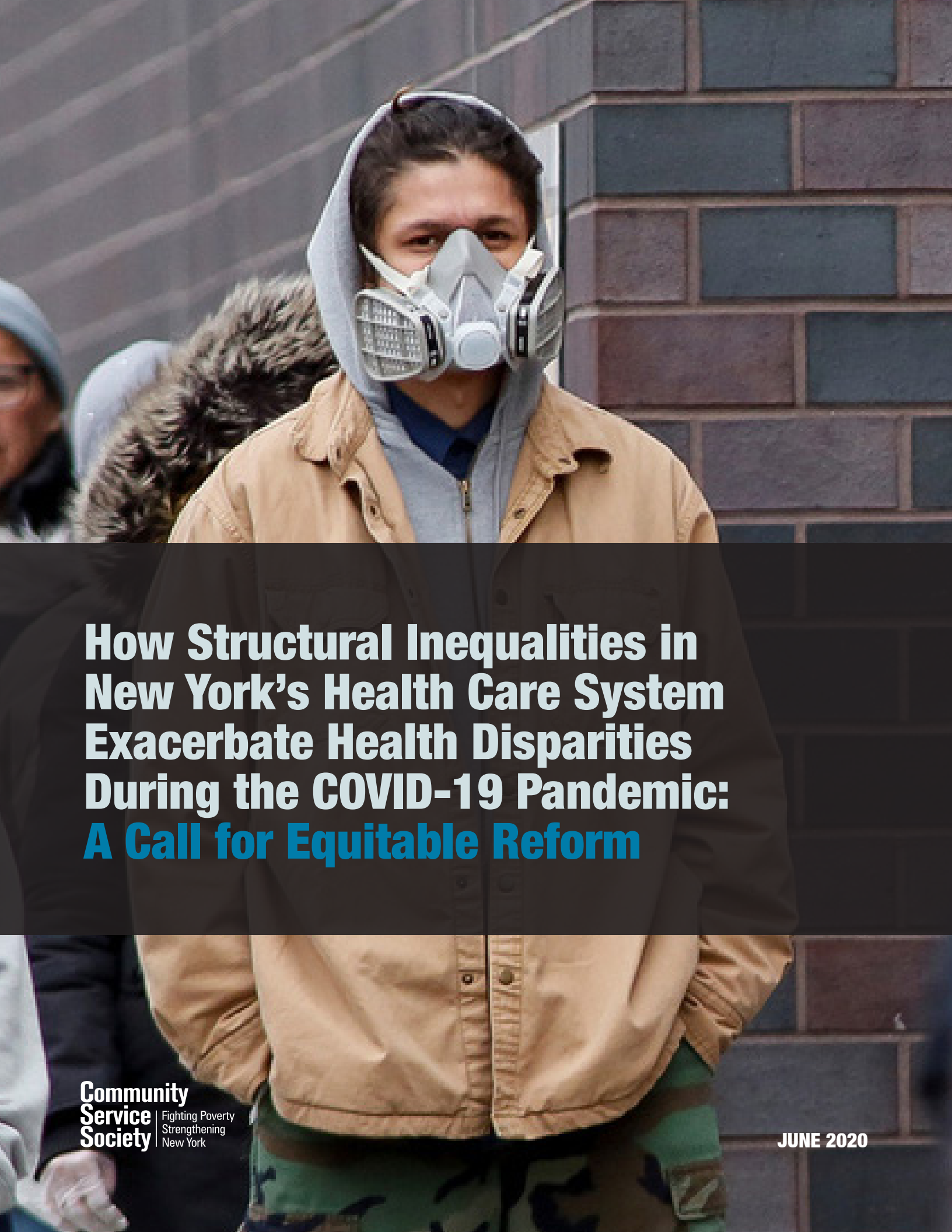

How Structural Inequalities in New York's Health Care System Exacerbate Health Disparities During the COVID-19 Pandemic: A Call for Equitable Reform

Community Service Society | Fighting Poverty Strengthening New York

JUNE 2020

About the Authors

Amanda Dunker, MPP, is a Health Policy Associate at CSS, where she focuses on consumer advocacy around payment and delivery system reform. Previously, she worked as a Senior Policy Analyst for the Health Division at the National Governors Association Center for Best Practices. She attended the University at Buffalo and the University of Chicago's Harris School of Public Policy.

Elisabeth R. Benjamin, MSPH, JD, is Vice President of Health Initiatives at CSS where she oversees the Society's health policy, advocacy, and health consumer assistance programs. Previously she worked at the New York Civil Liberties Union, The Legal Aid Society, and Bronx Legal Services. She attended Columbia Law School, Harvard School of Public Health, and Brown University.

Acknowledgements

We are grateful to the volunteers and interns who travelled to New York's courts to pull paper files including: Jacqueline Cummings, Zoe Diflo, Diane Gorczyca, Francis Lee, Peter Lee, Zarrin Mahmud, and Susan Palefsky.

We also thank our our colleagues here at CSS, including: David R. Jones, Steven Krause, Jeff Maclin, Alia Winters, Carrie Tracy, Jonathan Gettinger, Opal Lynch, Emily Dore, and Mahlet Moges.

Community Service Society | Fighting Poverty Strengthening New York

The Community Service Society of New York (CSS) is an informed, independent, and unwavering voice for positive action representing low-income New Yorkers. CSS addresses the root causes of economic disparity through research, advocacy, litigation, and innovative program models that strengthen and benefit all New Yorkers. **www.cssny.org**

Researchers and the media have extensively documented that people of color are more likely than white people to be exposed to COVID-19, require hospitalization, and die. But few reports have illuminated the historical and structural health policy decisions that form the underpinnings of the immense disparities witnessed in New York, the epicenter of the U.S. pandemic. This issue brief describes the cumulative impact of these decisions—particularly health policy and financing decisions in New York in the last 30 years—and proposes recommendations for addressing them moving forward.

TABLE 1. AGE-ADJUSTED RATE OF COVID-19 CASES PER 100,000 IN NEW YORK CITY (CASES WHERE RACE OR ETHNICITY WAS KNOWN)

Race/Ethnicity	Non-hospital cases	Non-fatal hospitalizations
Black/African American	806	395
Hispanic/Latinx	668	342
White	619	163
Asian/Pacific Islander	303	137

Source: New York City Department of Health, May 7, 2020.

DISPARATE COVID-19 MORTALITY AND MORBIDITY IN COMMUNITIES OF COLOR

The COVID-19 pandemic has had a substantially disparate impact on low-income communities of color in New York. The New York State Department of Health has reported that outside of New York City, the age-adjusted death rate per 100,000 population for white New Yorkers is 27, while this same rate is double or even quadruple for African Americans, Latinx, and Asian New Yorkers (109, 99, and 58, respectively). In New York City, the age-adjusted fatality rate per 100,000 population was 122 for white people and 109 for Asian people, while it was 238 for Latinxs and 244 for African Americans. Rates of non-fatal cases in New York City were also far higher for African Americans and Latinxs than for whites (see Table 1). A survey describing similar disparities affecting immigrant communities in New York City, Long Island, and Westchester found that 58 percent of respondents had been sick or had a sick family member and 16 percent had lost a family member to COVID-19.

The medical literature has documented the pervasive nature of racial and ethnic health disparities long before the pandemic and reiterates that there is no genetic or biologic basis for them. Rather, it is well settled that these disparities are social constructions related to social determinants of health as experienced in communities of color, such as: the nature and quality of employment opportunities; the quality of housing stock; the proximity to toxic environments; the widespread prevalence of food insecurity; and limited educational opportunities.

For example, many people of color work and live in environments that are injurious for their health and impose higher risks of exposure to COVID-19. Many of these jobs have been classified as "essential" during the pandemic and the workers who fill them have been asked to risk their own health for relatively low pay. In New York City, more than 75 percent of essential and front-line

workers are people of color. 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.

Similarly, housing policies founded on racially biased zoning and redlining policies have left communities of color living in low-quality housing that engenders poor health. Hypertension, obesity, chronic lung disease, diabetes, and cardiovascular disease—conditions that often lead to severe complications for COVID-19 cases—are more prevalent in non-white communities. In the Bronx, which now has the highest rate of COVID-19 in the state, 68 percent of apartments have maintenance defects.

Housing disparities also mean that people of color are more likely to live in crowded conditions—when one member of the household is exposed, the effect is multiplied because of the difficulty of social distancing under crowded conditions.1 The neighborhoods around Elmhurst Hospital—which The New York Times described as "apocalyptic" during the peak of the epidemic—have the highest rates of severe crowding (defined as a household in which there are more than 1.5 people per room) in the city: 10.5 percent in Jackson Heights and 10.9 percent in Elmhurst/Corona. People of color are also more likely to live in congregate settings like prisons or homeless shelters. Over policing of racial and ethnic minorities has continued even during the pandemic: over 80 percent of the citations and court summons issued by the New York Police Department for social distancing violations were issued to people of color—and over 90 percent of arrests were of people of color.

INSURANCE AND ACCESS TO CARE

The most immediate cause of the disproportionate impact COVID-19 has had on people of color may be an unequal ability to access quality, affordable health care. Lack of access to insurance and high medical costs are major barriers to seeking testing and treatment. Both issues are more prevalent for people of color than for white people. In New York, the largest group of uninsured people is immigrants, in part because they are excluded from many public coverage programs by federal law due to waiting periods or their immigration category. The public charge rule which took effect days before the first COVID-19 cases were confirmed in New York deters immigrants from enrolling in programs or using health care even when they are eligible. New York took action to help immigrants get health coverage by using state-funded Emergency Medicaid to cover cases of COVID-19 regardless of immigration status. But immigrants are not getting the help they need: a survey of immigrant communities found that 72 percent of respondents had lost their job but only 15 percent reported receiving assistance of any kind from the government.

Further, enormous numbers of New Yorkers have lost health coverage because of the pandemic. 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). Latinx New Yorkers reported losing health insurance nearly four times as often as white New Yorkers (23 percent compared to 6 percent).

Not having health insurance or having inadequate health insurance perpetuates disparities. For example, in many parts of New York there are substantial disparities in who has incurred medical

debt, as described in Table 2. In Onondaga County (Syracuse), 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. Similarly large disparities are observed throughout the state—for example, in Monroe (Rochester) and Albany counties, the difference in the rate of medical debt for white communities and communities of color is 19 percent and 16 percent, respectively.

During the COVID-19 pandemic, hospitals have continued to take collection actions, including filing lawsuits against patients. A search of the public E-Court database of 11 hospitals who have a history of suing their patients revealed 122 lawsuits filed against patients between the state of emergency declaration on March 7 and March 22, 2020, when the courts stopped accepting non-emergency filings. As the courts begin accepting new civil cases again, there is likely to be a tsunami of medical debt cases—and it is unlikely that the dynamics leading to disproportionate collection actions against people of color will have changed. The medical collection infrastructure has continued unabated, despite the fact that 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.

TABLE 2. 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%

THIRTY YEARS OF STATE HEALTH POLICY DECISIONS RESULTED IN ALLOCATION OF HEALTH CARE RESOURCES TO WEALTHY ACADEMIC MEDICAL CENTERS OVER SAFETY-NET HOSPITALS

Communities with majority African-American and Latinx residents experience provider shortages more than other communities all over the country. In New York, policymakers have made a number of decisions over the past 30 years that directed resources away from safety-net and community hospitals and the neighborhoods that they served. These decisions include the deregulation of hospital rates, the elimination of regional health planning agencies, and the siphoning of Indigent Care Pool funds to wealthier hospitals in lieu of true safety-net providers. The safety-net hospitals in New York serve populations that are more diverse than the state average (32 percent of patients they discharged were white in 2016 compared to 51 percent of patients overall). Thus, decisions that take resources away from these safety-net providers disproportionately hurt people of color.

First, New York dismantled its process of fairly setting hospital reimbursement rates. Between 1983 and 1997, New York used an all payer rate regulation system called the New York Prospective Hospital Reimbursement Methodology (NYPHRM). This rate setting law ensured that safety-net hospitals had adequate support to survive—reducing the number of hospitals running a deficit from 152 to 99. It also helped control growth in costs compared to national hospital costs. In 1997, New York State abandoned NYPHRM for a deregulated system that phased out commercial rate setting and the uncompensated care pool for financially distressed hospitals. Accordingly, the more powerful academic medical centers have been in a better position to command high reimbursement rates from commercial insurers and consolidate their market power than their safety-net counterparts that are located in communities of color.

A second policy decision, made during the same period, resulted in the elimination of New York's strong tradition of statewide health planning through regional Health Systems Agencies. To the extent statewide health planning still exists, it is conducted by the Public Health and Health Planning Council, which has come under fire for being unresponsive to community needs due to its domination by private interests.

The annual allocation of New York's $1.13 billion Indigent Care Pool (ICP) is a third example of structural policy decisions that result in profound disparities in communities of color and the safety-net hospitals that serve them. The ICP program is funded by federal disproportionate share hospital funding that is designed to stabilize safety-net hospitals that serve low-income communities. Although racial and ethnic health disparities persist regardless of income, research indicates that institutionalized racism leads to a situation in which people of color disproportionately live in communities that are also low-income. Unlike every other state in the nation, New York does not target these funds to safety-net hospitals, which are defined to be the top quartile of hospitals in a state that serve Medicaid and uninsured patients. Instead, New York only apportioned $520 million (or 46%) of the $1.13 billion ICP funds to the top 25 percent of safety-net hospitals and $672 million to the bottom 75 percent of hospitals that do not serve nearly as many low-income people.

Taken over the past 20 years, New York's choice to direct over half of its ICP allocation to hospitals that do not serve a substantial number of Medicaid and uninsured patients has meant its safety-net hospitals received roughly $13.4 billion less in funding than they would have if they had been located in any other state in the country. Compounding this inequity, the ICP funding is provided to relatively well-heeled hospitals even when they fail to provide patients with financial assistance. In a final injustice, the nonprofit hospitals that sued the most patients received millions more in ICP funds in excess of the amount of financial assistance that they provided to patients.

The inexorable result of structural disparities in New York's health financing and planning policies like these is the closure of 43 hospitals statewide, resulting in the loss of 21,000 beds (from almost 74,000 in 2003 to just 53,000 in 2020). These hospital closures mostly occurred in poorer neighborhoods and in neighborhoods where people of color live where there were fewer patients with health insurance or the means to pay for care—but not fewer patients. For example, the borough of Queens witnessed the closure of four safety-net hospitals (St. John's in Flushing, 2009; Parkway in Forest Hills, 2008; St. Joseph's in Fresh Meadows, 2004; Mary Immaculate in Jamaica, 2009), leaving Health + Hospitals/Elmhurst as the sole safety-net hospital serving one of the country's COVID-19 epicenters.

The neighborhoods with the missing and closed hospitals are the same neighborhoods where most New Yorkers are falling ill and dying from COVID-19. The Association for Neighborhood and Housing Development has mapped hospital closures over New York City's communities of color and the communities hardest hit by COVID-19 to display this overlap. Table 3 shows the data. Manhattan, which only has 12 COVID-19 cases per 1,000 residents, has 6.4 hospital beds per 1,000 residents. 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, with a rate of 22 COVID-19 cases per 1,000 residents—has the least hospital beds at only 1.5 per 1,000 residents.

TABLE 3. 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

THE FEDERAL COVID-19 HOSPITAL FUNDING ALLOCATION EXACERBATES THE EXISTING STRUCTURAL DISPARITIES AGAINST SAFETY-NET HOSPITALS

Federal COVID-19 funding has exacerbated the structural disparities created by New York's health care financing and planning decisions. The initial tranche of $72 billion (40 percent) of the $175 billion in federal COVID-19 for hospitals (created through the CARES act) was allocated through a formula based on a hospital's past history of Medicare payments. This policy decision ensures that wealthy hospitals secure substantially more funding than safety-net hospitals, who typically have a lower Medicare volume than Medicaid and self-pay. The results are shockingly unfair within New York City. For example, New York's richest hospital, New York-Presbyterian, received $119 million for just one facility, while the city's public hospital system, Health + Hospitals, received just $46 million for all 11 of its hospitals combined.

Nearly all of the other top nine hospitals in New York receiving the largest CARES Act payments are individual hospitals (see Table 4). And none of the other top ten hospitals serve as many patients as the Health + Hospitals system, including New York-Presbyterian, which received more than twice as much relief funding. As a result, the decision to pay out CARES Act payments based on how much the provider was paid by Medicare last year shortchanged key safety-net hospitals like Health + Hospitals Queens hospital (Elmhurst) which serve far fewer Medicare patients than wealthier hospitals. The government's common practice of using Medicare payments as a short-cut for provider funding decisions leads to enormous structural inequalities between communities.

TABLE 4. TEN HIGHEST CARES ACT PAYMENTS TO NEW YORK PROVIDERS (MAY 22, 2020)

Provider	Payment
New York-Presbyterian	$119,022,548
NYU Langone	$92,120,455
Memorial Sloan Kettering	$64,048,724
Montefiore Medical Center	$55,960,536
Mount Sinai Hospital	$53,666,868
New York City Health + Hospitals Corp.	$45,537,948
University of Rochester	$43,813,351
NYU Winthrop Hospital	$33,812,553
North Shore University Hospital	$32,183,293
University Hospital at Stony Brook	$29,281,202

Source: Centers for Disease Control and Prevention.

The decision to base CARES Act funding on a Medicare formula also means that within New York State, the hardest hit regions are receiving the least amount of relief funding (see Tables 5 and 6). The gap is enormous. Providers in Schuyler County, where there have been 11 COVID-19 cases (and no deaths), received $4.6 million from the CARES Act fund—or $426,000 per case. In Queens County, where there have been over 60,000 COVID-19 cases (including 4,800 deaths), providers received $93 million—just $1,500 per case.

TABLE 5. CARES ACT PROVIDER RELIEF PAYMENTS PER COVID-19 CASE, TOP TEN NEW YORK COUNTIES

County	Total Payment	Positive COVID-19 Tests as of May 22	Payment per COVID-19 Case
Schuyler	$4,684,881	11	$425,898
Lewis	$5,724,984	19	$301,315
Chautauqua	$15,741,381	63	$249,863
Jefferson	$16,677,022	72	$231,625
Franklin	$3,946,912	19	$207,732
Otsego	$12,181,289	67	$181,810
Yates	$6,174,861	34	$181,614
Cattaraugus	$11,798,204	74	$159,435
St. Lawrence	$28,958,076	195	$148,503
Clinton	$11,801,061	94	$125,543
Statewide	**$2,232,459,094**	**358,154**	**$6,233**

TABLE 6. CARES ACT PROVIDER RELIEF PAYMENTS PER COVID-19 CASE, BOTTOM TEN NEW YORK COUNTIES

County	Total Payment	Positive COVID-19 Tests as of May 22	Payment per COVID-19 Case
Orange	$43,474,565	10,142	$4,287
Suffolk	$165,587,746	38,672	$4,282
Brooklyn	$227,577,613	53,639	$4,243
Westchester	$126,326,614	32,767	$3,855
Hamilton	$14,968	5	$2,994
Richmond	$34,999,254	13,171	$2,657
The Bronx	$111,350,841	43,766	$2,544
Orleans	$434,839	175	$2,485
Rockland	$23,565,727	12,905	$1,826
Queens	$93,182,167	60,236	$1,547
Statewide	**$2,232,459,094**	**358,154**	**$6,233**

Source: Centers for Disease Control and Prevention.

This allocation amplifies the racial disparities in health care financing in New York State. According to the U.S. Census Bureau, Schuyler County is 96 percent white,1.5 percent African American, and 1.2 percent Hispanic or Latinx (of all races). By contrast, the borough of Queens is 27 percent white, 21 percent African American, 25 percent Asian, and 27.9 percent Latinx (of all races). Thus, the federal funding for COVID-19 radically shortchanged New York's communities of color and the safety-net institutions that serve them throughout the pandemic.

Federal and state health care financing policies establish and reinforce nearly insurmountable structural inequities for low-income communities and communities of color. 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, and will be worse off in the future absent government intervention.

RECOMMENDATIONS

New York must do more to protect people of color from COVID-19 and its financial repercussions. In the short term, New York can decrease gaps in health insurance coverage and affordability and protect New Yorkers from medical debt collection actions. In the long term, New York must achieve universal health coverage and must distribute health care resources according to population need.

Urgent Actions

New York should take immediate actions to reduce the impact of COVID-19 on communities of color by ensuring that New Yorkers impacted by COVID-19 have 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 groups of uninsured in New York. Federal law and policies exclude and deter many state residents from health coverage because of 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 have 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. 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.
- **Target Indigent Care Pool funds to safety-net hospitals:** In every other state, federal disproportionate share hospital funding is directed to true safety net hospitals that serve the highest proportions of Medicaid

or uninsured patients. New York must start using these scarce resources to support the top 25 percent of true safety-net hospitals instead of diluting the funds by distributing them to every hospital.

- **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.

Long-Term Solutions

New York must also address the systemic problems that created this crisis for 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.

- 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.

- 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. 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.

- Restore a Health Planning and 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. For example, the state should issue a moratorium on further hospital consolidation, downsizing, or closures.

Community Service Society | Fighting Poverty Strengthening New York

633 Third Ave, 10th FL
New York, NY 10017
PH 212.254.8900
www.cssny.org