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Affirmatively Furthering Health Equity

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INTRODUCTION

The COVID-19 pandemic opened the eyes of many Americans to the existence of unjust health disparities.[1] Early pandemic reporting recounted higher rates of infections and deaths among Black people in cities including Milwaukee, New York City, and New Orleans.[2] As the pandemic progressed and vaccines first became available, vaccination rates lagged in communities of color, leaving them less protected against illness and death.[3] Two years into the pandemic, Black Americans were still being hospitalized for COVID-19 at rates higher than the

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[1] One definition of the term "health disparities" explains that the term "refers to a higher burden of illness, injury, disability, or mortality experienced by one [population] group relative to another," and distinguishes health disparities from healthcare disparities, with the latter referring to "differences between groups in health insurance coverage, access to and use of care, and quality of care." Samantha Artiga et al., *Disparities in Health and Health Care: Five Key Questions and Answers*, KAISER FAM. FOUND. 1, 2 (Mar. 2020), https://files.kff.org/attachment/Issue-Brief-Disparities-in-Health-and-Health-Care-Five-Key-Questions-and-Answers [https://perma.cc/7BKF-WMH6]. Some definitions, however, treat healthcare disparities as a subset of health disparities. The federal government's decennial public health plan, *Healthy People 2020*, defines "health disparity" as "a particular type of health difference that is closely linked with economic, social, and/or environmental disadvantage . . . [one that] adversely affect[s] groups of people who have systematically experienced greater obstacles to health" based on some group trait. *Healthy People 2020: Disparities*, HEALTHYPEOPLE.GOV, https://wayback.archive-it.org/5774/20220414003754/https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities [https://perma.cc/EZ98-WSHG].

[2] *See generally* Mary Crossley, *Prisons, Nursing Homes, and Medicaid: A COVID-19 Case Study in Health Injustice*, 30 ANNALS HEALTH L. 101 (2021) (discussing health disparities affecting people with disabilities and racial minorities during COVID-19).

[3] ALLISON KOLBE, DEP'T HEALTH & HUM. SERVS., DISPARITIES IN COVID-19 VACCINATION RATES ACROSS RACIAL AND ETHNIC MINORITY GROUPS IN THE UNITED STATES (Apr. 2021), https://aspe.hhs.gov/sites/default/files/private/pdf/265511/vaccination-disparities-brief.pdf [https://perma.cc/EQ3S-M3AL].

rest of the population and facing disparities in diagnosis and treatment of long COVID.[4] People with disabilities have also faced numerous disparities during the pandemic, including elevated rates of illness and death, barriers to vaccination and care, and discrimination.[5] Media reporting explained that these worse health outcomes did not flow from innate genetic or physiological differences. Rather, they were products of social and economic influences that made some people more likely to be exposed to the virus (because they lived in multigenerational homes or crowded housing, or worked as essential workers), less likely to seek care (because they were less likely to have health insurance or a job that permitted sick leave), and more likely to suffer bad outcomes once infected (because of higher rates of underlying health conditions).[6]

Experiencing worse health was not new for Black people, disabled people, and members of other groups that society has marginalized. Reporting about the social and economic sources of pandemic health disparities did not surprise researchers, activists, and policy makers who have long sought to address unjust health disparities in the United States. The harsh light that the pandemic cast on these disparities, however, energized and added urgency to efforts to disrupt the structural features that lead to them. That disruption's goal is to advance the cause of health equity, where "everyone has a fair and just opportunity to be as healthy as possible."[7]

This article proposes a new mechanism to advance that cause, one that targets actors in the healthcare sector.

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[4] *See* Carol R. Oladele et al., *The State of Black America and COVID-19: A Two-Year Assessment*, BLACK COAL. AGAINST COVID (Mar. 2022), https://blackcoalitionagainstcovid.org/the-state-of-black-america-and-covid-19/ [https://perma.cc/8U52-X5EF].

[5] Crossley, *supra* note 2, at 106; *see also Building Back Better: Toward a Disability-Inclusive, Accessible, and Sustainable Post COVID-19 World*, CTRS. DISEASE CONTROL (Nov. 29, 2021), https://www.cdc.gov/ncbddd/disabilityandhealth/features/COVID-19-and-disabilities.html [https://perma.cc/27P5-9TND].

[6] Crossley, *supra* note 2, at 104–05; Julia Craven, *How Racial Health Disparities Will Play Out in the Pandemic*, SLATE (Mar. 30, 2020), https://slate.com/news-and-politics/2020/03/how-racial-health-disparities-will-play-out-in-the-coronavirus-pandemic.html [https://perma.cc/EX8D-WNQH]; *see also* Jennifer Abbasi, *Taking a Closer Look at COVID-19, Health Inequities and Racism*, 324 JAMA 427 (2020).

[7] Paula Braveman et al., *What is Health Equity?*, ROBERT WOOD JOHNSON FOUND. (May 1, 2017), https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html [https://perma.cc/U48F-VW4Q]. Definitions of health equity vary in their specifics. *Healthy People 2030*, the federal government's plan for addressing national public health priorities, defines it as "the attainment of the highest level of health for all people." *Healthy People 2030*, DEP'T HEALTH & HUM. SERVS., https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030 [https://perma.cc/V8YT-96RF].

Specifically, it argues for articulating an obligation for actors who receive federal healthcare funding to take affirmative steps to further health equity. To be sure, many structural features relating to employment, housing, education, transportation, environmental hazards, and food insecurity contribute to health disparities. Eradicating health disparities will require broad-ranging and sustained initiatives that reach beyond the healthcare sector. But dismantling discriminatory practices and addressing structural barriers within that sector is a necessary, if not sufficient, step on the road to health justice.

The proposed obligation to "affirmatively further health equity" (AFHE) is novel in several regards. Existing antidiscrimination statutes supply its foundation, but AFHE extends beyond conventional contemporary implementations of those laws. This extension is imperative because prohibiting intentional discrimination—even if vigorously enforced—fails to reach aspects of the twenty-first century healthcare industry that create or reinforce disparities. Establishing an AFHE obligation would enable civil rights laws to promote health equity, not simply prohibit intentional discrimination by healthcare actors.

The proposed AFHE obligation is unabashedly *legal* in character. Many discussions of how to address health disparities revolve around reforms to economic, social, or health policy to eliminate or mitigate the structures that feed health disparities. These range from arguments for paid sick leave,[8] to enacting protections against unjust evictions,[9] to reforming school discipline.[10] In the health arena, proposals span the spectrum from reforming Medicaid policy,[11] to extending coverage to incarcerated people,[12] to infusing antiracist content into medical education.[13] A legal obligation to affirmatively further health equity might prompt recipients of federal healthcare funding to

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[8] *See* Jody Heymann & Aleta Sprague, *Why Adopting a National Paid Sick Leave Law Is Critical to Health and to Reducing Racial and Socioeconomic Disparities – Long Past Due*, JAMA NETWORK (May 6, 2021), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779696 [https://perma.cc/GWD6-NBCL].

[9] *See* Katie Moran-McCabe & Scott Burris, *Eviction and the Necessary Conditions for Health*, 385 NEW ENG. J. MED. 1443, 1443 (2021).

[10] *See* Thalia Gonzalez et al., *Health Equity, School Discipline Reform, and Restorative Justice*, 47 S2 J. L. MED. & ETHICS 47, 48 (2019).

[11] *Medicaid's Role in Advancing Health Equity*, MACPAC (June 2022), https://www.macpac.gov/publication/medicaids-role-in-advancing-health-equity/ [https://perma.cc/3BHS-Y4F3.

[12] *See* Michelle Cottle, Opinion, *This Bill Could Save the Lives of Formerly Incarcerated People*, N.Y. TIMES (Dec. 20, 2021), https://www.nytimes.com/2021/12/20/opinion/medicaid-reentry-act.html [https://perma.cc/TJJ9-BXMS].

[13] *See* Betiol Asmerom, *An Abolitionist Approach to Antiracist Medical Education*, 24 AMA J. ETHICS 194, 194 (2022).

embrace advocacy for policy innovations along these lines, but fundamentally it would require them to act to advance health equity in their own domains. In other words, an AFHE obligation assigns actors within the healthcare sector roles to play in making healthcare more equitable.

Other legal scholars, activists, and policy makers have proposed law-based (or at least law-adjacent) interventions for addressing health disparities. For example, Angela P. Harris and Ayesha Pamukcu argue for "a civil rights of health initiative" in which civil rights advocates deploy public health knowledge and evidence to satisfy antidiscrimination law's "intent" requirement by building a record from which intent can be inferred.[14] To address how implicit bias contributes to health disparities, Dayna Bowen Matthew advocates for amending Title VI of the Civil Rights Act to recognize a private right of action to sue for disparate impact discrimination and to adopt a negligence standard of care in disparate impact cases.[15] Nearly two decades ago, Kevin Outterson made the legal case for health-specific reparations based on a history of unequal government treatment persisting during the lives of Black Americans who are still alive today.[16] More recently, Wendy Netter Epstein argued for a federally imposed and funded health equity mandate involving actors across a range of sectors working collaboratively to address social determinants of health.[17] By and large, the proposed AFHE obligation could fruitfully coexist with and complement these suggested interventions. It goes further, however, by establishing a legal expectation that public and private actors who receive federal healthcare dollars should take steps themselves to undo the harms of health disparities.

Inspiration for this obligation comes from housing law. Since 1968, the Fair Housing Act (FHA) has directed the Department of Housing and Urban Development (HUD) to administer its "programs and activities relating to housing and urban development in a manner affirmatively to further the

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[14] Angela P. Harris & Ayesha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758, 766, 814–15, 818 (2020).

[15] DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE 195–96, 208–09 (2015). Title VI of the 1964 Civil Rights Act prohibits discrimination based on race, color, or national origin by recipients of federal funding assistance. 42 U.S.C. § 2000d.

[16] Kevin Outterson, *Tragedy and Remedy: Reparations for Disparities in Black Health*, 9 DEPAUL J. HEALTH CARE L. 735, 736 (2005).

[17] Wendy Netter Epstein, *The Health Equity Mandate*, 9 J. L. & BIOSCIENCES 1, 7 (2022).

[FHA's] policies."[18] Congressional recognition of the federal government's historical role in enshrining racially segregated housing prompted this directive to act affirmatively to advance fair housing.[19] For nearly half a century, HUD's implementation of the directive was halting, but in 2015, the Obama Administration promulgated a rule establishing concrete obligations accompanying receipt of federal housing funds.[20] The Affirmatively Furthering Fair Housing (AFFH) Rule required HUD grantees to engage in a data driven assessment of fair housing issues in their communities and establish fair housing goals on an ongoing basis.[21] The AFFH Rule sought to ensure that grantees—at the very least—would no longer use federal housing funds in ways that ignorantly (or indifferently) perpetuated patterns of residential segregation. More ambitiously, the AFFH Rule also meant to support efforts to advance integrated and equitable housing opportunities in communities across the United States.

Much as government actions helped produce racially segregated housing, government action has produced or contributed to health disparities and segregated healthcare, both historically and today. Examples of government complicity range from the overt (a hospital construction program explicitly countenancing "separate but equal" hospital care) to the more subtle (structuring and funding the Medicaid program in a fashion that limits access to providers).[22] Thus, as in the housing context, a history of enabling discriminatory healthcare supplies a moral predicate for requiring that, going forward, government dollars be used in ways that will remedy the harms of segregated and unequal healthcare.

An important legal distinction exists between the housing and healthcare contexts, however. The FHA's statutory language explicitly directs the HUD Secretary to affirmatively pursue fair housing.[23] Civil rights laws applicable to healthcare settings lack similarly explicit directives.[24] Those statutes, however, have been interpreted to prohibit disparate impact discrimination. The Department of Health and Human Services (HHS) should develop guidance for recipients of federal funds

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[18] 42 U.S.C. § 3608(e)(5).

[19] *See* text accompanying notes 32–33, *infra*.

[20] Affirmatively Furthering Fair Housing, 80 Fed. Reg. 42,271, 42,274 (July 16, 2015) (codified as amended in scattered sections of 20 C.F.R.).

[21] Justin Steil & Nicholas Kelly, *The Fairest of Them All: Analyzing Affirmatively Furthering Fair Housing Compliance*, 29 HOUS. POL'Y DEBATE 85, 90 (2019).

[22] *See* Part II, *infra*.

[23] *See* 42 U.S.C. § 3608(e)(5).

[24] *See Id.* § 2000d; 29 U.S.C. § 794; 42 U.S.C. § 18116(a).

regarding affirmative steps they should take to ensure that their policies, practices, and operational decisions do not produce disparate impact discrimination. Informal agency guidance would not be legally binding on funding recipients. However, it could signal to healthcare actors that they face enforcement action by HHS if they fail to address policies producing a disparate impact *and* simultaneously support actors' efforts to avoid or repair such inequitable results.

The creation of an AFHE obligation would doubtless provoke opposition, perhaps even legal challenges. Opponents might argue that it exceeds HHS's statutory authority or runs afoul of constitutional constraints. Other objections to agency guidance establishing an AFHE obligation may be more political or pragmatic in nature, suggesting, for example, that HHS is ill-equipped to produce guidance adaptable to the diverse range of healthcare actors that receive federal funding. These arguments are to be reckoned with but do not overcome arguments in favor of an AFHE obligation.[25]

An AFHE obligation would not be a silver bullet for eliminating health disparities. But it could go far in establishing the expectation that federal funding cannot be used in a way that perpetuates health inequity. As President John F. Kennedy explained the need for Title VI of the Civil Right Acts: "Simple justice requires that public funds, to which all taxpayers of all races contribute, not be spent in any fashion which encourages, entrenches, subsidizes or results in racial discrimination."[26] Moreover, an AFHE obligation would bolster the efforts of those actors in the healthcare sector that are already engaging in initiatives to advance health equity and establish similar efforts as the norm, rather than the exception.

The article proceeds as follows: Part I presents an overview of the obligation that federal housing grantees have to "affirmatively further . . . fair housing."[27] This obligation, which originates in the language of the FHA and was fleshed out in the Obama Administration's AFFH Rule, provides the inspiration for the AFHE obligation that this article proposes. By providing examples of how government policies have produced, entrenched, or subsidized health inequity, Part II draws a parallel to how the government's complicity in supporting racial

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[25] *See* Part VI, *infra.*

[26] President John F. Kennedy, Special Message to the Congress on Civil Rights and Job Opportunities (June 19, 1963), https://www.presidency.ucsb.edu/documents/special-message-the-congress-civil-rights-and-job-opportunities [https://perma.cc/S97J-5W8A].

[27] 24 C.F.R. § 5.151 (2024).

residential segregation justified the FHA's affirmative obligation. In so doing, it supplies the moral foundation for establishing a health equity affirmative obligation on the part of those who receive federal healthcare funding. Part III draws upon Professor Olatunde Johnson's work examining "equality directives," civil rights tools that leverage federal funding to prompt recipients to engage in forward-looking planning to increase racial equity in their respective domains.[28] That part goes on to identify several antidiscrimination laws that offer foundations for HHS to issue an equality directive for healthcare. Part IV describes several existing planning or equity-oriented obligations that healthcare actors are already subject to and suggests that these precedents might supply a partial template for crafting a healthcare equality directive. Part V considers and responds to several potential objections to an AFHE obligation.

I. HOUSING LAW'S MODEL FOR AN AFFIRMATIVE OBLIGATION TO ADVANCE EQUITY

Enacted in 1968 and amended in 1988, the FHA prohibits a broad range of discriminatory housing practices by landlords, real estate companies, and lenders, and protects against discrimination on numerous bases, including race, color, religion, sex, national origin, and disability.[29] Enforcement of the FHA's antidiscrimination provisions can occur through administrative proceedings by HUD and by private and government lawsuits.[30]

In addition to prohibiting discriminatory housing practices, Section 3608 of the FHA directs HUD to administer its "programs and activities relating to housing and urban development in a manner affirmatively to further the [FHA's] policies."[31] The statute does not specify what its "affirmatively . . . further" directive requires. Legislative

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[28] Olatunde C.A. Johnson, *Beyond the Private Attorney General: Equality Directives in American Law*, 87 N.Y.U. L. REV. 1339, 1343 (2012).

[29] Fair Housing Act of 1968, Pub. L. No. 90-284, 82 Stat. 73 (codified as amended at 42 U.S.C. §§ 3601–3619).

[30] *Fair Housing Rights and Obligations*, DEP'T HOUS. & URB. DEV., https://www.hud.gov/program_offices/fair_housing_equal_opp/fair_housing_rights_and_obligations (noting the role of HUD's Office of Fair Housing and Equal Opportunity) [https://perma.cc/Z59Z-SD8C]; *The Fair Housing Act*, DEP'T JUST. (June 22, 2023), https://www.justice.gov/crt/fair-housing-act-1 (noting the potential for DOJ and private lawsuits) [https://perma.cc/J8HJ-NP6X].

[31] 42 U.S.C. § 3608(e)(5). A separate subsection imposes a parallel "affirmatively . . . further" requirement on all other federal departments and agencies. *Id.* § 3608(d).

history, however, makes clear that Congress viewed the FHA not only as a way to eradicate housing discrimination, but also as a mechanism for undoing entrenched patterns of racially segregated housing.[32] In short, the FHA does not simply proscribe discriminatory conduct; it also directs agency administration of the law to include affirmative steps to remedy existing segregation and to promote housing choice.

Congress's willingness to impose affirmative obligations to enable Black Americans and other people of color to move out of segregated neighborhoods and into communities with greater opportunities reflected a recognition that the federal government itself had been complicit in encouraging, and even compelling, racial segregation. In a Senate subcommittee hearing in 1966, Attorney General Nicholas Katzenbach explained: "it is highly relevant that government action—both State and Federal—has contributed so much to existing patterns of housing segregation."[33] Speaking in favor of the FHA, Senator Walter Mondale (one of the bill's sponsors) called out the FHA, the Veterans Administration, and other federal agencies as "at best . . . covert collaborator[s]" in policies that encouraged white flight from urban centers and entrenched racially segregated housing.[34]

Despite judicial affirmations that Congress intended Section 3608 to spur HUD (and those who received funding from it) to act vigorously to promote racial integration,[35] for decades agency implementation of the "affirmatively . . . further" directive was weak. Regulations called for recipients of HUD Community Development Block Grant funds to analyze impediments to fair housing in their communities, take some action to address those impediments, and document their analysis and actions.[36] But HUD did not actively monitor grantees' compliance; instead, grantees were permitted simply

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[32] Robert G. Schwemm, *Overcoming Structural Barriers to Integrated Housing: A Back-to-the-Future Reflection of the Fair Housing Act's "Affirmatively Further" Mandate*, 100 KY. L.J. 125, 127 (2012).

[33] Florence Wagman Roisman, *Affirmatively Further Fair Housing in Regional Housing Markets: The Baltimore Public Housing Desegregation Litigation*, 42 WAKE FOREST L. REV. 333, 375–76 (2007). For a compelling account of government's role in promoting racial residential segregation, see generally RICHARD ROTHSTEIN, THE COLOR OF LAW: A FORGOTTEN HISTORY OF HOW OUR GOVERNMENT SEGREGATED AMERICA (2017).

[34] Schwemm, *supra* note 32, at 130 (quoting 114 CONG. REC. 2528 (1968)).

[35] *Id.* at 137–44.

[36] ED GRAMLICH, NAT'L LOW INCOME HOUS. COAL., AFFIRMATIVELY FUTHERING FAIR HOUSING (ADDH): UNDER THE OLD ANALYSIS OF IMPEDIMENTS (AI) PROTOCOL 17 (2018), https://nlihc.org/sites/default/files/AG-2018/Ch07-S03_AFFH-Old-Analysis_2018.pdf [https://perma.cc/G3BT-E9C8].

to certify annually to HUD that they were taking these steps.[37] A 2010 Government Accountability Office report[38] found that many grantees' analyses of impediments either appeared to be outdated, failed to identify time frames for taking action to address impediments to fair housing, or lacked the signatures of top elected officials.[39] One fair housing scholar characterized the analysis of impediments process as "an empty bureaucratic ritual for many jurisdictions."[40] Writing in 2012, Robert Schwemm summarized a disheartening record: "For decades, . . . § 3608's commands have been ignored. Local governments regularly failed to act according to the AFFH mandate, and HUD rarely responded with disapproval, much less forceful action."[41]

The Obama administration's promulgation of its AFFH Rule[42] in 2015 established more robust requirements for HUD grantees. The AFFH Rule still directed funding recipients to analyze and act upon fair housing obstacles in their communities, but it heightened expectations for the rigor of the analysis and HUD's active involvement in the process.[43] It called for grantees to use a standardized assessment tool to evaluate fair housing challenges and contributing factors in their communities, as well as to establish fair housing goals and priorities at least every five years.[44] It provided that HUD would support these processes by providing data regarding residential segregation and place-based differences in access to opportunity and resources.[45] The AFFH Rule also treated community participation as integral to the fair housing assessment:[46] "HUD kept a participatory and decentralized planning process at the

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[37] *See generally id.* (explaining that jurisdictions are left to develop their own compliance plans and submit such documents to HUD; HUD only reviews these plans when the public challenges the adequacy of such plans).

[38] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-10-905, HOUSING AND COMMUNITY GRANTS: HUD NEEDS TO ENHANCE ITS REQUIREMENTS AND OVERSIGHT OF JURISDICTIONS' FAIR HOUSING PLANS 4–5 (2010) [hereinafter GAO Report], http://www.gao.gov/new.items/d10905.pdf [https://perma.cc/L4ED-K38J].

[39] *See id.* at 4, 9.

[40] Philip D. Tegeler, *Affirmatively Furthering Fair Housing and the* Inclusive Communities Project Case*: Bringing the Fair Housing Act into the Twenty-First Century*, *in* FACING SEGREGATION: HOUSING POLICY SOLUTIONS FOR A STRONGER SOCIETY 77, 79 (Molly W. Metzger & Henry S. Webber eds., 2018).

[41] Schwemm, *supra* note 32, at 175. Schwemm described the failure of the FHA to achieve its integration goals as "one of the great civil rights disappointments of the past generation." *Id.*

[42] Affirmatively Furthering Fair Housing, 80 Fed. Reg. 42,271 (July 16, 2015) (codified at scattered sections of 24 C.F.R.).

[43] Kim Kirschenbaum, *New Regulation Seeks to Combat Housing Segregation*, REGUL. REV. (July 16, 2015), https://www.theregreview.org/2015/07/16/kirschenbaum-housing-segregation/ [https://perma.cc/RHH3-Z9GF].

[44] *Id.*

[45] *Id.*

[46] Steil & Kelly, *supra* note 21, at 10.

core of AFFH."[47] In addition, departing from prior approaches, it provided for HUD review of grantees' resulting assessments, priorities, and goals.[48] The AFFH Rule's process-oriented dictates thus were more demanding than prior approaches. The Rule continued an agnostic stance, however, as to the specific substantive goals and methods grantees should pursue to satisfy the "affirmatively . . . further[]" obligation.[49] As administrative law scholar Blake Emerson put it, the rule was "expansive in its reach, but flexible in its prescriptive force."[50]

The AFFH Rule did not weather the Trump Administration intact, but the Biden administration reinstated much of it on an interim basis.[51] In January 2023, it proposed a new rule that seeks to streamline and simplify the AFFH process.[52]

For purposes of this article, the core takeaway regarding regulatory action to implement the FHA's "affirmatively . . . further" mandate is that recipients of federal housing funds must take steps to ensure that their use of federal dollars works to undo, rather than perpetuate, segregation and inequitable access to opportunity. Those steps include gathering and analyzing data regarding housing patterns in grantees' communities, considering the predictable impact of new housing developments, and engaging and seeking input from community members.[53] In sum, the obligation to act affirmatively to promote equitable housing does not simply reside at HUD; instead, the affirmative duty flows to recipients of HUD funding located in communities throughout the country.

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[47] Noah M. Kazis, *Fair Housing for a Non-Sexist City*, 134 HARV. L. REV. 1683, 1695 (2021).

[48] *See id.*

[49] *See id.*

[50] Blake Emerson, *Affirmatively Furthering Equal Protection: Constitutional Meaning in the Administration of Fair Housing*, 65 BUFF. L. REV. 163, 176 (2017).

[51] Restoring Affirmatively Furthering Fair Housing Definitions and Certifications, 86 Fed. Reg. 30,799 (June 10, 2021). During the Trump Administration, HUD repealed the 2015 AFFH Rule, but in 2021, HUD issued an interim final rule that reinstated much of the 2015 Rule. *See id.* at 30,782. While the Biden administration's interim final rule provides that HUD will continue to provide data and technical assistance to grantees engaged in fair housing planning, it did not reinstate a requirement to use a specific planning tool. *Id.*

[52] Katy O'Donnell, *HUD Revamps Obama-Era Discrimination Rule in Rebuke to Trump*, POLITICO (Jan. 19, 2023), https://www.politico.com/news/2023/01/19/hud-revamps-obama-era-discrimination-rule-in-rebuke-to-trump-00078539 [https://perma.cc/L7S8-JVK5].

[53] *See Understanding AFFH: What Is "Affirmatively Furthering Fair Housing" & How Does It Work?*, ALL. HOUS. JUST. (June 6, 2023), https://www.allianceforhousingjustice.org/post/understanding-affh [https://perma.cc/4HAH-E9UZ].

II. THE GOVERNMENT'S ROLE IN PRODUCING HEALTH DISPARITIES

Housing is widely recognized as a critical social determinant of health.[54] Consequently, promoting fair housing also effectively promotes equitable health outcomes. Recognizing this connection, public health advocates applauded the Obama Administration's AFFH Rule and decried the Trump Administration's retreat from robust AFFH enforcement. Urging preservation of the Obama AFFH Rule, the president of the Robert Wood Johnson Foundation described the AFFH Rule's data collection, community engagement, and planning requirements as "one critical piece of the work needed to ensure that everyone in America has a fair and just opportunity for good health and well-being."[55]

The FHA's affirmative mandate, however, calls only for steps to further fair housing, commonly interpreted to mean promoting integration and expanding opportunity and housing choice. Activity relating to the healthcare sector lies beyond its contemplation. But Congress's justification for the FHA's "affirmatively . . . furthering" obligations (namely, the government's historical role in promoting segregation and inequity) has clear—if less direct—analogs in the realm of health. To be sure, the federal government's role in compelling and supporting racial residential segregation is beyond compare. But government actions (and omissions) have contributed to health disparities in the United States. Like housing inequities, racial health disparities result from a combination of structural features and interpersonal racism.[56] The federal and state governments have played major roles, both historically and more

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[54] *See* SCOTT BURRIS ET AL., TEMPLE UNIV. CTR. PUB. HEALTH L. RSCH., A VISION OF HEALTH EQUITY IN HOUSING 6 (Nov. 2019), https://phlr.org/sites/default/files/uploaded_images/HousingHealthEquityLaw-Report1-Nov2019-FINAL.pdf [https://perma.cc/TME3-M58S].

[55] Richard Besser, *Statement from Richard Besser, MD, on Proposed Change to Affirmatively Furthering Fair Housing* Rule, ROBERT WOOD JOHNSON FOUND. (Feb. 18, 2020), https://www.rwjf.org/en/library/articles-and-news/2020/02/statement-from-richard-besser-on-proposed-change-to-affirmatively-furthering-fair-housing-rule.html [https://perma.cc/4ECC-TYCG]. The mission of the Robert Wood Johnson Foundation is "to improve the health and wellbeing of everyone in America." *About the Robert Wood Johnson Foundation*, ROBERT WOOD JOHNSON FOUND., https://www.rwjf.org/en/about-rwjf.html [https://perma.cc/4ECC-TYCG]. *See also* Brian D. Smedley & Philip Tegeler, *"Affirmatively Furthering Fair Housing": A Platform for Public Health Advocates*, 106 AM. J. PUB. HEALTH 1013, 1014 (2016) ("Both public and environmental health perspectives are embedded in the new 'Affirmatively Furthering Fair Housing' rule and its accompanying reporting forms, community engagement process, and guidebook.").

[56] Ruqaiijah Yearby et al., *Structural Racism in Historical and Modern US Health Care Policy*, 41 HEALTH AFFS. 187, 187 (2022).

recently, in engendering disparities in access to health insurance coverage and healthcare providers, as well as in reinforcing racist understandings in medicine and public health. Briefly describing several examples illustrates the pattern.

A. Healthcare Providers: Segregation and Access

Federal legislation from the mid-twentieth century that funded and explicitly blessed racially segregated hospitals provides perhaps the most blatant example of government's contribution to health inequities. Litigation and legislation—namely, Title VI of the 1964 Civil Rights Act—ended *de jure* segregation of hospitals. But lax enforcement in the nursing home context has left those institutions highly segregated even today.

In 1946, as part of an initiative by President Truman to improve the nation's health, Congress enacted the Hospital Survey and Construction Act,[57] commonly known as the Hill-Burton Act. The law sought to address the lack of health facilities in many parts of the country, particularly low income and rural areas, as well as the inadequacies in many existing hospitals.[58] It created a federal and state partnership for investing in hospital construction and modernization in communities that showed a need for and the ability to sustain those institutions.[59] The law spurred sizable public investments (in the form of grants and loans) in hospitals during the ensuing years.[60] By 1975, nearly one-third of the hospitals in the United States had been built or modernized with Hill-Burton funding.[61]

This public investment, however, did not equally benefit all members of the public. The Hill-Burton Act generally required that facilities receiving its funding not discriminate based on race.[62] But the law also authorized a regulatory exception to permit "equitable provision" for funding separate hospitals for different demographic groups, as long as the separate (i.e., segregated) facility was of "like quality" for each

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[57] Hospital Survey and Contruction Act of 1946, Pub. L. No. 79–725, 60 Stat. 1040 (codified as amended at 42 U.S.C. §§ 291–291o).

[58] Emily A. Largent, *Public Health, Racism, and the Lasting Impact of Hospital Segregation*, 133 PUB. HEALTH REP. 715, 715 (2018).

[59] *Id.*

[60] *Id.*

[61] John Henning Schumann, *A Bygone Era: When Bipartisanship Led to Health Care Transformation*, NPR (Oct. 2, 2016, 6:00 AM) https://www.npr.org/sections/health-shots/2016/10/02/495775518/a-bygone-era-when-bipartisanship-led-to-health-care-transformation [https://perma.cc/4CCR-82PT].

[62] Simkins v. Moses H. Cone Mem'l Hosp., 323 F.2d 959, 965 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964).

group.[63] In short, Hill-Burton permitted hospitals built or upgraded with federal funds to provide care in separate, but purportedly equal, facilities.[64] As with educational segregation, separate healthcare inevitably proved to be unequal. "[M]ixed-race" hospitals segregated Black patients onto separate floors or wings that offered fewer physical amenities, more limited nursing staffing, and more limited visiting hours for family.[65] A 1956 survey of hospitals in the South found that 47 percent had segregated wards for Black patients and white patients.[66] Many hospitals that benefited from Hill-Burton investment also refused to grant staff privileges to Black physicians.[67] Not until the 1963 case *Simkins v. Moses H. Cone Memorial Hospital* did a federal court rule the separate but equal provision of Hill-Burton unconstitutional.[68]

Simkins established the illegitimacy of using federal funds to support racial discrimination. Proponents of Title VI of the 1964 Civil Rights Act, which prohibits discrimination on the basis of race, color, or national origin by federal funding recipients, hailed *Simkins* as underscoring the need for congressional action prospectively prohibiting such conduct.[69] Title VI's prohibition extends to healthcare providers who receive funding through the Medicare and Medicaid programs.[70] In fact, the stream of federal funding created by Medicare's 1965 enactment, conditioned as it was on Title VI's nondiscrimination mandate, is credited with prompting widespread desegregation of hospitals.[71] The potent lever of federal healthcare funding smoothed the way for a rapid, and largely under the radar,

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[63] *Id.*

[64] Yearby et al., *supra* note 56, at 188.

[65] P. Preston Reynolds, *Professional and Hospital Discrimination and the US Court of Appeals Fourth Circuit, 1956–1967*, 94 AM. J. PUB. HEALTH 710, 711–12 (2004).

[66] *Id.* at 711.

[67] Largent, *supra* note 58, at 716.

[68] *Simkins*, 323 F.2d at 969.

[69] Largent, *supra* note 58, at 718. The Supreme Court declined to hear an appeal of *Simkins*.

[70] *See* Sara Rosenbaum & Sara Schmucker, *Viewing Health Equity Through a Legal Lens: Title VI of the 1964 Civil Rights Act*, 42 J. HEALTH POL. POL'Y & L. 771, 771–72, 774 (2017). The vast majority of hospitals participate in the Medicare and Medicaid programs. *Fact Sheet: Underpayment by Medicare and Medicaid*, AM. HOSP. ASS'N (Feb. 2022), https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid [https://perma.cc/7CQ5-5RGQ]. Physicians are somewhat less likely to participate in these federal programs, but a large majority still do. *Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey*, MACPAC (June 2021), https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf [https://perma.cc/JM5F-46RW].

[71] DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION 141 (1999).

process of desegregation by hospitals fearful of missing out on valuable federal payments.[72]

The federal government might have used the success of hospital desegregation as a prototype for broader efforts to address racial discrimination by healthcare providers. When it came to nursing homes, however, the federal government chose not to enforce Title VI in any meaningful way. In part, differences in how nursing homes were structured and paid made federal funding a less powerful lever for enforcing Title VI, at least in the statute's early days. Whatever the rationale for tepid enforcement, the result was "a half-hearted pro forma paper compliance effort that everyone understood was cosmetic."[73] More than a half century after the passage of Title VI, "[s]tark racial segregation" characterizes nursing homes in the United States.[74] And that segregation is associated with quality differences. Research has shown that nursing homes serving predominantly Black residents have lower staffing levels and worse outcomes on several quality measures.[75] The most recent manifestation of this pattern was the disproportionately high rates of COVID-19 infections and deaths in nursing homes with higher percentages of Black patients.[76]

B. Private and Public Health Insurance Coverage

Beyond support for and tolerance of racially segregated healthcare facilities, government policies shaping health insurance coverage have contributed to racial health disparities. New Deal era legislation produced a legacy of disproportionately low rates of employer-sponsored coverage among Black Americans. And the structure of the Medicaid program grants

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[72] Largent, *supra* note 58.

[73] SMITH, *supra* note 71, at 246; *see also* Crossley, *supra* note 2.

[74] Yearby et al., *supra* note 56, at 191 (citing Maricruz Rivera-Hernandez et al., *Quality of Post-Acute Care in Skilled Nursing Facilities That Disproportionately Serve Black and Hispanic Patients*, 74 J. GERONTOLOGY A BIOL. SCI. MED. SCI. 689, 694 (2019)).

[75] *Id.*

[76] *The Striking Racial Divide in How Covid-19 Has Hit Nursing Homes*, N.Y. TIMES (Sept. 10, 2020), https://nyti.ms/3e45iVv; Sidnee King & Joel Jacobs, *Near Birthplace of Martin Luther King, Jr., a Predominantly Black Nursing Home Tries to Heal After Outbreak*, WASH. POST (Sept. 9, 2020), https://www.washingtonpost.com/business/2020/09/09/black-nursing-homes-coronavirus/ [https://perma.cc/ZXW9-JRM8]. The analysis was conducted by *The Washington Post*, using data compiled by Brown University from about eleven thousand nursing homes, or nearly three-quarters of all nursing homes in the United States. *Id.* Another researcher described a similar but even starker finding: coronavirus cases and deaths were doubled at nursing homes with the highest percentage of nonwhite residents. *Id.* (describing the testimony of University of Chicago researcher R. Tamara Konetzka before the Senate Special Committee on Aging in May 2020).

states substantial discretion in implementing that public health insurance program, discretion often exercised to the detriment of racially minoritized groups. Even when the Affordable Care Act (ACA) sought to advance health equity by expanding eligibility for the program, the Supreme Court struck down that expansion as coercive of states. As a result, Black Americans have disproportionately been left without the ACA's coverage-related benefits.

1. Employer Sponsored Health Coverage

Though the percentage has declined over time, in 2020, a slim majority of Americans received health insurance coverage through their (or a family member's) employment.[77] Employers' practice of providing health insurance emerged during World War II, when government wage controls rendered nonwage benefits a centerpiece of union negotiations. As employers sought to attract and retain workers in a tight labor market, unions extracted health coverage as a benefit for their members. But not all workers benefited equally from union representation.[78] Federal legislation enacted during the New Deal "supported the occupational segregation of racial and ethnic minority workers in low-wage jobs in the service, domestic, and agricultural industries."[79] The Social Security Act, the Fair Labor Standards Act, and the National Labor Relations Act (NLRA) all exempted domestic and agricultural workers from statutory benefits and protections against exploitation.[80] While facially neutral regarding race, these statutory exclusions were "well-understood as a race-neutral proxy for excluding blacks from statutory benefits and protections made available to most whites."[81] Southern members of Congress, who saw the exclusions as necessary for maintaining the social and economic subordination of Black people characteristic of the Jim Crow

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[77] *Health Insurance Coverage in the United States: 2020*, U.S. CENSUS BUREAU (Sept. 14, 2021), https://www.census.gov/library/publications/2021/demo/p60-274.html [https://perma.cc/3PJW-4RHB]. According to this Census Bureau Report, 54.4 percent of the population had employment-based coverage in 2020. *Id.*

[78] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY (1982).

[79] Yearby et al., *supra* note 56, at 188.

[80] *See* Daiquiri J. Steele, *Enduring Exclusion*, 120 MICH. L. REV. 1667, 1677–79 (2022); Juan F. Perea, *The Echoes of Slavery: Recognizing the Racist Origins of the Agricultural and Domestic Worker Exclusion from the National Labor Relation Act*, 72 OHIO ST. L.J. 95, 118 (2011).

[81] Perea, *supra* note 80, at 96.

South, demanded them in return for their votes for worker-protective legislation.[82]

As a result, federal legislation has had the effect of leaving minority workers with less access to employer-sponsored health coverage, which is the primary source of private health coverage in the United States.[83] In addition to placing agricultural and domestic workers outside the ambit of protections for workers seeking to unionize, the NLRA tolerates racial discrimination by and within unions.[84] Without the ability to unionize, disproportionately Black agricultural and domestic workers had no leverage to gain health insurance coverage from their employers. Today, nearly a century after the New Deal, Black employment is less concentrated in the domestic and agricultural industries. Minority workers, however, are still more likely to work in blue collar, lower-paying jobs, which helps explain a disparity in private insurance coverage.[85] Jobs held disproportionately by minority workers are less likely to provide health insurance.[86] In 2021, 65 percent of white people received coverage through their employment, as compared to 46 percent of Black people, 41 percent of Latinx people, and 35 percent of American Indian/Alaska Native people.[87]

2. Medicaid Coverage

By contrast, Black and brown Americans are disproportionately likely to receive health coverage through

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[82] *Id.* at 98.

[83] *Health Insurance Coverage in the United States*, *supra* note 77, at 1, 6.

[84] *Id.* at 122–24.

[85] Yearby et al., *supra* note 56, at 189; Philathea Duckett & Samantha Artiga, *Health Coverage for the Black Population Today and Under the Affordable Care Act*, KAISER FAM. FOUND. (July 24, 2013), https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-for-the-black-population-today-and-under-the-affordable-care-act [https://perma.cc/A34G-236D].

[86] *Id.*

[87] *Employer-Sponsored Coverage Rates for the Nonelderly by Race/Ethnicity, Timeframe 2021*, KAISER FAM. FOUND., https://www.kff.org/other/state-indicator/nonelderly-employer-coverage-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/JC76-6YD5]. Moreover, according to a 2023 analysis by the Internal Revenue Service, white families' disproportionate coverage by employer-sponsored health insurance provides them with a disproportionate financial benefit from the federal rule that makes employers' health-insurance contributions a form of nontaxable compensation. JULIE-ANNE CRONIN, PORTIA DEFILIPPES & ROBIN FISHER, OFF. TAX ANALYSIS, WORKING PAPER 122, TAX EXPENDITURES BY RACE AND HISPANIC ETHNICITY: AN APPLICATION OF THE U.S. TREASURY DEPARTMENT'S RACE AND HISPANIC ETHNICITY IMPUTATION 28 (2023), https://home.treasury.gov/system/files/131/WP-122.pdf [https://perma.cc/2YMJ-5QA3]. According to this analysis, the exclusion of employers' payment of medical insurance premiums is the single largest income tax expenditure (effectively a form of forgone revenue) in the federal income tax system. *Id.* at 22.

Medicaid, the public health insurance program for low-income Americans. In 2021, among nonelderly Americans, 34.5 percent of Black people and 31.3 percent of Hispanic people were covered by Medicaid, while only 16.5 percent of whites were.[88] Because Medicaid eligibility is tied to income, higher unemployment rates and lower wages among Black people help drive these different rates.[89] Although historically stigmatized as "welfare medicine" and sometimes viewed as less desirable than private health coverage, Medicaid has been instrumental in improving healthcare access for persons of limited means.[90] That said, government decisions at the federal and state levels—both before and after the expansion of Medicaid in the ACA—have entrenched programmatic features that perpetuate racial inequities.[91] As described below, these decisions run the gamut from state-level decisions about the administration and expansion of Medicaid, to government research funding premised on false beliefs in racial physiological distinctiveness, to cost containment initiatives imposing disinvestment in healthcare for minority groups.

a. Before the Affordable Care Act: State Administration, Eligibility Thresholds, and Provider Reimbursement

Medicaid is a federal and state partnership. The federal and state governments jointly fund the program, and states administer it. Created in 1965, the program was meant to cover the healthcare needs of low-income persons who fell into certain categories (the so-called "deserving poor").[92] The federal government provides a majority of the funding for Medicaid and specifies parameters to which states wishing to participate

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[88] *Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity, Timeframe: 2021*, KAISER FAM. FOUND., https://www.kff.org/medicaid/state-indicator/nonelderly-medicaid-rate-by-raceethnicity [https://perma.cc/X7HP-9GW4].

[89] Valerie Wilson & William Darity Jr., *Understanding Black-white Disparities in Labor Market Outcomes Requires Models that Account for Persistent Discrimination and Unequal Bargaining Power*, ECON. POL'Y INST. (Mar. 25, 2022), https://www.epi.org/unequalpower/publications/understanding-black-white-disparities-in-labor-market-outcomes/ [https://perma.cc/H2SC-ANKQ].

[90] MARY CROSSLEY, EMBODIED INJUSTICE: RACE, DISABILITY, AND HEALTH 132–36 (2022).

[91] *See* Jane Perkins & Sarah Somers, *The Ongoing Racial Paradox of the Medicaid Program*, J. HEALTH & LIFE SCI. L. (May 23, 2022), https://www.americanhealthlaw.org/content-library/journal-health-law/article/1ace7226-252b-43c8-a52d-960a4dd3df8f/The-Ongoing-Racial-Paradox-of-the-Medica%E2%80%A6 [https://perma.cc/T9XS-BSF9].

[92] *Policy Basics: Introduction to Medicaid*, CTR. BUDGET & POL'Y PRIORITIES (Apr. 14, 2020), https://www.cbpp.org/research/health/introduction-to-medicaid [https://perma.cc/S8PY-Y6G7].

in the program must conform. States, however, retain substantial discretion in administering their programs.[93] As a result, wide variability exists among states with respect to many aspects of their Medicaid programs.[94] Two aspects of state discretion in particular—income thresholds for eligibility and provider reimbursement—historically have contributed to racial health disparities.

Prior to the ACA's enactment, low-income parents of minor children were one of the categories of people who—if their incomes were low enough—might be eligible for Medicaid. The Medicaid statute permitted states to set the income threshold for eligibility for this group, effectively letting states decide just how poor those parents had to be to enroll in Medicaid.[95] The resulting variability in states' income cutoff levels was breathtaking. In 2009 (just before Congress passed the ACA), eligibility thresholds ranged from 17 percent of the federal poverty level (FPL) in Arkansas to 215 percent of the FPL in Minnesota.[96] The variability among states often followed a racial pattern. Of the five states with the highest percentage of Black residents,[97] three (Mississippi, Louisiana, and Georgia) had income thresholds below the national average of 64 percent of the FPL.[98] Mississippi, the state with the highest percentage of Black residents, set its threshold at 44 percent of FPL.[99] In Alabama, the state with the second lowest eligibility threshold (at 24 percent of FPL), the population was 26.8 percent Black, nearly double the 13.6 percent nationally.[100]

In short, by granting states broad implementation discretion, Congress allowed states to choose how generous to be in making their poor citizens eligible for publicly-funded health insurance. "Welfare reform" undertaken in the 1990s enlarged states' ability to depress income eligibility thresholds by delinking Medicaid eligibility from eligibility for cash welfare payments.[101] Historian Tomiko Brown-Nagin has traced the

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[93] *Id.*

[94] *Id.*

[95] 42 U.S.C. § 1396a(e)(14)(A).

[96] *Medicaid Income Eligibility Limits for Parents, 2002–2023*, KAISER FAM. FOUND., https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents/ [https://perma.cc/4KP6-92DK].

[97] SONYA RASTOGI ET AL., U.S. CENSUS BUREAU, THE BLACK POPULATION: 2010 8 (2011), https://www.census.gov/content/dam/Census/library/publications/2011/dec/c2010br-06.pdf [https://perma.cc/BJ7P-4GZB].

[98] *Medicaid Income Eligibility Limits for Parents*, *supra* note 96.

[99] *Id.*

[100] *Id.*; *see* RASTOGI ET AL., *supra* note 97, at 8.

[101] LaShyra T. Nolen, Adam L. Beckman & Emma Sandoe, *How Foundational Moments in Medicaid's History Reinforced Rather than Eliminated Racial Health*

historical lineage of such state-level discretion to New Deal social welfare legislation. She describes federal laws giving implementation discretion to states as "amount[ing] to an imprimatur to discriminate against disfavored groups, including blacks and others deemed unworthy of charity because of color or perceived moral failings."[102] Depressed income eligibility thresholds for Medicaid help explain why rates of uninsurance among Black residents of southern states was higher than the national average before the ACA.[103]

Authorizing states to set payment rates for medical providers participating in their Medicaid programs also gives rise to racial health inequities. Physicians and other providers treating Medicaid enrollees receive payments that are typically lower than the amounts paid by private insurance and Medicare, sometimes strikingly so.[104] Medicaid's low (relative to other payers) payment rates are one reason why many physicians either refuse to accept Medicaid patients or limit how many they will accept.[105] As a result, Medicaid enrollees often have a harder time finding a provider who will treat them than privately insured patients do. Recent research found that increasing Medicaid payment rates to physicians increased patient access to care. That increased access translated into receipt of more care and improved health outcomes.[106] Depressed provider fees can negatively affect access to care[107] for Medicaid enrollees in any demographic. But because Black and brown Americans are overrepresented among Medicaid enrollees, states' decisions to

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Disparities, HEALTH AFFS. FOREFRONT (Sept. 1, 2020), https://www.healthaffairs.org/content/forefront/foundational-moments-medicaid-s-history-reinforced-rather-than-eliminated-racial-health [https://perma.cc/3UK4-79B8].

[102] Tomiko Brown-Nagin, *Two Americas in Healthcare: Federalism and Wars over Poverty from the New Deal-Great Society to Obamacare*, 62 DRAKE L. REV. 981, 990 (2014).

[103] Samantha Artiga, Latoya Hill & Anthony Damico, *Health Coverage by Race and Ethnicity, 2010-2021*, KAISER FAM. FOUND. (Dec. 20, 2022), https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/ [https://perma.cc/23BK-KVVR].

[104] Cindy Mann & Adam Striar, *How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost*, COMMONWEALTH FUND BLOG (Aug. 17, 2022), https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact [https://perma.cc/BY8Z-NEBM].

[105] Kayla Holgash & Martha Heberlein, *Physician Acceptance of New Medicaid Patients: What Matters and What Doesn't*, HEALTH AFFS. BLOG (Apr. 10, 2019), https://www.healthaffairs.org/do/10.1377/forefront.20190401.678690/full/ [https://perma.cc/P7KT-CNEL].

[106] Diane Alexander & Molly Schnell, *The Impacts of Physician Payments on Patient Access, Use, and Health*, NAT'L BUREAU OF ECON. RSCH. (July 2019), https://www.nber.org/papers/w26095 [https://perma.cc/BL44-9BGF].

[107] *See* Natalia I. Chalmers & Robert D. Compton, *Children's Access to Dental Care Affected by Reimbursement Rates, Dentist Density, and Dentist Participation in Medicaid*, 107 AM. J. PUB. HEALTH 1612, 1612–14 (2017).

cut Medicaid payments to save money disproportionately harms those groups.[108]

b. After the Affordable Care Act: Racially Inflected State Decisions About Expansion

In the ACA, Congress sought to use Medicaid as the mechanism for extending health coverage to lower-income persons who would be unable to afford private coverage even with the assistance of the ACA's premium tax credits (also referred to as subsidies). The health reform law expanded eligibility for Medicaid coverage to include *all* nonelderly persons with household incomes below 138 percent of the FPL.[109] Expanding Medicaid was also one of the ways Congress consciously sought to address health disparities. A majority of people expected to benefit from the expansion were people of color, who were disproportionately likely to be uninsured and to have low incomes.[110]

The Medicaid expansion didn't go as planned, however. In 2012, the Supreme Court ruled in *National Federation of Independent Businesses (NFIB) v. Sebelius* that Congress exceeded its Spending Clause authority when it required states to expand their Medicaid programs as a condition of receiving continued Medicaid funding from the federal government.[111] The Court reasoned that the amount of funding at stake left states with no meaningful choice about whether to expand their programs.[112] Thus, the directive to expand Medicaid was unconstitutionally coercive.[113] Rather than striking down the planned expansion entirely, however, the Court made it optional. States could choose to expand their Medicaid programs pursuant to the ACA's plan, or not, without risking federal funding for nonexpansion Medicaid populations.[114]

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[108] *See* Yearby et al., *supra* note 56, at 191 (describing lawsuits alleging that low Medicaid reimbursement rates were discriminatory); Tiffany N. Ford & Jamila Michener, *Medicaid Reimbursement Rates Are a Racial Justice Issue*, COMMONWEALTH FUND (June 16, 2022), https://www.commonwealthfund.org/blog/2022/medicaid-reimbursement-rates-are-racial-justice-issue [https://perma.cc/B494-JZW3].

[109] *About the ACA*, DEP'T HEALTH & HUM. SERVS., https://www.hhs.gov/healthcare/about-the-aca/index.html [https://perma.cc/FT8N-6PDH].

[110] *See* Samantha Artiga et al., *Changes in Health Coverage by Race and Ethnicity Since Implementation of the ACA, 2013–2017*, KAISER FAM. FOUND. (Feb. 2019), https://files.kff.org/attachment/Issue-Brief-Health-Coverage-by-Race-and-Ethnicity-Changes-Under-the-ACA [https://perma.cc/GQ4Y-XSDK].

[111] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 580 (2012).

[112] *Id.* at 581.

[113] *Id.* at 581–82.

[114] *Id.* at 585–86.

Making the Medicaid expansion discretionary led to state-level decisions that predictably entrenched racial inequities, with Black people disproportionately left behind in states that chose not to expand.[115] In the decade following *NFIB*, many of the states that refused to expand their Medicaid programs were southern states with large Black populations.[116] Nearly 60 percent of all Black Americans who stood to gain coverage from the planned expansion lived in states that initially rejected the expansion.[117] These choices left many poor adults for whom Congress sought to assure coverage without any health insurance.[118] The term "coverage gap" refers to the plight of persons who are unable to enroll in Medicaid because their state has not expanded eligibility and who are also ineligible for ACA subsidies for private insurance because their incomes are too low.[119] Uninsured Black adults were more than twice as likely to fall into the coverage gap, as compared to both whites and Hispanics.[120] Scholars exploring the influence of racial politics on states' Medicaid expansion decisions have found evidence that race played some role in those decisions.[121] Whatever the explanation, the decisions of many southern states not to expand have perpetuated racial health disparities by leaving Black people disproportionately bereft of any of the ACA's coverage-related benefits.[122]

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[115] *See* KAISER COMM'N MEDICAID & UNINSURED, THE IMPACT OF CURRENT STATE MEDICAID EXPANSION DECISIONS ON COVERAGE BY RACE AND ETHNICITY (2013), http://www.statecoverage.org/files/KFF_Impact_Medicaid_Expansion_Decision.pdf; *cf.* Madeline Guth, Samantha Artiga & Olivia Pham, *Effects of the ACA Medicaid Expansion on Racial Disparities in Health and Health Care*, KAISER FAM. FOUND. (Sept. 30, 2020), https://www.kff.org/medicaid/issue-brief/effects-of-the-aca-medicaid-expansion-on-racial-disparities-in-health-and-health-care/ [https://perma.cc/T8UL-RQQ5] (noting that research findings show that the Medicaid expansion has helped reduce racial disparities in health coverage).

[116] *See* Artiga et al., *supra* note 110.

[117] IMPACT OF CURRENT STATE MEDICAID EXPANSION DECISIONS, *supra* note 115.

[118] *See* Christina Andrews et al., *The Medicaid Expansion Gap and Racial and Ethnic Minorities with Substance Use Disorders*, 105 AM. J. PUB. HEALTH S452, S453 (2015).

[119] *See* Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid*, KAISER FAM. FOUND. (June 12, 2018), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ [https://perma.cc/R4QL-PCBN]. Under the ACA, subsidies for purchasing private insurance coverage are available to persons whose income falls between 100 percent and 400 percent of the FPL. *Id.*

[120] Samantha Artiga et al., *The Impact of the Coverage Gap for Adults in States Not Expanding Medicaid by Race and Ethnicity*, KAISER FAM. FOUND. (Oct. 2015), https://www.kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity/ [https://perma.cc/KJM8-D93B].

[121] JONATHAN M. METZL, DYING OF WHITENESS: HOW THE POLITICS OF RACIAL RESENTMENT IS KILLING AMERICA'S HEARTLAND 133, 165 (Basic Books 2019); Colleen M. Grogan & Sunggeun (Ethan) Park, *The Racial Divide in State Medicaid Expansions*, 42 J. HEALTH POL. POL'Y & L. 539, 545, 560–61 (2017).

[122] Crossley, *supra* note 2, at 128.

c. Government-Funded Research and Racialized Medicine

So far, the examples given of government culpability in tolerating or encouraging health disparities have been largely structural, including legislative, judicial, and administrative decisions about program scope and implementation. These decisions have permitted forms of segregation and disproportionate health-related disadvantages for Black people and people from other communities that have been marginalized. These results have mostly been viewed as unremarkable by the public at large. Widespread indifference to how government actions have fed racial health disparities likely reflects deep-rooted and longstanding beliefs in society, and in medicine specifically, that Black people are physiologically distinctive from and inferior to white people. In yet further complicity, government funding has underwritten research and experimentation meant to substantiate these false beliefs.

The most notorious example is the US Public Health Service's sponsorship of the Tuskegee Syphilis Study. Originally called the "Tuskegee Study of Untreated Syphilis in the Negro Male," this study examined how the disease would progress in the absence of medical treatment.[123] Its racist premise was that syphilis in Black men was a different disease from syphilis in white men. Researchers treated participants without regard to their physical wellbeing, failing to provide them with penicillin once that effective treatment became available.[124] They also undermined participants' human dignity, failing to inform them of the study's true nature or to obtain their informed consent.[125] By sponsoring the study for four decades, the federal government gave its imprimatur to racialized medicine: the belief that persons in different racial groups experienced illness differently.[126]

Tuskegee is one of many examples of government support for racially tinged research in medicine and public health. In

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[123] *The Syphilis Study at Tuskegee Timeline*, CTRS. DISEASE CONTROL & PREVENTION (Dec. 5, 2022), https://www.cdc.gov/tuskegee/timeline.htm [https://perma.cc/K28Z-MVTG].

[124] *Id.*

[125] Susan M. Reverby, *Listening to Narratives from the Tuskegee Syphilis Study*, 377 LANCET 1646, 1646–47 (2011).

[126] JAMES JONES, BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENT – A TRAGEDY OF RACE AND MEDICINE 241 (1981).

Medical Apartheid,[127] a sweeping history of medical abuse of and experimentation on Black people in the United States, Harriet Washington provides numerous other examples. One chapter describes radiation experiments disproportionately involving people of color carried out under the auspices of the US Atomic Energy Commission.[128] Another portrays how research on incarcerated Americans, among whom Black people are remarkably overrepresented, implicated prison officials and parole boards.[129] Even more than an erroneous belief in the medical distinctiveness of Black people, the unapologetic willingness to target that group for exploitation because of their vulnerability reverberates throughout Washington's work. Recurring government support for racialized medical research further reinforces the need for affirmative steps to remedy health inequities.

d. Government Funding as a Lever for Redressing Health Inequity Enabled by Government Policy

Examples of how government policies have produced, entrenched, or subsidized health inequity abound. Historian George Aumoithe describes how federal healthcare cost containment initiatives beginning in the 1970s spurred New York City to cut back its support for inpatient hospital beds, with most of those cuts occurring in predominantly Black and working class neighborhoods.[130] More broadly, a "systematic disinvestment in public and private sectors within segregated Black neighborhoods has resulted in under-resourced facilities with fewer clinicians," which affects both access to and utilization of care.[131] Commentators suggest that insufficient oversight over the use of funds that "disproportionate share" hospitals[132] receive from Medicare raises questions about

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[127] HARRIET A. WASHINGTON, MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT (2007).

[128] *Id.* at 216–42.

[129] *Id.* at 244–69.

[130] George Aumoithe, *The Racist History That Explains Why Some Communities Don't Have Enough ICU Beds*, WASH. POST (Sept. 16, 2020), https://www.washingtonpost.com/outlook/2020/09/16/racist-history-that-explains-why-some-communities-dont-have-enough-icu-beds/ [https://perma.cc/X63Q-C5LP].

[131] Zinzi D. Bailey, Justin M. Feldman, & Mary T. Bassett, *How Structural Racism Works—Racist Policies as a Root Cause of U.S. Racial Health Inequities*, 384 NEW ENG. J. MED. 768, 770 (2021).

[132] "Disproportionate share" hospitals serve a significantly higher share of indigent patients. CTRS. MEDICARE & MEDICAID SERVS., MEDICARE DISPROPORTIONATE SHARE HOSPITAL FACT SHEET 4 (2019), hhs.gov/guidance/sites/default/files/hhs-guidance-documents/DSH-Text-Only.pdf [https://perma.cc/2XCG-XJTE]. These safety

whether those government payments actually benefit low-income minority populations with the greatest need.[133] Scholars have illuminated how inequities in the COVID-19 pandemic flowed at least in part from government policy choices and oversight failures.[134]

A comprehensive accounting of the federal, state, and local policies that have fed into or perpetuated racial health disparities lies beyond this article's scope. The examples given, however, solidly connect government actions or omissions to racial disparities in health insurance coverage and access to healthcare providers. Echoing the government's role in creating racially segregated housing, government's connection to racial health disparities supplies a moral foundation for government's active role in remedying those disparities. This article argues that this active role should include requiring recipients of federal healthcare funding to take affirmative steps to mitigate disparities and advance health equity.

If anything, the pervasiveness and colossal volume of public funding for healthcare makes the argument for an AFHE obligation on the part of funding recipients even more compelling and promising than in the housing realm. The federal government's spending on health dwarfs its spending on housing. In fiscal year 2023, HUD plans to spend $60.84 billion in awards, including $21.35 billion in grants.[135] By contrast, although the United States stands alone among similarly developed nations in its failure to provide universal health coverage, the federal government accounted for 34 percent of the 4.3 trillion dollars of US healthcare spending in 2021 (roughly $1.462 trillion).[136] In 2021, more than 135 million Americans received coverage through Medicare, Medicaid, and the Children's Health Insurance Program.[137] In addition, over nine

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net hospitals are eligible to receive upward adjustments to the payments they receive from Medicare to reflect their uncompensated care costs. *Id.*

[133] Yearby et al., *supra* note 56, at 190–91.

[134] Crossley, *supra* note 2, at 109; *see generally* William P. Hanage et al., *COVID-19: US Federal Accountability for Entry, Spread, and Inequities—Lessons for the Future*, 35 EUR. J. EPIDEMIOLOGY 995 (2020) (discussing the US government's missteps in its response to COVID-19 and the pandemic's disproportionate impact on low-income racial minorities).

[135] *Agency Profile: Dep't of Housing and Urban Development (HUD)*, USA SPENDING, https://www.usaspending.gov/agency/department-of-housing-and-urban-development?fy=2023 [https://perma.cc/6DG8-QLEB].

[136] CTRS. MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES 2021 HIGHLIGHTS 3 https://www.cms.gov/files/document/highlights.pdf [https://perma.cc/53EG-GB49].

[137] *CMS Releases Latest Enrollment Figures for Medicare, Medicaid, and Children's Health Insurance Program (CHIP)*, CTRS. MEDICARE & MEDICAID SERVS. (Dec. 21, 2021), https://www.cms.gov/newsroom/news-alert/cms-releases-latest-enrollment-

million veterans are enrolled in the Veteran Affairs healthcare program[138] and approximately 2.2 million American Indians and Alaska Natives receive services from the Indian Health Service.[139] And, as of early 2022, nearly 90 percent of the 14.5 million people who purchased private health coverage through an ACA exchange paid for at least part of their coverage with a federally-funded premium subsidy.[140]

In short, the scope and depth of federal involvement in funding the healthcare sector make asking recipients of federal funding to help advance health equity an especially potent mechanism for achieving progress toward a more just health system.[141] By the same token, the large share of healthcare spending originating from the government makes "the stark inequalities in health care faced by millions of Americans seem particularly unjust."[142]

III. AN EQUALITY DIRECTIVE FOR HEALTHCARE: CONCEPT AND STATUTORY SOURCES

Over a decade ago, Professor Olatunde Johnson described an underexamined and underappreciated aspect of American civil rights regulation that she dubbed "equality directives."[143] Her 2012 article, titled *Beyond the Private Attorney General: Equality Directives in American Law*, described how equality directives advance civil rights norms of inclusion and equity by using both formal and informal forms of administrative action, including conditioned spending,

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figures-medicare-medicaid-and-childrens-health-insurance-program-chip [https://perma.cc/686Y-VJUQ].

[138] *About VHA*, VETERANS HEALTH ADMIN. (last updated Aug. 2, 2023), https://www.va.gov/health/aboutvha.asp#:~:text=The%20Veterans%20Health%20Administration%20(VHA,Veterans%20enrolled%20in%20the%20VA [https://perma.cc/2UPB-URA5].

[139] *Quick Look*, INDIAN HEALTH SERV. (Apr. 2017), https://www.ihs.gov/newsroom/factsheets/quicklook/ [https://perma.cc/C5AR-J9F4].

[140] *Will You Receive an ACA Premium Subsidy?*, HEALTHINSURANCE.ORG (Nov. 1, 2022), https://www.healthinsurance.org/obamacare/will-you-receive-an-aca-premium-subsidy [https://perma.cc/5WR4-PMPY].

[141] Olatunde Johnson makes a similar point with respect to the suitability of affirmative government intervention in the transit realm. Olatunde C.A. Johnson, *Lawyering That Has No Name: Title VI and the Meaning of Private Enforcement*, 66 STAN. L. REV. 1293, 1314–15 (2014) ("Transportation is a particularly fitting place for . . . affirmative government intervention . . . Past federal funding for highway development has helped construct patterns of urban-suburban settlement, contributing to concentrated poverty and spatial segregation that persists today.").

[142] Samuel L. Dickman et al., *Inequality and the Health-care System in the USA*, 389 LANCET 1431, 1435 (2017).

[143] Olatunde C.S. Johnson, *Beyond the Private Attorney General: Equality Directives in American Law*, 87 N.Y.U. L. REV. 1339, 1343 (2012).

regulatory oversight and guidance, and partnerships with community-based organizations.[144] In this way, equality directives are distinct from more commonly discussed civil rights tools like private litigation and agency proceedings to enforce antidiscrimination law.[145] According to Johnson, equality directives create a set of process-oriented obligations for recipients of public funding, which typically include some kind of planning measures, often entailing data collection and community engagement, to consider prospectively how recipients' use of federal funds will promote or detract from equity and inclusion. She writes: "This regulatory approach does more than require that governments address bias against minority or other groups. It requires entities to rethink and redesign government-supported structures to proactively promote the inclusion of groups that, whether through discrimination, historic exclusion, or structural difference, are disadvantaged socially and economically."[146]

The FHA's AFFH requirement is one fairly obvious example that Johnson gave of existing equality directives. For a second example, Johnson pointed to obligations articulated by the Federal Transit Administration (FTA) that require recipients of mass transit funding to assess how their programs affect minority communities and make any adjustments needed to avoid any negative impact on those communities.[147]

In a point relevant to this article's proposed AFHE obligation, no statute directly instructs the FTA to "affirmatively further" transportation equity. Instead, the FTA guidance is framed as implementing Department of Transportation (DOT) disparate impact regulations under Title VI of the 1964 Civil

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[144] *Id.* at 1363–66.

[145] Johnson highlights how increasing recognition of structural features' role in producing inequities and judicially constrained opportunities for private plaintiffs to sue for relief under civil rights statutes both magnify the importance of equality directives. *Id.* at 1344–45.

[146] *Id.* at 1365–66.

[147] *Id.* at 1379–80. This guidance was originally published in 2007 as the FTA's Circular on Title VI. DEP'T TRANSP., FED. TRANSIT ADMIN., FTA C 4702.1A, TITLE VI AND TITLE VI-DEPENDENT GUIDELINES FOR FEDERAL TRANSIT ADMINISTRATION RECIPIENTS V(4)(A) (2007). Johnson's discussion refers to this original version of the circular. The FTA updated and revised the Circular in 2012. DEP'T TRANSP., FED. TRANSIT ADMIN., FTA C 4702.1B, TITLE VI REQUIREMENTS AND GUIDELINES FOR FEDERAL TRANSIT ADMINISTRATION RECIPIENTS (2012). The 2012 Circular continued the planning and community engagement requirements of the 2007 Circular. *See* Jerett Yan, *Rousing the Sleeping Giant: Administrative Enforcement of Title VI and New Routes to Equity in Transit Planning*, 101 CAL. L. REV. 1131, 1159 (2013). In November 2021, the FTA published a Request for Information in the Federal Register about potential changes to the Circular. *See* Request for Information on Title VI Implementation, 86 Fed. Reg. 67,115 (Nov. 24, 2021). As of this writing, the FTA has not yet issued further revisions to the Circular.

Rights Act.[148] The FTA's equality directive effectively instructs grantees to use front-end assessment and planning to avoid using federal funds to develop inequitable transit projects.[149]

In theory, any federal agency that has promulgated disparate impact regulations implementing Title VI might follow the FTA's lead in developing an equality directive. The federal government's role in creating and perpetuating racial health disparities suggests that healthcare is an especially appropriate domain for an equality directive, a point underscored by the massive volume of federal government spending in the area. HHS spent more than $1 trillion on Medicare and Medicaid alone in 2021, indicating the potential impact of an equality directive for healthcare.[150]

Of course, for HHS to take any action establishing an obligation on the part of funding recipients to take affirmative steps to further health equity, statutory authority for such an obligation must be identified. This part will identify legal underpinnings for a potential equality directive for healthcare. Although Professor Johnson's focus is on equality directives targeting the structural features of racial injustice, this article argues that HHS should consider an equality directive for healthcare that is broader in scope, encompassing the need to address health disparities based on disability and sex, in addition to race, ethnicity, and national origin. Thus, the following section considers the foundations for an equality directive provided by Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 (along with the Americans with Disabilities Act), and Section 1557 of the ACA.

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[148] Johnson, *supra* note 28, at 1382–84. Unlike the Fair Housing Act, Title VI does not explicitly call for any federal agency or recipients of federal funding to "affirmatively further" racial fairness in their programs. Federal agencies, however, have consistently promulgated regulations that interpret Title VI as prohibiting not only intentionally different treatment, but also actions that have an adverse disparate impact on a protected group. *See* DEP'T OF JUST., TITLE VI LEGAL MANUAL, PROVING DISCRIMINATION- DISPARATE IMPACT 3-4, https://www.justice.gov/crt/book/file/1364106/download (noting that twenty-six federal agencies have promulgated Title VI regulations incorporating a disparate impact standard) [https://perma.cc/6CS2-N7MG].

[149] Henry Goldberg, *A Promise Deferred: An Examination of Race and Accessibility in the New York City Subway and Philadelphia Transit Systems*, 54 COLUM. HUM. RTS. L. REV. 780, 794 (2023).

[150] *National Health Expenditures Fact Sheet*, CTRS. MEDICARE & MEDICAID SERVS., https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet [https://perma.cc/W6Y4-AADV]. Johnson's article focuses only on equality directives applicable to public actors that receive federal funds, like states, municipalities, or housing or transit authorities. But private actors like hospitals, commercial insurers, nursing homes, and physicians are integral to healthcare system operations and governance and should be included within a health-oriented equality directive.

A. Title VI of the 1964 Civil Rights Act

Title VI of the 1964 Civil Rights Act offers the most obvious—and most congruent with Professor Johnson's model—footing for an AFHE obligation. This section first sets out that statute's language, along with its regulatory and enforcement history, as they relate to the proposed AFHE directive. It then identifies examples of how HHS has already relied on Title VI to call for funding recipients in the healthcare sector to take discrete affirmative steps to advance health equity.

1. Statutory Language, Regulations, and Enforcement History

Title VI prohibits discrimination based on an individual's race, color, or national origin by any program or activity that receives federal funding.[151] Its aim is "no less than to ensure that the vast machinery of federal social welfare funding is used to reduce segregation and discrimination in all its forms, not to enable it."[152] Title VI's prohibition thus is not specific to healthcare, or any policy domain for that matter. Rather, it applies across the spectrum of federal funding recipients, including both public and private actors.[153] It empowers federal agencies that distribute federal funding to issue regulations giving effect to Title VI's nondiscrimination mandate.[154]

In response, many agencies have adopted regulations that prohibit actors receiving federal funds from using facially neutral policies or practices that adversely and disproportionately affect racially or ethnically defined groups.[155] HHS is among the agencies prohibiting such disparate impact discrimination via regulation; its Title VI regulations state:

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[151] Section 601 of the Civil Rights Act provides: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 42 U.S.C. § 2000d.

[152] Rosenbaum & Schmucker, *supra* note 70, at 771–72.

[153] *Id.* at 774.

[154] 42 U.S.C. § 2000d-1.

[155] Title VI regulations for multiple federal agencies were originally crafted by a task force made up of representatives from the White House, the US Civil Rights Commission, the Justice Department, and the Bureau of the Budget. *See* Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn't Be So Easy*, 58 FORDHAM L. REV. 939, 942, 947 (1990). It started with the goal of developing a template for Title VI regulations that would be consistent but flexible. *See id.* at 947. In the end, the task force produced twenty-two sets of Title VI regulations for various federal agencies. *Id.* at 947–48.

> A recipient, . . . may not, directly or through contractual or other arrangements, utilize 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.[156]

This regulatory language parallels that used by the DOT's Title VI regulations,[157] which supply the basis for the FTA equality directive that Johnson examines.[158]

Since its enactment nearly sixty years ago, Title VI's application to the healthcare sector has fallen far short of its potential. To be sure, it got off to a promising start. David Barton Smith recounts the story of how Congress's 1965 enactment of the Medicare program, hot on the heels of the 1964 Civil Rights Act, created conditions that catalyzed the rapid desegregation of most hospitals.[159] Medicare's promised payment for services that hospitals rendered to Medicare beneficiaries would be a form of "federal financial assistance."[160] The threat of missing out on this new source of abundant, continuing funding motivated most hospitals to comply with Title VI by desegregating without much fuss or fanfare.[161] Efforts over the next several decades to use Title VI to address health inequities, however, produced mixed results. Disparate impact challenges to hospitals' and nursing homes' use of admissions policies that disproportionately excluded Black patients saw some success.[162] By contrast, lawsuits contesting hospital relocations or closures as having a disparate impact on Black patients tended not to succeed.[163] In

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156 45 C.F.R. § 80.3(b)(2) (2024).

157 The DOT's Title VI regulations include the following language: "A recipient, . . . may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting persons 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 with respect to the individuals of a particular race, color, or national origin." 49 C.F.R. § 21.5(b)(2) (2024).

158 *See supra* text accompanying notes 146–148.

159 *See generally* Smith, *supra* note 71 (describing the momentum Medicare's implementation gave to efforts to desegregate hospitals).

160 *See id.*

161 *Id.*

162 *See, e.g.*, Linton *ex rel* Arnold v. Carney *ex rel* Kimble, 779 F. Supp. 925, 935 (M.D. Tenn. 1990) (holding "limited bed certification policy has had a disparate adverse impact on" racial minorities in Tennessee), *aff'd*, 65 F.3d 508 (6th Cir. 1995); Cook v. Ochsner Found. Hosp., 61 F.R.D. 354, 360 (1972) (finding that an admission policy to a federally aided hospital "clearly discriminates against a very substantial segment of the public").

163 *See, e.g.*, Bryan v. Koch, 492 F. Supp. 212, 233–37 (S.D.N.Y. 1980) (holding that the closing of a hospital was related to legitimate business objectives and did not violate Title VI); NAACP. v. Wilmington Med. Ctr. Inc., 491 F. Supp. 290, 318 (D. Del. 1980) (finding no Title VI violation where minority groups alleged that the relocation of

short, discrimination claims based on a disparate impact theory proved hard for plaintiffs to win.[164]

Moreover, a 2001 Supreme Court decision severely undercut whatever value Title VI offered to plaintiffs seeking to invalidate healthcare practices and structures that produced discriminatory effects. In *Alexander v. Sandoval*,[165] the Court held that no private right of action existed to enforce disparate impact regulations issued pursuant to Title VI. While the Court did not invalidate those regulations, *Sandoval* means that only an agency can enforce Title VI against a federal funding recipient that employs practices or policies having a racially disparate impact. And agency enforcement in the healthcare sector has been limited at best. According to commentators writing in 2017, "the Office of Civil Rights [within HHS] is notoriously under-resourced and can only challenge a fraction of activities."[166] As a result, private plaintiffs are left largely powerless to address the "many forms of systemic discrimination that might be unintentional but no less harmful to protected classes."[167]

Finally, some types of healthcare providers have been spared an expectation of compliance with Title VI, either categorically or practically. From the nondiscrimination mandate's early days, the federal government has construed a statutory exclusion from the programs and activities subject to Title VI as excluding doctors providing services to Medicare patients from the law's scope.[168] This interpretation effectively

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an urban hospital to a suburban location would make it more difficult for minority group members to utilize the hospital).

[164] Rosenbaum & Schmucker, *supra* note 70. Plaintiffs must marshal statistical evidence demonstrating concretely that the defendants' conduct caused a more severe negative impact on a protected group. Even if they succeed in that showing, defendants can prevail by arguing that a legitimate purpose, such as cost savings, animated their conduct, unless the plaintiffs can prove that the defendant's purported reason was a pretext for discrimination or could be served by adoption of a nondiscriminatory alternative.

[165] Alexander v. Sandoval, 532 U.S. 275, 293 (2001).

[166] Amitabh Chandra, Michael Frakes & Anup Malani, *Challenges to Reducing Discrimination and Health Inequity Through Existing Civil Rights Laws*, 36 HEALTH AFF. 1041, 1044 (2017).

[167] Teneille Brown et al., *Should We Discriminate Among Discriminations?*, 14 ST. LOUIS U. J. HEALTH L. & POL'Y 359, 373 (2021).

[168] *See* Mary Crossley, *Infected Judgment: Legal Responses to Physician Bias*, 48 VILL. L. REV. 195, 265–66 (2003). The original interpretation was by the Department of Health, Education & Welfare, the predecessor of today's HHS. Specifically, the federal health agency has read the exclusion of any "contract of insurance or guaranty" from what counts as "federal financial assistance" as excluding payments made to physicians for providing services to patients enrolled in Medicare Part B. *Id.* Medicare Part B covers medical services including physicians' services and hospital services provided on an outpatient basis. *What is Medicare Part B?*, DEP'T HEALTH & HUM. SERVS.

shields some physicians (but not all) from Title VI's prohibition of racial discrimination.[169] By contrast, nursing homes that receive payment from either Medicaid or Medicare are ostensibly subject to Title VI, but have escaped meaningful enforcement.[170]

2. Title VI as a Basis for Health and Human Services to Issue an Equality Directive

Despite a generally flaccid enforcement history in healthcare, Title VI harbors untapped potential for addressing structural barriers that contribute to health disparities. An example from the COVID-19 pandemic offers a glimpse of that potential. In July 2020, the HHS Office of Civil Rights (OCR) issued a Bulletin reminding recipients of federal financial assistance that their responses to the COVID-19 pandemic must comply with Title VI.[171] OCR's guidance specifically identified steps that providers might need to take to guard against implementing practices or policies that disproportionately excluded racial and ethnic minorities. For example, in establishing testing sites, "recipients may consider making walk-in testing sites available in urban areas where racial and ethnic minority populations may not have access to vehicle transportation."[172] This guidance implicitly views Title VI as potentially demanding more from providers than simply avoiding intentional discrimination. It may also require them to change a customary or default approach to providing testing to avoid a disparate impact.

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https://www.hhs.gov/answers/medicare-and-medicaid/what-is-medicare-part-b/ [https://perma.cc/3LKU-MUT9].

[169] Mark A. Hall, *The Role of Courts in Health Equity*, 42 J. HEALTH POL., POL'Y & L. 749, 751 (2017). As recently as 2016, HHS has declined to reverse this interpretation. *Id.* at 753. Physicians who are paid by Medicaid arguably are subject to Title VI's prohibition on discrimination, but HHS has not sought to enforce the law against them. *Id.* at 751. Proposed regulations implementing Section 1557 of the ACA, published by the Biden Administration in July 2022, reversed course on this interpretation and would extend antidiscrimination prohibitions included in Title VI to physicians receiving Part B payments. MARA YOUDELMAN ET AL., NAT'L HEALTH L. PROGRAM, QUESTIONS AND ANSWERS ON THE 2022 PROPOSED RULE ADDRESSING NONDISCRIMINATION PROTECTIONS UNDER THE ACA'S SECTION 1557 4 (Aug. 15, 2022), https://healthlaw.org/wp-content/uploads/2022/10/1557-Reg-Revision-QA-FINAL-2022-Oct-14.pdf [https://perma.cc/449D-572B].

[170] *See supra* Section II.A.2.

[171] DEP'T HEALTH & HUM. SERVS. OFF. C.R., BULLETIN: CIVIL RIGHTS PROTECTIONS PROHIBITING RACE, COLOR AND NATIONAL ORIGIN DISCRIMINATION DURING COVID-19 1 (2020), https://www.hhs.gov/sites/default/files/title-vi-bulletin.pdf [https://perma.cc/UH6Y-MPMG].

[172] *Id.* at 3.

This reading of Title VI as sometimes requiring federal funding recipients to undertake affirmative efforts to avoid a disparate impact was not novel. Two decades earlier, HHS was one of more than twenty agencies[173] that issued guidance to federal funding recipients regarding their Title VI obligations to persons with limited English proficiency (LEP).[174] In 2000, HHS guidance indicated that recipients of HHS funding must take reasonable steps to ensure that people with LEP enjoy meaningful access to their programs. These "reasonable steps" would vary from recipient to recipient and community to community, but the core message was that funding recipients should take steps to learn of language assistance needs and resources in the populations they served and respond accordingly.[175] This obligation of healthcare providers and programs to take reasonable, affirmative steps[176] as needed to ensure meaningful access under Title VI has been remarkably durable.[177]

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[173] *Title VI Guidance for Recipients*, LTD. ENG. PROFICIENCY, https://www.lep.gov/title-vi-guidance-for-recipients [https://perma.cc/NY8L-A4KJ].

[174] These issuances were in response to President Bill Clinton's Executive Order directing federal agencies that provide federal financial assistance to develop guidance regarding their recipients' LEP-related obligations under Title VI. Exec. Order No. 13,166, 3 C.F.R. 289 (2000), *reprinted as amended in* 42 U.S.C. § 2000d-1 app. The Executive Order also directed each federal agency to "prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons." *Id.*

[175] *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, DEP'T HEALTH & HUM. SERVS. (July 26, 2013), https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-vi/index.html [https://perma.cc/XB2U-RFT8]. To ensure compliance with Title VI, HHS suggested that recipients assess the needs in their communities for language assistance and develop a language access plan. *See* CTR. MEDICARE & MEDICAID SERVS., GUIDE TO DEVELOPING A LANGUAGE ACCESS PLAN 6 (2023), https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan-508.pdf [https://perma.cc/C67A-FUVY].

[176] What steps would be deemed "reasonable" and thus obligatory to avoid violating Title VI depends on an analysis of four factors that include how many people risk being excluded if language assistance is not provided, how frequently people speaking a particular language come into contact with a federal funding recipient, the importance of the service provided by the recipient, and the costs of providing language assistance in light of the resources available to the recipient. *DOJ Clarifying Memorandum Regarding Limited English Proficiency and Executive Order 13166*, DEP'T JUST. (Oct. 26, 2001), https://www.justice.gov/crt/federal-coordination-and-compliance-section-190 [https://perma.cc/4LJQ-NU8Y].

[177] Some commentators have been critical of the federal government's interpretation of Title VI as requiring federal funding recipients to provide language assistance to persons with LEP. *See, e.g.*, Mona T. Peterson, *The Unauthorized Protection of Language Under Title VI*, 85 MINN. L. REV. 1437, 1439–74 (2001); Carrie Lynn Flores, *Translation Services Not Required: The Civil Rights Act Does Not Require Special Accommodations for Limited English Proficiency Individuals*, 14 HARV. LATINO L. REV. 193 (2011) (arguing that the Civil Rights Act does not require employers or healthcare providers to provide special accommodations).

Notwithstanding Title VI's sorry performance overall in addressing racial and ethnic health disparities, it offers a solid foundation for HHS to issue an equality directive to recipients of federal healthcare funding. Title VI remains, in the words of a former Assistant Attorney General, a "sleeping giant"[178] that might still be awakened and called forth. Instructing federal funding recipients to undertake a data-informed needs assessment and to consider how their existing and proposed policies and practices affect communities burdened by health disparities (as an example of what a health equality directive might entail) would echo HHS's LEP guidance. It would also acknowledge the broad range of ways that facially neutral customary practices can produce or reinforce health inequity. Given the outsized role of federal money in the healthcare sector, Title VI's federal funding hook offers a potent mechanism for addressing the sequelae of government-sponsored or sanctioned health inequities. At its core, an equality directive for healthcare would further Title VI's goal, which:

> is to be accomplished through the establishment of formal, regulatory expectations on the part of the federal government not only that certain types of practices will cease but also that recipients of federal financial assistance will take affirmative steps to ensure that they administer their programs and services in a manner that promotes equality.[179]

B. Section 1557 of the Affordable Care Act: Expanding and Strengthening Antidiscrimination Protections

Section 1557 of the ACA[180] and regulations implementing it reinforce and expand the statutory foundation for a health-oriented equality directive. Titled simply "Nondiscrimination," Section 1557 invokes existing antidiscrimination statutes and applies them broadly to actors operating in the healthcare industry.[181] The statute explicitly draws on prohibitions of discrimination based on race, color, and national origin (Title VI),[182] sex (Title IX),[183] disability (Section 504 of the 1973

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[178] *See* DEP'T JUST., PROTECTING AGAINST RACE, COLOR, AND NATIONAL ORIGIN DISCRIMINATION BY RECIPIENTS OF FEDERAL FUNDS 2 (2013), http://www.justice.gov/crt/about/cor/4yr_report.pdf [https://perma.cc/WXG3-KGNM].

[179] Rosenbaum & Schmucker *supra* note 70, at 772.

[180] 42 U.S.C. § 18116.

[181] *Id.*

[182] 42 U.S.C. § 2000d.

[183] 20 U.S.C. § 1681.

Rehabilitation Act),[184] and age (the Age Discrimination Act)[185] and applies them to entities not previously subject to them.

At the time of this writing, numerous aspects of Section 1557's meaning and scope remain contested.[186] The law's language is at once spare and convoluted,[187] rendering it susceptible to conflicting interpretations. Following the ACA's enactment, commentators suggested an interpretation of Section 1557 that would authorize private enforcement, including private suits based on a disparate impact theory,[188] thus effectively filling the enforcement gap left by *Alexander v. Sandoval*. Regulations promulgated in 2016 by the Obama administration adopted this interpretation, but it was subsequently rejected by the Trump Administration.[189] A related, broader question is whether Section 1557 simply restates the varying prohibitions set forth by the antecedent statutes it names, along with the procedural approaches and limitations associated with those laws. Or, by contrast, does Section 1557 create a new, unified antidiscrimination mandate?[190]

Several aspects of Section 1557 relevant to how it might undergird a health-focused equality directive are clearer, however. First, the statute offers new protection against sex-

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[184] 29 U.S.C. § 794.

[185] *Id.* § 623.

[186] The ACA's legislative history is apparently devoid of clues to congressional intent that might help resolve these debates. *See* Brown et al., *supra* note 167, at 368–69 (stating that the authors' search uncovered "no record of discussion or debate on Section 1557").

[187] Section 1557(a) provides: "In general—Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964, . . . title IX of the Education Amendments of 1972, . . . the Age Discrimination Act of 1975, . . . or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection." 42 U.S.C. 18116(a).

[188] *See* Sarah G. Steege, *Finding a Cure in the Courts: A Private Right of Action for Disparate Impact in Health Care*, 16 MICH. J. RACE & L. 439, 441 (2011).

[189] MaryBeth Musumeci et al., *The Trump Administration's Final Rule on Section 1557 Non-Discrimination Regulations Under the ACA and Current Status*, KAISER FAM. FOUND. (Sept. 18, 2020), https://www.kff.org/racial-equity-and-health-policy/issue-brief/the-trump-administrations-final-rule-on-section-1557-non-discrimination-regulations-under-the-aca-and-current-status/ [https://perma.cc/PH4R-XVH9].

[190] *See* Brown et al., *supra* note 167. In addition, Section 1557's application to transgender persons seeking gender-affirming care from providers and insurers is still hotly debated. *See* Katie Keith & Timothy S. Jost, *New Antidiscrimination Rule Aims to Advance Health Equity and Ensure Protections for Transgender People*, COMMONWEALTH FUND BLOG (Aug. 10, 2022), https://www.commonwealthfund.org/blog/2022/new-antidiscrimination-rule-aims-advance-health-equity-and-ensure-protections-transgender [https://perma.cc/VK7Q-DBRN].

based healthcare discrimination.[191] Previously, federal law proscribed such discrimination only when it occurred in the context of employment (so that Title VII's prohibition of sex discrimination in employment would apply)[192] or education (so that Title IX's prohibition of sex discrimination in federally funded educational programs would apply).[193] Thus, Section 1557 would offer HHS a basis for framing an equality directive expansively to include gender-based health disparities among the health inequities federal funding recipients could seek to address.

Second, in contrast to the antidiscrimination laws that it invokes, Section 1557 directly targets the healthcare sector. In doing so, it includes a broad range of healthcare entities that must not discriminate. Section 1557's prohibitions apply to "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title."[194] The precise reach of this language may be debated, but it seems clear that Section 1557 applies to a majority of healthcare industry actors, including health insurers.[195] Moreover, the Biden Administration's proposed Section 1557 regulations interpret the statute as applying to physicians who provide services to Medicare beneficiaries enrolled in Part B, thus rejecting a longstanding (and much criticized) interpretation of Title VI.[196]

Adopting a more expansive antidiscrimination mandate for the healthcare sector makes sense. A healthcare system that is awash in federal money *should* be subject to

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[191] *See* Elizabeth Cornachione et al., *Summary of HHS's Final Rule on Nondiscrimination in Health Programs and Activities*, KAISER COMM'N MEDICAID & UNINSURED (July 2016), https://files.kff.org/attachment/issue-brief-Summary-of-HHSs-Final-Rule-on-Nondiscrimination-in-Health-Programs-and-Activities [https://perma.cc/GW7C-BBTP] (describing Section 1557 as "the first federal civil rights law to prohibit discrimination on the basis of sex in health care").

[192] *See* Erickson v. Bartell Drug Co., 141 F. Supp. 2d 1265, 1276 (W.D. Wa. 2001) (holding that an employer's prescription drug plan to exclude coverage for prescription contraceptives discriminated against women).

[193] *See* Crossley, *supra* note 168, at 269.

[194] 42 U.S.C. § 18116.

[195] Rules issued by the Obama and Trump administrations differed, however, on whether Section 1557 applied only to private insurance policies sold on the exchanges (Trump) or to all policies sold by an insurer who sells any policies on an exchange (Obama). *See* Valarie K. Blake, *Health Care Civil Rights Under Medicare for All*, 72 HASTINGS L.J. 773, 798 (2021). Curiously, though, both sets of rules declined to extend Section 1557 to physicians and other providers who receive no source of federal funding other than Medicare Part B payments. *Id.* at 800.

[196] *See* YOUDELMAN ET AL., *supra* note 169, at 4.

pervasive constraints on the discriminatory use of those funds.[197] That logic applies whether, for example, public funding flows to state Medicaid agencies, to private health insurers that use ACA marketplaces to sell policies to purchasers using federal subsidies,[198] or to health-related education programs. With a broad swath of the healthcare sector subject to Section 1557, an equality directive developed by HHS could sweep similarly broadly.

Third, LEP regulations promulgated pursuant to Section 1557 fortify the foundation for an equality directive. Through the alchemy of notice-and-comment rulemaking, HHS's 2016 Final Rule[199] transformed an obligation previously articulated in nonbinding regulatory guidance documents into binding law.[200] The Trump Administration subsequently narrowed language assistance obligations somewhat in its Section 1557 regulations, but did not contest the elevation of LEP obligations to binding law.[201] Thus, LEP requirements codified in Section 1557 regulations exemplify this article's premise that antidiscrimination laws may require healthcare actors that receive federal funding to take affirmative steps to avoid discrimination.

In sum, the ACA's nondiscrimination mandate—which some commentators have dubbed the Health Care Civil Rights Act[202]—provides additional statutory authority for a health-oriented equality directive. Section 1557's breadth, in both the kinds of discrimination it prohibits and the healthcare actors subject to its dictates, would support a similarly expansive equality directive. Admittedly, HHS's early enforcement initiatives under Section 1557 have primarily targeted gender

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[197] *Cf.* Sara Rosenbaum, *The Affordable Care Act and Civil Rights: The Challenge of Section 1557 of the Affordable Care Act*, MILBANK Q. (Sept. 2016), https://www.milbank.org/quarterly/articles/affordable-care-act-civil-rights-challenge-section-1557-affordable-care-act/ [https://perma.cc/CG4Z-MKRX] ("[T]he terms of § 1557 mean that landmark federal civil rights laws now permeate the entire US health insurance system.").

[198] Blake, *supra* note 195, at 797 ("[P]rivate insurers who were traditionally left out of civil rights enforcement are now considered recipients of federal financial assistance.").

[199] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376–31,473 (May 18, 2016), http://federalregister.gov/a/2016-11458.

[200] *See* Cornachione et al., *supra* note 191 (describing the 2016 Rule as "codif[ying] HHS's long-standing policy guidance on language assistance services for individuals with LEP").

[201] *See* Musumeci et al., *supra* note 189 (describing, *inter alia*, the shift in focus from requiring that covered actors take reasonable steps to ensure that each individual with LEP who might seek their services have meaningful access to requiring that LEP populations have meaningful access).

[202] Dayna Bowen Matthew, *Structural Inequality: The Real COVID-19 Threat to America's Health and How Strengthening the Affordable Care Act Can Help*, 108 GEO. L.J. 1679, 1710 (2020).

discrimination, with little attention paid to deep-rooted racial health inequities.[203] Moreover, Section 1557's efficacy in addressing intersectional discrimination remains untested.[204] That said, Section 1557 and its regulations plainly bolster the statutory footing for a health-oriented equality directive.

C. Section 504 of the 1973 Rehabilitation Act and the Americans with Disabilities Act: Explicitly Affirmative Obligations to Avoid Discrimination

The same can be said regarding Section 504 of the Rehabilitation Act of 1973[205] and the Americans with Disabilities Act (ADA),[206] both of which prohibit disability-based discrimination in healthcare settings. Because their prohibitions of discrimination expressly create affirmative obligations for covered entities, including health sector actors, these laws supply useful support for a directive to affirmatively further health equity.

Section 504 was the federal government's original disability discrimination law, following in the footsteps of Title VI by prohibiting recipients of federal financial assistance from discriminating based on disability in their programs and activities. Recipients subject to Section 504 include state Medicaid agencies, as well as hospitals and other healthcare facilities that participate in Medicare or Medicaid.[207] It is one of the preexisting antidiscrimination provisions that the ACA's Section 1557 invokes.[208] The ADA extended the prohibition against disability discrimination to a broader universe of health actors who might not be subject to Section 504, breaking the link to federal financial assistance.[209] Although the ADA's statutory

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[203] *See id.* at 1712.

[204] *Cf.* Majesta-Dore Legnini, *An Unfulfilled Promise: Section 1557's Failure to Effectively Confront Discrimination in Healthcare*, 28 WM. & MARY J. RACE, GENDER & SOC. JUST. 487 (2022) (arguing that an intersectional approach is needed to address the forms of discrimination creating health disparities for marginalized communities).

[205] 29 U.S.C. § 794.

[206] 42 U.S.C. § 12101.

[207] *See Reminder to Facilities of Their Obligation to Provide Accessible Services to People with Disabilities*, N.Y. STATE DEP'T HEALTH (July 31, 2013), https://www.health.ny.gov/professionals/hospital_administrator/letters/2013/2013-07-31_provide_accessible_services_to_persons_with_disabilities.htm [https://perma.cc/E9R9-JBBS].

[208] 42 U.S.C. § 18116.

[209] Title II of the ADA applies to public entities, like state and local public health programs and activities, prohibiting discrimination based on disability regardless of the receipt or nonreceipt of federal funding. Americans with Disabilities Act of 1990, Pub. L. 101-336, tit. II, 104 Stat. 337 (codified at 42 U.S.C. §§ 12131–12165). Title III of the ADA prohibits discrimination by places of public accommodation, including the private offices of doctors and other providers. Americans with Disabilities Act of 1990,

text is more expansive than Section 504 and more explicitly addresses affirmative obligations, the two laws' mandates are, for the most part, comparable. Disability law scholar Robyn Powell summarizes those requirements:

> Together, the ADA and section 504 require that health care offices and facilities be accessible to people with disabilities. Although there are some distinctions between the specific requirements of Titles II and III of the ADA, generally, accessibility in health care settings includes physical access to health care services and facilities, including accessible spaces and the removal of barriers; effective communication (including auxiliary aids and services, e.g., sign language interpreters or materials in alternative formats); and reasonable modification of policies, practices, and procedures when necessary to accommodate individual needs.[210]

Thus, Section 504 and the ADA, along with their implementing regulations, require more than simply refraining from intentional discrimination. They also call for the removal of barriers that prevent disabled people from participating fully in society. Some such barriers are physical. Others reside in practices or policies that tend to exclude disabled people from equal participation. To avoid violating these laws' antidiscrimination mandate, most healthcare actors must take affirmative barrier removal steps when needed to support disabled people's access. In this framework, a failure to act (for example, failing to remove architectural barriers, provide sign language interpreters, or modify policies tending to screen out disabled people) when the law calls for action counts as discrimination every bit as much as, for example, intentional refusals of service based on disability. In short, federal prohibitions of disability discrimination may oblige actors subject to those laws to take affirmative barrier removal steps to avoid illegal discrimination.

This progressive approach to foregrounding inclusion in antidiscrimination law offers a model that extends beyond disability. Structural features of society and the built environment that function to exclude and segregate are perhaps most recognizable when they affect disabled people. Examinations of factors contributing to racial health disparities, however, also increasingly recognize their structural nature. For example, public health agencies and medical groups in recent

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Pub. L. 101-336, tit. III, 104 Stat. 337 (codified at 42 U.S.C. §§ 12181–12189). Thus, many healthcare actors are subject to both the ADA and Section 504.

[210] Robyn M. Powell, *Applying the Health Justice Framework to Address Health and Health Care Inequities Experienced by People with Disabilities During and After COVID-19*, 96 WASH. L. REV. 93, 101–02 (2021).

years have called out structural racism as a "[f]undamental [d]river of [h]ealth [d]isparities."[211] Racism has produced spatial barriers to good health via residential segregation, mass incarceration, and disproportionate siting of environmental hazards in low-income neighborhoods.[212] Medical schools' failure to reckon adequately with the profession's role in producing and perpetuating disparities[213] means that medical training may reinforce racist stereotypes regarding, for example, Black people's imperviousness towards pain.[214] How barriers like these exclude racial minorities from opportunities for good health may be less obvious than how a set of stairs renders a doctor's office inaccessible, but the impact is analogous. Disability discrimination law's requirement of barrier removal as a mechanism for ending exclusion should not be understood as an aberration in the realm of antidiscrimination law. Rather, we should use it as a model for how antidiscrimination law can end discriminatory exclusion of and ameliorate unjust disparities for other groups as well.

IV. FROM FOUNDATIONS TO BLUEPRINTS: MODELS FOR A HEALTH EQUALITY DIRECTIVE

This article has identified several statutory foundations for HHS guidance directing recipients of federal healthcare funding to take steps to affirmatively further health equity. The statutes identified prohibit discrimination—including disparate impact discrimination—based on race, color, national origin, disability, sex, and age. A health-oriented equality directive might be similarly broad. Simply identifying bases for an affirmative equity-oriented obligation, however, leaves open a plethora of questions about crafting and implementing an equality directive for the healthcare sector. How specifically

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[211] *See, e.g.*, Keith Churchwell et al., *Call to Action: Structural Racism as a Fundamental Driver of Health Disparities: A Presidential Advisory from the American Heart Association*, 142 CIRCULATION 454, 454 (2020), https://www.ahajournals.org/doi/full/10.1161/CIR.0000000000000936 [https://perma.cc/H7G6-D7LN].

[212] *Structural Racism is a Public Health Crisis: Impact on the Black Community*, AM. PUB. HEALTH ASS'N (Oct. 24, 2020), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2021/01/13/structural-racism-is-a-public-health-crisis [https://perma.cc/7FVG-4Q8D].

[213] J. Nwando Olayiwola et al., *Making Anti-Racism a Core Value in Academic Medicine*, HEALTH AFFS. FOREFRONT (Aug. 25, 2020), https://www.healthaffairs.org/do/10.1377/forefront.20200820.931674/full/ [https://perma.cc/5Y4H-7Q5Z].

[214] *Cf.* Kelly M. Hoffman et al., *Racial Bias in Pain Assessment and Treatment Recommendation, and False Beliefs about Biological Differences between Blacks and Whites*, 113 PROC. NAT'L ACAD. SCIS. 4296, 4296–99 (2016) (finding that a "surprisingly high" percentage of medical students and residents endorsed the false belief that Black people have thicker skin and less sensitive nerve endings than white people).

should the directive describe the affirmative steps required? To whom should it extend? Would announcing an obligation to take affirmative steps be so foreign to the self-conception of healthcare sector actors as to be unwise?

These are fair questions. After all, recipients of federal healthcare funding are quite heterogeneous. They range from behemoth state Medicaid agencies[215] to physicians in solo or small group practices. Recipients include community health clinics, hospitals, nursing homes, home health agencies, and private managed care plans. They engage in diverse activities—providing treatment for acute medical needs, offering preventive care, supplying supportive services, and designing and implementing health insurance plans, among other activities. Many healthcare providers likely feel keenly a responsibility to meet the medical needs of individual patients. I doubt, however, that a responsibility to "further health equity" broadly is as widely felt.

As it turns out, some precedents for a health equality directive already exist in the healthcare sector. In several contexts, health services providers or agencies are already called on to engage in planning comparable to what a health-focused equality directive might call for. The most obvious example is HHS's guidance (now codified in regulations) directing healthcare providers to ensure that persons with LEP have reasonable access to services,[216] as discussed in Part III. In other contexts, the federal government offers some incentives or support for funding recipients to engage in equity-enhancing activities. This part describes several examples that could supply a partial template for a health equality directive.[217] To be sure, the examples offered are neither clearly and rigorously articulated enough nor adequately enforced enough to permit a "copy and paste" approach to framing a health-oriented equality directive. They demonstrate, however, that creating a planning-based affirmative obligation for healthcare actors would not be a radical departure from existing expectations and norms. In short, HHS would not be writing on a purely blank slate in developing an AFHE obligation.

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[215] According to a 2022 report issued by the California Legislative Analyst's Office, California's Medi-Cal program (the state's Medicaid program) provides coverage to more than fourteen million low-income Californians, with federal funds supporting 69 percent of Medi-Cal expenditures. GABRIEL PETEK, LEGIS. ANALYST'S OFF., THE 2022-23 BUDGET: ANALYSIS OF THE MEDI-CAL BUDGET 2 (2022), https://lao.ca.gov/Publications/Report/4522 [https://perma.cc/RZ3A-8RVB].

[216] *See* Section III.A.2, *infra*.

[217] Part VI, *infra* discusses some of the practical, political, and legal challenges that HHS might face in issuing AFHE guidance.

A. Internal Revenue Code Section 501(r): Hospitals' Community Health Needs Assessment Obligation

Nonprofit hospitals that wish to achieve and maintain federal tax-exempt status are already subject to an obligation—set out in Section 501(r) of the Internal Revenue Code[218] (IRC)—to assess community health needs and devise a plan for meeting some of those needs. Hospital care is responsible for the single largest portion of personal healthcare expenditures in the United States, accounting for 37 percent of that spending in 2019.[219] More than two-thirds of private hospitals are incorporated as nonprofits and exempt from federal taxation.[220] Thus, a substantial segment of the healthcare sector is already regularly engaging in processes akin to those a health-oriented equality directive might call for.

The requirement articulated in Section 501(r), however, is of relatively recent vintage. It was enacted as part of the ACA and added new requirements for hospitals that achieve their tax exemption under IRC Section 501(c)(3).[221] Since the late 1960s, the Internal Revenue Service (IRS) has applied a "community benefit" standard for hospitals claiming tax-exempt status under Section 501(c)(3),[222] but that standard remained ill-defined and rarely enforced.[223] In asserting their satisfaction of the standard, hospitals typically pointed to charity care provided to patients, often construing "charity" care broadly to include medical debt they could not collect and the amount by which their compensation for treating Medicaid patients fell short of their costs of doing so.[224] Simmering debates over whether hospitals merited tax exemption heated up in the early 2000s, when the media featured stories about some hospitals' decidedly

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[218] 26 U.S.C. § 501(r).

[219] *Health, United States, 2020–2021: Health Care Expenditures*, CTRS. DISEASE CONTROL (June 26, 2023), https://www.cdc.gov/nchs/hus/topics/health-care-expenditures.htm [https://perma.cc/9RQA-TSK4].

[220] According to 2020 data from the American Hospital Association, 70.7 percent of private hospitals in the United States were nonprofits, and 57.6 percent of all community hospitals (a group that also includes hospitals owned and operated by state or local governments) were nonprofits. *Fast Facts on U.S. Hospitals, 2022*, AM. HOSPITAL ASS'N (2022), https://www.aha.org/statistics/fast-facts-us-hospitals [https://perma.cc/8GL4-2S5P].

[221] 26 U.S.C. § 501(c)(3).

[222] Rev. Rul. 69-545, 1969-2 C.B. 117.

[223] Daniel B. Rubin, Simone R. Singh & Gary J. Young, *Tax-Exempt Hospitals and Community Benefit: New Directions in Policy and Practice*, 36 ANN. REV. PUB. HEALTH 545, 545, 549 (2015).

[224] Gary J. Young et al., *Provision of Community Benefits by Tax-Exempt U.S. Hospitals*, 368 NEW ENG. J. MED. 1519, 1523 (2013).

uncharitable treatment of indigent patients.[225] After all, the argument went, hospitals should provide substantial benefits to their communities, especially in return for a federal tax exemption valued at nearly thirteen billion dollars annually.[226]

Against this backdrop, the ACA added Section 501(r), which layered new requirements on top of the community benefit standard. One condition imposed by Section 501(r) is that a hospital must conduct a community health needs assessment (CHNA) once every three years.[227] In sum, hospitals are directed to gather data and seek input regarding community health needs from external constituencies, including public health experts and members of minority, underrepresented, and low-income communities.[228] Once a hospital has completed its assessment, it must publish the results on its website and adopt an implementation strategy that responds to some of the needs the assessment identified.[229]

IRS regulations implementing the CHNA requirement provide more specific guidance. They indicate that a CHNA report should describe the data relied on and how they were analyzed.[230] It should also describe how the hospital solicited and considered input from persons broadly representing community interests.[231] At a minimum, a hospital must solicit and take into account input from at least one public health department, as well as "[m]embers of medically underserved, low-income, and minority populations in [its] community."[232] If they follow this direction, hospitals should be gathering input from people who experience health disparities and who face barriers to care.[233] The Section 501(r) regulations further specify that an "implementation strategy" should set out a hospital's plans to address one or more of the community health needs it identified, including planned actions, resources to be committed, anticipated impacts, and any collaboration involved.[234]

Prior to the ACA's passage, some states had required hospitals to conduct similar assessments, but for most hospitals,

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[225] *See* Erin C. Fuse Brown, *Fair Hospital Prices Are Not Charity: Decoupling Hospital Pricing and Collection Rules from Tax Status*, 53 U. LOUISVILLE L. REV. 509, 513–14 (2016).

[226] Sara Rosenbaum et al., *The Value of the Nonprofit Hospital Tax Exemption Was $24.6 Billion in 2011*, 34 HEALTH AFF. 1225, 1228, 1231 (2015).

[227] 26 U.S.C. § 501(r)(3)(A)(i).

[228] *Id.* § 501(r)(3)(B)(i).

[229] *Id.* §§ 501(r)(3)(A)(ii), (B)(ii).

[230] 26 C.F.R. § 1.501(r)-3(b)(6)(ii) (2024).

[231] *Id.* § 1.501(r)-3(b)(6)(i)(C).

[232] *Id.* § 1.501(r)-3(b)(5)(A)-(B).

[233] *Id.* § 1.501(r)-3(b)(5)(B).

[234] *Id.* § 1.501(r)-3(c).

the requirement was new.[235] It also seemed foreign to many of them. Hospitals typically understood "community benefit" as referring to benefits flowing from their customary activities—for example, treating sick or injured patients, training doctors, and supporting research. The CHNA requirement, by contrast, called on hospitals to do something new and (for many) unfamiliar. To maintain its tax exemption, a hospital must now consider the health needs of the surrounding community, including needs existing among people who were not its patients. By directing hospitals to consider and respond to community (rather than individual) health needs, the ACA gave hospitals a job more typically carried out by public health agencies.[236]

With its mandate for data collection, community and expert input, and planning, the CHNA mechanism resembles somewhat the assessment and planning processes that the AFFH Rule established for recipients of federal housing funds.[237] This resemblance is undercut, however, by important differences that render the CHNA requirement less potent as a health equity-promoting tool, at least as set out in current regulations. First, existing regulations do not require hospitals to consider racial impacts (or health disparities more broadly) when identifying and prioritizing their community's significant health needs. The IRS could remedy this shortcoming through new rulemaking that articulates an expectation that hospitals will employ a health equity lens when assessing community health needs. Revised regulations might direct hospitals to identify data regarding health and healthcare disparities in their communities and to grapple with how to prioritize and address those disparities. [238] Second, the CHNA requirement applies only to tax-exempt *hospitals*. Even if the IRS were to incorporate a health equity orientation into revised regulation, it would not extend to other important healthcare industry actors. Finally, research suggests that in the decade since the

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[235] Mary Crossley, *Health and Taxes: Hospitals, Community Health and the IRS*, 16 YALE J. HEALTH POL'Y, L. & ETHICS 51, 56 (2016).

[236] *See* Paula M. Lantz & Sara Rosenbaum, *The Potential and Realized Impact of the Affordable Care Act on Health Equity*, 45 J. HEALTH POL. POL'Y & L. 831, 839 (2020) (observing that the CHNA requirement "effectively redefine[s] the role of tax exempt hospitals as community public health actors beyond their traditional role as a source of clinical care").

[237] *See supra* text accompanying notes 42–47.

[238] *Cf.* Crossley, *supra* note 235 (arguing that the lack of explicit requirements regarding community engagement, transparency, and accountability represents a missed opportunity).

CHNA requirement became effective, tax-exempt hospitals' compliance in many cases has been incomplete.[239]

Nonetheless, some hospitals and health systems have made encouraging strides in the past decade in exploring ways to advance health equity in their communities, a point discussed below in Part V. It is entirely plausible that hospitals (and other healthcare system actors) *could* meaningfully contribute to alleviating health inequity. The CHNA requirement may not have effectively tapped into that potential to date. Its existence, however, means that over the past decade most hospitals—a core cohort of healthcare providers—have developed some familiarity with using data to consider how their activities affect the communities beyond their walls.

B. Olmstead *Plans*

Another example of an existing, planning-oriented affirmative obligation in the healthcare sector arose from a Supreme Court decision applying the ADA to state-provided services for persons with mental disability. *Olmstead v. L.C.*[240] involved two women in Georgia who were confined to a state hospital for psychiatric care, but who sought instead to receive the services they needed in the community. In deciding the case, the Court applied the ADA's "integration mandate," found in a regulation obligating public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[241] Because the segregation and isolation imposed by undesired and unneeded institutionalization violated this requirement, the Court concluded that, in providing services, states have an affirmative obligation to ensure that disabled people can receive those services in the most integrated settings that meet their needs.[242]

When *Olmstead* was decided in 1999, many states provided a sizable portion of their services to disabled people in institutions, notwithstanding a decades-old deinstitutionalization movement.[243] In opposing the *Olmstead*

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[239] Leo Lopez III et al., *US Nonprofit Hospitals' Community Health Needs Assessments and Implementation Strategies in the Era of the Patient Protection and Affordable Care Act*, JAMA NETWORK (Aug. 24, 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2783452 [https://perma.cc/FW2Q-ZUJH].

[240] Olmstead v. L.C., 527 U.S. 581, 593 (1999).

[241] *Id.* at 592; 28 C.F.R. § 35.130(d) (2024).

[242] *Olmstead*, 527 U.S. at 603–07.

[243] Chris Koyanagi, *Learning from History: Deinstitutionalization of People with Mental Illness as Precursor to Long-Term Care Reform*, KAISER COMM'N MEDICAID

plaintiffs' asserted right to community placement, Georgia's Department of Human Resources argued that a court order requiring it to immediately find a community placement for every disabled service recipient desiring one would be infeasible, since the State still needed to maintain institutions for persons who needed or desired institution-based care.[244] This defense invoked the regulatory "fundamental alteration" exception to states' obligations to make "reasonable modifications" to their policies and practices.[245] According to the regulation, reasonable modifications to avoid disability discrimination are required unless the state can "demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity."[246] In short, Georgia argued that having to provide community placements on demand would fundamentally alter its system of providing services to mentally disabled people.

Acknowledging the potential applicability of the fundamental alteration defense, Justice Ginsburg's plurality opinion conceded that Georgia's obligation to the plaintiffs was "not boundless."[247] Accordingly, *Olmstead* recognized a qualified right to community placement. A state could be excused from an obligation to provide community-based services to a specific plaintiff *if* it could show that being required to provide community placements would fundamentally alter its system of providing services.[248] As an example of such a showing, Justice Ginsburg suggested that a state might point to a "comprehensive, effectively working plan for placing qualified persons with . . . disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated."[249] In sum, *Olmstead* held that states must provide community-based services when a community placement would be appropriate in the opinion of treating professionals, not opposed by the disabled person, and could be reasonably accommodated, taking into consideration the state's resources and needs of other disabled people receiving state-funded services.[250]

Following the decision, the phrase "*Olmstead* plan" entered the lexicon of state health and human services

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& UNINSURED 1 (2007), https://www.kff.org/wp-content/uploads/2013/01/7684.pdf (last visited Jan. 14, 2024) (tracing the movement back to the mid-1950s).

244 *Olmstead*, 527 U.S. at 594.

245 *Id.* 594–95; 28 C.F.R. § 35.130(b)(7) (2022).

246 *Olmstead*, 527 U.S. at 592.

247 *Id.* at 603.

248 *Id.* at 604–07.

249 *Id.* at 605–06.

250 *Id.* at 607.

administrators. It refers to the mechanism they can employ to avoid being found in violation of the ADA's integration mandate, even if they are not providing community placement to every disabled service recipient who seeks one.[251] According to Justice Department guidance, to claim the fundamental alteration defense, a public entity must demonstrate that it has developed and is implementing a "comprehensive, effectively working *Olmstead* plan." [252] The guidance describes specific features the Department will consider:

> A comprehensive, effectively working plan must do more than provide vague assurances of future integrated options. . . . Instead, it must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting and must contain concrete and reliable commitments to expand integrated opportunities. The plan must have specific and reasonable timeframes and measurable goals for which the public entity may be held accountable, and there must be funding to support the plan. . . . To be effective, the plan must have demonstrated success in actually moving individuals to integrated settings in accordance with the plan.[253]

The similarities between the Justice Department's guidance regarding compliance with the ADA's integration mandate and the equality directives described by Professor Johnson are notable. According to the guidance, an effective *Olmstead* plan must (1) conduct a baseline analysis of the unmet demand for community-based services, (2) articulate and commit to concrete measures to meet that demand, (3) specify reasonable goals and a timeframe for meeting them, and (4) identify funding for the plan.[254] By undertaking these affirmative steps, a public entity avoids institutional segregation that violates that ADA.[255]

Admittedly, the expectation—now more than two decades old—that agencies providing publicly-funded services would engage in planning has not ensured community integration for disabled people who seek it. Assessments of *Olmstead*'s impact of have a "glass half full vs. glass half empty" quality. Some commentators describe it as "revolutionary."[256]

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[251] *See* Megan Flynn, Olmstead *Plans Revisited: Lessons Learned from the U.N. Convention on the Rights of Persons with Disabilities*, 28 L. & INEQ. 407, 408 (2010).

[252] *Statement of the Department of Justice on Enforcement of the Integration Mandated of Title II of the Americans with Disabilities Act and* Olmstead v. L.C., DEP'T JUST. C.R. DIV., https://www.ada.gov/olmstead/q&a_olmstead.htm#_ftnref7 [https://perma.cc/LRN7-9RBM].

[253] *Id.*

[254] *Id.*

[255] *See id.*

[256] Angela K. McGowan et al., *Civil Rights Law as Tools to Advance Health in the Twenty-First Century*, 37 ANN. REV. PUB. HEALTH 185, 191 (2016).

Others critique subsequent judicial interpretations as rendering *Olmstead*'s fundamental alteration standard "overly lenient, deferential to states, and vague,"[257] and effectively giving a "get out of jail free" card to states that take only superficial steps toward increasing integration.[258] On the one hand, *Olmstead* investigations by the Justice Department have produced significant settlements with states,[259] described as enabling thousands of disabled people to access community-based services.[260] On the other hand, in the decades since *Olmstead* was decided, waiting lists for home and community-based services have continued to grow.[261] Clearly, *Olmstead* has not proven to be a silver bullet enabling every disabled person who wishes to live in the community to do so.

For purposes of this article, however, the processes incorporated in *Olmstead* plans to diminish segregation and advance equity for disabled people are more important than the track record of those plans. Because of *Olmstead*, state agencies that provide services to disabled people should be familiar with practices of assessing needs, making plans, and evaluating efforts to advance equity as a way of meeting their nondiscrimination obligations under the ADA. Thus, the prevalence of *Olmstead* planning offers another model for how healthcare sector actors might respond to an equality directive to avoid discrimination and advance health equity. Moreover, *Olmstead* settlements obtained by the Justice Department suggest the importance of a commitment by HHS to monitor funding recipients' AFHE efforts.

C. Centers for Medicare and Medicaid Services Health Equity Initiatives

Because it is decentralized, the most robust existing model for an AFHE obligation defies simple description. In the past decade, the Centers for Medicare and Medicaid Services (CMS)[262] has initiated diverse programs and regulatory

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[257] Larisa Antonisse, *Strengthening the Right to Medicaid Home and Community-Based Services in the Post-COVID Era*, 121 COLUM. L. REV. 1801, 1832 (2021).

[258] John F. Muller, Olmstead v. L.C. *and the Voluntary Cessation Doctrine: Toward a More Holistic Analysis of the "Effectively Working Plan,"* 118 YALE L.J. 1013, 1014 (2009).

[259] *See, e.g.*, McGowan et al., *supra* note 256, at 191.

[260] *See Olmstead Enforcement*, DEP'T JUST. C.R. DIV., https://archive.ada.gov/olmstead/olmstead_cases_list2.htmhttps://archive.ada.gov/olmstead/olmstead_cases_list2.htm (describing settlements and other enforcement actions).

[261] *See* Antonisse, *supra* note 257, at 1805.

[262] CMS is the subagency within HHS that administers federal public healthcare programs. It oversees Medicare, Medicaid, and the Children's Health

measures to embed health equity in its administration of those massive public health insurance programs. These initiatives have ramped up during the Biden Administration. In 2021, the newly appointed Administrator of CMS, Chiquita Brooks-LaSure, included "advanc[ing] health equity by addressing . . . health disparities" as one of six strategic pillars at CMS.[263] According to Brooks-LaSure, this pillar manifests in CMS officials pervasively interrogating the equity implications of everything they do: "For every decision being made, we're asking ourselves 'how is this action advancing health equity?'"[264] This unrelenting attentiveness to equity models the mindset that an AFHE obligation would seek to inspire in federal healthcare funding recipients. Comprehensively detailing the mechanisms that CMS uses to pursue health equity is beyond this article's scope. But a few examples from both Medicaid and Medicare suggest how CMS initiatives might serve as cornerstones for an AFHE obligation.[265]

1. Medicaid

Writing in 2021, leaders at CMS identified equity as one of three key focus areas in their strategic vision for Medicaid.[266] As the country's single largest health coverage program (covering more than 80 million people in 2022),[267] Medicaid offers

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Insurance Program, as well as the federal and state health insurance marketplaces. *About Us*, CTR. MEDICARE & MEDICAID SERVS., https://www.cms.gov/about-cms [https://perma.cc/V3Z2-K39V].

[263] Chiquita Brooks-LaSure, *My First 100 Days and Where We Go From Here: A Strategic Vision for CMS*, CTR. MEDICARE & MEDICAID SERVS. BLOG (Sept. 9, 2021), https://www.cms.gov/blog/my-first-100-days-and-where-we-go-here-strategic-vision-cms [https://perma.cc/HCZ6-5UJJ].

[264] *Id.*

[265] It bears highlighting, however, how using CMS's initiatives as a model for an AFHE obligation is distinctive from the other models identified. Unlike the Supreme Court in *Olmstead*, CMS is not prescribing steps for program participants to avoid illegal discrimination. Nor is it detailing processes necessary to satisfy a statutory condition for tax exemption, as the IRS has done in its Section 501(r) regulations. Rather, CMS is looking for opportunities to administer massive public health insurance programs in ways designed to further health equity. Because the Medicare and Medicaid programs touch so many providers and health plans, CMS equity-oriented initiatives could provide a substantial boost to a health-oriented equality directive. They might offer healthcare sector actors a carrot ("you can tap into additional payments by participating in health equity initiatives") to complement an equality directive's stick ("you should engage in these processes to avoid liability for disparate impact discrimination").

[266] Chiquita Brooks-LaSure & Daniel Tsai, *A Strategic Vision for Medicaid and the Children's Health Insurance Program (CHIP)*, HEALTH AFFS. FOREFRONT (Nov. 16, 2021), https://www.healthaffairs.org/do/10.1377/forefront.20211115.537685/full/ [https://perma.cc/GFD5-PJSB]. The other two areas of focus are (1) coverage and access and (2) innovation and whole-person care. *Id.*

[267] Julie M. Donohue et al., *The US Medicaid Program: Coverage, Financing, Reforms, and Implications for Health Equity*, 328 JAMA 1085, 1085 (2022).

an enormous platform for deploying health equity initiatives. Its outsized role in covering Black and brown Americans positions it especially well to lead in health equity efforts.[268]

Moreover, Medicaid's nature as a cooperative federal and state program permits each state some flexibility to adapt its Medicaid program to its own particular needs and concerns. This gives states ample opportunities to identify and respond to health disparities. Most states are already attempting to address racial and ethnic healthcare disparities within Medicaid.[269] As one example, in 2020, to address disparities in maternal and child health, Pennsylvania began offering equity incentive payments to managed care organizations (MCOs) that reduce racial disparities among Medicaid enrollees in accessing timely prenatal care and making recommended well-child visits. [270] And in 2021, the Commonwealth revised its agreements with Medicaid MCOs to incorporate a bundled payment approach to maternity care, with rewards for providers that reduce racial disparities in quality.[271]

Federal health program administrators have tools to encourage states' equity initiatives. The Medicaid statute authorizes the Secretary of HHS to waive several of its requirements on application by a state. Section 1115 waivers, for example, permit states to implement demonstration projects to try out innovative ways of advancing the objectives of the Medicaid program.[272] To apply for a Section 1115 waiver, a state must provide analyses of the intended and likely impacts of its proposed innovation and commit to assessing its impacts.[273] CMS has signaled to states its openness to considering waiver applications that seek to foster greater equity,[274] and states have

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[268] *Id.* at 1095.

[269] KATHLEEN GIFFORD ET AL., KAISER FAM. FOUND., STATES RESPOND TO COVID-19 CHALLENGES BUT ALSO TAKE ADVANTAGE OF NEW OPPORTUNITIES TO ADDRESS LONG-STANDING ISSUES: RESULTS FROM A 50-STATE MEDICAID BUDGET SURVEY FOR STATE FISCAL YEARS 2021 AND 2022 6 (Oct. 2021), https://files.kff.org/attachment/Report-States-Respond-to-COVID-19-Challenges.pdf (indicating that three-quarters of states reported initiatives to address racial/ethnic disparities in Medicaid) [https://perma.cc/NJ4E-8XFC].

[270] PENN. DEP'T. HUM. SERV., RACIAL EQUITY REPORT 2021 5 (2021), https://www.dhs.pa.gov/about/Documents/2021%20DHS%20Racial%20Equity%20Report%20final.pdf [https://perma.cc/2PBH-DCQV].

[271] *Id.* at 6.

[272] *About Section 1115 Demonstrations*, MEDICAID, https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html [https://perma.cc/9GST-2756].

[273] *Id.*; *1115 Demonstration Monitoring & Evaluation*, MEDICAID, https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/index.html [https://perma.cc/PZ7H-W5XF].

[274] Brooks-LaSure & Tsai, *supra* note 266.

responded. Recent Section 1115 waiver applications have included proposals to expand coverage for justice-involved individuals, increase focus on social determinants of health, and incentivize or measure progress toward equity.[275]

As part of this article's proposed health-oriented equality directive, CMS could further leverage the equity-promoting potential of the Section 1115 waiver process. For example, it could inform states that Section 1115 waiver applications should include an articulation of how the demonstration project is expected to affect health equity within the state's Medicaid population. It could also ask states to gather and validate data to monitor those effects. Going further, CMS could require that any waiver application proposing delivery system reform include health equity objectives and commitments to progress reports on those objectives.[276]

2. Medicare

The Medicare program, which covers more than 60 million people[277] who are sixty-five years or older or permanently disabled, is also pursuing various program innovations to advance health equity. Writing in May 2022, CMS administrators described a two-pronged vision of health equity in Medicare.[278] One prong entails improving the program's operations broadly to better engage underserved communities (and their providers), as well as beefing up oversight of providers and Medicare Advantage health plans to enhance accessibility of both care and information.[279] The second prong calls for implementing new policies to advance health equity, including steps to ensure that Medicare's new reimbursement models that seek to incentivize high-quality care incorporate equity considerations.[280] As one example, CMS is exploring how to "stratify quality measures in hospital and skilled nursing

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[275] Madeline Guth & Elizabeth Hinton, *What to Watch in Medicaid Section 1115 Waivers One Year into the Biden Administration*, KAISER FAM. FOUND. (Jan. 27, 2022), https://www.kff.org/medicaid/issue-brief/what-to-watch-in-medicaid-section-1115-waivers-one-year-into-the-biden-administration/ [https://perma.cc/F2SE-WFHP].

[276] Donohue et al., *supra* note 267, at 194.

[277] *CMS Releases Latest Enrollment Figures for Medicare, Medicaid, and Children's Health Insurance Program (CHIP)*, CTRS. MEDICARE & MEDICAID SERVS. (Dec. 21, 2021), https://www.cms.gov/newsroom/news-alert/cms-releases-latest-enrollment-figures-medicare-medicaid-and-childrens-health-insurance-program-chip [https://perma.cc/6KA7-Y7FP].

[278] Meena Seshamani & Douglas B. Jacobs, *Leveraging Medicare to Advance Health Equity*, 327 JAMA 1757 (2022).

[279] *Id.*

[280] *Id.* at 1757–58.

facilities by markers of social risk to better identify and encourage the reduction of disparities."[281] In other words, quality measures must account for patients' social circumstances before they can be used to help address disparities. Similarly, CMS is considering how it can use social needs screenings and follow-up for targeted populations to advance health equity and emphasize equity in its push toward delivery system transformation.[282] Characterizing these initiatives as "a start" in the long overdue responsibility to "rectify the longstanding health inequities" afflicting some Americans, the CMS administrators conclude:

> It is the collective responsibility of all to work together to ameliorate the inequities present in the health care system and in society that have been reinforced for generations. Medicare can and will take a leadership role in mobilizing and catalyzing the work necessary to advance health equity. Infusing health equity into everything that Medicare does . . . requires every clinician and health care entity that provides services in Medicare and every Medicare Advantage plan to start the hard work of advancing health equity now.[283]

Thus, the top administrators at Medicare—a program that infuses billions of dollars into the healthcare ecosystem each year—are already committed to supporting widely distributed efforts to advance health equity.

3. Reflections on Centers for Medicare and Medicaid Services as a Potential Role Model

The foregoing indicates that CMS (at least in the Biden Administration) is fully on board with using its powers to advance health equity broadly. If HHS were to issue a health-oriented equality directive, it would be important to consider how to align its guidance with existing and proposed CMS health equity initiatives. For example, the guidance could indicate that a provider's participation in one of Medicare's equity initiatives would satisfy the obligation to affirmatively further health equity. Or HHS could encourage CMS administrators to provide targeted technical assistance for state Medicaid programs that propose Section 1115 waivers that include explicit equity objectives. Aligning the equity goals of federal grants in aid programs with nondiscrimination mandates supported both by the Constitution's Spending Clause and Section 5 of the Fourteenth Amendment could produce potent synergies, as it did historically when freshly available Medicare funding

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[281] *Id.* at 1758.
[282] *Id.*
[283] *Id.*

catalyzed the desegregation of hospitals after the enactment of Title VI.[284] David Barton Smith colorfully describes this use of federal healthcare dollars to address health disparities as employing "the economic version of the Golden Rule—those with the gold, rule."[285]

V. ADDRESSING POTENTIAL OBJECTIONS TO AN OBLIGATION TO AFFIRMATIVELY FURTHER HEALTH EQUITY

This article proposes that HHS should issue guidance to recipients of federal healthcare funding interpreting multiple statutes (Title VI, Section 1557, and Section 504) as obliging those recipients to take affirmative steps to further health equity. This equality directive, as suggested by Professor Olatunde Johnson's work, should call for funding recipients to analyze data to learn how their activities affect health disparities and to plan how they will adjust those activities to enhance equity.[286] The justification for imposing such an obligation is that analysis and planning are needed to avoid creating a prohibited disparate impact in recipients' use of federal funds.

Even if this proposed health-oriented equality directive can be legally supported, is it advisable? Some readers may critique the proposal as insufficiently ambitious; others may view it as overreaching. Moreover, aside from the sturdiness of its statutory underpinnings, questions about its legal or constitutional soundness may arise. Fully addressing these potential objections lies beyond the scope of this article, but this part briefly and preliminarily assesses their strength. Although these concerns overlap, I divide them into three buckets: political, practical, and legal.

A. Potential Political Challenges and Provider Pushback

Whatever its legal soundness, would issuing a healthcare equality directive be politically infeasible or inadvisable? Even a supporter of advancing health equity might doubt that sufficient political will exists to create such an obligation or worry that the political cost of issuing a directive would exceed its likely equity-enhancing benefits.

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[284] *See supra* text accompanying notes 70–73, 158–60.

[285] David Barton Smith, *The "Golden Rules" for Eliminating Disparities: Title VI, Medicare, and the Implementation of the Affordable Care Act*, 25 HEALTH MATRIX: J. L.-MED. 33, 34 (2015) (emphasis omitted).

[286] *See supra* notes 125–29 and accompanying text.

The current administration's commitment to vigorously pursuing racial equity and enforcing civil rights broadly suggests that a dearth of political will should not preclude issuance of an equality directive for healthcare. As one of his first official acts, President Joe Biden signed an Executive Order to advance "Racial Equity and Support for Underserved Communities Through[out] the Federal Government"[287] (the Equity Order). The Equity Order announces that "[a]ffirmatively advancing equity, civil rights, racial justice, and equal opportunity is the responsibility of the whole of our Government."[288] It calls for federal agencies government-wide to assess their programs and policies to determine whether underserved communities "face systemic barriers in accessing [the] benefits and opportunities" that agencies make available,[289] thus acknowledging the imperative to remove structural barriers to opportunity and inclusion. Its call for federal agencies to scrutinize whether systemic barriers affect underserved communities' ability to benefit from federal spending aligns with this article's proposal that agencies, in effect, delegate to funding recipients some responsibility for discerning and addressing those barriers.[290]

Another potential objection is that developing guidance obliging healthcare funding recipients to affirmatively further health equity is unlikely to be the most effective way to channel bureaucratic energy toward tangible equity gains. Given CMS's stated commitment to addressing inequities, one could argue it would be better to simply encourage CMS to keep plugging away at its initiatives. Assembling loosely connected initiatives to address disparities and eliminate barriers seems less likely to provoke political opposition (and provider pushback) than announcing a previously unarticulated legal obligation, especially in a highly-polarized political environment. That said, by effectively deputizing everyone receiving federal healthcare dollars as agents responsible for addressing disparities, an obligation to

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[287] Exec. Order No. 13,895, 86 Fed. Reg. 7009 (Jan. 20, 2021).

[288] *Id.*

[289] *Id.* Another Biden Executive Order focused on equity issues in the government's pandemic response. Exec. Order No. 13,995, 86 Fed. Reg. 7193 (Jan. 21, 2021). A third, focusing on responses to climate change, Exec. Order No. 14,008, 86 Fed. Reg. 7619 (Jan. 27, 2021), prompted the creation of an Office of Climate Change and Health Equity within HHS. *See also The Office of Climate Change and Health Equity (OCCHE)*, DEP'T HEALTH & HUM. SERVS., https://www.hhs.gov/ash/ocche/index.html [https://perma.cc/HZ79-M9PY].

[290] *Cf.* Olatunde C.A. Johnson, *The Equity E.O.: Building a Regulatory Infrastructure of Inclusion*, 46 ADMIN. & REG. L. NEWS 5 (2021) (characterizing the Executive Order as "announc[ing] an affirmative and proactive role for federal agencies in addressing inequities").

affirmatively further health equity would reach further than CMS initiatives. In short, an AFHE obligation pushes healthcare actors to be proactive in furthering health equity, not simply reactive in cooperating with CMS equity initiatives.[291]

Pushback by providers and other healthcare industry actors against an AFHE obligation is also a possibility. Because leaders in private sector healthcare fields have expressed commitments to advancing equity,[292] public opposition by those leaders may be muted. Some health systems are already pursuing initiatives to advance equity in their communities. For example, the Healthcare Anchor Network comprises more than seventy health systems that seek to leverage their economic power to benefit the health of their communities by addressing health-harming racial and economic inequities.[293] Healthcare providers and systems already devoting considerable effort and resources to equity-focused projects may welcome HHS guidance calling for *all* recipients of federal funding to take affirmative, equity-promoting steps as levelling the playing field in often competitive markets.

Some recipients of federal funds, however, might view an obligation to affirmatively further health equity as a new and unfunded mandate,[294] leading to opposition in the form of grumbling and foot-dragging. Providers might compare an AFHE obligation to the Emergency Medical Treatment and Labor Act of 1986[295] (EMTALA). This federal statute requires hospitals that participate in Medicare to provide medical screenings and stabilizing emergency care to patients who

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[291] Participating in equity-focused CMS initiatives may be how (or part of how) some recipients of federal healthcare funding will affirmatively further health equity.

[292] *See The AMA's Strategic Plan to Embed Racial Justice and Advance Health Equity*, AM. MED. ASS'N, https://www.ama-assn.org/about/leadership/ama-s-strategic-plan-embed-racial-justice-and-advance-health-equity [https://perma.cc/AKM3-PGQE]; Wright L. Lassiter III & Rick Pollack, *AHA Special Message: AHA Launches Health Equity Roadmap*, AM. HOSP. ASS'N (Mar. 29, 2022), https://www.aha.org/2022-03-29-aha-special-message-aha-launches-health-equity-roadmap [https://perma.cc/5P48-SZTD]; *Health Equity*, AM'S. HEALTH INS. PLANS, https://www.ahip.org/issues/health-equity [https://perma.cc/MRS8-T2TR].

[293] The Network articulates its members' "anchor mission" as "an intentional commitment to apply an anchor institution's long-term, place-based economic power and human capital in partnership with community to mutually benefit the long-term well-being of both." *About the Healthcare Anchor Network (HAN)*, HEALTHCARE ANCHOR NETWORK, https://healthcareanchor.network/about-the-healthcare-anchor-network/ [https://perma.cc/D9T4-UHAW].

[294] *Cf.* Christine M. Durham & Brian L. Hazen, *Unfunded Federal Mandates and State Judiciaries: A Question of Sovereignty*, 2014 UTAH L. REV. 913, 914 (2014) (characterizing the application of LEP guidance issued pursuant to Title VI to state judiciaries as an unfunded federal mandate).

[295] Emergency Medical Treatment and Labor Act of 1986, Pub. L. No. 99-272, 100 Stat. 82 (codified at 42 U.S.C. § 1395dd).

present at their emergency departments, regardless of patients' ability to pay for that care.[296] Failure to meet the law's requirements may subject hospitals to both civil liability to patients and civil administrative penalties.[297] EMTALA's critics portray it as an unfunded mandate[298] that adds to hospitals' burden of uncompensated care.[299] EMTALA's requirements, however, are more specific, prescriptive, and unavoidably expensive than the proposed AFHE obligation, which would not mandate providing specific services. In some cases (where funding recipients are already taking steps that further health equity), it would entail no additional expense.

Ultimately, the proposed AFHE guidance would not be a truly new obligation for federal funding recipients. Rather, it is premised on existing antidiscrimination mandates in Title VI, Section 504, and Section 1557. AFHE guidance would serve both to remind recipients of their legal obligation to avoid practices or policies that produce a prohibited adverse disparate impact and to suggest affirmative steps that would help them avoid violating antidiscrimination laws.

B. Practical Concerns

1. Effectiveness

Political challenges aside, opponents of an obligation to affirmatively further health equity may raise several practical concerns. One objection is that HHS guidance announcing an AFHE obligation may not have any positive effect. Unless enlisting all federally funded healthcare actors to take steps to advance health equity can be expected to produce positive results, developing and implementing such guidance would be a waste of time and resources. Admittedly, because of the role social determinants and structural factors play in producing health disparities, interventions in healthcare settings may

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[296] 42 U.S.C. § 1395dd(a)–(b).

[297] JENNIFER A. STAMAN, CONG. RSCH. SERV., IF12355, OVERVIEW OF THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) AND EMERGENCY ABORTION SERVICES 2 (2023), https://crsreports.congress.gov/product/pdf/IF/IF12355 [https://perma.cc/JFU2-26ZT].

[298] Robert Wanerman, *The EMTALA Paradox*, 40 ANNALS EMERGENCY MED. 464 (2002).

[299] *Cf.* Christopher Pope, *Assuring Hospital Emergency Care Without Crippling Competition*, HEALTH AFFS. FOREFRONT (July 6, 2015), https://www.healthaffairs.org/do/10.1377/forefront.20150706.049122 [https://perma.cc/TKU5-YYTL].

have only limited effect.[300] More research is needed to assess the effectiveness of strategies that are being employed.[301]

This concern is serious, but should not be overblown. Research has identified promising disparity-mitigating practices in an array of realms, from clinical care,[302] to health education outreach,[303] to insurance coverage.[304] That knowledge base is growing as interventions are attempted and then assessed for effectiveness. In a perfect world, the AFHE obligation would include a requirement that equity-promoting initiatives be subject to evaluation. While likely unrealistic across the board, an evaluation requirement might be manageable in some contexts. For example, the evaluation requirement for Section 1115 waivers could be beefed up to leverage state Medicaid programs as a source of knowledge. Similarly, the IRS could start enforcing the directive that tax-exempt hospitals report on the impact of their strategies to address community health needs. The National Institutes of Health (NIH), in its grant making capacity, could encourage researchers to seek opportunities to partner with providers and payers to measure the effect of the steps they take to affirmatively further health equity. As knowledge develops, HHS has a crucial role to play in disseminating it to federal funding recipients and offering technical assistance on how to translate knowledge for use in different settings.[305] HHS (and

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[300] Arleen F. Brown et al., *Structural Interventions to Reduce and Eliminate Health Disparities*, 109 AM. J. PUB. HEALTH S72, S72 (2019).

[301] For example, it remains unclear how best CMS might incorporate equity metrics into its value-based reimbursement schemes *Id.* at S76–S77; *see also* NAT'L QUALITY F., EFFECTIVE INTERVENTIONS IN REDUCING DISPARITIES IN HEALTHCARE AND HEALTH OUTCOMES IN SELECTED CONDITIONS 2–3 (2017), https://www.qualityforum.org/Publications/2017/03/Effective_Interventions_in_Reducing_Disparities_in_Healthcare_and_Health_Outcomes_in_Selected_Conditions.aspx [https://perma.cc/M3YW-MWG7].

[302] *See, e.g.*, Seth W. Glickman et al., *Impact of a Statewide ST-Segment-Elevation Myocardial Infarction Regionalization Program on Treatment Times for Women, Minorities, and the Elderly*, 3 CIRCULATION: CARDIOVASCULAR QUALITY & OUTCOMES 514, 514 (2010).

[303] *See, e.g.*, *Achieving Vaccine Equity: Resources & Best Practices to Bring Down Barriers*, PUB. HEALTH INST., (Feb. 15, 2022), https://www.phi.org/press/resources-best-practices-to-achieving-vaccine-equity/ [https://perma.cc/GA92-EYZC].

[304] *See, e.g.*, Jesse C. Baumgartner & Laurie C. Zephyrin, *How Health Care Coverage Expansions Can Address Racial Equity*, COMMONWEALTH FUND BLOG (Feb. 2, 2022), https://www.commonwealthfund.org/blog/2022/how-health-care-coverage-expansions-can-address-racial-equity [https://perma.cc/Y4DV-7PVK].

[305] The National Institute for Minority Health and Health Disparities (NIMHD) would be a valuable partner in developing and disseminating evidence-based interventions to address health disparities. *See About NIMHD*, NAT'L INST. MINORITY HEALTH & HEALTH DISPARITIES (Feb. 21, 2022), https://www.nimhd.nih.gov/about/ [https://perma.cc/FH69-DLJ9]. One of the goals of the NIMHD's 2021–2025 Strategic Plan is to "promote evidence-based community engagement, dissemination, and implementation of minority health disparities research best practices." *Outreach, Collaboration, and Dissemination: Goals and Strategies*, NAT'L INST. MINORITY HEALTH

CMS in particular) are well positioned to share both evidence-based approaches and information about promising practices.

As importantly, guidance establishing an AFHE obligation should include descriptions of "worst practices" for grantees to avoid. Fair housing scholar Noah Kazis makes an analogous point in the context of the "affirmatively furthering fair housing" obligation under the FHA.[306] He argues that, while local housing agencies (and courts) may have differing visions of what constitutes "fair housing," some practices that contribute to "unfair housing" can be identified with specificity.[307] By flagging healthcare practices deemed especially likely to impede health equity, HHS could adapt Kazis's idea to its AFHE guidance document. Provider refusals to accept Medicaid enrollees as patients are one example of practices likely to produce an adverse disparate impact on a population or community already suffering health disparities.[308] The "worst practices" list could also highlight practices that healthcare actors may be unaware are directly prohibited by antidiscrimination laws. For example, providers' failures to provide accessible medical equipment and reasonable modifications to policies to permit disabled people to receive medical services—failures that remain shockingly common—may be partially attributable to low levels of familiarity with the law's requirements.[309]

Adopting an AFHE obligation for healthcare actors who receive federal funding will not guarantee an appreciably positive impact. However, robust articulation of AFHE guidance that encompasses references to evidence-based methods, promising practices, and worst practices; sharing disparities-related data; and technical assistance would give funding recipients valuable guidance on how to help reverse the history of health injustice in the United States. Moreover, by fostering a mindset that all actors in the healthcare system share in a

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& HEALTH DISPARITIES (Mar. 31, 2021), https://www.nimhd.nih.gov/about/strategic-plan/nih-strategic-plan-outreach-collaboration-dissemination.html [https://perma.cc/HH7L-2XKH]. Private entities, like the Health Anchor Network, could usefully funnel promising results from health equity initiatives up to HHS for dissemination.

[306] Noah M. Kazis, *Fair Housing, Unfair Housing*, WASH. U. L. REV. ONLINE (2021), https://wustllawreview.org/2021/11/23/fair-housing-unfair-housing/ [https://perma.cc/89TZ-RUEC].

[307] *Id*.

[308] *Cf.* Linton *ex rel* Arnold v. Comm'r of Health & Env't, 779 F. Supp. 925, 935 (M.D. Tenn. 1990) (finding that a policy that limited Medicaid enrollees' access to nursing home care had a disparate impact on Black persons).

[309] Lisa I. Iezzoni et al., *US Physicians' Knowledge About the Americans with Disabilities Act and Accommodation of Patients with Disability*, 41 HEALTH AFFS. 96, 101–02 (2022).

collective responsibility to promote health equity, establishing an AFHE obligation could hold value beyond the direct results of steps taken to satisfy that obligation.

2. Adaptability and Scalability

Federal funding flows into virtually every nook and cranny of the healthcare financing and delivery system in the United States. The proposed AFHE obligation, in turn, would spread similarly as broadly. The recipients of federal healthcare funding range in size from physicians in a solo or small group practice to healthcare behemoths generating hundreds of millions in revenue annually.[310] They include doctors, hospitals, managed care plans, nursing homes, home health agencies, and other service providers.[311] Articulating clear but flexible expectations for those recipients in a healthcare equality directive will be challenging, as the guidance attempts to address the related challenges of scalability (for variations in size) and adaptability (across a range of functions).

Because the universe of actors subject to an AFHE obligation will be large and diverse, HHS guidance articulating the obligation must be adaptable. It should suggest the kinds of actions providers in contexts ranging from pediatrics, to acute care, to long term services and supports, and to hospice care can take to further health equity. Equality directives in other sectors offer rough models for crafting appropriately adaptable guidance. The Obama Administration's AFFH Rule[312] and the FTA's Circular on Title VI[313] both employ a forward-looking, data-driven, community-engaged approach to planning how to use federal funds in ways that advance racial and ethnic equity.

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[310] *See, e.g.*, *UPMC's Financial Results for 2020 Support Continued Outstanding Patient Care and Reinvestment in Clinical Excellence Amidst COVID-19 Pandemic*, U. PITT. MED. CTR. (Feb. 26, 2021) https://www.upmc.com/media/news/022621-calendar-year-2020-financial-results (reporting operating income of $836 million in 2020) [https://perma.cc/PLH6-UUPK]; *CARES Act/COVID 3.5: Loans & Other Financial Assistance for Physician Practices*, AM. MED. ASS'N (June 16, 2020), https://www.ama-assn.org/delivering-care/public-health/cares-actcovid-35-loans-other-financial-assistance-physician (delineating federal funds available for smaller practices through the Small Business Administration) [https://perma.cc/M737-BXDZ].

[311] Section 1557 expanded the universe of the healthcare actors forbidden from discriminating to include the health insurance marketplaces and HHS-administered programs, in addition to recipients of federal financial assistance—which the law defines broadly to include "credits, subsidies, or contracts of insurance." 42 U.S.C. § 18116(a). Clinical research performed by researchers at a university or at a hospital that receives federal funding (including NIH funding) is also subject to antidiscrimination prohibitions. Joseph Liss et al., *Applying Civil Rights Law to Clinical Research: Title VI's Equal Access Mandate*, 50 J. L. MED. & ETHICS 101, 103 (2022).

[312] *See supra* text accompanying notes 42–45.

[313] *See supra* text accompanying notes 146–149.

Consulting HHS regulations on the provision of language assistance services to LEP individuals may also be helpful.[314] HHS guidance establishing an AFHE obligation must also be scalable to healthcare actors of widely varying size. Applying the guidance to providers whose receipt of federal funds is limited to reimbursement for services provided to a relatively small number of Medicare and Medicaid patients may provoke a distinctive challenge. Recall that equality directives serve in part to help federal funding recipients avoid disparately impacting racial or ethnic minority communities by their use of funds. A physician (or other individual provider) who treats relatively few Medicaid or Medicare enrollees might argue that her policies or practices could not produce a statistically demonstrable disparate impact.[315] Therefore, she might argue, the prophylactic rationale[316] for imposing an AFHE obligation does not apply to her.

However, limiting the AFHE obligation to healthcare actors receiving large amounts of federal funding is unnecessary. Section 1557 explicitly extends its prohibitions of discrimination to "any health program or activity, *any part of which* is receiving Federal financial assistance."[317] Consequently, if the federal government pays for a provider's treatment of any patient, the obligation not to discriminate applies to all patients, and a disparate impact analysis would consider impacts across his entire patient population.[318] HHS guidance should articulate how AFHE obligations can adjust to fit entities of varying sizes.

Moreover, an expressive argument supports applying the obligation to affirmatively further health equity to healthcare actors regardless of size. A healthcare equality directive would treat all federal funding recipients as having some responsibility to help address health disparities, and that is part of its value.

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[314] *See Section 1557: Ensuring Meaningful Access for Individuals with Limited English Proficiency*, DEP'T HEALTH & HUM. SERVS. (Aug. 25, 2016), https://www.hhs.gov/civil-rights/for-individuals/section-1557/fs-limited-english-proficiency/index.html [https://perma.cc/2XC4-HY9Z].

[315] *Cf. DOJ Clarifying Memorandum*, *supra* note 176 (reasoning that having only a small number of infrequent contacts with LEP individuals may preclude any significant national origin-based disparate impact by recipients of federal funding).

[316] *Cf.* Johnson, *supra* note 28, at 1352–54.

[317] 42 U.S.C. § 18116(a) (emphasis added).

[318] This is consistent with the approach taken in the Civil Rights Restoration Act of 1987, Pub. L. No. 100–259, 102 Stat. 28 (1988) (codified as amended in scattered sections of 20 U.S.C.), which clarified that prohibitions of discrimination contained in Title VI, Title IX, Section 504, and the Age Discrimination Act of 1975 apply to the entire operations of a federal funding recipient. Similarly, a health insurer that provides individual coverage on ACA exchanges, which is funded in part by federal subsidies, is prohibited from discriminating throughout its lines of coverage. *See* 42 U.S.C. § 18116(a).

Treating everyone who takes healthcare-related funds from the federal government as signing up to be on "Team Health Equity" comports with the "simple justice" rationale motivating Congress's enactment of Title VI[319] and other antidiscrimination laws tied to federal funding. Given the government's demonstrated history of complicity in creating and perpetuating health disparities, deputizing all healthcare funding recipients to participate in remedial efforts is appropriate.

C. Legal Challenges

Finally, HHS guidance creating an AFHE obligation for federal healthcare funding recipients could provoke a legal challenge, arguing that the guidance directs recipients to engage in conduct that violates antidiscrimination laws or is unconstitutional. Critics may also characterize guidance establishing an AFHE obligation as exceeding HHS's authority. At the very least, they may portray it as unwise and antidemocratic administrative overreach.[320] Fully assessing these challenges lies beyond this article's scope. Here, I simply offer brief preliminary thoughts.

1. Challenges to the Substance of the Affirmatively Furthering Health Equity Obligation

As discussed above, the statutory underpinnings for an obligation to affirmatively further health equity lie in antidiscrimination laws. More precisely, guidance establishing an AFHE obligation would assist federal funding recipients to comply with regulations proscribing conduct that has an unjustified or avoidable discriminatory effect.[321] Disparate

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[319] *See supra* text accompanying note 25.

[320] For assessments of this critique in the context of education civil rights, see generally Samuel R. Bagenstos, *This is What Democracy Looks Like: Title IX and the Legitimacy of the Administrative State*, 118 MICH. L. REV. 1053 (2020); Lia Epperson, *Undercover Power: Examining the Role of the Executive Branch in Determining the Meaning and Scope of School Integration Jurisprudence*, 10 BERKELEY J. AFR.-AM. L. & POL'Y 146 (2008). The Supreme Court has emphasized that agencies have a good deal of discretion in providing guidance regarding the types of impact that violate the law. Alexander v. Choate, 469 U.S. 287, 293–94 (1985) ("Title VI had delegated to the agencies in the first instance the complex determination of what sorts of disparate impacts upon minorities constituted sufficiently significant social problems, and were readily enough remediable, to warrant altering the practices of the federal grantees that had produced those impacts.").

[321] Federal agencies, including HHS, have issued regulations that include the disparate impact standard under each of the Spending Clause statutes identified as supporting an AFHE obligation (Title VI, Section 504, and Section 1557). Regulations proposed by the Biden Administration to implement Section 1557 also incorporate a disparate impact approach. This is not surprising, as regulations implementing the

impact's durability as a basis for liability under antidiscrimination statutes is uncertain, however. The most recent Supreme Court decision addressing the disparate impact theory narrowly upheld its availability in actions brought under the FHA.[322] Since that decision, however, an enlarged conservative majority on the Court has signaled its willingness to overturn precedent.[323] Conservative politicians and jurists have repeatedly signaled their goal of eliminating liability in the absence of proof of discriminatory intent.[324] In what may have been a near death experience for disparate impact liability, in the fall of 2021, defendants held liable under a disparate impact theory in a Section 1557 disability discrimination case argued an appeal all the way to the Supreme Court, only to withdraw it weeks before scheduled argument.[325] The withdrawal came at the urging of disability rights groups, who warned the defendants (which included drugstore giant CVS) of the harm that their victory in the case—potentially upending disparate impact—could cause to their reputations and to legal protections for disabled people.[326]

Even with disparate impact regulations intact, opponents may argue that, in calling for funding recipients to take affirmative steps to further health equity, HHS would exceed the relevant regulations' prohibitions on disparate impact. This argument would frame disparate impact regulations as purely negative in nature. Invoking the Supreme Court's 2009 decision in *Ricci v. DeStafano*,[327] opponents could even argue that taking steps to remedy racial

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statutory progenitors of Section 1557 (Title VI, Title IX, Section 504, and the Age Discrimination Act of 1975) all include disparate impact as a form of prohibited discrimination. *See Discriminatory Conduct – Title IX Legal Manual*, JUSTIA (Oct. 2022), https://www.justia.com/education/docs/title-ix-legal-manual/discriminatory-conduct/ (describing Title IX regulations) [https://perma.cc/4J3M-5M4N]; 45 C.F.R. § 90.12(b) (2024) (Age Discrimination Act rules). As discussed in Part IV, *supra*, the Supreme Court's decision in *Alexander v. Sandoval* severely undermined the potency of Title VI's disparate impact regulations by holding that no private right of action exists for their enforcement. 532 U.S. 275, 289 (2001). Nonetheless, the funding agencies responsible for enforcement can use administrative mechanisms to give force to those regulations.

[322] Texas Dep't of Hous. & Cmty. Affs. v. Inclusive Cmtys., 576 U.S. 519, 545–46 (2015).

[323] *E.g.*, Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2242 (2022) (overruling Roe v. Wade, 410 U.S. 113 (1973)).

[324] *See* Annalise Wagner, *Rolling Back DOJ's Title VI Protections: Trump's Abandoned Attempt and Potential Impacts on EJ Enforcement*, HARV. UNIV., ENV'T & ENERGY L. PROGRAM, (Apr. 16, 2021), https://eelp.law.harvard.edu/2021/04/doj-title-vi/ [https://perma.cc/EC59-ZPUR].

[325] CVS Pharmacy, Inc. v. Doe, 142 S. Ct. 480, 480 (2021) (mem.).

[326] Jessica L. Roberts & Hannah Eichner, *Disability Rights in Health Care Dodge a Bullet*, JAMA HEALTH F. (June 3, 2022), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2793006 [https://perma.cc/763P-VC79].

[327] Ricci v. DeStefano, 557 U.S. 557 (2009).

or disability-based health disparities could expose funding recipients to liability for discrimination.

Ricci held that an employer's good faith belief that taking race into account is necessary to avoid liability for disparate treatment discrimination will not by itself protect the employer for liability for disparate treatment discrimination.[328] In *Ricci*, after the administration of tests for promoting firefighters produced outcomes favoring white test takers, the City of New Haven rejected the tests in order to avoid potential liability for disparate impact discrimination.[329] But the Court viewed the City's action as itself a race-based decision that *prima facie* violated Title VII.[330] It reasoned that such disparate racial treatment could be justified only if the City had a strong evidentiary basis for believing that it would face disparate impact liability if it failed to take the race-conscious step.[331]

Opponents of an AFHE obligation might frame HHS guidance as directing federal funding recipients to take steps analogous to New Haven's rejection of its promotion tests. But *Ricci* should not be read either to preclude HHS guidance establishing an AFHE obligation or to expose healthcare actors following the guidance to liability for engaging in so-called "reverse discrimination." First, the *Ricci* majority effectively viewed the firefighter promotions at stake in the case as a zero-sum game with winners and losers. Because tests determining promotability already had been administered, the Court viewed test takers as having a legitimate expectation that the tests' results would be given effect.[332] Thus, rejecting the test results *post hoc* to protect Black and Hispanic test takers from a disparate impact would deprive some white test takers of their legitimate expectation of promotion, based on their race.

By contrast, steps to promote health equity will rarely be taken in a zero-sum context where improving health opportunity for communities experiencing health disparities requires removing health resources from other groups. More commonly, steps to improve health equity entail strategies to eliminate biased actions and structures from healthcare settings, to improve resource availability for socially disadvantaged communities, and to address negative social determinants disproportionately affecting historically marginalized groups. Steps to mitigate health disparities often

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[328] *Id.* at 581.
[329] *Id.* at 561–62.
[330] *Id.* at 585–86.
[331] *Id.* at 585.
[332] *Id.*

will benefit low-income white persons alongside low-income Black and brown persons. For example, psychiatrist and sociologist Jonathan Metzl describes how Tennessee, by not expanding Medicaid (a step that mitigates racial health disparities), harmed low-income white persons who would have benefited from the expansion.[333] *Ricci* also made clear that Title VII does not prohibit employers' *ex ante* efforts to design their practices to provide fair opportunity to all individuals.[334] By extension, healthcare actors who receive federal funds should be permitted to take steps to advance health equity in ways that do not upset legitimate expectations.

Opponents may also argue that guidance calling for recipients to take steps to "affirmatively further" health equity creates a form of affirmative action that would violate the Fourteenth Amendment's equal protection clause (if engaged in by a state actor) or potentially violate applicable antidiscrimination laws (if engaged in by a nonstate actor). This argument is bolstered by the Supreme Court's decision striking down the used of raced-based affirmative action in higher education admissions;[335] it also implicates the porosity between disparate impact and affirmative action analyses. [336] But this tightening of Supreme Court jurisprudence on affirmative action does not invalidate an AFHE obligation's ability to generate positive impact. The affirmative action cases prohibited only the use of race in admissions decisions. In contrast, health equity promoting measures that are neutral on their faces but that effectively readjust the tilt of a playing field should not be prohibited. The Court has held that a racially disparate impact, without evidence of discriminatory purpose, does not violate the Fourteenth Amendment.[337] As health policy researchers Sara Rosenbaum and Sara Smucker argue: "Although specific racial quotas are not possible, standards of fair treatment and equity-conscious planning are."[338] Indeed, many measures that would help remedy racial health disparities would also offer significant health benefits for white populations.[339]

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[333] *See* METZL, *supra* note 121.

[334] *Id.*

[335] Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll., 143 S. Ct. 2141, 2175 (2023).

[336] *Cf.* Jonathan Feingold, *Colorblind Capture*, 102 B.U. L. REV. 1949, 2000 (2023) (framing affirmative action in education not as a form of racial preference, but rather as a remedial device needed to level the playing field in light of lingering effects of historical intentional discrimination).

[337] Washington v. Davis, 426 U.S. 229, 242 (1976).

[338] Rosenbaum & Schmucker, *supra* note 70, at 784.

[339] *See* METZL, *supra* note 121.

2. Challenges to Health and Human Services Authority to Issue Affirmatively Furthering Health Equity Guidance

Issuing the proposed guidance establishing an obligation for federal funding recipients to affirmatively further health equity may also prompt a challenge based on the "major questions doctrine" that recent Supreme Court decisions have solidified. Although this doctrine's roots can be traced back decades, four opinions issued in 2021 and 2022 solidified it as a potent, if ill-defined, weapon for challenging administrative actions.[340] In simple terms, the major questions doctrine holds that a regulatory action of major national significance should not be upheld in the absence of a clear statement in the statute authorizing the action.[341] Thus, an opponent of AFHE guidance would likely argue that a regulatory mandate that recipients of federal healthcare funding take affirmative steps to further health equity would have major economic and political significance and that Congress has not clearly authorized such a mandate. This argument might cite the extraordinary amount and pervasiveness of federal funding of the healthcare sector[342] to bolster claims of the policy's economic significance. It might also argue that the obligation announced by HHS is novel and politically controversial.[343]

For several reasons, this challenge seems unlikely to succeed, at least under existing case law. Without establishing a clear standard for what administrative actions count as "major," the Supreme Court's recent employment of the major questions doctrine has looked skeptically on "assertions of 'extravagant statutory power over the national economy'"[344] and guarded against serious regulatory intrusions on the lives of tens of millions of private citizens.[345] The number of healthcare

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[340] *See* Mila Sohoni, *The Major Questions Quartet*, 136 HARV. L. REV. 262, 269–72 (2022). The four cases comprising the quartet are Ala. Ass'n of Realtors v. Dep't of Health & Hum. Servs., 141 S. Ct. 2485 (2021) (per curiam); Nat'l Fed'n of Indep. Bus. V. Dep't of Lab., 142 S. Ct. 661 (2022) (per curiam); Biden v. Missouri, 142 S. Ct. 647 (2022) (per curiam); and West Virginia v. EPA, 142 S. Ct. 2587 (2022).

[341] Sohoni, *supra* note 340, at 264.

[342] *See* Section I.D., *supra*.

[343] *Cf.* Daniel T. Deacon & Leah M. Litman, *The New Major Questions Doctrine*, 109 VA. L. REV. 1009, 1070 (2023) (describing a regulatory action's novelty and politically controversial nature as indicia of "majorness").

[344] West Virginia v. EPA, 142 S. Ct. 2587, 2609 (2022) (quoting Util. Air Regul. Grp. v. EPA, 573 U.S. 302, 324 (2014)).

[345] Nat'l Fed'n of Indep. Bus. v. OSHA, 142 S. Ct. 661 (2022) (per curiam) (challenging OSHA's temporary standard imposing COVID-19 vaccination and testing mandates on much of the national workforce).

sector actors to whom HHS's guidance would be directed (by virtue of their receipt of federal funds) is quite large, to be sure. But the guidance that this article suggests would be procedurally oriented, flexible in its application, and not legally binding. It would not upend the operations of the healthcare actors to whom it applies. Moreover, as noted above, many public and some private actors are already engaged in efforts to advance health equity, suggesting that such actions are not disruptive.[346] These points would support an argument that AFHE guidance would not warrant characterization as presenting a "major question."

More fundamentally, however, to date the Supreme Court has applied the major questions doctrine to agency regulations carrying the force of law,[347] not to subregulatory agency guidance. The AFHE guidance proposed by this article would set forth HHS policy regarding the agency's enforcement of its disparate impact regulations; the proposed guidance would not create new legal obligations or impose specific requirements. Thus, any challenge to an AFHE guidance would be more properly conducted under *Auer* deference, a standard that accords agencies significant latitude in interpreting their own ambiguous regulations.[348]

A related basis for challenging the validity of an AFHE obligation, at least as applied to state Medicaid agencies or other state entities, could be that obliging state agencies to take steps affirmatively to further health equity or risk losing federal funding would effectively coerce states' compliance. In so doing (the argument would go), the AFHE guidance would run afoul of the anticoercion standard for Spending Clause legislation applied (if not clearly defined)[349] in *NFIB v. Sebelius*.[350] There,

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[346] *See* discussion *supra* Sections IV.C.1–2; *see also supra* text accompanying notes 290–291.

[347] *See, e.g.*, Ala. Ass'n of Realtors v. Dep't of Health & Hum. Servs., 141 S. Ct. 2485, 2486 (2021) (per curiam) (addressing CDC's "nationwide moratorium on evictions"); *West Virginia*, 142 S. Ct. at 2592 (addressing EPA's regulation of greenhouse gas emissions as part of its Clean Power Plan); *Nat'l Fed'n of Indep. Bus.*, 142 S. Ct. at 662 (addressing OSHA's emergency temporary standard imposing COVID-19 testing and vaccination requirements on employers).

[348] The doctrine is derived from the case *Auer v. Robbins*, 519 U.S. 452 (1997). To be sure, a recent Supreme Court decision has also cast the future of the *Auer* standard into doubt. In *Kisor v. Wilkie*, 139 S. Ct. 2400, 2415–18 (2019), a narrow majority of the Court declined to overrule *Auer*, but established a new multistep framework for courts to use in assessing the deferential standard's applicablity.

[349] *See* Nicole Huberfeld et al., *Plunging into Endless Difficulties: Medicaid and Coercion in* National Federation of Independent Business v. Sebelius, 93 B.U. L. REV. 1, 8 (2013) (noting that the *NFIB* plurality opinion "expressly declined to articulate any test or rubric for deciding whether a Spending Clause program crosses the coercion line").

[350] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 576–77 (2012).

the Supreme Court held that the ACA's requirement that states expand eligibility for their Medicaid programs was unconstitutionally coercive, citing the huge amounts of federal Medicaid funding that states stood to lose (because of a provision of the Medicaid statute) if they refused to expand.[351]

In fact, termination of federal funding is one possible remedy for Title VI violations. But HHS has alternatives to that drastic step. It can investigate an alleged violation and negotiate a resolution agreement with the funding recipient,[352] or it can refer a violation to the Department of Justice to bring a lawsuit. Persons aggrieved by alleged intentional discrimination also can bring a federal lawsuit.[353]

The *NFIB* anticoercion ruling seems unlikely to block the proposed guidance that antidiscrimination prohibitions attached to federal funding call for affirmative steps to further health equity. In *NFIB*, Chief Justice Roberts accepted the plaintiff states' contention that the Medicaid expansion was in fact a substantively *new* program and that Congress was trying to bully states into adopting that new program by threatening to withhold funds from the preexisting Medicaid program.[354] This finding was central to the Court's conclusion that Congress had crossed the line from permissible conditional funding to impermissible coercion.[355] Distinguishing the ACA's expansion of Medicaid to cover a broad, undifferentiated swath of low-income Americans from pre-ACA enlargements of the Medicaid program that expanded eligibility for persons in discrete, statutorily defined categories,[356] Chief Justice Roberts wrote: "The Medicaid expansion . . . accomplishes a shift in kind, not merely degree."[357] In short, the anticoercion holding in *NFIB* rests on the conclusion that the Medicaid expansion was not simply the

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[351] *Id.* at 581. As in *NFIB*, guidance issued by HHS for federal funding recipients would not directly command states to regulate in a particular fashion and thus fits better within the *NFIB*/conditional spending line of authority rather than the anticommandeering line of authority. *Cf.* Andrew B. Coan, *Commandeering, Coercion, and the Deep Structure of American Federalism*, 95 B.U. L. REV. 1, 2–3 (2015) (explaining, in describing the Supreme Court's holding in *NFIB*, that although the anticommandeering doctrine and Congress's conditional spending power are different principles, congressional coercive use of the conditional spending power is essentially commandeering the states).

[352] *Recent Civil Rights Resolution Agreements & Compliance Reviews*, DEP'T HEALTH & HUM. SERVS., https://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/agreements/index.html [https://perma.cc/9D5Y-829T].

[353] *Title VI of the Civil Rights Act of 1964*, DEP'T JUST., https://www.justice.gov/crt/fcs/TitleVI [https://perma.cc/SQ6L-WVE3].

[354] *NFIB*, 567 U.S. at 582–83.

[355] *Id.* at 585.

[356] *Id.* at 583–84.

[357] *Id.* at 583.

adjustment of the requirements for an established program; rather, it represented the creation of a new program.

By contrast, state Medicaid programs and other recipients of federal healthcare funding have long been subject to prohibitions of discrimination based on race, disability, and age (and more recently, sex), including regulations prohibiting disparate impact discrimination. Calling on funding recipients to take steps to guard against violating those regulations represents, at most, a shift in the expected degree of care and consideration funding recipients should exercise to avoid discrimination. It does not smack of a "shift in kind," representing an entirely new obligation.[358]

In short, none of these bases for challenging HHS's authority to issue the proposed AFHE guidance appears compelling, at least under existing case law. The Court's project of dismantling the administrative state, however, may not yet be complete.

CONCLUSION

Each year, the federal government spends billions of dollars on healthcare, making payments to hundreds of thousands of health sector actors. By elucidating how federal funding and policy have contributed to persistent health disparities in the United States, this article makes the case that receipt of federal funding should come with some responsibility for working to ameliorate those inequities. Antidiscrimination laws provide a legal foundation for HHS to issue guidance directing healthcare funding recipients to take steps to affirmatively further health equity. In doing so, HHS could use as models obligations to engage in assessment and planning that already exist in the healthcare industry. Attaching this obligation to take steps to help remedy health inequities to the receipt of federal funds is a matter of "[s]imple justice."[359] The resulting sector-wide commitment to eliminating health disparities is a necessary component of achieving health justice.

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[358] I am grateful to Michael Coenen for suggesting this point to me.

[359] *See supra* note 26 and accompanying text.