2 of 2 DOCUMENTS

Hastings Race and Poverty Law Journal

Winter, 2013

Hastings Race & Poverty Law Journal

10 Hastings Race & Poverty L.J. 69

LENGTH: 23472 words

ARTICLE: The **Affordable Care Act and Beyond: Opportunities for Advancing Health Equity and Social Justice**

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LEXISNEXIS SUMMARY:

... Poorly managed chronic conditions or missed diagnoses result in avoidable, higher subsequent health care costs that impose cost burdens on public programs, individuals, and other purchasers of private health insurance. ... Expanding Access to Health Insurance The ACA's expansion of public and private insurance is monumental and has the potential to close the insurance coverage gap between whites and communities of color. ... Moreover, the states that will have the greatest number of newly eligible adults under health care reform are precisely those states that historically have been worse at finding and keeping eligible adults enrolled in Medicaid. ... Of this amount, $ 1.5 billion will support major construction and renovation projects at CHCs nationwide, while $ 9.5 billion will create new health center sites in medically underserved areas and expand preventive and primary health care services at existing health center sites (including oral health, behavioral health, pharmacy and/or enabling services). ... Future policy options to expand primary care providers in medically underserved communities should include: increasing funding for the NHSC; continuing financial incentives for all primary care physicians practicing in shortage areas; and increasing payment levels to primary care physicians caring for Medicaid patients in the early years of health reform. ... The legislation requires the HHS Secretary to ensure that, by March 30, 2012, any "federally conducted or supported health care or public health program, activity, or survey ... collects and reports data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants," as well as any other demographic data regarding health disparities. ... Some states prohibit health insurers from requesting such information from applicants to prevent the possibility of "redlining," whereby health plans bypass zip codes containing high minority populations. ... The ACA takes steps to increase the representation of underrepresented minorities in the health care workforce by reauthorizing Titles VII and VIII of the Public Health Services Act, which has been successful in increasing racial and ethnic diversity in the health care workforce, improving cultural competence, and encouraging health care providers to practice in medically underserved areas. ... The signatories agreed that environmental justice means that all communities facing pollution - particularly minority, low income and tribal communities - deserve the same degree of protection from environmental and health hazards, equal access to the federal decision-making process, and a healthy environment in which to live, learn, and work.

TEXT:

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Introduction

Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane.

- Dr. Martin Luther King, Jr. [n1]

It's been more than a decade since Congress first officially acknowledged that this country has a problem with race and health equity. [n2] In 1999 Congress asked the Institute of Medicine to investigate disparities in health and health status among racial and ethnic minorities. [n3] The results were damning: The ensuing study **[*70]** found that racial and ethnic populations had poorer health and were consistently receiving lower quality care, even when factors such as insurance status and income did not enter the picture. They were also less likely to receive lifesaving heart medications, bypass surgery, dialysis, or kidney transplants; but, they were more likely to have their feet and legs amputated as a treatment for late-stage diabetes. [n4] Moreover, the study acknowledged that racial and ethnic differences in health status reflect general patterns of social and economic inequality. [n5]

Before and since the release of this report, numerous studies have verified, almost without exception, disparities in any number of disease and treatment settings. [n6] Similarly, prescriptions for how health care payers, providers, and government agencies should begin to eliminate these health equity issues are hardly in short supply. Disparities in health persist largely because policy makers have failed to act.

From a political perspective, eliminating racial and ethnic health disparities is sensitive and challenging, in part, because they are intertwined with a messy and contentious history of race relations in America. Socioeconomic differences, differences in health related risk factors, environment degradation and direct and indirect consequences of discrimination are among the complex causes of these disparities. Racial and economic discrimination itself may be an important contributor to health disparities, not merely through the persistent and historical disadvantages it creates for communities color, but also specifically through health provider bias - conscious or unconscious, individual and institutional. [n7] The systemic inequities in social institutions, therefore, set the stage for inequitable health care in the United States.

Moreover, there is a prevalent and pernicious belief that poor health among some racial and ethnic minorities is due to "bad behavior," such as sedentary lifestyles, poor diet and substance abuse. Of course, healthy lifestyles are important to help prevent **[*71]** poor health and to effectively manage illness. However, the "bad behavior" explanation ignores the fact that persons of color are more likely than whites to live in communities where healthy eating and active lifestyles are difficult to achieve. [n8] These are communities where grocery stores or markets selling fresh fruits and vegetables are few and far between; where fast-food outlets and take-out stands dominate neighborhood food options; where safe parks and recreational facilities are uncommon, if non-existent; and where doctors and good primary care are hard to find. [n9] These problems are too often coupled with other neighborhood pathogens, including disproportionate liquor and tobacco advertising, and environmental health risks such as engine exhaust and commercial and industrial wastes. [n10] The health challenges posed by these conditions are profound and can overwhelm even the most ardent attempts to stay healthy.

After a year of intensive negotiations, Congressional hearings, White House conferences, nationwide rallies, and raucous town hall meetings, the most monumental health care legislation in forty-five years was enacted. The Patient Protection and **Affordable Care Act** [n11] ("ACA") makes changes great and small in virtually every important component of the American health care system. The new law's implications will not be known fully for many years because state governments and federal agencies are in the process of interpreting key provisions, drafting rules and devising general implementation strategies. And, uncertainty exists about the scope of the ACA because of the recent

Supreme Court ruling in National Federal of Independent Business v. Sebelius. [n12] While the court upheld nearly all of the provisions in the ACA, it also ruled that the federal government cannot withhold Medicaid funds from states that refuse to expand their Medicaid programs to cover individuals with incomes of as much as 133% of the federal poverty level as called for **[*72]** by the law. [n13] This Article makes no effort to explicate the effect of the new law's multifaceted components on the cost, quality and delivery of health care in physicians' offices, hospitals, nursing homes, and other health care settings. Instead, it seeks to analyze the most significant changes that affect communities of color and to examine the health equity and **social justice** implications of those changes. The goal here is to consider both the enhancements that have been created and the drawbacks or caveats that are attached to those enhancements.

The Article is organized in five Parts. Part I provides the moral and economic case for eliminating racial and ethnic health care disparities, and then catalogues the types of disparities that exist. Part II analyzes provisions in the new law designed to expand access to health insurance. The ACA extends health insurance coverage to an estimated 32 million people - roughly half of them through an expanded Medicaid program and the other half through a subsidized health exchange. Significantly, the Medicaid expansion will serve as a key building block to expanding health insurance coverage to communities of color: it extends eligibility to an additional 4 million African Americans, [n14] and an additional 8 million Hispanic Americans, respectively. [n15] Whether the incentives to Medicaid providers will be sufficient, the subsidies will be adequate, the insurance rules effective, and the enrollment efforts aggressive enough are decidedly open questions.

Part III focuses on the special access challenges communities of color face. As a general matter, access to health insurance often facilitates access to care, but coverage alone does not guarantee access to quality health care. Indeed, communities of color face additional access barriers, including a maldistribution of health care resources, a shortage of primary care providers, lack of a usual source of care, and an absence of culturally and linguistically competent providers. For example, a study of the availability of **[*73]** pain medication revealed that only one in four pharmacies located in predominantly nonwhite neighborhoods carried adequate supplies, compared to 72% of pharmacies in predominantly white neighborhoods. [n16] This section analyzes the ACA provisions that attempt to address these challenges to health care access; many are the side effects of racial and ethnic segregation.

Part IV examines key ACA provisions that are explicitly intended to reduce health disparities and improve the health of racially and ethnically diverse populations. The narrative that follows discusses these provisions and considers challenges that may lie ahead in implementing them. Finally, Part V argues that achieving health equity for racial and ethnic minority groups will require policy strategies focused outside of the health care arena. These include efforts to improve housing, community living conditions, food resources, nutrition options, conditions for exercise, recreation, and ultimately, to reduce economic and educational gaps. This section also gives concrete examples from the ACA and beyond, and provides recommendations on how to leverage federal spending to advance racial and ethnic equality.

I. Racial and Ethnic Health Care Disparities

Health care disparities are not new; throughout American history, law and social custom have relegated minority groups to different and inferior treatment. Health care is no exception. [n17] An important historical antecedent is the racially segregated medical care that arose during slavery. When emancipation ended the plantation system of segregated medical care, Jim Crow laws barred Blacks from the "white" health care system. [n18] Even less than 40 years ago, minorities routinely received inequitable care in segregated settings, if care was received at all. [n19] Today, some of these problems resulting from de facto discrimination have been **[*74]** ameliorated, but the contemporary health care context remains shaped by this history.

The maximization of health equity represents a central philosophical value. As a society, we profess a moral commitment to equality of opportunity. Through the principle of fair equality and opportunity, influential thinkers like Norman Daniels defend the role of medicine and public health to maintain or promote health because health "makes a significant contribution to protecting the range of opportunities open to all individuals." [n20] Because the principle of fair opportunity is to be applied to the entire population, Daniels argues that it justifies not only improving population

health, but also reducing health inequalities while doing so. [n21]

A second moral foundation is offered by proponents of a "capabilities approach" that aims to specify constitutional principles that should be adopted by governments as a minimum standard to adequately respect human dignity. [n22] Because health is central to the freedom to choose other functioning in life, these theorists argue that it is essential that governments promote health for all of its citizens. Where disparities exist, they should be minimized to ensure that all have a minimum level of human functioning, a prerequisite for doing all things they are essential to communities - social, political and economic. [n23] Finally, from an antidiscrimination perspective, the racial and ethnic disparities among similarly situated patients should trigger heightened moral scrutiny because these groups are "morally suspect categories" analogous to legal suspect categories in equal protection law. [n24]

Less obviously, minimizing inequities in health care access, quality and outcomes may well be good for the nation's fiscal health. Poorly managed chronic conditions or missed diagnoses result in avoidable, higher subsequent health care costs that impose cost **[*75]** burdens on public programs, individuals, and other purchasers of private health insurance. [n25] Some would dispute the claim that inadequately treated and managed diabetes can lead to far more expensive complications and treatments, such as kidney failure, requiring dialysis or transplantation. The Urban Institute estimates that in 2009, disparities between African Americans and Hispanics, compared to whites, cost the health care system $ 23.9 billion. [n26] Thus, by imposing substantial burdens on the economy, racial and ethnic health disparities inflict suffering on the entire society, not just the individuals who live sicker and die younger.

A. Access and Quality Disparities

Communities of color experience significant disparities relative to whites in both access to care and in the quality of care received. The National Healthcare Disparities Report (NHDR) is an authoritative source for the documentation of access and quality differences. [n27] Summarizing a range of measures, the 2010 report found that for some groups, such as African Americans and Latino/as, access to the health care system was worse than for whites in the preponderance of the study's measures. [n28] Latino/as experienced the greatest access problems of all ethnic groups; they received equivalent care as whites in only 17% of the measures, while the remaining access measures were overwhelmingly poorer for Latinos. [n29]

[*76] Turning to health care quality, communities of color again fared poorly relative to whites: African Americans and Latino/as received poorer quality care than whites on 40% and 60% of measures, respectively, and Asian Americans and American Indians (AI/AN) received poorer care on 20% and 40% of measures, respectively. [n30] More disturbingly, disparities in quality of care are not decreasing. Over time, the gap between whites and African Americans, Hispanics, Asian Americans, and AI/ANs has either remained the same or worsened for more than half of the core quality measures being tracked. [n31]

Although the NHDR provides a window to the health care experiences of communities of color, it fails to sort out the influences of race, income, and insurance. A substantial and growing body of evidence demonstrates that racial and ethnic minorities receive a lower quality and intensity of health care than white patients, even when they are insured at the same levels, have similar incomes, and present with the same types of health problems. [n32] The sources of these disparities are complex, rooted in historic inequalities, perpetuated through stereotyping and biases in the health care system, and aggravated by barriers of language, geography, and cultural familiarity. [n33]

For example, racial and ethnic differences in the treatment of heart conditions among similarly situated patients are particularly well documented. African-American heart patients are less likely than white patients to receive diagnostic procedures, vascularization procedures like cardiac catheterization, bypass graft surgery, and thrombolytic therapy. [n34] Timeliness to interventions is also critical when faced with heart attacks and minorities in general experience **[*77]** longer "door to-balloon" [n35] times for cardiac catheterizations than whites. [n36] The disparities in cardiac care may begin almost as soon as patients arrive at hospital emergency rooms; a 2010 study reports that African-American and Latino/a patients assessed for chest pain were less likely than white patients to be categorized as requiring immediate care,

despite a lack of significant differences in symptoms. [n37]

Even routine care suffers. Black and Latino patients are less likely than whites to receive aspirin upon discharge following a heart attack, [n38] to receive appropriate care for pneumonia, [n39] and to have pain - such as the kind resulting from broken bones - appropriately treated. [n40]

Communities of color are also burdened with a higher prevalence of chronic diseases that require treatment in long-term care facilities. Diabetes, for example, is a serious, costly, and potentially preventable public health problem. Both the prevalence and incidence of diabetes have increased rapidly with racial and ethnic groups experiencing the steepest increases and most substantial effects from the disease. [n41] In 2005, both African-American and Hispanic adults were twice as likely as white adults to have been diagnosed with diabetes by a physician and also twice as likely to start treatment for end-stage renal disease related to diabetes. [n42]

[*78]

B. Health Insurance Disparities

Persons of color comprise about one-third of the nation's population; however, they make up over half of the millions uninsured. [n43] In 2005, nearly two-thirds of Hispanic adults (15 million) and one-third of African Americans (6 million) were uninsured compared to 20% of white adults. [n44] People of color are less likely to have health coverage through an employer, in part because they are more likely to be unemployed; however, when employed, they are more likely to work low-wage jobs, which rarely offer coverage. [n45] The uninsured often postpone health care, which is one reason people of color are diagnosed at more advanced stages of diseases, and once diagnosed, receive poorer care. Many more of these Americans do not have a usual source for health care, have substantially higher unmet health needs, and high out-of-pocket costs. [n46]

Compared to the insured, a larger percentage of the uninsured report problems paying medical bills. They also report relying on home remedies rather than seeking the care of a doctor, skipping dental care, and not filling a prescription due to cost. [n47] African Americans and Latino/as compared to whites are more likely to report experiencing these problems. [n48]

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II. Expanding Access to Health Insurance

The ACA's expansion of public and private insurance is monumental and has the potential to close the insurance coverage gap between whites and communities of color. This, in turn, has the potential to increase access to care, leading to improvements in health and a reduction in disparities. The law extends health insurance to an estimated 32 million people - almost half of them through an expanded Medicaid program providing coverage to all families with incomes below 133% of the federal poverty level, no matter the state they live in. [n49] In addition, the law establishes a health insurance marketplace that actually protects people when they're sick, ending insurers' ability to deny protection or cut off benefits when people need them most. To make private insurance coverage affordable, the law provides subsidies and tax credits that will be especially beneficial to lower-and middle-income persons of color. [n50]

The ACA's insurance coverage commitments will not be easy to achieve. Of those individuals newly eligible for Medicaid, a disproportionate share live in medically underserved urban communities where the health care risks are higher and the primary care resources are insufficient. Further, the contentious partisan politics that characterized the battle for enactment continue unabated in implementation. Medicaid makes a convenient target for conservative politicians because it represents many of the ideological right's lightning rods for outrage: federal control, major government spending, and a means-tested program that they view as rewarding poverty.

A. Medicaid

Among the most important provisions for reducing health disparities for low-income people of color is the expansion of **[*80]** Medicaid, the nation's safety net health insurance program. Medicaid provides federal financial assistance to states operating approved medical-assistance plans. [n51] The federal government contributes from 50% to 83% of Medicaid program costs (depending on the per capita income of the state) with the state covering the rest. [n52] Federal statutes and regulations establish basic requirements for eligibility, benefits, payment, and administration, but significant differences exist among the states in virtually all aspects of the Medicaid program. [n53]

Medicaid currently covers only a small percentage of poor, non-elderly adults; over the period 2006 to 2007, the program reached only 27.7% of these individuals. [n54] Absent a waiver, no federal funds are available to help states finance medical care for poor, non-elderly adults, unless they are pregnant, disabled, or parents or caretakers of a minor child. [n55] A few states have such waivers, but in forty-two states, childless adults cannot qualify for Medicaid. [n56] In addition, the current Medicaid program lacks a uniform definition of poverty for adults. For children and pregnant women, the program establishes a national income-eligibility ceiling of 133% of the federal poverty limit (FPL). [n57]

For those adults who do not fall into existing coverage categories, some states have restrictive Medicaid eligibility standards that allow coverage for only the very poorest of the poor. The income-eligibility threshold can be as low as 17% of the FPL for working parents. In addition, many of these are also the states with large numbers of racially and ethnically diverse populations. [n58]

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1. Medicaid Enhancements

The ACA extends and simplifies Medicaid eligibility beginning in 2014. The law replaces Medicaid's previous, multiple categorical groupings and limitations with one simplified overarching rule: All individuals under age 65 with incomes under 133% of the FPL who meet U.S. citizenship and state residency requirements, are entitled to medical assistance. [n59] Significantly, the Medicaid expansion will serve as a key building block to expanding health insurance coverage to communities of color; it will extend eligibility to an additional 4 million African Americans, [n60] and an additional 8 million Latinos/Hispanic Americans. [n61]

Although undocumented immigrants represent about 15% of the nation's 47 million uninsured, [n62] the legislation maintains the status quo; these individuals can get emergency care through Medicaid, but they cannot receive nonemergency care unless they pay. [n63] The RAND Corporation estimates that roughly 38% of those who remain uninsured after final implementation will be Medicaid eligible but not enrolled in it; they are people who have simply fallen through the cracks. [n64]

Without question, the Medicaid expansion is an important first step toward the goal of eliminating racial and ethnic health care **[*82]** disparities. A recent study by the U.S. Bureau of Economic Research shows that expanded access to Medicaid increases the utilization of health care resources (including primary and preventative care), decreases financial stress and results in across-the-board improvements in self-reported physical and mental health, including "a general sense of improved well-being." [n65] The authors are careful not to predict from their research the likely outcomes of the 2014 Medicaid expansion built into the ACA. [n66] The study also exposes serious defects in the partisan claim that Medicaid is "worse than no coverage at all," or is a "health care gulag." [n67] No one denies that Medicaid contains flaws and deficiencies, and needs improvement; however, its greatest detractors rarely propose improvements, only cuts or abandonment.

2. Implementation Challenges

Three topics deserve particular attention in assessing whether the ACA's Medicaid expansion will advance health equity. First, the issue of provider payments and incentives looms large. [n68] While varying from state to state, Medicaid

physician payment rates have **[*83]** traditionally trailed those of both Medicare and employer-sponsored insurance. After controlling for inflation, Medicaid physician fees declined from 2003 through 2008. [n69] Because reimbursement is lower, many doctors do not participate in the program or greatly restrict the number of Medicaid patients they treat. [n70] As a result, Medicaid enrollees often seek care from hospital emergency rooms, federally qualified health centers, or other safety-net institutions.

The ACA attempts to confront the provider payment issue by requiring states to establish Medicaid payment rates for primary care doctors practicing family medicine, pediatrics, or general internal medicine - that achieve parity with Medicare rates in 2013 and 2014. [n71] The federal government will absorb 100% of the added costs. [n72] However, because states set Medicaid provider payment rates, the new policy will have widely different impacts on physicians and provide different incentives to serve additional enrollees. Primary care physicians in states with lower Medicaid-to-Medicare fee ratios will benefit more from the policy than those in states where there is greater existing parity between the two programs' reimbursement rates. [n73] The ACA's changes to provider payment may improve Medicaid provider participation in the short-term, but it does not address the long-term problem. Unless Medicaid payment yields rates that motivate specialists and other **[*84]** providers to serve the program's enrollees, troubling issues of access and quality disparities will continue.

To complicate matters further, about a dozen states are currently seeking to shore up budget shortfalls by reducing already low payments to doctors, hospitals and other health care providers. [n74] In response, the Obama Administration recently issued a proposed rule that aims to provide guidance on how to assure access to Medicaid beneficiaries. [n75] The introductory section makes clear that the administration does not intend to prevent states from cutting Medicaid provider payments. [n76] From there the rule proposes a general requirement that states considering cuts show that Medicaid recipients will have "sufficient access" to care after the provider cuts. [n77] Influential health law scholars like Sara Rosenbaum have slammed the rule, characterizing it as a deeply flawed "information gathering exercise" that lacks measurable standards, meaningful reporting requirements, and enforceable sanctions. [n78] Physicians across the country have also reacted, emphasizing that without adequate payment rates, Medicaid beneficiaries may have coverage but not real access to care. [n79]

From a health equity perspective, there is little to commend. Further reductions in payment rates can only worsen existing disparities because many of the states considering cutting rates already have severe Medicaid physician shortages. [n80] Provider payment cuts will also disproportionately burden communities of color because they already face severe shortages of physicians and hospitals. The proposal clearly elevates states' short-term fiscal concerns over the quality and access demands of communities of color.

[*85] Second, lagging commitment and capacity in some of the most populous states could jeopardize the Medicaid coverage expansion. States have long manifested vast differences both in their commitment to Medicaid and their capacity to serve enrollees. [n81] Some states have proven much more committed and administratively effective than others in enrolling and retaining those who qualify for Medicaid. Participation rates range from just under 44% in Oklahoma, Oregon, and Florida to 80% in Massachusetts and 88% in the District of Columbia. [n82] The take-up challenge under the ACA will be far from trivial. Moreover, the states that will have the greatest number of newly eligible adults under health care reform are precisely those states that historically have been worse at finding and keeping eligible adults enrolled in Medicaid. [n83] Low-income persons of color already face a host of enrollment obstacles including: completing the long and complicated Medicaid application; finding translators to assist in completing the application process; and obtaining reliable transportation to apply for Medicaid or to secure the documents needed to apply. [n84] Though the details of enrollment outreach, application processes, and renewal procedures may not be glamorous, they hold the key to success and demand strong and creative leadership from the federal government, states, grassroots activists and **social justice** advocates.

In terms of capacity, eight states - Oklahoma, Georgia, Texas, Louisiana, Arkansas, Nevada, North Carolina, and Kentucky - face the greatest challenges. [n85] These states are expected to have large Medicaid expansions yet now have weak primary care capacity. [n86] In addition, most of these states have large populations of racial and ethnic minorities.

In the absence of additional efforts, the demand for care by newly eligible patients could be substantially greater than **[*86]** the supply of primary care providers in these states. n87

Third, the outcome of the political struggle over Medicaid in the wake of National Federation of Independent Business v. Sebelius (hereinafter NFIB v. Sebelius) will help determine the success of the Medicaid expansion. Likely the "biggest of the many surprises" found in NFIB v. Sebelius was the Court's conclusion that the ACA's Medicaid expansion scheduled for 2014 is unconstitutional. n88 Before the case was decided, most attention was squarely focused on whether the Court would uphold the individual mandate requiring all individuals to obtain health insurance coverage. n89 In the wake of the Court's decision, however, whether states will refuse to participate in the Medicaid expansion is a major issue, given the Court's conclusion that the Department of Health and Human Services ("HHS") Secretary cannot enforce the expansion as a mandate. n90

The twenty-six state petitioners argued that the Medicaid expansion exceeded Congress's authority under the Spending Clause because Congress' threat to withhold all Medicaid funding if the states did not participate coerced the states and therefore was unconstitutional. n91 Chief Justice John Roberts, joined by Justices Stephen Breyer and Elena Kagan and supported by a joint dissent from Justices Antonin Scalia, Anthony Kennedy, Clarence Thomas, and Samuel Alito, held that the states must be free to accept or reject federal funding and the ACA Medicaid expansion crossed this line. n92 The Court distinguished South Dakota v. Dole where the federal government conditioned receipt of highway funding on states raising their drinking age to twenty-one. n93 There, the funding in question was less than 1% of a state's overall budget, whereas the Medicaid funding at issue often accounts for over 20% of a state's **[*87]** total budget. n94 Justice Ginsburg argued in dissent that the ACA simply changed the rules of the already established program, but Justice Roberts characterized the ACA Medicare expansion as a change so fundamental in scope and nature that it was an entirely new program. n95

After finding the Medicaid expansion unconstitutional, the court did not strike the provision as the dissenting justices wanted. n96 The ruling simply prevents the HHS from requiring that all states participate or risk losing existing Medicaid funds. n97 As a practical matter, the ruling turns the expansion into a voluntary option for the states. n98

Some Republican governors have made noise they will opt out of the Medicaid expansion. n99 These pronouncements are consistent with a recurring line of partisan attack that the 2014 expansion will explode state budgets in the long term. Republicans have estimated that the expansion will cost state taxpayers an additional $ 118.4 billion through 2023. n100 However, according to the non-partisan Congressional Budget Office, the additional cost to states represents only a 1.25% increase in what states would have spent on Medicaid from 2014 to 2019 in the absence of health reform. Moreover, the CBO estimates that the federal government will assume 96% of the costs of the Medicaid expansion over the next ten years. n101 **[*88]** Nonpartisan budget experts have noted that the Republican estimate cherry-picks the worst-case scenarios from various studies that use different time frames and rely on flawed assumptions. n102

Further, the role of the federal government in bearing most of the expansion cost is clear in the statutory design. The federal government will cover 100% of the costs to states for the newly eligible population for the first three years, between 2014 and 2016. n103 The federal government will then cover 95% of all costs in 2017, n104 94% in 2018 n105 and 93% in 2019. n106 In 2020 and for every year following that, the federal government will pay 90% of all costs for the newly covered Americans. n107 Moreover, states that have been historically generous in providing coverage for low-income people will be rewarded. They will receive a higher federal match rate for the coverage they were already providing to adults without dependent children. n108

The Obama administration is putting pressure on the states to participate in the expansion, telling them that while there is no deadline for participation, they could lose federal funding if they delay. n109 The outcome of the 2012 presidential election is also likely to determine the fate of the expansion. Republican presidential candidate Mitt Romney pledged to repeal the ACA, cut Medicaid funding, and give each state a block grant. n110 Although the political strength of Medicaid has grown, unlike Medicare, the program does not have a large enough or consistent bloc of

advocates whose vote could make a difference.

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B. The Health Exchanges

The ACA creates a new marketplace - the health exchange - where individuals and families will be able to shop and compare health coverage policies. [n111] This is quite similar to the way members of Congress obtain health insurance. The law requires insurers to provide certain essential health benefits that will be equal to the scope of benefits provided under a typical employer plan. [n112] The essential benefits will be defined by the HHS Secretary, but the legislation specifies that it will include hospitalization, professional services, prescription drugs, rehabilitation services, mental health and substance use disorders services, and maternity care. [n113] In general, insurers will also be required to sell plans that provide payment, on average, of at least 60% of the total costs of covered benefits (60% actuarial value). [n114]

However, the creation of a "public option" insurance plan is noticeably absent. The "public option" is a hotly debated reform, which proponents argued would introduce much needed competition into the health exchanges. [n115] Instead, the ACA gives states various options to create their own new insurance plans and mandates that the Office of Personnel Management contract with insurance carriers to assure that at least two "multistate plans" are **[*90]** offered in every health insurance exchange in each state. [n116] It also enables the creation of non-profit Consumer Owned and Oriented Plans - co-ops. [n117] The law encourages that co-ops be statewide or in geographic regions throughout the country and provide loans and grants to help with start-up costs. [n118]

1. Premium Credits and Subsidies

To ensure that coverage in the health exchange will be affordable, premium credits will be available for individuals and some small businesses starting in 2014. [n119] Individuals are eligible for a sliding scale premium tax credit and cost-sharing reduction if their modified adjusted gross income is no greater than 400% FPL, they are not eligible for public coverage, and they do not have access to affordable employer-sponsored insurance. [n120]

Today, nearly half of the 16 million uninsured adults with incomes between 150% and 399% FPL belong to communities of color. [n121] The federal decision to subsidize the insurance purchased through the health exchange distributes federal resources in a way that is likely to move toward equalizing the health outcomes of persons of color with the outcomes of their more advantaged counterparts. In addition, the ACA ensures that premium credits are available to individuals and families at the time they purchase health coverage: The U.S. Department of the Treasury will make payment directly to the insurance company. [n122] This advance payment provision is especially important to racial and ethnic minorities due to wealth differences - the median wealth of white households is 20 times that of Black households and 18 times that of **[*91]** Hispanic households. [n123] These individuals would be far less likely to have sufficient cash on hand to pay the full premium upfront.

The ACA also removes all cost-sharing requirements for American Indians and Alaska Natives at or below 300% of the FPL, which is roughly $ 66,000 for a family of four ($ 83,000 in Alaska). [n124] While American Indians and Alaska Natives have long been entitled to medical care through the Indian Health Service (IHS), chronic under funding has limited the services it can provide and many IHS facilities only offer primary care services. [n125] Removing cost sharing requirements has the potential to improve access to health insurance and health care for the approximately 1.1 million American Indians and Alaska Natives that are at or below 300% FPL. [n126]

Finally, the ACA explicitly puts forth a mandate for nondiscrimination in federal health programs and health exchanges by directly incorporating numerous civil rights laws. [n127] This incorporation makes clear that health plans that receive federal premium tax credits are bound by existing federal civil rights laws applicable to other federally assisted programs. [n128] Moreover, because existing law reaches both intentional and de facto discrimination, the health exchange nondiscrimination provisions should be interpreted in a fashion that parallels existing civil rights law. [n129]

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2. Implementation Challenges

While the health exchange holds promise to reduce disparities in insurance coverage, targeted efforts will be necessary to ensure that persons of color are enrolled and take full advantage of benefits for which they are eligible. [n130] The health exchanges defined in the federal law are modeled on the Commonwealth Connector - the online marketplace created in 2007 for Massachusetts's health care reform. [n131] However, an important lesson from Massachusetts is that consumers using the health exchange will require considerable levels of education and support beyond customer support. [n132] In Massachusetts, consumers required significant levels of education about the health care reform program and the benefits and choices available, as well as more traditional customer support that focused on how to interact with the website and use the available tools. [n133]

The ACA explicitly recognizes that some consumers will need personal assistance to make educated decisions about their needs and the value of plans and establishes a navigator program as part of the health exchanges. [n134] The federal law proposes that groups navigate the exchange, including the chambers of commerce, unions, brokers, and community and consumer-focused nonprofit groups, chambers of commerce, unions, community-based organizations. [n135] Now, the work is making sure that states choose navigators that are **[*93]** appropriate to serve the needs of communities of color who will get insurance through exchanges.

More fundamentally, the health exchange will increase access only if the insurance coverage available is affordable. However, this issue is fraught with complexity and implicates a host of economic, consumer choice, and personal finance issues. Using a budget-based approach, MIT economist Jonathan Gruber found that after paying for necessities an overwhelming majority of low-income households have room in their budgets for health insurance premiums and moderate levels of out-of-pocket costs established by the ACA. [n136] Of particular importance, Gruber found that sicker low income individuals are unable to pay for premiums and typical out-of-pocket costs without reducing spending on necessities. [n137] This conclusion suggests that while the subsidies will make insurance affordable, the out-of-pocket expenses and cost-sharing will leave sicker individuals of color more vulnerable.

The affordability issue is also closely tied to the most controversial aspect of the ACA, the individual mandate, which requires that most people in the U.S. purchase health insurance coverage. [n138] Elementary health care economics informs us that if people who are in better health can opt out of the market and effectively gamble that they can pay for whatever health care they need at the point of service, prices rise in the health exchange for those who are in poorer health, leading to an "adverse selection" [n139] spiral that raises insurance prices for all. [n140]

[*94]

3. Insurance Market Reforms

Other provisions likely to play an important role in reducing health insurance coverage disparities focus on employer-based health insurance reforms. Again, race and ethnicity matter here. For example, the most recent data shows that while 71% of working-age whites obtained health insurance at work; only one-third of working-age Hispanics and half of working age African Americans had employer-sponsored coverage. [n141] The ACA requires employers with 50 or more employees to offer coverage to employees or pay a penalty for any full-time employee who receives a premium tax credit for purchasing their own coverage through exchanges. [n142] Large employers with 200 or more employees are mandated to automatically enroll employees into their health insurance plans. [n143] Finally, small employers with 25 or fewer employees and average annual wages of less than $ 50,000 will be provided a tax credit. [n144]

These employer mandates have the potential to expand coverage for sizeable numbers of low-income populations of color. Racial and ethnic minorities are more likely to be employed by a small firm that does not offer health

coverage. This is particularly true for minority owned firms; over 90% have fewer than 25 workers. [n145] Even if insurance is offered, persons of color are more likely than whites to decline coverage because of the high cost of **[*95]** health insurance purchased in the small group market. Indeed, data on workers in small firms indicates that approximately 57% of Hispanics, 40% of African Americans, 40% of AI/ANs, and 36% of Asians have declined employer-sponsored coverage, compared to 24% of whites. [n146] The availability of a small employer tax credit should help lower the cost of purchasing insurance in the group market and thereby decrease the cost to both the employer and the employee.

III. Expanding Access to Care

Standing by itself, expanding health insurance coverage is certainly a necessary condition for achieving health equity; but it is not a sufficient one. Communities of color face a host of additional barriers when seeking access to quality health care. For example, physicians who serve predominantly racial and ethnic minority patients have greater difficulties accessing high-quality specialists, diagnostic imaging, and nonemergency admission of their patients to the hospital than physicians serving predominantly nonminority patients. [n147] Nearly one in five Latinas (18%) and one in ten African-American women reported not seeking needed health care in the last year due to transportation problems, compared to 5% of white women. [n148] These problems are the by-product of residential segregation and economic pressures that reward the concentration of services in outer suburbs and wealthier communities, and create disincentives for practice in urban centers. [n149]

In addition, some empirical evidence suggests that having a usual source of care is more strongly associated with better access to and receipt of primary care services than is insurance coverage. [n150] **[*96]** Yet more than half of Hispanic adults report not having a regular doctor even when insured - a rate that is 2.5 times greater than the proportion of whites. [n151] Moreover, when compared to whites, Hispanics and African Americans are much less likely to receive care in a private doctor's office and more likely to seek medical care in community health centers or hospital emergency rooms. [n152]

A. Community Health Center Expansion

Hidden jewels in the new federal law are provisions that increase funding for community health centers (CHCs). The ACA provides $ 11 billion to bolster and expand CHCs over the next five years. [n153] Of this amount, $ 1.5 billion will support major construction and renovation projects at CHCs nationwide, while $ 9.5 billion will create new health center sites in medically underserved areas and expand preventive and primary health care services at existing health center sites (including oral health, behavioral health, pharmacy and/or enabling services). [n154] By 2015, CHCs will double their current capacity and serve 40 million at-risk low-income individuals and reach approximately one-third of those currently considered medically disenfranchised. [n155]

Doubling the capacity has powerful implications. CHCs are the essential primary care medical homes for millions of vulnerable Americans. [n156] Because two-thirds of the patient population is non-white, the expansion should significantly increase access for millions **[*97]** of individuals of color. [n157] Moreover, the total capacity of community health centers will for the first time ever exceed the total number of uninsured. [n158] This is nontrivial. It means that even those individuals who cannot obtain affordable insurance under the ACA will still be able to obtain health care. In fact, it's the CHC expansion that has the potential to fulfill the age-old progressive mission of health care for all.

Community health centers are an incredibly good investment because they bring a unique and comprehensive approach that has delivered proven cost-savings, improved patient health, and reduced visits to hospital emergency rooms for over 45 years. [n159] National estimates of the impact of CHCs on controlling health care costs played an important role in Congress' decision to invest in the health center expansion. [n160] Empirical evidence also strongly suggests that expanding CHCs will create jobs and stimulate economic activity in some of the most economically disadvantaged communities in the country. [n161] A consequential value of expanding CHCs is to increase the "dollar efficiency" of the health care reform legislation.

However, several qualifications are in order. As CHCs expand their range and reach, patients will need better access to a continuum of care, including specialty services. While CHCs are able to provide primary care, they report difficulty in connecting their patients to diagnostic testing and specialty care, even when **[*98]** patients are insured. n162 Indeed, 79% of CHCs report difficulty in obtaining specialist access for Medicaid patients, and 60% reported difficulty for Medicare patients. n163 Having access to a specialist is especially important for populations of color, since they have higher rates of mortality and disproportionately suffer from conditions such as HIV/AIDS, diabetes, heart failure, and stroke. As Medicaid eligibility and coverage expand, improved access and communication between specialty care providers, local hospitals, and diagnostic facilities are critical to coordinate patient care beyond a health center's walls.

While potentially serious, these issues and impediments are not insurmountable. Beyond merely investing in health center growth, the ACA provides numerous opportunities for these entities to enter into more integrated and innovative community-based partnerships that broaden and secure patient access to the full continuum of health care services. n164 The legislation provides new funding for networks comprised of a hospital and a CHC to provide comprehensive, coordinated, and integrated health care services for low-income populations. n165 In addition, it provides funding for hospitals to form patient-centered medical homes and allows for community providers such as CHCs to support primary care practices within the hospital service areas. n166 Furthermore, it provides funding to establish or expand primary care residency training programs in CHCs and encourages their permanent placement in these settings. n167

Collectively, these initiatives reflect the priorities of the Health Resources and Services Administration, the federal agency that **[*99]** oversees the CHC program. The agency has emphasized that collaboration is critical to ensuring the effective use of limited health center resources, providing a comprehensive array of services, and gaining access to critical assistance and support. n168

B. Workforce Development

As the number of the newly insured expands, many of those who gain health insurance coverage will be catching up on long overdue health needs. This pent-up demand is likely to strain the nation's health care workforce, particularly in communities where primary care providers are in very low supply already. n169 Labor analysts estimate that as many as 7,000 additional primary care physicians are currently needed in medically underserved areas. n170

The ACA takes key immediate steps to address the sufficiency of the primary care workforce. First, the legislation attempts to increase the number of primary care clinicians largely through loan repayment programs, training grants, and expansions in the National Health Service Corps Program (NHSC). n171 The NHSC scholarship program covers tuition, fees, and costs for students enrolled in a medical degree program. n172 After graduation, scholarship recipients are expected to work for up to four years as a primary care physician in an area of need. n173 Nearly half of NHSC clinicians fulfill their service commitment at community health centers. n174

Second, the ACA provides direct financial incentives to primary care providers. As discussed in Part II of the Article, Medicaid payment rates for primary care physicians will be raised to **[*100]** the level of Medicare payment rates for equivalent primary care services in 2013 and 2014; this change is intended to encourage physicians who already accept Medicaid insurance to continue accepting it, and to persuade those who do not to begin accepting Medicaid. n175 Between January 1, 2011, and December 31, 2016, the legislation increases Medicare Part B payments for primary care services and provides providers a 10% bonus for performing certain primary care services. n176

Third, the legislation envisions that the nursing profession will play a large and critical role in directly providing primary care services. n177 The ACA dedicates additional funds for Nurse-Managed Heath Centers (NMHC). n178 Community-based clinics run by advanced primary care nurse practitioners have grown over the past couple of years, providing a full range of primary care services that are comparable to services provided by primary care physicians. n179 Over half of the patients seen at NMHCs are women of color that are likely to have unmet health needs. n180 Evidence-based research has shown that these advanced practice nurse providers at NMHCs provide high-quality

primary care and women's health with outcomes that are similar to or better than other primary-care care and women's health providers. [n181]

While these workforce initiatives could provide much needed help to communities of color, it is likely that additional efforts will be needed to address both the current health professional shortage, and the increased demand for services resulting from the new legislation. Training programs will likely take many years to increase the primary care workforce, but the need for these providers will be more immediate. Future policy options to expand primary care providers in medically underserved communities **[*101]** should include: increasing funding for the NHSC; continuing financial incentives for all primary care physicians practicing in shortage areas; and increasing payment levels to primary care physicians caring for Medicaid patients in the early years of health reform. However, given the austerity fever currently sweeping Capitol Hill, additional congressional appropriations of this sort are highly unlikely.

C. Essential Community Providers

The new federal law requires that health plans competing in the health exchange include in their network of providers "essential community providers" who serve predominantly low-income and medically underserved populations. [n182] Originated as part of the Clinton health reform plan, the term describes health care providers that through legal obligation or mission, and patient population characteristics, play a significant role in providing health care for patients and populations at disparate risk for inadequate access. [n183] Examples of patient populations reached by essential community providers include uninsured and underinsured persons, residents of medically underserved urban and rural communities that experience primary health care shortages, persons with HIV/AIDS, high risk pregnant women and newborns, and farm workers and their families. [n184] The purpose of the provision is to assure that health plans competing within the health exchange, whose service areas include such providers (and therefore include at-risk populations who depended on them), will not exclude them from their provider networks. [n185]

A June 2011 HHS regulation follows the ACA and requires health plans to include a sufficient number of essential community providers who provide care to predominantly low-income and medically underserved populations. [n186] The rule defines essential community providers to include community health centers, public **[*102]** hospitals, sole community hospitals meeting disproportionate share adjustment payment thresholds, children's hospitals, among others. [n187] HHS is also considering broadening the definition to include additional providers that serve these populations. [n188]

In addition, HHS is currently debating whether to include broad contracting language that would either require a health plan to contract with all essential community providers in each plan's service area, or establish a requirement for issuers to contract with essential community providers on an any willing provider basis. [n189] The benefit of such a rule to communities of color is clear. It would allow continuity of care for enrollees with existing relationships with essential community providers such CHCs. In addition, to the extent that essential community providers serve people who are eligible for Medicaid, the presence of those providers in networks of health plans would allow people to maintain provider relationships in the event that an income change made them eligible for tax credits and private plans in the exchange, or vice versa. [n190]

However, the rule falls short in one important area - it fails to establish any parameters surrounding what constitutes network sufficiency for essential providers either by stipulating a provider to member ratio or with requirements related to geographic distribution. For now, the regulations leave states to determine participation requirements; however, the rule asks for comments on how HHS should define "sufficient."

Finally, the provisions within the ACA that define health plan contracting duties and responsibilities miss an opportunity to deal with the very serious complaint of some African-American, Latino/a and Asian-Americans physicians that health plans effectively discriminate against them. [n191] Evidence supports the claim that health plans exclude a disproportionate number of physicians of color from physician provider networks nationwide, by using race **[*103]** neutral hiring and firing criteria; exclusion devalues the products of these physicians and the preferences of minority health consumers. [n192] Existing Civil Rights laws have proven to be ineffective in providing a remedy.

Unfortunately, the ACA maintains the status quo.

IV. Disparities-Specific Provisions

A. Increasing the Visibility of Disparities

One of the fundamental difficulties in minimizing health care disparities is that the problem is invisible. Government agencies, health care providers, health plans, and insurers do not routinely collect race and ethnicity data, even though no federal and few state laws prohibit collection. Although Title VI of the Civil Rights Act of 1964 [n193] broadly prohibits discrimination on the basis of race, ethnicity, or national origin by federally funded entities and programs, it does not require data collection; nor does it require that covered entities follow any particular methodology when doing so. [n194]

Significant gains in reducing disparities require a much keener awareness of the nature and extent of existing disparities. Collecting data related to racial and ethnic differences in access, outcomes, choice of diagnostic, and treatment alternatives, can help identify potentially discriminatory practices; moreover, whether they are the result of intentional behaviors or unintended but no less harmful biases and practices that result in racial differences in care that are unjustified by patient preferences or clinical need. [n195] All health care is local; and the closer to home the disparities data are, the more difficult it is for the public, providers, and policy makers to dismiss the issues they pose as "someone else's problem." [n196] Indeed, a recent **[*104]** survey of cardiologists illustrates this point: 34% of respondents agreed that racial and ethnic disparities exist in care overall in the U.S. healthcare system, and 33% agreed that disparities existed in cardiovascular care; however, only 12% felt disparities existed in their own hospital setting, and even fewer, 5%, thought disparities existed in the care of their own patients. [n197]

The ACA takes important first steps to correct the federal government's failure to assume a leadership role on this issue. The legislation requires the HHS Secretary to ensure that, by March 30, 2012, any "federally conducted or supported health care or public health program, activity, or survey ... collects and reports data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants," as well as any other demographic data regarding health disparities. [n198] The statute does not define "federally conducted or supported health care or public health program, activity or survey," but the plain language suggests the provision is broad in scope and potentially covers health insurance plans operating within the health exchanges. [n199] The legislation further directs the Secretary to evaluate and implement approaches for the collection of Medicaid and SCHIP disparities data related to race, ethnicity, sex, primary language, and disability status. [n200] The Secretary must submit a report outlining proposed methodologies to be used for data collection and evaluation as well as recommendations for improving health disparities data collection under Medicaid and CHIP. [n201]

[*105]

1. Ensuring Data Accuracy and Uniformity

An overarching issue is how such data are collected and coded; a race/ethnicity reporting mandate does not necessarily ensure uniform or accurate data. [n202] As the health care debate raged in Congress, the Institute of Medicine (IOM) simultaneously studied the standardization issue and released a report that will likely guide the HHS Secretary's efforts. [n203] In the report, the IOM recommended: collecting race and ethnicity data using the Office of Management and Budget's recommended race and ethnicity categories; collecting more fine-grained categories of ethnicity; and collecting data on spoken language, including English proficiency and preferred language for medical encounters, by using a standard set of categories. [n204] IOM also encouraged the collection of data through self-reporting whenever practicable; self-reporting is generally considered more accurate than observational reporting of race and ethnicity by health care providers. [n205]

Last summer, HHS announced new draft standards for collecting and reporting data on race and ethnicity that

embraced many of the IOM's recommendations. [n206] The proposed rule emphasizes self-identification as the preferred means of obtaining information about an individual's race and ethnicity. [n207] The race and ethnicity standards also include fine-grained categories from which **[*106]** racial and ethnic differences in health care and outcomes can be examined in more detail, particularly among Asian, Hispanic/Latino and Pacific Islander populations. [n208] Because health disparities have been associated with limited English language proficiency, the draft standards assess degrees of language proficiency on a self-reported basis. [n209] At first blush, these proposed rules appear to address many of the uniformity and accuracy concerns. They also represent a huge step forward in unmasking the health care disparities that exist in the Asian American, Native Hawaiian and Pacific Islander communities.

2. Monitoring and Detecting Disparities at the Local Level

Many of the activities that will lead to a tangible reduction in, or elimination of, disparities in care, must be carried out by health care organizations that have responsibility for the health and well-being of defined groups of people - health plans serving defined sets of members, hospitals serving specific communities, and clinics or medical groups serving panels of regular patients. These are the local settings in which the current patterns of racial and ethnic disparities are found; therefore, they are the settings in which change must occur, to alter those patterns.

The collection of racial and ethnicity data by health plans pose a number of special challenges. Most health plans have only sporadic direct contact with enrollees, principally at the time of enrollment. [n210] Some states prohibit health insurers from requesting such information from applicants to prevent the possibility of "redlining," whereby health plans bypass zip codes containing high minority populations. [n211] However, these legal restrictions do not apply outside the insurance application process, allowing the collection of **[*107]** race and ethnicity data after enrollment through voluntary participation in disease management programs or questionnaires. [n212] Health plans that have attempted to collect race and ethnicity data after enrollment as a way to identify and monitor disparities have had only modest success.

Collection costs may be high, particularly at the beginning. Indeed, some plans have had to coordinate different information systems that serve different regions; others have attempted to bring together departments that address quality of care, marketing, and human resources to address disparities; and many plans face challenges relating to organizational changes such a mergers and acquisitions. [n213] Because many health plans experience enrollee turnover and compete in local markets, information sharing between plans has been a challenge. Aetna, one of the early leaders, began collecting data over a decade ago; yet they have self-reported data for only one-third of active members. [n214]

Money talks and the ACA provides little to lower collection costs or to assist health plans in developing information systems vital to reducing race-based disparities. Implementing the data collection and reporting requirement may ultimately depend on appropriations by Congress. The legislation specifically prevents data from being collected by covered entities unless specific funding is appropriated for this purpose. [n215] However, many federal data collection efforts are funded as components of larger programs or as discretionary funding.

However, one qualification is necessary here. Recent national legislation may lead to some improvements by providing financial incentives to providers. The section on "meaningful use" in the Health Information Technology for Economic and Clinical Health Act requires physicians to record the race or ethnic background for at least half their patients, in order to be eligible for financial **[*108]** incentives related to implementing electronic health records. [n216] Eventually, health information exchanges may be able to transmit this information to insurance companies. An HHS advisory group is currently considering including in pending meaningful use requirements measures showing that providers were able to reduce race, ethnic, and other disparities in the health of their patients. [n217]

3. Diversifying the Health Care Workforce

Because many minority neighborhoods have a shortage of physicians and less access to medical care, increasing the supply of minority physicians is an intervention that may help to ameliorate access disparities. Physicians of color are

much more likely than their white colleagues to locate their practices in areas with large minority populations. [n218] In a survey of physicians, researchers found that African-American and Hispanic physicians were five and two times more likely, respectively, than their white peers to practice in communities with high proportions of African-American and Hispanic residents. [n219] On average, over half of the patients seen by African-American and Hispanic physicians were members of these clinicians' racial or ethnic group. [n220]

Empirical research also suggests that increasing workforce diversity is an intervention that may help to reduce racial and ethnic disparities in the quality of care. As discussed in Part I of this Article, a large of body of research indicates that even when insured at the same levels as whites; patients of color receive fewer clinical **[*109]** services and receive a lower quality of care. [n221] At least some of these disparities may result from aspects of the clinical encounter and attitudes, both conscious and unconscious of health care providers. [n222] Further, persons of color tend to seek medical care at a higher rate, and are generally more satisfied with the care they receive, when clinicians of the same cultural and racial background provide health care. [n223]

The ACA takes steps to increase the representation of underrepresented minorities in the health care workforce by reauthorizing Titles VII and VIII of the Public Health Services Act, which has been successful in increasing racial and ethnic diversity in the health care workforce, improving cultural competence, and encouraging health care providers to practice in medically underserved areas. [n224] More specifically, the legislation reauthorizes: Centers for Excellence Programs that target, attract, and retain minority applicants in health professions schools; [n225] scholarships for disadvantaged students who commit to work in medically underserved areas; [n226] and faculty loan repayment programs that aim to attract and retain minority professors at health professions schools. [n227] Under a complicated allocation formula, the federal law makes an additional $ 12 million available for grants to health professions schools at historically Black colleges and universities (HBCUs). [n228] It provides that HCBUs must receive preference for mental and behavioral health education and training grants. [n229]

However, these programs do not directly address admissions **[*110]** policies and the institutional climate of colleges and universities that have a legacy of being historically white. Similarly, the ACA's workforce diversity provisions fail to address vast inequities in the quality of elementary and secondary school education, particularly in the sciences. While the ACA secures appropriations for modest workforce diversity initiatives through 2014, support for these programs is likely to come under fierce attack by fiscal conservatives and affirmative action foes alike. The continuity of these initiatives will require a strong commitment from congressional leaders, vigorous lobbying by health professions institutions and grassroots activists, as well as an abundance of data that clearly demonstrates their benefits.

B. Health Disparities Research

Research is a vital component of the national strategy to understand, reduce, and eliminate disparities. The research is complex and involves a broad range of biomedical, social, economic, and behavioral issues. [n230] Much of the research is conducted or funded by the National Institutes of Health (NIH), which recently declared disparities research to be third among its top five priorities. [n231] While research alone will not reduce persistent health disparities, the ACA sustains and enhances NIH disparities research, developing an evidence base that will inform disparity reduction initiatives.

For example, the law elevates the National Center on Minority Health and Health Disparities at the NIH to institute status - the National Institute on Minority Health and Health Disparities. [n232] The move authorizes the new institute to plan, coordinate, review and evaluate all minority health and health disparities research activities conducted and supported by the NIH institutes and centers; and it reaffirms the authority of the institute director as the primary federal official with responsibility for coordinating such activities. [n233] Among the research priorities for the new institute are the social **[*111]** determinants of health, patient-centered outcomes research; faith-based approaches to health disparities; and improving the participation of health disparity populations in clinical trials. [n234]

Health policy experts have identified three major challenges to maximizing the efficacy of health disparities

research: coordinating research efforts, translating research into policy and practice, and ensuring racial/ethnic diversity in clinical trials. [n235] Of these, recruiting and retaining persons of color in clinical trials may prove to be the most challenging. Although the NIH requires the inclusion of underrepresented minorities in medical research, there continues to be a lack of African American representation in research trials. [n236] Further, more than three decades after the shutdown of the notorious Tuskegee Experiment, [n237] a team of Johns Hopkins physicians has found that Tuskegee's legacy of Blacks' mistrust of physicians and deep-seated fear of harm from medical research persists; it is largely to blame for keeping African Americans from taking part in clinical trials. [n238] In turn, this lack of participation limits the ability of researchers to generalize data from clinical trials to African Americans and may ultimately contribute to the presence of health disparities. Clearly, more works needs to be done in this area.

[*112] Finally, NIH health disparities research must focus squarely on discrimination. Much of the current research focuses on physician perception and physician behavior in providing patient care, including the potential role of racial bias in physician decision making. [n239] This is important but it is not enough. In addition, health disparities researchers should examine the health care system, broadly defined, to determine whether there are policies and practices in place that have the effect of discriminating again communities of color. For instance, it is important to examine the location decisions of hospitals, nursing homes, and health care organizations. Are there institutional policies, norms, and practices in place that lead to the opening of new care facilities in affluent-majority-white suburbs to the detriment of the health of communities of color? As discussed in Part II, it is also important to examine whether there are policies and practices in place in the process of applying for Medicaid, that have the effect of discriminating against communities of color.

There are many other points in the health care system where disparate impact discrimination can and does occur. Overall, it is important for NIH to create robust and broadly defined research that focuses on the role of discrimination at each of these points.

V. Combating Structural Inequalities

From a structural perspective, housing, education, employment, transportation, and other systems interact to produce racialized outcomes; which, in turn, produce persistent health inequities. [n240] One of the most pressing fundamental causes of these disparities is residential segregation. Racial and ethnic minorities are more likely to live in segregated and high-poverty communities. [n241]

The research is clear - place matters. Where children and families live, learn, work and play affects their health. People thrive when they earn living wages and live in communities with safe affordable housing. They thrive when they have easy access to parks, playgrounds, and grocery stores that sell nutritious food. **[*113]** People cannot thrive in unhealthy environments and are therefore suffering from the many diseases and injuries, including stress, diabetes, cancer, high blood pressure, asthma, traffic injuries, and violence. [n242]

This suggests that policy interventions focused on social domains outside of the health care system are essential. These should include efforts to improve housing and community living conditions, food resources, nutrition options, conditions for exercise and recreation, and ultimately, to reduce economic and educational gaps. Almost all aspects of federal, state and local policy in education, transportation, housing, commerce, and criminal justice influence the health of residents; these aspects can have a disproportionate impact on marginalized communities. Governments that consider the health impacts of policy decisions are inherently engaging in health equity work.

The Obama administration is taking a number of promising steps to address the structural causes of health inequities. For instance, the federal government is developing and coordinating interagency plans that address health disparities in arenas outside the health care system. On June 10, 2010, President Obama signed an Executive Order creating a National Prevention Council. [n243] An important component of the ACA, the National Prevention Council brings together seventeen federal departments and agencies to plan and coordinate prevention efforts across the government and the nation through the development of a national prevention strategy. Significantly, promoting health

equity for communities of color is one of the core principles guiding the strategy. [n244]

In a bold and clear language, the federal government recognizes the causal effects that structural factors have on minority health: "Health disparities are often linked to social, economic, or environmental disadvantages (e.g., less access to good jobs, unsafe neighborhoods, and lack of affordable transportation options)." [n245] **[*114]** This federal recognition is welcome news for health equity advocates; and it is more than symbolic. The National Prevention Strategy commits the federal government to take action in a number of arenas including: supporting and expanding cross-agency activities to enhance access to high quality education, jobs, economic opportunity, and opportunities for healthy living; developing community-based interventions to reduce health disparities and health outcomes; identifying medically underserved areas that experience health disparities and aligning existing resources to meet these needs; and, supporting policies to reduce exposure to environmental and occupational hazards, among others. [n246]

Many of the federal agency initiatives have already started. For example, the U. S. Department of Agriculture's (USDA) Healthy Food Financing Initiative, aims to increase full-service grocery stores and other healthy food retailers in underserved urban and rural communities across America. [n247] Many of these neighborhoods and communities contain "food deserts" - a term that denotes limited access to affordable and nutritious foods. [n248] For decades, community activists have organized around the lack of access to healthy foods as an economic, health equity, and **social justice** issue. Empirical research has demonstrated that limited access to healthy food choices can lead to poor diets, higher levels of obesity, and other diet-related diseases. [n249] Predominantly African-American neighborhoods contain a disproportionate number of food deserts. [n250]

In concert with the USDA program, the ACA and several other Obama Administration initiatives takes additional important steps. HHS recently announced the availability of over $ 100 million in funding for grants created by the ACA [n251] to help communities **[*115]** address health disparities, including eliminating food deserts. [n252] These grants will allow communities to build on existing programs or create new initiatives. [n253] Empirical evidence confirms that community-based interventions have a potential for success, as measured by reported improvements in fruit and vegetable sales, consumer psychosocial behaviors, healthy food purchasing patterns, and consumer diet. [n254]

The Administration has committed to eliminating America's many food deserts in seven years, as part of the First Lady's Let's Move! campaign. The First Lady recently announced nationwide commitments from major food retailers to open or expand stores to help provide healthy and affordable food to millions of people living in underserved areas. [n255] Participating national retailers include: Wal-Mart, Walgreens, Supervalu, and regional supermarkets such as Brown's Super Stores in Philadelphia, and Calhoun Foods in Alabama and Tennessee. [n256] Together, they promised to open more than 500 stores that will employ tens of thousands of people. Additionally, the California Endowment has secured $ 200 million to finance healthy food projects in California. [n257] According to the organizations involved, all together, these commitments will serve 9.5 million individuals and create tens of thousands of jobs. [n258]

Several federal agencies are leading in other areas, including building and promoting healthy and safe community environments. For instance, the Environmental Protection Agency and Departments of Housing and Urban Development and Transportation are coordinating investments and aligning policies to give Americans more housing choices, make transportation systems more efficient and reliable, and support vibrant and healthy neighborhoods that **[*116]** attract businesses. [n259] This action marked a fundamental shift in the way the federal government structures its transportation, housing, and environmental spending, policies, and programs.

Currently, the three agencies have pilot programs in place in five communities where there is a convergence of structural factors that adverse affect health - multiple brownfield sites, economic distress, public transit needs, and the need for affordable housing. [n260] They are helping these communities clean up and reuse contaminated and vacant properties, which will provide new sustainable housing and transportation choices, create jobs, and expand economic opportunity. [n261] Since 2009, the agencies have dedicated more than $ 2.5 billion in assistance to more than 200 communities in 48 states to help meet housing and transportation goals; simultaneously, they have been reducing emissions, improving environmental quality, promoting equitable development, and improving health. [n262]

Advancing environment justice is a final concrete example of coordinated federal effort to address a structural problem that causes health inequity. Environmental contamination leads to costly health risks and discourages investments and development in affected communities. Racial and ethnic minority communities are disproportionately hurt by the presence of toxic waste dumps, industrial and occupational hazards. Recently, heads of 17 federal agencies signed a Memorandum of Understanding on Environmental Justice. [n263] The signatories agreed that environmental justice means that all communities facing pollution - particularly minority, low income and tribal communities - deserve the same degree of protection from environmental and health hazards, equal **[*117]** access to the federal decision-making process, and a healthy environment in which to live, learn, and work. [n264] The Memorandum requires each agency to identify and address any disproportionately high and adverse human health or environmental effects of its program's policies and activities on minority and low-income populations. [n265]

Separately, EPA Administrator Lisa Jackson has made environmental justice a priority and is in the process of integrating that policy into the agency's rulemaking and actions. [n266] The federal commitment is a welcome change from the policies of the previous administration, which allowed environmental justice to falter and become all but became invisible at the EPA.

In summary, federal efforts should continue to look to a broad range of social and economic policies, when crafting strategies to improve and equalize health status for all. Future efforts should focus more on community-level interventions to promote healthy behaviors and environments. State and federal agencies can exert legal and regulatory authority to reduce community-level health risks factors such as violence, public advertisement of tobacco products, the greater availability of alcohol, and the lack of access to health resources. Such interventions are vital for low-income communities and communities of color, which have fewer community resources for exercise (e.g., safe public parks and recreation centers), effective nutrition, and reduction of individual health risks.

Conclusion

Eliminating racial and ethnic disparities in health and health care is a moral imperative in which there is no single silver bullet. These disparities have a long history in the U.S. and are both a symptom of broader structural inequality and a mechanism by **[*118]** which disadvantage persists. The ACA has significant and far-reaching consequences for all Americans; it takes important first steps especially for persons of color.

Medicaid was created in 1965 as the nation's safety net insurance, and the new legislation makes many changes to that program. For the first time, childless low-income adults will be eligible for coverage; geographical disparities in eligibility will be eliminated, and the income threshold for eligibility will be raised. Other programmatic changes enhance the value of the basic Medicaid program, moving it in a more preventative-focused direction. Conventional insurance expansions alone could worsen conditions in communities of color because of transportation barriers, long travel times, lack of culturally competent providers, higher cost sharing, and thinner coverage.

Starting in 2014, many more persons of color will become eligible for highly subsidized private insurance. The ACA's expansion of public and private insurance is monumental, but it will still leave about 23 million residents uninsured. The new law greatly improves safety net access for the uninsured; first, by doubling the capacity of community health centers. Second, it does so by encouraging community-based collaborative networks that provide comprehensive, coordinated and integrated health care services for low-income populations. By stitching together better and improved safety net programs with insurance coverage expansion, the national goal of truly universal coverage finally looks within reach. But, because political capital and public coffers have been depleted in the monumental effort to enact the ACA on the heels of an extreme recession, the ultimate success of these coverage expansion provisions remains a decidedly open question.

Health disparities-specific provisions of health care reform hold the potential to diversify the health care workforce, monitor and detect health disparities, and advance the knowledge base about the causes and patterns of disparities through research. However, unfortunately, the ACA either ignores or allocates insignificant resources to causal factors

that disproportionately affect communities of color - such as policies and practices of health care systems, the legal and regulatory context in which they operate, and the behavior of people who work in them.

Finally, on a more promising note, the Obama Administration **[*119]** adds a new and complementary approach beyond the ACA. Specifically, for the first time, the federal government has coordinated federal effort to address structural problems that cause health inequity. Most of these federal efforts focus on the intersection of race and place and include cross-agency initiatives in areas such as environmental justice, food deserts, transportation, and healthy neighborhoods, among many others. These have long been the concern of health equity and **social justice** advocates alike.

Legal Topics:

For related research and practice materials, see the following legal topics:
Healthcare LawInsuranceExperimental TreatmentInsurance LawIndustry RegulationInsurance Company OperationsPersonal & Public InformationCommunity DataPublic Health & Welfare LawHealthcareGeneral Overview

FOOTNOTES:

n1. Dr. Martin Luther King Jr., Speech to the Medical Committee for Human Rights in Chicago (March 25, 1966). Dr. King was referencing a growing body of observations documenting racially and ethnically based disparities in health outcomes.

n2. Health equity exists when all individuals and populations have an equal opportunity for good health. See Paula Braveman & Sofia Gruskin, Defining Equity in Health, 57 J. Epidemiol. Community Health 254, 257 (2003) ("Equity in health means equal opportunity to be healthy ... [and] implies that resources are distributed and processes are designed in ways most likely to move toward equalizing the health outcomes of disadvantaged social groups with the outcomes of their more advantaged counterparts.").

n3. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, Institute of Medicine, (Brian D. Smedley et al., eds., 2003) [hereinafter Unequal Treatment]. Congress instructed the Institute of Medicine to prepare a report on racial disparities in health care. The study committee performed a literature review of articles in the PUBMED and MEDLINE databases published in peer-reviewed journals from 1992 to 2002. To be selected, the articles must have addressed racial differences in health care while controlling for access and a range of other potential confounding variables. More than one hundred studies were selected and summarized. Id. at 3.

n4. Id. at 5-6.

n5. Id. at 457-8.

n6. See infra Part I.A.

n7. See Unequal Treatment, supra note 3 at 418.

n8. See Hope Landrine & Irma Corral, Separate & Unequal: Residential Segregation & Black Health Disparities, 19 J. Ethnicity & Disease 177 (2009).

n9. Id. at 181-200.

n10. David R. Williams & Chiquita Collins, Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health, 115 pub. health rep. 404, 410-11 (2001).

n11. Patient Protection and **Affordable Care Act,** Pub. L. No. 111-148, 124 Stat. 119 (2010).

n12. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

n13. Id. at 2608.

n14. Kaiser Family Foundation, Medicaid's Role for Black Americans (May 2011) [hereinafter Medicaid's Role for Black Americans], available at http://www.kff.org/medicaid/upload/8188.pdf.

n15. Kaiser Family Foundation, Medicaid's Role for Hispanic American, (May 2011) [hereinafter Medicaid's Role for Hispanic Americans], available at http://www.kff.org/medicaid./upload/8189.pdf.

n16. R. Sean Morrison et al., We Don't Carry That - Failure of Pharmacies in Predominantly Nonwhite Neighborhoods to Stock Opioid Analgesics, 342 New Engl. J. Med 1023 (2000).

n17. See David R. Williams & Toni D. Rucker, Understanding and Addressing Racial Disparities in Health Care, Health Care Financing Rev. 75, 76 (Summer 2000).

n18. See generally David. Barton Smith, Health Care Divided: Race and Healing a Nation 12 (1999) (noting effect of Jim Crow laws on health care for Blacks).

n19. Id.

n20. See, e.g., Martha C. Nussbaum, Woman and Human Development: The Capabilities Approach 4-6 (2000); Amartya Sen, Inequality Examined 39-53 (1992).

n21. Id.

n22. See, e.g., Martha C. Nussbaum, Woman and Human Development: The Capabilities Approach 5 (2000).

n23. See Reinhard Priester, A Values Framework for Health System Reform, 84 Health Aff. (Spring 1992).

n24. Madison Powers & Ruth Faden, Racial and Ethnic Disparities in Healthcare: An Ethical Analysis of When and How They Matter, in Unequal Treatment, supra note 3, at 722.

n25. See generally R. Randal et al., Making a Business Case for Reducing Racial and Ethnic Disparities in Health Care: Key Issues and Observations, The Urban Institute (2009), available at http://www.urban.org/uploadedpdf/411951_Businesscarefinal.pdf; Timothy Waidmann, Estimating the Cost of Racial and Ethnic Health Disparities, The Urban Institute (Sept. 2009), available at http://www.urban.org/uploadedpdf/411962_health_disparities.pdf.

n26. Waidmann at 25 (noting that over the 10-year period from 2009 through 2018, they estimate that the total cost of these disparities is approximately $ 337 billion, including $ 220 billion for Medicare.).

n27. 42 U.S.C. § 299a-1(a)(6) (2010) (Mandated by the U.S. Congress, The National Healthcare Disparities Report focuses on "prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations.").

n28. U.S. Dep't of Health & Human Services, National Healthcare Quality Report 5 (2010) [hereinafter NHQR], http://www.ahrq.gov/qual/nhqr10/nhqr10.pdf.

n29. Id. at 6. There are six access core measures: (1) people under age 65 with health insurance; (2) people with a usual primary care provider; (3) people with a usual source of care who indicated a financial or insurance reason for not having a source of care; (4) people under 65 who were uninsured all year: (5) people with a specific source of ongoing care; and, (6) people who were unable to get or delayed in getting needed medical care, dental care or prescription medication in the last 12 months. Id. at 52.

n30. NHQR, supra note 28, at 6, 52.

n31. Id. at 7.

n32. See, e.g., Richard A. Williams ed., Eliminating Health Care Disparities in America: Beyond the IOM Report (2007).

n33. See Rene Bowser, Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities, 7 Mich. J. Race & Law 80 (2001).

n34. See generally Kaiser Family Foundation, Racial/Ethnic Differences in Cardiac Care: The Weight of the Evidence (Oct. 2002), available at http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14017 (analyzing peer-reviewed studies investigating racial/ethnic differences in cardiac care).

n35. Farlex, The Free Medical Dictionary, http://medical-dictionary.thefreedictionary.com/door-to-balloon (last visited Sept. 11, 2012).

n36. See E. Bradley et al., Racial and Ethnic Differences in Time to Acute Reperfusion Therapy for Patients Hospitalized with Myocardial Infarction, 292 JAMA 1563 (2004).

n37. See Liliana E. Pezzin et al., Disparities in the Emergency Department Evaluation of Chest Pain Patients, 14 Acad. Emergency Med. 149 (2007).

n38. Unequal Treatment, supra note 3, at 30.

n39. See Leslie R. Hausman et al., Racial and Ethnic Disparities in Pneumonia Treatment and Mortality, 47 Medical Care 1009 (2009).

n40. See Karen O. Anderson et al., Racial and Ethnic Disparities in Pain, Causes and Consequences, 10 J. Pain 1187 (2009).

n41. Center for Disease Control, National Diabetes Fact Sheet: United States (2005), available at http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2005.pdf.

n42. Id.

n43. See Brian D. Smedley, Moving Beyond Access: Achieving Equity in State Health Care Reform, 27 Health Aff. 447, 448 (2008).

n44. Michelle M. Doty & Alyssa L. Holmgren, Health Care Disconnect: Gaps in Coverage and Care for Minority Adults, The Commonwealth Fund 2 (Aug. 2006), available at http://www.commonwealthfund.org/[#x7E]/media/Files/Publications/Issue%20Brief/2006/Aug/Health%20Care%20Disconnect%20%20Gaps%20in%20Coverag

n45. Kaiser Family Foundation, Health Reform and Communities of Color: Implications for Racial and Ethnic Health Disparities 1 (Sept. 2010), available at http://www.kff.org/healthreform/upload/8016-02.pdf.

n46. See generally Thomas A. LaVeist et al., The Economic Burden of Health Inequalities in the United States, Joint Center for Political and Economic Studies (Sept. 2009), available at http://www.jointcenter.org/sites/default/files/upload/research/files/The%20Economic%20Burden%20of%20Health%20Inequalities%20in%20the%20United%20 Megan Thomas & Cara James, Kaiser Family Foundation, The Role of Health Coverage for Communities of Color (2009), available at http://www.kff.org/healthreform/upload/8017.pdf.

n47. Kaiser Family Foundation, Health and Security Watch 9 (June 2012), available at http://www.kff.org/healthpollreport/CurrentEdition/security/upload/8322.pdf.

n48. Id. For example, 35% of Hispanics compared to 24% of whites reported having a problem paying medical bills in the past year, and more than half of Hispanics reported relying on home remedies in the past year instead of going to the doctor because of cost compared to almost one-third of whites. Moreover, about 1 in 3 Blacks and Hispanics reported not filling a prescription in the past year due to cost compared to about 1 in 4 whites. Id. at 9.

n49. See Letter from Congressional Budget Office to the Honorable Nancy Pelosi (Mar. 20, 2010) [hereinafter Reconciliation Proposal], available at http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

n50. See infra Part II (B).

n51. See Social Security Act, 42 U.S.C. § 1396 (2010).

n52. Letter from Douglas Elmendorf, Director of the Congressional Budget Office, to Senate Finance Committee Chairman Max Baucus (Oct. 7, 2009), available at www.cbo.gov/sites/default/files/cbofiles/ftpdocs/106xx/doc10642/10-7-baucus_letter.pdf.

n53. See 42 U.S.C.§§1396(a), 1396(d) (2010).

n54. Sara Rosenbaum, Medicaid and National Health Care Reform, 361 N. Engl. J. Med. 2009 (2009), available at http://www.nejm.org/doi/pdf/10.1056/NEJMp0909449?ssource=hcrc.

n55. See 42 U.S.C. §§1396a(a)(10)(A)(i)(II), 1396a (f) (2010).

n56. Rosenbaum, supra note 54, at 2010.

n57. Id. at 2010-11.

n58. See id.

n59. 42 U.S.C. § 1396w-3 (2010).

n60. Medicaid's Role for Black Americans, supra note 14.

n61. Medicaid's Role for Hispanic Americans, supra note 15.

n62. Richard Wolf, Rising health care costs put focus on illegal immigrants, USA Today (Jan. 21, 2008), http://usatoday30.usatoday.com/news/washington/2008-01-21-immigrant-healthcare_N.htm. See also Jeffrey S. Passel & D'Vera Cohn, A Portrait of Unauthorized Immigrants in the United States, The Pew Hispanic Center 18 (Apr. 14, 2009), available at http://pewhispanic.org/files/reports/107.pdf (citing that most undocument-ed adults had no health insurance during all of 2007, more than double the uninsured share among authorized immigrants and four times the uninsured share among U.S.-born adults).

n63. See generally Alison Siskin, Treatment of Noncitizens Under the Patient Protection and **Affordable Care Act,** Cong. Res. Serv. (Mar. 22, 2011), http://www.ciab.com/workarea/downloadasset.aspx?id=2189.

n64. See RAND Corporation, Analysis of the Patient Protection and **Affordable Care Act** 5 (2010), available at http://www.rand.org/pubs/research_briefs/2010/RAND_RB9514.pdf. Other groups remaining uninsured after the reform goes into effect include: unauthorized immigrants, who cannot receive premium subsidies or Medicaid under the legislation and will not have access to the exchanges to purchase insurance (discussed below); and, younger, healthier and wealthier individuals who chose to pay the penalties imposed by the legislation rather than pay the cost of an insurance proposal. Id. at 3-5.

n65. See Amy Finkelstein et al., The Oregon Health Insurance Experiment: Evidence From the First Year, Nat'l Bureau Econ. Res. 4 (2011), available at http://econ-www.mit.edu/files/6796. In 2008, Oregon held a lottery to determine which uninsured Oregonians would be permitted to enroll in a limited expansion of the state's Medicaid program. The lottery provided a unique opportunity to gauge the effects of expanding access to public health insurance on the health care use, financial strain, and health of low-income adults using a randomized controlled design. The study found that in this first year, the treatment group had substantively and statistically significantly higher health care utilization (including primary and preventive care as well as hospitalizations), lower out-of-pocket medical expenditures and medical debt (including fewer bills sent to collection), and better self-reported physical and mental health than the control group. Id. at 19-29.

n66. Id. at 34. "Our estimates are therefore difficult to extrapolate to the likely effects of much larger health insurance expansions, in which there may well be supply side responses from the health care sector." Id.

n67. Juan E. Gastelum, Hatch Urges Change to End Medicaid "Gulag', Kaiser Health News (June 15, 2011), http://www.kaiserhealthnews.org/Stories/2011/June/15/Senator-Hatch-Medicaid.aspx (speaking before the Heritage Foundation, Senator Orrin Hatch (Rep. Utah) stated: "The bottom line is that those who are the biggest advocates for Medicaid, and most criticize conservatives for seeking to reform the program, are happy to consign America's poorest and sickest patients to a health care gulag.").

n68. See Frank J. Thompson, The Medicaid Platform: Can the Termites be Kept at Bay? 36 J. Health Pol. Pol'y & L. 549 (2011).

n69. Stephen Zuckerman et al., Trends in Medicaid Physician Fees: 2003-2008, 28 Health Aff. 511, 6 (2009).

n70. See Anna S. Sommers et al., Physician Willingness and Resources to Serve More Medicaid Patients: Perspectives from Primary Care Physicians, Kaiser Family Foundation (Apr. 2011), available at http://www.kff.org/medicaid/upload/8178.pdf. The study found that primary care physicians that restrict Medicaid patients also cite additional reasons including: difficulty in arranging for specialty care; the high clinical burden of Medicaid patients; and administrative burdens such as billing and paperwork. As a result, Medicaid enrollees often seek care from hospital emergency rooms, federally qualified health centers, or other safety-net institutions. Id. at 2.

n71. 42 U.S.C. § 1396(a) (2010).

n72. Id.

n73. See Melinda Abrams et al., Realizing Health Reform's Potential: How the **Affordable Care Act** Will Strengthen Primary Care and Benefit Patients, The Commonwealth Fund (Jan. 2011), available at http://www.commonwealthfund.org/[#x7E]/media/Files/Publications/Issue%20Brief/2011/Jan/1466_Abrams_how_ACA_will_strengthen_primary_care_reform_ For example, a physician practicing in New Jersey, whose Medicaid primary care rates for evaluation and management services and immunizations was 41% of the Medicare rates in 2008, will see a much greater increase in Medicaid payment than a physician practicing in Nevada, whose Medicaid rates in 2009 were 93% of Medicare rates - nearly the same. Id. at 6.

n74. See Phil Galewitz, Kaiser Health News, Medicaid Payments Go Under the Knife, USA Today (July 5, 2011), http://usatoday30.usatoday.com/news/washington/2011-07-05-state-medicaid-reimbursements_n.htm.

n75. See Medicaid Program: Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342 (2011) (to be codified at 42 C.F.R. § 447).

n76. See 76 Fed. Reg. 26, 343.

n77. See 76 Fed. Reg. 26, 347.

n78. Sara Rosenbaum, Medicaid and Access to Health Care: A Proposal for Continued Inaction?, 365 New Engl. J. Med. 2011, 102, 102-104 (July 14, 2011), available at http://www.nejm.org/doi/full/10.1056/NEJMp1106046?ssource=hcrc&.

n79. See Scott Smith, Physicians Call for Changes to Medicaid Rate Setting Rule, Minnesota Medical Association (July 13, 2011), http://www.mnmed.org/News/NewsFullStory/tabid/2266/ArticleID/4152/CBModuleId/3252/Default.aspx.

n80. See Sara Rosenbaum, supra note 78, at 102.

n81. See Thompson, supra note 68, at 551.

n82. See Benjamin D. Sommers & Arnold M. Epstein, Medicaid Expansion: The Soft Underbelly of Health Reform?, 363 N. Engl. J. Med. 2085 (Nov. 25, 2010), available at http://www.nejm.org/doi/pdf/10.1056/NEJMp1010866.

n83. Id.

n84. Jennifer Stuber & Elizabeth Bradley, Barriers to Medicaid Enrollment: Who is at Risk?, 95 Am J. Public Health 292, 295 (2005).

n85. See Leighton Ku et al., The States Next Challenge: Securing Primary Care for Expanded Medicaid Populations, 364 N. Engl. J. Med. 493, 494 (Feb. 10, 2011), available at http://www.nejm.org/doi/pdf/10.1056/NEJMp1011623?ssource=hcrc.

n86. Id. at 493.

n87. Id. at 494.

n88. Timothy S. Jost & Sara Rosenbaum, The Supreme Court and the Future of Medicaid, 367 N. Engl. J. Med. 983 (Sept. 13, 2012), available at http://www.nejm.org/doi/pdf/10.1056/NEJMp1208219.

n89. Id.

n90. Id.

n91. Id. See also Nat'l Fed'n of Indep. Bus. 132 S.Ct. at 2601 (noting the basic principle that the "Federal Government may not compel the States to enact or administer a federal regulatory program." (quoting New York v. United States, 505 U. S. 144, 188 (1992)).

n92. Jost & Rosenbaum, supra note 88, at 984. See also Nat'l Fed'n of Indep. Bus. 132 S.Ct. at 2603-5.

n93. Nat'l Fed'n of Indep. Bus. 132 S.Ct. at 2604-5.

n94. Jost & Rosenbaum, supra note 88, at 984. Nat'l Fed'n of Indep. Bus. 132 S.Ct. at 2604-5 (finding that the inducement in South Dakota v. Dole was not impermissibly coercive because Congress was offering only "relatively mild encouragement" to the States (quoting South Dakota v. Dole, 483 U. S. 203, 211 (1987)). The Court said that in this case, the financial inducement is much more than "relatively mild encouragement - it is a gun to the head." Id. at 2604.

n95. Nat'l Fed'n of Indep. Bus. 132 S.Ct. at 2605-6.

n96. Jost & Rosenbaum, supra note 88, at 984. See also Nat'l Fed'n of Indep. Bus. 132 S.Ct at 2607.

n97. Nat'l Fed'n of Indep. Bus. 132 S.Ct at 2605-7.

n98. Jost & Rosenbaum, supra note 88, at 984.

n99. Stephanie Condon, States opting out of the Medicaid expansion could leave many uninsured, CBS News (July 2, 2012), http://www.cbsnews.com/8301-503544_162-57465110-503544/states-opting-out-of-medicaid-expansion-could-leave-many-uninsured/.

n100. Staff of S. Finance Comm., Medicaid Expansion in the New Health Law: Costs to the States 2, available at http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/analysis/20110301medicaid.pdf (committee lead by Senators Orin Hatch & Fred Upton).

n101. John Holahan & Irene Head, Medicaid Coverage and Spending in Health Reform: National and State by State Results for Adults at or Below 133% FPL, Kaiser Family Foundation (May 2010), available at http://www.kff.org/healthreform/upload/Medicaid.-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-

n102. See January Angeles, Republican Report Inflates State Medicaid Costs Under Health Reform, center budget & pol'y priorities (Mar. 1, 2011), http://www.offthechartsblog.org/republican-report-inflates-state-medicaid.-costs-under-health-reform/.

n103. 42 U.S.C. § 1369(a) (2010).

n104. Id.

n105. Id.

n106. Id.

n107. Id.

n108. Id.

n109. Robert Pear, Administration Advises States to Expand Medicare or Risk Losing Federal Money, N.Y. Times (Oct. 2, 2012), http://www.nytimes.com/2012/10/02/us/us-advises-states-to-expand-medicaid-or-risk-losing-funds.html?ref=us.

n110. Id.

n111. See generally Alain Enthoven & Richard Kronick, A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy, 320 New Eng. J. Med. 29 (1989) (the idea is not new. Its ancestry can be traced to the concept of managed competition, as developed by economist Alain Enthoven and others, and to numerous purchasing cooperatives, health alliances, and connectors - among states and private entities.).

n112. 42 U.S.C. § 18021 (2010).

n113. 42 U.S.C. § 18022 (2010). Health plans offered in the individual and small group markets must cover specific percentages of actuarial value and are arrayed in "precious metal" categories: bronze plans must cover 60% of actuarial value, silver plans must cover 70% of actuarial value, gold plans must cover 80% of actuarial value, and platinum plans must cover 90% of actuarial value. Insurers may also offer a catastrophic plan to subscribers under thirty years of age (for a while the plan was referred to as the "young invincibles" plan because it is aimed at attracting younger subscribers inclined to doubt they need health insurance). Id.

n114. 42 U.S.C. § 18022 (2010).

n115. See Karen Davenport & Sonia Sekhar, Center for American Progress, Interactive Map: Insurance Market Concentration Creates Fewer Choices (Nov. 5, 2009), available at http://www.americanprogress.org/issues/2009/11/insurance_market.html (a discussion of the "public option" debate.).

n116. 42 U.S.C. § 18054 (2010).

n117. 42 U.S.C. § 18042 (2010).

n118. 42 U.S.C. § 18032 (2010).

n119. 26 U.S.C. § 36(B) (2010).

n120. Id.

n121. Dennis P. Andrulis et al., Joint Center for Political & Economic Studies, Patient Protection and **Affordable Care Act** of 2010: Advancing Health Equity for Racially and Ethnically Diverse Population, 9 (June 2010), available at http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf.

n122. Press Release, U.S. Department of the Treasury, Treasury Lays the Foundation to Deliver Tax Credits to Help Make Insurance Affordable for Middle Income Americans (Aug. 12, 2011), available at http://www.treasury.gov/press-center/Documents/36BFactSheet.PDF.

n123. Rakesh Kochan et al., Wealth Gap Rises to Record Highs between Whites, Blacks and Hispanics, Pew Research Center (July 26, 2011), http://pewresearch.org/pubs/2069/housing-bubble-subprime-mortgages-hispanics-blacks-household-wealth-disparity.

n124. 25 U.S.C. § 1623 (2010).

n125. See Cara James et al., A Profile of American Indians and Alaska Natives and Their Health Care, Kaiser Family Foundation (Sept. 2009), available at http://www.kff.org/minorityhealth/upload/7977.pdf.

n126. Andrulis et al., supra note 121, at 7.

n127. 42 U.S.C. § 18116 (2010) (specifically, it provides that: "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 504 of the Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity, any part of which is receiving federal financial assistance, including credits, subsidies, or contracts of insurance, or any program or activity that is administered by an Executive Agency or any entity established under this title.").

n128. See Sara Rosenbaum & Joel Teitelbaum, Commonwealth Fund, The Essential Health Benefit Provision of the **Affordable Care Act:** Implications for People with Disabilities (Mar. 2011), available at http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_E985318A-5056-9D20-3D44CD4E8D0F288B.pdf.

n129. Id. at 11.

n130. Andrulis et al., supra note 121, at 5-6.

n131. John Battani, Computer Science Corporation, Health Insurance Exchanges in Health Care Reform: Five Things Builders Should Know 1 (June 2010), available at http://assets1.csc.com/health_services/downloads/CSC_Health_Insurance_Exchanges_in_Health_Care_Reform.pdf.

n132. Id. at 4.

n133. Id.

n134. 42 U.S.C. § 18021 (2010). In accordance with the ACA, an Exchange must establish a program under which it awards grants to entities called Navigators to perform the following duties: (1) conduct public education activities to raise awareness of the availability of Qualified Health Plans; (2) distribute fair and impartial information concerning enrollment in Qualified Health Plans, and the availability of premium tax credits and cost-sharing reductions in accordance with federal tax laws; (3) facilitate enrollment in Qualified Health Plans; (4) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and (5) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange. See Id.

n135. Id.

n136. Jonathan Gruber & Ian Perry, Realizing Health Reform's Potential: Will the **Affordable Care Act** Make Health Care Affordable?, Commonwealth Fund 2-5 (Apr. 2011), available at http://www.commonwealthfund.org/[#x7E]/media/Files/Publications/Issue%20Brief/2011/Apr/1493_Gruber_will_**affordable_care_act**_make_hlt_ins_affordabl Drawing from the Consumer Expenditure Survey, the nation's largest representative survey of consumption expenditures, the authors assess how much "room" people have in their budget to pay for health care needs after paying for other necessities. It considers necessary expenditures as: child care: food; housing; taxes; transportation; and miscellaneous (calculated as 10% of other costs). Id. at 3. http://www.nejm.org/doi/pdf/10.1056/NEJMp1013067?ssource=hcrcble_reform_brief_compressed.pdf

n137. Id. at 8.

n138. 26 U.S.C. § 5000(a) (2010).

n139. See generally Amitabh Chandra et al., The Importance of the Individual Mandate: Evidence from Massachusetts, 264 N. Engl. J. Med. (Jan. 27 2011), http://www.nejm.org/doi/pdf/10.1056/NEJMp1013067?ssource=hcrc (explaining that adverse selection occurs when a larger fraction of relatively unhealthy people than healthy people purchase health insurance. Since the law prohibits health insurers from discriminating against applicants on the basis of health, either by charging higher premiums for sick people or by excluding preexisting conditions from coverage, the law encourages adverse selection. Absent an individual mandate to bring younger and healthier individual into the health exchange, such regulations would theoretically increase premiums for healthy people and lead them to exit the individual insurance market, which would cause premiums to rise even more).

n140. Gruber & Perry, supra note 136, at 2.

n141. Michelle M. Doty & Alyssa L. Holmgren, Health Care Disconnect: Gaps in the Coverage and Care for Minority Adults, The Commonwealth Fund 2-5 (August 2006), available at http://www.commonwealthfund.org/[#x7E]/media/Files/Publications/Issue%20Brief/2006/Aug/Health%20Care%20Disconnect%20%20Gaps%20in%20Coverag

n142. 26 U.S.C. § 4980 (West, Westlaw through P.L. 112-142 (excluding P.L. 112-140 and 112-141)).

n143. 26 U.S.C. § 218(a) (2010).

n144. 26 U.S.C. § 45(R) (Westlaw through P.L. 112-142 (excluding P.L. 112-140 and 112-141)).

n145. See Andrulis et al., supra note 121.

n146. Kaiser Family Foundation, supra note 45, at 5.

n147. Peter B. Bach et al., Primary care physicians who treat Blacks and whites, 354 New Engl. J. Med. 575, 583 (2004).

n148. Kaiser Family Foundation, Racial and Ethnic Disparities in Women's Health Coverage and Access to Care: Findings from the 2001 Kaiser Women's Health Survey 3 (Mar. 2004), http://mhrc.dopm.uab.edu/resources_new/Racial-disparities-in-Women.pdf.

n149. See David B Smith, Eliminating Disparities in Treatment and the Struggle to End Segregation (2005), http://www.commonwealthfund.org/[#x7E]/media/Files/Publications/Fund%20Report/2005/Aug/Eliminating%20Disparities%20in%20Treatment%20and%20the

n150. See Ernest Moy et al., Access to Hypertensive Care: Effects of Income, Insurance and Source of Care, 155 Archives of Internal Med. 1497 (1995) (finding that receiving inadequate follow-up care for hypertension more strongly correlated with lack of usual source of care than insurance); C.M. Sox et al., Insurance or a Regular Physician: Which Is the Most Powerful Predictor of Health Care?, 88 Am. J. Pub. Health 364, 370 (1998) (finding that without a usual source of care, the uninsured and Medicaid enrollees have strikingly similar odds of delay in seeking care); R.E. Zambrana et al., Use of Cancer Screening Practices by Hispanic Women: Analyses by Subgroup, 29 Preventive Med. 46 (1999).

n151. Andrulis et al., supra note 121, at 8.

n152. Id.

n153. National Association of Community Health Care Centers, Community Health Centers Lead the Primary Care Revolution (2010) [hereinafter Primary Care Revolution], available at http://www.nachc.com/client/documents/Primary_Care_Revolution_Final_8_6.pdf.

n154. Id.

n155. Id.

n156. Id.

n157. Id.

n158. Roughly 23 million Americans will be uninsured after full implementation. See Reconciliation Proposal, supra note 49.

n159. See generally Jennifer Rothkopf et al., Medicaid Patients Seen at Federally-Qualified Health Centers Use Hospital Services Less Than Those Seen by Private Providers, 30 Health Aff. 1335 (2011); E.S. Huang et al., The Cost-effectiveness of Improving Diabetes Care in U.S. Federally Qualified Community Health Centers, 46 Health Services Research 2174 (2007); Peter Shin, Financing Community Health Centers as Patient-and Community-Centered Medical Homes: A Primer, (May 2009), available at http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/PCMH_CHC.pdf.

n160. Letter from Douglas W. Elmendorf, Director of U.S. Congressional Budget Office, to Nancy Pelosi, U.S. House of Representatives (Mar. 20, 2010), available at http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

n161. See, e.g., Ellen-Marie Whelan, The Importance of Community Health Centers: Engines of Economic Activity and Job Creation, Center for American Progress (Aug. 2010), available at http://www.americanprogress.org/issues/2010/08/pdf/chc.pdf (estimating that by 2015 the community health center expansion will support over 450,000 jobs and generate over $ 57 billion in economic activity).

n162. See Michelle M. Doty, Commonwealth Fund, Enhancing the Capacity of Community Health Centers to Achieve High Performance: Findings from the 2009 Commonwealth Fund National Survey of Federally Qualified Health Centers (May 2010), http://www.commonwealthfund.org/[#x7E]/media/Files/Publications/Fund%20Report/2010/May/1392_Doty_enhancing_capacity_community_hlt_ctrs_2009_FC

n163. Id. at 5.

n164. See Sara Rosenbaum et al., Assessing and Addressing Legal Barriers to the Clinical Integration of Community Health Centers and Other Community Providers, The Commonwealth Fund 2 (July 2011), available at http://www.commonwealthfund.org/[#x7E]/media/Files/Publications/Fund%20Report/2011/Jul/1525_Rosenbaum_assessing_barriers_clinical_integration_CHCs

n165. 42 U.S.C. § 256(i) (2010).

n166. 42 U.S.C. § 256(a-1) (2010).

n167. 42 U.S.C. § 2931-1 (2010).

n168. Rosenbaum et al., supra note 164, at 7.

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n171. Taryn Morrissey, American Public Health Association, The **Affordable Care Act's** Public Health Workforce Provisions: Opportunities and Challenges 10 (June 2011).

n172. See 42 U.S.C. § 254(l) (2011).

n173. Id.

n174. See Primary Care Revolution, supra note 153, at 4.

n175. 42 U.S.C. § 1396(a) (2010).

n176. 42 U.S.C. § 13951(m) (2012).

n177. 42 U.S.C. § 254c-1a (2010).

n178. Mary K. Wakefield, Nurses and the **Affordable Care Act,** 110 American Journal of Nursing 11 (2010).

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n181. See Vanessa Barkauskas et al., Quality of Care in Nurse Managed Health Centers, 25 Nursing Admin. Q. 1, 35-41 (2010).

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n201. Social Security Act § 1946(b)(1) [42 U.S.C. 1396 et. seq.] (as added by ACA § 4302(b)(2)).

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