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The article in the title **"Health Coverage by Race and Ethnicity, 2010-2019" was published on Jul 16, 2021 by Samantha Artiga , Latoya Hill, Kendal Orgera and Anthony Damico**

Health coverage is critical in allowing people to receive health care and shielding families from expensive medical bills. People of color have historically suffered gaps in health coverage, which lead to health inequities. This brief investigates patterns in health coverage by race/ethnicity from 2010 to 2019, prior to the implementation of the COVID-19, and considers the consequences for health inequalities. It is based on a KFF analysis of data from the American Community Survey for the nonelderly population. It discovers:

Prior to the Affordable Care Act (ACA), individuals of color were more likely than Whites to be uninsured. Nonelderly Hispanic and American Indian and Alaska Native (AIAN) adults had the greatest uninsured rates in 2010, with over one-third without coverage, compared to 13.1% of nonelderly White people.

The Affordable Care Act (ACA) established new health-care alternatives that helped to lessen, but not eradicate, existing gaps in health-care coverage. Under the ACA, there were significant improvements in coverage across all racial/ethnic groups between 2010 and 2016. Over the period, Hispanics saw the greatest percentage point drop in their uninsured rate, which decreased from 32.6 percent to 19.1 percent. Despite these advances in coverage, individuals of color remained more likely than Whites to be uninsured in 2016.

Beginning in 2017, coverage improvements began to stall, and the number of uninsured climbed for three years in a row. Between 2016 and 2019, Hispanic, Black, and White uninsured rates climbed, undermining some of the ACA's recent coverage gains. These coverage losses were most likely the result of a variety of policy changes implemented by the Trump administration, which contributed to decreased access to and enrollment in coverage.

As of 2019, nonelderly AIAN, Hispanic, NHOPI, and Black persons were still more likely than White people to be without health insurance. The greater percentages of uninsured among these categories are mostly due to lower rates of private coverage among these groups. While Medicaid and the Children's Health Insurance Program (CHIP) assist address the gap in private coverage for persons of color, they do not totally offset the disparity, placing them at a higher risk of being uninsured. Across racial and ethnic groupings, uninsured rates were higher and Medicaid coverage levels were lower in states that did not expand Medicaid compared to states that did.

Job losses and income drops caused by the COVID-19 pandemic, which disproportionately affected people of color, may have contributed to interruptions in health coverage since 2019. The Biden administration and Congress have taken a number of steps to enhance access to and enrollment in health insurance, which may assist to boost coverage and eliminate gaps in coverage

among persons of color. Eliminating inequities in health coverage is a critical component of resolving long-standing racial health disparities. However, in order to promote health equality, it will also be necessary to address other injustices within the health-care system, as well as inequities across the broad spectrum of social and economic factors that influence health.

Reference: https://www.kff.org/

The second article in the title **"Racial and Ethnic Health Disparities Related to COVID-19"** was published on January 22,2021 by Leo Lopez III, MD, MHS[1]; Louis H. Hart III, MD[1]; Mitchell H. Katz, MD[1]

One of the most concerning elements of the coronavirus disease 2019 (COVID-19) epidemic in the United States is the disproportionate impact it has inflicted on historically underprivileged communities. When compared to White individuals, Black, Hispanic, and Asian persons had much greater rates of infection, hospitalization, and mortality. 1,2 According to a Kaiser Family Foundation and Epic Health Research Network analysis based on data from the Epic health record system for 7 million Black patients, 5.1 million Hispanic patients, 1.4 million Asian patients, and 34.1 million White patients as of July 20, 2020, the hospitalization and death rates per 10 000 were 24.6 and 5.6 for Black patients, 30.4 and 5.6 for Hispanic patients, 15.9 and 4.3 for Asian patients, and 7.4 and 2 for White patients. COVID-19 has also disproportionately afflicted two American Indians residing in the United States.

In the United States, racial and ethnic minority status is intrinsically linked to inferior socioeconomic position. In the United States, Black, Hispanic, and American Indian people are more likely to live in crowded areas, in multigenerational households, and to work in jobs that cannot be performed remotely, such as transit workers, grocery store clerks, nursing aides, construction workers, and household workers.

Even if they can hide at home, many low-income people live with an essential worker and are more likely to become infected with the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). People who have been marginalized are more likely to be hospitalized if they become infected with SARS-CoV-2 because they have a larger number of chronic medical comorbidities.

Furthermore, racial and ethnic minority communities have less access to health care, which likely leads to people seeking care later in the course of their COVID-19 disease. Since the beginning of the COVID-19 epidemic, 1.6 million Hispanic people in the United States have lost access to health care coverage.

Immigrants, whether illegally or lawfully present in the United States, are likely to avoid the health-care system entirely owing to fears of deportation or that usage of publicly funded services would be used to refuse future immigration.

Reference: https://jamanetwork.com/journals/jama/article-abstract/2