PIVOT

Advancing Racial Justice in U.S. Healthcare Policy

PIVOT Think Tank

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Civil Rights

Written by: Eshal Hameed

Led by: Mathew Habib

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Overview

Racial justice in health care fundamentally means ensuring that every individual has a fair opportunity to achieve their full health potential, free from disadvantages imposed by race or ethnicity. This concept requires actively dismantling systemic racism and bias within the health care system and addressing the social determinants of health that perpetuate health disparities.

Health disparities are defined as racial or ethnic differences in the quality of health care that are not attributable to access-related factors, clinical needs, or appropriateness of interventions. These disparities are consistently observed across various illnesses and health care services, even when controlling for socioeconomic status and health insurance.

The historical roots of racial disparities in U.S. healthcare are deeply intertwined with structural racism, including the legacy of segregation and discriminatory policies. Historically, health systems were structured to advantage the white population while disadvantageing racial and ethnic minority populations, leading to unequal access to resources and quality care. Even with legal desegregation, the effects of these historical practices continue to influence health outcomes through unequal resource allocation and implicit biases.

Key concepts underpinning this issue include structural racism, which describes how societies foster racial discrimination through reinforcing systems like housing, education, employment, and healthcare. Institutional racism involves individual biases, also significantly impacts patient-provider interactions and treatment quality. Understanding these interconnected factors is crucial for developing effective interventions to achieve health equity—the assurance that conditions necessary for optimal health are available to everyone.

Introduction

Racial justice in healthcare represents a pressing and multifaceted challenge in the United States, stemming from a deeply entrenched history of systemic racism and discrimination that continues to manifest as profound health inequalities. These disparities disproportionately affect racial and ethnic minority groups, leading to unequal access to quality care, unfortunate health outcomes, and a fundamental breach of societal fairness.

Health disparities are pervasive and persistent: Black Americans, for example, have higher rates of chronic illnesses such as hypertension, diabetes, and asthma; Native Americans and Alaska Native communities experience some of the worst maternal and infant health outcomes; and Latino populations face disproportionately high rates of uninsurance. These inequalities are not due to genetic differences but are driven by a legacy of discriminatory policy design, geographic

segregation, environmental injustice, underinvestment in public health infrastructure, and a healthcare system that is largely unresponsive to cultural differences.

The COVID-19 pandemic starkly illuminated and amplified the severe reality of these health inequalities, with racial and ethnic minority groups experiencing disproportionately higher infection rates, deaths, and limited access to treatment. According to CDC data, during the peak of the pandemic in 2020 and 2021, Black Americans were dying at 1.7 times the rate of white Americans, and Indigenous people at more than twice the rate.

Beyond infection and death, these communities also faced greater difficulty accessing COVID testing, treatment, and later vaccines. Many lacked paid sick leave or remote work options, and the burden of preexisting health disparities collided with the strain of economic marginalization, amplifying the crisis. Achieving racial justice in healthcare is not merely an ethical imperative but a critical component of ensuring the well-being and productivity of the entire population.

A pivotal piece of recent legislation influencing this landscape is the One Big Beautiful Act (OBBA), often referred to as the “Big Beautiful Bill.” Enacted in 2025, this extensive federal law introduced significant reforms, particularly affecting Medicaid, a program vital for low-income populations, including many racial and ethnic minorities. The OBBA imposed stricter work requirements, increased administrative barriers for enrollment, and restricted state funding mechanisms, leading to projected coverage losses for millions of Americans.

Given that racial and ethnic minority groups disproportionately rely on Medicaid, these provisions threaten to exacerbate existing health disparities and roll back earlier gains made to advance racial health equity. According to a 2025 Congressional Budget Office estimate, the OBBA could lead to coverage losses affecting over 4.5 million people within three years, with the sharpest drop-offs among Black and Latino adults.

In contrast, other landmark legislation, such as the Affordable Care Act (ACA), enacted in 2010, marked a watershed moment by expanding Medicaid, mandating race and ethnicity data collection, promoting workforce diversity, and fostering cultural competency. Similarly, Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, or national origin in federally funded programs, including health care, aiming to advance equity.

The legislative environment is complex, with some policies, like the ACA, striving to reduce disparities, while others, like the OBBA, risk deepening inequities by curtailing access and affordability. The ACA resulted in the uninsured rate among Black Americans dropping from 19% in 2010 to 11% by 2016, and for Latinos, from 32% to 19%.

Moreover, proposed legislation such as the Health Equity and Accountability Act (HEAA), reintroduced in Congress multiple times since 2003 but never passed, offers a blueprint for what racially just healthcare reform could look like. HEAA proposes comprehensive strategies to

eliminate disparities, including language access services, funding for minority-serving health institutions, and new requirements for equity audits in federal health agencies.

Another recent initiative is the John Lewis Medicare for All Act of 2023, which not only expands universal coverage but includes explicit provisions to redress historical racial inequities in access and outcomes.

This policy brief provides a comprehensive review of how structural racism is embedded in health care policy, analyzes the impact of existing laws including the OBBA, as well as proposes specific, actionable policy initiatives to dismantle barriers and foster equitable health outcomes for all.

Historical Foundations of Structural Racism in Healthcare

The roots of racial injustice in American healthcare date back to slavery, settler colonialism, and Jim Crow segregation. From the earliest days of the republic, enslaved Black Americans were subjected to non-consensual medical experimentation, famously exemplified by Dr. J. Marion Sims' procedures on enslaved women without anesthesia.

The 1932–1972 Tuskegee Syphilis study by the U.S. Public Health Service, in which treatment was deliberately withheld from Black men, further exemplifies how federal agencies have violated the bodily autonomy of African Americans under the guise of public health research. For Indigenous populations, healthcare was used as a tool of assimilation and control. The federal Indian Health Service (IHS), created in 1955, remains chronically underfunded and overburdened.

IHS per capita spending was $4,078 in 2019—less than half of the national average. Many Native communities still face extreme distances to basic care, particularly for maternal health and mental health services.

Racial segregation in hospitals was legal until the Civil Rights Act of 1964, particularly Title VI, which prohibited race-based discrimination in federally funded programs. However, enforcement was often delayed. As late as 1972, many Southern hospitals had not fully desegregated. The Hill-Burton Act of 1946, which funded hospital construction, explicitly allowed "separate but equal" facilities.

These historical foundations created a system where race determined access, outcomes, and quality of care. Understanding this context is vital for crafting modern policy interventions that aim not just to improve health access generally, but to undo race-based inequities intentionally built into the system.

Medicaid Policy and the One Big Beautiful Act (OBBA)

Medicaid, established in 1965, is the largest public insurer for low-income Americans and plays an outsized role in the health of communities of color. Over 60% of Black children, and nearly half of all Hispanic adults rely on Medicaid for health coverage. But the 2025 One Big Beautiful Act (OBBA) has significantly altered this landscape.

The OBBA, while touted as a fiscal reform bill, implemented a block grant funding structure that capped federal Medicaid contributions. States previously received matching funds for every dollar spent. Under OBBA, federal contributions are fixed, regardless of enrollment surges due to economic downturns or public health crises. The Congressional Budget Office estimated this would result in a $920 billion cut over 10 years.

The law also introduced strict work requirements: Medicaid recipients aged 19-55 must prove 80 hours of work or approved activity monthly, with no federal exemptions for caregiving or unstable gig work. Arkansas's 2018 pilot program with work requirements led to 18,000 people losing coverage in under a year—95% of whom were working but could not complete bureaucratic compliance steps. The OBBA replicated this model at the national level.

Administrative burdens disproportionately impact racial and ethnic minorities, who are more likely to experience job instability, housing insecurity, and unreliable internet access. Additionally, OBBA restricts retroactive coverage for new enrollees, which previously allowed hospitals to be reimbursed for treating uninsured patients. This affects safety-net hospitals that disproportionately serve Black and Latino communities.

Finally, OBBA allows states to waive coverage for certain "nonessential" services including adult dental, vision, and reproductive health—which are critical for overall well-being and disproportionately impact women of color. The law accelerates a two-tiered system: high-quality care for those with stable employer-sponsored insurance, and minimal coverage for low-income, often non-white populations.

The OBBA has reversed many gains made under the ACA, which expanded Medicaid to cover millions. It represents a case study in how federal legislation, under the guise of fiscal conservatism, can deepen racial disparities in health access and outcomes.

Hospital Deserts and Infrastructure Inequity

Across the United States, particularly in rural regions and urban neighborhoods with high Black and Latino populations, access to hospital-based care is diminishing. From 2010 to 2023, over 140 rural hospitals closed, with the greatest losses concentrated in the Southern region with both the largest Black and Latino populations and the highest uninsurance rates. In Mississippi, for instance, over 60% of rural hospitals are at immediate risk of closure.

This phenomenon is driven by multiple policy factors: non-expansion of Medicaid, high levels of uncompensated care, and state-level funding formulas that disadvantage low-income and minority communities. Safety-net hospitals, such as public hospitals and nonprofit community providers, rely heavily on Medicaid and Disproportionate Share Hospital (DSH) payments. OBBA's shift toward block grants reduced the predictability and sufficiency of these funds, forcing many providers to reduce services or shut down altogether.

In urban areas, "hospital deserts"—entire ZIP codes without a full-service hospital—are common in segregated black neighborhoods. A 2024 study by the Health Equity Institute found that Black-majority ZIP codes are 75% more likely to lack hospital access compared to white-majority ZIP codes. Even when hospitals remain open, service line closures are common: maternity wards, trauma centers, and mental health units are often the first to go.

Infrastructure investments have failed to keep up. The 2021 Infrastructure Investment and Jobs Act provided modest funding for broadband expansion and telehealth capacity, but it did not include a dedicated health facilities provision. The proposed Hospital Equity and Access Modernization (HEAM) Act of 2025—currently in the House Committee—would appropriate $15 billion over five years to expand hospital infrastructure in underserved areas.

Without legislative intervention to stabilize funding and incentivize service provision in marginalized communities, access gaps will worsen. A core racial equity strategy must include the preservation and expansion of healthcare infrastructure in high-need regions.

Data Transparency and Accountability

One of the most persistent barriers to racial equity in healthcare is the lack of complete, standardized, and actionable data on race as well as ethnicity in health services. The ACA mandated race and ethnicity data collection under section 4302, but compliance has been inconsistent across states and private health systems. Only 31 states require hospitals to report race and ethnicity data for all patient encounters.

This data gap makes it nearly impossible to evaluate the equity impact of insurance denials, treatment differences, or mortality outcomes in real time. A 2023 GAO report found that only 43% of Medicare Advantage plans submitted complete race/ethnicity data, and fewer than 25% of commercial plans did so.

The Equitable Data Collection and Disclosure Act (EDCDA), introduced in 2024, seeks to resolve these gaps. It would require all insurers participating in Medicaid, Medicare, and ACA exchanges to report disaggregated race and ethnicity data on coverage, cost-sharing, service denial, and outcomes. It also includes funding for states and tribal governments to upgrade IT infrastructure for data tracking.

Lack of data also obscures algorithmic bias. Many electronic health record systems use predictive risk scores that underestimate the severity of illness in Black patients due to reliance on prior healthcare usage as a proxy for need. This was documented in a 2019 study published in *Science*, which found that Black patients were systematically deprioritized for care management.

Effective policy must include enforceable standards: civil rights auditing mechanisms for federal health programs, transparency requirements for private insurers, and race-conscious regulatory reviews of health technology tools. These mechanisms are crucial not just for identifying disparities but for holding institutions accountable to fixing them.

Insurance Coverage and Medical Debt

Despite the ACA's successes, over 25 million Americans remain uninsured—and they are disproportionately people of color. According to the Kaiser Family Foundation, 31% of Latinos, 23% of Native Americans, and 19% of Black adults under 65 are uninsured, compared to 11% of white adults. Undocumented immigrants, excluded from federal programs including Medicaid and ACA subsidies, remain among the most vulnerable.

Even insured patients of color face higher rates of underinsurance and medical debt. A 2022 Urban Institute study found that Black adults were 50% more likely to have medical debt in collection than white adults. Medical debt not only limits access to care—it affects credit scores, housing eligibility, and job prospects, perpetuating poverty.

Insurance discrimination is also prevalent in employer-sponsored plans. A 2023 analysis by the Commonwealth Fund showed that large employers in majority-white industries tend to offer better coverage than those in disproportionately Black and Latino sectors. Even among unionized sectors, wage tiering has left low-income workers with higher deductibles and limited networks.

State-level policies also perpetuate inequality. For example, ten states (all with majority Republican legislatures) have opted out of Medicaid expansion as of 2025. This decision has left over 2 million people—primarily in the South—in a coverage gap. The proposed Medicaid Saves Lives Act, introduced in 2021 and reintroduced in 2024, would create a federal fallback plan for non-expansion states but has yet to pass the Senate.

Healthcare coverage is a racial justice issue. Without universal, affordable insurance that includes all residents regardless of immigration status, health disparities will continue to widen. Any federal racial equity agenda must center coverage as a core component—including banning medical debt reporting on credit scores and expanding subsidies to undocumented populations.

Workforce Diversity and Institutional Racism in Medical Education

The racial composition of the U.S. healthcare workforce does not reflect the population it serves. As of 2023, only 5.7% of doctors are Black, and just 6.8% are Latino. Native Americans make up less than 0.4% of physicians. These disparities are not due to individual choices alone—they reflect policy decisions that have hindered entry, advancement, and equity in training.

The Graduate Medical Education (GME) funding system, controlled by Medicare, allocates over $16 billion annually to teaching hospitals but does not tie funding to equity outcomes. Teaching hospitals serving low-income and minority populations often receive less per-resident funding. Additionally, few GME-funded programs are located in historically Black medical schools or tribal health systems.

The Resident Physician Diversity and Equity Act, proposed in 2024, would reform GME funding formulas to reward diversity in training pipelines. It includes a 25% bonus to teaching hospitals where more than 30% of residents are from underrepresented groups and creates dedicated slots for community-based teaching programs in medically underserved areas.

Racial bias in medical training further reinforces disparities. Numerous studies, including a 2016 *PNAS* survey, have shown that many white medical students and residents believe false biological myths about Black patients (e.g., that they have “thicker skin” or feel less pain). These beliefs translate into lower prescribing rates for pain medication and lower referral rates for specialty care.

Policy solutions must focus not only on increasing minority representation but on institutional reform. That includes mandating anti-racist curricula, holding licensing boards accountable for eliminating bias in assessments, and expanding scholarships for students from historically marginalized backgrounds.

Diversifying the healthcare workforce is one of the most evidence-based strategies for improving patient trust, satisfaction, and outcomes—especially in Black, Latino, and Native communities that have faced neglect.

Emergency Rooms, Discrimination, and Crisis Response Gaps

In the absence of consistent primary care access, many Black, Latino, and Native American patients rely heavily on emergency rooms. But ERs are not neutral spaces. Implicit bias, inadequate triage systems, and overcrowding mean that patients of color often receive delayed or substandard emergency care. A 2023 Yale School of Medicine study found that Black patients were 25% less likely to receive timely EKGs during suspected heart attacks—a delay that significantly increases mortality.

These disparities persist even after adjusting for income and insurance status. Why? Because triage systems often use clinical algorithms that underestimate pain in Black patients and over-prioritize white patients for care. Language barriers further delay care for Latinos and immigrant patients—less than 20% of ERs nationally meet federal requirements under Title VI to provide interpretation services.

State and federal laws already require nondiscriminatory care in ERs. The Emergency Medical Treatment and Labor Act (EMTALA) mandates that hospitals evaluate and stabilize any patient regardless of ability to pay. Yet, enforcement is weak. Between 2015 and 2022, only 11 hospitals nationwide were penalized for EMTALA violations related to race or language—despite thousands of complaints.

Moreover, in behavioral health emergencies—often involving police—Black patients are more likely to be met with force than support. In many counties, mental health crisis response is handled by police instead of trained clinicians. This has led to deadly outcomes: 30% of people shot by police during mental health crises are Black, according to the Treatment Advocacy Center.

Proposed reforms include the Improving Mental Health Emergency Response Act and the Behavioral Crisis Services Expansion Act, which would fund mobile crisis teams and require emergency departments to report race/ethnicity breakdowns in restraint use, security calls, and involuntary holds.

A racial justice lens requires redefining emergency care not just as a site of stabilization, but as a frontline for civil rights enforcement. Equity-focused ER standards, real-time reporting, and culturally competent crisis response are critical to transforming emergency medicine into a safe and just resource for all.

Exclusion of Immigrant Communities

While immigration and healthcare are often treated as separate policy domains, they intersect to produce some of the starkest racial inequities in the U.S. healthcare system. Latino, immigrant, and mixed-status families—particularly those from Mexico, Central America, and South America—are systematically excluded from coverage, benefits, and even access to basic health services due to federal policy, legal status, and racist enforcement practices. The consequences are deadly, and the legal foundations are both deliberate and ongoing.

Legal Barriers to Coverage

The foundation of this exclusion lies in the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). It created a “five-year bar” for lawful permanent residents (green card holders), preventing them from enrolling in Medicaid or CHIP for five years after arrival. It

also completely excluded undocumented immigrants from any federally funded health coverage, no matter how poor or sick.

The Affordable Care Act (ACA) reinforced these exclusions. It barred undocumented immigrants—and even DACA recipients—from purchasing ACA insurance plans, even if they paid full price. Today, Latinos remain the most uninsured racial group in the U.S., with nearly 1 in 5 uninsured—a number that rises sharply among non-citizens.

The "Public Charge" Rule and Its Aftershocks

The 2019 Trump-era expansion of the public charge rule triggered widespread fear. Though limited in technical scope, it caused immigrant families to withdraw from Medicaid and other benefits out of fear that doing so would jeopardize their legal status.

According to a 2021 Urban Institute report, 1 in 5 low-income immigrant families avoided health programs, even when their children were U.S. citizens. Latino families were most affected. Although President Biden formally reversed the rule in 2021, the chilling effect remains. In mixed-status households, undocumented parents often avoid enrolling their U.S.-born children, despite their eligibility—a devastating barrier during pandemics, natural disasters, and emergencies.

Healthcare Avoidance and Enforcement Fears

Federal exclusion is compounded by enforcement. ICE activity near clinics and hospitals, including reported surveillance and detentions, has contributed to healthcare avoidance. While international guidance discourages enforcement in "sensitive locations," reports from advocacy organizations like NILC and Human Rights Watch document continued intimidation.

For many Latino immigrants, even seeking COVID-19 testing or vaccination became a calculated risk. This fear-based avoidance led to higher COVID hospitalization and death rates among Latino populations—particularly in Texas, California, and Florida.

Fixing the System

1. Improve Medicaid and Health Coverage

- Change OBBA to remove strict work rules and funding caps that hurt many people of color who rely on Medicaid.
- Let immigrants get health coverage and stop policies that scare them away from getting care.

- Don’t allow medical bills to harm people’s credit; offer more financial help to low-income families of color.

2. Invest in Hospitals and Health Access

- Provide money to keep hospitals open in neighborhoods and rural areas that lack resources.
- Improve internet and telehealth services in poor or remote areas so people can get medical care more easily.

3. Collect Better Data

- Require hospitals and insurers to collect clear data on patients’ race and ethnicity to spot and fix unfair treatment.
- Use data to make hospitals and insurance companies responsible for closing health gaps.

4. Make Medical Education Fairer

- Give more money to teaching hospitals that have many minority doctors in training. Require all medical schools and hospitals to train staff on how racism hurts health and how to treat all patients fairly.

5. Fix Emergency Room Inequities

- Make sure emergency departments treat everyone quickly and fairly, provide language help, and fix biased policies.
- Fund mobile crisis teams that can help people instead of calling the police.

6. Enforce Equality Laws

- Make sure hospitals follow laws that stop racial discrimination and face penalties if they don’t.
- Include people from minority groups when making health policies to meet their real needs.

Conclusion

Achieving racial justice in healthcare demands comprehensive legislative and policy efforts that address structural racism’s multifaceted legacy and contemporary manifestations. Key priorities include reversing regressive Medicaid reforms, expanding inclusive coverage, investing in healthcare infrastructure in underserved minority communities, mandating transparent data

collection, diversifying the healthcare workforce, reforming emergency care practices, and rectifying exclusionary immigration-related health policies.

With focused leadership, meaningful community engagement, and sustained federal commitment, these measures can transform health equity from aspiration into reality for historically marginalized populations.

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