AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

HEALTH AND WEALTH INEQUALITY IN AMERICA: HOW COVID–19 MAKES CLEAR THE NEED FOR CHANGE

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, D.C., JUNE 23, 2020

Serial No. 116–27

Printed for the use of the Committee on the Budget

Available on the Internet:
www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

42–158 WASHINGTON : 2020

COMMITTEE ON THE BUDGET

JOHN A. YARMUTH, Kentucky, *Chairman*

SETH MOULTON, Massachusetts, *Vice Chairman*
HAKEEM S. JEFFRIES, New York
BRIAN HIGGINS, New York
BRENDAN F. BOYLE, Pennsylvania
ROSA L. DELAURO, Connecticut
LLOYD DOGGETT, Texas
DAVID E. PRICE, North Carolina
JANICE D. SCHAKOWSKY, Illinois
DANIEL T. KILDEE, Michigan
JIMMY PANETTA, California
JOSEPH D. MORELLE, New York
STEVEN HORSFORD, Nevada
ROBERT C. "BOBBY" SCOTT, Virginia
SHEILA JACKSON LEE, Texas
BARBARA LEE, California
PRAMILA JAYAPAL, Washington
ILHAN OMAR, Minnesota
ALBIO SIRES, New Jersey
SCOTT H. PETERS, California
JIM COOPER, Tennessee
RO KHANNA, California

STEVE WOMACK, Arkansas, *Ranking Member*
ROB WOODALL, Georgia
BILL JOHNSON, Ohio, *Vice Ranking Member*
JASON SMITH, Missouri
BILL FLORES, Texas
GEORGE HOLDING, North Carolina
CHRIS STEWART, Utah
RALPH NORMAN, South Carolina
KEVIN HERN, Oklahoma
CHIP ROY, Texas
DANIEL MEUSER, Pennsylvania
DAN CRENSHAW, Texas
TIM BURCHETT, Tennessee

PROFESSIONAL STAFF

ELLEN BALIS, *Staff Director*
BECKY RELIC, *Minority Staff Director*

CONTENTS

	Page
Hearing held in Washington, D.C., June 23, 2020	1
Hon. John A. Yarmuth, Chairman, Committee on the Budget	1
Prepared statement of	4
Hon. Steve Womack, Ranking Member, Committee on the Budget	6
Prepared statement of	8
Sir Angus Deaton, Ph.D., Senior Scholar, Princeton University Woodrow Wilson School, Presidential Professor of Economics, University of Southern California	11
Prepared statement of	13
Patrice Harris, M.D., M.A., Immediate Past President of The American Medical Association	19
Prepared statement of	21
Damon Jones, Ph.D., Associate Professor, University of Chicago Harris School	30
Prepared statement of	32
Avik Roy, President, Foundation for Research on Equal Opportunity	41
Prepared statement of	43
Statements from America's Essential Hospitals and the Campaign for Tobacco-Free Kids submitted for the record	90
Hon. Sheila Jackson Lee, Member, Committee on the Budget, statement submitted for the record	104
Hon. Barbara Lee, Member, Committee on the Budget, questions submitted for the record	108
Answers to questions submitted for the record	109

HEALTH AND WEALTH INEQUALITY IN AMERICA: HOW COVID–19 MAKES CLEAR THE NEED FOR CHANGE

TUESDAY, JUNE 23, 2020

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, D.C.

The Committee met, pursuant to notice, at 2:34 p.m., via Webex, Hon. John A. Yarmuth [Chairman of the Committee] presiding.

Present: Representatives Yarmuth, Higgins, Boyle, DeLauro, Schakowsky, Kildee, Panetta, Morelle, Horsford, Scott, Jackson Lee, Peters; Womack, Woodall, Johnson, Flores, Holding, Norman, Meuser, Crenshaw, and Burchett.

Chairman YARMUTH. This hearing will come to order.

Good afternoon, and welcome to the Budget Committee's hearing on Health and Wealth Inequality in America: How COVID–19 Makes Clear the Need for Change. I want to welcome our witnesses here today.

At the outset, due to the new virtual hearing world that we are in, I ask unanimous consent that the Chair be authorized to declare a recess at any time to address technical difficulties that may arise with such remote proceedings.

Without objection, so ordered.

As a reminder, we are holding this hearing virtually, in compliance with the regulations for committee proceedings, pursuant to House Resolution 965.

First, consistent with regulations, the Chair or staff designated by the Chair may mute participants' microphones when they are not under recognition for the purposes of eliminating inadvertent background noise. Members are responsible for unmuting themselves when they seek recognition, or when they are recognized for their five minutes.

We are not permitted to unmute Members unless they explicitly request assistance. If I notice that you have not unmuted yourself, I will ask you if you would like staff to unmute you. If you indicate approval by nodding, staff will unmute your microphone. They will not unmute you under any other conditions.

Second, Members must have their cameras on throughout this proceeding, and must be visible on screen in order to be recognized. As a reminder, Members may not participate in more than one committee proceeding simultaneously.

Now I will introduce our witnesses. This afternoon we will be hearing from Professor Sir Angus Deaton, Senior Scholar at Prince-

ton University Woodrow Wilson School, and Presidential Professor of Economics at the University of Southern California; Dr. Patrice Harris, Immediate Past President of the American Medical Association; Dr. Damon Jones, Associate Professor at the University of Chicago Harris School; and Mr. Avik Roy, President of the Foundation for Research on Equal Opportunity.

I will now yield myself five minutes for an opening statement.

The word "unprecedented" is often overused, but right now, what we are facing as a nation and a society is truly unprecedented. We are simultaneously battling a global pandemic as the coronavirus rages on, an economic freefall from business closures and waves of mass unemployment, and a crisis of conscience as we grapple with the deadly effects of entrenched systemic racism in our country.

Nearly every American has experienced uncertainty and far too many extreme hardships during the last several months. But these crises have something else in common: they all disproportionately impact Americans of color.

Today the Budget Committee will examine one aspect of this: the underlying health and economic inequalities that have exacerbated COVID–19's impact on our minority communities. Historic and persistent racial disparities in income, employment, education, wealth, health care, housing, and more have made Americans of color more vulnerable to the virus, both in terms of health and economic status.

Nowhere is the disproportionate impact of coronavirus clearer than in the virus's death rates. If Black and Latino Americans died of COVID–19 at the same rate as white Americans, at least 14,400 Black Americans and 1,200 Latinos would still be alive today. While the CDC may not list structural racism as one of the chronic conditions putting people at a higher risk for severe COVID–19 disease, long-term health inequities and barriers to accessing quality, affordable health care have made communities of color more vulnerable to serious illness and death from coronavirus.

Where you live, where you work, and how you get to work all influence health status and outcomes. And more often than not, it is to the detriment of Black and Latino families. These longstanding inequities are only hard to see if you refuse to look. And when it comes to economic justice, the facts are plentiful: in terms of median household earnings, the most recent Census data shows that, for every dollar a white family earns, a Latino family earns $.73, while a Black family earns just $.59.

Decades of income inequality and the resulting wealth gap have left Black and Latino Americans with less savings and far less ability to weather a serious health emergency or an economic crisis. Today families are battling both. The same households that had less going into this economic crisis have faced far more layoffs and job loss. While all groups have seen a historic rise in unemployment compared to pre-pandemic levels, the May 2020 unemployment rates for Black and Latino Americans were substantially higher than for white Americans.

The pandemic has redefined essential work. And while Black and Latino workers comprise—compose 29 percent of the national work force, they account for 34 percent of frontline workers. Every day they are forced to choose between their health and a paycheck. De-

spite this, many of these workers still do not have access to paid leave or hazard pay. And more than one in four frontline workers have said the coronavirus has made it harder to meet their basic needs.

But workers aren't the only ones whose daily life has been upended. The coronavirus has led to widespread school closures across communities, and children of color may be impacted the most. One study estimated that, while the average white student may lose about six months of learning, the average Latino student may lose nine months, and the average Black student may lose 10 months. Without action, this could exacerbate graduation rates, disparities among students of color, further perpetuating economic inequality for generations to come.

The COVID–19 pandemic has exposed the cracks in our systems and laid bare the underlying inequities that have existed in the United States for generations. And our health care system, our economy, in education, and in our justice systems. It threatens to widen the economic chasm between white Americans and Americans of color. If not contained and reversed, we will not only jeopardize the future of millions of American families, we risk the well-being of our nation.

As we look forward to the next phase of recovery efforts, we must strive for structural change that will not only help our economy recover, but also help more people, specifically people of color, prosper when it does. We cannot be foolish enough to think that a rising tide will lift all boats. If we are, we will sink the country. This has to be a turning point. There is too much need, too much pain, and too much anger for Congress to do little or nothing.

I know we cannot end institutional racism overnight, but we can certainly start. We can build a stronger nation, a more inclusive economy, and an America that better reflects our values. And that is what I hope to focus on today.

[The prepared statement of Chairman Yarmuth follows:]

Chairman John A. Yarmuth
Hearing on Health and Wealth Inequality in America:
How COVID-19 Makes Clear the Need for Change
Opening Statement
June 23, 2020

The word unprecedented is often overused, but right now what we are facing as a nation and as society is truly unprecedented. We are simultaneously battling a global pandemic as the coronavirus rages on; an economic free fall from business closures and waves of mass unemployment; and a crisis of conscience as we grapple with the deadly effects of entrenched, systematic racism in our country. Nearly every American has experienced uncertainty, and far too many extreme hardships during the last several months. But these crises have something else in common: they all disproportionately impact Americans of color.

Today, the Budget Committee will examine one aspect of this – the underlying health and economic inequalities that have exacerbated COVID-19's impact on our minority communities. Historic and persistent racial disparities in income, employment, education, wealth, health care, housing, and more have made Americans of color more vulnerable to the virus – both in terms of health and economic status.

Nowhere is the disproportionate impact of coronavirus clearer than in the virus' death rates. If Black and Latino Americans died of COVID-19 at the same rate as white Americans, at least 14,400 Black Americans and 1,200 Latinos would still be alive today.

While the CDC may not list structural racism as one of the chronic conditions putting people at a higher risk for severe COVID-19 disease, long-term health inequities and barriers to accessing quality, affordable health care have made communities of color more vulnerable to serious illness and death from coronavirus. Where you live, where you work, and how you get to work all influence health status and outcomes, and more often than not, it's to the detriment of Black and Latino families.

These longstanding inequities are only hard to see if you refuse to look. And when it comes to economic injustice, the facts are plentiful. In terms of median household earnings, the most recent Census data shows that for that every dollar a white family earns, a Latino family earns 73 cents while a Black family earns just 59 cents. Decades of income inequality and the resulting wealth gap have left Black and Latino Americans with less savings, and far less ability to weather a serious health emergency or economic crisis – today families are battling both.

The same households that had less going into this economic crisis have faced far more lay-offs and job loss. While all groups have seen a historic rise in unemployment compared to pre-pandemic levels, the May 2020 unemployment rates for Black and Latino Americans were substantially higher than for white Americans. The pandemic has redefined "essential" work and while Black and Latino workers compose 29% of the national workforce, they account for 34% of frontline workers. Every day, they are forced to choose between their health and a paycheck. Despite this, many of these workers still do not have access to paid leave or hazard pay and more than one in four frontline workers have said the coronavirus has made it harder to meet their basic needs.
But workers aren't the only ones whose daily life has been upended. The Coronavirus has led to widespread school closures across communities, and children of color may be impacted the most. One

study estimated that, while the average white student may lose about six months of learning, the average Latino student may lose nine months and the average Black student may lose ten months. Without action, this could exacerbate graduation rate disparities among students of color, perpetuating economic inequality for generations to come.

The COVID-19 pandemic has exposed the cracks in our systems and laid bare the underlying inequities that have existed in the United States for generations – in our health care system, our economy, in education, and in our justice systems. It threatens to widen the economic chasm between white Americans and Americans of color. If not contained and reversed, we will not only jeopardize the future of millions of American families, we risk the well-being of our nation.

As we look toward the next phase of recovery efforts, we must strive for structural change that will not only help our economy recover but also help more people – specifically people of color – prosper when it does. We cannot be foolish enough to think that a rising tide will lift all boats. If we are, we will sink the country.

This has to be a turning point. There is too much need, too much pain, and too much anger for Congress to do little or nothing.

I know we cannot end institutional racism overnight. But we can certainly start.

We can build a stronger nation, a more inclusive economy, and an America that better reflects our values – and that is what I hope to focus on today.

Chairman YARMUTH. I now yield five minutes to the Ranking Member, Mr. Womack, for his opening remarks.

Mr. WOMACK. I thank the Chairman, and thanks to all of the Members of the Committee for participating today. It is great to be in this hearing.

Prior to the coronavirus, the U.S. economy was increasing wages and living standards. The median average income, adjusted for inflation, increased by 3.4 percent in 2018. The poverty rate fell from 12.3 to 11.8 percent, according to the latest Census Bureau data. Unemployment was at a five-decade low of 3.5 percent. Black, Hispanic, and Asian unemployment rates fell to 5.4, 3.9, and 2.1 percent, respectively, all of which were record lows. Wages were growing faster for low-income workers and for higher-income workers. But the pandemic, as we all know, brought these upward trends to a screeching halt.

While I think the topic of today's hearing is extremely important, and one that we need to carefully discuss and address, I am concerned that this Committee ought to be focused on a large and growing crisis that threatens income security programs for all Americans. And that threat is our out-of-control deficit and debt. Congress has—and, I might add, appropriately, and on a bipartisan basis—enacted $2.5 trillion worth of legislation to address our current public health and economic crisis.

Even while we take such unprecedented action, we can no longer ignore our country's long-term fiscal imbalance. The nation's structural budget deficits, which exist not only in economic emergency, but also during peace and prosperity, are a severe challenge to the critical programs that millions of our seniors and low-income Americans rely on every day, like Social Security, Medicare, Medicaid—and that list goes on and on.

The federal government's future ability to fund these programs is under a real threat by the growth of net interest payments, which are growing far more rapidly than the rest of the federal budget, even with historically low interest rates.

Ultimately, if we fail to live up to our duty to responsibly budget, future generations may face a sovereign debt crisis that would not only threaten our ability to fund these programs that tens of millions of Americans rely on, but would also cause economic hardship for all Americans. And let me just add, too, that the pressure on the discretionary budget of the U.S. Congress is—speaks for itself in—with deficits and debt the way we are calculating them today.

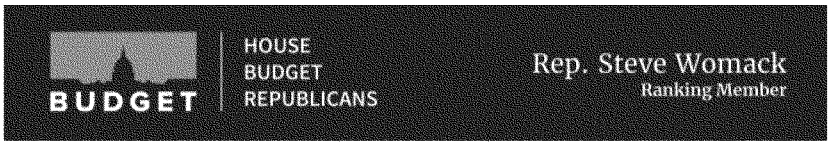
Since we failed to do our job during normal times and put the nation on a fiscally responsible path, we set ourselves up for an even more challenging budget outlook when the pandemic crisis hit. Now our deficit this year is projected to be under just under $4 trillion, by far the highest in American history.

This Committee needs to get back to its job of writing a budget resolution for Congress and making the tough choices we have been tasked to do. It is not going to be easy. Indeed, it is going to be much more difficult with a pandemic. But it needs to be done. This is the only way these critical safety net programs, programs so vital to our most vulnerable communities, will continue to exist for current and future generations.

The past few months have been extremely challenging for the entire country and, in fact, the entire world. In the United States, over 2 million cases of COVID–19 have ravaged the health of our nation,and our economy has been infected, as well. The economic downturn caused by the quarantine orders has significantly increased the impact of COVID–19 on our most vulnerable. Today, we will discuss how the pandemic has exacerbated pre-existing health care and economic inequalities in the nation.

So I look forward to today's discussion. And, Mr. Chairman, again, I thank you for hosting the hearing today, and I look forward to it. And I yield back the balance of my time.

[The prepared statement of Steve Womack follows:]



Ranking Member Steve Womack (R-AR) Opening Statement at Hearing Titled: "Health and Wealth Inequality in America: How COVID-19 Makes Clear the Need for Change"

June 23, 2020

Remarks as prepared for delivery:

Thank you, Chairman Yarmuth, for holding this hearing, and thank you to our witnesses for joining us today.

Prior to the coronavirus, the U.S. economy was increasing wages and living standards. Median average income (adjusted for inflation) increased by 3.4 percent in 2018, and the poverty rate fell from 12.3 percent to 11.8 percent, according to the latest Census Bureau data. Unemployment was at a five-decade low of 3.5 percent. Black, Hispanic, and Asian unemployment rates fell to 5.4, 3.9 and 2.1 percent, respectively — all of which were record lows. Wages were growing faster for low-income workers than for higher-income workers. But the pandemic brought these upward trends to a screeching halt.

While I think the topic of today's hearing is extremely important, and one that we need to carefully discuss and address, I'm concerned that this committee ought to be focused on a large and growing crisis that threatens income security programs for all Americans. And that threat is our out of control deficit and debt. Congress has, appropriately, and on a bipartisan basis, enacted $2.4 trillion worth of legislation to address

our current public health and economic crisis. Even while we take such unprecedented action, we can no longer ignore our country's long-term fiscal imbalance. The nation's structural budget deficits, which exist not only in economic emergency, but also during peace and prosperity, are a severe challenge to the critical programs that millions of our seniors and low-income Americans rely on every day, such as Social Security, Medicare, Medicaid—the list goes on and on.

The federal government's future ability to fund these programs is threatened by the growth of net interest payments, which are growing far more rapidly than the rest of the federal budget—even with historically low interest rates. Ultimately, if we fail to live up to our duty to responsibly budget, future generations may face a sovereign debt crisis that would not only threaten our ability to fund these programs that tens of millions of Americans rely on but would also cause economic hardship for all Americans.

Since we failed to do our job during normal times and put the nation on a fiscally responsible path, we set ourselves up for an even more challenging budget outlook when the pandemic crisis hit. Now, our budget deficit for this year is projected to be $3.7 trillion, by far the highest ever in American history.

This committee needs to get back to its job of writing a budget resolution for Congress and making the tough choices we have been tasked to do. This is not going to be an easy job, but it needs to be done. This is the only way these critical safety net programs—programs so vital to our most vulnerable communities—will continue to exist for current and future generations.

The past few months have been extremely challenging for the entire country, and, in fact, the entire world. In the United States, over 2 million cases of COVID-19 have ravaged the health of our nation, and our

economy has been infected as well. The economic downturn caused by the quarantine orders has significantly increased the impact of COVID-19 on our most vulnerable communities. Today, we will discuss how the pandemic has exacerbated preexisting health care and economic inequalities in the nation.

I look forward to today's discussion. Thank you, Mr. Chairman. I yield back.

####

Chairman YARMUTH. I thank the Ranking Member. I would also again, once again, like to thank our witnesses for being here this afternoon.

The Committee has received your written statements, and they will be made part of the formal hearing record. Each of you will have five minutes to give your oral remarks.

As a reminder, please unmute your microphone before speaking.

Dr. Angus Deaton, please unmute on your microphone. You may begin when you are ready. You are recognized for five minutes. Thank you for being here.

STATEMENT OF SIR ANGUS DEATON, PH.D., SENIOR SCHOLAR, PRINCETON UNIVERSITY WOODROW WILSON SCHOOL, PRESIDENTIAL PROFESSOR OF ECONOMICS, UNIVERSITY OF SOUTHERN CALIFORNIA; PATRICE HARRIS, M.D., M.A., IMMEDIATE PAST PRESIDENT OF THE AMERICAN MEDICAL ASSOCIATION; DAMON JONES, PH.D., ASSOCIATE PROFESSOR, UNIVERSITY OF CHICAGO HARRIS SCHOOL; AND AVIK ROY, PRESIDENT, FOUNDATION FOR RESEARCH ON EQUAL OPPORTUNITY

STATEMENT OF SIR ANGUS DEATON, PH.D.

Dr. DEATON. Chairman Yarmuth, Ranking Member Womack, and Committee Members, thank you for inviting me to talk on the inequalities in the COVID–19 pandemic.

The pandemic is exposing and exaggerating longstanding inequalities in health and wealth. It will worsen the inequalities between Black and white, between the more and the less educated, and between ordinary people and the well-off. Enlightened policy can moderate these effects, as is already being the case, but we are not done.

The pandemic may turn tolerable inequalities into intolerable inequalities. There is a danger of social unrest, but there are also opportunities to address all problems. The need to repair our policing has already become urgent. Other outstanding issues include health care, antitrust policy, and our system of unemployment benefits.

In the past half century, the lives of Americans have become increasingly divided according to whether or not people have a four-year college degree. Those with a BA have prospered and are living longer, while those without are foundering. Not only are the gaps widening, but the lives of less educated Americans are getting worse. The American economy is not delivering for less educated Americans.

In our book, "Deaths of Despair and the Future of Capitalism," Anne Case and I document this disaster. Mortality rates have risen, driven by rapid increases in deaths of despair, suicides, overdoses, alcoholic liver disease, and an uptick in deaths from heart disease. At the same time, wages and employment have declined, as have marriages, socializing, and churchgoing. In all of these areas, more educated Americans continue to make progress.

The disintegration of white working class life parallels the earlier disintegration among African-American communities in the 1960's and 1970's, culminating in the crack epidemic. African-American

mortality rates have long been higher than those of whites. The gap has diminished steadily, closing particularly rapidly when white mortality rates began to rise in the mid–1990's. This convergence came to a halt after 2013, when fentanyl deaths among Blacks where Blacks with a BA were largely exempt.

American health care played a role in the disaster. Pharmaceutical companies were largely responsible for the first wave of the opioid epidemic. The exorbitant cost of health care, much of which is financed through employment, has lowered wages and destroyed goods jobs for less educated Americans. At the same time, it is expanding wealth inequality.

This was before the pandemic. COVID death rates are higher for African-Americans and Native Americans than for whites. Occupation, segregation, population density, transportation, and the patterns of pre-existing health conditions for all involved. High incarceration rates for African-Americans have brought excess mortality from COVID.

Lives of the more educated are less at risk because many of us can work and earn while social distancing. Poorer kids are likely to do less well with Internet classes.

The pandemic has exposed the folly of tying health insurance to work. African-Americans and Hispanics were less likely to have insurance pre-COVID, and they and the millions who became unemployed find themselves at risk. Temporary arrangements are covering COVID-related health care, but they are not sustainable. America needs what other rich countries have: health care that is not tied to employment, that covers everyone from birth, and that controls costs.

Our patchwork, state-based system of unemployment benefit is also being exposed by the pandemic. Many have been concerned about consolidation and growing market power of large firms, prices rising faster in the U.S. than in Europe, and the falling share of labor and national income. COVID has shuttered many businesses, increased the power of big tech, and will cause further consolidation. Reinvigorating antitrust enforcement was a priority before, and will be urgent afterwards.

The four largest states have a third of the population, but only 8 percent of the votes in the Senate. COVID victims are even less well represented: half of all deaths, and only 8 percent of Senate votes, an inequality that will narrow as the epidemic moves into rural America. Unequal political representation in the pandemic serves further to divide us.

Thank you.

[The prepared statement of Angus Deaton follows:]

Congressional Testimony to the House Budget Committee

Angus Deaton, Princeton University and University of Southern California

June 23rd, 2020

Health and wealth inequality in America: how COVID-19 makes clear the need for change

Chairman Yarmuth, Ranking Member Womack, and Committee Members, thank you for inviting me to talk about inequalities and the COVID-19 pandemic. It is a privilege to meet with you at this critical juncture in American history, indeed in world history.

The pandemic is exposing and exaggerating longstanding inequalities in health and wealth. It will worsen the inequalities between black and white, between the more and the less educated, and between ordinary people and the well off. Enlightened policy can moderate these effects, as has already been the case. But we are not done

This pandemic, like other pandemics before it, lights up anew the fault lines in society. Inequalities that we knew about, like racial and ethnic inequalities, are more starkly visible. Inequalities in work and in living conditions have become salient in new ways, as people are sorted into essential and inessential workers, as jobs, transportation, and activities that once were safe become unsafe, and as access to the internet becomes the difference between learning or not learning, or working safely or not working at all.

The pandemic may turn tolerable inequalities into intolerable inequalities. There is a danger of social unrest, but there are also opportunities to address long-standing problems. The need to repair our policing has already become urgent. Other outstanding issues include healthcare, antitrust policy, and our system of unemployment benefits.

I want to start by describing inequalities in the US before the pandemic struck. I shall then discuss how these inequalities shaped the experience of the pandemic, often amplifying them, and then I shall go on to discuss issues for the future.

My guess is that, left to itself, the pandemic will worsen inequalities in the US, between blacks and white, between the more and the less educated, and between ordinary people and the very well off. Enlightened policy can moderate the worsening, or there could be serious disruption. But we have been here before; the income and wealth inequalities of 2000, if they had seen from 1960, would have seemed intolerable, but tolerated they were.

BEFORE THE PANDEMIC

Educational attainment, race, and unequal lives

In the past half century, the lives of Americans have become increasingly divided according to whether or not people have a four-year college degree; those with a BA are prospering and living longer, while those without are foundering. Not only are the gaps widening in the outcomes that make for a good life, but for less-educated Americans, life is getting worse. The American economy is not delivering for less-educated Americans.

In our recent book, *Deaths of despair and the future of capitalism*, Anne Case and I document the disaster and the divide. Most stunningly, mortality rates in midlife, which had been declining for a century since the last pandemic, began to rise in the mid-1990s, driven by increases in suicides, drug overdoses and alcoholic liver disease (what we call "deaths of despair") as well as by a reversal of progress against mortality from heart disease. There were 158,000 deaths of despair in 2018 (the latest year we have data) compared with 65,000 in the mid-1990s. The increase was almost entirely among the two-thirds of white non-Hispanics who do not have a bachelor's degree. Until 2013, black non-Hispanics, who had suffered their own catastrophe in the 1970s and 80s, escaped this epidemic. After 2013, when illegal fentanyl hit the streets of eastern cities, black deaths of despair began to rise too, again almost exclusively among African Americans without a bachelor's degree. Other rich countries appear to be exempt from deaths of despair, at least for now, although here are much smaller epidemics in other English-speaking rich countries, most notably in Britain.

There has also been a surge of pain, of disability, of difficulty in socializing, and in loneliness, again largely confined to the less-educated. The fraction of men in employment has fallen for many decades and, since 2000, for women too. Yet labor force participation has held steady for educated men and women. Median earnings of less-educated men have fallen for half a century; if benefits are included, especially employer-provided health insurance, the decline is moderated, but, as I argue below, these "benefits" are worth much less than they cost, and are harming working people in other ways. The earnings premium between those with at least a BA and those without has now risen to an astonishing 80 percent.

Community and social lives of the less-educated have deteriorated, creating a widening gap with the more educated. For those without a BA, divorce has risen, as has out of wedlock childbearing, and many never marry, though they participate in serial cohabitations that often bring children, many of whom lose touch with their fathers. The decline in unions has depleted an important social and community resource, and rates of churchgoing have fallen. Again, these dysfunctions are confined to less-educated Americans, whose lives are getting worse, and whose lives are diverging from the third of the population with a BA or more.

African American mortality rates have long been higher than those of whites; it is true today, and it has been true for as long as we have data. In the 1930s, midlife mortality rates for blacks were two-and-a-half times those for whites. The gap has diminished steadily, closing particularly rapidly when white mortality rates began to rise in the mid-1990s. This convergence came to a halt after 2013, with the rise in fentanyl deaths among blacks; blacks with a BA—22.5 percent of the black population—were largely exempt.

In our book, we argue that the disintegration of life among inner-city African Americans in the 1960s and 1970s, culminating in the crack epidemic, was echoed forty years later by the epidemic of deaths of despair among whites. Black Americans, then among the least-skilled workers, faced the leading-edge of globalization as manufacturing jobs in cities were lost.

In the last thirty years, globalization and automation has eliminated many more jobs, especially for less-skilled workers. Wages fell along with employment as good jobs vanished and workers relocated to less well-paying jobs, gig jobs, or jobs in labor supply firms, or dropped out of the labor force altogether. Some of the worst jobs like chicken processing plants in rural America, or meat packing plants—where many immigrants work—have become danger zones in the COVID-19 epidemic.

Good, stable, jobs with high wages became scarcer, undermining the foundations of community and social life. In many of the worst-affected communities, where despair ran deep, pharma companies pushed doctors to prescribe huge numbers of opioids—essentially FDA approved heroin—a ladder from despair to addiction and death. Meanwhile, globalization opened up new worlds of opportunities for the educated elite, who prospered as never before, some quite spectacularly so.

African Americans have long done worse than whites on almost all positive outcomes, in unemployment, wages, wealth, housing, health insurance and access to quality healthcare, and especially in rates of imprisonment. On some indicators, such as self-reported pain, or life-satisfaction, education now appears to be as important a divide as race. However, while a third of white Americans have a BA or more, less than a quarter of blacks Americans do.

Health insurance and healthcare pre-COVID

American healthcare played an important role in the disaster even before COVID-19. There are three key facts: American health care is exorbitantly expensive; much of it is financed through employer provided health insurance; and it delivers relatively poor outcomes. It is a major driver of income inequality, because it transfers unnecessarily large sums upward from the general public to providers, some of whom are very wealthy, and it lowers wages and destroys good jobs for lower paid workers. An average family (single) policy cost $20,000 ($10,000) in 2019 which has to come out of what the worker is worth to the firm. This means lower wages, or often for the least skilled, elimination of the job. Outsourcing firms can provide the same work, but often without benefits, and at lower wages; few large firms now hire their own janitors, security guards, drivers, or food-service workers. Those low-level jobs—the proverbial mailroom worker—often provided the sense of being part of an important firm, and for some, the opportunity for promotion. The rapid increase in the cost of healthcare—now twice as expensive as in any other country—has lowered wages, destroyed jobs for the less-educated, and enriched hospital executives, pharmaceutical companies, device manufacturers, insurance executives, and a minority of physicians—the most common occupation among the top one percent.

All of this harm is over and above the role of the system in the opioid epidemic.

DURING THE PANDEMIC

The quick and the dead: age, sex, race, and ethnicity

Death does not come equally to all, especially not COVID deaths. COVID infections and death are structured by sex, by age, by race and ethnicity, by education, and by geography. Pre-existing inequalities shape who dies and who lives, just as the pandemic itself creates new inequalities.

In some cases, the odds of dying are *approximately* (and only approximately) proportionally elevated for everyone so that the epidemic reinforces pre-existing health inequalities. Men are more likely to die than women from COVID; by June 10, 51,397 men had died, and 44,209 women. In 2018, with no COVID, 1.5 million men died and 1.4 million women; the normal disadvantage of men is has been exaggerated by COVID. Older people were more likely to die at baseline, and are more likely to die in the pandemic. By June 10, the ratio of COVID deaths for those aged 85 and over to deaths for those aged 55 to 64 was 2.8 to 1; in 2018, that ratio was 2.3 to 1. Once again, COVID somewhat exaggerates the mortality inequalities by age and sex that already exist.

While we are used to the fact that the old are more likely to die than the young, and that men are more likely to die than women, we do not fully understand why these differences exist, and if, as seems likely, they are influenced in part by social arrangements, they are potentially correctable. The mechanisms of COVID are even less well understood. It could be that, like a predator in the wild, it singles out the weak. Or it could be something more specific, like older people are less likely to have had another childhood vaccine that is partially protective—like rubella. Old people who live in nursing homes have been heavily affected. There is also evidence that women are more likely than men to accept and observe social distancing restrictions.

The exaggeration of pre-existing mortalities is much larger for African Americans relative to whites, while, for Hispanics, a pre-existing mortality *advantage* (the so-called Hispanic paradox) has changed into a mortality *disadvantage* with more Hispanics dying than their proportion in the population. In 2018, relative to white non-Hispanics, blacks' death rates were 18 percent higher, and white Hispanic death rates a third lower. During the pandemic, and up to June 10, blacks' mortality rates from COVID were 84 percent higher than for whites, and Hispanics four percent higher. It is important to note that these differences have already changed and will change more with time and as the geographic composition of the epidemic changes. As the pandemic spreads to more places that are predominately white, the white advantage will diminish, although it almost certainly will not vanish.

Death rates have been disturbingly high among native Americans. In Arizona, AIANs account for 22 percent of COVID deaths, but are only four percent of the population. In New Mexico, they are 50 percent of deaths, but are only nine percent of the population.

What explains these racial and ethnic differentials? We will not have definitive answers for some time, but we know something.

Where and how people live matters a great deal for any infectious disease, including COVID. The disease has not yet reached some areas, many of them predominately white. Many minorities live in segregated communities, with high population density and multifamily living arrangements. Segregated communities are often less well-served by healthcare. These inequalities have long been known, but have a new significance with COVID.

Transportation seems to have been important in New York City, as people commuted in crowded subway trains to Manhattan from the ethnic and racially structured communities in which they lived. The patterns of mortality by race and ethnicity are quite different in New Jersey and Massachusetts than in New York, showing less or no white advantage. Geography, transportation, and segregation all help control the spread of an infectious disease.

Pre-existing conditions make COVID more deadly. Patients who suffer from underlying health conditions, particularly cardiovascular disease, diabetes, or chronic lung disease, are six times more likely to be hospitalized, and once hospitalized twelve times more likely to die from COVID. Because underlying health conditions are more common among the less educated, and among African Americans, they contribute to the COVID mortality differences among those groups.

Minority workers are disproportionately represented in services and in healthcare. The CDC reports that 25 percent of Hispanics and non-Hispanic blacks work in services occupations, compared with

only 16 percent of whites. African Americans are 12 percent of all employment but 30 percent of nurses.

African Americans are disproportionately incarcerated, and prisons have become hotspots for COVID.

The patterns we document in *Deaths of despair*, with mortality and income gaps expanding simultaneously, will be further exaggerated by the pandemic, or rather by the measures that have been taken to moderate and control it. Many educated people get to stay at home, continue to earn their salaries, communicate with colleagues and friends electronically. Their health is protected along with their incomes. Their children take zoom classes and their attendance is monitored by their parents.

People without a college degree keep their jobs, if they are essential workers, but may risk infection, or, if they are not essential, lose their jobs and risk their earnings, but stay safe. Essential occupations include food and agriculture (including retail and the infamous meatpacking jobs) where only 14 percent of workers have a BA, and where about half of workers are people of color. For non-essential workers who lose their jobs, most have been at least temporarily covered by emergency payments. In the longer term, some jobs may never return, and some workers may feel they have to return to work, even when they do not feel safe. Otherwise, they risk not having money to buy food, or to pay rent.

Under these conditions, the gaps by education in both health and earnings will surely expand.

Healthcare is supposed to be met by the money paid to hospitals in the CARE act, and insurers are largely foregoing copays and deductibles. But the situation remains murky, and many people may face hospital charges. A quarter of a million people have been hospitalized with COVID since the pandemic began, and that number could more than double by the end. If insurers pay now, they will have to recoup later. There is scope here for enormous popular discontent as this situation unwinds. If so, there will also be demands for reform.

Other issues and looking forward to post-COVID

The Constitution of the US embodies sharp inequalities in political representation in the Senate. The largest four states, California, Texas, Florida, and New York, have a third of the population, but only eight percent of the Senate. In contrast, Wyoming, Vermont, Alaska, and South Dakota comprise less than one percent of the population but also have eight Senate seats. The distribution of COVID cases, hospitalizations and deaths are more concentrated than population and have even fewer Senate votes. The four states with the highest number of deaths, New York, New Jersey, Massachusetts, and Michigan have half of all deaths so far, and, once again, eight percent of Senate votes.

This inequality will narrow as the pandemic moves across the country and into more rural areas. But, for the present, the inequality of representation makes it harder to provide financial relief to the states that are hardest hit.

In the gilded age, with vast material inequalities, antitrust laws were introduced to break up trusts and to make capitalism fairer to workers and consumers. Many commentators and researchers have

recently been concerned about increasing industrial concentration today: hospitals are an important example, airlines another, though the champion is retail, with Amazon and Walmart. A related but distinct concern is about big tech, their quasi monopoly position, and whether they are a net benefits or threats to society. At the same time, the share of labor in GDP—long thought to be an immutable constant—has been falling, not only in the US but around the world. If there is prolonged unemployment post-COVID, the position of labor will weaken further. Many have argued that government anti-trust enforcers, and the courts, have lost interest in antitrust enforcement. Prices of many goods and services that used to be cheaper in the US than in Europe are now more expensive, arguably because the EC has been a more effective regulator than the US.

All this can be argued both ways. Big tech, and retailers like Amazon and Walmart have brought great benefits to us all. Yet there is a level of discomfort that is growing to something like alarm as COVID causes greater consolidation. Many bricks and mortar facilities have been closed, whether inessential retail or manufacturing, while anything with an e- in front of it has been open. Many stores have gone bankrupt. Big tech has money to purchase firms in difficulties, as does private equity.

One thing that I do not worry about is that the unemployment we see now, and that may last for a while, will bring an epidemic of deaths of despair. Our book argues that deaths of despair are the consequence of a prolonged, half-century undermining of the supports of working-class life in America. These deaths do not respond to the ups and downs of employment and unemployment. Deaths of despair were rising before the Great Recession, they rose during the Great Recession, and they continued to rise after the Great Recession. We expect deaths of despair to continue through the pandemic, but not to spike in response to the unemployment that has been generated as a part of social distancing.

Chairman YARMUTH. Thank you, Dr. Deaton.

I now recognize Dr. Harris for five minutes.

Please unmute your mic, Dr. Harris.

STATEMENT OF PATRICE HARRIS, M.D., M.A.

Dr. HARRIS. Thank you. Good afternoon, Chairman Yarmuth, Ranking Member Womack, and Committee Members. The American Medical Association commends you for holding today's hearing. My name is Dr. Patrice Harris, and I am Immediate Past President of the AMA. I am a practicing child and adolescent psychiatrist from Atlanta. And thank you for the opportunity to testify today.

As our nation confronts a dual crises of a deadly pandemic that has triggered economic instability and joblessness unseen since the Great Depression, inequities have been starkly revealed, most notably among Black Americans, the Latinx community, and Native American communities, and I would like to highlight just a few facts.

Black Americans have been among the hardest hit population by this virus. Not only are we hospitalized and dying in disproportionate numbers, we also are more likely than white Americans to have lost income because of the pandemic. In 42 states plus Washington, DC, Hispanics and the Latinx community make up a greater share of confirmed cases than the share of their population. In eight states, it is more than four times greater. The death rate in the Navajo Nation is higher than in any single U.S. state.

So clearly, COVID–19 is having a disproportionate impact on minoritized and marginalized communities. And why? Structural inequities that result from long-term policies, practices, and procedures that determine access to comprehensive health care, as well as those determinants of health: inadequate housing, education, food insecurity.

And these are all influenced by bias and racial discrimination; higher prevalence of chronic health conditions such as diabetes, hypertension, asthma, and obesity; an increased likelihood of working essential jobs such as bus drivers, train operators, those who are working in our supermarkets and meat packing plants, hospitals and nursing home—and, of course, that increases the risk of exposure; a stronger likelihood of living in congregate, multigenerational living arrangements; and major mistrusts of medical institutions because of historical abuses of science and research; and, of course, misinformation and disinformation.

So the AMA is very concerned that the pandemic and the economic fallout will further exacerbate these longstanding and long-term health, economic, and social inequities experienced by minoritized and marginalized communities.

Now, these dual crises are also having an impact on our collective mental health. The toll is not yet known, but I will tell you that people are angry, exhausted, and frustrated. And in nearly every community, people are demanding change.

New data from the Household Pulse survey suggests that COVID–19 is worsening mental health for communities of color, which, as a group, have less access to mental health services. As a child and adolescent psychiatrist, I worry about the short-term

and the long-term mental health impact this pandemic will have on our children, particularly our children of color.

The AMA is deeply committed to achieving greater health equity by raising awareness about its importance to patients and communities, and by working to identify and eliminate inequities. The good news is we are talking about it. The public is more aware; we are having this conversation today. So we must use this opportunity to move our country forward on health equity through change at the individual level in our policies and procedures and in our culture.

And how do we move forward? Briefly, some suggestions. We have to address implicit and unconscious bias at all levels and in all systems. We need targeted outreach on COVID–19 testing. We need to make sure that vaccine trials include a diverse population. We need federal and state agencies to collect and report COVID–19 data on infections. We need support for increasing diversity of the medical work force. We need a national strategy with state partnerships for increased resources for a mental health infrastructure that has, for decades, gone under-resourced and underfunded. And we need to expand access to health insurance and high-quality health care.

We cannot go back to business as usual. We must work together to build a society that supports equitable opportunities for optimal health for all.

Thank you.

[The prepared statement of Patrice Harris follows:]

STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives
Committee on the Budget

Re: Health and Wealth Inequality in America:
How COVID-19 Makes Clear the Need for Change

Presented by Patrice Harris, MD, MA
Immediate Past President of the American Medical Association

June 23, 2019

Division of Legislative Counsel
(202) 789-7426

STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives Committee on the Budget

Re: Health and Wealth Inequality in America:
How COVID-19 Makes Clear the Need for Change

June 23, 2020

The American Medical Association (AMA) appreciates the opportunity to provide testimony to the U.S. House of Representatives Committee on the Budget as part of its June 23, 2020 hearing on "Health and Wealth Inequality in America: How COVID-19 Makes Clear the Need for Change." The AMA commends the Committee for focusing on this critically important issue. As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA is deeply committed to confronting and addressing the alarming health disparities and inequities that exist in minoritized and marginalized communities across the United States.

Disproportionate Impact of COVID-19 on Minoritized and Marginalized Communities

As our nation confronts the dual crises of a deadly pandemic that has triggered joblessness unseen since the Great Depression, the pandemic has revealed starkly the disproportionate impact of the virus on minoritized and marginalized communities. While the data remains incomplete, the data that have emerged on the racial and ethnic patterns of the COVID-19 pandemic show that the virus has clearly disproportionately affected Black and Latinx, American Indian/Alaska Native—particularly in the Navajo nation—Asian-American, and Pacific Islander communities. An April 2020 report from the Centers for Disease Prevention and Control (CDC) found that 33 percent of hospitalized patients with COVID-19 were Black, despite only comprising 18 percent of the community being evaluated, while amfAR, the Foundation for AIDS, found that 22 percent of US counties are disproportionately Black and those counties account for 52 percent of COVID-19 infections and 58 percent of COVID-19 deaths.

As widely noted in recent media reports and research studies, Black Americans have been among the hardest hit populations by the virus. Not only are they hospitalized and dying in disproportionate numbers, they also are more likely than White Americans to have lost income because of the pandemic. The latest data from the COVID Racial Tracker shows that while Black Americans account for 13 percent of the U.S. population, they account for 24 percent of the deaths where race is known: this means Black people are dying at a rate nearly two times higher than their population share. According to NPR's analysis, based in part on the COVID Racial Tracker, in 32 states plus Washington D.C., Black Americans are dying at rates higher than their proportion of the population, and in 21 states, it is much higher, more than 50 percent above what would be expected. Preliminary data from the APM Research Lab shows that the overall mortality rate for Black Americans is 2.3 times as high as the rate for Asian-Americans and Whites. In analyzing the most recent CDC data, a recent report from the Brookings Institution found that death rates among Black people are much higher than for White people. In addition, according to Brookings, these disparities can be seen more clearly by comparing the ratio of death rates among Black people to the rate for White people in each age category. Among those aged 45-54, for example, Black death rates are at least six times higher than for whites. Underscoring the disproportionate

toll on Black Americans, a study published in the *New England Journal of Medicine* found that Black coronavirus patients made up three-fourths of those hospitalized and 70.6 percent of those who died in Ochsner hospitals, Louisiana's largest health system, whereas Blacks comprise only 31 percent of the Ochsner Health population. In the District of Columbia, according to the data on the COVID Racial Tracker, Black or African Americans represent 52 percent of COVID cases and 74 percent of COVID deaths.

Why does the Black community seem to be at greater risk? There are three key factors: 1) structural inequities that are a consequence of long time racist policies, practices, and procedures that determine access to comprehensive health care and social determinants of health (SDOH) that are influenced by bias and racial discrimination; 2) pre-existing conditions, such as diabetes, hypertension, and obesity that disproportionately impact the African American community; and 3) an increased likelihood of working essential jobs, such as bus drivers, train operators, custodians, and in supermarkets, meatpacking plants, hospitals and nursing homes. In addition, there has been major mistrust of medical institutions, misinformation and disinformation, and myths that have had to be combated, as a consequence of historical abuses of science and experimentation by medical institutions. Aside from deeply evaluating fissures of communal trust in historically White institutions, our nation has to reckon with the role of social and biological sciences to ensure our future care decisions reflect the unique needs of historically marginalized and minoritized communities. As AMA Immediate Past President Patrice A. Harris, MD, MA has noted, "We have to be grounded and rooted in the science and the evidence and the data, and decisions around this pandemic have to be data-driven decisions."

According to the COVID Racial Data Tracker, in the District of Columbia and 41 states, Latino Americans are disproportionately testing positive for the coronavirus as well. The rates are two times higher in 30 states, and over four times higher in eight states. For example, in Virginia, the Hispanic and Latinx community, which makes up only 10 percent of the population, represent 45 percent of all cases with known ethnicity. In Iowa and Wisconsin, the Latinx case rate is five times their population share, according to the COVID Racial Data Tracker as of May 22, 2020. Overall, more than 28 percent of people diagnosed with COVID-19 in the United States are Hispanic, according to the CDC. Despite that percentage and the fact that Latinx are the largest racial marginalized group in the United States, the effect of COVID-19 on this community has not been widely addressed, according to Aletha Maybank, MD, MPH, chief health equity officer and group vice president of the AMA.

American Indian and Alaska Native (AI/AN) communities in the U.S. have also suffered disproportionately higher rates of infection and death from COVID-19 during the pandemic. The Navajo Nation has been severely affected by the pandemic with at least 322 confirmed deaths, more than 16 states including Kansas, Nebraska, and South Dakota. The death toll equates to a death rate of 177 per 100,000, higher than any single U.S. state. Other tribes across the country are also suffering from high case numbers and severe economic fallout. As reported by the Albuquerque Journal, America Indians across New Mexico, the majority of whom live on remote tribal lands, are dying of COVID-19 at rates 19 times that of all other populations combined, according to data provided by the state Department of Health. They account for 57 percent of the state's cases—despite only being 11 percent of the population—and have infection rates 14 times that of the rest of the population. The AMA recently sent a letter to U.S. Department of Health and Human Services (HHS) Secretary Alex Azar expressing the urgent need to address the dire situation that AI/AN are facing with respect to confronting the COVID-19 pandemic, particularly pointing out the problems in the Navajo Nation. We noted our concern that promised federal funding to AI/AN tribes has been either very slow to be released or has not reached many tribal nations at all. Such assistance is vitally important to ensure that the tribes have the resources they need to successfully address the numerous issues involved in fighting the COVID-19 health crisis and to save lives.

There is also a striking racial and ethnic divide in how COVID-19 has hit nursing homes. Of the U.S.'s more than 116,000 COVID-19 deaths, over 50,000 died in nursing homes or other long-term care facilities, according to a recent analysis by The Wall Street Journal. And, according to the New York Times, nursing homes where Black American and Latinx individuals make up a significant portion of the residents—no matter their location, no matter their size, no matter their government rating—have been twice as likely to get hit by the coronavirus as those where the population is overwhelmingly White. According to the New York Times, "The nation's nursing homes, like many of its schools, churches and neighborhoods, are largely segregated. And those that serve predominantly black and Latino residents tend to receive fewer stars on government ratings. Those facilities also tend to house more residents and to be located in urban areas, which are risk factors in the pandemic." The analysis found, however, that the five-star rating the government uses was not a predictor; even nursing homes that had predominantly Black or Latinx residents were more likely to be affected by the coronavirus than were predominantly White nursing homes with low ratings.

Primary Factors behind Minoritized Populations being Disproportionately Impacted by COVID-19

Minoritized and marginalized communities experienced inequities in health and economic outcomes long before the COVID-19 pandemic. Thus, it should not come as a surprise that these communities have been disproportionately impacted by COVID-19 in light of the historic and persistent health, social, and economic inequities experienced by them. As pointed out recently by the Kaiser Family Foundation, despite reductions in health inequities since the passage of the Affordable Care Act, people of color continue to fare worse disproportionately to Whites in terms of health access, coverage, and utilization. These long-term health disparities made people of color more vulnerable to being afflicted by, hospitalized, and dying from COVID-19. In turn, COVID-19 has exacerbated the underlying, long-term health and economic disparities and inequities experienced by minoritized and marginalized communities.

The AMA defines health equity as "optimal health for all" and recognizes the importance and urgency of advancing health equity and addressing structurally determined factors of health to ensure that all people and communities reach their full health potential. The World Health Organization (WHO) defines health equity as the "absence of unfair and avoidable or remediable differences in health among social groups." This definition clarifies that inequities do not have to exist, but that inequities are produced, they do not just happen, the people who are negatively impacted by experiencing the injustice are not to blame, and there is something that we can do to close the gap.

The pandemic has highlighted the importance of acknowledging the important role played by structural factors of health and the SDOH. According to Healthy People 2020, the "social determinants of health are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risk." These social determinants include, but are not limited to, education, housing, wealth, income, and employment. We all experience conditions that socially determine our health. However, we do not all experience SDOH equally. The SDOH are impacted by larger and powerful systems that lead to discrimination, exploitation, marginalization, exclusion, and isolation. In the U.S., these historic and systemic realities are baked into structures, policies, and practices and produce, exacerbate, and perpetuate inequities among the SDOH, and, therefore, affect health itself. These larger, powerful systems of racism and gender oppression—also known as the root cause inequities—are "upstream" to the SDOH. In other words, racism and gender oppression are fundamental factors behind how SDOH affect individuals. They have shaped the social conditions in which men, women, and families live, and they work to produce inequities across society in complex ways, especially for those in minoritized and marginalized communities.

At the provider and institutional levels, there is a growing body of evidence demonstrating that implicit and explicit biases exist that negatively impact the quality of health care equity and patient safety and

drive these inequities. This was described originally in an Institute of Medicine (now the National Academy of Medicine) report, more than 15 years ago (Institute of Medicine. 2003. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/10260). The evidence shows that Blacks are more likely to receive poorer quality of care and less likely to receive the standard of care even when controlling for insurance status and income. This was linked with higher death rates for Blacks.

In addition, there has been a growing body of work examining the impact of structural racism on health in this country. In 2017, Dr. Zinzi Bailey et al. published a study in the *Lancet*, "Structural Racism and Health Inequities in the US: Evidence and Interventions," that explains structural racism to be the "totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources." And one key example of structural racism included how "residential segregation systemically shapes health care access, utilization, and quality at the neighborhood level, health-care system, and provider levels." There is evidence that experiences of discrimination and racism have a "weathering" effect on the body. Dr. Arline Geronimus, who coined the "weathering" hypothesis, explained that "Blacks experience early health deterioration as a consequence of the cumulative impact of repeated experience with social or economic adversity and political marginalization" over one's life course. This physiologic pressure, also later described as allostatic load, can cause stress hormones, such as cortisol, and cause organ and cardiovascular, metabolic, and immune systems damage over time. In addition, chronic stress and trauma due to discrimination that occurs as early as in-utero and early childhood, also known as adverse childhood experiences (ACEs), have been associated with poor health outcomes and early death as an adult.

Additional SDOH considerations have also contributed to the disproportionate impact of COVID-19 on marginalized and minoritized communities, including poverty and lack of access to health care, nutritious food, affordable housing, and accessible transportation, as well as a stronger likelihood of living in congregate living with multi-generational family members and the fact that many people of color have a greater probability of working in essential jobs that increase their exposure to the virus, such as in meatpacking plants, warehouses, supermarkets, hospitals, and nursing homes. From an economic perspective, minoritized populations serving in many types of essential jobs receive lower wages, which increases susceptibility to market forces. The high rates of job losses in minoritized communities stemming from COVID-19 also has resulted in a decline in employer sponsored health coverage and the loss of income exacerbates financial challenges for patients interested in and who can afford purchasing insurance policies through the individual market. The structural inequities built into the U.S. health system—inequities measured and documented for decades—explain why communities of color have higher rates of chronic heart disease, diabetes and obesity, the underlying conditions that make these individuals significantly more vulnerable to complications and death from COVID-19.

At the same time, the recent deaths of Breonna Taylor, a Black woman and emergency medical technician in Louisville who was shot and killed in her own home due to mistaken identity by law enforcement, and George Floyd, a Black man in Minneapolis killed in the custody of law enforcement, spotlight the linkages among violence, racism, and health inequities. As noted recently by AMA leaders Jesse M. Ehrenfeld, MD, MPH, Immediate Past Chair of the Board and Dr. Harris, "AMA policy recognizes that physical or verbal violence between law enforcement officers and the public, particularly among Black and Brown communities where these incidents are more prevalent and pervasive, is a critical determinant of health." Moreover, Drs. Ehrenfeld and Harris noted that "Recognizing that many who serve in law enforcement are committed to justice, the violence inflicted by police in news headlines today must be understood in relation to larger social and economic arrangements that put individuals and populations in harm's way, leading to premature illness and death. Police violence is a striking reflection of our

American legacy of racism—a system that assigns value and structures opportunity while unfairly advantaging some and disadvantaging others based on their skin color…Importantly, racism is detrimental to health in all its forms." Research shows that racially marginalized communities are disproportionally subject to police force, and there is a correlation between policing and adverse health outcomes. An increased prevalence of police encounters is linked to elevated stress and anxiety levels, along with increased rates of high blood pressure, diabetes, and asthma—and fatal complications of those comorbid conditions.

What the AMA is doing to Address Structural and SDOH by Centering Health Equity

The AMA is deeply committed to helping achieve greater equity by raising awareness about its importance to patients and communities and by working at the system-level to identify and eliminate inequities. A commitment to health equity means we must address the SDOH and we must elevate and name the root causes of why health inequities exist and how they came to be—both in society and at the institutional level. The AMA demonstrates its commitment through addressing the social conditions that impact health, increasing health workforce diversity, advocating for equity in health care access, promoting equity in care, and ensuring equitable practices and processes in research and data collection. For example, over the last two years, the AMA has been actively involved in working with stakeholders and policymakers at the state and federal levels to support efforts to reduce and prevent rising rates of maternal mortality and serious or near-fatal maternal morbidity among Black women. Although physicians cannot control all factors that need to change to achieve health equity, the AMA understands its important role in identifying their importance and both urging and educating those who can have a direct role to act.

Last year, the AMA launched the Center for Health Equity (CHE), led by our first Chief Health Equity Officer, Aletha Maybank, MD. The CHE's goal is to embed health equity across the AMA so that it becomes part of the organization's practice, process, action, innovation, and organizational performance and outcomes. The CHE's mission is to: 1) identify and address inequities in how care is delivered; 2) advocate for equitable access to care and research; 3) increase diversity and inclusion in the medical workforce; 4) influence determinants of health; and 5) elevate the AMA as a recognized leader and a model for equity across health care and in our society. As part of this work, earlier this year the AMA announced a $2 million investment in a community collaborative focused on improving economic conditions for residents on Chicago's West Side, neighborhoods where life expectancy is far below the national average, and significantly lower than in communities just a few miles away. Investing in neighborhoods and ensuring improved and equitable distribution of resources can help begin to tackle these complex challenges and improve the health prospects for individuals and entire communities.

Long-term Effects of the COVID-19 Pandemic and the Economic Fallout on Health Inequities

While the combined impact of the pandemic and economic fallout on minoritized and marginalized communities has been devastating, one positive result is that there is more awareness, especially outside the health care and academic communities, about health inequities and health disparities. More people (i.e., White people) are talking about these issues, and expressing their concern and the need for change to happen and for that change to be centered in an anti-racist and structural justice lens, particularly within our health system. This also is applicable to racial justice, policing reform, and justice reform. It is critical that these conversations continue, especially after the pandemic subsides.

Without a doubt, an influx of mental health issues is coinciding with the COVID-19 pandemic and will continue in its immediate aftermath. The combined toll of the pandemic, economic downturn, and incidents of police violence on our collective mental health is not yet known, but people are angry, tired, and frustrated – and in nearly every community, people are demanding change in a system that is unjust

and that has historically treated the Black community and other groups unfairly. Long before COVID-19, a mental health crisis existed in the Black community, created by a lack of mental health resources, unequal distribution of and access to other resources, and a host of other factors including determinants of health. New data culled from this spring's Household Pulse Survey conducted by the U.S. Census Bureau suggests that COVID-19 is widening mental health challenges for communities of color, which as a group has less access to mental health services than Whites. According to the survey, nearly one-fourth of respondents show signs of major depressive disorder, while nearly one-third report symptoms of generalized anxiety disorder. The findings were significantly higher for adults under age 30, among women, and those with low incomes. Overall, levels of anxiety and depressive disorders were three to five times higher than those measured in the first half of 2019, echoing findings from other polls and studies, including the Kaiser Family Foundation.

The COVID-19 pandemic is inherently a trauma event. Stress and anguish can affect a variety of individuals. Patients who personally contract and recover from COVID-19 may suffer from the impact of the illness and fear of acquiring the virus in the future. Individuals caring for patients afflicted with the virus, especially those who may not have been able to be with their loved-ones as they ultimately succumbed to COVID-19, will experience tremendous grieving and loss. On a more macroeconomic level, individuals that experience financial setbacks from the impact of the virus, including salary cuts or loss of employment, will experience added stress from the changes in their personal fiscal situation.

The need for physical distancing during the pandemic – combined with major disruptions such as unemployment and the risk posed by attending religious services or other large gatherings – serves to heighten the sense of isolation and anxiety many are experiencing. The effects can be even more profound among adolescents and the elderly, those dealing with substance abuse, and individuals who have struggled previously with behavioral disorders. The fear and anxiety triggered by the COVID-19 pandemic will remain long after the last cases are diagnosed.

Suggested Solutions

As a leader in confronting and addressing both the COVID-19 pandemic and the public health crisis of health disparities and inequities, the AMA believes that we need to use this moment in time as an opportunity to move our country forward on health equity through anti-racism reflected in our policies, practices, protocols, and performance metrics. The recent attention in the media and among policymakers to the disproportionate impact of COVID-19 on minoritized and marginalized communities has led to more conversations on historical and structural racism, along with other factors, that have led to longstanding health disparities and social and economic inequities. This is a conversation that is long overdue, and it must continue after the current pandemic subsides. The AMA is committed to helping to lead the country forward to promote inclusion, equity, and diversity, and anti-racism. This requires a "whole-of-a-nation" approach, with multiple stakeholders, including government at all levels and public-private partnerships, promoting change.

The AMA recommends the following policies to promote equity and reduce health inequities:

Addressing Implicit Bias/Unconscious Bias and Structural Racism. These biases are learned stereotypes that are automatic, unintentional, deeply engrained, universal, and able to influence behavior. Such biases contribute to racism in the health care system; both institutional and individual racism has been demonstrated to impact the care people of color, particularly pregnant Black women, receive and is, in turn, responsible for some of the differences in health outcomes. As mentioned above, programs at all levels of medical education are helping to address these biases and teaching about the SDOH, but such education needs to be expanded structurally throughout the health care system and the broader society.

Data Challenges. Overall, issues with accurate, consistent, and complete data have been a continuing concern throughout the pandemic, including on the number of tests, the number of positive results, testing results (e.g., many states combined statistics on diagnostic tests and antibody tests), hospitalizations, and deaths. Without improvements in data collection at all levels of government, it is difficult to know where virus "hot-spots" are occurring, and where testing and other resources need to be focused. This is particularly important as the country lifts restrictions on physical distancing and businesses, schools, and governments reopen. It is also critically important to fully understand the impact of COVID-19 on minoritized and marginalized communities. That is why in April 2020, the AMA and several other medical organizations called upon HHS to collect, analyze, and make available to the public, explicit, comprehensive, standardized data on race, ethnicity, and patients' preferred spoken and written language related to the testing status, hospitalization, and mortality associated with the novel coronavirus. In addition, the AMA supports H.R. 6585 (Kelly, D-IL), the "Equitable Data Collection and Disclosure on COVID-19 Act of 2020," which would require HHS to collect and report racial, ethnic, and other demographic data on COVID-19 testing, treatment, and fatality rates, and provide a summary of the final statistics and a report to Congress within 60 days after the end of the public health emergency. We urge support for this legislation. We note, however, that all data collection efforts must be culturally sensitive and appropriate and must respect patient privacy. Patients should not be compelled by the health care system or the government to disclose racial or ethnic information (including immigration status or country of origin) against their will.

Addressing SDOH. As noted previously, the SDOH can have a negative impact on health outcomes and have contributed to the disproportionate impact of COVID-19 on communities of color. Social risk factors, e.g., poverty, lack of access to health care, nutritious food, affordable housing, and accessible transportation, in addition to where people live and work, must be addressed beyond just the parameters of the pandemic. Congress is already working on numerous proposals to address SDOH, and the AMA supports a specific SDOH proposal, H.R. 4004, the "Social Determinants of Health Accelerator Act" (Bustos, D-IL), which is aimed at providing local communities with the funding and planning tools to implement solutions to the SDOH. Most importantly, improved access to health care—specifically related to the pandemic but also more generally—must be addressed. The pandemic has starkly revealed that it is critically important that every individual has access to health care, and we support expanding health insurance to those individuals who remain uninsured, both through the private market and Medicaid.

Investment in Professional Diversity. We need to increase the pipeline of racially and ethnically diverse, practicing physicians. This need extends to medical school, residency, and physicians in teaching and academic settings. For example, we support continuing the development of a more diverse physician work force by supporting programs such as the Health Careers Opportunity Program (HCOP). The purpose of this grant program is to assist individuals from disadvantaged backgrounds to enter a health profession through the development of academies that will support and guide them through the educational pipeline. We also support increased funding for Title VII health professions programs and the National Health Service Corps.

Language diversity among practicing physicians, medical students, and residents is an equally important component of professional diversity. Physicians who can speak the native languages of minority populations are more adept at gaining patient trust and that, in turn, can lead to greater adherence to courses of treatment and improved health outcomes.

Conclusion

It will take all of us working in partnership—and the AMA is committed to doing so—to build and continue on a path forward to address not only the specific health disparities that the COVID-19 pandemic has revealed, but also the underlying structural and institutional racism and SDOH and to

advance health equity. The AMA looks forward to working with members of this Committee and in Congress to advance these critical goals.

Chairman YARMUTH. Thank you, Dr. Harris.

And I now recognize Dr. Jones for five minutes.

Dr. Jones, thank you for joining us. Unmute your mic, please.

STATEMENT OF DAMON JONES, PH.D.

Dr. JONES. Thank you, Chairman Yarmuth and Ranking Member Womack, for having me. I am Damon Jones, an Economist and an Associate Professor at the University of Chicago Harris School of Public Policy. My research and teaching focus on inequality, tax policy, and household financial well-being. My comments today will focus on four aspects of inequality in the U.S. and how they interact with the current COVID–19 pandemic.

I will begin with the well-documented decline in the individual and collective leverage of workers relative to their employers. Unionization rates have reached record lows, and recent research has highlighted market power by employers, which allows them to suppress worker pay. These developments have coincided with stagnant wages for the typical worker.

It is in this context that we now find frontline workers in between a rock and a hard place. On the one hand, they have an opportunity to continue working when many others are forced into unemployment. On the other hand, they are being asked to risk exposure to COVID–19 infection. And the erosion in worker power I just mentioned leaves them unable to demand adequate protection equipment, paid sick leave, or hazard pay. To paraphrase Economist Rhonda Sharp, though these jobs are deemed essential, the workers who perform them are being treated as anything but.

My second point will be quite brief. By linking one's insurance coverage to one's employment status, the U.S. is in the minority amongst peer OECD countries. The flaws of this system are made painfully clear as we undergo historically rapid spikes in unemployment, thrusting millions into the ranks of the uninsured. During both a public health crisis and a recession, many are dreading the potential of enduring long-term unemployment and chronic health complications related to COVID–19 infection, all the while with limited access to health care.

Next, let me turn to wealth inequality. Many households lack adequate liquid assets, which I define as cash on hand or assets that can be easily converted into cash. The typical household has less than one month of income saved up for a rainy day, meaning—leaving many in a state of financial precarity. In recent research, my colleagues and I have shown that, when faced with an unexpected cut in pay or a job loss, households with the least amount of assets have to cut spending on necessities by two to four times as much as their wealthier counterparts.

During the current pandemic millions of families found themselves in this very position. While payments via the CARES Act and extensions to unemployment insurance have filled the gaps for many, there remain households who have experienced delays in receiving relief. And there are others, people experiencing homelessness and undocumented people, who are unlikely to receive payments or who are outright excluded from these benefits.

I will end with the issue of racial inequality. In the above three instances, the patterns of inequality are strongly predicted by one's

racial and ethnic identity. Black workers make up a disproportionate share of frontline workers and Latinx workers are over-represented in key frontline industries.

Insurance coverage is lower for people of color, especially native families, relative to white ones. And the disproportionate increases in unemployment among these groups is likely to exacerbate this gap.

The typical white household has between nine to 10 times as much wealth as their Black and Latinx counterparts. Our research shows that this racial wealth gap leads Black and Latinx households to have to cut spending significantly more than white ones when faced with a reduction in pay or job loss.

Given the above discussion, I recommend the Committee consider the following policies.

First, protect workers' right to engage in collective bargaining, strengthen and enforce existing U.S. labor standards. And during a pandemic, convene bodies with representation from both workers and employers to address ongoing concerns of workplace health and safety.

Second, in the short run, expand Medicaid eligibility for those who have experienced job loss. In the longer run, transition to a system of universal health care provision and health insurance coverage.

Third, continue extensions of the unemployment insurance program beyond their expiration at the end of July. Tie this continued renewal to macroeconomic indicators, and disperse additional periodic direct payments to households through the IRS. Provide resources to state and local governments to better reach individuals not covered by either of these previous two channels, and extend relief to undocumented families.

Finally, the racial disparities I have summarized are driven by longstanding factors such as historical and structural racism. They, therefore, require more fundamental interventions. As an example, we should move forward with H.R. 40 and establishing a committee to explore reparations for African-Americans. Such policies directly address racial inequality by moving toward what William Darity, Jr. and A. Kirsten Mullen described as acknowledgment, redress, and possible closure with respect to historic racial injustice.

Thank you, and I look forward to your questions.

[The prepared statement of Damon Jones follows:]

Statement of Damon Jones
Testimony prepared for the US House of Representatives Committee on the Budget

Hearing on "Health and Wealth Inequality in America: How COVID-19 Makes Clear the Need for Change"

June 23, 2020

Introductions

Thank you Chairman and Members of the Committee for inviting me to speak today. I am Damon Jones, an economist by training, and an associate professor at the University of Chicago, Harris School of Public Policy. My research and teaching focuses on inequality, tax policy, and household financial wellbeing.

My comments today will focus on four areas of inequality and how they interact with the current COVID-19 pandemic: the long-term declines in worker power, the coupling of health insurance coverage and employment status, wealth inequality and the strengths and weaknesses of our existing social safety net, and, finally, economic inequality along racial lines.

Declining Worker Power

According to several indicators, the bargaining power of workers, in particular low-wage workers, has been on the decline. A commonly cited metric for worker bargaining power is the share of workers who are represented by a union. At its peak, U.S. unionization rates were above one third, and possibly closer to 40 percent in the early 1950s. Today, unionization rates are closer to 10 percent.[1] Other measures consistent with a decline in worker power includes declining share of profits going to labor relative to capital and the rise of non-compete contracts.[2] Other studies are now identifying strong evidence of employer power in setting wages, known as "monopsony power."[3] Collective bargaining can help workers push for more fair pay and better working conditions, and have historically been responsible for securing what are now commonplace workplace health and safety measures. Over the same period of time where unionization has waned and worker power has eroded, median wages have remained stagnant, even despite the increasing productivity of firms.[4] It is in this setting where we find workers in low wage jobs, at the onset of the COVID-19 pandemic.

---

[1] "Unions and Inequality Over the Twentieth Century: New Evidence from Survey Data," (2018), by Henry Farber, Daniel Herbst, Ilyana Kuziemko, and Suresh Naidu, NBER Working Paper 24587
[2] See "The Declining Worker Power Hypothesis: An Explanation for the Recent Evolution of the American Economy" (2020), by Anna Stansbury and Lawrence H. Summers, NBER Working Paper 27193, for one summary of these trends.
[3] "Monopsony in Online Labor Markets," (2018), by Arindrajit Dube, Jeff Jacbos, Suresh Naidu, and Siddharth Suri, NBER Working Paper 24416
[4] Stansbury and Summers (2020)

With worker bargaining power at the lowest it has been in decades, how have workers in these jobs fared during the COVID-19 pandemic? A Roosevelt Institute Survey of frontline workers found that over 25% expressed high concern about COVID-19 infection risk. Despite these fears, these workers continue to clock in, and rising bills and expenses appear to be a key factor driving this. What's more, many of these workers have not received significant increases in hazard pay in return for their work: essential workers report over average an increase of $1 in hourly compensation, and at least half report no change in wages.[5] With more robust bargaining power, these workers would likely be able to command safer working conditions, better benefits, and higher compensation in return for their essential work. Unionized workers in this same survey report a higher likelihood of always using personal protective equipment (PPE) at work, access to paid sick leave in the event of an infection, disinfecting of the workplace, and are more likely to have been tested for COVID-19.

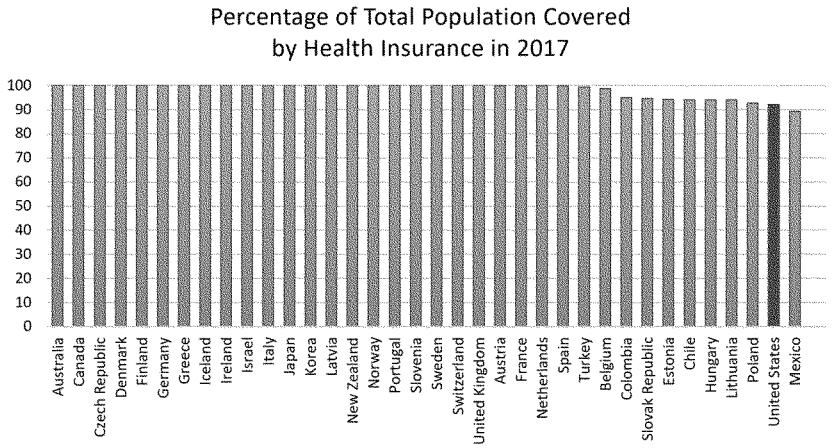
As calls for reopening the economy increase, the discussion is likely to be driven by those with interest in lost business revenue, but this must be balanced with the consideration of the workers who will be put most at risk. Organized business interests are in a much better position to lobby for their preferred measures, relative to the disaggregated frontline workers who share a common interest in exercising prudence in bringing back normal economic activity. Elevating the voice of these workers is of the utmost importance, both as it pertains to safe working conditions during the pandemic and also given the long-term trend in declining worker power.

Incomplete Insurance Coverage

Another important dimension of inequality in the U.S. involves access to health care and health insurance coverage. There has been a longstanding debate surrounding these issues, including in the most recent presidential campaign cycle, but I will only offer a few succinct observations related to the current COVID-19 pandemic. First, our approach to health insurance in the U.S. places in the minority among our counterpart OECD countries. Prior to the pandemic, the U.S. ranked second to last in insurance coverage among OECD countries (Figure 1). Given the levels of coverage that are achieved in the majority of our peer countries, we have to view this outcome as nothing other than a policy choice. There are a variety of models of and paths to universal health insurance coverage. Our approach in the U.S., in which a majority of non-elderly families receive health insurance coverage through an employer, has proven inadequate at achieving this goal.

[5] All of the results in this paragraph are taken from "Understanding the COVID-19 Workplace: Evidence from a Survey of Essential Workers," (2020), by Alexander Hertel-Fernandez, Suresh Naidu, Adam Reich, and Patrick Youngblood. Roosevelt Institute Report

Figure 1: Health Insurance Coverage Among OECD Countries



Source: Organization for Economic Co-operation and Development (OECD)

The flaws of our approach to health insurance and health care have been laid bare during this current crisis in which we have experienced an unprecedented rise in the unemployed. It is estimated that among the nearly 78 million people living in households where a job was lost, just under 27 million are likely to become uninsured due to separation from an employer and loss of employer sponsored insurance (ESI).[6] Among these newly uninsured, approximately 80 percent are estimated to be eligible for publicly subsidized insurance. And even among those who are eligible, additional barriers to coverage remain. First, for families considering Medicaid, the eligibility for this option varies significantly from state to state, depending on whether or not the state has adopted Medicaid expansions of the Affordable Care Act (ACA). Alternatively, for those that might wish to turn to insurance exchanges for coverage, they must be aware of their options and must be able to navigate the registration process at a time when funding for outreach and enrollment assistance. Finally, there is the option to extend prior health insurance through the Consolidated Omnibus Budget Reconciliation Act (COBRA), but this is typically an expensive proposition.

If we were to instead have a system of universal health care in place, where insurance were not linked to employment status, these families would have access to continuous coverage and health care, which is particularly valuable during a public health crisis. Furthermore, for those who have contracted COVID-19, there is a potential for longer-term chronic complications, in

[6] "Eligibility for ACA Health Coverage Following Job Loss," (2020), by Rachel Garfield, Gary Claxton Anthony Damico, and Larry Levitt. Kaiser Family Foundation

which case broad health insurance coverage will play a key role in the management and or prevention of chronic illness or irreversible adverse health outcomes.

Wealth Inequality and Financial Vulnerability

Wealth inequality in the U.S. is high, and has increased over time. Although there are vigorous debates about just exactly how much wealth is concentrated at the top, economists estimate that the top 1 percent of households own anywhere between 30 and 39 percent of total U.S. wealth. By contrast, the bottom 90 percent households holds at most 34 percent of U.S. wealth.[7] This has implications for how inequality plays across different groups and places, across different generations, and how equally or unequally power in society is distributed. One component of wealth in particular, liquid assets, are particularly important for understanding how families will fare during a crisis such as the one we currently face. Liquid assets refer to cash on hand, in your wallet, or checking and savings accounts, and/or assets that can be easily converted into cash.

Many households have very little cash on hand for an emergency. Surveys suggest that about 42 percent of households do not have money set aside that could be used for an unexpected emergency.[8] In 2016, more than half of U.S. households had less than one month of liquid assets available in the case of an emergency.[9] This means that when these households face cuts in their take-home pay or worse, when they become unemployed, they will have to make painful reductions in spending on necessary household items: food, groceries, and the like.

In a recent study, we found this vulnerability to be highly sensitive to the amount of liquid assets present in the household. When faced with a 10 percent drop in pay, households with the lowest level of liquid assets are likely to cut their spending by 4 percent, while households with the highest levels of liquid assets would only reduce spending by about 1 percent.[10] Likewise, when a family member becomes unemployed, households with the lowest level of liquid assets reduce spending by 46 cents for each dollar in lost income, while those with the highest levels of liquid assets only reduce their spending by 24 cents.[11] Overall, this prior evidence suggests that during this pandemic, households with the lowest levels of liquid assets will be the hardest hit by lower pay and unemployment during the pandemic.

In the absence of personal savings to help weather the storm, many families may turn to public support to maintain economic security. In the U.S., our social safety net consists of various

---

[7] See "Top Wealth in America: New Estimates and Implications for Taxing the Rich," (2020), by Matthew Smith, Owen Zidar, and Eric Zwick, for an overview and comparison of many recent estimates of top wealth shares, Working Paper.
[8] Current Population Survey (CPS) June 2015 and June 2017 unbanked/underbanked supplement.
[9] Survey of Consumer Finances (SCF), 2016.
[10] "Wealth, Race, and Consumption Smoothing of Typical Income Shocks," (2020), by Peter Ganong, Damon Jones, Pascal Noel, Diana Farrell, Fiona Greig, and Chris Wheat, Working Paper.
[11] "Consumer Spending during Unemployment: Positive and Normative Implications," (2019), by Peter Ganong and Pascal Noel, *American Economic Review*, Vol. 109, No. 7.

policies designed to provide this type of relief. During the current economic downturn, we have provided cash relief to families through two primary channels: economic impact payments (also known as "stimulus payments") through the Coronavirus Aid, Relief, and Economic Security (CARES) Act and generous extensions of the unemployment insurance (UI) program, in terms of who long UI may be claimed, who may be eligible, and how much workers receive each week. Indeed, these measures have provided a considerable amount of relief at the onset of the pandemic. One study, relying on simulations, estimates a projected poverty rate of 12.7 percent that could have been as high as 16.3 percent in the absence of the economic relief.[12] Another study, using data from the Current Population Survey (CPS), estimates that because of our economic relief payments, the number of households below the poverty line actually fell during the first months of the pandemic, even in spite of widespread job loss.[13]

Despite these promising outcomes, we may still have reason to believe that some families are still in dire need and others may be missed by our primary means of providing relief. First, measures of food insecurity rose at the beginning of the pandemic, before decreasing slightly over time.[14] In addition, some families may face delays in receiving either the CARES Act economic impact payments, in some extreme cases, as much as a year.[15] Similarly, some households may face a lag in determining whether they qualify for unemployment insurance.[16] For households with low levels of liquid assets, even a short delay can create significant challenges. In addition, the CARES Act payments were only a one-time measure and the extensions in unemployment insurance are set to expire at the end of the July.

In general, some of our most direct income support programs, such as the Earned Income Tax Credit and Child Tax Credits, are delivered annually through the income tax filing system, while families who face short-term needs for cash relief require more responsive and steady income support.

Finally, we must point out that there are a number of families that are unlikely to benefit from this relief. There are some adult dependents of other tax filers who are not eligible for CARES payments. There are also homeless people who are very unlikely to access these benefits. And importantly, a large class of families with members who are undocumented or who do not have a social security number are left out. These members of our community are in as just as much need as any.

---

[12] "The CARES Act and Poverty in the COVID-19 Crisis," (2020), by Zachary Parolin, Megan A. Curran, and Christopher Wimer. Columbia University Center on Poverty and Social Policy Brief.
[13] "Income and Poverty in the COVID-19 Pandemic," (2020), by Jeehoon Han, Bruce D. Meyer, and Jamex X. Sullivan, Working Paper.
[14] "Vast Federal Aid has Capped Rise in Poverty, Studies Find," June 21, 2020, by Jason DeParle, *The New York Times*.
[15] "IRS tells parents still waiting for their $500 stimulus child benefit it won't arrive until next year," May 1, 2020, by Michelle Singletary,, *The Washington Post.*
[16] See article by Jason Deparle (2020) above.

Racial Inequality

A final type of inequality present in the U.S. at the onset of the pandemic is that between racial groups. In all three of the above cases, the patterns of inequality also exist across racial and ethnic lines. According to one estimate, Black workers comprise 17 percent of frontline workers but only 12 percent of the total workforce, and Latinx workers are overrepresented in a number of essential industries, including grocery and retail, trucking, warehouse, and postal services, and building cleaning services.[17] This racial and ethnic clustering within specific sectors and industries has led to divergent patterns of job loss during the pandemic. Initially, an overrepresentation in essential jobs meant that the unemployment gap between White and Black workers became smaller at the onset of the pandemic. The ratio of Black to White unemployment is typically around 2, but was closer to 1.25 in April. However, as time has passed, the unemployment gap has begun to return to prior levels. The White unemployment rate declined during the month of May, while remaining steady for Black workers. On the other hand, Latinx workers now find themselves with the highest rates of employment, in part due to their concentration in restaurant and hospitality industries.

With regards to health insurance coverage, the share of nonelderly people uninsured was higher for Black (11 percent) and Latinx (19 percent) families, relative to White ones (8 percent). In the case of Latinx families, uncodumented status is likely to play a major role. Notably, the share uninsured among Native people is even higher, at 22 percent.[18] Because insurance is generally tied to employment status, the employment trends discussed above are likely to make it harder for these households to maintain continuity in coverage, if retaining coverage at all, during the pandemic.

And finally, the U.S. faces dramatic racial wealth gaps. The typical White household has $171,000 in net wealth, while the level among Black households is only a tenth of that amount, at $17,150, and Latinx households fare slightly better with $20,720 in nex wealth.[19] This translates directly into higher financial vulnerability. In a recent study, we found that if a worker's paycheck was reduced by 10 percent, a White worker is likely to reduce household spending by 2 percent, while the impact on Black and Latinx households was 50 percent and 20 percent larger, respectively.[20] Figure 2 shows how these same dynamics unfold during an unemployment spell. In Panel A, we see that in this sample of households with bank accounts, income drops at about the same rate at the onset of unemployment (i.e. time "0" on the x-axis). However, in Panel B, we see that spending on necessary goods falls by a greater amount for Black and Latinx (Hispanic) households, as compared to White households. Although these

[17] "A Basic Demographic Profile of Workers in Frontline Industries," April 7, 2020, by Hye Jin Rho, Hayley Brown, and Shawn Fermstad. Center for Economic and Policy Research.
[18] "Uninsured Rates for the Nonelderly by Race/Ethnicity," (2018), Kaiser Family Foundation.
[19] Survey of Consumer Finance, 2016. Separate data for Asian and Native households is not available in the public use data.
[20] "Wealth, Race, and Consumption Smoothing of Typical Income Shocks," (2020), by Peter Ganong, Damon Jones, Pascal Noel, Diana Farrell, Fiona Greig, and Chris Wheat, Working Paper.

data are taken from years preceding the pandemic, it is likely that similar disparities will emerge during the current crisis.

As mentioned above, there are various policy measures in place to provide relief for households with few assets. However, there are likely to be racial disparities in access to this support. For example, there are approximately 12 million households that fall for whom CARES payments are not automatically sent. These are households that did file a tax return in either 2018 or 2019, generally because their income was so low that a tax return was not required. These households must file additional paper work by October 15th in order to receive a payment. It is estimated that Black and Latinx households are disproportionately represented among this group.[21] Moreover, among the households that have received a payment form the IRS, payment processing is much slower for those who do not use direct deposit. In this respect, we might again worry that Black and Latinx households are more likely to experience a delay, with 17 and 14 percent not having a bank account, respectively, compared to 3 and 2.5 percent among White and Asian households, respectively.[22] More generally, we have shown above that economic impact payments and unemployment insurance extensions have caused poverty rates to be lower than they would have been otherwise, poverty rates among Black and Latinx households still hover near 20 percent, as compared to a much lower rate of 8 percent among White households.[23]

Policy Solutions

Given the above discussion, I recommend the committee consider the following policy options for addressing inequality both during the pandemic and beyond.

1. **Worker Power:** Empower workers by protecting their right to engage in collective bargaining, including potential bargaining options at the levels higher than firm, e.g. sectoral, and also by strengthening and enforcing existing U.S. labor standards.
2. **Incomplete Insurance Coverage:** Implement some version of universal health care provision and health insurance coverage, doing away with the tight linking of health insurance coverage and employment status.
3. **Economic Vulnerability:** Continue regular delivery of cash relief to U.S. households via direct payment through the IRS and by renewing extensions of the unemployment insurance program. Tie continued extension of the unemployment insurance program to macroeconomic indicators to avoid further uncertainty. Provide resources to state and local governments to better reach individuals not covered by either of the aforementioned forms of relief, and extend relief to undocumented families.

---

[21] "Aggressive State Outreach Can Help Reach the 12 Million Non-Filers Eligible for Stimulus Payments," June 16, 2020, by Chuck Marr, Kris Cox, Kathleen Bryant, Stacy Dean, Roxy Caines, and Arloc Sherman. Center on Budget and Policy Priorities.
[22] FDIC National Survey of Unbanked and Underbanked Households, 2017.
[23] See article by Jason Deparle (2020) above.

4. **Racial Inequality**: While all of these factors are exacerbated by existing racial inequalities, alleviating longstand racial disparities in economic outcomes, such as the racial wealth gap, will require a more fundamental shift in combating structural racism. A promising first step in that direction would include measures such moving forward with H.R. 40 in establishing a committee to explore reparations for African-Americans. These policies are central in achieving what William Darity Jr. and A. Kirsten Mullen describe as acknowledgement, redress, and closure with respect to historic racial injustice.[24]

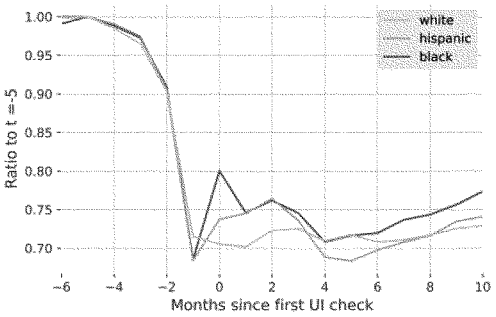
Thank you for this opportunity and I look forward to your questions.

[24] "Resurrecting the Promise of 40 Acres: The Imperative of Reparations for Black Americans," (2020), by William Darity Jr. and A. Kirsten Mullen. The Roosevelt Institute.

Figure 2: Net Income and Nondurable Spending During Unemployment, by Race

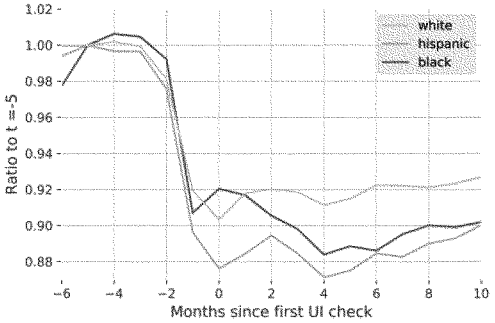
Panel A: Net Income (income plus unemployment insurance)

(a) Labor income + UI



Panel B: Nondurable Spending

(b) Nondurable spending



Chairman YARMUTH. Thank you very much, Dr. Jones.

And now I yield five minutes to Mr. Roy.

Welcome to the Committee, Mr. Roy. Thanks for being with us.

STATEMENT OF AVIK ROY

Mr. ROY. Thank you, Mr. Chairman, and also to Ranking Member Womack and Members of the Committee. Thanks for inviting me here today.

The Foundation for Research on Equal Opportunity, or FREOPP, for short, is a nonpartisan think tank that focuses exclusively on ideas that can improve the lives of Americans on the bottom half of the economic ladder. I welcome the opportunity to discuss our work on how COVID–19 economic lockdowns have widened racial inequities in education, health, and the work force.

My written statement contains a more detailed discussion of our findings. In my oral remarks I will focus on three topics. First, I will discuss how economic lockdowns imposed by states and localities have disproportionately harmed minority employment and minority owned businesses; second, I will touch on how economic lockdowns have further destabilized the fiscal sustainability of the United States; third, I will discuss how COVID–19 mortality by race and ethnicity, and how states' failure to protect nursing homes in particular has harmed vulnerable seniors of all races.

As Mr. Womack noted, in late 2019 Black unemployment reached its lowest rate in history, 5.4 percent. Today the Black unemployment rate is 16.8 percent. The Hispanic unemployment rate was 3.9 percent in late 2019. Now it is at 17.6 percent. In my written testimony I detail how disparities between white and non-white unemployment rates also reached their lowest levels in history prior to the pandemic. But the economic lockdowns have brought those disparities back to levels last seen a decade ago.

Compared to whites and Asians, Blacks and Latinos are less likely to work in white collar occupations, where working from home is feasible. Instead, they are seeing their jobs and hours slashed. Hourly wage work is down 50 percent, on average, and even more in places with the most stringent lockdowns.

But Black-owned businesses have also been hit far harder than white-owned businesses. It is estimated that Black-owned businesses have experienced losses of 41 percent between February and April, versus 32 percent for Hispanic-owned businesses, and 17 percent for white-owned businesses. Put simply, racial and ethnic disparities are worse when the economy is worse, and especially during the government-mandated shutdowns of the economy we are experiencing today.

As you know, the CARES Act and related legislation has increased the federal deficit by trillions of dollars. Material increases in the federal debt further destabilize what is already a dangerous situation. If demand for U.S. Treasury bonds declines on account of decreased U.S. credit worthiness such that Congress must enact substantial austerity measures, it will be low-income Americans who bear the greatest burden. Higher taxes, resulting in shrinkage of the economy, will harm economically vulnerable Americans through rising unemployment.

Second, reductions in federal spending will most harm those who most depend on that spending, such as Medicare and Medicaid beneficiaries. Hence, it is essential that Congress consider ways to pay for the recent COVID relief packages and also avoid further destabilizations of the federal budget.

One rising concern is how COVID–19 is affecting different racial and ethnic populations. The latest data from CDC indicates that Blacks represent a greater share of COVID deaths than they do of the general population, even when adjusted for the fact that COVID is more prevalent in cities. Mortality rates are also higher, as has been noted by others, in Native American communities, especially in Arizona and New Mexico.

What may be surprising is that whites are also dying of COVID at higher-than-predicted rates. On the other hand, Hispanics and Asians represent a lower share of COVID deaths than would be implied by their geographically adjusted share of the U.S. population.

The likely reason for these differences is that morbidity and mortality from COVID–19 is most common among the elderly. Eighty-one percent of all COVID deaths in the U.S. have occurred in people aged 65 or older, and whites are the oldest racial group in the U.S., with a median age of 44. Asians have a median age of 37; Blacks, 34; Hispanics, 30. Hence, we should expect to see higher fatality rates in whites versus Asians and Hispanics, due to their age. And we do. On the other hand, African-Americans are also relatively young, but we are still seeing higher mortality among Blacks.

Some of you are familiar with our research on the tragedy taking place in our nursing homes and assisted living facilities: 0.6 percent of Americans live in long-term care facilities. And yet, within this 0.6 percent of the population lies 43 percent of all deaths from the novel coronavirus, 43 percent. As you know, nursing homes are residential facilities for medically vulnerable seniors who have challenges with activities of daily living, such as taking a shower or getting dressed. Nursing homes are disproportionately poor, nonwhite, and enrolled in Medicaid.

The nursing home tragedy has a bronze lining, if you will, because it means that the risk of death from COVID for the rest of the population is considerably lower than we may have thought. We can use that information to reopen the economy and reduce the harm we are imposing on hundreds of millions of Americans of all colors.

Thank you.

[The prepared statement of Avik Roy follows:]

TESTIMONY BEFORE THE UNITED STATES CONGRESS

House Budget Committee

HEALTH & WEALTH INEQUALITY IN AMERICA

How COVID-19 Makes Clear the Need for Change

AVIK S. A. ROY

President, The Foundation for Research on Equal Opportunity

June 23, 2020

The Foundation for Research on Equal Opportunity (FREOPP) is a non-partisan, non-profit, 501(c)(3) organization dedicated to expanding economic opportunity to those who least have it. FREOPP does not take institutional positions on any issues. The views expressed in this testimony are solely those of the author.

Figure 1a. Black Unemployment Rate Minus White Unemployment Rate, 1972–2020

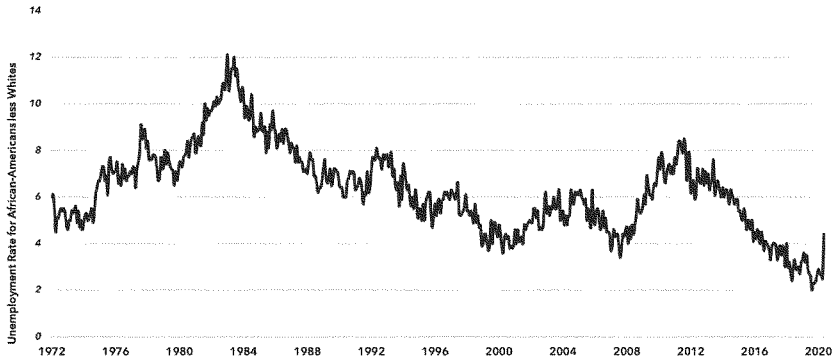
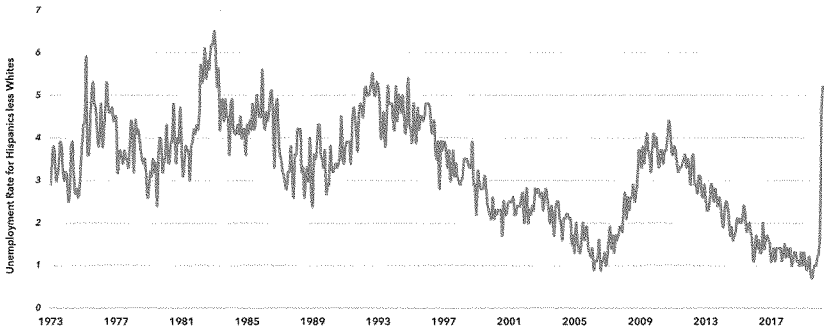


Figure 1b. Hispanic Unemployment Rate Minus White Unemployment Rate, 1973–2020



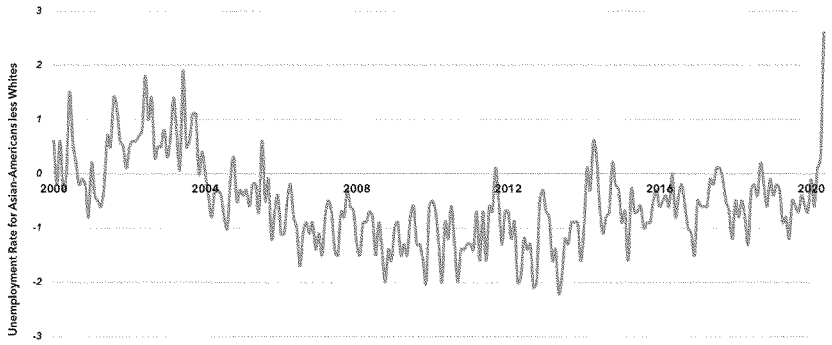
Lockdowns have widened the disparities between white vs. black and Hispanic unemployment. Hourly-wage workers, who are disproportionately non-white, were most harmed by economic lockdowns that forced small businesses to close. *(Source: Bureau of Labor Statistics; Graphics: A. Roy / FREOPP)*

INTRODUCTION

Prior to the COVID-19 pandemic, important measures of economic inequality were in decline. The overall unemployment rate reached a record low in the second half of 2019, and disparities between white and non-white unemployment also reached record lows during this period. Unfortunately, the economic lockdowns imposed by state and local governments have obliterated these gains.

Furthermore, extended lockdowns have led Congress to increase federal spending by trillions of dollars, further destabilizing the federal budget. The fiscal reckoning to come will disproportionately harm economically vulnerable Americans, by increasing unemployment through higher taxes, and by requiring reductions in federal spending that may harm those who most depend on government assistance.

Figure 2. Asian Unemployment Rate Minus White Unemployment Rate, 2000–2020



The disparity between the Asian and white unemployment rates has reached a record high. For most of the 21st century, Asians have enjoyed a lower unemployment rate than whites. That changed during the COVID-19 pandemic. *(Source: Bureau of Labor Statistics; Graphics: A. Roy / FREOPP)*

ECONOMIC LOCKDOWNS HAVE HARMED MINORITIES

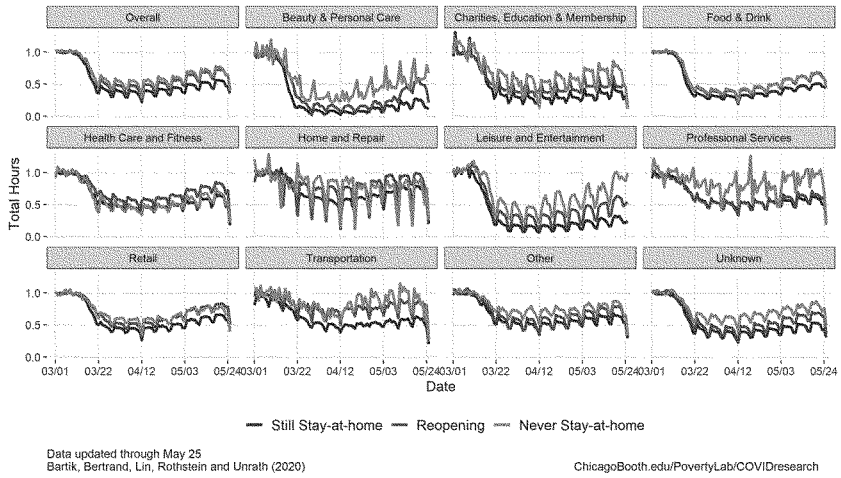
Prior to the pandemic, unemployment rates for all racial and ethnic groups reached record lows. In August of last year, black unemployment fell to 5.4 percent: the lowest rate ever recorded. The following month, Hispanic unemployment hit a record low of 3.9 percent. And in June of that year, Asian unemployment hit a record low of 2.1 percent.

The economic lockdowns have destroyed those gains. Today, the unemployment rates for whites, blacks, Hispanics, and Asians are 12.4, 16.8, 17.6, and 15.0 percent, respectively.

Notably, last fall, the disparities between white and black unemployment, and between white and Hispanic unemployment, also fell to record lows. Over the last five decades, the association is clear: a strong economy most benefits minorities, and a worsening economy most harms them.

For most of the 21st century, Asian-Americans have enjoyed a lower unemployment rate than whites. But since the lockdown, Asians have faced record unemployment.

Figure 3. Hourly Wage Reductions by Industry and Economic Lockdown Policies



Racial and ethnic minorities have been disproportionately harmed by economic lockdowns. Blue-shaded curves represent work reductions for those in lockdown states; red and orange curves represent reopening and open states, respectively. *(Source: A. Bartik et al., University of Chicago)*

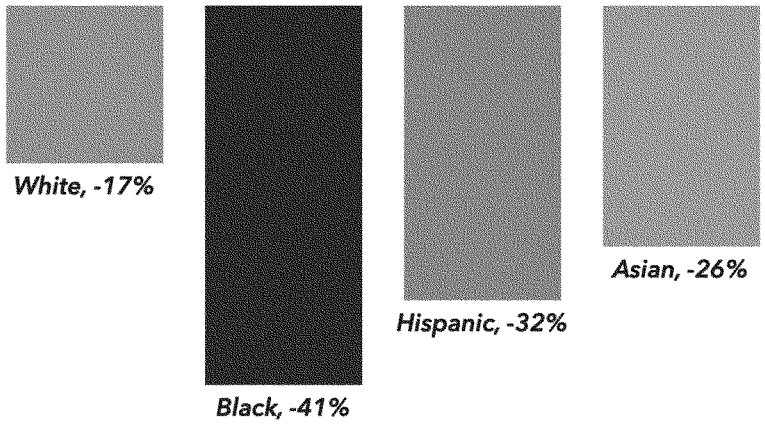
These disparities are in part caused by the fact that racial and ethnic minorities make up a disproportionate share of hourly wage earners; 25% are Hispanic, 15% are black, and 5% are Asian. In contrast, for the overall workforce, 17% are Hispanic, 13% are black, and 6% are Asian.[1] [2]

[1] M. Ross and N. Bateman, Meet the Low-Wage Workforce. The Brookings Institution. 2019 Nov: https://www.brookings.edu/wp-content/uploads/2019/11/201911_Brookings-Metro_low-wage-workforce_Ross-Bateman.pdf; accessed June 9, 2020.

[2] Bureau of Labor Statistics, Labor force characteristics by race and ethnicity, 2018. 2019 Oct: https://www.bls.gov/opub/reports/race-and-ethnicity/2018/home.htm; accessed June 9, 2020.

While many white workers are in white collar professions in which remote work is possible, blacks and Hispanics often work in hourly-wage jobs where in-person attendance is essential. Researchers at the University of Chicago's Rustandy Center for Social Sector Innovation have found that hourly-wage workers have seen their hours cut by 50 percent in states that have continued to lock down their economies. In states that have reopened their economies, by contrast, hourly work is recovering.[3] Racial and ethnic minorities, unfortunately, live in many states where lockdowns have continued.

Figure 4. Reduction in Small Business Activity, by Ownership, February–April 2020



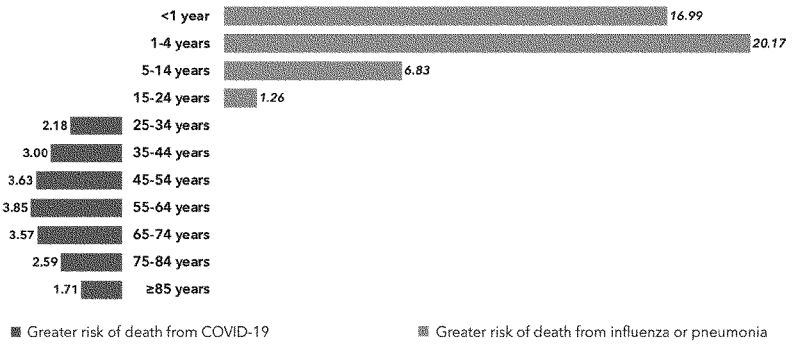
Minority-owned businesses have been disproportionately harmed by the COVID-19 lockdowns. In particular, businesses owned by African-Americans have seen substantial losses. *(Source: R. Fairlie, National Bureau of Economic Research)*

Small businesses have also been hammered by the policy response to COVID-19. A new working paper by Robert Fairlie of the University of California, Santa Cruz, estimates that "the number of active business owners in the United States plummeted by 3.3 million or 22 percent over the crucial two-month window from February to April 2020." Black-owned

[3] A. Bartik, M. Bertrand, F. Lin, J. Rothstein, & M. Unrath, Week 7 and 8: Labor Market Impacts of COVID-19 on Businesses: Update with Homebase Data Through May 23. University of Chicago: https://www.chicagobooth.edu/research/rustandy/blog/2020/week-7-labor-market-impacts-from-covid19; accessed June 3, 2020.

businesses fell 41 percent, Hispanic-owned businesses 32, percent, and Asian-owned businesses 26 percent. Immigrant-owned businesses dropped by 36 percent.[4]

Figure 5. Estimated Relative Risk of Death from Influenza vs. COVID-19
(Assuming 150,000 Total COVID-19 Deaths)



Those under aged 25 are at the lowest risk of death from COVID-19. A clear pattern emerges from what we know, in which those under aged 25 are at the lowest risk of death from COVID-19, relative to influenza or pneumonia. *(Source: A. Roy, FREOPP.org)*

LOCKDOWNS WIDEN EDUCATIONAL DISPARITIES

A necessary step to allow the nation to go back to work is to reopen K-12 schools, preschools, and child care centers. Beyond their mission of providing learning opportunities, K-12 schools, preschools and child care centers allow their parents to work.

Reopening the nation's education and child care programs is also important to ensure that American children continue to learn, and particularly to help children from lower-income families who often have fewer opportunities to learn outside of school. Researchers have found that differences in outside of school learning opportunities contribute to the academic achievement gap between rich and poor children.[5] The current situation is likely

[4] R. Fairlie, The Impact of Covid-19 on Small Business Owners: Evidence of Early-Stage Losses from the April 2020 Current Population Survey. National Bureau of Economic Research. 2020 Jun: https://www.nber.org/papers/w27309.pdf; accessed June 9, 2020.
[5] J. McCombs et al., Making Summer Count. RAND Corporation: 2011: https://www.rand.org/content/dam/rand/pubs/monographs/2011/RAND_MG1120.pdf; accessed June 19, 2020.

exacerbating this opportunity gap, particularly since poor children are less likely to have internet access at home.[6]

Widespread school closures have other negative consequences for the nation's children, and particularly those from low-socioeconomic backgrounds. For example, American schools provide food to more than half of the school aged population. Nearly 30 million children receive free or reduced-price lunch through the National School Lunch Program. (While most children will not go hungry without free or subsidized meals, children from the poorest families could be affected by the lack of regular access to these services.) Schools and child care centers also play a critical role in state child welfare systems and supporting children's health.

In addition, other student populations, including children with special needs and English language learners, suffer from school closures and the lack of specialized instruction outside of school.

Beyond these direct educational effects, widespread closures are having significant impacts on school systems. For example, dozens of private schools are closing due to the loss of revenue and families' inability to afford tuition after the pandemic. These closures may increase the burdens on traditional public school systems as private school students enroll in public schools. (A coalition of organizations that support choice in education estimated that public schooling costs will increase by $15 billion if 20 percent of private school students enroll in public schools.) Moreover, many states are projecting revenue shortfalls due to the pandemic and economic downturn.

American policymakers and school leaders have an opportunity to study and learn from international examples, particularly as several nations have already reopened and are operating their school systems. Schools in other countries are applying a range of tactics to protect public health, such as modifying school calendars and schedules, promoting social distancing, keeping windows open to improve ventilation, and checking students' temperatures.

The good news is that children and young adults are at extremely low risk of dying of COVID-19, as detailed in Figures 2 and 11.

State and local policymakers must quickly work to develop two distinct but aligned education systems: (1) a physical school system for in-person learning consistent with public health guidance, and (2) a virtual or distance learning that supports all children's options to learn at-home or outside of the traditional school setting. A forthcoming paper from the Foundation for Research on Equal Opportunity, co-authored by Dan Lips, Preston Cooper, and Avik Roy, among others, will explore these questions in detail.

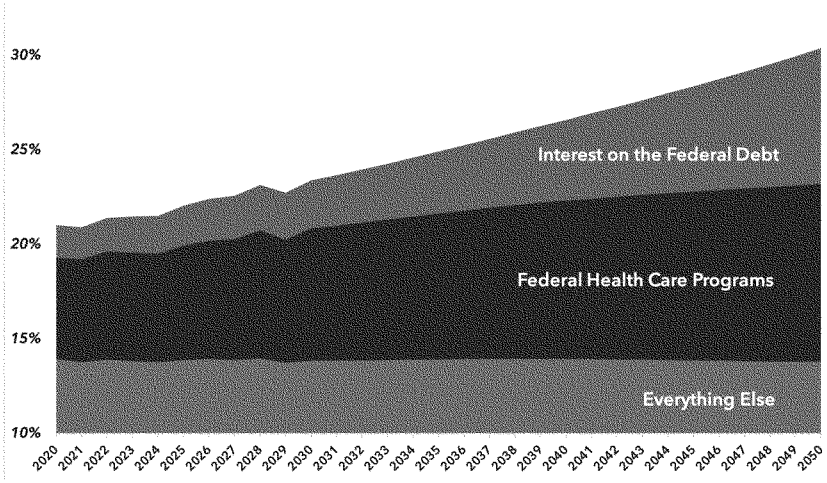
RISING FEDERAL DEBT HARMS LOW-INCOME AMERICANS

Congress has enacted several major pieces of legislation in order to compensate for economic lockdowns, most notably the Coronavirus Aid, Relief, and Economic Security Act

[6] National Center for Education Statistics. Table 218.70: Number and percentage distribution of 5- to 17-year-old students, by home internet access, poverty status, and locale: 2017. https://nces.ed.gov/programs/digest/d18/tables/dt18_218.70.asp?current=yes; accessed June 19, 2020.

of 2020. In total, these bills have increased the federal debt by over $2 trillion.[7] Continued lockdowns will increase pressure on Congress to enact further deficit-increasing legislation.

Figure 6. CBO: Long Term Budget Projections, 2020–2050



Medicare, Medicaid, and interest on the debt drive unsustainable federal spending. As a share of gross domestic product, growth in federal health care programs and interest on the debt drive all federal spending as a share of economic output. The trillions in COVID-19 economic relief passed by Congress further destabilize the federal budget. *(Source: Congressional Budget Office)*

Material increases in the federal debt further destabilize what is already a dangerous situation, in which federal health care entitlements like Medicare and Medicaid, along with interest payments, overwhelm the ability of the federal government to collect sufficient revenue. If demand for U.S. Treasury bonds declines on account of decreased U.S. creditworthiness, such that Congress must enact substantial austerity measures, it will be low-income Americans who will bear the greatest burden.

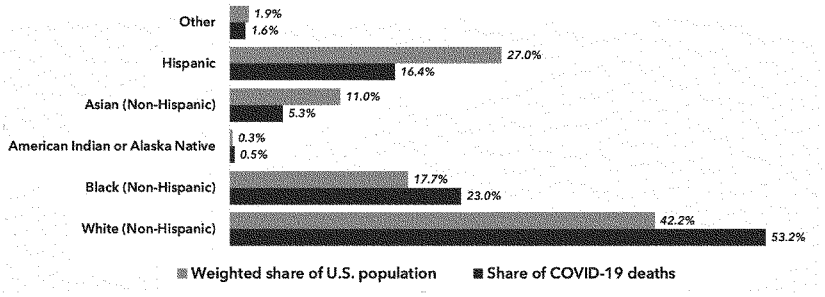
First, if Congress significantly raises taxes in order to reduce the debt, the resulting shrinkage of the economy will most harm economically vulnerable Americans, as shown above, through rising unemployment.

[7] Congressional Budget Office. H.R. 748, CARES Act, Pubic Law 116-136. 2020 Apr 16: https://www.cbo.gov/publication/56334; accessed June 20, 2020.

Second, reductions in federal spending will most harm those who most depend on that spending, such as Medicare and Medicaid beneficiaries.

Hence, it is essential that Congress consider ways to pay for the recent COVID-19 relief packages, and also avoid further destabilizations of the federal budget. One small contribution to that effort would be the enactment of the Prescription Drug Pricing Reduction Act reported by the Senate Finance Committee in the summer of 2019, which the Congressional Budget Office projects as reducing federal spending by $94 billion from 2021–2030.[8]

Figure 7. CDC: Share of COVID-19 Fatalities by Race & Ethnicity, vs. Geographically Weighted Share of U.S. Population



Racial and ethnic distribution of COVID-19 fatalities is mixed. Whites and blacks are both overrepresented in their share of COVID-19 deaths, relative to their geographically adjusted share of the U.S. population. In contrast, Asians and Hispanics are underrepresented in their share of COVID-19 fatalities. *(Source: Centers for Disease Control and Prevention)*

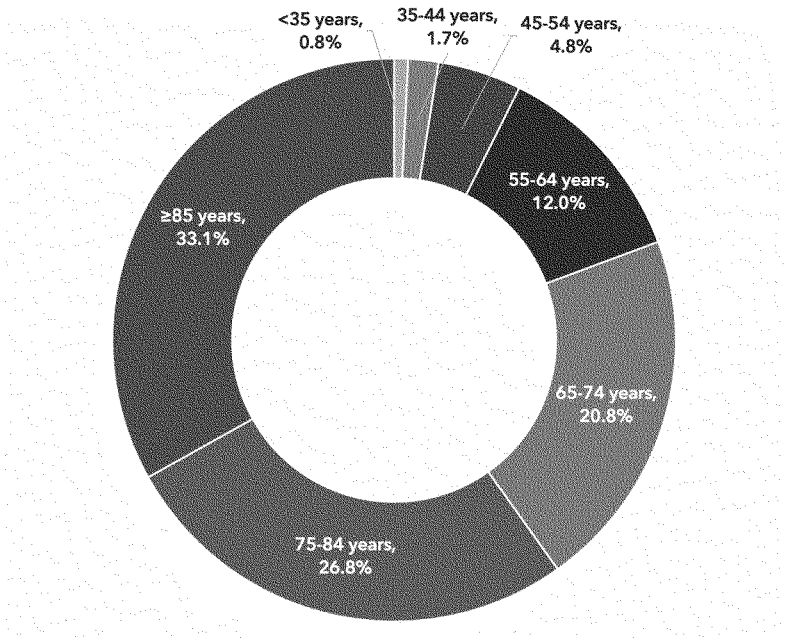
RACIAL DISPARITIES IN COVID-19 MORTALITY ARE MIXED

On a population level, both whites' and blacks' shares of COVID-19 deaths are higher than one would expect if deaths were evenly racially distributed. On the other hand, Asians' and Hispanics' shares of COVID-19 deaths are lower than one would expect. For example, whites represent 53 percent of all COVID-19 deaths, but only 42 percent of a geographically adjusted population. 23 percent of fatalities are among blacks, while blacks represent 18 percent of the geographically adjusted population.[9]

[8] Congressional Budget Office. Prescription Drug Pricing Reduction Act of 2019. 2019 Dec 6: https://www.finance.senate.gov/imo/media/doc/2020-03-13%20PDPRA-SFC%20CBO%20Table.pdf; accessed June 20, 2020.

[9] Centers for Disease Control and Prevention. Weekly Updates by Select Demographic and Geographic Characteristics. https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/; accessed June 3, 2020.

Figure 8. Share of COVID-19 Fatalities by Age Bracket



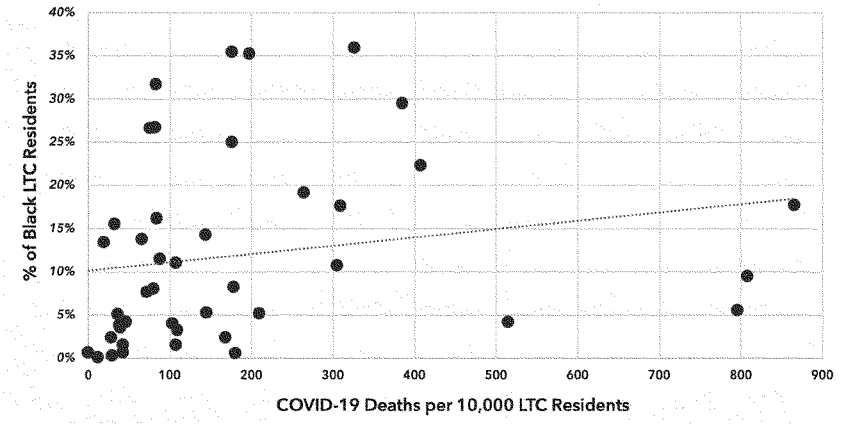
COVID-19 mortality is heavily skewed toward those over 65. 81 percent of all deaths from COVID-19 have occurred among those 65 and older. Those under 35 years of age represent 0.8 percent of deaths.. *(Sources: CDC, FREOPP analysis)*

(The Centers for Disease Control and Prevention geographically adjust racial and ethnic groups' shares of the U.S. population in order to take into account the fact that COVID-19 fatalities are concentrated in cities, where a higher percentage of the overall population is non-white.)

The most probable explanation for most of these differences is related to age. Serious illness and death from COVID-19 are highly concentrated among the elderly. 81 percent of all U.S. COVID-19 deaths have taken place among those aged 65 or older; by contrast, only 0.8 percent of U.S. COVID-19 deaths have taken place among U.S. residents younger than 35. This is important to account for, because while the median age of white Americans is 44, for Asians it is 37, and for Hispanics it is 30. In other words, the disparity in share of deaths

relative to whites, Hispanics, and Asians may turn out to be mostly explained by age differences, even though working-age adults represent a higher share of COVID-19 deaths among non-white racial and ethnic groups.

Figure 9. No Correlation Between Long-Term Care COVID-19 Fatality Rates and State-Level African-American LTC Resident Share



At the state level, there is no correlation between African-American race and mortality in nursing homes and assisted living facilities. States with high black population shares in nursing homes and assisted living facilities were not correlated to those with high levels of black mortality. The r^2–the probability of a linear correlation–was only 3.5%. *(Sources: Brown University, FREOPP analysis)*

The same explanation does not fully apply to blacks. The median age of African-Americans is 34—somewhere in between that of Hispanics and Asians—but blacks suffer from a disproportionate share of COVID-19 mortality.

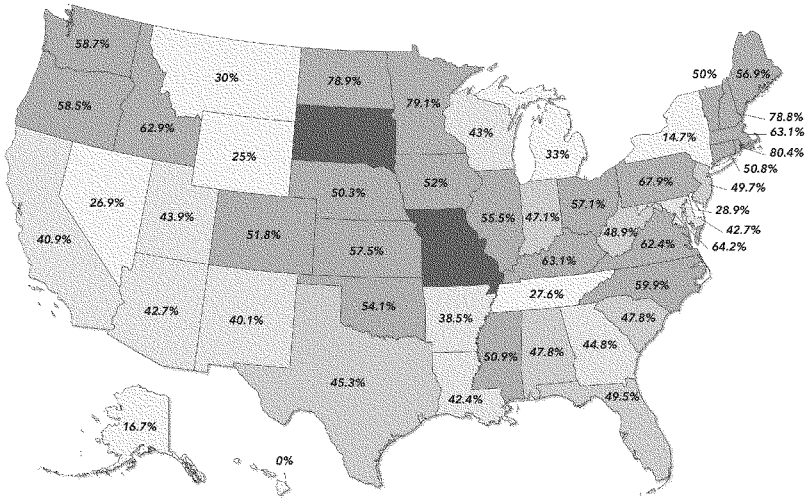
Further data from the CDC, breaking out racial and ethnic shares by age bracket, should help us learn more about these differences, though in our view that data is not yet mature enough for us to draw firm conclusions.

LTC FACILITIES: 43% OF COVID-19 DEATHS, BUT 0.6% OF THE POPULATION

Another source of racial disparities in COVID-19 health outcomes may come from nursing homes and assisted living facilities. Nursing homes, in particular, serve disproportionately

poor individuals, with a large number of Medicaid enrollees. Vulnerable seniors residing in such long-term care facilities represent 43 percent of U.S. COVID-19 fatalities, while residents of such facilities only account for 0.6 percent of the total U.S. population.[10]

Figure 10. COVID-19 Deaths in Long-Term Care Facilities as a Share of Total COVID-19 Deaths (as of June 19, 2020)



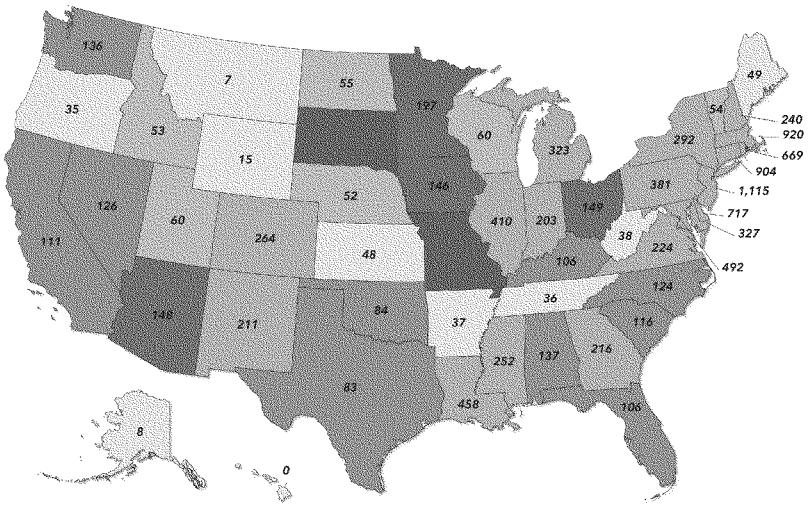
0.6% of Americans live in long-term care facilities that account for 42% of all COVID-19 deaths. In some states, this tragedy was compounded by policies that forced nursing homes to accept patients infected with the novel coronavirus SARS-CoV-2. *(Source: G. Girvan and A. Roy, FREOPP.org)*

In part this is due to disastrous decisions taken by some state governors to force nursing homes to accept COVID-infected patients who had been discharged from a hospital, including New York, New Jersey, and Michigan.[11] This catastrophic policy helped spread

[10] G. Girvan and A. Roy, Nursing Homes & Assisted Living Facilities Account for 42% of COVID-19 Deaths. The Foundation for Research on Equal Opportunity. 2020 May 7: https://freopp.org/the-covid-19-nursing-home-crisis-by-the-numbers-3a47433c3f70?source=collection_home---1------0----------; accessed June 3, 2020.
[11] A. Roy, The Most Important Coronavirus Statistic: 42% of U.S. Deaths Are From 0.6% Of The Population. *Forbes*. 2020 May 26: https://www.forbes.com/sites/theapothecary/2020/05/26/nursing-homes-assisted-living-facilities-0-6-of-the-u-s-population-43-of-u-s-covid-19-deaths/#232a01f074cd; accessed June 3, 2020.

COVID-19 in long-term care facilities, leading to needless deaths and additional hospitalizations that we then asked our health care personnel to take on.

Figure 11. COVID-19 Deaths in Long-Term Care Facilities per 10,000 Long-Term Care Residents (as of June 19, 2020)



COVID-19 deaths in nursing home and assisted living facilities are concentrated in the Northeast. In New Jersey, more than one in ten long-term care facility residents have died of the novel coronavirus. *(Source: G. Girvan and A. Roy, FREOPP.org)*

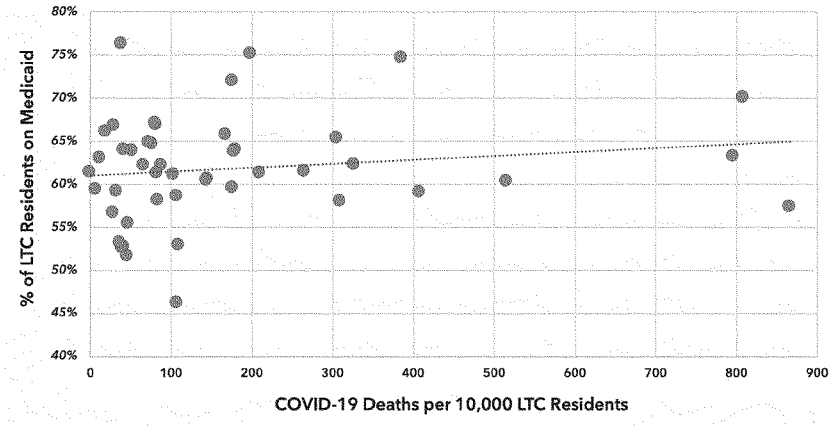
In order to examine racial disparities in COVID-19 deaths in nursing homes, Gregg Girvan and I looked at state-level long-term care facility mortality rates, and compared them to the percentage of blacks living in long-term care facilities, and also the relationship between nursing home mortality and Medicaid eligibility.

There was no correlation between black race and state-level long-term care fatalities. The r^2—the probability of a linear relationship between high black population and high long-term care death rates—was only 3.5 percent. Similarly, there was no correlation between states with high Medicaid enrollment and those with high COVID-19 mortality rates in their assisted living facilities; the probability of a linear correlation was only 2.3 percent.

This finding was surprising, because we would expect to see that nursing homes with a high volume of low-income patients would fare worse under COVID-19. We aim to investigate

this question further, at the county level, in order to determine if the correlations are stronger within states.

Figure 12. No Correlation Between Long-Term Care COVID-19 Fatality Rates and State-Level Medicaid LTC Resident Share



At the state level, there is no correlation between enrollment in Medicaid and COVID-19 mortality in nursing homes and assisted living facilities. States with high Medicaid enrollment in nursing homes and assisted living facilities were not correlated to those with high levels of COVID-19 mortality. The r^2–the probability of a linear correlation–was only 2.3%. *(Sources: Brown University, FREOPP analysis)*

One explanation for this finding could be that nursing home and assisted living facility residents are, as a group, vulnerable to the coronavirus pandemic, and that therefore African-American resident share is less impactful on overall long-term care mortality statistics.

ECONOMIC LOCKDOWNS IMPACT PUBLIC HEALTH

It is essential and urgent that states and localities do everything possible to responsibly reopen their economies.[12] We can do this by focusing on protecting high-risk populations,

[12] L. Chen, B. Kocher, A. Roy, & B. Wachter, A New Strategy for Bringing People Back to Work During COVID-19. The Foundation for Research on Equal Opportunity. 2020 Apr 14: https://freopp.org/a-new-strategy-for-bringing-people-back-to-work-during-covid-19-a912247f1ab5; accessed June 3, 2020.

like the elderly in nursing homes; reopening schools; and reopening workplaces where it is safe to do so, especially for low-risk workers.

Economic lockdowns do not merely have a financial impact on racial and ethnic minorities who lose their jobs or have their hours cut. Economic dislocation also worsens health outcomes in myriad ways, whether by deaths of despair, inability to access or afford physicians, or disruption in health insurance coverage.

Reopening the economy is not merely about livelihoods, but also about lives.

APPENDIX: REOPENING THE U.S. ECONOMY EVEN IF THE PANDEMIC ENDURES

Avik Roy, The Wall Street Journal, April 24, 2020

As the Covid-19 shutdown enters its second month, policy makers and commentators have emphasized that we're not yet out of the woods. Deaths and hospitalizations are continuing to rise, albeit more slowly than before. The flattening curves have encouraged some people to talk about reopening the economy, and others to rise in protest against ongoing restrictions, but most Americans remain cautious. We've been willing to endure the staggering economic damage because we're convinced that it's necessary for public health—and that the lockdowns won't last too long.

Indeed, a kind of conventional wisdom has emerged among public health officials and policy experts. We're told that life will go back to normal just as soon as we've reached a series of public health milestones: near-universal testing, the development of effective treatments, the emergence of herd immunity and, ultimately, approval of a vaccine.

But this conventional wisdom has a critical flaw. We've taken for granted that our ingenuity can solve almost any problem. But what if, in this case, it can't? What if we can't scale up coronavirus testing as quickly as we need to? What if it takes us six or 12 months, instead of three, to identify an effective treatment for Covid-19? What if those who recover from the disease fail to gain immunity and are therefore susceptible to getting reinfected? And what if it takes us years to develop a vaccine?

Once we start asking these questions, a terrible truth becomes clear: The scenario in which we meet all the public health milestones, and then return to our regularly scheduled economic programming, is highly optimistic. A more realistic scenario is that we will fail to reach one or more of the milestones. If that happens, do we prolong the economic shutdown for six months or longer? Do we impose a series of on-and-off stay-at-home orders that could go on for years?

The damage from a prolonged economic shutdown is difficult to contemplate. Tens of millions of Americans have already lost their jobs. Countless small businesses have closed—many for good. Two months ago, 20% unemployment seemed unthinkable. Two months from now, 20% unemployment might seem like the good old days.

Americans are optimistic by nature, and the public is right to hope for the best. But policy makers must prepare for the worst. And that means we must consider options for reopening the economy in a world in which we have not completely controlled the Covid-19 pandemic.

Time is of the essence. Every week matters. A 2016 study by the JPMorgan Chase Institute found that the median small business holds just 27 days' worth of cash in reserve. For restaurants, retail shops and construction firms, the buffer is even thinner.

The good news is that there are ways to get America back to work while we control the spread of SARS-CoV–2, the novel coronavirus that causes Covid-19. We need to escape from the false dichotomy which insists that the only way to improve public health is by shutting down the economy and the only way to improve the economy is by sacrificing public health.

How hard will it be to achieve the conventional public health milestones? Harder than it looks.

Consider testing. There are two principal kinds of tests: those that detect if a patient has developed antibodies to the virus and those that measure viral RNA levels in a patient's

nasal secretions. Both have significant technical limitations. Antibody tests often suffer from accuracy problems and can fail to detect an active infection. Viral RNA tests are highly accurate, but most versions must be administered in a clinical setting like a doctor's office or a hospital, making them difficult to scale up.

To match the modestly high level of coronavirus testing for which South Korea has been praised, the U.S. would need to administer 7 million tests a week. We'll be fortunate if we reach half that number by September.

There's good reason to be confident that we'll eventually find an effective treatment against Covid-19. According to the Milken Institute, there are more than 150 drugs being actively tested against the disease. Some of them are likely to work. But when will we know?

The first drug to get some positive buzz was hydroxychloroquine, but in the latest published clinical trial, more patients on the drug died relative to those taking a placebo. Over the past week, remdesivir, a failed Ebola drug, was generating excitement because of positive anecdotal data out of Chicago. On Thursday, however, the World Health Organization inadvertently posted preliminary findings from a larger, randomized study, in which patients on remdesivir actually fared worse than those on a placebo.

Gilead Sciences, remdesivir's manufacturer, insists that "trends in the data suggest a potential benefit." But if future studies produce similarly negative results, we may be waiting several more months to find an effective therapy.

We'd be less dependent on treatments if more Americans could become immune to SARS-CoV-2. Most people who recover from Covid-19 develop antibodies to the virus; epidemiologists hope that these antibodies will confer protection from future reinfection. If more people can gain immunity, the virus will have a harder time spreading, eventually dying out.

But what if antibodies don't confer immunity or if the protection doesn't last very long? This is a very real possibility, based on our experience with other coronaviruses, like the original SARS from 2003 and even the common cold.

The same issue may make it hard for biotech companies to develop an effective vaccine. Vaccines are hard enough to develop in normal circumstances. After decades of trying, we still don't have vaccines against HIV or hepatitis C. The fastest vaccine ever developed for a viral infection is the Ebola vaccine, which took five years. And yet many commentators talk about developing a SARS-CoV-2 vaccine within 12 to 18 months, as if it were a piece of cake.

For these reasons, it's essential for the U.S. to move rapidly away from an unrealistic checklist of public health milestones and to focus instead on the specific biology of the new coronavirus and specific evidence of how Covid-19 spreads. If we do that, we'll find that we have better options to reopen the economy than we once believed.

The starting point for a more realistic strategy is the key fact that not everyone is equally susceptible to hospitalization and death due to Covid-19. There is considerable evidence that younger people largely avoid the worst health outcomes. According to the Centers for Disease Control and Prevention, those over the age of 65 are 22 times more likely to die of Covid-19 than those under 55.

That is not to say that younger people are invulnerable. We've seen significant numbers of deaths among those of middle age and above who suffer from chronic diseases like high

blood pressure, cardiovascular disease, diabetes and kidney failure. Men appear to have nearly twice the fatality rate of women.

Still, the much lower incidence of death among younger people warrants a reconsideration of our one-size-fits-all approach to stay-at-home policies, especially outside the hard-hit tri-state region of New York, New Jersey and Connecticut.

To start, states and localities should work as quickly as possible to reopen pre-K and K-12 schools. Children have a very low risk of falling seriously ill due to Covid-19, and the majority can and should return to school this academic year. Switzerland, for example, is planning to reopen schools on May 11, based on research showing that school closures were among the least effective measures at reducing European Covid-19 cases.

Children who live with the elderly or other at-risk individuals should continue to stay home. Teachers and staff from vulnerable populations should stay home as well, with paid leave. School districts should immediately begin to develop virtual lesson plans for those who must remain home.

Similarly, we should reopen workplaces to healthy, non-elderly individuals who don't live with vulnerable people. At-risk individuals with jobs should continue to have opportunities to work from home or to receive paid medical leave.

And we should reopen businesses that may not be "essential" but can be safely operated while maintaining appropriate physical distance between workers and customers. We should offer a fixed-dollar per-worker tax credit to employers who test their employees, thereby giving businesses an incentive to scale up testing and increase consumer confidence.

Nursing homes are at especially high risk for Covid-19. Indeed, in many European countries, roughly half of all deaths due to Covid-19 have taken place in assisted living facilities. In the U.S., the share of nursing home deaths is lower. But, disastrously, New York state has forced nursing home operators to accept previously hospitalized Covid–19 patients, exacerbating the outbreak.

We must ensure that nursing homes get all the help that they need to protect their residents, including regular testing for residents and staff. Jails and prisons will also need additional resources to manage their most crowded facilities.

While we're reopening the schools and the economy to lower-risk individuals, and protecting the vulnerable, we should make sure that we're using modern public health techniques to help slow the spread of the virus. The most important of these is contact tracing.

Once someone tests positive for Covid-19, local officials should interview the patient to see who he or she has spent time with in previous weeks. The officials can then work backward to talk to those contacts—and their contacts, and so on—to ensure that those at risk get tested and treated.

In recent months, East Asian countries like Singapore, Taiwan and South Korea have deployed a much more sophisticated version of contact tracing, in which Bluetooth or GPS-enabled smartphones help officials automatically alert those who have recently been in close contact with an infected individual. U.S. companies are working on versions of the technology, including some with robust privacy protections.

A key virtue of contact tracing is that it can work in an environment where testing for SARS-CoV-2 is far from universal. Indeed, if we succeed in encouraging people to use

contact tracing apps in the U.S., we may be able to control the spread of Covid-19 with the modest levels of testing we already have.

On April 16, President Trump unveiled his plan for reopening the economy. It improves on the conventional wisdom by setting aside comprehensive testing, effective treatment and herd immunity as absolute prerequisites for action. Still, the Trump plan is overly cautious about reopening the economy and especially schools. The president's team recommends that schools only reopen in "states and regions with no evidence of a rebound" in infections and hospitalizations.

Reopening the schools is important for the welfare of children, especially those in low-income communities, but it's also important for their parents. Think of the pharmacist single mother who can't go to work because the schools are closed and her children would be left alone at home. We might even consider extending school into the summer, so that children and parents can make up for lost time, and camps and summer programs also should be released from lockdown restrictions.

There are more things that we can do to help improve our economy. We should expand the role of telemedicine for those who cannot see their physicians in person. We should accelerate highway construction projects while road traffic is meaningfully reduced. And we should do more to restore consumer confidence in air travel.

But most of all, we have to completely change our mind-set. Instead of thinking up creative ways to force people to stay home, we should think hard every day about how to bring more people back to work.

That doesn't mean the choices are easy. Minority communities are the ones most harmed by school closures, because they often lack the resources and opportunities to educate their children in other ways. At the same time, however, a larger share of African-Americans are at high risk from Covid-19, so under a partial reopening, more black children may need to stay home to protect their families.

Similarly, a faster reopening of workplaces will require vulnerable individuals of working age to remain home. While that may feel like an inequity, getting many more Americans back to work will have beneficial effects even for those who aren't among the first to return.

Reopening the economy is not merely about livelihoods, but also about lives. All of us can see the mounting mental and emotional toll of our ongoing lockdowns, and we've learned a great deal in recent years about how high unemployment increases deaths of despair. If we keep these urgent problems in mind—and not just infection rates and case fatality ratios—we may yet find our way out of this crisis.

Mr. Roy is president of the Foundation for Research on Equal Opportunity and the co-author (with Lanhee Chen, Bob Kocher and Bob Wachter) of the foundation's "A New Strategy for Bringing People Back to Work During Covid-19," from which this essay is partially adapted.

Chairman YARMUTH. Thank you for your testimony, Mr. Roy.

Thanks once again to all the witnesses for their testimony. And we will begin our question-and-answer period right now.

As a reminder, Members can submit written questions to be answered later in writing. Those questions and the witnesses' answers will be made part of the formal hearing record. Any Members who wish to submit questions for the record may do so by sending them to the clerk electronically within seven days.

As is our custom, the Ranking Member and I will defer our questions until the end. So I now recognize the gentleman from New York, Mr. Higgins, for five minutes.

[Pause.]

Chairman YARMUTH. Please unmute.

Would you like the staff to unmute you? Please nod.

Mr. HIGGINS.

[Nodded.]

Thanks, I think you are good to go.

Mr. HIGGINS. All right, thank you very much, Mr. Chairman, and thank you, panel.

Just a couple of thoughts here, first and foremost, and that is that 120,000 Americans are dead, and we have a government lockdown of the American economy because federal government failed to protect the American people.

We have a highly infectious, contagious disease that attacks the lung, the liver, and the heart. And the best thing that our fragile health care system can do for people suffering through the symptoms of COVID–19 is to provide them with Tylenol to help break their fever and to help them with their pain. The United States is the richest country in the world. We pay more for health care than any other country, and we have no treatment and we have no vaccine.

Dr. Harris, I think this is an appalling set of circumstances for our country. And what has been done to the African-American community with the higher than—the percentage of their population, cases of COVID–19, whether it is in Buffalo or any other city in this country, is very revealing, and exposes the acute fragility of the American system.

Now, I have heard Dr. Fauci, who probably is the most credible public health official, say that he is optimistic about the possibility of a vaccine at the end of this year. That is about eight months from when we discovered this. From what I can tell, the quickest development of a vaccine was by Merck in response to Ebola, which was five years.

Do you, as a medical professional, the formal head—the former head of the American Medical Association, share my concerns that what Dr. Fauci is saying and what people hear are two different things?

I am concerned when he advances that optimistic view, perhaps overly, of having a vaccine by the end this year, what people hear is that they can become complacent about the things that we are doing now, social-physical distancing, face masks, and personal hygiene. I would like to get your thoughts on that.

[Pause.]

Chairman YARMUTH. Please unmute, Dr. Harris. There.

Dr. HARRIS. Yes, yes, sorry about that.

Thank you, Congressman. And let me first say that, of course, Dr. Fauci is the foremost expert on infectious diseases in our country.

And look, I want to parse a little bit what I hear Dr. Fauci saying, as well. And I do think that there is certainly nothing wrong with being optimistic. But when Dr. Fauci—and you are right, that an end-of-year timeframe is optimistic and ambitious. But certainly when you have an all-hands-on-deck approach, I know it is possible.

But I also hear Dr. Fauci saying that a vaccine could perhaps be developed by the end of the year. And I think what this body knows is that is just the first step, is development. Then you have to manufacture. Then you have to distribute. And you have to, of course, make sure that the vaccine is ultimately equitably distributed.

So certainly, Dr. Fauci is—has information that I don't have, and certainly I would follow his lead when it comes to his timeline. But I also know that it will be important not just to develop the vaccine, but also get it distributed. And we have to make sure that there is a diverse population who is included in the clinical trials.

Mr. HIGGINS. OK. Thank you. And just a final thought. It is like a tale of two countries.

I represent Buffalo on the Canadian border. And the United States' federal response to coronavirus, COVID–19 was late, sloppy, and adversarial. The Canadian Federal response was early, strong, and united. I am trying to help get the U.S.-Canadian border opened up, and, you know, we have been unsuccessful. I am doing this with Elise Stefanik, who is my co-chair on the Northern Border Caucus.

Here is why. The entire province of Ontario that includes Toronto, has 250 cases of COVID–19 for every 100,000 population. New York City has 2,576 cases for every 100 (sic) population, 10 times more. The reason we can't get the border open is because the Canadians in Ontario don't want Americans over there, because, given our high numbers, we are super-spreaders. And again, I just think that underscores—I love optimism, but I want reality, as well. And unless and until we develop an effective treatment in vaccine, there is no normalcy, not in terms of our health care, and not in terms of our economy.

With that, I will yield back, Mr. Chairman.

Chairman YARMUTH. I thank you. The gentleman's time has expired. I now recognize the gentleman from Georgia, Mr. Woodall, for five minutes.

Please unmute.

Sorry, hold on. I think Rob dropped out. I now recognize the gentleman from Ohio, Mr. Johnson, for five minutes.

Mr. JOHNSON. Well, thank you, Mr. Chairman. I appreciate your holding this hearing—and Ranking Member Womack. I think it is an important hearing.

You know, over the past few months we have seen the devastating impacts of the COVID–19 pandemic on our communities, and we have also seen the positive power of deregulation when it

comes to removing barriers to health care and stimulating our economy.

And as we continue the long road to recovery, we must recognize the importance of deregulation and the need to continue removing unnecessary regulations that may inhibit economic recovery.

I know in my district we are already seeing the benefits of deregulation, especially when it comes to reducing barriers to telehealth access. The deregulation of telehealth during the COVID–19 pandemic has not only improved access to health care for my constituents in eastern and southeastern Ohio, but it also provided invaluable care for those in under-served rural areas across the nation. Deregulation has helped change the way health care is delivered. We saw it play out over the past few months.

It is my hope that Congress will embrace more regulatory flexibility that will ultimately help in our economic recovery, and lead to greater access to quality, affordable health care.

So there is no question that this crisis has exposed the need for more health care reform. But the solution is certainly not to expand the Affordable Care Act, which has resulted in fewer choices and higher health care costs. The American people deserve better than a continuation of the ACA's broken promises, most notably the broken promise that it would reduce insurance costs, the broken promise that it would improve access, and the broken promise that it would increase patient choice.

Future health care reform must be patient-centered. Americans need more choices when it comes to health care. And Congress should do everything in its power to prioritize a patient-centered, consumer-controlled health care system, rather than an inefficient, expensive government-run health care system. The American people deserve patient-centered, market-based reforms that will strengthen the patient-doctor relationship, and give patients the ability to choose how best to meet their health care needs.

And I look forward to working with my colleagues on these important issues as Congress takes additional steps to mitigate the impacts of the COVID–19 pandemic.

So, Dr. Roy, prior to the COVID–19 pandemic, the federal budget was unsustainable, with the debt rising uncontrollably. In your opinion, what effect does the rising federal debt have on low-income Americans?

Mr. ROY. Well, as I mentioned in both my written and oral remarks, Mr. Johnson, I am very concerned that both the spending of the CARES Act and related legislation and also the declining tax revenue from the economic lockdowns creates a perfect storm, which is going to massively increase the deficit. And then that is going to push forward—meaning closer in time to us today—the fiscal reckoning that is sure to come with runaway federal debts.

We are almost already at the point in which the interest on the federal debt exceeds what we pay for national defense. And when we get to a point where we have to cut back spending on Medicare and Medicaid because our bondholders leave us no choice, who is going to be most harmed? It is the people who most depend on those programs. Those who have high incomes, who can afford private insurance will be fine. It is those that can't who will be most harmed.

Mr. JOHNSON. Yes, I agree. You know, continuing with you, Dr. Roy, according to your research, what have been the public health impacts of the lockdowns and the extended lockdowns on low-income and minority communities?

Mr. ROY. Well, that is an excellent question and one that doesn't get asked enough, Mr. Johnson. And what I would say is that it is going to take us years to really know what the effects are. But what we can certainly expect is that there are going to be people who didn't get their mammogram or their prostate exam during the lockdown. And as a result, when their cancer does get diagnosed, it is too late to do something about it.

There are going to be people who had a heart attack, but that heart attack went untreated. But we know that because the number of people who have gone into hospitals reporting heart attacks has declined precipitously during the lockdown. I could go on and on. But there are many, many different areas of public health where we ought to be concerned.

And then there is just the overall effects of massive unemployment for a prolonged period of time, and the effect that has on life expectancy and other public health measures.

Mr. JOHNSON. Yes, OK. Well, I have other questions. I will submit those for the record, Mr. Chairman, but thanks and I yield back my time.

Chairman YARMUTH. Absolutely. The gentleman's time has expired. I now recognize the gentlelady from Connecticut, Ms. DeLauro, for five minutes.

Ms. DELAURO. Can you hear me?

Wonderful. Oh, my gosh. I have become a technological genius in all of this. Thank you so much. Thank you so much, Mr. Chairman, Mr. Womack, for this hearing, and to our panelists.

Dr. Deaton, I wanted to ask you, along with my colleague, Suzan DelBene, and Senators Michael Bennet and Sherrod Brown, I have introduced the American Family Act that would take our Child Tax Credit and essentially turn it into a child allowance by extending full eligibility to one-third of all children and families who earn too little to get the full credit. It increases its value and it delivers it monthly.

The Child Tax Credit is our nation's largest expenditure on children, and the recent data shows that the American Family Act would cut child poverty, that rate, by about two-fifths; the Black child poverty rate in one-half; and the Hispanic child poverty rate by 41 percent. What we do in the House-passed Heroes Act, it contains a one-year version of this policy that would provide $300 a month for young children and $250 for older children. In essence, the credit is fully refundable, you get $3,600 for young children under 6, $3,000 for older children ages six to 17. It is monthly installments indexed to inflation.

My question is, you have spoken about the importance of family allowances when you were a young father. Help us—and can you please talk, I guess, what it meant to you, what it might mean for families and for children in the United States in the short term and in the longer term, as we look to deal with the issue of inequality, of poverty, and those whom are essentially the most affected about this today?

Dr. DEATON. Thank you. Thank you very much. I would tend to defer to some of my colleagues on child poverty in the United States, but I know it is a huge problem.

Ms. DELAURO. It is.

Dr. DEATON. And a great scandal. And it really is important, not just for the suffering it engenders now, but the suffering it engenders in the future. There is really good evidence that children who grow up in poverty tend to suffer throughout their lives as a consequence.

You asked me of my own experience. I grew up in Britain, and I was a young widower when I was 29, and the child allowances that were paid to my two kids made the real difference for me between being able to go on and having enough money to put food on the table and look after my kids.

I think it is not just children, but, I mean, I think one of the things that Anne Case and I talk about in our book is that the social safety net in America, compared with what has happened in Europe, is very frayed in many, many places. And, you know, people on the other side—and I, too—would say, well, you know, how are you going to finance that?

And I think it is long past time for Americans to think seriously about a value added tax, which they have in Europe. It is a tax that people don't mind paying very much. It also generates a lot of revenue. It is somewhat regressive in who pays it, because everybody pays it. But the net effect, when it goes to things like child credits, and child tax credits, and so on, and child benefits, is that it is extremely progressive.

It also means that, when you have something horrible happen like this happened here, that kicks into place immediately in a way that it just doesn't in this country at all, so that we have a sort of automatic set of responses to bad times when we come. So I am very much in favor of that sort of expansion, and in using a value added tax to try to pay for it.

Ms. DELAURO. I would—just would say with the just remaining few seconds that I have, Dr. Deaton, I think we are looking probably—it is unlikely that we are going to deal with a value added tax. But I believe that what we can do is to look at—and the child poverty rates, and to take a look at how a child tax credit, where we have got one-third of kids today, mostly African-American kids and Latino kids, who are not eligible because their families make too little, but to try to do something that we might in a positive way move forward on, because it is already in existence and we are just adding it—to it.

Thank you so much, and thanks to all of you for your testimony.

I yield back.

Chairman YARMUTH. The gentlelady's time has expired. I now recognize the gentleman from North Carolina, Mr. Holding, for five minutes.

Mr. HOLDING. Thank you——

Chairman YARMUTH. Please unmute.

Mr. HOLDING [continuing]. very much, Mr. Chairman. I appreciate that.

As pointed out, this virus and the statewide closures we used to contain it have highlighted several inequities in access to child care

and nutrition services. And not only are minority children more likely to depend on school food programs, but they are also more likely to have parents who work in the services industry, and are unable to stay at home when schools close.

And as we have seen, disparities in nutrition access are not just short-term problems. Over time they lead to higher rates of comorbidities and chronic conditions that make minority communities especially vulnerable to viruses like the COVID–19.

From the beginning of this crisis, non-profits like the YMCAs in Raleigh and Charlotte have stepped up to address the nutrition and child care gap and support under-represented communities in their time of need. And over the past few weeks, the YMCA of the Triangle has served almost 50,000 meals to families across the region, and provided child care programs to over 1,700 health care workers. In Garner, North Carolina, in my district, the Poole Family YMCA has set up day camps for children, and runs blood drives to assist the health care community. These assistance programs played an essential role in providing stability to minority communities that have been disproportionately affected by this national emergency.

But despite the tremendous work that the YMCAs have done throughout the country, they have been left out of the federal assistance programs they desperately need. Under the Paycheck Protection Program, which Congress enacted specifically to help groups like this, affiliated organizations like the YMCA of Charlotte and the YMCA of the Triangle cannot access funds if they collectively employ over 500 people. And, as a result, these two YMCAs have furloughed over 95 percent of their staffs, and continue operating at a loss.

So, without immediate federal assistance, YMCAs across the U.S. will no longer be able to provide these invaluable community services. I am strongly urging all of my colleagues to support an adjustment in our next round of the Paycheck Protection Program to ensure non-profits like the YMCA continue to serve those in need.

So my question to you, Dr. Roy, can you speak to the potential long-term effects of irregular access to food and child care in low-income communities, and how the federal government can best work with the private sector and non-profits to bridge that gap?

Mr. ROY. Well, this is—there is a lot of things to say about this topic. Let me highlight one thing that I mentioned in my written testimony, sir, which is that the closure of schools is a big disruptor in the delivery of nutrition to low-income children because so many low-income children get their lunch through the federal school lunch program.

So this is a way the school closures interact with a lot of federal assistance which flows through public schools, and why—one of the reasons why it is important to reopen schools where it is prudently possible to do so. And we at FREOPP are putting out a plan very soon on how you can reopen schools in a way that is consistent with public health.

Mr. HOLDING. Excellent. Thank you very much.

Mr. Chairman, I yield back.

Chairman YARMUTH. The gentleman yields back. I now recognize the gentlelady from Illinois, Ms. Schakowsky, for five minutes.

Please unmute.

Ms. SCHAKOWSKY. Here I am. Thank you very much, Mr. Chairman.

And when I look at the name of this hearing, "Health and Wealth Inequities in America: How COVID–19 Makes Clear the Need for Change," this could not be a more important moment to have this—the discussion. We have seen so many—and you listed some of them—inequities that have really come to light because of this.

I want to talk about one of the things that I worry about. Thirty-four million Americans know someone who has died from not being able to afford their prescription drugs. But while 10 percent of white Americans know someone who has died because of that, 20 percent, twice as many of non-white Americans, know someone who has died from being unable to afford treatment.

Similarly, people of color are twice as likely as white Americans to consider high drug prices to be among our most pressing issue today. This was even before—you know, well before we had COVID–19 this was the problem.

And yesterday, Representative Doggett and Representatives DeLauro and DeFazio, and Representative Rooney—bipartisan—and I introduced what we call the MAP Act, H.R. 7296, and H.R. 7288, which is called the TRACK Act, to prevent price gouging at this time of the COVID–19 virus, and prohibiting monopolies that no one company can control the remedies for the vaccines, and to ensure transparency on taxpayer-funded COVID–19 drugs.

So Dr. Harris and Dr. Jones, I wonder if you could discuss why people of color, and Black Americans in particular, may be severely or even fatally impacted by high drug prices, and if this is something that you see in your practices, in your lives.

Dr. HARRIS. Am I unmuted? Can you hear me?

Ms. SCHAKOWSKY. Yes.

Dr. HARRIS. Thank you. This is absolutely a critical issue, and that is why everyone needs to have access to affordable, meaningful health coverage. And that does include the ability to get help to pay for prescription medications.

You ask about my own experience, and I have, over the course of my career—for those who had insurance, I spent a great deal of my career working with children in the foster care system, or adults in the substance—with substance use disorders who relied on Medicaid or our state mental health system to pay for their services. And if they were able to access that, they were often not able to access the medications that I wanted to prescribe.

And so, as we move forward on making sure that everyone has access to affordable, meaningful coverage, of course, the affordability of prescription drugs has to be a part of that equation.

Ms. SCHAKOWSKY. Thank you. So you wrote prescriptions sometimes that weren't filled, probably, right?

Dr. HARRIS. Yes. That is a significant problem.

Ms. SCHAKOWSKY. Yes. Dr. Harris, did you want—I mean, Dr. Jones, did you want to respond?

Dr. JONES. Yes. Well, I would just add briefly that, you know, another dynamic is that Black people in the United States and other

people of color are less likely to have health insurance coverage. And so that is definitely going to introduce an additional barrier.

And in terms of prescription drug prices, I think another thing to look at is how to make things more competitive. So how quickly can generic drugs be provided that can help to bring down the price of those prescription drugs, once they are made available?

Ms. SCHAKOWSKY. Thank you. You know, we are working on—we have introduced legislation that would stop price gouging during this pandemic, because the pharmaceutical companies are prone to try and take advantage of a situation, but also to guarantee that any therapy or any vaccine that is discovered is affordable—and sometimes that may mean free—so that all Americans have access to that. I think we have to all accept that challenge, and make sure all people will have access to the vaccines and therapies.

So thank you very much. I yield back.

Chairman YARMUTH. The gentlewoman yields back. I now recognize the gentleman from Pennsylvania, Mr. Meuser, for five minutes.

Mr. MEUSER. Thank you, Mr. Chairman. Thank you all to the witnesses, I appreciate it. It is an important hearing.

Our economy was in a good place, a very good place, up until February of this past year. It had many benefits to the vast majority of Americans.

Mr. Roy, let me ask you—the economy, the data from where we were come—the beginning of 2020.

The wage increases, levels of unemployment for all segments of the economy, for low income, for minorities, for rural areas, or for our cities always can be better. But would you say that we had some pretty positive trends that were beneficial to solving various inequalities that may have existed before?

Mr. ROY. There is no doubt, Mr. Meuser. And as I mentioned in my opening remarks and also in my written testimony, where I go into this in a lot of detail, the disparity between white and Black unemployment, the disparity between white and Hispanic unemployment reached record lows in late 2019. So we had made remarkable progress in reducing some of these disparities. And obviously, the economic lockdowns have reversed a lot of those gains. And so the sooner we can get out of lockdown, get the economy back going again, maybe we can get back on that plane.

Mr. MEUSER. Yes. And, you know, I am a Republican, but I am always interested in a better plan. This might be a difficult question, but are you hearing anything so far in this hearing on health and wealth inequities that you think would be a—pursuable for solving the inequity issue?

Mr. ROY. Well, the most important thing we can do to reduce inequities is drive economic growth. That is both in terms of reopening the economy and in general. Pro-growth policies—a rising tide does lift all boats. That is what we have seen throughout the last several decades of the American economic experience. The better and stronger our economy is, the better it is, particularly for economically vulnerable populations. So I would highlight that, in particular.

Mr. MEUSER. There was a $3.3 trillion Heroes Act proposed exclusively by the House Democratic Caucus. No input from Repub-

licans, whatsoever. Was there anything in that that would help this, these levels of inequality for health and wealth?

Would you see election law changes as something that is dealing with this crisis?

Do you think allowing state and local taxes being able to be deducted for over $10,000 is something important for—to create better equality within the society, particularly now, as we are recovering from this crisis?

Mr. ROY. Well, I can't say that I have read the Heroes Act line by line, so you will have to forgive me for that. But I am aware of several provisions that I have looked at more closely.

One that I am concerned about is a provision that would basically be a lottery for the trial lawyers to sue on behalf of anyone who was somehow connected, no matter how tenuously, to COVID–19, to sue their employer, sue the federal government, effectively, get some sort of federal slush fund relief for injuries that may or may not be related to COVID–19. I was very concerned about that.

And I am also concerned about the restoration of tax breaks for high-income individuals living in states with high state and local taxes. I don't understand why that is good policy.

Mr. MEUSER. Yes, neither do I. You are not alone.

Would you think that we can help solve this problem by opening up our schools come September?

Mr. ROY. I think that is very important. And, I mean, we would argue, actually, at FREOPP—and we have put out some work on this, and we are going to put out more—we argue that, actually, the school year should start earlier than September to make up for lost time. It is essential for low-income parents and families to be able to get their kids back in school because the disparities in educational outcomes, let alone economic and public health outcomes that come from poor educational attainment, are incredibly important.

And the good news is children are not vectors of infection. At least we have a lot of evidence that they are not very infectious. We don't understand exactly why. There are theories.

Mr. MEUSER. Right.

Mr. ROY. But there is good reason to believe that reopening schools is the most—the safest thing we can do among all the reopening tools we have.

Mr. MEUSER. That is why liability coverage that the schools talk about is essential for their opening.

Mr. ROY. Yes, and for all employers. I think liability coverage protection, that is the most important thing Congress can do. A lot of reopening decisions are at the state and local level, but Congress can take action on liability protection.

Mr. MEUSER. I agree. Thank you, Chairman. I yield back.

Chairman YARMUTH. The gentleman yields back. I now recognize the gentleman from Michigan, Mr. Kildee, for five minutes?

Mr. KILDEE. Well, first of all, thank you, Chairman Yarmuth, for hosting this very important hearing.

As you know, I am from Flint, Michigan. The residents of my home town are dealing with back-to-back crises, the ongoing water crisis and now the coronavirus pandemic. Both of these crises have disproportionately impacted people of color.

Michigan currently ranks ninth among the states with the most coronavirus cases in the country. Genesee County, where my hometown of Flint is located, where I am right now, has had 258 COVID–19 fatalities. In Genesee County African-Americans account for 47 percent of the fatalities, despite making up 20 percent of the county's population. This kind of disparity is heartbreaking.

We are also experiencing the loss of social interactions, those interactions that help us cope with—during times of stress. We are also seeing record levels of unemployment, causing many to wonder how they will pay their own bills, maintain access to health care, and feed their families.

And on top of this, of course, people in Flint don't have access to water that they trust or that is affordable, many having to leave home just to get bottled water.

Because of these compounding stressors and traumas, I am concerned that there may be an additional crisis on the horizon, a mental health crisis that disproportionately impacts our already hard-hit communities.

The House-passed Heroes Act, which contained policies to help address inequities like creating an ACA special enrollment period for uninsured Americans, and also increased Federal Medicaid payments, and $3 billion to support mental health during this challenging time, that was what was included in the Heroes Act.

I have also introduced legislation—again, which was included in the Heroes Act—that would extend unemployment benefits to help millions of Americans who are out of work.

With that as a background, Dr. Harris, I wonder if you might comment on why a special enrollment period and increased access to health coverage is so important to address the resulting racial inequalities, particularly mental health impacts of COVID–19, and what other health care policies are important for Congress to consider as we go forward.

Dr. HARRIS. Well, thank you, and I will make a couple of quick points.

But we know that people without health insurance will live sicker and die younger. We also know that Medicaid expansion, and the expansion through the Affordable Care Act marketplace, has allowed so many individuals who would not have been able to access mental health services to do so. And certainly, it is important to have this coverage so that you can get this coverage.

You also mentioned issues around the water in Flint, and we know that environmental toxins are another determinant of health. And we have to make sure that we look at those issues.

And I want to make one more point about language that we use. And one of the reasons that we use "inequities" is because we want to talk about avoidable differences, those differences that can be prevented. And, of course, we have mentioned those structural determinants of health, as well, that have driven us to these social determinants of this ill health.

So—and I remember, as a child psychiatrist in training, we used to always check for lead, because so many—I have trained in Atlanta at Emory, a large African-American population—and so many children have been exposed to lead. This is several years ago, but now—because of where they lived.

And so, all of these issues are critical if we are to address these health inequities. And clearly, the ability to have insurance is one.

You mentioned expanding the enrollment period for Medicaid, special open enrollments, the Affordable Care Act. We could also help folks retain their COBRA benefits. We could also support employers to offer temporary subsidies to preserve their health benefits. So those are just a few solutions that we would offer.

Mr. KILDEE. I really appreciate your comments. My initial career was in the child welfare system, working with children who had been traumatized. And I have a particular concern, particularly for the kids of Flint, who are experiencing a trauma on top of a trauma, not to mention the daily trauma that they see because of their conditions. So I really appreciate the perspective that you bring to this conversation.

And thank you so much to all of you for your testimony.

With that, Mr. Chairman, I yield back.

Chairman YARMUTH. The gentleman yields back. I now recognize the gentleman from Texas, Mr. Crenshaw, for five minutes.

Mr. CRENSHAW. Thank you, Mr. Chairman. Thank you for holding this hearing. I will, of course, say again—will state the obvious, and it has been said many times throughout this hearing—that economic lockdowns, in essence, choosing the costliest, most extreme possible option before we went through a series of other options to mitigate the spread of the virus and save our hospital system, that overwhelmingly hurt working-class people.

And while a bunch of city-dwelling, teleworking—I am sure very nice—people advocated for safety, and saving lives, and continuing to lock down the economy because, God forbid, anybody chooses themselves to go out to a restaurant, or chooses themselves to go to work, God forbid, that hurt the people that we are talking about today, overwhelmingly. And yes, they are hurt by COVID–19 as well, disproportionately, as all the data points to.

Of course, the data, of course, it doesn't even come close to our elderly population. And I hope we do have a hearing about that, too, and question why Governors such as the Governor of New York could actually implement policy which harmed the elderly population the most by forcing infected patients back into nursing homes. That has been conveniently ignored.

Because we should always be looking for specific policies that actually help the disparity that we are talking about, things we can actually affect. And I have heard a lot of talking out of both sides of the mouth in much of this. On the one hand, the economic devastation of lockdowns harms minorities' communities. It does.

I just interviewed a Black-owned business owner of—a Black business owner here. And their main problem right now is that they can't get their workers to come back. Why? Well, because their workers are getting paid more on unemployment than they were back at work.

I can't get a single Democrat to cosponsor a bill that would do a simple fix for that. Not take away benefits, actually, let them keep the bonus while the program is still going, keep that $600-a-week bonus, even if you come back to work. It seems like a win-win. I can't get a single Democrat on it. I don't know why, because I don't think there is any actual desire to solve problems here, and

that is really frustrating if we actually care about really helping people we want to help.

Mr. Roy, is there any data comparing minority incomes between states that are still in lockdown or came out of lockdown later and those that came out of lockdown earlier?

Mr. ROY. Mr. Crenshaw, there is preliminary information on that score. What we do see is that, for example, as I was citing in my written testimony, the stuff around how minimum wage or—hourly wage jobs excuse me—hourly wage jobs have been cut significantly, there is significant state variation. In the states that have reopened, hourly wage jobs are coming back at much higher rates. And in states that have continued to lock down—the New Yorks, the Virginias—the hourly wage reduction in employment and in hours and wages is massively lower.

Mr. CRENSHAW. So I have heard over and over again that the only reason that—and the only solution, I mean, that we could possibly have to solving the disparities in health outcomes with something like COVID–19 is a single-payer health care system. It has got to be the only solution, right?

But do countries with a single-payer health care system such as England, have health outcome inequalities, as well? I have heard they are almost exactly the same as here.

Mr. ROY. Well, it is interesting that you mention this, Mr. Crenshaw, because just today at FREOPP we published a ranking of the 31 wealthiest countries in the world on the basis of their pandemic response: mortality per million residents; the economic stringency of their lockdowns; and the relative isolation of their economies relative to other countries.

And what we found is, just as you said, there are some countries with single-payer health care that did well. Taiwan has single-payer health care. They come out No. 1 in our ranking. But Italy comes in second to last, if I recall correctly, and they are—they also have single-payer health care. The UK has single-payer health care. Their mortality is far higher per million residents than the United States——

Mr. CRENSHAW. But—and it is also far higher for minorities, too.

Mr. ROY. Yes, that is true, yes.

Mr. CRENSHAW. The same disparities that we do, and yet they have single payer. We just have to point these—out these facts. If we are going to just jump to a single solution, we have to at least agree on the—a common set of facts.

Also, what are the public health impacts of lockdowns, especially with low-income and minority communities? Aside from economic and job loss, what about public health?

Mr. ROY. This is a really important question, and, you know, I mentioned it a bit earlier in one of my other responses.

A lot of this is going to be difficult to measure, because we don't actually—some of these effects are going to be long term. The person with chronic disease that didn't have it managed over this period of time, the manifestations of that——

Mr. CRENSHAW. By the way, the uptick in cases is that, it is not their lungs being inflamed. I realize that I am out of time, and sorry to interrupt you.

But thank you, Mr. Chairman, for—and I yield back.

Chairman YARMUTH. The gentleman yields back. I now recognize the gentleman from California, Mr. Panetta, for five minutes.

Mr. PANETTA. Thank you, Mr. Chairman, Mr. Womack, and I appreciate both of you holding today's hearing on the inequalities and dealing with the COVID–19 pandemic. And of course, thank you for the witnesses, for all of their expertise, all of the preparation and their time for coming to talk about, hopefully, not just the problems, but some solutions that we can have, going forward in this pandemic and addressing the inequalities in our nation.

As many of you know, over the last three months what has been highlighted are those inequalities, from health care to wealth, education, to justice and, yes, to housing, as well. And they have collided, clearly, with one of the deadliest pandemics the world has faced in a century or more. But unfortunately, what we are seeing is that the lower income—and, yes, the communities of color—have borne the brunt of this pandemic.

And we see it right here in where I represent, where I live, where I grew up, on the central coast of California, as my friend, Mr. Kildee, likes me to say, here in the salad bowl of the world. Obviously, we have a lot of agriculture, but we have a unique sort of agriculture that doesn't take machines, it takes human beings to harvest. And so we have a large—thankfully, a large immigrant community that has contributed so much to our economy, to our community, and to our culture, who we are.

In Monterey County alone, look, I will be the first to admit we are not a hotbed at this point. We only have about—as of yesterday, about just over 1,200 cases of COVID–19, and we have endured 12 deaths, unfortunately, because of the disease. But within that number, 80 percent of the COVID–19 cases have been found in the Latinx community, and nearly 40 percent have been farm workers.

And so, unlike some parts on the central coast, this community has not had the option to work from home, as you know. It is our farm workers that continue to work through the pandemic, put food on all of our tables across this country, not just here on the central coast, and, yes, provide this country with the food security that is so needed, especially at this time—and even now, as cases spike up in California.

And so, Dr. Harris, I want to address questions to you, if that is all right. As you probably know, 25 percent of undocumented farm workers in the United States have health care, health insurance. That is only 25 percent of undocumented farm workers, which—unfortunately, I think we know there are a significant number of undocumented farm care—farm workers. What do you feel are the ways that we can ensure that farm workers get health—the health care that they need, despite the obstacle of uninsurance?

And are there changes, solutions, like I said, that Congress can make, can put forward to help undocumented immigrants gain access to health care providers, Dr. Harris?

[Pause.]

Mr. PANETTA. Your microphone. The——

Dr. HARRIS. Yes, thank you. Certainly I leave it up to the wisdom of this body, your colleagues in the Senate, to the how. But I can

tell you that it is important for everyone to have access to insurance because, just like this virus that may have impacted first others in other countries, you know, we say the pandemic or an epidemic anywhere certainly impacts us here in the U.S.

And so illnesses don't respect state boundaries, county boundaries. They don't know who is here, and who is documented, who does not have proper documentation. And so it is really important we—the AMA made a strong statement about making sure that children had access to vaccinations and quality care from their pediatrician.

And so I will just say it is important for everyone to have access to appropriate health care.

Mr. PANETTA. Understood. Now, obviously, we have heard from a couple of my colleagues—and I am seeing it here on the central coast—telemedicine has been helping. Yet there are some difficulties, obviously, with foreign-born or non-English-speaking population. Dr. Harris, are there ways that we can improve that for rural areas and communities of color?

Dr. HARRIS. Absolutely. Telemedicine certainly—and many, many of us—I know I used telemedicine pre-COVID, but certainly COVID did accelerate that use, and we appreciate the relaxation of the regulations.

But we need to look at issues around broadband, actually in both urban areas and rural areas. We need to look at the issue of whether or not there is a computer or more than one computer. And confidentiality, you know, we are talking about a private medical need. So these are all needs that need to be addressed, as we move forward with telemedicine.

Mr. PANETTA. Thank you, Dr. Harris.

Thank you again, Mr. Chairman. I appreciate the opportunity. I yield back.

Chairman YARMUTH. The gentleman yields back. I now recognize the gentleman from Tennessee, Mr. Burchett, for five minutes.

Mr. BURCHETT. Thank you, Mr. Chairman, and thank you all for being here—Mr. Ranking Member. If I could take a personal privilege, I hope we all remember our colleague, Andy Barr, in our prayers. He lost his wife and two beautiful little girls lost their mama, and that is just—to me, it is just heartbreaking. My wife was a widow, and I married her and adopted a little girl, so I know—and she has talked to me about the impact of that. So I hope we all remember Andy in our prayers.

And I appreciate the opportunity to be here.

And Ms. Harris, I would ask of you, when you started to talk about telemedicine, I was up in Claiborne County, and I am sure you know what Claiborne County is—nobody does. It is a very small county. It is about 2 percent of my district. But they actually utilize telemedicine. And I would encourage you all to reach out to them and some of the folks up there, because they had some great success with that up there, especially during this outbreak of the virus.

But Mr. Roy, I was wanting to know, you have studied and published some of the failures of Medicaid to improve our care for low-income Americans. How can we leverage some of that to create and contain and prevent the spread of the coronavirus?

And how will the solution actually provide better care to some of our more vulnerable populations?

Mr. ROY. Well, you know, let me go back to something Mr. Crenshaw was pointing out, which is that the biggest disparity, the single biggest disparity when it comes to the impact——

Mr. BURCHETT. Can I stop you? Can I stop you one second? Don't ever refer to Dan Crenshaw, because his ego is so big I don't know if his head is going to fit on screen much more, but please continue.

Mr. ROY. Fair enough. I respect that, Mr. Burchett, so my apologies.

The biggest disparity is the fact that 0.6 percent of the U.S. population lives in long-term care facilities, nursing homes and assisted living facilities. And that is where 43 percent of all U.S. COVID–19 deaths are occurring. And 81 percent of all deaths from COVID–19 are happening among people aged 65 or older.

And how does this relate to your question? It is because Medicaid is one of the biggest drivers of this problem, because if you are medically vulnerable, and you need help with activities of daily living, and you are in Medicaid, you have to go to a nursing home to get the care you need. You are not allowed to use Medicaid dollars to get that care in your own home. That is one of the things about Medicaid that is incredibly inflexible, and that has led to an enormous distortion in the way we deliver nursing home care, and it has also put the Medicaid population in disproportionate—disproportionately in harm's way.

Mr. BURCHETT. Let me ask you also—I know you have done some research on the economy prior to the coronavirus. What would you suggest that we can do when state, federal, and local elected offices and—I guess just the bureaucracy can make this thing work out better and provide better health care for our country?

Mr. ROY. Well, I think the most important thing we can do, and as you may know, we have a plan that we have put out at FREOPP called Medicare Advantage for All. And the basic idea is that everyone should own their own health insurance, and they should be able to take it from job to job.

And the way you do that is by reforming the market for people who buy insurance on their own, the one that Obamacare made so much more expensive, and improve that market so people really have choices that are high-quality coverage, but also affordable; that allow them, if they lose their job, to then buy insurance that they can keep and then take wherever they go.

Mr. BURCHETT. I will yield back the rest of my time, unless Jimmy Panetta wants to discuss anything else.

Chairman YARMUTH. The gentleman yields back the rest of his time. I now recognize the gentleman from California—from New York, Mr. Morelle, for five minutes.

Mr. MORELLE. Thank you, Mr. Chairman, very much. And thank you, once again, for holding a series of important hearings to talk about the pandemic and the impact that it has had.

I do just want state for the record that if the President of the United States had demonstrated half the leadership of my friend, the Governor of New York, thousands of Americans might not have contracted COVID–19 in the first place. But I will leave that to another day. But I do want to defend my friend from New York.

I do want to talk about, obviously, the wealth and health inequality in America. And the devastation that has occurred in the wake of this crisis has been made all the worse by the deep-seated inequalities that have plagued our country for decades.

Racial and wealth disparity were at the root of our nation's academic achievement gaps before COVID–19. I don't have to tell any of you that; we know that health and education are intrinsically linked, and economically marginalized and segregated neighborhoods are more likely to have less access to resources that help children and adults lead healthier, safer lives. And the resulting and persistent cycle of systemic disadvantage, whether it is academic achievement gaps, health care disparities, and unjust wage differences for Black Americans compared to their white peers, has made it near impossible to gain equity in this country.

The pandemic has not only shined a glaring spotlight on the lack of investment in resources available to Black communities and schools, it has exacerbated the health and educational gaps to a breaking point. So as we begin to rebuild our communities and regain our footing, we have a very real opportunity and a responsibility to take intentional and preemptive actions to safeguard these communities against further fallout, and to address the underlying social deterrents to health that we have seen reflected in other diseases for decades.

And deep-seated inequalities have played our community—in my community. We have seen a four-times rate of infection, over a five-times rate of hospitalization, and a two-and-a-half time mortality rate among Black Americans in the Rochester, New York community. So I know that we are not alone; that is being experienced around the country.

I want to ask Dr. Harris—how has the COVID pandemic worsened pre-existing racial inequities in neighborhood quality and in the built environment, as well as access to community health support services for people of color?

Dr. HARRIS. I think three overarching areas, and thank you for the opportunity to answer the question.

I think, first of all, again, the pre-existing conditions, again, that were already there before COVID–19, the disproportionate impact of diabetes, hypertension, asthma, obesity.

Second was you had more members from communities of color who were working those essential jobs. It has been noted they didn't have the privilege of staying at home. They had to go out and work. Actually, so many of us who had the privilege could have the food security. And, of course, that increased their risk of exposure.

And third, you know, I think it is the misinformation, the disinformation that has been out there.

And then we really have to talk about 401 years of racism and discrimination and bias that have led us. Here in Atlanta I was working with the group, and we were looking at the discriminatory housing policy of redlining. And we could line up those neighborhoods with the zip codes now that we see with severe health inequities.

I do want to say something. I do respect Dr. Roy and, of course, respect a marketplace of ideas. I do want us to have a closer look

to the rising tide lifts all boats. That is true, but that is not sufficient. I think we need to dig deeper, because it may lift all boats, but it may not lift everyone up—may not lift every boat up to where it needs—everyone can get an equitable opportunity for health. So I think, as we think about that, we have to—at least I would worry about these—sort of these one-size-fits-all solutions.

Mr. MORELLE. Thank you. I want to ask Dr. Deaton—and any of the other panelists might comment, as well—but how can we, as we get—begin to move forward, rebuild our economies and our communities in a purposeful way that prevents the further deepening of the academic achievement gap, particularly as we head into the summer months? Do you have any thoughts on that, sir?

Dr. DEATON. Sorry, sorry, I didn't hear a question. Was that directed——

Mr. MORELLE. Yes, I just want to know, as we sort of—and I may be running out of time, so—I just want to—any thoughts you had on rebuilding our——

Chairman YARMUTH [continuing]. give you more time.

Mr. MORELLE [continuing]. communities in a purposeful way to prevent the further deepening of the academic achievement gap, particularly as we head into the summer months, when many students are not in school.

Dr. DEATON. Yes, I think that is going to be one of the hardest problems that we are going to have to deal with, especially, as the lockdown of schools, which was probably not a very good idea, has widened these gaps enormously. So I am very much with that.

Mr. MORELLE. I yield back my time. Thank you, Mr. Chair.

Chairman YARMUTH. The gentleman yields back. I now recognize the gentleman from Texas, Mr. Flores, for five minutes.

Mr. FLORES. Thank you, Mr. Chairman. I appreciate the opportunity to participate in today's hearing. My broadband service has been a little bit spotty today, so I am hopeful that everybody can hear me, and that I don't drop off in the middle of this, in my middle of my five minutes.

Mr. Roy, in previous testimony you said, "The association is clear. A strong economy most benefits minorities, and a worsening economy most hurts them." House Democrats have made known their desire for heavy top-down structural changes in our economy.

And so my question is this. In your view, is this top-down, heavy-handed approach the best policy direction for helping minorities, or would you recommend policies more focused on strengthening the economy, thus providing greater opportunities for minorities?

Mr. ROY. Well, leaving aside the party piece of it, I mean, I would just say, definitely, that economic growth is incredibly important, and we have to be extremely mindful of policies that would not only suppress economic growth, but suppress job growth. You know, we have talked a little bit today about the $600 bonus that is leading people to basically not get back into the work force, and that is retarding the economic recovery.

So I am very concerned that I hear the Congress is thinking about renewing or restoring or extending that policy. That is going to make it a lot harder for employers to get back on their feet, and we are going to see—we already have seen 100,000 or more small

businesses close because of lockdowns. That number could increase considerably if that feature of the CARES Act is extended.

Mr. FLORES. One of the related features that has come out of the pandemic—and not only in terms of economic impact, but it has a follow-on economic impact—is the fact that we have several regulations that were found to impede our ability to respond to the pandemic, things like hand sanitizer guidelines, truck driving limits, things like this.

So I have a question for all of the panelists, starting with Dr. Deaton. Are there any regulations that you think of that have hindered the ability to respond to challenges of the pandemic?

And are there any regulations you can think of that disproportionately harm minorities and low-income communities?

Dr. DEATON. Well, I am someone who feels that one of the greatest disasters in America these days is the health care system, and much of that is to do with regulation. I have a different view, though, that I think removing regulations is not the right way to go. I think that what we need is a system that automatically insures everyone from birth. I think we have to have a system that controls costs, which is very important.

It is true that our health care system has not done any worse in this pandemic than other countries' health care systems, and it is too much, really, to ask any health care system to deal well with something that only happens—only happened 100 years ago before. But——

Mr. FLORES. I have just a few minutes——

Dr. DEATON. Every other country——

Mr. FLORES. Dr. Deaton?

Dr. DEATON. Sorry?

Mr. FLORES. Excuse me, can I go to Dr. Harris?

The regulations question.

Dr. HARRIS. Well, I think we chatted earlier about the regulations regarding telehealth, and I think that was very important.

And I will say this from a broader perspective regarding substance use disorder, not necessarily just communities of color, it was important to reduce a lot of those regulations so that patients who had an opioid use disorder could get the medications that they needed, and we didn't have the dose limit or the time limit. So those were very helpful, as well.

And there was some loosening of regulations regarding prior authorizations for services and medications, and those were helpful, as well, during this time.

Mr. FLORES. OK, thank you.

Dr. Jones, can you give me 30 seconds in terms of regulations that have hindered the ability to respond to the pandemic, and regulations that disproportionately harm minority communities?

Mr. Roy, we will get to you when we have got about 30 seconds left.

Dr. JONES. At the moment, I—there are no specific regulations that are coming to mind to me, so I will pass.

Mr. FLORES. OK, Mr. Roy, you——

Mr. ROY. Well, I would love, Mr. Flores, for Congress to make permanent some of the regulatory relief that has been temporary around telemedicine, telehealth, practicing medicine across state

lines, allowing your license to be used if you move states without having to get recertified. Those are some of the simple things we could do, not just for physicians, but also for nurses.

Mr. FLORES. Right.

Mr. ROY. Broadly speaking, I should mention that the regulatory reforms of the last several years are a big driver of the record low unemployment that we enjoyed prior to the pandemic. That is worth noting, as well.

Mr. FLORES. Right, and I appreciate it, and I agree with you. I think the regulations that we have modified in light of this pandemic should be extended permanently.

I yield back, Mr. Chairman.

Chairman YARMUTH. The gentleman yields back. I now recognize the gentleman from Nevada, Mr. Horsford, for five minutes.

Mr. HORSFORD. Thank you, Mr. Chairman and to the Ranking Member, for holding this hearing, and to all of our panelists for joining us today.

Dr. Harris, it is great to see you again. Thank you for your tremendous leadership over the years at the American Medical Association and in your practice.

As many of you may be aware, Nevada, my home state, is the hardest-hit state, economically, in our nation and has the worst unemployment rate, at over 25.2 percent as a result of the coronavirus pandemic. Few places were hit harder than Las Vegas, where a full one-third of the Las Vegas economy is in the leisure and hospitality industry, more than any other major metropolitan area in the country. Most of those jobs cannot be done from home.

The New York Times did an article back in April that was titled, "How Las Vegas Became Ground Zero for the American Jobs Crisis." And they brought to light the devastating impacts that this virus has on African-American families and those Latinx and other communities throughout southern Nevada. The article highlighted how Mr. and Mrs. Anderson both lost their jobs at a restaurant and a call center, respectfully (sic), and immediately began to worry about how they would pay rent and provide food for their daughter. This is one of the many examples as to how COVID–19 has dramatically impacted African-American households.

In 2018 the poverty rate for African-American families was more than two-and-a-half times the poverty rate for whites. And the poverty rate for Latinx families was more than twice that of whites.

Disparities in the child poverty rate are even more stark. The child poverty rate for African-Americans in 2018 was more than three times the child poverty rate for whites, up from about two-and-a-half times the rate for whites in 2013.

But none of this is a coincidence. The inequities we see today were not caused by COVID–19. They are a result of systemic racism that has impacted every aspect from health, education, financial, housing, and other institutions, and it has affected the opportunities across the board.

Now, there is data that I just read yesterday from the Center on Poverty and Social Policy that indicates how the child poverty rate could be cut in half if Congress would approve the American Family Act, which expands the Child Tax Credit that would provide $3,600 for kids under six years of age, and $3,000 for older kids.

That poverty rate among Black children would drop by 52 percent and among Latinx children by 41 percent.

Dr. Harris, what long-term effects might the COVID–19 pandemic have on children, and how might it affect their physical and mental health, as well as their economic potential in the long term?

Dr. HARRIS. Well, certainly, many areas there, but let me just highlight one or two, and the first is the issue around trauma. We have bourgeoning evidence that trauma experienced early in childhood—many may be familiar with the adverse childhood experience survey—leads to both short-term and long-term health impacts, and not just mental health, not just psychological health, but also long-term cardiovascular health, diabetes, and some of these other issues.

We certainly think about abuse and violence as typical trauma. But certainly the day-to-day traumatic experience of racism, and perhaps living in poverty, and some of these other issues can also have a cumulative effect. It is known in some papers as "weathering effect" on African-Americans.

And so again—and earlier I talked about previous housing, discriminatory—discriminatory housing policies. So all of these impact both short and long-term health.

Mr. HORSFORD. Thank you.

Dr. Jones, briefly, how does structural racism affect health care outcomes in the United States, and how does it affect the quality of care that people of color receive, some of the health behaviors relating to housing and food availability and other social determinants?

Dr. JONES. Yes. I think that there are a number of ways in which structural racism can affect these health outcomes.

I think that, when we look at the United States and compared it to other countries in terms of health outcomes, we have relatively higher rates of maternal mortality, for example, during childbirth. And some of this could be linked to discrimination and biases among doctors and how they view, for example, Black women.

And so these deep-seated issues of racism, they are prevalent when doctors are being trained, among—it feeds into the composition of doctors that we have, and then it can spill over into the types of services that are delivered. That is just one example.

Mr. HORSFORD. Thank you very much. And I yield back.

Chairman YARMUTH. The gentleman yields back. I now recognize the gentlelady from Texas, Ms. Jackson Lee, for five minutes.

Ms. JACKSON LEE. Thank you very much, Mr. Chairman. I am in the office with one or two staff. I will take off my mask as, obviously, in Texas we have been hitting a spike of enormous proportion. Our hospital beds are now overwhelmed. Our emergency rooms are overwhelmed with COVID–19. And I think this is certainly an appropriate hearing, as it deals with wealth inequality in America and really, as I have been listening, the lack of access to health care.

So I am going to, if I might, Dr. Harris, if I might focus on you, and my focus will hopefully be an area that you have had some exposure to, just by hearing the word, but I am going to articulate it in a more definitive manner.

And I would really like—first of all, let me congratulate you, Dr. Harris, for your leadership of the American Medical Association and, really, the innovative work that you have been doing as relates to health care disparities. It is very distinguished and well appreciated.

So I would like to, as well, comment on this inequity in wealth. I heard someone attacking the Affordable Care Act. If all of the states, the red states, had accepted the Medicare expansion, we would have included more persons. If we had allowed the Affordable Care Act to take its will and to be able to develop the body politic and to include young people, we would have had a very strong health care system. But it has been attacked and stripped and strained, and it is an outrage.

I do believe that Medicare should be modified to include the opportunities for individuals to be in their homes and still have the ability to have care, as persons who are in need of care.

But my question to you is that we have experienced over the last couple of weeks the recognition by many of systemic racism. We have introduced the legislation for over 30 years called the commission to develop proposals for reparations and proposals (sic). It is a thoughtful, articulate expression of addressing the question of systemic racism, and presenting a commission that will look at the issues of health care, the economy, psychological issues, sociological issues, scientific issues. And I think we have a vehicle that can address what we are trying to do piecemeal, meaning that we have people focus on the over 200 years of slavery that have, obviously, had an impact in the denial of wealth, the inability to transfer wealth.

So you are a doctor. I would appreciate your commentary on looking at it through the eyes of the commission to deal with and develop real proposals on the question of the plight of African-Americans as relates to any number of issues. And you may speak to the issue of access to health care.

I believe another witness is Dr. Jones from the Chicago—University of Chicago. But Dr. Harris, could you please answer the question?

Dr. HARRIS [continuing]. issues that you mention and that might be addressed in that legislation are critically important issues.

For many years I think we looked at health through a narrow lens, and now we really have to open up that lens. And when we are talking about these health inequities, we do have to go back to the 400 years of slavery, and Jim Crow, and all of those issues.

I will say something that the AMA has done regarding reconciliation. Many of the audience and many of the Members of Congress may know that for decades the AMA did not allow Black physicians to belong to the AMA. And we do believe that that probably impacted where we are today. So we are looking internally, as we move forward.

But in 2008 the AMA went on record to apologize for that. Now, that was a necessary step. Not sufficient. And we have done things since then. We have a new center for health equity. But critically, an important note in reconciliation is admitting your past mistakes.

Ms. JACKSON LEE. So you understand reparations is repair, and is different from reconciliation. So I am talking about H.R. 40.

Dr. HARRIS. I do.

Ms. JACKSON LEE. And do you believe we need reparations, repair, and restoration, as well?

Dr. HARRIS. Well, I have to say I am here representing the AMA today. I don't think we have taken an official position, but I am a Black woman in this country, and I do think we need to look at that issue seriously, and particularly how those issues impacted health.

Ms. JACKSON LEE. Thank you. Is Dr. Jones there, Dr. Damon Jones?

Thank you very much, Madam President.

Hello?

Dr. HARRIS. Thank you.

Dr. JONES. Yes. Yes.

Ms. JACKSON LEE. Could you respond to that, as well?

Dr. JONES. Yes. So I think that, as I mentioned, I think that that—we should move forward with that bill to create a committee.

One of the steps has to do with reconciliation and, again, getting closure. But as you mentioned, there is also redress for what has happened in the past. And so material reparations, I think, as well, should be included. Both of those are important, because we continually see ourselves back at the same point with racial strife in this country. And so we are not going to get past that without looking deeply into this country's history, and trying to repair some of those problems.

Ms. JACKSON LEE. I commend H.R. 40 to both of you, in terms of looking at it from your perspective on health care. The commission, appointed by Members of the U.S. Congress leadership and the President of the United States, would then be tasked with a repairing and restoring of the seismic impact of slavery, the original sin, on African-Americans who don't have the inherited wealth, who are impacted by health disparities in a very severe manner, and are impacted more severely by COVID–19, both economically and health-wise. We need a systemic change dealing with systemic racism. And I think, as we look at it from the budget perspective, all of our committees should look at this extensively.

And I am just going to you, Dr. Jones. I know I have a second or two. But we have to look at it holistically, and——

Chairman YARMUTH. No, you——

Ms. JACKSON LEE.—is a way to do so.

Dr. Jones?

Chairman YARMUTH. No, you are way over time. You are way over time.

Ms. JACKSON LEE. All right, well——

Chairman YARMUTH. I am sorry. The gentlewoman's time has expired.

Ms. JACKSON LEE. Thank you.

Chairman YARMUTH. I now——

Ms. JACKSON LEE. Thank you, I yield back.

Chairman YARMUTH. I now yield five minutes to the gentleman from Virginia, Mr. Scott.

Mr. SCOTT. Thank you. Thank you, Mr. Chairman. And Mr. Roy, let me ask Mr. Roy a question first.

And I thank you for testifying on the Education and Labor Committee yesterday. When you say liability protection on coming back and reopening, are you talking about liability insurance coverage so that victims can get covered, or are you are talking immunity, where the victim is stuck with his own bills?

Mr. ROY. Well, I don't know if I am exactly talking about either of those things. What I am talking about is employers are very reluctant to reopen their workplaces, because they are concerned that if a single worker at their place of employment eventually gets COVID–19, and that COVID–19 was contracted somewhere else but——

Mr. SCOTT. Well, yes, yes——

Mr. ROY [continuing]. outside the workplace——

Mr. SCOTT. They—but who would—people get sick, and the employer could pay under present law.

Mr. ROY. Oh, well, that is different, right? So if the employer is paying for their health insurance, then the health insurance should cover COVID–19, of course.

Mr. SCOTT. Yes. OK. So when you talk about liability protection, are you talking about an insurance company to cover the liability, or are you talking about immunity, where the employer is home free?

Mr. ROY. Well, I am talking about legal protection for employers, so that they are not at risk of bankruptcy due to someone who contracts COVID–19——

Mr. SCOTT. And you could do——

Mr. ROY [continuing]. outside the workplace——

Mr. SCOTT. You could do that with insurance.

Mr. ROY. You could do that——

Mr. SCOTT. So it—yes.

Mr. ROY. But the employer pays for the insurance, right? So if the employer pays for the insurance, that increases the cost of employment.

Mr. SCOTT. OK, well, I don't think you had an answer to that.

Let me ask Dr. Harris a question. We have heard a lot of disparaging remarks about the Affordable Care Act. Dr. Harris, you are aware that when the Republicans tried to replace the Affordable Care Act, their replacement was scored by the CBO, and it concluded that the cost would go up 20 percent the first year, 20-some million fewer people would have insurance, those with pre-existing conditions would lose their insurance, and the insurance you get is worse than what you got.

Can you say—so we know that ACA—repeal and replace, but repeal just generally—and Medicaid expansion, could you just say how Medicaid expansion would be helpful to reduce the disparities, and how ACA repeal would be harmful, and make the disparities worse?

[Pause.]

Mr. SCOTT. Dr. Harris?

Dr. HARRIS. Can you hear me? Thank you.

Mr. SCOTT. Yes, I can hear you now.

Dr. HARRIS. Thank you. Yes. And as you know, the American Medical Association did support the Affordable Care Act. Certainly, it was not a perfect piece of legislation, but it did move us further in reducing the number of uninsured in this country. And at this point, we believe that the best path forward is to strengthen and enhance the Affordable Care Act, and that does include the expansion of Medicaid.

Certainly, I know so many—and I am a psychiatrist—but in all disciplines of medicine so many previously uninsured patients were able to gain access to health care through the Affordable Care Act.

And we also know that if you don't have insurance—and, of course, for other—many other reasons, lack of access, all of the social determinants of health—you live sicker and die younger.

And so we at the AMA continue to support strengthening and enhancing the Affordable Care Act. We continue to support a bipartisan and bicameral solution to getting us to a point where everyone has affordable, meaningful coverage in this country.

Mr. SCOTT. Thank you. And I will ask our other witnesses—we can talk about the problem, or we can come up with solutions. We are talking about a lot of solutions about income and wealth inequality. Some of the things we are working on are increasing the minimum wage; making it easier to form a union so you can negotiate for higher wages; investments in education, particularly higher education and making that affordable; housing andj home ownership initiatives, because that is where most middle-class families get their wealth; and fighting discrimination, everything from employment to business loans to housing, so that equally postured people will get—the minorities will not be worse off.

Can you say anything about which of those initiatives are most important, or anything else that we ought to be actually working on?

Dr. DEATON. This is Angus Deaton here. Yes. I mean, I think I made a case for all of these in some of my writings.

The one I would emphasize that you didn't emphasize is I think we have to somehow rein in the cost of health care. The cost of entitlements, as we have heard, are bankrupting the nation. But the cost of entitlements are so large because health care costs so much, and we have got to bring those costs down. The waste in health care is 50 percent more than we spend on national defense, and that is just a completely crazy number. And other countries manage to do this not necessarily any better than we do it, but they do it at less than half the cost.

And that would stop the—of employment for less skilled Americans, for African Americans. And it would give us a chance to get back a reasonable chance of prosperity for less fortunate Americans who have really been suffering over the past 50 years. It is OK to say the economy was doing pretty well up until February, but people were dying in droves, and there were 158,000 deaths of despair last year. That is not something that happens in a well-functioning economy. Thank you.

Chairman YARMUTH. Thank you. The gentleman's time has expired. I now recognize——

Mr. SCOTT. I——

Chairman YARMUTH. Oh, sorry. I now recognize the Ranking Member, Mr. Womack, for 10 minutes.

Mr. WOMACK. Thank you, Mr. Chairman. And thanks to all of our panelists today.

Let me begin with part of my thesis. When I opened in my opening remarks in talking about deficits and debt and the need for certainty, the need for—I didn't talk necessarily about budget reform, but the Chairman and I have a long history on promoting some kind of reform so that we can get to the business of doing the people's work without CRs, omnibus packages, and those kinds of things. I just kind of put all that in the category of bringing certainty to the governmental process.

But in my thesis I talk about the pressure that deficit and debt and, in particular, the net interest on the debt, which is rising exponentially, and the impact it is going to have on programs that benefit, largely, the vulnerable population, and whether it is in the minority communities, or vulnerable seniors, or this sort of thing.

So here is my question for each of the four panelists. And be very brief in your response, because I don't have a lot of time, and I am—and I hope not to use all of my time. But we will start with Mr. Deaton.

Does deficit and debt matter, and is it a concern of yours? Because we have had a lot of proposals thrown out in this last couple of hours. All of them have a price tag to them. Do deficits and debt matter? And if so, when should we be serious about it?

Dr. DEATON. I think deficits and debts do matter. They matter in a somewhat complicated way, and it is a very lively topic of discussion among my colleagues.

But let me go back to something I said a minute or two ago. Before COVID came—and COVID is a whole special case, because we have never had budget deficits, we have never had a pandemic like this before. Before COVID, all the red ink out into the future is driven by the high cost of medical care. If we can bring that under control, then we wouldn't have this problem. So this problem is important, and that is the key to getting it under control.

Mr. WOMACK. Dr. Jones?

Dr. JONES. Yes, I would say that it is important to think about deficits and debt. I don't think now is the time to place the most weight on that. I think we are in an emergency situation, we are in a crisis, and that is the time where you draw into the deep pockets of the federal government to bail people out, because there are people in deep need, and they are in need of relief.

I think that if interest rates were rising, or if we thought that there was not enough capital flowing around for people to borrow, then you may think more about these things. But I don't think that that is the case right now.

Mr. WOMACK. Dr. Harris?

Dr. HARRIS. I don't feel qualified to talk about deficits and debt. But I do want you to know that, as physicians in the physician community, we do think that we need to continue to have fair-minded debates around the cost of health care, the value of health care, and health care financing. So I can commit that I will be a part of that conversation, and I will leave it to the economists for the deficits and debt.

Mr. WOMACK. OK. So, Dr. Roy, as you get ready to answer the question—and I am paging through some of your testimony, but you said early on, if I can—and I may not be able to find it, but you said—you made a case early on in your testimony, in your opening remarks, about the impact of deficits and debt and the pressure it is going to have on all of the programs, particularly the social safety net programs, but in addition to a lot of other programs that affect specific communities that we are talking about here today. So I am assuming that you believe that deficits and debt do matter.

Mr. ROY. Absolutely. I completely agree with what you were describing earlier about how a fiscal reckoning will particularly harm economically vulnerable populations. And I do describe that in my testimony.

One thing I should mention is that we have actually put out a comprehensive plan called Medicare Advantage for All that involves universal private insurance like that in Medicare Advantage for everyone. And there is actually a bill that has been introduced in Congress by one of your colleagues from Arkansas, Bruce Westermann, that is based on on that bill.

And one thing I should mention that we talk about extensively in that report is how to reduce the high cost of U.S. health care.

One thing I should mention in this hearing in particular is the fact that one of the ways—the way in which Medicare pays physicians for their care, and the prices that Medicare pays for that care, are determined by physicians. There is a secret committee of specialty societies called the RUC Committee that basically determines what prices the taxpayer pays through Medicare for those services. It is one of the most egregious examples of conflict of interest in the federal budget, and it is something that I hope Congress can revisit as it tries to find ways to reduce the high cost of health care.

Mr. WOMACK. Well, and back to your testimony, I subscribe to the notion that deficits and debt do matter, because eventually we are going to become a credit risk. And when you become a credit risk you are going to be paying more in interest for the people that are buying your paper.

And if that is the case, then the more interest you pay—and, let's face it, I don't know what the deficit or the debt is today. I know the deficit we are going to rack up is somewhere in the vicinity of $4 trillion. But the net interest on the debt that we are going to pay for—and I am an appropriator, too, so I can speak to this—is going to put a lot more pressure on our ability to fund a lot of the things that most of the panelists, all of the panelists, my colleagues on this panel, believe are important to our country on the discretionary side. It is going to put an enormous amount of pressure on that. We are going to pay more in net interest. And I believe that, eventually, net interest on the debt is probably going to exceed what we spend on national security, which would be unheard of, in my opinion.

So I subscribe to the notion that deficits and debt do matter, and we have got to be careful when throwing around a whole lot of other programs that are going to cost an extraordinary amount of

money, not necessarily intent on raising the revenue that would need to go to support it.

I said in my opening statement that before COVID this country was clicking along at a pretty good pace, and specifically to our minority communities: Black, Hispanic, Asian unemployment, 5.4, 3.9, 2.1 percent, respectively. Now they have gone higher because of COVID. It makes sense to me, Dr. Roy, that when we climb out of this COVID hole, that we need to go back to the policies that had us on track and had historic lows of unemployment and economic prosperity before COVID hit. Would you agree?

Mr. ROY. Well, there is no doubt that the quicker we can get back to that policy mix, that would be great. I am very concerned that we won't, and I am very concerned that Congress is on the verge of making it worse, because if Congress gives states a powerful incentive to stay locked down, then that is going to continue to retard the recovery, retard the ability of those lower-income, economically vulnerable populations to get back to work.

Mr. WOMACK. In my remaining time, one of the things that an emergency like COVID forces a country to do is to become less dependent on the way we have always done things, and start looking for innovative ways.

And so, in the area of—particularly of health care and education, we have had to rely a lot more on what we are all doing on computers, kind of like what we are doing here today. And so I would assume I would get an affirmative response from every single one of you that in a future infrastructure package the ability for this country to get rural broadband—and maybe I shouldn't just say rural broadband. I think one of you said earlier even on the inner city we have some connectivity issues. But this country does have the capacity to become very innovative in the way we teach, in the way we do research, and in the way we do particularly telemedicine, using these devices that we are all on here today.

Do you agree with that, Dr. Deaton?

Dr. DEATON. Yes, I do. I mean, I am not sure I would—we would agree on all the details. But, for sure, fast Internet access for everybody is incredibly important. And then we can let this grow from there.

Mr. WOMACK. Dr. Jones——

Dr. DEATON. And——

Mr. WOMACK. Dr. Jones, would you not agree that one of the things that we could be doing to boost the opportunities for particularly—for everybody, but particularly the minority community, is get Chromebooks or iPads or the connective devices attached to the worldwide web for the express purpose of helping educate and better treat people with underlying medical conditions? Would you not agree that broadband is important?

Dr. JONES. I would agree that it is important, especially now, when we need to be socially distant, when we need to replace our usual interactions with Internet access. That access is uneven for a number of reasons, and making broadband widely available would be——

Mr. WOMACK. Dr. Harris, from the AMA perspective, obviously, we have come a long way with telehealth, and probably could go a lot further, could we not?

Dr. HARRIS. Absolutely. And broadband is critical and so is innovation.

Mr. WOMACK. Dr. Roy?

Mr. ROY. Agreed.

Mr. WOMACK. All right. Chairman Yarmuth, I am going to yield back. It looks like I am down to zero, so I have nothing to yield back to my friend from the Commonwealth.

Chairman YARMUTH. All right.

Mr. WOMACK. Thanks to all of you. I appreciate it. Thank you so much.

Chairman YARMUTH. I thank the Ranking Member.

Before I get into my questioning, I ask unanimous consent to submit statements from America's Essential Hospitals and the Campaign for Tobacco-Free Kids into the record.

Without objection, so ordered.

[The information referred to follows:]

June 23, 2020

Statement for the Record
House Committee on the Budget

Health and Wealth Inequality in America: COVID-19 Makes Clear the Need for Change

America's Essential Hospitals appreciates the opportunity to submit a statement for the record as the House Committee on the Budget examines the persistent health and socioeconomic disparities highlighted by the COVID-19 pandemic. We commend the Budget Committee, as well as other committees in the House of Representatives, for convening conversations on inequality in the United States, and we are eager to work with all interested parties to address racism as a public health crisis.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to providing high-quality care to all, regardless of ability to pay. Our more than 300 member hospitals and health systems form the very fabric of the nation's health care safety net. They care for vulnerable people and anchor communities across the country, from the largest cities to expansive rural regions. They are sources of lifesaving care, jobs, and vital public health services that influence the social, economic, and environmental circumstances of a person's life. Essential hospitals serve communities where need is greatest and in areas that might otherwise lack health care access. They reach outside their walls to care for communities where 23.3 million people live below the federal poverty line, 9.7 million have limited access to nutritious food, and 360,000 experience homelessness. Three-quarters of patients cared for at essential hospitals are uninsured or covered by Medicaid or Medicare.[1]

Essential hospitals also see a high number of patients of color, with racial and ethnic minorities making up more than half of discharges in 2018. As such, they bear witness to the adverse health outcomes tied to systemic inequities that disadvantage low-income populations and communities of color. The consequences of these inequities—which we have seen in numerous public health crises, from Hurricane Katrina to maternal mortality—are playing out in real time amid the COVID-19 pandemic. Racial and ethnic minorities disproportionately experience morbidity and mortality from COVID-19. Because of pervasive societal and economic inequality, minority populations are more likely to have underlying health and chronic conditions that might exacerbate a COVID-19 diagnosis. Such individuals are more likely to work in front-line professions where social distancing and remote working are not possible. And, despite important gains made under the Affordable Care Act, racial and ethnic minorities are less likely to have health insurance.

We should not be surprised by the disparities exacerbated by COVID-19, which has unavoidably laid bare the compounding effects of endemic inequality. In an April 20 *Modern Healthcare* op-ed, America's Essential Hospitals President and CEO Bruce Siegel, MD, MPH, stated, "The question for us

---

[1] Clark D, Roberson B, Ramiah K. Essential Data: *Our Hospitals, Our Patients—Results of America's Essential Hospitals 2018 Annual Member Characteristics Survey.* America's Essential Hospitals. May 2020. essentialdata.info. Accessed June 22, 2020.

essentialhospitals.org

AMERICA'S ESSENTIAL HOSPITALS
401 Ninth St NW Ste 900
Washington DC 20004

t: 202 585 0100
f: 202 585 0101
e: contact@essentialhospitals.org

now is whether we learn from COVID-19 or accept the status quo."[2] Complacency and inaction at this critical juncture are unacceptable.

The health care system must use this moment to commit to equity. Essential hospitals will build on their efforts to mitigate social determinants of health, especially those that allow racial and ethnic disparities to persist. This includes implementing bias training for health care providers, committing to culturally and linguistically appropriate care, and developing a workforce that reflects the patients they treat. Doing so will require support from Congress to ensure a robust health care safety net and additional policy recognition to mitigate social determinants of health.

America's Essential Hospitals thanks Congress for its attention to this critical public health issue and is eager to engage in continued conversations on eliminating health disparities. The association looks forward to working with the committee to develop policies to achieve health and socioeconomic equity for all.

---

[2] Siegel B. A legacy of health disparities laid bare by COVID-19. *Modern Healthcare*. April 20, 2020. https://www.modernhealthcare.com/opinion-editorial/legacy-health-disparities-laid-bare-covid-19. Accessed June 22, 2020.

Written Statement for the Record

Campaign for Tobacco-Free Kids

Committee on the Budget, United States House of Representatives

Health and Wealth Inequality in America: How COVID-19 Makes Clear the Need for Change

June 23, 2020

COVID-19 is a respiratory disease that has killed more than 100,000 people in the United States and is disproportionately harming communities of color and other vulnerable groups. It has revealed serious shortcomings in our public health and health care systems and intolerable health inequities in our society. The poor health experienced by many in the U.S., often from preventable diseases, has made us particularly vulnerable to this pandemic. More must be done to ensure that all Americans have an equal opportunity to attain their highest level of health.

As Congress responds to the COVID-19 pandemic, the Campaign for Tobacco-Free Kids urges you to consider the benefits of an aggressive effort to reduce tobacco use, which remains the leading preventable cause of death in the U.S. There is growing evidence that tobacco users are at greater risk of severe complications from COVID-19, yet there are evidence-based strategies to reduce tobacco use that remain under-utilized. As our nation combats this pandemic and the long-standing disparities in health that it has exposed and exacerbated, there has never been a more important time to take every measure possible to keep our lungs healthy.

Now is the time to implement and expand policies and programs that we know are effective in reducing tobacco use and helping tobacco users to quit. Specifically, we urge Congress to:

- Prohibit flavored tobacco products, including menthol cigarettes. For decades the tobacco companies have systematically targeted black communities with marketing for menthol cigarettes, resulting in great harm to the health of African Americans;

- Ensure that all Medicaid and Children's Health Insurance Program (CHIP) enrollees have barrier-free access to the full array of proven tobacco cessation treatments at this critical time; and
- Provide additional funding to the Office of Smoking and Health (OSH) at CDC so it can increase its efforts to help tobacco users to quit, including assisting populations and regions of the country with disproportionately high rates of tobacco use, tobacco-related disease and premature death.

COVID-19 and Tobacco Use

The coronavirus attacks the lungs and the harmful impact of smoking on the lungs is well documented. There is conclusive evidence that smoking increases the risk for respiratory infections and weakens the immune system, making it less successful at fighting disease. Smoking is a major cause of underlying health conditions, including heart disease, chronic obstructive pulmonary disease (COPD), other lung diseases and diabetes that increase risk of severe complications from COVID-19.[1]

There is also a growing body of evidence that vaping can harm lung health. Dr. Nora Volkow, director of the National Institute on Drug Abuse, has stated that "emerging evidence suggests that exposure to aerosols from e-cigarettes harms the cells of the lung and diminishes the ability to respond to infection."[2]

Disparities in Health

The COVID-19 pandemic has exposed long-standing disparities in health that are harming communities of color and other vulnerable groups. For too long, the nation has tolerated higher rates of disease and shorter life expectancy among certain racial, ethnic and other groups. These health disparities have become more glaring as a result of COVID-19. Disturbingly, data demonstrate that COVID-19 isn't simply exposing disparities, it's making them worse. The coronavirus is infecting and killing black people in the United States at disproportionately high rates.

- A CDC report on hospitalization rates of patients with confirmed COVID-19 across 14 states found that while only 18% of the population captured by their report are African Americans, they found that 33% of all hospitalized patients with race/ethnicity data were African American, suggesting an overrepresentation of African Americans among hospitalized patients.[3]
- Another study, which is currently under review, evaluated COVID-19 diagnoses and deaths across United States counties with disproportionate numbers of African

American residents. The study found disproportionately higher COVID-19 deaths in primarily black counties in both small metro areas as well as rural areas."[4]

- Similarly, an earlier Washington Post analysis found that counties with majority black residents have three times the rate of infections and nearly 6 times the rate of deaths compared to counties with majority white residents.[5]
- A new CDC report provides additional evidence that Black Americans are disproportionately impacted by COVID-19. The report analyzed medical records for COVID-19 patients in the Atlanta area and found that Black patients were more likely than white patients to be hospitalized. The report also identified smoking as a factor that was independently associated with hospitalization for the disease, adding to concerns that smokers may face more serious complications from COVID-19.[6]

Health experts have identified a number of factors that contribute to these disparities, including barriers to accessing health care, racism, employment in essential jobs (too often without adequate personal protective equipment), residence in more densely populated areas and multi-generational households, and inequalities in other social determinants of health. Many of the groups disproportionately suffering from COVID-19 are also groups that the tobacco industry has targeted for decades. Data on COVID-19 patients reveal that those with underlying health conditions like heart disease, lung disease and diabetes are at higher risk for becoming severely ill from the coronavirus.[7] Since smoking is a major cause of many of these underlying conditions, action to reduce smoking among communities of color and other vulnerable groups would both reduce their risk during COVID-19 and address health disparities in general.

Despite the enormous progress that has been made in reducing tobacco use, certain populations continue to suffer from disproportionately high rates of tobacco use, tobacco-related disease and premature death including American Indians/Alaskan Natives; individuals with behavioral health conditions; and lesbian, gay, and bisexual individuals. Tobacco use has become increasingly concentrated among those with lower incomes -- 21.3 percent of adults with a household income less than $35,000 smoke, compared to 13.3 percent of adults with a household income between $75,000 and $100,000, and 7.3 percent of those with a household income of $100,000 or more.[8] And this is reflected in our health insurance system -23.9 percent of Medicaid enrollees[1] and 23.9 percent of uninsured individuals smoke, compared to 10.5 percent with private insurance coverage.[9]

Tobacco use has had a devastating impact on the health of African Americans. Smoking-related illnesses such as lung cancer, COPD, heart disease and stroke are the leading preventable cause

[1] Those with Medicaid coverage, but no other insurance coverage (e.g., excludes those who are dual eligible for Medicaid and Medicare)

of death for African Americans, causing 45,000 deaths in the African American community each year.[10] While African Americans generally start smoking at a later age, smoke at about the same rate as white Americans and typically smoke fewer cigarettes per day, they are more likely to die from a smoking-caused disease.[11]

A key reason for higher rates of tobacco-related death and disease among African Americans is the availability and marketing of menthol cigarettes.[12] Menthol cigarettes are especially popular among African American smokers - roughly 70 percent of African American youth smokers smoke menthol cigarettes and 85 percent of all African-American smokers smoke menthol cigarettes, compared to 29 percent of white smokers.[13] Menthol cools and numbs the throat, reduces the harshness of tobacco smoke, and makes menthol cigarettes more appealing to youth who are starting to smoke. As a result, the availability of menthol cigarettes increases the number of youth, especially Black youth, who experiment with cigarettes and who become regular smokers.[14] Menthol cigarettes also increase nicotine dependence and make it more difficult to quit. African American smokers have higher levels of nicotine dependence because of their preference for menthol cigarettes.[15] In fact, while African American smokers are more likely than White smokers to have made a quit attempt in the previous year, they are less likely than White smokers to successfully quit smoking.[16]

The popularity of menthol cigarettes among African Americans is no accident. It's the result of the tobacco industry's long history of systematically targeting African Americans with marketing for menthol cigarettes. As far back as the 1950s, the tobacco industry has targeted these communities with marketing for menthol cigarettes through sponsorship of community and music events, targeted magazine advertising, youthful imagery, and marketing in the retail environment.[17] Today, menthol cigarettes continue to be heavily advertised, widely available, and priced cheaper in certain African American communities, making them more appealing, particularly to price-sensitive youth.[18] The tobacco industry's targeting of the African American community has had a destructive health impact.

Action is Needed to Address Health Disparities Worsened by COVID-19

The increased risk the coronavirus poses to smokers and vapers makes it more important than ever to take action to help smokers and vapers quit. Helping individuals who use tobacco products to quit should be part of Congress's response to the COVID-19 pandemic. To prompt and help more tobacco users to quit and to reduce the harmful impact of smoking on African Americans, Hispanics, Native Americans, and other vulnerable groups, policymakers should prohibit flavored tobacco products, including menthol cigarettes, expand the availability of smoking cessation treatments under Medicaid and CHIP, and provide additional funding to OSH to increase efforts to help tobacco users to quit.

Prohibit the Sale of Flavored Tobacco Products, Including Menthol Cigarettes

The tobacco industry has a long history of targeting kids with flavored products. Flavors improve the taste and mask the harshness of tobacco products, making it easier for kids to try the product and ultimately become addicted.[19] Tobacco companies continue to target kids with other flavored products, including cigars in hundreds of flavors and menthol cigarettes. Research shows that flavors play a key role in youth use of tobacco products. Over 80% of kids who have used tobacco started with a flavored product.[20]

With African Americans suffering so disproportionately from COVID-19 and growing evidence that smoking can increase the severity of the disease, it is more urgent than ever that Congress prohibit menthol cigarettes and stop the tobacco industry's predatory marketing of menthol cigarettes to African Americans, kids and other vulnerable populations.

Prohibiting the sale of menthol cigarettes will reduce the burden of tobacco-related illness among African Americans. A 2013 Food and Drug Administration (FDA) report on the health impact of menthol cigarettes determined that menthol cigarettes lead to increased smoking initiation among youth and young adults, greater addiction and decreased success in quitting smoking.[21] In its 2011 report, FDA's Tobacco Products Scientific Advisory Committee estimated that by this year, 4,700 excess deaths in the African American community will be attributable to menthol in cigarettes, and over 460,000 African Americans will have started smoking because of menthol in cigarettes. [22]

Banning menthol cigarettes addresses both a critical public health issue and a matter of social justice. As noted previously, the tobacco industry's decades-long targeting of the African American community has contributed to African Americans suffering unfairly and disproportionately from tobacco-related diseases and death. It must end.

Prohibiting flavors in e-cigarettes, cigars and other tobacco products would help protect a new generation of kids from nicotine addiction and tobacco-caused disease.

Enhance Medicaid and CHIP Coverage of Tobacco Cessation

Most adult smokers want to quit (nearly 70%), and use of evidence-based treatments increases their odds of quitting successfully.[23] Quitting tobacco use lowers the risk of disease and improves life expectancy.[24] Because lung function begins to improve relatively soon after quitting (i.e., 2 weeks to 3 months),[25] helping more tobacco users to quit could also reduce the number of people at risk for serious complications from the COVID-19 pandemic.

Providing barrier-free access to comprehensive tobacco cessation treatment for all enrollees in Medicaid and CHIP is critical because, as noted above, Medicaid beneficiaries smoke at twice

the rate of those with private insurance (23.9% to 10.5%), which increases their risk of cancer, heart disease, COPD, diabetes and other tobacco-caused diseases.[26] It is also cost-effective as Medicaid spends about $40 billion a year on health care for smoking-related diseases.[27] These services include individual, group and telephone counseling, as well as seven FDA-approved medications. In addition to being fully covered, these services must be widely promoted to health care providers and Medicaid and CHIP enrollees so people know they are available. While states have made progress in providing cessation coverage under Medicaid, only 15 states currently cover all available treatments and only two states cover all treatments without any barriers to access.[28]

Expanding Medicaid and CHIP coverage of tobacco cessation treatments will improve health and lower health care costs. After Massachusetts provided comprehensive Medicaid coverage of smoking cessation services and conducted an outreach campaign to raise awareness of the benefit, the smoking rate among beneficiaries declined by 26 percent in the first 2.5 years.[29] The state dramatically reduced hospitalizations for heart attacks and cardiovascular disease among Medicaid recipients, saving more than $3 for every $1 spent on cessation services.[30]

Increase CDC Funding to Help More Tobacco Users to Quit

There remains a great need to help adult tobacco users who want to quit. With additional funding, CDC will be able to expand programs that have proven to be highly effective at helping tobacco users to quit at a time when respiratory health is particularly important. CDC runs a highly effective media campaign, Tips from Former Smokers, that has motivated more than 16.4 million people to make a quit attempt and resulted in approximately one million smokers quitting for good since its inception in 2012.[31] CDC also provides funding for state quitlines, which provide tobacco cessation counseling services and free Nicotine Replacement Therapy (NRT), such as nicotine gum and patches. Smokers who use quitlines are two to three times more likely to succeed in quitting than those who quit on their own.[32] Additional funding will help ensure that all smokers are aware that free help is available to help them quit. Smokers can get help in quitting by calling 1-800-QUIT-NOW or visiting smokefree.gov.

Tobacco users can quickly and greatly improve their health by quitting – and there has never been a better time to do so than during the COVID-19 pandemic. Prohibiting the sale of menthol cigarettes, enhancing Medicaid coverage of tobacco cessation services, and providing additional funding to OSH to prompt and help tobacco users to quit, will give tobacco users the best chance to quit successfully, help to reduce the glaring health disparities facing our nation, and potentially avoid the most serious consequences of COVID-19.

The Campaign for Tobacco-Free Kids is committed to advancing social justice and health equity. The health of every person should be valued equally, and government should work to create

the conditions that permit people to be healthy. We appreciate the opportunity to comment on these important issues.

---

[1] NIDA, COVID-19: Potential Implications for Individuals with Substance Use Disorders, viewed 24 March 2020, https://www.drugabuse.gov/about-nida/noras-blog/2020/03/covid-19-potential-implications-individuals-substance-use-disorders; CDC, *Preliminary Estimates of the Prevalence of Selected Underlying Health Conditions Among Patients with Coronavirus Disease 2019 — United States*, February 12–March 28, 2020. MMWR 2020; 69:382–386. http://dx.doi.org/10.15585/mmwr.mm6913e2.

[2] NIDA, COVID-19: Potential Implications for Individuals with Substance Use Disorders, viewed 24 March 2020, https://www.drugabuse.gov/about-nida/noras-blog/2020/03/covid-19-potential-implications-individuals-substance-use-disorders

[3] Garg S. Hospitalization rates and characteristics of patients hospitalized with laboratory-confirmed coronavirus disease 2019—COVID-NET, 14 States, March 1–30, 2020. MMWR. Morbidity and Mortality Weekly Report. 2020;69.

[4] "A new study shows just how badly black people have been hit by Covid-19". Politico. May 5, 2020. https://subscriber.politicopro.com/health-care/article/2020/05/a-new-study-shows-just-how-badly-black-people-have-been-hit-by-covid-19-1932050

[5] The coronavirus is infecting and killing black Americans at an alarmingly high rate, The Washington Post, Apr. 7, 2020

[6] Killerby, Marie E, et al., "Characteristics Associated with Hospitalization Among Patients with COVID-19 – Metropolitan Atlanta, Georgia, March-April, 2020, MMWR. Morbidity and Mortality Weekly Report. 2020;69.

[7] Killerby, Marie E, et al., "Characteristics Associated with Hospitalization Among Patients with COVID-19 – Metropolitan Atlanta, Georgia, March-April, 2020, MMWR. Morbidity and Mortality Weekly Report. 2020;69.

[8] Centers for Disease Control and Prevention (CDC), "Tobacco Product Use and Cessation Indicators Among Adults—United States, 2018," MMWR 68(45): 1013-1019, November 15, 2019, https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6845a2-H.pdf Current smoking is defined as persons who reported having smoked ≥ 100 cigarettes during their lifetimes and, at the time of the survey, reported smoking every day or some days.

[9] CDC, "Tobacco Product Use and Cessation Indicators Among Adults—United States, 2018," MMWR 68(45): 1013-1019, November 15, 2019, https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6845a2-H.pdf.

[10] HHS, "Tobacco Use Among US Racial/Ethnic Minority Groups—African Americans, American Indians and Alaskan Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General," 1998; American Heart Association, Heart Disease and Stroke Statistics— 2019 Update A Report From the American Heart Association, 2019. https://www.ahajournals.org/doi/10.1161/CIR.0000000000000659

[11] American Heart Association, Heart Disease and Stroke Statistics— 2019 Update A Report From the American Heart Association, 2019. https://www.ahajournals.org/doi/10.1161/CIR.0000000000000659; American Cancer Society, "Cancer Facts & Figures for African Americans, 2019-2021," 2019, https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-facts-and-figures-for-african-americans/cancer-facts-and-figures-for-african-americans-2019-2021.pdfHHS, "Tobacco Use Among US Racial/Ethnic Minority Groups—African Americans, American Indians and Alaskan Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General," 1998, http://www.cdc.gov/tobacco/data_statistics/sgr/1998/complete_report/pdfs/complete_report.pdf. See also, Roberts, ME, et al., "Understanding tobacco use onsent among African Americans," *Nicotine & Tobacco Research*, 18(S1): S49-S56, 2016; Alexander, LA, et al., "Why we must continue to investigate menthol's role in the African American smoking paradox," *Nicotine & Tobacco Research, 18(S1):* S91-S101, 2016.

[12] American Heart Association, Heart Disease and Stroke Statistics— 2019 Update A Report From the American Heart Association, 2019; American Cancer Society, "Cancer Facts & Figures for African Americans, 2019-2021," 2019.
[13] Villanti, A., et al., "Changes in the prevalence and correlates of menthol cigarette use in the USA, 2004–2014," *Tobacco Control*, published online October 20, 2016
[14] FDA. *Preliminary Scientific Evaluation of the Possible Public Health Effects of Menthol versus Nonmenthol Cigarettes* (2013).
[15] FDA, "Preliminary Scientific Evaluation of the Possible Public Health Effects of Menthol Versus Nonmenthol Cigarettes," http://www.fda.gov/downloads/ScienceResearch/SpecialTopics/PeerReviewofScientificInformationandAssessments/UCM361598.pdf, 2013; Tobacco Products Scientific Advisory Committee, FDA, "Menthol Cigarettes and Public Health: Review of the Scientific Evidence and Recommendations, 2011, http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/TobaccoProductsScientificAdvisoryCommittee/UCM269697;pdf.; Alexander, LA, et al., "Why we must continue to investigate menthol's role in the African American smoking paradox," *Nicotine & Tobacco Research, 18(S1):* S91-S101, 2016;
[16] See e.g., CDC, "Quitting Smoking Among Adults—United States, 2000-2015," *MMWR*, 65(52): 1457-1464, January 6, 2017, https://www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm6552a1.pdf. Royce, J, et al., "Smoking cessation factors among African Americans and Whites: COMMIT Research Group," *American Journal of Public Health* 83(2):220-6, February 1993.
[17] Gardiner, P.S. "The African Americanization of menthol cigarette use in the United States," *Nicotine & Tobacco Research* 6(S1): S55-S65, 2004.
[18] See e.g., Lee, JGL, et al., "A Systematic Review of Neighborhood Disparities in Point-of-Sale Tobacco Marketing," *American Journal of Public Health*, published online ahead of print July 16, 2015. Henriksen, L., et al., "Targeted Advertising, Promotion, and Price for Menthol Cigarettes in California High School Neighborhoods," Nicotine & Tobacco Research, June 24, 2011.
[19] HHS, *Preventing Tobacco Use Among Youth and Young Adults, A Report of the Surgeon General*, 2012.
[20] Ambrose, BK, et al., "Flavored Tobacco Product Use Among US Youth Aged 12-17 Years, 2013-2014," *Journal of the American Medical Association*, published online October 26, 2015.
[21] FDA. *Preliminary Scientific Evaluation of the Possible Public Health Effects of Menthol versus Nonmenthol Cigarettes* (2013).
[22] TPSAC, FDA, "Menthol Cigarettes and Public Health: Review of the Scientific Evidence and Recommendations, 2011.
[23] HHS, *Smoking Cessation: A Report of the Surgeon General*, Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2020.
[24] HHS, *Smoking Cessation: A Report of the Surgeon General*, Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2020.
[25] HHS, *The health consequences of smoking: A report of the Surgeon General*, Atlanta, GA: HHS, CDC, 2004, http://www.cdc.gov/tobacco/data_statistics/sgr/sgr_2004/index.htm.
[26] CDC, "Tobacco Product Use and Cessation Indicators Among Adults—United States, 2018," MMWR 68(45): 1013-1019, November 15, 2019, https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6845a1-H.pdf
[27] Xu, X et al., "Annual Healthcare Spending Attributable to Cigarette Smoking: An Update," *Am J Prev Med,* 2014.
[28] DiGiulio, A, "State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Accessing Treatments—United States, 2008–2018," MMWR. Morbidity and Mortality Weekly Report, 69, 2020.
[29] Land, Thomas, et al., "Medicaid Coverage for Tobacco Dependence Treatments in Massachusetts and Associated Decreases in Smoking Prevalence," *PloS One,* Volume 5, Issue 3, March 5, 2010.
[30] Richard, P., et. al., "The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts," *PloS One*, Volume 7, Issue 1, January 6, 2012.
[31] CDC, "*Tips* Impact and Results,", https://www.cdc.gov/tobacco/campaign/tips/about/impact/campaign-impact-results.html

[32]Fiore, MC, et al., *Treating Tobacco Use and Dependence: 2008 Update—Clinical Practice Guideline*, U.S. Public Health Service, May 2008, http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf.

Chairman YARMUTH. I now yield myself 10 minutes.

First of all, let me once again thank all of our panel. Your responses have been very helpful and insightful, and your prepared statements, as well. I enjoyed reading all of them, and there is a lot of real good food for thought in all of the statements.

One of the things that I have been doing a lot of recently, and I think probably most people who are in this hearing have, is what happens after we get through this current challenge. What happens when we are on a more stable economic footing? And what happens once we can at least control the coronavirus?

And it seemed to me that there are a couple of things that we probably have learned, or are learning. And one of those is that there are a lot of jobs in this economy that nobody really gave much thinking to, but now have become pretty important jobs.

And I was on a phone call several weeks ago with a group of union members—and, Professor Deaton, I really appreciate your discussion of unions in your testimony, and the importance of revitalizing unions.

But anyway, there was a guy on the phone call named Greg. And I don't know whether Greg was Black or white. Greg is a maintenance worker in one of the public high schools in my district. And it occurred to me that six months ago there was not a person in the country who would have given any thought to Greg. But now, as we start thinking about sending our kids back to school, and worrying about their safety, all of a sudden Greg is a very important person, as are the people who stock the grocery shelves, and the people who drive the buses, and a lot of people who have never really been valued and compensated as commensurate with the role that they play.

And so it occurs to me that one of the things that is going to happen as, again, as we get through this—and we know, particularly, if there is a Democratic Senate and a Democratic president after this next election, that there is going to be a serious conversation about universal basic income. There is going to be a very serious conversation, as has been mentioned here before, about reparations. There are going to be very serious discussions about Medicare for all, or some kind of single-payer system. And there—all of these programs absolutely do come with a cost.

On the other hand, as I think we all recognize—and I am getting to a question for you, Professor Deaton—is that programs by themselves are not going to end systemic racism. A federal government, no matter what we do, is never going to end that. It is the responsibility of the entire society. Corporate America has a role, and so forth. But the idea that the only way to—the primary way to address the systemic racism and inequities in the country is to create a stronger economy that—where the ships all rise seems to me to be—to defy history. We basically relied on that theory for a long time, and it has not really helped.

Could you elaborate, and could you comment on that, Professor?

Dr. DEATON. I would love to. Thank you very much, Chairman.

It is certainly true that growth is good. I mean, we would all like more economic growth than less economic growth. And when growth is high, there is—you can give someone to everyone—some-

thing for everybody. And it is much easier to deal with social conflict. I think those days have, by and large, gone.

And while there has been a lot of growth in the American economy over the last 30 years, it is not equally distributed. And—but I don't really care that much about inequalities. I am saying a horrible thing here. But what I really care about is the people, the large number of people, who have been left behind by this economic growth, and this economic growth is going to the top, it is not going to the bottom, whether you are talking about African-Americans, or whether you are talking about less educated whites.

And, you know, for a long time people were saying, "Well, the numbers aren't really right. People are getting a lot more economic growth than the government is measuring, you should use these measures rather than those other measures." But, you know, that is not really right. And when you see people actually destroying themselves in huge numbers—158,000 people who destroyed themselves through drug addiction, through suicide—we are the only rich country in the world whose suicide rates are actually rising. Everybody else in the world—and all those people who are killing themselves, who are doing away with themselves, are the less educated Americans.

And it is true that our wages were rising up until February. The unemployment was the lowest it had been for a very long time. But they are still worse off than any time they were in the 1980's. And this economy is just not delivering for them. I mean, it may be rising, but it is only raising the boats at the top—and it is very hard for me to see how anyone with serious straight face can continue to talk about trickle down, and how, if the economy goes up, everyone goes with it. The factual record is just 100 percent against that.

Thank you.

Chairman YARMUTH. Yes. It seems like we also have a very recent experience with kind of the systemic disadvantages that Blacks face in this country. When the PPP program came out in CARES, and one of the first things that we realized after—and it got off to a rocky start, but that was understandable. We didn't have agencies that were prepared to deal with millions of applications.

But one thing we found out was none of this money was going to Black entrepreneurs, Black business owners, very little of it, and partially because they didn't have banking relationships significant enough to get help. They didn't have an opportunity to go out and get legal counsel to help them navigate through it. And so we actually set aside some more money in the Heroes Act to go specifically to Black and women-owned and minority-owned businesses.

But to me, that seems to me—one of the big arguments against relying on economy-wide initiatives to actually attack the inequities, because there are these fundamental disadvantages that many people in the country largely—and most—many of them are Black—face in trying to even deal with the systems that we set up that might help them if we can—if they had access to them.

One of the things I want to talk about briefly, and I hate to get into health care debates because you can talk about it forever, but Mr. Roy talked about Medicare for All that was transferable and

encouraged mobility. And one of the things that occurs to me is that employer-based insurance—and we are the only country in the world that has that, the only industrialized nation that has employer-based insurance—also exacerbates the disparities, because you have so many people in the category in Black America and poor whites and so forth who are working in jobs where there is no coverage through their employer, or they are the first ones that are going to be let go and lose their coverage, or the coverage is so expensive that they get no growth in their wages.

Now, I would love to see Dr. Harris, Dr. Jones, if—how you think about—if you see that as a huge problem, the idea that employer-based insurance is a problem with exacerbating inequities.

Dr. JONES. Yes, I—maybe if I can comment first, I would just say a couple of things on that.

I think that right now, as we are going into a recession, we are seeing that there is a huge cost to having your insurance tied with your employer. There are a lot of people who are losing their job, and that is going to provide—that is going to create a break in the continuity of their care, and their access to health care.

I also think that the other thing is that when I talk about the labor market and workers' bargaining power, a lot of what you are seeing in terms of workers not being covered by health insurance is related to their inability to have collective bargaining, and to command better compensation and benefit packages from their employers.

So in the meantime, I think that increasing the ability for people to collectively bargain is going to allow them to have higher quality jobs and compensation.

Chairman YARMUTH. I appreciate that. I apologize, I attributed the union comments to Professor Deaton; they were yours in your testimony.

Well, my time is running out. So I just want to close and say I think Fed Chair Jay Powell had it best—said it best when he acknowledged that those least able to withstand the downturn had been affected the most. And the impact of this virus on the health and economic security of the American people has been brutal, and it has hit Black and Latino families particularly hard.

And we can't move forward with a full recovery without addressing the underlying racial inequities in our system. I think we do have the fiscal space right now and, I believe, the public will to make those systemic and long-overdue changes. We have some bold policies that are ready to go, like the Heroes Act and the George Floyd Justice and Policing Act that we will vote on later this week.

And if we are going to reunite this country and come out on the other side of this crisis as a better nation, Congress must ensure that our recovery efforts include proactive policies to spur not only an inclusive recovery, but inclusive growth and opportunities for all.

And with that, I will thank the panel once again for your time, and your insights, and your expertise. And if there is no further business before the Committee, this hearing is adjourned.

[Whereupon, at 4:47 p.m., the Committee was adjourned.]

SHEILA JACKSON LEE
18TH DISTRICT, TEXAS

WASHINGTON OFFICE:
2160 Rayburn House Office Building
Washington, DC 20515
(202) 225-3816

DISTRICT OFFICE:
1919 SMITH STREET, SUITE 1180
THE GEORGE "MICKEY" LELAND FEDERAL BUILDING
HOUSTON, TX 77002
(713) 655-0050

ACRES HOME OFFICE:
6719 WEST MONTGOMERY, SUITE 204
HOUSTON, TX 77019
(713) 691-4882

HEIGHTS OFFICE:
420 WEST 19TH STREET
HOUSTON, TX 77008
(713) 861-4070

FIFTH WARD OFFICE:
4300 LYONS AVENUE, SUITE 200
HOUSTON, TX 77020
(713) 227-7740

Congress of the United States
House of Representatives
Washington, DC 20515

COMMITTEES:
JUDICIARY
SUBCOMMITTEES:
COURTS AND COMPETITION POLICY
IMMIGRATION, CITIZENSHIP, REFUGEES, BORDER SECURITY, AND INTERNATIONAL LAW
CRIME, TERRORISM AND HOMELAND SECURITY
CONSTITUTION, CIVIL RIGHTS, AND CIVIL LIBERTIES

HOMELAND SECURITY
SUBCOMMITTEES:
CHAIR
TRANSPORTATION SECURITY AND INFRASTRUCTURE PROTECTION
BORDER, MARITIME, AND GLOBAL COUNTERTERRORISM

FOREIGN AFFAIRS
SUBCOMMITTEES:
AFRICA AND GLOBAL HEALTH
MIDDLE EAST AND SOUTH ASIA
TERRORISM, NONPROLIFERATION, AND TRADE

SENIOR WHIP
DEMOCRATIC CAUCUS

CONGRESSWOMAN SHEILA JACKSON LEE OF TEXAS

STATEMENT
HEARING:
"HEALTH AND WEALTH INEQUALITY IN AMERICA: COVID-19 MAKES CLEAR THE NEED FOR CHANGE"

COMMITTEE ON THE BUDGET
WEBEX
JUNE 23, 2020
2:30 P.M.

- Thank you Chairman Yarmuth and Ranking Member Womack for convening this hearing on the subject of how COVID-19 makes crystal clear the near for systemic change to reduce health and wealth inequality in America.

- Let me welcome our witnesses:

  Sir Angus Deaton, Ph.D.
  Senior Scholar
  Princeton University Woodrow Wilson School

  Patrice Harris, M.D., M.A.
  Immediate Past President

American Medical Association (President: June 2019-June 2020)

Damon Jones, Ph.D.
Associate Professor
University of Chicago Harris School of Public Policy

Avik Roy
President
Foundation for Research on Equal Opportunity (FREOPP)

- Health and economic inequalities are not new, but the COVID-19 pandemic has shined a spotlight on them.

- These underlying conditions help explain the disproportionate effects COVID-19 has had on communities of color and suggests that the financial and public health toll of the pandemic may be even greater for these communities in the long-term – and recovery may be slower.

- Even before COVID-19, deep-rooted inequities left us more vulnerable to this pandemic and other economic shocks.

- From the end of World War II to the early 1970s, a broad spectrum of workers shared in the economic growth of the United States, with real family income doubling across the income distribution.

- Since the late 1970's, however, economic gains have become significantly concentrated at the top of the distribution, while workers and families in the middle and bottom of the distribution have seen fewer gains.

- The consequences of rising economic inequality are substantial.

- Rising income inequality has cost the United States six to nine percentage points in cumulative economic growth over the past two decades and increases the likelihood of recessions.

- Economic inequality is even more alarming when viewed through a racial and ethnic lens.

- According to the most recent data from the Census Bureau, the median African American household earned 59 cents for every dollar earned by the median non-Hispanic white household in 2018, a ratio that has changed very little over the past five decades.

- The median Hispanic household earned 73 cents for every dollar earned by non-Hispanic whites.

- Structural racism is not listed as one of the chronic conditions that put people at a higher risk for severe COVID-19 disease according to the CDC, but it certainly makes communities of color more vulnerable to the economic crisis that followed.

- Racial wealth gaps that have existed for generations mean that many communities of color are more vulnerable to income shocks, such as a furlough or layoff due to COVID-19 closures.

- Too many workers do not have the type of employment supports that could help our nation weather the storm, such as paid sick leave.

- And millions of Americans lack access to quality, affordable health care.

- The public health and economic crises of COVID-19 have magnified those underlying health and economic disparities.

- People who were more vulnerable before the pandemic are the hardest hit by it.

- African Americans represent 13 percent of the U.S. population, but 24 percent of COVID-19 deaths.

- The recent unemployment numbers show a historic rise in unemployment for all groups compared to pre-pandemic levels, but unemployment rates for people of color were substantially higher than for whites.

- School closures and distance learning are disproportionately affecting low-income students and students of color; without action, this may exacerbate graduation rate disparities and further perpetuate economic inequality for generations to come.

- We must close the gaps and build a stronger, healthier, and more just country.

- Structural racism cannot be reversed overnight, but its effects on American families can be mitigated and I am proud that House Democrats are taking key steps to achieve structural change for Americans affected by COVID-19 and racial injustice more broadly through the *Heroes Act* and the *George Floyd Justice in Policing Act*.

- In addition, House Democrats continue working to strengthen the programs that people rely on to meet their basic human needs, ensure fairness for all working families by raising the minimum wage, and invest in education and infrastructure to raise all working families' quality of life.

- I look forward to hearing from our witnesses.

- Thank you, Mr. Chairman, for convening this important hearing.

Congresswoman Lee's Questions for the Record

Health and Wealth Inequality in America: How COVID-19 Makes Clear the Need for Change

Tuesday, June 23rd

Menthol (Directed at Dr. Harris) - Use of menthol tobacco products is disproportionally prevalent in African-American communities, where 85 percent of all smokers use menthol products (as compared to only 29 percent of white smokers), the result of systematic targeting by the tobacco industry. Menthol makes it easier to start and harder to quit. Tobacco use has had a profound impact on African-Americans with approximately 45,000 individuals dying from smoking-related illnesses each year. These same communities have experienced significant disparities in access to healthcare, disparities that have been further exposed and exacerbated by the COVID-19 pandemic. Would you agree that COVID highlights the urgency for Congress and the Administration to take decisive action in response to menthol?

Cessation (Directed at Mr. Roy) - Tobacco is the leading cause of death, killing more than 480,000 Americans each year. Underlying these dramatic numbers are stark disparities based on race and socio-economic status. According to 2018 CDC data, 21.3 percent of adults with household incomes of less than $35,000 smoke compared to just 13.3 percent of adults with incomes between $75,000 and $100,000 and only 7.3 percent of adults with incomes over $100,000.

As economies across the country begin to open, low-income and minority populations will continue to be as increased risk of adverse health consequences of result of COVID-19. Isn't it important during this time to ensure that smokers who want to quit have access without barriers to evidence based cessation programs through public health programs, Medicaid or however they have health insurance coverage?

Social Justice (Directed at Dr. Jones) - The tobacco industry has systematically targeted and marketed menthol cigarettes to African-American communities for decades, hooking too many people on a product that's easier to start and harder to quit. African Americans today suffer the greatest burden of tobacco-related death of any racial or ethnic group in the U.S. COVID-19 has further exposed disparities that must be addressed. Isn't it time for Congress to take meaningful action on menthol tobacco products and provide access to services to help people break the cycle of tobacco addiction once and for all?

FREOPP

Response to Questions for the Record

House Budget Committee Hearing • June 23, 2020

"Health and Wealth Inequality in America:
How COVID-19 Makes Clear the Need for Change"

From Rep. Barbara Lee: "Tobacco is the leading cause of death, killing more than 480,000 Americans each year. Underlying these dramatic numbers are stark disparities based on race and socio-economic status. According to 2018 CDC data, 21.3 percent of adults with household incomes of less than $35,000 smoke compared to just 13.3 percent of adults with incomes between $75,000 and $100,000 and only 7.3 percent of adults with incomes over $100,000.

"As economies across the country begin to open, low-income and minority populations will continue to be as increased risk of adverse health consequences of result of COVID-19. Isn't it important during this time to ensure that smokers who want to quit have access without barriers to evidence based cessation programs through public health programs, Medicaid or however they have health insurance coverage?"

Answer from Mr. Avik Roy: "Yes. However, it will important to guard against certain unintended consequences, depending on the type of policy change one is considering to address this problem. For example, mandating that insurers cover smoking cessation, without regard to the prices providers charge, will incentivize those providers to increase their prices, knowing that insurers would be required by law to pay them irrespective of the price."

AMA Responses to Questions for the Record
House Budget Committee Hearing
"Health and Wealth Inequality in America: How COVID-19 Makes Clear the Need for Change"
6.23.20

1. Use of menthol tobacco products is disproportionally prevalent in African American communities, where 85 percent of all smokers use menthol products (as compared to only 29 percent of white smokers), the result of systematic targeting by the tobacco industry. Menthol makes it easier to start and harder to quit. Tobacco use has had a profound impact on African-Americans with approximately 45,000 individuals dying from smoking-related illnesses each year. These same communities have experienced significant disparities in access to healthcare, disparities that have been further exposed and exacerbated by the COVID-19 pandemic. Would you agree that COVID highlights the urgency for Congress and the Administration to take decisive action in response to menthol?

Response from Dr. Harris: The American Medical Association (AMA) agrees that Congress, specifically the Senate, and the Trump Administration need to take more decisive action in response to the widespread use of menthol products within African American communities.

For decades, the AMA has championed seminal anti-tobacco efforts including: prohibiting smoking in public places, as well as on public transportation and in airplanes; calling on tobacco companies to stop targeting children in advertising campaigns; and supporting laws setting the minimum age for purchasing tobacco products, including e-cigarettes, at 21.

In November 2019, the AMA House of Delegates adopted a variety of policies related to e-cigarettes and vaping. These new policies included:

- Urgently advocating for regulatory, legislative, and/or legal action at the federal and/or state levels to ban the sale and distribution of *all* e-cigarette and vaping products, with the exception of those approved by the FDA for tobacco cessation purposes and made available by prescription only;
- Advocating for research funding to study the safety and effectiveness of e-cigarette and vaping products for tobacco cessation purposes;
- Calling for immediate and thorough study of the use of pharmacologic and non-pharmacologic treatment strategies for tobacco use disorder and nicotine dependence resulting from the use of non-combustible and combustible tobacco products in populations under the age of 18;
- Actively collaborating with health care professionals, particularly pharmacist and other health care team members, to persuade retail pharmacies to immediately cease sales of tobacco products; and
- Advocating for diagnostic codes for e-cigarette and vaping associated illnesses, including pulmonary toxicity.

On January 2, 2020, the US Food and Drug Administration announced it intends to leave all tobacco and menthol flavored nicotine delivery systems (ENDS) and all flavors of e-liquids for "open tank" ENDS on the market. Although an interim step in the effort to combat youth tobacco use, AMA felt that the partial ban on flavored e-cigarettes and vaping products did not go far enough as it did not fully meet the policies adopted at the 2019 House of Delegates meeting. In addition, AMA

continues to oppose use of traditional tobacco products, including menthol cigarettes, due to the well documented public health risks.

On February 28, 2020, the House of Representatives passed sweeping legislation, specifically H.R. 2339, the Protecting American Lungs and Reversing the Youth Tobacco Epidemic Act of 2020, to curb flavored tobacco and e-cigarettes. Introduced by Reps. Frank Pallone, Chairman of the House Energy and Commerce Committee, and Rep. Donna Shalala (D-FL), H.R. 2339 would remove all flavored e-cigarettes from the market and only permit them to return if the manufacturer demonstrates that the product helps current tobacco users stop smoking, will not lead non-tobacco users to start, and does not increase the risk of harm from using the product. In addition, all other flavored tobacco products, including menthol cigarettes, would be made illegal.

The legislation also includes strong safeguards against mass criminalization of individuals consuming flavored tobacco products. In fact, the bill prevents any individual who purchases or possesses a banned flavored tobacco product, including menthol cigarettes, for personal consumption from being subjected to criminal penalties. The bill also prevents law enforcement from using possession of flavored tobacco products as justification for individual searches or any other investigative measure. Instead, the legislation places the liability on manufacturers, distributors, and retailers selling illegal flavored products.

AMA strongly supports H.R. 2339 and worked diligently so that it passed the House of Representatives. Not only does the bill promote public health by banning menthol tobacco products, it also helps to ensure marginalized and minoritized communities, including African Americans, aren't unjustifiably targeted by law enforcement. AMA urges the Senate to expeditiously pass H.R. 2339 or the Trump Administration to expand its policies to ban all menthol tobacco products.

Response to Congresswoman Lee's Questions for the Record

Health and Wealth Inequality in America: How COVID-19 Makes Clear the Need for Change

Prepared by Damon Jones

Question: The tobacco industry has systematically targeted and marketed menthol cigarettes to African-American communities for decades, hooking too many people on a product that's easier to start and harder to quit. African Americans today suffer the greatest burden of tobacco-related death of any racial or ethnic group in the U.S. COVID-19 has further exposed disparities that must be addressed. Isn't it time for Congress to take meaningful action on menthol tobacco products and provide access to services to help people break the cycle of tobacco addiction once and for all? las

Answer: My expertise is not in the area of tobacco-related death or if there is an interaction between COVID-19 related illness and pre-existing tobacco-related health complications. Nevertheless, I do agree that supporting people in breaking with their tobacco addiction would be a valuable service. I have done research in the past on workplace wellness programs. In general, my research did not find these programs to be that successful in generally improving the health or lower the health spending of employees. However, I do think there may be ways to improve the health of workers with more targeted versions of workplace wellness. In particular, my understanding from the literature is that smoking cessation programs, which are by definition targeted to smokers, tend to be an outlier in yielding benefits for health promotion in the workplace. This may be one avenue for improving outcomes related to tobacco addiction, subsidized smoking cessation programming.