and physical decline in the elderly.[67] Therefore, Texas instituted new state rules that allow for a "failure to thrive" exception to the isolation order.[68] Under this rule, if a resident's physical or mental health is declining and they are failing to thrive, a physician can diagnose the condition and a permanently designated visitor be allowed to visit with the resident.[69]

## WHEN MANDATES ACTUALLY HARM THE CITIZENS THEY AIM TO PROTECT

The COVID-19 pandemic has resulted in a series of both federal and state executive orders.[70] These have included strict and mandatory stay-at-home quarantine orders, forced mask-wearing mandates, and restricted access to elective surgeries.[71] Presumably all laws are thought by their makers to be justified by a concern for the welfare of the people.[72] However, protecting

---

[65] Juleyka Lantigua-Williams, *More Prisons are Phasing Out the 'Box'. A New Study Offers Data on the Continued use of Solitary Confinement, and a Corrections Leader Weighs in on the Practice's Future*, ATLANTIC (Dec. 1, 2016), https://www.theatlantic.com/politics/archive/2016/12/more-prisons-are-phasing-out-the-box/509225.
[66] Champagne, *supra* note 23.
[67] *Id*.
[68] *Id*.
[69] *Id*.
[70] Cheryl K. Chumley, *Executive Orders are Not Laws*, WASH. TIMES, (May 5, 2020), https://www.washingtontimes. com/news/2020/may/5/executive-orders-are-not-laws/.
[71] American College of Surgeons, *COVID-19: Executive Orders by State on Dental, Medical, and Surgical Procedures*, ACS: COVID-19 and Surgery, ACS (June 8, 2020), https://www.facs.org/covid-19/legislative-regulatory/executive-orders.
[72] Davidus, *Salus Populi Suprema Lex (Or Someone Always Knows What's Best for You)*, MEDIUM (Oct. 8, 2015), https://medium.com/the-jurisprude/salus-populi-suprema-lex-f6360fd10f1.

the public should involve not merely stopping viral spread, but also protecting the physical and mental health of a society's citizens.[73] Freedom to travel is a basic right protected under the United States Constitution.[74] However, both state and federal governments have asserted that the public health crisis necessitated that drastic restrictions be placed upon their citizens' civil liberties of freedom of movement in order to protect them.[75]

American jurisprudence has long relied on the doctrine of *parens patriae*, in order to uphold executive orders that at first blush, serve to protect the public at large, but may actually cause harm to individual citizens.[76] The powers of this doctrine stemmed from the King of England's capacity as "father of his country" and therefore, passed to the states after the Revolutionary War.[77] While courts initially sided with Governors' broad executive authority during the beginning of the COVID-19 crisis, more courts are holding that Governors are exceeding their authority under their state constitution.[78] For example, most recently, the Michigan Supreme Court denied Governor Whitmer's request to extend her executive orders.[79] Many state constitutions only allow a governor to issue an executive order with an effect of thirty days unless extended by the legislature through

---

[73] Maria Nicola et al. *The Socio-Economic Implications of the Coronavirus Pandemic (COVID-19): A Review*. 78 INT'L. J. SURGERY 186, 188 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7162753/.
[74] Shapiro v. Thompson, 394 U.S. 618, 629 (1969).
[75] Jorge Galva, et al., *Public Health Strategy and the Police Powers of the State*, 120 PUB. HEALTH REP. 20, 20 (2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2569983/.
[76] Hawaii v. Standard Oil Co. of Cal, 405 U.S. 251, 257 (1972).
[77] *Id*.
[78] Alex Ebert, *Pennsylvania Covid Restrictions Unconstitutional, Judge Says*, BLOOMBERG L. (Sept. 14, 2020), https://news.bloomberglaw.com/health-law-and-business/pennsylvania-covid-restrictions-unconstitutional-judge-says?context=article-related.
[79] Jennifer Henderson & Steve Almasy, *Michigan Supreme Court Rules Against Governor Again, Ending Covid-19 Executive Orders*, CNN (Oct. 12, 2020), https://www.cnn.com/2020/10/12/politics/michigan-supreme-court-whitmer-covid-emergency/index.html.

resolution.[80] Therefore, governors must ensure that their executive orders do not cause more harm than good to vulnerable populations and require nursing homes to provide their residents with a minimum amount of FTFC with others each day.

## EXECUTIVE ORDERS AND PROVISIONS FOR FACE-TO-FACE CONTACT

On March 27, 2020, Congress passed the Coronavirus Aid, Relief, and Economic Security ("CARES") Act and President Donald Trump signed it into law.[81] It released two trillion dollars in federal funding to battle the spread of COVID-19 in the United States and lessened the burdens felt by Americans due to the suspension of businesses and stay-at-home orders.[82] The CARES Act injected massive amounts of money to various sectors within the United States.[83] Specifically, it designated $14 billion to farmers, $337 billion to small businesses with another $500 billion to small businesses that retained their staff, $100 billion for healthcare, and "$1,200 for every adult American with an income less than $75,000."[84] However, nowhere does the CARES Act specify any particular amount designated for one of the largest and most vulnerable populations in our country; it shamelessly forgot the elderly nursing home residents.[85]

---

[80] Pam Greenberg, *Legislative Oversight of Emergency Executive Powers*, NAT'L CONF. ST. LEGIS. (NCSL) (Oct. 7, 2020), https://www.ncsl.org/research/about-state-legislatures/legislative-oversight-of-executive-orders.aspx.
[81] Nicola, *supra* note 73, at 188.
[82] *Id.*
[83] *Id.*
[84] *Id.*
[85] *Id.*

HOW FACE-TO-FACE CONTACT CAN PROMOTE HEALTH

Face-to-face human contact decreases feelings of loneliness and the risk of depression.[86] Studies have shown that engaging in FTFC, a mere three times each week can decrease symptoms of depression.[87] Social isolation may contribute to FTT because eating alone may be unappealing.[88] FTFC can help prevent a loss of interest in daily life activities which adversely affects a person's eating and sleeping habits.[89] Loneliness causes the stress hormone Cortisol to increase, resulting in immune system compromise.[90] FTFC can strengthen the immune system by decreasing cortisol.[91] Although phone calls are an easy communication method, they do not provide the same level of support as FTFC.[92] Providing access to FTFC through tablets and other touch technology ("TT") can promote nursing home residents' health outcomes.[93] Therefore, nursing home residents confined by quarantine should have "access to resources that can make their separation psychologically bearable—for example, television, tablets, radio, reading materials, and means of communicating with loved ones—since they are enduring isolation" in favor of the greater good, not as a punishment.[94]

---

[86] Christopher Bergland, *Face-to-Face Social Contact Reduces Risk of Depression*, PSYCHOL. TODAY (October 5, 2015), https://www.psychologytoday.com/us/blog/the-athletes-way/201510/face-face-social-contact-reduces-risk-depression.
[87] *Id*.
[88] Claire Samuels, *Loss of Appetite in the Elderly: Why it Happens & How to Get it Back*, PLACE FOR MOM (Mar. 22, 2020), https://www.aplaceformom.com/caregiver-resources/articles/appetite-loss.
[89] *Id*.
[90] Cleveland Clinic, *What Happens in Your Body When You're Lonely*, HEALTH ESSENTIALS (Feb. 23, 2018), https://health.clevelandclinic.org/what-happens-in-your-body-when-youre-lonely/.
[91] *Id*.
[92] Aetonix, *Communicating with An Elderly Loved One? Go Digital*, (2020), https://aetonix.com/monitoring-home-patients/communicating-elderly-loved-one-go-digital/.
[93] *Id*.
[94] Cloud, *supra* note 60, at 2739.

Providing access to FTFC can be accomplished in a variety of cost-effective manners because of the CARES Act and would not impose an expense on any nursing home. The CARES Act provided a twelve hundred dollar advanced tax credit for individuals.[95] The stimulus check belongs to the nursing home resident, not the nursing home and is not considered income nor a Medicaid resource.[96] Therefore, most nursing home residents should have received the twelve hundred dollar stimulus check under the CARES Act, to be used however they wished.[97]

The money furnished through the CARES Act is more than enough to provide every nursing home resident with a variety of options to ensure and improve socialization, such as a powered air purifying respirator (PAPR) or foldable plexiglass partition, to allow in-person visits with family; or a touch technology device, such as a tablet to allow for remote interactions. The average cost of a tablet is one-hundred forty dollars.[98] The average cost of a foldable plexiglass shield is seventy-nine dollars.[99] The average cost of a PAPR is one-hundred eighty dollars.[100] Combined, these three devices amount to a mere three hundred ninety-nine dollars, well short of the twelve-hundred dollars each resident should have received. Therefore, there is no reason that nursing homes are unable to provide measures which ensure that their residents have access to FTFC with others during their confinement.

---

[95] Michelle Singletary, *No, The Nursing Home Cannot Take Your Stimulus Payment*, WASH. POST (June 22, 2020), https://www.washingtonpost.com/business/2020/06/22/no-nursing-home-cannot-take-your-stimulus-payment/.
[96] *Nursing Home Residents, Medicaid, and Stimulus Checks: What You Need to Know*, Nat'l CTR.LAW & ELDER RTS., https://ncler.acl.gov/getattachment/Resources/Nursing-Home-Residents-and-Stimulus-Checks-(1).pdf.aspx?lang=en-US.
[97] *Id*.
[98] *Tablets*, AMAZON (Nov. 15, 2020), https://www.amazon.com/s?k=tablets.
[99] *Foldable Plexiglass Shield*, AMAZON (Nov. 15, 2020), https://www.amazon.com/Student-Sneeze-Plexiglass-Acrylic-Shield/dp/B08GYDPL3R/.
[100] *PAPR*, AMAZON (Nov. 15, 2020), https://www.amazon.com/Efficiency-Respirator-Rechargeable-Electrical-Industrial/dp/B08F45VD9C/.

Barriers to using modern technology by elderly populations have been identified as cost, lack of instruction, guidance, knowledge and confidence.[101] However, despite these barriers, the majority of older adults enjoy using a tablet to gain access to quick information and social inclusion.[102] Furthermore, tablets offer less complex interfaces than other technology, like laptop computers and enable older populations to forego keyboards which may be difficult to use with arthritic hands.[103] Interestingly, when using a touch technology device, older people aged sixty to seventy-two are able to reach a similar performance level as that of younger people aged twenty to thirty-nine.[104]

## CONCLUSION

What was thought to be a short-term disease process, isolated to East Asia, has continued, with forecasts of subsequent "waves" mimicking three separate waves of the 1918 Spanish flu.[105] Dr. Anthony S. Fauci, director of the National Institute of Allergy and Infectious Diseases, has recently warned Congress that COVID-19 cases could ultimately reach 100,000 per day.[106] Further, it could be a year or more before an effective vaccine has been created, tested, proven safe, and ready for administration to the world's

---

[101] Eleftheria Vaportzis et al., *Older Adults Perceptions of Technology and Barriers to Interacting with Tablet Computers: A Focus Group Study*, 8 FRONTIERS IN PSYCHOL. 1, 1-11 (Oct. 4, 2017), https://www.ncbi.nlm.nih.gov /pmc/articles/PMC5649151/.
[102] *Id.* at 9.
[103] *Id.*
[104] *Id.* at 2.
[105] CDC, *Three Waves of Pandemic, Influenza (Flu)*, CDC (May 11, 2018), https://www.cdc.gov/flu/pandemic-resources/1918-commemoration/three-waves.htm.
[106] Clare Foran & Jamie Ehrlich, *Fauci Warns Congress that New US Coronavirus Cases Could Rise to 100,000 a Day*, CNN (June 30, 2020), https://www.cnn.com/ 2020/06/30/politics/fauci-redford-testimony-senate-coronavirus /index.html.

population.[107] Or it could be never, as is the case with the Human Immunodeficiency virus, Zika virus, Hepatitis C Virus, tuberculosis, malaria, West Nile, and others.[108] Developing natural immunity through exposure to an active disease is the best type of immunity because it can sometimes provide life-long immunity.[109] However, according to the Chief of the World Health Organization ("WHO"), Tedros Ghebreyesus, allowing a dangerous virus, like COVID-19, which is not fully understood to progress unchecked, is simply unethical.[110] Therefore, herd immunity is not a feasible option to combat COVID-19.[111]

Because there seems to be no near end in sight, and executive orders have far-reaching effects, federal and state governments must consider the effects of their executive orders, not only on society as a whole, but on the individuals that make up that society. In order to do this, they must act in a more holistic approach in assessing not only to the public's health needs as a whole but incorporating assessments which identify and address the health needs of the most vulnerable populations. Practically, governors should be required to include FTT visitor exceptions within their strict quarantine orders and require that nursing homes provide a minimum amount of face-to-face contact with others each day to support their health and vitality.

---

[107] Berkeley Lovelace, *Why a Coronavirus Vaccine Might be Ready Next Year – and what Could go Wrong*, CNBC (May 21, 2020), https://www.cnbc.com/2020/05/21/coronavirus-vaccine-why-it-may-be-ready-early-next-year-and-what-could-go-wrong.html.
[108] Donald G. McNeil Jr., *Why Don't We Have Vaccines Against Everything*, N.Y. TIMES (Nov. 19, 2018), https://www.nytimes.com/2018/11/19/health/vaccines-poverty.html.
[109] *Vaccines and Immunizations*, CDC (Mar. 10, 2017), https://www.cdc.gov/vaccines/vac-gen/immunity-types.htm.
[110] Antonia Farzaan & Miriam Berger, *Trying to Reach erd Immunity to the Coronavirus is 'Unethical'*, WASH. POST, (Oct. 13, 2020), https://www.washingtonpost.com/world/2020/10/13/herd-immunity-coronavirus-unethical-who/.
[111] *Id.*

# The Unconstitutionality of Access to Health Care in Prisons During COVID-19

*Nitika Suchdev*

## INTRODUCTION

In the United States, it is estimated that there are 1.5 million prisoners within the correctional system.[1] This large number of individuals imprisoned has created an overcrowding issue, with the penitentiary system working at a capacity of 103.9%.[2] This presents an issue of receiving and allocating adequate resources to prisons. Indeed, overcrowding causes major health issues within the prison community and makes it difficult for a prison to adequately and effectively allocate resources to its prisoners.[3] Our recently formed socially-distanced society due to COVID-19 has forced prisons to rethink the way they function and how to prevent the spread of the virus.[4]

The 1976 case, *Estelle v. Gamble* established that prisoners had a right to health care under the Eighth Amendment.[5] Subsequent holdings have broadened this ruling by stating that not only do prisons need to afford adequate and timely health care, but that the services rendered must "reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards."[6] This signals that with

---

[1] Statista Rsch. Dep't, *Prisoners in the United States – Statistics & Facts*, STATISTA (Jan. 28, 2020) https://www.statista.com/topics/1717/prisoners-in-the-united-states/#dossierSummary__chapter2.
[2] Nial McCarthy, *The World's Most Overvowded Prison Systems [Infographic]*, FORBES (Jan. 26, 2018), https://www.forbes.com/sites/niallmccarthy/2018/01/26/the-worlds-most-overcrowded-prison-systems-infographic/#652132713724.
[3] THAILAND INST. JUST. & PENAL REFORM INT'L, GLOBAL PRISON TRENDS 2020 3 (Penal Reform Int'l 2nd ed. 2020).
[4] Statista Rsch. Dep't, *Coronavirus Courses Through U.S. Prisons*, STATISTA (Sep. 15, 2020) https://www.statista.com/chart/21895/covid-in-prison-system/.
[5] *See* Estelle v. Gamble, 429 U.S. 97, 106 (1976) (where the court held that deliberate indifference to a prisoner's serious medical needs constitutes cruel and unusual punishment).
[6] U.S. v. DeCologero, 821 F.2d. 39, 43 (1st Cir. 1987).

the presence of new health concerns, health care must be adapted to ensure a prisoner's right to health care under the Eighth Amendment is protected and satisfied.[7]

However, the prison system has not met its burden in evolving methods that are constitutionally acceptable.[8] *Estelle* held that deliberate indifference to prisoners' serious illnesses is cruel and unusual punishment under the Eighth Amendment.[9] Subsequent cases establish that the meaning of "deliberate indifference" evolves as society, and medicine, advance.[10] In the time of a pandemic when no cure or vaccine is available, it is deliberately indifferent to not take basic precautions to help prevent the spread of the virus.[11] This paper will analyze how prisons failed to take basic precautions through lack of social-distancing, limited personal-protective equipment and sanitation methods, and lack of mass testing. This analysis then concludes that prisons failed to take such basic precautions during pertinent times during COVID-19, which led to many prisoners experiencing grave illnesses and even death.[12] This failure was deliberate indifference to prisoners' health and was violative of the Eighth Amendment.[13] Therefore, remedies must be

---

[7] *Id.*
[8] *See generally id.* (services must be reasonably commensurate with modern medical advancements and the prison system has failed to show this).
[9] Estelle v. Gamble, 429 U.S. 97, 106 (1976).
[10] *See generally* U.S. v. DeCologero, 821 F.2d. 39, 43 (1st Cir. 1987) (stating that medical services that reasonably commensurate with modern science and quality are generally acceptable within professional standards).
[11] *See generally* Estelle v. Gamble, 429 U.S. 97, 106 (1976) (stating that acts or omissions that are sufficiently harmful constitute deliberate indifference); Brown v. Plata, 563 U.S. 493, 511 (2011) (stating that denying prisoners basic health care contravenes basic principles of human life).
[12] Carlos Franco-Paredes et. al., *Covid-19 in Jails and Prisons: A Neglected Infection in a Marginalized Population*, 14 PLoS NEGLECTED TROPICAL DISEASES 1, 2 (2020).
[13] *See generally* Estelle v. Gamble, 429 U.S. 97, 106 (1976) (stating that acts or omissions that are sufficiently harmful constitute deliberate indifference); *See* Brown v. Plata, 563 U.S. 493, 511 (2011) (stating that denying prisoners basic health care contravenes basic principles of human life) (it can be inferred from these holdings that the prison system not evolving with the standards of medicine is deliberately indifferent).

instilled, such as social distancing measures, free availability of soap and hand sanitizer, and a prioritizing of the prison population when a vaccine is available.[14]

## THE "TYPICAL" HEALTH CARE IN PRISONS

While *Estelle* determined that prisoners have the right to health care under the Eighth Amendment, the court recognized that this right was not unlimited.[15] For example, as the court mentioned, a prisoner claiming that a physician negligently diagnosed or treated a condition does not mean that a prison violated the prisoner's Eighth Amendment right.[16] Additionally, a more recent ruling, *Brown v. Plata,* affirmed *Estelle* and further held that the government has an obligation to provide basic sustenance to prisoners, including adequate medical care.[17] Therefore, as long as a prison provides health care that meets a modern "standard of decency," a prisoner's Eighth Amendment right to health care will not be violated.[18]

These somewhat flexible holdings have led to an underwhelming health system within prisons.[19] Medical care in prisons is typically scarce because of the difficulty in hiring medical personnel willing to work in such conditions and for lower pay.[20] Prisons usually have a clinic for inmates

---

[14] *See generally* Franco-Paredes et al., *supra* note 1212 (inferring that it is necessary to prevent and mitigate the impact of COVID-19 in custodial settings).
[15] *See* Estelle v. Gamble, 429 U.S. 97, 105 (1976) (where the court stated that not every claim raised regarding access to adequate medical treatment is a violation of the Eighth Amendment).
[16] *Id.*
[17] Brown v. Plata, 563 U.S. 493, 511 (2011).
[18] *Id;* Lugo v. Senkowski, 114 F. Supp. 2d 111, 115 (N.D.N.Y 2000) (stating that a standard of decency has gone beyond just providing care to inmates while in prison, and extends to outgoing prisoners who receive continued treatment when they are released).
[19] *What Type of Medical Care do Prisoners Receive?*, PRISON FELLOWSHIP https://www.prisonfellowship.org/resources/training-resources/in-prison/faq-medical-care/# (Last visited Nov. 7, 2020).
[20] *Id.*

who need care, but the inmate needs a permission slip to utilize it.[21] This system of getting ill prisoners medical attention is mediocre at best and often times leaves a prisoner to care for themselves when they need medical professional help.[22] If a prisoner is deemed "seriously ill," the prison will transport them to a contracted hospital and the prisoner will be overseen by security officers during this time.[23] However, many state prisons charge prisoners for medical care, so many prisoners avoid seeking attention because they cannot afford it.[24] This obstacle can pose serious health risks and can raise issues of whether prisons are meeting their constitutional requirements to prisoners when there is wide-spread illness, like COVID-19, within a prison.

## PROCEDURES IN PRISONS DURING COVID-19

With the emergence of COVID-19, the importance of social distancing, wearing masks, and increasing sanitation cannot be understated to control the spread of the virus.[25] However, prisons are epicenters for the spread of COVID-19 due to overcrowding, lack of testing, poor sanitation, and indifference to the health of prisoners, and as a result thousands of prisoners have been victimized.[26] COVID-19 demands that prisons change their internal functions in order to comply with governmental recommendations and mandates, but many prisons have not implemented changes in

[21] *See id.* (further stating that it takes upwards of a week to process the permission slip).
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *See generally Coronavirus Disease 2019*, CDC https://www.cdc.gov/coronavirus/2019-ncov/index.html (Last visited Oct. 17, 2020) (stating that social distancing, wearing masks, and increasing sanitation are key measures advised by the CDC).
[26] Franco-Paredes et al., *supra* note 12, at 1.

constitutionally-appropriate ways.[27] For the following three reasons, prisons cannot meet the governmental mandates regarding access to adequate health care.

*Lack of Social Distancing*

The social distancing methods called for by the Centers for Disease Control ("CDC") and other professionals is nearly impossible in the average prison due to overcrowding.[28] For instance, at Marion Correctional Institution in Ohio, the inmate capacity was supposed to be capped at 1,500 but they reported over 2,000 COVID-19 cases by late April.[29] The facility was able to house over-capacity limits because Ohio halted capacity reports to the U.S. Department of Justice in 2015, stating that the limits were not meaningful to the changing nature of the populations.[30] This set a precedent for many states to exceed capacity and/or misreport capacity numbers, diminishing a national capacity standard and leading to more prisons being able to get away with over-capacity.[31]

However, states have agreed that overcrowding contributes to the rapid spread of COVID-19 and that social distancing is necessary to prevent the spread of the virus.[32] After the report of over 2,000 prisoners infected,

---

[27] *See id.* at 3 (stating that although changes have been made since COVID-19 emerged, there has been a disproportionate impact of COVID-19 on marginalized populations, such as prisoners, revealing structural violence that needs to be remedied).
[28] *See generally* Alyssa G. Wurcel et al., *Spotlight on Jails: COVID-19 Mitigation Policies Needed Now*, 71 CLINICAL INFECTIOUS DISEASES 891, 891 (Aug. 2020) (stating that social distancing is not feasible in jails because people are confined to small living areas and are often over capacity).
[29] *See* Dara Lind, *The Prison Was Built to Hold 1,500 Inmates. It Had Over 2,000 Coronavirus Cases.*, PROPUBLICA (Jun. 18, 2020) https://www.propublica.org/article/the-prison-was-built-to-hold-1500-inmates-it-had-over-2000-coronavirus-cases (further explaining that 2,000 inmates was just 80% of the total population at the facility and at 153% of the capacity limit).
[30] *Id.*
[31] *Id.*
[32] *Id.*

authorities decided to isolate infected prisoners from the healthy ones by moving the healthy into the gym.[33] This was in late April, months after COVID-19 became a world-wide sensation; and while the facility did take measures to prevent continued spread, their lack of preventative measures before the virus infected many shows a deliberate indifference to the health of the inmates.[34] The lack of preventative measures is deliberately indifferent based on the reasoning from both *Estelle* and *Brown*.[35] The fact that prison authorities were aware of changes in the health system, knew that there were precautions that had been recommended to reduce the impact of the disease, but still failed to take even minimal steps to protect prisoners' health, contravenes the basic principles of human life and dignity.[36] This is contradictory of the *Estelle* ruling regarding deliberate indifference and is violative of the Eighth Amendment.[37]

*Limited PPE and Sanitation Methods*

In many prisons, soap and paper towels are not freely available for use and prisoners often have to pay for it through commissary.[38] Many prisoners cannot afford to make purchases and have to wait to earn enough through their assigned work duties (which often pays under one dollar per hour) to

[33] *Id.*
[34] *Id.*
[35] *See generally* Estelle v. Gamble, 429 U.S. 97, 106 (1976) (stating that acts or omissions that are sufficiently harmful constitute deliberate indifference); Brown v. Plata, 563 U.S. 493, 511 (2011) (stating that denying prisoners basic health care contravenes basic principles of human life).
[36] *See generally* Estelle v. Gamble, 429 U.S. 97, 106 (1976) (stating that acts or omissions that are sufficiently harmful constitute deliberate indifference); Brown v. Plata, 563 U.S. 493, 511 (2011) (stating that denying prisoners basic health care contravenes basic principles of human life).
[37] Estelle v. Gamble, 429 U.S. 97, 106 (1976).
[38] Lauren-Brooke Eisen & Jennifer Weiss-Wolf, *No Soap. Broken Sinks. We Will All Pay for Coronavirus Ravaging Prisons*, BRENNAN CTR. FOR JUST., Apr. 10, 2020.

make such a purchase.[39] Basic hygiene customs, such as washing your hands with soap and water after using the restroom, cannot be practiced in many prisons since these resources are not provided to all prisoners. In the time of COVID-19, these customs turn into necessary precautions to prevent the spread and this is made impossible due to the lack of basic resources, like soap, and properly functioning sinks and toilets.[40]

Not only does requiring the purchase of soap, a basic and abundant hygiene resource, offend basic human dignity, in a pandemic it violates a prisoner's right to health care under the Eighth Amendment.[41] Courts should recognize that not supplying a basic necessity, such as soap, is deliberate indifference, as defined in *Estelle*, to what could gravely affect the prisoners.[42] This deliberate indifference stems from inadequate planning, and prison officials should have understood when the pandemic became known that proper hygiene was a necessity to keep the prisoners healthy.[43]

Furthermore, most, if not all prisons, do not allow hand sanitizer and often treat it as contraband because of its alcohol content.[44] Although some prisons have allowed certain forms due to the pandemic,[45] it should be a priority to offer it in all prisons to prioritize the health of prisoners. While there may be

---

[39] *Id.*
[40] *See id.* (referencing that Mississippi prisons had dozens of broken sinks and toilets).
[41] *See generally* Estelle v. Gamble, 429 U.S. 97, 106 (1976) (stating that acts or omissions that are sufficiently harmful constitute deliberate indifference under the Eighth Amendment); Brown v. Plata, 563 U.S. 493, 511 (2011) (stating that denying prisoners basic health care contravenes basic principles of human life).
[42] *See id.* at 106 (the act of not supplying basic hygiene supplies is sufficiently harmful as to constitute deliberate indifference).
[43] *See generally* Eisen & Weiss-Wolf, *supra* note 38 (the fact that prisoners are forced to pay for personal hygiene products signifies that the prison system did not plan to supply basic hygiene necessities to prisoners at least at the front of the pandemic. This is deliberate indifference because a reasonable person knew at the beginning of the pandemic that COVID-19 was to be taken seriously, and prison officials did not).
[44] Byran Nelson, *A COVID-19 Crisis in US Jails and Prisons*, 128 CANCER CYTOPATHOL 513, 514 (2020).
[45] *Id.*

concerns of prisoners ingesting it, or otherwise using it for nefarious purposes because of its alcohol content[46], the protective value of allowing it seems to outweigh the speculative risks it may pose. There are also safeguards to ensure that prisoners do not misuse it, such as having hand sanitizer available only in supervised areas and not allowing it back to their living spaces.[47] If prisons had taken this measure earlier in the pandemic, it could have helped slow the spread, even if minimally.[48]

Lastly, prisons have been deemed a high-risk environment for transmission of COVID-19, epitomizing the need for prisoners to have access to adequate personal protective equipment (PPE) such as face masks.[49] However, along with many other resources, there has been an inadequate supply of PPE, including masks, in prisons.[50] The lack of PPE could have been prevented by better planning by prison authorities earlier in the pandemic, and due to lack of planning, the spread of COVID-19 in prisons has become close to uncontrollable.[51] This is deliberate indifference to the health of prisoners, and many prisoners have been subjected to serious illness

---

[46] TJ Macias, *Hand Sanitizer can be Used for Nefarious Purposes, Say Prison Officials who Ban it*, FORT WORTH STAR-TELEGRAM, May 5, 2020.
[47] *See id.* (stating that some prisons allowed hand sanitizer, but prisoners were not allowed to keep a bottle on their person).
[48] *See id.* (stating that many corrections departments are still not allowing hand sanitizer, and this may have contributed to a positivity rate of 70% in federal prisons).
[49] *See* Jiao Wang et. al., *Mask Use During COVID-19: A Risk Adjusted Strategy*, 266 ENVTL. POLLUTION 1, 4 (2020) (referencing to a table ranking the lowest risk to highest risk environments and when wearing a face mask is most critical).
[50] *See* Franco-Paredes et. al., *supra* note 12, at 3 (constant influx and overcrowding combined with inadequate PPE stockpiles led to limited supply for prisoners) (also inferring that this default can potentially spread the virus through contamination (for example, if a prisoner is given one mask to use for a month, the outside will be continuously contaminated through airborne particles)).
[51] *See generally* Carlos Franco-Paredes et. al., *Covid-19 in Jails and Prisons: A Neglected Infection in a Marginalized Population*, 14 PLOS NEGLECTED TROPICAL DISEASES 1, 2–4 (2020) (stating that prisons have faced outbreaks before and were notified of COVID-19's implications but due to long-term neglect, the prison system could not take necessary steps to control the virus adequately).

and even death because of it,[52] and this constitutes a violation of the Eighth Amendment requiring redress.[53]

### *Lack of Mass-Testing*

Initially, most prisons did not test prisoners for COVID-19 unless they were symptomatic.[54] Despite recommendations from many officials and medical professionals, many states continued to not conduct mass-testing in prisons.[55] Although some prisons have prioritized social distancing, this is nearly impossible with the layout of most facilities, emphasizing the importance of mass-testing to identify those who may be asymptomatic spreaders.[56] Ultimately, the lack of mass testing in prisons has inevitably contributed to the spread of COVID-19 within facilities.[57] Prisons should have prioritized mass-testing soon after learning that asymptomatic carriers could contribute to the spread, and not doing so, and continuing not to do so, was and is deliberate indifference to the health of the prisoners.[58]

## POTENTIAL REMEDIES TO THESE EIGHTH AMENDMENT VIOLATIONS

As demonstrated, the procedures within prisons to tackle COVID-19 did not meet, and still have not fully met, the standards of health care afforded to prisoners under *Estelle*.[59] While prisons have worked towards implementing

---

[52] *See generally* Estelle v. Gamble, 429 U.S. 97, 106 (1976) (stating that acts or omissions that are sufficiently harmful constitute deliberate indifference; therefore, the act of not supplying adequate PPE constitutes deliberate indifference).
[53] *Id.*
[54] *See* Nelson, *supra* note 44 at 514 (symptomatic prisoners were the only ones tested, and even sometimes they were not tested, only isolated).
[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] *See generally* Estelle, 429 U.S. at 106 (prisons should have prioritized mass-testing soon after learning that asymptomatic carriers could contribute to the spread because not doing so was, and is, deliberate indifference to prisoners' health).
[59] *Id.*; Nelson, *supra* note *44*44.

changes to reduce the spread of COVID-19[60], more can be done to ensure constitutional requirements are met.

The first suggestion, and most likely the easiest one to implement, is to make basic hygiene necessities, such as soap, hand sanitizer, and clean water, readily and freely available to all prisoners. Making soap available, along with having enough properly-functioning sinks, can help to reduce the risk of spreading COVID-19 through surface contamination.[61] The supply of soap, along with hand sanitizer at least temporarily, could be funded through county taxes.[62]

Furthermore, hand sanitizer should be available to prisoners. Although hand sanitizer is labeled a contraband product due to its alcohol content,[63] prisons need to balance the risks against the potential benefits from allowing the use of hand sanitizer at least temporarily. With the proper precautions, the risk of prisoners misusing hand sanitizer can be substantially lowered and offering hand sanitizer, even in limited areas of a prison, can have substantial positive effects on the health of prisoners.[64] This, combined with supplying soap, can help ameliorate the constitutional violation that has already occurred.

---

[60] *See generally* Lind, *supra* note 29 (stating that many prisoners were moved into gyms to try to achieve social distancing); *see generally* Wang et al., *supra* note 49 (stating that some prisons have permitted the use of hand sanitizer).
[61] *See generally* Coronavirus Disease 2019, CDC https://www.cdc.gov/coronavirus/2019-ncov/index.html (Last visited Oct. 17, 2020) (social distancing, wearing masks, and increasing sanitation are key measures advised by the CDC).
[62] *See* Conor Friedersdorf, *Can't We at Least Give Prisoners Soap?*, ATLANTIC (Apr. 1, 2020) https://www.theatlantic.com/ideas/archive/2020/04/make-soap-free-prisons/609202/ (stating that allocating taxpayer money to provide basic hygiene products in prisons could cost taxpayers less in the long-run as proper hygiene could reduce illnesses requiring medical attention).
[63] Nelson, *supra* note 44, at 514.
[64] Macias, *supra* note 46 (explaining that although it has been shown that hand sanitizer can reduce the risk of COVID-19 transmission, many prison systems have maintained their ban on it due to the risk of prisoners using it for nefarious purposes).

While face masks were in short supply at the beginning of the pandemic, there are now enough to distribute among prisoners.[65] It is recommended by the CDC that those within correctional facilities wear cloth masks,[66] and these types of masks are feasible for lay individuals to make.[67] Not only is it critical to ensure that all prisoners have access to masks, but also that there is education on how to properly wear, fit, and handle the masks to prevent contamination.[68] Studies have shown that the proper use of cloth face coverings is critical to slow the spread of COVID-19 by preventing people infected from transmitting it to others.[69] Through basic processes like these, the spread of COVID-19 can be lessened, even if marginally, further protecting prisoners' health under the Eighth Amendment.[70]

Testing is also crucial to determine who is a carrier of COVID-19. The CDC found that the prevalence rate of COVID-19 among tested prisoners was as high as 86.8%, exemplifying that testing can potentially help control

---

[65] *See* Rebecca Heilweil, *America Still Doesn't Have Enough N95 masks*, VOX (Jul. 10, 2020) https://www.vox.com/recode/2020/7/10/21319960/n95-masks-shortage-trump-supply-chain (stating that there is still a shortage of N95 masks. These types of masks, however, are not needed to prevent the spread of COVID-19).

[66] Guidance for Correctional & Detention Facilities, CDC https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (Last visited Nov. 12, 2020).

[67] *Making Masks*, CDC (Jul. 6, 2020) https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-to-make-cloth-face-covering.html.

[68] *See* Jiao Wang et. al., *supra* note 49 (referencing to a table ranking the lowest risk to highest risk environments and when wearing a face mask is most critical) (this infers that in higher risk environments, those within them need to know the importance of wearing masks correctly).

[69] *See CDC Calls on Americans to Wear Masks to Prevent COVID-19 Spread*, CDC https://www.cdc.gov/media/releases/2020/p0714-americans-to-wear-masks.html (Last visited Nov. 12, 2020) (citing to a study by the Journal of American Medical Association).

[70] *See generally* Estelle v. Gamble, 429 U.S. 97, 106 (1976) (inferring that prisoners must be afforded care that does not substantially harm them in order to adhere to the Eighth Amendment) (by providing something as attainable as cloth masks, the prison system is exhibiting deliberate care for the health of prisoners); *See* Brown v. Plata, 563 U.S. 493, 511 (2011) (stating that denying prisoners basic health care contravenes basic principles of human life).

transmission.[71] Furthermore, asymptomatic persons can spread the virus and are more likely to be conducting their business in a normal manner than symptomatic persons.[72] In overcrowded spaces like prisons, this can mean that an asymptomatic carrier who is interacting with others is unknowingly spreading the virus.[73] Mandatory, frequent testing of all prisoners can help identify infected individuals who need to be isolated to protect the prison population as a whole.[74]

Lastly, the issue of overcrowding needs to be addressed. Although this is the most complicated of the suggestions, it is arguably the most important to reduce the spread of COVID-19 and to protect prisoners' health. Since most prisons have not been built to support a socially-distanced lifestyle, I am suggesting that prisons utilize external facilities to house prisoners who are not deemed releasable or who need to be placed in medical isolation. For example, many schools and universities have been closed due to COVID-19 and remain unused until their reopening.[75] These spaces, many of which have living-quarters like dorms and large gymnasiums, could be utilized to house prisoners who do not require a maximum-security facility. This could decrease crowding in prisons, therefore reducing the spread of COVID-19.

While there is grey area regarding how this solution could be funded and how security could properly function, a source of funding could potentially

---

[71] *See* Liesl M. Hagan et al., *Mass Testing for SARS-CoV-2 in 16 Prisons and Jails – Six Jurisdictions, United States, April-May 2020*, CDC (Aug. 21, 2020) https://www.cdc.gov/mmwr/volumes/69/wr/mm6933a3.htm (a prevalence rate can help determine the procedures needed to isolate those infected to control the spread of the virus).
[72] Vanderbilt University Medical Center, *Can COVID-19 be Spread by Persons who are Asymptomatic?* VUMC (June 26, 2020) https://www.vumc.org/coronavirus/latest-news-you-asked-we-answered/can-covid-19-be-spread-persons-who-are-asymptomatic.
[73] *Id.*
[74] *Id.*
[75] *See* Emma Whitford, *August Wave of Campus Reopening Reversals*, INSIDE HIGHER ED (Aug. 12, 2020) https://www.insidehighered.com/news/2020/08/12/colleges-walk-back-fall-reopening-plans-and-opt-online-only-instruction (stating that many universities, such as Princeton, as conducting all or nearly all classes online in the Fall 2020 semester).

come directly from the schools themselves. Under 42 U.S.C. § 1983, counties are responsible to provide prisoners with medical care, or else they face penalties.[76] Therefore, since many county public schools are taxpayer funded and the facilities may not be in use for schooling purposes during the pandemic, these same funds could be used to maintain the facilities to house prisoners while students are not present. This can help meet the medical standards required under *Estelle* and 42 U.S.C. §1983.[77] Furthermore, some of the guards at the original prison could assume their position at the school facility during this time, decreasing the need to hire more guards and decreasing the chances that prison employees will be infected with COVID-19 (since they will be more distanced). This deliberate planning will help counteract the deliberate indifference towards prisoners' health at the beginning of the pandemic.

## CONCLUSION

The lack of planning during critical moments of the COVID-19 pandemic was deliberately indifferent to prisoners' health, violating their Eighth Amendment right to healthcare. This violation can be remedied though through deliberate planning, including but not limited to making basic hygiene resources available, mandating COVID-19 screenings, and utilizing external, free spaces to socially-distance prisoners. Through these steps, the prison system can ensure that prisoner's Eighth Amendment rights are protected.

---

[76] *Who Pays The Medical Bills For Inmates In the County Jail?*, CTAS http://www.ctas.tennessee.edu/content/who-pays-medical-bills-inmates-county-jail (Last visited Nov. 12, 2020).

[77] *See generally id.;* Estelle v. Gamble, 429 U.S. 97, 106 (1976) (stating that acts or omissions that are sufficiently harmful constitute deliberate indifference; however, the act of providing socially-distant facilities is not deliberately indifferent).