Research-Backed Policy Recommendations for Health Equity

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Brief #1: Expanding Medicaid Coverage

Issue Summary

Medicaid expansion under the Affordable Care Act has been one of the most significant health equity interventions of the past decade. As of 2026, 40 states and Washington D.C. have expanded Medicaid to cover adults with incomes up to 138% of the federal poverty level ($20,120 for an individual). However, 10 states have not expanded, leaving approximately 1.9 million people in the "coverage gap"—earning too much to qualify for traditional Medicaid but too little to afford marketplace insurance.

These individuals, disproportionately people of color living in the South, face impossible choices: forgo needed care, accumulate medical debt, or spend down to extreme poverty to qualify for Medicaid. The consequences are measured in preventable suffering, disability, and death.

Key Evidence

Coverage and Access:

• Expansion states saw a 7.3 percentage point decrease in uninsurance rates vs 1.8 points in non-expansion states (2013-2022)
• 21 million people gained Medicaid coverage through expansion
• Uninsurance rates among low-income adults dropped from 42.7% to 23.9% in expansion states
• Primary care visits increased by 8.2% and preventive services by 11.5% in expansion states

Health Outcomes:

• Expansion reduced mortality rates by 9.4 deaths per 100,000 adults annually—approximately 19,200 deaths averted between 2014-2020
• Cancer diagnosis at earlier, more treatable stages increased by 10.4%
• Diabetes management improved: A1C testing increased 5.2%, eye exams increased 6.1%
• Cardiovascular disease mortality declined 4.3% faster in expansion states
• Self-reported health status improved 3.9% in expansion states

Equity Impact:

• Uninsurance among Black adults decreased 10.9 points in expansion states vs 3.1 in non-expansion states
• Latino uninsurance decreased 11.2 points in expansion states vs 4.3 in non-expansion states
• Racial disparities in coverage decreased by 35% in expansion states
• Low-income women's access to reproductive healthcare improved significantly

Economic Impact:

• Hospital uncompensated care costs decreased by $6.2 billion annually
• Expansion states saw 240,000 new jobs in healthcare sector (2014-2021)
• State and local tax revenues increased by $3.2 billion from economic growth
• For every dollar states spent, federal government contributed $9 in matching funds
• Reduced medical debt: bankruptcies decreased 18% in expansion states

• Return on investment: Every $1 spent on expansion saves $2.40 in other state costs

Detailed Policy Recommendations

1. Expand Medicaid in Remaining States

• Cover all adults with incomes up to 138% FPL ($20,120 individual, $41,400 family of 4)
• Accept enhanced federal match: 90% federal funding vs 50-75% for traditional Medicaid
• Model successful expansion: Study implementation in states with similar political contexts
• Address political concerns: Implement work reporting (not requirements), wellness incentives, premium contributions for higher earners if needed to gain support

2. Strengthen Continuous Eligibility

• Implement 12-month continuous eligibility for all adults (currently only required for children)
• Reduce "churning": People losing and regaining coverage multiple times per year
• Evidence: Continuous eligibility reduces administrative costs by $400 million annually and improves chronic disease management
• Multi-year eligibility: Pilot 24-36 month eligibility for individuals with stable circumstances

3. Streamline Enrollment and Renewal

• Ex parte renewals: Use existing data to automatically renew eligibility without requiring individuals to submit paperwork
• Presumptive eligibility: Allow qualified entities to make immediate temporary eligibility determinations
• Simplified applications: Reduce from 10+ pages to 2 pages; eliminate asset tests
• Multi-benefit applications: Apply for Medicaid, SNAP, and TANF simultaneously
• Mobile-friendly online enrollment and document upload

4. Targeted Outreach and Enrollment Assistance

• Fund community-based navigators and application assisters, especially in areas with high uninsurance
• Partner with trusted community organizations, faith institutions, and libraries
• Culturally and linguistically appropriate outreach materials and enrollment support
• Meet people where they are: Enrollment at food banks, emergency departments, schools, jails
• Use data to identify and target eligible but unenrolled individuals

5. Expand Covered Services and Provider Networks

• Ensure adequate reimbursement rates to maintain robust provider participation
• Expand dental, vision, and hearing coverage (currently optional in many states)
• Cover doula services, midwifery care, and community health worker services
• Increase access to behavioral health and substance use treatment
• Address healthcare deserts through telehealth, loan repayment, and facility investment

Federal Policy Options

• Close the coverage gap nationwide: Create a federal Medicaid option for individuals in non-expansion states
• Increase federal matching rate: Incentivize expansion with 100% federal funding for first 3 years
• Condition other federal funding: Link other federal health or infrastructure funding to Medicaid expansion

• Allow Medicaid buy-in: Let individuals with incomes above 138% FPL purchase Medicaid coverage
• Lower Medicare age: Expand Medicare eligibility to age 60 or 55, reducing uninsurance among older adults

Implementation Considerations

States considering expansion should:

• Conduct actuarial analysis: Project enrollment, costs, and economic impact
• Build stakeholder coalition: Hospitals, providers, businesses, advocates, faith leaders
• Ensure adequate infrastructure: Eligibility system capacity, provider network, managed care
• Plan for enrollment surge: Immediate eligibility determination and adequate staffing
• Monitor and report: Track enrollment, access, quality, costs, and health outcomes
• Timeline: Most states successfully implemented expansion within 12-18 months

Key Sources

• KFF (2025). "Status of State Medicaid Expansion Decisions" • ASPE (2024). "Medicaid Expansion Impact on Coverage and Access" • NEJM (2023). "Medicaid Expansion and Mortality" • Health Affairs (2024). "Economic Impact of Medicaid Expansion" • Urban Institute (2025). "The Coverage Gap in Non-Expansion States"

Brief #2: Addressing Food Insecurity

Issue Summary

Food insecurity—the inability to consistently access adequate, nutritious food—affects 44 million Americans (13.5 million children). It is not merely hunger; it is the chronic stress of not knowing where your next meal will come from, the impossible choice between food and medicine, and the slow accumulation of poor health from inadequate nutrition.

Food insecurity is both a cause and consequence of poor health. It increases risk of chronic diseases, worsens disease management, and leads to higher healthcare costs. It is strongly linked to social determinants: poverty, unemployment, housing instability, and lack of transportation. Black and Latino households experience food insecurity at rates 2-3 times higher than white households.

Key Evidence

Prevalence and Disparities:

• 10.5% of U.S. households (13.8 million) experienced food insecurity in 2024
• 19.1% of Black households, 16.2% of Latino households, vs 7.0% of white households
• 29.3% of households headed by single mothers
• 33.8% of households living below poverty line
• 12.8% of households in rural areas

Health Impacts:

• Food-insecure adults have 32% higher annual healthcare costs ($6,821 vs $5,180)
• Diabetes: 2.5 times higher prevalence; worse glycemic control; higher hospitalization rates
• Hypertension: 1.6 times higher prevalence; poor blood pressure control

• Obesity paradox: Higher rates of obesity due to reliance on inexpensive, calorie-dense, nutrient-poor foods
• Mental health: 2-3 times higher rates of depression and anxiety
• Medication adherence: 40% of food-insecure adults report choosing between food and medications
• Children: Developmental delays, behavioral problems, lower academic achievement, and chronic diseases in adulthood

Food as Medicine Evidence:

• Medically tailored meals: A1C reductions of 0.4-0.6%, reduced hospital admissions by 16%, saved $2,400 per patient annually
• Produce prescriptions: Increased fruit/vegetable intake by 26%, improved A1C and blood pressure
• Food insecurity screening + referral: 68% of screened patients accessed food resources

Detailed Policy Recommendations

1. Integrate Food Insecurity Screening into Healthcare

• Require screening: Mandate food insecurity screening as a quality measure for hospitals, health centers, and accountable care organizations
• Standardize tools: Use validated 2-item Hunger Vital Sign or USDA 6-item module
• Train providers: Educate healthcare teams on screening, referral, and follow-up
• Build referral systems: Establish "closed-loop" referrals to food assistance with confirmation of connection
• Payment: Reimburse for screening and referral through Medicaid, Medicare, and commercial insurance

2. Strengthen and Expand SNAP (Food Stamps)

• Increase benefit levels: Current average benefit of $230/month is insufficient; increase to align with USDA Low-Cost Food Plan
• Expand eligibility: Raise gross income limit from 130% to 200% FPL; eliminate asset tests
• Streamline enrollment: Simplify applications; allow online application and recertification; reduce documentation requirements
• Continuous eligibility: Extend certification periods from 6-12 months to 24-36 months for stable households
• Restaurant meals program: Expand to allow older adults, people with disabilities, and people experiencing homelessness to purchase prepared meals
• Incentivize healthy foods: Provide additional benefits for purchases of fruits, vegetables, and whole grains

3. Invest in Food as Medicine Programs with Sustainable Funding

• Medicaid coverage: Allow states to cover medically tailored meals, produce prescriptions, and nutrition counseling as Medicaid benefits
• Medicare coverage: Add food insecurity as a supplemental benefit under Medicare Advantage; pilot food benefits in traditional Medicare
• Target high-risk populations: Diabetes, heart disease, pregnancy, post-hospital discharge, chronic conditions
• Partner with community organizations: Contract with food banks, meal delivery services, and community kitchens
• Evidence generation: Fund rigorous evaluation to demonstrate clinical and economic impact

4. Increase Access to Healthy Food in Underserved Neighborhoods

• Eliminate food deserts: Incentivize grocery stores in underserved areas through tax credits, grants, low-interest loans
• Support small retailers: Help corner stores and bodegas stock fresh produce through financing and supply chain support

• Mobile markets: Fund mobile food trucks bringing fresh food to food deserts
• SNAP acceptance: Ensure all retailers, farmers markets, and online vendors accept SNAP
• Transportation: Provide free or reduced-cost transit to grocery stores from food deserts

5. Fund Community-Based Food Programs

• Food banks and pantries: Increase federal funding (TEFAP, CSFP) to support capacity, fresh produce, and culturally appropriate foods
• Community gardens: Provide land, water, technical assistance, and start-up funding
• Urban agriculture: Support commercial-scale farming in cities; streamline zoning and permitting
• Gleaning programs: Coordinate harvest of surplus crops from farms for donation to food banks
• Community kitchens: Support facilities where communities can prepare and preserve food

6. Support Child Nutrition Programs

• Universal school meals: Provide free breakfast and lunch to all students, eliminating stigma and administrative burden
• Summer EBT: Expand Summer EBT program nationwide to replace school meals during summer
• WIC modernization: Increase benefit levels; expand food packages; improve retailer access and technology
• Afterschool and childcare meals: Expand CACFP to serve more children in afterschool and childcare settings

Implementation Roadmap

Healthcare Systems:

• Months 1-3: Select screening tool; integrate into EHR; train staff
• Months 3-6: Pilot screening in 1-2 clinics; build referral relationships
• Months 6-12: Scale to all clinics; track outcomes; refine processes
• Year 2+: Integrate food as medicine programs; evaluate impact on health and costs

State Policymakers:

• Short-term (1 year): Streamline SNAP enrollment; fund food bank infrastructure; pilot produce prescriptions
• Medium-term (2-3 years): Medicaid waiver for food as medicine; grocery store incentives; universal school meals
• Long-term (3-5 years): Evaluate impact; scale successful programs; address root causes (wages, housing)

Key Sources

• USDA (2025). "Household Food Security in the United States" • Feeding America (2024). "Map the Meal Gap" • Health Affairs (2024). "Food Insecurity and Healthcare Utilization" • JAMA (2023). "Medically Tailored Meals as Covered Benefit" • Center on Budget and Policy Priorities (2025). "Policy Basics: SNAP"

Brief #3: Investing in Maternal Health

Issue Summary

The United States faces a maternal health crisis. With 22.3 deaths per 100,000 live births, the U.S. has the highest maternal mortality rate among high-income nations—more than double Canada (10.0) and four times Germany (4.0). Even more troubling, the rate is increasing while other countries' rates decline.

The crisis is not experienced equally. Black women die at 3-4 times the rate of white women (49.5 vs 14.1 per 100,000). American Indian/Alaska Native women die at 2.5 times the rate. These disparities persist across all income and education levels—college-educated Black women have worse outcomes than white women without high school diplomas. This is not about individual choices; it is about systemic racism in healthcare and society.

Key Evidence

Magnitude and Trends:

• 1,205 pregnancy-related deaths in 2021 (latest data); 22.3 per 100,000 live births
• Rate increased 40% from 2000 to 2021 (from 16.9 to 22.3)
• 50,000+ women experience severe maternal morbidity annually (near-death experiences)
• Leading causes: Cardiovascular conditions (29%), infection (12%), hemorrhage (10%), embolism (8%), cardiomyopathy (7%)

Preventability:

• 60% of maternal deaths are preventable with quality care
• 80% of deaths occur during the postpartum period (after birth), when coverage often lapses
• Timing: 31% occur during pregnancy, 17% at delivery, 52% postpartum (up to 1 year)
• Missed opportunities: Many women had warning signs or risk factors that went unrecognized or unaddressed

Racial Disparities:

• Black women: 49.5 deaths per 100,000 (3.5 times white rate of 14.1)
• American Indian/Alaska Native: 34.1 per 100,000 (2.4 times white rate)
• Latino women: 17.8 per 100,000 (1.3 times white rate)
• Disparities exist in all states and at all income levels
• Black women with college degrees have worse outcomes than white women without high school diplomas
• Evidence points to implicit bias, discrimination, and quality of care differences, not underlying health status

Contributory Factors:

• Insurance coverage gaps: 600,000 women lose Medicaid coverage at 60 days postpartum when risks remain high
• Quality of care variation: Stark differences between hospitals in maternal outcomes; some hospitals have 10x higher complication rates
• Workforce shortages: Maternity care deserts (counties with no obstetric providers) affect 2.2 million women (36% of counties)
• Implicit bias: Studies show Black women's pain is undertreated; their concerns are dismissed; they receive lower-quality care
• Social determinants: Chronic stress from racism, housing instability, food insecurity, lack of transportation
• Underlying health conditions: Higher rates of hypertension, diabetes, obesity in part due to social determinants and healthcare access

Detailed Policy Recommendations

1. Extend Medicaid Postpartum Coverage from 60 Days to 12 Months

• Policy: American Rescue Plan (2021) gave states option to extend postpartum coverage to 12 months; 46 states have adopted as of 2026
• Impact: Ensures continuous coverage during highest-risk period; improves management of chronic conditions

• Evidence: States with extension saw 17% reduction in postpartum mortality
• Next steps: Make 12-month coverage mandatory nationwide; ensure adequate provider reimbursement; simplify enrollment and renewal

2. Address Implicit Bias and Racism in Maternity Care

• Mandatory training: Require implicit bias training for all maternity care providers, grounded in understanding structural racism
• Accountability: Include anti-racism and cultural competence in provider performance evaluations and credentialing
• Patient advocacy: Train patient advocates/doulas to support women in asserting their needs and navigating discriminatory care
• Reporting systems: Create confidential channels for reporting discrimination and disrespectful care
• Diverse workforce: Increase recruitment and retention of Black, Indigenous, and Latino providers; provide loan repayment and scholarships
• Evidence: Training alone is insufficient; must be paired with system-level accountability and culture change

3. Expand Access to Doulas and Midwives

• Doulas: Medicaid reimbursement for doula services in all states (currently 13 states); recommended reimbursement $1,000-1,500 per birth
• Evidence: Doula support reduces cesarean sections by 39%, preterm birth by 22%, and improves satisfaction; particularly effective for Black and low-income women
• Midwives: Increase reimbursement rates to match physician rates; eliminate scope-of-practice restrictions; expand midwifery education programs
• Evidence: Midwifery care associated with lower cesarean rates, fewer interventions, higher patient satisfaction, and equivalent safety
• Integration: Collaborative care models with seamless referral between midwives and physicians for high-risk pregnancies

4. Improve Quality of Care Through Data and Accountability

• Maternal Mortality Review Committees: Establish in all states to investigate every maternal death; identify preventability and root causes
• Public reporting: Require hospitals to publicly report maternal outcomes including severe maternal morbidity, stratified by race
• Quality improvement: Implement evidence-based bundles (AIM Program: hypertension, hemorrhage, opioid use)
• Hospital designation: Create levels of maternity care (like trauma centers) to ensure high-risk pregnancies are cared for at appropriate facilities
• Liability reform: Provide liability protection for hospitals implementing safety protocols to encourage improvement without fear of lawsuits

5. Address Maternity Care Deserts

• Workforce investment: Loan repayment for providers practicing in underserved areas; increase residency slots in family medicine and OB/GYN
• Telehealth: Expand virtual prenatal care, remote monitoring, and access to specialists via telehealth
• Freestanding birth centers: Support midwife-led birth centers in underserved areas as alternative to hospital closure
• Transportation: Fund medical transportation for prenatal appointments and delivery
• Financial sustainability: Higher Medicaid reimbursement for rural hospitals; payment for prenatal care even when delivery occurs elsewhere

6. Address Social Determinants of Maternal Health

• Prenatal social support: Medicaid coverage for home visiting, care coordination, and social services
• Housing: Emergency housing assistance for pregnant women; eviction protection during pregnancy and postpartum
• Nutrition: WIC expansion; medically tailored meals for high-risk pregnancies
• Mental health: Universal screening for perinatal depression and anxiety; ensure accessible treatment
• Paid leave: Federal paid family and medical leave to reduce stress and enable postpartum recovery and bonding
• Income support: Expand EITC and Child Tax Credit to reduce poverty

7. Invest in Research and Data

• Increase funding for maternal health research, particularly on disparities
• Standardize data collection on race, ethnicity, language, and social determinants
• Study interventions specifically designed by and for Black, Indigenous, and Latino communities
• Evaluate impact of policies on reducing disparities, not just overall outcomes

Implementation Timeline

Immediate (Within 1 year):

• States: Extend postpartum Medicaid to 12 months; begin Medicaid reimbursement for doulas
• Hospitals: Implement evidence-based safety bundles; launch implicit bias training; establish maternal mortality review
• Federal: Increase funding for maternal mortality prevention; require data collection and reporting

Short-term (1-2 years):

• Public reporting of hospital outcomes; designate levels of maternity care
• Expand midwifery scope of practice and education programs
• Launch telehealth and transportation initiatives in maternity care deserts
• Increase provider diversity through scholarships and loan repayment

Medium-term (2-5 years):

• Evaluate and scale successful interventions
• Address social determinants: housing, nutrition, paid leave
• Transform maternity care culture to center equity, respect, and anti-racism
• Achieve 50% reduction in maternal mortality and eliminate racial disparities

Key Sources

• CDC (2024). "Pregnancy Mortality Surveillance System" • National Partnership for Women & Families (2025). "Black Women's Maternal Health" • March of Dimes (2024). "Maternity Care Deserts Report" • Cochrane Review (2023). "Doula Support for Childbearing Women" • Amnesty International (2025). "Deadly Delivery: Maternal Health Crisis in the U.S."

Brief #4: Transforming Mental Health and Substance Use Care

Issue Summary

The United States faces intersecting mental health and substance use crises. 58 million adults (23%) experience mental illness annually; 14 million have serious mental illness that substantially interferes with life activities. 48 million people have substance use disorders. Overdose deaths reached 107,000 in 2024, driven by fentanyl. Suicide rates increased 33% from 2000-2024.

Despite high prevalence, only 47% of adults with mental illness and 11% with substance use disorders receive treatment. Barriers include lack of providers (especially in rural areas), insurance coverage limitations, cost, stigma, and fragmentation between physical and mental healthcare. Communities of color face additional barriers including discrimination and culturally inappropriate care.

Key Evidence

• Treatment gap: 27.2 million adults with mental illness receive no treatment; 43 million with substance use disorders untreated

• Workforce shortage: 159 million Americans live in mental health professional shortage areas; average wait for psychiatrist is 48 days

• Cost: Mental health and substance use disorders cost U.S. economy $280 billion annually in healthcare, criminal justice, and lost productivity

• Incarceration: 37% of state prisoners and 44% of jail inmates have diagnosed mental illness; jails are now largest mental health facilities

• Mortality: Suicide is 12th leading cause of death; people with serious mental illness die 10-25 years earlier than general population

Policy Recommendations

1. Integrate Behavioral Health into Primary Care

• Collaborative care models: Co-locate therapists and psychiatric consultants in primary care; use measurement-based care

• Evidence: Reduces depression symptoms 50% more than usual care; improves diabetes and heart disease management

• Payment: Reimburse collaborative care management codes (99492-99494) at adequate rates

• Screening: Universal screening for depression, anxiety, and substance use in primary care with warm handoff to treatment

2. Expand Capacity Through Workforce Innovation

• Peer support specialists: Medicaid reimbursement for peer-delivered services; training and certification programs

• Telehealth: Permanent telehealth flexibilities; licensure compacts for cross-state practice

• Loan repayment: Expand National Health Service Corps and state programs for providers in shortage areas

• Training pipeline: Increase residency slots in psychiatry; integrate behavioral health in all medical training

• Task-shifting: Train primary care providers in evidence-based brief interventions (motivational interviewing, problem-solving therapy)

3. Ensure Parity and Adequate Coverage

• Enforce parity: Strengthen enforcement of Mental Health Parity Act; increase audits and penalties for violations

• Eliminate prior authorization barriers for mental health and substance use treatment

• Cover evidence-based services: Peer support, community-based interventions, care coordination

• Adequate reimbursement: Increase rates to ensure network adequacy and reduce wait times

4. Strengthen Crisis Response Systems

• 988 Suicide & Crisis Lifeline: Sustain federal and state funding for nationwide rollout
• Mobile crisis teams: Deploy mental health professionals, not police, to mental health crises
• Crisis stabilization units: Short-term residential alternatives to hospitalization and jail
• Evidence: Crisis Intervention Teams reduce arrests by 40%; mobile crisis reduces hospitalization by 60%

5. Expand Medication-Assisted Treatment for Opioid Use Disorder

• Remove barriers: Eliminate X-waiver requirement for buprenorphine prescribing (accomplished 2023)
• Increase access points: Offer MAT in primary care, emergency departments, jails, homeless shelters
• Ensure continuity: Mandate Medicaid coverage with no prior authorization; ensure 30-day supply at jail release
• Harm reduction: Expand syringe services programs, naloxone distribution, safe consumption sites

Key Sources

• SAMHSA (2024). "National Survey on Drug Use and Health" • NAMI (2025). "Mental Health By the Numbers" • CDC (2025). "WONDER Overdose Data" • Cochrane Reviews (2023). "Integrated vs. Non-Integrated Care" • Health Affairs (2024). "Behavioral Health Parity Analysis"

Brief #5: Building a Diverse Health Workforce for Equity

Issue Summary

The U.S. health workforce does not reflect the diversity of patients it serves. While people of color comprise 40% of the U.S. population, they represent only 18% of physicians, 20% of nurses, and 10% of healthcare executives. This matters: Workforce diversity improves cultural competence, patient-provider communication, trust, satisfaction, and health outcomes—particularly for minority patients.

Key Evidence and Recommendations

Evidence:

• Racial concordance (same-race patient-provider pairs) improves communication, trust, and adherence
• Black men with Black doctors are more likely to agree to preventive services; cardiovascular mortality decreases 19%
• Diverse teams make more innovative decisions; homogenous teams have blind spots
• Underrepresented minority physicians are more likely to practice in underserved areas and care for minority patients

Recommendations:

• Pipeline programs: Invest in K-12 STEM education in underserved communities; mentorship and exposure to health careers
• Holistic admissions: Use holistic review considering experiences, not just test scores; provide MCAT/GRE prep support
• Financial support: Expand scholarships, loan repayment, and tuition assistance for underrepresented students
• Inclusive culture: Address bias, microaggressions, and discrimination in training; provide mentorship and affinity groups

• Retention: Create pathways to leadership; address pay equity; ensure inclusive workplace culture
• Data: Collect and report workforce diversity data; set goals and measure progress

Advocacy Tools and Resources

How to Use These Policy Briefs

• Share with legislators: Email PDFs or print and mail to state and federal elected officials
• Media outreach: Submit op-eds to local papers; share on social media; brief journalists
• Coalition building: Use to align diverse stakeholders around shared priorities
• Public testimony: Cite evidence when testifying at hearings or public comment periods
• Grant applications: Include data to support need for programs
• Community education: Present at community meetings, faith institutions, civic groups

Sample Advocacy Script

"Hello, my name is [Name] and I'm a constituent from [City]. I'm calling to urge [Legislator] to support [specific policy]. [One sentence about why it matters to you or your community]. Research shows [one compelling statistic from brief]. This policy would [specific impact]. Can I count on [Legislator]'s support? Thank you."

For more information, contact the Bridge to Health Equity Foundation at policy@bridgetohealthequity.org