



November 7, 2022

**To:** Centers for Medicare & Medicaid Services, Department of Health & Human Services  
**Subject:** Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, 87 Fed. Reg. 54,760 (proposed Sept. 7, 2022) (CMS-2421-P)

The Institute for Policy Integrity (Policy Integrity) at New York University School of Law<sup>1</sup> respectfully submits the following comments to the Centers for Medicare & Medicaid Services (CMS) regarding its proposal to simplify the processes for eligible individuals to enroll and retain eligibility in Medicaid, the Children’s Health Insurance Program (CHIP), and the Basic Health Program (BHP) (Proposed Rule).<sup>2</sup> Policy Integrity is a non-partisan think tank dedicated to improving the quality of government decisionmaking through advocacy and scholarship in the fields of administrative law, economics, and public policy.

In keeping with the goals of the Affordable Care Act (ACA), the Proposed Rule will provide the United States’ low-income population with broader and more consistent access to health insurance. CMS calculates that the Proposed Rule will increase Medicaid enrollment by 2.81 million by 2027 and CHIP enrollment by 0.12 million by 2027.<sup>3</sup> But while CMS’s regulatory impact analysis (RIA) extensively analyzes how this additional enrollment will affect federal and state spending, the agency does not pay similarly close attention to enrollment’s social benefits, such as reduced annual mortality. Nor does the RIA expressly discuss the Proposed Rule’s desirable distributional consequences. To strengthen its economic justification for the Proposed Rule, CMS should:

- More thoroughly analyze the Proposed Rule’s benefits, which include improvements to health and increased labor force productivity.
- Discuss the Proposed Rule’s distributional impacts and potential to increase health equity.

We expand on these suggestions below.

**I. CMS should analyze the myriad benefits of increasing Medicaid, CHIP, and BHP enrollment in its Regulatory Impact Analysis.**

In discussing the benefits of the Proposed Rule, CMS focuses almost exclusively on administrative

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<sup>1</sup> These comments do not reflect the views of NYU School of Law, if any.

<sup>2</sup> Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, 87 Fed. Reg. 54,760 (proposed Sept. 7, 2022) [hereinafter Proposed Rule].

<sup>3</sup> *Id.* at 54,838.

cost savings that will result from the Rule’s simplification of the Medicaid, CHIP, and BHP enrollment processes. But by increasing program enrollment and reducing churn, the Proposed Rule will also generate improved health and economic outcomes for beneficiaries. Per the Department of Health and Human Services’ *Guidelines for Regulatory Impact Analysis*, these indirect consequences of increased government healthcare spending “should be taken into account in [any HHS subagency’s] benefit-cost analysis.”<sup>4</sup> CMS can thus strengthen its RIA for the Proposed Rule by describing the health and economic benefits of expanded and more consistent access to health insurance.

### **A. The Proposed Rule will improve health by expanding access to health insurance.**

A substantial body of empirical literature links increased access to government health insurance programs with a variety of health benefits—including reduced annual mortality, receipt of earlier and more successful treatment, behavioral improvements, and better mental health.

#### *1. Mortality reduction*

Several studies have found that Medicaid expansion following the passage of the ACA reduced annual mortality. For example, one study found that states that expanded Medicaid experienced a 9.4% reduction in annual mortality compared to non-expansion states.<sup>5</sup> Another study determined that Medicaid expansion resulted in approximately 11.8 fewer annual deaths per 100,000 adults and concluded that each percentage point decrease in a state’s proportion of uninsured residents resulted in 1.6 fewer deaths per 100,000 adults.<sup>6</sup> A third study found that the mortality reduction attributable to Medicaid expansion was worth between \$21 and \$102 billion per year from 2014 to 2017.<sup>7</sup> These positive impacts are distributed across the population. One study found that a 10% increase in Medicaid/CHIP eligibility (for example, from 30% of children in a particular age group to 40%) resulted in a roughly 4% decline in child mortality.<sup>8</sup> Another found that Medicaid expansion following the ACA saved the lives of at least 19,200 adults aged 55 to 64 over a four-year period.<sup>9</sup> Conversely, 15,600 older adults died prematurely because of other states’ decisions not to expand Medicaid.<sup>10</sup>

#### *2. Improved access to care*

Studies have also shown that post-ACA Medicaid expansion led to increased consumption of preventive care and more successful post-care outcomes. Having Medicaid increased a person’s probability of obtaining cholesterol checks, blood tests, mammograms, and pap tests;<sup>11</sup> it also increased the probability of having a personal doctor by 6% and the probability of receiving an HIV

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<sup>4</sup> DEP’T OF HEALTH & HUM. SERVS., GUIDELINES FOR REGULATORY IMPACT ANALYSIS 23 (2016), <https://perma.cc/GB7K-X4KE> (“Where the imposition of transfer payments affects behavior, associated impacts should be taken into account in the benefit-cost analysis. For example, reductions in government payments to hospitals would often be viewed as a transfer. However, the affected hospitals may accept fewer patients or use less expensive treatments, in turn affecting health outcomes. This change in health should be addressed in the benefit-cost analysis, if significant.”).

<sup>5</sup> Sarah Miller, Norman Johnson & Laura R. Wherry, *Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data*, 136 Q.J. ECON. 1783, 1783 (Aug. 2021).

<sup>6</sup> Brian P. Lee, Jennifer L. Dodge & Norah A. Terrault, *Medicaid Expansion and Variability in Mortality in the USA: A National, Observational Cohort Study*, 7 THE LANCET e48, e48, e52 (Dec. 2021).

<sup>7</sup> Mark Borgschulte & Jacob Vogler, *Did the ACA Medicaid Expansion Save Lives?*, 72 J. HEALTH ECON. 102,333, 102,333 (2020). Note that this welfare estimate is conservative, as it measures only welfare gains from mortality reduction and does not account for the total welfare gains attributable to Medicaid expansion, such as quality-of-life improvements and ancillary benefits like increases in financial stability or reductions in crime.

<sup>8</sup> Embry Howell et al., *Declining Child Mortality and Continuing Racial Disparities in the Era of the Medicaid and SCHIP Insurance Coverage Expansions*, 100 AM. J. PUB. HEALTH 2500, 2503 (2010).

<sup>9</sup> Miller, Johnson & Wherry, *supra* note 5, at 23.

<sup>10</sup> *Id.*

<sup>11</sup> Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year*, 127 Q.J. ECON. 1057, 1088 (2012).

test by 5%.<sup>12</sup> Additionally, Medicaid expansion was associated with a significantly greater likelihood of patients presenting with earlier, less complicated diseases at the time of hospital admission and an increased likelihood of receiving optimal care after admission for certain conditions.<sup>13</sup>

### 3. Healthier behaviors

Medicaid expansion led to behavioral improvements that may contribute to lower mortality rates and increases in quality of life. Studies have found that Medicaid expansion resulted in a decrease in the purchase of sugar-sweetened beverages<sup>14</sup> and a reduction in cigarette consumption.<sup>15</sup>

### 4. Improved mental health and quality of life

As a result of Medicaid expansion following the ACA, adults with chronic health conditions experienced a reduction in self-reported poor mental health days and depression diagnoses.<sup>16</sup> One study found that expanding access to Medicaid increased the probability of screening negative for depression by 7.8%.<sup>17</sup> Medicaid expansion also resulted in improvements to physical health, including self-reported physical health.<sup>18</sup> Evidence suggests that early childhood access to Medicaid improved an index of health outcomes for individuals in their prime working years,<sup>19</sup> and children whose mothers became eligible for Medicaid while they were in utero experienced improved later-life health outcomes, such as fewer hospital visits related to diabetes and obesity.<sup>20</sup>

## B. The Proposed Rule will improve health by reducing churn.

In addition to expanding insurance access, the Proposed Rule will benefit health by reducing churn, a phenomenon characterized by losing and regaining healthcare coverage within a short time period.<sup>21</sup> If patients lose insurance coverage for even a few months, their health can deteriorate. Gaps in healthcare coverage are associated with delays in the screening, detection, and treatment of cancer, which may result in higher mortality.<sup>22</sup> Churn may reduce the effectiveness of disease management programs<sup>23</sup> and results in greater use of emergency rooms, higher rates of hospitalizations for conditions that can be mediated by effective primary care, and higher rates of serious mental health problems leading to

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<sup>12</sup> Kosali Simon, Aparna Soni & John Cawley, *The Impact of Health Insurance on Preventive Care and Health Behaviors: Evidence from the First Two Years of the ACA Medicaid Expansions*, 36 J. POL'Y ANALYSIS & MGMT. 390, 404 (2017).

<sup>13</sup> See generally Andrew P. Loehrer et al., *Association of the Affordable Care Act Medicaid Expansion with Access to and Quality of Care for Surgical Conditions*, 153 JAMA SURGERY e175,568 (Mar. 2018).

<sup>14</sup> Xi He, Rigoberto A. Lopez & Rebecca Boehm, *Medicaid Expansion and Non-Alcoholic Beverage Choices by Low-Income Households*, 29 HEALTH ECON. 1327, 1327 (2020).

<sup>15</sup> Chad Cotti, Erik Nesson & Nathan Tefft, *Impacts of the ACA Medicaid Expansion on Health Behaviors: Evidence from Household Panel Data*, 28 HEALTH ECON. 219, 219 (2019).

<sup>16</sup> Tyler Winkelman & Virginia W. Chang, *Medicaid Expansion, Mental Health, and Access to Care Among Childless Adults with and Without Chronic Conditions*, 33 J. GEN. INTERNAL MED. 376, 376 (2018).

<sup>17</sup> Finkelstein et al., *supra* note 11, at 1095.

<sup>18</sup> See, e.g., Simon, Soni & Cawley, *supra* note 12, at 404 (finding that Medicaid expansion led to improvement in self-assessed health by 2% for low-income adults); Benjamin D. Sommers et al., *Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults*, 36 HEALTH AFFS. 1119, 1119 (2017) (finding a 23% increase in "excellent" self-reported health for people who gained medical coverage from the ACA's Medicaid expansion).

<sup>19</sup> See generally Michel H. Boudreaux, Ezra Golberstein & Donna D. McAlpine, *The Long-Term Impacts of Medicaid Exposure in Early Childhood: Evidence from the Program's Origin*, 45 J. HEALTH ECON. 161 (2016).

<sup>20</sup> Sarah Miller & Laura R. Wherry, *The Long-Term Effects of Early Life Medicaid Coverage*, 54 J. HUM. RES. 785, 785 (2018).

<sup>21</sup> LAURA SUMMER & CINDY MANN, *INSTABILITY OF PUBLIC HEALTH INSURANCE COVERAGE FOR CHILDREN AND THEIR FAMILIES: CAUSES, CONSEQUENCES, AND REMEDIES*, at viii (2006), <https://perma.cc/2HNE-RRN5>.

<sup>22</sup> See generally K. Robin Yabroff et al., *Health Insurance Coverage Disruptions and Cancer Care and Outcomes: Systematic Review of Published Research*, 112 J. NAT'L CANCER INST. 671 (2020).

<sup>23</sup> SUMMER & MANN, *supra* note 21, at 13.

hospitalization.<sup>24</sup> Finally, the administrative burdens imposed by churn may themselves worsen health outcomes by introducing more stress into applicants' lives,<sup>25</sup> which research demonstrates is detrimental to health.<sup>26</sup>

CMS should discuss these and any other significant health benefits of the Proposed Rule in its final RIA.

### C. The Proposed Rule will yield broader economic benefits.

In addition to improving the health of Medicaid, CHIP, and BHP enrollees, the Proposed Rule could yield sizable benefits for the broader economy.

#### 1. Increased labor productivity

Expanding health insurance coverage leads to a healthier and more productive workforce. Medicaid has made it easier for enrollees both to look for work and to work once they have a job.<sup>27</sup> This is important because the costs of health-related work absence are substantial, potentially in the hundreds of billions of dollars every year.<sup>28</sup> One study found that workers with health insurance missed 76.5% fewer workdays (1.7 versus 7.25 days per year) than workers without health insurance.<sup>29</sup> Access to Medicaid is also associated with higher lifetime earning potential. Research demonstrates that lengthening childhood Medicaid eligibility lowered the amount of money that affected individuals received from the Earned Income Tax Credit program later in life and resulted in increases in those individuals' federal tax payments;<sup>30</sup> by the time an affected individual turned 28, the federal government regained 58 cents of each dollar it spent on that child's Medicaid coverage.<sup>31</sup>

#### 2. Reduced evictions

Medicaid expansion has been found to reduce the rate of evictions—a phenomenon that contributes to long-term poverty and increases reliance on governmental assistance<sup>32</sup>—by 1.15 per 1,000 renter-occupied households.<sup>33</sup>

#### 3. Increased educational attainment

Expansions in childhood Medicaid eligibility are associated with lower high school dropout rates and higher college completion rates.<sup>34</sup> Evidence suggests that better health during teen years is a driving

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<sup>24</sup> Leighton Ku, Erika Steinmetz & Tyler Bysshe, *Continuity of Medicaid Coverage in an Era of Transition 2* (Ass'n for Cmty. Affiliated Plans, Working Paper, 2015), <https://perma.cc/WSK9-L4KM>.

<sup>25</sup> See Fabian Hattke, David Hensel & Janne Kalucza, *Emotional Responses to Bureaucratic Red Tape*, 80 PUB. ADMIN. REV. 53, 53 (2019) (finding that paperwork and confusing directions increase emotions such as frustration and anger).

<sup>26</sup> E.g., Robert-Paul Juster, Bruce S. McEwen & Sonia J. Lupien, *Allostatic Load Biomarkers of Chronic Stress and Impact on Health and Cognition*, 35 NEUROSCIENCE & BIOBEHAVIORAL REVS. 2, 2 (2010).

<sup>27</sup> CTR. ON BUDGET & POL'Y PRIORITIES, CHART BOOK: THE FAR-REACHING BENEFITS OF THE AFFORDABLE CARE ACT'S MEDICAID EXPANSION 16 (2020), <https://perma.cc/3PA5-79B3>.

<sup>28</sup> Press Release, Commonwealth Fund, "Lost Labor Time" Costs U.S. \$260 Billion Each Year (Aug. 31, 2005), <https://perma.cc/DYQ7-FHKL>.

<sup>29</sup> Allan Dizioli & Roberto Pinheiro, *Health Insurance as a Productive Factor*, 40 LABOUR ECON. 1, 2 (2016).

<sup>30</sup> David W. Brown, Amanda E. Kowalski & Ithai Z. Lurie, *Long-Term Impacts of Childhood Medicaid Expansions on Outcomes in Adulthood*, 87 REV. ECON. STUD. 792, 792 (2020).

<sup>31</sup> *Id.*

<sup>32</sup> Matthew Desmond & Carl Gershenson, *Housing and Employment Insecurity Among the Working Poor*, 63 SOC. PROBS. 46, 46 (2016).

<sup>33</sup> Naomi Zewde et al., *The Effects of the ACA Medicaid Expansion on Nationwide Home Evictions and Eviction-Court Initiations: United States, 2000–2016*, 109 AM. J. PUB. HEALTH 1379, 1379 (2019).

<sup>34</sup> Sarah R. Cohodes et al., *The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions*, 51 J. HUM. RES. 727, 727 (2016).

force behind this result.<sup>35</sup>

#### 4. *Reduced crime*

Medicaid expansion is linked to reductions in crime. States that expanded Medicaid experienced a 5.3% reduction in annual reported violent crime rates relative to non-expansion states, or 17 fewer incidents per 100,000 people.<sup>36</sup> This decrease in crime amounted to an estimated annual cost savings of approximately \$4 billion.<sup>37</sup>

CMS should address these and any other significant economic benefits of the Proposed Rule in its final RIA.

## **II. CMS should describe why the transfers caused by the Proposed Rule are desirable as a distributional matter.**

Executive Order 12,866 directs agencies to consider “distributive impacts” and “equity” when assessing a potential rule’s costs and benefits.<sup>38</sup> Executive Order 13,563 likewise affirms the importance of accounting for “equity, human dignity, fairness, and distributive impacts” in regulatory analysis.<sup>39</sup> In keeping with these orders, the Office of Management and Budget’s Circular A-4, the executive branch’s principal guidance on cost-benefit analysis, advises agencies to “provide a separate description of distributional effects (i.e., how both benefits and costs are distributed among sub-populations of particular concern) so that decision makers can properly consider them along with the effects on economic efficiency” and to describe distributional effects “quantitatively to the extent possible.”<sup>40</sup> Circular A-4 also acknowledges distributional fairness as a value that can justify regulation.<sup>41</sup>

In light of this executive branch guidance, and the fact that one of the ACA’s primary purposes is to expand healthcare coverage,<sup>42</sup> CMS should discuss why the Proposed Rule’s distributional consequences are desirable. In particular, the Proposed Rule will enhance fairness by providing households with benefits they are entitled to under law and reducing income- and race-based disparities in access to healthcare.

### **A. The Proposed Rule will further basic fairness by removing arbitrary barriers to program enrollment.**

The ACA and various executive orders recognize the need for the government to remove barriers to access for people who qualify for healthcare coverage under Medicaid, CHIP, and BHPs. Executive Order 14,009 specifically calls for agencies to remove barriers to obtaining coverage for the millions of individuals who are eligible for healthcare but remain uninsured.<sup>43</sup> Executive Order 14,070 similarly

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<sup>35</sup> *Id.*

<sup>36</sup> Jacob Vogler, *Access to Healthcare and Criminal Behavior: Evidence from the ACA Medicaid Expansions*, 39 J. POL’Y ANALYSIS & MGMT. 1166, 1166 (2020).

<sup>37</sup> *Id.*

<sup>38</sup> Exec. Order No. 12,866 § 1(b)(5), 58 Fed. Reg. 51,735 (Oct. 4, 1993).

<sup>39</sup> Exec. Order No. 13,563 §1(c), 76 Fed. Reg. 3821, 3821 (Jan. 21, 2011).

<sup>40</sup> OFF. OF MGMT. & BUDGET, CIRCULAR A-4: REGULATORY ANALYSIS 14 (2003) [hereinafter CIRCULAR A-4].

<sup>41</sup> *Id.* at 4 (listing distributional fairness as an “intangible value” and a problem that could “warrant new agency action”).

<sup>42</sup> Nat’l Fed’n of Indep. Bus. v. Sebelius, 567 U.S. 519, 538 (2012) (“The [ACA] aims to increase the number of Americans covered by health insurance and decrease the cost of health care.”); *Morris v. Cal. Physicians’ Serv.*, 918 F.3d 1011, 1016 (9th Cir. 2019) (“The purpose of the ACA, as demonstrated by the content of its provisions and the implementing regulations, as well as its history, is to broaden access to health care.”).

<sup>43</sup> Exec. Order No. 14,009, 86 Fed. Reg. 7793 (Jan. 28, 2021).

directs federal agencies to identify ways to help more Americans enroll in quality health coverage.<sup>44</sup> The ACA itself includes a number of provisions designed to expand healthcare access by simplifying Medicaid and CHIP enrollment processes and requiring the establishment of a seamless system of coverage for all insurance affordability programs.<sup>45</sup> For example, under the ACA, individuals must be able to obtain a determination of eligibility for all state medical assistance programs using a single application.<sup>46</sup>

Many people who are entitled to healthcare under these programs do not currently receive coverage due to unnecessary barriers. The Proposed Rule identifies that in 2019, 7.7% of Medicaid-eligible children did not have any health insurance, and in 2017, only about half of eligible Medicare beneficiaries were enrolled in Medicare Savings Programs.<sup>47</sup> Evidence suggests that restrictive state enrollment policies contribute to coverage disruptions and create churn as people lose Medicaid and CHIP coverage and re-enroll.<sup>48</sup>

By streamlining program enrollment, the Proposed Rule will enable low-income households to access the benefits they are entitled to under law, resulting in a transfer<sup>49</sup> of \$61.9 billion over five years to Medicaid and CHIP beneficiaries through additional healthcare spending by those programs.<sup>50</sup> Not only will this transfer enhance the health of the United States' low-income population, but it is also likely to improve their financial well-being. One study found that for adults with family incomes between 100 and 138% of the federal poverty line, living in a state that expanded Medicaid was associated with a \$344 decline in average out-of-pocket spending.<sup>51</sup> Another found that, among people residing in zip codes with the highest share of low-income, uninsured individuals, Medicaid expansion significantly reduced the number of unpaid bills and the amount of debt sent to third-party collection agencies.<sup>52</sup>

In its final RIA, CMS should expressly discuss whether and why removing barriers to health insurance enrollment for otherwise-eligible individuals is consistent with basic fairness.

## **B. The Proposed Rule will reduce income- and race-based disparities in access to healthcare.**

The ACA includes provisions designed specifically to advance health equity.<sup>53</sup> For example, the law requires that all states establish outreach and enrollment plans for vulnerable and underserved populations eligible for benefits, including children, racial and ethnic minorities, rural populations, and individuals with mental health or substance-related disorders.<sup>54</sup> The law also prohibits discrimination

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<sup>44</sup> Exec. Order No. 14,070, 87 Fed. Reg. 20,689 (Apr. 5, 2022).

<sup>45</sup> See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1413, 2201, 124 Stat. 119, 233–35, 289–91 (2010) (codified at 42 U.S.C. §§ 18071, 1396w-3).

<sup>46</sup> *Id.* § 1413(c)(1), 124 Stat. at 234 (codified at 42 U.S.C. § 18083(c)(1)).

<sup>47</sup> Proposed Rule, *supra* note 2, at 54,761.

<sup>48</sup> *Id.*

<sup>49</sup> See CIRCULAR A-4, *supra* note 40, at 38 (identifying transfers as “monetary payments from one group to another that do not affect total resources available to society,” whereas benefit and cost estimates “reflect real resource use”).

<sup>50</sup> Proposed Rule, *supra* note 2, at 54,833.

<sup>51</sup> Fredric Blavin et al., *Medicaid Versus Marketplace Coverage for Near-Poor Adults: Effects on Out-of-Pocket Spending and Coverage*, 37 HEALTH AFFS. 299, 299 (2018).

<sup>52</sup> Luoia Hu et al., *The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing*, 163 J. PUB. ECON. 99, 99 (2018).

<sup>53</sup> Katie Keith, *How Insurers Can Advance Health Equity Under the Affordable Care Act*, COMMONWEALTH FUND (Aug. 10, 2021), <https://perma.cc/SB8M-PSLD> (highlighting ACA provisions that advance health equity, such as civil rights protections, coverage of essential health benefits, and inclusion of essential community providers such as Indian healthcare providers and family planning providers).

<sup>54</sup> See Patient Protection and Affordable Care Act § 2201, 124 Stat. at 289–90 (codified at 42 U.S.C. § 1396w-3(b)(1)(F)).

based on race.<sup>55</sup> More recently, President Biden issued an executive order on “Advancing Racial Equity and Support for Underserved Communities Through the Federal Government,” which charged Federal agencies with identifying potential barriers that underserved communities may face to enrollment in programs like Medicaid, CHIP, and BHPs.<sup>56</sup> By expanding access to Medicaid, CHIP, and BHPs, the Proposed Rule will further the ACA and Biden Administration’s goal of reducing race- and income-based disparities in access to healthcare.

People of color are disproportionately likely to rely on Medicaid for their health coverage and are correspondingly disproportionately likely to benefit from the expansion of Medicaid access.<sup>57</sup> In 2019, nearly 60% of Medicaid enrollees were people of color, compared to 35% in employer-sponsored insurance.<sup>58</sup> An examination of federal survey data showed that, nationwide, after the implementation of the ACA, the gap between Black and white adult uninsurance rates dropped by 4.1%, and the gap between Hispanic and white uninsurance rates decreased by 9.4%.<sup>59</sup> This drop was concentrated in states that chose to expand Medicaid.<sup>60</sup> One recent study even found that the reduction in mortality associated with Medicaid expansion was greatest among women and Black residents.<sup>61</sup>

In its final RIA, CMS should discuss whether and why the Proposed Rule can be expected to reduce race- and income-based disparities in access to healthcare.

Respectfully,

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<sup>55</sup> See *id.* § 1557, 124 Stat. at 260 (codified at 42 U.S.C. § 18116).

<sup>56</sup> Exec. Order No. 13,985, 86 Fed. Reg. 7009 (Jan. 20, 2021).

<sup>57</sup> See, e.g., MEDICAID & CHIP PAYMENT & ACCESS COMM’N, RACIAL AND ETHNIC DISPARITIES IN MEDICAID: AN ANNOTATED BIBLIOGRAPHY (2021), <https://perma.cc/ZPQ4-B2XA>; Madeline Guth, Samantha Artiga & Olivia Pham, *Effects of the ACA Medicaid Expansion on Racial Disparities in Health and Health Care*, KAISER FAM. FOUND. (Sept. 30, 2020), <https://perma.cc/3PK7-4SCL>.

<sup>58</sup> See *Distribution of the Nonelderly with Medicaid by Race/Ethnicity*, KAISER FAM. FOUND., <https://perma.cc/XAT2-PYVL>.

<sup>59</sup> JESSE C. BAUMGARTNER ET AL., COMMONWEALTH FUND, HOW THE AFFORDABLE CARE ACT HAS NARROWED RACIAL AND ETHNIC DISPARITIES IN ACCESS TO HEALTH CARE (2020), <https://perma.cc/5FBX-8P9M>.

<sup>60</sup> JESSE CROSS-CALL, CTR. ON BUDGET & POL’Y PRIORITIES, MEDICAID EXPANSION HAS HELPED NARROW RACIAL DISPARITIES IN HEALTH COVERAGE AND ACCESS TO CARE 2–3 (2020), <https://perma.cc/7KXX-7WVC>; see also Lynn A. Blewett, Colin Planalp & Giovann Alarcon, *Affordable Care Act Impact in Kentucky: Increasing Access, Reducing Disparities*, 108 AM. J. PUB. HEALTH 924, 924 (2018) (finding that after the implementation of the ACA, Black individuals had the greatest decline in uninsurance and were no longer overrepresented among the uninsured population in Kentucky).

<sup>61</sup> Lee, Dodge & Terrault, *supra* note 6, at e48.