The Potential and Realized Impact of the Affordable Care Act on Health Equity

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Abstract The Affordable Care Act (ACA) was designed with multiple goals in mind, including a reduction in social disparities in health care and health status. This was to be accomplished through some novel provisions and a significant infusion of resources into long-standing public programs with an existing track record related to health equity. In this article, we discuss seven ACA provisions with regard to their intended and realized impact on social inequalities in health, focusing primarily on socioeconomic and racial/ethnic disparities. Arriving at its 10th anniversary, there is significant evidence that the ACA has reduced social disparities in key health care outcomes, including insurance coverage, health care access, and the use of primary care. In addition, the ACA has had a significant impact on the volume/range of services offered and the financial security of community health centers, and through section 1557, the ACA broadened the civil rights landscape in which the health care system operates. Less clear is how the ACA has contributed to improved health outcomes and health equity. Extant evidence suggests that the part of the ACA that has had the greatest impact on social disparities in health outcomes—including preterm births and mortality—is the Medicaid expansion.

Keywords health policy, Affordable Care Act, health equity, health disparities, Medicaid expansion, community health centers, clinical preventive services, discrimination

Extensive research documents the serious population health problems afflicting the Unites States, including racial/ethnic, socioeconomic, and other types of social inequalities for almost every health behavior, condition, disease, and health indicator (Baiciu et al. 2017). The Patient Protection and Affordable Care Act (ACA) significantly overhauls public policies related

Journal of Health Politics, Policy and Law, Vol. 45, No. 5, October 2020
DOI 10.1215/03616878-8543298

Table 1 Key Provisions in the Affordable Care Act Related to Health Equity Goals

Title	Provisions
Title 1: Quality, Affordable Healthcare for All Americans	Health insurance reforms and subsidies Section 1557—Nondiscrimination Provision
Title 2: The Role of Public Programs	Medicaid expansion Home visiting Reauthorization of Children's Health Insurance Program
Title 4: Prevention of Chronic Disease and Improving Public Health	Clinical preventive services coverage National prevention strategy
Title 5: Health Care Workforce	Community Health Center Fund
Title 9: Revenue Provisions	Nonprofit hospitals and community benefit
Title 10: Reauthorization of the Indian Health Care Improvement Act	Reauthorization of the Indian Healthcare Improvement Act

to health insurance and health care with a number of overarching goals, the most prominent being to improve the accessibility, affordability, and value of health insurance, and to improve health care quality, efficiency, and outcomes. The ACA, however, also reached beyond health care coverage to address health status disparities related to race/ethnicity, socioeconomic status, geography, and other social factors. Indeed, the ACA refers multiple times to the need to address underserved and "health disparities populations," defined as identifiable social groups with significant differences in disease incidence/prevalence, morbidity, mortality, or survival compared to the general population.

As Grogan (2017) summarized, the ACA was designed to both explicitly and implicitly address health equity through many of its provisions. Some ACA reforms were designed to address inequities in the structures and processes of health care delivery; other reforms focused on more equitable distributions of specific "means and ends" (Grogan 2017). Although many ACA provisions are innovative and novel, this landmark legislation was also designed to build on and further strengthen a number of public programs with a documented track record of addressing health disparities. This includes the ACA's reauthorization of the Children's Health Insurance Program or CHIP (first enacted in 1997) and the Indian Health Care Improvement Act (first enacted in 1976). The ACA also provided major expansions of Medicaid, community health centers, legal protections against health care discrimination, and public health prevention efforts (Table 1).

In this article, as the ACA reaches its 10th anniversary, we review several components of the ACA in regard to their intended and realized impact on social inequalities in health care and health status outcomes, focusing primarily on socioeconomic and racial/ethnic disparities. We focus on seven key provisions that were either novel or involved a major infusion of resources: 1) health insurance reforms and subsidies; 2) the "Section 1557" nondiscrimination provision; 3) the Medicaid expansion; 4) home visiting programs; 5) first dollar coverage of clinical preventive services; 6) the Community Health Center Fund; and 7) nonprofit hospitals and community benefit.

FINDINGS

Title 1: Quality, Affordable Healthcare for All Americans

Health Insurance Reforms and Subsidies. The majority of evaluations of the ACA insurance reforms have analyzed health care coverage, access, and utilization outcomes rather than health status outcomes. Population-based data from multiple national sources reveals that the health insurance reforms and subsidies implemented through the ACA ushered in significant increases in health insurance coverage and access to care and decreased out-of-pocket costs and spending on premiums, especially for lower-income individuals (Glied, Solis-Roman, and Parikh 2016; Goldman et al. 2018). In a unique experimental study, Goldin, Lurie, and McCubbin (2019) found that an informational intervention aimed at people who paid the individual mandate tax penalty of the ACA (before it was rescinded) subsequently led to increased health insurance coverage, which in turn produced a small yet significant decrease in mortality among middle-aged adults.

Because ACA-related gains in coverage were greater for minority groups and people with incomes below 139% of the poverty level, social disparities in health insurance coverage have been significantly reduced (Chaudry, Jackson, and Glied, 2019; Chen et al. 2016). For example, the black/white gap in adult uninsured rates dropped by 4.1% between 2013 and 2018, and the Hispanic/white gap fell by 9.4% (Baumgartner 2020). In addition, the ACA appears to have also reduced racial/ethnic gaps in other measures of health care access, including having a usual source of care and foregoing care/prescriptions because of cost concerns.

Although racial/ethnic and socioeconomic gaps in health insurance coverage and care access narrowed in all states, reductions in disparities

were even greater in those states that expanded Medicaid (Griffith, Evans, and Bor 2017; Buchmueller et al. 2016), as discussed in more detail below. However, a 2020 report from the Commonwealth Fund suggests that progress in increasing health care access and reducing social disparities stalled after 2016 and has eroded since (Baumgartner 2020). Jost (2018) argues that since taking power in 2017, the Trump administration openly engaged in policy strategies that intentionally undermined and weakened the ACA. This includes reducing the tax penalty for not having health insurance to $0, ending cost-sharing reduction subsidies to insurance plans in the exchanges, significantly reducing education and outreach efforts for Marketplace open enrollment, moves to create an individual insurance market that operates free of ACA reforms, and continuous negative comments in public statements and social media. While correlation is not causation, it is not surprising that gains in health insurance coverage in the US stalled right after President Trump—who actively campaigned against the ACA—took office.

Section 1557—Nondiscrimination Provision of the ACA. Within title 1 of the ACA, section 1557 further expands decades of civil rights law including the Civil Rights Act of 1964, the Rehabilitation Act of 1973—whose protections later would be incorporated into the Americans with Disabilities Act—and the Age Discrimination Act of 1975. Section 1557 builds on these legal watersheds by effectively reshaping civil rights law to fit a twenty-first century health care system (Rosenbaum 2016).

Section 1557 does two important things. First, it expands the range of protected classes to include discrimination on the basis of sex. Second, the law dramatically expands the reach of what is considered a federally assisted program to include contracts of insurance (previously understood to be exempt from the reach of prior antidiscrimination laws). In doing so, the new law encompasses not only Medicare, Medicaid, and CHIP but also federal funding in connection with health insurance purchased through the Marketplace. Furthermore, because civil rights law standards interpret their reach as "entity-wide," 1557 applies to *all* health plans sold by large insurers, not only plans directly supported with public subsidies. Under this interpretation, tax-advantaged employer plans also are covered by this ACA legal provision.

Section 1557, like earlier civil rights laws, broadens the legal landscape in which the US health care system operates. As such, if left intact, it can be expected to further infuse and enforce "equal treatment" principles into the health system in many important ways. For example, the law already has had a significant, measurable effect on health insurance

and health care by barring coverage exclusions and discriminatory treatment against transgender persons as tantamount to unlawful discrimination on the basis of sex.

Title 2: The Role of Public Programs—Medicaid Expansion

The ACA provides significant incentives to states to expand their Medicaid programs to nearly all low-income adults up to 138% of the federal poverty level. There is clear and mounting evidence that expansion states have experienced significant increases in health care coverage and access to care. Miller and Wherry (2019) estimate that the Medicaid expansions increased health insurance coverage by 12% over the increase in nonexpansion states from title 1 provisions alone.

Guth and colleagues (2020) recently synthesized results from more than four hundred evaluation studies, with a key finding that state Medicaid expansions led to significant increases in health insurance coverage in "vulnerable" populations including low-income adults, people with HIV and substance use disorders, veterans, LGBTQ adults, and people in rural areas. This review also concluded that the Medicaid expansions have improved access to and affordability of care, use of health care services, and financial security among low-income populations.

Buchmueller and colleagues (2016) found that by 2014 state Medicaid expansions had significantly reduced racial/ethnic differences in health insurance rates within expansion states. More recent analyses confirm that the Medicaid expansions significantly reduced racial disparities in health insurance coverage nationwide (Baumgartner 2020). For example, the black/white percent coverage gap in expansions states dropped from 8.4 in 2013 to 3.7 in 2018; and the Hispanic/white coverage gap dropped from a 23.2% difference in 2013 to 12.2 in 2018. In fact, black adults in expansion states are now more likely to have insurance than white adults in nonexpansion states (Baumgartner 2020)

The Medicaid expansions also reduced racial/ethnic disparities in such measures as having a consistent source of health care and foregoing needed care because of cost concerns (Baumgartner 2020). In terms of health status, expanding Medicaid has been associated with improvement in a number of important diseases and outcomes, including self-reported general health, cardiovascular disease, birth outcomes, and end-stage renal disease mortality (Guth et al. 2019). Studies have also demonstrated an association between ACA Medicaid expansion and a reduction in racial disparities in preterm birth, increased treatment for opioid addiction, and earlier diagnosis of certain types of cancers (Brown et al. 2019; Guth et al. 2019).

In addition, there is strong evidence that expanding Medicaid has saved lives. Miller and colleagues (2019) concluded that the Medicaid expansion reduced mortality among low-income "near-elderly" adults, and that an additional 15,600 deaths would have been averted between 2010 and 2014 if all states had expanded their Medicaid programs.

State Medicaid expansions have also had a positive impact on a number of economic outcomes, including state budget savings, revenue gains, and economic growth (Guth et al. 2019). For example, the Michigan Medicaid expansion produced an approximately 50% reduction in unpaid bills and uncompensated care costs for hospitals, and also produced fiscal benefits for the state including increased revenue from provider, sales, and income taxes (Levy et al. 2020).

The impact of expanding Medicaid on community health centers is also noteworthy. In expansion states, health centers have been able to increase the number of patients receiving behavioral health services, medication assisted treatment for opioid addiction, and coordinated care with social service providers. In addition, by further increasing health insurance coverage, health centers in expansion states are reporting significantly increased financial stability (Lewis et al. 2019).

Despite this progress, it is important to note that serious racial/ethnic and other social disparities in health insurance coverage still remain within and across states. Rates of uninsurance and racial disparities were, on average, smaller in the states that expanded Medicaid, especially among the early adopters. However, because a greater share of black, American Indian/Alaska Native, and Hispanic adults ages 18–64 live in states that have not expanded Medicaid (primarily southern states), they are more likely than whites nationwide to be uninsured (Artiga, Orgera, and Damico, 2019). For example, the 2018 uninsurance rates in Massachusetts (an early expansion state) were estimated as 2.08% for whites, 4.26% for blacks, 5.33% for Hispanics, and 4.22% for low-income adults, compared with Texas's rates of 10.29% for whites, 15.29% for blacks, 27.29% for Hispanics, and 25.50% for low-income adults (Kiernan 2019). Also, as discussed above, it appears that progress in reducing racial/ethnic disparities in health insurance coverage stalled after the Trump administration took office in 2017 (Artiga, Orgera, and Damico, 2019).

Maternal, Infant, and Early Childhood Home Visiting Programs. Title 2 of the ACA created the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, allocating more than $1.5 billion to states, territories, and tribal entities to fund evidence-based home visiting programs. Research has demonstrated that well-designed interventions with a

home visiting component have a positive impact on a number of maternal, child, and family outcomes, and are an especially important approach to increasing health equity in pregnancy outcomes and child health/development (Abbott and Elliott 2017). The MIECHV Program stipulates that 75% of the allocated federal funding must be used to support evidence-based home visiting models, with 18 models currently meeting this standard.

The MIECHV program is currently the largest source of funding for home visiting in the US, serving nearly 80,000 families in 2017 alone (Sandstrom 2019). A 2015 report to Congress evaluated 4 models that have been supported with MIECHV funds in 10 or more states: Early Health Start-Home Based Program Option, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers (Michalopoulos et al. 2015). The evaluation concluded that the MIECHV Program is being implemented as designed, expanding evidence-based interventions in high-risk families and in communities explicitly targeting racial and ethnic disparities in child health and welfare.

The further dissemination of interventions shown to improve maternal, child, and family outcomes in low-income and minority populations has the potential to have a positive impact on health equity. Unfortunately, however, there is currently no evidence for such an impact. Although recipients of MIECHV funding are required to assess and report on performance in six different "benchmark domains," programs are not required to assess and compare impact across sociodemographic subgroups (Sandstrom 2019).

Title 4: Prevention of Chronic Disease and Improving Public Health

Clinical Preventive Services Coverage. The ACA entails a clear emphasis on primary and secondary prevention and other public health approaches to improving health (Chait and Glied 2018). Our review focuses on the title 4 provision to increase insurance coverage for evidence-based clinical preventive services. Using value-based insurance design principles, the ACA established "first dollar" insurance coverage requirements for a wide range of clinical preventive services for children and adults, prohibiting deductibles or copayments for a defined set of evidence-based services. Such services include immunizations and screening tests for cancer, other chronic diseases, sexually transmitted infections and depression; smoking cessation interventions; obesity screening and counseling; and statins and other preventive medications (Lantz 2013; Chait and Glied 2018).

This ACA provision was built on a plethora of research demonstrating that consumer cost sharing plays a role in the underuse of effective clinical preventive services and the long-standing disparities in use by race/ethnicity and socioeconomic status. This reform is estimated to have provided more than 71 million people no-cost access to disease screenings, vaccines, and other important prevention services (Chait and Glied 2018). The impact of this reform on overall trends and social disparities in utilization, however, is not yet clear. While receipt of a number of clinical preventive services has increased over the past decade across sociodemographic groups, most of these increases appear to be the continuation of trends that started before the ACA (Chait and Glied 2018). Also, it is challenging to disentangle the impact of the ACA's provisions regarding clinical preventive services from expanded health insurance coverage in general.

Nonetheless, some findings to date are encouraging. Han and colleagues (2015) reported that, among private insurance enrollees, the use of flu shots, blood pressure monitoring, and cholesterol screening increased significantly post ACA. Sabik and Adunlin (2017) found that cancer screening and early-stage diagnosis increased in the Medicaid expansion population and also among Medicare beneficiaries who did not have preventive service coverage before the ACA. Snyder and colleagues (2018) reported that the ACA significantly reduced out-of-pocket costs for contraception and increased the use of long-acting reversible contraception methods.

A national survey conducted in 2013 revealed that only about one-third of US adults (36.5%) knew that the ACA requires insurance companies to cover clinical preventive services without cost sharing, and that there was significant mistrust of how the government determines which preventive services have sufficient research or evidence behind them (Lantz et al. 2016). Consumer knowledge and understanding of this provision of the ACA is likely an ongoing issue.

Title 5: Health Care Workforce

Community Health Center Fund. Community health centers are a long-standing and increasingly important part of the health care safety net. Extensive research continues to show health centers' positive impact on multiple measures of access and health status (Saloner, Wilk, and Levin 2020). Within the ACA, the Community Health Center Fund created a 5-year funding authorization to extend the reach and impact of the federal community health center program (Rosenbaum 2017). This authorization was extended in 2015 and again in 2018, growing from $1 billion in 2011 to $4 billion in 2019.

The ACA operates in two structural ways to build on the long-standing record of health centers (Rosenbaum et al. 2019). First, the law transformed the grants provided to health centers for basic operational support from an annual discretionary spending model into a multiyear mandatory program. Spending was also set at a level that enabled existing health centers to sustain their operations yet also underwrite a major expansion in service capacity and the scope of care. Second, the ACA Medicaid expansion had the indirect effect of insuring millions of community health center patients, thereby strengthening clinical care capacity and significantly increasing the revenue health centers need to provide and expand services. As a result, while the Health Center Fund has strengthened all health centers, those in Medicaid expansion states show even greater increases in size and service capacity (Lewis et al. 2019).

As a result of these investments, between 2010 and 2017 the number of health centers increased by 59%, the number of patients served increased by 43%, and there was a significant increase in centers offering mental health and substance abuse services (Rosenbaum et al. 2019). Hatch and colleagues (2018) found that the ACA, through both the Community Health Center Fund and the Medicaid expansion, increased patient visits by 19%, including increased utilization of primary care services and patient supports such as interpreters, transportation services, and connections to social and legal services.

Previous research has demonstrated that community health centers have contributed to reducing socioeconomic, geographic, and racial/ethnic disparities in health care access/utilization and some key health outcomes (Saloner, Wilk, and Levin 2020). Expanding the number of health centers and people served through the ACA is likely to have further strengthened and enhanced this legacy of impact on health equity, although empirical studies are currently lacking.

Title 9: Revenue Provisions

Nonprofit Hospitals and Community Benefit. The ACA added a section to the Internal Revenue Code that contains new requirements for nonprofit hospitals in regard to their reporting of community benefits to qualify for tax-exempt status. These requirements bring greater fairness to the treatment of medically indigent patients. They also effectively redefine the role of tax-exempt hospitals as community public health actors beyond their traditional role as a source of clinical care. This redefinition takes the form of an obligation to conduct a community-health-needs assessment (CHNA)

at least every 3 years, and to accompany this assessment with an annual strategy for meeting identified community needs. Although the law does not require hospitals to align their own community benefit expenditures with identified community health needs, the CHNA amendments in essence ensure that hospitals will look beyond their own priorities to those of the community.

Current research does not suggest that this provision has had a significant impact on how nonprofit hospitals engage in and report their community benefit activities to the IRS. Early research by Young and colleagues (2018) found that in 2014, nonprofit hospitals had increased their average spending for all community benefits from 7.6% to 8.1% of operating expenses, with no change in direct spending on community health. IRS data continue to demonstrate that the vast majority of community benefit spending is on uncompensated care, graduate medical education, and research. Rozier, Goold, and Singh (2019) argue that community health improvements and health equity could become a more central focus of hospital community benefit, but only if hospitals are encouraged to embrace these objectives beyond the nudges from the ACA.

While the national data are not positive, there are some encouraging and innovative examples of hospitals investing in local community health. For example, Bon Secours Mercy Health in Baltimore is investing in affordable housing in its neighboring community. Also, the University of Michigan health system offers grants to local nonprofit organizations with high-quality proposals for addressing social determinants of health issues identified in the local community needs assessment. For communities in which a local hospital has made a significant investment in addressing some kind of social disparity, the impact could be significant. Rigorous evaluations of local efforts are needed.

DISCUSSION

The ACA was designed with multiple goals in mind, including a reduction in social disparities in health care and health status outcomes. This was to be accomplished through some novel provisions and also a significant reinfusion of resources into long-standing public programs with an existing track record of progress toward health equity. As such, the potential for the ACA to achieve its intended goals related to "health disparities populations" is strong.

Arriving at its 10th anniversary, there is significant evidence that the ACA has indeed reduced social disparities in some key health care

outcomes, including health insurance coverage, health care access, the use of primary care, and some specific clinical preventive services. Less clear is how the ACA has contributed to improved health outcomes and health equity. The evidence to date suggests that the part of the ACA that has had the greatest impact on health outcomes (including mortality) and social disparities in health is the Medicaid expansion.

Evaluating the impact of the ACA on gains in health equity is quite challenging for several reasons. First, many studies of the impact of the ACA have not conducted the requisite subgroup analyses to determine if racial and other social disparities are narrowing or widening underneath more general findings and trends. Longitudinal data with adequate sample sizes for subgroup analyses by race, ethnicity, income, or educational status is challenging to find. Additional research explicitly focused on the impact of the ACA on disparities and relative gains/impact by race, ethnicity, and other social markers is sorely needed.

Second, synergies between different parts of the ACA make it difficult for evaluation research to detect the specific impact of individual components. It could be that the evidence for the Medicaid expansions is the most robust because this provision has not been implemented in all states and thus allows for more rigorous evaluation research through natural experiments. Third, rather than being novel, many provisions in the ACA build on prior investments in prevention and the health care safety net for underserved populations, which have already been demonstrated to have important impacts on health outcomes and social disparities. Researchers have not focused on reproving the case in the context of reauthorization or continued funding through the ACA.

Although there are many reasons to believe that the ACA has made significant contributions toward health equity in the US, such progress is extremely challenging. It is sometimes the case that interventions that create overall improvements in population health serve to widen rather than narrow disparities in the near term, as majority populations are often the first to be exposed to and benefit from new technologies, programs, and policy reforms.

In addition, as discussed above, since the Trump administration took office in 2017, the ACA has been undermined and weakened in myriad administrative and legal ways, including the rollback of the tax penalty of the individual mandate, restricting outreach and marketing for Marketplace open enrollment, the gutting of the Prevention Fund, and some proposed changes to section 1557. As Michener (2020) argues, even when *policies* are explicitly and intentionally designed to target racial and socioeconomic disparities, *politics* often intercedes to undermine and reverse progress.

After the initial success of the ACA in increasing health insurance coverage and other outcomes, in the single year between 2017 and 2018, the uninsurance rate went back up 7.5% (or 25.6 million people), with larger increases in minority populations (Berchick, Barnett, and Upton 2019). Using the lens of racialized political processes, Michener (2020) reveals how race intersected with politics to drive policy creation and change during the first decade of the ACA, making this large public policy less equitable and more vulnerable to erosion.

One final yet important note: Although high-quality and affordable health care is necessary for population health improvement, it is not sufficient for preventing or significantly reducing social inequalities in health. The upstream drivers of health inequity—the macro-level factors that create systems of disadvantage and structural discrimination (including racism)—are not the primary focus of the ACA. Significant investments are also needed in the upstream social determinants of health, such as high-quality educational systems, employment and income security, affordable housing, safe environments, and institutions free from racism/discrimination (Lantz, Lichtenstein, and Pollack 2007). Key provisions in the ACA can assist in the journey toward high-quality health care and positive health outcomes for all, but are insufficient for addressing the fundamental social, economic, and political factors that drive health inequity in the first place (Link and Phelan 1995).

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Acknowledgments

Graduate students Wendy Hawkins and Tory Lowy provided valuable research assistance. Sarah Rosenbaum gives special thanks to the RCHN Community Health Foundation, whose ongoing gift to the department's Geiger Gibson Program in Community Health Policy has provided core support over so many years of research and scholarship focusing on medical underservice and health equity.

References

Abbott, Laurie S., and Lynn T. Elliott. 2017. "Eliminating Health Disparities through Action on the Social Determinants of Health: A Systematic Review of Home Visiting in the United States, 2005–2015." *Public Health Nursing* 34, no. 1: 2–30.

Artiga, Samantha, Kendal Orgera, and Anthony Damico. 2020. "Changes in Health Coverage by Race and Ethnicity since Implementation of the ACA, 2010–2018." Kaiser Family Foundation, March 5. www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/.

Baumgartner, Jesse C. 2020. "How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care." Commonwealth Fund, January 16. www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access.

Berchick Edward R., Jessica C. Barnett, and Rachel D. Upton. 2019. "Health Insurance Coverage in the United States: 2018." US Census Bureau, November. www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.

Brown, Clare C., Jennifer E. Moore, Holly C. Felix, M. Kathryn Stewart, T. Mac Bird, Curtis L. Lowery, and J. Mick Tilford. 2019. "Association of State Medicaid Expansion Status with Low Birth Weight and Preterm Birth." *JAMA* 321, no. 16: 1598–1609.

Buchmueller, Thomas C., Zachary M. Levinson, Helen G. Levy, and Barbara L. Wolfe. 2016. "Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage." *American Journal of Public Health* 106, no. 8: 1416–21.

Chait, Nadia, and Sherry Glied. 2018. "Promoting Prevention under the Affordable Care Act." *Annual Review of Public Health* 39, no. 1: 507–24.

Chaudry, Ajay, Adlan Jackson, and Sherry A. Glied. 2019. "Did the Affordable Care Act Reduce Racial and Ethnic Disparities in Health Insurance Coverage?" Commonwealth Fund, August 21. www.commonwealthfund.org/publications/issue-briefs/2019/aug/did-ACA-reduce-racial-ethnic-disparities-coverage.

Chen, Jie, Arturo Vargas-Bustamante, Karoline Mortensen, and Alexander N. Ortega. 2016. "Racial and Ethnic Disparities in Health Care Access and Utilization under the Affordable Care Act." *Medical Care* 54, no. 2, 140–46.

Glied, Sherry, Claudia Solís-Román, and Shivani Parikh. 2016. "How the ACA's Health Insurance Expansions Have Affected Out-of-Pocket Cost-Sharing and Spending on Premiums." Commonwealth Fund, September 12. www.commonwealthfund.org/publications/issue-briefs/2016/sep/how-acas-health-insurance-expansions-have-affected-out-pocket.

Goldin, Jacob, Ithai Z. Lurie, and Janet McCubbin. 2019. "Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach." National Bureau of Economic Research, NBER Working Paper No. 26533, December. www.nber.org/papers/w26533.

Goldman, Anna L., Steffie Woolhandler, David U. Himmelstein, David H. Bor, and Danny Mccormick. 2018. "Out-of-Pocket Spending and Premium Contributions after Implementation of the Affordable Care Act." *JAMA Internal Medicine* 178, no. 3: 347–55.

Griffith, Kevin, Leigh Evans, and Jacob Bor. 2017. "The Affordable Care Act Reduced Socioeconomic Disparities in Health Care Access." *Health Affairs* 36, no. 8: 1503–10.

Grogan, Colleen M. 2017. "How the ACA Addressed Health Equity and What Repeal Would Mean." *Journal of Health Politics, Policy and Law* 42, no. 5: 985–93.

Guth, Madeline, Rachel Garfield, and Robin Rudowitz. 2020. "The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review." Kaiser Family Foundation, March 17. www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/.

Han, Xuesong, K. Robin Yabroff, Gery P. Guy, Zhiyuan Zheng, and Ahmedin Jemal. 2015. "Has Recommended Preventive Service Use Increased after Elimination of Cost-Sharing as Part of the Affordable Care Act of the United States?" *Preventive Medicine* 78: 85–91.

Hatch, Brigit, Ning Smith, Mary Ann McBurnie, Thu Quach, Kenneth H. Mayer, Mary J. Dunne, and Erika Cottrell. 2018. "Impacts of the Affordable Care Act on Community Health Centers Characteristics of New Patients and Early Changes in Delivery of Care." *Journal of Ambulatory Care Management* 41, no. 4: 250–61.

Jost, Timothy S. 2018. "The Affordable Care Act under the Trump Administration." Commonwealth Fund, August 30. www.commonwealthfund.org/blog/2018/affordable-care-act-under-trump-administration.

Kiernan, John S. 2019. "States with the Highest and Lowest Uninsured Rates." WalletHub, October 10. wallethub.com/edu/uninsured-rates-by-state/4800/.

Lantz, Paula M. 2013. "The Affordable Care Act and Clinical Preventive Services for Women: Achievements and Caveats." *Womens Health* 9, no. 2: 121–23.

Lantz, Paula M., W. Douglas Evans, Holly Mead, Carmen Alvarez, and Lisa Stewart. 2016. "Knowledge of and Attitudes toward Evidence-Based Guidelines for and against Clinical Preventive Services: Results from a National Survey." *Milbank Quarterly* 94, no. 1: 51–76.

Lantz, Paula M., Richard Lichtenstein, and Harold Pollack. 2007. "Health Policy Approaches to Vulnerable Populations: The Limits of Medicalization." *Health Affairs* 25, no. 5: 1253–57.

Levy, Helen, John Z. Ayanian, Thomas C. Buchmueller, Donald R. Grimes, and Gabriel Ehrlich. 2020. "Macroeconomic Feedback Effects of Medicaid Expansion: Evidence from Michigan." *Journal of Health Politics, Policy and Law* 45, no. 1: 5–48.

Lewis, Corrine, Akeiisa Coleman, Melinda K. Abrams, and Michelle M. Doty. 2019. "The Role of Medicaid Expansion in Care Delivery at Community Health Centers." Commonwealth Fund, May 3. www.commonwealthfund.org/press-release/2019/role-medicaid-expansion-care-delivery-community-health-centers.

Link, Bruce G., and Jo Phelan. 1995. "Social Conditions as Fundamental Causes of Disease." *Journal of Health and Social Behavior* 51, suppl. 1: S28–40. www.jstor.org/stable/2626958?seq=1#metadata_info_tab_contents.

Michalopoulos, Charles, Helen Lee, Anne Duggan, Erika Lundquist, Ada Tso, Sarah Shea Crowne, Lori Burrell, Jennifer Somers, Jill H. Filene, and Virginia Knox. 2015. "The Mother and Infant Home Visiting Program Evaluation: Early Findings on the Maternal, Infant, and Early Childhood Home Visiting Program: A Report to Congress." January. www.acf.hhs.gov/sites/default/files/opre/mihope_report_to_congress_final_1.pdf.

Michener, Jamila. 2020. "Race, Politics, and the Affordable Care Act." *Journal of Health Policy, Politics and Law* 45, no. 4: 547–66.

Miller, Sarah, Sean Alterkruse, Norman Johnson, Laura R. Wherry. 2019. "Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data." National Bureau of Economic Research, NBER Working Paper 26081, August. www.nber.org/papers/w26081.

Miller, Sarah, and Laura R. Wherry. 2019. "Four Years Later: Insurance Coverage and Access to Care Continue to Diverge between ACA Medicaid Expansion and Non-Expansion States." *AEA Papers and Proceedings* 109: 327–33.

Rosenbaum, Sara. 2016. "The Affordable Care Act and Civil Rights: The Challenge of Section 1557." *Milbank Quarterly* 94, no. 3: 464–67.

Rosenbaum, Sara. 2017. "The Community Health Center Fund: What's at Risk?" *Milbank Quarterly* 95, no. 4: 706–9.

Rosenbaum, Sara, Jessica Sharac, Peter Shin, and Jennifer Tolbert. 2019. "Community Health Center Financing: The Role of Medicaid and Section 330 Grant Funding Explained." Kaiser Family Foundation, March 26. www.kff.org/medicaid/issue-brief/community-health-center-financing-the-role-of-medicaid-and-section-330-grant-funding-explained/.

Rozier, Michael, Susan Goold, and Simone Singh. 2019. "How Should Nonprofit Hospitals' Community Benefit Be More Responsive to Health Disparities?" *AMA Journal of Ethics* 21, no. 3: e273–e280.

Sabik, Lindsay M., and Georges Adunlin. 2017. "The ACA and Cancer Screening and Diagnosis." *Cancer Journal* 23, no. 3: 151–62.

Saloner, Brendon, Adam S. Wilk, and Jonathan Levin. 2020. "Community Health Centers and Access to Care among Underserved Populations: A Synthesis Review." *Medical Care Research and Review* 77, no. 1: 3–18.

Sandstrom, Heather. 2019. "Early Childhood Home Visiting Programs and Health." *Health Affairs*, April 25. www.healthaffairs.org/do/10.1377/hpb20190321.382895/full/.

Snyder, Ashley H., Carol S. Weisman, Guodong Liu, Douglas Leslie, and Cynthia H. Chuang. 2018. "The Impact of the Affordable Care Act on Contraceptive Use and Costs among Privately Insured Women." *Womens Health Issues* 28, no. 3: 219–23.

Weinstein, James N., Amy Geller, Yamrot Negussie, and Alina Baciu, eds. 2017. *Communities in Action: Pathways to Health Equity*. Washington, DC: National Academies Press.

Young, Gary J., Stephen Flaherty, E. David Zepeda, Simone Rauscher Singh, and Geri Rosen Cramer. 2018. "Community Benefit Spending by Tax-Exempt Hospitals Changed Little after ACA." *Health Affairs* 37, no. 1: 121–24.