Statement of Community Catalyst on Hearing on the Disproportionate Impact of COVID-19 on Communities of Color

As an organization committed to health equity, Community Catalyst welcomes the Committee's attention and focus on the important issue of disproportionate impact of COVID-19 on communities of color. This conversation is crucial as states are mid-stream in their efforts to construct a response that leads to an equitable recovery from this health and economic threat to the nation's livelihood. Specifically, we appreciate how Congress' actions to address inequity have the potential to shine light on and result in changes to our long-standing systems and structures that currently deny people of color equitable access to high quality health care and health opportunity.

The coronavirus (COVID-19) pandemic has rattled our nation. While the crisis has brought to light many faults in national, state and local infrastructures, the ever-present truth threaded throughout the unfolding narrative is that pervasive health and economic inequities are resulting in dramatically disproportionate impacts. Without these inequities being properly addressed through aggressive policy change, our nation will continue to fail the very people who make our nation whole. The virus does not discriminate, but some populations are being hit especially hard— especially people of color. It is impossible to deny the devastating effect the pandemic is having on Black and brown people across the country. Data shows that Black Americans face alarming rates of infection and death in states throughout the country.

Disproportionate Impact for People of Color and Inadequate Federal Response
Throughout our country's history, racism has led to the construction of policy, programs and systems that perpetuate inequity in health care, wealth, housing and education. These deep inequities over time have led to two Americas – one with greater chances of wealth and health and one denied these pathways—divided by the color of one's skin and reinforced by classism. The existence of this divide has been confirmed by scientific and public health data and by the testimony of countless individuals of color whose everyday struggles underscore the persistent racism that disfigures our nation.

These long-standing and well-documented experiences reveal that people of color are more vulnerable to the pandemic and more broadly susceptible to chronic illnesses and underlying conditions that complicate their recovery and increase their mortality. This has long been true and is most acute now – during a pandemic – and an urgent response is necessary.

A number of independent groups have conducted analyses of the racial disparities of COVID-19 cases and deaths nationwide in the absence of robust federal investigation. However, as noted by many on this Committee and others, the Centers for Disease Control and Prevention has yet to publicly report racial and ethnic data for COVID-19 tests performed across the country in a thorough and robust manner, and only a dozen or so states are releasing such data. There is a loud and consistent call from people across the country for more government action to bring transparency to longstanding inequity through data collection, analysis, and strong policy responses that move our nation forward with the urgency that justice demands.

Recommendations to Advance Equity

Policymakers must do more for those who are being hardest hit to give everyone a fair shot at coming through this crisis healthy and whole. Advocates across the country are demanding the collection and reporting of race, ethnicity, gender identity, sexual orientation and language data, increased access to testing for people of color—many of whom are on the front lines of essential work—and increased financial and health security. This includes access to affordable health care, protection from financial ruin and robust implementation of safety standards including access to protective equipment and accountability to essential workers. Below we offer key recommendations regarding how to advance racial equity in this moment by addressing three key domains: 1) access to affordable comprehensive coverage; 2) high quality accessible care; and 3) social determinants of health or key factors that influence health outcomes.

Coverage & Affordability

As people lose their jobs, they are losing their health insurance too – widening the coverage gap for people of color in this country. Even before COVID-19 hit, 29 million people in the U.S. lacked health insurance coverage, including a disproportionate share of people of color who face unjust and discriminatory barriers to health and economic security. For example, 11.5% of Black people are uninsured versus 7.5% of white people and the disparity is even greater for Hispanic/Latinx and American Indian/Alaska Native at 19% and 21.8%. With the COVID-19 pandemic already causing a nearly 15% unemployment rate and rising, it is estimated that 27 million people have lost their employer-sponsored insurance – further exacerbating the underlying coverage gap for people of color. Further, we know that uninsured Blacks are more likely to fall in the coverage gap in states that have not expanded Medicaid. These disparities in coverage can be reduced by expanding Medicaid in non-expansion states and improving Marketplace affordability.

Medicaid Financing

- **Shore up the Medicaid program by increasing and extending the federal matching rate to 14 percentage points.** State revenues are declining precipitously, while demand for coverage is going up. Although the House has already passed an increase of 6.2 percentage points in the federal matching rate, it is not enough; a fourteen-percentage point increase is essential, which is why its recommended by a range of stakeholders, including the National Governor's Association (NGA), provider groups, and consumer advocates. Further, we support the inclusion of Division G, Title I, Section 70101 of the Take Responsibility for Workers and Families Act, the House proposal in response to the Senate version of CARES, that addresses countercyclical funding of Medicaid to address the predictable problem of declining state revenue and increased demand for Medicaid that occurs every time there is an economic contraction.
- **At a minimum, the enhanced match and the FFCRA maintenance of effort (MOE) provision should last for the duration of the economic contraction and phase back down gradually as state revenues recover.** The enhanced match should extend to the expansion population (up to a cap of 100%). The 100% federal match for non-expansion states (and the equivalent for late-expanders) should last for several years to encourage these states to expand.
- **Allow states to receive enhanced FMAP for administrative services, and in particular, for interpretation/translation services for individuals with limited**

English proficient (LEP). Enhanced funding for administrative services is essential to ensure adequate support for outreach and enrollment activities, which communities will desperately need as the uninsurance rate climbs. As unemployment continues to surge, states need additional capacity to ensure the public has information and that eligibility is determined promptly. In addition, while Medicaid does have a state option for reimbursement of language services, many states have not taken it up. A temporary enhanced FMAP for interpretation services under Medicaid and CHIP would assist in ensuring availability of interpretation services during the economic downturn.

- **Suspend Public Charge rule and remove barriers for immigrants.** The Public Charge rule, which forces immigrant families to choose between basics like food and housing and staying together, should be suspended immediately. At minimum, the rule's "public charge" test should exempt not only COVID-19 testing and treatment, but all emergency assistance received during this crisis, including cash and food assistance provided via federal, state, or local programs. Further, Congress should take steps to remove barriers to access to health care for immigrants. Specifically, they can eliminate restrictions currently in place for five years after an immigrant has established lawful status; enable all lawfully present people granted deferred action–most notably, young people with DACA status–to enroll in Medicaid or CHIP, if they are eligible, and to buy private insurance coverage on the ACA marketplaces and obtain the ACA's subsidies designed to make coverage affordable; and reinstate COFA migrant eligibility for Medicaid.
- **Allow Medicaid coverage to begin 30 days pre-release for criminal justice populations**. Congress can change federal law to permit use of federal matching funds for this purpose, and/or could direct CMS to speedily approve state waiver requests to use Medicaid funds in this way. During the pandemic, uses of this funding must include COVID-19 testing and treatment, support of community-based providers with infectious disease expertise to provide treatment in jails and prisons, and facilitating warm hand-offs to community providers on reentry.
- **Provide greater access to Medicaid for the Indian Health System.** Tribes have reported shortfalls in reimbursements from payers like Medicaid ranging from $800,000 to $5 million per Tribe per month of the COVID-19 pandemic. Congress should extend full federal funding (through 100% FMAP) to Medicaid services furnished through urban Indian health programs to American Indians/Alaska Natives (AIANs), in addition to services furnished through IHS/Tribal providers to AIANs. Congress should also fix the "four walls" limitations on IHCP "clinic" services by removing the prohibition on billing for services provided outside a clinic facility. Currently, IHS and Tribal clinics can only get reimbursed for services provided inside the facility. This restricts reimbursements for services like home visits, or services referred outside the IHS or Tribal facility.
- **Repeal the Medicaid Fiscal Accountability (MFAR) proposed rule**. The MFAR proposed rule would take billions of funding away from states at a time when our public health system needs resources most. The current proposal arbitrarily limits already approved state Medicaid financing arrangements, such as provider taxes and intergovernmental transfers. As a result, states will have even fewer resources available to draw down federal Medicaid matching funds. Reducing state Medicaid funding during a pandemic would financially destabilize hospitals and other health care providers.

Marketplace Affordability

Marketplaces and ACA plans continue to be an important coverage option for people of color – analysis of 2018 data show that 37 percent of uninsured Blacks, 27 percent of Hispanics, 29 percent of Asians, 33 percent of American Indian and Alaska Natives and Native Hawaiians and other Asian Pacific Islanders are eligible for Marketplace coverage. These numbers have likely gone up recently given rising unemployment and reduced work hours for many people of color.

- **Create a Special Enrollment Period (SEP).** A special enrollment period will get more people covered and also ensure that providers are paid for delivery care. The emergency SEP should be open to anyone who wishes to enroll. Limiting the SEP to defined groups who must verify eligibility would not only delay care, it would deter enrollment by healthy consumers, endangering the individual-market risk pool.
- **Make Marketplace coverage more affordable by taking three key steps:**
    - **Eliminate premiums for all with income below 200% FPL**
    - **Cap the total percentage of income for premiums for all households (we suggest a cap of 8.5%)**
    - **Create a smooth gradual taper of financial assistance to avoid abrupt premium spikes.**
- **Eliminate cost sharing for COVID-19 related treatment in all private health plans, including short-term limited duration insurance (STLDI) plans and other coverage arrangements not subject to federal coverage standards.** According to a recent study, the cost for COVID-19 related treatment during an average hospitalization stay could reach as high as $20,000, with privately insured patients on the hook for over $1,000 of the total cost, on average. While the previous relief efforts require private health plans to cover testing and the associated visit related to the diagnosis of COVID19 without cost sharing for patients, the legislation does not address costs associated with treating the virus. Congress must take the next step and require all private health plans – including short-term plans, health care sharing ministries and farm bureau plans – to cover COVID-19 related treatment without cost sharing. This standard should apply even in cases where due to a testing shortage a formal COVID-19 test is not administered, but a patient is treated as if they tested positive.
- **Provide additional resources to support multilingual enrollment assistance.** Enrollment assistance has a proven track record, helping states track consumer complaints and identify problems to strengthen enrollment and programs and provide consumers clear information about their rights. Congress should provide at least $400 million in funding, which represents double the last House proposal for both navigators and outreach, given the spike in demand. In addition, Congress should fund consumer assistance programs (CAPs) for states that maintain these entities, appropriating at least $30 million in grant funds.

Medical Debt

In addition to the above policies addressing Medicaid and private insurance, in recognition of financial difficulties being faced by many people and especially people of color, Congress should take steps to protect people from medical debt. Prior to the COVID-19 pandemic, 45 million or 23% of working-age American adults had medical debt or medical bills they were paying off

over time. Two-thirds of them had no insurance at the time they incurred these bills and a third had coverage that did not sufficiently protect them.

- **Protect people from medical debt.** Congress should require health care providers that receive federal emergency funding to provide uninsured patients with free COVID-19 testing and treatment. In addition, any medical debt incurred or accrued from February 1, 2020 until 60 days following the lifting of the state of emergency should be subject to enhanced consumer protections including, but not limited to: a one-year prohibition on collection activity; a one-year prohibition on credit reporting; an extension of state and federal health insurance appeal deadlines; a prohibition on balance billing for all health care services (including testing, treatment and preventive services) provided to COVID-19 patients; a prohibition of any extraordinary collection actions as listed at 26 CFR 1.501r (which includes wage garnishment and property liens); and a prohibition of interest or collection fees related to these debts. While HHS has announced that healthcare providers receiving funding through the Provider Relief Fund must abstain from "balance billing" for any patient receiving COVID-related treatment, Congress should require these providers, as well as insurers, to notify consumers of their rights and the existence of this consumer protection.
- **Provide a continuous special enrollment period (SEP) for dual eligible beneficiaries.** Dually eligible beneficiaries are currently only able to change their Medicare Advantage or Part D plan enrollment once per quarter. These individuals, who are already living in poverty, do not have the financial resources to weather any disruption or denial of care when in a plan that does not meet their needs. This is particularly problematic during this current crisis when their care and treatment needs are extremely likely to change. Providing a continuous SEP would reduce administrative complexity and mitigate disruptions and access to care.

Access & Quality

While coverage and affordability are key components of responding to the public health crisis, it is vital to ensure access to high quality care—and advance policies that specifically address inequity in access to resources and support populations that are left behind. We know that some populations are disproportionately affect by COVID-19. People who work in jobs that are deemed “essential” have greater exposure to the virus – many of these jobs lack any guaranteed health insurance and are low-wage professions leaving people without savings, paid leave and social supports. According to the Bureau of Labor Statistics, Black and Hispanic workers are two times as likely to earn wages below the poverty level and Blacks, Hispanics, AIANs, and Native Hawaiians Other Pacific Islanders (NHOPIs) are more likely to be uninsured to Whites—taken together, these place people of color at greater risk. We must use policy interventions to address these inequities by directing resources to where they are needed, building infrastructure that reorients our systems toward equity and reversing policies that perpetuate inequity. Many of these recommendations are included in the HEROES Act, recently passed by the House. These include:

Data Collection and Transparency

- **Require U.S. Department of Health and Human Services (HHS) and its sub-agencies, such as the Centers for Disease Control and Prevention (CDC), the**

Centers for Medicare and Medicaid Services (CMS), U.S. Food and Drug Administration (FDA), the Agency for Healthcare Research and Quality (AHRQ), and other relevant agencies, to monitor and address racial and other disparities in our nation's response to the coronavirus disease 2019 (COVID19) public health emergency. Without demographic data, policy makers and researchers will have no way to identify and address ongoing disparities and health inequities that risk accelerating the impact of the novel coronavirus and the respiratory disease it causes. Disaggregated data should include: race, ethnicity, geographic location, primary language, socioeconomic status, gender identity, sexual orientation, age, and disability status of patients being tested, the rate of positive test results for each group, insurance coverage status and outcomes for those diagnosed with COVID-19.

Essential Workers

Direct additional funding to under-resourced communities to support health and financial security of essential workers. Essential workers are defined as those who are working to ensure that daily life continues – from home health workers who care for older people and people with disabilities to grocery store, delivery and transportation workers. They also include our community health workers, peer support workers, and others who provide front line care. Essential workers are disproportionately people of color and survive on minimum wage; they live in low-resourced communities with limited access to health care services. Many of these recommendations are included in the HEROES Act, recently passed by the House.

- **Increase funding for PPE for health care and essential workers by passing S. 3570. It is well-documented that there continues to be a shortage of personal protective equipment (PPE) for our health care workers and our essential workers.** Congress must direct the President to use the Defense Production Act to require U.S. companies to produce PPE to meet the demands of the pandemic. Funds for this directive are available under section 304 of the Defense Production Act of 1950 (50 U.S.C. 4534).
- **Provide, at a minimum, $150 billion to states and localities to help ramp up testing centers in communities that are disproportionately affected and/or are medically underserved health areas.**
- **Create a Heroes Fund to provide premium pay to essential workers through the end of the calendar year. Frontline workers should also be granted the new benefit of up to $25,000**.
- **Direct OSHA to investigate complaints of essential workers.** The agency announced that it would not require employers outside health care, emergency response or corrections to formally investigate whether COVID-19 cases among employees are work-related unless there is a clear cluster of illness. There must be stricter protections for essential workers that are not medical workers.

Frontline Workers

Support frontline health workers and communities disproportionately impacted by COVID-19. Many of the providers serving hard-hit communities are at-risk of closure, depleting already under-resourced systems of care.

- **Increase funding for the Coronavirus Provider Relief Fund and direct at least 30 percent to non-Medicare providers.** Currently, the Coronavirus Provider Relief Fund leaves out needed support for pediatricians, OBGYNs, substance use treatment providers,

providers of long-term services and supports (LTSS) and other Medicaid providers to maintain access for Medicaid patients; this is because to date, funding is distributed through the Medicare payment system. More congressional guidance is needed to ensure that we maintain health system infrastructure in states and localities. Congress should direct HHS to reserve 30 percent of provider relief funds to support providers who serve a disproportionate share of low income and uninsured patients and include community-based service providers receiving state-only funding (e.g. certain SUD treatment providers, doulas, Community Health Workers (CHWs), LTSS providers and others).

- **Invest $4.5 billion in state and local public health infrastructure.** As part of the public health response, infrastructure is necessary to collect data, analyze, monitor and support quarantine and recovery for both individuals and communities. As part of this investment, contact tracing is vital for the economy to recover. However, contact tracing requires a workforce with deep connections to community. Public health funding should promote the hiring community health workers (CHWs) and other community workers (doulas, peer supports and others); funding should require bias training for all workers.

Key Populations At-Risk

Invest in key programs and policies that directly support populations disproportionally harmed by COVID-19 and address longstanding inequity.

- **Provide at least $250 million of new funds in the Substance Abuse Prevention and Treatment (SAPT) Block Grant Program**. This mechanism quickly directs resources to all 50 states with flexibility in how states spend the money, including for prevention, treatment and recovery services. Allow carryover into FY 2021 of any unspent funds in existing substance use disorders or mental health block or discretionary grants.
- **Pass the Coronavirus Relief for Seniors and People with Disabilities Act (S. 3544), including its HCBS grants to support the Direct Support Professional (DSP) and Home Health Workforce.** This bill is vital to supporting older adults and people with disabilities in their homes, keeping them out of congregate spaces that are high risk.
- **Provide $58 million to the CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention for grants to states, territories, tribes, counties, and local health departments and to community-based organizations.** These funds should provide, sustain, and expand essential harm reduction and overdose prevention services, including syringe services programs, and overdose education and naloxone distribution.
- **Reduce the number of individuals incarcerated in federal prisons, and in state prisons and jails.** Congress can expand eligibility for release, order streamlined review and set hard deadlines to speed releases from federal prisons of people who do not pose a threat of violence to communities. Following Congressional direction, the DOJ and Bureau of Prisons began this process but it is moving far too slowly to save lives, and the criteria may reinforce racial disparities in the prison system. To reduce incarceration in state prisons and jails, Congress can double funding for pre-arrest diversion programs offered through the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) that provide people with needed community services instead of incarceration.
    - **Improve prevention, identification and treatment of COVID-19 among people incarcerated as well as prison and jail employees.** Congress should fund an expansion of screening in jails and state and federal prisons, including all

employees and people incarcerated at-risk of COVID-19. Congress should fund infectious disease community-based providers to provide treatment in jails.

- **Provide $20 million in funding to sustain school-based health centers so they are able to reopen alongside schools.** Young people are experiencing increased trauma, depression, anxiety, and substance misuse as a result of COVID-19; this is most acute for youth of color. Investing in school-based health centers increases access to critical mental health care as well as substance use prevention and early intervention services.
- **Direct the Office of Civil Rights (OCR) to issue guidance to protect people with disabilities.** Notably, health inequities among people with disabilities are compounded by race and ethnicity, leading to greater risk for people of color with disabilities during COVID-19. OCR should clearly communicate what constitutes unlawful discrimination on the basis of disability and age as it relates to the allocation of limited resources due to the COVID-19 pandemic, including in determinations concerning the denial, removal, or suspension of health care and services based on perceptions concerning quality of life or the intensity of services needed, and the provision of reasonable modifications under the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, or section 1557 of the Patient Protection and Affordable Care Act. The guidance should consider medical expertise and necessity.

Remove barriers to high quality care:

- **Make funding for rapid build of digital infrastructure available to groups working to meet demand for health services.** For example, programs should direct funding to substance use and mental health Recovery Community Organizations (RCOs) for immediate purchasing of items to support telehealth services and infrastructure, such as cell phones, tablets, cell service, and internet accessibility.
- **Invest in broadband and telecommunications access.** The HEROES Act provides $4 billion in funding to assist with households' costs related to connectivity including an additional $1.5 billion for students, schools and libraries and $24 million for broadband mapping. Provisions include expansion of broadband subsidies for urban and rural hospital and creates protections for consumers from disconnection and late fees due to non-payment. Finally, the Act requires providers of Lifeline to offer unlimited minutes and data. These are all vital to at-risk consumers as they navigate virtual work and living.
- **Guarantee Patient Access to Telehealth.** All health insurance plans, including all ERISA plans, Medicare and state Medicaid programs, must cover telehealth at parity with in-person care. This must include all levels of mental health and addiction outpatient care, including intensive outpatient and partial hospitalization care, as well as other types of screening, assessment, treatment, and recovery services. This should also include equitable access and payment for telehealth services. To ensure equitable access, audio-only should be fully reimbursed at the same rate as a telehealth visit to ensure that poor internet connectivity or lack of video conferencing ability by seniors and others do not inhibit access to care. Finally, out-of-network restrictions and penalties should be temporarily waived for telehealth services. Finally, Congress should increase access to provider types and services. For example, open more tele-dentistry codes for oral health providers so that they can begin to serve patients who are awaiting treatment.

Social Determinants of Health

The social determinants of health — poverty, unequal access to care, housing, geography, employment, education, and structural racism — must be confronted as they are significant contributing factors to worsening health disparities, as well as obstacles to the coverage and quality objectives in addressing the COVID-19 pandemic. As such, individuals and families need their most basic needs fulfilled during this crisis in order to mitigate spread, allow people to recover and ensure long-term health and economic security.

Targeted cash assistance

- **Require businesses that receive financial assistance to provide sick leave, and continue to pay workers whose hours have been cut back due to physical distancing related reductions in staffing needs.** This will ensure that the funding goes where it will do the most good. The most important interventions are to preserve the essential purchasing power of people earning low-wages – including many who are not eligible for Unemployment Insurance (UI) – so they can continue to afford food, housing, utilities, etc. While the CARES Act included robust additions to the UI system, the expanded benefits are short-term and do not address the continued need for economic assistance after the pandemic passes. Instead, duration should be tied to economic conditions via automatic 'triggers' tied to an uptick in the unemployment rate. Funding for state and local governments should also be provided to better administer gravely overburdened UI systems, and get cash into the hands of consumers faster. Cash assistance and UI benefits should be disregarded as income for the purposes of any means tested programs including Medicaid and Marketplace subsidies.
- **Expand access to paid leave and eliminate exemptions.** Legislation should provide paid family leave support for the family care needs of all workers in addition to funding to meet other basic necessities. Paid leave should be available to individuals who must attend to their own medical conditions and those who have been advised to self-quarantine due to exposure or high-risk status. Paid sick, family and medical leave should be available to individuals employed by businesses with more than 500 employees, businesses with fewer than 50 employees, and federal agencies. This can be done by eliminating existing carveouts and OMB authority to exempt federal agencies.
- **Include all immigrant workers and tax filers in the tax rebate so that people can receive vital cash assistance.** Cash rebates are available to recent tax filers based upon their taxpayer identification numbers, but limited to those using Social Security numbers (SSNs). Many people file their tax returns using an Individual Taxpayer Identification Number (ITIN). Under the CARES Act, if ITIN users file jointly with a spouse or child with an SSN, everyone in the household will be denied access to the cash assistance. Cash assistance is not available to many immigrant workers who are risking their health as essential worker without access to COVID-19 testing and care.

Housing and Food Stability

- **Ensure a national, uniform moratorium on evictions and foreclosures.** Several states and localities have instituted eviction and foreclosure moratoriums. Congress should implement a uniform policy that assures that renters will not lose their homes during a pandemic where our collective health depends on each of us staying home. The law should prohibit rent arrears accumulated during the period covered by the moratorium from forming the basis of an eviction. This also includes providing $11.5 billion in

Emergency Solutions Grants (ESG) Additional funds are needed to respond to coronavirus among people experiencing homelessness, who are at particularly high risk for infection, hospitalization and death. Finally, Congress should pass emergency rental assistance and eviction prevention. A moratorium on evictions, on its own, is not enough. Congress must also provide $100 billion in rental assistance to avoid creating a financial cliff for renters when eviction moratoria are lifted and back rent is owed. This assistance can be provided through a combination of Emergency Solutions Grants, Housing Choice Vouchers, Section 521 Rural Rental Assistance, or the Disaster Housing Assistance Program (DHAP).

- **Boost SNAP maximum benefits by 15 percent, increase the minimum SNAP benefit from $16 to $30; and suspend all SNAP administrative rules that would terminate or weaken benefits.** As businesses shut their doors and lay off workers, many are struggling to access nutritious food. Systemic discrimination and inequalities cause higher rates of food insecurity for people of color. The COVID pandemic worsens this reality and leaves even more people of color food insecure. Research shows that SNAP plays a critical role in keeping families healthy and secure, and expanded SNAP coverage would play a pivotal role in stopping hunger during the pandemic.

Responsibility to All People by Ensuring Election Integrity

People of color are more likely to be forced to wait in long lines to cast ballots this November. In the current pandemic this is not only unjust, but forces people to put their health at risk in order to exercise their rights and responsibilities in our democracy. Congress must take steps to protect people of color as they exercise their freedoms.

- **Support for mail-in voting in all states.** In order to ensure the safety and equity of elections, we recommend the HEROES Act provision that provides $3.6 billion in grants to states for contingency planning and preparation of federal elections.

COVID-19 has unveiled the pervasive nature of racial and ethnic inequities in our society. These times are calling for all advocates addressing health, housing, social supports, economic security and various other social determinants of health to identify opportunities for collaboration, as well as be more effective in supporting each other's collective policy asks. We must work to continue to call out the long-term impact of structural racism, uplift and share practices that will lead to systemic change, and make long-standing policy recommendations that will address root problems.

In closing, James Baldwin noted, "People who shut their eyes to reality simply invite their own destruction, and anyone who insists on remaining in a state of innocence long after that innocence is dead turns himself into a monster." Now is the moment to open our eyes the vast and deep inequity the pandemic has laid bare. Congress has the power and resources to alter our course and we encourage them to take urgent action.