Community Service Society | Fighting Poverty Strengthening New York

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Before the New York State Joint Legislative Hearing on Exploring Solutions on the Disproportionate Impact of COVID-19 on Minority Communities

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The Community Service Society of New York (CSS) would like to thank the Chairs and members of the Senate and Assembly Committees, Caucus and Task Forces for holding this hearing. CSS is a 175-year-old non-profit dedicated to fighting poverty. Our health programs help New Yorkers enroll into health insurance coverage, find healthcare if they are ineligible or cannot afford coverage, and help them use their coverage or otherwise access the healthcare system. We do this through a live-answer helpline and through our partnerships with over 50 community-based organizations throughout New York State. Throughout the COVID-19 crisis, our helpline has maintained a live-answer rate of above 95 percent to ensure that New Yorkers are able to access the care they need during these difficult days. Annually, CSS and its partners serve approximately 130,000 New Yorkers in multiple languages.

The COVID-19 pandemic is having a drastically disparate impact on communities of color in comparison to white communities. The crude death rate per 100,000 population for white New Yorkers is 23, while this same rate is double or triple for African Americans, Latinx, and Asian New Yorkers (98, 55, and 53, respectively).[1] In New York City, African American and Latinx New Yorkers also make up a disproportionate number of non-fatal COVID-19 cases, both those that require hospitalization and those that do not.[2]

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[1] New York State Department of Health COVID-19 tracker, as of May 10, 2020, available at: https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-FatalityDetail?%3Aembed=yes&%3Atoolbar=no&%3Atabs=n.

[2] New York City Department of Health, "Age-adjusted rates of lab-confirmed COVID-19 non-hospitalized cases, estimated non-fatal hospitalized cases, and total persons know to have died (lab-confirmed and probable) per 100,000 by race/ethnicity group," https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity-05072020-1.pdf.

African American, Latinx, and Asian New Yorkers are also suffering more financial repercussions from the pandemic than white New Yorkers—including job loss, food insecurity, and involuntary terminations of health insurance.

- By April 19, 2020, 32 percent of households identified as Caucasian or white reported job loss.[3] For African American, Asian, and Latinx households the percentage of households reporting job loss were 35, 40, and 44 percent, respectively.
- While 44 percent of all New York City households reported being worried about running out of food, 65 percent of households identified as Latinx did so.[4]
- African Americans in New York City reported losing health insurance twice as often as white New Yorkers (14 percent of all households compared to 6 percent). Shockingly, Latinx New Yorkers reported losing health insurance nearly four times as often as white New Yorkers (23 percent compared to 6 percent).[5]
- Immigrant communities are also being disproportionately affected by the pandemic in terms of health, mortality, and financial hardship.[6]

As the Reverend Jesse Jackson Jr. said: *"The coronavirus does not discriminate, but people do. African Americans and Hispanics are more likely to die because we bear the pre-existing condition known as race.*"[7] This outcome is the result of decades of federal and state policies that systematically denied resources and opportunities to communities of color in favor of white communities.[8] In New York City, more than 75 percent of essential and front-line workers are people of color.[9] A recent study found that only 17 percent of Latinx workers and 20 percent of African American workers have jobs that permit working remotely, while 30 percent of white workers can do so.[10] And these jobs often have a higher risk of viral exposure while lacking paid sick leave and comprehensive health coverage.

There are multi-year structural policy reasons for these disparate health outcomes. Racist public policies and redlining left communities of color living in low-quality housing that quite

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[3] CUNY Graduate School of Public Health & Health Policy, COVID-19 Survey Week 6, available at: https://sph.cuny.edu/research/covid-19-tracking-survey/week-6/.
[4] CUNY Graduate School of Public Health & Health Policy, COVID-19 Survey Week 8, available at https://sph.cuny.edu/research/covid-19-tracking-survey/week-8/.
[5] CUNY Graduate School of Public Health & Health Policy, COVID-19 Survey Week 7, available at https://sph.cuny.edu/research/covid-19-tracking-survey/week-7/
[6] "Despite Their Impact From COVID-10, Undocumented New Yorkers Have Few Options For Financial Help," Gothamist, April 24, 2020, https://gothamist.com/news/despite-their-impact-covid-19-undocumented-new-yorkers-have-few-options-financial-help.
[7] Chicago Sun Times, "Coronavirus Illustrates Our Failure to Create a Fair Society," April 14, 2020, https://chicago.suntimes.com/columnists/2020/4/13/21219740/jesse-jackson-coronavirus-covid-19-african-americans.
[8] Keith C. Ferdinand and Samar A. Nassar, "African American COVID-19 Mortality: A Sentinel Event," Journal of the American College of Cardiology (2020), doi: https://doi.org/10.1016/j.jacc.2020.04.040.
[9] Yoav Gonen, Ann Choi, and Josefa Velasquez, "NYC Blacks and Hispanics Dying of COVID-19 at Twice the Rate of Whites, Asians," The City, April 8, 2020, https://thecity.nyc/2020/04/nyc-blacks-and-hispanics-dying-of-covid-19-at-twice-the-rate.html.
[10] Economic Policy Institute, "Not Everybody Can Work From Home: Blacks and Hispanic Workers Are Much Less Likely to Be Able to Telework," March 19, 2020, https://www.epi.org/blog/black-and-hispanic-workers-are-much-less-likely-to-be-able-to-work-from-home/.

literally made them ill.[11] Asthma, heart disease, obesity, and diabetes – all conditions linked to severe complications for sufferers from COVID-19 – are more prevalent in non-white communities.[12] Once the pandemic arrived, housing disparities also meant that people of color were more likely to live in crowded conditions – making social distancing much harder.[13]

The most immediate cause of the disproportionate impact COVID-19 has had on people of color may be an inability to access quality, affordable health care. According to the Kaiser Family Foundation, lack of access to insurance and high medical costs are major deterrents to seeking testing and treatment.[14] Both issues are more prevalent for people of color than for white people.[15] In many parts of New York there are huge differences in the number of residents with medical debt in collections depending on whether the community is majority people of color or majority white. For example, in Onondaga County, 14 percent of residents in white communities had been put into collections because of medical expenses – but in communities of color, 41 percent of residents had.[16] Table 1 shows the profound medical debt disparities in many New York counties.

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[11] RR Habib et al., "Housing quality and ill health in a disadvantaged urban community," Public Health, Feb. 2009: 174-81, doi: 10.1016/j.puhe.2008.11.2002. J. Valasquez et al., "COVID sends Public Housing-Zone Residents to Hospitals at Unusually High Rates," The City, May 15, 2020.

[12] Shika Garg et al., "Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 – COVID-NET, 14 States, March 1-30, 2020," Center for Disease Control and Prevention, Morbidity and Mortality Weekly Report, April 8, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm.

[13] Keeanga-Yamahtta Taylor, "The Black Plague," The New Yorker, April 16, 2020, https://www.newyorker.com/news/our-columnists/the-black-plague and Dan Vergano and Kadia Goba, "Why the Coronavirus is Killing Black Americans at Outsize Rates Across the US," Buzzfeed News, April 10, 2020, https://www.buzzfeednews.com/article/danvergano/coronavirus-black-americans-covid19. *See also,* Tenants on the Edge, Community Service Society, April 2018, https://smhttp-ssl-58547.nexcesscdn.net/nycss/images/uploads/pubs/Tenants_at_the_Edge_-_4_18_18_-_web_2.pdf

[14] Kaiser Family Foundation, "What Issues Will Uninsured People Face with Testing and Treatment for COVID-19," March 16, 2020, https://www.kff.org/uninsured/fact-sheet/what-issues-will-uninsured-people-face-with-testing-and-treatment-for-covid-19/.

[15] Samantha Artiga, Kendal Orgera, and Anthony Damico, "Changes in Health Coverage by Race and Ethnicity since the ACA, 2010-2018, Kaiser Family Foundation, March 5, 2020, https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/ and Jamila Taylor, "Racism, Inequality, and Health Care for African Americans," The Century Foundation, December 19, 2019, https://tcf.org/content/report/racism-inequality-health-care-african-americans/.

[16] Urban Institute, "Debt in America: An Interactive Map," retrieved May 13, 2020, available at https://apps.urban.org/features/debt-interactive-map/?type=overall&variable=pct_debt_collections.

Table 1. Share of Residents with Medical Debt in Collections

County	White Communities	Communities of Color	Difference
Onondaga	14%	41%	27%
Monroe	7%	26%	19%
Albany	10%	26%	16%
Erie	8%	22%	14%
Schenectady	14%	28%	14%
Franklin	11%	19%	8%
Westchester	6%	11%	8%
Kings	5%	7%	4%
Rockland	5%	8%	3%
Nassau	4%	5%	2%
New York	3%	4%	2%
Richmond	4%	5%	1%
Suffolk	5%	5%	1%
Bronx	6%	6%	0%
Queens	5%	5%	0%

Further, decisions about health care resources in New York favor wealthier neighborhoods. Since 2003, in the wake of hospital rate deregulation and the elimination of regional health planning agencies, 43 hospitals have closed around New York State, dropping the number of beds statewide from almost 74,000 in 2020 to just 53,000 in 2020.[17] Previously, New York's all payer rate regulation system ensured that safety-net hospitals had adequate support to survive.[18] These hospital closures mostly occurred in poor neighborhoods where there were fewer patients who could pay – not fewer patients.[19] And these are the same neighborhoods where most New Yorkers are falling ill and dying from COVID-19. Table 2 shows the results – Manhattan, which only has 12 COVID-19 cases per 1,000 residents, has 6.4 hospital beds per resident. In the Bronx, with a COVID-19 rate over twice as high, there are only 2.7 hospital beds for every 1,000 residents. Queens has the biggest population of the five boroughs and a high rate of COVID-19 cases – but has the least hospital beds at only 1.5 per 1,000 residents.

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[17] David Robinson, April 10, 2020, LoHud/USA Today, "Why NY hospital closures, cutbacks made COVID-19 pandemic worse," https://www.recordonline.com/news/20200410/why-ny-hospital-closures-cutbacks-made-covid-19-pandemic-worse. C. Campanile, "New York Has Thrown Away 20,000 Beds, Complicating Coronavirus Fight," New York Post, March 17, 2020, https://nypost.com/2020/03/17/new-york-has-thrown-away-20000-hospital-beds-complicating-coronavirus-fight/.

[18] Sharon Shallit, Steven Fass, and Mark Nowak, "Out of the Frying Pan: New York City Hospitals in the Era of Deregulation," Health Affairs, January 2002, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.21.1.127.

[19] Lena Afridi and Chris Walters, "Land Use Decisions Have Life and Death Consequences," Association for Neighborhood & Housing Development, April 10, 2020, https://anhd.org/blog/land-use-decisions-have-life-and-death-consequences.

Table 2. Hospital Beds Compared to COVID-19 Cases in New York City's Five Boroughs

Borough	Beds per 1,000 People	COVID-19 Cases per 1,000 People
Bronx	**2.7**	**27**
Brooklyn	**2.2**	**17**
Manhattan	**6.4**	**12**
Queens	**1.5**	**22**
Staten Island	**2.5**	**25**

All hospitals in New York are non-profits that pay no taxes and receive billions of dollars in federal and state support every year. However, state funding is not allocated based on rigorous health planning that takes into account population need. The allocation of New York's $1.1 billion Indigent Care Pool is yet another example of structural policy decisions that result in profound disparities in communities of color and the safety-net hospitals that serve them. This funding is provided to relatively well-heeled hospitals even when they fail to provide patients with financial assistance.[20] The safety-net hospitals that logically would receive most of this support because of their high volume of uninsured or Medicaid-covered patients are often at the bottom of the list for Indigent Care Pool funding, while hospitals with huge surpluses receive the most funding. To make matters worse, the non-profit hospitals that sued the most patients received millions of dollars from the Indigent Care Pool in excess of the costs of indigent care they provided.[21]

Policies like this established nearly insurmountable structural inequities. As a result, the hospitals that anchor care in low-income communities of color that are suffering the most from COVID-19 were already under-resourced, even before the pandemic started.

Urgent Actions

New York should take immediate actions to reduce the impact of COVID-19 on communities of color, including increasing the number of New Yorkers with health insurance and protecting New Yorkers from medical debt collection actions.

- Ensure Immigrants Have Health Coverage. Prior to the COVID-19 emergency, immigrants formed one of the largest group of uninsured in New York. Federal law and policies exclude and deter many residents of New York from health coverage because of

[20] Carrie Tracy, Elisabeth Benjamin, and Amanda Dunker, "Unintended Consequences: How New York State Patients and Safety-Net Hospitals Are Shortchanged," Community Service Society of New York, January 2018, https://nyshealthfoundation.org/wp-content/uploads/2018/01/new-york-state-patients-safety-net-hospitals-jan-2018.pdf.

[21] Amanda Dunker and Elisabeth Benjamin, "Discharged Into Debt: New York's Non-Profit Hospitals Are Suing Patients," March 2020, https://smhttp-ssl-58547.nexcesscdn.net/nycss/images/uploads/pubs/2020_Hospital_Report_V3_web.pdf.

their immigration status. New York could partially fill in this coverage gap by opening the Essential Plan to income-eligible New Yorkers who have had COVID-19 regardless of immigration status. This would ameliorate these racial and ethnic disparities in COVID-19 fatalities by providing coverage to low-income immigrant communities so that they can timely access diagnosis and treatment of COVID-19. This action would build on the state's leadership in extending Emergency Medicaid coverage to low-income immigrants for testing and treatment on COVID-19. It would improve on this action by providing full health coverage, not just coverage linked directly to COVID-19.

- Enact a Moratorium on Medical Debt Collections and Lawsuits: As discussed above, medical debt is an issue that disproportionately impacts communities of color. All patients have less ability to plan ahead for care, respond to medical bill issues such as mistakes, or respond to collection actions during the pandemic. However, hospitals continued to take collection actions, including filing lawsuits against patients, during the emergency – an E-Court search of 11 hospitals revealed 122 lawsuits filed against patients between the state of emergency declaration on March 7 and March 22 when the courts stopped accepting non-emergency filings. The state should prohibit hospitals from filing new medical debt lawsuits or taking other collection actions against patients for the duration of the state of emergency.

- Reduce Interest on Medical debt. The state should ensure that interest does not accrue on medical debt during the emergency. After the emergency, the state should limit the interest that hospitals may add to medical debt from the extraordinarily high commercial interest rate of 9 percent to the United States Treasury rate—a policy proposed by Governor Cuomo in his initial state budget proposal, but which was not enacted in the final budget.

- Increase Access to Hospital Financial Assistance. New York should standardize its hospital financial assistance process so that eligible low- and moderate-income patients can successfully apply no matter which hospital they go to.

- Require Hospitals to Use Relief Funds Before Billing and Suing Uninsured Patients. New York should require hospitals to prove that they filed claims with the Health Resource and Services Administration's relief fund before attempting to collect from uninsured patients.

- Protect New Yorkers Struggling to Pay Insurance Premiums. For health insurers, the COVID-19 emergency has meant a financial windfall as all elective and most non-urgent care has stopped. Insurers should thus preserve coverage for those who are having trouble paying premiums. Governor Cuomo and Superintendent Lacewell took critical administrative action to temporarily achieve this. The Legislature should extend that protection for people experiencing financial hardship as a result of the pandemic until it ends and require insurers to notify members that are struggling to pay premiums of alternative coverage options and consumer assistance programs.

- Create a Certificate of Need Process That is Responsive to Affected Communities. Decisions about hospital closures must be approved by the state. The body that makes these decisions is overly influenced by the hospitals that benefit the most from consolidation and the closure of community safety-net hospitals. These decisions should take into account the need to preserve access to care in all communities, and they should be made with the full engagement of communities that are losing infrastructure.

Long-Term Solutions

These actions will help in the short run, but New York must address the systemic problems that created this crisis that has had such a profound and disparate impact on communities of color. In the realm of health policy, that means ensuring that all New Yorkers have affordable health insurance and that resources are distributed to providers based on need, not community wealth or the provider's ability to lobby.

1. Universal health coverage

Most New Yorkers still get health insurance through employment. The result is that an emergency of this scale automatically means millions of people lose health insurance. New York must break the link between employment and health coverage. The New York Health Act would do this by creating one public health program that covers all residents of New York, regardless of income or other characteristics.

In the absence of the New York Health Act's universal coverage, New York could also take steps to expand public programs for those who cannot get coverage through work. One way to do this would be to permanently expand the Essential Plan to cover all immigrants, not just those who have had COVID-19. New York could also build on its successful Navigator and other consumer assistance programs to conduct outreach in communities with low rates of insurance coverage but high likelihoods of qualifying for assistance.

2. Global budgeting to stop the unfair distribution of resources to safety-net hospitals

New York cannot continue to allow "free market" forces to dictate where health care infrastructure exists. In the past, New York has taken a much stronger role in regulating hospital rates and in health care planning. Without that oversight, the result is that wealthy New Yorkers have access to a well-resourced health care system while everyone else must rely on an under-resourced, chaotic system for care. Maryland sets hospital rates for all payers, and caps the amount of revenue that hospitals may take in.[22] New York should take steps towards a similar global budgeting process to eradicate the disparities in resources that have led to so many unnecessary deaths and illnesses.

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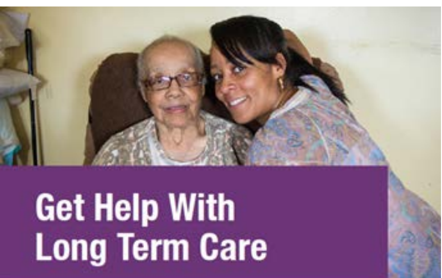
[22] Tara Golshan, "The answer to America's health care cost problem might be in Maryland," January 22, 2020, Vox, https://www.vox.com/policy-and-politics/2020/1/22/21055118/maryland-health-care-global-hospital-budget.

Thank you again for considering our comments. A list of resources for your constituents follows.

Should you have any questions or seek further elaboration, please do not hesitate to contact me at: ebenjamin@cssny.org or 212-614-5461.

Community Health Advocates (CHA)
Community Health Advocates is New York's statewide health insurance consumer assistance program under the Affordable Care Act. CHA helps New Yorkers navigate the complex health care system, use their health insurance, and access the health care they need. CHA helps New Yorkers through a toll-free live-answer Helpline and a statewide network of 27 community-based organizations.

CSS Navigator Network (CNN)
CNN offers health insurance enrollment assistance through community based and small business serving groups. We help New Yorkers and small businesses shop for and enroll in health coverage through NY State of Health Marketplace. CSS partners with 18 community-based organizations and small business-serving groups to serve 54 of New York's 62 counties.



Independent Consumer Advocacy Network (ICAN)
ICAN is the New York State Ombudsprogram for people with Medicaid who need long term care or behavioral health services. ICAN helps New Yorkers with enrolling in and using managed care plans that cover long term care or behavioral health services. ICAN provides education and one-on-one assistance through a statewide network of 17 community-based organizations and a toll-free live-answer Helpline.

CHAMP Helpline

New York State's Community Health Access to Addiction & Mental Healthcare Project

A program to help you get the most from your insurance benefits.

888-614-5400

Community Health Access to Addiction and Mental Healthcare Project (CHAMP)
CHAMP is the New York State Ombudsprogram to help individuals and their families resolve issues in accessing substance use disorder and mental health services. CHAMP is a joint project of the Office of Alcoholism and Substance Abuse Services (OASAS) and the NYS Office of Mental Health (OMH). CSS partners with three specialist agencies and five community-based organizations and operates CHAMP's toll-free live-answer Helpline.