



**The Fierce Urgency of Now:
Federal and State Policy Recommendations to Address
Health Inequities in the Era of COVID-19**



HEALTH EQUITY ACTION
CENTER ON FOR SYSTEM TRANSFORMATION

AT **FAMILIESUSA**



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The Center on Health Equity Action for System Transformation is the only national entity exclusively dedicated to the development and advancement of patient-centered health system transformation policies designed to reduce racial, ethnic, and geographic inequities.

We focus on advancing equity while improving outcomes, increasing value, and lowering costs. We catalyze and coordinate action to develop and implement health care delivery and payment policies focused on health equity. We make an impact by partnering with and supporting community leaders, health equity experts, and other stakeholders at national, state, and local levels.

The Center on Health Equity Action for System Transformation works to achieve an equitable, high-value, high-quality, and affordable health care system by:

Building a movement for equity-focused health care system transformation by galvanizing and coordinating action among diverse organizations and community leaders to ensure that a transformed health care system centers on the needs of those most affected by inequities.

Channeling and translating the power of the best ideas and the most innovative thinking from top thought leaders and policy experts into concrete, actionable strategies and recommendations that community leaders, stakeholders, and decision-makers can use.

Working with leaders who represent communities of color and other underserved groups to enhance their capacity to engage effectively in system transformation. We provide critical strategic guidance, training, and technical support, while highlighting the urgency of tackling inequities through health system reform.

In addition to being the leading national resource for community leaders, decision-makers, and other stakeholders on equity-focused health care system transformation, the Center on Health Equity Action houses the Health Equity Task Force for Delivery and Payment Transformation and the Community Health Worker Sustainability Collaborative.

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The views expressed here do not necessarily reflect the views of the Foundation.*

Introduction

Disparities in COVID-19 health outcomes stem from health inequities rooted in systemic and unjust social and economic policies.



Introduction

The COVID-19 pandemic has shone a harsh light on existing disparities in health and health care in the United States. Preliminary data we've analyzed for counties across the country reveal dramatically higher rates of COVID-19 infection and fatalities in Black and Latino communities.¹ Indeed, one of the primary reasons we have the highest rate of COVID-19 infections and deaths in the world is because of our extraordinary rate of infections and deaths in Black and Latino communities. Delays in testing and the slow federal response to the pandemic further exacerbated these disparities.

As a nation, we are at a critical moment of reflection and decision about the state of our health care system, public health infrastructure, and the social and structural drivers of health. We can do better. This brief lays out a plan for how.

Disparities in COVID-19 health outcomes stem from health inequities rooted in systemic and unjust social and economic policies.² These policies are political choices, in that underlying every social determinant is a political action that either perpetuates inequity or accelerates equity.³ There is a “fierce urgency of now” for evidence-based policy solutions that either address the underlying systemic injustices or mitigate their impacts on poor health.⁴

This report begins by describing the link between social injustice and COVID-19 outcomes at the local level, including original analysis of economic and disease data for 11 counties with high Black and Latino populations that are among the hardest-hit counties in the United States. We still do not know the full national extent of COVID-19 health disparities, which will be vital in order to tailor policy solutions to the specific needs of diverse vulnerable communities. However, our preliminary data paints a clear enough picture to inform policy recommendations.

These data are an important counterpoint to an emerging, only partly accurate national narrative regarding what is driving inequities and disparities in COVID-19 outcomes. Public conversations surrounding COVID-19 health outcomes in Black and Latino communities have centered on the link between pre-existing conditions and health inequity, rather than how differential rates of chronic conditions came about, how exposures such as community trauma, neighborhood disinvestment, and environmental toxins can cause or further exacerbate those conditions, and how these in turn are driven by inequities in political power and economic opportunities.

The Prevention Institute's Trajectory of Health Equity Model (Figure 1) further illustrates these relationships and provides a compelling summary of how we need to widen our policy lens to capture the full scope of what's needed to drive health equity.

Figure 1. Prevention Institute’s Trajectory of Health Equity



The second section of this paper provides an action guide for health equity advocates, identifying short-term policy options that respond to the current pandemic and longer-term policy recommendations that federal and state policymakers should adopt once the national emergency declaration has been lifted. Following the pathways identified in the Trajectory of Health Equity model above (Figure 1), the policy recommendations target broad drivers of our disturbing COVID-19 outcomes. These recommendations move from “upstream” social drivers of health inequities to the operation of our health care system in the pandemic. Our five recommendations are:

- Priority 1:** Address the social determinants of health.
- Priority 2:** Build strong financial incentives for improved health equity in our health care system.
- Priority 3:** Organize and build national public health capacity both to fight COVID-19 and to reduce the burden of chronic illness in vulnerable communities.
- Priority 4:** Ensure equitable access to affordable health insurance.
- Priority 5:** Expand access to COVID-19 treatment for vulnerable populations.








Part I: COVID-19 Health Inequities: What Do County-to-County Differences Tell Us?

In much of the United States, racial and ethnic disparities in COVID-19 have been extreme. But there are important exceptions that demonstrate the central importance of socioeconomic factors and improved population health in building health equity at the community level.

Most states and the District of Columbia are reporting COVID-19 cases by race (42 states) and ethnicity (36 states), and some of those states are using that data to inform their COVID-19 responses.⁵ While federal reporting of disaggregated COVID-19 data has been limited despite calls from across the country, the CDC released partial data about a month after the national emergency declaration. All of these reports reveal stark demographic

disparities in COVID-19 outcomes. According to the CDC, Black Americans account for about 30% of COVID-19 patients but make up only about 13% of the U.S. population.⁶

To better demonstrate the power of structural drivers of health inequities, we have produced a county-level analysis across 11 counties that are at the center of national COVID-19 disparities:

COVID-19 Disparities by County-Level Analysis of 11 Central Counties	
	Cook County, Illinois (including the city of Chicago)
	Los Angeles, California
	All five New York City boroughs (New York, Bronx, Kings, Richmond, and Queens)
	Milwaukee County, Wisconsin
	Orleans Parish, Louisiana (Including the city of New Orleans)
	Prince George's County, Maryland
	Wayne County, Michigan (including the city of Detroit)

To establish a baseline picture of the structural drivers and community determinants of inequality in each county, we use three measures: the Robert Wood Johnson Foundation County Health Rankings, the GINI Index of economic inequality, and the Area Deprivation Index (ADI).^{*} Our analysis suggests a strong connection between inequality, population health and COVID-19 disparities.

Across almost all counties for which the racial breakdown of COVID-19 data was released, Black Americans are diagnosed with and dying from COVID-19 at much higher rates than White Americans (see Appendix A on page 22). For example, in Milwaukee County Wisconsin, as of May 5, there were approximately 532 cases of COVID per 100,000 Black residents, compared to 169 cases per 100,000 White residents. Even though Milwaukee has almost twice as many White residents as Black residents, there were more than three Black Milwaukeeans diagnosed for every White Milwaukeean diagnosed. The death rates for Blacks and Whites are also starkly different: the death rate is 2.6 times higher for Black residents than for White residents.

We see similar disparities in Chicago, where Black residents are diagnosed at more than two times the rate of White residents and the death rate is 3.3 times as great. In Detroit, the case and death rates for Black residents are more than two times higher those of White residents. And although New York City does not break down county-level COVID case rates by race, a ZIP code analysis and citywide figures make clear that our nation's largest COVID outbreak was heavily concentrated in parts of the city with high Black and Latino populations, as were COVID-19 death rates.⁷

^{*}The Robert Wood Johnson Foundation County Rankings includes two composite scores, one representing how healthy counties are within the state (health outcomes), and the other measuring a variety of health factors (behaviors, clinical care, and the social, economic, and physical environment) that influence health outcomes. For example, [see their rankings for Texas](#).

The [GINI Index](#) is a measure of income inequality and ranges from 0 to 1, with greater inequality indicated by a higher score.

The [ADI](#), a measure created by the Health Resources and Services Administration (HRSA), accounts for rankings of socioeconomic status by region and is used by health systems and providers to target program delivery; Quintile 1 (privileged) to Quintile 5 (deprived).

COVID-19 Exacerbates Existing Health Disparities at the County Level

In all of these places, COVID-19 cases and deaths are correlated with poor population health outcomes, low measures on drivers of health, and economic inequality and deprivation. For example:

- » Bronx County has the highest COVID-19 case rate of any borough of New York City and has the poorest health outcomes and health factors in New York, coupled with the highest ADI score (5th quintile, with quintile five representing the highest level of deprivation).
- » In comparison, Manhattan County has the lowest ADI and highest health outcomes and factors rankings, and the lowest COVID-19 case rate of all New York City boroughs.
- » Both Wayne County (Detroit) and Milwaukee County rank close to last in their respective states for scores on health factors and health outcomes, and they have similarly high area deprivation indices: the 3rd and 4th quintiles of the United States, respectively.
- » And in Orleans Parish, which ranks in the middle for Louisiana on health outcomes and factors but has one of the highest ADI and GINI indices out of the counties studied, Black residents are dying from COVID-19 at twice the rate of White residents.

In contrast, two large counties with majority Black and Latino populations but better levels of economic well-being and basic population health than the other counties in our analysis showed much more limited disparities in COVID-19 case rates.

- » Los Angeles County, a majority Black and Latino county that ranks in the middle of the state of California for health outcomes and has an ADI score in the 2nd quintile, has much more uniform cases and death rates across race and ethnicity than the other counties described above.
- » Prince George’s County, Maryland, a majority-Black county, has the lowest GINI Index and ADI score of all the counties we studied. And it has a much more proportional distribution of COVID-19 cases relative to its population: 64% of the population and 57% of COVID cases where race is known are Black. The COVID-19 death rate for Black residents of Prince George’s County is 27% higher than for White residents, a significant but much narrower disparity than in the other hard-hit counties described earlier.

Prince George’s County and Los Angeles County also have lower overall prevalence of COVID-19 in their Black populations compared to the other counties.

Figures 2 and 3 illustrate how racial and ethnic disparities in COVID-19 case rates are related to underlying population health problems and with economic deprivation in six large counties.

In Figure 2, we graphed the ratio of Black and Hispanic/Latino to White case rates against their Robert Wood Johnson Health Factors Rankings, translated into percentiles (for example, a county in the 90th percentile would mean that 90% of the counties in the state rank higher in Health Factors). In Figure 3, we graphed the ratio of Black and Hispanic/Latino to white case rates against Area Deprivation Indices. (Note that Hispanic/Latino ratios for Detroit are missing due to incomplete data.)

Due to the small sample size of regions that have released COVID-19 data by race and ethnicity, the high variability in testing that leads to biased prevalence estimates, and the small case and fatality numbers, our comparison is not definitive. However, the disparities we found are dramatic, and the

Figure 2. COVID Case Disparity Correlates With Health Factors

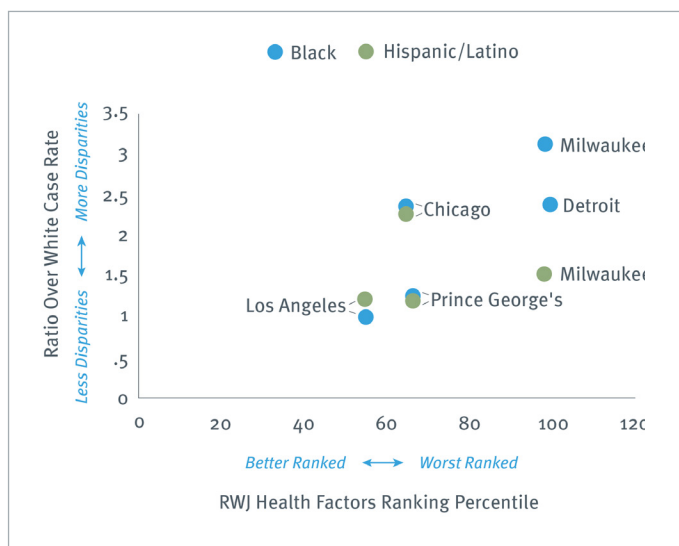
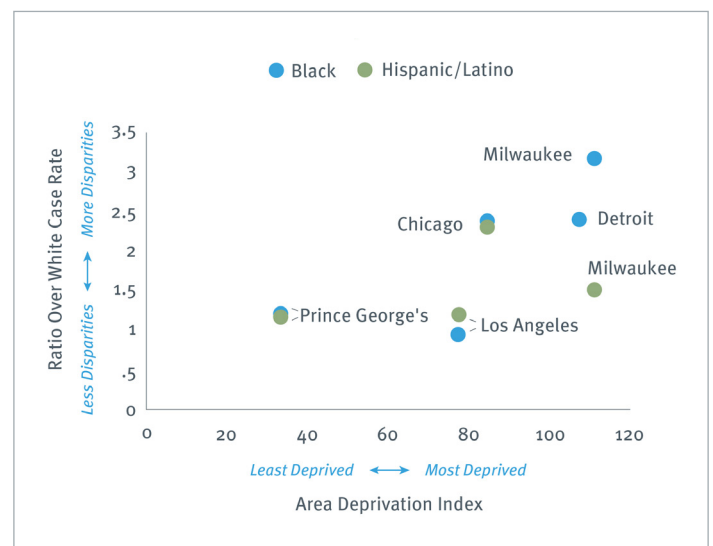


Figure 3. COVID Case Disparity Correlates With Area Deprivation Index



Note: These figures do not include New Orleans or New York City, which do not report COVID-19 case rates by race and county. However, New York City’s and New Orleans’ COVID-19 case and death rates, when analyzed by ZIP code or by race city-wide, strongly indicate the same relationship among population health, economic deprivation, and outcomes disparities, as described above and in Appendix 1.

Health equity policy solutions must address access to health care and the factors that shape health in order to have the greatest impact.

relationship between racial and ethnic disparities in COVID-19 outcomes and racial and ethnic disparities in basic measures of population health and social and economic well-being is consistent across these important centers of COVID-19 incidence.

What Do These Correlations Mean for Health Equity Policy Today?

As a starting point, they mean that the mechanisms that are driving disparities are political and economic, not biological. These mechanisms include economic deprivation, poor access to health care, and resulting poor community health. Community disinvestment and barriers to medical care both also contribute to health inequity. Health equity policy solutions must address access to health care and the factors that shape health in order to have the greatest impact.

Given the central role of structural racism and inequality in health inequities, it is important to acknowledge that the policy solutions we offer are neither a panacea nor a comprehensive proposal for reparatory justice. **In order to truly address the structural inequities that have produced and exacerbated the disparities we are witnessing, our country would need to do what Dr. King referred to as a “radical revolution of values...which will call us to question the fairness and justice of many of our past and present policies.”**⁸ Despite the urgency of the current crisis and the urgency that was described over 50 years ago, our nation has much more work to do that is outside the scope of this brief. However, this brief is an effort to address Dr. King’s challenge within the major spheres of health policy, public health and social drivers of health.

We have applied an equity lens, specifically a racial equity lens, in our diagnoses of the policy issues and identified policy solutions. We have included both short-term policy approaches that mitigate the effects of the current crisis, as well as policy proposals that address some of the long-standing drivers of inequities in health outcomes.

Structural injustice interacts with public policy in ways that federal and state governments can address.

- » For example, variations in how each county is able to manage the outbreak in implementing social distancing, testing, and economic support may well be reinforcing disparities — and federal funding can help low-resource counties to cope more effectively.
- » A second example: Physical distancing is a privilege that is much less available to low-income communities. This includes low-income communities of color, where Black and Latino Americans are overrepresented in service industry jobs that have less access to paid sick leave protections, and women of color are more likely to be considered “essential” workers. Not only does this type of work expose workers to COVID-19, it also increases the risk of exposure for their family members and neighbors, as people of color are more likely to live in multi-unit dwellings or intergenerational households.

Federal and state paid sick leave protections and more resources for quarantining would make a major difference. We address both of these examples and many others in the following policy recommendations.

Part II: Federal and State Health Equity Policy Recommendations

We have organized our policy recommendations across five themes, broadly in order from “upstream” social determinants of health to “downstream” equity in access to COVID-19 treatment.

Priority 1: Address the social determinants of health.

Priority 2: Build strong financial incentives for improved health equity in our health care system.

Priority 3: Organize and build national public health capacity both to fight COVID-19 and to reduce the burden of chronic illness in vulnerable communities.

Priority 4: Ensure equitable access to affordable health insurance.

Priority 5: Expand access to COVID-19 treatment for vulnerable populations.

Priority 1: Address the Social Determinants of Health

Research has shown that addressing social determinants of health is important for improving overall health.⁹ Social determinants of health – the conditions in which people live, learn, grow, work and play – drive health outcomes and health care costs. The COVID-19 pandemic has presented challenges for individuals and families in their capacity to address the many social and economic factors that affect their health.

Our recommendations are based on several basic principles regarding the relationship between social determinants of health and health equity.

- » Policies that target “midstream” determinants like health-related social needs (for example,

access to high-quality nutrition, transportation, education and housing) must be paired with more upstream policies that address the structural drivers that created the conditions for those unmet health-related social needs at the community level.¹⁰

- » A related principle is that it is not sufficient to make services available on paper: We need to build community coordination systems that connect people to health promotion and support services.¹¹
- » Finally, as noted above, policy solutions that target upstream determinants of health are one part of a comprehensive health equity strategy and are not a substitute for policies that address structural and political drivers of health or racial injustice more broadly.

Note that we also include recommendations for children. Children are an important focus for social determinants policy in a post-COVID-19 context. Before the COVID-19 crisis, disparities in children's health were particularly stark.¹² The pandemic and social distancing are making challenges for children in vulnerable communities even worse.

While children make up a relatively small portion of the coronavirus patient population, almost every aspect of their daily lives has been disrupted by COVID-19. This includes lack of access to well-child visits, their regular child care providers, and education in schools; increased family stress and economic instability due to job loss; and increased anxiety related to isolation. The crisis is having a devastating impact on children's health, and mental and emotional well-being.

Short-Term Recommendations for Congress

- » **Improve paid sick leave:** Significantly improve paid sick leave for workers affected by the pandemic by removing exemptions for certain employers, increasing the level of support, including hazard pay for lower-wage workers, and expanding access to the benefit.
- » **Improve Supplemental Nutrition Assistance (SNAP):** Increase the maximum SNAP benefit by 15%; increase the monthly minimum SNAP benefit from \$16 to \$30; and halt rules that weaken SNAP eligibility and benefits. All of this should be done on an emergency basis that recognizes the uniquely severe loss of job income our country is experiencing.
- » **Increase funding for public transportation:** Provide additional relief to public transportation agencies after initial CARES funding is exhausted,

since it's critical for communities to be connected to essential transportation services during the pandemic.

- » **Respond to the rise in child abuse and neglect:** Take immediate action to prevent and respond to the rise in child abuse and neglect (a key social determinant of health for children) stemming from pandemic-related stress. This is especially important when children lack interactions with the mandatory reporters (health care providers, educators, etc.) that would be most likely to identify these issues. This includes an immediate increase in funding for child welfare programs like CAPTA's Community-Based Child Abuse Prevention grants, the Promoting Safe and Stable Families Program, and the Title IV-E Prevention Program.

Short-Term Recommendations for States

- » **Provide housing supports through Medicaid:** Use Medicaid funds and apply for any needed Medicaid waiver authorities to provide housing supports and temporary shelter for people experiencing homelessness who have been diagnosed with COVID-19, have a known exposure, or live in a hotspot.
- » **Improve access to nutritious foods:** Reduce barriers to accessing the Supplemental Nutrition Program for Women, Infants and Children (WIC) and the Temporary Assistance for Needy Families (TANF) program to help families meet basic needs such as food, housing and childcare. For example, states like California, Connecticut and Minnesota have suspended time limits for TANF and halted termination of families who have reached their limit.

Long-Term Recommendations for Congress

- » **Address the social determinants of health:** Pass legislation that targets the reduction of health disparities by addressing the social determinants of health, such as the *Researching and Ending Disparities by Understanding and Creating Opportunities (REDUCE) Act* and *The Improving Social Determinants of Health Act of 2020 Act*.
- » **Reduce mass incarceration:** Pass legislation (for example, *The Reverse Mass Incarceration Act*) that invests in evidence-based programs designed to reduce the rate of mass incarceration. Since jails have become a new epicenter for coronavirus cases, mass incarceration is a major threat to health equity.

Long-Term Recommendations for the Administration

- » **Improve payment for community health workers (CHWs):** The Centers for Medicare and Medicaid Services (CMS) should provide guidance on how states can use existing Medicaid authority (for example, waivers and state plan amendments) to reimburse the full range of services that CHWs provide. These services should include those that address the social determinants of health, health promotion, advocacy and COVID-19 prevention. CHWs serve as trusted bridges among communities, public health agencies and the health care system.
- » **Address social determinants of health:** CMS should issue further guidance regarding evidence-based strategies that states can implement under current authority, or through waivers, to address social determinants of health (SDOH).¹³
 - » In addition, CMS should provide hands-on technical assistance (TA) for state Medicaid agen-

cies as they work with managed care organizations (MCOs) to negotiate contracts that include a focus on SDOH. CMS should also provide direct support for data collection and analysis of SDOH activities.

Long-Term Recommendations for States

- » **Pass paid family and medical leave legislation:** Enact paid family and medical leave laws, such as *The Family and Medical Insurance Leave Act*. Every other advanced country mandates paid family and medical leave.
- » **Build pathways to blend and braid funds across sectors:** States should build pathways (for example, joint investments in capacity and infrastructure) to collaborate and braid funding across agencies to facilitate coordinated payment for services that reward collective impact and collaboration, with a focus on optimizing health and healthy development.
- » **Pay for peer support services through Medicaid:** States should exercise their options for funding the reimbursement of peer support services under their Medicaid programs, either by adding peer support services through a Medicaid state plan amendment (usually under the Medicaid Rehabilitation Option) or as part of a waiver program. Racial and ethnic minorities in the U.S. are more likely than other groups to have severe and persistent mental illnesses and less likely to obtain mental health care.¹⁴ A disproportionate burden of chronic and untreated behavioral health problems (and their interaction with physical health) is one of the important mechanisms that makes many communities of color more vulnerable to COVID-19.

Priority 2: Build Strong Financial Incentives in Our Health Care System for Improved Health Equity

Health care payment reform is a powerful potential tool to advance equity in health care delivery.

As payers and purchasers implement pay-for-performance and related reforms to health care reimbursement, they need to incorporate plan and provider performance on health equity. State and federal payment reform efforts should incorporate specific incentives tied to improved health equity. Importantly, new payment structures will fail if we do not address the conditions that created health inequities in the first place.

Long-Term Recommendations for Congress and States

- » **Improve data collection:** States and the federal government should require and incentivize the collection of patient and social and behavioral risk data through Medicare, Medicaid, and commercial insurance value-based payment programs, with appropriate privacy and antidiscrimination protections. Accurate collection of data on race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age, and disability status has emerged as a critical and difficult step in implementing equity payment incentives in health care.
- » **Close disparity gaps:** States should incentivize Medicaid managed care to close disparity gaps, including setting metrics and benchmarks by race and ethnicity and including required metrics in Medicaid managed care contracts that explicitly measure equity. Oregon's Medicaid Coordinated Care Organizations program has initiated a Medicaid managed care pay-for-performance program that includes measures of health equity.¹⁵

- » **Incentivize providers to improve equity:** The federal government and states should incorporate provider incentives to improve equity in process and outcome measures into Advanced Payment Methods.¹⁶

Priority 3: Organize and Build National Public Health Capacity Both to Fight COVID-19 and to Reduce the Burden of Chronic Illness in Vulnerable Communities

Experts warn that, depending on the effectiveness of our public health strategies, COVID-19 infections could either resurge -- or we could contain the pandemic and prevent further outbreaks. The *CARES Act* includes significant new funding for the CDC to implement a public health pandemic response. But in the absence of careful allocation of new resources, many low-resource counties will not have the capacity to implement staff-intensive steps like widespread testing and contact tracing.

An equitable approach to the surveillance of COVID-19 should also recognize assets within vulnerable communities, such as CHWs, who can serve a critical role in this crisis.¹⁷ The entire public health workforce, including CHWs, should be brought to bear to create innovative, community-centered solutions that protect and strengthen vulnerable communities.

Over the longer term, substantial ongoing funding for public health is critical to improving population health in communities of color. The COVID-19 crisis should become a compelling reason to make long overdue investments in public health prevention funding.

Short-Term Recommendations for Congress

- » **Improve CDC funding for contact tracers:** Building on the testing funds in the previous round of COVID-19 legislation, Congress should fund

the CDC with at least \$3.7 billion in emergency supplemental funding to be distributed to local, state, territorial, tribal, and federal public health agencies to support a force of at least 100,000 community-based contact tracers. States should submit binding plans to allocate these funds based on disease prevalence and local public health staffing needs, prioritizing communities that are limited in their fiscal capacity to stand up pandemic response quickly.

- » **Be more flexible when hiring health care workers:** Provide flexibility for U.S. federal agencies, including the CDC, in their procurement and hiring process, including employing CHWs and ensuring a diverse workforce, to act as quickly as possible to secure the public health resources they need to fight the pandemic.
- » **Require collection of data on impact by race and ethnicity:** Require that health and economic data based on race and ethnicity about the impact of the pandemic be collected, made available to researchers, and reported quickly and on a rolling basis by the CDC and other federal and state bodies. Whether under congressional mandate or under its own initiative, the CDC and other federal agencies should report race and ethnicity data related to COVID-19 testing and treatment, at a minimum, for all six Office of Management and Budget race and ethnicity categories, including Native Hawaiians and Pacific Islanders.
- » **Require cross-agency collaboration:** Direct HHS to ensure that experts at the CDC are leading and coordinating efforts across the federal government and with private payers and providers, to identify new approaches, best practices, and supporting tools to develop effective COVID-19 strategies as the pandemic's impact on our nation evolves.

Short-Term Recommendations for the Administration

- » **Allocate funds equitably based on need:** As the Administration manages existing and potential new authorized funding for testing and contact tracing, states should submit binding plans to allocate these funds based on disease prevalence and local public health staffing needs. Resources should be prioritized for communities that are limited in their capacity to acquire PPE for testing and necessary testing supplies, and to hire contact tracers.
 - › States should submit plans to make testing available for people with and without access to cars.
 - › States should provide an assurance that people will not be required to bring insurance information to receive a test. (We have heard that uninsured people are being scared off by the request to bring an insurance card.)
- » **Scale up payment for CHW services:** CMS should provide guidance clarifying that services provided by CHWs are eligible for increased FMAP, and that if such services are part of a resiliency strategy for the public health emergency, they are eligible for the 100% FMAP authorized under the CARES Act.

Short-Term Recommendation for States

- » **Implement tracing programs in low-income areas:** States need to ensure that deployment of “test, trace and quarantine” strategies is robust in low-income and low-revenue counties and municipalities. Without federal funding and/or state funding, local funding of public health prevention will create inequities that mirror the inequities in COVID-19 cases and deaths.

Long-Term Recommendation for Congress

» Increase annual funding for the CDC:

CDC funding should be increased both to ensure infrastructure is in place for effective monitoring and reporting of future outbreaks, and to support robust preventive public health interventions to reduce the prevalence of diabetes, asthma and other risk factors for coronavirus mortality.

Long-Term Recommendation for States

» **Fund CHWs sustainably:** Identify and implement ways to sustainably finance CHW services through Medicaid, and to integrate CHWs into care delivery teams to provide culturally competent care and link social supports to communities with the greatest need.

Priority 4: Ensure Equitable Access to Affordable Health Insurance

COVID-19 has led to a significant economic downturn, and tens of millions of people, particularly people of color, have lost their jobs, their economic security, and their employer-sponsored health insurance. This reality compounds pre-existing disparities: The data show differential rates of uninsured adults by race and ethnicity (see Table 1) prior to the COVID-19 crisis.

Furthermore, we cannot fully address this health crisis if we leave large segments of the population entirely out of our insurance-based health care financing system, including:

- » Justice-involved populations
- » Mixed immigration status families

Table 1: Percentage of Uninsured Adults Ages 18-64, by Race and Ethnicity, 2018

Race or Ethnicity	Percentage
Non-Hispanic White	8.9%
Non-Hispanic Black	15.6%
Non-Hispanic American Indian/Alaska Native	25.9%
Non-Hispanic Asian/Pacific Islander	7.8%
Other races or more than one race, non-Hispanic	12.4%
Hispanic	25.0%
American Indian/Alaska Native (Hispanic and non-Hispanic, combined)	25.4%

Source: National Center for Coverage Innovation at Families USA analysis of American Community Survey data for 2018. IPUMS USA, University of Minnesota, www.ipums.org.

- » People who were granted Deferred Action for Childhood Arrivals (DACA)
- » Pacific Islanders who entered the U.S. under the Compacts of Free Association (COFA)
- » People with Temporary Protected Status
- » People without residency status

This pandemic underscores the importance of health coverage for everyone in order for public health approaches to work.

Short-Term Recommendations for Congress

- » **Increase immigrants' access to Medicaid and CHIP:** Lift the five-year waiting period and other restrictions currently in place for lawful permanent residents and other lawfully residing immigrants to access Medicaid and CHIP.
- » **Withdraw the “public charge” rules:** Halt the implementation of the Department of Homeland Security and Department of State “public charge” rules retroactive to February 24, 2020.
- » **Expand Medicaid for migrants:** Restore Medicaid eligibility for COFA migrants and recommend inclusion of the bipartisan *Covering Our FAS Allies Act* (H.R. 4821 and S. 2218).
- » **Expand Medicaid for new mothers:** Extend Medicaid coverage to one year postpartum for women made eligible for Medicaid at 100% FMAP for the duration of the pandemic.
- » **Improve access to all needed health care:** To ensure that those who have lost their jobs due to COVID-19 can obtain treatment for medical, mental, oral, and other health needs, Congress should:
 - » Open and strengthen the individual and work-based health insurance market to the

uninsured by providing enhanced premium tax credits and COBRA subsidies.

- » Open a national special enrollment period.
- » Provide financial assistance for low-income, uninsured patients in the health insurance exchange in states that have not expanded Medicaid.
- » Enhance Medicaid coverage by offering a state option for 100% Federal Medical Assistance Percentages (FMAP) for all uninsured individuals, regardless of immigration status, for COVID-19 screening and treatment, and by replicating the 100% FMAP and phasedown for states that newly expand Medicaid.
- » Invest in robust consumer assistance, particularly in the communities hit hardest by the pandemic – such as communities of color -- to help newly uninsured people navigate health programs and enrollment.

Short-Term Recommendations for States

- » **Expand Medicaid in every state:** All states should expand Medicaid to low-income adults. The urgency of this expansion has grown given the massive loss of employer-based coverage.
- » **Extend Medicaid to people leaving incarceration:** States can implement automatic Medicaid re-enrollment for decarcerated people who have COVID-19 symptoms. This step would be critical for increased access to outpatient care and testing. Since 2016, 31 states and the District of Columbia had policies to suspend such coverage, at least temporarily.¹⁸
- » **Extend Medicaid coverage to incarcerated people pre-release:** Include full pre-release coverage for incarcerated people in COVID-19 emergency Section 1115 Medicaid waiver proposals. Research has found that one month

following re-entry, formerly incarcerated persons were **twice as likely** to be hospitalized than people in a control group.

- » **Extend Medicaid and CHIP to immigrant children and pregnant women:** States should exercise their option to provide Medicaid and CHIP benefits to lawfully residing immigrant children and pregnant women without a waiting period.

Long-Term Recommendations for Congress

- » **Establish universal health insurance:** The United States must finally move to a national and universal guarantee of health insurance like that in every other advanced nation.
- » **Remove risk of becoming a public charge as grounds for denying legal residency:** Rescind the statutory limitation on immigration admissibility that is the basis of the public charge exclusion.
- » **Expand coverage for DACA recipients:** Provide states with the option to extend Medicaid, CHIP, and ACA benefits for DACA recipients.

Priority 5: Expand Access to COVID-19 Treatment and Safe Living Environments for Vulnerable Populations

Access to health care through insurance is a key determinant of health. However, health insurance does not ensure access to timely COVID-19 treatment, linguistically and culturally appropriate care, ethical allocation of critical care resources, or even that the care a patient receives is informed by representative clinical trials and a transparent evidence base.

Discrimination against people based on age, disability status, and race is prohibited by law and should not be disregarded in times of crisis. Longstanding civil rights laws, such as the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and Section 1557 of the ACA, prohibit such discrimination. Entities covered by civil rights authorities must adhere to their obligations even in a time of strained health care capacity. The HHS Office of Civil Rights (OCR) released a bulletin¹⁹. However, the guidance does not go far enough.²⁰

Short-Term Recommendations for Congress

- » **Improve access to home- and community-based services (HCBS):** Provide additional resources to support access to HCBS and the HCBS workforce to prevent anyone from being forced into congregate settings, at grave risk to their health.
 - › First, provide targeted grants to states to increase HCBS to ensure older adults and people with disabilities can receive the services they need in their homes and communities rather than nursing facilities.
 - › Secondly, give states additional flexibility so they can make retainer payments to HCBS providers to protect the fragile network of entities that provide services to beneficiaries.
- » **Increase Medicaid and CHIP funding for language services:** Provide a temporary 100% FMAP for language interpretation services under Medicaid and CHIP based on the emergency. Many states have not taken up the Medicaid option for reimbursement of language services.
- » **Improve Medicare funding for language services:** Provide for Medicare reimbursement of interpretation services during the COVID-19 outbreak. Traditional Medicare does not reimburse providers for using interpretation services.

- » **Develop and disseminate translated public health content:** Direct the CDC to translate public health materials into multiple languages and to engage in outreach to linguistically diverse communities using the new resources it has received under multiple legislative responses to the pandemic.

Short-Term Recommendation for the Administration

- » **Improve access to clinical trials for people of color:** The FDA should prioritize racial and ethnic minority populations in clinical trials for COVID-19 vaccines and treatments. People of color must be included in COVID-19 study designs to ensure participants reflect the general population.
- » **Ensure fair allocation of treatment and resources:** The HHS OCR should update guidance to include recommendations on best practices related to the triage of critically ill patients and ethical allocation of critical care resources (for example, critical care beds and ventilators). Guidance should also include reassessment criteria to determine whether ongoing provision of scarce critical care resources are needed for individual patients. Timing of assessments, to be conducted by a triage team, should be based on disease trajectory and severity of the crisis.²¹ In addition, HHS should prohibit use of categorical exclusion criteria (for example age or disability) related to COVID-19 treatment.

Short-Term Recommendation for States

- » **Improve outreach to communities:** Use new dollars in a potential fourth federal pandemic legislative package to fund local health departments and community organizations to conduct strategic outreach in hard-to-reach communities.

- » For example, states and local health departments could focus funds on creating an information hub for culturally relevant tools and resources. These resources could be promoted through strategically targeted multimedia campaigns to create awareness and connect vulnerable communities with those resources.
- » Funds could also be used to deploy CHWs on the ground to help patients navigate resources and connect with needed services.

Long-Term Recommendation for Congress

- » **Pass health equity legislation:** Pass the *Health Equity and Accountability Act*, comprehensive health equity legislation that includes provisions for federal reimbursement for culturally and linguistically appropriate services under Medicare, Medicaid and CHIP.
- » **Increase funding for the REACH program:** The Racial and Ethnic Approaches to Community Health (REACH) program, housed under the CDC's Division of Nutrition, Physical Activity and Obesity, should be authorized above current funding levels. This program provides funds to state and local health departments, tribes, universities, and community-based organizations to build partnerships and implement culturally tailored interventions. It is the only CDC program that specifically funds communities working to reduce racial and ethnic health disparities.
- » **Expand access to community-based services:** Enact civil rights legislation, such as the *Disability Integration Act*, that prohibits government entities and insurance providers from denying community-based services (for example, long-term services and supports) to people with disabilities.

Conclusion

Unfortunately, this country has a legacy of health inequities, which is well-documented in a robust body of evidence. The COVID-19 pandemic is reflecting back to us the problems that many health equity advocates have been communicating for decades. Therefore, this pandemic calls for both short-term solutions to mitigate the impact of the immediate crisis and a thoughtful long-term approach to address the root causes.

Health equity advocates have an opportunity and an obligation to hold federal and state policymakers accountable to communities that have historically been ignored and excluded, and to put forward strong

reforms to our health system and to broader public policy. The recommendations presented in this brief seek to apply health equity principles across multiple domains of health and human services policy.

It is long past time for policymakers to take action. Too many people have died, and many more lives are at risk. This crisis has revealed that our collective health as a nation depends on high-quality, affordable health care and improved health for all. Health equity must be prioritized as we take steps to end this pandemic and bend the arc of the moral universe toward health justice.²²

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Appendix 1

County	Racial/Ethnic Makeup	COVID Cases (per 100,000 people)	COVID Deaths (per 100,000 people)	RWJ County Health Rankings	GINI Index	Area Deprivation Index
Cook (Chicago)	White: 42.1% Black: 23.9% American Indian/Alaska Native: 0.8% Asian: 7.9% Hispanic/Latino: 25.5%	City of Chicago: Black: 854 White: 359 Hispanic/Latino: 828 Asian: 340 Other: 804	City of Chicago: Black: 66 White: 20 Hispanic/Latino: 30 Asian: 17 Other: 8	Outcomes: 47/102 Factors: 66/102	0.51	92.25 (2nd quintile)
Los Angeles	48.6% Hispanic or Latino 26.1% White 15.4% Asian 9.0% Black	Asian: 102 Black: 120 Hispanic/Latino: 148 White: 120 Other: 1209	Asian: 14 Black: 16 Hispanic/Latino: 9 White: 13 Other: 1	Outcomes: 21/58 Factors: 32/58	0.50	88.70 (2nd quintile)
Milwaukee	White: 51.0% Black: 27.2% American Indian/Alaska Native: 1% Asian: 4.7% Hispanic/Latino: 15.4%	Black: 532 White: 169 Asian: 259 Hispanic/Latino: 465 American Indian/Alaska Native /Pacific Islander: 190	Black: 38 White: 17 Asian: Hispanic/Latino: 9 American Indian/Alaska Native/Pacific Islander: 21	Outcomes: 71/72 Factors: 71/72	0.48	105.38 (4th quintile)
New York (The Bronx/ Bronx County)	White: 9.1% Black: 43.6% American Indian/Alaska Native: 3.3% Asian: 4.5% Hispanic/Latino: 56.4%	2,667 per 100,000	155 per 100,000	Outcomes: 62/62 Factors: 62/62	0.52	135.44 (5th quintile)

County	Racial/Ethnic Makeup	COVID Cases (per 100,000 people)	COVID Deaths (per 100,000 people)	RWJ County Health Rankings	GINI Index	Area Deprivation Index
New York (Brooklyn/Kings County)	White: 36.4% Asian: 12.7% Black: 34.1% American Indian/Alaska Native: 1% Hispanic/Latino: 19.1%	1,683 per 100,000	131 per 100,000	Outcomes: 15/62 Factors: 53/62	0.52	101.2 (3rd quintile)
New York (Manhattan/New York County)	White: 47% Black: 17.9% Asian: 12.8% American Indian/Alaska Native/Pacific Islander: 1.4% Hispanic/Latino: 25.9%	1,133 per 100,000	79 per 100,000	Outcomes: 6/62 Factors: 11/62	0.59	75.8 (1st quintile)
New York (Queens/Queens County)	White: 25% Black: 20.7% American Indian/Alaska Native: 1.5% Asian: 26.8% Hispanic / Latino: 28.1%	2,131 per 100,000	147 per 100,000	Outcomes: 7/62 Factors: 20/62	0.45	87.44 (2nd quintile)
New York (Staten Island/Richmond County)	White: 60.3% Asian: 10.2% American Indian/Alaska Native: 0.7% Black: 11.7% Hispanic/Latino: 18.7%	2,434 per 100,000	101	Outcomes: 21/62 Factors: 19/62	0.44	69.84 (1st quintile)

County	Racial/Ethnic Makeup	COVID Cases (per 100,000 people)	COVID Deaths (per 100,000 people)	RWJ County Health Rankings	GINI Index	Area Deprivation Index
Orleans Parish (New Orleans)	Black: 60.2% White: 30.8% Asian: 2.9% American Indian/Alaska Native/Pacific Islander: 0.4% Hispanic/Latino: 5.6%	1,581 per 100,000 *Orleans Parish does not report case breakdown	Black: 145 White: 70 Other: 108	Outcomes: 32/64 Factors: 29/64	0.56	112.65 (4th quintile)
Prince George's County	White: 12.5% Black: 64.4% Hispanic/Latino: 19.1%	Black: 477 Hispanic/Latino: 466 White: 385 Other: 2103	Black: 33 Hispanic/Latino: 12 White: 26 Other: 17	Outcomes: 11/24 Factors: 16/24	0.40	66.58 (1st quintile)
Wayne (Detroit)	White: 49.5% Black: 38.8% Hispanic/Latino: 6.1%	City of Detroit: Black: 1,145 White: 478 Other: 781	City of Detroit: Black: 102 White: 48 Other: 61	Outcomes: 83/83 Factors: 83/83	0.50	103.42 (3rd quintile)

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This publication was written by:
Amber Hewitt, Director of Health Equity, Families USA
Eliot Fishman, Senior Director of Policy, Families USA
Winne Luo, Health Equity Intern, Families USA
Lee Taylor-Penn, Senior Policy Analyst, Families USA

The following Families USA staff contributed to this publication (in alphabetical order):

Kimberly Alleyne, Senior Director of Communications
Justin Charles, Digital Media Associate
Stan Dorn, Director of the National Center for Coverage Innovation and Senior Fellow
Nichole Edralin, Senior Manager of Design and Publications
Frederick Isasi, Executive Director
Hannah Markus, National Center for Coverage Innovation Intern
Adina Marx, Communications Associate
Emmett Ruff, Policy Analyst
Joe Weissfeld, Director of Medicaid Initiatives

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1225 New York Avenue NW, Suite 800 | Washington, DC 20005 | 202-628-3030 | info@familiesusa.org
FamiliesUSA.org | [facebook / FamiliesUSA](https://www.facebook.com/FamiliesUSA) | [twitter / @FamiliesUSA](https://twitter.com/FamiliesUSA)