

## POLICY BRIEF

# Guaranteed Healthcare

By Charlisa Goodlet, Emanuel Nieves, Jeremie Greer, and Alicia Atkinson

*“Living in safe communities, with adequate health-care services, outdoor space, clean air and water, public transportation, and affordable healthy food—as well as education, employment, and social support—contributes to longer, healthier lives. And the opposite is true: when residents lack a healthy environment and basic services and support, their lives are cut short.”*

– Linda Villarosa. *Under the Skin: The Hidden Toll of Racism on American Lives and on the Health of Our Nation*. Doubleday, 2022.

## The Problem

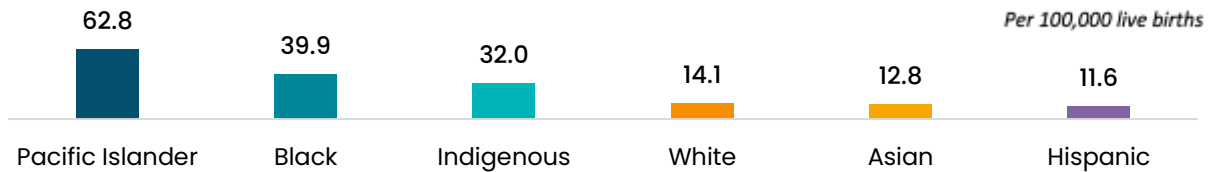
While economic resources, mobility, and financial security are fundamental for surviving, participating, and progressing in our economy, the ultimate foundation for a long, fulfilling life is good health. Without good health, our ability to work, care for loved ones, and advance in life is severely constrained, if not impossible.

Unfortunately, in the [Oppression Economy](#), where white elites exploit racism to build wealth and power, people of color<sup>1</sup> face tremendous health disparities in nearly every way imaginable when compared with white people. For example, the [maternal mortality rate](#) among Indigenous and Black women is between 2 and 3 times higher, and their infants [are between 1.7 and 2.4 times as likely](#) to die in their first year. Black and Indigenous people have [shorter lifespans](#); are more likely to suffer or die from [chronic health conditions](#), such as asthma, hypertension, and heart disease; and are less likely to access [mental health services](#). Likewise, Latine and Asian households have higher incidences of [diabetes](#) than their white counterparts.

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<sup>1</sup> Throughout this document, we use the terms “people of color,” “communities of color,” “workers of color,” and other similar phrases to refer to Black, Indigenous, Latine, Arab, Middle Eastern, Asian, and Pacific Islander people. We use these terms not to erase the experience of any group but to demonstrate the shared impact that systemic racism and white supremacy have had on us.

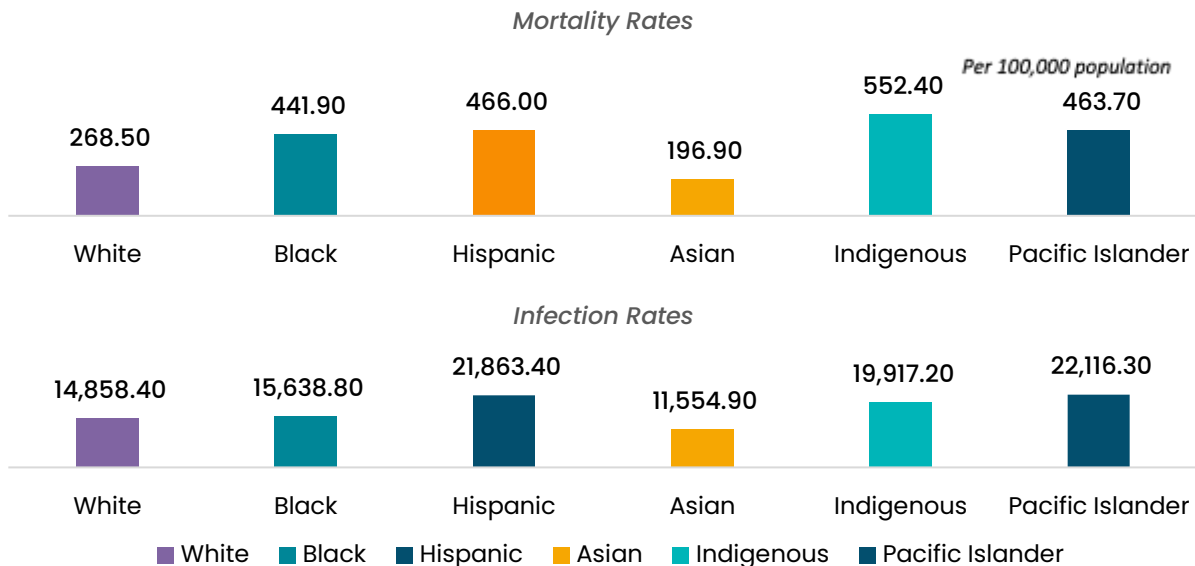
### Pregnancy-Related Deaths by Race/Ethnicity Mortality Ratio, 2017-2019



**Source:** Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. "[Pregnancy Mortality Surveillance System](#)." Centers for Disease Control and Prevention. 2023.

Notably, people of color experienced [disproportionately higher COVID-19 infection and death rates](#) throughout the pandemic, partly because they were more likely to have underlying health conditions. While unjust, disparities like these are the byproduct of racially exclusionary economic decisions and systemic racism, and are present in the medical profession, which has a long [history of subjugating, exploiting, and harboring racist beliefs toward people of color](#). These disparities are also a byproduct of a healthcare system centered on profits.

### Cumulative Age-Adjusted COVID-19 Infection and Mortality Rates by Race/Ethnicity, 2020-2022



**Source:** Hill, Latoya and Samantha Artiga. "[COVID-19 Cases and Deaths by Race/Ethnicity: Current Data and Changes Over Time](#)." The Kaiser Family Foundation. 2022.

Dependent on the private market, our patchwork healthcare system of public and private programs is a **conditional system of care**, where access is often contingent on economic and employment status. This system creates a situation where our income, wealth, and job status become the conditions for receiving high-quality care. This is appalling, especially considering that [27.6 million people](#) in the U.S. (about 8.4% of the population) had no health insurance in 2022. Unfortunately, having access to health insurance does not automatically translate into affordable care, as [23% of working-age adults—about 47 million—in the U.S. are currently underinsured](#), meaning they have health coverage, but cannot affordably access the care they need.

Due to nonexistent or insufficient health insurance coverage, families in the U.S. have been forced to take on massive amounts of medical debt, regardless of their coverage status, to access the care they need. For example, conditional on having medical debt, a [recent study](#) found that about 28% of households without insurance have an average medical debt balance of \$31,948, while the 17% of insured households held an average medical debt balance of \$18,827. [Medical debt is particularly oppressive](#), dragging down our economic potential by suppressing our ability to build wealth and access credit. Nearly one in [every five households in the country holds a total of between \\$81 billion and \\$140 billion](#) in medical debt today—[80% of this debt](#) is held by households with zero or negative net worth. Unfortunately, [people of color are more likely to hold medical debt](#) than white people.

One reason for the [high cost of the U.S. healthcare system](#) has nothing to do with the actual delivery and quality of care but rather is due to the cost of administering healthcare. From executive pay to medical billing, record coding, and claims specialists, this administrative web is not only unique to the U.S., but also results in [one-third of our healthcare spending being directed toward system administration rather than our actual care](#). Another reason for high healthcare costs in the U.S. is the [high cost of prescription drugs](#). While the pharmaceutical industry gives numerous reasons why [U.S. patients pay far more for prescription drugs than most patients elsewhere in the world](#), a big factor in rising drug prices in this country is the protections afforded to drugmakers through [the U.S. patent system, which can prevent generic alternatives from entering the market for years](#). This system gives pharmaceutical companies

huge latitude to set prices to maximize profits, [leading them to reap millions more in revenue from U.S. patients and the U.S. market than anywhere else in the world.](#)

The profit motive at the core of our healthcare system ultimately creates a situation where self-interested entities, such as insurance and pharmaceutical companies, wield significant power in deciding what healthcare is deemed "medically necessary." In fact, the profit motive of our system is so strong that even nonprofit hospitals—[which make up more than half of all hospitals in the U.S.](#)—end up behaving like other profit-maximizing entities. This focus leads some of these hospitals to [engage in harmful practices](#) and many more to take in more tax savings than they spend on charity care and community investment. For example, a recent [study](#) found that 77% of nonprofit hospital systems spent less on charity care and community investment than the value of their estimated tax exemptions, which [amounted to \\$14.2 billion in 2020](#). Together, these and other issues not only end up adding layers of complexity and unnecessary costs to our healthcare, but also contribute to outcomes in which Americans as a whole [experience shorter lives, higher rates of preventable deaths, and elevated infant and maternal mortality](#)—despite the fact that [the United States spends more on healthcare than any other high-income, industrialized country in the world.](#)

To realize a [Liberation Economy](#) that serves the basic needs of people of color, where we find safety and security, and where we are valued, we need to establish healthcare as the inherent human right that is and should always be. To do that, we must dismantle our current conditional system of healthcare. In its place, we must create a new system of healthcare that centers our needs and **guarantees for all healthcare** that is comprehensive, accessible, and affordable, regardless of one's place in society.

## **The Policy Solution and Potential Benefit to People of Color**

After generations of attempts and marginal progress toward creating a more accessible and equitable healthcare system, the Affordable Care Act (ACA) was enacted into law in 2010. Aimed at lowering costs and expanding access to healthcare, the ACA mandated health insurance for individuals, required insurance companies to cover pre-existing conditions, established a marketplace for purchasing health

insurance plans, and provided subsidies to lower-income individuals for more affordable coverage. Among its [many accomplishments](#), the ACA led to [one of the largest expansions of health coverage in U.S. history](#), leading to record-low uninsured rates and 20 million individuals gaining coverage. It also ensured that people [cannot be denied coverage or charged more](#) because of a pre-existing condition or their gender, and extended [affordable healthcare to millions](#) of low-income people through the expansion of Medicaid.

Yet, despite being one of the most important pieces of healthcare legislation in U.S. history, the success of ACA's goal—ensuring that all Americans have access to affordable healthcare—remains limited. For example, more than a decade after the ACA became law, [Black and Brown adults are now between 1.7 and 3.7 times more likely to lack access to health insurance than white adults](#). And as of 2021, Indigenous communities were [four times more likely to be uninsured](#) than their white counterparts. Issues like these are partly due to private insurance purchase subsidies that still leave [many facing high out-of-pocket costs and deductibles, forcing them to pay a significant portion of their income toward coverage](#). Similarly, [non-ACA-compliant plans, lack of Medicaid expansion in certain parts of the country](#), and the lack of a true [public option for healthcare](#) also have limited accessibility and affordability. But perhaps most notably, the ACA's limitations are a function of its reliance on a system of care where access is largely tied to our employment and where decisions and delivery of care are largely in the hands of for-profit providers.

For people of color, lack of affordable healthcare coverage means they are less likely to find and receive the level of care they need, leading many to [forgo doctor visits due to costs](#) and many others to turn to [debt to pay for healthcare expenses](#), which can lead to [past-due medical debt](#), and, even worse, bankruptcy. To build a Liberation Economy, we need a system that does not require going into debt to receive care, does not depend on employers' goodwill, and does not put profits over people's well-being. Instead, we need a system that provides equitable access to essential care for everyone and fosters cultural competence among healthcare providers so that our needs are not ignored or dismissed. We also [need a system that provides strong primary care and improves the delivery of services](#). In effect, we need a universal

healthcare system that provides everyone with comprehensive coverage for critical health services—including prescription drugs, doctor visits, medical devices, lab services, hearing, dental, vision, diagnostic services, behavioral and mental healthcare—without premiums and little to no cost-sharing (co-payments).

To get there, we need to replace our largely private system of healthcare with a public system that centers on us and our needs while also implementing meaningful, short-term reforms that reorient our healthcare system toward us and away from its for-profit focus. We also need to leave behind all the oppressive aspects of our current system, including medical debt that weighs on so many families. By prioritizing our health needs, affordability, and access within our system, both now and in the future, we can foster a thriving, equitable society where people of color have the opportunity to flourish and be well.

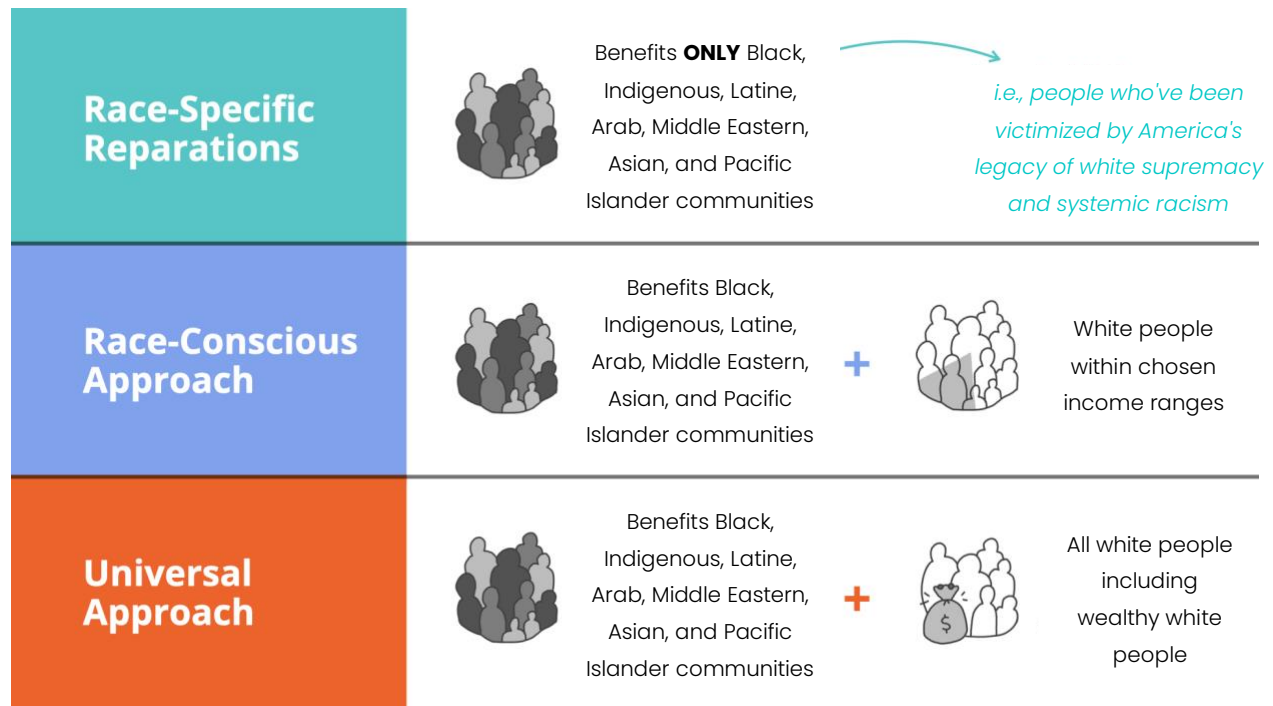
## **Moving Toward Liberation: Guaranteed Healthcare Policy Design**

The universal healthcare system we aim for is one that provides affordable, equitable access to high-quality healthcare services; eliminates health disparities; and addresses specific challenges that historically marginalized communities face. It is a system that ensures all individuals have access to affordable and comprehensive healthcare services, regardless of their income, employment status, or current health condition.

While the ultimate goal is a single-payer universal healthcare system—facilitated by the government—that would cover all costs associated with medical care, the pathway toward this new system of healthcare also requires careful consideration of how our current and future healthcare policies are designed, who benefits most from them, and the tradeoffs we may need to make to achieve our ultimate goal.

For example, the policies outlined below could be implemented as **race-specific reparations**, meaning that they are offered exclusively to people of color—Black, Indigenous, Latine, Arab, Middle Eastern, Asian, and Pacific Islander people—who've

been victimized by America’s legacy of white supremacy and systemic racism. Policies could also be implemented through a **race-conscious approach** that uses income as a proxy to target support to those with the least resources,<sup>2</sup> or they could be implemented through a **universal approach**, meaning that supports are broadly available to all.



Of course, the tradeoff between these choices is that only people of color will directly benefit from a race-specific reparations approach, while in a race-conscious approach, a large percentage of people of color will benefit; however, many white people who fall within the chosen income targets will benefit as well. In a universal approach, the tradeoff may be that many wealthy white households and wealthy households of color may also benefit from the policy, making it perhaps the least equitable response to challenges we face in the [Oppression Economy](#).

<sup>2</sup> Ideally, using wealth as a proxy to target support would better serve to uplift communities of color. Unfortunately, as of today, governments—both at the federal and state level—have not developed reliable or consistent methods to value assets and track wealth over time as they have for income.

While not comprehensive, the following are among the many steps we should now take to begin creating a more equitable, affordable, and accessible healthcare system today.

- **Expand public hospitals and clinics to increase public access to our current systems of care:** As we work toward a more affordable and inclusive healthcare system, it is critical to establish and expand public options that can not only effectively and affordably serve our needs, but also offer viable alternatives to our current conditional system. With aid from state and local governments, the federal government should make significant investments in the nation's public hospitals, clinics, and other publicly funded healthcare delivery systems. By doing so, these investments would better enable these institutions to upgrade and replace aging facilities, conduct critical research, hire additional healthcare workers, and better ensure that all individuals, particularly people of color, have access to key healthcare services that prioritize patients and communities over profits.
- **Increase funding for public health initiatives:** Considering the critical role that public health has had and continues to have on our lives, and the fact that our public health system has long been underfunded, federal and state policymakers must move to make meaningful, long-term, and sustainable investments in our public health systems. Doing so would allow our public health systems to prevent the spread of diseases better, promote better health outcomes through preventative care, and prolong life expectancies.

If intentionally supported and sufficiently funded, investments in public health can help our public health infrastructure perform just as well as, if not better than, private health systems—[something already evident in parts of our Veterans Affairs Healthcare system](#). However, without sufficient funding for public health, it becomes incredibly difficult to compete for public resources to address adverse health consequences and rising costs. Therefore, increasing funding for public health initiatives is a wise investment in individuals and in society's present and future provision of universal healthcare.



- **Improve maternal health care by expanding Medicaid coverage to all expecting parents:** To address the rising disparities of maternal mortality for Black, Indigenous, and other people of color, the U.S. Congress should extend Medicaid coverage for birthing people from two months to a full year after childbirth. We should also expand access and support for doulas, [who have been shown to contribute to improved health outcomes for mothers and infants](#) and can help to [reduce racial disparities in maternal care](#). These and other recommendations have been outlined in the [MOMMIES \(Maximizing Outcomes for Moms through Medicaid Improvement and Enhancement of Service\) Act](#), which is focused on increasing access to primary care and reproductive health providers and ensuring that all pregnant and postpartum mothers have full Medicaid coverage in this window.
- **Cap the price of life-saving drugs:** Building on the Inflation Reduction Act's (IRA) insulin cost cap, policymakers should also move to [cap the price of the nation's top-selling drugs](#), including Gilead Sciences' Biktarvy (HIV), AbbVie's Humira (autoimmune diseases), Eli Lilly's Trulicity (type 2 diabetes) and Pfizer's Ibrance (HR+ and HER2- subtypes of metastatic breast cancer), for all patients not just those on Medicaid (as the IRA did with insulin) or some other subset of patients.
- **Establish cost commissions:** To address rising healthcare costs, state governments should [establish cost commissions](#) that set industry-wide standards and goals for containing and curbing costs. These commissions should also provide regulatory oversight of the healthcare industry to prevent and address market consolidation and other abuses of market power that can lead to higher costs and reduce the quality of care.
- **Improve how care is delivered and encourage delivery innovation:** To better ensure that our current healthcare system reaches and serves our vulnerable, marginalized, and disconnected populations, policymakers should encourage and require healthcare providers to offer and use telemedicine. In making it easier and more convenient for people to access the care they need, [health systems should ensure that telemedicine remains as broadly available as possible](#). In addition,

they should be given flexibility to innovate and develop alternative healthcare delivery models, such as mobile clinics, community health centers, and home-based care and visits, that can increase convenience, reduce costs, and provide tailored healthcare services to specific populations. Ultimately, these alternative delivery options will improve patient satisfaction and outcomes. However, to ensure that such alternative models are successful, state and federal policymakers must also meaningfully confront the digital divide facing many people of color in urban and rural settings.

- **Create and fund community preventative healthcare support programs:** Currently, our system perpetuates an [overreliance on high-cost, reactive care at the expense of routine and preventive care](#). To better serve our communities, federal and state governments should fund community healthcare programs that monitor and evaluate emergency room wait times, patient satisfaction, and other relevant metrics and engage with patients outside the offices of their medical providers to offer additional support. This support can include medication adherence support, blood pressure monitoring, other holistic interventions, nutrition, and fitness support that can help reduce the reliance on reactive care. While such an approach deviates from the high-cost, high-touch level of healthcare our system currently provides, having a dedicated group of community healthcare support programs and staff engaging with high-risk patients and communities would help improve preventive care and the health of our communities.

As part of their charge, these community healthcare programs and community healthcare workers should be embedded in all aspects of our healthcare system. These community programs and healthcare workers should also work with providers to develop and implement standardized triage protocols and screen patients to see if they are struggling with food, housing, or transportation through a social determinants of health screening tool. These programs and healthcare workers should also work with the systems they are embedded in to collect data on race and ethnicity that can help improve our healthcare system. Systems should also provide regular training for healthcare professionals to improve their

skills in identifying patients' acuity levels and prioritizing care. Further, community healthcare programs should also be equipped with and provide up-to-date culturally competent training that includes understanding how different races and gender identities present life-threatening illnesses or complications, which can be shared with providers.

- **Develop and launch community awareness campaigns to reach the remaining uninsured and to improve access and quality care.** Federal and state governments should develop and launch outreach campaigns to raise awareness about available healthcare support among the public, [particularly those eligible for Medicaid and subsidized private insurance but who have not signed up for care yet.](#)

In addition, since people must first have access to primary care providers to avoid the use of emergency rooms for primary, routine, and preventive care, these programs should also empower individuals and families to access and use non-emergency-care providers for primary, routine, and preventive care.

- **Mandate a combination of free healthcare services for marginalized people:** To combat our history of medical racism and profit-centered care, every healthcare provider should be required to develop and provide free basic healthcare services for marginalized people who historically have lacked access to proper care and/or have been systematically harmed by the healthcare industry. Funded and monitored largely by the federal government in partnership with state governments, this race-specific reparations policy approach would help to address historical injustices and provide compensation or redress for past wrongs.
- **Make the American Rescue Plan Act's healthcare premium support permanent and provide support to those who are not currently eligible for Medicaid:** As part of its effort to support our recovery from the pandemic, [the American Rescue Plan Act \(ARPA\) expanded eligibility for marketplace premium subsidies to those with incomes above 400% of the federal poverty level](#) (\$52,000 for an individual to \$106,000 for a family of four). The law also boosted the subsidies provided to those

who were already eligible. [As a result of these changes](#), nearly all of the 14.5 million people who signed up for health coverage received financial assistance. Unfortunately, these changes expired at the end of 2022.

[While the IRA extended the ARPA enhanced ACA subsidies through 2025](#), Congress should [make these eligibility and subsidy improvements permanent](#). It should also [provide additional resources to families in the states that have not expanded Medicaid](#) to better access affordable care at little or no cost to them. Doing these two things would [lower the number of uninsured non-elderly Black people by 1.2 million](#) and [the number of uninsured non-elderly Latine people by 1.7 million](#).

- **Hold nonprofit hospitals accountable for providing community care:** To ensure that the nation’s vast nonprofit hospital systems operate and behave in a way that reflects their nonprofit status and tax advantages, policymakers should establish [clear and enforceable standards for charity care and other benefits](#) that better link tax savings to charity care provided. As advocated by the [Alliance for Advancing Nonprofit Healthcare](#), federal policymakers could require nonprofit hospitals to provide charity care with a cost equal to their federal tax savings or pay the difference back. At the same time, state policymakers could limit any tax savings to the amount of care provided or could require these systems to provide care valued above whatever tax savings they are expected to receive in a given year. Additionally, policymakers should require that these systems engage in [community needs assessments](#); incorporate findings from these assessments into their care plans; and provide dedicated and [unrestricted support to community-based organizations led by people of color](#) that offer health, social, and behavioral health services to their communities.
- **Build more robust data collection systems to ensure marginalized communities are being served and to hold private insurance companies accountable:** To better understand how our current healthcare system is serving communities of color or failing to do so, federal and state policymakers should [require healthcare systems to collect and publicly share data disaggregated by race and ethnicity, as well as data that relate to the many other identities we hold in our day-to-day](#)

[lives](#), including gender, sexual orientation, and disability status. Policymakers should also require healthcare systems to track social determinants of health among the patients they serve—including affordable food access, transportation, access to safe places to exercise, stress, and inadequate income—which often present barriers to basic health maintenance.

At the same time, to ensure that private insurance companies are actually serving people of color and their needs, [policymakers should require these companies to collect and report data on race and ethnicity](#) and other identifiers during enrollment and throughout the year of coverage that is connected to claims approved or denied in that year. Also, these companies should be held to ACA requirements for providing essential and preventative care.

- **Make it easier for immigrants to access healthcare coverage:** Because of their immigration status, today [about 3 million uninsured people cannot enroll in Medicaid or receive marketplace subsidies](#). The federal government could allow certain groups of undocumented, low-income, immigrant adults and children to enroll in Medicaid or other affordable coverage, as several states already have done. Building on efforts in [California, seven other states, and Washington, D.C.](#), federal and state policymakers should move to expand eligibility and resources to other income-eligible adults and children, regardless of their immigration status.
- **Make it easier for individuals to stay on Medicaid and ensure that Medicaid dollars support our needs:** To help ensure that Medicaid-eligible individuals remain on the program and are not “[churned](#)” out of it during re-enrollment periods for [a variety of reasons, states should leverage other means-tested programs with similar income requirements and other tools to verify and re-enroll participants](#). Further, to ensure that Medicaid program dollars are being used to serve our needs rather than to pad the pockets of for-profit providers, [a vast majority of Medicaid payments—80%—for personal care, homemaker, and home health aide services should go directly to those providing services, and not to the companies that are essentially serving as lucrative middlemen](#).

- **Limit the use of excessive patenting practices:** To begin addressing the [excessively high costs of prescription drugs](#), we need to [reform the U.S. patent system](#) so that pharmaceutical companies can no longer exploit the system to unfairly limit competition and arbitrarily raise prices to boost their bottom lines. As part of this effort, we should also establish a definitive and unchangeable period—without loopholes or exceptions—in the life cycle of pharmaceuticals when a drugmaker’s exclusivity ends and generics can begin to enter the market.
- **Establish benchmarks and incentives for improving healthcare and health outcomes:** To ensure that our system is affordable, accessible, and improving our health, federal and state governments should move to [establish benchmarks](#) to slow healthcare cost increases and improve care. Key performance indicators should be developed to monitor and evaluate emergency department wait times, patient satisfaction, costs, and other relevant metrics as part of this effort. To foster accountability, these and other measures should link reimbursement rates and other forms of payments provided through our system to measures tied to improvements in preventative care and health outcomes.

In doing so, healthcare providers, insurers, and other entities within our system could be penalized for excessively increasing healthcare costs by providing high-cost care and services that do not improve our health, while those that look after and improve our health—early on without needlessly overcharging us, deepening our financial burden, or making us wait for long periods of times in emergency departments—receive additional resources and supports for reducing our costs and improving our quality of care and health.

### **Our Destination: A New Kind Of Healthcare System**

While the above recommendations are necessary to improve our current system, we eventually need to establish a comprehensive [universal healthcare system to ensure accessible and equitable healthcare services for all](#). To get to our destination, we must create a system that provides access to basic care for everyone, regardless of our financial standing or background. More importantly, we need a system of healthcare

that separates health insurance from employment and that leaves behind the oppressive, extractive aspects of our current system. As such, coverage should not be conditioned on our employers' goodwill or our job status, and all medical debt should be canceled and excluded from credit reports.

Fortunately, we do not have to start from scratch, as we can use what we know about the [Veterans Affairs system](#) and Medicare to expand those systems to more people. However, in designing this new system of healthcare—one facilitated by the government that centers our needs over profits—we should ensure that coverage is available and accessible to all and that it covers all costs associated with healthcare. For example, in this new system, through their preferred healthcare providers and facilities, everyone must be provided comprehensive health insurance coverage that ensures access to essential care, such as prescription drugs, doctor visits, medical devices, lab services, hearing, dental, vision, diagnostic services, and behavioral and mental healthcare. Additionally, to enhance their coverage, under this new system, individuals should also be able to opt to add benefits to this standard public plan.

Ultimately, by implementing healthcare for all, we can effectively eliminate disparities in healthcare coverage and promote a healthier, more prosperous society. Moreover, doing so would eliminate the need for private insurance, provide universal coverage, [and reduce healthcare spending](#). And if carefully designed with intention, a robust universal healthcare system would enable everyone to receive necessary healthcare without incurring significant financial burdens and better promote preventative care, early detection, and timely treatment of illnesses, leading to improved public health outcomes.

## **The Road Ahead to Liberation**

Because the impact of limited access to healthcare is particularly pronounced for marginalized communities, it is imperative that we create a universal health system if we want to achieve structural change that will foster a Liberation Economy.

As a national movement-support organization building the power of people of color to totally transform the economy, we believe those closest to the problems are best suited to develop, shape, and advance the solutions that will get us to where we need to go. This brief, [which is part of an ongoing series of resources](#), aims to provide organizers with bold policy platforms and policy design frameworks that can be used to guide conversations with their communities and policymakers about how policy can be shaped to advance racial justice. We invite you to use and refine the information in this brief in whatever ways are most helpful for your work and your community. We also invite you to engage with [Liberation in a Generation](#) in further developing this idea.

To build a Liberation Economy in one generation, we must ensure that advocates, community organizers, residents, and other proven and emerging leaders of color are empowered and at the center of the work to create an economy where all people of color can truly prosper.

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Liberation in a Generation is a national movement support organization building the power of people of color to totally transform the economy—who controls it, how it works, and most importantly, for whom. We bring together advocates, community organizers, economists, and other proven and emerging leaders of color across the country to build a Liberation Economy, within one generation.

[www.liberationinageneration.org](http://www.liberationinageneration.org)