



**MECHANISMS FOR ADVANCING HEALTH EQUITY
POLICY BRIEF**

Six Policies that Advance Black Health and Wellbeing

In honor of Black History Month, Network attorneys and staff have highlighted six policies that have the power to reduce health disparities and improve outcomes for Black people and communities of color throughout the United States. This policy brief serves as a practical tool to help public health professionals, leaders, and partners share strategies that can advance, rather than threaten, Black health and wellbeing over the long-term.

Overview

Selection of Policies that Advance Black Health and Wellbeing

POLICY	DESCRIPTION	STRATEGY IN ACTION
Restoration of voting rights.	Access to voting is linked to better health outcomes. States can restore the right to vote for people with felony convictions, including those who may be currently incarcerated. Felony disenfranchisement laws disproportionately affect Black people.	In 2020, Iowa Governor Kim Reynolds issued an executive order to restore the right to vote to people with felony convictions who had already served their sentences. ¹ Following this order, nearly 4,000 people re-registered to vote before the 2020 general election, and 77 percent of those people actually voted. ² According to a 2020 report from The Sentencing Project, of the more than 34,000 disenfranchised Iowans, 21.2 percent are Black. ³ However, Black people make up only 4.3 percent of Iowa’s population. ⁴
Enact legal standards to restrict police contacts during crisis response.	States can legislate to restrict police involvement in crisis response to remove unnecessary police contact.	California passed legislation to fund and support the new national crisis lifeline 988, which includes studying the viability of 988 mobile crisis teams that would only involve the police “in high-risk situations” in which police are needed. Limiting police contacts supports racial health equity as police disproportionately kill Black people, including individuals who are experiencing a mental health crisis. Such violence adds to racial trauma experienced by Black communities.

Appointing a public heat officer to help address extreme heat in formerly redlined communities.

Having a heat officer and team can enable jurisdictions to enact equitable, comprehensive heat mitigation to protect individuals from extreme heat and remedy past harms.

In 2021 Miami-Dade County appointed the first heat officer in the world, followed by Phoenix who appointed the first publicly funded heat officer, both of which are working on ways to mitigate heat including in neighborhoods that experience disproportionate urban heat due to structural inequities like redlining.

Providing insurance coverage for doula care.

Doula care can reduce morbidity and mortality during pregnancy, childbirth, and postpartum, particularly for Black pregnant people.

By 2021, Minnesota, New Jersey, and Oregon had expanded their Medicaid programs to include coverage for doula care for all covered patients; Florida's program allows managed care programs to cover the services. Several jurisdictions recently expanded Medicaid coverage to include doula care and are in the process of implementing the policy: California, District of Columbia, Illinois, Indiana, Maryland, Nevada, Rhode Island, and Virginia.⁵

Utilizing Medicaid demonstration waivers to help address social determinants of health.

States should utilize the authorities given to them by the Centers for Medicare & Medicaid Services to implement interventions which address the social determinants of health, which disproportionately impact Black people.

In 2022 California shifted their state Medicaid program, Medi-Cal, to a population health-based approach called Cal-AIM which places an emphasis on prevention, and on addressing social determinants of health, and advancing health equity. Prior to being integrated with Medi-Cal, CalAIM began as two pilot programs: county-based Whole Person Care (WPC) pilots and plan-based Health Homes Program (HHP) pilots where they found decreases in the number of emergency department visits and inpatient utilization rates. Justice-involved individuals saw an increase in their ability to control their blood pressure. Pilots also saw an increase in the percentage of individuals experiencing homelessness who received permanent housing, housing services, and supportive housing. Rates of initiation and engagement of alcohol and other drug abuse or dependence treatment also increased.

Expanding Medicaid and providing no-cost coverage of abortion care.

Black individuals are more likely to be enrolled in Medicaid than individuals who are White, Hispanic, Asian, and Native Hawaiian or Pacific Islander; as such, ensuring access to reproductive health care for Medicaid enrollees is a key priority to advancing Black health and wellbeing. States should not only expand their Medicaid populations to ensure that pregnancy-capable individuals have greater access to reproductive health care before and after becoming pregnant; they should also ensure no-cost coverage of abortion through Medicaid and private insurance programs to alleviate cost barriers to access.

In addition to repeatedly expanding its Medicaid population after passage of the ACA, California passed Senate Bill 245 in March 2022, which prohibits most cost-sharing or co-pay arrangements for abortion and abortion-related care in the state, eliminating additional cost-based barriers to abortion services.

Discussion

Restoration of Voting Rights

Felony disenfranchisement laws prevent millions of people from voting—an estimated 5.2 million as of 2020.⁶ These individuals are disproportionately Black, largely due to systemic issues in policing⁷ and the legacy of historical efforts to suppress the Black vote. In one recent report, an analysis showed that traffic stops by police in Hillsborough County, Florida reduced voter turnout in the 2014, 2016, and 2018 federal elections.⁸ Felony disenfranchisement laws vary widely across



the U.S. In Maine, Vermont, and Washington, DC, people with felony convictions never lose the right to vote. On the other end of the spectrum, in 11 states, people lose the right to vote until the completion of their sentence and then often have to take additional action or face a waiting period before their rights are restored.⁹

This matters for health because felony disenfranchisement is about more than the right to vote. It is about having access to the resources and opportunities that create health and well-being. People have better health outcomes across their lifespan when they have access to education, economic stability, safe and affordable housing, and health care. People with felony convictions experience barriers in obtaining housing and employment, accessing education, and having health care coverage and access. These are issues decided and shaped by elections. As seen in the 2022 midterms, significant issues including abortion rights, housing, energy and climate, criminal justice and policing, and transportation were all decided via ballot initiatives and referendums.

People should have a say in the policies that affect them, their families, and their communities. As shown in the Health & Democracy Index, states that make voting more accessible have better health outcomes, including lower premature and infant mortality, where significant disparities exist for Black Americans.¹⁰ Ensuring that everyone can engage in the political process will reduce significant voting disparities for Black people and can help make headway on disparities in health. The importance of voting as a determinant of health has been recognized by both the American Public Health Association¹¹ and American Medical Association.¹² In 2020, the American Bar Association passed a resolution calling on all levels of government to repeal laws that disenfranchise individuals and restore voting rights to those currently and formerly incarcerated.¹³ As of February 15, 2023, 22 states have introduced 75 bills related to felony disenfranchisement and rights restoration.¹⁴

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Enact Legal Standards to Restrict Police Contacts During Crisis Response

This policy brief would be incomplete without a discussion of policing. The Washington Post, one of the few entities tracking police caused fatalities (which governments refuse to do in any systemic way), found that in 2022 the police killed more people than any other year since they began tracking the deaths (1,096 deaths versus 958 in 2016).¹⁵ Police consistently and disproportionately kill Black people. Mapping Police Violence determined police are 2.9 times more likely to kill Black versus White people.¹⁶ People experiencing a mental health crisis are also vulnerable, representing at least 20 percent of people killed by the police.¹⁷ These deaths inflict racial trauma that runs deep and wide. Racial trauma is a product of not only directly experiencing racism, but also witnessing, reading about, and living within a system defined by structural racism and violence.¹⁸ As professor Monnica T. Williams and others explain in assessing racial trauma and post-traumatic stress disorder “[people of color] suffering from the symptoms that have arisen as a result of their trauma often cope with their issues in an environment that further traumatizes them.”¹⁹ This includes being subjected to what feels like a never-ending onslaught of violent police killings.

This raises the question of why police are so often used in crisis response. The new federally enacted national dialing code 988 is for individuals experiencing a suicide, mental health, or substance use crisis.²⁰ Congress authorized states to pass legislation to fund 988 and accompanying services, including crisis response. This presents an opportunity for states to legislatively restrict police involvement in crisis response. California passed the Miles Hall Lifeline and Suicide Prevention Act to support 988 services and study the feasibility of mobile crisis teams that could respond to 988 contacts “as an alternative to law enforcement, except in as needed high-risk situations that cannot be managed without law enforcement.”²¹ This is important because other states are generally eliminating, or not including, language in 988 legislation that would limit police involvement in mobile crisis teams as legislation moves forward.²² California has taken steps that support the goal of 988 being an alternative to 911 and a police response. Contrast this with popular co-responder models, in which police are paired with mental health and other professionals to respond to people in crisis, and in which police are often trained through crisis intervention programs to make them better equipped to help people in crisis. Co-responder teams operate throughout the nation. They are often presented as an equitable solution to policing. This cannot be. There is no evidence that either decreases racial disparities in the use of police force.²³ Supporting Black peoples’ health means reforming these practices



and removing unnecessary police contacts. 988 can be a system that promotes racial health equity, but states must connect the dots between policing and racial trauma.

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Appointing a Public Health Officer Can Help Address Extreme Heat in Formerly Redlined Communities

Extreme and record-breaking heat events are on the rise as the United States feels the effects of climate change.²⁴ Among other things, extreme heat can affect physical and mental health; increase health risks for individuals with heart disease, lung disease, and kidney disease; and lead to adverse birth outcomes and heat stroke.²⁵ Heat causes more deaths annually than any other weather event – by some estimates as many as 12,000 heat related deaths occur in the United States each year.²⁶ Like most climate-related disasters, the impacts of extreme heat are inequitable, with increased risks for outdoor workers, unhoused persons, aging populations, and individuals living in urban heat islands.²⁷ Urban heat islands are often located in communities with low incomes and communities of color, where a high percentage of hot impervious surface and limited greenspace increase heat exposure and extreme heat.²⁸ This is the result of racist housing policies including redlining: in the 1930s “residential security” maps created for the Home Owner’s Loan Corporation shaded areas red that were deemed hazardous for real estate investments, largely based on the racial makeup and income of the neighborhood.²⁹ These redlined areas saw subsequent disinvestment, and residents had reduced access to credit, which led to lower levels of home ownership.³⁰ Redlined neighborhoods had fewer owner-occupied premises, or green spaces, and were often slated as sites for industrial and transportation development that increased heat-trapping impervious surfaces.³¹ Today formerly redlined areas are, on average, 5 degrees hotter, and in some cases more than 10 degrees hotter, than neighborhoods with higher percentages of White residents.³²

Having a dedicated heat office can help address the continuing harms of redlining. Miami-Dade County (MDC) in Florida, the cities of Phoenix and L.A. have each appointed heat officers.³³ MDC was the first to create such an office in 2021 and Phoenix was the first to use public funds to do so. These offices have the potential to take a holistic approach to heat mitigation that is responsive to the nuances of racially driven health inequities in formerly redlined communities. The heat officers are engaged in multiple strategies to mitigate and respond to heat. They also provide a unique platform to receive community input on all things heat-related, including issues that are of concern for individuals living in formerly redlined communities. The Chief Heat Officer in MDC, for instance, leads a cross-sector climate and heat health task force.³⁴ The task force created an Extreme Heat Action Plan (Plan), with broad input from communities, and other stakeholders, to address the health and economic impacts of extreme heat.³⁵ One of the Plan’s guiding principles is that equity requires “recognizing that historic discriminatory policies have led some residents to have fewer resources to adapt to climate change.”³⁶ As such, access to air conditioning and affordable housing and utility bills are key components of the Plan’s heat resiliency goals.³⁷ This approach recognizes that housing justice is interwoven with health justice and must be included in other more traditional climate priorities.

Why is this important to the intersection of heat, health, and redlining? The needs of Black communities in redlined neighborhoods diverge from those of many privileged affluent White communities who may focus on green reforms like more shade, trees, and renewable energy. Formerly redlined neighborhoods do need more shade; but affordable utility bills, home weatherization and even public goods like community solar are often of equal or even higher priority. Moreover, increasing green infrastructure, e.g., planting more trees, can decrease the health impacts of urban heat islands but can also increase property values.³⁸ This can lead to community displacement, a form of climate gentrification.³⁹ Heat offices can center racial health equity by understanding how racism makes some communities hotter and ensuring that racism does not creep into heat response and mitigation through a failure to prioritize the needs of Black communities.

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Insurance Coverage for Doula Care

Maternal morbidity and mortality in the U.S. are astoundingly high as compared to other wealthy nations.⁴⁰ For Black pregnant people, regardless of education or income level, the rate of maternal injury, illness, or death during pregnancy, childbirth, or postpartum far exceeds that of White pregnant people.⁴¹ Myriad factors cause this inequity and there are many policy options designed to improve health outcomes for pregnant Black people, including providing access to doula care.

Doula care improves health outcomes for pregnant Black people by providing emotional, physical, and educational support throughout the perinatal period. Doulas can assist with managing chronic medical conditions, developing a birthing plan, and advocating for the pregnant person, particularly during childbirth.⁴² The cost of doula care can vary greatly, from several hundred to several thousand dollars, depending on the type of doula and the scope of the care provided. Despite the known benefits of doula care, no state mandates that private health insurance policies cover the cost of doula care. To the extent progress is being made on doula care coverage, it has been in state Medicaid programs.

As of 2022, 12 states offer some coverage of doula care to Medicaid patients. Minnesota, Florida, and Oregon have offered such coverage for several years and newcomer states are in various phases of implementation of doula coverage for Medicaid patients: California, District of Columbia, Illinois, Indiana, Maryland, Nevada, New Jersey, Rhode Island, and Virginia.⁴³ According to Maryland's policy, "doulas serving Maryland Medicaid members will provide person-centered, culturally-competent care that supports the racial, ethnic, and cultural diversity of members while adhering to evidence-based best practices."⁴⁴ Coverage of doula care varies across the states, but most provide coverage for a modest number of doula visits during pregnancy and postpartum and all cover, to some extent, doula support during childbirth.

Recent qualitative studies support the value of access to doula care. "Community doulas play an instrumental role in the birth experiences of Black women and birthing people. Efforts should be made to expand access to this needed support via policy and hospital practices."⁴⁵ "Including a trusted, knowledgeable advocate . . . may be an important intervention in improving Black women's prenatal care experiences, reducing stress associated with medical interactions, and ultimately reducing pregnancy-related health disparities."⁴⁶

States that have expanded access to doula care for Medicaid patients are taking a step in the direction of reducing maternal health disparities for Black families. A jump in that direction would be mandating doula coverage for all pregnant people by adding a mandate for private health insurance policies.

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Utilizing Medicaid Demonstration Waivers to Help Address Social Determinants of Health

In December of 2021, the California Department of Health Care Services (DHCS) received CMS approval for the CalAIM Section 1115 demonstration and CalAIM Section 1915(b) managed care waivers.⁴⁷ This approval authorized \$1.44 billion in one-time funding to aid in transitioning Whole Person Care and Health Homes Program pilots, which leverage care coordination and offer non-medical interventions from Medi-Cal 2020 to CalAIM. This approval also makes way for DHCS to address the needs of California's most vulnerable residents, provide more equitable programs, and increase access across the state.⁴⁸ Key provisions of CalAIM include community supports delivered through community providers; enhanced care management; delivery system transition and alignment; access to and transforming health supports; substance use disorder services and initiatives; supporting coordination and integration for dual eligibles; dental benefits; chiropractic services for Indian Health Service and Tribal facilities; and a global payment program.

On any given night over 161,000 people are experiencing homelessness in California and there are stark racial disparities within California's homeless population; Black people make up 39 percent of California's homeless population while only making up 13 percent of the state's general population.⁴⁹ These racial disparities are connected to racist policies like redlining, which resulted in housing, economic, educational, and health inequities. Experiencing homelessness also puts Black people at an increased risk of being justice-involved due to the increased likelihood of interacting with law enforcement.⁵⁰ A key aim of CalAIM is to address the needs of individuals experiencing chronic homelessness by providing them with enhanced care management and community supports that offer coordinated and community-based whole person care. Housing related community support includes assisting enrollees with finding and securing housing, assistance with



securing housing deposits and support maintaining stable tenancy once housing has been secured. In paying special attention to those who face the biggest barriers to accessing stable housing (i.e., those re-entering the community after incarceration) DHCS is better able to reach those most impacted to better ensure successful transition into safe and stable housing. CalAIM's goals to improve access to coordinated health and social services have the potential to positively impact the lives of Black people and promote their health and wellbeing, especially in relation to addressing homelessness and housing instability. Since launching in 2022, initial observations from the roll out of community supports and enhanced care management recognized the importance of outreach and engagement activities and the crucial role that community health workers, peer support providers and those with lived experiences play in engaging those who need these services most.⁵¹ Other states may adopt this type of strategy as a means to address social determinants of health in their communities.

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Expanding Medicaid and Providing No-cost Coverage of Abortion Care

Almost 13 years after passage of the Patient Protection and Affordable Care Act (ACA) in 2010, only 11 states still refuse to expand their Medicaid coverage populations.⁵² Expansion is critically important for Black patient populations, which, according to 2021 data,⁵³ make up a larger percentage of the Medicaid population than individuals who are White, Hispanic, Asian, Native Hawaiian or Pacific Islander. While uninsured individuals may be able to enroll in Medicaid during pregnancy, the lack of coverage in non-expansion states preceding or following the pregnancy can severely limit access to general reproductive health care.⁵⁴ Notably, as of February 2022, 37 percent of uninsured Black individuals live in just three non-expansion states: Texas, Florida, and Georgia.⁵⁵

When it comes to abortion post-*Dobbs v. Jackson Women's Health Organization* (decided June 24, 2022), access may be out of reach for many Black pregnancy-capable individuals (even in states which have not outlawed the procedure) because of cost-based barriers.⁵⁶ While the Hyde Amendment prevents the use of *federal* funds for abortions (except in the cases of rape, incest, or to save the life of the mother), states may choose to use their own *state* funds to provide broader Medicaid coverage for abortion services.⁵⁷ According to the Guttmacher Institute, roughly 16 states provide state Medicaid funding for abortions beyond what the Hyde Amendment allows.⁵⁸ This pathway could prove politically achievable in states like Michigan, which currently allows Medicaid coverage of abortions only when the mother's life is in danger. In November 2022, Michigan voters passed an initiative to expressly enshrine reproductive rights in the Michigan Constitution.⁵⁹ In Michigan, 48.9 percent of Black individuals are on Medicaid, illustrating the clear impact this change in policy could have.⁶⁰ California's Medicaid program, Medi-Cal, already covers abortions without cost-sharing for enrollees, which is highly impactful, as roughly half of all abortions performed in California are Medi-Cal-covered.⁶¹ In addition, in March 2022, California enacted Senate Bill 245, which prohibits most insurance plans from imposing cost-sharing arrangements on abortion and abortion-related services and eliminates abortion services delays, including prior authorization.⁶² Senate Bill 245 ensures increased access to abortion services by continuing to eliminate deterrent cost-based barriers previously passed onto patients.

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Conclusion

This policy brief has examined only a selection of policies that have the power to advance equity. The Network will continue to examine existing and emerging law and policy approaches that will truly promote health for Black communities. We encourage you to contact the Network contributors with questions, comments, or thoughts so that we can aid in your work.

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