



Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9911–P, P.O. Box 8016
Baltimore, MD 21244–8016

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 (RIN 0938–AU65; CMS-9911-P)

We respectfully submit this comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule—**Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023** (hereinafter “NBPP 2023 Rule”).

UnidosUS, formerly the National Council of La Raza, is the nation’s largest Hispanic civil rights and advocacy organization. Along with our Affiliate Network of nearly 300 local, community-based organizations in 37 states, the District of Columbia, and Puerto Rico, UnidosUS works to build a stronger America by increasing opportunities for the nation’s more than 62 million Latinos.

These comments focus primarily on elements of the proposed rule that would have the largest impact on health equity by increasing access to affordable, quality health coverage for Latinos.

Key Lessons from a History of Gains and Setbacks on Insurance Coverage for Latinos

The Affordable Care Act (ACA) created new health coverage options, and in the years following its enactment, the United States experienced historic gains in the number of people who had access to affordable, comprehensive health insurance: between 2010 and 2016, 20 million Americans gained health insurance.¹

Over the same period, the percentage of people without insurance decreased in every racial and ethnic group, with minority groups experiencing the biggest decreases. Latinos experienced the steepest decline in those who lacked insurance, with a decrease of 13.5 percentage points (32.6% to 19.1%). Yet racial and ethnic disparities persisted. Even in 2016, after considerable progress, Latinos were 2.7 times more likely to be uninsured than were non-Latino whites.²

Then, in 2017, policy changes made by the Trump administration led to reduced access to and enrollment in coverage, reversing the downward trend in the uninsured rate. Between 2016 and 2019, the overall uninsured rate for non-elderly people increased from 10% to nearly 11%.³ Similarly, the uninsured rate for Latinos increased from 19.1% in 2016, to 20% in 2019.⁴

Latinos have the second-highest uninsured rate (behind Native Americans) among all racial or ethnic groups in the country. Overall, nearly 30% of the remaining uninsured are Latino.⁵ Further, 40% of the U.S. population that are uninsured but are eligible for subsidized insurance are Latino.⁶

The need for health care coverage for Latinos remains acute. The COVID-19 pandemic continues to disproportionately impact Latinos⁷ and other people of color due to a combination of factors.⁸ First,

Latinos are more likely to work in “essential” jobs that expose them to the virus.⁹ Latinos are also less likely to have important benefits to help them if or when they do become ill, including comprehensive health insurance¹⁰ and access to paid medical leave.¹¹

The fluctuations in coverage rates described above demonstrate how ACA Marketplace policies can make a measurable impact on the number of people without insurance and, in turn, the number of people who have access to health care especially during a global crisis. For these reasons, increasing access to affordable health coverage must be a key component of the administration’s effort to beat the pandemic and have an equitable and inclusive recovery. As Latinos are a majority of the population who are eligible for subsidized Marketplace coverage but are still unenrolled, the administration must consider the unique needs of Latinos when proposing improvements to the ACA’s Marketplace enrollment and coverage.

CMS proposes several changes to improve and expand enrollment opportunities in Marketplace plans. We strongly support these changes. We have also provided additional recommendations to strengthen these efforts. In brief, we make the following comments, and address each in turn below:

- We strongly support the proposal to re-interpret the guaranteed availability requirement to require issuers to accept individuals who apply for coverage, even if the individual owes past-due premiums.
- CMS should increase user fees to ensure that it has adequate revenue for:
 - Consumer information, outreach, and assistance activities
 - Maintenance and improvement to the Marketplace website and systems
- CMS should update its rules to require that a portion of user fees be permanently used to fund the Navigator program.
- We support the proposed tightening of the standards of conduct for agents, brokers, and web-brokers, and we urge CMS to dedicate the funding needed to support monitoring and enforcement of these and other agent, broker, and web-broker standards.
- We recommend HHS change the automated annual redetermination policy so that when the enrollee has access to a nearly identical plan at a lower cost (specific parameters outlined below), the enrollee is shifted to that plan, unless they opt out.
- CMS should perform targeted outreach to consumers who have been auto-enrolled and their premium has increased to let them know they can still change plans for the upcoming year.
- To allow sufficient time for consumers to choose a plan, or to opt out of an automated enrollment, we urge CMS to extend open enrollment to January 31 each year in the Federally-facilitated Marketplaces (FFMs) and require coverage to begin on February 1 of each year.
- We support HHS’s proposal to raise the essential community providers (ECP) participation standard to 35%. We urge HHS to require qualified health plans (QHPs) to meet this standard for each category of ECP, rather than for all ECPs taken as a whole, to ensure that QHP enrollees maintain adequate access to each type of ECP.

- We strongly support HHS’s proposal that for plans with tiered networks, to count toward the issuer’s satisfaction of the network adequacy and ECP standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation.
- We support the proposal to require all QHPs that have at least two consecutive years in a market for their quality improvement strategies (QIS) to include at least one payment structure that provides financial incentives for activities aimed at reducing health and health care disparities. In addition, CMS should require public transparency and accountability about the process being used by QHPs to select, implement, evaluate, and report the outcomes of QIS interventions.
- We provide several suggestions in response to the “Solicitation of Comments on Health Equity, Climate Health, and Qualified Health Plans” specifically:
 - We support requirements for QHPs to collect and utilize demographic data to address health disparities and improve health equity.
 - We support a requirement for QHPs to obtain the National Committee for Quality Assurance’s (NCQA’s) Health Equity Accreditation (HEA).

Moreover, there are several recommendations that were included in our comments on *Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule* (herein referred to as the “UPP rule for 2022”) that were not included in the UPP 2022 final rule and are also not addressed in the NBPP for the 2023 plan year but remain important for the success of these efforts. Specifically, CMS should also consider the following recommendations:

- CMS should end the exclusion of Deferred Action for Childhood Arrivals (DACA) recipients from the definition of lawfully present for the purposes of eligibility for Marketplace coverage.
- CMS should clarify that individuals granted Special Immigrant Juvenile Status (SIJS), as well as those applying for that status, are “lawfully present” for the purposes of ACA coverage.
- CMS should reinstate the requirement that each Exchange include at least two navigator entities, at least one of which must be a community and/or consumer-focused nonprofit group.
- Critically, CMS should reinstate the previous requirement that Navigators receiving grants maintain a physical presence in the Exchange service area to provide in-person outreach and enrollment support.

These priority recommendations are further detailed below followed by detailed descriptions of the remaining recommendations in rule order.

The rule should address DACA eligibility (45 CFR § 152.2) and address coverage those with special immigrant juvenile status, clarifying that they are “lawfully present” for ACA coverage purposes.

While not raised in the Notice of Proposed Rulemaking, **we urge CMS to issue an administrative action, such as an Interim Final Rule, making clear that the DACA recipients should not be excluded from those considered to be “lawfully present” for the purposes of eligibility for Marketplace coverage and other benefits.**

While an estimated 89% of people with DACA were employed in 2019, only about half had health insurance—substantially lower than the total rate of insurance among all U.S. adults (89%).¹² Without insurance, many people with DACA are unable to access affordable and timely health care and often delay care for fear of the financial cost and the impact of medical debt on their immigration status prospects.¹³

We are all safer when everyone has access to health care—including coverage for COVID-19 testing, treatment, and vaccinations. Unless CMS acts as soon as possible to address the arbitrary exclusion of DACA recipients, these hardworking Latinos will continue to face ongoing health and economic impacts of the pandemic, without the protection of health insurance coverage.

In the same action, we also urge the agency to clarify that individuals granted SIJS, in addition to those applying for that status, are lawfully present for the purposes of ACA coverage, given that SIJS recipients are facing green card backlogs that were not considered when the original regulation was drafted.

Navigator Program Standards (§ 155.210) should prioritize in-person assistance provided by trusted community-based organizations.

Navigators are an essential component of efforts to increase the number of Americans with health insurance. Research shows that more than one in four consumers sought help when attempting to enroll or re-enroll in ACA or Medicaid coverage in 2020.¹⁴

Further, Latinos are significantly more likely than other groups to seek out and use enrollment assistance, including Navigators.¹⁵ Navigators help to demystify the complexity of applying for and using health insurance, especially for those with potentially complex situations such as immigrants and mixed-status families, as well as individuals who are not English-dominant. Navigators can help to reduce health disparities by improving health literacy for underserved communities, including Latino communities.¹⁶

As noted in our previous comments to the UPP Rule for 2022, we are concerned that CMS did not propose to restore three critical requirements for an effective Navigator program. Prior rules required that there must be at least two in-person Navigator organizations in each state; that at least one of those organizations would be a trusted community nonprofit; and that Navigators maintain a physical presence in the state.

These requirements are critical, particularly for Latinos. **Simply put, in-person, culturally competent enrollment assistance from a trusted community organization is essential to achieve robust Latino enrollment in Marketplace coverage.** In-person assistance is also especially critical in rural and underserved communities in which many people do not have reliable access to a computer or telephone. Conversely, reducing the number of navigator entities with a physical presence in an Exchange service area would only make it more difficult for many Latinos to enroll in coverage.

For these reasons, we strongly recommend that CMS reinstate the requirement that each Exchange include at least two navigator entities and that at least one of them is a community and consumer-focused nonprofit group. We also urge CMS to reinstate the requirement that Navigators receiving grants maintain a physical presence in the Exchange service area to provide in-person outreach and enrollment support.¹⁷ This is consistent with its own analysis that “[e]ntities with a physical presence

and strong relationships in the Federally-Facilitated Exchange (FFE) service areas tend to deliver the most effective outreach and enrollment results.” If needed, CMS could allow specialized groups to provide targeted assistance to vulnerable populations under special circumstances across state lines, so long as the agency determines that it does not undermine access to community-based, in-person assistance.

Guaranteed availability of coverage requirement (§ 147.104) should be re-interpreted to require issuers to accept individuals and employers who apply for coverage, even where the individual or employer owes past-due premiums.

In the proposed rule, HHS revises its previous interpretation of the ACA’s guaranteed issue provision, as that interpretation had allowed insurers to refuse to cover persons who owe past due premiums until they satisfy arrearages. We strongly support revising HHS’s interpretation of the ACA’s guaranteed issue provision to allow individuals to enroll in coverage even if they have past-due premiums. The legal basis for this action, under the statute, is clear—an issuer “must accept every employer and individual in the State that applies for such coverage.”¹⁸

We agree with the agency that allowing insurers to deny coverage to individuals who owe past due premiums has the “consequence of creating barriers to health coverage that disproportionately affect low-income individuals and is therefore inconsistent with the intent of the guaranteed availability statutory requirements.”

The reinterpretation of this provision is particularly needed in the wake of the economic hardship created by the COVID-19 pandemic. Latino families experienced widespread economic hardships during the pandemic. According to Pew Research Center, 35% of Latinos families had trouble paying bills; this rate is even higher for Latinos who are non-citizens (49%) and those age 18-29 (41%).¹⁹ Locking individuals out of coverage due to past due premiums serves only to further exacerbate existing economic and health disparities and the impact of the pandemic on minorities.

Additional standards of conduct (§ 155.220(j)) for agents, brokers, and web-brokers are needed to protect consumers from fraudulent practices.

We support proposed tightening of the standards of conduct for agents, brokers, and web-brokers and we urge CMS to dedicate the funding necessary to support monitoring and enforcing compliance with these and all agent, broker, and web-broker standards. These changes are important. Unlike Navigators funded by marketplaces, agents, brokers and web-brokers have not, thus far, been required to provide accurate and unbiased information to individuals.

The proposed rule would tighten the standards of conduct for agents, brokers, and web-brokers to further protect consumers and give CMS additional grounds for enforcement. Specifically, the rule spells out more specific guidelines for what it means to submit accurate client information by making it a violation to submit information such as their own business’s email, phone number, or address instead of a client’s information. Certain malfeasance, such as using email addresses consumers cannot access or submitting inaccurate income, would also violate the rules. Also, automated interactions that lead to unauthorized enrollment or changes to enrollment would be prohibited, information used for identity proofing would need to belong to the client, and special enrollment period (SEP) eligibility would need to be ascertained individually with the consumer informed of the reason for their SEP.

CMS should do more to protect consumers from spikes in premiums resulting from automated annual eligibility determinations (§ 155.335) and further extend the open enrollment period (§ 155.410) to allow additional time to choose a plan.

We appreciate HHS's request for comments on incorporating consumer costs into redetermination and reenrollment procedures. We recommend changing two policies that affect enrollees who are being renewed automatically—that is without making an affirmative selection for their plan.

First, current policy keeps an enrollee in their past plan if it remains available during the new plan year, even if a change in market conditions has significantly raised that plan's costs to the consumer. We recommend that HHS change this policy to create a limited exception to the norm, which is plan continuity. A person would be shifted to a new plan when the following apply:

- Both plans are sponsored by the same carrier, are included in the same product, have the same provider network, and the same prescription drug formulary.
- The new plan has neither higher net premiums nor lower actuarial value (AV) than the previous plan.
- The new plan has lower net premiums, significantly higher AV, or both, compared to the former plan.

The exchange would need to provide both notice and reasonable opportunities, before and after the shift, for the consumer to return to their former plan or to drop coverage altogether.

Second, current CMS policy provides that if the former plan is no longer available, the enrollee is shifted to the most similar available exchange plan offered by the same carrier, even if consumer costs are far higher with the new plan. We recommend that CMS address this scenario in two ways:

- First, CMS should perform targeted outreach to consumers who have been auto-enrolled and their premium has increased to let them know they can still change plans for the upcoming year.
- Second, as UnidosUS suggested in our comments to the UPP rule for 2022, CMS should extend the open enrollment period to January 31 and require coverage to begin February 1. This will allow individuals automatically moved into a new plan sufficient opportunity to choose a different plan if they so choose.

As the states' experience has shown, extending open enrollment greatly benefits consumers and helps reduce the number of uninsured.²⁰ CMS should follow the lead of California and New Jersey, as states that extended enrollment times, and extend open enrollment to January 31 in the FFMs and require coverage to begin February 1.

Providing this additional time for open enrollment makes sense. Applying for health insurance and selecting a plan can be challenging and the choice of a plan can significantly impact both finances and health. Requiring people to make these important and complicated decisions in just a few weeks, and during the holiday season, makes it more difficult for consumers to get the best coverage for them.

Extending open enrollment to January 31 would be especially valuable for those consumers who are auto-enrolled into coverage but will receive a lower subsidy than they did in the prior year because the cost of their benchmark plan has dropped. These enrollees may have to contribute a higher level of

premium towards coverage. Because these consumers are auto-enrolled, they are often unaware of their higher premium contribution until they receive their bill in early January. We are concerned that an open enrollment period that ends on January 15 does not allow sufficient time for consumers to seek assistance, shop, and select a different plan after they have obtained their January premium bill.

Due to lower wealth and discretionary income racial and ethnic minorities are disproportionately impacted by cost increases. Compared to non-Latino whites, Latinos are more likely to report having no money left over after paying their bills²¹ and to have difficulty paying their bills.²² Updating policies to acknowledge the importance of affordability may prevent Latino families from forgoing health insurance or dropping their health insurance due to unexpected increases in their monthly premium during the annual redeterminations.

User Fee Rates for the 2023 Benefit Year (§ 156.50) Must Be Adequate to Support an Effective Program

The Marketplace user fee—a fixed percentage of premium revenue paid by insurers—supports critical functions, including operation of and improvements to the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising.

User fees are essential to operate the Marketplace, improve the consumer interface, provide consumer support, fund outreach, and overall ensure a smooth enrollment system for consumers. These include enhancing the consumer experience through improvements to the application and HealthCare.gov, as well as addressing other behind-the-scenes issues.

Yet in the NBPP 2023 Rule, CMS proposes to maintain the current user fee for 2023. As we did in our comments for the proposed UPP rule for 2022, we question whether this will be sufficient to support these many needs and uses. The proposals in this rule and the changes finalized in prior rules will be successful only if they are supported by sufficient revenue for implementation.

HHS anticipates that spending on consumer outreach and education, eligibility determinations, and enrollment processes will need to increase by \$140 million above the 2022 benefit year level. This is in part due to projected enrollment declines when the enhanced premiums of the American Rescue Plan Act expire. Modeling shows that investing in a robust marketing and outreach campaign increases Exchange enrollment,²³ which has the direct effect of leading to a healthier risk mix and thus, lowering health care premiums by far more than any user fee savings. HHS should consider the increased marketing and outreach efforts needed to effectively enroll consumers in the FFEs and SBE-FPs in 2023, and incorporate adequate funding in the user fee rates, even if this means a slight increase in the user fee rates.

We greatly appreciate HHS's substantial increase in navigator funding over the past year. We believe a strong Navigator program is essential to ensuring individuals have the fair, accurate, and impartial information they need to enroll and select a plan.

Yet we would recommend even greater funding which could be supported by user fees. We also urge the CMS to require, through regulation, that a portion of the user fees permanently fund Navigator grants, so that funding levels could never again fall to such devastatingly low levels as were seen under the previous administration.

Further, organizations have made numerous recommendations to improve both the user experience and back-end systems of HealthCare.gov. Some of these recommendations have been longstanding, such as making changes to application questions that are well-known to confuse individuals and linking the appeals system to the application system, so that HealthCare.gov Call Center staff can access appeals documents, appeals staff can access documents consumers have sent to HealthCare.gov and appeals staff can effectuate appeals decisions without having to go through Center for Consumer Information and Insurance Oversight (CCIIO). We recognize that the improvements entail significant time, resources and funding. A robust user fee should be used to address many of these issues, as they have lingered for years without actions to fix them.

Finally, HHS proposes new requirements for agents, brokers and web-brokers to ensure the accuracy of information they provide and protect individuals. HHS will need sufficient funding and resources to ensure effective oversight of these new provisions—oversight which an adequate user fee could support.

For this reason, CMS should ensure that the increase it is proposing is truly enough to support a robust and successful program. In sum, CMS should increase user fees to ensure adequate revenue for consumer information, outreach, and assistance activities, as well as maintenance and improvement to the Marketplace website and systems. And regulations should require that a portion of the user fees be permanently required to fund the Navigator program.

Essential Community Providers (ECPs) (§ 156.235) participation standards for QHPs should be raised to improve access to culturally competent care for Latinos.

Essential Community Providers, such as federal-qualified health centers (FQHCs), disproportionately serve members of racial and ethnic minorities. For example, 36% of FQHC patients are Latino compared to 18% of the generally U.S. population.²⁴ Community-based organizations such as FQHCs are well-positioned to deliver services in a way that is both linguistically and culturally relevant to their communities. For these reasons, we believe that QHP are better able to serve Latinos if their networks include ECPs.

HHS proposes that for plan year (PY) 2023 and beyond, the required ECP provider participation standard be raised from 20% to 35% of available ECPs based on the applicable PY HHS ECP list, including approved ECP write-ins that would also count toward a QHP issuer's satisfaction of the 35% threshold. Specifically:

- We support HHS's proposal to raise the ECP participation standard to 35%.
- We urge HHS to require QHPs to meet this standard for each category of ECP rather than for all ECPs taken as a whole, to ensure that QHP enrollees have adequate access to all of the important types of ECPs which range from Ryan White providers to FQHCs.
- We strongly support HHS's proposal that for plans with tiered networks, to count toward the issuer's satisfaction of the network adequacy and ECP standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation.

Quality Standards: Quality Improvement Strategy (§ 156.1130)

The proposed rule would require all QHPs that have at least two consecutive years in a market for their quality improvement strategies (QIS) to include at least one payment structure that provides financial incentives for activities aimed at reducing health and health care disparities.

We support this policy change as it is a positive initial step. Similarly, CMS should do more to address these disparities by requiring public transparency and accountability about the process being used by QHPs to select, implement, evaluate, and report the outcomes of QIS interventions.

The proposed QIS policy does tie effective performance on reducing health and health care inequities to financial reward, but it lacks two important elements. First, QHPs should have to seek input from underserved enrollees or stakeholders who represent underserved communities to guide their QIS activity selection as this could assist them in deciding which activities related to health or health care inequities they prioritize. Second, more public accountability is necessary to reassure the public that issuers (and CMS) take these initiatives seriously. We urge CMS to propose and seek input on the elements and requirements for such a proposal, and to develop a plan to deepen accountability in this manner.

In sum, we recommend that CMS add these public accountability improvements to the regulation at § 156.1130, in addition to the proposed requirement that plans develop at least one payment structure aimed at reducing health inequity in their quality improvement strategy.

Solicitation of Comments on Health Equity, Climate Health, and QHPs

We strongly support requirements for QHPs to collect information on each enrollee's race, ethnicity, gender, sexual orientation, primary language, and disabilities. Asking enrollees to provide this information is necessary to illuminate persistent health inequities and to monitor those that are yet unidentified. (To ensure consumer protection, it is essential that CMS finalize all requirements proposed in this rule relating to prohibiting discrimination based on sexual orientation and gender identity.)

HHS—for all of its programs and not solely marketplaces—should review expert recommendations and research on demographic data collection and set standards for the language used by QHPs to collect data.

Recommendations already exist from the Institute of Medicine,²⁵ the Williams Institute at UCLA,²⁶ and forthcoming from the National Academies of Sciences, Engineering, and Medicine²⁷ that draw on both studies and stakeholder input. The ultimate purpose of collecting demographic information from enrollees is to advance health equity. HHS should also set expectations for QHPs to engage in systematic review of enrollee data and take action to correct disparities that become apparent through this review.

We also recommend that HHS set an example by improving data collection in its own programs and activities, such as by collecting comprehensive demographic data in HealthCare.gov and requiring SBEs to do the same. To be clear, this would not likely alleviate the additional need for QHPs to collect these data, particularly because some individuals will be more confident providing demographic data to a plan or provider (who shares it with a QHP), as opposed to a government agency. However, it would demonstrate HHS's own commitment to collecting and utilizing demographic data to address health disparities and improve health equity.

HHS also requested comment on whether QHPs should be required to obtain National Committee for Quality Assurance’s (NCQA) Health Equity Accreditation, which is a contract differentiator substantiating a higher level of commitment to health equity. We support this requirement. HEA’s standard for accreditation captures the importance of data collection and sets out affirmative steps that QHPs may take to use health disparity data to improve health equity. HHS should retain responsibility for oversight of QHP accreditation, and materials provided to NCQA by QHPs, such as scorecards and evaluations, should be publicly available.

Notably, the HEA lacks specific standards that address people with disabilities. We recommend that HHS work with NCQA and stakeholders to add standards that promote equity for disabled enrollees, including comprehensive data collection.

Conclusion

The COVID-19 pandemic and the disproportionate impact on racial and ethnic minorities exposed historical inequities in the U.S. health care system. For us to recover equitably as a nation, we must, among other things, fully commit to closing racial and ethnic disparities in access to health coverage and care.

We support the proposals in this rule that expand and improve opportunities for enrollment and make important steps to improving the quality of health coverages offered through Exchanges. Thank you for the opportunity to comment on these important issues.

Should you have any questions or need any further information, please contact Melissa McChesney mmcchesney@unidosus.org.

Notes

¹ Nicholas Bakalar, “Nearly 20 Million Have Gained Health Insurance Since 2010”, (New York: The New York Times, May 22, 2017), <https://www.nytimes.com/2017/05/22/health/obamacare-health-insurance-numbers-nchs.html>

² Samantha Artiga, et al., *Health Coverage by Race and Ethnicity, 2010-2019*, (San Francisco: Kaiser Family Foundation, July 16, 2021), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/>

³ Ibid.

⁴ Ibid.

⁵ Assistant Secretary for Planning and Evaluation, Office of Health Policy, Arielle Bosworth, Kenneth Finegold, and Joel Ruhter, *The Remaining Uninsured: Geographic and Demographic Variation*, HP-2021-06, (March 23, 2021), <https://aspe.hhs.gov/sites/default/files/private/pdf/265286/Uninsured-Population-Issue-Brief.pdf>

⁶ Daniel McDermott and Cynthia Cox, *A Closer Look at the Uninsured Marketplace Eligible Population Following the American Rescue Plan Act*, (San Francisco: Kaiser Family Foundation, May 27, 2021), <https://www.kff.org/private-insurance/issue-brief/a-closer-look-at-the-uninsured-marketplace-eligible-population-following-the-american-rescue-plan-act/>

⁷ 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.

⁸ Population Reference Bureau analysis of data from the U.S. Census Bureau and the U.S. Centers for Disease Control and Prevention, for UnidosUS, “By the Numbers: Latinos in the Time of Coronavirus,” <https://www.unidosus.org/campaigns/coronavirus-covid-19/Latino-COVID-19-Dashboard> (accessed June 23, 2021).

⁹ David P. Bui et al., “Racial and Ethnic Disparities among COVID-19 Cases in Workplace Outbreaks by Industry Sector—Utah, March 6–June 5, 2020,” *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention 69, no. 33 (August 21, 2020): 1133–1138, <https://www.cdc.gov/mmwr/volumes/69/wr/mm6933e3.htm>.

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- ¹⁰ Samantha Artiga, Jennifer Tolbert, and Kendal Orgera, *Hispanic People are Facing Widening Gaps in Health Coverage* (San Francisco: Kaiser Family Foundation, November 6, 2020), <https://www.kff.org/policy-watch/hispanic-people-facing-widening-gaps-health-coverage/>.
- ¹¹ Ann P. Bartel et al., “Racial and ethnic disparities in access to and use of paid family and medical leave: evidence from four nationally representative datasets,” *Monthly Labor Review*, Bureau of Labor Statistics, January 2019, <https://www.bls.gov/opub/mlr/2019/article/racial-and-ethnic-disparities-in-access-to-and-use-of-paid-family-and-medical-leave.htm>.
- ¹² Jennifer Tolbert, Kendal Orgera, and Anthony Damico, *Key Facts about the Uninsured Population* (San Francisco: Kaiser Family Foundation, November 6, 2020), <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>.
- ¹³ Marissa Raymond-Flesch et al., “There Is No Help Out There and If There Is, It’s Really Hard to Find”: A Qualitative Study of the Health Concerns and Health Care Access of Latino ‘DREAMers’” *Journal of Adolescent Health* 55, no. 3 (September 1, 2014): 323–328, [https://www.jahonline.org/article/S1054-139X\(14\)00235-3/fulltext](https://www.jahonline.org/article/S1054-139X(14)00235-3/fulltext).
- ¹⁴ Karen Pollitz et al., *Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need*, (San Francisco: Kaiser Family Foundation, August 07, 2020), <https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/>
- ¹⁵ Ibid.
- ¹⁶ Victor G. Villagra, et al., “Health Insurance Literacy: Disparities by Race, Ethnicity, and Language Preference,” *The American Journal of Managed Care* 25, no. 3 (March 2019), <https://www.ajmc.com/view/health-insurance-literacy-disparities-by-race-ethnicity-and-language-preference>
- ¹⁷ 82 Fed. Reg. 51109
- ¹⁸ 42 U.S.C. § 300gg–1(a).
- ¹⁹ Luis Noe-Bustamente et al., *Latinos have experienced widespread financial challenges during the pandemic*, (Washington D.C.: Pew Research Center, July 15, 2021), <https://www.pewresearch.org/race-ethnicity/2021/07/15/latinos-have-experienced-widespread-financial-challenges-during-the-pandemic/>
- ²⁰ Coleman Drake and David Anderson, *Next Year, Extend Open Enrollment of The ACA Marketplaces Into January*, Health Affairs (blog). Health Affairs. February 18, 2021, <https://www.healthaffairs.org/doi/10.1377/hblog20210211.159357/full/>
- ²¹ Ben Meyerson, *As the safety net shrinks again, vulnerable Americans are changing the way they plan*, Ipsos.com. September 21, 2021, <https://www.ipsos.com/en-us/news-polls/safety-net-shrinks-vulnerable-americans-are-changing-way-plan>
- ²² United States Consumer Financial Protection Bureau, *Insights from the Making Ends Meet Survey*, CFPB Office of Research, Research Brief No. 2020-1, (July 2020) https://files.consumerfinance.gov/f/documents/cfpb_making-ends-meet_survey-results_2020-07.pdf
- ²³ https://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf
- ²⁴ National Association of Community Health Centers, *Community Health Center Chartbook 2020*, (January, 2020). <https://www.nachc.org/wp-content/uploads/2020/01/Chartbook-2020-Final.pdf>
- ²⁵ <https://www.ahrq.gov/research/findings/final-reports/iomracereport/reldatasum.html>
- ²⁶ <https://williamsinstitute.law.ucla.edu/publications/data-collection-sogi/>; <https://williamsinstitute.law.ucla.edu/publications/smart-so-survey/>; <https://williamsinstitute.law.ucla.edu/publications/geniuss-trans-pop-based-survey/>
- ²⁷ <https://www.ahrq.gov/research/findings/final-reports/iomracereport/reldatasum.html>