Council on Black Health™
Reimagining Black Health™

LAW AND POLICY STRATEGIES TO ADVANCE BLACK HEALTH:

# An Advocacy Roadmap for the Council on Black Health Policy Roundtable

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# About this Report

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# Purpose

This agenda is intended to support the Council on Black Health and its member organizations and individuals in their efforts to work with state and local decision-makers, government agencies, public health practitioners, and community members to advocate for policies to protect and improve the health of Black communities. It presents 10 policy strategies that are supported by peer-reviewed evidence and backed by experts from the Council on Black Health Policy Roundtable. Most of these strategies were selected for their potential to save lives, advance health equity, and be feasibly implemented at the federal, state, local, or institutional levels (e.g., by schools or health care systems).

# Methods

The policy strategies in this agenda were identified based on information gatheredthrough the following methods:

- **Policy scan:** A review of policies found in peer-reviewed literature, gray literature, and previous policy scans conducted by ChangeLab Solutions across a variety of sectors, including health care, the criminal legal system, civic engagement, housing, schools, planning and the built environment, and labor and employment. Midwifery policies were excluded from the scan. Every state covers midwifery services under Medicaid to some degree, though provider requirements vary. Some states reimburse only certified nurse midwives while others reimburse any licensed midwife.
- **Black legislative caucuses scan:** An analysis of the legislative areas supported by Black Caucuses and the frequency in which these issues were prioritized across the different caucuses. See Appendix B for detailed information about the assessment criteria.
- **Feedback sessions:** Meetings with Council on Black Health Policy Roundtable members representing each of their organizations, which gathered members' perspectives, experiences, and recommendations.
- **Policy assessment:** An assessment of policies identified in the scan across a range of feasibility and impact criteria (e.g., evidence of positive impact on Black health and jurisdiction authority). See Appendix B for detailed information about the assessment criteria.

# Overview of Policy Strategies

The table below lists all policy solutions included in this agenda, each with a brief description. For a more detailed explanation of each policy, please refer to the next section.

| Policy | Description |
|---|---|
| **Increase funding for community health centers** | Encourage increased and sustained governmental and philanthropic investment in community health centers (CHCs)—public and nonprofit entities that provide care to patients in medically underserved areas regardless of the patient's ability to pay. |
| **Pathway programs to strengthen the health care workforce** | A set of policies to improve the recruitment and retention of health care workers that represent populations at the highest risk of poor health outcomes (e.g., rural communities and low income). Examples of these policies include pathway programs, which offer financial aid, educational resources, and mentorship (e.g., internships and training opportunities), as well as academic support, scholarships, holistic review and admission policies, loan forgiveness, partnerships with academic institutions, improved Science Technology Engineering and Mathematics (STEM) education in K–12, and increased hiring and pay transparency. |
| **Increasing state and local minimum wage** | State or local laws that increase the minimum amount employees must be paid per hour above the federal minimum wage of $7.25 |
| **Paid Leave** | ***Paid family leave***. Paid family leave provides employees with paid time off during pregnancy, after the birth or adoption of a child, or when a family member or child requires serious medical care. Paid family leave is distinct from the 12 weeks of unpaid job-protected leave for eligible employees offered by the federal Family and Medical Leave Act (FMLA). |
| | ***Earned paid sick time***. Earned paid sick leave policies require that employers provide paid time off. Usually, this time off is accrued based on time worked and can be used by employees who are ill or caring for an ill family member. These laws or policies may apply to all employers or to employers with employees above a predetermined cap. |
| **Controlling and reducing prescription drug costs** | Reducing the price of prescription drugs, and other reforms, that reduce or limit how much individual patients pay for their prescription drugs. |

Continued on next page

| Policy | Description |
|---|---|
| **Increasing access to doula care** | These state policies cover and reimburse community-based doula services under Medicaid and provide financial support for doula training and workforce development. Community-based doulas often share the social and cultural characteristics of the communities they serve. This alignment leads to more appropriate care and helps build a trusting relationship between doulas and their clients. |
| **Regulating healthcare related use of artificial Intelligence** | Regulate the use of artificial intelligence (AI), algorithms, and related technology to prohibit and/or help prevent AI-related biases in the context of health care decisions and services. |
| **Codifying reproductive choice** | Some states have codified abortion measures that affirm state protections for the right to an abortion and other reproductive rights through amending their state constitutions or through legislative actions. |
| **Zoning for improved food access** | ***Zoning for food production.*** Zoning for food production involves using zoning laws that define and create clear rules and regulations about specific agricultural land uses within urban areas, usually in commercial and residential areas. These zoning laws seek to allow small-scale agricultural production while limiting the potential for nuisances to neighboring properties in the form of sounds, sights and smells. |
| | ***Healthy food overlay districts.*** A healthy food overlay district is a zoning tool that applies an additional set of regulations over one or more existing zoning districts to address challenges or advance development goals specific to that geographic area. The goal is to increase access to and affordability of fresh, nutrient dense foods while limiting the concentration of low nutrition, calorie dense, highly processed foods. Zoning for food production is one tool that can be used within a healthy food overlay district. |

# Policy Strategies

Policy strategies are organized into two sections of this agenda—those that met all or most of the policy assessment criteria and those identified by the Council on Black Health as new and emerging or particularly relevant to members' current work.

Each policy strategy is introduced with a brief description and summarized across the following key sections:

- **Description of the policy and how it works in practice**
  Describes the policy; evidence that the policy affects health or addresses conditions for health; legal restrictions (e.g., preemption) or jurisdictional considerations; notable political challenges in enacting or implementing the policy (e.g., Executive Order, trend of preemptive compliance, etc.)
- **Overview of the policy's impact on Black health and racial equity**
  Briefly describes how the policy addresses health disparities in the Black community; potential to create an outsized positive impact within the Black community; if applicable, likelihood of harmful unintended consequences and/or likelihood that other underserved groups are excluded from the benefits of the policy.
- **Summary of information from policy assessment**
  Summarizes the policy assessment based on the inclusion criteria
- **Examples of the successful implementation of the policy in Black communities**
  Offers examples from institutions, state, or local jurisdictions

## Well-Established Policies to Improve the Health of Black Communities

Policies in this section possess a strong evidence base, as defined by the authors' assessment criteria, and have been implemented in multiple jurisdictions across the U.S.

# Increase Funding for Community Health Centers (CHCs)

## Description of the policy and how it works in practice

Encourage increased and sustained governmental and philanthropic investment in community health centers (CHCs)—public and nonprofit entities that provide care to patients in medically underserved areas regardless of the patient's ability to pay.

For further background, the vast majority of CHCs participate in the Health Resources & Services Administration (HRSA) Health Center Program or are "look-alikes" (meaning they meet all the requirements of the Health Center Program but do not currently receive funding from it). Many CHCs additionally register with the Centers for Medicare & Medicaid Services (CMS), allowing them to receive Medicare and Medicaid reimbursement as Federally Qualified Health Centers (FQHCs). Health centers may also be school based or run by charitable or other social services organizations that provide additional social services or limited medical care.

In 2023, there were about 1,400 HRSA-funded health centers, operating more than 15,000 service sites, which served over 31 million people.[1] Over 43% of CHC revenue came from Medicaid reimbursement, while another 15% came from other federal grants through a combination of HRSA funding and COVID relief payments.[1] Another 25% of CHC funding came from potentially more stable sources, including direct patient payments, Medicare, and private insurance.[2] The remaining 16% of CHC funding came from other grants or forms of revenue (including other federal grants, state and local grants, philanthropic funding, contracts, fundraising, interest, and other miscellaneous sources).[2]

## Health Impact

There is strong evidence, including systematic review, that increased funding for CHCs results in improved access to care, which can be complemented by ensuring and increasing health insurance coverage such as through Medicaid expansion.[3]

## Feasibility

Because Medicaid provides such a large portion of funding for CHCs, the primary policy mechanism to improve their funding is federal advocacy focused on Medicaid (increased funding and increased reimbursement rates). However, to the extent Medicaid funding is threatened by federal policy changes under the Trump administration in 2025 and 2026, CHCs can benefit from sustained and increased state, local, and philanthropic investments, or other changes like increases in other types of federal funding (such as 340B) or value-based payment models.[1]

## Overview of the policy's impact on Black health and racial equity

Numerous studies have shown that CHCs address disparities for BIPOC, low-income, and rural communities, particularly because they provide care regardless of ability to pay, and a patient's ability to pay is affected by the various forms of structural discrimination they face.[3] Nationwide, CHCs served almost 5.5 million Black patients in 2023, making up about 21% of the total CHC patient population.[4] Due to the way race and ethnicity are reported, this is at least a slight undercount. In total, CHCs served over 18 million patients from "racial and/or ethnic minority," backgrounds, making up about 63% of all their patients, some of whom may also count as part of the Black population.[4] In addition, health center look-alikes served almost 200,000 Black patients in 2023, making up almost 20% of their total patient population.[5]

## Summary information from policy assessment

- **Policy status**

  **MODERATE —** While evidence of the health and equity impacts of funding for CHCs is strong, potential policy advocacy in this space is rated as moderate, given (1) the high resource requirements (below) and (2) limitations on using the primary federal policy levers in the policy landscape as of November 2025.

- **Jurisdiction authority (federal, state, county, municipality, other)**
  Federal, state, county, municipality, and other funding can be implemented through any level or organization of government, as well as through private organizations like philanthropies.

- **Resource requirements (high, moderate, low)**
  **HIGH —** CHCs have long been underfunded and need substantial, sustained investment.[1]

- **Return on investment (no, yes-social, yes-environmental, yes-economic)**
  **YES-ECONOMIC —** There is strong evidence that funding for community health centers results in cost savings by providing more preventive care and reducing the need for costlier health services like emergency care.[6] At least one analysis has also looked at the economic impact of CHCs through job creation or support, economic output, and labor income.[6]

- **Legal considerations**
  There are little to no legal considerations that act as a barrier to policy implementation. Barriers are primarily political and budgetary.

- **Strength of evidence (strong, moderate, weak)**
  **STRONG —** There is strong evidence that increased funding for CHCs results in improved access to care, especially for BIPOC, low-income, and rural communities.[6]

- **Equity (yes, unclear/sometimes, no)**
  **YES —** CHCs are present throughout the nation and disproportionately serve Black and other BIPOC patients, increasing equity in access to care.

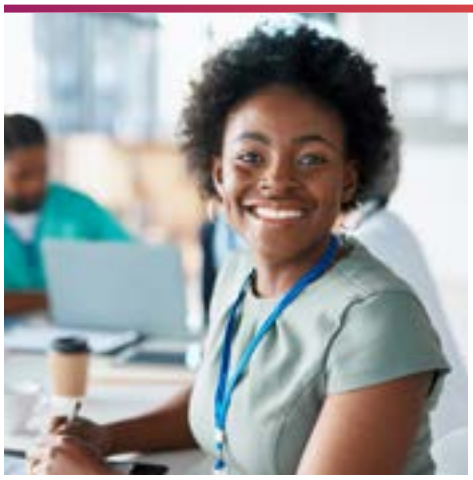
- **Operational approach to equity (structural, procedural, distributional)**
  **STRUCTURAL, PROCEDURAL, AND DISTRIBUTIONAL —** Investment in CHCs contributes to structural change in the health care system through their emphasis on, and availability of, services regardless of ability to pay, and efforts they engage in to address upstream, nonmedical determinants of care.[7] CHCs contribute to increased procedural equity through requirements that recipients of services serve on boards — exercising power over how these dollars are spent and services are implemented. Finally, CHCs contribute to distributional equity by further ensuring availability of health care services in underserved communities.

## Examples of the successful implementation of the policy in Black communities

Others working in this space include KFF, the National Association of Community Health Centers (NACHC), and the Commonwealth Fund. As NACHC has documented, CHCs were originally developed by Black leaders in the 1960s and 1970s as part of the Civil Rights Movement.[8] Examples of successful implementation include:

- Funding and technical assistance for CHCs has been a priority of the New York State Black, Puerto Rican, Hispanic, and Asian Legislative Caucus through their Empower Black New York Agenda.[9] In the past three fiscal years, the New York state legislature has approved appropriations of $450,000 to the Primary Care Development Corporation (PCDC), to provide funding and technical assistance to primary care providers—especially CHCs in underserved communities.[10] PCDC has noted that historical redlining and modern disinvestment in predominantly Black neighborhoods in New York contributes to disparities in access to care and recommends targeted investment in these areas.[11]
- NACHC has conducted assessments of state funding for CHCs in partnership with state Primary Care Associations (PCAs). As of the last published policy assessment in 2024, at least 13 states provided direct funding to CHCs in FY 23, although the report does not identify which specific states provided funding.[12] NACHC's latest, more comprehensive report from FY 2016 indicates that 22 states provided funding to CHC's, either from the state's general budget or from the state's tobacco tax.[13] States with the largest Black populations, or largest proportions of Black population, that provided CHC funding according to this report include: Florida, Georgia, Illinois, Maryland, Mississippi, New York, South Carolina, and Virginia.
- As an example of successful philanthropic funding, the Episcopal Health Foundation (EHF) in Texas has provided sustained funding to at least seven CHCs through its Community Centered Health Homes Initiative since 2017, based on models and funding developed by Prevention Institute and Kresge Foundation.[14] EHF's current strategic framework prioritizes grants related to food and nutrition security, maternal health, and diabetes prevention, in part out of recognition for how these issues disproportionately affect Black communities.[15]

# Pathway Programs to Strengthen the Health Care Workforce



## Description of the policy and how it works in practice

A set of policies to improve the recruitment and retention of health care workers that represent populations at the highest risk of poor health outcomes (e.g., rural communities and low income). Examples of these policies include pathway programs, which offer financial aid, educational resources, and mentorship (e.g., internships and training opportunities), as well as academic support, scholarships, holistic review and admission policies, loan forgiveness, partnerships with academic institutions, improved STEM education in K–12, and increased hiring and pay transparency.

These efforts are particularly important given that the proportion of Black physicians has increased by just four percentage points over the past 120 years, with the share of Black male physicians barely changing since 1940. Most of the increase in Black physicians has come from more Black women entering the field.[16] Research suggests that retention along the physician pipeline is an issue. A 2023 study in JAMA Surgery examined program-reported censuses covering 112,205 individual surgical residents from 2001 to 2018 and found that residents underrepresented in medicine carried a 40% higher relative risk of attrition than their peers.[17] An unpublished Accreditation Council for Graduate Medical Education analysis, reported by STAT in 2022, found that Black physicians were about 5% of all medical residents but nearly 20% of those dismissed in 2015.[18]

Health care worker pipeline programs and financial incentives can be implemented through multiple sources: federal, state, and local governments; public institutions, such as colleges and universities; as well as by private and professional organizations. A few examples include UCLA Medical School Pipeline Program, Rush University Pipeline Program, and organizations such as the Minority Association of Pre-Medical Students. Government Loan Forgiveness Programs designed to support health care professionals include the Health Resources and Services Administration Faculty Loan Repayment Program, the National Health Service Corps Loan Repayment Program, and initiatives from the National Institute of Minority Health Disparities. Some states, such as Illinois and Michigan, offer loan forgiveness for high need professions like behavioral health workers and mental health providers.

Pipeline programs and financial incentives are more efficacious in achieving health care worker diversification when utilized together.

## Health Impact

Health care worker diversity pipeline programs increase not only the overall number of available health care professionals, but the increased diversity of providers improves the care and outcomes of patients from diverse backgrounds. These programs also increase the availability of health care professionals in underserved communities such as rural areas.

## Feasibility

Beginning in January 2025, the Trump administration has issued executive orders and taken other actions attacking diversity, equity, and inclusion (DEI) initiatives throughout the federal government and, in some cases, seeking to undermine DEI initiatives undertaken by nonfederal actors. In general, these attacks on DEI are overly broad, many of the federal government's actions are likely unconstitutional/ illegal and they're being challenged in court, and preemptive compliance could make federal agencies, states and local governments, and private sector organizations vulnerable to legal challenges.[19]

## Overview of the policy's impact on Black health and racial equity

Medical students of color are more likely to be financially burdened by the cost of higher education than their white counterparts.[20] Because of this, participation in pipeline programs becomes especially important. These programs not only help improve attendance and graduation rate of medical students from structurally excluded backgrounds,[21] but also offer support to those who are most financially burdened. Health care workers who received financial support, such as scholarships and loan forgiveness, were more likely to practice in rural areas, high shortage areas, and with medically underserved populations.[22]

Practicing in a diverse community appears to be especially meaningful for underrepresented physicians, who benefit more from the protective effects of diversity than their non-underrepresented peers.[23] This connection is reflected in patient care as well. Black patients experience better health outcomes, lower mortality, and increased life expectancy when cared for by Black doctors, highlighting the broader impact of diversity in medicine for both providers and patients.[22, 24]

## Summary information from policy assessment

- **Policy status**[25]
  Similar policy efforts have been implemented across multiple jurisdictions, including several states and federal public health agencies.

- **Jurisdiction authority (federal, state, county, municipality, other)**
  These policies and programs have been implemented at the state and federal levels in addition to various professional health care and social justice organizations, such as the American Association of Colleges of Nursing and the United Negro College Fund.

- **Resource requirements (high, moderate, low)**
  While pipeline programs may require a moderate level of financial investment to implement mentoring, tutoring and increased stem education, there is a high-level financial investment that is required for the implementation of scholarships and loan forgiveness.

- **Return on investment (no, yes — social, yes — environmental, yes — economic)**
  There are both social and economic returns from this policy investment. On the social benefit side, health care workers who received financial scholarships and loan forgiveness were more likely to practice in rural areas and high shortage areas with medically underserved populations.[20] There are also potential economic benefits from improved workforce health in those rural and underserved areas.

- **Legal considerations**[25]
  Before January 2025, many of these programs were race conscious. Since then, the administration has issued several executive orders targeting DEI efforts at all levels of education.

- **Strength of evidence (strong, moderate, weak)**
  There is moderate evidence that shows that pipeline efforts improve the recruitment and retention of Black physicians. The evidence is even stronger when multipronged pipeline efforts that include financial incentives are utilized together.

- **Equity (yes, unclear/sometimes, no)**
  **YES**

- **Operational approach to equity (distributional, procedural, structural)**
  **DISTRIBUTIONAL EQUITY** — These policies ensure that financial resources and other efforts are dedicated to underserved populations to ensure that they are adequately prepared to have rewarding medical careers and serve the most vulnerable patients.

## Examples of the successful implementation of the policy in Black communities

### The United Negro College Fund's Health Care Worker Diversity Program

The United Negro College Fund (UNCF) partnered with the global pharmaceutical company AbbVie and several Historically Black Colleges and Universities (HBCUs) to launch a health care worker diversity program. The program provides Black people interested in health care careers with $5,000 scholarships, mentorship and other academic and career development support. AbbVie donated $10 million for scholarships and the AbbVie employees volunteer to provide students with mentorship and career coaching. Across

all fields of study, UNCF reports raising more than $5 billion and supporting more than 500,000 students on their college journeys since its founding in 1944.[26]

### The Health Resources and Services Administration (HRSA) Health Careers Opportunity Program (HCOP) Academies and Health Careers Opportunity Program Skills Training and Health Workforce Development of Paraprofessionals (HCOP Skills)

HCOP Academies assist and prepare students from disadvantaged backgrounds in meeting the admissions requirements and completing their health profession degrees and certificates. The program improves the recruitment and retention of these students by utilizing tailored enrichment programs designed to meet the academic and social needs of the students. They also provide opportunities for community-based experiential health professions training in underserved communities. Between 2008 and 2024, the program distributed just over $147 million to these efforts.

HRSA assessed the impact of these programs for the 2017–2018 academic year and found that the HCOP and HCOP Skills programs enrolled 5,017 and 683 trainees respectively, with 71% and 76% being from an underrepresented minority group.[27] A large share of trainees served in medically underserved communities and rural areas.

### Illinois Behavioral Health Workforce Education Center

The Illinois Behavioral Health Workforce Education Center (The Center) is a joint initiative between the Department of Human Services and the Illinois Board of Education designed to address the shortage of behavior and mental health providers, particularly from diverse backgrounds and with lived experience. The Center developed the Certified Recovery Support Specialist (CRSS) Success Program.

The CRSS program provides scholarships to eligible students from diverse backgrounds and lived experience with mental health and substance use recovery. The funding can be used for a comprehensive list of support and include but are not limited to things such as[28]:

- Tuition
- Books
- Fees
- Illinois Certification Board (ICB) credentialing fees
- Stipends for internships
- Clothing for internships
- Childcare
- Transportation
- Housing support
- Laptops

Students can apply for scholarships at a variety of public colleges, community colleges, and universities throughout the state.

While the program did increase the diversity of mental health providers, the diversity of providers varied greatly by region.[29] For example, providers in Central and Southern Illinois remained majority white. The Chicago region on the other hand had an overrepresentation of Black and Latino providers. Despite these variations in provider diversity, the distribution is strongly correlated with the overall demographic makeup of those regions.

# Increasing State and Local Minimum Wage

## Description of the policy and how it works in practice

State or local laws that increase the minimum amount employees must be paid per hour above the federal minimum wage of $7.25.

## Health Impact

Increased minimum wages are associated with "reduced rates of mortality due to suicides, alcohol, or drugs," reduced rates of low birth weight among low-wage workers, reduced incidence of smoking, and "improved parent-reported health among young children."[30] Conversely, low minimum wages negatively impact health by affecting individual and household ability to meet basic needs for things like food, shelter utilities, transportation, and medical care.[31] Low minimum wages have been associated with other negative health impacts, such as difficulty affording childcare and substandard living conditions.[31]

## Feasibility

Most Black Belt states have no state minimum wage above the federal floor of $7.25. Alabama, Louisiana, Mississippi, South Carolina, and Tennessee have no state minimum wage at all. Georgia sets a statutory minimum of $5.15. North Carolina sets its minimum at the federal rate. In each of these states, the federal minimum of $7.25 applies to covered workers.

About half of all states have enacted laws that prohibit local governments from increasing their own minimum wages.[32] No new states have preempted local minimum wage laws since 2019, and the majority of state preemption was already in place prior to 2015.

In some states, this means the federal minimum wage of $7.25 applies, while in other states a higher state minimum wage may apply. According to the National Conference of State Legislatures, as of January 1, 2025, 32 states have minimum wages higher than $7.25.[33] Ten states and Washington, D.C., have minimum wages of $15 or

**States Preempting Local Minimum Wage Laws**

- Alabama (2016)
- Arkansas (2017)
- Florida (2003)
- Georgia (2004)
- Idaho (2016)
- Indiana (2011)
- Iowa (2017)
- Kansas (2013)
- Kentucky (2017)
- Louisiana (1997)
- Michigan (2015)
- Mississippi (2013)
- Missouri (2015)
- North Carolina (2016)
- North Dakota (2019)
- Ohio (2016)
- Oklahoma (2014)
- Oregon (2001)
- Pennsylvania (2006)
- Rhode Island (2014)
- South Carolina (2002)
- Tennessee (2013)
- Texas (2003)
- Utah (2001)
- Wisconsin (2005)

higher.[33] According to the Congressional Research Service, as of October 3, 2024, 20 states and D.C. index, or are scheduled to index, their state minimum wage based on some established measure of inflation, such as a version of the Consumer Price Index (CPI).[34]

It is important to note that even though several states have no minimum wage above the federal floor, few workers report earning that exact rate. In 2024, about 1.0% of hourly paid workers earned at or below the prevailing federal minimum wage of $7.25.[35] That share understates the reach of low pay. Oxfam's 2024 analysis found that more than 39 million workers, about 23% of the US workforce, earn less than $17 per hour.[36]

In addition, minimum wage can be affected by case law. While Kentucky passed a minimum wage preemption statute in 2017, the Kentucky Supreme Court had already found in a 2016 decision that localities did not have the authority to pass their own minimum wage laws.[32] This means if minimum wage advocacy were to be pursued in Kentucky, changes could only happen at the state legislative level. Even if the legislature repealed its preemption of local minimum wage laws, localities would not be able to pass their own minimum wage laws because they would still be bound by the state supreme court's decision. For local change, the legislature would likely have to pass a statute expressly granting authority to localities to regulate their own minimum wage. While this may be unique to minimum wage in Kentucky, case law review would likely need to be conducted for all policies based on the specific jurisdictions where advocacy is planned.

Some businesses and decision-makers also oppose increased minimum wage on economic grounds, arguing that it could result in loss of jobs and disproportionately burden small businesses, while advocates argue that increased minimum wage benefits businesses by "boosting employee productivity, reducing turnover rates, and enhancing consumer spending."[31]

## Overview of the policy's impact on Black health and racial equity

In 2024, 32% of Black workers earned less than $17 per hour, compared with 21% of white workers and 23% of the workforce overall.[36] The share is higher for Black women, at 35%. Low pay is concentrated in states that have not raised their wage floor above $7.25, including the Black Belt states of Mississippi, Louisiana, and North Carolina, where 33.9%, 30.9%, and 28.8% of all workers respectively earn less than $17 per hour.[36]

Low minimum wages also disproportionately impact women, youth, and people with less education.[31] An increasing number of workers may fall outside of minimum wage protections, such as exceptions for "tipped workers, workers with disabilities, and independent contractors" as well as students and gig workers.[31] As an example, Black people are more likely to be independent contractors and, therefore, potentially less likely to benefit from legal requirements to increase the minimum wage.[31] Tipped workers are also disproportionately Black, stemming from the use of tipping as a form of exploitation of newly emancipated slaves following the Civil War.[37]

Nevertheless, increased minimum wage policies are, overall, likely to provide a disproportionate benefit to Black communities.[37]

## Summary information from policy assessment

- **Policy status**
  **STRONG** — The policy has been implemented and can be implemented in many jurisdictions; there is strong evidence it improves Black health and equity, despite legal barriers in some states due to preemption.

- **Jurisdiction authority (federal, state, county, municipality, other)**
  **STATE, COUNTY, MUNICIPALITY, OTHER** — Minimum wages can be increased through state and local legal requirements, while employers can also voluntarily choose to pay higher wages. Increased wages can also be implemented through wage boards.[38]

- **Resource requirements (high, moderate, low)**
  **MODERATE** — States and localities may need to invest in enforcement to ensure that labor and employment laws like minimum wage are enforced and enforced equitably. For example, women, Black, and low-income communities are disproportionately burdened by underpayment and wage theft.[37] To the extent that minimum wage

laws apply to government employees, increases in minimum wage will also increase government spending, although overall it may result in cost savings through reductions in other expenditures (see below).

- **Return on investment (no, yes—social, yes—environmental, yes—economic)**
  YES—ECONOMIC AND SOCIAL—Studies have found that increases to minimum wage can result in large savings on government benefits programs like CHIP, TANF, and SNAP, while also reducing government health care expenditures through increasing access to preventive care and better nutrition.[31]

- **Legal considerations**
  Local minimum wage laws may be preempted by state law, and in rare instances, courts have found that localities lack authority to pass minimum wage laws.

- **Strength of evidence (strong, moderate, weak)**
  STRONG

- **Equity (yes, unclear/sometimes, no)**
  YES—Increasing minimum wage improves equity, with the small caveat that some Black workers are disproportionately likely to fall outside of legal protections, so changes to wage policy should take into account potential gaps, such as those for tipped workers, independent contractors, and sectors like agriculture.

- **Operational approach to equity (distributional, procedural, structural)**
  DISTRIBUTIONAL—Increasing minimum wage can result in more equitable distribution of economic resources in Black and lower-income communities.

## Examples of the successful implementation of the policy in Black communities

Several states with either a large Black population by number or a high proportion of Black residents have minimum wage requirements that exceed the federal minimum wage, including Florida, New York, California, Maryland, Illinois, Virginia, Ohio, Washington, D.C., and Delaware.[33]

Increasing wages has been a priority of the Texas, Virginia, and New York Black legislative caucuses, with the New York Caucus having a particular focus on supporting human services workers

**Other successful implementation examples include:**

- Colorado repealed its preemption of local minimum wage laws in 2019.[32]
- Nationwide upward of 65 localities have adopted their own minimum wage laws.[39]
- Others working in this space include the Economic PolicyInstitute and Oxfam.

# Paid Family Leave

## Description of the policy and how it works in practice

Paid family leave (PFL) provides employees with paid time off during pregnancy, after the birth or adoption of a child, or when a family member or child requires serious medical care. Length of leave, amount of benefit, job protection, and qualifying conditions vary by employer and state. Paid family leave is distinct from the 12 weeks of unpaid job-protected leave for eligible employees offered by the federal Family and Medical Leave Act (FMLA). Currently, 14 states and Washington, D.C., provide at least six weeks of paid family and medical leave.[40]

## Health Impact

PFL policies offer the greatest potential benefits to low-income workers and workers of color. Studies have demonstrated that access to PFL has a positive effect on social determinants of health through advancing employment opportunities, public health, and economic security for families, thus improving health equity for all workers.[41] These effects are especially important for women of color who make up nearly 50% of low-wage workers.[42] PFL policies have been associated with improvement in infant health, decreased likelihood of preterm birth and infant mortality, increased parental bonding, and improved maternal, physical and mental health.[41] Additionally, many fathers report wanting to have a greater role in caring for young children and PFL has been associated with greater paternal involvement in childcare activities even after leave ends.[41] Despite these advantages, in the United States, only 6% of low-wage workers have access to PFL. Several studies have found that workers of color and part-time workers are significantly less likely to work for employers that offer PFL.[42] Moreover, a recent report examining the PFL policies of the nation's top 60 private employers revealed that half of the companies that disclosed their PFL policy information had "discriminatory policies that leave out fathers, adoptive parents, and low-wage employees."[43]

## Feasibility

State paid family leave policies are typically financed through payroll contributions or deductions (premiums) that provide coverage for the full cost of benefits and administration of the program.[44] Although state funding may be provided to start up paid family leave programs, these funds will be paid back to the state after implementation of the policy.[44] Premiums for PFL can be paid by workers, employers, or both. On January 14, 2025, the Wage and Hour Division (WHD) of the U.S. Department of Labor (DOL) issued an opinion letter stating that employers cannot require employees to use their employer-provided paid time off such as vacation time while the employee is taking leave under the FMLA and receiving pay under a state or local PFML program. The WHD explained that the "DOL's FMLA regulations on substitution of paid leave apply to leave taken under a PFML program in the same way they apply when an employee is on FMLA leave and receiving benefits under a paid disability plan."[45]

Several states[46] have implemented laws that preempt local laws from requiring private employers to provide paid family leave.[32] In response, local governments in over 30 states have enacted PFL policies for their own government employees.[47] Similarly, six states—Georgia, Nevada, New Hampshire, South Carolina, Texas, and Utah—offer PFL for state employees.[48] Additionally, Rhode Island, Maine, and Oregon passed state laws that prohibited local governments from developing more restrictive paid family leave requirements that differ from state standards. As of February 2025, 14 states and Washington, D.C., have enacted mandatory paid family leave policies while an additional 10 states have voluntary policies that provide paid family leave through private insurance.[49]

## Overview of the policy's impact on Black health and racial equity

Black women are more likely to be the primary or co-breadwinners for their households, primary caregivers, and are among the highest demographics of labor participation in low-paid jobs with little benefits. An estimated 38% of Black women who need leave do not take it, 55% take parental unpaid leave, and 36% take unpaid caregiver leave. Increased access to paid family leave will help Black women to retain and sustain their economic stability, while maintaining their physical and mental health. There is a small body of evidence that examines the economic and physical impact of paid

family leave policies by racial demographics. For example, a study of California's PFL law suggests that the largest increases in leave-taking after implementation were among Black mothers.[50] Another study that simulated leave-taking under various policy scenarios suggests that paid family leave would allow Black workers to gain a greater percentage of their family income back in comparison to white workers but would ultimately have less impact on the prevention of short-term economic hardships.[50]

However, it is important to ensure an equitable uptake of PFL policies that consider historical marginalization and discrimination of those most in need of the policy. For example, in 2016, Washington, D.C., implemented the Universal Paid Leave Amendment Act that established a paid family and medical leave program.[51] Due to the interconnectedness of Washington, D.C., Maryland, and Virginia, any private worker who spent more than 50% of their work time in the District was eligible. However, for the first 18 months after implementation, uptake rates for PFL were unequally distributed among the population and across the wards of the city. At face value, claims made by Black residents were comparable to their white counterparts. However, when examining uptake rates by ward and economic demographics, wards with higher rates of Black residents — who also reside in lower-income wards — had the highest rates of denial for paid leave applications. This highlights the need for additional administrative resources to help residents navigate the process successfully.

## Summary information from policy assessment

- **Policy status**
  **STRONG** — The policy has been implemented and can be adopted in many jurisdictions; there is moderate evidence it improves Black health and equity when key considerations are incorporated to ensure equitable implementation.

- **Jurisdiction authority (federal, state, county, municipality, other)**
  **STATE, COUNTY, MUNICIPALITY** — PFL policies can be increased through state and local legal requirements, while employers can also voluntarily choose to implement policies for PFL.

- **Resource requirements (high, moderate, low)**
  **HIGH** — States and localities will need to invest funding and administrative support in establishing and implementing sustainable PFL policies.

- **Return on investment (no, yes—social, yes—environmental, yes—economic)**
  **YES — ECONOMIC AND SOCIAL** — PFL policies have demonstrated both economic and social benefit. Economically, families are less likely to experience financial stress and reduced gender bias in the workforce. Socially, parents are afforded more time to spend bonding and supporting their children.

- **Legal considerations**
  There are some states that have preempted local governments from implementing PFL policies. Additionally, depending on the funding mechanism for PFL policies, there might be some legal considerations for how these policies are funded and regulated (i.e., qualifying employers, qualifying events, etc.).

- **Strength of evidence (strong, moderate, weak)**
  **MODERATE** — While there is strong evidence demonstrating positive financial, physical, and mental health benefits of PFL policies as well as equitable outcomes, there is little evidence that focuses specifically on the impact on Black families and women.

- **Equity (yes, unclear/sometimes, no)**
  **SOMETIMES** — PFL policies have the potential to improve equity outcomes; however, implementation of these policies can either exacerbate or improve equity outcomes.

- **Operational approach to equity (distributional, procedural, structural)**
  **STRUCTURAL AND DISTRIBUTIONAL** — PFL policies promote economic equity and gender pay equity for Black families, which have historically worked in jobs that don't permit PFL or only offer a limited amount of PFL.

## Example of the successful implementation of the policy in Black communities

California has been a leader in implementing PFL policies at state and local levels.[52] MomsRising, the Black Maternal Health Caucus, and the NAACP have also been involved in some advocacy efforts.

In 2009, California became the first state to implement a PFL policy The policy permits up to 12 weeks (up to four weeks before birth and six or eight weeks after birth) of PFL for expectant mothers and birthing individuals. As of 2025, California provides a maximum wage replacement rate of at least 90% for lower earners.[53] Eligibility for PFL is broad for family leave programs and has an inclusive approach to tenure and contribution requirements to ensure the majority of workers who earn wages in California are eligible.[53] Additionally, California also provides job protection for those who choose to take family leave. One study found that after passage of the law, mothers in CA took double the amount of leave, with Black and Hispanic mothers as the groups showing the greatest gains.[54]

# Earned Paid Sick Leave

## Description of the policy and how it works in practice

Earned paid sick leave policies require that employers provide paid time off. Usually, this time off is accrued based on time worked and can be used by employees who are ill or caring for an ill family member. These laws or policies may apply to all employers or to employers with employees above a predetermined cap.

Paid sick leave is shown to reduce the transmission of COVID-19 and other communicable diseases in the workplace.55 Paid sick leave also has the potential to improve health indicators and outcomes due to improved access and capacity to take advantage of preventive screenings and care. Studies indicate that workers without paid sick leave are 1.6 times more likely to forgo medical care for their family and three times more likely to avoid medical care for themselves.[56]

## Health Impact

Paid sick leave improves health for all workers and their families by encouraging the use of preventive care and reducing the spread of communicable diseases.

## Feasibility

Earned paid sick time can be implemented at the state, county, or local level. Some local jurisdictions with earned sick leave policies include Chicago, IL, Bloomington, MN, and Montgomery County, MD. It has also been implemented in states such as Arizona, California,

Colorado, Connecticut, Illinois, Maine and Maryland.[57] However, some states prohibit local jurisdictions from enacting their own paid sick leave requirements, these include:[58]

- Alabama (2014)
- Florida (2013)
- Arkansas (2017)
- Georgia (2004)
- Mississippi (2013)
- Missouri (2015)
- Maine (2019)
- North Dakota (2021)
- Wisconsin (2011)
- Michigan (2015)
- Rhode Island (2017)
- Oregon (2015)
- Iowa (2017)
- Indiana (2013)
- Ohio (2016)
- New Jersey (2018)
- Kentucky (2017)
- Tennessee (2013)
- North Carolina (2016)
- South Carolina (2017)
- Oklahoma (2014)
- Louisiana (2012)
- Texas (2023)
- Maryland (2018)
- Kansas (2013)

Preemption and a statewide standard can operate together. In several states on this list, including Maine, Maryland, Michigan, New Jersey, Oregon, and Rhode Island, a statewide paid sick leave law sets a single floor for all workers while state law bars cities and counties from adopting their own, often stronger, ordinances. Advocacy in those states runs through the legislature rather than city hall.

There has been some opposition to paid sick leave laws mainly from various chambers of commerce and business associations regarding the additional cost. Some groups that have opposed Chicago's paid sick leave policy (discussed below) include the Illinois Restaurant Association, the Chicagoland Chamber of Commerce, the Illinois Hotel and Lodging Association and a group of Black Chicago restaurant owners. The Black restaurant owners in Chicago have expressed that they are severely under resourced compared to white restaurant owners and, therefore, do not have the fiscal capacity to maintain current staffing levels and the required PSL policies. It is also well documented that Black-owned businesses disproportionately hire Black employees. This could potentially lead to reduced Black employment.

## Overview of the policy's impact on Black health and racial equity

Paid sick leave isn't distributed evenly across the workforce. Workers in service, production, construction, maintenance, and transportation roles—especially those in the private sector, at smaller companies,or with less job tenure—are much less likely to have access to paid sick leave than their counterparts in management or professional

positions.[59, 60] Part-time employees are also at a disadvantage, and since women are more likely to hold low-wage or part-time jobs, they're disproportionately affected by a lack of paid leave.[60]

Access tends to improve as companies get larger and as employees stay longer, but many still fall through the cracks. For example, Fedewa and colleagues (2017) found that 40% of workers eligible for crucial cancer screenings like cervical, breast, and colorectal are employed by small businesses, which often hire people with lower socioeconomic status.[59] These workers face additional barriers to getting screened that go beyond lack of insurance.

Racial disparities are also stark. Paid sick leave policies overwhelmingly benefit higher-paid white workers, while only about half of Black and Latina workers have access to these benefits. The stakes are especially high for women of color As of 2017, 84.4% of Black mothers were the primary or sole breadwinners for their families, and Black women make up 40% of all family caregivers. Without paid sick leave, many women of color are forced to leave the workforce to care for their families, highlighting just how urgent it is to improve access for historically marginalized workers.[61, 62]

## Summary information from policy assessment

- **Policy status**
  Paid sick leave policies have been implemented across several states and cities.[57]

- **Jurisdiction authority**
  States, counties and local governments have jurisdictional authority to implement earned and paid sick leave policies.

- **Resource requirements**
  There is a low cost to governments to enact these earned sick leave policies. However, depending on the size of the employer, there may be a moderate to high relative cost of implementation. This means that smaller employers will pay a higher share of revenue toward earned paid sick leave benefits when compared to larger employers.

- **Return on investment**
  The ROI from paid sick leave mainly comes from lower turnover rates and higher productivity. The dollar-value ROI varies by industry, with tech companies experiencing a $2.64 ROI for every $1 invested, whereas manufacturing experienced a $2.57 return.[63] Paid sick leave saved employers between $0.63 and $1.88 billion per year in influenza-like illness-related absenteeism cost from 2007 to 2014 (in 2016 dollars).[64]

- **Legal considerations**
  Some states prohibit local jurisdictions from implementing their own paid sick leave requirements.

- **Strength of evidence**
  There is a strong body of evidence that demonstrates the health and economic benefits of earned paid sick leave.

- **Equity**
  YES

- **Operational approach to equity**
  Earned paid sick leave policies address equity at a structural level by ensuring that all workers have access to the same opportunities for caring for themselves and loved ones regardless of the classification of employment i.e., white collar vs. blue collar.

## Examples of the successful implementation of the policy in Black communities

### Chicago

Chicago City Council enacted the Chicago Paid Leave and Paid Sick and Safe Leave Ordinance to be implemented beginning July 1, 2024. This ordinance outlines paid time off requirements for general PTO and sick leave for employers. Any employee that works at least 80 hours within any 120-day period is eligible for both PTO and PSL. This policy applies to day laborers regardless of their immigration status. PSL accrues at a rate of one hour for every 35 hours worked.[65]

Employees are eligible to use the accrued PSL no later than 30 days after beginning employment. PSL may be for care and recovery of the employee or the care of the employee's family member. Eligible circumstances include:[66]

- Illness or injury that requires professional care, including preventive care, diagnosis or treatment of medical, mental or behavioral issues, including substance abuse disorders.
- Victims of domestic violence, sexual assault or stalking.
- School, class or place of care closure due to a public health emergency.
- Requiring isolation or quarantine to minimize the transmission of a communicable disease.

Some Black owned business owners have expressed opposition to earned and paid sick leave policies because they are under resourced when compared to their white business owner counterparts. As such, it would be more of a financial burden to implement these policies resulting in potential closures and layoffs.

# Controlling and Reducing Prescription Drug Costs

## Description of the policy and how it works in practice

Reducing the price of prescription drugs, and other reforms, that reduce or limit how much individual patients pay for their prescription drugs.

While numerous policies could affect prescription drug prices, a 2024 study by the Congressional Budget Office found that setting a maximum price or limiting price growth for prescription drugs would have the largest potential effect on reducing prices.[67] Proposals with more moderate potential included increasing the number of drugs in Medicare price negotiation, expanding the benefits of negotiated prices to commercial insurance, and requiring drug manufacturers to pay governments if they raise prices above the rate of inflation.[67]

At the federal level, the Trump administration issued two executive orders in April and May 2025 that build on work begun under the Inflation Reduction Act to reduce prescription drug prices. In terms of the most potentially impactful policies identified above, these executive orders require HHS to develop further guidance on Medicare drug price negotiation68 and to either encourage or require drug manufacturers to cap U.S. drug payments at most-favored-nation pricing.[69]

According to the National Academy for State Health Policy, as of May 1, 2025, just 10 states have enacted Prescription Drug Affordability Boards (PDABs), which review drug affordability and can set upper payment limits or caps on pricing.[70] In the 2025 legislative session, 14 states are considering bills related to PDABs, while six states are considering bills related to reference rates, which would limit drug pricing in the state based on some established external reference, such as those the federal government negotiates through Medicare.[71] These reference rates can help states enact the more moderate policy described above—expanding the benefits of negotiated prices to commercial insurance. Finally, states may have

the authority to enact the other more moderate policy described above, applying inflation rebates to commercial health plans.[72]

At the federal level, other strategies to reduce prescription drug costs include reforming Medicaid drug rebates and reforming 340B drug pricing.[73] At the federal and state levels, other policy strategies include, but are not limited to, reducing consumer expenses through limits on cost sharing and out-of-pocket caps, drug importation, increasing access to generics and biosimilar drugs, and transparency in brand-name drug pricing.[70]

## Health Impact

About 60% of adults in the U.S. take at least one prescription medication.[74] The U.S., when compared with similar nations, consistently has the highest per capita spending on prescription drugs.[75] In 2021, over 9 million adults reported not taking prescription medication due to cost.[74] Based on poll data from KFF in 2023, 55% of adults were worried about affording prescription medication, 28% experienced difficulties affording prescription medication, and 31% did not take medicine as prescribed due to cost.[76]

## Feasibility

In addition to the challenges posed by the federal policy landscape as of November 2025, as states increasingly seek to intervene on prescription drug prices, their regulatory efforts have faced some legal challenges, primarily under federal preemption and the Commerce Clause.[77] These challenges have mostly involved laws seeking to regulate Pharmacy Benefit Managers (PBMs), price transparency, and price gouging.

## Overview of the policy's impact on Black health and racial equity

There are well-documented disparities in prescription access and affordability for Black communities, as well as inequities affecting other BIPOC groups, women, people with disabilities, people with lower income, and uninsured people. These inequities include concerns about affording prescriptions, actual difficulty paying for medications, and not taking medicine as prescribed.[74, 76] More expansive policy efforts to address prescription drug pricing, and targeted efforts to reduce the cost of medicine that treat conditions disproportionately impacting these populations, can further help improve equity.[78]

## Summary information from policy assessment

- **Policy status**
  **MODERATE**—While there is strong evidence of disparities in prescription medication affordability, there is more moderate evidence for which legal or policy mechanisms most effectively address these disparities.

- **Jurisdiction authority (federal, state, county, municipality, other)**
  **FEDERAL, STATE**—Regulations of prescription medication prices are enacted at the federal and state level.

- **Resource requirements (high, moderate, low)**
  **MODERATE**—States may need to invest in order to establish a PDAB and to enforce payment limits or other regulations like reference rates and rebates. At the federal level, continued funding is needed to support Medicare drug pricing negotiation and other efforts to enact price limits.

- **Return on investment (no, yes—social, yes—environmental, yes—economic)**
  **NO**—No research identified demonstrating ROI.

- **Legal considerations**
  The most promising prescription drug pricing policies are legally feasible with little to no risk, even though other potential state regulations have faced some challenges.

- **Strength of evidence (strong, moderate, weak)**
  **MODERATE**—Again, while there is strong evidence of prescription medication disparities, there is more moderate evidence for which legal or policy mechanisms most effectively address these disparities.

- **Equity (yes, unclear/sometimes, no)**
  **UNCLEAR/SOMETIMES**—Less comprehensive drug pricing regulation can perpetuate disparities in terms of who benefits. For example, Medicare drug pricing negotiation primarily benefits white communities as the majority (over 70%) of Medicare beneficiaries are white.[78] In addition, addressing prescription drug pricing only benefits those who already have access to the health care system and prescription drugs. Equity could be greater improved by pairing regulation of prescription drug pricing with other efforts to increase access to health care, such as funding for community health centers.

- **Operational approach to equity (structural, procedural, distributional)**
  Structural, procedural, and distributional — Regulation of prescription drug pricing involves making structural changes in the U.S. health care and prescription medication system. These regulations often seek to make decision-making processes fairer and transparent and ultimately result in more equitable distribution of and access to prescription medication across communities.

## Examples of the successful implementation of the policy in Black communities

Addressing prescription drug costs has been a priority of the Maryland and Virginia Legislative Black Caucuses. Others working in this space include the National Academy for State Health Policy (NASHP).

NASHP has a library of model legislation.[79]

In the 2023 legislative session, Colorado, Maryland, Minnesota, and Oregon enacted laws related to PDABs and affordability review.[80] In total, 18 states considered bills related to affordability review, reference rates, or regulation of unsupported price hikes.[80]

In the 2024 session, Colorado and Vermont enacted laws related to Prescription Drug Affordability Boards and affordability review.[81] Colorado's PDAB conducted the first state-level affordability reviews in the nation—reviewing one drug in 2023, and four drugs in 2024.[83] The board found three drugs to be unaffordable and eligible for price regulation. The drugs are all primarily used to treat various chronic inflammatory diseases, which may disproportionately impact Black communities.[84] In 2025, the Colorado PDAB is still developing its rules and processes for establishing an upper payment limit (UPL) for these drugs, and future drugs, found to be unaffordable.

In total during the 2024 session, 20 states considered bills related to affordability review, reference rates, or regulation of unsupported price hikes.[81]

# Increasing Access to Doula Care[84]

## Description of the policy and how it works in practice

These state policies cover and reimburse community-based doula services under Medicaid and provide financial support for doula training and workforce development. Community-based doulas often share the social and cultural characteristics of the communities they serve. This cultural alignment leads to more appropriate care and helps build a trusting relationship with doulas and their clients.[85] Research shows that doula care is associated with reduced premature deliveries, shorter length of labor, and less C-sections. Complications such as death, cardiac arrest, blood clots and infections are three times more common following a C-section. Doula care is also shown to reduce stress and anxiety in mothers. Among low-income women, doula care was shown to improve breastfeeding success.[86]

## Health Impact

Medicaid expansion to cover doula care is shown to improve health outcomes for both mothers and their infants by improving breastfeeding rates and lowering hospital interventions and complications such as C-sections.

## Feasibility

If there are significant federal cuts to the Medicaid budget, states may be limited in their ability to offer Medicaid coverage and reimbursement for doula services. Typically, states must apply to the CMS for a State Plan Amendment to their Medicaid program in order to initiate or change Medicaid coverage and reimbursement of doulas. This process limits state authority and gives the federal government partial control over these decisions.[87] Medicaid cuts could force states to limit doula coverage, for example, by reducing the number of prenatal visits or limiting coverage during labor and delivery only. These restrictions could weaken the policy's efficacy to reduce maternal and infant mortality. If covered by Medicaid, there are additional policy choices around whether to implement doula

coverage through preventive services, services of licensed practitioners, clinic services, or freestanding birth center services.[88] To the extent this policy is limited by federal actions, jurisdictions can explore other state and local funding mechanisms to support doula services, such as requiring private insurers to cover doula services through state legislation.[89]

## Overview of the policy's impact on Black health and racial equity

In 2024, the most recent year of final data, the maternal mortality rate for Black women in the United States was 44.8 deaths per 100,000 live births, compared with 14.2 for white women, according to the National Center for Health Statistics.[90] Black mothers also experience disproportionately higher rates of premature births and low birth weights. These disparities can be attributed to several factors, including racism in health care, limited access to prenatal care, and broader gaps in education and socioeconomic status. Since Medicaid covers 65% of births to Black mothers compared to 42% of all births nationally, this policy intervention would very likely improve maternal and infant mortality and health for Black and low-income mothers by improving access to supportive, culturally responsive, and community-based prenatal care.[91] Expanding access to doulas, for example, has been shown to improve health outcomes like lower C-section rates and increased rates of breastfeeding.[92, 93]

## Summary information from policy assessment

- **Policy status**
  The policy has been implemented in approximately 23 states and D.C.[94]
- **Jurisdiction authority**
  Medicaid expansion to cover doula care is implemented at the state level.
- **Resource requirements**
  A moderate number of additional resources are needed to reimburse doulas for the supportive care they provide.
- **Return on investment**
  There is an economic return on investment. Doula care is shown to reduce costly hospitalizations, C-sections and other high-cost interventions.

- **Legal considerations**
  States must apply to the CMS for a State Plan Amendment to their Medicaid program in order to initiate or change Medicaid coverage and reimbursement of doulas.

- **Strength of evidence**
  There is moderate evidence that supports the positive impacts of doula care on maternal and infant health and mortality. Doula care by itself cannot address all causes of poor maternal health due to long-standing systemic factors linked to environment, education, diet, and other social determinants of health.

- **Equity**
  YES

- **Operational approach to equity**
  Distributional equity because it allocates additional financial resources targeted toward low-income women who are disproportionately Black.

## Examples of the successful implementation of the policy in Black communities

### Washington, D.C.'s implementation model

During the period 2014–2018, approximately half of all women who gave birth in D.C. were Black women; however, they accounted for 90% of all pregnancy-related deaths. Approximately 19% of all pregnancy-related deaths were due to pregnancy or delivery-related injuries or complications.[95] The District of Columbia established the Maternal Mortality Review Committee to study these disparities and propose strategies. As a result, D.C. mandated the Department of Health Care Finance (DHCF) to begin covering doula services under Medicaid beginning October 1, 2022.

Under the updated DHCF doula service rules, the following changes were made to improve maternal and infant mortality and health

- All pregnant women with low to moderate incomes regardless of immigration status are eligible.
- Doula services are covered from the date of confirmed pregnancy to six months postpartum.

### New York City's Citywide Doula Initiative[96]

New York City's Doula Initiative was implemented by the New York City Department of Health and Mental Hygiene (DOHMH) in March 2022. The city allocated just over $4 million to the program for the period of March 1, 2022, through June 30, 2024. The objective of this initiative was to reduce maternal and infant mortality disparities through the following efforts:

- Track and report birth-related data in the city.
- Identify geographic areas and priority populations within the city where residents experience higher rates of maternal mortality, infant mortality and other adverse birth outcomes.

Eligibility for the program is based on income and other proxies for low-income socioeconomic status.

- The primary mechanism for reducing maternal and infant mortality disparities was to increase access to training for doulas and provide free doula services to residents in under resourced neighborhoods. To do this, DOHMH contracted with seven vendors to provide doula services.

The program yielded some successes and experienced some challenges. Some of the successes include lower C-section rates, preterm births, and low birth weight among Black and Hispanic mothers who participated in the program, compared to city averages. Black and Hispanic mothers in the program also experienced no pregnancy-associated deaths, even though they usually account for 75% of all pregnancy-related deaths in the city. The initiative also had a 77% satisfaction rate. Areas for improvement identified by the program include increased incentives and recruitment for non-English speaking doulas, improved partnerships with shelters to ensure doula access for housing insecure mothers and legislative requirements for doula friendly hospital policies.

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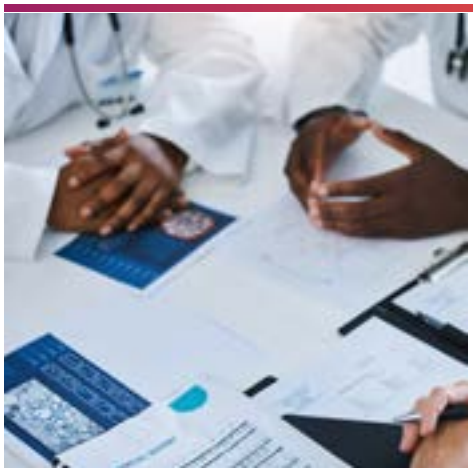
# New and Emergent Policies to Improve the Health of Black Communities

# Regulating Health Care-Related Use of Artificial Intelligence



## Description of the policy and how it works in practice

Policy strategies in this section were selected because they show significant promise as strategies that will impact Black health and/or complement Policy Roundtable members' current health promotion efforts.

## Regulating Health Care-Related Use of Artificial Intelligence (AI)

Regulate the use of artificial intelligence (AI), algorithms, and related technology to prohibit and/ or help prevent AI-related biases in the context of health care decisions and services.

While the Food and Drug Administration (FDA) currently regulates a limited scope of AI technologies as "medical devices," many more uses of AI fall outside this scope and are federally unregulated.[97]

According to a 50-state legal survey conducted by a private law firm, as of May 2025, 14 states have enacted the same, or very similar, consumer bill of rights—giving consumers the right to opt out of automated processing of their information (including through the use of AI) in ways that would impact their health care, or other important areas of life, including housing, insurance, education, and criminal justice, among others.[98]

According to the National Conference of State Legislatures, in the 2024 legislative session 45 states and D.C. proposed AI-related bills, and 31 states adopted or enacted legislation.[99] The most commonly proposed health-related AI laws sought to regulate the use of AI in insurance utilization review (four states—California, New Jersey, New York, Pennsylvania) and in mental health services (three states—Illinois, Massachusetts, and Rhode Island).[100] California was the only state to enact one of these proposed health-related AI laws.[99, 101]

In the 2025 legislative session so far, all 50 states and D.C. have proposed AI-related legislation, and 28 states have already enacted new laws.[100]

## Health Impact

AI has potential to improve medical decision-making and health care systems to the benefit of populations facing systemic barriers and biases,[102-104] with evidence for potential benefits in the context of primary care.[102-104] However, AI can also perpetuate and exacerbate health disparities in a variety of ways, such as through biased algorithms or model development and biased or unrepresentative datasets.[102] In addition, there are inequities in who has access to AI and associated benefits or exposure to harms.[105]

## Feasibility

Federal preemption of state AI regulation has not been enacted, but federal pressure on state AI laws has grown sharply. In July 2025, the Senate voted 99 to 1 to strip a proposed ten-year moratorium on state AI regulation from the budget reconciliation bill.[106] In December 2025, an executive order titled Ensuring a National Policy Framework for Artificial Intelligence directed the Department of Justice to create an AI Litigation Task Force to challenge state AI laws, directed the Department of Commerce to identify state laws it considers onerous, and conditioned remaining Broadband Equity, Access, and Deployment funds on state compliance. In April 2026, the Department of Justice intervened in a suit against the Colorado AI Act, the first time the federal government sought to invalidate a state AI law in court. States retain the authority to legislate, and advocacy in this area now carries litigation and funding risk.[107, 108]

## Overview of the policy's impact on Black health and racial equity

AI can perpetuate systemic biases in the health care system against Black communities, which regulation can seek to prevent. For example, in a landmark study examining the use of AI to identify patients for more resourced care management, the algorithm required Black patients to be sicker to qualify compared to white patients.[109] The researchers identified that the algorithm was perpetuating existing disparities by using health costs, or spending, as a proxy for need. And due to systemic biases, less is spent on Black patients.[109] In another example, AI used to classify skin lesions was less

accurate in its analysis of lesions on Black patients because it was disproportionately trained on images of white patients.[110] Several other examples have been documented.[111]

General policy recommendations to help ensure that AI can improve Black health equity include using more inclusive and complete data, as well as adopting community-centered AI development.[110, 111] Examples of the potential to improve Black health equity include studies that have shown mixed success in mitigating a physician's implicit bias through use of AI, and the use of AI to reduce racial disparities in pain management.[111]

## Summary information from policy assessment

- **Policy status**
  **LOW TO MODERATE —** While evidence illustrates the potential harms and benefits of health care-related AI use, policy advocacy in this space is rated as low to moderate, given (1) the relative newness of AI regulation and lack of evidence around which policies are most effective or most likely to improve health equity, and (2) limitations on using federal policy levers in the policy landscape as of November 2025.

- **Jurisdiction authority (federal, state, county, municipality, other)**

  **FEDERAL, STATE, COUNTY, MUNICIPALITY, OTHER —** AI regulations can currently be passed at federal and state levels. While localities might theoretically be able to enact AI regulations, our research identified only a single, limited example in New York City. Government agencies and private entities may also develop internal policies governing their own AI use.

- **Resource requirements (high, moderate, low)**
  **LOW TO MODERATE —** While, theoretically, all states or governments must put AI laws in place, they may benefit from additional funding related to implementation and enforcement. Funding may also be needed to establish and sustain committees or task forces examining potential AI regulation. AI companies have also increased spending on lobbying in the past year, particularly at the federal level.[112]

- **Return on investment (no, yes — social, yes — environmental, yes — economic)**
  **NO** — No research identified demonstrate ROI.

- **Legal considerations**
  Federal preemption has not been enacted, but the federal government is actively seeking to deter state AI regulation through litigation and conditions on federal funding.

- **Strength of evidence (strong, moderate, weak)**
  **MODERATE** — While there is increasing evidence of the potential harms and benefits of AI in terms of health equity, given the newness of regulation, there is little to no evidence of which laws and policies may be effective for helping to ensure AI-related equity.

- **Equity (yes, unclear/sometimes, no)**
  **UNCLEAR/SOMETIMES** — While regulation of AI has the potential to improve health equity, it is currently unclear which laws or policies can, or would best, help achieve greater equity.

- **Operational approach to equity (distributional, procedural, structural)**
  **STRUCTURAL AND PROCEDURAL** — Regulation of health care-related AI use seeks to interrupt systemic biases within the health care system and make decision-making processes fairer and more transparent.

## Examples of the successful implementation of the policy in Black communities

AI regulations have been proposed by the Virginia Legislative Black Caucus.

Colorado enacted the first comprehensive state AI law, SB 24-205, in 2024, which sought to prevent algorithmic discrimination by placing duties of care, disclosure, impact assessment, and risk management on AI developers and deployers.[113] The law never took effect. Its start date was delayed once, from February 1 to June 30, 2026, a federal court suspended enforcement in April 2026 after xAI sued and the Department of Justice intervened, and on May 14, 2026, Governor Polis signed SB 26-189, which repealed and replaced it with a disclosure and consumer rights framework for automated decision-

making technology, effective January 1, 2027.[114] The replacement drops the algorithmic discrimination duties and the mandatory impact assessments that made the original law significant for health equity.[114]

For more targeted AI regulation, in addition to California's insurance laws (described above), Utah regulates the use of AI chatbots in the context of mental health services.[115]

MultiState, a state policy tracking firm, reports that 34 states have a committee, task force, or working group studying AI regulation.[116] Among the states with the largest Black population shares, Mississippi is the only one without such a group.

# Codifying Reproductive Choice

## Description of the policy and how it works in practice

Some states have codified abortion measures that affirm state protections for the right to an abortion and other reproductive rights through amending their state constitutions or through legislative actions.

## Health Impact

States with the most restrictive abortion laws, primarily Southern states, have the worst maternal and infant health outcomes as they often have inadequate and unsustainable Medicaid and children's health programs needed to support mothers and babies.[117] Additionally, these states also have some of the highest rates of Medicaid births despite failing to choose to expand Medicaid programs.[118] Limitations on reproductive rights and health services have been linked to lower educational attainment and opportunity, income, political participation, and well-being among women.[119] Access to abortion and reproductive services is vital to the physical, mental, and financial health of individuals. Research has demonstrated that access to these services has been linked to improved mental health, decreased likelihood of adverse maternal health outcomes, increased economic and social well-being, and decreased likelihood of financial hardship.[119]

## Feasibility

In June 2022, the Supreme Court struck down a landmark case—Roe v. Wade—ruling that the accessibility and legality of abortion and abortion-related services in the U.S. was a decision left to the states, rather than a guaranteed federal right.[120] This includes services that allow abortion care even in traumatic instances such as rape or incest regardless of age.[120] In response to the Supreme Court action, some states have moved to codify abortion measures that affirm state protections for the right to an abortion through amending their state constitutions or through legislative actions.

Since 1977, the Hyde Amendment has prohibited federal funds from being used to provide coverage for abortion services, except for circumstances that endangered the life of the woman or resulted from rape and incest.[121] However, the amendment is not a permanent law and has been attached to every Congressional appropriations bill since 1976.[121] Therefore, the amendment must be renewed annually

in the Congressional appropriations bill for the Department of Health and Human Services (HHS). Given Medicaid is a joint financial venture between federal and state governments, states may elect to cover abortion care for Medicaid enrollees in certain instances using state funds rather than federal funding.[121] Of the states that have not banned abortion, 19 and the District of Columbia use state funds to cover abortion care for Medicaid enrollees.

In *Dobbs v. Jackson Women's Health Organization*, the Supreme Court overturned Roe v. Wade, fundamentally shifting the legal landscape surrounding reproductive rights and abortion care to be state-law dependent. States are in a unique position to continue to uphold reproductive rights that are no longer recognized or secured by federal law. States are able to use their own constitutions, legislative processes, and court systems to regulate and protect abortion care and reproductive rights. Some states have begun codifying reproductive rights into their state constitutions, while others have used this authority to create more restrictive approaches to reproductive rights, including preempting local governments from allocating funds to certain reproductive services and sex education programming or altering ballot measure rules to make it more difficult to amend state constitutions.[122] Additionally, some states are attempting to criminalize abortion access for individuals who travel to a state that offers abortion services, as well as to criminalize the actions of out-of-state providers who perform these services to these individuals.[123] As of May 2025, 23 states and the District of Columbia protect access to abortion through their state constitutions, statutes, or state court decisions.[124] Those protections were established in different ways. Arizona, Colorado, Missouri, Montana, New York, and Ohio acted through ballot measures amending their constitutions.

Others acted through legislation. In Alaska and Kansas, protection rests on state supreme court rulings rather than on an enacted law. In contrast, 27 states have laws that severely limit or prohibit abortion.[124]

## Overview of the policy's impact on Black health and racial equity

Legislation that limits access to or coverage of abortion services and care places significant threats to the economic, financial, and physical well-being of Black women/birthing people. This is particularly concerning considering the high rates of Black women residing in the South, which have the most hostile abortion laws.[120] Currently, six in ten Black women ages 18–49 reside in states with abortion bans or restrictions.[125] Black women are more likely than white women to experience contraceptive failure, poor contraception counseling, higher rates of maternal mortality and morbidity, high-risk pregnancy, and race-based discrimination in seeking contraceptive care.[126] Additionally, Black women experience disparate outcomes in wage and economic equality that impacts access to and affordability of childcare services, transportation, and leave from work.[119] These laws will decrease medical training opportunities for providers, place barriers on access to abortion care, and result in an overall increase in Black maternal morbidity and mortality rates.[127] Access to reproductive services is important to promote economic, financial, and physical well-being of Black women.[128]

## Summary information from policy assessment

- **Policy status**
  **Moderate —** This policy has been implemented in a limited number of states and localities with the potential to increase in commonality as more ballot initiatives and litigation efforts continue to unfold.

- **Jurisdiction authority (federal, state, county, municipality, other)**
  **STATE AND LOCAL —** Reproductive rights can be passed at the state and local level; however, most strategies focus on state level initiatives.

- **Resource requirements (high, moderate, low)**
  **LOW —** Few financial resources will be needed; however, political power and organization will be key to initiate and support ballot initiatives and potential litigation.

- **Return on investment (no, yes—social, yes—environmental, yes—economic)**
  **YES — ECONOMIC —** Research has demonstrated that access to abortion services and other reproductive rights improves women's economic well-being.[129]

- **Legal considerations**
  There are implications for preemption of any federal laws that directly or indirectly relate to reproductive access. For example, there have been federal attempts to remove Mifepristone and Misoprostol—a drug used to terminate pregnancies—as an FDA approved drug for abortion.[130]

- **Strength of evidence (strong, moderate, weak)**
  **MODERATE—** As demonstrated above, there is strong evidence demonstrating the need for the protection of reproductive rights and abortion care due to socioeconomic factors. There is little evidence that focuses on how protecting access to reproductive rights will specifically impact Black families and women. Additionally, there is little evidence that has examined the outcomes of Black families and women in states that have protected abortion access.

- **Equity (yes, unclear/sometimes, no)**
  **YES—** Access to reproductive services and abortion care will improve equitable outcomes, with some of the highest potential benefits being for Black women.

- **Operational approach to equity (distributional, procedural, structural)**
  **PROCEDURAL AND STRUCTURAL—** Expanding access to reproductive rights and abortion care would significantly decrease the financial, social, and physical burden experienced by individuals. One study found that women living in the South, where 13 states have banned or restricted abortion care, have had to drive as much as six times more than people in other states to end a pregnancy.[131]

## Examples of the successful implementation of the policy in Black communities

Others doing work in this space include organizations such as National Black Women's Reproductive Justice Agenda, Black Women's Health Imperative, Guttmacher Institute, the Center for Reproductive Rights, and Sister Song. Codifying reproductive choice is one of the strongest actions states can take to protect reproductive rights and abortion access. State and local level legal and policy strategies should include considerations for both patients who choose to utilize abortion services, as well as providers who are administering these services.

- **New York:** NY voters approved an amendment that will strengthen legal foundations for protecting the state's current access to abortion along with additional protections for various forms of discrimination. The amendment holds that "no one can face discrimination due to sex, including sexual orientation, gender identity, gender expression, pregnancy, pregnancy outcomes, and reproductive health care and autonomy."[132]
- **Colorado:** Residents of CO approved an amendment that codifies protections for abortion, including preempting local governments from passing their own laws to try to restrict the procedure. Additionally, the amendment removed the state's previous constitutional ban against public funding for abortions, and it allows the state to cover the procedure under Medicaid and add it to state employee health plans.[132]

# Zoning for Food Production and Healthy Food Overlay Districts

## Description of the policy and how it works in practice

Land use and zoning practices influence population health through a number of pathways. Two policies, zoning for food production (urban agriculture) and healthy food overlay districts, have the potential to improve the health indicators for residents of priority communities. Zoning for food production involves using zoning laws that define and create clear rules and regulations about specific agricultural land uses within municipalities, usually in commercial and residential areas. Typical urban food production activities include subsistence gardens, backyard chicken coops, community gardens, backyard beekeeping, etc. These zoning laws seek to allow small-scale agricultural production while limiting the potential for nuisances to neighboring properties in the form of sounds, sights and smells.

To ensure compatibility, the types of regulations vary widely. In some instances, regulations can specify whether commercial agriculture is allowed, meaning permitting on-site sale. They also regulate the placement and design of accessory farming structures, such as greenhouses, coops, beehives, hoophouses, sheds, etc.

Restrictions may also be placed on the hours of operation for certain activities, such as sales, the use of loud heavy machinery or even the type and quantity of animals that can be reared on site. For example, the City of Champaign in Illinois licenses residents of single-family and two-family homes to keep up to six hens in a rear-yard coop and prohibits roosters, under an ordinance adopted in 2013.[133]

A healthy food overlay district, by contrast, is a zoning tool that applies an additional set of regulations over one or more existing zoning districts to address challenges or advance development goals specific to that geographic area. The goal is to increase access to and affordability of fresh, nutrient dense foods while limiting the concentration of low nutrition, calorie dense, highly processed

foods. Zoning for food production is one tool that can be used within a healthy food overlay district. Other potential regulations include mechanisms to encourage a healthy food retail environment by imposing density and spacing requirements on fast-food restaurants, convenience stores, liquor stores and dollar stores. They also encourage the development of full-service grocery stores and farmers' markets by providing incentives such as zoning flexibility in the form of reduced parking, reduced setbacks, expedited permitting and tax incentives to name a few.

## Health Impact

Zoning for food production and Healthy Food Overlay Districts aim to improve community health outcomes by addressing food insecurity and making health promoting food more available. The food retail environment is shown to influence dietary quality in children and adults.[134] A higher density of fast-food establishments increases fast-food consumption and BMI in children regardless of socioeconomic status.[134] A similar relationship was observed in Black and Hispanic female adults. The presence of more fast-food outlets is also associated with higher rates of Type 2 diabetes, cardiovascular disease and stroke.[135] Urban agriculture may also increase food security and increase fruit and vegetable consumption.[136]

## Feasibility

Urban agriculture as a policy has been widely accepted and implemented across many jurisdictions of varying sizes and political leanings. There have been instances of public opposition to some animal husbandry operations, such as backyard ducks, roosters and chickens, due to concerns over noise, diseases, pest attractions, and odors. For example, in 2014, the City of Columbus, Ohio, received 140 complaints about backyard chickens and other barnyard animals compared to 30 in 2010.[137] There are increasing contemporary concerns about the spread of Bird Flu from wild birds to backyard flocks that are not as regulated as large-scale commercial operations. There have also been economic challenges to implementing urban gardens, especially in dense urban areas with high land values. This is because all property owners are entitled to develop their property to its highest and best use, meaning the most profitable legally permissible use. Urban gardens are rarely the most profitable use for a piece of land in a dense urban area.

With respect to Healthy Food Overlay Districts, there has been opposition by free market advocates to restricting the number and location of certain types of businesses. Some of these include arguments against the "nanny state" whereby there is increased government involvement in personal consumer choices. Others claim that restricting economic activities may result in lost neighborhood employment. Many of these pushbacks come from industry actors and a small number of local residents.

## Overview of the policy's impact on Black health and racial equity

Food insecurity and access to nutritious food remain a challenge for many Black citizens. Approximately 20% of Black households are in a food desert, and counties with above average Black populations have fewer fresh food options.[138] This inequity in access to fresh food means that Black Americans have a 16% higher risk of poor diet quality when compared to white Americans.[139] The research also shows that living in a food desert is associated with a 17% higher risk of poor diet.[139] Disparities in poor dietary quality have led to a disproportionately higher risk of lifestyle-related chronic illness in Black people. When compared to the white population, Black people have higher rates of cancer, are 60% more likely to develop diabetes, and are 30% more likely to die from heart disease.[140] Improvements in nutritious food access and security through the food retail environment have been shown to yield improvements in Black health. The data show that when the food retail environment is improved, BMI improvements were greatest for all children and Black and Hispanic women.

Evidence on urban agriculture's impact on the health of Black residents is limited. However, research suggests that urban gardens can improve social cohesion and mental health of Black residents.[141] There is moderate evidence that increased exposure to fruits and vegetables may lead to a slight increase in consumption, but this effect is hindered by already engrained dietary preferences.[142] Most of the physiological health benefits from urban gardens are speculative with a lack of quantifiable improvements in chronic diseases.

## Summary information from policy assessment.

- **Policy status**
  Zoning for urban agriculture has been widely implemented across cities nationwide. In contrast, Healthy Food Overlay Districts are a fairly new policy intervention and have been adopted in a handful of urban areas.

- **Jurisdiction authority (federal, state, county, municipality, other)**
  MUNICIPALITY

- **Resource requirements (high, moderate, low)**
  Enacting the zoning ordinance requires a low level of resource investment. However, if supportive fiscal incentives are implemented, then those can require a moderate to high level of investment.

- **Return on investment (no, yes—social, yes—environmental, yes—economic)**
  Urban agriculture has social and environmental returns on investment. Healthy Food Overlay Districts have social return on investment.

- **Legal considerations**
  Urban agriculture can have some opposition in residential areas due to the potential for nuisances. However, these nuisances can be mitigated with additional special zoning and permitting requirements.

- **Strength of evidence (strong, moderate, weak)**
  The strength of evidence for the impact of Healthy Food Overlay Districts (which aim to change the food retail environment) on community health is moderate to strong. However, the evidence supporting an impact of urban agriculture on health outcomes is weak.

- **Equity (yes, unclear/sometimes, no)**
  YES

- **Operational approach to equity (distributional, procedural, structural)**
  Distributional equity in terms of how green space and fresh food access is distributed across urban areas.

## Examples of the successful implementation of the policy in Black communities

### The City of Birmingham Healthy Food Overlay District

In 2019, the City of Birmingham, Alabama, established a healthy food overlay district as a means to combat the widespread food deserts throughout the city. At the time, 69% of the city's residents lived in a food desert.[143] To accomplish this goal, the city aims to restrict the density of discount dollar stores and encourage the development of full-service grocery stores in food deserts. Some of the incentives employed to encourage the development of full-service grocery stores include reduced parking requirements and larger square footage.[144]

As part of this healthy food overlay district, the city also established a healthy food fund that has been used to offer financial incentives and tax breaks to various grocery stores since its establishment in 2019. For example, the city allocated $865,000 to redevelop Village Market into a full-service grocery store.[145] The fund also allocated $600,000 to redevelop a vacant Sav-a-Lot to a Dollar General Market, which is Dollar General's full-service grocery model.[146] That award sits in tension with the overlay district's goal of limiting dollar store density. Birmingham treated the full-service grocery format as a distinct use from a standard discount store, which shows how much the result of an overlay district depends on how the ordinance defines the store types it restricts. Jurisdictions writing similar ordinances should define those categories precisely and decide in advance whether a discount retailer's grocery format qualifies for incentives.

### The City of Chicago Urban Agriculture Zoning Ordinance

The City of Chicago enacted its urban agriculture zoning ordinance in 2011. The ordinance allowed community gardens in all zoning districts and commercial urban farms in most nonresidential districts.[147] In addition to updating its zoning ordinance, the city also created a supportive Large Lot Program, which allows community groups and nonprofits to purchase some city owned vacant land for $1 for the purpose of developing a community garden. These zoning and programmatic changes yielded several benefits in many under resourced neighborhoods such as East Garfield Park, Englewood, and Woodlawn. Some of which included community beautification, improved morale, and improved neighborhood cohesion.

# Limitations and Conclusion

This agenda reflects the policy landscape as of November 2025 and the evidence available at that time. The policy scan drew on peer-reviewed literature, gray literature, and prior ChangeLab Solutions scans, so it carries the coverage and the gaps of those sources.

Evidence on impacts specific to Black communities was thin for several strategies, and no evidence on return on investment was identified for others. The Black legislative caucus scan relied on publicly posted agendas, which varied widely in detail and currency across states, so the absence of a policy domain in a caucus row may reflect a reporting gap rather than an absence of interest. Feasibility depends on jurisdiction and will shift as federal and state policy changes. Users should verify the current status of any strategy in their own state before acting on it.

The strategies outlined in this agenda offer a roadmap of policy strategies that are grounded in peer-reviewed evidence, backed by experts from the Council on Black Health Policy Roundtable, and positioned to advance health equity. These policies not only address structural barriers and improve access to care but also promote economic stability and better health outcomes.

This agenda serves as a starting point for the Council on Black Health and its member organizations and individuals as they seek to collaborate with state and local decision-makers, government agencies, public health practitioners, and community members to advocate for policies that protect and improve the health of Black communities. Meaningful engagement with these stakeholders is essential to identify and implement strategies that best address the unique needs and context of each jurisdiction.

For more information on the process of enacting and implementing the policies outlined in this agenda, see the resources listed in Appendix B and the ChangeLab Solutions materials referenced throughout. We hope these resources support the Council in their efforts to pursue policy interventions that respond to the pressing needs affecting Black people's health and their communities.

# Appendix A.
# Black Legislative Caucus Scan

## Summary

Of the caucuses listed, three had no information about their recent policy agendas or legislative priorities readily available online (Alabama, Louisiana, and South Carolina).

Eight caucuses had limited information about their policy agendas or legislative priorities available through journalism and newsletters (Florida, Georgia, Illinois, Mississippi, New Jersey, Ohio, Pennsylvania, and Tennessee).

Three caucuses had broad policy domains listed on their websites, without further information readily available (Michigan, North Carolina, and Texas).

Five caucuses had self-published legislative packages, legislative agendas, or policy agendas (California, Maryland, New York, Virginia, and the Congressional Black Caucus). Two of these caucuses had particularly detailed agendas (New York, Virginia).

The research recently identified the National Black Caucus of State Legislators, an organization that publishes policy resolutions yearly.

**Sources** provides links to the sources reviewed for each caucus.

**Table 1** On the next page summarizes which legislative domains were prioritized by each caucus, along with the year of the priority, if available. The domains do not appear in any order. Domains with two or fewer caucuses in support were classified under miscellaneous.

**Black Caucus Priorities by Legislative Domain** provides an expanded table identifying specific bills or named policies included in caucuses' agendas and priority lists.

## Table 1. **Summary of Legislative Domains Supported by Black Caucuses**

| Legislative Domain | Caucuses in Support |
|---|---|
| **Democracy/Voting Rights** | [8] Florida (2024), Michigan, Mississippi (2025), New York, North Carolina (2023), Ohio, Virginia (2025), Congressional Black Caucus (2025) |
| **Public Safety/Prison and Criminal Legal System Reform/Restorative Justice** | [13] California (2024), Florida (2024), Illinois (2023), Maryland (2025), Michigan, Mississippi (2025), New York, North Carolina (2023), Ohio, Pennsylvania (2024), Texas, Virginia (2025), Congressional Black Caucus (2025) |
| **Reparations** | [3] California (2024), Maryland (2025), National Black Caucus of State Legislators (2025) |
| **Education and Schools** | [14] California (2024), Florida (2024), Illinois (2023), Maryland (2025), Michigan, Mississippi (2025), New York, North Carolina (2023), Ohio, Tennessee (2024), Texas, Virginia (2025), Congressional Black Caucus (2025), National Black Caucus of State Legislators (2025) |
| **Health and Health Care** | [14] California (2024), Florida (2024), Maryland (2025), Michigan, Mississippi (2025), New York, North Carolina (2023), Ohio, Pennsylvania (2024), Tennessee (2024), Texas, Virginia (2025), Congressional Black Caucus (2025), National Black Caucus of State Legislators (2025) |
| **Individual Income and Wealth** | [8] California (2024), Georgia (2023), Michigan, Mississippi (2025), Texas, Virginia (2025), Congressional Black Caucus (2025), National Black Caucus of State Legislators (2025) |
| **Civil Rights/Social Justice/ Systemic Discrimination and Racism** | [4] California (2024), North Carolina (2023), Ohio, Virginia (2025) |
| **Climate and Environmental Justice** | [8] Georgia (2023), Illinois (2023), Michigan, New York, North Carolina (2023), Virginia (2025), Congressional Black Caucus (2025), National Black Caucus of State Legislators (2025) |
| **Food Insecurity** | [4] California (2024), Illinois (2023), New York, Virginia (2025) |
| **Economic & Urban Development** | [10] Georgia (2023), Maryland (2025), Michigan, Mississippi (2025), New Jersey (2024), New York, North Carolina (2023), Texas, Virginia (2025), National Black Caucus of State Legislators (2025) |
| **Housing/Home Ownership** | [8] Florida (2024), Maryland (2025), New York, North Carolina (2023), Pennsylvania (2024), Virginia (2025), Congressional Black Caucus (2025), National Black Caucus of State Legislators (2025) |
| **Gun Violence Prevention/ Gun Regulation** | [4] New York, Ohio, Tennessee (2024), Virginia (2025) |
| **Miscellaneous, e.g.:**<br>• Prohibiting slavery<br>• Black culture, history, and society<br>• Agriculture<br>• Immigration<br>• Childcare<br>• Consumer protections<br>• Digital privacy<br>• CPS reform and family rights | [8] California (2024), Florida (2024), Georgia (2023), Illinois (2023), Michigan, New York, Virginia (2025), National Black Caucus of State Legislators (2025) |

**NOTE:** Table 1 lists every caucus whose published agenda or priorities identified the legislative domain. The expanded table lists only the specific bills and named policies that were publicly available at the time of the scan. A caucus may appear in Table 1 without a corresponding entry in the expanded table where its agenda named the domain but did not identify specific legislation.

## Sources

**No information on policy agenda or legislative priorities available.**

**1) Alabama**

a) No dedicated web presence identified. The Alabama House Black Caucus has a Facebook page that has not been updated since 2016, and the link to a website on that page (alhouseBlackcaucus.org) is broken.

b) No further information about a policy agenda or legislative priorities identified, although the new chair of the Caucus recently spoke about the Caucus's commitment "to supporting DEI programs and preserving the teaching for Black American history in public schools."

**2) Louisiana**

a) The Louisiana Legislative Black Caucus website does not appear to have been updated since 2023, and no information about a policy agenda or legislative priorities was identified other than an older interview from 2022 where a Caucus member described priorities around redistricting, police reform, and education.

**3) South Carolina**

a) The South Carolina Legislative Black Caucus website does not appear to be active. It did not identify any other information about a policy agenda or legislative priorities.

**Limited information is available through journalism and newsletters.**

**1) Florida**

a) Websites were found for a Democratic Black Caucus of Florida and a Florida Conference of Black State Legislators, though neither provided any information.

b) The Florida Legislative Black Caucus website does not provide any information on a policy agenda or legislative priorities; however, members of the caucus spoke about their priorities for the 2024 legislative session in a press conference.

2) **Georgia**

a) The Georgia Legislative Black Caucus website does not provide any information on a policy agenda or legislative priorities, and their Facebook page has not been updated since 2023. However, the caucus announced legislative priorities at a press conference for the 2023 legislative session.

3) **Illinois**

a) The Illinois Legislative Black Caucus website did not provide any information on a policy agenda or legislative priorities; however, the Illinois Senate Democrats published a summary of laws that had been championed by the Black caucus that would go into effect on January 1, 2024.

4) **Mississippi**

a) The policy agenda webpage of the Mississippi Legislative Black Caucus does not appear to be working; however, members announced their agenda for the 2025 session at a press conference to include "focus on promoting literacy and nutrition in schools, funding for public schools, early voting access, Medicaid expansion, and prison reform."

5) **New Jersey**

a) The New Jersey Legislative Black Caucus website did not provide any information about a policy agenda or legislative priorities; however, the caucus introduced a package of 12 bills in September 2024 in response to findings of the New Jersey Disparity Study.

6) **Ohio**

a) Six broad policy areas are listed on the home page of the Ohio Legislative Black Caucus website. Members of the caucus announced their 2024 legislative priorities at a press conference. At a separate press conference for Juneteenth in 2024, death penalty abolition was identified as another legislative priority.

7) **Pennsylvania**
   a) The Pennsylvania Legislative Black Caucus Summer 2024 newsletter (accessible through their News Center) highlighted several priority bills moving through the legislature.

8) **Tennessee**
   a) No website was identified for the Tennessee Legislative Black Caucus, and though they have social media accounts, the accounts do not provide any information about a policy agenda or legislative priorities. However, members of the caucus announced legislative priorities at a June 2024 press conference "focusing on issues that include public education, gun regulations and reproductive health care."

**Broad policy priority domains, without more detailed information.**

1) **Michigan**
   a) The Michigan Legislative Black Caucus has published seven broad policy pillars.

2) **North Carolina**
   a) The North Carolina Legislative Black Caucus published a broad list of priorities in 2023.

3) **Texas**
   a) The Texas Legislative Black Caucus has 5 priority areas listed on their website.

**Self-published legislative packages, legislative agendas, or policy agendas available.**

1) **California**
   a) There is a 2024 reparations package with 14 bills across five domains.
   b) No further updates since the January 31, 2024, news release of the prior legislative package.

2) **Maryland**
   a) The Maryland Legislative Black Caucus has a 2025 legislative agenda, accessible from this page.

3) **New York**
   a) The New York State Black, Puerto Rican, Hispanic, and Asian Legislative Caucus has an Empower Black NY Agenda.

4) **Virginia**
   a) The Virginia Legislative Black Caucus has a 2025 legislative agenda (accessible from their website).

5) **Congressional Black Caucus**
   a) The Congressional Black Caucus released a policy agenda for the 118th Congress (2023–2025 session).

6) **National Black Caucus of State Legislators**
   a) There is also a National Black Caucus of State Legislators, which regularly publishes policy resolutions.

## Black Caucus Priorities by Legislative Domain

| Legislative Domain | Caucuses in Support | Specific bills/named policies |
|---|---|---|
| **Democracy/Voting Rights** | Florida (2024)<br>Michigan<br>Mississippi (2025)<br>New York<br>North Carolina (2023)<br>Ohio<br>Virginia (2025)<br>Congressional Black Caucus (2025) | FL—protection of voting rights<br>MI—protecting Black judicial districts in redistricting<br>MI—early voting reform<br>NY S1085—prohibits voter suppression and creates stricter penalties<br>NY S2240—remove lifetime ban on jury duty for people with prior felony convictions<br>VA HB2165 / SB1002—Campaign Integrity Act<br>VA HJ2—restore voting rights of returning citizens<br>VA SB813—regulate review of voter registration records<br>VA HB2276—establishing voter protections, including right to be notified of potential registration cancellation<br>VA HB2277—clarify an enforceable election certificate process<br>CBC—John Lewis Voting Rights Advancement Act and supporting civic education and voter registration<br>CBC—Black participation in the Census<br>CBC—representation and inclusivity in the federal judiciary |
| **Public Safety/ Prison and Criminal Legal System Reform/Restorative Justice** | California (2024)<br>Florida (2024)<br>Illinois (2023)<br>Maryland (2025)<br>Michigan<br>Mississippi (2025)<br>New York<br>North Carolina (2023)<br>Ohio<br>Pennsylvania (2024)<br>Texas<br>Virginia (2025)<br>Congressional Black Caucus (2025) | CA AB 1986 (Bryan)—eliminate Department of Corrections banning of books without oversight and review<br>CA AB 2064 (Jones-Sawyer)—state-funded grant program to fund community-driven solutions to decrease community violence in African American communities<br>CA AB 280 (Holden)—restricts solitary confinement<br>FL—improvements in conditions of carceral facilities; including oversight to prevent law enforcement violence against incarcerated people<br>FL—restorative justice practices; reduced sentencing and alternative pathways<br>IL HB 3345—simplifies process for returning residents to obtain a state ID<br>IL HB 3140—bans solitary confinement in youth detention centers, except for immediate physical harm prevention<br>MD second look act<br>MD medical and geriatric parole reform<br>MD youth equity and safety (YES) Act<br>MD repeal felony murder<br>MD expungement expansion<br>MD reform driver's license suspension for child support arrearage<br>MD safer traffic stops for all<br>MD Eric's ID Law<br>MI—overhaul youth court system<br>MI—address prison conditions<br>NY A162/S307—reform parole eligibility to support fair and timely release<br>NY A2035/S2423—expand parole eligibility for individuals 55 and up |

## Black Caucus Priorities by Legislative Domain (continued)

| Legislative Domain | Caucuses in Support | Specific bills/named policies |
|---|---|---|
| **Public Safety/ Prison and Criminal Legal System Reform/Restorative Justice** (continued) | | NY A8569/S8044—defines "mass shooting" and access to accompanying resources as an incident with at least four victims<br>NY A8524A/S2881B—Treatment Not Jail Act creating alternative treatment courts<br>NY S1707—establishes correctional Ombudsman<br>NY A9335A—automatically expunges records from unconstitutional NYPD stops occurring between 2004 and 2013<br>NY A0403/S0394—establishes application process and review of gubernatorial pardons<br>NY S1403—requires police officers to intervene when witnessing excessive force<br>NY—establishing community-based mental health response team to reduce harmful police interactions<br>NY—cash assistance for formerly incarcerated individuals in the first six months of reintegration<br>NY—funding alternatives to incarceration to reduce youth involvement in the criminal legal system<br>NY—establishing independent monitoring of state carceral facilities<br>OH—death penalty abolition<br>OH—Suicide Self-Defense Act<br>OH—transparency of parole board hearings<br>OH—certificate of qualification for housing to support returning citizens<br>OH—expungement for minor marijuana offenses<br>OH—mandating access to menstrual products for incarcerated women<br>PA—Clean slate criminal record clearance<br>PA—Paul Miller's Law; law enforcement required to collect race, ethnicity, and gender data when stopping drivers<br>TX—bail reform<br>TX—ban the box<br>TX—end racial profiling by law enforcement<br>TX—increase age of criminal responsibility from 17 to 18<br>TX—reduce small marijuana penalties to Class C (fine only)<br>TX—restart reintegration program<br>VA HB222 & HB2235—regulate shackling of youth and pregnant people; restrict use of solitary confinement<br>VA HB2196—implement restorative justice pilot and grant funding in public schools<br>VA HB2555—create an avenue to modify previous marijuana sentences<br>VA HB1886—prevent full payment of court costs from being a condition of case dismissal<br>VA HB1665—require itemized statements of court costs<br>VA HB1873—increase release of accused prior to trial<br>VA HB1661—standardize minimum monthly court payments to reduce excessive financial burdens |

## Black Caucus Priorities by Legislative Domain (continued)

| Legislative Domain | Caucuses in Support | Specific bills/named policies |
|---|---|---|
| **Public Safety/ Prison and Criminal Legal System Reform/Restorative Justice** (continued) | | VA HB2223—remove attorney fees for low-income defendants<br>VA HB1865—increase public defender offices and support for court-appointed counsel<br>VA HB2242—ensure prompt court appearances for probation violations, without arrest warrant or court process<br>VA HB1642—prohibit criminal legal processes from relying solely on the recommendation of AI<br>VA HB2411—require department of criminal justice to develop standards for safe, ethical AI/ML and surveillance<br>CBC—opposing the school-to-prison pipeline<br>CBC—improving conditions of confinement in jails and prisons<br>CBC—decrease law enforcement violence against the Black community and fortify laws holding law enforcement officers accountable<br>CBC—providing alternative mechanisms for nonpunitive and non-carceral community-based responses to harm |
| **Reparations** | California (2024)<br>Maryland (2025)<br>National Black Caucus of State Legislators (2025) | CA ACR 135 (Weber)—recognizes and accepts government responsibility in the harms and atrocities of chattel slavery<br>CA SB 1050 (Bradford)—restore property ownership or make restitution for race-based use of eminent domain<br>CA AB 3089 (Jones-Sawyer)—formal apology for human rights violations and crimes against humanity on African slaves and their descendants<br>MD commission to study reparation proposals<br>NBCSL LJE-25-06 ESTABLISHING AN AMERICAN FREEDMEN TASK FORCE |
| **Education and Schools** | California (2024)<br>Florida (2024)<br>Illinois (2023)<br>Maryland (2025)<br>Michigan<br>Mississippi (2025)<br>New York<br>North Carolina (2023)<br>Ohio<br>Tennessee (2024)<br>Texas<br>Virginia (2025)<br>Congressional Black Caucus (2025)<br>National Black Caucus of State Legislators (2025) | CA AB 1929 (McKinnor)—expand access to career technical education<br>CA AB 3131 (McCarty)—financial aid for redlined communities<br>FL—increasing higher education opportunity for homeless youth<br>IL HB 381—provides annual retention bonus for two years to national Board-Certified teachers working in challenging schools<br>IL HB 342—establishes Whole Child Task Force to create safe and supportive school environments for students dealing with trauma and mental health challenges<br>MD strengthening restorative practices<br>MD interstate teacher mobility compact<br>MD reduce chronic absenteeism<br>MD implementation and sustained investment in blueprint for Maryland's future<br>MD permanent state funding for land grant institutions<br>MI—promoting literacy and nutrition for children<br>MI—ensuring equitable funding for public schools and universities<br>NY A2362/S4154—expands discrimination protections and provides greater transparency in the hiring of education professionals |

## Black Caucus Priorities by Legislative Domain (continued)

| Legislative Domain | Caucuses in Support | Specific bills/named policies |
|---|---|---|
| **Education and Schools** (continued) | | NY A2125—prohibits legacy admissions in higher education<br>NY—increasing access to college education and degree programs for incarcerated individuals and improving youth access to education in detention facilities and placement settings<br>NY A2362/S4154—expands discrimination protections and provides greater transparency in the hiring of education professionals<br>NY—increasing financial aid for students<br>NY—connecting high school students to careers environmental science and sustainability<br>NY—DEI efforts for educators, including recruitment, training, retention, and organizing conventions<br>NY—state-funded student debt relief<br>NY—increased funding for higher education opportunity programs<br>OH—anti-school lunch shaming<br>TX—adequate funding, including for pre-K and HBCUs and Black schools<br>TX—eliminate unreasonable discretionary discipline and policing<br>VA HB1594—raise teacher pay to national average<br>VA SB1236—increase outdated school support cap<br>VA HB2201 & SB1230—extend long-term substitute timeframes<br>VA SB829—establish professionally licensed teacher supplemental pay program to reduce shortages<br>VA HB564—create study of potential wage raise for all school support staff<br>VA HB2118 & HB2454—encourage integration by reversing and revising new school accountability system<br>VA SB251—produce a report on removal of books from public school libraries since 2020<br>CBC—funding for HBCUs<br>CBC—opposing curriculum censorship of Black history<br>CBC—student debt relief<br>CBC—affirmative action<br>NBCSL—ETE-25-12 SUPPLEMENTAL STUDENT TRANSPORTATION |

## Black Caucus Priorities by Legislative Domain (continued)

| Legislative Domain | Caucuses in Support | Specific bills/named policies |
|---|---|---|
| **Health and Health Care** | California (2024)<br>Florida (2024)<br>Maryland (2025)<br>Michigan<br>Mississippi (2025)<br>New York<br>North Carolina (2023)<br>Ohio<br>Pennsylvania (2024)<br>Tennessee (2024)<br>Texas<br>Virginia (2025)<br>Congressional Black Caucus (2025)<br>National Black Caucus of State Legislators (2025) | CA ACA 7 (Jackson)—constitutional amendment to allow state funding of programs that increase life expectancy, improve educational outcomes, or lift out of poverty specific groups<br>FL—require insurers to cover breast cancer screenings<br>FL—reducing maternal morbidity and mortality<br>FL—education on sickle cell management and treatment for physicians<br>GA Pharmacy Desert Prevention Act—increasing Medicaid reimbursement rates and supporting the establishment and expansion of pharmacies in low-income and minority communities<br>MD Health equity data dashboard<br>MD Prescription Drug Affordability Board authority<br>MD calcium score testing insurance coverage<br>MD annual mental and behavioral health wellness visits<br>MD safeguarding state and federal health care protections<br>MI—Medicaid expansion<br>MI—improve maternal and infant health<br>MI—address nursing shortage<br>NY A4017/S3881—establishes maternal and childcare service centers in Kings and Bronx counties<br>NY A7546/S6956—requires commissioner of health to develop a sustainability plan for state university of New York downstate medical center<br>NY A1633A/S8843—requires notice and public engagement before a general hospital, or a unit providing maternity, mental health, or substance use care seeks to close<br>NY A4018—requires evidence-based implicit bias program for providers of perinatal care<br>NY A1888—creates NYC housing authority-based health centers<br>NY Child and Family Wellbeing Fund—invest in local community-based organizations that provide families with necessities, including material support and mutual aid, doulas and maternal health services, activities for children, and peer support groups<br>NY A1797—requires labeling of hair relaxers given their link to health conditions disproportionately affecting Black women<br>NY—financial support to expectant and postpartum mothers<br>NY—expanding doula services and research on fibroids and diabetes<br>NY—funding for prostate, breast, and colon cancer screenings for Black New Yorkers facing insurance barriers<br>NY—investing in youth mental health support<br>NY—funding for 5 sickle cell treatment centers and 10 outpatient treatment centers<br>NY—establishing Black youth suicide prevention task force<br>NY—providing financing and TA to primary care providers, especially community health centers in underserved communities |

## Black Caucus Priorities by Legislative Domain (continued)

| Legislative Domain | Caucuses in Support | Specific bills/named policies |
|---|---|---|
| **Health and Health Care** (continued) | | NY—Medicaid for undocumented immigrants<br>OH—doula reimbursement through Medicaid<br>PA—momnibus maternal health package<br>TN—reproductive health care and abortion access<br>TX—supporting access to mental health care<br>TX—Medicaid expansion and expansion of insurance coverage to working uninsured<br>TX—maternal morbidity and mortality<br>VA—constitutional amendment for fundamental right to reproductive freedom<br>VA—momnibus bill package<br>VA—sickle cell research endowment fund<br>VA—unconscious bias and cultural competency training for license renewal through Board of Medicine<br>VA—creating a State Pharmacy Benefits Manager to direct prescription drug coverage of Medicaid plans<br>CBC—codifying reproductive rights<br>CBC—Momnibus legislation<br>CBC—funding for research into ailments disproportionately affecting the Black community<br>NBCSL HHS-25-01 RESPIRATORY SYNCYTIAL VIRUS (RSV) AWARENESS<br>NBCSL HHS-25-04 EMERGENCY MEDICINE BUFFER STOCKPILE<br>NBCSL HHS-25-05 ENSURING EQUITABLE ACCESS TO SAFE AND EFFECTIVE PAIN MANAGEMENT TREATMENT<br>NBCSL HHS-25-08 COMPREHENSIVE CARE FOR SICKLE CELL DISEASE<br>NBCSL HHS-25-15 ZERO COST SHARING TO PREVENT HIV<br>NBCSL HHS-25-16 CHILD HEALTH EQUITY TASK FORCES |
| **Individual Income and Wealth** | California (2024)<br>Georgia (2023)<br>Mississippi (2025)<br>Texas<br>Virginia (2025)<br>Congressional Black Caucus (2025)<br>National Black Caucus of State Legislators (2025) | CA AB 2862 (Gipson)—eliminate barriers to occupational licensure for people with criminal records<br>GA Credit Desert Act—increase access to non-predatory loans and reduce predatory lending practices<br>GA Racial Wealth Gap Reduction and Financial Inclusion Act—create funding opportunities to expand affordable housing, financial education programs, and incentives for Black-owned small businesses<br>MI—opening workforce development pathways and funding more training programs<br>TX—increase minimum wage to $15<br>VA HB1610—establish a 7-year statute of limitations for state debt collection<br>VA HB1928 & HB1625—gradually increase minimum wage to $15 and include farm workers in minimum wage<br>VA SB810 & HB1717—improve and expand Earned Income Tax Credit<br>VA HB2531—require paid family and medical leave insurance<br>CBC—expanding access to Pell Grants to individuals pursuing short-term education |

## Black Caucus Priorities by Legislative Domain (continued)

| Legislative Domain | Caucuses in Support | Specific bills/named policies |
|---|---|---|
| **Individual Income and Wealth** (continued) | | CBC—investing in workforce development of clean energy jobs in communities most affected by climate change<br>CBC—center racial equity in STEM workforce development<br>NBCSL—BED-25-02 PROMOTING ACCESS TO SAFE AND AFFORDABLE LENDING PRACTICES |
| **Civil Rights/Social Justice/Systemic Discrimination and Racism** | California (2024)<br>North Carolina (2023)<br>Ohio<br>Virginia (2025) | CA AB 1815 (Weber)—prohibits discrimination against natural, protective hairstyles in competitive sports<br>VA HJ9—constitutional amendment to affirm the right to same-sex marriage |
| **Climate and Environmental Justice:** | Georgia (2023)<br>Illinois (2023)<br>Michigan<br>New York<br>North Carolina (2023)<br>Virginia (2025)<br>Congressional Black Caucus (2025)<br>National Black Caucus of State Legislators (2025) | GA Environmental Justice Act—promote policies addressing environmental degradation and pollution in Black communities<br>IL HB 1541—prohibits gas or electric services disconnection during heat advisories or on days exceeding 90F<br>NY—climate and clean energy workforce development<br>VA HB2233—require large fossil fuel companies to offset costs of extreme weather caused by climate change<br>VA SB777—establish low-income energy efficiency and weatherization task force<br>VA HB1618—direct commissioner of health to study and develop recommendations for the reduction of microplastics in public drinking water<br>VA HB2178—limit pre-production plastic pellet pollution<br>VA HB1616—establish offshore wind industry workforce program and fund<br>VA HB1672—eliminate renewable energy kill switch, allowing consumers to purchase 100% renewable energy from competitive suppliers<br>VA SB1225—create electric vehicle rural infrastructure program and fund<br>VA SB823—improve electric utility workforce development for renewable energy facilities<br>CBC—equitable implementation to remediate environmental harm against Black communities<br>CBC—increased funding for efficient energy projects<br>NBCSL—ETE-25-03 WILDFIRE RESILIENCE<br>NBCSL—ETE-25-17 A CLEAN, RELIABLE AND AFFORDABLE ENERGY FUTURE |

## Black Caucus Priorities by Legislative Domain (continued)

| Legislative Domain | Caucuses in Support | Specific bills/named policies |
|---|---|---|
| **Food Insecurity** | California (2024)<br>Illinois (2023)<br>New York<br>Virginia (2025) | CA AB 1975 (Bonta)—make medically necessary supportive food and nutrition interventions a permanent part of state health insurance benefits<br>CA SB 1089 (Smallwood-Cuevas)—require advance notice of grocery store closures in underserved or at-risk communities<br>IL SB 850—provides grants and financial aid to grocery stores opening or operating in food deserts<br>NY—expansion of SNAP to undocumented residents<br>VA HB1723—create task force to improve food access and maximize participation in federal public assistance programs |
| **Economic & Urban Development** | Georgia (2023)<br>Maryland (2025)<br>Michigan<br>Mississippi (2025)<br>New Jersey (2024)<br>New York<br>North Carolina (2023)<br>Texas<br>Virginia (2025)<br>National Black Caucus of State Legislators (2025) | GA Equitable Contracting Opportunity Act—creating a "Division of Supplier Diversity" in state government and providing certification resources for minority- and women-owned businesses<br>GA Regulated Industry Community Investment Act—create community investment requirements for industries receiving government support<br>MD Governor Wes Moore Procurement Reform Act<br>MD small business development fund expansion<br>MI—Redressing inequities in state spending and hiring of minority contractors<br>MI—more support of minority businesses and addressing vendor disparities<br>NJ A4487 (Sumter/Reynolds-Jackson)—requires monitoring of subcontractors on State contracts<br>NJ A4548 (Sumter/Hall)—corporate business tax and gross income tax credits for employers of people with disabilities<br>NJ A4586 (Sumter/Reynolds-Jackson/Hall)—Establishes "Minority and Women-Owned Businesses State Contractor Remedies Act."<br>NJ A4648 (Sumter/Reynolds-Jackson)—Provides for State agencies to issue advanced payments to certified business enterprises awarded State contracts.<br>NJ A4719 (Reynolds-Jackson/Haider/Atkins/Sampson)—Requires certain notifications to subcontractors listed on bid for State contract by prime contractor.<br>NJ A4720 (Morales/Ramirez/Rodriguez/Haider)—Requires Chief Diversity Officer in Department of Treasury and other State officers to conduct certain outreach events, training workshops, and educational programs for minority and women-owned businesses.<br>NJ A4721 (Wimberly/Park/Collazos-Gill/Spearman)—Requires Department of Treasury to update New Jersey Disparity Study every five years.<br>NJ A4722 (Wimberly/Lopez/Carter/Spearman)—Requires State agencies to make good faith effort to increase awarding of contracts procured without advertisement to minority- and women-owned businesses.<br>NJ A4723 (Wimberly/Reynolds-Jackson/Park/Atkins)—Modifies title and role of Chief Diversity Officer; establishes New Jersey Office of Supplier Diversity and Business Opportunities. |

## Black Caucus Priorities by Legislative Domain (continued)

| Legislative Domain | Caucuses in Support | Specific bills/named policies |
|---|---|---|
| **Economic & Urban Development** (continued) | | NJ A4724 (Stanley/Quijano/McCoy)—Establishes sheltered market program for certain business enterprises seeking State contracts.<br>NJ A4725 (Wimberly/Speight/Bagolie)—Requires State agencies to make good faith effort toward certain goals to use certified minority and women-owned businesses as prime contractors and subcontractors.<br>NJ A4744 (Wimberly/Morales/McCoy/Ramirez)—Requires NJTA, SJTA, EDA, CRDA, PANYNJ, and DRPA to consider minorities and women when hiring or awarding contracts.<br>NY—Advancing Black New Yorkers: funding for Black-led community organizations offering economic empowerment, workforce development, and social services.<br>NY—upstate transportation expansion<br>NY—expanding bus rapid transit programs<br>NY—youth and young adult employment immersion program<br>NY—Bring Up Minimum Pay (BUMP) Act increasing wages, creating professional development opportunities and workforce retention<br>NY—Addressing Bias in Civil Service Exams<br>NY—creating a pipeline for Black youth to enter the AI field<br>NY A827/S1996—exploring creation of a state-run public bank<br>NYA7584—prevent Medicaid audits from penalizing small businesses for minor errors<br>NY A3852/S1548—expand MWBE participation in state contracts<br>NY A3945/S5077—independent oversight of MWBE procurement<br>NY A10254/S8498—requires detailed debriefing for denied bidders in state procurement<br>NY A2590/S1580—increases cost of living adjustments for human services programs<br>TX—increasing opportunities for minority businesses to contract with State agencies<br>VA SB970—regulate the cannabis market and provide for creation of retail cannabis market<br>VA HB1922—create minority- and women-owned business support program and increase state contracting<br>VA SB971—incentivize businesses to opt into second chance employment program through tax credit<br>VA HB1189—financial assistance to localities to support affordable housing development<br>VA SB1113—create income tax credit for underutilized structures repurposed for affordable housing<br>NBCSL—BED-25-13 ENSURE EQUITY IN STATE CONTRACTING |

## Black Caucus Priorities by Legislative Domain (continued)

| Legislative Domain | Caucuses in Support | Specific bills/named policies |
|---|---|---|
| **Housing/Home Ownership** | Florida (2024)<br>Maryland (2025)<br>New York<br>North Carolina (2023)<br>Pennsylvania (2024)<br>Virginia (2025)<br>Congressional Black Caucus (2025)<br>National Black Caucus of State Legislators (2025) | FL—rent, housing insurance, and affordability<br>MD ban the box<br>MD good cause evictions<br>MD fair housing testing<br>MD property appraisal and valuation equity task force<br>NY—Housing Access Voucher Program<br>NY—additional funding and legal support for Black homeowners and renters testing Fair Housing claims<br>NY—funding for low- and moderate-income homeowners for home repairs<br>NY—funding for legal support to homeowners facing deed theft<br>NY—expanding cease & desist zones to address gentrification<br>NY A0787/S3150—establish the New York state first home grant program<br>NY A8386A/S7971—faith-based affordable housing act<br>NY A9332—designating Kings County a cease-and-desist zone<br>NY A2274/S9309—allocates fines imposed on real estate appraisers to the anti-discrimination in housing fund<br>NY A9744/S9309—House New Yorkers First Act<br>NY A3353/S221—Tenant Opportunity to Purchase Act<br>NY A1808/S224—expands homes qualifying for the Historic Homeownership Rehabilitation Credit<br>NY A00446—requires NYC housing authority to remediate mold once reported within 15 days (about 2 weeks)<br>PA funding for right to counsel<br>PA increased funding for homelessness assistance program and shelter development<br>PA home repairs<br>PA removing racially restrictive deed covenants<br>VA SB1221—reduce eviction burdens and prevent excessive maintenance charges<br>VA SB830 & HB1623—extend eviction diversion pilot program<br>VA improvements to landlord tenant act including waiting period between notice of nonpayment and eviction, empower localities to enforce habitability requirements, banning corporate landlord price collusion and dynamic/algorithmic pricing, develop model criminal record screening policy for affordable housing, and mandate written notice for lease non-renewal decisions<br>VA SB828—extend housing opportunity tax credit<br>VA SB832—establish rental assistance voucher pilot program<br>VA HB2175—allow localities to adopt ordinances to restrict landlords from raising rent above trends<br>NBCSL--HCD-25-11 AFFIRMING THE RIGHT TO AFFORDABLE QUALITY HOUSING |

## Black Caucus Priorities by Legislative Domain (continued)

| Legislative Domain | Caucuses in Support | Specific bills/named policies |
|---|---|---|
| **Gun Violence Prevention/Gun Regulation** | New York, Ohio, Tennessee (2024), Virginia (2025) | NY—establishes a dedicated government office and advisory council on gun violence prevention<br>NY—expands funding to address gun violence<br>OH—safe and secure gun storage<br>TN—gun regulation<br>VA—extensive gun regulation: prohibit manufacture, sale, or possession of devices altering firing rates; further regulate purchase, possession, or transportation of firearms by intimate or dating partners who commit domestic assault or battery with a firearm; prohibit carry in hospitals, state capitol, and college campuses; create legal penalty for failure to securely store firearm; Create Center for Firearm Violence Intervention and Prevention and accompanying fund; require a locking device and warning against accessibility to children for firearm sales and transfers |
| **Miscellaneous** | California (2024)<br>Florida (2024)<br>Georgia (2023)<br>Illinois (2023)<br>Michigan<br>New York<br>Virginia (2025)<br>National Black Caucus of State Legislators (2025) | CA ACA 8 (Wilson)—prohibit involuntary servitude for incarcerated persons<br>FL—creating a taskforce on missing and murdered Black women<br>GA Racial Equity in Agriculture Act—address discrimination and systemic barriers by increasing funding for programs and establishing a land trust<br>IL SB 1623—statewide task force to create historical map and narrative of Underground Railroad in Illinois<br>MI Culture & Society<br>MI Immigration & International Diaspora Relations & Advancement<br>NY Universal Child Care Act—expands access to state-funded care<br>NY A1211—establishes a government center of fatherhood initiatives<br>NY A1234/S551—requires disclosure of information to parents and caretakers subject to CPS investigation<br>NY A66/S550—prohibits anonymous reporting to prevent use of CPS as a form of harassment<br>NY A109/S320—requiring specific informed consent before drug testing of pregnant people and newborns to prevent unnecessary reports to CPS<br>NY A9000/S8153—establishing procedures related to visitation and contact after termination of parental rights<br>NY A9321/S8724—safe landings for youth leaving foster care<br>NY—financial and advocacy support for Black farmers and agribusiness owners<br>VA HB1320 & SB1212—required disclosure of all fees and charges included in the advertised or displayed price of any good or service<br>VA HB2214, HB2368, HB2213—increase access to cars and mobility through regulations on towing practices, maximizing charges for toll relief, and funding driver's ed in school<br>VA early childhood and childcare—provide matching funds to employers for employee childcare assistance pilot program; maintain an Early Childhood Care and Education Fund with minimum slots; income-based Child Care Subsidy Program; expanded Child Tax Credit for low- & middle-income families |

## Black Caucus Priorities by Legislative Domain (continued)

| Legislative Domain | Caucuses in Support | Specific bills/named policies |
|---|---|---|
| **Miscellaneous** (continued) | | VA SB1214 & HB2094—regulate use of high-risk AI systems by private industry and public bodies<br>VA HB1648—provide additional support and resources to Office of Data Governance and Analytics<br>VA HB2462—create a property right for one's voice and visual likeness, pertaining to digital replicas<br>VA HB2250—allow consumers to opt out of third-party processing of their personal data and require developers to disclose information on datasets used to train generative AI<br>NBCSL—GSE-25-09 CONSUMER PROTECTIONS IN EVENT TICKETING<br>NBCSL—TST-25-10 CALLING FOR A SUSTAINABLE BROADBAND SUBSIDY<br>NBCSL—ETE-25-07 PREVENTING CHILD SLAVE LABOR |

# Appendix B.
# Policy Scan Assessment Criteria

## Feasibility Criteria

**Policy status: Have other jurisdictions introduced, passed, and/or implemented this policy?**

Open response. For each policy, the team recorded the number and level of jurisdictions that had implemented the policy, the jurisdictions where it had passed but was not yet in effect, and the jurisdictions where it had been introduced but did not pass. The team also noted other organizations pursuing the same policy change. Policy status was then summarized in each policy section as strong, moderate, or low to moderate, based on how many jurisdictions had adopted the policy, at what level, and what legal or political constraints applied to the primary policy levers.

**Jurisdiction Authority:** *At what jurisdiction level has this policy, typically, been implemented?*
**Assessment measure(s):**

**1.** Federal

**2.** State

**3.** County

**4.** Municipality

**5.** Other (Specify)

**(Note, examples of "other" may include school districts, transit authorities, etc.)**

**Resource requirements**. *Does this policy require significant funding or other resources (including staff capacity, training, expertise, or infrastructure) for governments to implement? Ratings are relative to the implementing jurisdiction. A moderate cost in a large county may be a high cost in a smaller one, so the ratings below describe the scale of investment rather than a fixed dollar amount.*

**Assessment measure(s):**

1. **High:** The policy may require a high level of financial investment to implement. It may also require personnel or infrastructure resources to implement, including new or additional staff capacity, training, and expertise.
2. **Moderate:** The policy may require a moderate level of financial investment and/or some new or additional resources to implement.
3. **Low:** The policy may require little to no financial investment and can be largely implemented with existing resources/infrastructure.

**Return on Investment (ROI):** *Is there evidence available on return on investment (ROI) or cost of implementation? If so, how is the ROI described? Evidence on ROI was often unavailable, and where it existed it was frequently context dependent. Policy sections report ROI only where published evidence was identified, which is why several sections record no ROI.*

**Assessment measure(s):**

1. There is evidence (white papers, peer-reviewed articles, or reports) that describe ROI (Y/N)
2. If yes, how is ROI described (select an option)
    1. Social (changes in knowledge, behavior, living conditions, political power)
    2. Environment (changes in environment, structural discrimination)
    3. Economic (changes in income/income inequality, economic opportunity, wealth/income/investment)
    4. Multiple (indicate)

**Legal considerations/jurisdictional issues**. *How common is existing or proposed preemption of this policy? Are there other legal restrictions that make this policy difficult to pass and/or implement (e.g., federal court rulings)?*

**Assessment measure(s):**

Open response noting legal considerations and/or anticipated issues

# Impact Criteria

**Evidence of Positive Impact on Black Health**: *How much evidence exists to support the positive impact(s) of this policy on Black health?*

**Assessment measure(s):**

1. **Strong:** The policy is well supported by reviews synthesizing evidence from multiple studies and sources.
2. **Moderate:** The policy is supported by small-scale studies; there may be conflicting evidence in the literature.
3. **Weak:** There is little or no evidence supporting the policy, or the evidence is speculative.

**Equity.** *Does this policy advance racial equity, and other forms of equity, by addressing policies, practices, systems, and structures to prioritize measurable change in the lives of Black, Indigenous, and People of Color (BIPOC), and other groups experiencing systemic or structural discrimination?*

**Assessment measure(s):**

1. **Yes:** The policy improves racial equity, and other forms of equity, by effecting change across one or more domains of structural racism and other intersecting forms of structural discrimination (e.g., voting rights, stand-your-ground, racial profiling, mandatory minimum prison sentencing, immigrant exclusion/protections, fair housing, minimum wage, predatory lending, punishment in schools, stop-and-identify laws, and environmental justice).
2. **Unclear/Sometimes:** The policy addresses a domain of structural racism or other intersecting forms of structural discrimination, but it is unclear whether the policy improves racial equity or other forms of equity or could result in potential harms. The policy's ability to advance equity may depend on the details of its implementation.
3. **No:** The policy does not address racial equity or other forms of equity, it results in potential harm or reinforces racial or other intersecting inequities in power, opportunity, wealth, or health.

**Operational Approach to Equity.** *Does the policy advance equity using one or more of the following approaches? (Check all that apply)*

**Assessment measure(s):**

1. Distributional equity "relates to resource allocation and procurement that responds to a history of unequal treatment and outcomes."
2. Procedural equity "relates to the fairness of processes, often in terms of access to services."
3. Structural equity "relates to designing policies and systems to minimize obstacles and change incentives in ways that promote equity."

# Footnotes

## Increase Funding for Community Health Centers (CHCs)

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Policy is promising based on qualitatively assessed criteria that includes recently passed in multiple states and little to no legal considerations that would restrict implementation.

**Example of rationale for "weak" qualitative assessment**:

Policy is promising based on all quantifiable criteria, but it's typically implemented at the federal level (policy status) and, due to the policy being race conscious, may be challenging in current political context (legal considerations).

**Example of rational for "mixed" qualitative assessment:**

Policy is promising based on all quantifiable criteria, but it's typically implemented at the federal level (policy status), though recently, many states have introduced or passed legislation to address legal void (legal considerations).

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