DePaul Law Review

Volume 71
Issue 2 *Spring 2022*

Article 16

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RACIAL INEQUALITY, COVID-19, AND HEALTH AND UNEMPLOYMENT INSURANCE: LESSONS LEARNED AND PATHWAYS FORWARD

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INTRODUCTION

COVID-19 impacted the entire world, and the United States is no exception. In addition to pervasive death and illness, COVID-19 wreaked havoc on the U.S. economy. Many people in the United States lost their jobs, others worked remotely, and many essential workers continued working in their workplace settings at great risk to themselves. The public health and economic impacts—particularly in employment—have been devastating. But the impact of this global pandemic has not been spread out evenly. This pandemic highlights how little progress we have made in remedying racial and economic inequality in the United States, as low-paid essential workers risk their lives daily to provide more affluent at-home workers their supplies and needs.[2] Structural racism and racial inequality across critical institutions such as health, employment, and education caused Black and Brown communities to especially suffer.[3] Black Americans contracted

1. * Professor of Law, and by courtesy, Professor of Sociology and Criminology, Law & Society, University of California, Irvine. An earlier version of this Article was presented at the Association of American Law Schools, Section of Insurance Law, Co-Sponsored by Business Associations, Agency, Partnership, LLC's and Unincorporated, and Securities Regulation - Insurance Lessons from the Pandemic, January 2022. I would like to thank Stephan Landsman for inviting me to submit this Article as part of the Clifford Symposium on Tort Law and Social Policy. I would also like to thank Stephanie Lee for excellent research assistance on this project.

2. Aaron van Dorn et al., *COVID-19 Exacerbating Inequalities in the U.S.*, 395 THE LANCET 1243, 1243 (2020) (highlighting how COVID-19 disproportionately impacted racial minorities and economically disadvantaged communities and exacerbated existing problems); Clare Bambra et al., *The COVID-19 Pandemic and Health Inequalities*, J. EPIDEMIOLOGY & CMTY. HEALTH, Nov. 2020, at 964, 967 ("COVID-19 has laid bare our longstanding social, economic and political inequalities."); *see* Walter Scheidel, *Inequality and Instability in the Time of COVID-19*, INFERENCE REV. (May 2020), https://inference-review.com/report/inequality-and-instability-in-the-time-of-covid-19 (explaining that COVID-19 is especially harmful to service workers who cannot work from home and low-income individuals and exploring how COVID-19 has been very difficult for service workers who cannot work from home and who lack the financial stability to deal with the economic downturn).

3. Redlining, the policy that limits lending in certain neighborhoods based on race, continues to contribute to racial segregation and adversely affect the wealth of non-white neighborhoods.

COVID-19 at significantly higher rates than white Americans.[4] Moreover, Latinx, Black Americans, and Indigenous people are more likely to die of COVID-19 than white and Asian people.[5] Structural and employment inequity, racism, and disparate experiences in the social determinants of health, such as safe housing, access to healthy food, and environmental factors, lead Black and Brown persons to be more at risk in times of public health or economic crises.[6] Moreover, racial minorities shouldered the burden of continuing to work—at great risk to their health—as essential workers.[7] What happened during the pandemic cannot be viewed in a vacuum: COVID-19 *amplified* existing inequalities in society and racial minorities have suffered at disproportionate levels.[8] Our health and employment systems failed because these systems are rooted in longstanding inequality.

See Amy Scott, *Inequality by Design: How Redlining Continues to Shape Our Economy*, MARKETPLACE (Apr. 16, 2020), https://www.marketplace.org/2020/04/16/inequality-by-design-how-redlining-continues-to- shape-our-economy/. Moreover, systemic inequalities are perpetuated as children in poor communities have less educational opportunities and show diminished academic performance. EMMA GARCIA & ELAINE WEISS, EDUCATION INEQUALITIES AT THE SCHOOL STARTING GATE 37 (2017), https://www.epi.org/publication/education-inequalities-at-the-school-starting-gate/; *see generally* Gerhard Glomm & B. Ravikumar, *Public Education and Income Inequality*, 19 EUR. J. POL. ECON. 289 (2003).

4. *See* Richard A. Oppel et al., *The Fullest Look Yet at Racial Inequity of Coronavirus*, N.Y. TIMES (July 5, 2020), https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html (highlighting the racial inequity between Black and white Americans).

5. *See COVID-19 Cases, Hospitalization, and Death by Race/Ethnicity*, CDC, https://stacks.cdc.gov/view/cdc/91857 (last updated Aug. 8, 2020); *The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S.*, APM RESEARCH LAB (Mar. 5, 2021), https://www.apmresearchlab.org/covid/deaths-by-race; *see also* Oppel et al., *supra* note 4; Daniel Wood, *As Pandemic Deaths Add Up, Racial Disparities Persist — And in Some Cases Worsen*, NPR (Sept. 23, 2020, 1:01 PM), https://www.npr.org/sections/health-shots/2020/09/23/914427907/as-pandemic-deaths-add-up-racial-disparities-persist-and-in-some-cases-worsen.

6. *Social Determinants of Health*, NEW ENG. J. MED. CATALYST (Dec. 1, 2017), https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0312; Bobbi M. Bittker, *Racial and Ethnic Disparities in Employer-Sponsored Health Coverage*, ABA (Sept. 7, 2020), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/health-matters-in-elections/racial-and-ethnic-disparities-in-employer-sponsored-health-coverage/ (stating that "[p]ublic health insurance programs play a major role in providing affordable health care and better outcomes for [Black, Indigenous, and people of color]").

7. *See infra* Part I.

8. Professors Yearby and Mohapatra describe three different levels of racism embedded in society:

> There are three different levels of racism: institutional, interpersonal, and structural. Institutional racism operates through 'neutral' organizational practices and policies that limit racial and ethnic minorities equal access to opportunity. Interpersonal racism operates through individual interactions, where an individual's conscious and/or unconscious prejudice limits racial and ethnic minorities' access to resources. Structural racism operates at a societal level and refers to the way laws are written or enforced, which advantages the majority, and disadvantages racial and ethnic minorities in access to opportunity and resources.

Consistent with the Clifford Symposium's charge to assess the justice system in a post-COVID-19 world, this Article articulates the lessons learned and pathways forward concerning racial inequality and health and employment. In particular, rather than focus on how to address the current pandemic, I focus my analysis on health and unemployment insurance (UI), two key structural resources that are supposed to assist individuals during periods of crisis but generally did not provide enough equitable support and relief during COVID-19. I evaluate the legal responses by the government—particularly concerning the first year of the pandemic—and reveal how such responses largely reproduce existing inequalities because they ignore the structural and institutionalized racism embedded over time in our health and employment systems. Moreover, I also offer suggestions for how to improve the structures in society to reduce inequality across racial and economic lines.

Part I of this Article examines how institutional and structural racism and discrimination have increased inequality in health and employment, and the accompanying health and unemployment insurance systems.[9] It also explores how the COVID-19 pandemic amplified racial inequity in health and employment.[10] Part II examines how the U.S. government responded to COVID-19 with various legislation aimed at supporting our health and unemployment insurance systems and how these responses largely reproduced inequality.[11] Part III offers some structural recommendations for how to reform our health and unemployment systems to lessen racial inequality in society moving forward.[12] To be clear, the suggestions offered in this Article are not a panacea. Rather, I offer recommendations for how government and private industry can engage in more systemic and holistic reform that addresses many of the structures that reproduce racial inequality.[13]

Ruqaiijah Yearby & Seema Mohapatra, *Law, Structural Racism, and the COVID-19 Pandemic*, 7 J.L. & THE BIOSCIS. 1, 3–4 (2020) [hereinafter Yearby & Mohapatra, *Law, Structural Racism, and COVID-19*].

9. *See infra* Part I.A–B.

10. *See infra* Part I.C.

11. *See infra* Part II.A–C.

12. *See infra* Part III.A–C.

13. Suggestions in this Article should be treated as a snapshot in time because it focuses only on the first twelve months of the pandemic and government responses starting from March 2020. However, this pandemic has continued into 2022. Structural reforms aimed at addressing longstanding inequality, therefore, need to be part of any response moving forward into 2022.

I. How COVID-19 Amplified Racial Inequality in Employment and Health

I begin by exploring some of the legacies of discrimination that have created a situation where racial and ethnic minorities in the United States face significant disadvantages in health and employment. I then discuss how COVID-19 amplified existing inequalities.

A. Racial Inequality in Employment

The legacy of institutional racism and its impact on employment is long. First, African Americans were enslaved and forced to work in agriculture, domestic, and service work.[14] During the Jim Crow Era (1875–1968), employment laws were enacted that provided protections for white workers and disadvantaged racial and ethnic minorities. Many laws that expanded collective bargaining rights either explicitly excluded racial and ethnic minorities or allowed unions to discriminate against racial and ethnic minorities.[15]

During the Great Depression in the 1930s, the New Deal passed several reforms which ended up negatively impacting persons of color. The National Labor Relations Act of 1935 (NLRA), also known as the Wagner Act, excluded domestic and agricultural workers and permitted labor unions to discriminate against workers of color:[16] "[I]n order to secure the votes of Southern Democrats" the final version of the NLRA excluded huge numbers of "Black workers, women, immigrant workers" and many "industries dominated by women and people of color. . . . "[17] While workers eventually convinced lawmakers to ban unions from engaging in racial discrimination, many domestic and

14. *See* Danyelle Solomon et al., *Systematic Inequality and Economic Opportunity*, Ctr. for Am. Progress (Aug. 7, 2019, 7:00 AM), https://www.americanprogress.org/issues/race/reports/2019/08/07/472910/systematic-inequality-economic-opportunity/. Enslaved people's labor provided the economic foundation for society:

> By some estimates, slaveholders extracted more than $14 trillion worth of labor, in today's dollars, from their captives. Enslaved people plowed and sowed fields; harvested and packaged crops; and raised, milked, and butchered livestock. They cooked and served food, cleaned houses, weaved and mended clothing, and provided child care services. They cut hair, carried luggage, and drove wagons, carts, and carriages.

Id. Charles Post, *Plantation Slavery and Economic Development in the Antebellum Southern United States*, 3 J. Agrarian Change 289, 293 (2003).

15. *See* Solomon et al., *supra* note 14 (stating that trade unions organized by white workers generally excluded African Americans, so African Americans had to form their own where possible).

16. National Labor Relations Act, 29 U.S.C. § 152(3) (2021) ("The term 'employee' shall include any employee . . . but shall not include any individual employed as an agricultural laborer, or in the domestic service of any family or person at his home.").

17. *See* Sharon Block & Benjamin Sachs, Clean Slate for Worker Power, Building a Just Economy and Democracy 2 (2018), https://uploads-ssl.webflow.com/

agricultural workers, who are disproportionately people of color, remained excluded from NLRA protections.[18] Moreover, the Fair Labor Standards Act of 1938 (FLSA) improved wages and working conditions for white workers but "largely excluded African American workers from receiving these benefits by exempting many domestic, agricultural, and service occupations,"[19] again deepening racial disparities and furthering occupational segregation. This in turn led to persistent benefit and wage gaps.[20]

Indeed, many employment laws benefitted white people by allowing them access to unions that had effectively bargained for paid sick leave.[21] The problem is that it left racial and ethnic minority workers without union representation and paid sick leave.[22] This forced minority workers to work even when sick and increase their exposure to illnesses.[23] Even after the Jim Crow Era ended, many racial and ethnic minorities did not have sick leave, and other labor and employment laws limited racial and ethnic minority access to equal pay.[24]

Tying health coverage to employment produced "job lock"[25] and undermined labor market mobility.[26] Workers who cannot afford

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5fa42ded15984eaa002a7ef2/
5fa42ded15984ea6a72a806b_CleanSlate_SinglePages_ForWeb_noemptyspace.pdf.

18. *Employee Rights*, NAT'L LAB. REL. BD., https://www.nlrb.gov/about-nlrb/rights-we-protect/your-rights/employee-rights (last visited Mar. 20, 2021). *See* National Labor Relations Act, 29 U.S.C. § 152(3) (2021).

19. Solomon et al., *supra* note 14; *see generally Fact Sheet #12: Agricultural Employers Under the Fair Labor Standards Act (FLSA)*, U.S. DEP'T LAB. WAGE & HOUR DIV. (Jan. 2020), https://www.dol.gov/agencies/whd/fact-sheets/12-flsa-agriculture (explaining that agricultural workers are excluded from minimum wage or overtime provisions); *Fact Sheet #79B: Live-in Domestic Service Workers Under the Fair Labor Standards Act (FLSA)*, U.S. DEP'T LAB. WAGE & HOUR DIV. (Sept. 1993), https://www.dol.gov/agencies/whd/fact-sheets/79b-flsa-live-in-domestic-workers (explaining that live-in domestic workers may be excluded from overtime provisions).

20. Shelly Steward, *Imagining a Workplace Safety Net Rooted in Equity*, ASPEN INST. (June 12, 2021), https://www.aspeninstitute.org/blog-posts/imagining-a-workplace-safety-net-rooted-in-equity/.

21. Yearby & Mohapatra, *Law, Structural Racism, and COVID-19*, *supra* note 8, at 5 ("These employment laws benefited whites by providing them access to unions that bargained for paid sick leave.").

22. *See id*. (noting that racial minorities without union representation and paid sick leave were forced "to go to work even when they were sick . . . increasing disparities in their exposure to pandemic viruses").

23. *See id.* at 4–5 (highlighting the impacts of unequal employment laws and the Jim Crow Era).

24. *See id* at 5.

25. Bittker, *supra* note 6.

26. Ed Dolan, *What's Wrong with Employer Sponsored Health Insurance*, NISKANEN CTR. (Nov. 6, 2018), https://www.niskanencenter.org/whats-wrong-with-employer-sponsored-health-insurance/ (arguing that "*job lock* refers to the tendency of employer-sponsored health insurance to discourage people from changing jobs; from starting a business of their own; or from reducing their hours to care for family members or move gradually toward retirement").

health insurance coverage without their employer subsidizing it and who might not qualify for Medicaid are forced to depend on an employer to defray its cost. Employer-sponsored health insurance provides private insurance, which generally delivers "more consistent care than publicly funded insurance programs like Medicaid. . . ."[27] This disparately impacts workers of color because they, compared to fellow cohorts, are more likely at risk of losing their jobs and ending up financially vulnerable:

> [They] have far less wealth to fall back on because of a deep racial wealth gap, and are more likely to be the workers in retail, food service, and shipping jobs who are sent to the front lines to put their lives at risk for corporate bottom lines.[28]

Thus, state policies that nudge or force workers back to work or limit mobility highlight how "racism intersects with capitalism" to form "racial capitalism."[29] The interconnection between employment and health coverage provides many opportunities for racial, economic, and health inequity to expand.

This job lock concerns not only health coverage. Unemployment insurance has historically excluded persons of color by design.[30] Social insurance programs were created under the Social Security Act of 1935 as part of the New Deal and included both federal and state programs.[31] In general, the plan was for the federal government to run the social security program while states focused on unemploy-

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27. *See* Bittker, *supra* note 6.

28. Emma Janger et al., *Making Unemployment Insurance Work for Working People*, 68 UCLA L. REV. DISCOURSE 102, 104 (2020); *see* Nancy Leong, *Racial Capitalism*, 126 HARV. L. REV. 2151, 2210 (2013) (discussing how the "racial commodification that racial capitalism enforces renders racial minorities particularly vulnerable to broad fluctuations in market conditions"); K. Sabeel Rahman, *COVID-19 and the Crisis of Racial Capitalism*, DEMOS (Apr. 6, 2020), https://www.demos.org/blog/covid-19-and-crisis-racial-capitalism; Darrick Hamilton, *A Paycheck Guarantee is Popular With Voters*, DATA FOR PROGRESS (July 8, 2020), https://www.dataforprogress.org/blog/2020/7/8/paycheck-guarantee-is-popular ("During recessions, corporations treat Black workers as the 'first fired, last hired'—as the economy recovers, the Black unemployment rate falls more slowly.").

29. Janger et al., *supra* note 28, at 109 (relying on Ruth Wilson Gilmore's definition of racism and racial capitalism to argue that "[w]hen racism intersects with capitalism to violently exploit the labor of people of color, a system of racial capitalism is created").

30. There has been a debate whether the exclusion of certain occupations was racially motivated and whether the effect of their exclusion was incidental rather than intentional. *See* Kathryn A. Edwards, *There Are Racial Disparities in American Unemployment Benefits. That's by Design*, L.A. TIMES (Oct. 3, 2020, 3:06 AM), https://www.latimes.com/opinion/story/2020-10-03/racial-disparities-unemployment-benefits [hereinafter Edwards, *Racial Disparities by Design*]; KILOLO KIJAKAZI et al., AFRICAN AMERICAN ECONOMIC SECURITY AND THE ROLE OF SOCIAL SECURITY 1-2 (2019), https://www.urban.org/sites/default/files/publication/100697/african_american_economic_security_and_the_role_of_social_security.pdf.

31. *See* Edwards, *Racial Disparities by Design*, *supra* note 30.

ment.[32] Since they were social insurance programs, "workers paid into trust via a payroll tax, and this made them eligible for benefits."[33] Yet both programs excluded certain occupations, including domestic workers and agricultural workers, which were jobs occupied by racial minorities.[34] "Although African Americans made up 11.3 percent of the labor force in 1930,"[35] "about 65% of Black workers at the time fell outside the act, compared with 27% of white workers," due to their occupations.[36] This exclusion was done to relieve the burden on the Treasury.[37] In the aftermath, systematically inadequate social programs coupled with pervasive poverty, the Great Depression, and a racial caste system, particularly in the South, created generational structural inequity.[38] Without a meaningful government safety net, minority workers had to work any wage they could until they could no longer physically do so. The original design significantly increased the economic gap between Black and white Americans in the United States.[39]

While coverage was eventually expanded for both old-age and unemployment insurance in the 1950s by the Social Security Amend-

32. *See id*. "The federal government would run the old-age program, while states would run the unemployment program." *Id.*

33. *See id*.

34. *See generally* KIJAKAZI et al., *supra* note 30, at 2; Edwards, *Racial Disparities by Design*, *supra* note 30. *See generally* Larry Dewitt, *The Decision to Exclude Agricultural and Domestic Workers from the 1935 Social Security Act*, 70 SOC. SEC. BULL. 49, 53 (2010).

35. KIJAKAZI et al., *supra* note 30, at 2.

36. Edwards, *Racial Disparities by Design*, *supra* note 30; *see* Dewitt, *supra* note 34, at 53 (acknowledging that "65 percent of the African American workforce was excluded by this provision").

37. Dewitt, *supra* note 34, at 58 (noting that Treasury Secretary Henry Morgenthau stated the "the idea of virtually universal coverage of all workers in the country would impose an intolerable administrative burden on the Treasury Department (which would have responsibility to collect the taxes at a time well before automatic payroll deductions or computers)" and thus suggested "that coverage be dropped" for "scattered farm and domestic workers"); David Stoesz, *The Excluded: An Estimate of the Consequences of Denying Social Security to Agricultural and Domestic Workers* 7 (George Warren Brown Sch. Soc. Work, CSD Working Paper No. 16–17, 2016) (noting that antebellum plantation workers reasoned that retaining control over the agricultural workforce would maintain labor market competition and that members of the Chamber of Commerce worried that enrolling these groups would "present[ ] prohibitive problems in enrollment").

38. Derrick Johnson, *Viewing Social Security Through the Civil Rights Lens*, NAACP (Aug. 14, 2020), https://naacp.org/articles/viewing-social-security-through-civil-rights-lens (highlighting how government programs worsened the economic gap between racial minorities and white people).

39. *See id.* "The NAACP's Charles Hamilton Houston described the law as a 'sieve with the holes just big enough for the majority of Negroes to fall through.'" *Id.*

ments,[40] and while the 2009 American Recovery and Reinvestment Act (ARRA) included several provisions for enhancing unemployed workers' access to unemployment insurance in response to the 2009 recession,[41] any amendments to the system did little to relieve racial disparities. For example, the ARRA "provided $7 billion in financial incentives for states to expand their UI [unemployment insurance] eligibility to vulnerable populations."[42] Many states have acted on those incentives; unfortunately, some still have not.[43] Moreover, a 2010 study found that, coupled with occupational segregation as "low-wage, part-time, and seasonal workers," Black and Latinx workers were "less likely than unemployed [w]hites to receive benefits."[44] Similar results were seen again in 2012.[45] These flaws are caused by structural design:

> The unemployment compensation system is designed so that not all workers will be eligible for UI benefits should they become unemployed. People who have short periods of employment broken up by nonworking spells have a harder time establishing eligibility. Lower-paid workers, seasonal workers, and those in certain indus-

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40. KIJAKAZI et al., *supra* note 30, at 2 (President Truman extended coverage to those who were "regularly employed," and previously, President Eisenhower extended it to all domestic and farm workers.).

41. These provisions included federally funded benefits (which begin when state basic benefits end) via a program called "Emergency Unemployment Compensation, with up to 33 weeks of additional coverage for workers without jobs for more than six months (the typical duration of state benefits)." *See* AUSTIN NICHOLS & MARGARET SIMMS, RACIAL AND ETHNIC DIFFERENCES IN RECEIPT OF UNEMPLOYMENT INSURANCE BENEFITS DURING THE GREAT RECESSION 2 (2012), https://www.urban.org/sites/default/files/publication/25541/412596-Racial-and-Ethnic-Differences-in-Receipt-of-Unemployment-Insurance-Benefits-During-the-Great-Recession.PDF. The federal government also "funded an additional $25 in weekly benefits for all unemployed workers." *Id.* "The [A]ct also provided [financial] incentives for states to modify their programs in ways that would extend benefits to previously ineligible workers and enhance payments for workers with dependents." *Id.* As a result, "[m]any states relaxed constraints on eligibility." *Id.*

42. KIRWAN INST. FOR THE STUD. OF RACE & ETHNICITY, UNEMPLOYMENT INSURANCE, THE RECESSION, AND RACE 8 (2010), http://www.kirwaninstitute.osu.edu/reports/2010/07_2010_UnemploymentInsurance_Race.pdf.

43. *Id.* (providing a table showing which programs the fifty states have enacted).

44. *Id.* at 1; *see generally* Jessica Menton, *Unemployment benefits: Racial Disparity in Jobless Aid Grows as Congress Stalls on COVID-19 Stimulus*, USA TODAY (Oct. 27, 2020, 10:39 AM), https://www.usatoday.com/story/money/2020/10/22/stimulus-check-black-unemployment-rate-racial-disparity-coronavirus-trump-biden/3650844001/ ("Black workers were on average 13% less likely than white workers to receive benefits, and Latino workers were 4% less likely.").

45. NICHOLS & SIMMS, *supra* note 41, at 1. These scholars note:

> Even when workers with similar characteristics are compared, African Americans are still more likely to be without UI benefits. For example, within educational categories in which UI receipt tends to be lower, African Americans are less likely to receive UI than other similarly educated workers. . . . Even when workers with similar job tenures are compared, unemployed blacks have rates of UI receipt consistently below those of non-Hispanic whites.

Id. at 3.

> tries are less likely to meet monetary eligibility or other requirements. African Americans are more likely than non-Hispanic whites to have characteristics linked to low UI recipiency, including low levels of education, concentration in occupations or industries where workers are less likely to be covered, and short tenure on jobs.[46]

When workers with similar characteristics are compared across categories such as experience and education, Black workers are more likely than their white counterparts to be without UI benefits.[47] Disparities also remain in terms of the length of time it takes to get benefits and the amount of the benefit.[48]

Government policies that not only cut safety net programs but also often invoked racist tropes led to low unemployment benefits and forced workers of color to take any available low-paying jobs. Indeed, a recent study by the Center for Popular Democracy reveals that "47 percent of Black people in America live in the fourteen states with the lowest caps on unemployment benefits. By contrast, the seven states with the highest benefits are, on average, only 7 percent Black."[49] Due in large part to the United States's deep racial wealth gap, Black and Brown workers have less resources to fall back on if they lose their jobs during an economic or public health crisis.[50] Having financial security is particularly important when one considers that oftentimes people use unemployment insurance to help cover food expenses. Food insecurity is often correlated with unemployment.[51] Hence, communities of color face institutional racism in unemployment insurance with radiating effects.

B. Racial Inequality in Health

Racial health inequities in the United States derive from structural inequities, social determinants of health, and racism. Institutional ra-

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46. *Id.* at 2.

47. *See id.* at 3 (noting that "within educational categories in which UI receipt tends to be lower, African Americans are less likely to receive UI than other similarly educated workers.").

48. *See* Menton, *supra* note 44; Ava Kofman & Hannah Fresques, *Black Workers Are More Likely to Be Unemployed but Less Likely to Get Unemployment Benefits*, PROPUBLICA (Aug. 24, 2020, 5:00 AM), https://www.propublica.org/article/black-workers-are-more-likely-to-be-unemployed-but-less-likely-to-get-unemployment-benefits ("If your historical earnings reflect labor market discrimination, you're going to get hit with lower benefits. . . . The underlying formulas of the system reflect this historical discrimination.").

49. Janger et al., *supra* note 28, at 110.

50. *Id.* at 110 (highlighting how racial minorities often have less resources to fall back on during periods of crisis).

51. *See* Julia Raifman et al., *Unemployment Insurance and Food Insecurity Among People Who Lost Employment in the Wake of COVID-19*, JAMA NETWORK OPEN (forthcoming July 2020).

cism has emanating effects on societal institutions such as education, housing, nutrition, health, insurance, and employment, to name a few.[52] Although health outcomes in the United States have generally improved over the past few decades, the progress is far less for those that are low income, less educated, Black or Native American, or those living in particular regions of the country.[53] Health disparities by race are glaring in the United States. Although the intersection of race and poverty is predictive of health inequity, even more affluent Black Americans suffer worse health outcomes when compared to wealthy white Americans.[54] Black, Latinx, and Native American populations also have greater infant mortality rates than white Americans and higher rates of chronic disease.[55]

The manner in which criminal law is enforced in African American and Latinx communities as compared to white neighborhoods highlights how institutional racism can impact the health of people of color in a disproportionate way. Black men and women are more likely to be arrested, charged, and convicted than whites who commit similar crimes.[56] Sentencing after conviction is no better, with Black men serving prison sentences that are almost 20% longer than the sentences served by white men for similar crimes.[57]

The public health impact on Black communities of disparate criminal law enforcement is significant. Incarceration affects the mental

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52. *See* Bittker, *supra* note 6. Institutional racism impacts many social institutions that are linked to health:

> Your home, schooling, environment, and nutrition directly affect your likelihood of earning a degree, exposure to toxins, and your foundation, and are therefore predictors of whether you will secure a well-paying job, be offered employer-sponsored health insurance, have a regular health provider, and develop chronic health problems as you age.

Id.

53. *See* Douglas C. Dover & Ana Paula Belon, *The Health Equity Measurement Framework: A Comprehensive Model to Measure Social Inequities in Health*, 18 INT'L J. EQUITY HEALTH 1, 5 (2019) (highlighting health inequities for minorities).

54. *See* Emily E. Peterson et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States 2007–2016*, 68 MORBIDITY & MORTALITY WKLY. REP. 762, 763 (2019). In fact, a publication from the Harvard Gazette indicated "in terms of health, there's approximately a five-year penalty for being African-American compared to being a white male." Alvin Powell, *The Costs of Inequality: Money = Quality Health Care = Longer Life*, THE HARV. GAZETTE (Feb. 22, 2016), https://news.harvard.edu/gazette/story/2016/02/money-quality-health-care-longer-life/.

55. Gianna Melillo, *Racial Disparities Persist in Maternal Morbidity, Mortality and Infant Health*, AM. J. MANAGED CARE (June 13, 2020), https://www.ajmc.com/view/racial-disparities-persist-in-maternal-morbidity-mortality-and-infant-health.

56. *See* Dayna Bowen Matthew, *Structural Inequality: The Real COVID-19 Threat to America's Health and How Strengthening the Affordable Care Act Can Help*, 108 GEO. L.J. 1679, 1703 (2020).

57. *Id.*

and physical health not only of the incarcerated individual, but also of the family left behind. For example, family members often experience increased incidence of mental illness and increased risk of poverty and homelessness.[58] Moreover, growing evidence reveals that these health consequences are multi-generational.[59] Incarceration, for example, is associated with a 30% increase in infant mortality.[60] Incarcerated populations are also at greater risk for transmission of infectious disease such as viral hepatitis, tuberculosis, and sexually transmitted diseases as well as susceptibility to developing a mental illness or worsening mental illness.[61] The prevalence of mental illness and injection drug use among incarcerated populations is also significantly higher than in the communities at large.[62] Importantly, when prisoners are released back into poor and segregated communities, they bring their higher incidence of disease back with them to the detriment of the entire community's health.[63] The public health harms associated with imprisonment—where Blacks outnumber whites—are disproportionately borne by Black communities and cause health disparities.[64] Thus, the disproportionate treatment of Blacks caused by institutional racism has detrimental impacts not only on their individual health but also on their communities' health.

Law has institutionalized racial inequities in healthcare. In 1946, the federal government enacted the Hill-Burton Act to provide funding for the construction of public healthcare facilities.[65] Although the Act mandated that adequate healthcare facilities be made available to all state residents regardless of race, it allowed states to construct racially separate and unequal facilities. The Hill Burton Act used racial and ethnic minorities' tax money for the construction of healthcare facilities that provided care to white people but prevented and denied racial and ethnic minorities from receiving care.[66]

Although Title VI of the Civil Rights Act of 1964 was enacted to improve access to healthcare for all ethno-racial groups, its applica-

58. *Id.*

59. *See id.*

60. *See id.*

61. Sandro Galea, *Incarceration and the Health of Populations*, BOS. U. SCH. PUB. HEALTH (Mar. 22, 2015), https://www.bu.edu/sph/2015/03/22/incarceration-and-the-health-of-populations/ .

62. *See* Matthew, *supra* note 56, at 1703.

63. *See* Galea, *supra* note 61.

64. *See* Matthew, *supra* note 56, at 1703–04. (noting how Black communities bear the brunt of the health impact from an incarceration system with a large Black population).

65. *See* Hospital Survey and Construction Act, Hill-Burton Act, 42 U.S.C. § 291(a), (e) (2021).

66. Yearby & Mohapatra, *Law, Structural Racism, and COVID*-19, *supra* note 8, at 17.

tion is not very effective.[67] In particular, the U.S. Department of Health and Human Services (HHS) has not applied Title VI to physician treatment decisions based on race or hospital closures connected to race.[68] In addition, racial and ethnic minority access to healthcare is limited because laws ban immigrants from accessing healthcare benefits under the Affordable Care Act (ACA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act.[69] Compared to whites, Black people have higher rates of untreated respiratory disease and cardiovascular disease—key risk factors for COVID-19—and lack access to treatment for COVID-19 and other health conditions.[70]

Even though the Black population in particular neighborhoods increased, the closure or relocation of hospital services increased for every period from 1980 to 2003, except between 1990 and 1997.[71] These findings were replicated in 2009,[72] 2011,[73] 2012,[74] and 2014.[75]

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67. *Id.*

68. *See* Ruqaiijah Yearby, *When is a Change Going to Come: Separate and Unequal Treatment in Health Care Fifty Years After the Title VI of the Civil Rights Act of 1964*, 67 SMU L. REV. 287, 324–29 (2014); Brietta R. Clark, *Hospital Flight From Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023, 1033 (2005) (explaining how hospitals engaged in both covert and overt discrimination against minorities). *See also* Yearby & Mohapatra, *Law, Structural Racism, and COVID-19*, *supra* note 8, at 13 n.59.

69. *See Immigrants and the Affordable Care Act (ACA)*, NAT'L IMMIGR. L. CTR. (Jan. 2014), https://www.nilc.org/issues/health-care/immigrantshcr/ (outlining differences in coverage between naturalized citizens, lawfully present immigrants, and undocumented immigrants, with immigrants eligible to limited or no health coverage under the ACA); Felicity Sanchez, *COVID-19 and Immigrants*, NAT'L CONF. ST. LEG. (July 24, 2020), https://www.ncsl.org/research/immigration/covid-19-and-immigrants.aspx (estimating "the act excludes 15.4 million individuals in families who have 'mixed status' with citizens, legal immigrants and undocumented family members").

70. Mercedes R. Carnethon et al., *Cardiovascular Health in African Americans: A Scientific Statement from the American Heart Association*, 136 CIRCULATION e393, e394–96 (2017); Yearby & Mohapatra, *Law, Structural Racism, and COVID-19*, *supra* note 8, at 17 (briefly noting how Americans have higher rates of respiratory and cardiovascular disease).

71. ALAN SAGER & DEBORAH SOCOLAR, CLOSING HOSPITALS IN NEW YORK STATE WON'T SAVE MONEY BUT WILL HARM ACCESS TO CARE 42 (2006), http://dcc2.bumc.bu.edu/hs/SagerHospitalClosingsShortReport20Nov06.pdf.

72. Yu-Chu Shen et al., *Understanding the Risk Factors of Trauma Center Closures: Do Financial Pressure and Community Characteristics Matter?*, 47 MED. CARE 968, 968 (2009) (noting that "proposals to cut public spending could exacerbate the trauma closure particularly among areas with high shares of minorities" and that "the number of trauma center closures increased from 1990 to 2005, with a total of 339 during this period").

73. Consider these statistics concerning health inequity and geography:

> By 2007, sixty-nine million Americans (24% of the population) had to travel farther to the nearest trauma center than they did in 2001, and almost sixteen million people had to travel an additional thirty minutes or more. This deterioration in geographical access to trauma centers has been more acute in communities with high shares of poor, uninsured, and African American populations. Our findings reveal that rural communities have a higher risk of experiencing declines in geographic access than urban communi-

African Americans' access to healthcare is limited as a result of these closures:

> As hospitals closed in predominately African American neighborhoods, physicians connected to the hospitals left the area and the remaining hospitals' resources were strained, causing the care provided to gradually deteriorate. Research shows that hospital closures decreased beds in African American neighborhoods, while increasing beds in white neighborhoods where the hospitals reopened.[76]

Thus, despite the link between hospital closures and race, Title VI has been unable to provide regulators leverage to curb this problem. The impact of this structural inequity on race is clear: African American communities have been harmed by the hospital closures and the limited access to care while white communities have benefited by increasing access to healthcare.

Interpersonal racism and poor treatment by healthcare providers is another structural challenge for racial and ethnic minorities. Medical students and physicians often exhibit implicit bias in favor of white people and against Black patients across a series of categories.[77] Interpersonal racism encountered in the healthcare system also leads to a series of collateral but important impacts on their experience, such as delays seeking care, mistrust, interruption in continuity of care, and avoidance of the healthcare system.[78] Additionally, mistrust caused by historical practices against persons of color, including the Tuskegee

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> ties. This is troubling because, at baseline, residents in these areas already must travel farther to reach their nearest trauma center.

Renee Y. Hsia & Yu-Chu Shen, *Changes in Geographical Access to Trauma Centers for Vulnerable Populations in the United States*, 30 HEALTH AFF. 1912, 1918 (2011).

74. Renee Hsia et al., *System Level Health Disparities in California Emergency Departments: Minorities and Medicaid Patients are at Higher Risk of Losing Their EDs*, 59 ANNALS EMERGENCY MED. 358, 362 (2012) (finding that "[b]etween 1998 and 2008, closure of EDs in California was relatively infrequent but appeared more likely to occur in hospitals that admitted a higher proportion of black and Medi-Cal patients").

75. Michelle Ko et al., *Residential Segregation and the Survival of U.S. Urban Public Hospitals*, 71 MED. CARE RES. & REV. 243, 243 (2014) (finding that "a high level of residential segregation . . . in combination with a high percentage of poor residents, conferred a higher likelihood of hospital closure").

76. Yearby & Mohapatra, *Law, Structural Racism, and COVID-19*, *supra* note 8, at 13.

77. Kimani Paul-Emile, *Patients' Racial Preferences and the Medical Culture of Accommodation*, 60 UCLA L. REV. 462, 492–93 (2012) (citing a 2011 study from Johns Hopkins analyzing unconscious race and social-class bias among medical students, including "69 percent of medical students surveyed exhibited implicit preferences for white people" and "other studies have found that physicians tend to rate African American patients more negatively than whites on a number of registers, including intelligence, compliance, and propensity to engage in high-risk health behaviors").

78. Janice Sabin et al., *Physicians' Implicit and Explicit Attitudes About Race by MD Race, Ethnicity, and Gender*, 20 J. HEALTH CARE POOR UNDERSERVED 896, 907 (2009).

experiment,[79] and by current policies, such as the public charge rule,[80] effectively deter persons of color from seeking care, which exacerbates the issue.[81]

African Americans receive poorer quality of care than whites. Studies show that lower death rates are associated with prompt administration of antibiotics and collection of blood cultures.[82] But these lifesaving therapies are often withheld from elderly African Americans. African American Medicare patients receive poorer care than Caucasians who are treated for similar illnesses.[83] Another study of three state hospitalization rates for Medicare beneficiaries experiencing congestive heart failure and pneumonia during 1991 and 1992 revealed that whereas 53% of other pneumonia patients with Medicare were given antibiotics within six hours of admission, only 32% of African American pneumonia patients with Medicare received such care.[84] Black patients with pneumonia were also less likely to have blood cultures done during the first two days of hospitalization.[85] This is an example of structural racism. Because HHS does not apply Title VI to healthcare providers, physicians are allowed to limit African

79. The Tuskegee Experiment was conducted between 1932 and 1972 by the United States Public Health Service and the Centers for Disease Control and Prevention with the purpose of observing the natural history of untreated syphilis. Elizabeth Nix, *Tuskegee Experiment: The Infamous Syphilis Study*, HISTORY (Dec. 15, 2020), https://www.history.com/news/the-infamous-40-year-tuskegee-study. After being recruited by the promise of free medical care, "600 African American men in Macon County, Alabama were enrolled in the project." *Id.* "In order to track the disease's full progression, researchers provided no effective care as the men died, went blind or insane or experienced other severe health problems due to their untreated syphilis." *Id.*; *The Tuskegee Timeline*, CDC (Apr. 22, 2021), https://www.cdc.gov/tuskegee/timeline.htm.

80. Under the Public Charge Rule, effective October 15, 2019, legal immigrants who have received public benefits such as Supplemental Security Income, Temporary Assistance for Needy Families, the Supplemental Nutrition Assistance Program, Medicaid, and public housing assistance for more than a total of twelve months within any thirty-six-month period may be classified as a "public charge" ineligible for permanent residency. Daniel Trotta & Mica Rosenberg, *New Trump Rule Targets Poor and Could Cut Legal Immigration in Half, Advocates Say*, REUTERS (Aug. 12, 2019, 8:22 AM), https://www.reuters.com/article/us-usa-immigration-benefits-idUSKCN1V219N.

81. Leana S. Wen & Nakisa B. Sadeghi, *Addressing Racial Health Disparities in the COVID-19 Pandemic: Immediate and Long-Term Policy Solutions*, HEALTH AFF. BLOG (July 20, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200716.620294/full/ (explaining the longstanding disparities in healthcare practice and policy).

82. Manreet Kanwar et al., *Misdiagnosis of Community-Acquired Pneumonia and Inappropriate Utilization of Antibiotics: Side Effects of the 4-h Antibiotic Administration Rule*, 131 CHEST 1865, 1865, 1868 (2007) (highlighting the association between timely antibiotic therapy and improved health outcomes in patients with community-acquired pneumonia).

83. John Z. Ayanian et al., *Quality of Care by Race and Gender for Congestive Heart Failure and Pneumonia*, 37 MED. CARE 1260, 1265 (1999) (assessing quality of care by race and gender).

84. *See id*.

85. *See id*.

Americans' access to quality healthcare based on interpersonal racism.

Structural racism also prevents other racial and ethnic minorities from accessing healthcare services. Agricultural workers are primarily immigrants, lack health insurance, and are poor.[86] As a result, they forgo healthcare. Additionally, undocumented immigrants in the United States do not have access to healthcare under the ACA.[87] Harsh immigration policies[88] and heightened Immigration and Customs Enforcement presence increase the likelihood that immigrant communities forgo care.[89] When the government and employers choose to contain costs and not provide health insurance, immigrant access to healthcare is also limited. The government and employers' decisions to save money by not providing health insurance, over time, leads to structural inequality and forces marginalized groups, such as immigrants, to bear the most harm.

Structural racial inequity in employment and health is institutionalized, systemic, and has developed over decades. The inequity in many instances is multi-generational and not subject to easy remedies. An extreme economic downturn or public health crisis, therefore, leaves racial and ethnic minorities particularly vulnerable in subtle but powerful ways. The following Part highlights how the COVID-19 pandemic amplified racial inequity in health and employment.

C. Racial Inequality in Employment and Health due to COVID-19

As of March 2021, persons of color made up the largest share of those who contracted COVID-19 in almost all fifty states.[90] It is not something biological that made Black and Latinx populations at greater risk of contracting COVID-19 and suffering serious illness or

86. Monica Schoch-Spana et al., *Stigma, Health Disparities, and the 2009 H1N1 Influenza Pandemic: How to Protect Latino Farmworkers in Future Health Emergencies*, 8 BIOSECUR. & BIOTERRORISM 243, 244 (2010).

87. *See* Medha D. Makhlouf, *Health Justice for Immigrants*, 4 U. PA. J.L. & PUB. AFF. 235, 245 (2019).

88. Wendy E. Parmet, *Trump's Immigration Policies Will Make the Coronavirus Pandemic Worse*, STAT (Mar. 4, 2020), https://www.statnews.com/2020/03/04/immigration-policies-weaken-ability-to-fight-coronavirus/ (noting "there have been highly publicized cases of individuals being detained by immigration agents on their way to seeking care").

89. Wendy E. Parmet, *In the Age Of Coronavirus, Restrictive Immigration Policies Pose a Serious Public Health Threat*, HEALTH AFF. BLOG (Apr. 18, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200418.472211/full/ (highlighting the increased raids).

90. Ibram X. Kendi, *What the Racial Data Show*, THE ATLANTIC (Apr. 6, 2020), https://www.theatlantic.com/ideas/archive/2020/04/coronavirus-exposing-our-racial-divides/609526/; *The Data*, THE COVID TRACKING PROJECT (Mar. 7, 2020), https://covidtracking.com/data (recording how in almost all fifty states, persons of color make up the largest share of those who contracted COVID-19).

death. Rather, it is state-sanctioned discriminatory practices that have increased their exposure and susceptibility to the virus. Here, I discuss (1) employment and labor conditions, (2) economic conditions, and (3) health and housing conditions that led to increased racial stratification during COVID-19.

1. Employment and Labor Conditions Increased Racial Inequality During COVID-19

In the United States, "Black workers make up about one in nine workers overall"[91] but "make up about one in six of all front-line-industry workers" that are considered "essential."[92] Minorities are overrepresented in many frontline occupations or low-wage jobs that put them at higher risk of contracting the virus:[93] "They are disproportionately represented in employment in grocery, convenience, and drug stores (14.2%); public transit (26.0%); trucking, warehouse, and postal service (18.2%); health care (17.5%); and child care and social services (19.3%)."[94] Although these jobs protect Black workers from job loss, it exposes them to a higher likelihood of contracting COVID-19 while doing their jobs. Indeed, a recent study revealed that "one in three jobs held by women has been designated as essential" during this pandemic, and "[n]onwhite women are more likely to be doing essential jobs than anyone else."[95] Minority workers make up huge chunks of the essential worker population and were unable to stay at home and shelter in place.[96] Racial minorities contracted COVID-19 in disproportionately high rates in "hotspot" areas such as New York

91. ELISE GOULD & VALERIE WILSON, BLACK WORKERS FACE TWO OF THE MOST LETHAL PREEXISTING CONDITIONS FOR CORONAVIRUS—RACISM AND ECONOMIC INEQUALITY 4 (2020), https://www.epi.org/publication/black-workers-covid/.

92. *See id.*

93. Elise Gould & Heidi Shierholz, *Not Everybody Can Work from Home: Black and Hispanic Workers Are Much Less Likely to Be Able to Telework,* ECON. POL'Y INST.: WORKING ECON. BLOG (Mar. 19, 2020, 1:15 PM), https://www.epi.org/blog/black-and-hispanic-workers-are-much-less-likely-to-be-able-to-work-from-home/ (finding "[o]nly 16.2% of Hispanic workers and 19.7% of black workers can telework").

94. *See* GOULD & WILSON, *supra* note 91, at 4.

95. Campbell Robertson & Robert Gebeloff, *How Millions of Women Became the Most Essential Workers in America*, N.Y. TIMES (Sept. 22, 2021), https://www.nytimes.com/2020/04/18/us/coronavirus-women-essential-workers.html.

96. Mohapatra & Yearby, *Law, Structural Racism, and the COVID-19 Pandemic*, *supra* note 8, at 7 ("[T]he Centers for Disease Control and Prevention (CDC) found that African Americans account for 30% of all licensed practical and vocational nurses, while Latinos account for 53% of all agricultural workers, jobs deemed 'essential' during the COVID-19 pandemic.").

City, Milwaukee, Louisiana, and Chicago as well as in specific industries.[97]

In fact, the meat-packing industry has been one of the hardest hit during the pandemic and is illustrative of the problem. Rather than order meat and processing plants to temporarily close when these plants were becoming COVID-19 hotspots, former President Donald Trump issued Executive Order 13917, which allowed him to delegate authority to the United States Department of Agriculture (USDA) to regulate and ensure that meat and poultry processing plants remained open or re-opened during the COVID-19 pandemic.[98] Moreover, even though these plants remained open, they did not adapt their practices to meet the health demands of the pandemic. Under Occupational Safety and Health Administration (OSHA), employers must provide employees with personal protective equipment and develop a respiratory protection standard to prevent occupational disease, and under OSHA's general-duty clause, employers must provide their employees with a place of employment free from recognized hazards that are causing or likely to cause death or serious harm.[99] Despite having power and discretion, OSHA and some states with OSHA-approved plans failed to enforce laws to protect worker health and safety as demonstrated by the COVID-19 infections and deaths of meat and poultry processing workers.[100] The failure or inability to enforce these laws left essential workers—many of whom are racial and ethnic mi-

97. Sanya Mansoor, *Data Suggests Many New York City Neighborhoods Hardest Hit by COVID-19 Are Also Low-Income Areas*, TIME (Apr. 5, 2020, 3:36 PM), https://time.com/5815820/data-new-york-low-income-neighborhoods-coronavirus/ (tracing by zip code which regions in New York have contracted the virus and finding it is hitting low-income communities of color the hardest); Reis Thebault et al., *The Coronavirus Is Infecting and Killing Black Americans at an Alarmingly High Rate*, WASH. POST (Apr. 7, 2020), https://www.washingtonpost.com/nation/2020/04/07/coronavirus-is-infecting-killing-black-americans-an-alarmingly-high-rate-post-analysis-shows/?arc404=true (tracing cities like Chicago, Milwaukee, Louisiana, and New York City where African Americans make up the largest share of coronavirus cases but the lowest share of the general population); Samantha Michaels, *70 Percent of People Killed in Chicago by the Coronavirus Are Black*, MOTHER JONES (Apr. 5, 2020), https://www.motherjones.com/coronavirus-updates/2020/04/70-percent-of-people-killed-in-chicago-by-the-coronavirus-are-black/ ("In Chicago, new data . . . showed that 70 percent of people who have died from COVID-19 in the city were Black. . . . Black people make up 29 percent of the city's total population.").

98. Ruqaiijah Yearby & Seems Mohapatra, *Systemic Racism, the Government's Pandemic Response, and Racial Inequities in COVID-19*, 70 EMORY L.J. 1419, 1443–44 (2021) (highlighting the racial stratification during COVID-19 and using the meat industry as an example) [hereinafter Yearby & Mohapatra, *Systemic Racism*].

99. 29 C.F.R. § 1910.32(a) (2017) (listing standard personal protection equipment); 29 U.S.C. § 654(a)(1) (2021) (requiring employers to furnish each worker "employment and a place of employment, which are free from recognized hazards that are causing or are likely to cause death or serious physical harm").

100. *See* Yearby & Mohapatra, *Systemic Racism*, *supra* note 98, at 1438.

norities—without meaningful access to health and safety protections to curb workplace exposure to COVID-19. Moreover, transparency concerning reporting COVID-19-related infections in workplaces was deemphasized.[101] In addition to not being held accountable for unsafe practices, the meat-packing industry also has punitive attendance policies or no paid sick leave.[102] Thus, workers were compelled to continue working and risk exposure to the virus.

Structural racism produces racial differences regarding who has paid sick leave, which ends up being a major cause of health disparities. Because many racial and ethnic minorities are employed in jobs that often do not have paid sick leave, racial disparities in COVID-19 infections and deaths are higher:

> [T]hey must go to work even when they are sick, while most whites have paid sick leave and can stay at home. Consequently, racial and ethnic minorities without paid sick leave are more likely than whites to be exposed to COVID-19 in the workplace, resulting in racial and ethnic disparities in COVID-19 infections and deaths.[103]

Institutionalized employment and work conditions, often anchored in structural racism, exacerbate racial disparities during COVID-19.

2. Economic Conditions Amplified Racial Inequality by COVID-19

Racial and ethnic minorities have historically been overrepresented in low-paying service jobs and jobs that are more likely to be eliminated during periods of economic downturns.[104] The pandemic has led to high unemployment rates, particularly for racial and ethnic minorities in the United States:

> The employment rate for Black and Hispanic men hit its lowest level ever in April, and these workers have struggled to get their jobs back. Black men have recovered fewer than 40 percent of jobs

101. *See id*. at 1441 ("OSHA is not enforcing the reporting requirements for COVID-19 infections, hospitalizations, and deaths."); *see* Memorandum from the Occupational Safety & Health Admin., Patrick J. Kapust, Acting Dir., Directorate of Enf't Programs & Scott Ketcham, Dir., Directorate of Constr., Discretion in Enforcement when Considering an Employer's Good Faith Efforts During the Coronavirus Disease 2019 (COVID-19) Pandemic (Apr. 16, 2020), https://www.osha.gov/memos/2020-04-16/discretion-enforcement-when-considering-employers-good-faith-efforts-during (permitting employer discretion in enforcement of OSHA standards during the pandemic).

102. Yearby & Mohapatra, *Systemic Racism*, *supra* note 98, at 1436. (noting punitive attendance policies and lack of sick leave "persisted throughout the COVID-19 pandemic").

103. Ruqaiijah Yearby, *Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause*, 48 J.L., MED. & ETHICS 518, 518 (2020).

104. Heather Long et al., *The COVID-19 Recession Is the Most Unequal in Modern U.S. History*, WASH. POST (Sept. 30, 2020), https://www.washingtonpost.com/graphics/2020/business/coronavirus-recession-equality/.

> lost — the worst of any demographic group, other than Black women. Hispanic men have recovered about 47 percent of lost jobs.[105]

Black women, unfortunately, suffer a similar fate.[106] Even in a tight labor market, Black unemployment is often higher than the white unemployment rate.[107] Not surprisingly, Black unemployment during COVID-19 is rising at a faster rate than their white counterparts.[108] Urban areas, where substantial communities of African American and Latinx people live, "have the largest numbers of workers who are in immediate-risk industries."[109]

Underlying economic factors exacerbated the effect of the COVID-19 recession on persons of color. To be clear, many Black workers and their families were economically insecure prior to the onset of the pandemic. But the pandemic and related job-losses have been especially devastating for Black households because they historically suffer from higher unemployment rates, lower wages, lower incomes, and much less savings to fall back on, as well as significantly higher poverty rates than their white counterparts. Moreover, the intersectionality of racial and economic inequality is pervasive regardless of educational attainment:

> Historically, [B]lack workers have faced unemployment rates twice as high as those of their white counterparts. When the overall unemployment rate averaged 3.7% in 2019, the white non-Hispanic unemployment rate was 3.0% and the [B]lack unemployment rate was twice as high, coming in at an average of 6.1% over the year. This difference cannot be explained away by differences in educational attainment. . . . [A]t every level of education, the [B]lack unemployment rate is significantly higher than the white unemployment rate, even for those workers with college or advanced degrees.[110]

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105. *Id*.

106. *See id.* Recent empirical data suggests:

> Black women are facing the largest barriers to returning to work, data shows, and have recovered only 34 percent of jobs lost in the early months of the pandemic. They are among the most likely to work in low-paying service-sector jobs, which have been slow to rebound at a time when it is still a major health risk to be around others. Nearly 30 percent of Black women work in services, compared with only a fifth of White women.

Id.

107. *See id.*

108. *See* GOULD & WILSON, *supra* note 91, at 2 ("Both began rising in March and then skyrocketed in April. As of the latest data, the black unemployment rate is 16.7%, compared with a white unemployment rate of 14.2%.").

109. Catherine Powell, *Color of Covid: The Racial Justice Paradox of Our New Stay-at-Home Economy*, CNN (Apr. 18, 2020), https://www.cnn.com/2020/04/10/opinions/covid-19-people-of-color-labor-market-disparities-powell/index.html.

110. *See* GOULD & WILSON, *supra* note 91, at 5 (comparing data levels from less than high school education through an advanced degree).

Among the employed, Black workers face significant benefit, wage, and wealth gaps compared to their white peers, even across various education and occupation levels, and often Black households will have single parents and wage earners to support the family.[111] These gaps were magnified during COVID-19.

3. Inequality in Health and Housing Conditions were Amplified due to COVID-19

Racial segregation in housing and the health concerns that emanate from that have increased risk among communities of color during the pandemic.[112] Even if racial minorities were able to shelter at home, people of color are more likely to live in densely populated areas where it is harder to maintain social distancing and where people are more likely to face exposure to pollution—which in turn has been linked to higher mortality rates from COVID-19.[113] The high rate of contagion associated with COVID-19 made social distancing critical to slowing the spread of infection. African Americans are more likely than their white counterparts to live in multi-unit housing and less likely to live in single-unit housing.[114] In smaller or more densely populated home environments, it is more difficult to "isolate vulnerable family members from those who have been infected or who face greater risk of exposure to the virus because of their work conditions."[115] Empirical data suggests that Black families are more likely to live in multigenerational households with older family members that are considered high risk for contracting the COVID-19 virus.[116] Although elderly people in society have been encouraged to isolate

111. *Id.* at 6 (noting "[o]n average, [B]lack workers are paid 73 cents on the white dollar"); KIJAKAZI et al., *supra* note 30, at 10 (noting that African American workers "receive lower wages at every education level . . . and receive lower wages in every occupation. . . . ").

112. Racial segregation in housing is due to structural racism:

> The federal government created the Federal Housing Administration (FHA) in 1933, which subsidized housing builders as long as none of the homes were sold to African Americans, a practice that was called redlining. The FHA also published an underwriting manual that stated that housing loans to African Americans would not be insured by the federal government. The FHA policies, examples of structural racism, advantaged whites seeking to buy homes by creating the suburbs, while relegating African Americans to racially segregated neighborhoods.

Yearby & Mohapatra, *Law, Structural Racism, and COVID-19*, *supra* note 8, at 11–12.

113. Andrew Hammond et al., *How the COVID-19 Pandemic Has and Should Shape the American Safety Net*, 105 MINN. L. REV. HEADNOTES 154, 157 (2020).

114. *See* GOULD & WILSON, *supra* note 91, at 9–10 (noting how "54.5% of African American households live in single-unit structures, compared with 74.2% of white households").

115. *Id*. at 9.

116. *See id.* at 10 (discussing a study showing that 29.2% of African American households live in structures that include five or more units—more than double the rate of white households).

themselves as a preventative measure, multigenerational households with people still working and active in society face increased risk and danger. Moreover, environmentally dangerous conditions, such as toxic dumping sites, chemical plants, and municipal waste facilities, are disproportionately located in Black and low-income communities.[117] Racially segregated housing spaces, therefore, do not have the luxury of a green space with fresh air.

Racially segregated African American neighborhoods are also more likely to have code violations for asbestos and mold.[118] Black Americans are also more likely to suffer from comorbidities that put them at higher risk of serious illness from COVID-19.[119] African American and Latinx neighborhoods are also more likely to have inferior access to early diagnostic and aggressive therapeutic care that would decrease the chance of developing these comorbidities.[120] There is a vicious cycle at play here.

On the one hand, the governmental response to the pandemic includes stay-at-home orders and physical distancing recommendations. These recommendations are consistent with public health guidelines. On the other hand, these governmental guidelines do not address the lived experiences of racial and ethnic minorities who are disproportionately essential workers and do not have the ability to stay at home while working and may face challenges with physical distancing. Although these government public health recommendations seem race neutral, they reinforce systemic racism because racial and ethnic minorities do not receive the equivalent access to resources as white persons and face exposure to COVID-19, preventing their access to necessary care and treatment. Health inequities are compounded because Black and Latinx Americans are less likely to have health insur-

117. Matthew, *supra* note 56, at 1702; *see* Robert Bullard, *New Report Tracks Environmental Justice Movement over Five Decades*, DR. ROBERT BULLARDBLOG (Feb. 9, 2014), https://drrobertbullard.com/new-report-tracks-environmental-justice-movement-over-five-decades/ (revealing how African American school children are more likely to attend schools near pollution sites); Paul Mohai et al., *Air Pollution Around Schools Is Linked to Poorer Student Health and Academic Performance*, 30 HEALTH AFF. 852, 857–58 (2011) (stating that having schools closer to pollution sites results in poorer student health and academic performance, particularly among African American students); ROBERT D. BULLARD, DUMPING IN DIXIE: RACE, CLASS AND ENVIRONMENTAL QUALITY 1–20, 97–137 (3d ed. 2000) (showing how both intentional and unintentional discrimination led to these conditions).

118. *See* Yearby & Mohapatra, *Law, Structural Racism, and COVID-19*, *supra* note 8, at 12–13.

119. *See* Hammond et al., *supra* note 113, at 157–58 (arguing that Black Americans are more likely to suffer comorbidities "like asthma, heart disease, and diabetes, which put them at higher risk of severe illness from COVID-19, and their symptoms may be further exacerbated by the physiological stresses caused by racism and discrimination").

120. *See* Matthew, *supra* note 56, at 1685.

ance and more likely to suffer discriminatory treatment in medical settings when they do seek treatment.[121] Although parts of society have been able to shelter at home, many low-income communities and communities of color continue to work or lose their jobs. Many frontline workers—especially in the food industry—have unequally carried the risk of COVID-19 and will likely carry a larger burden of economic and food insecurity once the pandemic ends.[122]

Empirical research of the pandemic's impact in Georgia using a county-level analysis highlights how the multi-layered structural inequities across housing, employment, and health have put Black Americans at greater risk:

> [Researchers] found that the proportion of [B]lack population in a county was significantly and positively associated with the county confirmed case rate of COVID-19 in Georgia. This relationship persisted even after controlling for other socio-ecologic factors like population density, poverty, and uninsured rates. Notably none of these socio-ecologic variables had a statistically significant association with county COVID-19 confirmed case rates in the fully adjusted model. These results should not be interpreted as causal, but these results do highlight the potential importance of multi-layered vulnerability to COVID-19 among African American populations. Some factors that may account for these findings include racial biases at the individual, health system, and structural level as well as cultural or biologic factors independent of other socio-ecologic vulnerabilities.[123]

The study concludes that the counties with the highest rates of confirmed COVID-19 cases also have very high concentrations of people

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121. *See* Hammond et al., *supra* note 113, at 158; *see, e.g.*, Marcella Alsan & Marianne Wanamaker, *Tuskegee and the Health of Black Men*, 133 Q.J. ECON. 407, 407 (2018) (finding that the disclosure of the Tuskegee Study in 1972 was linked to increases in mistrust of the medical profession, decreases in physician interactions, and reduced life expectancy for Black men); RACHEL GARFIELD et al., THE UNINSURED AND THE ACA: A PRIMER – KEY FACTS ABOUT HEALTH INSURANCE AND THE UNINSURED AMIDST CHANGES TO THE AFFORDABLE CARE ACT 1 (2019), https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-care/ ("Uninsured people are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected.").

122. *See* Kara Young et al., *The Effect of COVID-19 on the Food System*, CONTEXTS (Apr. 16, 2020), https://contexts.org/blog/inequality-during-the-coronavirus-pandemic/ (noting that "[t]hese frontline food workers are being asked to unequally shoulder the risk of COVID-19 now and will undoubtedly shoulder a larger burden of economic and food insecurity in its aftermath").

123. ANNE GAGLIOTI et al., COUNTY-LEVEL PROPORTION OF NON-HISPANIC BLACK POPULATION IS ASSOCIATED WITH INCREASED COUNTY CONFIRMED COVID-19 CASE RATES AFTER ACCOUNTING FOR POVERTY, INSURANCE STATUS, AND POPULATION DENSITY 4 (2020), https://www.msm.edu/RSSFeedArticles/2020/May/documents/County-Level-Proportion-of-AA-Case-Rate-of-COVID19.pdf.

without insurance, living in poverty, and with limited access to healthcare services and hospitals.[124]

In fact, the impact on certain racial and ethnic groups is not novel to the COVID-19 pandemic. During the H1N1 public health crisis, racial and ethnic minorities were unable to stay at home, suffered from health problems that were risk factors for H1N1, and did not have access to healthcare for treatment, which consequently increased their H1N1 death rates as evidenced by health and survey data.[125] A national survey revealed that racial and ethnic minorities were unable to practice social distancing or stay at home during the H1N1 pandemic because they could not work at home and lacked paid sick leave or access to healthcare.[126] Thus, it comes as no surprise that racial and ethnic disparities are being replicated in infections and death rates concerning COVID-19.[127]

Overall, institutional and structural racism that minorities face regarding their housing, unemployment, economic conditions, and health contributes to the disparate impact in employment and health during the pandemic, particularly in the first six months of 2020. Black populations in the United States face disproportionate employment in high-exposure fields, disproportionate burdens of underlying health conditions, disproportionate burdens of poverty, and significantly higher rates of uninsured status.

II. Government Responses to COVID-19 and Why They Have Not Reduced Racial Inequity

To address the COVID-19 crisis, Congress passed four major pieces of legislation in March and April 2020. Enacted on March 6, 2020, the Coronavirus Preparedness and Response Supplemental Appropriations Act "provided $8.3 billion in funding for federal agencies to respond to the outbreak of the virus in the United States and

124. *See id.* at 4–5.

125. *See* Sandra Crouse Quinn et al., *Racial Disparities in Exposure, Susceptibility, and Access to Health Care in the US H1N1 Influenza Pandemic*, 101 Am. J. Pub. Health 285, 285 (2011) (empirically showing that racial and ethnic minorities accounted for increased hospitalization and death from H1N1 and that racial and ethnic minorities' inability to stay at home and lack of access to healthcare increased their infection and death rates); Stephen A. Mein, *COVID-19 and Health Disparities: the Reality of "the Great Equalizer,"* 35 J. Gen. Internal Med. 2439, 2439 (2020) ("During the 2009 H1N1 influenza pandemic, minority groups had higher rates of serious infection requiring hospitalizations compared with non-minority groups.").

126. *See* Quinn et al., *supra* note 125, at 287–88; Supriya Kumar et al., *The Impact of Workplace Policies and Other Social Factors on Self-Reported Influenza-Like Illness Incidence During the 2009 H1N1 Pandemic*, 102 Am. J. Pub. Health 134, 134 (2012).

127. *See* Yearby & Mohapatra, *Law, Structural Racism, and COVID-19*, *supra* note 8, at 2–3.

abroad."[128] The second, the Families First Coronavirus Response Act (FFCRA), signed into law on March 18, 2020, focused on both the epidemiological and economic crises and included additional funding for food assistance.[129] On March 27, 2020, former President Trump signed the CARES Act, a $2 trillion stimulus bill aimed at COVID-19 and the attendant economic crisis.[130] Finally, on April 24, 2020, former President Trump signed the Paycheck Protection Program and Health Care Enhancement Act (PPP) into law, which provided additional funding for programs under the CARES Act.[131]

Although these laws target the health and economic challenges of the pandemic, they fail to account for systemic racial inequality, and therefore, serve to reproduce inequality. This Part analyzes shortcomings of the FFCRA, the CARES Act, the PPP, and changes to unemployment insurance requirements. I focus largely on the impacts on health and employment.

A. The CARES Act: Unemployment Benefits and Paid Leave

The CARES Act attempted to fight off economic collapse from job loss by increasing unemployment benefits, providing employer incentives largely in the form of forgivable loans, and giving workers paid sick leave and health coverage for COVID-19.[132]

1. Unemployment Insurance Benefits

The CARES Act created three new federally funded unemployment insurance programs: Pandemic Emergency Unemployment Compensation (PEUC), Pandemic Unemployment Assistance (PUA), and Pandemic Unemployment Compensation (PUC).[133] The PEUC program provided an additional thirteen weeks of unemployment compensation through December 31, 2020, for workers who exhausted state unemployment compensation benefits.[134] The PUA program provided "up to 39 weeks of unemployment benefits to individuals who are ineligible for regular [state] unemployment com-

128. *See* Hammond et al., *supra* note 113, at 163.

129. *See* Families First Coronavirus Response Act, Pub. L. No. 116-127 (2020).

130. *See* Coronavirus Aid, Relief, and Economic Security Act of 2020, Pub. L. No. 116-136.

131. *See* Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139 (2020).

132. *See* Hammond et al., *supra* note 113, at 174–77. The CARES Act also provided $1,200 to each adult and $500 to each child, which begins to phase out for income above $75,000 for individuals ($150,000 for married couples). *Id.* at 164.

133. *See* Coronavirus Aid, Relief, and Economic Security Act of 2020 § 2107, Pub. L. No. 116-136; *see also* 15 U.S.C. §§ 9021, 9025 (2021).

134. *See* Raifman et al., *supra* note 51.

pensation or extended benefits."[135] Like the PEUC program, the PUA program also expired on December 31, 2020.[136]

The PUC program provided eligible individuals with $600 per week in addition to the weekly benefit received through regular or pandemic unemployment insurance or, in some states, Short-Time Compensation (STC).[137] Through the end of 2020, the federal government under the PUC program reimbursed states with existing STC programs for the entire cost of those benefits (up to the equivalent of twenty-six weeks of total unemployment benefits per worker).[138]

Despite these benefits, Black Americans were the least likely to receive them. A national study showed that just 13% of Black Americans out of work from April to June of 2020 received unemployment benefits, compared with 24% of white workers, 22% of Latinx workers, and 18% of workers of other races.[139] This is partially because some states made it more difficult to access benefits, with the states that have made the deepest cuts to their unemployment programs being mostly in the South—where a higher share of Black Americans reside.[140] Because benefit levels are determined by salary, even when Black workers do receive benefits, they receive smaller payments than white workers at every education level.[141] Additionally, Black workers often stay unemployed longer than white workers.[142] Black workers, therefore, are more likely to exhaust the standard twenty-six weeks of benefits than their white counterparts are.[143] Further, Black workers face additional barriers that their white counterparts do not, including job discrimination and fewer workplace protections.[144] This means

135. *See* JASON FURMAN, 20-10 US UNEMPLOYMENT INSURANCE IN THE PANDEMIC AND BEYOND 5 (2020), https://www.piie.com/system/files/documents/pb20-10.pdf.

136. *See id.* at 5.

137. *See id.*

138. *See* FURMAN, *supra* note 135, at 5. While the PUC program expired July 31, 2020, the CARES Act also "provide[d] federal funding to cover up to half of the cost of new programs implemented by states by December 2020 and additional grants for implementing new programs." *Id.*

139. Kofman & Fresques, *supra* note 48.

140. *See id.* (noting, for example, that "10% of jobless residents in North Carolina got benefits in 2018, compared with 50% in New Jersey," and "[a]mong those who received unemployment benefits in 2018, the program replaced 36% of lost wages in Louisiana, compared with 53% in Iowa").

141. *See id*. (noting the differential payments between Black and white workers). "If your historical earnings reflect labor market discrimination, you're going to get hit with lower benefits. . . . The underlying formulas of the system reflect this historical discrimination." *Id.*

142. *See id.*

143. *See id.* (tracing data from the past three recessions to show that unemployment rates increase sooner and faster for African American workers and noting that more people lose jobs and possibly stay out of a job longer in groups with higher unemployment rates).

144. *See id.*

Black workers are often the first to lose their jobs and the "last to get them back."[145]

The CARES Act II extended these programs through March 14, 2021, but limited PUA to $300 per week.[146] Because benefit levels were so low, millions of people were at risk of losing their homes or being evicted for failure to pay rent.[147] Even when there was a federal moratorium on evictions when the first CARES Act was in effect, landlords disregarded the law as a result of poor enforcement procedures.[148] This selective enforcement penalized racial minorities. One study found that among those who were unable to pay rent, about 23% were Black and 20% were Latinx—more than double the 9% for both whites and Asians.[149] These findings are, once again, unsurprising as separate studies found that between 2012 and 2016, "[n]early one in four black renters (23.7 percent) lived in a county in which the [B]lack eviction rate was more than *double* the white eviction rate."[150] Thus, although both CARES Acts provided some relief, they fell well

145. *See id.* Thus, Black workers face systemic barriers to obtaining sustainable jobs:

> These persistent differences reflect systematic barriers to quality jobs, such as outright discrimination against African American workers, as well as occupational segregation—whereby African American workers often end up in lower-paid jobs than whites—and segmented labor markets in which Black workers are less likely than white workers to get hired into stable, well-paying jobs.

Christian E. Weller, *African Americans Face Systematic Obstacles to Getting Good Jobs*, CTR. FOR AM. PROGRESS (Dec. 5, 2019), https://www.americanprogress.org/issues/economy/reports/2019/12/05/478150/african-americans-face-systematic-obstacles-getting-good-jobs/.

146. Richard Reibstein, *CARES Act, Take 2: Pandemic Unemployment Assistance Extended for Independent Contractors*, LOCKE LORD BLOG (Dec. 28, 2020), https://www.lockelord.com/newsandevents/publications/2020/12/cares-act-take-2-pandemic-unemployment-assistance.

147. Alana Semuels, *$600 a Week in Extra Unemployment Benefits May Soon End, but Millions of Americans Still Can't Find Jobs*, TIME (July 17, 2020, 10:52 AM), https://time.com/5867908/stimulus-unemployment-benefits-coronavirus/; Emily Benfer et al., *The COVID-19 Eviction Crisis: An Estimated 30–40 Million People in America Are at Risk*, ASPEN INST. (Aug. 7, 2020), https://www.aspeninstitute.org/blog-posts/the-covid-19-eviction-crisis-an-estimated-30-40-million-people-in-america-are-at-risk/.

148. Annie Nova, *How the CARES Act Failed to Protect Tenants from Eviction*, CNBC (Aug. 29, 2020, 9:46 AM), https://www.cnbc.com/2020/08/29/how-the-cares-act-failed-to-protect-tenants-from-eviction.html. "From March 27 to July 24 . . . nearly a quarter of the filed evictions [from Harris County, Texas] should have been barred by the CARES Act [but were not]. That amounted to more than 1,000 illegal evictions in that one county alone." *Id.* "Fewer than half of states required landlords to attest that their evictions didn't violate the CARES Act." *Id.*

149. PAUL M. ONG, SYSTEMIC RACIAL INEQUALITY AND THE COVID-19 RENTER CRISIS 9 (2020), https://ucla.app.box.com/s/t8x503d781kfmocclgdgeibielo0q234; Les Dunseith, *Black, Latino Renters Far More Likely to Be Facing Housing Displacement During Pandemic*, UCLA NEWSROOM (Aug. 10, 2020), https://newsroom.ucla.edu/releases/blacks-latinos-more-likely-to-face-housing-displacement.

150. Peter Hepburn et al., *Racial and Gender Disparities Among Evicted Americans*, 7 SOC. SCI. 649, 653 (2020).

short of providing what families living on the margins needed to pay for basic necessities.

2. Employer Incentives and the PPP

The CARES Act enacted several programs designed to incentivize employers to maintain their existing workforces, including a tax credit equal to 50% of qualified wages up to $10,000 per employee per calendar quarter and a forgivable loan administered through the Small Business Administration, called the PPP.[151] These efforts tried to free up capital to keep the financial system afloat and maintain job stability during the pandemic.

Serious inequities hampered the distribution of PPP loans. Significant funds went to large businesses like global hotel and restaurant chains, such as Ruth's Chris Steakhouse and Shake Shack, that qualified because a single location is considered a "small business."[152] Also, by delivering funds through commercial banks, the distribution of PPP loans reinforced existing race-related lending gaps. For exam-

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151. *See Cares Act Aids Employers Who Continue to Pay Employees*, BDO UNITED STATES (Apr. 2020), https://www.bdo.com/insights/tax/compensation-benefits/cares-act-aids-employers-who-continue-to-pay-emplo. Some of the ways the CARES Act attempted to incentivize employers includes the following:

> Congress built on the principles of the Small Business Administration's existing 7(a) loan guarantee program to distribute loans through certified lenders (banks, credit unions, CDFIs, and, eventually, financial technology companies and non-bank lenders). SBA removed the majority of the 7(a) program's rules—requiring no fees, no credit scores, and no collateral from applicants. This enabled the financial system to move a historic amount of capital in a very short period.

Sifan Liu & Joseph Parilla, *New Data Shows Small Businesses in Communities of Color Had Unequal Access to Federal COVID-19 Relief*, BROOKINGS INST. (Sept. 17, 2020), https://www.brookings.edu/research/new-data-shows-small-businesses-in-communities-of-color-had-unequal-access-to-federal-covid-19-relief/. Employers with more than 500 employees were provided additional incentives:

> Businesses with up to 500 employees were able to apply for up to $10 million. . . . Recipients can apply for the loan to be forgiven, provided that at least 75 percent of the loan proceeds were used for payroll costs, among other eligibility requirements. . . . These two workforce incentives are mutually exclusive—that is, employers can only receive one.

Hammond et al., *supra* note 113, at 175-76.

152. *See* Hammond et al., *supra* note 113, at 1776. In particular, the PPP defined:

> '[S]mall businesses' as entities with up to 500 employees, [and] the law included a provision pertaining to the food and hospitality sectors wherein companies with individual locations of fewer than 500 people were still eligible. That meant that large, multimillion dollar chains, like Ruth's Chris Steakhouse and Shake Shack were able to apply, often edging out the smaller mom-and-pop enterprises that the law was touted as propping up.

Alana Abramson, *'No Lessons Have Been Learned.' Why the Trillion-Dollar Coronavirus Bailout Benefited the Rich*, TIME (June 18, 2020, 4:13 PM), https://time.com/5845116/coronavirus-bailout-rich-richer/.

ple, large banks in the last few decades operated less in the small-loan area due to low profit margins. Moreover, many small banks closed as bank consolidations occurred since the financial crisis.[153] Since 2006, communities of color have lost more small community banks than other communities.[154] Fintech online lenders stepped up to fill the gap with internet-based technologies that allow for more efficient loan processing and lower transaction costs, albeit with higher interest rates.[155] But the online lenders were not made eligible to issue PPP loans until April 14, 2020, two days before the first round of PPP funds was depleted.[156] At the same time, independent contractors and self-employed individuals were not eligible for PPP loans until April 10, 2020.[157]

Because the PPP initially relied on traditional banks to deliver loans, existing customers at large banks were favored; those who were disfavored included microbusinesses (businesses with fewer than ten employees), non-employer businesses, and African American- and Latinx-owned businesses (which all tend to be unbanked or underbanked).[158] On average, it also took longer "for small businesses with paid employees in majority-Black ZIP codes to receive PPP loans" than in majority-white communities.[159] For non-employer businesses, the loan delay between majority-Black and majority-white neighborhoods was almost three weeks.[160] This delay is particularly acute because in 89% of majority-Latinx communities and 94% of

153. Liu & Parilla, *supra* note 151.

154. *See* Stacy Mitchell, *Update: PPP Loan Data Continues to Show that Big Bank Consolidation has Hampered Small Business Relief*, INST. FOR LOCAL SELF-RELIANCE (June 15, 2020), https://ilsr.org/update-ppp-loan-data/. For a thorough analysis of the racial wealth gap, Black banks, and the challenges, see MEHRSA BARADARAN, THE COLOR OF MONEY: BLACK BANKS AND THE RACIAL WEALTH GAP (2017).

155. Gene Marks, *Online Lenders Are Stepping Up to Fill the Gap Left by Banks During the Pandemic*, THE GUARDIAN (Apr. 16, 2020, 6:00 AM), https://www.theguardian.com/business/2020/apr/16/online-lenders-paycheck-protection-program-banks (providing Kabbage, Lendio, PayPal, Square, and Intuit as example fintechs that are accepting and processing paycheck protection program applications).

156. Jen Wieczner, *The SBA Gave Fintech Companies the Green Light Too Late, Leaving the Smallest of Businesses Without PPP Loans*, FORTUNE (Apr. 17, 2020, 10:09 PM), https://fortune.com/2020/04/17/ppp-loans-sba-paycheck-protection-fintech-lenders-funding.

157. Liu & Parilla, *supra* note 151.

158. Li Zhou, *The Paycheck Protection Program Failed Many Black-Owned Businesses*, VOX (Oct. 5, 2020, 7:00 AM), https://www.vox.com/2020/10/5/21427881/paycheck-protection-program-black-owned-businesses; Liu & Parilla, *supra* note 151; Li Zhou, *Many Small Businesses Are Being Shut Out of a New Loan Program by Major Banks*, VOX (Apr. 7, 2020, 3:40 PM), https://www.vox.com/2020/4/7/21209584/paycheck-protection-program-banks-access.

159. *See* Liu & Parilla, *supra* note 151 (noting it took "small businesses with paid employees in majority-Black ZIP codes to receive PPP loans—seven days longer than those in majority-white communities").

160. *See id.*

majority-African American neighborhoods, a majority of small businesses have cash buffers of less than two weeks, compared to only 35% of majority-white neighborhoods.[161]

Beyond the preexisting disparate access to banking, outright lending discrimination also led to more Black business owners being denied PPP loans as compared to white business owners with a similar application profile.[162] Thus, the PPP was relatively ineffective at assisting Black businesses due to structural racism against individuals and Black businesses. Because the PPP required banks to act as intermediaries for loan access, more established businesses with existing relationships and lines of credit with banks received funds before smaller businesses, who sometimes feared that their collapse was imminent.[163] This result is devastating because businesses most impacted by the pandemic are those in food services, retail, and healthcare and social assistance sectors and are primarily made up of African American-owned businesses.[164] Thus, in addition to individuals, businesses owned by persons of color face disparate treatment during this pandemic.

The Department of Treasury did not release the recipients of the program, making it impossible to completely assess which enterprises benefited most.[165] However, independent analysis exposed the inequity.[166] The Global Strategy survey of Black and Latinx workers found that just 12% of workers received the assistance they requested.[167] Another survey from the Arensmeyer's group revealed that, while 63% of Black and Latino small business owners sought and received financing, 30% did not receive the amount that they requested.[168] The PPP suffered from familiar problems of lack of enforcement and incentives to guarantee banks to prioritize minority workers and busi-

161. JP MORGAN CHASE & CO. INST., PLACE MATTERS: SMALL BUSINESS FINANCIAL HEALTH IN URBAN COMMUNITIES 5 (2019), https://www.jpmorganchase.com/content/dam/jpmc/jpmorgan-chase-and-co/institute/pdf/institute-place-matters.pdf.

162. Liu & Parilla, *supra* note 151 ("A matched-pair test conducted in April found that Black business owners were more likely to be denied PPP loans compared to white business owners with similar application profiles due to outright lending discrimination.").

163. Abramson, *supra* note 152.

164. *See* GOULD & WILSON, *supra* note 91, at 11 (discussing the impacts on Black-owned businesses of pandemic-related reforms).

165. *See* Liu & Parilla, *supra* note 151 ("This disparate access has been hard to measure directly because PPP loan-level data provided by the Treasury Department does not consistently report the race and ethnicity of the loan recipient.").

166. *Id.* (explaining that the study traced businesses by zip code and neighborhood demographics to determine results).

167. Abramson, *supra* note 152.

168. *Id.*

nesses.[169] The Biden administration has since recognized this inequitable distribution and adjusted the loan calculation to include gross profit rather than net profit, set aside funding for underserved groups, and created a priority application window for businesses with fewer than twenty employees (the majority of minority-owned businesses fall into this category).[170]

Moreover, the CARES Act—through the PPP—also provided "a total of $175 billion in funding for hospitals and other healthcare entities, which have suffered steep revenue losses due to the cancellation of elective procedures."[171] However, because of the methodology that HHS used when allocating funding, "a disproportionate share of it has gone to larger, wealthier institutions, rather than those hospitals with the greatest financial need or the largest COVID-19 burden."[172] Moreover, the HHS allocated less funding than was warranted to communities with higher Black populations based on the health or financial impacts of COVID-19.[173] In sum, although the CARES Act and PPP were supposed to provide structural relief to Americans during the pandemic, it reproduced inequality at multiple levels.

3. Omissions from the CARES Act that Exacerbate Structural Inequality

A number of omissions from the CARES Act enhanced racial inequality. The CARES Act left out certain workers from its benefits because it only applied to businesses with less than 500 workers.[174]

169. *See id.* (While the CARES Act specified that lenders prioritize underserved markets, including female and minority-owned businesses, the Small Business Administration (SBA) did not follow through.).

170. Press Release, U.S. Small Business Administration, SBA Prioritizes Smallest of Small Businesses in the Paycheck Protection Program (Feb. 22, 2021) https://www.sba.gov/article/2021/feb/22/sba-prioritizes-smallest-small-businesses-paycheck-protection-program.

171. *See* Hammond et al., *supra* note 113, at 172.

172. *Id.* at 173; *See* Karyn Schwartz & Anthony Damico, *Distribution of CARES Act Funding Among Hospitals*, KAISER FAM. FOUND. (May 13, 2020), https://www.kff.org/health -costs/issue-brief/distribution-of-cares-act-funding-among-hospitals/; Jesse Drucker et al., *Wealthiest Hospitals Got Billions in Bailout for Struggling Health Providers*, N.Y. TIMES (July 1, 2020), https://www.nytimes.com/2020/05/25/business/coronavirus-hospitals-bailout.html; *see generally* Abramson, *supra* note 152 ("Because the formula relied on net patient revenue, it meant that wealthier hospitals, where patients are more likely covered by private insurance, received more funds than community health centers and hospitals in poor regions, where patients are more likely to be on Medicaid.").

173. Hammond et al., *supra* note 113, at 173; *see* Pragya Kakani et al., *Allocation of COVID-19 Relief Funding to Disproportionately Black Counties*, 324 J. AM. MED. ASS'N 1000, 1002 (2020) (finding that while among counties receiving the same PPP funding, disproportionately Black counties had a higher COVID-19 burden, more comorbidities, and worse hospital finances than other counties).

174. Pub. L. No. 116-138, § 1102 (2020) (highlighting the 500-worker limit).

However, half the workforce in the United States is situated in businesses that employ more than 500 workers, such as FedEx, Amazon, and most meat and poultry producers.[175] This means that these workers were excluded from being eligible for these benefits. This omission highlights racial inequality at the structural level:

> The failure to ensure that these workers were covered by the CARES Act, while lobbying to have them designated as essential workers is an example of structural racism. By working together to have their workers added to the essential list, but not supporting the distribution of employment benefits to these workers, the companies ensured that the workers would have to continue to go to work even if they were sick. Thus, laws advantaged the companies, while disadvantaging racial and ethnic minorities.[176]

Employment relief or the expanded healthcare protections provided by the CARES Act do not cover agricultural workers, which are approximately 50% undocumented immigrants.[177] Homecare workers, two-thirds of whom are women of color, are also not covered by the CARES Act because homecare industry lobbyists convinced lawmakers that there would be a worker shortage if home health workers were included.[178] Thus, although the CARES Act is framed as protecting workers, it primarily helps white workers while disadvantaging racial and ethnic minorities.[179]

B. FFCRA and its Ineffective Impact on Structural Inequality

The FFCRA expanded paid leave protections for employees, requiring certain employers to provide two weeks of paid sick leave at full pay if an employee is sick or quarantined due to COVID-19, and up to twelve weeks of paid leave at two-thirds of the employee's regular pay to care for a child whose school or daycare closed due to the pandemic.[180] This benefit was also extended to self-employed workers

175. *See* Yearby & Mohapatra, *Systemic Racism*, *supra* note 98, at 1435; Catherine Albiston, *Paid Leave for Precarious Workers During COVID-19*, CONTEXTS BLOG (Apr. 16, 2020), https://contexts.org/blog/inequality-during-the-coronavirus-pandemic/.

176. Yearby & Mohapatra, *Systemic Racism*, *supra* note 98, at 1435.

177. *Id.*

178. *See* Yearby & Mohapatra, *Law, Structural Racism, and COVID-19*, *supra* note 8, at 9, 11.

179. *Id.*

180. *See* Albiston, *supra* note 175 (highlighting what is covered under FFCRA); Heather Long, *Paid Sick Leave: Who Gets It During the Coronavirus Outbreak*, WASH. POST (Mar. 17, 2020), https://www.washingtonpost.com/business/2020/03/16/paid-sick-leave-coronavirus-house-bill/. Although the FFCRA dealt primarily with employee paid leave rights, it did attempt to temporarily alter the healthcare system to account for the public health emergency. The Families First Act requires most private health plans, Medicare, and Medicaid to cover FDA-approved testing for COVID-19, as well as most out-of-pocket costs associated with the tests, for as long as there is a declared public health emergency. *See* Families First Coronavirus Response Act

in the form of a tax credit.[181] The FFCRA prohibits employers from retaliating against employees taking paid leave.[182] Paid leave is crucial during times of crisis because without it, workers are forced to decide between caring for their health or losing their jobs and necessary income. Workers who lack paid leave are more likely to go to work sick, forgo medical care for sick family members, and experience unemployment.[183]

However, the FFCRA has significant gaps in coverage. The FFCRA exempts large employers with more than 500 employees and, similar to the CARES Act, excludes undocumented workers.[184] Excluding large employers carves out almost half the force from receiving paid leave relief.[185] Employees in smaller businesses also face hurdles invoking relief under FFCRA. The FFCRA allows businesses with fifty or fewer employees to seek an exemption from paid sick leave if they believe their business would be adversely affected.[186] This exemption seems peculiar since the federal government is paying for this addi-

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§§ 6001?04 (2020). The law also authorizes full federal funding for states that use their Medicaid program to cover the cost of testing for uninsured people during this period and authorizes $1 billion for the National Disaster Medical System to pay for COVID-19 testing for the uninsured population. *See* CONG. RES. SERV., HEALTH CARE PROVISIONS IN THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT, P.L. 116-127 9 (Apr. 17, 2020), https://crsreports.congress.gov/product/pdf/R/R46316#. To help defray the costs of rising Medicaid enrollment and to prevent states from cutting benefits, the Families First Coronavirus Response Act temporarily increased the Federal Medical Assistance Percentage (FMAP) for state and territorial Medicaid programs by 6.2 percentage points until the end of the public health emergency. MaryBeth Musumeci, *Key Questions About the New Increase in Federal Medicaid Matching Funds for COVID-19*, KAISER FAM. FOUND. (May 4, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-the-new-increase-in-federal-medicaid-matching-funds-for-covid-19/.

181. Long, *supra* note 180.

182. *See* Albiston, *supra* note 175 ("Importantly, the legislation prohibits employers from retaliating against employees for taking paid leave, which research shows is a concern that discourages workers from taking leave even when they have it.").

183. *Id.* (discussing the impacts of paid leave laws during COVID-19).

184. *See* Steven Findlay, *Congress Left Big Gaps in the Paid Sick Days and Paid Leave Provisions of the Coronavirus Emergency Legislation*, HEALTH AFF. BLOG (Apr. 29, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200424.223002/full/.

185. The large employer exclusion left many workers without protection:

> The justification for this large employer exclusion is that most such companies already offer paid sick days and leave, and thus they don't need federal (tax dollar) subsidizes [sic]. In fact, the exemption leaves some 60 million workers—roughly half the nation's full-time workforce—carved out of the law's protections, according to the National Partnership for Women and Families. That's because those workers' employers either offer no paid sick days or fewer than 10 days. As for extended paid leave, most large companies provide that only for parents with a new baby.

Id.

186. *See id.*

tional relief in the form of tax credits.[187] Given that over 30 million people work for businesses with fewer than ten paid sick days, the small business exemption means workers in these businesses have no federal guarantee of paid time off if they, or a family member, are infected with the COVID-19 virus.[188]

Healthcare workers and emergency responders can be excluded at the discretion of their employers.[189] The rationale used to justify this exclusion was that healthcare facilities need to assure that employees work during periods of crisis and high need.[190] But it makes little sense to require sick healthcare workers to report to work during a pandemic because research shows that healthcare workers are at increased risk for exposure and infection relative to the general population.[191] Research suggests that among healthcare workers, racial and ethnic minorities "are more likely to report reuse of or inadequate access to [personal protective equipment] and to work in clinical settings with greater exposure to patients with COVID-19."[192] Finally, pay per day under the FFCRA is capped at $511 for sick leave, but

187. *Id.* ("This provision would have made some sense if businesses were footing the bill for the emergency time off, but they aren't. The federal government is paying most of the tab, via tax credits.").

188. *See id.* ("About 34 million people work for businesses with 50 or fewer workers. The majority of small firms offer either zero or fewer than 10 paid sick days. Very few offer extended paid leave.").

189. Michelle Long & Matthew Rae, *Gaps in the Emergency Paid Sick Leave Law for Health Care Workers*, KAISER FAM. FOUND. (June 17, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/gaps-in-emergency-paid-sick-leave-law-for-health-care-workers/.

190. Findlay, *supra* note 184. The rationale for this policy leaves healthcare workers and emergency responders in a challenging situation:

> Hospitals, clinics, nursing homes, and emergency responder firms (public or private) may need to assure that workers show up at this time of high need and crisis. That's understandable but the exemption means that around 13 million workers and their families have no guaranteed access to paid sick days or paid leave.

Id.

191. Samantha Artiga et al., *COVD-19 Risks and Impacts Among Health Care Workers by Race/Ethnicity*, KAISER FAM. FOUND. (Nov. 11, 2020), https://www.kff.org/racial-equity-and-health-policy/issue-brief/covid-19-risks-impacts-health-care-workers-race-ethnicity/. Consider one recent evaluation of studies evaluating healthcare workers' exposure risk vis-à-vis the general population:

> Studies show that health care workers are at increased risk for exposure and infection relative to the general population, with particularly high risks for health care workers who provide direct patient care, work in inpatient hospital or residential or long-term care settings, are in nursing or direct support staff roles, or do not have adequate access to PPE.

Id.

192. *Id.*

only $200 or, two-thirds pay, (whichever is smaller) for family leave.[193] This striking difference devalues women who often shoulder heavier family care-related responsibilities.

Although the sun set on FFCRA in December 2020, Congress extended the tax credit to employers through March 31, 2021.[194] However, employers are no longer required to participate.[195] This means that some workers may not receive this benefit if their covered employer chooses to forgo the tax credit and not provide leave. While some states have enacted COVID-19 leave laws to cover this gap,[196] this initiative has not been uniform across the states.[197]

In sum, the FFCRA provided little structural relief around work, inadequate paid leave, and economic insecurity and inequality. For racial and ethnic minorities, the impact of an ineffective paid leave policy, when coupled with other structural inequities in housing, education, and healthcare access, is magnified.

C. Changes to Unemployment Insurance Requirements

Because the pandemic has led to many business closures or reductions, workers have faced high unemployment costs. In response, some states changed their unemployment rules, hoping to sweep more workers under its coverage. For example, in order to qualify for unemployment insurance, workers must show they are undergoing a weekly job search.[198] However, to promote social distancing and reduce the spread of the virus, over forty states have temporarily waived or relaxed the weekly job search requirement.[199] Some states have also

193. Catherine Albiston & Catherine Fisk, *Covid-19 Reveals Gaping Holes in U.S. Social Safety Net*, CAL. L. REV. BLOG (May 2020), https://www.californialawreview.org/covid-19-holes-in-us-social-safety-net/.

194. Abigail Rosenblum et al., *Congress Extends FFCRA Tax Credit into 2021, Declines to Extend FFCRA Leave*, PROSKAUER: L. & THE WORKPLACE BLOG (Dec. 28, 2020), https://www.lawandtheworkplace.com/2020/12/congress-extends-ffcra-tax-credit-into-2021-declines-to-extend-ffcra-leave/.

195. *See id.*

196. Abigail Rosenblum et al., *Colorado Governor Signs Paid Sick Leave Act into Law*, PROSKAUER: L. & THE WORKPLACE BLOG (July 21, 2020), https://www.lawandtheworkplace.com/2020/07/colorado-governor-signs-paid-sick-leave-act-into-law/ (announcing that Colorado Governor Jared Polis signed the Healthy Families and Workplaces Act into law, which will require employers in Colorado to provide employees with up to six paid sick days a year and more if there is a public health emergency).

197. *See* Rosenblum et al., *supra* note 194.

198. ZOE XIE, CHANGES IN STATE UNEMPLOYMENT INSURANCE RULES DURING THE COVID-19 OUTBREAK IN THE U.S. 3 (2020), https://www.frbatlanta.org/-/media/documents/research/publications/policy-hub/2020/04/09/changes-in-state-unemployment-insurance-rules-during-the-covid-19-outbreak-in-the-us.pdf.

199. For example, Maine, Maryland, Nevada, North Dakota, Pennsylvania, Texas, Washington, West Virginia, and Wisconsin waived the job search requirement for all unemployed work-

modified the concept of "able and available" to work.[200] Quarantine or illness related to COVID-19 could make workers unable to work, while caring for family with COVID-19 or children would make workers unavailable for work. Many states modified their rules to include those who are quarantined, sick, or taking care of family.[201] Other states extended eligibility for unemployment insurance to self-employed workers, contract workers, and small business owners for employees that worked for employers for less than eighteen months.[202]

Also, in an effort to rapidly get unemployed workers monetary relief during the pandemic, over twenty states temporarily waived the waiting period between when unemployed workers are eligible and when they start receiving benefits.[203] Once workers on temporary or permanent layoffs due to employer downsizing or closing meet the state's requirements on work history, they are eligible under the usual unemployment insurance rules.[204] States with partial benefits cover workers whose hours are reduced due to COVID-19.[205]

Despite these changes, the eligibility and requirements for those receiving unemployment insurance and the base period used to calculate benefit amounts continue to vary significantly from state to state.[206]

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ers. *Id.* Hawaii, Iowa, Kansas, Louisiana, and North Carolina only waived it for claims related to COVID-19. *Id.* California, Minnesota, and Oregon modified the search requirement to online search only. *Id.*

200. *Id.*

201. Thus, "Alabama modified the rules to include those who are quarantined, sick or taking care of family. Delaware and North Dakota treated quarantined or sick workers as if they are on temporary leave[s]" and thus eligible for unemployment benefits. *Id.* "Illinois relaxed the 'able' standard by requiring workers to only demonstrate ability to do certain work from home." *Id.* Kansas presumed workers are able and available for work unless they refused suitable work due to illness. *Id.* Massachusetts removed the requirement to accept suitable jobs unless the situations that prevent workers from working have been resolved. *Id.* "Arizona, Michigan, and New Hampshire extended coverage to workers who are quarantined, sick, caring for sick family [or] at-home children. Oregon considered workers who are sick at home or quarantined and asymptomatic as able to work. West Virginia waived the 'able and available' requirement." *Id.*

202. *See id*. (Kentucky, New Hampshire, and New York are three states that extended eligibility to employees working less than eighteen months.). Employees who miss work because they fear catching the virus but are not under quarantines recommended by a physician, the employer, or the government are treated as ending employment without a good cause. *Id.* While the majority of states still do not provide coverage to these employees, others extend coverage to workers who were expected to return to work. *Id.* Florida and Kentucky deemed a worker leaving work due to reasonable risk of exposure to COVID-19 as not the worker's fault. *Id.* In contrast, Alabama, Indiana, and Wyoming "treated asymptomatic workers missing work due to self-quarantine as 'at fault' or not good cause." *Id.*

203. *See id.* (noting that more than half of states have temporarily waived the waiting period).

204. *See id.* at 3–4.

205. *See id*. at 4.

206. *See* Raifman et al., *supra* note 51 (noting the variation in unemployment insurance benefits).

Thus, the proportion of people receiving unemployment insurance and the amount that people are receiving vary. The federal government's goal with the formulas and calculations is to assure that the states replace approximately half of the work's lost wages.[207] Thus, if a worker is earning approximately $25,000 a year, a 50% replacement rate would be around $241 dollars per week.[208] Massachusetts, which is the most generous state, has benefits capped at $823, but in Mississippi, the least generous state, the cap is $235; this means that instead of receiving 50% replacement, a worker receives 24%.[209]

Racial disparities emerge from the state variation in unemployment policies. For example, the Black population, and therefore, the Black labor force, are not evenly distributed across the United States. One recent study highlighted an uneven distribution of Black workers across the country:

> Six states have a near-zero percentage of the country's Black workforce: Maine, South Dakota, Idaho, Vermont, Wyoming, and Montana. Another dozen states have fewer than 0.5 percent each. On the other hand, one in four Black workers lives in just three states: Texas (8.5 percent), Florida (8.1 percent), and Georgia (8.0 percent). The problem is that, overall, the states with more Black workers have less generous unemployment benefits.[210]

Although all workers in "low benefit" states are vulnerable, these states tend to include a higher number of Black workers. Black workers, therefore, are not as financially supported in unemployment than white workers based on where they live. Moreover, existing research suggests that Black workers are "less likely than white workers to receive unemployment at all, a difference that cannot be explained by education or prior job tenure."[211] It is not accidental that Black workers live in less generous states in terms of unemployment benefits. Unlike Social Security, unemployment insurance benefits are largely administered by states.[212]

During the establishment of the New Deal in the 1930s, a political compromise took place largely because a handful of states already created unemployment programs and did not want a federal pro-

207. *See* Edwards, *Racial Disparities by Design*, *supra* note 30.

208. Kathryn A. Edwards, *The Racial Disparity in Unemployment Benefits*, RAND CORP. BLOG (July 15, 2020), https://www.rand.org/blog/2020/07/the-racial-disparity-in-unemployment-benefits.html (arguing that the "federal government's intention [is] that at the end of all those calculations states replace about half of a worker's lost wages. So a worker earning $50,000 a year, at 50 percent replacement, should get $481 per week.").

209. *See id.*

210. *See id.*

211. *Id.*

212. *Id.*

gram.[213] In order to pass the New Deal legislation, Northern and Southern Democrats needed to reach a compromise.[214] Northern Democrats wanted to expand worker support, while Southern Democrats were more eager to make sure Black workers in the South did not benefit from that support.[215] Allowing unemployment insurance programs to remain under state control allowed both groups to accomplish their goals. Therefore, the legacy of racial hierarchy and stratification embedded state policies with racial implications that still exist: "Southern states today have not only the lowest benefits, but they also have the lowest recipiency rates among Black workers."[216] In sum, legal reforms enacted at the outbreak of the pandemic did not account for structural and institutional barriers and, consequently, were ineffective at ameliorating racial inequality.

III. Pathways Forward for Reducing Racial Inequality in the Health and Unemployment Insurance Context

The challenges racial and ethnic minorities are experiencing during COVID-19 are exacerbated by structural inequality and racism.[217] Unfortunately, laws legitimize the existing social structure and class relationships within that structure. Because anti-discrimination law is largely based on the concept that discrimination is tied to the actions of an individual, it focuses on neutralizing the discriminatory conduct of the perpetrator.[218] Under this approach, the social structure is legitimized because law does not question or address the social, economic, and institutional structures built to limit racial and ethnic minorities' access to housing, education, employment, and healthcare.[219] As a result, laws benefiting the ruling elite (which in the United States has been white people) and harming racial and ethnic minorities remain in place. Although anti-discrimination laws across a variety of sectors of society can decrease racial disparities, racial health and employment disparities continue because law has not changed these social and institutional structures. Even though many laws were passed when the

213. *See id.*

214. *See id.* (highlighting the historical legacy of racial disparity in unemployment benefits during the New Deal).

215. *See id.*

216. *Id.*

217. *See* Matthew, *supra* note 56, at 1685 (arguing that COVID-19 highlights the "structural inequality that characterizes [minority populations'] lives and historic experiences in this country").

218. Yearby, *supra* note 103, at 521 (highlighting Freeman's analysis of how racial discrimination is legitimized through antidiscrimination law).

219. *See id.*

pandemic began to assist individuals in need, they often ignored the layered and deeply embedded inequality. Because systemic racism embodies the entire social structure, we need structural solutions.

This Part offers proposals that address racial inequities amplified by COVID-19 through employment practices, unemployment insurance, and healthcare insurance coverage. I focus less on how to address the current pandemic or national or economic crises that invariably occur from time to time, but rather, I offer suggestions for how to improve the structures in society and how to reduce inequality across racial and economic lines. Although these recommendations are preliminary and are certainly not the only solutions, they reflect some potential pathways forward that may reduce institutionalized and structural inequities that amplify themselves during periods of crisis and economic downturn. My focus is largely on health and unemployment insurance, which are interwoven and key structural gateways for addressing systemic racial inequality in society. To address the systemic racial inequality that COVID-19 further highlighted, the government needs to reform the very institutional structures that lead to racial inequality. It appears that the U.S. government in March 2021 took a step in that direction with the passage of the American Rescue Plan (ARP). I begin by analyzing the ARP and offer suggestions on building on this legislation.

A. American Rescue Plan: A "Good Faith" Attempt at Combatting Structural Inequity

The ARP was enacted on March 11, 2021, under the Biden-Harris administration and offers some structural approaches toward improving education, housing, health coverage, food insecurity, and unemployment benefits.[220] Although not perfect, it is a step in the right direction because it takes a more holistic approach toward inequality.[221]

In addition to providing more stimulus checks, the ARP dramatically expands the Child Tax Credit for 2021.[222] Families with children, now including those with low or no income, will receive periodic payments of up to $300 per child per month from July through the end of

220. *See* American Rescue Plan, Pub. L. No. 117-2 (2021).

221. Tony Romm, *Congress Adopts $1.9 Trillion Stimulus, Securing First Major Win for Biden*, WASH. POST (Mar. 10, 2021, 4:02 PM), https://www.washingtonpost.com/us-policy/2021/03/10/house-stimulus-biden-covid-relief-checks/.

222. *See* Barbara Sprunt, *Here's What's in the American Rescue Plan*, NPR (Mar. 11, 2021, 2:39 PM), https://www.npr.org/sections/coronavirus-live-updates/2021/03/09/974841565/heres-whats-in-the-american-rescue-plan-as-it-heads-toward-final-passage.

2021, so that the total credit amounts to $3,000 for children ages six to seventeen and $3,600 for children under age six.[223] These changes could dramatically reduce child poverty.[224] Indeed, the ARP is projected to bring over 4 million children above the poverty line, 1.2 million of which are Black and 1.7 million of which are Latinx.[225] Currently about *half* of all African American and Latinx families with children "get only a partial Child Tax Credit or no credit at all because their families' incomes are too low to qualify for the full credit."[226]

For low-paid adults who are not raising children at home, the ARP also increases the Earned Income Tax Credit (EITC).[227] Specifically, it raises the maximum EITC "from about $540 to about $1,500, raise[s] the income cap for them to qualify from about $16,000 to at least $21,000, and expand[s] the age range of those eligible to include younger adults aged 19-24" who are not full-time students and those 65 and over.[228] These changes provide timely income support to over 17 million people who work for low pay, including the 5.8 million childless workers aged nineteen to sixty-five who are the ones that the federal tax code taxes into (or deeper into) poverty because the payroll taxes (and income taxes) they owe exceed any EITC they receive.[229] These workers are also disproportionately people of color: about 26% are Latino and 18% are African American, compared to 19% and 12% of the population, respectively.[230] Thus, this credit will help reduce racial disparities caused by structural and institutional racism.

The ARP also allocates $128 billion in grants to state educational agencies, with 90% allocated to local educational agencies.[231] It also

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223. *Id.*

224. *See* Romm, *supra* note 221 (legislators estimate "the changes could cut child poverty by up to half").

225. *See* CTR. ON BUDGET & POL'Y PRIORITIES, AMERICAN RESCUE PLAN ACT WILL HELP MILLIONS AND BOLSTER THE ECONOMY 3 (2021), https://www.cbpp.org/research/poverty-and-inequality/american-rescue-plan-act-will-help-millions-and-bolster-the-economy. The Center on Budget and Policy Priorities projects the ARP:

> [W]ill lift 4.1 million additional children above the poverty line . . . and lift 1.1 million children above half the poverty line (referred to as 'deep poverty'). Among the children that the Child Tax Credit expansion will lift above the poverty line, some 1.2 million are Black and 1.7 million are Latino.

Id.

226. *See id.* at 4.

227. *See id.*

228. *See id.*

229. *See id.*

230. *See id*.

231. Sprunt, *supra* note 222. "Nearly $15 billion in funds are directed to the Child Care & Development Block Grant program to help support child care facilities, particularly in high-need areas." *Id.*

includes a provision to make any student loan forgiveness passed between December 31, 2020, and January 1, 2026, tax-free rather than having the forgiven debt be treated as taxable income.[232] The ARP also provides support for low-income families. It allocates $1.4 billion for programs authorized under the Older Americans Act, including support for nutrition programs, the National Family Caregiver Support Program, and community-based support programs.[233]

Additionally, the ARP provides $37 million to the Commodity Supplemental Food Program for low-income seniors.[234] It also extends the Supplemental Nutrition Assistance Program benefits and the Pandemic EBT (P-EBT) program, which provides grocery benefits to replace meals that children miss when they do not attend school or child care in person.[235] Food insecurity and inequity disproportionately affect households that have children, especially African American and Latinx households,[236] so again, the ARP may provide some relief. Thus, the ARP is attempting to address broader issues relating to education, child care, food insecurity, and income inequality that are often ignored or devalued but tend to disproportionately put racial minorities in difficult situations. To the extent these structural reforms improve racial and economic inequality, they should continue even when the pandemic subsides.

B. Unemployment Insurance — Beyond the Pandemic

Unemployment for many racial and ethnic minorities and workers without a college degree will likely continue in 2022.[237] Moreover, as noted earlier, structural inequities make it more likely that racial and ethnic minorities will bear a heavier burden in periods of economic downturn. This is an important moment to think about structural reform concerning unemployment insurance. More lasting improvements to UI, including supplementary programs and structural changes, should be made. As prior Parts illustrate, there is tremendous intersectionality between race and class, with the economic impacts of COVID-19 being felt most significantly by communities of color. Thus, improving the administration of unemployment insurance will assist vulnerable populations.

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232. *See id.*

233. *See id.*

234. *See* Sprunt, *supra* note 222.

235. *See* CTR. ON BUDGET & POL'Y PRIORITIES, *supra* note 225, at 5.

236. *See id.* at 4.

237. *See id.* at 2 ("Unemployment, particularly among workers of color and workers without a college degree, will likely remain elevated in the fall.").

For example, Congress should consider adopting a Jobseeker's Allowance (JSA). A JSA provides weekly cash benefits to people who are searching for a job but are not eligible for UI because they do not have a recent work history.[238] Graduating college students and people exiting incarceration are ideal candidates for this allowance as it sometimes takes time to find a job.[239] One JSA proposal suggests "the program would last up to thirteen weeks, cover anyone whose household income was below $118,500 a year, and provide people seeking a job with help to mitigate barriers to employment."[240]

Congress could also expand "worksharing," or partial unemployment benefits that workers can receive if employers cut their hours.[241] Known as short-time compensation, worksharing can help stop mass layoffs during economic crises.[242] Rather than lay off workers during a temporary decline in demand, employers reduce workers' hours and allow workers to maintain employment and their accompanying benefits.[243] In turn, workers receive partial unemployment insurance benefits to make up the difference.[244]

Worksharing offers a viable "bridge" for workers in vulnerable situations and should be available in all states and easily accessible during recessions or other periods when job losses surge. Over 200,000 workers in the United States are receiving benefits through worksharing

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238. *See* Janger, et al., *supra* note 28, at 115.

239. *See id.*

240. *Id.*

241. *See id.* at 116; Rachel Arnow-Richman, *Temporary Termination: A Layoff Law Blueprint for the COVID Era*, 64 WASH. UNIV. J. LAW & POL'Y 1, 19–27 (2021) (offering a variety of worksharing approaches that could assist workers in need).

242. *See id.*

243. *See id.*

244. *See Work Sharing: An Alternative to Layoffs*, NAT'L EMP. L. PROJECT (July 16, 2016), https://www.nelp.org/publication/work-sharing-an-alternative-to-layoffs/. The following analysis explains precisely how it works:

> A firm facing a 20 percent reduction in production might normally lay off one-fifth of its work force. Faced with this situation, a firm with a work sharing plan could retain its total workforce on a four-day-a-week basis. This reduction from 40 hours to 32 hours would cut production by the required 20 percent without reducing the number of employees. All affected employees would receive their wages based on four days of work and, in addition, receive a portion of unemployment benefits equal to 20 percent of the total weekly benefits that would have been payable had the employee been unemployed a full week. In this example, if the employee making $500 per week is normally eligible for $250 a week in unemployment benefits, the person would receive $400 in wages and $50 in work sharing benefits for the week (20 percent of the $250 weekly benefits). Like regular unemployment benefits, work sharing benefits do not fully cover lost income, but they help mitigate the loss.

Id.

during the pandemic, but many others cannot.[245] Worksharing is currently not available in all states.[246] Twenty-nine states and the District of Columbia have worksharing programs, and it is optional for employers.[247] Moreover, some states limit employees' ability to claim worksharing to situations in which they face high reductions in hours.[248]

Engaging and empowering racial and ethnic minorities disproportionately harmed by systemic racism in employment should involve creating a worker protection policy pervasive in employment sectors. Establishing a worker protection coordinator that is appointed by the President of the United States and charged with developing and implementing a worker protection policy and research agenda would be constructive. Equally helpful would be an employee safety board that assists in the development and implementation of a worker protection policy and research agenda:

> [E]mployee safety boards . . . [could] advise Congress, OSHA, and the USDA in the creation, implementation, tracking, and evaluation of a national COVID-19 worker protection plan. These boards would give workers the same power meat and poultry processing companies have to influence Congress, OSHA, the USDA, ensuring that the lives of workers are protected.[249]

Structural changes concerning how technology is mobilized could help. This includes modernizing the administration of UI, particularly the information technology and data used to administer claims, which is outdated and underfunded.[250] In fact, due to insufficient federal funding to administer the state UI programs, 40% of states failed to meet the federal guidelines on their benefit payment obligations due

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245. David Wagner, *Work-Sharing Programs Allow Companies to Keep Furloughed Workers*, MARKETPLACE (June 17, 2020), https://www.marketplace.org/2020/06/17/work-sharing-programs-unemployment-furloughs.

246. *See* Janger et al., *supra* note 28, at 116.

247. *See id.* (highlighting how worksharing operates). The JSA should cover (a) students looking for work after completing school/training; (b) workers who have exhausted UI; (c) family caregivers returning to or otherwise seeking formal employment and other returning workers; (d) people exiting incarceration; (e) people who are often intermittently employed, including people with criminal records or some people with disabilities; (f) workers who are low-paid and/or who have erratic schedules; and (g) workers properly classified as Independent Contractors. GEO. CTR. ON POVERTY & INEQ. et al., A JOBSEEKER'S ALLOWANCE WOULD RESPOND TO COVID-19 AND BEYOND 1–2 (2020), https://www.georgetownpoverty.org/wp-content/uploads/2020/05/JSA-COVID-brief-20200519.pdf.

248. *See* Janger et al., *supra* note 28, at 116.

249. Yearby & Mohapatra, *Systemic Racism*, *supra* note 98, at 1455.

250. Till von Wächter, *Unemployment Insurance Reform*, 686 ANNALS AM. ACAD. POL. & SOC. SCI. 121, 136 (2019) ("[S]tates have encountered various challenges related to the administration of their UI programs, mostly due to insufficient funding for newer information technology.").

to the large volume of claims submitted during the recession in 2009.[251] A similar issue occurred during the COVID-19 pandemic. An audit of the California Employment Development Department revealed that "the agency's outdated computer system . . . delayed jobless benefits for millions."[252] Some claimants had to wait months to receive benefits.[253] This program was also not prepared for the high unemployment rate seen during the pandemic.[254]

Thus, updating the current administration and information technology of the UI system by improving data collection, setting up a national database administered by a government entity like the Department of Labor or Census Bureau, and providing funding and technical assistance will partially address these issues.[255]

Another structural reform involves ensuring that state trust funds remain financially sound in order to disburse the UI benefits, particularly in times of recession.[256] The UI system is a collaboration "between the federal government and state governments that provides a temporary weekly benefit to qualified workers who lose their job through no fault of their own."[257] Payroll taxes imposed on employers under the State Unemployment Tax Act (SUTA) and the Federal Unemployment Tax Act (FUTA) provide funding for the state and federal portions of the UI system, respectively.[258] The states administer the UI system, including establishing eligibility rules, setting regular benefit amounts, and paying those benefits to eligible people.[259] State

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251. *Id.*

252. Michael Finney & Randall Yip, *'80s Computer Technology Delays EDD Benefits for Millions of Californians*, ABC 7 NEWS S.F. (Jan. 27, 2021), https://abc7news.com/edd-suspension-unemployment-covid-19-fac-payment-id-me/10072442/.

253. Greg Iacurci, *While Dems and GOP Squabble over Extending $600 Unemployment Benefits, Outdated Technology May Slow Any Solution*, CNBC (June 19, 2020, 2:15 PM), https://www.cnbc.com/2020/06/19/outdated-technology-may-slow-any-solution-to-extend-unemployment-benefits.html. Specifically, California is using a computer-programming language called COBOL that's "more than 60 years old and is often used on big, old, mainframe computers." *Id.*

254. One other roadblock was due to the fact that the CARES Act expanded eligibility to self-employed and gig workers, which "complicate[d] the states' ability to administer a benefit formula beyond a flat weekly payment. . . . Workers who had traditionally been eligible for unemployment insurance had their wages reported regularly to state unemployment offices by their employers." *Id*.

255. *See U.S. Department of Labor Issues New Guidance to States on Implementing American Rescue Plan Act Unemployment Insurance Provisions*, U.S. DEP'T LAB. (Mar. 16, 2021), https://www.dol.gov/newsroom/releases/eta/eta20210316 (noting that even with the passage of the ARP, the Department of Labor recognized that states would need time to modify their computer systems to accommodate the extensions and modifications provided under ARP).

256. *See id.*

257. *Increase Taxes That Finance the Federal Share of the Unemployment Insurance System*, CONG. BUDGET OFF. (Dec. 13, 2018), https://www.cbo.gov/budget-options/2018/54809.

258. *See id.*

259. *See id*.

payroll taxes also vary, and revenues from these taxes are deposited into dedicated state accounts that are included in the federal budget.[260]

The federal government sets broad guidelines for the UI system, pays a portion of the administrative costs that state governments incur, and subsidizes states that lack the money to pay UI benefits.[261] If states are unable to pay out regular benefits using their existing trust fund balances, they can take out federal loans.[262] By October 2020, "[s]eventeen states have depleted their trust fund and have had to get loans from the federal government."[263] The inability of states to fund unemployment payments poses considerable problems, particularly for vulnerable populations.

The United States needs to improve the financial stability of the federal and state UI systems in order to ensure that the states' trust funds can weather a recession or, in the case of the pandemic, severe economic downturns. Recent analysis from the Congressional Budget Office (CBO) provides some guidance. To that end, increasing the federal taxable wage base by indexing it to wage growth while decreasing the FUTA tax rate would result in an additional $18 billion in revenue from 2019 to 2028.[264] Under FUTA, employers pay taxes on up to $7,000 of each worker's wages, and the revenues are deposited into federal accounts.[265] According to the CBO, the amount of wages subject to the FUTA tax (i.e., the taxable wage base) are not adjusted, or indexed, to increase with inflation.[266] Although the FUTA tax rate is 6.0%, it is reduced by a credit of 5.4% for state UI taxes paid, for a

260. *See id.*

261. *See id.* To measure whether states have enough in their trust funds to disburse UI benefits, the Department of Labor calculates the forward-funding solvency of the states' funds via:

> [T]he Average High Cost Multiple (AHCM), which is equal to the average of the three highest benefit cost rates over the last 20 years compared to the reserve ratio. The states with an AHCM value of greater than one have reached the minimum level of solvency needed before entering the next recession to cover UI benefits.

Wächter, *supra* note 250, at 135.

262. *See* Jared Walczak, *Are States Prepared for Skyrocketing Unemployment Insurance Claims?*, TAX FOUND. (Mar. 20, 2020), https://taxfoundation.org/states-prepared-skyrocketing-unemployment-insurance-claims/.

263. Edwards, *Racial Disparities by Design*, *supra* note 30.

264. *See Increase Taxes That Finance the Federal Share of the Unemployment Insurance System*, *supra* note 257 (The Congressional Budget Office conducted projections and made this prediction.).

265. *See id.*

266. *See id.*

net tax rate of 0.6%.[267] This breaks down to $42 per year for each employee earning at least $7,000 annually.[268]

However, indexing the federal taxable wage base to wage growth, while decreasing the FUTA tax rate, would have raised the amount of wages subject to the FUTA tax from $7,000 to $40,000 in 2019 and then indexed that threshold to the growth in future wages.[269] The Congressional Budget Office notes, "it would also reduce the net FUTA tax rate, after accounting for the 5.4 percent state tax credit, from 0.6 percent under current law to 0.167 percent."[270] Under the CBO analysis, states would receive additional revenues if their state wage base met the wage base set by the federal government via FUTA.[271] If implemented, this proposal would likely improve the financial state of the federal part of the UI system along with the individual state UI systems and ensure that the states' trust funds can weather a recession, or in the case of the pandemic, severe economic downturns.[272] Adding $18 billion would be a significant improvement.

Relatedly, the duration of UI benefits and average effective replacement rate should be adjusted. One policy analyst recommends the following: "Federal law should mandate a minimum amount of potential duration of UI benefit of 26 weeks, an average effective replace rate of 50 percent of benefits (with gradual adjustments of the maximum benefit amount), and a dependent allowance to support families with children with higher consumption commitments."[273] State UI programs should also consider replacing at least 60% of a worker's weekly wages, with a maximum of 67% of a state's average weekly wage.[274] This would provide consistency for similarly-situated workers in different states. To ensure states update their laws, the federal government can limit the credit for the SUTA tax that employers receive against the FUTA tax.[275] These types of changes increase the likelihood that low-wage workers, who are disproportionately people of color and women, can turn to the UI system for meaningful assistance.

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267. *See id.*

268. *See id.*

269. *See id.*

270. *See id.*

271. Wächter, *supra* note 250, at 136

272. *Id.*

273. *See id.* at 133.

274. *Fixing Unemployment Insurance and the Coronavirus Response*, ECON. POL'Y INST. (Mar. 23, 2020, 2:15 PM), https://www.epi.org/blog/fixing-unemployment-insurance-and-the-coronavirus-response/.

275. *See* Wächter, *supra* note 250, at 133.

Additionally, federal and state governments need to implement different strategies to increase unemployment application rates.[276] Unlike with health insurance or other social benefit programs, there is no systematic outreach program at the federal level to educate the public about unemployment insurance and their potential eligibility, though some states may have programs of their own.[277] Information dissemination and promoting awareness about eligibility may help reduce the gap.[278] State agencies should be encouraged to allow broader application of employer filings, meaning employers file claims on behalf of their separated employees. This occurs in some states, usually in industries where mass layoffs or seasonal shutdowns are common, such as construction, and employees who have benefitted from employer filing are more likely to successfully file continuing applications.[279] Lastly, and arguably a policy that should be mandated at the federal level, employers should inform former employees who involuntarily lose their jobs that they may be eligible for unemployment insurance and to provide instructions on how to apply.[280] Programs such as the Wagner-Peyser Employment Services and periodic reemployment services should be bolstered and expanded to help UI claimants get back to work.[281]

The suggestions regarding how to fix our UI system offered above are not a panacea. There are a lot of moving parts, including political, economic, and social tensions. But adopting even some of these proposals will help combat some of the structural inequities that invariably fall harder on communities of color.

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276. *See generally* NICHOLS & SIMMS, *supra* note 41, at 4 (noting that disseminating information alone may not be enough to reduce the gap so a variety of strategies, some related to information dissemination and some related to differences in state policies and procedures, may likely be needed).

277. ALIX GOULD-WERTH & CLAIRE MCKENNA, UNEMPLOYMENT INSURANCE APPLICATION AND RECEIPT: FINDINGS ON DEMOGRAPHIC DISPARITIES AND SUGGESTIONS FOR CHANGE 7 (2012), https://www.issuelab.org/resources/15145/15145.pdf (explaining that the federal government funds effective outreach programs to increase enrollment in Children's Health Insurance Program, Medicaid, and Supplemental Nutrition Assistance Program, and these programs use methods ranging from media campaigns to targeted outreach through schools and community-based organizations).

278. A recent report suggests that "in some instances Blacks [sic] workers were discouraged from applying because they thought that they were ineligible, they didn't know where or how to apply, or they didn't know benefits existed." Menton, *supra* note 44. Black workers "reported that they thought they didn't work enough or earn enough." *Id.*

279. GOULD-WERTH & MCKENNA, *supra* note 277, at 7–8.

280. *See id*. at 9 (proposing that a simple letter that advises former employees of the program and how to access it could suffice).

281. *See Fixing Unemployment Insurance and the Coronavirus Response*, *supra* note 274 (offering perspectives on getting unemployed persons back to work).

C. Health Insurance: Structural Pathways Forward Beyond the Pandemic

The ARP took an important step forward after the ACA to relieve racial disparities. Because healthcare inequity is systemic, generational, and institutionalized, more needs to be done. To eradicate systemic disparities, we must address it structurally and learn from the challenges of COVID-19. To the extent universal health insurance remains politically unfeasible, Medicaid and Marketplace insurance expansion are two viable pathways for expanding comprehensive healthcare coverage to vulnerable populations.

1. Medicaid and Marketplace Insurance Expansion

Undoubtedly, expansion in healthcare coverage insurance correlates with improved health outcomes and reduces health insurance coverage disparities between whites and racial and ethnic minorities.[282] When the ACA first passed in 2010, it aimed to make affordable health insurance available to more people, expand the Medicaid program to cover all adults with income below 138% of the federal poverty level, and expand innovative medical care delivery methods designed to lower the costs of healthcare.[283]

One of the ACA's central goals was to significantly reduce the number of uninsured by providing a continuum of affordable coverage options through Medicaid and the health insurance Marketplaces. Medicaid expansion is associated with (1) increases in cancer diagno-

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282. *See* Matthew, *supra* note 56, at 1708. Consider the ACA's impact on reducing the rate of uninsured persons in the United States:

> Since its passage, the ACA has registered large reductions in uninsured rates–the percentage of nonelderly adults lacking health insurance fell from 16.8% in 2013 to 10.2% in 2017, a nearly 65% drop. All racial groups showed gains in health-insurance coverage after the passage of the ACA, but gains were especially strong for minority groups and low-income groups below 200% of the federal poverty level.

Id. Once study recently highlighted how Medicaid expansion has reduced the gap in uninsured rates between white and minority populations:

> The gap in uninsured rates between white and Black adults shrunk by 51 percent in expansion states (versus 33 percent in non-expansion states), while the gap between white and Hispanic adults shrunk by 45 percent in expansion states (27 percent in non-expansion states). Medicaid expansion has also helped lower uninsured rates among American Indians and Alaska Natives. Their non-elderly adult uninsured rate fell from 31 percent in 2013 to 20 percent in 2017 in expansion states, while declining only slightly in non-expansion states.

JESSE CROSS-CALL, MEDICAID EXPANSION HAS HELPED NARROW RACIAL DISPARITIES IN HEALTH COVERAGE AND ACCESS TO CARE 2–3 (2020), https://www.cbpp.org/research/health/medicaid-expansion-has-helped-narrow-racial-disparities-in-health-coverage-and.

283. *Affordable Care Act (ACA)*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/affordable-care-act/ (last visited Feb. 28, 2021).

sis rates (especially early-stage diagnosis rates); (2) access to and utilization of cancer surgery; and (3) access to medication-assisted treatment for opioid-use disorder and opioid overdose.[284] Overall, Medicaid expansion increases "access to services and medications for behavioral health among the most vulnerable members of American society."[285]

Still, this expansion is not uniform, as only thirty-six states implemented it and, therefore, racial and ethnic disparities continue to exist:

> While coverage rates increased for all minorities after the ACA was passed, states that adopted the Medicaid expansion saw greater rates of growth in coverage compared to states that rejected Medicaid expansion. Most southern states denied their residents Medicaid expansion, disproportionately affecting the large population of Black Americans living there. Conditions preventing the gap from narrowing more between Latinx and whites include the five-year waiting period after obtaining lawful status before Medicaid eligibility and the inability of undocumented immigrants to become eligible for Medicaid or to purchase a marketplace plan.[286]

In fact, the COVID-19 crisis hit hardest in states where the ACA did not expand insurance coverage. In these states, low-income populations lacked access to preventive care, which heightened their risk of contracting and dying from COVID-19, and the federal government did not share in the cost of testing and treating patients, which means patients were not able to pay or receive the care they needed.[287] The relief measures that policymakers enacted over the last year in response to COVID-19 and its fallout did not extend health coverage nor make it more affordable. Addressing Medicaid availability for workers losing their jobs—or the affordability of individual market or

284. LARISA ANTONISSE et al., THE EFFECTS OF MEDICAID EXPANSION UNDER THE ACA: UPDATED FINDINGS FROM A LITERATURE REVIEW 2 (2019), http://files.kff.org/attachment/Issue-brief-The-Effects-of-Medicaid-Expansion-under-the-ACA-Findings-from-a-Literature-Review.

285. *See* Matthew, *supra* note 56, at 1709.

286. Bittker, *supra* note 6.

287. *See* Matthew, *supra* note 56, at 1709; Robin Rudowitz, *COVID-19: Expected Implication for Medicaid and State Budgets*, KAISER FAM. FOUND. (Apr. 3, 2020), https://www.kff.org/coronavirus-policy-watch/covid-19-expected-implications-medicaid-state-budgets/ ("More than 2 million poor uninsured adults below poverty don't qualify for Medicaid and fall into the coverage gap because they live in one of 14 states that have not yet adopted the ACA expansion."); *see also* CTRS. FOR MEDICARE & MEDICAID SERVS., COVERAGE AND BENEFITS RELATED TO COVID-19 MEDICAID AND CHIP 4 (2020), https://www.cms.gov/files/document/03052020-medicaid-covid-19-fact-sheet.pdf (explaining that for Medicaid recipients, while services cannot be withheld for failure to pay, enrollees may be held liable for unpaid copayments).

Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage—is vital.[288]

Expanding Medicaid in non-expansion states and broadening the income range for eligibility for premium subsidies in the ACA Marketplaces will help mitigate the rise in the uninsured population due to job loss from the pandemic.[289] Indeed, job loss results not only in loss of income, but also in the risk of loss of health insurance for people who were receiving health coverage as a benefit through their employer. People who lose employer-sponsored insurance (ESI) are typically presented with a few options: (1) continue receiving the same health insurance coverage for a period by paying the full premium (called COBRA continuation); (2) apply for Medicaid or subsidized coverage through the ACA Marketplaces; or (3) continue without insurance. Over an extended period of time, as unemployment benefits end, many fall into the "coverage gap" that exists in states that have not expanded Medicaid under the ACA. In fact, while the majority of Black Americans have health coverage, they are also the group most likely to fall into the "'coverage gap': Their earnings are too high for Medicaid eligibility, but not high enough to take advantage of subsidies under marketplace plans."[290]

There are tangible steps that can be taken to prevent or reduce the coverage gap, including increasing state resources directed to marketing, outreach, and enrollment for Medicaid, the Children's Health Insurance Program (CHIP), and the Marketplaces. This would raise awareness that those losing their ESI coverage may be eligible for subsidized coverage through one of these programs. Another solution

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288. ANJU GANGOPADHYAYA & BOWEN GARRETT, UNEMPLOYMENT, HEALTH INSURANCE, AND THE COVID-19 RECESSION 6 (2020), https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf/.

289. BOWEN GARRETT & ANUJ GANGOPADHYAYA, HOW THE COVID-19 RECESSION COULD AFFECT HEALTH INSURANCE COVERAGE 7 (2020), https://www.urban.org/sites/default/files/publication/102157/how-the-covid-19-recession-could-affect-health-insurance-coverage_0.pdf ("Some people who lose their jobs and access to employer-based insurance may be newly eligible for Medicaid or marketplace-based subsidized coverage but not realize it, which could contribute to increasing uninsurance.") [hereinafter GARRETT & GANGOPADHYAYA, COVID-19 RECESSION AND HEALTH INSURANCE COVERAGE].

290. Bittker, *supra* note 6. Concerning the coverage gap, it is important to note:

> [E]ligibility varies across racial and ethnic groups. . . . For example, uninsured Blacks are more likely than Whites to fall in the coverage gap in states that have not expanded Medicaid, and uninsured Hispanics and Asians are less likely compared [sic] Whites to be eligible for coverage options, in part, reflecting higher shares of noncitizens who face immigrant eligibility restrictions among these groups compared to Whites.

SAMANTHA ARTIGA et al., CHANGES IN HEALTH COVERAGE BY RACE AND ETHNICITY SINCE THE ACA, 2010-2018 6 (2020), https://files.kff.org/attachment/Issue-Brief-Changes-in-Health-Coverage-by-Race-and-Ethnicity-since-the-ACA-2010-2018.pdf.

is to expedite Medicaid expansion in non-expansion states and make sure there is proper staffing to enroll people in various programs, especially in the midyear. More subsidies for Marketplace coverage at the federal level and restoration of funding for outreach and enrollment assistance will help unemployed adults identify and explore their coverage options and avoid lower premiums. At the state level, expanding Medicaid will prevent adults from falling into a coverage gap.

The ARP is using marketplace and Medicaid expansion to provide structural relief. The Biden administration's creation of a national special open enrollment period for Marketplace insurance from February 15 to May 15, 2021, led to more than 200,000 people signing up for Marketplace coverage through HealthCare.gov in the first two weeks—a three-fold year over year increase.[291] Almost 15 million Americans who currently lack health insurance and many current enrollees will receive additional financial support to find the coverage that best meets their needs at a price they can afford.[292] The ARP expands ACA subsidies, introduces COBRA subsidies, and improves Medicaid coverage.[293] Altogether, these measures could reduce the number of Americans without insurance and ease the healthcare-related financial strain exacerbated by the pandemic.

Under the ARP, people enrolling in health coverage through HealthCare.gov qualify to save money on their premiums through expansive premium tax credits (PTCs).[294] By altering the structure of these premiums, the ARP reduces the cost of healthcare coverage for 9 million consumers currently receiving financial assistance.[295] This ensures that consumers who qualify for PTCs have at least a few plans to choose from that will not cost more than 8.5% of their household income on their Marketplace plan premium per year.[296] These structural changes are likely to have a positive impact on economically

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291. *Fact Sheet: The American Rescue Plan: Reduces Health Care Costs, Expands Access to Insurance Coverage and Addresses Health Care Disparitie*s, U.S. DEP'T. HEALTH & HUM. SERVS. (Mar. 12, 2021), https://www.hhs.gov/about/news/2021/03/12/fact-sheet-american-rescue-plan-reduces-health-care-costs-expands-access-insurance-coverage.html [hereinafter *Fact Sheet: The American Rescue Plan*].

292. Deb Gordon, *The $1.9 Trillion American Rescue Plan Offers Great News On Health Insurance; Here Are the Provisions That Cut Insurance Costs*, FORBES (Mar. 12, 2021, 6:31 PM), https://www.forbes.com/sites/debgordon/2021/03/12/the-19-trillion-american-rescue-act-offers-great-news-on-health-insurance-here-are-the-provisions-that-cut-insurance-costs/?sh=2d6bf2001fe5.

293. *See id.*

294. *See id.* (detailing how the American Rescue Plan addresses premium tax credits by waiving "repayment for people who received more subsidies than they should have due to underestimating their 2020 income").

295. *Fact Sheet: The American Rescue Plan*, *supra* note 291.

296. One analysis suggests:

challenged communities. HHS predicts that: (1) 3.6 million uninsured people will be newly eligible for healthcare coverage savings; (2) 1.8 million uninsured people will be eligible for zero-dollar benchmark Marketplace coverage (100% premium subsidy); and (3) an additional 9.5 million uninsured people with incomes between 150% and 400% of the federal poverty line will likely qualify for additional financial support to reduce out-of-pocket costs for marketplace premiums.[297]

The ARP also expands Medicaid both in terms of how comprehensive it is and in terms of the number of states engaged in it. This structural alteration to Medicaid will cover more vulnerable populations and provide relief. For example, the ARP expands funding for home- and community-based services by increasing the Federal Medical Assistance Percentage (FMAP) by ten percentage points for state Home and Community Based Services (HCBS) expenditures for four fiscal quarters, from April 1, 2021, through March 30, 2022; this funding is a supplement to current HCBS funding and will meet the needs of people who prefer to receive such services in their home or community.[298] The ARP will also increase financial incentives for the fourteen states that have not implemented the ACA's Medicaid expansion by providing a five-percentage-point increase in the Medicaid FMAP for eight calendar quarters.[299] Additionally, it will allow states to provide twelve months of postpartum coverage for low-income new mothers, and it expands coverage for COVID-19 testing, treatment, and vaccination without cost-sharing.[300]

In fact, during 2021, individuals who qualified for unemployment benefits received the maximum subsidy level and zero-premium Marketplace coverage.[301] For people who lost their health insurance because of involuntary job loss or reduction in hours between April 1

> Premium tax credits (PTCs), one form of ACA subsidy, have only been available to people earning between 100% and 400% of the federal poverty level (between $12,880 and $51,520 for an individual in 2021). Many people earning more than 400% of FPL earned too much to get assistance but not enough to afford full-price premiums. The new law removes this 'subsidy cliff' so there will no longer be an upper bound on income to qualify for subsidies in 2021 and 2022.

Gordon, *supra* note 292; *see also Fact Sheet: The American Rescue Plan*, *supra* note 291 (explaining how the ARP reduces coverage for over 9 million consumers and is likely to decrease premiums by $50 per person per month and $85 per policy per month).

297. *Fact Sheet: The American Rescue Plan*, *supra* note 291.

298. Mara McDermott et al., *American Rescue Plan Act of 2021: Key Healthcare Provisions*, 11 NAT'L L. REV. (Mar. 11, 2021), https://www.natlawreview.com/article/american-rescue-plan-act-2021-key-healthcare-provisions.

299. *See* CTR. ON BUDGET & POL'Y PRIORITIES, *supra* note 225, at 6; McDermott et al., *supra* note 298.

300. Gordon, *supra* note 292; CTR. ON BUDGET & POL'Y PRIORITIES, *supra* note 225, at 5.

301. *See* Gordon, *supra* note 292.

and September 30, 2021, the ARP also provided a 100% COBRA subsidy.[302] COBRA allows people to stay on an employer's health insurance plan for eighteen months after losing a job or their health benefits.[303] The downside is that COBRA requires individuals to pay the entire premium themselves, which makes COBRA very expensive.[304] As noted earlier, many of the workers losing their jobs during COVID-19 are racial and ethnic minorities. This new subsidy makes COBRA a more attainable coverage option for many more Americans.[305]

Expansions in coverage and reduction in costs may reduce racial health inequities. Increased affordability and health insurance coverage expansion will allow historically uninsured communities, especially those who have faced significant health disparities, to access coverage, thereby improving opportunities for healthcare during and beyond the COVID-19 pandemic. Most importantly, these reforms will allow hundreds of thousands of uninsured Black, Latinx, American Indians, and Asian Americans to be newly eligible to save money on healthcare coverage and to also be potentially eligible for zero-dollar benchmark Marketplace plans.[306]

Moving forward, Congress should also extend the FMAP increase and associated eligibility requirements for states beyond the end of the pandemic, since the economic crisis caused by the pandemic seems likely to outlast the pandemic itself. Congress should increase the Medicaid expansion federal match to 100% to encourage more states to expand their Medicaid programs.[307] Even more, Congress should consider automatically increasing federal funding to Medicaid, CHIP, and UI programs any time a state's unemployment rate exceeds a threshold level. This alteration would better protect vulnerable populations during economic crises by preventing states from making harmful cuts and would be administratively efficient.[308]

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302. *See id.*

303. *See id.*

304. *See id.*

305. *See id.*

306. *Fact Sheet: The American Rescue Plan*, *supra* note 291 (identifying by category the likely improved insurability of racial and ethnic minorities due to the ARP).

307. Nicole Huberfeld et al., *Federalism Complicates the Response to the COVID-19 Health and Economic Crisis: What Can Be Done?*, 45 J. HEALTH POL., POL'Y & L. 951, 960 (2020); Hammond et al., *supra* note 113, at 179.

308. *See* Hammond et al., *supra* note 113, at 184; *see also* Matthew Fiedler et al., *Increasing Federal Support for State Medicaid and CHIP Programs in Response to Economic Downturns*, BROOKINGS INST. (May 16, 2019), https://www.brookings.edu/research/increasing-federal-support-for-state-medicaid-and-chip-programs-in-response-to-economic-downturns/ (explaining how state governments face large declines in tax revenues and increased demand for state pro-

Helping make previously held ESI coverage options affordable for those who are unemployed but ineligible for Medicaid or Marketplace subsidies is also critical. Providing subsidies for COBRA coverage could assist this problem. Augmenting Medicaid matching rates beyond those mandated under the FFCRA and the CARES Act "would help secure states' finances as they prepare to provide Medicaid coverage to what will likely be record-setting numbers of new enrollees, especially in Medicaid expansion states."[309] Also, efforts should be made to assure coverage is comprehensive, particularly when individuals have lost the insurance beforehand and risk exposure to conditions detrimental to their health.

Although these structural solutions mentioned above do not solve all the problems, they would attempt to reorganize our health and unemployment insurance laws and policies in ways that could make a deeper dent into the systemic and generational inequality that falls most heavily on minority populations. Thus, the issue is not what should we do during a pandemic or national crisis, but rather, how can we create structures that decrease health inequality in society. Making sure people can access health insurance should be a priority, regardless of whether we are in pandemic. Because these problems are institutionalized and systemic, we need solutions that address these problems at those levels.

Conclusion

COVID-19 and the pandemic that followed have had devastating effects in the United States. But the impact for communities of color in the United States is especially harsh. Institutional and structural racism has pervaded our society for generations, and the COVID-19 pandemic placed a spotlight on the gaps in our current employment structure, unemployment, and health insurance systems. While legislation was passed to offer relief to people living in the United States, broader and more sweeping changes must be done to eradicate these disparities. In order to achieve greater racial health equity and more equal employment opportunities, public health officials, the government, and private industries must address structural and institutional-

grams during and after recessions, which places fiscal pressure to cut programs and/or raise taxes; these changes "deprive states' residents of valuable public services and substantially reduce overall economic activity, thereby worsening economic downturns.").

309. Increasing funding for staffing to assist with the expansion in Medicaid enrollment is important. *See* Garrett & Gangopadhyaya, COVID-19 Recession and Health Insurance Coverage, supra note 289 ("Additional funding for and staffing of enrollment assisters for both Medicaid and marketplace coverage will be necessary to keep up with the increasing need for these programs.").

ized racism and economic inequality. In addition to highlighting why and how legal responses by the government largely reproduced and amplified existing racial inequality, I have tried to offer tangible structural solutions to increase the likelihood that racial and ethnic minorities can achieve health and economic equality and not face additional barriers. Legal and political institutions need to be mobilized in ways to solve this problem, not reproduce it.