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Lessons from Ferguson and Beyond: Bias, Health, and Justice

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Lessons from Ferguson and Beyond: Bias, Health, and Justice

Sidney D. Watson*

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INTRODUCTION

August 9, 2014, Michael Brown, an 18-year-old African American teen, killed by police in Ferguson, Missouri.

November 22, 2014, Tamir Rice, a 12-year-old African American child, killed by police in Cleveland, Ohio.

April 4, 2015, Walter Scott, a 50-year-old African American man, killed by police in Charlotte, North Carolina.

November 15, 2015, Jamar Clark, a 24-year-old African American man, killed by police in Minneapolis, Minnesota.

July 6, 2016, Philando Castile, a 32-year-old African American man, killed by police in Falcon Heights, Minnesota.

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The list of Black men and women killed by police goes on and seems to grow by the week: Eric Garner, Keith Lamont Scott, Amadou Diallo, Manuel Loggins Jr., Ronald Madison, Kendra James, Sean Bell, Alton Sterling.¹

The shooting of Michael Brown in Ferguson sparked protests and demonstrations, ignited the Black Lives Matter movement, and prompted national media to report other stories of police shootings of Black² children, teens, women, and men. The ongoing protests have forced a national conversation about race, bias and justice in America.

Much of that conversation has focused on the immediate context of policing and criminal justice: in Ferguson, Missouri, where Michael Brown was shot, the city supported itself on traffic and misdemeanor tickets issued to African Americans.³ More than 80% of Black residents had outstanding traffic tickets, and the city's jails were full of African Americans jailed for failure to pay these tickets.⁴ Police aggressively stopped

1. See Daniel Funke & Tina Susman, *From Ferguson to Baton Rouge: Deaths of Black Men and Women at the Hands of Police*, L.A. TIMES (July 12, 2016, 3:45 PM), <http://www.latimes.com/nation/la-na-police-deaths-20160707-snap-htlstory.html>.

2. Black denotes a specific cultural group rather than merely a skin color and therefore the author capitalizes the word throughout the article. See, e.g., Kimberlé Williams Crenshaw, *Race, Reform and Retrenchment: Transformation and Legitimation in Antidiscrimination Law*, 101 HARV. L. REV. 1331, 1332 n.2 (1988) (“I shall use an upper-case ‘B’ to reflect my view that Blacks, like Asians, Latinos and other ‘minorities,’ constitute a specific cultural group and, as such, require denotation as a proper noun.”) (citing Catherine MacKinnon, *Feminism, Marxism, Method, and the State: An Agenda for Theory*, 7 SIGNS: J. WOMEN IN CULTURE & SOC’Y 515, 516 (1982) (noting that “Black” should not be regarded “as merely a color of skin pigmentation, but as a heritage, an experience, a cultural and personal identity, the meaning of which becomes specifically stigmatic and/or glorious and/or ordinary under specific social conditions”)); see also Lori L. Tharps, *The Case for Black with a Capital B*, N.Y. TIMES (Nov. 18, 2014), <http://www.nytimes.com/2014/11/19/opinion/the-case-for-black-with-a-capital-b.html> (opining that “Black with a capital B refers to people of the African diaspora. Lowercase black is simply a color,” and tracing the history of the term).

3. See U.S. DEP’T OF JUSTICE CIVIL RIGHTS DIV., INVESTIGATION OF THE FERGUSON POLICE DEPARTMENT 9–15 (2015), https://www.justice.gov/sites/default/files/opa/press-releases/attachments/2015/03/04/ferguson_police_department_report.pdf.

4. Cf. *id.* at 66 (discussing the details of the disparate impact of Ferguson police charging practices, and noting that from “October 2012 to July 2014, African Americans accounted for 85%, or 30,525, of the 35,871 total charges brought by [the Ferguson Police Department]”).

African Americans and cited them for minor violations.⁵ Those who got traffic tickets and did not have the money to pay in full at their court hearing were arrested and sent to jail.⁶ Those who failed to appear in municipal court, which many did because they knew the outcome was likely to be jail, were subject to arrest warrants and jailed anyway.⁷

As Ferguson illustrates, racial bias operates at many levels: structural, institutional, and personal.⁸ Racial bias permeates the structure of a criminal justice system in which those with money make bail and those without money remain behind bars while awaiting trial.⁹ Racial bias infects institutions, like police departments, when routine stop and frisks are standard operating policy in Black neighborhoods but not in white ones.¹⁰ Racial bias influences even well-intentioned individual police officers when officers react differently to a Black man wearing a hoodie sweatshirt than a white man.¹¹ Black men are more likely to be stopped by

5. *Cf. id.* at 77 (“In 2001 . . . African Americans comprised about the same proportion of the population as whites, but while stops of white drivers accounted for 1,495 stops, African Americans accounted for 3,426, more than twice as many.”).

6. *See, e.g., id.* at 53 (finding that Ferguson courts did not “provid[e] any process by which a person can seek a fine reduction on account of financial incapacity,” and that the courts would issue an arrest warrant after a single missed payment of a fine).

7. *Cf. id.* at 53–54. Here, the report discussed that the original “arrest warrant after a single missed placement” rule was eventually softened, and the courts allowed a hearing before the issuance of an arrest warrant. *Id.* at 53. However, the report found that this softened rule provided “minimal relief,” as the trial was automatically scheduled on the first Wednesday of the month, at 11:00 AM. *Id.*

8. *See generally* INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE* (Brian Smedley et al. eds., 2001) [hereinafter *IOM UNEQUAL TREATMENT*] (describing different levels at which bias and discrimination operate).

9. *See generally* Symposium, *Preliminary Report on Race and Washington’s Criminal Justice System*, 35 SEATTLE U. L. REV. 623 (2012) (discussing the effects of race on a criminal justice system).

10. *See, e.g.,* U.S. DEP’T OF JUSTICE CIVIL RIGHTS DIV., *supra* note 3, at 2 (suggesting that FPD officers may, as a result of historical department evaluation policies, disproportionately target “productive” neighborhoods in their enforcement, and commenting that many officers may thus view those residents “less as constituents to be protected than as potential offenders and sources of revenue”).

11. *See* John Minchillo, *Trayvon Martin Case: Is Young, Black and Wearing a Hoodie a Recipe for Disaster?*, NBC NEWS (Oct. 30, 2016, 5:20 PM), http://usnews.nbcnews.com/_news/2012/03/22/10814211-trayvon-martin-case-

police.¹² Black men are more likely to be arrested.¹³ Black men are six times more likely to be incarcerated than white men.¹⁴ Since Michael Brown's shooting in Ferguson, Americans talk publicly about how Black men are more likely to be killed by a police officer.

Racial bias takes a toll on Black Americans. As Ta-Nehisi Coates says in his award winning book *Between the World and Me*, for Black people in America “racism is a visceral experience, . . . it dislodges brains, blocks airways, rips muscle, extracts organs, cracks bones, breaks teeth.”¹⁵ The book is a moving letter from Mr. Coates, a Black man, to his 15-year-old son. Mr. Coates describes growing up Black in America and how “powerfully, adamantly, dangerously afraid” everyone was of the police, white mobs, and neighborhood gangs who redirected their won fear into rage.¹⁶ He talks about how the “need to be on guard” was exhausting.¹⁷ He tells of the toll it takes “upon the body” for African Americans to constantly be on guard so as to “not lose their body” to violence, be it the police, school, neighborhood, or other.¹⁸ Researchers have documented the toll living in America extracts on Black health, both physical and mental.¹⁹

is-young-black-and-wearing-a-hoodie-a-recipe-for-disaster (discussing outside perceptions of Black men wearing hoodies).

12. See, e.g., Richard J. Lundman & Robert L. Kaufman, *Driving While Black: Effects of Race, Ethnicity, and Gender on Citizen Self-Reports of Traffic Stops and Police Actions*, 41 CRIMINOLOGY 195, 215 (2003) (concluding that black men are more likely to be stopped, nationally, by police).

13. See Brad Heath, *Racial Gap in U.S. Arrest Rates: ‘Staggering Disparity’*, USA TODAY, (Nov. 19, 2014, 2:24 PM), <http://www.usatoday.com/story/news/nation/2014/11/18/ferguson-black-arrest-rates/19043207/>.

14. MICHAEL DIMCOCK ET AL., PEW RESEARCH CTR., KING’S DREAM REMAINS AN ELUSIVE GOAL; MANY AMERICANS SEE RACIAL DISPARITIES 5 (2013), <http://www.pewsocialtrends.org/2013/08/22/kings-dream-remains-an-elusive-goal-many-americans-see-racial-disparities/>.

15. TA-NEHISI COATES, *BETWEEN THE WORLD AND ME* 10 (2015).

16. *Id.* at 14.

17. See generally *id.* at 1–33.

18. See *id.* at 22–26.

19. See Ruqaiijah Yearby, *Sick and Tired of Being Sick and Tired: Putting an End to Separate and Unequal Health Care in the United States 50 Years After the Civil Rights Act of 1964*, 25 HEALTH MATRIX 1, 14 (2015) (finding that “African American women who had experienced racial bias and had chosen not to object to it were 4.4 times more likely to have hypertension,” as well as that there is a correlation between increased alcohol abuse, infant mortality rate, and rate of aging, amongst those who have experienced racial prejudice); see also David Satcher et al., *What If We Were Equal? A*

This article focuses on racial bias, its impact on African American health and health care, and the new legal tools that the Affordable Care Act (ACA) creates to redress racial bias and discrimination. Section I explores the role that racial bias plays in harming African American health and creating health disparities between Black and white Americans. It also explores the structural, institutional, and interpersonal biases that operate in the health care system and that exacerbate Black/white health disparities. Section II describes how health equity advocates fought to include provisions in the ACA designed to identify and eliminate racial and other disparities in health and health care. Section III describes Section 1557 of the ACA, a new civil rights law, and how it provides an important new legal tool for redressing health care discrimination. The article ends with a call to action to use implementation of Section 1557 as an opportunity to engage in a community-wide conversation about race, health, and health care.

I. RACIAL BIAS, HEALTH, AND HEALTH CARE

The police killings of Michael Brown and other Black men and women have focused attention on how segregated neighborhoods and layers of racial bias taint police practices, municipal courts, and the criminal justice system. Yet segregation and racial bias operate broadly across American society limiting employment, housing, education, and access to high quality food, social supports, and health care for Black Americans.²⁰ These systemic inequities take a toll on African American health.²¹

Comparison of the Black-White Mortality Gap in 1960 and 2000, 24 HEALTH AFF. 459, 459 (2005) (estimating that 83,570 African Americans die annually from health disparities).

20. See U.N. COMM. ON THE ELIMINATION OF RACIAL DISCRIMINATION WORKING GRP., UNEQUAL HEALTH OUTCOMES IN THE UNITED STATES: RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE TREATMENT AND ACCESS, THE ROLE OF SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH, AND THE RESPONSIBILITY OF THE STATE 21, 25–26 (2008). See generally SAMANTHA ARTIGA ET AL., KEY FACTS ON HEALTH AND HEALTH CARE BY RACE AND ETHNICITY 1 (2016), <http://files.kff.org/attachment/Chartpack-Key-Facts-on-Health-and-Health-Care-by-Race-and-Ethnicity> (identifying and documenting “demographics, health access and utilization, health status and outcomes, and health coverage by race and ethnicity” as a prelude to addressing disparities); U.S. DEP’T OF HEALTH & HUMAN SERVS., HEALTH, UNITED STATES, 2015:

Decades of research confirm that African Americans die earlier, and suffer more chronic conditions and disability than other Americans.²² African American men and women have shorter life expectancies than both white Americans and Hispanic Americans.²³ African American babies have the highest rates of infant mortality.²⁴ African American men and women have the highest death rates of heart disease, breast and lung cancer, and stroke for all racial and ethnic backgrounds.²⁵ These differences are called health disparities—differences in health outcomes for a specific group within a population.²⁶

Disparities in African American health exist even in states, like Minnesota, that report the longest life spans and best health in the country.²⁷ In Minnesota, death rates for non-

WITH SPECIAL FEATURE ON RACIAL AND ETHNIC HEALTH DISPARITIES 22 (2015).

21. See sources cited *supra* notes 19–20. Cf. U.N. COMM. ON THE ELIMINATION OF RACIAL DISCRIMINATION, UNEQUAL HEALTH OUTCOMES IN THE UNITED STATES 3 (2008), <http://www.prrac.org/pdf/CERDhealthEnvironmentReport.pdf> (acknowledging that “racial and ethnic disparities in health outcomes in the U.S. are caused not only by structural inequities in our health care systems, but also by a wide range of social and environmental determinants of health”).

22. See ARTIGA ET AL., *supra* note 20, at 1, 14 exhibit 3.10 (showing that Blacks fare worse than whites on the majority of examined measures of health status and outcomes, with the exception of breast cancer, where Black women are less likely to be diagnosed with breast cancer but more likely to die).

23. U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 20, at 22, 22 fig.18.

24. See *id.* at 23, 23 fig.19.

25. *Minority Population Profiles*, U.S. DEP’T OF HEALTH & HUMAN SERVS., <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlID=61> (last modified July 13, 2016, 3:16 PM) (for data on individual types of conditions, reference the menu on the upper left-hand side of the website).

26. PETRY UBRI & SAMANTHA ARTIGA, DISPARITIES IN HEALTH AND HEALTH CARE: FIVE KEY QUESTIONS AND ANSWERS 2 (2016), <http://files.kff.org/attachment/Issue-Brief-Disparities-in-Health-and-Health-Care-Five-Key-Questions-and-Answers> (further distinguishing between “health” disparities—“a higher burden of illness, injury, disability, or mortality experienced by one population group relative to another”—and “health care” disparities—“differences between groups in health insurance coverage, access to and use of care, and quality of care”).

27. See MINN. DEP’T OF HEALTH, ADVANCING HEALTH EQUITY IN MINNESOTA: REPORT TO THE LEGISLATURE 5 (2014), http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf.

elderly African Americans are almost twice those for whites.²⁸ African American babies die at twice the rate of white babies.²⁹

African American health disparities persist even as some states have made significant progress in reducing illness and increasing life expectancy.³⁰ From 2000 to 2007 the Minneapolis-St. Paul region reported a 12% drop in age-adjusted mortality.³¹ However, when the statistics were stratified by race, U.S.-born African Americans saw a 3% increase in death rates over the period, even as death rates dropped for every other racial and ethnic group.³²

African American health disparities result from a complex interplay among a number of factors, such as an individual's behavior, social and economic circumstances, physical environment, genetics, and health care.³³ At a population health level, individual behavior accounts for 30% of health status, genetics 10%, and health care 10%; but the most important factors impacting population health are the social, economic and physical environments in which Americans live, learn, work, pray, and play—such as income, education, employment, food, housing, family and social supports, and community safety.³⁴

28. *Id.* at 79 & tbl.1.

29. *Id.* at 5.

30. As can be observed in the Minnesota example. *See generally id.* at 73–74 (identifying some historical causes of the health disparities in Minnesota's African-American and African-born populations).

31. WILDER RESEARCH, HEALTH INEQUITIES IN THE TWIN CITIES 4 (2012), <http://www.wilder.org/Wilder-Research/Publications/Studies/Health%20Inequities%20in%20the%20Twin%20Cities/Health%20Inequities%20in%20the%20Twin%20Cities%202012,%20Full%20Report.pdf>.

32. *Id.*

33. *See* MINN. DEP'T OF HEALTH, *supra* note 27, at 12; *see also* Bridget C. Booske et al., *Different Perspectives for Assigning Weights to Determinants of Health* 4 (Feb. 2010) (unnumbered County Health Rankings Working Paper), <https://uwphi.pophealth.wisc.edu/publications/other/different-perspectives-for-assigning-weights-to-determinants-of-health.pdf> (reviewing the medical literature to assign relative weights to health determinant factors); Steven A. Schroeder, Special Article, *Shattuck Lecture: We Can Do Better—Improving the Health of the American People*, 357 *NEW ENG. J. MED.* 1221 (2011) (discussing some determinants of premature death).

34. *See* MINN. DEP'T OF HEALTH, *supra* note 27, at 10–14; *see also* HARRY J. HEIMAN & SAMANTHA ARTIGA, HENRY J. KAISER FAMILY FOUND., ISSUE BRIEF, BEYOND HEALTH CARE: THE ROLE OF SOCIAL DETERMINANTS IN PROMOTING HEALTH AND HEALTH EQUITY 1–2 (2015), <http://files.kff.org/attachment/issue-brief-beyond-health-care> (discussing the various factors of health disparities and outcomes).

These “social determinants” of health combined with economic factors account for 60% of health status and health disparities.³⁵ They also play a powerful role in influencing individual healthy behavior and access to health care.³⁶ The social determinants of health instruct us that place matters: neighborhoods can either encourage or discourage healthy behavior. People cannot walk for exercise in neighborhoods that are dangerous or that do not have parks or sidewalks. People cannot make healthy food choices when neighborhoods are food deserts where the only options are fast food and convenience stores that sell only junk food. People cannot find a regular source of medical care when hospitals, private physicians, and nursing homes avoid minority neighborhoods and cluster in primarily white communities.³⁷ All told, after taking into account how the social determinants of health are mirrored in physical environment and impact individual behavior, the social determinants of health influence 90% of health outcomes and health disparities.³⁸

Racial bias disadvantages African Americans across the social determinants of health in employment, housing, education, social supports, and health care.³⁹ Employment discrimination continues to disadvantage African Americans, who are more likely to be unemployed and more likely to be employed in low wage jobs.⁴⁰ A long history of housing

35. See MINN. DEP’T OF HEALTH, *supra* note 27, at 12 (social and economic factors, 40%; physical environment, 10%; clinical care, 10%).

36. See Schroeder, *supra* note 33, at 1222 (finding that individual behavior is responsible for 40% of premature deaths).

37. For a discussion on this point, see Lillian Thomas, *Poor Health: Poverty and Scarce Resources in U.S. Cities*, PITT. POST-GAZETTE (June 14, 2014, 2:38 PM), <http://newsinteractive.post-gazette.com/longform/stories/poorhealth/> (reporting in multiple interactive segments).

38. Social determinants of health directly impact 60% of health status, they also indirectly impact the 30% that results for behavior. See MINN. DEP’T OF HEALTH, *supra* note 27, at 12.

39. See *id.*, at 73–74.

40. See IOM UNEQUAL TREATMENT, *supra* note 8, at 100 (showing that in a study using Black and white testers with identical qualifications, 20% of the time potential employers denied an employment opportunity (a job application, interview, or offer of employment) to the Black applicant that was offered to a white applicant); see also U.S. DEP’T OF LABOR, THE AFRICAN-AMERICAN LABOR FORCE IN THE RECOVERY 1–2 (2012), https://www.dol.gov/_Sec/media/reports/blacklaborforce/BlackLaborForce.pdf (providing Black/white unemployment statistics and earnings, and comparing general wage levels).

discrimination results in Black Americans continuing to live in racially segregated neighborhoods that are overwhelmingly Black.⁴¹ Neighborhood racial segregation occurs across the income spectrum: African American families earning more than \$50,000 a year are just as likely to live in segregated communities as those earning a mere \$2500 a year.⁴²

African American neighborhoods, regardless of the income level, have fewer resources—fewer good schools, safe streets, and quality healthcare—and higher levels of health risks from environmental hazards.⁴³ As Douglas Massey, a leading researcher on neighborhood segregation has noted, “[c]ompared with Whites of similar social status, Blacks tend to live in systematically disadvantaged neighborhoods, even within suburbs.”⁴⁴

Neighborhood segregation takes a particular toll on low income African Americans because they are more likely to live in neighborhoods with concentrated poverty than are poor white Americans.⁴⁵ Since 2000, the number of poor Black neighborhoods has skyrocketed, and now almost 25% of poor Black Americans live in a high poverty neighborhood.⁴⁶ What used to be a problem for a few large cities can now be seen in smaller cities and across the country.⁴⁷ Richer suburbs have used exclusionary zoning laws to keep out affordable housing, so that poor and low-income people—who are disproportionately African American—can only live in the central city and dying suburbs that are being abandoned as

41. See IOM UNEQUAL TREATMENT, *supra* note 8, at 96, 99 (discussing discriminatory denials of rentals and home loans to African Americans); see also Douglas S. Massey, *Residential Segregation and Neighborhood Conditions in U.S. Metropolitan Areas*, in 1 AMERICA BECOMING: RACIAL TRENDS AND THEIR CONSEQUENCES (Smelser et al. eds., 2001). The authors point out that in the north, the typical African American lives in a neighborhood that is 78% Black and, in the south, in a neighborhood that is 67% Black; in Chicago, Cleveland, Detroit, Gary, New York, and Newark the average African American lives in a community that is more than 80% Black. *Id.* at 399, 401.

42. See Massey, *supra* note 41, at 411.

43. *Id.* at 392.

44. *Id.*

45. See PAUL A. JARGOWSKY, ISSUE BRIEF, THE ARCHITECTURE OF SEGREGATION: CIVIL UNREST, THE CONCENTRATION OF POVERTY, AND PUBLIC POLICY 10 (2015), <https://tcf.org/content/report/architecture-of-segregation/>.

46. *Id.* at 7–8, 13 tbl.5.

47. *Id.* at 7–8 (mapping the changes in poverty concentration since 2000).

wealthier people move further and further out to the fringe suburbs.⁴⁸

Ferguson is a prime example of how segregation and the concentration of poverty impacts African Americans. In 1990, “Ferguson was 75 percent white, but by 2010 it was about two-thirds Black. [At the same time, the] poverty rate shot up from 7 percent to 22 percent. Three out of ten neighborhoods in Ferguson now have poverty rates of more than 40 percent.”⁴⁹ Michael Brown lived in one of these high poverty neighborhoods anchored by a poorly maintained low-income housing project—where good jobs are far away, apartments are in poor repair, and the school system is low-performing.⁵⁰

High poverty and segregated neighborhoods exact a toll on African American health. Across the country, residents of poor, primarily African American communities die up to twenty years sooner than do residents of higher income, more racially mixed neighborhoods where unemployment is lower, and schools and other amenities are more plentiful.⁵¹ In St. Louis, Missouri, two zip codes less than ten miles apart have an eighteen-year difference in life expectancy.⁵² Residents of Clayton, zip code 63105, live on average eighty-five years.⁵³ The

48. *Id.* at 13.

49. *Id.* at 14.

50. See Jesse Bogan, Denise Hollinshed & Stephen Deere, *Why Did the Michael Brown Shooting Happen Here?*, ST. LOUIS POST-DISPATCH (Aug. 17, 2014), http://www.stltoday.com/news/local/metro/why-did-the-michael-brown-shooting-happen-here/article_678334ce-500a-5689-8658-f548207cf253.html.

51. See *Mapping Life Expectancy*, VA. COMMONWEALTH UNIV. CTR. ON SOC’Y & HEALTH (Sept. 26, 2016), <http://www.societyhealth.vcu.edu/work/the-projects/mapping-life-expectancy.html> (project is supported by the Robert Wood Johnson Foundation).

52. See WASH. UNIV. IN ST. LOUIS & SAINT LOUIS UNIV., DISCUSSION GUIDE, FOR THE SAKE OF ALL: A REPORT ON THE HEALTH AND WELL-BEING OF AFRICAN AMERICANS IN ST. LOUIS AND WHY IT MATTERS FOR EVERYONE 2 (2014), https://forthesakeofall.org/wp-content/uploads/2016/06/discussionguide_1_econopp_community.pdf [hereinafter 2014 FOR THE SAKE OF ALL REPORT DISCUSSION GUIDE]. A similar graphic, showing only updated life expectancy numbers without any mention of racial makeup, unemployment, poverty, or household income, can be found at WASH. UNIV. IN ST. LOUIS & SAINT LOUIS UNIV., FOR THE SAKE OF ALL: A REPORT ON THE HEALTH AND WELL-BEING OF AFRICAN AMERICANS IN ST. LOUIS AND WHY IT MATTERS FOR EVERYONE 27, fig.17 (rev. 2015), <https://forthesakeofall.files.wordpress.com/2014/05/for-the-sake-of-all-report.pdf>.

53. 2014 FOR THE SAKE OF ALL REPORT DISCUSSION GUIDE, *supra* note 52, at 2.

median household income is more than \$90,000, the unemployment rate is 4%, and only 7% live below the poverty line.⁵⁴ Residents are approximately 78% white, 9% African American, and 14% identify as a different demographic.⁵⁵ Ten miles away in the Jeff-Vander-Lou neighborhood of north St. Louis City, zip code 63106, people typically live only to age sixty-seven.⁵⁶ The population is 95% African American, 2% white, and 3% other.⁵⁷ Unemployment runs at 24%, and more than half the population, 54%, lives below the poverty line.⁵⁸ The median household income is only \$15,000.⁵⁹

In Minneapolis, Minnesota, two neighborhoods just a few miles apart have a thirteen-year difference in life expectancy.⁶⁰ In Edina, zip code 55410, a second ring suburb west of Minneapolis, the neighborhood is 93% white, 3% of the population lives in poverty, the median income is \$64,084, and life expectancy is a fulsome 83 years.⁶¹ Just ten miles away, in North Minneapolis, zip code 55411, where police killed Jamar Clark, the neighborhood is 83% minority, 33% of the population lives in poverty, the median income is \$28,434, and people typically live only to age 70–75.⁶²

Racial bias also infects health care: African Americans have greater health care needs but get less health care, different health care, and lower quality health care than do white Americans.⁶³ Again, racial bias operates at all levels

54. *Id.*

55. *Id.*

56. *Id.*

57. *Id.*

58. *Id.*

59. *Id.*

60. See *Mapping Life Expectancy*, *supra* note 51 (available under the link “earlier maps”).

61. See CRAIG HELMSTETTER ET AL., BLUE CROSS & BLUE SHIELD OF MINN. FOUND., THE UNEQUAL DISTRIBUTION OF HEALTH IN THE TWIN CITIES 38, 5 (Oct. 2010).

62. *Id.*

63. See IOM UNEQUAL TREATMENT, *supra* note 8 (collecting studies that document Black-white disparities in health care access and treatment); see also ARTIGA ET AL., *supra* note 20 (presenting data on Black-white disparities in health care access and treatment); ROBIN L. KELLY, 2015 KELLY REPORT: HEALTH DISPARITIES IN AMERICA (Brandon F. Webb et al. eds., 2015) (examining country-wide Black-white health care disparities); DAYNA BOWEN MATTHEW, JUST MEDICINE 35 (2015) (discussing nationwide disparities); Ruqaiyah Yearby, *When is Change Going to Come? Separate and Unequal*

impacting the structure of the health care system, health care institutions, and interpersonal interactions between patients and caregivers.⁶⁴

During slavery times, Black slaves were often denied the most basic medical treatment, and white physicians performed ghastly experiments on the bodies of slaves.⁶⁵ During Jim Crow, white hospitals and doctors refused to care for Black patients.⁶⁶ While “white only” signs are gone, a segregated health care system continues with private doctors and hospitals serving predominately white communities, and community health centers and public hospitals serving African American communities.⁶⁷

At the structural level, racial bias is built into America’s pay-as-you-go health care system. In a system in which private health insurance has historically been tied to employment, Black Americans are less likely to work for employers who offer health insurance, less likely to have private health insurance, more likely to be covered by Medicaid, and more likely to be uninsured.⁶⁸ Black Americans are more likely to delay or go without care because of cost or other problems.⁶⁹ They are also less likely to have a regular source of medical care.⁷⁰

Institutional racism runs rampant among health care providers where seemingly race-neutral policies have a disproportionate negative impact on African Americans.⁷¹ One out of four doctors and most dentists refuse to treat Medicaid patients.⁷² Their reasons may be based on Medicaid payment

Treatment in Health Care Fifty Years After Title VI of the Civil Rights Act of 1964, 67 SMU L. REV. 287, 332–33 (2014) (showing that Blacks receive lower quality nursing home care).

64. See sources cited *supra* note 63.

65. See, e.g., MATTHEW, *supra* note 63, at 14.

66. See, e.g., DAVID BARTON SMITH, *HEALTH CARE DIVIDED: RACE AND HEALING A NATION* (1999).

67. See, e.g., ARTIGA ET AL., *supra* note 20, at 7; Yearby, *supra* note 19, at 19–21.

68. ARTIGA ET AL., *supra* note 20, at 17, exhibits 4.1, 4.2; IOM *UNEQUAL TREATMENT*, *supra* note 8, at 84.

69. ARTIGA ET AL., *supra* note 20, at 6, exhibit 2.2.

70. *Id.* at 7, exhibit 2.3.

71. See generally Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855 (2012).

72. See Sandra L. Decker, *In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help*, 31 HEALTH AFF. 1673, 1675 (2012) (finding that “69.4 percent of physicians

rates or other seemingly race neutral reasons, but the impact disadvantages African Americans who rely disproportionately on Medicaid.⁷³ Most nursing homes only admit patients who can self-pay, excluding a disproportionate percentage of elderly African Americans who tend to be poorer and have less savings than do whites.⁷⁴ Private hospitals, physicians, and nursing homes all avoid locating in primarily African American neighborhoods.⁷⁵

Explicit and implicit racial bias also operates at the interpersonal level when medical care is delivered.⁷⁶ Hundreds of studies document that when African Americans receive care, they receive poorer quality care than do white patients.⁷⁷ Compared to whites, Black patients “are less likely to receive appropriate medical treatment for cardiovascular disease, cancer, cerebrovascular disease, renal disease, HIV/AIDs, asthma, [and] diabetes.”⁷⁸ African Americans are also “more likely to receive poorer quality rehabilitative, maternal, pediatric, mental health and hospital-based medical services” than white patients.⁷⁹ Doctors spend less time on average with their African American patients.⁸⁰ Doctors are less likely to refer African American patients to specialists and high quality

accepted new patients with Medicaid”). See generally Watson, *supra* note 71, at 856–57 (“Most private physicians either refuse outright to treat Medicaid patients or restrict the number of Medicaid patients they accept.”).

73. See Watson, *supra* note 71, at 856–57.

74. See, e.g., Linton *ex rel.* Arnold v. Carney *ex rel.* Kimble, 779 F. Supp. 925, 928–29 (M.D. Tenn. 1990).

75. See ALAN SAGER & DEBORAH SOCOLAR, CLOSING HOSPITALS IN NEW YORK STATE WON’T SAVE MONEY BUT WILL HARM ACCESS TO HEALTH CARE 29–31 (2006); Brietta R. Clark, *Hospital Flight From Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023, 1024 (2005); Yearby, *supra* note 19, at 19–21 (finding that hospital closure in minority neighborhoods leads to private physicians also leaving).

76. See MATTHEW, *supra* note 63, at 57–64 (collecting studies to support implicit personal bias); Yearby, *supra* note 19, at 22.

77. See MATTHEW, *supra* note 63, at 35, 57–64.

78. *Id.* at 57 (describing health disparities for all minorities).

79. *Id.* (describing health disparities for all minorities).

80. See Tara Culp-Ressler, *Challenging Medical Racism and Physicians Preference for White Patients*, THINKPROGRESS (Feb. 23, 2015), <https://thinkprogress.org/challenging-medical-racism-and-physicians-preference-for-white-patients-59bec589df88> (summarizing several studies that indicate doctors spend less time with African American patients).

hospitals.⁸¹ Doctors are less likely to recommend appropriate surgical interventions to their African American patients.⁸² Doctors are less likely to prescribe appropriate pain medication.⁸³ The studies confirm that these treatment differences are not linked to source of insurance, income, patient preference or clinical need or appropriateness of intervention.⁸⁴ These treatment differences are race-based.⁸⁵

Much of the interpersonal racial bias in health care is unconscious bias, also known as implicit bias.⁸⁶ Doctors, like the overwhelming majority of Americans, believe they are not racially biased.⁸⁷ However, deep-seated stereotypes operating below the conscious level cause doctors to associate Black patients with negative attributes, like being uncooperative and medically noncompliant, and influence their treatment decisions.⁸⁸

Conscious racial bias is also at work, often based upon misinformation.⁸⁹ A 2016 University of Virginia study surveyed medical students and residents trying to uncover why physicians prescribe less pain medication to African American patients.⁹⁰ Forty percent of first year medical students and 25%

81. Rene Bowser, *Race and Rationing*, 25 HEALTH MATRIX 87, 90–91 n.25 (2015); Justin Dimick et al., *Black Patients More Likely Than Whites to Undergo Surgery at Low-Quality Hospitals in Segregated Regions*, 32 HEALTH AFF. 1046, 1048–50 (2013); Elizabeth A. Mort et al., *Physician Discretion and Racial Variation in the Use of Surgical Procedures*, 154 ARCHIVES INTERNAL MED. 761, 761 (1994).

82. MATTHEW, *supra* note 63, at 58–59 (highlighting treatment recommendation data for coronary and renal illnesses).

83. See Kelly M. Hoffman et al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROC. NAT'L ACAD. SCI. 4296, 4296, 4301 nn.1–10 (collecting studies on pain treatment disparities).

84. IOM UNEQUAL TREATMENT, *supra* note 8, at 109, 139, 159.

85. See, e.g., Kevin Shulman et al., Special Article, *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618, 622–24 (1999). Researchers showed primary care physicians vignettes of Black and white patients with identical symptoms, same insurance, same dress, and even similar physical appearance. Physicians referred Black patients less frequently for specialty care. *Id.*

86. MATTHEW, *supra* note 63, at 64–74 (analyzing implicit bias across several disease types and care decisions).

87. *Id.* at 48–51.

88. See *id.* at 64–74; Yearby, *supra* note 63, at 322–23.

89. Yearby, *supra* note 19, at 22.

90. Hoffman et al., *supra* note 83, at 4296.

of residents reported that they believed that African Americans have thicker skin than whites, thus they feel less pain and need less pain medication.⁹¹ A scientifically inaccurate racial stereotype was influencing their decisions on pain treatment.⁹²

Black-white health care disparities are persistent.⁹³ Despite increasing awareness of the problem, health care providers have made almost no progress in reducing and eliminating Black-white disparities in health care treatment.⁹⁴ Since 2000, the federal Agency for Healthcare Research and Quality (AHRQ) has tracked 148 Black vs. white racial disparities in health care and 126 show no change, 9 got worse, and only 13 show some improvement.⁹⁵ State-by-state reports on health care disparities are particularly troubling because the states that are doing best on health care quality indicators for their overall populations tend to be the states that report the largest racial and ethnic health care disparities.⁹⁶ For example, the Midwestern states of Minnesota, Iowa, and Wisconsin are all in the top quartile of states reporting the highest overall health care quality measures.⁹⁷ However, they are also all in the lowest quartile reporting the highest racial and ethnic disparities in health care quality.⁹⁸ As health care providers improve the overall quality of care, African Americans are being left further behind.

Layers of racial bias and segregation operate across the social determinants of health—limiting employment, housing,

91. *Cf. id.* at 4298 (comparing the effects of mistaken biological beliefs on perceptions of necessary pain relief).

92. *Cf. id.* at 4299–300.

93. *See generally* U.S. DEP'T OF HEALTH & HUMAN SERVS., AGENCY FOR HEALTHCARE RES. & QUALITY, PUB. 15–0007, 2014 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT, at 19 (2015) (displaying graphically the fact that the vast majority of health care disparity measures are not changing, or are even worsening, over time).

94. *See id.* at 2–3 (describing the lack of progress in reducing Black-white disparities); JENNIFER K. BENZ ET AL., TRENDS IN U.S. PUBLIC AWARENESS OF RACIAL AND ETHNIC HEALTH DISPARITIES (1999–2010) 5 (2010), <http://www.minorityhealth.hhs.gov/assets/pdf/checked/1/2010StudyBrief.pdf> (noting that even disproportionately affected minority groups may have low awareness of health disparities).

95. AGENCY FOR HEALTHCARE RES. & QUALITY, *supra* note 93, at 19.

96. *Id.* at 22 (maps illustrating both overall health quality and racial/ethnic health disparities).

97. *Id.*

98. *Id.*

education, and access to high quality medical care, food, and social supports—creating and exacerbating Black/white health inequities. In health care as elsewhere, bias taints individual decisions, institutional policies, and the very structure of our institutions. The next section explains how the Affordable Care Act tackles these problems.

II. AFFORDABLE CARE ACT: A HEALTH EQUITY AGENDA

The Affordable Care Act not only reforms and expands access to health insurance, it also includes a bold health equity agenda intended to reduce health and health care disparities and to allow all Americans, especially those in historically vulnerable groups like Black Americans, to attain their full health potential.⁹⁹ This section explains the role of health insurance coverage in reducing health disparities. It also explains how a group of health equity advocates made sure that the ACA also included additional provisions aimed at reducing health and health care disparities.

The ACA's health insurance expansions, via the new Health Insurance Marketplace and Medicaid, offer an essential tool to improve African American access to health insurance and health care. According to the Institute of Medicine, lack of health insurance is the biggest barrier to timely and affordable health care.¹⁰⁰ Prior to the ACA, African Americans were almost twice as likely to be uninsured as white Americans.¹⁰¹

The ACA's Health Insurance Marketplaces and Medicaid Expansion have both increased insurance coverage for Black Americans and reduced racial disparities in health insurance coverage.¹⁰² Overall, the uninsurance rate for the nonelderly has dropped from 17% to 11%, with the rate for Blacks dropping from 19% to 11%, and the rate for whites dropping from 12% to 7%.¹⁰³ African Americans are less likely to gain coverage through the new Marketplaces, more likely to get coverage through the Medicaid Expansion, and also more likely

99. "Attain full potential" is a paraphrase of the WHO health equity language. *Glossary of Terms Used*, WORLD HEALTH ORG., <http://www.who.int/hia/about/glos/en/> (last visited Oct. 20, 2016).

100. See INST. OF MED., AMERICA'S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE 120–21 (2009).

101. See UBRI & ARTIGA, *supra* note 26, at 6, fig.7.

102. See *id.* at 6.

103. *Id.*

to be caught in the coverage gap left when states decide not to adopt the ACA's Medicaid Expansion for adults.¹⁰⁴

The Supreme Court's decision in *National Federation of Independent Businesses v. Sebelius*, making the ACA's Medicaid Expansion for adults voluntary for the states, highlights both how important Medicaid is for African Americans and how racial bias operates at the societal level.¹⁰⁵ Three million people remain uninsured who could be covered by the ACA Medicaid Expansion, and these people are disproportionately Black.¹⁰⁶ Uninsured African Americans are twice as likely as whites or Hispanics to fall into the coverage gap.¹⁰⁷ African Americans make up almost a third of the uninsured adults caught in the gap.¹⁰⁸

African Americans are more likely to fall in the coverage gap because African Americans disproportionately reside in the South, and Southern states have, by and large, refused to expand Medicaid.¹⁰⁹ The only Southern states that have expanded Medicaid are Arkansas, Kentucky, and Louisiana. As of July 2016, 31 states and the District of Columbia had expanded Medicaid, and 19 states had not.¹¹⁰ Twelve of the nineteen states that have refused to expand were slave-holding states of the Old South.¹¹¹ Of the eleven states that made up the former Confederate states, nine have refused to expand Medicaid.¹¹² Of the three former slave states that have opted to

104. *Id.*

105. *See generally* 132 S. Ct. 2566 (2012).

106. *See* Samantha Artiga et al., *The Impact of the Coverage Gap for Adults in States Not Expanding Medicaid by Race and Ethnicity*, KAISER FAMILY FOUND. 2–3, 3 fig.5 (Oct. 26, 2015), <http://kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity/>.

107. *Id.*

108. *See id.* (noting that African Americans make up about 30% of those who fall in the coverage gap).

109. *Id.* at 4.

110. *See Status of State Action on Medicaid Expansion Decision*, KAISER FAMILY FOUND., <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Nov. 12, 2016; information current up to Oct. 14, 2016).

111. *Id.* The twelve former slave holding states are South Carolina, Mississippi, Florida, Alabama, Georgia, Louisiana, Texas, Virginia, Arkansas, North Carolina, Tennessee, and Missouri.

112. *Id.* The members of the Confederacy were South Carolina, Mississippi, Florida, Alabama, Georgia, Louisiana, Texas, Virginia, Arkansas, North

expand Medicaid, two are now threatening to drop the expansion.¹¹³ Old attitudes about race run deep. Racism impacts political decisions.

As the Obama administration and Congress began to consider health reform, a health equity movement coalesced to promote the core principle that health reform needed to prioritize health equity, not just equal access to health insurance.¹¹⁴ Health insurance reform was key, but equal access to quality affordable health insurance coverage alone would not eliminate health and health care disparities.¹¹⁵ Reform also needed to focus on policy initiatives that would improve health outcomes and eliminate health disparities.¹¹⁶

The National Working Group on Health Disparities and Health Reform began with thirty-five groups and within a month grew to include over 250 organizations, coalitions, and associations.¹¹⁷ The Working Group included organizations across the equity spectrum: race and ethnicity, disability, women's rights, LBGTQ, rural, mental and behavioral health, civil rights, and faith-based groups.¹¹⁸ The Group urged Congress that health reform should "addres[s] health inequities among underserved communities and populations, and ensur[e] the safety and quality of health services for all."¹¹⁹ The Working Group developed an advocacy strategy and wrote model bill language. They followed the ACA legislative process, scrutinizing proposals to try to ensure that health equity provisions were included in the legislation.¹²⁰

Carolina, and Tennessee. Missouri and Kentucky were slave states that did not join the Confederacy.

113. See *Current Status of State Medicaid Expansion Decisions*, KAISER FAMILY FOUND., <http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/> (last visited Nov. 13, 2016; information current up to Oct. 14, 2016). *Id.* Only Arkansas, Kentucky, and Louisiana have expanded Medicaid. Both Arkansas and Kentucky are in pitched internal debates about whether and, if so, how to continue their Medicaid expansions. *Id.*

114. See generally DANIEL E. DAWES, 150 YEARS OF OBAMACARE 93–138 (2016).

115. *Id.* at 128.

116. *Id.*

117. *Id.* at 105.

118. *Id.* at 102.

119. *Id.* at 103, fig.3.2.

120. *Cf. id.* at 104 (stating the desired objectives of the Working Group).

The Working Group's goal was to ensure that the final health reform bill included provisions that addressed health inequities broadly and sought to eliminate health disparities across the spectrum.¹²¹ The Working Group's issue list included health insurance coverage that addressed social inequities through coverage for "prevention, wellness, chronic disease management, behavioral health, and the social support services"; public health interventions; workforce development; better data on health and health care disparities, and quality improvement policies designed to reduce, not inadvertently exacerbate, health disparities.¹²²

The Working Group included long time advocates for African American equity, like the NAACP, National Urban League, National Black Nurses Association, National Medical Association, and others focused primarily on racial equity, like the National Alliance for Hispanic Health, National Hispanic Medical Association, and Japanese American Citizens League.¹²³ But the Working Group's letters and formal correspondence with members of Congress addressed disparities and equity in general terms as they impacted a wide variety of vulnerable groups, not just racial and ethnic minorities.¹²⁴ Advocates for African Americans and other racial and ethnic groups had to speak up for their respective populations and raise any group-specific issues.¹²⁵

The Working Group did bring Black/white and other racial disparities to the forefront of the ACA debate by making the business case that treating minority health disparities costs money and reducing minority health care disparities will save health care dollars.¹²⁶ The Working Group publicized the research of Drs. Thomas LaVeist, Darrell Gaskin, and Patrick Richards that showed that between 2003 and 2006, 30.6% of direct medical care expenditures for African Americans, Asians, and Hispanics were excessive—and unnecessary—costs

121. *See id.* at 106.

122. *Id.* at 106–07.

123. *Id.* at 102.

124. *See, e.g., id.* at 103, fig.3.2 (“[We] urge your support for addressing health inequities among underserved communities and populations, and ensuring the safety and quality of health services for all.”).

125. *Id.* at 109–10.

126. *Id.* at 128.

due to health disparities.¹²⁷ Eliminating minority health disparities “would have reduced direct medical care expenditures by \$229.4 billion.”¹²⁸ Taking into account the human costs of health disparities in terms of disability and death, over the three-year period of the study, the combined costs of health inequalities and premature death came to \$1.24 trillion.¹²⁹

The Affordable Care Act that emerged from the legislative process embraces a health equity agenda.¹³⁰ Health insurance reform and expansion includes new prevention, wellness services, and mental health services to help address economic, social, and environmental inequities.¹³¹ Workforce education and training programs will create a more robust pipeline of health and public health professionals who come from underserved communities with the goal of creating a more diverse health and public health workforce.¹³² Robust data collection and reporting requirements for race and ethnicity, gender, primary language, and disability status will provide new insights into where disparities exist and which interventions can reduce and eliminate them.¹³³ Delivery and payment reforms include person-centered medical homes, community-based health teams, financial penalties for unnecessary hospital readmissions, and other innovations to encourage medical providers to address the role of social determinants of health as they provide care for patients.¹³⁴

The ACA also includes a new civil rights law that prohibits insurers and health care providers from discriminating on the basis of race, ethnicity, gender, disability, and age.¹³⁵ While many of the ACA’s health equity provisions encourage health care providers to help reduce the health care disparities that result from social, economic, and environmental factors,

127. *Id.*; THOMAS A. LAVEIST ET AL., JOINT CTR. FOR POLITICAL & ECON. STUDIES, THE ECONOMIC BURDEN OF HEALTH INEQUALITIES IN THE UNITED STATES 4 (2009).

128. *See* LAVEIST ET AL., *supra* note 127.

129. *Id.* at 6.

130. *See* DAWES, *supra* note 114, at 226–32.

131. *Id.* at 227–28, 230.

132. *Id.* at 229–31.

133. *Id.* at 220.

134. *See id.* at 211–16.

135. Patient Protection and Affordable Care Act § 1557, 42 U.S.C. § 18116 (2012).

Section 1557 demands that health care providers and insurers attend to and correct their own racial bias.¹³⁶

III. SECTION 1557 OF THE AFFORDABLE CARE ACT

Strengthening civil rights protections was part of the National Working Group on Health Disparities and Health Reform's health equity agenda.¹³⁷ Several civil rights laws pre-dating the ACA apply to portions of the health insurance and health care system, but they all have significant limitations. Title VI of the 1964 Civil Rights Act prohibits programs and activities that receive federal financial assistance, including health care providers and insurers, from discriminating on the basis of race, color, or national origin, but does not include a private right of action to enforce claims of unintentional, disparate impact discrimination.¹³⁸ Title VII prohibits employers from discriminating on the basis of race, national origin, or gender in their health insurance benefits, but does not reach health care providers or insurers.¹³⁹ The Americans with Disabilities Act prohibits discrimination based on disability but does not cover the terms of health insurance.¹⁴⁰ No civil rights laws were designed specifically to address inequities and discrimination in health care and health insurance.¹⁴¹ Section 1557 of the ACA fills in the gaps in pre-existing civil rights law, and obligates health care providers and health insurers to take a more active role in eliminating health care disparities.¹⁴²

Section 1557 prohibits discrimination in health care and coverage based upon race, color, national origin, sex, age, or disability.¹⁴³ It prohibits both intentional discrimination and unintentional discrimination, forbidding facially neutral

136. *See id.*

137. *See* DAWES, *supra* note 114, at 222.

138. *See* Watson, *supra* note 71, at 860–70 (outlining the limits of pre-ACA civil rights remedies in health care).

139. *See* Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 73–75 (2005).

140. *Id.* at 92–94.

141. *See, e.g.,* Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn't Be So Easy*, 58 FORDHAM L. REV. 939, 948 (1990) (explaining how Title VI regulations used by HHS are based on a template used by twenty-two different agencies).

142. *See* DAWES, *supra* note 114, at 222.

143. 45 C.F.R. § 92.1 (2016).

policies and practices that have a disparate impact on protected groups.¹⁴⁴ Section 1557 can be enforced through a private right of action and through administrative complaints filed with the Department of Health and Human Services (HHS) Office for Civil Rights.¹⁴⁵ Aggrieved individuals can, in some cases, recover compensatory damages in either an administrative or judicial action.¹⁴⁶ Section 1557 requires that health care programs and activities that have fifteen or more full time employees must implement a Section 1557 Civil Rights Compliance Program.¹⁴⁷

Section 1557 is a health-specific civil rights law intended to further the goals of the ACA to expand access to health insurance and health care, to reduce health disparities among underserved communities, and lead to a more equitable distribution of health care resources.¹⁴⁸ Section 1557 went into effect on March 23, 2010, when President Obama signed the ACA, but implementing regulations were not promulgated until May 18, 2016.¹⁴⁹ Six years after Section 1557 went into effect, many are hearing about it for the first time. Civil rights and health reform are just beginning to impact health insurance and health care delivery.¹⁵⁰

144. *Id.* §§ 92.101(b)(1)(i), (b)(3)(iii), (iv) (cross referencing to the Title VI regulations codified at 45 C.F.R. §§ 80.3(b)(1)–(6) for claims involving race, color, national origin, disability, and age); *id.* § 80.3(b)(2) (2016) (providing that prohibited discrimination includes “criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color or national origin”).

145. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,440 (May 18, 2016) (codified at 45 C.F.R. pt. 92) (“OCR interprets Section 1557 as authorizing a private right of action for claims of disparate impact discrimination . . .”); *see also* Rumble v. Fairview Health Servs., No. 14-CV-2037, 2015 WL 1197415, at *11 (D. Minn. Mar. 16, 2015) (finding private right of action to enforce Section 1557).

146. 45 C.F.R. § 92.301(b).

147. *Id.* § 92.7(a).

148. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,444.

149. *Id.* at 31,376.

150. Litigation in this arena is still new. For a brief discussion on the history (and future) of health care discrimination litigation, see *The Future of Healthcare Discrimination Litigation — Section 1557 of the ACA*, ARNALL GOLDEN GREGORY LLP (Aug. 17, 2015), <http://www.agg.com/The-Future-of-Healthcare-Discrimination-LitigationSection-1557-of-the-ACA-08-17-2015/>.

For analysis of some of the first federal cases under Section 1557, see William

Section 1557's protected classes are defined by reference to four pre-existing civil rights statutes: Title VI (race, color, national origin), Title IX (sex), the Age Discrimination Act (age), and Section 504 (disability).¹⁵¹ Implementing regulations appropriately rely on these statutes, their implementing regulations, and judicial opinions to define the scope of Section 1557's protection.¹⁵² Thus, race and national origin include limited English language proficiency as provided by existing Title VI law.¹⁵³ Disability is broadly and inclusively defined as in the Rehabilitation Act and the Americans with Disabilities Amendments Act of 2008.¹⁵⁴ "On the basis of sex" includes discrimination based on sex stereotyping or gender identity, reflecting agency and court interpretations of Title IX that draw on Title VII, protecting transgender persons and lesbian, gay, and bisexual individuals subjected to sexual stereotyping.¹⁵⁵

Stoeri et al., *Health Care Discrimination Litigation Gets a New Set of Teeth under the ACA: 2015 Litigation Review and Preview of 2016*, DORSEY & WHITNEY LLP (Mar. 29, 2016), <https://www.dorsey.com/newsresources/publications/client-alerts/2016/03/health-care-discrimination-change-under-aca>.

151. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,376.

152. See, e.g., *Section 1557 of the Patient Protection and Affordable Care Act*, HHS.GOV, <http://www.hhs.gov/civil-rights/for-individuals/section-1557/> (last visited Nov. 28, 2016) (linking to various examples of administrative documents and OCR enforcement actions relying on previous civil rights statutes).

153. 45 C.F.R. § 92.4 (2016).

154. See *id.*; Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,381–82 (HHS responded to comments asking that chronic conditions be added to the definition of disability by saying that the definition would be the same as that used for ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (codified at 42 U.S.C. § 12102 (2012))). However, the agency also responded that their intent, consistent with the ADA Amendments Act, was to broadly interpret the term disability. *Id.* at 31,382.

155. See 45 C.F.R. § 92.4; Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,387–90 (the sex stereotyping and gender identification prohibition are imported from the Supreme Court case *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989)). HHS supports banning discrimination in health programs on the basis of sexual orientation "as a matter of policy," but the regulations note that the current law is mixed and thus does not justify the inclusion of that language in the list of prohibited activities, at least at this time. *Id.* at 31,388. HHS's use of a non-exclusive list defining "on the basis of sex" is the agency's way of creating regulatory space in Section 1557 as the law of Title IX changes and evolves. *Cf. id.*

Section 1557 applies to three types of health programs or activities: (1) those in which any part is receiving federal financial assistance; (2) those administered by an Executive Agency; and (3) those established under Title I of the ACA including both the Federally-facilitated Marketplace and State-based Marketplaces.¹⁵⁶ The first prong of Section 1557 coverage reaches broadly because federal financial assistance includes Medicaid, CHIP, federal premium tax credits, and most Medicare payments.¹⁵⁷ Almost all hospitals, physician offices, community health centers, nursing homes, home health agencies, clinical laboratories, residential and community based treatment facilities, hospices, and organ procurement centers receive Medicaid, CHIP, or Medicare.¹⁵⁸ All five of the

156. See 45 C.F.R. §§ 92.2, 92.4; see also *Frequently Asked Questions*, HHS.GOV, <http://www.hhs.gov/civil-rights/for-individuals/section-1557/section-1557-proposed-rule-faqs/index.html> (last visited Nov. 23, 2016) (Question 1). HHS's implementing regulations only address health programs and activities administered by HHS. Cf. 45 C.F.R. §§ 92.2, 92.4. HHS has sent a memorandum to other Departments encouraging coordination of enforcement responsibilities under Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,379 (memo sent in November 2015).

157. 45 C.F.R. § 92.4. Federal financial assistance includes grants, loans, and similar funds, credits, subsidies, and contracts of insurance. *Id.* Federal financial assistance includes Medicare Parts A, C, and D, but HHS declined to interpret the term "contracts of insurance" to include Medicare Part B payments for physician and other outpatient services as federal financial assistance. 81 Fed. Reg. at 31,383. Decades ago, HHS interpreted Title VI's specific exclusion of "contracts of insurance" from its definition of Federal Financial Assistance to apply to Medicare Part B payments because Medicare Part B operated almost exclusively as indemnity insurance with the patient paying the provider, and then seeking indemnification from the insurance company. See *Watson*, *supra* note 71, at 865–66 & n.67. Medicare Part B now operates as a direct payer of provider and many thought that the language "contracts of insurance" was included in Section 1557 specifically to bring Medicare Part B payments into the definition of federal financial assistance, but HHS disagreed. See *id.* at 861–62 & n.36. HHS concluded that Section 1557 will cover almost all practicing physicians because they accept some form of federal financial assistance other than Medicare Part B. See *Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. at 31,466–68.

158. See *Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. at 31,445 (providing examples of recipients of federal financial assistance). The recipient of federal financial assistance is the agency, institution, organization, or individual, to whom federal financial assistance is extended directly or through another recipient, and which operates a health program or activity. *Id.* at 31,468. In determining who is the recipient of the federal financial assistance, courts look to see who Congress intended to assist or subsidize with the funds. See *id.* at 31,383. Following courts' analyses, HHS

nation's largest health insurers receive federal premium tax credits, Medicare, or Medicaid.¹⁵⁹ State agencies that administer programs like Medicaid, CHIP, and public health also receive these forms of federal financial assistance.¹⁶⁰ These entities are all "recipients" of federal financial assistance subject to Section 1557.

Section 1557 also applies to health programs and activities administered by HHS and other federal agencies.¹⁶¹ This prong covers both the federal agency administering the program and the program itself, even if the health program or activity does not involve grants of federal-financial assistance.¹⁶² Thus, Section 1557 covers the Centers for Disease Control and Prevention, Institute of Medicine, Food and Drug Administration, Veterans Administration, Centers for Medicaid and Medicare Services, and the health programs and activities they administer.¹⁶³

has determined that an insurance company selling on the Marketplace is a recipient of federal financial assistance whether it receives premium tax credits directly, or enrolls individuals who receive such credits themselves, because the credits are intended to make health insurance more affordable. *See id.* at 31,383. A provider who contracts with, and is paid by, a Marketplace insurance company does not become a recipient of federal financial assistance solely by virtue of that contractual arrangement and payment, because the provider is not the intended recipient of the Federal premium tax credits; the insurance company is. *Cf. id.* On the other hand, a provider who accepts Medicaid or Medicare Parts A or C is a recipient. *See id.*

159. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,445. In 2016, all five of the nation's major insurers (Anthem, Blue Cross/Blue Shield, Cigna, Aetna, and United Health Care) sold plans on the Marketplace, and thus received premium tax credits. *Cf.* Elizabeth Harrington, *Blue Cross, Aetna, United, Humana Flee Obamacare Exchanges*, CNSNEWS.COM (Aug. 7, 2013, 5:16 PM), <http://www.cnsnews.com/news/article/blue-cross-aetna-united-humana-flee-obamacare-exchanges>. In 2017, Aetna and United Health Care will no longer offer Marketplace plans in many locations, but both continue to sell Medicare Advantage plans and Medicaid plans. *See* Tami Luhby, *Aetna to Pull out of Most Obamacare Exchanges*, CNN MONEY (Aug. 16, 2016, 5:41 PM), <http://money.cnn.com/2016/08/15/news/economy/aetna-obamacare/>.

160. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,445.

161. 45 C.F.R. § 92.2 (2016).

162. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,446; *see also id.* at 31,383 (HHS is not covered as a federally assisted program, but as an administrator of health programs and activities).

163. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,466.

Finally, Section 1557 applies to both the Federally-facilitated Marketplace and the State-based Marketplaces.¹⁶⁴ Section 1557 non-discrimination provisions cover the Marketplace web-portals, health insurance plans offered through the Marketplaces, and the navigators and other assisters who help consumers enroll in the Marketplace.¹⁶⁵

Federal regulations define a “health program or activity” subject to Section 1557 as any entity that administers or provides health-related services, insurance, and coverage including assistance in obtaining health-related services or insurance coverage.¹⁶⁶ Health programs and activities also include health education and research programs.¹⁶⁷

The regulations provide that a health program and activity includes all the operations of an entity that is principally engaged in the provision or administration of health-related services or health-related insurance.¹⁶⁸ This means that Section 1557 covers not just the health services and insurance provided by a hospital, physician practice, or health insurer, but also their employee benefit plans.¹⁶⁹

164. *Id.*

165. *See* 45 C.F.R. § 92.4 (definition of state-based marketplace); *id.* § 92.204 (Marketplace web portals).

166. *See id.* § 92.4.

167. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,379. Prior to the ACA, federal law already prohibited discrimination in federally funded research and research done at universities. Section 1557 extends anti-discrimination protection to research conducted within HHS and in non-educational settings. HHS recognized that research projects are often limited in scope and has acknowledged that research protocols that target or exclude certain groups are warranted when justified for the subjects’ health or safety, scientific study design, or the research purpose. *See, e.g., Nondiscrimination on the Basis of Age in Programs or Activities Receiving Federal Financial Assistance from HHS*, HHS.GOV, <http://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/nondiscrimination-basis-of-age/index.html> (last visited Nov. 23, 2016) (noting in the answer to Important Question #10 that certain age discrimination may be permissible, but “only if those actions do not result in the denial of services to the individual or in the provision of lesser or different services”).

168. 45 C.F.R. § 92.4.

169. *See id.* § 92.208. Unless the primary purpose of the federal financial assistance is to fund employee health benefits, Section 1557 does not apply to an employer’s employee health benefits where the provision of those benefits is the only health program or activity operated by the employer. *See also* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,437 (showing that Section 1557 does not generally apply to discrimination by a

This also means that health insurance carriers who are covered by Section 1557 because they offer Marketplace, Medicaid or Medicare plans, must comply with Section 1557 in all their products including off-Marketplace individual plans, employer-sponsored plans, and third party administrator services for self-insured employers.¹⁷⁰ HHS has determined that employers who are *not* principally engaged in health services or health insurance are not covered by Section 1557 simply because they use a third party administrator or purchase a plan from an insurer that receives federal financial assistance.¹⁷¹ However, HHS has also made it clear that the insurer is covered by Section 1557 and potentially liable for discriminatory benefit design over which it has control.¹⁷²

The regulations provide specific details regarding prohibited discrimination by health insurers.¹⁷³ Insurers may not deny, cancel, or limit health insurance coverage or claims on the basis of race, color, national origin, sex, disability, or age.¹⁷⁴ The regulations prohibit insurers from using discriminatory benefit designs or discriminating in the marketing of plans.¹⁷⁵ They also prohibit health insurance companies from imposing cost sharing or other limitations or restrictions on coverage in a way that discriminates on the basis of race, color, national origin, sex, disability, or age.¹⁷⁶

covered entity against its own employees in hiring firing or terms of employment); *see id.* at 31,404.

170. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,428–32.

171. *Id.* at 31,385–86.

172. *See* 45 C.F.R. § 92.208; *see also* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,432. HHS determined that broad applicability of Section § 1557 to health insurers “serves the central purpose of the ACA, and effectuates Congressional intent, by ensuring that entities principally engaged in health services, health insurance coverage, or other health coverage do not discriminate in any of their programs and activities, thereby enhancing access to services and coverage.” Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,386 (prohibiting discrimination throughout an entire institution or corporation is also consistent with provisions of the Civil Rights Restoration Act which defines “program or activity” for Title VI, Title IX, Section 504, and the Age Act).

173. *E.g.*, Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,428.

174. 45 C.F.R. § 92.207(b)(1) (2016).

175. *Id.* § 92.207(b)(2); *see* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,434–35.

176. 45 C.F.R. § 92.207(b)(1).

Section 1557 is a new health-specific civil rights law and HHS has promulgated regulations that reflect this and that further the purposes of the ACA and Section 1557.¹⁷⁷ As part of the rule making process, HHS carefully identified how Section 1557 incorporates and extends existing anti-discrimination provisions in Title VI, Section 504, ADA, ADEA, and Title IX.¹⁷⁸ The regulations also flesh out Section 1557-specific definitions of prohibited discrimination in the health care and coverage context, in many cases providing specific substantive guidance, applications, and instructions to help health care providers and health insurers identify and eliminate prohibited discrimination.¹⁷⁹

For example, with sex discrimination, the Section 1557 regulations prohibit treating patients differently because of their sex and require “equal program access” for all sexes.¹⁸⁰ HHS has provided examples of ways that providers may treat patients differently based upon their sex that are discriminatory and prohibited by Section 1557: being hostile to patients, refusing to serve an individual, providing different levels of care to different sexes, and providing care based on sex-based assumptions.¹⁸¹ The equal access requirement prohibits sex-specific programs and activities unless a covered entity can show “an exceedingly persuasive justification” that the sex-based classification is “substantially related to the

177. See, e.g., Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,377. “Covered entities should bear in mind the purposes of the ACA and Section 1557—to expand access to care and coverage and eliminate barriers to access—in interpreting requirements of the final rule.” *Id.*

178. See 45 C.F.R. § 92.3. The regulations prohibit construing any part of the regulations to apply a lesser standard for protection from discrimination than the standards that apply under Title VI, Title IX, Section 504, or the Age Discrimination Act, and their respective implementing regulations. See *id.* § 92.4 (The regulations also adopt many definitions that appear in pre-existing civil rights law); *id.* §§ 92.101(b)(1)(i), (3)(i). The regulations adopt the definition of specific prohibited discrimination provided in Title VI regulations and Title IX. *Id.*

179. See Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,377. Many comments to the proposed regulations asked for even more examples of prohibited discrimination.

180. 45 C.F.R. § 92.206.

181. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,403–06.

achievement of an important health-related or scientific objective.”¹⁸²

For people with limited English proficiency (LEP), the regulations provide that health care and coverage programs must provide “meaningful access” to those who need language assistance.¹⁸³ For LEP patients, health care providers and insurers must do more than treat them the same as English speaking patients. The regulations provide detailed guidance on the specific steps that providers must take to provide meaningful access including when written materials must be translated, and when and how oral interpretation is to be provided.¹⁸⁴

Similarly, the regulations require health providers and insurers to make “reasonable modifications” and take affirmative steps to adjust their way of delivering care and doing business to avoid discriminating against people with disabilities.¹⁸⁵ The regulations provide guidance for altering communication, web and information technology, and buildings to make them accessible.¹⁸⁶

Aside from the directives on meaningful access for those with limited English proficiency, the Section 1557 regulations contain no specific guidance on how providers and insurers can assure meaningful, nondiscriminatory access and care for racial and ethnic minorities, including African Americans.¹⁸⁷ Instead, 45 C.F.R. § 92.101 provides a general definition of

182. 45 C.F.R § 92.101(b)(3)(iv). The Section 1557 regulations draw on and adapt the constitutional standard established by the Supreme Court rather than using the sex-specific standards authorized by Title IX regulation. *Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. at 31,408–09.

183. *Id.* § 92.201(a).

184. *Id.* §§ 92.201(b)(1)–(2). HHS does not outline minimum requirements for a language access plan, but notes that effective plans often address how the entity will determine an individual’s primary language, identify a telephonic interpretation service, identify a translation services, identify the types of language assistance services that may be required, and identify any documents for which written translations should be routinely available. *See Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. at 31,415.

185. 45 C.F.R § 92.205. Reasonable modification is required unless the covered entity can demonstrate that making the modifications would “fundamentally alter the nature of the health program or activity.” *See id.*

186. *Id.* §§ 92.202–.204.

187. *Cf.* *Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. at 31,437.

prohibited discrimination by cross-referencing to Title VI regulations drafted in the 1960s.¹⁸⁸ The Title VI regulations define prohibited discrimination broadly and generally as policies and practices that deny, segregate, treat different, restrict, or have the effect of discriminating.¹⁸⁹ The Title VI regulations were drafted to create a set of uniform, government wide regulations to implement Title VI and as such, they had to be drafted in very general terms.¹⁹⁰ For decades, scholars and advocates have complained vociferously that the Title VI regulations lack the specificity needed to give health care providers and insurers clear guidance on the kinds of policies and practices that discriminate on the basis of race in the health care setting.¹⁹¹ The Section 1557 regulations need a section that defines prohibited discrimination generally, but just as health care providers and health care insurers needed specific guidance on prohibited sex, disability, and limited English proficiency discrimination, they also need specific guidance of prohibited race discrimination.¹⁹²

Section 1557 offers a potent new tool to reduce racial discrimination, but a clear statement of the legal standard and further guidance on how it applies at the practice level are needed.¹⁹³ What is the civil rights goal when we talk about race discrimination? If our goal is health equity, then an “equal access” standard like that applied to sex discrimination may not address the social, economic, and environmental factors that play such a pivotal role in African American health inequities. The reasonable accommodation standard used for disability or the meaningful access standard used for limited English proficiency may better promote a health equity goal.

Just as important as stating the standard is providing health care providers with examples, applications, and instructions on how to comply with Section 1557. New quality benchmarking and payment incentives may create financial

188. See 45 C.F.R. § 92.101 (2016); see generally Watson, *supra* note 141.

189. See 45 C.F.R §§ 80.3(b)(1)–(6).

190. *Id.*

191. See, e.g., Watson, *supra* note 71 at 883–84 (praising the specificity of Section 1557’s LEP guidelines, as an example of the kind of guidance “lawyers are familiar with and comfortable using” and which is needed for race-based discrimination legal analysis).

192. See *id.*

193. See *supra* notes 185–90 and accompanying text.

incentives for hospitals, physicians, and nursing homes to avoid African American and other minority patients. How does Section 1557 apply? How do the standards apply to insurance company networks that have no or few providers of color who are preferred by patients of color? How do the standards apply to insurance networks that exclude or severely limit specialists who treat conditions that disproportionately impact African Americans like HIV and sickle cell? How do the standards apply to hospitals, nursing homes, and outpatient clinics that tend to avoid minority neighborhoods? Is it prohibited discrimination for a nursing home to accede to a white patient's request that he not be treated by an African American staff member?

How does Section 1557 apply to the kinds of interpersonal interactions that result in African American patients getting poorer quality care? Regulations or guidance that clearly spell out that being hostile to African American patients, refusing to serve African Americans, providing them a different level of care than other patients, or providing care based on race-based assumptions violates Section 1557 would identify many of the main forms of interpersonal bias and help prompt a conversation about racial bias in the clinical setting. Such guidance would provide a fuller framework for new Section 1557 Civil Rights Compliance officers, providers, and grassroots advocates to begin a conversation about race, health, and health care.

CONCLUSION

We have work to do around race, bias, and health in America. As HHS has said,

[o]ne of the central aims of the ACA is to expand access to health care and health coverage for all individuals. Equal access for all individuals without discrimination is essential to achieving this goal. Discrimination in the health care context can often lead to poor and inadequate health care or health insurance or other coverage for individuals and exacerbate existing health disparities in underserved communities. Individuals who have experienced discrimination in the health care context often postpone or do not seek needed health care; individuals who are subject to discrimination are denied opportunities to obtain health care services provided to others, with resulting adverse effects on their health status. Moreover, discrimination in health care can lead to poor and ineffective distribution of health care resources, as needed resources fail to reach many who need them. The result is a marketplace comprised of higher medical costs due to delayed

treatment, lost wages, lost productivity, and the misuse of people's talent and energy.¹⁹⁴

The ACA and Section 1557 offer powerful new tools to promote community-level and institution-level conversations and actions to reduce racial bias and improve health equity. As providers create new Section 1557 Civil Rights Compliance Programs, they have an opportunity and the obligation to scrutinize the role that institutional policies and individual treatment decisions play in creating Black/white health care inequities. Section 1557 and the ACA also prompt providers to look beyond their walls to understand how the social determinants of health contribute to health inequities.

The shooting of Michael Brown and other Blacks has forced a national conversation about race, bias, and justice in America. Implementation of Section 1557 provides the opportunity to bring that conversation and that activism into the health care arena. We need to talk about race, health, and health care. We need take action to reduce and eliminate racial inequities in health care. We need community wide engagement by grassroots voices, consumer advocates, and health care providers. Let us use Section 1557 as a call to action to address and redress the problems wrought by Black/white health inequities.

194. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,444.