

Introduction

The Center for Law and Social Policy (CLASP) is a national, nonpartisan, nonprofit organization whose mission is advocating for policies that advance economic and racial justice. Founded more than 50 years ago, CLASP works to develop and implement federal, state, and local policies (in legislation, regulation, and on the ground service delivery) that reduce poverty, improve the lives of people with low incomes, tear down barriers arising from systemic racism, and create pathways to economic security. In the last several years, CLASP has strengthened our commitment to racial equity internally and externally, in all aspects of our operations, advocacy, and partnerships.

The root cause of health inequity is the unequal allocation of power and resources. Access to transportation, education, food, health care, recreation, community, and housing that's affordable promotes good health because people need all these resources to care for themselves and their loved ones. Therefore, health inequities emerge when groups of people are systemically denied these resources and the political power to fight against injustice. These inequities—which all stem from racism and poverty—are referred to as social determinants of health.¹ Simply put, meeting people's basic needs leads to improved health outcomes and overall well-being.² Overwhelmingly, federal housing and public benefits policies³ have predetermined people's access to the resources that we all need to thrive. For individuals and families with low incomes and little wealth due to systemic racism, a strong social safety net is critical to promoting health in the long-term.

The first section of this comment highlights urban renewal (1930s-70s) and disinvestment from public housing (1960s-present) as two federal housing policies that, over the course of several decades, have worsened racial health inequities. Both policies intensified residential segregation, and, as a result, saddled Black, brown, and immigrant communities with the negative health outcomes associated with displacement, environmental hazards, substandard housing. The second section outlines the historical impetus for administrative burdens in federal benefit programs, using Medicaid as an example. Lastly, the third section discusses how preventive health services are covered differently under Medicaid than under Medicare or private insurers, and the inequitable health outcomes that results from this policy decision.

We are thankful for the opportunity to respond to the National Academies' request for information about federal policies that contribute to racial and ethnic health inequities. If you have further questions, please contact Jessi Russell (jrussell@clasp.org) and Juliana Zhou (jzhou@clasp.org).

Sincerely,

Jessi Russell
Research Assistant, Income and Work Supports
Center for Law and Social Policy

Juliana Zhou
Policy Analyst, Income and Work Supports
Center for Law and Social Policy

Section I: Urban Renewal and Divestment from Public Housing

In this section, we highlight urban renewal (1930s-70s) and disinvestment from public housing (1960s-present) as two federal housing policies that, over the course of several decades, have worsened racial health inequities. Both policies intensified residential segregation, and, as a result, saddled Black, brown, and immigrant communities with the negative health outcomes associated with displacement, environmental hazards, substandard housing.

Policy History of Urban Renewal and Federal Disinvestment from Public Housing

Brief History of Public Housing Pre-1940s

Throughout the late 1800s and early 1900s, U.S. cities in the North, Midwest, and West experienced rapid population growth. Individuals and families fleeing Jim Crow laws and organized anti-Black violence migrated to U.S. cities in search of safety and work⁴. During this period, several immigrants from Asia, Europe, South America, and the Caribbean also arrived in the U.S.⁵ Due to this population growth, neighborhoods near factories, railroads, or other big employers became densely populated, with some families doubling up in one-bedroom homes. A study from 1917 analyzing the spread of tuberculosis⁶ in Chicago claimed that an average of six people occupied a single room in a tenement.⁷ Residents of these low-income rentals suffered unsanitary conditions because indoor plumbing wasn't standard and building codes weren't enforced.

The federal government started to experiment with public housing in the 1930s under Franklin D. Roosevelt.⁸ The Roosevelt Administration believed that federally funded housing in cities would increase economic investment, improve public health, and reduce crime.⁹ Segregated complexes in Atlanta, GA and Washington, DC were some of the first public housing units built on land that the federal government had acquired and cleared.¹⁰ In 1937, public housing expanded greatly when Congress passed the Wagner-Steagall Housing Act and established the United States Housing Authority (USHA). Tasked with subsidizing local efforts to build low-cost public housing, the USHA could issue low-interest loans amounting to 90 percent of project costs and on 60-year terms.¹¹ The 1937 law decentralized public housing, putting most of the responsibility on local housing authorities to demolish, design, build, and manage projects while the federal agency acted like a financial advisor.¹² Most of the affordable housing developed in the following decade was for people who moved to factory towns during WWII—some of which became public housing after the war despite being cheaply made.¹³

Urban Renewal and the Housing Act of 1949

In response to white flight to the suburbs, Congress passed the Housing Act of 1949, which enabled the federal government to fund cities' clearance of "slums" and redevelopment of "blighted" areas.¹⁴ The Housing Act of 1949 escalated the federal government's commitment to urban renewal. The Act dedicated funds to build up to 810,000 units of public housing nationwide by 1955, but, by that year, under 240,000 had been constructed. An unequal number of homes had been demolished, displacing as many as 70,000 families. Over 60 percent of the people displaced were Black¹⁵. Importantly, the people whose homes were demolished didn't necessarily qualify for public housing, which limited eligibility to working families for many years.¹⁶

Anti-Blackness embedded in the laws governing public housing undermined federal and local governments' ability to house Black people after destroying their homes. Residential segregation was permitted by the Act and often encouraged by the Roosevelt Administration.¹⁷ As a result, Black people weren't legally allowed to rent many of the public housing units their old neighborhoods had been demolished to build. The first public housing unit ever built with federal dollars, Techwood Homes in Atlanta, GA, for example, displaced hundreds of black families to create a 604-unit, whites-only neighborhood.¹⁸ At large, Black people in the 1950s needed housing assistance because the federal government denied them access to homeownership and other wealth-building supports that were offered to white people through New Deal programs.¹⁹ The federal government's failure to proactively integrate public housing further

entrenched segregation and displaced thousands of families who were forced to relocate to Black-only units or double up with loved ones.

In addition to permitting segregation, the Act authorized local housing authorities to use redevelopment funds to cover construction costs not directly related to housing such as public amenities (e.g., outdoor spaces) and infrastructure (e.g., sewage facilities). There was no federal requirement for local governments to directly replace cleared “slum” areas with housing. Moreover, because government officials did not believe working-class Black people deserved access to these resources, public housing units with community centers, parks, playgrounds, and other green spaces were not distributed equally: white-only units were much more likely to have these amenities.²⁰ If new neighborhoods were designed in partnership with people living in tenements, this flexibility to build parks where a high-rise used to be may have led to vibrant neighborhoods that improved public health. But the federal government did not require housing authorities to get any input from people whose homes were being demolished, nor did the U.S. guarantee people housing in their old neighborhoods. The types of projects that city planning officials could use urban renewal dollars for broadened with the Housing Act of 1954 and subsequent amendments, eventually covering public facilities like event centers, universities, hospitals, and more.²¹

The Federal-Aid Highway Act of 1956 marked a clear shift in federal priorities from building affordable housing for low-income people to preserving white suburbanites’ access to cities. The federal and local governments decided that highways were essential infrastructure, as they enabled white, middle-class families to commute to town for work or shopping.²² In practice, this Act offered another funding source cities could pull from to demolish neighborhoods where most people had low incomes.²³ Between the 1950s and 70s, local governments primarily used these federal dollars to route highways and interstates through Black, brown, and immigrant neighborhoods. Importantly, at this time in the history of urban renewal projects, local governments were no longer just demolishing tenements: several of the neighborhoods destroyed were home to Black-owned properties and businesses.²⁴ This new construction displaced thousands of families and increased exposure to environmental hazards for residents who stayed. Today, Black homes and schools are more likely to be near major roadways and breathe in more pollutants. Broad flexibility in how redevelopment funds could be used broke up entire neighborhoods and resulted in fewer affordable housing units being constructed overall.²⁵

Lastly, the federal government did not invest enough federal dollars into developing quality housing units. The Housing Act of 1949 and preceding legislation all capped construction costs per room,²⁶ disincentivizing use of quality building materials. In addition, public housing policies had created an overreliance on rent revenue (capped at 30 percent of residents’ paycheck) as the income stream that local housing authorities could use to make renovations or repairs. These decisions led to units built in the 30s and 40s deteriorating as early as the 1950s. After 1949, the majority of public housing units developed were high-rises with a uniform, almost institutional appearance.²⁷ This design, which characterized units at a time when public housing began to serve people below the poverty line and racist depictions of residents were rampant,²⁸ was stigmatizing. Prioritizing quantity of units over quality and not investing enough federal dollars in regular maintenance made future deterioration of units inevitable.

Federal Disinvestment from Public Housing and the HOPE IV Program

In the 1960s, around the same time that the Department of Housing and Urban Development (HUD) was established as a cabinet-level federal agency, President Lyndon B. Johnson started experimenting with housing assistance again. This time, the roles of private and public developers were reversed. The Johnson Administration allowed housing authorities to contract with landlords as an alternative to building more public housing units. The federal government’s shift toward a subsidy-based model for housing assistance was solidified in the 1980s when Congress further expanded the housing choice voucher (HCV) program and established the Low-Income Housing Tax Credit (LIHTC). These two housing programs depended on private developers to create and maintain affordable housing.

As mentioned above, there were several issues with the first laws governing public housing, but steady underfunding through the 70s and 80s accelerated the deterioration of many units, including those built after 1950. This disrepair,

combined with racist depictions of public housing units occupied by Black and Latinx families as centers for crime,²⁹ provided “tough-on-crime” politicians with the perfect excuse to disinvest from public housing. Between the late 1970s and 1980s, local housing authorities sold or demolished 15,000 units. The HOPE IV Program, which ran from 1992 to 2010 and was appropriated \$600 million, nationalized this divestment by giving grants to local governments to demolish public housing units that were “severely distressed”. The program also offered flexible funding for cities to replace public units with mixed-income housing and provide relocation services to displaced residents.

While the housing produced by HOPE IV was higher-quality, the program resulted in a net loss of affordable housing nationwide, especially units that were publicly owned and operated.³⁰ There was no one-for-one replacement rule for housing authorities that received HOPE IV funds. Therefore, local governments who used HOPE IV dollars to demolish public housing units did not have to invest in a new, publicly owned replacement. In a government-cited report from 2004, the Urban Institute stated that projects rebuilt through HOPE IV lost units without the one-for-one replacement rule. The units that were lost were disproportionately occupied by Black families living below the poverty line.³¹ By 2004, the number of deeply affordable units (primarily public housing) had been cut nearly in half.³²

Importantly, HOPE IV's rollout coincided with welfare reform legislation under the Clinton Administration, which limited eligibility for cash and food assistance programs.³³ One of these bills changed the purpose of the 1937 U.S. Housing Act from ensuring everyone has access to “decent, safe, and sanitary” homes to protecting the private market’s right to develop housing. In cities where eligibility rules for public housing had changed, lawsuits and community organizing efforts commonly won original residents the right to return, but years-long demolition and building schedules stopped many people from moving back. Some local authorities even lost track of families they once housed because of neglectful recordkeeping.³⁴ By reducing the total number of public housing units and, once again, failing to require that cities offer displaced people housing in new developments on a reasonable timeline, the HOPE IV program funneled renters with low incomes into the private rental market, where there weren’t and still aren’t any real tenants’ rights or protections.³⁵

Ultimately, HOPE IV solidified the federal government’s new strategy of providing housing assistance through subsidies, which, in the long run, contributed to the disrepair of public housing units. Since the early 1990s, over 250,000 public housing units have been demolished or converted to private units that accept vouchers, and federal funds for public housing have steadily decreased.³⁶ A 2010 HUD study noted a nationwide backlog of \$26 billion needed for renovations in public housing units—a number that has at least doubled as of 2022.³⁷ The federal government made the decision to invest in private, mixed-use housing instead of public housing repairs and management reforms that could have revitalized “severely distressed” units.³⁸ Furthermore, as with the families displaced in urban renewal projects between the 1930s and 70s, the HOPE IV Program failed to protect the rights of low-income people to return to their former neighborhoods—the rights of people to rebuild on and determine the future of land that they had occupied for decades. Demolishing “dilapidated” public housing units displaced thousands of families who were forced by a long legacy segregationist housing policies to live there.

Health Inequities Caused by Urban Renewal and Divestment from Public Housing

Like all housing and land use policies from the 20th century that denied homeownership and other wealth-building opportunities to the majority of Black Americans, the lingering effects of urban renewal contribute to present-day racial health inequities.

Displacement

Displacement is the forced removal of a person from their home.³⁹ Today, we associate displacement with eviction proceedings or gentrification,⁴⁰ but the U.S. has a long history of government-funded efforts to displace Indigenous, Mexican, Black, Japanese, and immigrant communities.⁴¹ The Dawes Act of 1887 forcibly seized two-thirds of reservation land and converted it into small, individually owned lots to redistribute to white Americans.⁴² The U.S. Department of Agriculture (USDA) played a central role in dispossessing hundreds of thousands of Black owners of their farmland.⁴³ In

1914, there were a million Black farmers; there were 18,000 in 1992.⁴⁴ Forced removal in the U.S. has often been the result of racist policies and programs. Urban renewal projects throughout the 1900s represent just one example of systemic displacement funded with federal dollars.⁴⁵

Children who experience housing instability or homelessness—both direct consequences of displacement—have a 25 percent greater risk of poor health in adulthood than young people who resided in stable housing. These children also experience higher mortality rates in adulthood.⁴⁶ Displacement increases people’s risk of experiencing:

- Overcrowding⁴⁷
- Substandard housing conditions (e.g., lead, mold, pests, etc.)⁴⁸
- Homelessness⁴⁹
- Financial hardship
- Social isolation or exclusion⁵⁰
- Chronic stress⁵¹
- Post-Traumatic Stress Disorder (PTSD)⁵²

Exposure to Environmental Hazards

Environmental hazards can include but are not limited to air contaminants, toxic waste, lead, arsenic, radiation, pesticides, and extreme temperature or weather events. In the 1900s, local decisions to place facilities (e.g., landfills) or structures (e.g., highways) that produce environmental hazards near segregated neighborhoods were propped up by federal dollars. Urban renewal enabled local governments to disproportionately burden Black, Indigenous, and Latinx neighborhoods by granting city planners broad authority to make land use decisions without input from communities with low incomes, invest redevelopment dollars in projects unrelated to housing people, and, until 1968, explicitly segregate new units. The programs also thrust residents into an unpredictable cycle of displacement, which stripped people of their social assets—their relationships, networks, and sense of belonging—and denied them the same political power over land use decisions provided to white people who lived in the suburbs.⁵³

The United States General Accounting Office finally recognized environmental racism in a 1983 report comparing the racial distribution of people who lived close to landfills where companies could dispose of hazardous waste.⁵⁴ As many as 75 percent of communities near these landfills were Black.⁵⁵ A report published in 1986 confirmed that, nationwide, race was “the single most important factor in determining where toxic waste facilities were sited” in the U.S.⁵⁶ Living near an active or abandoned toxic waste site can expose residents to poor water quality, unsanitary conditions, and carbon dioxide emissions. The Environmental Protection Agency (EPA) recently confirmed that people of color across all income levels and regions in the U.S. breathe in more air pollution than white people from over 5,000 different sources of emission (e.g., roadways and construction vehicles).⁵⁷ Lastly, research from the last decade has warned that neighborhoods with large Black and Latinx populations will face the brunt of climate change’s disastrous effects without large-scale government intervention.⁵⁸

The negative health effects caused by exposure to environmental hazards are worse for children, pregnant people, elders, and people with chronic illnesses. Exposure to environmental hazards increases people’s risk of:

- Cancer⁵⁹
- Respiratory conditions (e.g., asthma)⁶⁰
- Cardiovascular diseases⁶¹
- Financial hardship⁶²
- Displacement⁶³

Substandard Housing Conditions

When the physical conditions of a house violate federal, state, or local codes, it is considered substandard housing. Substandard housing conditions, which can range from structural hazards like leaks or broken windows to pest or vermin infestations,⁶⁴ endanger the health and physical well-being of occupants. Approximately 10 percent of households earning \$15,000 or less a year live in substandard housing.⁶⁵ Large-scale disinvestment from public housing has led to a massive backlog in repairs, as well as lackluster enforcement of health codes in privately-owned units.⁶⁶ Throughout the 1900s, governments displaced thousands of Black, Latinx, and immigrant residents by choosing to “fix” substandard housing through demolition and redevelopment. The federal government risks reproducing that violence if Congress does not invest in public housing and protect low-income tenants in the private rental market.

Substandard housing conditions are associated with a wide range of health conditions and risks, including but not limited to:

- Respiratory conditions (e.g., bronchitis or asthma)⁶⁷
- Cardiovascular diseases⁶⁸
- Lead poisoning⁶⁹
- Pest-associated diseases⁷⁰
- Gas poisoning (e.g., carbon monoxide)⁷¹
- Bodily injuries
- Chronic stress⁷²
- Displacement⁷³

Federal Actions to Mitigate the Health Inequities Caused by Urban Renewal and Disinvestment from Public Housing

Urban renewal policies of the 20th century and the ongoing disinvestment from public housing have increased Black and Latinx peoples’ risk of experiencing displacement, environmental hazards, substandard housing, and the negative health outcomes associated with each. Because racial health inequities are the product of decades of discrimination, exclusion, and violence enacted against Black, Indigenous, and other people of color, policies designed to mitigate these inequities must be restitutive and community driven. The federal government must deliver reparations to people displaced by urban renewal, invest in public and social housing, and establish federal protections for tenants who have been herded into the private rental market.

Deliver Reparations to People Displaced by Urban Renewal

Black Americans whose ancestors experienced enslavement and/or displacement make up 12 percent of the U.S.’s population yet hold less than 2 percent of the nation’s wealth. Scholars estimate that the racial wealth gap is at least 11 trillion dollars,⁷⁴ making it a debt that only the federal government has the capacity to pay. More importantly, it should be the U.S. government’s duty to recognize and atone for federal policies like urban renewal that have systematically disadvantaged Black Americans, eroding wealth across generations and worsening racial health inequities. Urban renewal projects throughout the 1900s also displaced thousands of Latinx, Asian, and immigrant communities. In addition to passing HR40⁷⁵, which would assemble commission to study the effects of slavery and discriminatory policies on African Americans and develop recommendations for reparations, the federal government should:

- Encourage place-based research on racist housing and land use decisions made by state or local government, which should include oral histories from people who were impacted. The Renewing Inequality project at the University of Richmond has mapped family displacements caused by urban renewal between 1950 and 1966 in several U.S. cities.⁷⁶ To support governments in understanding environmental racism, the EJI was recently created. The tool identifies census tracts that experience the greatest cumulative impacts of environmental burdens on their health.⁷⁷

- Study state and local attempts to develop restitutive programs (e.g., recent programs in Santa Monica; CA and Evanston, IL; and Asheville, NC)⁷⁸
- Recognize and support community-driven efforts to secure reparations for people harmed by eminent domain abuses and environmental racism⁷⁹
- Improve state and local governments' capacity to engage with impacted communities through financial support and technical assistance

Invest in Public and Social Housing

The federal government's current approach to developing and preserving quality, affordable housing depends on the private rental market. Today, approximately 900,000 households reside in public housing while millions participate in voucher-based programs. Yet families that are lucky enough to receive a voucher spend close to two and a half years on waitlists first, exposing many to homelessness, overcrowding, eviction, and their related negative health outcomes.⁸⁰ To correct the health inequities caused by substandard housing conditions and displacement, the federal government must recommit to public housing. A large-scale reinvestment would preserve developments that are at risk of being demolished and protect current residents from substandard conditions such as lead poisoning, faulty plumbing, or broken air conditioning/heating units. In addition to providing at least \$70 billion⁸¹ in public housing capital funds to cover unmet renovation needs, the federal government should expand public housing by:

- Repealing the Faircloth Amendment, which caps the number of units any public housing authority can own and operate⁸²
- Increasing ongoing subsidies through the public housing operating and capital funds to ensure that agencies consistently have sufficient funds to operate, maintain, and repair developments
- Creating low-barrier, direct-to-HUD pathways for residents of "obsolete" public housing to contest demolition plans put forth by their local housing authority⁸³
- Implementing a federal "one-to-one" replacement policy⁸⁴ that encourages local housing authorities to maintain their public housing stock in cases where demolition is necessary
- Providing compensation to people who are forced to live in dilapidated public housing units for unreasonable or extended periods of time
- Increasing sources of federal funding available to community land trusts (CLTs) and other nonprofit housing groups dedicated to social housing models⁸⁵ and providing technical assistance to groups interested in applying for these funds
- Establishing a new federal entity with the authority to purchase distressed real estate and transfer it to cooperatives, nonprofits, and community land trusts⁸⁶

Establish and Enforce Federal Protections for Tenants

Urban renewal projects and the federal government's disinvestment from public housing have herded millions of people with low incomes into the private rental market. By not guaranteeing basic rights and protections for renters before transitioning millions into the private rental market, the federal government has, over time, endangered hundreds of thousands of renters. To protect all tenants from displacement and its related negative health outcomes, the federal government must:

- Establish a national tenants' bill of rights, which should include a tenant opportunity to purchase provision, ban on source of income discrimination, expungement of eviction records after 3 years, and any other key protections that local housing justice organizations and tenant unions have championed⁸⁷

- Establish a program to help states and localities develop right to counsel programs for tenants with low incomes who are facing eviction⁸⁸
- Establish a Tenant Protection Bureau tasked with hearing tenant complaints, advising further action, and providing officials with the data they need to enforce tenant protection laws⁸⁹

Section II: Administrative Burdens in Medicaid

More than half (61.1 percent) of the 73 million people enrolled in Medicaid as of 2020 are Black, Hispanic, Asian-American, or another non-white race or ethnicity.⁹⁰ As a result, policies limiting eligibility and access to Medicaid directly exacerbates racial and ethnic health inequities.

Burdens associated with completing public benefit applications and staying enrolled fall almost exclusively on applicants and/or recipients, particularly racial and ethnic marginalized ones, with the state and administering agencies facing few consequences when a large percentage of eligible people are not enrolled in these federally funded programs. These administrative burdens described include learning costs, psychological costs, and compliance costs:

- **Learning costs** are the burdens placed on individuals to research and learn about the Medicaid program, including gathering information, figuring out if they may be eligible, determining how to apply, learning what services are covered, and finding health care providers who accept Medicaid.
- **Psychological costs** include the stigma associated with receiving public benefits and the psychological stresses associated with navigating the bureaucratic process such as how beneficiaries are treated when applying for benefits.
- **Compliance costs** include the time spent filling out forms, waiting to speak with an eligibility worker, collecting the documentation required to prove eligibility, and completing the process of renewing eligibility.

This section will summarize some of the compliance costs that government entities administering Medicaid impose on individuals through policy and operational choices. It is worth noting that although many federally funded benefit programs including Medicaid are administered by state governmental agencies, federal policies often set baseline recommendations for that it deems to be “appropriate” levels of administrative burdens and allow states to increase those limits.

Policy History of Administrative Burdens in Medicaid

The fractured system of healthcare coverage and delivery found in the U.S. is an enduring legacy of slavery. The end of the Civil War and legal slavery in the United States coincided with a smallpox epidemic in the South that lasted from 1862 to 1928. As a direct result of political resentment and chronic underfunding, the Freedman’s Bureau struggled to connect newly freed Black Americans with the basic needs and preventative health care necessary to keep the epidemic at bay. Although white leaders recognized the toll of smallpox on their own communities, they also worried that a healthy, free Black populace would threaten the racial caste system of the South.⁹¹

After Reconstruction, states where slavery was legalized formed a powerful voting bloc that opposed desegregation and racially equitable policies for decades thereafter. For example, when New Deal-era federal programs like Aid to Families with Dependent Children (AFDC), Social Security, and the G.I. Bill were created, it was this bloc of states that ensured federally funded programs were administered at the state level. State officials then administratively excluded Black Americans from accessing these benefits while the federal government failed to penalize them for this discrimination.^{92,93}

When the Medicaid program was formed in 1965, eligibility for children and parents originally depended on their eligibility for AFDC. AFDC has a lengthy racist history.⁹⁴ The program established a policy approach to public benefits as being for the “deserving” poor. Defining people as “deserving” or “undeserving” was racially coded, and the dichotomy

is still used as a dog whistle today for large groups of people of color perceived as being unworthy of assistance based on unfounded negative stereotypes of laziness and abuse of government programs.

Many states implemented conduct- or morals-based AFDC eligibility rules that targeted Black and unmarried mothers. “Suitable home” requirements and policies that denied benefits if there was any sign of a “man in the house” (which could be as little as an extra toothbrush or a large pair of shoes) were applied subjectively and often unequally to Black mothers and their children. Some states halted benefits during planting and harvesting seasons to coerce Black parents to work in agricultural jobs.⁹⁵

Under AFDC, States set their own benefit levels and income eligibility limits, and states with large Black populations — often in the South — typically set lower benefit amounts and eligibility levels. Upon Medicaid’s enactment in 1965, these racist AFDC policies also applied to eligibility for Medicaid since the programs were linked. Tying Medicaid eligibility to that for AFDC also meant that adults without dependent children in the home were not eligible for Medicaid, a limitation that continues today in 11 states.⁹⁶

In 1996 the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) replaced AFDC with the Temporary Assistance for Needy Families (TANF) block grant and delinked Medicaid from cash assistance. Minimum Medicaid income eligibility thresholds for parents and caretaker relatives, though, were still based on states’ 1996 AFDC eligibility thresholds. States could, but were not required to, raise their income thresholds for parent and caretaker eligibility. States with large populations of Black people and other people of color — particularly those in the South — kept their thresholds at the minimum AFDC levels. Even today, states like Texas and Alabama limit eligibility for parents and caretaker relatives to those with household income below 20 percent of the federal poverty line (\$4,606 annually for a family of three).⁹⁷

PRWORA also imposed burdensome Medicaid eligibility restrictions on immigrants, most notably requiring that most lawfully present immigrants be in the U.S. for five years before qualifying for Medicaid and limiting Medicaid eligibility to certain immigrant groups.⁹⁸ For those who meet these strict eligibility criteria, the administrative burdens of proving it are significant. In 2005, the Deficit Reduction Act created a requirement for many Medicaid applicants to prove their citizenship or immigration status by submitting paper documentation (known as “cit-doc”).⁹⁹ This requirement along with the complexity of restrictions on immigrant eligibility cause additional administrative burden on eligible individuals.

The Affordable Care Act (ACA) included provisions to address health inequities and administrative burdens. Section 1557 of the ACA was established to protect populations that have been marginalized, including people of color, in health care settings. The provision prohibited “discrimination on the basis of race, color, national origin, sex, age, or disability” by any entities receiving funding from the federal government, including state Medicaid programs.¹⁰⁰ State Medicaid agencies cannot deny, cancel, limit, or refuse to renew someone’s Medicaid coverage because of their race. They must also provide meaningful language access to the program for those with limited English proficiency. The rule also established a mechanism for enrollees to file complaints and pursue legal action if rights have been violated.

The ACA also made changes in the eligibility and enrollment process to reduce administrative burden and eliminated asset tests for families with children and adults under 65 who aren’t eligible based on a disability. The law prohibits in-person interview requirements; requires that states allow people to complete their applications and renewals in person, online, through the mail, or over the phone; requires states to use available data to verify eligibility; and requires that states attempt to use electronic data to renew people’s coverage automatically, on an *ex parte* basis, before asking them to submit a renewal form or other documentation.

For a deeper exploration of historical legacy of racism in administrative burdens in Medicaid, we recommend reading:

- [How Foundational Moments In Medicaid’s History Reinforced Rather Than Eliminated Racial Health Disparities](#), LaShyra T. Nolen, Adam L. Beckman, and Emma Sandoe, Health Affairs Forefront
- [States Can Reduce Medicaid’s Administrative Burdens to Advance Health and Racial Equity](#), Suzanne Wikle (CLASP), Jennifer Wagner, Farah Erzouki, and Jennifer Sullivan (CBPP).

- [How to Address the Administrative Burdens of Accessing the Safety Net](#), Justin Schweitzer, Center for American Progress
- [Racial Equity Framework Assessing Health Policy](#), Jamila Michener, The Commonwealth Fund

Health Inequities Caused by Administrative Burdens in Medicaid and Other Federal Benefit Programs

Public benefits are supposed to compensate for the failures of the labor market by providing wider access to health care, food, housing and other basic needs. Public benefits should remove systemic and institutional inequities and create conditions that allow all to thrive. But just as racism in education, employment, and housing denies people of color equitable access to income and wealth, our core basic needs programs have also reinforced systems of oppression through the use of administrative burdens. Sociologists Victor Ray, Pamela Herd, and Donald Moynihan neatly summarize the racial injustice of administrative burdens in public benefit programs in the passage below:

“Contemporary racialized burdens in social welfare programs are rooted in their historical design. Racially marginalized groups are more likely to be served in means-tested social welfare programs that impose higher levels of administrative burdens on beneficiaries, including Temporary Aid to Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), and Medicaid. By contrast, White beneficiaries are disproportionately served in social insurance like Social Security and tax subsidy welfare programs like employer-based health insurance where administrative burdens are borne by government or private bureaucracies instead of beneficiaries. The shifting of administrative burdens from the state, or organizations, to beneficiaries for means-tested program has significant consequences in terms of stealing time from racially marginalized groups and their access to benefits. ... The differences in the racial composition of these two categories of social welfare programs, and thus the racial distribution of administrative burden, are large.”¹⁰¹

Administrative burdens prevent eligible people from enrolling and staying enrolled in Medicaid. More than 1 in 4 people under 65 are eligible for Medicaid or CHIP but are not enrolled, often due to enrollment barriers.¹⁰² Eligible individuals may begin the application process but be unable to complete a complex application or navigate a website that doesn’t work on mobile devices. Someone may successfully enroll but then be sent a request for information a few months later that they don’t receive, don’t understand, or don’t timely respond to, resulting in loss of coverage. Finally, many eligible people lose coverage during their annual renewal because they don’t receive their notice or don’t submit the required documentation in time. Some eligible people who can’t enroll in Medicaid remain uninsured; others become uninsured despite still being eligible.¹⁰³ Still others apply, are denied or lose coverage at some point after they enroll due to procedural reasons, then successfully reapply, in a process known as churn. Churn is costly both to individuals, who have to navigate multiple time-consuming processes, and to Medicaid agencies, which have to process additional applications. Further, many people who churn off of Medicaid experience a gap in coverage that may interrupt treatment or access to medications.

Administrative Burdens Result in Unmet Health Needs, Medical Debt, and Distrust of Medical and Governmental Institutions

Administrative barriers can result in people remaining uninsured or experiencing gaps in health coverage. Many of these barriers are likely greater for people whose primary language is not English. Even temporary loss of health coverage leads to a higher risk of hospitalizations for chronic conditions, lower likelihood of primary care visits, more unmet health needs, and increased medical debt.¹⁰⁴ Beyond the direct impact on people’s health when they experience a gap in health coverage, the psychological costs of churn cause confusion about eligibility rules and create frustration that leads to people’s distrust of government services.¹⁰⁵

Despite the ACA’s access and nondiscrimination requirements, many states continue to operate systems rife with unnecessary administrative burdens. For example, some states allow people to begin an application over the phone but require a signed form to complete the process. Many states require applicants and enrollees to submit pay stubs and

other documents even though the state has access to reliable data sources that can confirm eligibility. Some states don't even attempt an automated ex parte renewal, instead mailing a form to clients and requiring that they return it with supporting documents to continue receiving benefits.¹⁰⁶ By continuing to impose unnecessary administrative burdens, states and counties are impeding access to care and disproportionately affecting people of color.

Administrative burdens causing people to remain uninsured, lose coverage, or churn on and off coverage include:

- **Relying on paper documentation when electronic information is available.** Requiring people to provide documents to show they are eligible is a significant barrier, particularly when information is available through electronic data sources. Most eligibility factors for Medicaid can be verified using electronic data from federal, state, and commercial entities, and Medicaid regulations strongly encourage states to use these highly reliable data sources to streamline eligibility determinations. However, many Medicaid agencies continue to require applicants or enrollees to submit paper documents such as pay stubs to prove their eligibility. This delays people's access to health care, requires time and energy for them to gather and submit the needed documents, and often results in eligible people not enrolling in Medicaid because they were unable to submit the right documents or the agency failed to properly process them.
- **Poorly designed websites.** Online applications and account management portals make it easier for many people to enroll in Medicaid and update their information. However, the design of state websites, especially whether they are mobile friendly, greatly affects how easily people can use them to apply for or renew their Medicaid coverage. People with lower incomes are more likely than higher earners to rely on a smartphone for internet access.¹⁰⁷ When websites do not load properly on a smartphone or don't allow people to easily enter their information, they can impede access. In contrast, websites that are designed for mobile phones, have undergone extensive user testing, and allow people to upload pictures of verification documents can increase access.¹⁰⁸
- **Long wait times.** People attempting to enroll in Medicaid often experience long wait times, either on the phone or when waiting to speak to an eligibility worker in person. People with low incomes may have limited minutes on cell phones and can't afford to stay on hold for long periods. People who want to meet in person with an eligibility worker may not be able to take time off work to account for long wait times or limited office hours.
- **Periodic data checks.** Once enrolled, people often face administrative barriers that can cause them to lose Medicaid before their renewal date. Thirty states check electronic data sources periodically in an enrollee's 12-month Medicaid enrollment period to identify changes in income or other circumstances.¹⁰⁹ If the state finds data suggesting someone may no longer be eligible, it mails a request for information requiring the enrollee to submit documents within ten days of the date on the notice. Often, people receiving these requests may have picked up an extra shift during a pay period, switched employers, or experienced other changes that don't affect their eligibility. But many enrollees lose coverage because they don't receive the notice, don't understand what action is required, or are unable to provide the required information within the tight timeframe. Periodic data checks can lead to significant coverage loss. Frequent data checks burden Medicaid enrollees by repeatedly requiring them to prove their eligibility. Gathering income documentation is time consuming. Workers with low incomes often work inconsistent hours, may have multiple jobs from which they need to gather paperwork, and may have high turnover rates.
- **Reliance on mail for important communication.** Medicaid programs typically rely on postal mail for communication with applicants and enrollees and make limited use of email, text messages, or phone calls. Many low-income families with Medicaid experience housing instability and may move frequently or lack access to a reliable mailbox. Individuals who don't receive mail from the agency requiring them to submit verification documents or renewal forms often lose coverage, even though they remain eligible, and must frequently restart the application process. Moreover, states often use mail that is returned as undeliverable as justification for terminating people's coverage, without any attempt to reach them through other means of communication.¹¹⁰
- **Complex immigrant eligibility rules.** Immigrants must navigate a confusing web of eligibility criteria for benefit programs, including Medicaid, which impose barriers to coverage on the basis of eligibility — often due to

erroneous application of the rules — but also administratively.¹¹¹ Applications may unnecessarily ask for information about people in the household who are not applying for benefits and may not have a documented immigration status, which may deter many eligible immigrants from applying altogether.¹¹²

- **Complex forms and notices** are another barrier that disproportionately affects immigrants and people with limited English proficiency, low levels of literacy, or cognitive or intellectual disabilities. Many individuals don't complete the application process because the forms are lengthy and intimidating.
- **Language access barriers.** Immigrant applicants and enrollees whose first language is not English face additional barriers in accessing coverage through many stages of the enrollment and renewal process. Important notices may not be available in someone's first or preferred language, and enrollment assistance may not be available in languages other than English.

Asset Tests in Medicaid and Other Federal Benefit Programs

After Medicaid was “delinked” from cash assistance with the 1996 PRWORA legislation, administrative burdens rooted in racist origins remained. For example, applicants subject to asset tests and interview requirements faced barriers to enrollment. Asset tests are harmful because they discourage saving among those concerned about losing benefits and impose onerous paperwork verifications on people applying for and renewing Medicaid.

Although the ACA eliminated asset tests in 2010 for families with children and adults under 65 who aren't eligible based on a disability, asset tests persist for individuals with disabilities and people participating in other federal benefit programs, such as TANF, Supplemental Nutrition Assistance Program (SNAP), and Social Security Income (SSI).

SSI provides a modest amount of monthly cash assistance to older or disabled individuals with low incomes but requires that recipients can't own more than \$2,000 in assets. If recipients go above this asset limit, they will be kicked off the program. SSI recipients can also lose their benefits if they get married to someone who is working. These limits are set at the federal level, have not changed since 1984, and do not index to inflation.¹¹³ When combined with the program's low monthly benefit value (SSI's maximum benefit for an individual is \$841 in 2022) and strict marriage penalty, SSI's asset limit yields a devastating but expected outcome: individuals who rely on SSI benefits and their families are kept in poverty with no way to build up substantial savings.

Asset tests are harmful to everyone because they discourage or even prevent people from saving without risking the loss of benefits. However, asset tests historically have not counted home equity. Due to historical racism that limited access to homeownership, white people with low incomes are far more likely to own their homes than people of color with the same incomes. Eliminating asset tests benefits everyone by allowing people to save as they are able, erasing the disparity of which assets are counted, and reducing the amount of paperwork verifications people need to submit to the state when applying for and renewing Medicaid.¹¹⁴

Federal Actions to Mitigate Health Inequities Caused by Administrative Burdens

Children's Health Insurance Program (CHIP) demonstrates how a streamlined process can increase program access and help eligible people enroll. Expanding coverage to children with somewhat higher incomes and state adoption of effective streamlining strategies successfully reduced paperwork and simplified the enrollment and renewal process for eligible children in many states, which helped reduce the uninsured rate among children.

In December 2021, the Biden Administration issued an executive order requiring federal agencies to deliver services more equitably and effectively, especially for those who have been historically underserved.¹¹⁵ Additionally, the Center for Medicaid and Medicare Services (CMS) has also begun to direct states to phase out premiums for those earning between 100 percent and 138 percent of the poverty level.

Proposed Solutions to Eliminate Racial and Ethnic Health Inequities Due to Administrative Burdens

The Centers for Medicare & Medicaid Services, in its role funding and overseeing the program, should also provide guidance on best practices, policy clarity, and state accountability to make sure administrative barriers are dismantled to ensure eligible people have access to the program. If necessary, enforcement policies should be put in place to ensure that federal policies meant to address racial and ethnic health inequities have teeth.

To address these known burdens and barriers to benefits access, administering agencies must reduce the amount of labor asked of applicants/recipients and assume more responsibility for getting new people enrolled and keeping existing recipients covered. We know this is doable because CLASP has been working to reduce barriers to program access for many years, with lessons documented through our Work Support Strategies (WSS) project in six states.¹¹⁶

In general, agencies should use information that has already been collected and verified by other administering agencies to determine eligibility rather than requiring applicants to resubmit that information. As much as possible, agencies should use eligibility for one program to deem people eligible under other programs with similar requirements. Once determined eligible, enrollees should retain eligibility for extended periods by having short-term income fluctuations disregarded. Customers should be given the option of using simplified standardized deductions or of providing documentation of expenses that exceed the standard amount. Additionally, agencies should ensure that applications are simplified to only request information mandated by law or federal guidance, written and designed clearly (including at an accessible reading level), mobile-friendly, and available online, by phone (including telephonic signature), in person, and in paper form. Extending certification periods is another important step to reducing barriers because doing so reduces the frequency of renewals, which is a time when many eligible people become disconnected from benefits. Some burdens are amplified due to the different eligibility and verification requirements across programs. Federal agencies could reduce burdens by coordinating to eliminate barriers across programs. Examples of

The COVID-19 pandemic has likewise demonstrated that programs can be much more flexible and adaptable than they have traditionally been. Several states quickly made changes to their benefits administration that they had resisted for years when faced with a public health and economic crisis, such as putting up an online application for TANF and eliminating a requirement that SNAP applicants provide proof that their employment ended.¹¹⁷ Allowing some flexibilities provided during the COVID-19 pandemic to be made permanent and ensuring that states know about such flexibilities and are encouraged to use them will be an important step toward reducing barriers to care. Such flexibilities include greater utilization of self-attestation, continuous enrollment, and extended certification periods.

Section III: Coverage of Prevention Practices Through the ACA

The ACA included many ways to promote preventative services that have the backing of evidence-based research and community practices (e.g., mammograms), including requiring coverage of these services. Sections 2713, 4105, and 4106 of the ACA states that private insurers, Medicare, and Medicaid must reimburse for preventive services given an A or B grade by the United States Preventive Services Task Force (USPSTF).

However, the precise definition of which preventative services are covered differs by type of insurer. Whereas Medicaid coverage for preventive services relies solely on ACIP recommendations or an A or B grade from the USPSTF to cover services with no-cost sharing, private insurers must also reimburse for services recommended by Bright Futures, and the Health Resources and Services Administration's (HRSA) guidelines for women's health. Medicare must also cover services that receive a C or I grade from the USPSTF. The disparity in these coverage regulations, for those who are covered by private insurance and Medicare versus those who are covered by Medicaid, is notable, and has implications for racial and ethnic inequities in health outcomes. As previously stated, 61.1 percent of Medicaid enrollees belong to a racially or ethnically marginalized group. White, non-Hispanic Americans are far more likely to be covered by private health insurance.¹¹⁸ Among older American, 74.8 percent of Medicare enrollees are White, non-Hispanic.¹¹⁹ Therefore, the differential levels of preventative care coverage across these three insurance types affects the types of preventative

care racially and ethnically marginalized American can access and as a result, their health outcomes and life expectancies.

Medicaid coverage of preventive services is also far more complicated. Individuals who enrolled in Medicaid after the ACA rollout can receive preventive services with an A or B grade from the USPSTF with no-cost sharing. However, there is no mandate to ensure that individuals enrolled in “traditional” Medicaid before the ACA rollout would be able to benefit from no-cost sharing.¹²⁰ Without no-cost coverage for preventive services such as screenings for perinatal depression,¹²¹ or hepatitis B or C,^{122,123} many people of color with Medicaid coverage may not get care early, causing adverse health conditions when it is harder to intervene. Although coverage is not the only barrier preventing racially and ethnically marginalized in the United States from accessing preventive health services,¹²⁴ it is a federal policy that differentially harms people of color and therefore the responsibility of policymakers to address.

Proposed Solutions to Eliminate Racial and Ethnic Health Inequities Due to Coverage of Preventative Services

CMS should encourage state Medicaid plans to include coverage of § 2713, § 4105, and § 4106 services without cost sharing for all enrollees and promote the no-cost sharing coverage of preventive care services to enrollees.

Congress should act legislatively to ensure that those who enrolled in Medicaid before the ACA rollout have access to the same no-cost sharing preventative care coverage as other enrollees.

Conclusion

In this comment, we took a historical perspective, identifying key programmatic decisions made by the federal government that have compounded to produce the racial health inequities we see today. In the future, to ensure that federal housing and public benefits policies eliminate instead of exacerbate racial and ethnic health inequities, the federal government must develop solutions in partnership with communities who deserve restitution for their experiences with displacement, disinvestment, and exclusion from public benefits programs. Community-based organizations and tenant unions who represent many of these communities have voiced their support for reparations, investments in public and social housing, and nationwide protections for tenants. The federal government must also reduce administrative burdens and coverage inequities placed on Medicaid applicants and recipients by creating alignment across all benefits programs and states. The federal government should explore strategies to centralize or enforce decisions about benefits administration for federally funded benefit programs like Medicaid and SNAP.

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