

# JUSTICE IN AGING

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FIGHTING SENIOR POVERTY THROUGH LAW

September 4, 2020

Committee on Equitable Allocation of Vaccine for the Novel Coronavirus  
National Academies of Sciences, Engineering, and Medicine  
500 5<sup>th</sup> St NW  
Washington, DC 20001

Committee Members:

Justice in Aging appreciates the opportunity to provide comments on the proposed Framework for Equitable Allocation of COVID-19 Vaccine (the Framework). We have included comments and recommendations for the proposed Framework.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable healthcare, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations that are most marginalized and excluded from justice such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Equitable allocation of a COVID-19 vaccine is crucial to the lives of older adults who have experienced devastating effects of COVID-19. Rates of infection, hospitalization, and deaths are much higher for older adults of color. We applaud the Framework for recognizing these disparities are not based on any biological factors, but rather on socioeconomic inequities. With those considerations in mind we submit the following comments.

- Principles of the Framework for Allocating Pandemic Influenza Vaccines

We support the Framework's foundational principles for equitable allocation of a COVID-19 vaccine including: maximization of benefits, equal regard, mitigation of health inequities, fairness, evidence-based, and transparency. (Framework p. 35). The Framework identified and rejects past discriminatory vaccine allocation frameworks which prioritized "maximizing quality-adjusted life years or minimizing years of life lost" or based on a "fair innings" theory. (Framework pp. 12, 40). Allocation principles based on life-years saved instead of maximizing lives saved always cuts against older adults and persons with disabilities by making generalized assumptions about an older or disabled person's health status instead of a prognosis based on an individualized assessment.<sup>1</sup> We support the Framework's rejection of "life-

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<sup>1</sup> American Geriatric Society (AGS) Position Statement (May 6, 2020) available at: <https://www.americangeriatrics.org/media-center/news/new-ags-position-statement-addresses-one-health-cares-most-difficult-issues>.

years saved” or “fair-innings” principles and instead, consider age only as a factor of heightened risk of infection, transmission, and complications or mortality due to COVID-19. (Framework p. 39).

Further, the Framework’s recognition of inequities with first-come, first-serve resource allocation principles is crucial to understanding the many challenges low-income older adults, especially older adults of color, face in accessing healthcare. (Framework pp. 14-15). Similarly, the Framework’s identification of disparities in COVID-19 complications and deaths among Black, Latinx, and American Indian and Alaska Native populations as a result of systemic racism versus biological factors is crucial to curbing health inequities in communities of color. (Framework p. 37). The Framework must also recognize rampant health disparities among Native Hawaiians and Pacific Islanders in determining allocation of a COVID-19 vaccine.<sup>2</sup> We support acknowledgment that vaccine distribution must respect tribal sovereignty. (Framework p. 38).

We agree with the assertion that state, local, tribal, and territorial (SLTT) authorities should be allowed some discretion in distributing vaccines based on local and community factors. (Framework p. 40). However, the major principles and prioritization groups identified in the Framework should still be extensively followed. We also support an individual’s right to appeal the allocation of vaccines if distribution is done in a manner which deviates from the Framework’s principles and priority groups. (Framework p. 41). We recommend the Framework automatically overturn an allocation based on the discrimination of protected statuses including race, national origin, age, disability status, sex or gender identity, sexual orientation, immigration status, or socioeconomic or insurance status.<sup>3</sup> However, given the complexity and novelty of COVID-19 vaccine allocations, many individuals will need additional information and assistance to appeal an improper vaccine decision. We suggest the Framework include robust information about appeal rights.

Transparency of vaccine allocation is crucial to earning the public’s trust that decisionmakers will remain true to the Framework’s principles. (Framework p. 42). Historical racism and ongoing health disparities has led to distrust of healthcare systems among communities of color, particularly among Black older adults.<sup>4</sup> As a result, we recommend the Framework clarify that communication of the vaccine allocation principles should be made clearly and accommodate individuals with Limited English Proficiency (LEP), disabilities, and/or other communication access limitations.

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<sup>2</sup> See “COVID-19 Exposes How Native Hawaiians and Pacific Islanders Face Stark Health Care Disparities” (August 15, 2020) available at: <https://newsroom.ucla.edu/stories/covid-19-stark-differences-NHP/>; See also “Pacific Islanders in US Hospitalized with COVID-19 at up to 10 times the rate of other groups” (July 26, 2020) available at: <https://www.theguardian.com/world/2020/jul/27/system-is-so-broken-covid-19-devastates-pacific-islander-communities-in-us>.

<sup>3</sup> See OCR Bulletin, Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19) (March 28, 2020) available at: <https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf> (affirming decisions on medical care or treatment cannot be based on “stereotypes, assessments of quality of life, or judgments about a person’s relative “worth” based on the presence or absence of disabilities or age.”).

<sup>4</sup> Darcell P. Scharff et. al. “[More than Tuskegee: Understanding Mistrust about Research Participation,](#)” *Journal of Health Care for the Poor and Underserved*, 2010 Aug, 21(3); 879-897.

- Vaccine Allocation Phases

Phase 1

We support the allocation of vaccines to frontline health workers at greatest risk of contracting COVID-19 in Phase 1a. In addition to being essential to preventing COVID-related complications and mortalities, frontline health workers are also at great risk of spreading COVID-19 to others, including older adults, due to their high risk of exposure. We strongly support the Framework's recognition that non-clinical health workers like transporters, environmental services staff, home health aides, nursing home workers, first responders, and other facility workers are given the same priority as clinicians like doctors and nurses. (Framework p. 60). People of color, and in particular women of color, often work in essential non-clinical roles and the prioritization of these workers is crucial to stemming systemic racism.<sup>5</sup> Allocating vaccines based on actual risk of exposure to COVID-19 versus professional titles mitigates these racial and socioeconomic inequities.

Older adults in congregate settings and persons with high risk comorbidities should continue to be prioritized in Phase 1. As the Framework acknowledges, older adults in congregate settings face the greatest risk of serious morbidity and mortality and, due to the confined nature of congregate settings, infection can spread rapidly. (Framework p. 55). We recommend the Framework clarify congregate settings to include more than just nursing homes or skilled nursing facilities, but also assisted living facilities, intermediate care facilities, group homes and other areas where individuals reside in close proximity for an extended period of time.<sup>6</sup> The Framework also considers crowded living environments like multigenerational households in addition to congregate settings. (Framework p. 65). We applaud these considerations and using senior poverty as a measuring tool for older adults who are more likely to reside in crowded, non-congregate residences. However, the Framework considers the group size for crowded residences as below the federal poverty level. (Framework p. 65). Data from Centers for Medicare and Medicaid Services shows massive COVID-19 disparities among Medicaid and Medicare dual eligibles.<sup>7</sup> To maintain the principle of health equity, we suggest the Framework expand this group to include older adults living below the poverty level and dual eligible older adults, including partial dual eligibles receiving Medicare Savings Programs (MSPs).

There is a discrepancy in the allocation phases where group home residents are allocated under Phase 2 (Framework p. 71) yet group home staff are allocated under Phase 1a as high risk frontline workers (Framework p. 59). We believe older adults and persons with high or moderate risk comorbidities in group homes should be included in Phase 1b. If group home staff are considered frontline health workers, then group home residents who are older or with comorbidities are also at high risk of morbidity and death and are susceptible to high rates of infection due to their setting.

The Framework also differentiates between individuals with high risk comorbidities for Phase 1 distribution (Framework p. 62), of which an individual must have two or more of the listed conditions,

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<sup>5</sup> See Kaiser Family Foundation, "COVID-19 and Workers at Risk: Examining the Long-Term Care Workforce," (April 23, 2020) available at: <https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-and-workers-at-risk-examining-the-long-term-care-workforce/>.

<sup>6</sup> See CDC Guidance for Group Homes for Individuals with Disabilities, available at: <https://www.cdc.gov/coronavirus/2019-ncov/community/group-homes.html>.

<sup>7</sup> CMS, Preliminary Medicare COVID-19 Data Snapshot, available at: <https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf>.

from individuals with moderate risk comorbidities in Phase 2 (Framework p. 69). The Framework does not account for any variation between congregate settings and comorbidities that could increase likelihood of morbidity and mortality. Older adults in congregate settings and individuals with designated high risk comorbidities are in Phase 1. However, the Framework does not consider if a younger adult with moderate risk comorbidities but lives in a congregate setting or group home should receive a higher allocation. Similarly, older adults in non-congregate settings with only one designated comorbidity may also need to be placed in Phase 1. The Framework does state group home residents and homeless persons may suffer from underlying health conditions putting them at high risk, and that their autonomy is reduced by living in group homes or shelters, but does not state whether those factors allow for higher allocation. (Framework p. 71). We request the Framework specifically acknowledge that the intersectionality of high risks statuses like advanced age, comorbidities, and congregate or crowded settings may require allocation that differentiates from the current Framework.

## Phase 2

We support the Framework's consideration of critical risk workers, including individuals who may live in multigenerational households and who face additional hardships like low wages and reduced access to healthcare due to immigration status. (Framework p. 67). The Framework should also recognize that distribution of the vaccines requires sufficient language access, cultural competency, and collaborations with community-based organizations.

As discussed above, we request the Framework consider the effects of intersectional risks in allocating vaccines. For example, all other older adults are placed in Phase 2 allocation, with the reasoning that "age is itself an underlying condition for COVID-19 given the high risk of severe disease and death due to COVID-19 among older adults." (Framework p. 70). The effects of age plus a moderate comorbid condition or moderate risk comorbid condition plus congregate setting should be considered for higher allocation. Additionally, the Framework should address limitations for homeless populations to maintain healthy practices like frequent hand washing and sanitizing and the effects that may have on infection control for the population at large.

### ▪ Additional Considerations

Once again, we appreciate the Framework's commitment to health equity and recognizing social determinants of health as indicators of access to a COVID-19 vaccine. (Framework p. 77). We also appreciate the Framework's recommendation that in order to prevent outbreaks, the vaccine must be free of charge to all individuals regardless of insurance or immigration status. (Framework pp. 77-79). We request the Framework advise state and local governments to implement creative strategies to address barriers to vaccinations, including locality, disability, and transportation.

The Framework does not discuss the absence of racial and ethnic minorities in vaccine clinical trials. While it is crucial for clinical trials participants to represent the demographics of the country, people of color have justified concerns about medical research due to the historic racism of the Tuskegee Study and ongoing racial bias in healthcare leading to worse health outcomes for people of color.<sup>8</sup> Similarly, the Framework does not discuss vaccine hesitancy and concerns people may have, including high risk populations and communities of color, to receiving a COVID-19 vaccine. These realities must be

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<sup>8</sup> See Scharff et. al.

addressed in any allocation scheme to honor individual rights, maximize vaccination rates, and reduce the spread of COVID-19.

Thank you for the opportunity to review the proposed Framework. If any questions arise concerning these comments, please contact Gelila Selassie, Staff Attorney, at [gselassie@justiceinaging.org](mailto:gselassie@justiceinaging.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Jennifer Goldberg". The signature is fluid and cursive, with a long horizontal stroke at the end.

Jennifer Goldberg  
Deputy Director