



STRONGER COMMUNITIES. STRONGER AMERICA.

July 31, 2021

The Honorable Frank Pallone, Jr.
Chairman
House Committee on Energy and
Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Patty Murray
Chair
Senate Committee on Health, Education,
Labor & Pensions
U.S. Senate
428 Senate Dirksen Office Building,
Washington, DC 20510

Dear Chairman Pallone and Chair Murray:

On behalf of UnidosUS, I write to offer our recommendations for consideration as you contemplate the design of a federal public health insurance option. UnidosUS, formerly the National Council of La Raza (NCLR), is the nation's largest Hispanic¹ civil rights and advocacy organization. Through its unique combination of expert research, advocacy, programs and an Affiliate Network of nearly 300 community-based organizations across the United States and Puerto Rico, UnidosUS simultaneously challenges the social, economic, and political barriers at the national and local levels, working to build a stronger America by increasing opportunities for the nation's Latinos.

Any Public Option Must Advance Health Equity as a Primary Goal

UnidosUS has long worked to shape and defend policies that ensure the highest quality of health coverage for the greatest number of Latinos. We recognize that there may be more than one pathway toward achieving this goal, including a potential federally administered public option.

We appreciate your stated goal of creating a quality, affordable health coverage option that lowers costs and makes our health care system simpler and more affordable for families. Yet the shortcomings of our existing system have resulted in long-standing health disparities that disproportionately leave Latinos unable to access or afford quality health care. In addition to lower costs and universal access, any public option must advance health equity as a primary goal. While COVID-19 showed the flaws of our current system, it equally demonstrates the opportunity and a responsibility to build an inclusive approach.

Latinos make up approximately 18% of the U.S. population, as well as one in every four children in the U.S. By 2050, Latino children are expected to comprise one-third of the child population.ⁱ

¹ The terms "Hispanic" and "Latino" are used interchangeably by the U.S. Census Bureau and throughout this document to refer to persons of Mexican, Puerto Rican, Cuban, Central and South American, Dominican, Spanish, and other Hispanic descent; they may be of any race. This document may also refer to this population as "Latinx" to represent the diversity of gender identities and expressions that are present in the community.

Despite the growing role that Latinos play in our country, many were left behind by recent health reforms, and even positive trends that followed the Affordable Care Act's (ACA) implementation have begun to reverse course or stall (as described below). Given the growth of the Latino population, it is clear that the long-term health and well-being of the country depends on the health and well-being of our community.

A federally administered public option has the potential to advance ambitious health policy goals, such as universal access, health equity, and affordability. Earlier this year, UnidosUS released a framework for assessing health reform proposals to identify barriers to health coverage; surface solutions that take into account the unique situation that Latino families and workers face; and assess how health reform proposals can create a stronger system that leaves no one out.ⁱⁱ Any public option proposal must ensure that no one is left behind as Congress strives to achieve universal health coverage.

Below, we outline the impact of recent policies on the Latino community's ability to access affordable health coverage, including:

- The progress and shortcomings of the ACA
- The effect of anti-immigrant rhetoric and policies
- The effect of state Medicaid expansion (or refusal to expand) on Latino coverage
- Additional considerations, including lower rates of employer-sponsored insurance (ESI)

We then provide answers to the specific questions contained in the Request for Information.

The Impact of Recent Policies on the Latino Uninsured Rate

- **The Affordable Care Act covered millions, but its gains have stalled or reversed course in recent years.**

In 2013, Latinos had one of the highest uninsured rates in the country (30%), more than twice the rate for non-Hispanic Whites. Still, since the implementation of the ACA, the overall Latino uninsured rate fell more than 10%, and the uninsured rate for Latino children decreased more than 4.5%.ⁱⁱⁱ The ACA also guaranteed that as many as 20 million Latinos would not be denied coverage as a result of a pre-existing condition.^{iv} The ACA made tremendous progress by expanding access to coverage, establishing important consumer protections, and reducing the number of uninsured people from nearly 45 million in 2013 to a low of 27 million in 2016.^v

Despite already having the second-highest uninsured rate among all racial or ethnic groups in the country, Latino coverage rates began to move in the wrong direction over the past four years. The uninsured rate for Latino children increased significantly after 2016, and the disparity between coverage rates for Latino children and all children widened in 2018 for the first time in a decade.^{vi} By 2019, nearly 19% of Latinos were uninsured, compared to 6.3% of non-Hispanic Whites.^{vii} Nearly 30% of the remaining uninsured are Latino.^{viii} It is clear that,

while the ACA made progress, long-standing disparities in access to health coverage remain, and further action is necessary to reach those left behind.

Even before the pandemic and recent changes included in the American Rescue Plan Act (ARPA), more than 770,000 Latinos (with incomes below 200% of the federal poverty level (FPL)) were uninsured, despite being eligible for advance premium tax credits (APTCs).^{ix} While ARPA made the financial assistance for Marketplace coverage far more generous, these changes are available only through 2022. By making some of the temporary changes included in ARPA permanent, and incorporating our recommendations below into a new public option design, Congress can close the remaining gaps in coverage and advance a more equitable health system.

Even without the confusion generated by recent anti-immigrant policy changes and repeated attempts to repeal the ACA, Latinos are more likely than non-Hispanic Whites to rely on consumer assistance in navigating the enrollment process, due in part to lower rates of health insurance literacy and the added difficulty of understanding immigration-based restrictions.^x Yet the Trump administration also made severe cuts to ACA outreach and enrollment assistance, including Navigators, designed to help families identify and enroll in Marketplace coverage.

- **Exclusionary policies and anti-immigrant rhetoric contribute to wider Latino coverage disparities.**

While the ACA reduced the overall Latino uninsured rate considerably, the law's exclusion of many immigrants from eligibility for Marketplace coverage leaves many with few coverage options. Individuals with certain lawful immigration statuses (e.g., lawful permanent resident and Temporary Protected Status) are able to purchase coverage on the Marketplace, but Deferred Action for Childhood Arrivals (DACA) recipients are excluded, along with undocumented immigrants. As a result, Latino noncitizens have the highest uninsured rate among all noncitizen groups—more than 46% in 2018.^{xi}

The coverage losses that Latinos experienced over the past four years are undoubtedly the result of various factors at both the state and federal levels, but the Trump administration's anti-immigrant rhetoric and policies likely contributed significantly to this trend. The climate of fear and confusion created by the administration's revised public charge rule led many families to disenroll or forgo coverage for themselves or their children, despite being eligible.^{xii} In fact, some experts predicted that between 1 and 3 million members of immigrant families would disenroll or forgo Medicaid coverage because of the rule.^{xiii} In 2019, the U.S. Census Bureau concluded that—while Latinos did see a small increase in private coverage between 2018 and 2019—the overall increase in the Latino uninsured rate was “driven by a 1.4% decrease in the percentage of Hispanics with public coverage.”^{xiv} Though multiple drivers are at play, mixed-status families even avoided programs and coverage options not impacted by the revised rule

(such as the ACA Marketplace) due to confusion about the rule's impact and fear about its consequences.^{xv}

- **State Medicaid expansion decisions have resulted in widening disparities for Latinos based on where they live.**

As a result of lower rates of ESI, Medicaid serves a critical role for many Latinos in accessing affordable health coverage and care. Medicaid expansion was intended to serve as one key part of the ACA's overall coverage strategy. Yet, as a result of the Supreme Court decision in *National Federation of Independent Business v. Sebelius* and the ongoing refusal of 12 states to expand, millions of Americans are today denied access to quality coverage through Medicaid.

In fact, pre-pandemic estimates show that 4.3 million uninsured adults would be newly eligible if the remaining states expanded. There are also more than 2 million individuals living in the "coverage gap," where they earn too much to qualify for traditional Medicaid and too little to qualify for financial assistance to purchase coverage via the Marketplace.^{xvi} Nearly 30% of those living in the coverage gap are Latino.^{xvii}

While Medicaid expansion is primarily a means to cover more adults, children are also negatively impacted when their parents and caregivers cannot access health coverage. Throughout the country, Latino children and parents are disproportionately likely to be uninsured, but the disparities are wider and growing faster in non-expansion states such as Texas and Florida. While only around 38% of Latino parents live in non-expansion states, more than half of uninsured Latino parents live in these states (52.4%). The disparity is even more alarming for Latino children. While only 38% of all Latino children live in non-expansion states, nearly 61% of uninsured Latino children live in these states.^{xviii}

Latinos would likely benefit considerably from a public option, given both their share of adults in the coverage gap and the uninsured rate for Latino children and families living in non-expansion states. President Biden has stressed the importance of a public option for those living in non-expansion states and within the coverage gap, in particular, and we agree that this is critical.^{xix}

- **Lower rates of employer-sponsored insurance also contribute to health disparities among Latinos.**

A federal public option has the potential to fill a need created by the limits of our employment-based insurance system. COVID-19 has had disproportionate health and economic impacts on communities of color.^{xx} Early estimates suggested that as many as 3 million Latinos might lose ESI as a result of the pandemic's health and economic crisis.^{xxi} While Latinos have a higher workforce participation rate than the overall population, they have suffered disproportionate job losses as a result of the pandemic.^{xxii} Latinos are also less likely to work in jobs that offer ESI. In 2019, less than half of Latinos had ESI, compared to around two-thirds of non-Hispanic

Whites and Asians. Many uninsured Latino parents also work in occupations that were considered “essential jobs” throughout the pandemic, including retail workers, custodial workers, truck drivers, farmworkers, and others.^{xxiii}

Increasing evidence substantiates the role of work environments in perpetuating COVID-19 racial disparities.^{xxiv} More than half of Hispanic workers have jobs that require working either in person or in close contact with others (the highest rate for any racial or ethnic group), and 30% of these individuals work in “essential jobs.”^{xxv} Even as they continued to help keep their states and the national economy running, many Latinos exposed themselves and their children to greater risk. Nearly 65% of Latino adults with severe risk for COVID-19 live in a household with at least one worker unable to work from home, compared to only 46% of non-Hispanic Whites.^{xxvi} Yet nearly 30% of Latino workers are uninsured, compared to only 10% of White workers.^{xxvii}

Answers to Specific Questions in the Request for Information

Who should be eligible for the public option? Should a federally administered plan be available to all individuals or be limited to certain categories of individuals?

A federally administered public option should be made available to all individuals, regardless of immigration status, to address long-standing health inequalities and advance the goal of universal coverage. Many federal public option proposals introduced thus far base eligibility on existing criteria for qualified health plans (QHPs) as set out by the ACA. In others, public option coverage would be available to “residents of the United States” with the determination of who qualifies as a resident left to the Secretary of Health and Human Services.

The Latino uninsured rate remains the second highest in the country, despite the progress made since the ACA, and will likely remain high without broad eligibility for any new coverage option. As described above, ACA Marketplace coverage and financial assistance are available to lawful immigrants without the five-year waiting period that applies to Medicaid and CHIP, but those with DACA status and undocumented immigrants do not qualify.

- **Deferred Action for Childhood Arrivals**

It is essential that any federal public option legislation make clear that DACA recipients are eligible. Although those with DACA status represent a small share of the overall uninsured population, they are overwhelmingly Latino (91%). In addition, pre-pandemic estimates suggest that more than half of DACA recipients are uninsured—and nearly 20% have U.S. citizen children.^{xxviii} Extending health coverage options to those with DACA status has the potential to benefit not only parents but their children as well. DACA recipients also played critical roles throughout the pandemic in health, custodial, and education sectors.^{xxix}

Although the QHP-eligible standard did not on its face exclude those with DACA status (as it allows other categories of immigrants with deferred action to participate), they were ultimately excluded from the ACA Marketplace after the implementation of the program.

- **Undocumented Immigrants**

To make meaningful progress toward significantly reducing the Latino uninsured rate, Congress must make all individuals eligible for the public option, regardless of immigration status. Eligibility for undocumented immigrants is necessary to accomplish this goal. Like Latinos overall, Latino citizens have the second-highest uninsured rate by race or ethnicity. However, as mentioned above, Latino noncitizens have the highest uninsured rate among all noncitizen groups.

This eligibility is well deserved. Millions of undocumented immigrants have worked in positions considered “essential” during the pandemic, putting themselves and their families at greater risk.^{xxx} These individuals have demonstrated their commitment to this country and deserve a similar commitment from Congress as it considers who is eligible for public option coverage. It may be necessary to establish ordinary state residency parameters, as is the case for purchasing on-Exchange coverage, but this cannot be used as an excuse for otherwise excluding undocumented immigrants who live and work in this country.

- **Availability Nationwide**

Any federal public option should be made available nationwide and in all counties. President Biden has recognized the role that a public option could play in covering individuals living in states that have yet to expand Medicaid. It will be especially important for Latino families living in these states. Still, while the Latino uninsured rate in expansion states is lower, in some states with high Latino populations (e.g., California) the number of uninsured Latinos remains significant.^{xxxii}

Congress should not recreate an inequitable system that limits what coverage options are available based on where you live—as has resulted from certain states’ ongoing refusal to expand Medicaid. Allowing for broad eligibility is important to attract as broad participation as possible, both from patients and providers, which can ease the impact of overall costs.

How should Congress ensure adequate access to providers for enrollees in a public option?

Depending on reimbursement rates, pairing broad eligibility for a public option with requirements for Medicare and Medicaid providers is likely necessary to incentivize providers to participate (at least initially). Adequate access is essential to guaranteeing that a public option meets individuals’ needs. Without sufficient provider participation, a public option would likely not be able to achieve the larger goals of affordability and quality care.

Some existing proposals (such as the “Medicare-X Choice Act” and the “CHOICE Act”) would make participation in the public option a requirement for current Medicare and Medicaid providers. Other plans rely on the Medicare provider network only, which could inadequately capture certain types of providers (e.g., pediatricians).

Any public option should ensure access to a wide network of culturally and linguistically competent providers. Even today, nearly 60% of Latino adults experience difficulty communicating with a health care provider due to either a language or cultural barrier.^{xxxii} Linguistically and culturally competent care is essential to delivering quality care by improving a patient’s ability to adhere to a prescribed course of treatment, contributing to reduced readmissions and better health outcomes. Consistently lower health care spending on limited English proficient (LEP) Latinos—when compared to English proficient Latinos and non-Hispanics—suggests that LEP Latinos may not be receiving the care they need due to miscommunication or avoidance.^{xxxiii}

Under the “CHOICE Act,” the public option, as proposed, would be subject to the same requirements applicable to health plans offered through the Exchanges, including requirements related to provider networks. If this route is taken, it should also incorporate additional network adequacy requirements like those proposed in the “Health Equity and Accountability Act of 2020” to ensure that enrollees have access to information on the ability of the plan’s providers to provide care in a language other than English, and “other network adequacy standards to ensure that care through these plans is accessible to diverse communities, including individuals with limited English proficiency” (Section 432).^{xxxiv} Reimbursement for medical interpreter services—largely excluded under most current coverage—would also allow a public option to add value for LEP patients seeking a plan more suited to their needs.

How should the public option’s benefit package be structured?

We encourage Congress to consider incorporating additional benefits—such as adult dental, vision, and hearing benefits, as well as language access services (including oral interpretation and written translations)—as a required category into any public option design. While using the ACA’s essential health benefits (EHBs) as the foundation for a public option is an important first step, the lack of access to the benefits listed above can exacerbate racial inequalities in our current system and lead to worse outcomes for communities of color.

In 2018, nearly half of Latinos reported that lack of access to dental care was a problem for their family.^{xxxv} Older Latinos are far less likely than their non-Hispanic White, Black, or Asian peers to have dental coverage, and as a result report unmet dental needs at a rate nearly twice that of non-Hispanic Whites. Vision problems are also higher among Latinos than among Whites.^{xxxvi} The inclusion of these benefits would help any public option plan add value to our current system and make the option more attractive to potential enrollees, given the lack of required coverage under existing alternatives such as Marketplace plans.

A public option benefit package should also recognize the need to account for social determinants of health (SDOH). Tackling the factors outside the clinical setting that affect an individual’s health will be critical to advancing health equity. Under the “Medicare-X Choice Act,” the Secretary is given authority to integrate medical care under the public option plan with food, housing, transportation, and income assistance provided that (among other benefits) it reduce racial, ethnic, or other disparities.

A majority of physicians agree that addressing SDOH (e.g., lack of transportation, inadequate food, and housing issues) would benefit their patients.^{xxxvii} But to adequately incentivize providers to address SDOHs, a public option would need to pay physicians for their role in providing these services and leverage coordinated care teams that include community health workers (or *promotores de salud*) to alleviate some of the physician burden.

What type of premium assistance should the Federal government provide for individuals enrolled in the public option?

Any public option proposal must make a meaningful difference in the affordability of health coverage, including overall premiums and out-of-pocket costs. Simply creating a public option is an insufficient goal if it fails to deliver affordable coverage for more people. Prior to recent changes, many Latinos were already eligible for APTCs to make coverage more affordable but remained uninsured.^{xxxviii} The APTC policies in the ARPA may change this but, as of now, they are only temporary. Latinos also consistently report avoiding care due to cost at higher rates than non-Hispanics.^{xxxix}

High premiums have led some individuals to avoid health coverage via the ACA Marketplaces and will undoubtedly have the same effect on a public option plan. The ARPA increased affordability for millions of Americans, but these temporary changes only last through 2022. Congress should ensure that premium assistance for a public option incorporates recent changes made under the ARPA, as the “Medicare-X Choice Act” would do.

In the absence of Medicaid expansion, it is particularly important that individuals with incomes below 138% FPL qualify for premium assistance to make them eligible for a zero-dollar premium plan. As a result of the ARPA’s changes, more than 730,000 Latinos with incomes over 400% FPL are eligible for APTCs for the first time, and nearly 600,000 Latinos are eligible for zero-dollar premium benchmark plans. To add value, a public option proposal should go further. More than 2 million people live in the Medicaid coverage gap alone, nearly 30% of whom are Latino.

Additional limits on cost-sharing (e.g., for those with incomes below 200% FPL) could also benefit some of the 770,000 uninsured Latinos within this income bracket who are currently eligible for APTCs but still unenrolled. While the premium assistance included in the ARPA will help address some cost concerns, more steps may be necessary to improve affordability such as limiting or eliminating cost-sharing for individuals below a certain poverty threshold, establishing an out-of-pocket cap for individuals above the threshold, or making certain services

available outside the deductible. Additional affordability barriers that prevent otherwise-eligible Latinos from meaningful access to health coverage and care include high deductibles and out-of-pocket costs, as well as the obstacle posed by the “family glitch.” Nearly 1.2 million Latinos could benefit from a family glitch fix that alters the current affordability test to account for the employee’s premiums for family coverage (rather than “self-only” coverage), as included in the “Medicare-X Choice Act of 2021.”^{xi}

What role can the public option play in addressing broader health system reform objectives, such as delivery system reform and addressing health inequities?

A public option can address inequities in an intentional and targeted way by encouraging value-based care that addresses SDOHs and providing for adequate data collection to improve quality and close disparities. In addition to greater affordability and universality, any public option proposal should advance health equity as one of its chief design goals. The pandemic worsened—but did not create—the long-standing disparities that result from our current health system.

Value-based care can improve the quality of care patients receive and reduce overall costs to the system by better addressing SDOHs and coordinating care with other providers, such as community health workers and *promotores de salud*. Integrating community health workers into multidisciplinary care teams can result in improved outcomes (including better disease understanding and self-management) and lower costs among Latinos and other communities experiencing health disparities.^{xii}

Data on the effectiveness of different interventions varies—as efforts to leverage value-based care to better address SDOHs are nascent—but there is evidence that cross-sector partnerships between traditional health care providers and community-based organizations to tackle issues such as nutrition and housing can reduce costs and unnecessary utilization.

The collection of more accurate, disaggregated data will be key to assessing whether a public option is improving long-standing health inequities. Some current proposals—for example, the “Keeping Health Insurance Affordable Act” and the “CHOICE Act”—would empower the HHS Secretary to collect data on racial, ethnic, and other demographic characteristics to reduce disparities. The “Health Equity and Accountability Act of 2020” includes numerous improvements to health data collection that could benefit any final public option proposal (Section 101 and 106), including the submission of these data to a centralized electronic repository of government data on the well-being of the U.S. population.^{xiii}

The COVID-19 pandemic highlighted the importance of collecting comprehensive demographic data and this has been a key element of President Biden’s early agenda, as demonstrated by the establishment of his COVID-19 Health Equity Task Force, the Equitable Data Working Group, and his Executive Order on *Ensuring an Equitable Pandemic Response and Recovery*. More detailed and complete data collection can help policymakers and health providers design better interventions that target and account for SDOHs.

The Long-term Health and Well-being of the Country Depends on Addressing Long-standing Health Disparities

A public option represents one avenue to achieving the larger goals of universal access, affordability, and health equity. Previous major health reforms have resulted in significant progress toward these goals but have fallen short in other ways.

The Affordable Care Act reduced the overall Latino uninsured rate by more than 10%, but by leaving many Latinos out of coverage (due to immigration-based restrictions and states' refusal to expand Medicaid), Latinos' overall share of the remaining uninsured grew.^{xliii} A public option proposal cannot repeat the mistakes of past reforms.

As Congress considers how to design a public option, it must address the long-standing systemic barriers keeping coverage out of reach for too many, including a disproportionate share of Latinos. Latinos today account for around 18% of the U.S. population, but by 2060 are projected to make up more than one in four Americans.^{xliiv} The long-term health and well-being of the country will depend on intentionally addressing Latinos' needs.

UnidosUS looks forward to working with Congress to achieve our shared goals for our community and country. Please contact Matthew Snider, Senior Health Policy Analyst, at msnider@unidosus.org with any questions.

Sincerely,

A handwritten signature in black ink that reads "Laura MacCleery". The signature is written in a cursive style and is enclosed within a thin black rectangular border.

Laura MacCleery
Senior Director of Public Policy, UnidosUS

-
- ⁱ Federal Interagency Forum on Child and Family Statistics (Forum), *America's Children in Brief: Key National Indicators of Well-Being, 2020* (Washington, DC: Forum, 2020), Table POP3, www.childstats.gov/americaschildren/tables/pop3.asp (accessed June 2021).
- ⁱⁱ UnidosUS, *Health and the Latino Community: A Framework for Assessing Health Reform Proposals* (Washington, DC: UnidosUS, January 2021), <http://publications.unidosus.org/handle/123456789/2116> (accessed June 2021).
- ⁱⁱⁱ Kaiser Family Foundation, "Uninsured Rates for the Nonelderly by Race/Ethnicity: 2013" (San Francisco: Kaiser Family Foundation, 2013), <https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-raceethnicity/?currentTimeframe=6&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed June 2021); and Kelly Whitener et al., *Decade of Success for Latino Children's Health Now in Jeopardy* (Washington, DC: UnidosUS and Georgetown University Health and Policy Institute, Center for Children and Families, March 2020), <http://publications.unidosus.org/handle/123456789/2039> (accessed June 2021).
- ^{iv} Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act* (Washington, DC: ASPE, January 5, 2017), <https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf> (accessed June 2021).
- ^v Kaiser Family Foundation, "Uninsured Rates for the Nonelderly by Race/Ethnicity: 2013–2019" (San Francisco: Kaiser Family Foundation 2019), <https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-raceethnicity/?dataView=1&activeTab=graph¤tTimeframe=0&startTimeframe=6&selectedDistributions=total&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed June 2021).
- ^{vi} Kelly Whitener et al., *Decade of Success for Latino Children's Health Now in Jeopardy*.
- ^{vii} Katherine Keisler-Starkey and Lisa N. Bunch, *Health Insurance Coverage in the United States: 2019*, Current Population Reports, P60-271 (Washington, DC: U.S. Census Bureau, September 2020), <https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf> (accessed June 2021).
- ^{viii} Arielle Bosworth, Kenneth Finegold, and Joel Ruhter, *The Remaining Uninsured: Geographic and Demographic Variation*, Issue Brief no. HP-2021-06 (Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy, March 23, 2021), <https://aspe.hhs.gov/system/files/pdf/265286/Uninsured-Population-Issue-Brief.pdf> (accessed June 2021).
- ^{ix} Linda J. Blumberg et al., *U.S. Health Reform—Monitoring and Impact, Characteristics of the Remaining Uninsured: An Update* (Washington, DC: Urban Institute, July 2018), https://www.urban.org/sites/default/files/publication/98764/2001914-characteristics-of-the-remaining-uninsured-an-update_2.pdf (accessed June 2021).
- ^x Karen Pollitz et al., *Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need* (San Francisco: Kaiser Family Foundation, August 7, 2020), <https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/> (accessed June 2021); and Victor G. Villagra, MD et al., "Health Insurance Literacy: Disparities by Race, Ethnicity, and Language Preference," *American Journal of Managed Care* 25, no. 3 (March 7, 2019), <https://www.ajmc.com/view/health-insurance-literacy-disparities-by-race-ethnicity-and-language-preference> (accessed June 2021).
- ^{xi} Gerald F. Kominski, PhD et al., *Ten Years of the Affordable Care Act: Major Gains and Ongoing Disparities* (Los Angeles: UCLA Center for Health Policy Research, April 2020), <https://healthpolicy.ucla.edu/publications/Documents/PDF/2020/10yearsACA-report-apr2020.pdf> (accessed June 2021).
- ^{xii} Randy Capps, Michael Fix, and Jeanne Batalova, *Anticipated "Chilling Effects" of the Public-Charge Rule Are Real: Census Data Reflect Steep Decline in Benefits Use by Immigrant Families* (Washington, DC: Migration Policy Institute, December 2020), <https://www.migrationpolicy.org/news/anticipated-chilling-effects-public-charge-rule-are-real> (accessed June 2021); and Samantha Artiga, Rachel Garfield, and Anthony Damico, *Estimated Impacts of Final Public Charge Inadmissibility Rule on Immigrants and Medicaid Coverage* (San Francisco: Kaiser Family Foundation, September 18, 2019), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/estimated-impacts-of-final-public-charge-inadmissibility-rule-on-immigrants-and-medicaid-coverage/> (accessed June 2021).

-
- ^{xiii} U.S. District Court, Northern District of California, *Declaration of Leighton Ku in La Clínica de la Raza v. Trump*, September 1, 2019, <https://healthlaw.org/resource/declaration-of-leighton-ku-in-la-clinica-de-la-raza-v-trump/> (accessed June 2021).
- ^{xiv} Katherine Keisler-Starkey and Lisa N. Bunch, *Health Insurance Coverage in the United States: 2019*.
- ^{xv} Hamutal Bernstein et al., *Amid Confusion over the Public Charge Rule, Immigrant Families Continued Avoiding Public Benefits in 2019* (Washington, DC: Urban Institute, May 2020), https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019_3.pdf (accessed June 2021).
- ^{xvi} Rachel Garfield, Kendal Orgera, and Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid* (San Francisco: Kaiser Family Foundation, January 21, 2021), <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/> (accessed June 2021).
- ^{xvii} Gideon Lukens and Breanna Sharer, *Closing Medicaid Coverage Gap Would Help Diverse Group and Narrow Racial Disparities* (Washington, DC: Center on Budget and Policy Priorities, June 14, 2021), <https://www.cbpp.org/sites/default/files/6-10-21health.pdf> (accessed June 2021).
- ^{xviii} Kelly Whitener, Matthew Snider, and Alexandra Corcoran, *Expanding Medicaid Would Help Close Coverage Gap for Latino Children and Parents* (Washington, DC: Georgetown University Health Policy Institute, Center for Children and Families and UnidosUS, June 2021), <https://ccf.georgetown.edu/wp-content/uploads/2021/06/Expanding-Medicaid-Would-Help-Close-Coverage-Gap-for-Latino-Children-and-Parents.pdf> (accessed July 2021).
- ^{xix} *Biden-Sanders Unity Task Force Recommendations* “Securing Universal Health Care through a Public Option,” July 2020, 31-37 <https://joebiden.com/wp-content/uploads/2020/08/UNITY-TASK-FORCE-RECOMMENDATIONS.pdf> (accessed June 2021); and The White House, Office of Management and Budget, *Budget of the U.S. Government: Fiscal Year 2022*, https://www.whitehouse.gov/wp-content/uploads/2021/05/budget_fy22.pdf (accessed June 2021).
- ^{xx} Centers for Disease Control and Prevention, “Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity,” July 16, 2021 <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html> (accessed July 2021); APM Research Lab, *The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S.* (St. Paul, Minnesota: APM Research Lab, March 5, 2021), <https://www.apmresearchlab.org/covid/deaths-by-race> (accessed June 2021); and Carlos Guevara and Emily Ruskin, “The Great American Pandemic Recovery: Tackling Systems of Inequality that Impede Full Latino Inclusion in the COVID-19 Response,” *Harvard Journal of Hispanic Policy* 33 (Spring 2021): 46-56, <https://hjhp.hkspublications.org/wp-content/uploads/sites/15/2021/05/HJHP-Volume-33-Full.pdf> (accessed June 2021).
- ^{xxi} Robin Duddy-Tenbrunsel et al., *COVID-19 Projected to Worsen Racial Disparities in Health Coverage* (Washington, DC: Avalere Health, September 16, 2020), <https://avalere.com/press-releases/covid-19-projected-to-worsen-racial-disparities-in-health-coverage> (accessed June 2021).
- ^{xxii} UnidosUS, *Latino Jobs Report: Latino Unemployment Rate at 7.3%* (Washington, DC: UnidosUS, June 2021), <http://publications.unidosus.org/handle/123456789/2167> (accessed July 2021).
- ^{xxiii} Kelly Whitener, *Expanding Medicaid Would Help Close Coverage Gap for Latino Children and Parents*.
- ^{xxiv} D. Phuong Do and Reanne Frank, “Using race- and age-specific COVID-19 case data to investigate the determinants of the excess COVID-19 mortality burden among Hispanic Americans,” *Demographic Research* 44, no. 29 (2021): 699–718, <https://www.demographic-research.org/volumes/vol44/29/44-29.pdf> (accessed June 2021).
- ^{xxv} Lisa Dubay et al., *How Risk of Exposure to the Coronavirus at Work Varies by Race and Ethnicity and How to Protect the Health and Well-Being of Workers and Their Families* (Washington, DC: Urban Institute, December 2020), https://www.urban.org/sites/default/files/publication/103278/how-risk-of-exposure-to-the-coronavirus-at-work-varies_1.pdf (accessed June 2021).
- ^{xxvi} Thomas M. Selden and Terceira A. Berdahl, “COVID-19 and Racial/Ethnic Disparities in Health Risk, Employment, and Household Composition,” *Health Affairs* 39, no. 9 (2020), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00897> (accessed June 2021).
- ^{xxvii} Lisa Dubay, *How Risk of Exposure to the Coronavirus at Work Varies by Race and Ethnicity*.

-
- ^{xxviii} Center for American Progress survey, August 14, 2019 to September 6, 2019, “Results from Tom K. Wong et al., 2019 National DACA study,” <https://cdn.americanprogress.org/content/uploads/2019/09/18122133/New-DACA-Survey-2019-Final-1.pdf> (accessed June 2021).
- ^{xxix} Nicole Prchal Svajlenka, *A Demographic Profile of DACA Recipients on the Frontlines of the Coronavirus Response* (Washington, DC: Center for American Progress, April 6, 2020), <https://www.americanprogress.org/issues/immigration/news/2020/04/06/482708/demographic-profile-daca-recipients-frontlines-coronavirus-response/> (accessed June 2021).
- ^{xxx} FWD.us, *Immigrant Essential Workers are Crucial to America’s COVID-19 Recovery* (Washington, DC: FWD.us, December 2020), <https://www.fwd.us/wp-content/uploads/2020/12/FWD-essential-worker-report-FINAL-WEB.pdf> (accessed June 2021).
- ^{xxxi} Kelly Whitener, *Expanding Medicaid Would Help Close Coverage Gap for Latino Children and Parents*.
- ^{xxxii} Associated Press-NORC Center for Public Affairs Research, *Communication and Long-Term Care: Technology Use and Cultural Barriers among Hispanics* (Chicago: Associated Press-NORC, 2018), https://apnorc.org/wp-content/uploads/2020/02/APNORC_LTC_2018_Hispanic_report.pdf.
- ^{xxxiii} Jessica Himmelstein et al., “Health Care Spending and Use among Hispanic Adults with and without Limited English Proficiency, 1999–2018,” *Health Affairs* 40, no. 7 (July 2021): 1126–1134, <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.02510> (accessed July 2021).
- ^{xxxiv} *Health Equity and Accountability Act of 2020*, H.R. 6637, 116th Congress (2019-2020), <https://www.congress.gov/bill/116th-congress/house-bill/6637> (accessed July 2021).
- ^{xxxv} UnidosUS and Hart Research Associates survey June and July 2018, “How Will Healthcare Impact the Latino Vote?” http://publications.unidosus.org/bitstream/handle/123456789/1886/healthcare_2018latinovote.pdf?sequence=1&isAllowed=y (accessed June 2021).
- ^{xxxvi} Ellen A. Kramarow, PhD, “Dental Care among Adults Aged 65 and Over, 2017,” Data Brief no. 337 (Hyattsville: MD: National Center for Health Statistics, 2019), <https://www.cdc.gov/nchs/data/databriefs/db337-h.pdf> (accessed June 2021); and Hannah Katch and Paul N. van de Water, *Medicaid and Medicare Enrollees Need Dental, Vision, and Hearing Benefits* (Washington, DC: Center on Budget and Policy Priorities, December 8, 2020), <https://www.cbpp.org/research/health/medicaid-and-medicare-enrollees-need-dental-vision-and-hearing-benefits> (accessed June 2021).
- ^{xxxvii} Lia Winfield, PhD, Karen DeSalvo, MD, and David Muhlestein, PhD, *Social Determinants Matter, but Who Is Responsible? 2017 Physician Survey on Social Determinants of Health* (Washington, D.C. Leavitt Partners, May 2018), <https://leavittpartners.com/whitepaper/social-determinants-matter-but-who-is-responsible/> (accessed July 2021).
- ^{xxxviii} Linda J. Blumberg et al., *Characteristics of the Remaining Uninsured: An Update*; and Samantha Artiga, Kendal Orgera, and Anthony Damico, *Changes in Health Coverage by Race and Ethnicity since the ACA, 2010–2018* (San Francisco: Kaiser Family Foundation, 2020), <https://files.kff.org/attachment/Issue-Brief-Changes-in-Health-Coverage-by-Race-and-Ethnicity-since-the-ACA-2010-2018.pdf> (accessed July 2021).
- ^{xxxix} Jesse Baumgartner et al., *How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care* (New York: The Commonwealth Fund, January 16, 2020), <https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access> (accessed June 2021).
- ^{xl} Matthew Buettgens, Lisa Dubay, and Genevieve M. Kenney, “Marketplace Subsidies: Changing the ‘Family Glitch’ Reduces Family Health Spending but Increases Government Costs,” *Health Affairs* 35, no. 7 (2016): 1167–1175 <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2015.1491> (accessed June 2021).
- ^{xli} Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, *Policy Evidence Assessment Report: Community Health Worker Policy Components* (Atlanta, GA: CDC, 2014), https://www.cdc.gov/dhdsp/pubs/docs/chw_evidence_assessment_report.pdf (accessed June 2021).
- ^{xlii} *Health Equity and Accountability Act of 2020*, H.R. 6637.
- ^{xliii} Sara R. Collins et al., *Who Are the Remaining Uninsured and Why Haven’t They Signed Up for Coverage?* (New York: The Commonwealth Fund, August 18, 2016), <https://www.commonwealthfund.org/publications/issue-briefs/2016/aug/who-are-remaining-uninsured-and-why-havent-they-signed-coverage> (accessed June 2021).

^{xliv} Jonathan Vespa, Lauren Medina, and David M. Armstrong, *Demographic Turning Points for the United States: Population Projections for 2020 to 2060*, Current Population Reports, P25-1144 (Washington, DC: U.S. Census Bureau, February 2020), <https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf> (accessed June 2021).