Health Injustice and Justice in Health: The Role of Law and Public Policy in Generating, Perpetuating, and Responding to Racial and Ethnic Health Disparities Before and After the Affordable Care Act

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HEALTH INJUSTICE AND JUSTICE IN HEALTH:  
THE ROLE OF LAW AND PUBLIC POLICY IN  
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RACIAL AND ETHNIC HEALTH DISPARITIES BEFORE  
AND AFTER THE AFFORDABLE CARE ACT  

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The past century witnessed unprecedented advances in health and health care. For example, the average American life expectancy at birth increased from 47.3 years in 1900 to a record high of 78.7 years in 2010. Beyond increased length of life, significant gains in health and quality of life have resulted from our improved ability to prevent or alleviate pain, disfigurement, and disability. These gains are credited to the rapid accumulation of biomedical knowledge, technological advances in the diagnosis and treatment of diseases, and public health measures such as improvements in immunization programs, infectious disease control, workplace safety, motor-vehicle safety, food safety,

maternal and baby health, and tobacco control. However, significant health disparities exist for certain subsets of the American population, including “ethnic minorities, women, children, the elderly, the handicapped, the poor, prisoners, lesbians, gays, and the transgender population.” For instance, the life expectancy of black Americans is 3.8 years lower than that of white Americans, the life expectancy for American Indians is 4.2 years less than that for the U.S. general population, and thirty percent of U.S. counties witnessed declining life expectancy of women in the past decade while that of men has increased. Furthermore, when compared to whites, many minority groups have poorer health outcomes and higher incidence of diseases, such as cardiovascular disease, hypertension, HIV/AIDS, diabetes, and infant mortality. Even proven quality-of-life-restoring orthopedic procedures such as total knee replacement and total hip replacement are provided less frequently to black patients than to white patients, despite similar degrees of radiographic arthritis, pain, and disability. Beyond the severe human toll of these inequities, racial and ethnic health disparities also have a profound economic toll on the United States. Between 2003 and 2006, thirty percent (or $229.4 billion) of direct medical care expenditures for African Americans, Asians, and Hispanics were excess costs due to

5. KENNETH D. KOCHANEK, ELIZABETH ARIAS & ROBERT N. ANDERSON, NAT’L CTR. FOR HEALTH STATISTICS, NCHS DATA BRIEF No. 125, How Did Cause of Death Contribute to Racial Differences in Life Expectancy in the United States in 2010?, at 6 (2013) (predicting that disproportionately high rates of suicide, unintentional injuries, and chronic lower respiratory diseases in the black population will increase the gap in life expectancy to 4.4 years).
health inequities.\(^9\) Over this three-year period, eliminating minority health inequities “would have reduced indirect costs associated with illness and premature death by more than one trillion dollars.”\(^{10}\) Annualized, the direct and indirect costs of health inequities in the United States exact a $309.3 billion burden on the economy.\(^{11}\)

Health disparities are rooted in a complex system of past and present social, cultural, economic, political, medical, and legal issues that, either individually or collectively, result in poorer health or health outcomes for some Americans. This Article explores the relationships between racial and ethnic health disparities and American legislation, regulation, and litigation. First, this Article reviews the history and current state of health disparities in America with a focus on the legal issues that have contributed to the formation of health disparities, as well as the legal solutions that have been advanced to promote health equity.\(^{12}\) Finally, this Article examines how the law currently confronts health disparities and how legal approaches will impact health disparities in the future, particularly in light of recent health reform measures, including the Affordable Care Act of 2010 (ACA).\(^{13}\)

II. OVERVIEW OF HEALTH DISPARITIES

A. Definition of “Health Disparities”

In the broadest sense of the term, “health inequality” refers to any difference or lack of similarity in health or health care that exists between populations.\(^{14}\) Many health disparities result from fundamental and immutable differences among populations. For example, cystic fibrosis is most prevalent among people of European heritage, Tay-Sachs disease is most prevalent in Ashkenazi Jews, hereditary hemochromatosis is most prevalent in people of Celtic descent, and sickle-cell anemia is most prevalent in

\(^{9}\) Thomas A. LaVeist et al., Joint Ctr. for Political & Econ. Studies, The Economic Burden of Health Inequalities in the United States 4 (2009).

\(^{10}\) Id. at 5.

\(^{11}\) Id. at 6.

\(^{12}\) See infra Parts II–III.

\(^{13}\) See infra Part IV.

populations with sub-Saharan African, Latin American, Indian, and Saudi Arabian or Mediterranean ancestry. Like genes, age and sex also matter; however, “their significance lies not in their essence, but in their interrelation with the other components of health.”

However, other health disparities exist without an underlying biologic basis, and certain health care disparities exist without underlying differences in access-related factors, clinical needs, or patient preferences. Accordingly, the U.S. Department of Health and Human Services (HHS) defines a health disparity as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.” Although the disadvantages referred to in this definition often are tied to race or ethnicity, health disparities also affect broad segments of the American population along lines of age; gender; sexual orientation or gender identity; cognitive, sensory, or physical disability; religion; socioeconomic status; incarceration; mental health; geographic location; or “other characteristics historically linked to discrimination or exclusion.” Health care disparity refers to “differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of interventions. These differences would include the role of bias, discrimination, and stereotyping at the individual (provider and patient), institutional, and health-system levels.” Health equity, on the other hand, is the “attainment of the highest level of health for all people.” According to HHS, achieving health equity “requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”


18. Id.

19. Id. (citing Inst. of Med. of the Nat’l Acads., supra note 7, at 3–4).

20. Id.

21. Id. (footnote omitted).
B. The History of Health Disparities

1. A Century of Recognition, Research, and Resolve Regarding Health Disparities

In the United States, attention to race-based health disparities began around the turn of the twentieth century. Established in 1895 when black physicians were refused membership in the American Medical Association, the National Medical Association (NMA) was formed to promote medical care for all people and to combat the inadequacies of the segregated American health care system. In addition to organizing its own hospitals and training black physicians, the NMA also studied tuberculosis, hookworm, pellagra, and other diseases disproportionately contracted by minorities through the appointment of special commissions.

One year after the NMA was established, Prudential Life Insurance statistician Frederick L. Hoffman published a report entitled *Race Traits and Tendencies of the American Negro.* Although Hoffman is credited with significant contributions to the fields of statistics and public health, his foundational work on health disparities would ultimately prove to be a troubling and highly influential factor in perpetuating unequal treatment of blacks in the American health care and insurance systems. Consuming two full issues of the *Journal of the American Economic Association,* Hoffman’s treatise employed statistics, eugenic theory, observation, and speculation to conclude that the poor health status of blacks was attributable to inherent racial inferiority. “It is not in the conditions of life,” Hoffman concluded, “but in the race traits and tendencies that we find the causes of excessive mortality.”

23. *Id.*
26. *Id.*
27. *Hoffman, supra* note 24, at 95.
Although Hoffman’s work was heralded as genius, it did not go unchallenged. In his 1906 monograph entitled *The Health and Physique of the Negro American*,
28 prominent black scholar W. E. B. DuBois used census reports, vital statistics, and insurance company records to refute Hoffman’s work, concluding that “[i]f the population were divided as to social and economic condition[,] the matter of race would be almost entirely eliminated.”
29 DuBois concluded that the mortality of the race would steadily improve with “improved sanitary condition, improved education, and better economic opportunities.”
30 Although DuBois discredited Hoffman’s conclusions on the basis of the earlier researcher’s “unscientific use of the statistical method,” Hoffman’s theories prevailed for over three decades.

Inspired by business firms, fraternal societies, and community organizations, the first organized efforts to improve the health of black communities began in Virginia in the early 1900s as annual initiatives to provide health education and to clean up homes, lots, and fields throughout the state.
31 It was not long before the medical profession, including many members of the NMA, took notice and began to contribute to the effort. In 1912, Alabama’s Tuskegee Institute held the first Annual Clinic where physicians from around the country assembled at Tuskegee’s John A. Andrews Hospital to provide free care to patients, including those suffering with malaria, typhoid fever, small pox, and tuberculosis.
32 Two years later, recognizing their broader potential value, prominent black educator and leader Dr. Booker T. Washington initiated the national expansion of the Virginia campaigns and established leadership of the efforts at the Tuskegee Institute.
33 Between 1915 and 1950, Washington’s National Health Improvement Week garnered widespread support among blacks and evolved into

29. *Id.* at 89.
30. *Id.*
34. *Id.* at 78–79.
National Negro Health Week, and ultimately, the National Negro Health Movement.\textsuperscript{35} According to historian Susan L. Smith,

Black health activists turned National Negro Health Week into a vehicle for social welfare organizing and political activity in a period when the vast majority of African Americans were without formal political and economic power. Much like white social reformers of the early twentieth century, black reformers turned to government and charity organizations to ensure the permanency of their volunteer efforts. Unlike their white counterparts, however, black activists found only limited government and private resources available for health promotion in their communities.\textsuperscript{36}

In 1932, the U.S. Public Health Service (USPHS) established the Office of Negro Health Work (ONHW) as the first federal office devoted to black health care issues.\textsuperscript{37} Staffed by a secretary and Dr. Roscoe C. Brown, a black dentist, \textquotedblleft[t]he main purpose of [ONHW] was health education,\textquotedblright rather than a source of health policy or surveillance.\textsuperscript{38} ONHW coordinated the efforts of the growing National Negro Health Movement, provided promotional materials, and served as an important source of information through \textit{National Negro News}, its quarterly journal on black health issues.\textsuperscript{39}

Although ONHW made significant strides in improving health for many blacks, health disparities clearly persisted through the 1930s and 1940s. In 1944, Nobel-laureate economist Gunnar Myrdal noted:

Medical knowledge has advanced beyond medical practice, and medical practice has advanced far beyond most people's opportunity to take advantage of it. A reduction in these lags would have tremendous

\textsuperscript{35} Id.
\textsuperscript{36} \textit{Susan L. Smith, Sick and Tired of Being Sick and Tired: Black Women's Health Activism in America, 1890–1950}, at 34 (1995).
\textsuperscript{38} \textit{Smith, supra note 36}, at 68.
consequences for the well-being and happiness of every person in the nation. Of special significance to the Negroes is the lag of opportunity for some people to obtain the advantage of medical practices available to other people. Area for area, class for class, Negroes cannot get the same advantages in the way of prevention and cure of disease that whites can. There is discrimination against the Negro in the availability to him of medical facilities.40

This discrimination, according to Myrdal, "increases Negro sickness and death both directly and indirectly and manifests itself both consciously and unconsciously."41 Myrdal’s recognition of the disproportionate shortage of medical facilities available to blacks was consistent with a 1938 survey by the Council on Medical Education and Hospitals of the American Medical Association. Despite the then accepted standard that there should be 4.5 general hospital beds per 1000 of population, the survey found 0.7 beds available for blacks and 2.4 for whites.42 As discussed below, although Congress responded with the 1946 passage of the Hospital Survey and Construction Act, government action failed to correct the discrepancy and, in some ways, exacerbated the problem of discrimination and segregation in health care.

Due to the beliefs of certain civil rights leaders like physician-activist Dr. W. Montague Cobb, as well as the growing broader interest in racial integration in health, education, and welfare, the ONHW was dismantled in 1950.43 During the 1950s and 1960s, the nation was preoccupied with a civil rights movement that encompassed broad social, political, and economic objectives. Health equity was a high-priority, albeit relatively less visible, goal compared to issues such as disparities in housing, education, and public accommodations.44 During this time, the Reverend Dr. Martin Luther King, Jr. declared, “Of all the forms of inequality,

41. Id. at 172.
42. "It is the current accepted standard that there should be 4.5 general hospital beds per [1000] of population." W. Montague Cobb, Medical Progress and African Americans, 92 AM. J. PUB. HEALTH 191, 192 (2002).
43. Gamble & Stone, supra note 39, at 102.
44. DAVID BARTON SMITH, ELIMINATING DISPARITIES IN TREATMENT AND THE STRUGGLE TO END SEGREGATION 1–2 (2005).
injustice in health care is the most shocking and inhumane.\footnote{Amanda Moore, \textit{Tracking Down Martin Luther King, Jr.'s Words on Health Care}, \textit{HUFFINGTON POST} (Jan. 18, 2013), http://www.huffingtonpost.com/amanda-moore/martin-luther-king-health-care_b_2506393.html. Moore attempts to substantiate these powerful and often quoted words of Dr. King, concluding that although no written transcript of the quote apparently exists, credible personal accounts rightfully attribute the quote to Dr. King. \textit{Id.}} Reflecting on this era, "Dr. W. Montague Cobb, then editor of the Journal of the NMA, wrote, 'With the deadline for social justice long overdue, Negroes in the medical and allied professions threw themselves into the battle to close the citizenship gap in the health field.'\footnote{\textit{History: The Founders Early Years Later Years Recent and Current Programs}, \textit{supra} note 22.}

Such an effort was the Medical Committee for Human Rights (MCHR). Organized in Mississippi during the so-called "Freedom Summer of 1964," MCHR was a group of physicians, dentists, nurses, and other health professionals, originally organized to provide health services to southern civil rights workers who, due to a combination of discrimination, lack of available services, and the physical danger they faced, were often unable to get adequate care from local services.\footnote{\textit{See MED. COMM. FOR HUMAN RIGHTS, MANUAL FOR SOUTHERN MEDICAL PROJECTS I} (1966), \textit{available at} http://www.crmvet.org/docs/mchr.pdf.} Building on the significant success of its early efforts, MCHR expanded its program to include the direct provision of health care to poor black communities throughout the South, with now internationally renowned Harvard Medical School psychiatrist Dr. Alvin Poussaint as its first southern field director.\footnote{\textit{JOHN DITTMER, THE GOOD DOCTORS: THE MEDICAL COMMITTEE FOR HUMAN RIGHTS AND THE STRUGGLE FOR SOCIAL JUSTICE IN HEALTH CARE} 100 (2009).} Despite significant contributions to medical access for blacks (demonstrated reductions in black infant mortality and increased awareness of health disparities), MCHR was finally dissolved in the early 1980s as many of its members assumed leadership roles in state and national organizations and the group developed more progressive interests beyond health disparities.\footnote{\textit{Id.} at 251-64.}

The social, legislative, and judicial milestones reached during the civil rights era notwithstanding, race-based health disparities remained a significant problem for the nation.\footnote{\textit{See History: The Founders Early Years Later Years Recent and Current Programs}, \textit{supra} note 22.} In 1985, Margaret

\begin{quote}
45. Amanda Moore, \textit{Tracking Down Martin Luther King, Jr.'s Words on Health Care}, \textit{HUFFINGTON POST} (Jan. 18, 2013), http://www.huffingtonpost.com/amanda-moore/martin-luther-king-health-care_b_2506393.html. Moore attempts to substantiate these powerful and often quoted words of Dr. King, concluding that although no written transcript of the quote apparently exists, credible personal accounts rightfully attribute the quote to Dr. King. \textit{Id.}

46. \textit{History: The Founders Early Years Later Years Recent and Current Programs}, \textit{supra} note 22.


49. \textit{Id.} at 251-64.

50. \textit{See History: The Founders Early Years Later Years Recent and Current Programs}, \textit{supra} note 22.
\end{quote}
Heckler, President Ronald Reagan’s Secretary of HHS, concluded that “there was a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation’s population as a whole.” The disparity had persisted, Heckler wrote, “ever since accurate federal record keeping began—more than a generation ago. And although our health charts do itemize steady gains in the health status of minority Americans, the stubborn disparity remained—an affront both to our ideals and to the ongoing genius of American medicine.” As a result of this “national paradox of phenomenal scientific achievement and steady improvement in overall health status,” in the face of “persistent, significant health inequities,” Heckler established the Secretary’s Task Force on Black and Minority Health.

The report of the Task Force, commonly known as the Heckler Report, was self-characterized as “a landmark effort in analyzing and synthesizing the present state of knowledge of the major factors that contribute to the health status of Blacks, Hispanics, Asian/Pacific Islanders, and Native Americans.” It concluded that blacks experienced nearly 60,000 “excess deaths” each year from 1979 to 1981. Collectively, approximately sixty percent of the excess deaths were attributable to heart disease and stroke, cancer, infant mortality, cirrhosis, and diabetes. The remaining forty percent were divided between homicide and accidents, and all other causes.

Recognizing “that the factors responsible for the health disparities are complex and defy simplistic solutions,” the task force developed recommendations to incorporate minority health initiatives into existing [HHS] program areas in order to address health

52. Id.
53. Id. at 2.
54. Id. at vii.
55. Id. at 5. The Task Force defined “excess deaths” as “the difference between the number of deaths actually observed in a minority group and the number of deaths that would have occurred in that group if it experienced the same death rates for each age and sex as the White population.” Id. at 63.
56. See id. at 69.
57. See id.
58. Id. at 7.
conditions amenable to immediate improvement, press for greater public and private involvement in a common effort to eliminate the health disparity, resolve unanswered questions through a concerted program of research and data collection, and seek new strategies to ameliorate health inequities between minorities and nonminorities. 59

In 1985, to implement the task force’s recommendations, HHS established the Office of Minority Health (HHS-OMH)—an action that would formally house efforts to eliminate health disparities within a department of the federal government for the first time since the Office of Negro Health Work closed three and a half decades earlier. 60 Unlike the earlier office, HHS-OMH was charged with improving all “minority health, rather than [just] black health [to] reflect[] the recognition of [health] disparities in other minority groups and the changing demograph[ics] of the [nation].” 61 Also credited in large part to the Heckler Report, by 2004, thirty-five states and territories had established some variant of an office, commission, council, or advisory panel on minority health. 62

The remainder of the 1980s and 1990s brought significant growth in academic, government, and public interests in racial and ethnic disparities in health and health care. On the national scene, studies of racial and ethnic health and health care disparities continued to proliferate and were characterized by “increasingly sophisticated control or adjustment for such confounding variables as health insurance status, income and education, severity or stage of disease, comorbidity, and hospital type and resources.” 63 The problem of racial and ethnic disparities in health and health care had become viewed as an important component of American

59. Id. at 8.
60. Gamble & Stone, supra note 39, at 105. Secretary Heckler established OMH and appointed Herb W. Nickens, MD, as its first Director. U.S. DEP’T OF HEALTH & HUMAN SERVS., NATIONAL LEADERSHIP SUMMIT ON ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH (2006) [hereinafter NATIONAL LEADERSHIP SUMMIT]. However, OMH was first legislatively authorized by the Disadvantaged Minority Health Improvement Act of 1990, Pub. L. No. 101-527, § 2, 104 Stat. 2311, 2312. See NATIONAL LEADERSHIP SUMMIT, supra, at iv.
61. NATIONAL LEADERSHIP SUMMIT, supra note 60, at iv.
62. Gamble & Stone, supra note 39, at 105 (citing JOHN E. MCDONOUGH ET AL., A STATE POLICY AGENDA TO ELIMINATE RACIAL AND ETHNIC HEALTH DISPARITIES (2004)).
63. INST. OF MED. OF THE NAT’L ACADS., supra note 7, at 5–6, 61–62, 64.
health, and as a "particularly troubling component of the problems of race and ethnicity in the larger society." 64

Much of the momentum during the later 1980s and early 1990s can be attributed to the pioneering efforts of Dr. Louis W. Sullivan—the seventeenth Secretary of HHS and second African American to hold that office. 65 Dr. Sullivan had been the founding dean and director of the Medical Education Program at the historically black Morehouse College in 1975, and led the program to full accreditation as a four-year medical school in April 1985. 66 Tapped by President George H. W. Bush for the cabinet position, Dr. Sullivan arrived in Washington in 1989 and began an aggressive campaign of efforts to improve the health and behavior of all Americans, including tireless efforts to eliminate racial and ethnic health disparities. 67

Before Dr. Sullivan arrived in office, Assistant HHS Secretary and Surgeon General Julius Richmond had issued a document titled Healthy People, which was "a survey of where the nation stood on a broad array of health issues, what each meant, and what could be done to improve behaviors and outcomes." 68 Although Dr. Sullivan believed the document made "great sense," he felt that it had not achieved its full potential because it had not been publicized and disseminated aggressively. 69 In a follow-up to the report, Dr. Sullivan launched Healthy People 2000 in September 1990. This was a strategy for improving the health of Americans through 319 individual objectives in twenty-two priority areas of (1) health promotion, (2) health protection, (3) preventive services, (4) surveillance and data systems, and (5) the development of an infrastructure to track the objectives and to identify and evaluate emerging public health issues at the national,
Ultimately, it was Dr. Sullivan's goal to achieve the highest public profile possible for Healthy People 2000, in order to raise the issues, influence people and organizations, and show how people could affect their own health by the end of the century. Notably, together with the goals to increase the span of healthy life and achieve preventive services for all for Americans, Healthy People 2000 unambiguously identified the reduction of health disparities among Americans as one of the nation's three primary health goals of the decade.

Furthermore, recognizing that women and minorities were dramatically underrepresented in clinical research, Dr. Sullivan focused significant attention on the National Institutes of Health, where he helped increase the annual operating budget from $8 billion in 1989 to $13 billion in 1993. He established the Office of Research on Women's Health at the National Institutes of Health (NIH) and brought in Dr. Vivian Pinn—a respected black pathologist—to run it. Similarly, Dr. Sullivan established the NIH Office of Research on Minority Health (ORMH) and named Dr. John Ruffin as its first director.

Dr. Sullivan's other significant accomplishments as Secretary include the inauguration of a $100 million minority male health and injury prevention initiative and implementation of greater gender and ethnic diversity in senior positions of HHS, including the appointment of the first female director of the National Institutes of Health, the first female and first Hispanic Surgeon General of the U.S. Public Health Service, the first African-

71. Sullivan with Chanoff, supra note 65, at 175.
73. Sullivan with Chanoff, supra note 65, at 175.
74. Id. at 179. ORMH would become the Center for Minority Health and Health Disparities (CMHHD) under the Minority Health and Health Disparities Research and Education Act of 1998 (MHHDREA). MHHDREA, in turn, was elevated to the National Institute on Minority Health and Health Disparities (NIMHD) under the ACA.
75. Bernadine Healy.
76. Toni Novello.
American Commissioner of the Social Security Administration, and the first African-American Administrator of the Health Care Financing Administration.

Following Dr. Sullivan’s tenure at HHS, another prominent African-American leader in academic medicine would enter the public life and make significant contributions to the elimination of health disparities. Largely credited with saving Meharry Medical College from financial ruin and closure in the 1980s (at which time the college had educated nearly half of the black physicians and dentists in this country), Dr. David Satcher led the Centers for Disease Control and Prevention from 1993 to 1998, until President Bill Clinton appointed him as the sixteenth U.S. Surgeon General and first African American to hold the post. Dr. Satcher also served as Assistant Secretary of HHS from February 1998 to January 2001, making him only the second person in history to simultaneously serve in both capacities. Among his myriad contributions to the elimination of health disparities, Dr. Satcher published reports on: tobacco use among U.S. racial and ethnic minority groups; culture, race and ethnicity issues in mental health; and bone health and osteoporosis, including the special considerations of the uninsured and underinsured, the poor, minority populations, men, nursing home residents, frail elderly

77. Gwendolyn King.
78. William “Bill” Toby.
persons, and rural or other remote populations. In what might be considered one of his most significant accomplishments while in office, Dr. Satcher spearheaded, along with Dr. Sullivan, the launch of Healthy People 2010. Specifically, the Healthy People 2000 goal to reduce health disparities was strengthened in Healthy People 2010, with the focus on eliminating health disparities clearly identified as one of two overarching goals.

2. The Changing National Perspective on Health Disparities After “Unequal Treatment”

By 1999, prompted by the growing concern regarding health disparities in the United States, Congress requested an Institute of Medicine (IOM) study to: (1) “[a]ssess the extent of racial and ethnic differences in healthcare that [were] not otherwise attributable to known factors such as access to care (e.g., ability to

87. The description of the IOM provided on its website states:

   The [IOM] is an independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public.

   Established in 1970, the IOM is the health arm of the National Academy of Sciences, which was chartered under President Abraham Lincoln in 1863. Nearly 150 years later, the National Academy of Sciences has expanded into what is collectively known as the National Academies, which comprises the National Academy of Sciences, the National Academy of Engineering, the National Research Council, and the IOM.

   Many of the studies that the IOM undertakes begin as specific mandates from Congress; still others are requested by federal agencies and independent organizations. While our expert, consensus committees are vital to our advisory role, the IOM also convenes a series of forums, roundtables, and standing committees, as well as other activities, to facilitate discussion, discovery, and critical, cross-disciplinary thinking.

pay or insurance coverage"); (2) assess “potential sources of racial and ethnic disparities in healthcare, including the role of bias, discrimination, and stereotyping at the individual . . . , institutional, and health system levels”; and (3) “[p]rovide recommendations regarding interventions to eliminate healthcare disparities.” The IOM responded to the congressional mandate with coordinated health disparities research and the publication of the landmark 2002 report entitled, Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare. 89 Unequal Treatment concluded that, despite a century of broad-based inquiry and action, “evidence of racial and ethnic disparities in health care is, with few exceptions, remarkably consistent across a range of illnesses and healthcare services.” Disparities persist, according to the report, “even when access-related factors, such as patients’ insurance status and income, are controlled,” 91 and many sources, including “health care systems, health care providers, patients and utilization managers,” contribute to such inequities. Additionally, Unequal Treatment provided an equally broad series of recommendations to facilitate the elimination of health disparities. 93 These recommendations included: collecting and reporting health care access and utilization data by patients’ race/ethnicity, encouraging the use of evidence-based guidelines and quality improvement, supporting the use of language interpretation services in the clinical setting, increasing awareness of racial/ethnic disparities in health care, increasing the proportion of underrepresented minorities in the health care workforce, integrating cross-cultural education into the training of all health care professionals, and conducting further research to identify sources of disparities and promising interventions. Finally, Unequal Treatment catalyzed unprecedented interest, research, and action to further understand and address racial and ethnic disparities in health care.

88. INST. OF MED. OF THE NAT’L ACADS., supra note 7, at 3.
89. Id.
90. Id. at 5.
91. Id. at 1.
92. Id.
93. Id. at 1–2.
94. Id.
III. HEALTH DISPARITIES AND THE LAW PRIOR TO 2010

Individual and population health is influenced by strong and incompletely understood relationships between biological, behavioral, socioeconomic, political, social, and environmental factors, collectively referred to as determinants of health.\textsuperscript{95} While much of the interest, inquiry, and literature regarding health disparities has focused on factors such as explicit and implicit bias,\textsuperscript{96} poverty and inadequate health insurance,\textsuperscript{97} and environmental factors such as poor nutrition and smoking,\textsuperscript{98} international, federal, state, and local laws, regulations, and judicial decisions also contribute to historic and ongoing health disparities and provide tools for identifying and eliminating disparate health and health care. The following sections provide an overview of the historical legal determinants of health disparities and the legal approaches to eliminating health disparities prior to passage of the Affordable Care Act.

A. Federal Law

1. The Constitution

   a. Constitutional Contributions to Health Disparities and the “Right” to Health Care

The U.S. Constitution contains no provisions that expressly create health inequities. However, during the seventy-seven years between its ratification in 1788 and passage of the Thirteenth Amendment in 1865,\textsuperscript{99} the Constitution protected slavery and


\textsuperscript{96.} See, e.g., Janice A. Sabin et al., Physician Implicit Attitudes and Stereotypes About Race and Quality of Medical Care, 46 MED. CARE 678 (2008).


\textsuperscript{98.} George A. Mensah et al., State of Disparities in Cardiovascular Health in the United States, 111 CIRCULATION 1233 (2005).

legalized the racial subordination of blacks. Since slaves suffered poor health and received inferior health care compared to whites during this time, arguably the Constitution implicitly contributed to past and present race-based health disparities.

Similarly, the Constitution contains no provisions that expressly guarantee health or protect against health inequities. Although legal scholars have debated the distinctions between negative and positive rights, it is generally held that the U.S. Constitution almost exclusively grants negative rights (i.e., “protections against government invasion of [one’s] rights”), as opposed to positive rights (i.e., “require[ments] that the government provide [individuals] with any specific benefits or protections”). Specifically, with the exception of the constitutional right to health care afforded to prisoners, the

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100. See Juan F. Perea, Race and Constitutional Law Casebooks: Recognizing the Proslavery Constitution, 110 Mich. L. Rev. 1123 (2012) (reviewing the proslavery origins of the Constitution and examining the significant difference that a proslavery interpretation of the Constitution makes in our understanding of how the Constitution structures race relations and racial inequality, past and present).

101. See Darrell J. Gaskin et al., Racial Disparities in Health and Wealth: The Effects of Slavery and Past Discrimination, 32 Rev. Black Pol. Econ. 95, 95 (2005) ("[A] substantial portion of current racial disparities in health and wealth are due to prior government and societal restrictions on black human capital investment during the periods of slavery and legal segregation[, and the] effects of these restrictions did not disappear when these policies were discontinued but persist even until today.").


103. See William J. Rold, Legal Considerations in the Delivery of Health Care Services in Prisons and Jails, in CLINICAL PRACTICE IN CORRECTIONAL MEDICINE 522 (Michael Puisis ed., 2d ed. 2006) (discussing the 1976 Supreme Court decision in Estelle v. Gamble, 429 U.S. 97 (1976), in which the Court held that deprivation of health care constitutes cruel and unusual punishment in violation of the Eighth Amendment to the Constitution, thereby creating a de facto right to health care for all persons in government custody); see also Farmer v. Brennan, 511 U.S. 825, 837 (1994) (defining and establishing a three-part test for “deliberate indifference” to the health care needs of prisoners). Namely, prison officials can be found liable under the Eighth Amendment for denying an inmate humane
Constitution does not require federal, state or local governments to protect or provide for the health of citizens, either collectively or individually.\textsuperscript{104} This is in contrast to the constitutions of other nations, which provide explicit positive and negative rights.\textsuperscript{105} For example, the 1996 post-Apartheid South African Constitution championed by President Nelson Mandela recognizes both a negative obligation to be free from government interference with socio-economic rights and an affirmative obligation that the government develop reasonable policies to meet individuals' socio-economic needs, including access to health care services.\textsuperscript{106} South African law specifically recognizes that "[f]or access to be effective, it must be culturally appropriate and timely."\textsuperscript{107} However, according to the South African Constitutional Court, this is a progressive right that recognizes the imbalance between significant demands and limited resources, and imposes an obligation on the government to "ensure that correct, coherent and coordinated programs are implemented and maintained to ensure that a right is realised over time for all of the citizens of the Republic."\textsuperscript{108}

While the progressive ideals of the South African Constitution may provide a valuable framework for addressing health disparities in the United States, remaining social, political, and economic challenges have, according to one author, relegated South Africa's health care provision to "an aspiration that may only find its

\begin{itemize}
  \item \textsuperscript{104} Kenneth R. Wing, \textit{The Right to Health Care in the United States}, 2 \textsc{Annals Health L.} 161, 162 (1993).
  \item \textsuperscript{105} See Karrisha Pillay, \textit{Tracking South Africa's Progress on Health Care Rights: Are We Any Closer to Achieving the Goal?}, 7 \textsc{Law Democracy & Dev.} 55, 58 n.17 (2003), available at http://www.ldd.org.za/images/stories/Ready_for_publication/V7-1_Tracking_SA_progress.pdf ("[T]he constitutions of Equador and Suriname contain a right to health protection. Brazil, Dominican Republic, El Salvador, Haiti and Uruguay oblige their respective states to protect health. The Finnish Constitution protects a right to health services and the promotion of the health of the population. The Hungarian Constitution protects the right to the highest level of physical and mental health.").
  \item \textsuperscript{106} See Soohoo & Goldberg, supra note 102, at 1001–02.
  \item \textsuperscript{108} \textit{Id. at} 492.
\end{itemize}
meaning in science fiction as opposed to jurisprudence and practical implementation of healthcare delivery and services."\(^{109}\) Unfortunately, almost two decades after the country's rebirth and reformation, access to physical and mental health care remains vastly unequal between blacks and whites.\(^{110}\) Similarly, although an amendment to the U.S. Constitution providing Americans a positive right to equitable health and health care seems unlikely in the near future, it is doubtful that such a provision would alone eliminate health disparities in light of the remaining social, political and economic hurdles.

\(b.\) The Equal Protection Clause

Despite the fact that the U.S. Constitution does not provide a positive right to health or health care—let alone equitable health care—constitutional claims to health theoretically still could be brought under the Equal Protection Clause of the Fourteenth Amendment.\(^{111}\) Services provided voluntarily by the government should be provided without discrimination, but courts will evaluate Equal Protection discrimination claims with varying degrees of scrutiny.\(^{112}\) Where government actions target populations on the basis of a "suspect classification" such as race, national origin, alienage, or other "obvious, immutable, or distinguishing characteristics,"\(^{113}\) U.S. courts will apply a strict scrutiny\(^{114}\) standard

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109. \textit{Id.} at 496.


111. U.S. CONST. amend. XIV, § 1 ("All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." (emphasis added)).


of review to insure that the government action is: (1) justified by a
compelling governmental interest, (2) narrowly tailored to achieve
the government's interest, and (3) the least restrictive means of
achieving that interest. Although the strict scrutiny standard is
not insurmountable, the heavy burden the government faces in
justifying its actions under this type of judicial review led Gerald
Gunther to famously characterize this standard as "strict in theory,
but fatal in fact." For example, federal courts have applied strict
scrutiny to strike down state decisions cutting medical benefit
programs to aliens. Similarly, in Memorial Hospital v. Maricopa
County, the Supreme Court struck down an Arizona statute
requiring an indigent person to have been a resident of his or her
county for the preceding 12 months in order to be eligible for free
nonemergency medical care. Although the subjects of the
litigation were three undocumented Mexican nationals, the case
did not turn on race or national origin. The Court also stopped
short of declaring health care a fundamental right. Alternatively,
the durational residence statute, according to the Court, created
"an 'invidious classification' that impinges on the [fundamental]

Ullman, 367 U.S. 497, 548 (1977) (Harlan, J., dissenting)).

115. Id. at 721 (quoting Reno v. Flores, 507 U.S. 292, 302 (1993)).

116. Adam Winkler, Fatal in Theory and Strict in Fact: An Empirical Analysis of
Strict Scrutiny in the Federal Courts, 59 VAND. L. REV. 793, 795, 808–10 (2006); see also
Fisher v. Univ. of Tex. at Austin, 133 S. Ct. 2411, 2421 (2013) ("Strict scrutiny must
not be strict in theory, but fatal in fact. But the opposite is also true. Strict scrutiny
must not be strict in theory but feeble in fact." (citation omitted) (internal
quotation marks omitted)).

117. Gerald Gunther, Foreword, In Search of Evolving Doctrine on a Changing

(W.D. Wash. Jan. 28, 2011) (finding that the plaintiff’s challenge to Washington’s
decision to repeal a state-funded food assistance program was subject to strict
scrutiny); Finch v. Commonwealth Health Ins. Connector Auth., 946 N.E.2d 1262,
1277 (Mass. 2011) (holding that a state’s exclusion of aliens from health insurance
premium program was subject to strict scrutiny).


120. Id. at 254–262 (discussing the fundamental right of interstate travel and
the level of scrutiny used when evaluating laws abridging fundamental rights).

121. Id. at 286–87.
right of interstate travel by denying newcomers "basic necessities of life." 122

By definition, racial and ethnic health disparities impact "discrete and insular minorities" 123 for whom the Constitution provides well-established protections, and to which strict scrutiny would apply in any claim brought under the Equal Protection Clause. However, two significant factors present nearly insurmountable obstacles to any potential court intervention in the case of health disparities. The first obstacle is the "state action" doctrine. The Equal Protection Clause of the Fourteenth Amendment protects individuals' Constitutional rights from government conduct, not the conduct of private actors. 124 Generally, "[t]herefore, courts are powerless to halt private infringements of even the most basic constitutional values," 125 and offer "no shield against private conduct, however discriminatory or wrongful." 126 Notably, for example, while the Americans with Disabilities Act (ADA) classifies private health care establishments as "places of public accommodation irrespective of whether the provider or entity receives federal funding," the same protections against racial segregation and exclusion are not extended to the private health care sector. 127 Accordingly, potential claims seeking remedies for health disparities under the Equal Protection Clause are likely limited to those against government health care entities

122. Id. at 269. While not mentioning race or national origin classification, the Court held that the "Appellees [State] have not met their heavy burden of justification, or demonstrated that the State, in pursuing legitimate objectives, has chosen means which do not unnecessarily impinge on constitutionally protected interests." Id. The relevant constitutionally protected interest being the fundamental right to interstate travel. Id.


124. Erwin Chemerinsky, Rethinking State Action, 80 Nw. U. L. REV. 503, 507 (1985). "Private behavior need comply with the Constitution only if the state is so intimately involved in the conduct—that is, if the nexus to the state is so great—that the state can be held responsible for the activity." Id. at 508 (citing Civil Rights Cases, 109 U.S. 3, 17 (1883)); see also Julie K. Brown, Less Is More: Decluttering the State Action Doctrine, 75 Mo. L. Rev. 561, 562–63 (2008). "Only the Thirteenth Amendment’s prohibition on slavery directly restricts actions of private individuals." Id. at 562 n.12 (citation omitted).

125. Chemerinsky, supra note 124, at 508.

126. Id. at 508 (quoting Jackson v. Metropolitan Edison Co., 419 U.S. 345, 349 (1974)) (internal quotation marks omitted).

or to private actors where "the nexus to the state is so great . . . that the state can be held responsible for the activity."128

Second, and perhaps more importantly, constitutional challenges to health disparities are limited by the doctrine of "discriminatory purpose." In his classic work entitled The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism, Professor Charles Lawrence critically examined the doctrine of "discriminatory purpose"129 that was established by the 1976 Supreme Court decision in Washington v. Davis.130 The discriminatory purpose doctrine "requires plaintiffs challenging the constitutionality of a facially neutral law to prove a racially discriminatory purpose on the part of those responsible for the law's enactment or administration."131

As the doctrine of discriminatory purpose applies to health disparities, Professor Barbara Noah concluded:

No matter how compelling the evidence of racial inequities in the health care context, nothing convincingly suggests a pattern of widespread intentional discrimination. Clearly, discrimination can exist without proof of invidious intent, but not all documented inequities across racial lines constitute discrimination. "Intent" in the equal protection context embodies ideas of willfulness and morally reprehensible motivation. Even so, disparate health treatment decisions that do not result from poor preventive care, or from a patient's presenting with a more acute condition, may well arise from unconsciously biased decisions on the part of health care professionals. Given these complexities, it seems appropriate to reconsider the current equal protection analysis requirement that plaintiffs prove intentional discrimination.132

128. Chemerinsky, supra note 124, at 508.
131. Lawrence, supra note 129, at 318 (emphasis added).
In the Supreme Court case of *Ricci v. DeStefano*, Justice Antonin Scalia admonished that “the war between disparate impact and equal protection will be waged sooner or later, and it behooves us to begin thinking about how—and on what terms—to make peace between them.” However, three decades after Professor Lawrence challenged the Court to ask whether there was constitutional injury in the cultural meaning of racially discriminatory impact, despite the more recent pleas of legal scholars like Professor Noah, and in the face of considerable psychological and social science evidence of the role of the unconscious in discrimination, the courts still refuse to consider evidence of disparate impact in Equal Protection challenges to government actions and policies. To the contrary, in a follow-up to his earlier treatise, Professor Lawrence laments the Supreme Court decision in *Parents Involved in Community Schools v. Seattle School District* that “turned *Brown v. Board of Education* on its head, declaring it unconstitutional for us to see our racism, to speak of it out loud, to make it visible so that we can fight it together.” In *Parents*, the Court ruled that Seattle’s compelling interest of diversity could not justify the school district’s use of racial classification in student assignment plans. In delivering the five-to-four majority opinion overturning the Seattle policy, Chief Justice John Roberts concluded:

> Before *Brown*, schoolchildren were told where they could and could not go to school based on the color of their skin. The school districts in these cases have not carried the heavy burden of demonstrating that we should allow this once again—even for very different reasons. For schools that never segregated on the basis of race, such as Seattle, or that have removed the vestiges of past segregation, such as Jefferson County, the way “to achieve

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134. See, e.g., Shankar Vedantam, *See No Bias*, WASH. POST, Jan. 23, 2005, available at 2005 WLNR 28697768 (analyzing tens of thousands of administrations of implicit bias tests on the Harvard University website, which shows significant externalized and internalized racial bias).
136. *Id.* at 977.
a system of determining admission to the public schools on a nonracial basis," is to stop assigning students on a racial basis. The way to stop discrimination on the basis of race is to stop discriminating on the basis of race. 138

To compound the challenges to the strict scrutiny standard of review, more commonly courts will apply the "rational basis" standard of review to claims brought under the Equal Protection Clause. Under rational basis review, courts are highly deferential to the government, and the burden is upon the plaintiff to negate any reasonably conceivable basis that might support the government's action or policy, whether or not the conceived basis actually motivated the government. 139 As summarized by the Sixth Circuit Court of Appeals:

Under rational basis review, the governmental policy at issue "will be afforded a strong presumption of validity and must be upheld as long as there is a rational relationship between the disparity of treatment and some legitimate government purpose." Under rational basis review, a plaintiff faces a severe burden and must "negate all possible rational justifications for the distinction." 140

Most notably, social and economic classifications typically are subject to rational basis review. In Dandridge v. Williams, the Supreme Court considered a Maryland Department of Public Welfare regulation placing an absolute limit of $250 per month on grants of Aid to Families with Dependent Children (AFDC), regardless of the size of the family or the family's actual need. 141 Citing its legitimate state interests "in encouraging gainful

138. Id. at 747-48 (quoting Brown v. Bd. of Educ. of Topeka, Kan., 349 U.S. 294, 300-01 (1955)).

139. See generally 16B AM. JUR. 2D Constitutional Law § 859 (2014), available at Westlaw ("In a rational basis equal protection review, the state need not articulate its reasoning at the moment a particular decision is made; rather, the burden is upon the challenging party to negative any reasonably conceivable state of facts that could provide a rational basis for the classification. The Equal Protection Clause does not demand for purposes of a rational basis review that the legislature or governing decision maker actually articulate at any time the purpose or rationale supporting its decision, but a court's review does require that a purpose may conceivably or may reasonably have been the purpose and policy of the relevant governmental decision maker." (footnotes omitted)).


employment, in maintaining an equitable balance in economic status as between welfare families and those supported by a wage-earner," as well as "providing incentives for family planning, and in allocating available public funds in such a way as fully to meet the needs of the largest possible number of families," Maryland argued that its maximum grant regulation was "wholly free of any invidious discriminatory purpose or effect." The Supreme Court upheld Maryland's regulation, concluding that "[a] statutory discrimination will not be set aside if any state of facts reasonably may be conceived to justify it." with ominous portent for poor people," as described by Professor Julie Nice, "Dandridge sweepingly suggested that challenges to socioeconomic regulation might not even be justiciable by announcing: 'the intractable economic, social, and even philosophical problems presented by public welfare assistance programs are not the business of this Court.'" Three years later, in San Antonio Independent School District v. Rodriguez, the Supreme Court reiterated its rejection of wealth-based suspect classification where schools received higher funding in high tax districts and lower funding in lower tax districts. The Court concluded that poor families challenging the school financing scheme had "none of the traditional indicia of suspectness: the class is not saddled with such disabilities ... or relegated to such a position of political powerlessness as to command extraordinary protection from the majoritarian political process." Like those who suffer race-based health disparities, under this line of reasoning, those who suffer poverty-related health disparities are likely to have little to no recourse under the Equal Protection Clause.

142. Id. at 483–84.
143. Id. at 483.
144. Id. at 485 (quoting McGowan v. Maryland, 366 U.S. 420, 426 (1961)).
147. Id. (holding that education is not a fundamental right for purposes of the Due Process Clause); see supra text accompanying note 111.
148. See Christopher J.L. Murray, Sandeep Kulkarni & Majid Ezzati, Eight Americas: New Perspectives on U.S. Health Disparities, 29 Am. J. Preventive Med. 4, 5–6 (2005). The authors divide the U.S. population into eight distinct groups with different health-related epidemiologic patterns and mortality experience. Id. The "Eight Americas" are Asians (America 1), below-median-income whites living in...
Finally, analysis of any potential constitutional claim regarding health disparities is complicated by courts' use of a third "zone" of judicial review that lies somewhere between the exacting strict scrutiny standard and the rational basis standard, where all but the most egregious government actions are allowed. Variably referred to by terms such as "intermediate scrutiny," "heightened scrutiny," and "rational basis 'with teeth'," this standard of judicial review was first articulated in the 1970s as a means to assess sex-based Equal Protection claims. \(^{149}\) The Supreme Court determined that certain classifications must "serve important governmental objectives," and must be "substantially related to achievement of those objectives." \(^{150}\) These requirements—which are less rigorous than the "compelling governmental interest" and "narrowly tailored, least restrictive means" requirements, yet more restrictive than the "any reasonably conceivable basis" and "any reasonable means" requirements—are intermediate between those of strict scrutiny review and rational basis review, respectively. In addition to sex-based classifications, intermediate scrutiny review has most commonly been applied to restrictions based on illegitimacy, regulations affecting content-neutral speech, \(^{151}\) and, most recently, sexual orientation. \(^{152}\) To date, no cases directly claiming disparate health treatment on the basis of gender or sexual orientation have been decided by federal courts.

the Northland (America 2), middle America (America 3), poor whites living in Appalachia and the Mississippi Valley (America 4), Native Americans living on reservations in the West (America 5), black middle-America (America 6), poor blacks living in the rural South (America 7), and blacks living in high-risk urban environments (America 8). \(^{Id.}\) Although Americas 2 and 4 describe white Americans, poverty in these groups contributes to significant health disparities. \(^{Id.; see also Bruce Behringer & Gilbert H. Friedell, Appalachia: Where Place Matters in Health, 3 Preventing Chronic Disease A113, A115 (2006) (noting that although seven out of eight Appalachians are white, residents of this geographic region spanning from New York's southern counties to the foothills of Mississippi suffer disparately poor health compared with the rest of the nation).}


\(^{150}\) Id. at 197. This case struck down a sex classification that made it lawful for women to buy 3.2% beer at age eighteen, while men could not purchase it until the age of twenty-one, treating them differently because of their sex. \(^{Id.}\) In invalidating the law, the Supreme Court articulated the intermediate scrutiny standard now used in cases involving challenges to sex-based classifications.


\(^{152}\) See Windsor v. United States, 699 F.3d 169, 188 (2d Cir. 2012), aff'd, 133 S. Ct. 2675 (2013).
c. Substantive Due Process

The Fifth and Fourteenth Amendments of the Constitution provide that the government shall not deprive persons of “life, liberty, or property without due process of law.” In his opinion for the Court in Washington v. Glucksberg, Chief Justice Rehnquist asserted:

The Due Process Clause guarantees more than fair process, and the “liberty” it protects includes more than the absence of physical restraint. The Clause also provides heightened protection against government interference with certain fundamental rights and liberty interests. In a long line of cases, we have held that, in addition to the specific freedoms protected by the Bill of Rights, the “liberty” specially protected by the Due Process Clause includes the rights to marry, to have children, to direct the education and upbringing of one’s children, to marital privacy, to use contraception, to bodily integrity, and to abortion. We have also assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment.

Although the term “fundamental right” has myriad “inherently problematic, open-ended, and insufficient” definitions, the Constitution does not, by virtually any definition, provide a fundamental right to health or to receive health care, let alone equitable health care. The Supreme Court has found implicit fundamental rights within certain penumbras—or surrounding...

156. See id. For the purposes of this discussion, fundamental rights may be best considered according to the definition provided by Davis as “[t]hose rights which are protected as ‘privileges and immunities under the Constitution,’ to embrace ‘nearly every right for the establishment and protection of which organized government is instituted.’” Id. (quoting Twining v. New Jersey, 211 U.S. 78, 94 (1908)). However, as discussed above, a notable exception is the right to health care afforded to prisoners.
areas—of explicit constitutional rights. For example, reasoning that "specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance," the Supreme Court in *Griswold v. Connecticut* concluded that a Connecticut law forbidding the use of contraceptives by married couples was an unconstitutional invasion of the fundamental "notions of privacy surrounding the marriage relationship," although the term "privacy" is not expressly mentioned in the Constitution. Likewise, although "travel" is not found in the text of the Constitution, the "'constitutional right to travel from one State to another' is firmly embedded in our jurisprudence," as a right "so important that it is 'assertable against private interference as well as governmental action . . . a virtually unconditional personal right, guaranteed by the Constitution to us all.'"

Generally, however, courts have been reluctant to recognize new fundamental constitutional rights. For example, despite their individual and societal significance, the Court has declined to recognize a fundamental right to public welfare assistance programs or housing. Most notably, despite its conclusion that "the grave significance of education both to the individual and to our society cannot be doubted,'" the Supreme Court in *San Antonio Independent School District v. Rodriguez* said the Constitution does not provide a fundamental right to education. Holding that "[i]t is not the province of the Court to create substantive constitutional rights in the name of guaranteeing equal protection of the laws," the Court concluded,

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158. *Id.* at 486.
160. *Id.* (quoting *Shapiro v. Thompson*, 394 U.S. 618, 643 (1969) (Stewart, J., concurring)).
164. *Id.; see also supra* text accompanying notes 112–14. In addition to the Court's holding regarding the fundamental right to education, the Court also held that poverty is not a "suspect classification" triggering strict scrutiny review under the Equal Protection Clause. *Rodriguez*, 411 U.S. at 28.
The key to discovering whether education is ‘fundamental’ is not to be found in comparisons of the relative societal significance of education as opposed to subsistence or housing. Nor is it to be found by weighing whether education is as important as the right to travel. Rather, the answer lies in assessing whether there is a right to education explicitly or implicitly guaranteed by the Constitution.\textsuperscript{165}

Following Rodriguez, the Supreme Court seems to have “shut the door on the recognition of additional rights” and has expressly declined to recognize a broad spectrum of asserted fundamental rights.\textsuperscript{166} In keeping with this trend, no court has been willing to interpret the Constitution broadly enough to imply a fundamental right to health within the penumbra of the right to life. Professor Elizabeth Weeks Leonard has noted:

Accepting that health is not a constitutionally protected right, any Due Process claim, like any Equal Protection claim, would be viable only if the government voluntarily undertakes to provide health care. Even then, the statute or regulation establishing the government service would have to create a legitimate claim of entitlement. Furthermore, the government would be liable under Due Process only if it unjustly deprived individuals of the health care service or benefit.\textsuperscript{167}

2. The Hospital Survey and Construction Act (The Hill-Burton Act)

During the period of 1929 to 1945, the Great Depression and World War II resulted in diminished capital investments in hospitals and other health care facilities.\textsuperscript{168} Despite the failure of his larger plan to reform health care,\textsuperscript{169} including a national health

\textsuperscript{165} Rodriguez, 411 U.S. at 33.


insurance plan, President Harry S. Truman signed into law the Hospital Survey and Construction Act of 1946, commonly known as the Hill-Burton Act.\textsuperscript{170} Considered by some as "the last and perhaps the most progressive expression of redistributive New Deal liberalism,"\textsuperscript{171} the Act provided grants and loans to hospitals to grow and modernize, particularly in underserved areas across the rural South. In return, funded facilities agreed to provide a "reasonable volume" of free or reduced-fee care for a period of twenty years after receiving funding, to all people living in the area "without discrimination on account of race, creed or color," and to those with an inability to pay.\textsuperscript{172} However, just prior to passage, Senator J. Lister Hill (D-Ala.), who co-sponsored the bill with Senator Harold Burton (R-Ohio), was able to add the wording: "But an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provisions on the basis of need for facilities and services of like quality for each such group."\textsuperscript{173} While this Jim Crow provision of the Hill-Burton Act made facilities separate, it did not make them equal. The Hill-Burton Act provided construction grants to ninety hospitals that refused to accept black patients or subjected black patients to inferior and unhealthy accommodations.\textsuperscript{174} In addition to "separate-but-equal" hospitals, significant federal funds went to hospitals that segregated patients on the basis of race. From its inception in 1946 until December 31, 1962, the Hill-Burton program provided $36,775,994 in federal grants to aid in the construction or remodeling of eighty-nine medical facilities intended for the exclusive use of either white or


\textsuperscript{172} See Noah, \textit{supra} note 132, at 166 ("The original Act required participating hospitals to ensure that their facilities were available to all persons residing in the hospital's territorial area without discrimination based on race, creed, or color, but this provision was later amended to require simply that facilities be available to all residing within the territorial area of the hospital receiving Hill-Burton funds.").

\textsuperscript{173} 92 CONG. REC. 10,232 (1946).

\textsuperscript{174} DITTMER, \textit{supra} note 48, at 19.
black persons.\footnote{175} Despite the significantly greater shortage of beds available for blacks, only $4,080,308 of such grants went to thirteen projects intended for the use of blacks.\footnote{176}

In 1954, at the time of the \textit{Brown v. Board of Education} decision to desegregate schools,\footnote{177} many saw little promise for racial integration in hospitals and health care.\footnote{178} However, the decision in the 1963 case of \textit{Simkins v. Moses H. Cone Memorial Hospital} prompted Department of Health and Human Services Secretary Anthony Celebrezze to implement a permanent ban on separate-but-equal facilities in all pending and future applications to the Hill-Burton program.\footnote{179} In \textit{Simkins}, a group of Greensboro, North Carolina black physicians, dentists, and patients brought discrimination suits against one Hill-Burton separate-but-equal hospital that excluded black physicians and patients altogether, and a second that admitted some black patients, but imposed restrictions on black patients that did not apply to white patients.\footnote{180}

Following the district court’s decision in favor of the defendant hospitals,\footnote{181} the plaintiffs appealed to the Fourth Circuit Court of Appeals. In a November 1, 1963 decision, the circuit court reversed the decision of the district court, ordering the hospitals to cease their discriminatory practices and declaring the separate-but-equal provisions of the Hill-Burton Act unconstitutional under the Fifth and Fourteenth Amendments.\footnote{182} The United States Supreme Court declined to review the case, leaving the circuit court’s decision standing in favor of the plaintiffs.

Moreover, with the passage of Title VI of the Civil Rights Act of 1964, the federal government “prohibited the provision of federal

\footnotesize{\begin{itemize}
\item 175. The majority of the facilities constructed under the Hill-Burton program were designated “non-discriminatory” facilities, rather than so-called “separate but equal” facilities allowed during the first seventeen years of the program. \textit{See U.S. Comm’n on Civil Rights, Equal Opportunity in Hospitals and Health Facilities: Civil Rights Policies Under the Hill-Burton Program 5} (1965).
\item 177. \textit{Smith, supra note 44, at 4}.
\item 178. \textit{U.S. Comm’n on Civil Rights, supra note 175, at 7}.
\item 181. \textit{Simkins}, 323 F.2d at 969–70.
\end{itemize}}
funds to organizations . . . that engaged in racial . . . or other forms of discrimination.” 183 Given their heavy reliance on federal funds from the Medicare and Medicaid program enacted one year later, hospitals were suddenly faced with choosing “between affluence through compliance or bankruptcy.” 184 While the visible remnants of Jim Crow policies were quickly removed from many institutions, significant segregation of health services continued. 185

By 1971, as the Hill-Burton program approached its scheduled expiration in 1973, the program had provided $3.7 billion in federal funding and $9.1 billion in matches from state and local governments to create nearly a half million beds in 10,748 projects, including nursing homes, mental-health facilities, public-health centers and hospitals. 186 Although for the first twenty years of the act’s existence, most Hill-Burton funded southern facilities remained closed to black physicians and there were no compliance mechanisms to ensure that facilities were providing non-discriminatory care, historian Edward H. Beardsley provides the view that, with the help of Hill-Burton projects, “Southerners of both races, but blacks particularly, began to enjoy an access to modern hospital care that they had never known before.” 187

In 1975, the Hill-Burton Act was amended as Title XVI of the Public Health Service Act. 188 Under the Title XVI Hill-Burton regulations, facilities assisted by the program are “required to provide uncompensated services in perpetuity.” 189 The Title XVI amendments also transferred the program’s “enforcement responsibilities from States to the Federal government” and refined compliance standards. 190 Program modifications in 1979 further refined “compliance levels, eligibility [criteria], record maintenance, and reporting requirements.” 191 By the time the program ceased funding in 1997, $4.6 billion in federal grants and

183. SMITH, supra note 44, at 4.
184. Id. at 5.
185. Id. at 8.
186. See Thomas, supra note 171, at 823; Truman Special Message, supra note 169.
188. Hill-Burton Facilities Compliance & Recovery, supra note 168 (see box on right entitled “About Hill-Burton, Titles VI & XVI”).
189. Id.
190. Id.
191. Id.
$1.5 billion federal loans had been distributed to 6800 health care facilities in more than 4000 U.S. communities.  

Hill-Burton health care facilities have provided “more than $6 billion in uncompensated services . . . to eligible patients” since 1980, with approximately “170 facilities . . . still obligated to provide free or reduced-cost care” under the program. Currently, patients may qualify “for Hill-Burton free care if [their] income is at or below the current HHS Poverty Guidelines,” or reduced care if their income is less than or equal to two times the HHS Poverty Guidelines, or three times the HHS Poverty Guidelines for nursing home care.  

In addition to the uncompensated care requirements, the Hill-Burton program under the amended Title XVI provisions has community service requirements. These rules require recipient facilities to make services provided by the facility available to persons residing or employed “in the facility’s service area without discrimination on the basis of race, color, national origin, creed, or any other ground unrelated to the individual’s need for the service or the availability of the needed service in the facility,” and may not adopt policies that have the effect of excluding patients on these discriminatory grounds. Additionally, under Title XVI, Hill-Burton program facilities must participate in the Medicare and Medicaid programs unless they are ineligible to participate, and must post notices informing the public of its community service obligations in English and Spanish. Facilities also must translate such notices into any language spoken by ten percent or more of the households in its service area and must “make reasonable efforts to communicate the contents of the posted notice to persons who it has reason to believe cannot read the notice.”

192. See id.
195. See Hill-Burton Free and Reduced-Cost Health Care, supra note 193.
197. Id. § 124.603(d).
198. Id. § 124.603(c)(ii) (Medicare/Medicaid requirement); id. § 124.604 (notice requirement).
199. Id. § 124.604(c).
Despite its strong and clear anti-discrimination stance, the Hill-Burton Act provides limited means of redress for patients against hospitals that implement discriminatory admissions practices or policies. Under 42 C.F.R. § 124.606, an aggrieved party may file a complaint against a facility with the Secretary of HHS. HHS will, “based on priorities for the disposition of complaints that are established to promote the most effective use of enforcement resources,” either investigate or dismiss the complaint. If HHS determines that a facility has violated the Act, it may require the facility “to establish an effective affirmative action plan . . . designed to insure” compliance with the Act, or may “take any action authorized by law to secure compliance, including but not limited to voluntary agreement or a request to the Attorney General to bring an action against the facility for specific performance.” If the secretary dismisses a complaint or the attorney general has not brought an action for compliance within six months from the date on which the complaint is filed, the aggrieved party may bring a private action to effectuate compliance with the Act. Notably, “the Act does not grant individual patients a private right of action to demand medical treatment.” Moreover, “individual suits to compel enforcement of the Act’s uncompensated care and community service provisions . . . are limited to this enforcement role only.” Several cases interpreting the Act and its implementing regulations have concluded that suits for personal relief are not supported by the Act, leading one author to conclude that “although an individual who is subjected to discriminatory admissions policies at a Hill-Burton hospital can file a private action to compel the hospital’s compliance with statutory obligations, such a right of action appears more of a symbolic victory than a practical means of remedying the wrong.”

200. *Id.* § 124.606(a)(4).
201. *Id.*
202. *Id.* § 124.606(b)(2).
203. *Id.* § 124.606(b)(1).
204. *Id.* § 124.606(a)(4).
205. Noah, *supra* note 132, at 166.
206. *Id.* at 166–67.
208. *Id.* at 167.
3. Civil Rights Law—Title VI of the Civil Rights Act

Although the 1963 decision in *Simkins v. Moses H. Cone Memorial Hospital* marked a significant milestone in the journey toward elimination of disparities in health care, its impact was limited because the ruling applied only to Hill-Burton facilities. However, in 1964, the Fourth Circuit Court of Appeals followed its *Simkins* decision with a ruling that extended the prohibition against racial discrimination to a hospital that had not received Hill-Burton funds. In *Eaton v. Grubbs*, black physicians and two of their patients brought a claim to enjoin a Wilmington, North Carolina, hospital from denying their “admission to staff membership and treatment facilities on racially discriminatory and segregated basis.” The circuit court had previously affirmed a 1958 district court’s dismissal of an action by the same plaintiffs on the grounds that the “act of discrimination in denying [black] physicians courtesy staff privileges at hospital did not constitute state action which the federal court had power to interdict.” Relying in large part on the recent United States Supreme Court decision in *Burton v. Wilmington Parking Authority* that a private business can operate in such close relationship to a government that it becomes a state actor, here the court held,

[T]he record in its entirety leads to the conclusion that the hospital is performing the state’s function and is the chosen instrument of the state. Under our constitutional commitment the James Walker Hospital is therefore bound by the provisions of the Fourteenth Amendment to refrain from the discrimination alleged in the complaint.

With the decisions in *Simkins* and *Eaton*, the prohibition against discrimination and segregation in health care applied to Hill-Burton and state-affiliated facilities under the jurisdiction of the Fourth Circuit, which are those in North Carolina, South Carolina, Virginia, and West Virginia. The rulings did not, however,
apply to other private facilities or facilities outside the court’s jurisdiction.

Eight months after the Simkins decision, and three months after the Eaton decision, President Lyndon B. Johnson signed the Civil Rights Act into law on July 2, 1964. This landmark legislation outlawed discrimination in voter registration requirements and racial segregation in schools, the workplace, and in public accommodations. Championed by President John F. Kennedy, H.R. 7152 was introduced by Representative Emanuel Celler (D-NY) on June 20, 1963. The bill made a contentious way through Congress until President Kennedy’s assassination on November 22, 1963. In succeeding Kennedy, President Johnson led the charge for passage of the legislation and, with strong support from Majority Whip Hubert H. Humphrey, Jr. (D-MN), a Senate compromise version of the bill passed in the House on July 2, 1964.

Title VI of the Civil Rights Act of 1964, codified as 42 U.S.C § 2000d, states, “No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”

The regulations promulgated under Title VI impose significant requirements upon federally funded programs, including the mandate that programs provide contractually binding assurances that they will adhere to Title VI regulations. Federally funded programs also must file compliance reports with the Office of Civil Rights (OCR) at HHS documenting the quantity and type of services the program provides to minorities. Shortly following its enactment, the Federal Department of Health, Education, and Welfare (DEHW) limited the role of the Civil Rights Act with respect to physicians. It did so through its

216. Id. § 101, 78 Stat at 241-42.
217. Id. § 401, 78 Stat at 246-47.
218. Id. § 701, 78 Stat at 253-55.
219. Id. § 201, 78 Stat at 243.
221. 110 CONG. REc. 15,897 (1964).
223. Id.
224. Id. § 2000d.
interpretation of the language in Title VI excluding any "contract of insurance or guaranty." Considering Medicare Part B typical indemnity insurance for patients' losses, the payment of insurance proceeds received from Medicare Part B to a treating physician does not, according to the DEHW, constitute federal financial assistance to the physician for the purposes of the Civil Rights Act. Accordingly, individual physicians were considered a "program or activity receiving Federal financial assistance" only when providing services under Medicaid, the State Children's Health Insurance Program (SCHIP)—another federally funded program—or when contractually linked to a managed care plan that provides services for Medicare or Medicaid enrollees.

Furthermore, in Alexander v. Choate, the Supreme Court concluded that despite widely varying interpretations of Title VI, the Act itself prohibits only intentional discrimination, but the implementing regulations specifically prohibit facially neutral activities that impair the agency's objectives "and those that result in a disproportionate impact on a group." The Choate decision was based largely on the Court's analysis of Guardians Association v. Civil Service Commission of New York. In Guardians, although the Court held that "Title VI does not explicitly allow for any form of a private right of action[,]" three of the five Justices who also voted to uphold disparate-impact regulations "expressly reserved the question of a direct private right of action to enforce them." Thus, according to the Court, a private plaintiff may secure equitable relief if he is able to prove intentional discrimination, but the Court did not "clearly answer the question of whether similar relief might be available where the plaintiff can only prove the disparate impact of a facially neutral policy."

228. Noah, supra note 132, at 159 n.94.
229. Choate, 469 U.S. at 292–94.
230. Guardians Ass'n, 463 U.S. at 600.
232. Guardians Ass’n, 463 U.S. at 584.
233. Noah, supra note 132, at 162.
While some scholars aptly chronicle both congressional intent and judicial precedent authorizing the private right to bring suit for enforcement of Title VI’s prohibition of disparate impact discrimination, any remaining question as to the Supreme Court’s position regarding such a right was resolved in *Alexander v. Sandoval.* Martha Sandoval, a Mexican immigrant, was not sufficiently fluent in English to pass the written portion of Alabama’s driver’s license exam. Claiming that Alabama’s English-only driver’s license test policy had an unjustified discriminatory effect on the basis of national origin in violation of Title VI and its implementing regulations, Sandoval initiated suit to challenge the policy. The Court of Appeals for the Eleventh Circuit affirmed the district court’s judgment in favor of Sandoval, enjoining Alabama’s continued use of the English-only test. The Supreme Court granted review of the decision on the question of whether private individuals may sue to enforce disparate impact regulations promulgated under Title VI. In a five-to-four decision, authored by Justice Antonin Scalia, the Court held that an individual plaintiff may challenge the policy of a federally funded program only if he or she can show intentional discrimination. As summarized by the Department of Justice, “only the funding agency issuing the disparate impact regulation has the authority to

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236. 532 U.S. at 276 (holding there is no private right to action under Title VI for a disparate-impact discrimination).

237. See id. at 278–79.

238. See id. at 279.

239. Id.

240. Id.

241. See id. at 275. The *Sandoval* decision clearly bars disparate impact suits brought by private plaintiffs against private organizations that receive federal funds, such as private hospitals and clinics. See generally id. However, in his dissenting opinion, Justice Stevens stated that the decision leaves open the question of whether Title VI’s disparate impact regulations may be enforced against public recipients of federal funds under 42 U.S.C. § 1983 (2000). See *Sandoval*, 532 U.S. at 299–300 (Stevens, J., dissenting); see also Noah, supra note 132, at 158–63. On the other hand, as Professor Noah notes, even if private plaintiffs could bring disparate impact claims, such claims would be difficult to sustain against a “state actor” unless the plaintiff could “prove that the challenged policies are arbitrary and fail to advance any legitimate purpose.” See id. at 163.
challenge a recipient's actions under this theory of discrimination.\textsuperscript{242}

The Court's decision in \textit{Sandoval} certainly creates barriers to challenging policies that have disproportionate impact on the health and health care of minorities. First, few federally funded private health care institutions or programs are overtly discriminatory, and where discrimination on the basis of race, color, or national origin does exist, it is likely difficult to prove.\textsuperscript{243} Second, OCR has announced few noteworthy Title VI actions related to race-based disparate impact.\textsuperscript{244} According to OCR, "[m]ost OCR resolution agreements address the need to improve access for persons with disabilities and for people with limited English proficiency."\textsuperscript{245} In fact, in a list of forty recent health-related civil rights resolution agreements and compliance reviews on the OCR website, twenty-seven involve allegations of disparate impact discrimination toward persons with disabilities, eight involve limited English proficiency, and only five involve race-based disparate impact.\textsuperscript{246} In an enforcement action against University of Pittsburgh Medical Center (UPMC), OCR announced:

OCR Region III reached a voluntary resolution agreement with UPMC, prior to conducting a full-scale investigation. The complaint alleged that UPMC violated Title VI of the Civil Rights Act of 1964, when it closed one of its affiliated hospitals located in a small, predominately black community near Pittsburgh, Pennsylvania. UPMC


\textsuperscript{244} Recent Civil Rights Resolution Agreements & Compliance Reviews, U.S. DEP'T HEALTH & HUM. SERVICES, http://www.hhs.gov/ocr/civilrights/activities/agreements/index.html (last visited Apr. 2, 2015). The HHS Office of Civil Rights publishes a database of recent civil rights resolution agreements and compliance reviews where it has determined that "it is necessary to negotiate resolution agreements requiring covered entities to take needed corrective action to comply with Federal civil rights laws." \textit{Id.}

\textsuperscript{245} Alice Wershing, \textit{Agreement, Settlement and Acceptance: How Did We Get Here?}, ACCESS FOR ALL (Aug. 14, 2014), http://blogs.pstcc.edu/access4all/2014/08/14/agreement-settlement-and-acceptance-how-did-we-get-here/.

\textsuperscript{246} Recent Civil Rights Resolution Agreements & Compliance Reviews, supra note 244. Of forty examples listed on the website, twenty-six involve health providers or facilities, while the fourteen remaining examples involve non-health-care human service issues. \textit{Id.}
maintains that it closed the facility due to millions of dollars in financial losses as well as underutilization by the community. In order to ensure that the hospital’s closure does not have a disparate impact on the predominantly minority community, UPMC agreed to subsidize expanded hours and services at a federally qualified health center; provide door to door transportation for residents to three outpatient facilities in a neighboring community; and provide door to door service to another UPMC affiliated hospital. UPMC also agreed to conduct six health-screening programs throughout the year as well as a diabetes-screening program twice a year; designate an ombudsperson to help individuals navigate the UPMC health care system; and provide outreach to faith-based health ministries in the community.247

As summarized by Professor Dana Matthew,

Now that Alexander v. Sandoval has eliminated the private avenues for enforcement of Title VI disparate impact claims, only two alternatives remain. A private plaintiff may still obtain injunctive and declaratory relief under Title VI for intentional discriminatory treatment, or vigilant and committed administrative agencies can enforce the disparate impact regulations promulgated under Title VI. Unfortunately, there is no evidence of any such commitment in the current administration. In fact, much has been written to confirm that where healthcare is concerned, Title VI enforcement to eliminate racial disparity and injustice is no longer a priority. One commentator has opined that the “timid and ineffectual enforcement efforts of the government through . . . OCR . . . have fostered, rather than combated, the discrimination that continues to infect the nation’s health care system.”248


4. Indian Health Care

As part of the federal government’s efforts since the nineteenth century to assimilate Native American health care into the mainstream American process, the Bureau of Indian Affairs at the Department of the Interior originally oversaw congressional appropriations used for health care programs offered to American Indians. The Snyder Act of 1921, which is the first acknowledgement by the federal government of the need to provide for the health care needs of Native Americans, provided for appropriations as needed to the Bureau of Indian Affairs to assist Native Americans in many respects, including “relief of distress and conservation of health.”

Following several organizational transfers, the responsibility for Indian health care oversight ultimately came to lie with the Indian Health Service (IHS), a division of the U.S. Department of Health and Human Services.

The Indian Health Care Improvement Act (IHCIA) was enacted by the 94th Congress and signed into law by President Gerald Ford on October 1, 1976. Congress found that many IHS facilities were “inadequate, outdated, inefficient and understaffed,” and while recognizing that spending for IHS had grown from $128 million in fiscal year 1970 to $425 million in fiscal year 1977, President Ford acknowledged that “Indian people still lag behind the American people as a whole in achieving and maintaining good health.” The law was intended to provide for improvements in Indian health manpower, services, and facilities;

and, through a series of amendments since its passage, it has been the cornerstone legal authority for the provision of health care to American Indians and Alaska Natives.

Today, IHS utilizes direct, tribal, and contracted service providers to deliver health care to 2.2 million of the estimated 3.4 million nationwide American Indians and Alaska Natives belonging to 566 federally recognized tribes. Federal IHS resources consist of 28 hospitals, 61 health centers, 34 health stations, a clinical workforce of approximately 2590 nurses, 790 physicians, 660 pharmacists, 670 engineers/sanitarians, 330 physician assistants/nurse practitioners, 290 dentists, and various allied health professionals (such as nutritionists, health administrators, and medical records administrators). Together with American Indian tribes and Alaska Native corporations (which administer 17 hospitals, 249 health centers, 70 health stations, and 164 Alaska village clinics), IHS delivers preventive and therapeutic measures in a national system. Although most IHS funds are appropriated for American Indians and Alaska Natives who live on or near reservations or Alaska villages, Congress also has authorized funding to support programs that provide some access to care for American Indians and Alaska Natives who live in urban areas.

Despite significant improvements provided by the Indian health model and the participation of Indian people in decisions affecting their health, American Indians continue to experience large disparities in life expectancy and death due to chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory disease compared to the U.S. general population. Moreover, the authorization of appropriations for the IHCIA expired in 2000, and while Congress considered various efforts to reauthorize it since then, the IHCIA's future was uncertain until it

256. Quick Look, supra note 6.
258. Quick Look, supra note 6.
259. Id.
260. Id.
261. Id.
was amended and permanently reauthorized in 2010 under the Patient Protection and Affordable Care Act.  

5. The Emergency Medical Treatment and Labor Act (EMTALA)

The Emergency Medical Treatment and Labor Act (EMTALA) applies to all hospitals that receive federal Medicare funds and that have emergency departments or provide emergency medical care. In 1986, there was a growing crisis of hospital “patient dumping”—a practice whereby uninsured, minority, or other “undesirable” patients were transferred to other hospitals to receive inferior care, or no care at all. To ensure that hospitals would provide equal treatment regardless of citizenship, race, ethnicity, or ability to pay, Congress passed EMTALA in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA). EMTALA imposes affirmative duties on hospitals to screen and, if necessary, treat and stabilize every individual who comes to the emergency department. Specifically, hospitals must: (1) provide “an appropriate medical screening examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition ... exists”; (2) provide treatment to stabilize the medical condition or appropriately transfer the individual to another hospital if an emergency medical condition exists; and (3) abide by restrictions on transferring unstable individuals and transfer stable individuals only in cases of medical necessity. The Act does not, however, provide for reimbursement for hospital services rendered under the mandate.


263. EMTALA was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, 100 Stat. 82, 717-19 (1986), and was enacted under § 1867 of the Social Security Act, 42 U.S.C. § 1395dd (2006).


265. Id. § 1395dd(a).

266. Id. § 1395dd(b).

267. Id. § 1395dd(c).
Physicians, including on-call physicians, who violate EMTALA may be subject to a civil penalty of up to $50,000; and, if the violation is gross and flagrant or is repeated, to exclusion from participation in federal and state health care programs. A participating hospital that negligently violates a requirement of EMTALA is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. Additionally, EMTALA provides a civil cause of action for damages and/or equitable relief to "[a]ny individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement" of the Act, according to the laws of the state in which the hospital is located.

The private right of action created by EMTALA does not require that a patient specifically allege discrimination on the basis of race or ethnicity. In Cleland v. Bronson Health Care Group, Inc., the Sixth Circuit Court of Appeals explained that a hospital violates the Act when it fails to provide a medical screening or stabilization due to an “improper motive,” such as indigence or “prejudice against the race, sex, or ethnic group of the patient; distaste for the patient’s condition (e.g., AIDS patients); personal dislike or antagonism between the medical personnel and the patient; disapproval of the patient’s occupation; or political or cultural opposition.” Although the Supreme Court subsequently overruled the requirement to show an improper motive in a “failure to stabilize” claim under § 1395dd(b), it declined to address the Sixth Circuit’s interpretation of EMTALA’s “appropriate medical screening” language, leaving the improper motive requirement intact under § 1395dd(a). Assuming, however, that a plaintiff can demonstrate that a hospital violated the screening and/or stabilization requirements of EMTALA, he or she cannot prevail in an action against the hospital where there is

268. Id. § 1395dd(d)(1)(B).
269. Id. § 1395dd(d)(1)(A).
270. Id. § 1395dd(d)(2)(A).
no compensable injury, or where there is no causal link or nexus between the violation and the compensable injury. 273

Ultimately, however, remedies available under EMTALA are of limited impact to overall reduction of disparities in health and health care, since the Act applies only to emergency medical care. 274 Moreover, as articulated by one legal scholar:

The frequent inability of plaintiffs suing under EMTALA to survive summary judgment has substantially curtailed the Act’s capacity to remedy and deter disparities in emergency-department screenings. At summary judgment, many federal courts, often without a detailed explanation of what constituted the hospital’s uniform practice, are highly deferential to the assertions, judgments, and perceptions of treating physicians. To the extent that this practice constitutes a “weighing of the evidence,” it amounts to an aggressive, if not improper, use of summary judgment. And it puts a tremendous evidentiary burden on EMTALA plaintiffs that precludes meaningful private enforcement of the Act. 275

6. Federal and State Law Regarding the Collection and Use of Race, Ethnicity, and Preferred Language Data

Although it is generally agreed that improvements in health care quality can result from the collection and use of race, ethnicity, and preferred language data, or REL data, to identify disparities and target specific interventions to reduce gaps in care and outcomes, 276 legal concerns historically led few health plans to

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276. David R. Nerenz et al., Race, Ethnicity, and Language Data Collection by Health Plans: Findings from 2010 AHIPF-RWJF Survey, 24 J. HEALTH CARE FOR POOR & UNDERSERVED 1769, 1769 (2013); see also Sarah S. Rittner et al., Collecting Race, Ethnicity and Primary Language Data in Physician Practices: The Minnesota Community Measurement Experience, ROBERT WOOD JOHNSON FOUND. (Aug. 2010), http://www.rwjf.org/content/dam/web-assets/2010/08/collecting-race-ethnicity-and-primary-language-data-in-physicia. Organizations such as the Joint Commission, the American Hospital Association, the National Committee for Quality Assurance, the Institute of Medicine, and the American Medical Association have recognized
collect such data. However, as concerns regarding the legal implications have subsided, hospitals, physician groups, and health plans have significantly increased their collection of REL data from patients or members as a way to identify disparities in health or health care, implement effective quality improvement, and provide support for culturally appropriate communications to patients or plan members.

No federal law prohibits health care providers or health insurance plans from collecting REL data. Although programs receiving financial assistance from the federal government are prohibited from discriminating on the basis of race, color, or national origin under Title VI of the Civil Rights Act, Title VI neither mandates nor prohibits collection of REL data. In Madison-Hughes v. Shalala, the Sixth Circuit Court of Appeals "found no statutory or regulatory requirements pursuant to Title VI that [REL] data be collected, but rather that such data collection is left to HHS's discretion." "Federal inclusion policies for the collection of [REL] data" do, in fact, "mandate the collection of such data in HHS-sponsored and HHS-maintained data collection activities." Interestingly, however, "black," "white," and "other" were the only race or ethnicity designations included in the CMS administrative database until 1993. "Native American," "Asian American or Pacific Islander," and "Hispanic" were added in 1994,

280. Id. at 6 n.vii (citing Madison-Hughes v. Shalala, 80 F.3d 1121, 1125 (6th Cir. 1996)).
and a 1997 revision separated “Asian American or Pacific Islander” into two distinct categories. Also in 1997, with the adoption of a government-wide REL data collection standard, participants could identify more than one category. Presently, ethnicity is asked first (“Are you Hispanic, Latino/a, or Spanish Origin?”), and then race (“What is your race?”).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) governs many aspects of the collection, storage, use, and disclosure of personal health information. HIPAA also contains no prohibition on the collection of REL data, but the HIPAA Privacy Rule does limit the use and disclosure of such data for purposes other than treatment, payment, and health operations without the patient or plan member’s written authorization. Finally, at the time of a 2001 survey, forty-six states and the District of Columbia placed no restrictions on the collection of REL data by health care providers and health plans; California, Maryland, New Hampshire, and New Jersey had some prohibitions against health insurers and/or HMOs collecting REL data; no state policy was found requiring the collection of race or ethnicity data; and Texas required the collection of primary language data.

The changing regulatory and accreditation environment actually has provided support for efforts to collect REL data. “The National Committee for Quality Assurance has developed voluntary accreditation standards for Culturally and Linguistically Appropriate Services that include the collection and use of race, ethnicity, and language data (REL),” and some states, including

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283. Eichner & Vladeck, supra note 282, at 368; see also Arday et al., supra note 282, at 108–09.
284. See Arday et al., supra note 282, at 109.
289. Nerenz et al., supra note 276, at 1770; see also Joseph R. Betancourt et al., Cultural Competence and Health Care Disparities: Key Perspectives and Trends, 24
Massachusetts and California, have required health plans to collect REL data and report standardized quality of care measures stratified by race and ethnicity. Other states, such as Minnesota, have strongly supported voluntary efforts to collect REL data.

Partnering with the Minnesota Department of Health's Office of Minority and Multicultural Health, the MN Community Measurement (MNCM) has been a pioneer in working with medical groups to standardize the collection of REL data to reduce disparities and improve quality. Despite its significant ultimate success, however, the Minnesota experience encountered substantial barriers to widespread REL data collection, including:

- Data collection is not a priority for many physicians, especially among those who serve in areas with very little diversity;
- Staff are reluctant to ask patients about their race, ethnicity, and language;
- Information technology systems cannot accommodate the data collection requirements;
- Small numbers do not allow for reliable analysis of performance in different groups;
- Perceptions by clinical staff that disparities do not exist in their own practice; and
- Limited resources to dedicate to data collection activities.

Others have noted some resistance to providing REL data from individuals or communities who fear potential misuse of the data, such as to deny benefits or to deny coverage entirely.

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290. Nerenz et al., supra note 276, at 1770 (citing Robin M. Weinick et al., Measuring Racial and Ethnic Health Care Disparities in Massachusetts, 26 HEALTH AFF. 1293 (2007)).

291. See Rittner et al., supra note 276, at 4–5.

292. Id. at 2, 4. MN Community Measurement, “a community-based nonprofit organization comprising representatives from Minnesota’s state medical associations, medical groups, hospitals, local businesses, health plans and consumer groups,” id., “creates and refines measures, and collects and reports health care data used to drive improvement in health care,” About Us, MN COMMUNITY MEASUREMENT, http://mncm.org/about-us/ (last visited Apr. 7, 2015).

293. Rittner et al., supra note 276, at 5.
7. The Minority Health and Health Disparities Research and Education Act

In his radio address on February 21, 1998, President Bill Clinton used the occasion of Black History Month to celebrate improvements in our nation’s health over the prior six years and to decry “the alarming fact that too many Americans do not share in the fruits of our progress, and nowhere are the divisions of race and ethnicity more sharply drawn than in the health of our people.” In announcing his goal to eliminate racial and ethnic disparities in infant mortality, diabetes, cancer screening and management, heart disease, AIDS, and immunization by 2010, President Clinton went on to say:

We do not know all the reasons for these disturbing gaps. Perhaps inadequate education, disproportionate poverty, discrimination in the delivery of health services, cultural differences are all contributing factors. But we do know this: No matter what the reason, racial and ethnic disparities in health are unacceptable in a country that values equality and equal opportunity for all. And that is why we must act now with a comprehensive initiative that focuses on health care and prevention for racial and ethnic minorities.

Recognizing “continuing disparities in the burden of illness and death experienced by African Americans, Hispanics, Native Americans, Alaska Natives, and Asian Pacific Islanders, compared to the U.S. population as a whole,” Senate Bill 1880, sponsored by Senator Edward Kennedy (D-MA), was signed into law by President Clinton on November 22, 2000 as the Minority Health and Health

296. Id.
Disparities Research and Education Act (MHHDREA). Notably, MHHDREA was not just a minority health bill. The bill’s authors also recognized that despite a higher proportion of racial and ethnic minorities in the United States represented among the medically underserved, the “largest numbers of the medically underserved are white individuals, and many of them have the same health care access problems as do members of minority groups.” Congress found that “[n]early 20,000,000 white individuals live below the poverty line with many living in nonmetropolitan, rural areas such as Appalachia, where the high percentage of counties designated as health professional shortage areas (47 percent) and the high rate of poverty contribute to disparity outcomes.”

One of the major provisions of MHHDREA was the elevation of the Office of Minority Health at the National Institutes of Health (NIH) to the Center for Minority Health and Health Disparities (CMHHD). Supported by an initial budget of approximately $150 million, and the guidance of Dr. John Ruffin as its first director, the purpose of CMHHD was to conduct and support research, training, dissemination of information, and other programs with respect to minority health conditions and other populations with health disparities. Additionally, MHHDREA: (1) directed the Agency for Health Care Research and Quality to conduct and support research on health disparities, (2) directed

299. See 42 U.S.C § 285t(a). The National Institute on Minority Health and Health Disparities (Institute) also researches “other populations with health disparities.” Id.
300. Minority Health and Health Disparities Research and Education Act § 2(2).
301. Id.
304. See id. at xi, 72.
305. See Minority Health and Health Disparities Research and Education Act § 201.
306. Id.
the National Academy of Sciences to conduct a comprehensive study of HHS systems and practices “[related] to the collection of data on race or ethnicity,” (3) provided grants for the “training and education of health professionals for the reduction of disparities in health care outcomes and the provision of culturally competent health care,” and (4) ordered HHS to “conduct a national campaign to inform the public and health care professionals about health disparities in minority and other underserved populations by disseminating information and materials available on specific diseases affecting these populations and programs and activities to address these disparities.”

CMHHD administered an aggressive agenda of research, training, and education until it “was re-designated to the National Institute on Minority Health and Health Disparities (NIMHD) with the passing of the Patient Protection and Affordable Care Act” in 2010.

B. **State Law**

1. **State Constitutions and Legislation**

Overall population health and health disparities differ significantly from state to state in America, and across population subgroups within each state. Similarly, states differ significantly in

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307. *Id.* § 301.
308. *Id.* § 401.
309. *Id.* § 501.
311. See generally B.K. Gibbs et al., *Reducing Racial and Ethnic Health Disparities: Exploring an Outcome-Oriented Agenda for Research and Policy*, 31 J. HEALTH POL. POL’Y & L. 185 (2006); Bridget C. Booske et al., *Grading and Reporting Health and Health Disparities*, PREVENTING CHRONIC DISEASE: PUB. HEALTH RES. PRAC. & POL’Y (Dec. 15, 2009), http://www.cdc.gov/pcd/issues/2010/jan/pdf/08_0235.pdf. Gibbs’ report provides a comprehensive review of the state and local policy interventions that have been implemented to address disparities in minority health and health care. Gibbs, supra. The report divides minority health and health disparities programs into those targeting infrastructure, management, and capacity, and those targeting specific health conditions, and identifies key needs that state and national policymakers should consider. *Id.* Although this Article makes the case for construction and nationwide application of two objective indices, the “Disparity Reduction Profile” (DRP) to measure effort and the “Disparity Index” (DI) to measure outcomes, there are limited subsequent reports documenting substantial interest or effort to devise or implement such a scheme. *Id.* at 198.
their recognition of a right to health. As summarized by Professor Elizabeth Weeks Leonard:

The text of state constitutions reveals certain trends. Some constitutions arguably create enforceable rights. Others merely recognize health as an important value, public concern, or aspiration. Some contain mandatory language that the state or, specifically, state legislature, "shall pass suitable laws" or "shall provide" for the health of citizens. Other constitutions identify the state's power or authority over health but do not establish a duty. In addition to varying strength of rights-creating language, state constitutions differ in their inclusiveness. Some limit the right or duty to the indigent, insane, or other vulnerable members of society. Other constitutions specify types of services, such as public health or hospital care.\(^{312}\)

Professor Leonard notes, however, that like the federal Constitution, all of the state constitutional provisions "fall well short of a broad guarantee of health."\(^{313}\)

Likewise, wide variations exist among states with respect to their laws, policies, and practices to detect and/or eliminate health disparities.\(^{314}\) For example, in their effort to evaluate state and local effort, leadership, capacity, and infrastructure to reduce health disparities, Amal Trivedi and co-authors developed and reported criteria for a state minority health policy "report card."\(^{315}\) The results of applying the tool to all fifty states reveal wide variations, with geographic location within the nation being a significant predictor of performance.\(^{316}\) The study concluded that Western states had larger insurance disparities, less diverse physician workforces, and were less likely to have an Office of Minority Health than the national average; states in the West region reported more race and ethnicity categories in their vital statistics reports than the national average; and states in the South had significantly fewer insurance disparities and collected data in fewer vital statistics categories than the other states.\(^{317}\) The authors found

\(^{312}\) Leonard, supra note 167, at 1348.

\(^{313}\) Id.

\(^{314}\) See generally Amal N. Trivedi et al., Creating a State Minority Health Policy Report Card, 24 HEALTH AFF. 388 (2005).

\(^{315}\) See generally id.

\(^{316}\) Id. at 395.

\(^{317}\) Id. at 390–93.
no association between performance and state fiscal capacity. Interestingly, however, there was a statistically significant inverse relationship between the percentage of minorities within a state and the diversity of the physician workforce, such that "states with the highest proportion of racial and ethnic minorities had physician workforces that were the least reflective of their demographic composition."

While these offices have various titles, structures, authorities, procedures, and priorities, every state now has some form of office dedicated to minority health or health equity, all sharing the common goal to improve health disparities within their state. Many states have completed disparities impact studies, and most have prepared or are in the process of preparing state plans to reduce racial and ethnic health disparities. As summarized in Table 1 of this Article, all but eight states have passed some form of minority health and/or health disparities legislation.

Consistent with the principles of state autonomy embodied in the Tenth Amendment of the U.S. Constitution, the states continue to be the most active source of laws and regulations addressing health disparities, with over one hundred bills addressing various aspects

318. Id. at 393; see also Gibbs et al., supra note 311, at 185–218.
319. Trivedi et al., supra note 314, at 393.
321. Id.; see also KAREN M. ANDERSON, INST. MED. NAT’L ACADS., STATE AND LOCAL POLICY INITIATIVES TO REDUCE HLTH DISPARITIES: WORKSHOP SUMMARY 2 (2011) (“On May 11, 2009, the Institute of Medicine’s Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities sponsored a public workshop to discuss the role of state and local policy initiatives in reducing health disparities. The hope is to advance the dialogue about health disparities by facilitating discussion among stakeholders in the community, academia, health care professionals, business, policy-making entities, and philanthropic organizations. The goal of the meeting was to discuss how to highlight the importance of ‘community’ when ways to address health disparities are addressed. A focus on several different geographic areas could help identify commonalities in community strategies, best practices, and lessons learned from community successes and failures in addressing health disparities.”).
323. Id. Alaska, Idaho, New Hampshire, North Dakota, South Dakota, Vermont, West Virginia, and Wyoming had not reported minority health or health disparities legislation to the NCSL as of January 20, 2014. Id.
324. Id.
of health disparities introduced in the council of the District of Columbia and the legislatures of twenty-seven states during 2014.\footnote{325}

Minnesota was among the first states to recognize and formally combat health disparities. Alerted to the problem of health disparities in populations of color and American Indians in a 1987 report by the Minnesota Center for Health Statistics,\footnote{326} Minnesota established the Office of Minority and Multicultural Health in 1993. From 1997 to 2009, the state produced an annual \textit{Populations of Color: Health Status Report}\footnote{327} to provide the foundation for the data collection, analysis, decision guidance, and actions to follow.\footnote{328}

In a pair of reports released prior to the publication of \textit{Unequal Treatment}, Minnesota groups studied health disparities and issued recommendations for their elimination. In the report titled \textit{Closing the Gap: A Public Health Report on Health Disparities}, the Metro Minority Health Assessment Project\footnote{329} found significant race-based disparities in infant mortality, prenatal care, immunizations, low-birth-weight babies, sexually-transmitted disease, suicide, and life expectancy.\footnote{330}

\footnotesize
\begin{itemize}
  \item 326. \textit{MINN. CTR. FOR HEALTH STATISTICS, MINN. DEP'T OF HEALTH, MINORITY POPULATIONS IN MINNESOTA—A HEALTH STATUS REPORT} (1987).
  \item 328. \textit{See generally MINN. DEP’T OF HEALTH, ADVANCING HEALTH EQUITY IN MINNESOTA: REPORT TO THE LEGISLATURE} (2014).
  \item 329. This was a collaborative effort among health agencies in the seven-county metro area surrounding the Minneapolis/St. Paul region (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties).
\end{itemize}
The report recommended that public health officials:
Look for answers "outside of what has traditionally been considered the realm of public health," including discrimination, housing, employment and education;
Increase the role of minorities in health professions;
Educate community leaders and the public about the benefits of reducing health disparities;
Increase quality and availability of interpreters in health and social service;
Improve racial and ethnic information in health data. \(^{331}\)

In the second report, titled *A Call to Action: Advancing Health for All Through Social and Economic Change*, the Social Conditions and Health Action Team of the Minnesota Health Improvement Partnership concluded that:
People with higher incomes have better health and live longer than do those with lower incomes;
People are healthiest when they feel "safe, supported and connected" to family, neighborhood, workplace and community members;
Workers are healthiest when they believe their job is secure, the work they produce is "important and valued," the workplace is safe and there are "ample opportunities for control, decision-making, advancement and personal growth." \(^{332}\)

Based on these findings, the group advised the state to:
Build a "representative and culturally competent workforce;"
Identify ways to more actively involve community members and groups in health improvement;
Establish stable funding and leadership to "support innovative long term collaborative efforts with potential to achieve and sustain change;" and

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332. *See id.* (citing *SOC. CONDITIONS & HEALTH ACTION TEAM, MINN. HEALTH IMPROVEMENT P'SHIP, A CALL TO ACTION: ADVANCING HEALTH FOR ALL THROUGH SOCIAL AND ECONOMIC CHANGE* (2001)).
Strengthen assessment, evaluation and research of racial disparities... 333

"To target racial and ethnic health disparities, Gov. Jesse Ventura (I) ... earmarked $13.9 million in his proposed budget to address minority health problems, and the health department ... made eliminating disparities a 'primary goal.' 334 With the 2001 passage of Minnesota Statutes section 145.928, creating the Eliminating Health Disparities Initiative, Minnesota became one of the first states in the United States to pass a legislative mandate to reduce health disparities. 335

Fourteen states (Alabama, Alaska, Arkansas, Hawai'i, Illinois, Louisiana, Michigan, Mississippi, Missouri, Montana, New York, North Carolina, South Carolina, and Wyoming) also have specific references to health (or language regarding "'[b]eneficent provision' for the needy" that has been interpreted to include health care) in their state constitutions. 336 However, where state constitutions extend enforceable rights to health care at all, they tend to extend such rights to certain "vulnerable groups," including the mentally ill, indigent persons, and prisoners. 337 Notably, no state constitution contains specific reference to minority health or health disparities.

2. Tort Law

Much of the discussion regarding racial and ethnic health disparities involves systemic determinants of disparate care and large scale economic, political, social, and legal approaches to achieving health equity. Conversely, two objectives of tort law—deterrence and redress—seek broad societal benefits by dissuading individual actors from engaging in derelict behavior and compensating individual victims injured by such behavior. 338 Since

333. See id. (quoting SOC. CONDITIONS & HEALTH ACTION TEAM, supra note 332).

334. See id.

335. MINN. DEP’T OF HEALTH, supra note 328, at 21.

336. See Leonard, supra note 167, at 1347 (citing ALA. CONST. art. IV, § 93.12; ALASKA CONST. art. VII, § 4; ARK. CONST. art. 19, § 19; HAW. CONST. art. IX, §§ 1, 3; ILL. CONST. pmbl.; LA. CONST. art. XII, § 8; MICH. CONST. art. 4, § 51; MISS. CONST. art. IV, § 86; MO. CONST. art. 4, § 37; MONT. CONST. art. II, § 3; N.Y. CONST. art. 17, §§ 1, 3; S.C. CONST. art. XII, § 1; WYO. CONST. art. 7, § 20).

337. Id. at 1370.

recent studies strongly suggest that conscious or unconscious physician bias in the individual patient-physician interaction plays a significant role in contributing to disparities, a patient subjected to substandard care at the hands of a racially biased caregiver could (at least theoretically) have a cause of action in tort law against the derelict caregiver.

The success of a tort claim for medical malpractice depends on the plaintiff’s ability to prove negligence on the part of a caregiver. A finding of medical negligence, in turn, depends on the caregiver’s departure from the generally accepted standard of care. If, then, personal bias leads a caregiver to deviate from the professional standard of care and a patient suffers injury as a result, the caregiver may be liable. Notably, however, the fact that bias resulted in the substandard care is irrelevant in the case; the nature and effects of the substandard care are the focuses of the inquiry, not the bias that motivated the substandard care. In other words, racially biased physicians cannot be sued for bias alone—only for substandard care, and then, the reason for the substandard care is irrelevant.

Furthermore, since health disparities resulting from clinical discretion tend to fall within the bounds of generally accepted clinical variations, “so long as a defendant has not acted far outside the bounds of generally accepted standards, he or she can easily turn a suit stemming from racial disparity in medical treatment into a dispute over the proper standard of ‘reasonable care.’” Ultimately, therefore, individuals seeking redress for racial disparities in medical treatment will not likely find a resolution in bringing a medical malpractice claim.

C. International Law

In 2012, Sara Bleich and co-authors summarized the policy commitments and activities to address health inequalities in nine

340. 61 AM. JUR. 2D Physicians, Surgeons, Etc. § 331, available at Westlaw.
341. See id.
342. See id.
343. Crossley, supra note 225, at 240.
345. Id. at 2079–80.
countries (Australia, Canada, Finland, Netherlands, New Zealand, Spain, Sweden, United Kingdom, and United States), identifying whether the relevant activity is focused primarily on information (descriptive reports or data), priority setting (policy actions or documents that include goals, objectives, or targets), or action (activities that change programs or law or that create accountability to the public).\textsuperscript{346} These authors concluded that, compared with several decades ago, understanding of health inequalities has increased tremendously, and reduction or elimination of health inequalities has become a policy target for many developed countries.\textsuperscript{347} However, progress to reduce health inequalities at the national level varies by health indicator, and "[l]arge gaps remain in our understanding of the mechanisms underlying health inequalities and the most effective methods for evaluating progress toward the reduction or elimination of health inequalities."\textsuperscript{348}

Beyond the intranational issues, efforts to reduce racial and ethnic health disparities have international implications as well. Two international treaties—the International Covenant on Economic, Social and Cultural Rights and the International Covenant on the Elimination of All Forms of Racial Discrimination—have direct provisions addressing racial inequities in health and health care.\textsuperscript{349}

1. *International Covenant on Economic, Social and Cultural Rights*

The International Covenant on Economic, Social and Cultural Rights (ICESCR) provides the most comprehensive article on the rights to health in international law.\textsuperscript{350} In interpreting article 12 of ICESCR, the United Nations Committee on Economic, Social and Cultural Rights defines the right to health to include four

\textsuperscript{346} See generally Sara N. Bleich et al., *Health Inequalities: Trends, Progress, and Policy*, 33 ANN. REV. PUB. HEALTH 7 (2012).

\textsuperscript{347} Id. at 12.

\textsuperscript{348} Id.


interrelated and essential elements: availability, accessibility, acceptability, and quality of health care.\(^{351}\) Notably, the element of accessibility includes “non-discrimination [in access to] health facilities, goods and services . . . [to] marginalized groups such as ethnic minorities . . . .”\(^{352}\) Acceptability of health care, according to the committee, requires that “[a]ll health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.”\(^{353}\) To date, ICESCR has been ratified by 164 countries.\(^{354}\) Although the United States signed ICESCR on October 5, 1977, and despite the urging of Presidents Carter and Clinton, Congress has not ratified the Covenant.\(^{355}\)

2. The International Convention on the Elimination of All Forms of Racial Discrimination

The International Convention on the Elimination of All Forms of Racial Discrimination (CERD) prohibits racial discrimination, defined as:

Any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.\(^{356}\)

\(^{351}\) Id. ¶¶ 12(a)–(d).
\(^{352}\) Id. ¶ 12(b).
\(^{353}\) Id. ¶ 12(c).
\(^{356}\) International Convention on the Elimination of All Forms of Racial Discrimination, supra note 349, art. 1 (emphasis added).
Although the U.N. General Assembly adopted CERD by unanimous vote in 1965 and the United States signed the treaty on September 28, 1966, the U.S. Senate did not ratify CERD until October 21, 1994—nearly three decades later. Article 2 of CERD requires that signatory states: (1) not practice racial discrimination; (2) not “sponsor, defend or support racial discrimination”; (3) review existing laws and regulations and amend or revoke those that cause or perpetuate racial discrimination; (4) “prohibit and bring to an end, by all appropriate means, including legislation,” racial discrimination; (5) encourage means that eliminate barriers between races and discourage racial division; and (6) take, when warranted, “special and concrete measures to ensure the adequate development and protection of certain racial groups or individuals belonging to them, for the purpose of guaranteeing them the full and equal enjoyment of human rights and fundamental freedoms’ to guarantee “the full and equal enjoyment of human rights and fundamental freedoms.”

Moreover, article 5(e)(iv) of CERD specifically requires that parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of . . . [t]he right to public health, medical care, social security and social services. However, upon signing the Convention, the United States declared:

The Constitution of the United States contains provisions for the protection of individual rights, such as the right of free speech, and nothing in the Convention shall be deemed to require or to authorize legislation or other action by the United States of America incompatible with
the provisions of the Constitution of the United States of America.  

Furthermore, the United States ratified the Convention with three reservations limiting its consent to be bound by several of CERD’s provisions, including certain “protections of [the] individual freedom of speech, expression [or] association,” and “individual privacy and freedom from governmental interference in private conduct.” Finally, the United States declared that the provisions of CERD are not self-executing, and that “before any dispute to which [it] is a party may be submitted to the jurisdiction of the International Court of Justice under [CERD], the specific consent of the United States is required in each case.”

The United States’ reservations notwithstanding, Professor Vernellia Randall argues that “U.S. health policy is inconsistent with several provisions of CERD, including virtually all of Articles 2 and 5” since federal agencies have consistently failed to address problems of discrimination and bias found in the American healthcare system. Citing current trends toward managed care as a source of worsening disparities and bias across a broad range of access, treatment, diagnostic, funding, and training issues for racial minorities, Randall provides the CERD Committee on the Elimination of Racial Discrimination (the CERD Committee) with several recommendations. Specifically, she argues that the CERD Committee should: (1) “clearly define the current situation related to health care for minorities in the United States . . . to be a violation” of CERD; (2) “make it clear to the United States that ‘justifiable’ discrimination does not include racial discrimination

361. 2. International Convention on the Elimination of All Forms of Racial Discrimination, supra note 357.
362. Id.
364. Id.
365. The CERD Committee “examines evidence of de facto discrimination” and reviews periodic reports from signatory states to determine “whether adequate legal protections for groups that have experienced racial discrimination have been implemented.” Id. at 49. “Although not legally binding, the CERD Committee makes concluding observations about the reports and may make suggestions on how the reporting states could improve their application” of the Convention. Id. at 49 (citations omitted).
resulting from policies and practices that limit access and quality of health care received[,] or "that have a disparate impact where there is an alternative that would either not discriminate or have less impact"; (3) "ask the United States to make significant [and broad] progress . . . in eliminating disparities in health and health care"; and (4) "ask the United States to develop a unified data-collection system in government programs . . . , which would allow easy determination of facilities, providers, and organizations that discriminate in the diagnosis and treatment of illness." 366

In response to American reports submitted to CERD for consideration at its meeting on March 5, 2008, the CERD Committee recognized "the wide range of measures and policies adopted by the [United States] to improve access to health insurance and adequate health-care services," but expressed concern that "a large number of persons belonging to racial, ethnic and national minorities still remain without health insurance and face numerous obstacles to access to adequate health care and services." 367 The CERD Committee recommended that the United States continue its efforts to address the persistent health disparities . . . by eliminating the obstacles that . . . prevent or limit their access to adequate health care, such as lack of health insurance, unequal distribution of health-care resources, persistent racial discrimination in the provision of health care and poor quality of public health-care services." 368

The CERD Committee made special note of persistent disparities in the field of sexual and reproductive health, particularly with regard to the high maternal and infant mortality rates among women and children belonging to racial, ethnic and national minorities, especially African Americans, the high incidence of unintended pregnancies.

366.  Id. at 74–75.
368.  Id.
and greater abortion rates affecting African American women, and the growing disparities in HIV infection rates for minority women.\textsuperscript{369}

To combat these inequities, the CERD Committee recommended that the United States (i) improve access to maternal health care, family planning, pre-and post-natal care and emergency obstetric services, inter alia, through the reduction of eligibility barriers for Medicaid coverage; (ii) facilitate access to adequate contraceptive and family planning methods; and (iii) provide adequate sexual education aimed at the prevention of unintended pregnancies and sexually-transmitted infections.\textsuperscript{370}

\section*{IV. HEALTH DISPARITIES SINCE THE PASSAGE OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) OF 2010}

During the campaign leading up to the 2008 presidential election, Illinois Senator Barack Obama touted health reform, including the elimination of health disparities, as a major objective of his presidency if he were elected.\textsuperscript{371} Following his victory, the official website of the president-elect said:

President-elect Barack Obama and Vice President-elect Joe Biden will tackle the root causes of health disparities by addressing differences in access to health insurance coverage and promoting prevention and public health, both of which play a major role in addressing disparities. They will also challenge the medical system to eliminate inequities in health care through quality measurement and reporting, implementation of effective interventions such as patient navigation programs and diversification of the health workforce.\textsuperscript{372}

\begin{footnotesize}
\begin{enumerate}[\textsuperscript{369}]
\item Id. ¶ 33.
\item Id.
\end{enumerate}
\end{footnotesize}
Just over a year later, and following an unusual and highly controversial series of ad hoc legislative procedures, President Barack Obama signed the Patient Protection and Affordable Care Act into law on March 23, 2010. Together with Executive Order 13535, Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act, issued by President Obama on March 24, 2010, and the Health Care and Education Reconciliation Act of 2010, signed into law six days later, these laws—collectively referred to as the Affordable Care Act (ACA), and commonly referred to as Obamacare—represent "the culmination of more than 70 years of attempts by the federal government to expand health care access and coverage." Amidst sweeping changes to the U.S. health care system, ACA includes several provisions addressing disparities in health and health care.

A. Goals of the ACA to Eliminate Disparities in Health and Health Care

President Obama’s signature health reform legislation includes both general and specific measures to eliminate disparities in health and health care.

1. General Measures to Reduce Disparities Through Increased Access to Affordable Quality Health Insurance and Health Care

The ACA was designed to fill gaps in the existing framework of American health insurance coverage with both public and private sector provisions aimed at the states, insurance companies, employers, and individuals. According to a 2010 report prepared by the Robert Wood Johnson Foundation (RWJF), full implementation of the ACA, as written, would result in 22.1 million
nonelderly uninsured Americans, as opposed to over twice as many (49.9 million) without the Act’s reform provisions.\(^{376}\)

\[\textbf{a. Expansion of Medicaid and the Children's Health Insurance Program}\]

A cornerstone of the ACA is its provision for expanded health coverage through the reform of existing state-run Medicaid programs.\(^{377}\) Prior to passage of the ACA, on average, states restricted Medicaid eligibility to unemployed parents with annual income below thirty-seven percent of the federal poverty level (FPL) and employed parents with income below sixty-three percent of the FPL.\(^{378}\) However, most states denied Medicaid benefits to adults without dependent children regardless of income,\(^{379}\) and only certain “categories of low-income individuals, such as children, their parents, pregnant women, the elderly, and individuals with disabilities”\(^{380}\) have been eligible for benefits. Under the Act as written,\(^{381}\) the AAC required, as of January 1, 2014 and as a condition of continuing eligibility for federal Medicaid funds, the states to expand Medicaid coverage to all non-Medicare eligible individuals under age sixty-five (including children, pregnant women, parents, and adults without dependent children) with household incomes up to 133% of the FPL.\(^{382}\) To finance the

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379. Sebelius, 132 S. Ct. at 2601.


381. Patient Protection and Affordable Care Act § 2001.

382. The ACA provides for a Medicaid expansion to 133% of the FPL plus a five percent income disregard, making the threshold for Medicaid eligibility effectively 138% of the FPL. Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision, CONG. BUDGET OFF. 7 n.13 (July 2012), http://www.cbo.gov/sites/default/files/cbofiles/attachments
coverage for the newly eligible Medicaid enrollees, the states would receive one hundred percent federal funding for 2014 through 2016, ninety-five percent federal financing in 2017, ninety-four percent federal financing in 2018, ninety-three percent federal financing in 2019, and ninety percent federal financing for 2020 and subsequent years. Medicaid expansion, together with less dramatic expansions to coverage rules and federal reimbursements under the Children’s Health Insurance Program (CHIP), would provide new insurance coverage to 13.1 million uninsured adults and 3.7 million uninsured children, or approximately twenty-nine percent of the estimated 49.9 million nonelderly uninsured.

b. American Health Benefit Exchanges

Another hallmark of the ACA was its requirement that each state would establish an American Health Benefit Exchange (Exchange) to facilitate each person or family’s purchase of a qualified health plan (QHP). The health insurance exchanges were meant to be consumer-friendly marketplaces, operated mainly on the Internet, where consumers can browse through the available qualifying health plans and choose the plan that is best for themselves and their families. Notably, the ACA requires that processes for outreach, marketing, and benefit explanations—for QHPs offered through new exchanges—serve “[t]he needs of underserved and vulnerable populations” and are “culturally and linguistically appropriate.”

c. Premium Assistance Tax Credits

Beginning in 2014, taxpayers with household income between 100 percent and 400 percent of the federal poverty level can qualify for a health insurance premium assistance credit for qualified

health plans purchased through the state Exchanges.\textsuperscript{388} As of April 2014, the Congressional Budget Office (CBO) and Joint Committee on Taxation estimated that, over the course of calendar year 2014, an average of six million people would be covered by insurance obtained through the Exchanges.\textsuperscript{389} CBO anticipates “that coverage through the Exchanges will increase substantially over time to an average of 13 million people in 2015, 24 million in 2016, and 25 million in each year between 2017 and 2024.”\textsuperscript{390} Roughly three-quarters of those enrollees are expected to receive exchange subsidies.\textsuperscript{391} Theoretically, since Hispanics and African Americans tend to have lower rates of employer-sponsored health insurance coverage, these groups are more likely to take advantage of the Exchanges and premium assistance tax credits.\textsuperscript{392}

d. Community Health Centers

For more than forty-five years, the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services has supported Community Health Centers (CHCs) to provide comprehensive, culturally competent, quality primary health care and supportive services to medically underserved communities and vulnerable populations.\textsuperscript{393} CHCs are governed by community boards composed of at least a fifty-one percent majority of health center patients who represent the population served and fees are adjusted based on the patient’s ability to pay.\textsuperscript{394} Of the 21.7 million patients served in CHCs during 2013, ninety-two percent were below the federal poverty level, sixty-

\textsuperscript{388} Patient Protection and Affordable Care Act § 1401.
\textsuperscript{390} Id.
\textsuperscript{391} Id.
\textsuperscript{392} See infra text accompanying notes 473–78. This, however, is the subject of current litigation pending before the United States Supreme Court regarding the availability of premium assistance tax credits for those who purchase plans through the Federal Exchanges. See infra Part IV.C.2; see also King v. Burwell, 759 F.3d 358 (4th Cir.), cert. granted, 135 S. Ct. 475 (2014) (argued Mar. 4, 2015).
\textsuperscript{393} What Is a Health Center?, HEALTH RESOURCES & SERVICES ADMIN., http://bphc.hrsa.gov/about/ (last visited Apr. 5, 2015) (noting that CHC supportive services include services that promote access to health care, such as education, translation, and transportation).
\textsuperscript{394} See id.
two percent were racial and ethnic minorities, thirty-five percent had no health insurance, and thirty-two percent were children. The ACA provides $11 billion in increased appropriations between 2011 and 2015 for the operation, expansion, and construction of health centers throughout the nation, allowing CHCs to nearly double their patient capacity over this time period.

2. Specific Measures of the ACA Aimed at Eliminating Health Disparities.

a. Nondiscrimination Under Section 1557 of the ACA

Section 1557 of the ACA leaves intact the civil rights protections established under Title VI of the Civil Rights Act of 1964, including the prohibition against intentional discrimination in “any program or activity receiving Federal financial assistance.” Moreover, section 1557 expressly extends the health care–specific civil right to also prohibit discrimination on the basis of gender, disability, or age. Section 1557 also extends the prohibition against discrimination to federally administered health programs and new ACA-authorized entities like Exchanges, in addition to federally funded health programs.

Perhaps most significantly, section 1557 provides enforcement mechanisms under Title VI, Title IX of the Education Amendments of 1972, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. Thus, according to Professor Sidney Watson, because of the various enforcement mechanisms provided, section 1557 “reaches both intentional discrimination and policies and practices that have a disparate impact in

395. Id.
398. Patient Protection and Affordable Care Act § 1557(a).
minorities and provides for a private right of action to enforce claims of both intentional and disparate impact discrimination. 403

b. Diversifying the Workforce

Based on the premise that minority health care providers are significantly more likely to treat minority patients and practice in poor and underserved areas, 404 and that having more diverse providers who reflect the racial and ethnic composition of the population, the ACA incorporated a number of provisions to improve the "access and the delivery of health care services for all individuals, particularly low income, underserved, uninsured, minority, health disparity, and rural populations."405 Evidence also indicates that greater health care workforce diversity is associated with "greater patient choice and satisfaction, and better educational experiences for health profession students, among many other benefits."406

Among the workforce expansion provisions of the ACA is the establishment of the National Health Care Workforce Commission (the NHCWFC).407 The NHCWFC serves as a national resource for Congress, the President, and states and localities to: (1) communicate and coordinate with federal departments; (2) develop and commission evaluations of education and training activities; (3) identify barriers to improved coordination at the federal, state, and local levels and recommend ways to address them; and (4) encourage innovations that address population needs, changing technology, and other environmental factors.408

Section 5401 of the ACA amended the Public Health Service Act to continue to provide Center of Excellence grants to educational entities (including designated health professions schools and other public and nonprofit health or educational programs) for the purpose of supporting programs of excellence in

403. Watson, supra note 399, at 880.
407. Patient Protection and Affordable Care Act § 5101.
408. See id.
health professions education for under-represented minority students.\footnote{409} Section 5402 authorizes loan repayment, scholarships, and other educational assistance for disadvantaged health professions students, and sections 5403 and 5404 reauthorize Area Health Education Centers (AHEC)\footnote{410} and Workforce Diversity Grants (WDG),\footnote{411} respectively. AHEC grants enable eligible entities to initiate, maintain, or improve community-based training and education in order to, among other things, increase the number of underrepresented minorities and individuals from disadvantaged or rural backgrounds into health professions, and support such individuals in attaining such careers.\footnote{412} Similarly, WDG provide scholarships, stipends, pre-entry preparation, advanced education preparation, and retention services to increase nursing education opportunities for individuals from disadvantaged backgrounds.\footnote{413} The ACA also reauthorizes and expands Health Professional Opportunity Grants (HPOG), designed to “provide training in high-demand health care professions to Temporary Assistance for Needy Families (TANF) recipients and other low-income” populations with high concentrations of Native American, Hispanic, and African American people.\footnote{414}

Consistent with compelling evidence that providers who have participated in cultural competence training and education can improve the quality of care given to diverse populations,\footnote{415} the ACA also invests in the development and evaluation of culturally competent curricula in educational training.\footnote{416}

\footnote{409. See id. § 5401.}
\footnote{410. See id. § 5403.}
\footnote{411. See id. § 5404.}
\footnote{412. See id. § 5403.}
\footnote{413. See id. § 5404.}
\footnote{415. Daryll C. Dykes & Augustus A. White, III, Cultural Competent Care Pedagogy: What Works?, 469 CLINICAL ORTHOPÆDICS & RELATED RES. 1813, 1813–16 (2011); see AUGUSTUS A. WHITE, III WITH DAVID CHANOFF, SEEING PATIENTS: UNCONSCIOUS BIAS IN HEALTH CARE 257–76 (2011); Betancourt et al., supra note 289, at 499.}
\footnote{416. Patient Protection and Affordable Care Act § 5307.}
c. Structural Changes in the Accountability Mechanism

Although the section did not create any new regulatory authority, ACA section 10334 transferred the Department of Health and Human Services' Office of Minority Health to the Office of the Secretary, and established and funded six other Offices of Minority Health within existing HHS offices and agencies. The section also re-designated "the National Center on Minority Health and Health Disparities (NCMHD) to the National Institute on Minority Health and Health Disparities (NIMHD)." Directed by the twenty-four-year veteran leader of NIH's minority health initiatives, Dr. John Ruffin (until his retirement in March 2014), the ACA charged NIMHD with the planning, coordination, review and evaluation of federally funded research on minority health and health disparities.

d. Amendment and Reauthorization of the Indian Health Care Improvement Act

The original IHCIA provided funding for IHS programs through fiscal year 1980, with additional appropriations through 1984 to be authorized through subsequent legislation. A series of amendments authorized IHS funding through fiscal year 2000, but until 2010, IHS relied upon Congress to annually authorize funds

417. The ACA created Offices of Minority Health within the Agency for Healthcare Research and Quality (AHRQ), the Center for Disease Control (CDC), the Centers for Medicare and Medicaid (CMS), the U.S. Food and Drug Administration (FDA), the Health Resources and Services Administration (HSRA), and the Substance Abuse and Mental Health Services Administration (SAMHSA). See Offices of Minority Health at HHS, OFF. MINORITY HEALTH, http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=7 (last visited Apr. 5, 2015).


420. NIH Announces Institute, supra note 418.

421. Fusselman, supra note 250, at 392-93.
to support and continue its operations. However, with the passage of the ACA, the IHCIA was reauthorized “permanently and indefinitely” with funds appropriated through fiscal year 2010 and every fiscal year thereafter until all federal funds are expended.

The amended version of the IHCIA differs in several respects from the original version passed by Congress in 1976. Included among the major changes are: (1) enhancement of the authorities of the IHS director, including the responsibility to facilitate advocacy and promote consultation on matters relating to Indian health within the Department of Health and Human Services; (2) authorization for hospice, assisted living, long-term, and home and community-based care; (3) extension of the ability to recover costs from third parties to tribally operated facilities; (4) updates to current law regarding collection of reimbursements from Medicare, Medicaid, and CHIP by Indian health facilities; (4) provisions for tribes and tribal organizations to purchase health benefits coverage for IHS beneficiaries; (5) authorization for IHS to enter into arrangements with the Departments of Veterans Affairs and Defense to share medical facilities and services; (6) provisions for a tribe or tribal organization carrying out a program under the Indian Self-Determination and Education Assistance Act and an urban Indian organization carrying out a program under Title V of IHCIA to purchase coverage for its employees from the Federal Employees Health Benefits Program; (7) authorization of a Community Health Representative program for urban Indian organizations to train and employ Indians to provide health care services; and (8) direction for IHS to establish comprehensive behavioral health, prevention, and treatment programs for Indians.

e. Data Collection and Monitoring

The ACA requires that any federally conducted or supported health care or public health program, activity, or survey collects and reports, among other things, data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or
participants. The secretary must make these reports available to a number of federal agencies, and must ultimately identify approaches to improve the identification of health care disparities, and must lead efforts in analyzing and monitoring trends in health disparities from the data collected. The data and analyses must be publicly reported on the HHS website, and may be made available for other federal agencies, non-governmental entities, and the public for additional research or analysis.

f. The Patient-Centered Outcomes Research Institute

Section 6301 of the ACA created and authorized funding for the Patient-Centered Outcomes Research Institute (PCORI)—an independent non-profit, non-governmental organization that funds comparative clinical effectiveness research and programs to provide information about the best available evidence to help patients and their health care providers make more informed decisions. One of PCORI’s five national priorities for research is to address disparities by “[i]dentifying potential differences in prevention, diagnosis, or treatment effectiveness, or preferred clinical outcomes across patient populations and the healthcare required to achieve best outcomes in each population.” For fiscal years 2014–19, the Patient-Centered Outcomes Research Trust Fund will receive a combined estimated average total of $650 million per year.

B. HHS Initiatives to Implement ACA and Eliminate Disparities

On April 8, 2011 the U.S. Department of Health and Human Services launched two strategic plans aimed at reducing health disparities: the National Stakeholder Strategy for Achieving Health

425. See Patient Protection and Affordable Care Act § 4302.
426. Id.
427. See id.; see also 1 CCH, supra note 375, at 657.
428. Patient Protection and Affordable Care Act § 6301; see also About Us, PATIENT-CENTERED OUTCOMES RES. INST. (Oct. 6, 2014), http://www.pcori.org/about-us.
429. How We’re Funded, PATIENT-CENTERED OUTCOMES RES. INST. (June 1, 2012), http://www.pcori.org/content/how-were-funded.
430. Id. ("$150 million from the general fund in appropriation, an annual $2 fee per individual assessed on Medicare and private health insurance and self-insured plans and an adjustment for increase in healthcare spending.")
Equity and the HHS Action Plan to Reduce Racial and Ethnic Health Disparities.\textsuperscript{431} Together, the plans are intended to “provide strong and visible national direction for leadership among public and private partners” toward the goal of health equity.\textsuperscript{432}

1. Healthy People 2020

Since 1979, the Healthy People initiative has engaged a growing network of professional and public partners in a systematic approach to health improvement through “setting goals, identifying baseline data and 10-year targets, monitoring outcomes, and evaluating the collective effects of health-improvement activities nationwide.”\textsuperscript{433} Since the first iteration launched by HHS, Healthy People has identified emerging public health priorities and helped to align health-promotion resources, strategies, and research. Healthy People 2010 (released in 2000) focused on the overarching goals of increasing the quality of life for Americans and eliminating health disparities.\textsuperscript{434} In assessing the nation’s progress over the decade, it was clear that overall life expectancy had increased, but the goal of eliminating health disparities remained unmet.\textsuperscript{435}

Healthy People 2020 seeks to (1) eliminate preventable disease, disability, injury, and premature death; (2) achieve health equity, eliminate disparities, and improve the health of all groups; (3) create social and physical environments that promote good health for all; and (4) promote healthy development and healthy behaviors across every stage of life.\textsuperscript{436} Specifically, according to HHS Assistant Secretary Howard Koh, in reaffirming the goal of eliminating health disparities, Healthy People 2020 “breaks new ground . . . [by emphasizing] the need to consider factors such as

\textsuperscript{432} Id.
\textsuperscript{434} Id.
\textsuperscript{435} Id.
poverty, education, and numerous aspects of the social structure that not only influence the health of populations but also limit the ability of many to achieve health equity.\footnote{437} This explicit acknowledgment of "social determinants of health"—the powerful, complex relationships between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies—brings broadened approaches to eliminating health disparities and "an action model that aligns these approaches and articulates a feedback loop as the nation monitors its progress toward achieving its goals.\footnote{438} Additionally, throughout the next decade, Healthy People 2020 will assess health disparities in the U.S. population by tracking rates of illness, death, chronic conditions, behaviors, and other types of outcomes in relation to demographic factors including: race and ethnicity; gender; sexual identity and orientation; disability status or special health care needs; and rural or urban geographic location.\footnote{439}

2. The National Stakeholder Strategy for Achieving Health Equity

The Office of Minority Health at HHS initiated and sponsored the National Partnership for Action to End Health Disparities (NPA) "to mobilize a nationwide, comprehensive, community-driven, and sustained approach to combating health disparities and to move the nation toward achieving health equity.\footnote{440} This collaborative—composed of stakeholders from local, state, and tribal communities; government agencies; and places of education, business, and health care delivery—convened in February of 2009 for the Third National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health to identify and help shape the "core actions for a coordinated national response to ending health

\footnote{438} Stephen B. Thomas et al., Toward a Fourth Generation of Disparities Research to Achieve Health Equity, 32 ANN. REV. PUB. HEALTH 399, 401 (2011).
As a result of the Summit and through two years of subsequent regional conversations, focused stakeholder meetings, public review and input, and a period of analysis, discussion, and planning throughout HHS, the NPA produced the National Stakeholder Strategy for Achieving Health Equity (the National Stakeholder Strategy or NSSAHE).

The National Stakeholder Strategy provides “an overarching roadmap for eliminating health disparities through cooperative and strategic actions” at the federal level. This is coordinated by the Federal Interagency Health Equity Team (FIHET), now comprising representatives of HHS and eleven other federal, cabinet-level departments, and through regional “Blueprints for Action” at local, state, and regional levels by partners across the public and private sectors. The National Stakeholder Strategy is composed of twenty strategies for action to end health disparities—each linked to one of five fundamental goals, broadly labeled “Awareness,” “Leadership,” “Health System and Life Experience,” “Cultural and Linguistic Competency,” and “Data, Research, and Evaluation.” The National Stakeholder Strategy is intended to provide “a common reference, language, and starting point for those who wish to join in partnership with like-minded individuals and organizations to achieve health equity in the United States.”

“Local groups can use the National Stakeholder Strategy to identify which goals are most important for their communities and adopt the most effective strategies and action steps to help reach them.”

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442. See National Stakeholder Strategy, supra note 17, at 3–5.
443. Id. at 1.
444. See id. at 22.
445. See infra Table 2.
446. National Stakeholder Strategy, supra note 17, at 5.
3. **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**

The HHS Action Plan to Reduce Racial and Ethnic Health Disparities (Action Plan)—"the first federal strategic disparities plan and the most comprehensive federal commitment in this area to date"—leverages key provisions of the Affordable Care Act and an array of national strategic planning initiatives. The Action Plan’s framework consists of four overarching HHS Secretarial priorities. The Action Plan further identifies five goals—each of which provides specific pragmatic strategies and high impact actions HHS will take to reduce health disparities among racial and ethnic minorities. Released simultaneously with and intended to complement the National Stakeholder Strategy, the Action Plan builds on national health disparities goals and objectives previously unveiled in Healthy People 2020.

4. **Other**

The U.S. Department of Health and Human Services has identified a number of opportunities to advance health disparity reduction activities at the department. According to HHS, these initiatives and prevention programs "present a unique opportunity to use innovative approaches to improve and change healthcare practices and policies across the public health system to sharply reduce disparities among racial and ethnic minority populations." A significant advancement among these initiatives has been the release of Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). Building on the earlier standards, which provide certain mandates, guidelines, and recommendations for language

449. Id. at 1822–23.
access services, and based on tremendous growth in the field of cultural and linguistic competence since 2000, the OMH announced the enhanced National CLAS Standards on April 24, 2013. The enhanced CLAS Standards more broadly align with the HHS Action Plan and the National Stakeholder Strategy to advance health equity, improve quality, and help eliminate health care disparities by promoting the implementation of culturally and linguistically appropriate services by health care organizations and workers. Specifically, the Standards’ conceptualization of culture, audience, health, and recipients was expanded to more broadly address the importance of cultural and linguistic competency “at every point of contact throughout the health care and health services continuum.” For instance, the original definition of “culture” was expanded from its previous terms of “racial, ethnic and linguistic groups” to also include “geographical, religious and spiritual, biological, and sociological characteristics,” and the term “health” was expanded from its implicit definition to the explicit inclusion of “physical, mental, social and spiritual well-being.”

The principal standard is to “[p]rovide effective, equitable, understandable, and respectful quality care and services that are responsive to the diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication


458. Id. at 2.
Fourteen related standards are divided among the general categories of (i) governance, leadership, and workforce; (ii) communication and language assistance; and (iii) engagement, continuous improvement, and accountability.

Although the enhanced CLAS Standards are guidelines, to date, "[a]t least six states have moved to mandate some form of cultural and linguistic competency for either all or a component of [their health care workforce]." One of these states strongly recommends cultural competence training, eight states currently have provisions under consideration, and cultural competency legislation either died in committee or was vetoed in six states. However, the enhanced Standards align closely with standards of the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which provides voluntary accreditation of hospitals, ambulatory care centers, laboratories, nursing care facilities, and behavioral health centers.

C. Legal Challenges to the ACA that May Impact Health Disparities

Several hundred lawsuits have been filed challenging various provisions of the ACA and, at the time of this writing, around one hundred cases are currently making their way through the courts. Most notable with respect to health disparities is the landmark United States Supreme Court decision in National Federation of Independent Business v. Sebelius (NFIB), decided on June 28, 2012, and other ongoing litigation regarding premium subsidies

459. Id.
460. OFFICE OF MINORITY HEALTH, supra note 454.
462. Id. (Maryland).
463. Id. (Arizona, Georgia, Indiana, Kentucky, Oklahoma, Ohio, Missouri, and New York).
464. Id. (Colorado, Florida, Hawaii, Illinois, Iowa, and Texas).
465. See A Crosswalk of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to the Joint Commission Hospital Accreditation Standards, JOINT COMM’N (July 2014), http://www.jointcommission.org/assets/1/6/Crosswalk_CLAS_-_20140718.pdf.
provided as tax credits for individuals who purchase insurance on federally run exchanges.


In *NFIB*, the National Federation of Independent Business, joined by twenty-six Republican governors, challenged many provisions of the ACA, including the individual mandate and the requirement that states expand Medicaid or risk losing federal funding for their existing Medicaid programs. Although the Court held that the individual mandate is a permissible exercise of congressional taxing authority under Article I of the Constitution, it held that the federal government could not threaten the loss of existing Medicaid funding to incentivize states to participate in the Medicaid expansion.

As of August 24, 2014, twenty-seven states and the District of Columbia were implementing Medicaid expansion, twenty-one states opted out of Medicaid expansion under the ACA, and two states were in open debate regarding their plans. Five million uninsured people in the states that have not elected to opt into the expansion have fallen into a "coverage gap," which has formed between those eligible under existing programs and those unable to obtain premium tax credits due to being at or below 100% of the federal poverty level (FPL). Notably, many of the states not

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467. *Id.* at 2572.
468. *Id.* at 2608.
470. *Id.* Alabama, Alaska, Florida, Georgia, Idaho, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Virginia, Wisconsin, and Wyoming.
471. *Id.* Indiana and Utah.
472. *Id.*
expanding Medicaid are in the South where a disproportionately large number of poor blacks will experience a coverage gap.\textsuperscript{474} While twenty-nine percent of uninsured whites fall into this coverage gap, forty percent of uninsured blacks in non-expansion states will have very limited coverage options and are likely to remain uninsured.\textsuperscript{475} American Indians and Alaska Natives face a similar fate, since half of these Americans also live in non-expansion states.\textsuperscript{476} Moreover, because some American Indian tribal nations extend across states, “differing expansion decisions . . . will drive variations in coverage, access, and health status both within and between tribes.”\textsuperscript{477} Although Hispanic non-elderly adults were at the highest risk of being uninsured prior to the ACA, and twenty-four percent of Hispanics still fall into the coverage gap, the impact of Medicaid non-expansion on the Hispanic population is smaller since several key states that have large numbers of uninsured Hispanics (including California, New York, and Arizona) have implemented Medicaid expansion.\textsuperscript{478}

2. Availability of Subsidies on the Federal Exchanges

In another series of related cases, plaintiffs in several federal court districts challenged the federal government’s legal authority to offer premium subsidies to citizens who purchase insurance on federally run exchanges.\textsuperscript{479} The plaintiffs in these cases relied on the language of section 36B of the Internal Revenue Code, enacted as part of the ACA, which makes tax credits available to individuals

\textsuperscript{474} Id.  
\textsuperscript{475} Id.  
\textsuperscript{477} Id.  
\textsuperscript{478} Id.  
who purchase health insurance through exchanges “established by the State under section 1311” of the Act. The plaintiffs argue that the IRS’s interpretation of section 36B to broadly allow tax credits to participants of both state run and federally run exchanges is inconsistent with the plain language of the law and, therefore, impermissible under the Administrative Procedure Act.

The U.S. District Court for the Eastern District of Oklahoma also ruled against the IRS interpretation in Pruitt v. Burwell. Similarly, in Halbig v. Burwell, a three judge panel of the D.C. District Court of Appeals ruled that the IRS misinterpreted section 36B, but the court has since vacated the panel judgment and granted the government’s petition to rehear the case en banc. However, in King v. Burwell, the Fourth Circuit Court of Appeals found that the IRS’s interpretation is permissible, but the United States Supreme Court has since granted the appellants’ petition for writ of certiorari, ultimately leaving the issue to be decided by the high court. In both cases, it remains to be seen if the IRS interpretation stands.

While there is considerable speculation about the likely Supreme Court decision, one thing seems clear. The resolution of this issue has significant implications for the elimination of health disparities in the United States since—at the time of this writing—only seventeen states operate state-based exchanges, seven states partner with the federal government to operate exchanges, and twenty-seven states have opted to not operate exchanges, leaving individuals to rely on the federal exchange.

481. King, 759 F.3d at 363.
483. 758 F.3d at 393.
485. 759 F.3d at 360.
Without action to rectify these unintended consequences of the ACA, the United States seems likely, as one pair of authors put it, “to consign its poorest and most vulnerable residents to a continued tenuous health status, in which the only options for care are emergency rooms and those institutions that are willing to provide free or nearly free health services.”

D. International Response to the ACA

The United States prepared its most recent report to the U.N. Committee on the Elimination of Racial Discrimination (CERD) on June 12, 2013. In response to the report, CERD commended the adoption of the ACA, but expressed concern regarding the coverage gap created when many states with substantial numbers of racial and ethnic minorities opted out of the Medicaid expansion program, “thus failing to fully address racial disparities in access to affordable and quality health care.” Six years after its previous recommendations, CERD also reiterated its concern regarding “the persistence of racial disparities in the field of sexual and reproductive health, particularly with regard to the high maternal and infant mortality rates among African American communities.” Finally, CERD expressed a new concern regarding the exclusion of undocumented immigrants and their children from coverage under the Affordable Care Act, as well as the limited coverage of undocumented immigrants and immigrants residing lawfully in the United States for less than five years by Medicaid and CHIP, resulting in difficulties for immigrants in accessing adequate health care.

492. Id.
493. Id.
V. CONCLUSION

For as long as health status and outcomes have been recorded and studied in America, many racial and ethnic minorities have suffered poorer health, inferior access to quality health care, and shorter life expectancies, even when factors such as insurance status and income are controlled. Such health disparities have lingered despite decades of attention, discourse, study, activism, regulation, legislation, and litigation. While health disparities largely result from past and present social, cultural, economic, political, and medical issues, all facets of law—international covenants; federal and state constitutions; federal, state, and local statutes; agency regulations; executive orders; and judicial rulings—have helped shape health injustice as it exists today. More importantly, the law will remain both a formidable hurdle and an indispensable resource in our national drive toward true justice in health: health equity for all Americans. Although substantial challenges remain, passage of the Patient Protection and Affordable Care Act of 2010 is a monumental and unprecedented leap toward the goal.
VI. FIGURES AND TABLES

FIGURE 1: Schematic Diagram of Major Legal Efforts to Eliminate Health Disparities

(1) International law (primarily the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Committee on the Elimination of Racial Discrimination (CERD)) influences federal policy and action. 494

(2) Federal laws, policies, and actions directly influence state laws, policies, and actions, primarily through mandates imposed on the states as conditions of receiving federal health care funds. 495

(3) Miscellaneous federal programs (such as First Lady Michelle Obama's Let's Move! initiative) 496 directly and indirectly impact health disparities.

494. See supra Part III.C (International Law).
495. See supra Part IV.A.1.a (Expansion of Medicaid and the Children’s Health Insurance Program).
(4) State law, policies, and actions directly influence health disparities. All fifty states have some form of office or entity dedicated to minority health or health equity, and many have passed specific legislation aimed at reducing or eliminating disparities.

(5) The Federal Interagency Health Equity Team (FIHET) is comprised of eleven federal cabinet-level agencies and several offices and agencies of the Department of Health and Human Services (HHS). FIHET coordinates the federal effort to eliminate health disparities.

(6) The ACA included explicit provisions to elevate the National Institute of Health (NIH) Office of Minority Health to the National Institute on Minority Health and Health Disparities (NIMHD), one of twenty-one institutes at NIH.

(7) Section 10334 of the ACA transferred HHS's Office of Minority Health to the Office of the Secretary. The majority of ACA provisions related to health disparities directly target HHS.

(8) Section 10334 of the ACA provided for offices of minority health in six HHS departments and agencies (Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), and Substance Abuse and Mental Health Services Administration (SAMHSA)).

(9) The ACA provides direct mandates to the IRS regarding the administration of premium tax credits for low-income individuals who purchase qualified health plans through the American Health Benefit Exchanges.

(10) In addition to existing mandates imposed on the states as conditions of receiving federal health care funds, the ACA

497. See supra Part III.B (State Law).
498. See Hanlon et al., supra note 320.
499. See infra Table 1.
500. See NATIONAL STAKEHOLDER STRATEGY, supra note 17.
501. See NIH Announces Institute, supra note 418.
502. See Offices of Minority Health at HHS, supra note 417.
503. See id.
504. See supra Part IV.A.1.c (Premium Assistance Tax Credits).
provides new and expanded benefits and requirements for states that elect to expand Medicaid. As of August 24, 2014, twenty-seven states and the District of Columbia were implementing Medicaid expansion,505 twenty-one states opted out of Medicaid expansion under the ACA,506 and two states507 were in open debate regarding their plans.508

(11) The mission of NIMHD is to lead scientific research to improve minority health and eliminate health disparities. To accomplish this, NIMHD: (i) plans, reviews, coordinates, and evaluates all minority health and health disparities research and activities of the NIH; (ii) conducts and supports research in minority health and health disparities; (iii) promotes and supports the training of a diverse research workforce; (iv) translates and disseminates research information; and (v) fosters innovative collaborations and partnerships.509

(12) The Action Plan to Reduce Racial and Ethnic Health Disparities (APRREHD) is “the first federal strategic disparities plan and the most comprehensive federal commitment in this area to date.”510

(13) The Office of Minority Health directly oversees a number of initiatives and programs aimed at the elimination of health disparities, including the Federal Collaboration on Health Disparities Research (FCHDR),511 the Enhanced National

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507. Indiana and Utah.

508. Status of State Action on the Medicaid Expansion Decision, supra note 469.


510. Koh, Graham & Glied, supra note 448, at 1822.

511. See Fed. Collaboration on Health Disparities Research, About the FCHDR, OFF. MINORITY HEALTH (Feb. 10, 2010), http://minorityhealth.hhs.gov/fchdr/default.aspx?title=about. (“FCHDR was established to engage a wide range of federal agencies in cross-agency research partnerships to promote more coordinated efforts that target health improvement in populations disproportionately affected by disease, injury and/or disability. . . . FCHDR research topics are selected based on needs and opportunities for pooling
Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS), and Healthy People 2020.

(14) The Office of Minority Health addresses disease prevention, health promotion, risk reduction, healthier lifestyle choices, use of health care services and barriers to health care for racial and ethnic minorities. Key strategies of [their] mission include: improving data collection, reporting and sharing for ethnic and racial minority populations; establishing and strengthening networks, coalitions and partnerships to identify and solve health problems; developing and promoting policies, programs and practices to achieve health equity; fostering research and evaluations; and funding demonstration programs at the regional, state and local level that can contribute to health policy and the effectiveness of strategies for improving health.

(15) The National Partnership for Action to End Health Disparities (NPA) is a collaborative of stakeholders from local, state, and tribal communities; government agencies; and places of education, business, and health care delivery committed to improving the health and health outcomes of racial and ethnic minorities.

(16) The National Stakeholder Strategy for Achieving Health Equity (NSSAHE) is a product of the National Partnership for Action (NPA).
(17) The NSSAHE, together with regional, state, and local Blueprints for Action (BFA), provides a common set of goals and objectives for public and private sector initiatives and partnerships to help racial and ethnic minorities achieve health equity. The strategy incorporates ideas, suggestions, and comments from thousands of individuals and organizations across the country that local groups can use to identify which goals are most important for their communities and adopt the most effective strategies and action steps to help reach them.  

(18) The mission of the Office for Civil Rights is “to improve the health and well-being of people across the nation; to ensure that people have equal access to and the opportunity to participate in and receive services from HHS programs without facing unlawful discrimination; and to protect the privacy and security of health information in accordance with applicable law.” Through investigations, voluntary dispute resolution, enforcement, technical assistance, policy development and information services, OCR protects the civil rights of all individuals who are subject to discrimination in health and human services programs and the health information privacy rights of consumers.

Legend

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<th>Abbreviation</th>
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<td>ACA</td>
<td>Affordable Care Act</td>
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<td>APRREHD</td>
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517. See National Stakeholder Strategy, supra note 17; supra Part IV.B.2 (The National Stakeholder Strategy for Achieving Health Equity); see also Nat’l Partnership for Action to End Health Disparities, supra note 516.

ASPE  Assistant Secretary for Planning and Evaluation
BRA   Blueprints for Action
CDC   Centers for Disease Control and Prevention
CERD  International Convention on the Elimination of All Forms of Racial Discrimination
CFBNP Center for Faith Based and Neighborhood Partnerships
CLAS  The Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care
CMS   Centers for Medicare & Medicaid Services
CPSC  U.S. Consumer Product Safety Commission
DOA   U.S. Department of Agriculture
DOC   U.S. Department of Commerce
DOD   U.S. Department of Defense
DOE   U.S. Department of Education
DOL   U.S. Department of Labor
DOT   U.S. Department of Transportation
DOVA  U.S. Department of Veterans Affairs
FCHDR Federal Collaborative on Health Disparities Research
FDA   Food and Drug Administration
FIHET Federal Interagency Health Equity Team
HP 2020 Healthy People 2020
HHS   U.S. Department of Health and Human Services
HRSA  Health Resources and Services Administration
HUD   U.S. Department of Housing and Urban Development
ICESCR International Covenant of Economic, Social and Cultural Rights
IHS   Indian Health Service
IRS   Internal Revenue Service
NAT'L LEADERSHIP SUMMITS
NIH   National Institutes of Health

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<th>Acronym</th>
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<tr>
<td>ONC</td>
<td>Office of the National Coordinator</td>
</tr>
<tr>
<td>OS</td>
<td>Office of the Secretary of HHS</td>
</tr>
<tr>
<td>OWH</td>
<td>Office of Women’s Health</td>
</tr>
<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
</tr>
</tbody>
</table>
### TABLE 1: State Legislative Action Related to Minority Health and/or Health Disparities

<table>
<thead>
<tr>
<th>State</th>
<th>Statute, Executive Action, Bill, or Regulation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>ALA. CODE § 16-47-124</td>
<td>Established a student loan program for medical students who commit in writing to general practice in a medically underserved area following graduation.</td>
</tr>
<tr>
<td></td>
<td>§ 16-47-126</td>
<td>Established a student loan repayment program for medical students who practice in a medically underserved area after graduation.</td>
</tr>
<tr>
<td>Alaska</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Arizona</td>
<td>ARIZ. REV. STAT. § 15-1643</td>
<td>Established the Arizona health education system in the college of medicine at the University of Arizona, which includes programs to recruit and retain minority students in health professions.</td>
</tr>
<tr>
<td></td>
<td>§ 15-1721(1) −(5)(b)</td>
<td>Established a medical student loan fund for students agreeing to practice in medically underserved areas and/or with medically underserved populations.</td>
</tr>
</tbody>
</table>

519. Adapted primarily from Health Disparities: State Laws, supra note 322. Unless otherwise noted, all of the statutes in this table are current on Westlaw as of the publication date of this Article.
<table>
<thead>
<tr>
<th>Arizona</th>
<th>§ 15-1751</th>
<th>Requires the University of Arizona medical school to give priority consideration to applicants who show a willingness to practice in medically underserved areas.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>§ 36-2172</td>
<td>Created the primary care provider loan repayment program for physicians, dentists, and mid-level providers who practice in a federally designated health professional shortage area.</td>
</tr>
<tr>
<td>Arkansas</td>
<td>ARK. CODE ANN. §§ 6-5-801 to -804.</td>
<td>Established the “Health Care Student Summer Enrichment Program for Underrepresented Student Populations” within the Department of Higher Education, an intensive six-week program aimed at increasing awareness of medical career opportunities for racial and ethnic minority undergraduate students.</td>
</tr>
<tr>
<td></td>
<td>§ 6-60-212</td>
<td>Allows for public colleges and universities to give special consideration to and to recruit students interested in nursing or other health fields from medically underserved areas.</td>
</tr>
<tr>
<td></td>
<td>§ 6-64-406</td>
<td>Requires that the Board of Trustees of the University of Arkansas give additional consideration to applicants to the College of Medicine from rural and medically underserved areas in an effort to address and alleviate health disparities.</td>
</tr>
<tr>
<td>Arkansas</td>
<td>§§ 17-80-301 to -302</td>
<td>Requires appointing authorities for state health-related agencies, boards, and commissions to consider appointment recommendations submitted by minority health-related professional associations in order to ensure that minority health issues and cultural competency are represented in health policy decisions.</td>
</tr>
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</tr>
<tr>
<td>§ 19-12-114</td>
<td>Instructs the Arkansas Minority Health Commission to establish and administer the Arkansas Minority Health Initiative for screening, monitoring, and treating hypertension, strokes, and other disorders that are disproportionately critical to minority groups within Arkansas.</td>
<td></td>
</tr>
<tr>
<td>§§ 20-2-101 to -107</td>
<td>Established the Arkansas Minority Health Commission to address health disparities.</td>
<td></td>
</tr>
<tr>
<td>§§ 20-15-1801 to -1805</td>
<td>Established the Arkansas HIV-AIDS Minority Task Force to study ways to strengthen HIV prevention programs, address the needs of those living with HIV and AIDS, and develop specific strategies for reducing the risk of HIV and AIDS in the state’s minority communities.</td>
<td></td>
</tr>
<tr>
<td>§ 25-10-122</td>
<td>Created an Office of Minority Mental Health within the Division of Mental Health of the Department of Human Services.</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Code and Section</td>
<td>Description</td>
</tr>
<tr>
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</tr>
<tr>
<td>Arkansas</td>
<td>§ 25-10-102</td>
<td>Established the Arkansas Minority Health Commission, to be comprised of twelve members who have actively participated in health issues for minorities or who have special knowledge or experience with minority health issues.</td>
</tr>
<tr>
<td>California</td>
<td>CAL. BUS. &amp; PROF. CODE § 852</td>
<td>Established a Task Force on Culturally and Linguistically Competent Physicians and Dentists to (1) develop continuing education programs that include and/or require foreign language training for physicians and dentists, and (2) assess the need for voluntary cultural and linguistic competency certification standards.</td>
</tr>
<tr>
<td></td>
<td>§ 2190.1</td>
<td>Requires cultural competency training to be a component of the continuing education requirements for licensure of physicians and surgeons.</td>
</tr>
<tr>
<td></td>
<td>CAL. CODE REGS. tit. 28, § 1300.67.04</td>
<td>Requires health insurance plans to provide language assistance to enrollees and to provide translations for vital documents depending on the enrollment size of the plan and the linguistic makeup of the enrollees.</td>
</tr>
<tr>
<td></td>
<td>CAL. GOV’T CODE § 8310.5</td>
<td>Requires any state agency, board, or commission that collects ancestry or ethnic origin data to use a separate collection categories for each major Asian and Pacific Islander group.</td>
</tr>
<tr>
<td>California</td>
<td>§ 8310.7</td>
<td>Requires the Departments of Industrial Relations and Fair Employment and Housing to collect and publish the demographic data established in § 8310.5 on the web site of the agency on or before July 1, 2012, and annually thereafter.</td>
</tr>
<tr>
<td>CAL. HEALTH &amp; SAFETY CODE § 152</td>
<td></td>
<td>Established the Office of Health Equity within the State Department of Public Health to work towards closing health status gaps among racial and ethnic minorities.</td>
</tr>
<tr>
<td>§§ 1568.15 −.17</td>
<td></td>
<td>Alters the composition of the Alzheimer’s Disease and Related Disorders Advisory Committee, requires a review of state policies related to the disease, and recognizes the need to serve non-English speakers and ethnically diverse populations. Established a Task Force on Diabetes and Obesity to study factors contributing to the high rates of diabetes and obesity in Latinos, African-Americans, Asian Pacific Islanders, and Native Americans.</td>
</tr>
<tr>
<td>§§ 106000, 106005, 106010</td>
<td></td>
<td>Established the Urban Community Health Institute: Centers to Eliminate Health Disparities at the Charles R. Drew University of Medicine and Science to address the problem of disparate health care in the Los Angeles County Service Planning Area and other multicultural communities.</td>
</tr>
<tr>
<td>California</td>
<td>§§ 124174-.6</td>
<td>Established rules regarding, and provided some funding for, public school health centers, with special recognition of the role that student health centers can play in reducing health disparities.</td>
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<tr>
<td>§ 124174.6</td>
<td>Gives priority to schools with large numbers of limited English proficient (LEP) children and youth for a Public School Health Center Support Program Grant to provide technical assistance and funding for the expansion, renovation, and retrofitting of existing school health centers, and the development of new school health centers.</td>
<td></td>
</tr>
<tr>
<td>§§ 127875, 127880, 127885</td>
<td>Created the Health Professions Career Opportunity Program, which is designed to increase the number of ethnic minorities in health professional training and minority health professionals practicing in medically underserved areas.</td>
<td></td>
</tr>
<tr>
<td>§§ 128330, 128335</td>
<td>Requires the establishment of the Health Professions Education Foundation, to be comprised of members of minority groups that are underrepresented in the health professions, with one goal being to offer scholarships or loans to African-American, Native American, Hispanic-American, and other students from underrepresented groups accepted to or enrolled in schools of medicine, dentistry, nursing, or other health professions.</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Code/Statutory Reference</td>
<td>Description</td>
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</tr>
<tr>
<td>California</td>
<td>CAL. INS. CODE § 10133.8</td>
<td>Requires insurance providers to assess the needs and language preferences of their insured and provide appropriate access to translated materials and language assistance.</td>
</tr>
<tr>
<td>Colorado</td>
<td>COLO. REV. STAT. § 25-4-2203</td>
<td>Established the Health Disparities Grant Program within the Department of Public Health and Environment, to provide financial support for statewide initiatives that address prevention, early detection, and treatment of cancer and cardiovascular/pulmonary diseases in underrepresented populations.</td>
</tr>
<tr>
<td></td>
<td>§§ 25-4-2204, -2205</td>
<td>Created the Office of Health Equity within the Department of Public Health and Environment to serve in a coordinating, educating, and capacity-building role for state and local public health programs and community-based organizations. Outlined powers and duties, including promoting health equity in Colorado by implementing strategies to address the varying causes of health disparities, including economic, physical, and social environment. Provided public education on health equity, health disparities and the social determinants of health.</td>
</tr>
<tr>
<td></td>
<td>§ 25-4-2206</td>
<td>Established the Health Equity Commission to advise the Department on Public Health and Environment on issues relating to</td>
</tr>
<tr>
<td>State</td>
<td>Code</td>
<td>Description</td>
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<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Colorado</td>
<td>health equity, specifically focusing on alignment, education, and capacity building for state and local health programs and community-based organizations. Dedicated the commission to promoting health equity and eliminating health disparities.</td>
<td></td>
</tr>
<tr>
<td>Connecticut</td>
<td>Requires the University of Connecticut Health Center to include a health disparities institute to enhance research and the delivery of care to minority and medically underserved populations of the state.</td>
<td>Requires the University of Connecticut Health Center to include a health disparities institute to enhance research and the delivery of care to minority and medically underserved populations of the state.</td>
</tr>
<tr>
<td></td>
<td>§ 2-122</td>
<td>Established the Asian Pacific American Affairs Commission to address, among other topics, any issues dealing with access to health care or mental health and addiction services.</td>
</tr>
<tr>
<td></td>
<td>§ 4-124dd</td>
<td>Established the Connecticut Allied Health Workforce Policy Board, which is given the duty to develop recommendations for promoting diversity in the allied health workforce, including, but not limited to, racial, ethnic, and gender diversity.</td>
</tr>
<tr>
<td></td>
<td>§ 17b-306</td>
<td>Requires a plan to both improve health outcomes for all children enrolled in the HUSKY Plan and reduce racial and ethnic disparities among children.</td>
</tr>
<tr>
<td>Connecticut</td>
<td>§ 20-10b</td>
<td>Requires that medical professionals applying for licensure renewal after October 1, 2010 must have at least one contact hour of continuing medical education or training in cultural competency.</td>
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</tr>
<tr>
<td></td>
<td>§ 38a-1051</td>
<td>Established a Commission on Health Equity with the mission of (1) eliminating disparities in health status based on race, ethnicity, gender, and linguistic ability, and (2) improving the quality of health for all of the state’s residents.</td>
</tr>
<tr>
<td></td>
<td>§ 19a-4j</td>
<td>Established the Connecticut Department of Public Health’s Office of Multicultural Health (OMH) to improve the state’s health status by eliminating differences in disease, disability, and death rates in ethnic, racial, and cultural populations.</td>
</tr>
<tr>
<td>Delaware</td>
<td>DEL. CODE ANN. tit. 16, § 9908</td>
<td>Requires the Board of Directors of the Delaware Institute of Medical Education and Research to serve as an advisory board to the Health Care Commission, with the goal of developing recruitment programs to increase medical school applications from minorities and residents of rural and underserved areas in Delaware.</td>
</tr>
<tr>
<td></td>
<td>Tit. 16, § 196</td>
<td>Established the Delaware Healthy Mother and Infant Consortium to address health disparities related to the health of women of childbearing age and infants.</td>
</tr>
<tr>
<td>Florida</td>
<td>FLA. STAT. § 14.27 (repealed 2010)</td>
<td>Created the Florida Commission on African-American Affairs within the Executive Office of the Governor, with a mandate to develop strategies to address the economic, social, educational, health, and welfare needs of Florida’s African-Americans.</td>
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</tr>
<tr>
<td></td>
<td>§ 20.43</td>
<td>Established the Office of Minority Health within the Department of Health.</td>
</tr>
<tr>
<td></td>
<td>§ 381.0405</td>
<td>Established a program to (1) provide financial support for primary care specialty interns and residents in order to promote practice in medically underserved areas of the state and (2) encourage racial and ethnic diversity within the state’s physician workforce.</td>
</tr>
<tr>
<td></td>
<td>§ 381.4018</td>
<td>Requires the Department of Health (DOH) to serve as a coordinating and strategic planning body to actively assess the state’s current and future physician workforce needs. Requires DOH to develop strategies that would provide monetary incentives for physicians to relocate to underserved areas of the state.</td>
</tr>
<tr>
<td></td>
<td>§§ 381.7351-.7356</td>
<td>Created the Reducing Racial and Ethnic Health Disparities: Closing the Gap Act grant program to stimulate the development of community- and neighborhood-based projects in order to improve the health outcomes of racial and ethnic populations.</td>
</tr>
<tr>
<td>Florida</td>
<td>Requires the Office of Minority Health to provide workshops and conferences on innovative and evidence-based approaches to equip projects and the community with methods to identify, address, and eliminate racial and ethnic health disparities.</td>
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</tr>
<tr>
<td>§ 381.7353</td>
<td>Re-designated the existing Minority Health Affairs Council to the Minority Health Affairs Commission.</td>
<td></td>
</tr>
<tr>
<td>§ 381.91</td>
<td>Established the Jessie Trice Cancer Prevention Program to both reduce the rates of illness and death from lung cancer and other cancers and improve the quality of life among low-income African-American and Hispanic populations through increased access to early, effective screening and diagnosis, education, and treatment programs.</td>
<td></td>
</tr>
<tr>
<td>§ 381.911</td>
<td>Authorizes the University of Florida Prostate Disease Center, in collaboration with other organizations and institutions, to establish a prostate cancer council to replace the existing advisory committee, with the objective to minimize prostate cancer disparities through outreach and education.</td>
<td></td>
</tr>
<tr>
<td>§ 383.2162</td>
<td>Created the Black Infant Health Practice Initiative to review infant mortality in select counties in the state in order to identify factors in the health and social services systems.</td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td></td>
<td>contributing to higher mortality rates among African-American infants.</td>
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</tr>
<tr>
<td><strong>§ 409.147</strong></td>
<td>Provides for the designation of “children’s zones” where children in disadvantaged areas can be provided with a more positive educational and social environment in order to eliminate health disparities between racial and cultural groups.</td>
<td></td>
</tr>
<tr>
<td><strong>§ 641.217</strong></td>
<td>Requires entities contracting with the Agency for Health Care Administration to provide health care services to Medicaid recipients or state employees on a prepaid or fixed-sum basis to submit a plan for recruitment and retention of health care practitioners who are minorities.</td>
<td></td>
</tr>
<tr>
<td><strong>§ 765.5155</strong></td>
<td>Recognizes a need to reach out to minority populations to increase organ donor registrations.</td>
<td></td>
</tr>
<tr>
<td><strong>§ 1009.68 (repealed 2013)</strong></td>
<td>Established the Florida Minority Medical Education program to provide scholarships to minority students to encourage the pursuit of medical education at state schools for the purpose of addressing the primary health care needs of underserved groups.</td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>GA. CODE ANN. § 31-2-4</td>
<td>Relating to the powers, duties, functions, and responsibilities of the Office of Minority Health within the Department of Community Health.</td>
</tr>
<tr>
<td>State</td>
<td>Law/Resolution</td>
<td>Description</td>
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</tr>
<tr>
<td>Hawaii</td>
<td>HAW. REV. STAT. § 321-1.5</td>
<td>Established within the Department of Health a Primary Health Care Incentive Program to (1) investigate and analyze the extent, location, and characteristics of medically underserved areas, and the numbers, location, and characteristics of medically underserved persons in Hawaii; and (2) develop a strategy for meeting the health needs of those populations based upon the findings.</td>
</tr>
<tr>
<td></td>
<td>§ 371-34 (repealed 2012)</td>
<td>Requires state-funded entities to provide free language services.</td>
</tr>
<tr>
<td></td>
<td>Haw. S.R. 79-12</td>
<td>Requests that the Governor direct all state departments to comply with the U.S. Office of Management and Budget's Statistical Policy Directive No. 15, which separates the “Asian and Pacific Islander” category into two categories: “Asians” and “Native Hawaiians and Other Pacific Islanders.”</td>
</tr>
<tr>
<td>Idaho</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td>20 ILL. COMP. STAT. 5/5-565</td>
<td>Requires the State Board of Health to create a State Health Improvement Plan, which includes priorities and strategies for reducing and eliminating health disparities in areas such as racial, ethnic, gender, age, socio-economic, and geographic disparities, by January 1, 2016, and every five years thereafter.</td>
</tr>
</tbody>
</table>
Amended the Department of Public Health power and duties, creating the Chronic Disease Prevention and Health Promotion task force and placing particular emphasis on addressing health disparities and targeting high-risk populations, especially in communities where racial, ethnic, and socioeconomic factors contribute to higher incidence of chronic disease.

Created an Advisory Panel on Minority Health consisting of twenty-five members appointed by the Director of Public Health.

Requires the Advisory Panel on Minority Health to assist the Department of Public Health in matters relating to minority health.

Established a Center for Minority Health Services to advise the Department of Public Health on matters pertaining to the health needs of minority populations and to recommend treatment methods and programs that are sensitive and relevant to minority populations.

Established the Culturally Competent Healthcare Demonstration Program (aimed at improving the quality of health care for ethnic and racial minorities).

Created the Commission on Children and Youth Act, which mandated the
<table>
<thead>
<tr>
<th>Illinois</th>
<th>development of a five-year plan addressing disparities in access and outcomes based on racial, ethnic, geographic, gender, sexual orientation, disability, and other variables.</th>
</tr>
</thead>
<tbody>
<tr>
<td>110 ILL. COMP. STAT. 925/2</td>
<td>Requires the Department of Public Health to establish a program to encourage minority students to enroll in and complete dental school in the state.</td>
</tr>
<tr>
<td>978/5</td>
<td>Requires the Department of Public Health to establish a program providing grants to podiatric medicine residency programs, scholarships to podiatry students, and a loan repayment option for podiatrists who will agree to practice in underserved areas of the state. Gives minority students a scholarship preference.</td>
</tr>
<tr>
<td>Indiana</td>
<td>Allows the distribution of monies from the Indiana Health Care Trust Fund to programs with a specific purpose, including those programs that assist community health centers in providing health care services and preventive measures that address the special health care needs of minorities; address minority health disparities; and expand community based minority health infrastructure—among others.</td>
</tr>
</tbody>
</table>

Dykes: Health Injustice and Justice in Health: The Role of Law and Publi

Published by Mitchell Hamline Open Access, 2015
<p>| Indiana | § 12-15-44 .2-14 | Requires any insurer or a health maintenance organization that contracts with the state to provide health insurance coverage under the Indiana Check-Up Plan to incorporate cultural competency standards. |
| §§ 16-19-14 -1, -7 | Established the Office of Minority Health within the state Department of Health (this chapter expires on July 1, 2017). |
| §§ 16-46-6-1 to -13 | Established the Interagency State Council on Black and Minority Health within the Department of Health to identify and study the special health care needs and health problems of minorities as well as the factors that contribute to these problems. |
| § 16-46-6-2 | Added Alaska Native, Native Hawaiian, and other Pacific Islander to the definition of minority under the interagency state council on black and minority health; changed council membership; and required the council to develop and implement a plan to address health disparities of minority populations in regards to objectives including mental health and substance abuse. |
| § 16-46-11-1 | Directs the Department of Health to develop/implement a structure more conducive to addressing health disparities, including: monitoring minority health progress; funding |</p>
<table>
<thead>
<tr>
<th>State</th>
<th>Code/Statute</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana</td>
<td></td>
<td>minority health programs, research, and initiatives; staffing a minority health hotline; creating an awareness program to inform health and social service providers of the special needs of minorities; and creating culturally and linguistically appropriate health promotions and disease prevention programs.</td>
</tr>
<tr>
<td>Iowa</td>
<td>IOWA CODE § 135.12</td>
<td>Established the Office of Minority and Multicultural Health within the Department of Public Health.</td>
</tr>
<tr>
<td></td>
<td>§ 135.158</td>
<td>Provided that a purpose of a “medical home” is to reduce disparities in health care access, delivery, and health care outcomes.</td>
</tr>
<tr>
<td>Kansas</td>
<td>KAN. STAT. ANN. § 74-3266</td>
<td>Created a scholarship program for osteopathic students who agree to practice in a rural or medically underserved area.</td>
</tr>
<tr>
<td></td>
<td>§§ 74-32,131 to -32,134</td>
<td>Established the Advanced Registered Nurse Practitioner Service Scholarship Program for students who agree to practice in a rural area or medically underserved area.</td>
</tr>
<tr>
<td>Kentucky</td>
<td>KY. REV. STAT. ANN. § 200.700</td>
<td>Established the Early Childhood Development Authority in the Office of the Governor, which, among other things, oversees activities to reduce disparities in maternal and child health status within select groups.</td>
</tr>
<tr>
<td>Kentucky</td>
<td>§ 205.201</td>
<td>Outlines the duties of the Cabinet for Health and Family Services, which includes, but is not limited to, preparing an annual report for the Legislative Research Commission, which contains an overview of the health status of minority elderly Kentuckians and identifies specific diseases and health conditions for which the minority elderly are at greater risk than the general population.</td>
</tr>
<tr>
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</tr>
<tr>
<td>§§ 216.2920 - .2929</td>
<td>Provides guidelines for health data collection, including requirements for evaluating the status of women’s health, data on ethnicity, reporting on the special health needs of the minority population, identifying the diseases that affect this population disproportionately, and providing recommendations to address disparities.</td>
<td></td>
</tr>
<tr>
<td>§ 216.2929</td>
<td>Requires the Cabinet for Health Services to prepare biennial reports on the special health needs of the minority population, including an overview of the health status and morbidity rates on minority Kentuckians and recommendations to meet the identified health needs of the minority population.</td>
<td></td>
</tr>
<tr>
<td>Louisiana</td>
<td>LA. REV. STAT. ANN. § 17:1817</td>
<td>Authorizes the Board of Supervisors of Southern University and Agricultural and Mechanical College to create and operate an office or offices of minority health.</td>
</tr>
<tr>
<td>Louisiana</td>
<td>§ 17:2048.51</td>
<td>Established (1) the Louisiana Health Works Commission within the Department of Education to study and make recommendations on programs to recruit and retain health care professionals in the Louisiana workforce, (2) models for predicting the supply and demand for health care workers in the state, and (3) incentives for health care workers to practice in Louisiana's medically underserved areas.</td>
</tr>
<tr>
<td>§ 40:1300 .132</td>
<td>Requires the Department of Health and Hospitals to adopt regulations and payment methodologies intended to fully reimburse federally qualified health centers (FQHC) so that FQHCs may retain primary health professionals and continue to provide health care services in medically underserved areas.</td>
<td></td>
</tr>
<tr>
<td>§ 40:2195.6</td>
<td>Requires the Department of Health and Hospitals to establish primary health care clinics in each of the rural parishes in the state if and when one hundred percent federal funding becomes available for this purpose, to expand primary health care and medical services to rural areas and develop greater access to health care for the underprivileged, working poor, and minorities.</td>
<td></td>
</tr>
<tr>
<td>§§ 46:978.1 −.2</td>
<td>Requires the Department of Health and Hospitals to develop and implement a medical home system of care for Medicaid recipients and the</td>
<td></td>
</tr>
<tr>
<td>Louisiana</td>
<td>low-income uninsured citizens of the state, with the goal of reducing the disparities in access to health care.</td>
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<td></td>
</tr>
<tr>
<td>§ 46:2731</td>
<td>Established the “Health Trust Fund” within the state treasury, which can be used for approved purposes such as health workforce development and retention, disease specific treatment programs, and expanding access to health care services in medically underserved areas.</td>
<td></td>
</tr>
<tr>
<td>2012 LA H.R. 146</td>
<td>Created a study committee to examine and make recommendations with respect to the structure of the African American family as it relates to education outcomes, socioeconomic factors, and health disparities.</td>
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<tr>
<td>Maine</td>
<td>Requires representation from populations in the state facing health disparities on the Statewide Coordinating Council for Public Health.</td>
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<td>ME. REV. STAT. tit. 22 § 412</td>
<td>Requires the Maine Center for Disease Control and Prevention to undertake a universal wellness initiative to ensure that all people of the state have access to resources and evidence-based interventions in order to know, understand, and address health risks and to improve health and prevent disease, with a particular focus on the uninsured and others facing health disparities.</td>
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</table>
Maine  |  Tit. 22, § 2097  |  Requires five interested citizens representing a balance of diverse socioeconomic groups and geographic locations on the Maine Dental Health Council.

Maryland  |  MD. CODE ANN., HEALTH-GEN. § 13-1115  |  Established a Baltimore City Community Health Coalition, which has representatives from community-based groups, including minority and medically underserved populations.

|  § 15-143  |  Requires the Governor to include in the budget bill for fiscal year 2008 at least $3,000,000 in General Fund State support for an immigrant health initiative to provide health care services for all legal immigrant children under the age of 18 years and pregnant women who meet program eligibility standards and arrived in the United States on or after August 22, 1996.

|  §§ 18-1001 to -1002  |  Requires the Department of Health and Mental Hygiene to coordinate with the Office of Minority Health and Health Disparities to develop a plan to address Hepatitis B and Hepatitis C viruses, which disproportionately affect minority populations in the state.

Requires the Maryland Health Care Commission to examine research findings surrounding health disparities and the most effective treatment for African Americans with Hepatitis C.
| Maryland | § 19-1A-01 | Requires the Health Care Commission to establish a Patient Centered Medical Home Program and charges this commission with ensuring that a participating patient centered medical home provides ongoing culturally and linguistically appropriate care for the purpose of reducing health disparities. |
| § 19-134 | Requires the Maryland Commission on Health Care to compile data on Minority Health and Health Disparities and publish its findings in the “Health Care Disparities Policy Report Card,” as required under § 20-1004(22). |
| §§ 19-2101 to -2103 | Established the Maryland Community Health Commission to increase access to health care through community health resources with the requirement that Commission membership have geographic balance and promote racial/gender diversity. |
| §§ 20-901 to -904 | Encourages the inclusion of courses or seminars that address the identification and elimination of health care services disparities for minority populations as part of: curriculum courses or seminars offered or required by institutions of higher education, continuing education requirements for health care providers, and continuing education programs offered by hospitals for hospital employees and staff and health care practitioners. |
| Maryland       | §§ 20-1001, -1004                                                                 | Established an Office of Minority Health and Health Disparities (OMHHD).
                                                                  |                                                                 | Requires OMHHD to work collaboratively with universities, public health and social work programs, and allied health to create courses focusing on cultural competency, sensitivity, and health literacy. |
|----------------|---------------------------------------------------------------------------------|------------------------------------------------------------------|
| §§ 20-1301     | §§ 20-1301 to -1302                                                              | Established the Cultural and Linguistic Health Care Professional Competency Program with the purpose of incorporating cultural and linguistic abilities into therapeutic and medical evaluation and treatment. |
| §§ 20-1401     | §§ 20-1401                                                                       | Created the Health Improvement and Disparities Reduction Act of 2012. Requires the secretary of mental health and hygiene to designate certain areas as Health Enterprise Zones, and to adopt an evaluation and reporting system for racial and ethnic health disparities. |
| MD. CODE ANN., HEALTH OCC. § 1-214 |                                                                                  | Requires health occupations boards to collect specified racial and ethnic information and, to the extent practicable, members of health occupations boards must reasonably reflect the geographic, racial, ethnic, cultural, and gender diversity of the state. |
| **Maryland** | **§ 1-216** | Requires health occupations boards to develop, collaboratively, a training process as well as materials for new board members on cultural competency. |
| MD. CODE ANN., INS. § 27-914 | Prohibits the use of specified racial or ethnic information to deny or otherwise affect a health insurance policy. |
| **H.B. 1455, 2006 Sess.** | Requires the Family Health Administration in the Department of Health and Mental Hygiene, in consultation with the Office of Minority Health and Health Disparities, to provide technical assistance to community-based entities for a pilot program that addresses the cultural competency training of specified health care providers and specified health outcomes. |
| **S.B. 182, 2005 Sess.** | Altered the membership of the Procurement Advisory Council by the Special Secretary for the Office of the Minority Affairs. |
| **S.B. 903, 2004 Sess.** | Designated the Special Secretary for the Office of Minority Affairs as head of the office. Requires requests for proposals, invitations for bids, and responsive bids to include information about minority business enterprise participation. |
| Maryland         | H.B. 883, 2003 Sess. | Requires the Department of Health and Mental Hygiene, in consultation with the Maryland Healthcare Foundation, to develop a state plan to reduce health care disparities. 
Created the Secretary's Task Force on Eliminating Health Disparities, which serves as an internal advisory group for the department. |
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<tr>
<td>Massachusetts</td>
<td>MASS. GEN. LAWS ANN. ch. 6A, § 16K (repealed 2012)</td>
<td>Established a health care quality and cost council within, but not subject to the control of, the Executive Office of Health and Human Services, with the goal of promoting public transparency of the quality and cost of health care in the commonwealth, and to seek to improve health care quality, to reduce racial and ethnic health disparities, and to contain health care costs.</td>
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<tr>
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<td>Ch. 6A, § 16O</td>
<td>Established a health disparities council within, but not subject to the control of, the Executive Office of Health and Human Services to make recommendations to reduce and eliminate racial and ethnic disparities in access to quality health care and in health outcomes within the commonwealth.</td>
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<td>Ch. 23H, § 9</td>
<td>Established a health professions worker training grant program for the purpose of responding to the need for workers in various health care professions.</td>
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<td>Massachusetts</td>
<td>Ch. 40J, § 6D</td>
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<td>Established an institute for health care innovation, technology, and competitiveness, to be known as the Massachusetts e-Health Institute, with duties to include preparing an annual update to statewide electronic health records plans that are focused on community-based implementation, particularly for providers such as community health centers that serve underserved populations, including, but not limited to, racial, ethnic, and linguistic minorities, uninsured persons, and areas with a high proportion of public payer care.</td>
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<th>Ch. 111, § 4O</th>
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<td>Authorized, subject to appropriation, a commissioner-appointed dental director whose duty is to oversee the department of public health dental program in order to increase access to oral health services, oral health prevention activities, and other initiatives to address oral health disparities.</td>
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<th>Ch. 111, § 25L</th>
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<td>Established a health care workforce center within the Department of Public Health to improve access to health care services and to coordinate the department's health care workforce activities with other state agencies and public and private entities involved in health care workforce training, recruitment, and retention.</td>
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<td><strong>Michigan</strong></td>
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<tr>
<td><strong>MICH. COMP. LAWS ANN. §§ 330.1162 -1164</strong></td>
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<td><strong>§ 333.2227</strong></td>
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<td><strong>§ 333.2707</strong></td>
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<td><strong>§ 333.2721</strong></td>
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<tr>
<th><strong>Minnesota</strong></th>
<th><strong>Requirements</strong></th>
<th><strong>Details</strong></th>
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<tr>
<td><strong>MINN. STAT. § 62J.495</strong></td>
<td>Requires all hospitals and health care providers to have in place an interoperable electronic health records system by January 1, 2015, which includes stated goals such as: improving the quality and...</td>
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coordination of health care and continuity of patient care among health care providers, reducing medical errors, improving population health, reducing health disparities, and reducing chronic disease.

§ 62J.496 Established an account to (1) finance the purchase of certified electronic health records or qualified electronic health records, (2) enhance the utilization of electronic health record technology, (3) train personnel in the use of such technology, and (4) improve the secure electronic exchange of health information.

Defining “eligible borrowers” under these programs to include entities that serve uninsured, underinsured, and/or medically underserved individuals, regardless of whether the physical location is urban or rural.

§ 137.38 Requested that the Board of Regents of the University of Minnesota, through the medical school, implement initiatives designed to encourage newly graduated primary care physicians to establish practices in areas of rural and urban Minnesota that are medically underserved.

§ 137.42 Requires the Commissioner of Health to give funding priority to programs that address disparities among populations of color related to tobacco use and other high-risk health-related behaviors.
| Minnesota | Prioritizes smoking cessation activities in low-income, indigenous, and minority communities. |
| § 144.1501 | Established a health professional education loan forgiveness program account for eligible recipients, which includes medical residents who agree, upon graduation, to practice in designated rural areas or underserved urban communities. |
| § 145.928 | Sets forth the goal of eliminating health disparities as part of the Minnesota’s community health services.  
Established a program to close the gap in the health status of American Indians and populations of color as compared with whites in the following priority areas: infant mortality, breast and cervical cancer screening, HIV/AIDS and sexually transmitted infections, adult and child immunizations, cardiovascular disease, diabetes, and accidental injuries and violence.  
Established the Eliminating Health Disparities Initiative (EHDI).  
Provided funding and goals for the state to eliminate disparities by 2010. |
<p>| § 145.986 | Requires (1) the Commissioner of Health to award competitive grants to community health boards established pursuant to section 145A.09 and (2) tribal governments to convene, coordinate, and implement evidence- |</p>
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<tr>
<th>Minnesota</th>
<th>Based strategies targeted at reducing the percentage of Minnesotans who are obese or overweight and to reduce the use of tobacco.</th>
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<tr>
<td>§ 145A.14</td>
<td>Allows the Commissioner of Health to make special grants to furnish health services for migrant agricultural workers and their families in areas of the state where significant numbers of migrant workers are located and to establish, operate, or subsidize clinic facilities and services to furnish health services for American Indians who reside off reservations. Provides $1,500,000 per year to tribal governments for maternal and child health activities, activities that reduce health disparities, and emergency preparedness.</td>
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<tr>
<td>§ 256.962</td>
<td>Established a statewide campaign to (1) raise public awareness on the availability of health coverage through medical assistance, general assistance medical care, and MinnesotaCare and (2) educate the public on the importance of getting and keeping health care coverage. Directed the Commissioner of Human Services to award grants to organizations for outreach activities, such as: targeting geographic areas with high rates of eligible but unenrolled children, including children who reside in rural area, racial and ethnic minorities, and health disparity populations.</td>
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<td>State</td>
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<tr>
<td>Minnesota</td>
<td>S.F. 3780, 85th Leg., Reg. Sess. (Minn. 2008)</td>
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<td>Mississippi</td>
<td>MISS. CODE ANN. §§ 37-144-1 to -7</td>
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<td>§ 41-3-61</td>
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<tr>
<td>Mississippi</td>
<td>practices in Mississippi that incorporate the principles of the patient-centered medical home based upon legislative findings and studies which demonstrate that when minorities have a medical home, racial and ethnic disparities in terms of medical access disappear and the costs of health care decrease.</td>
</tr>
<tr>
<td>§§ 41-99-1 to -3</td>
<td>Established the Mississippi Qualified Health Center Grant Program for the purpose of making service grants to Mississippi qualified health centers for their use in providing care to uninsured or medically indigent patients in Mississippi. Defining “Mississippi qualified health center” to mean a public or nonprofit entity that provides comprehensive primary care services to designated medically underserved areas or populations, as provided in Section 330 of the Public Health Service Act.</td>
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<tr>
<td>§§ 41-119-1 to -5 (repealed 2014)</td>
<td>Established the Mississippi Health Information Network to (1) promote the use of certified electronic health records technology in a manner that improves quality, safety, and efficiency of health care delivery, (2) reduce health care disparities, (3) engage patients and families, (4) improve health care coordination, (5) improve population and public health, and (6) ensure adequate privacy and security protections for personal health information.</td>
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<td>Missouri</td>
<td>MO. REV. STAT. § 191.980</td>
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<td>§ 192.040</td>
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<td>§§ 192.350 -.355</td>
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<td>Missouri</td>
<td>§§ 208.533 - .535</td>
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<td>Montana</td>
<td>MONT. CODE ANN. §§ 20 -26-1501 to -1503</td>
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<td>Nebraska</td>
<td>NEB. REV. STAT. ANN. § 71-701</td>
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<td>§ 71-1628.07</td>
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<td>§§ 71-7605 to -7611</td>
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<td><strong>Nebraska</strong></td>
<td>Nebraska and organizations that focus on the health of minority groups. Requires that the Department of Health and Human Services contract with the health clinics of Nebraska’s federally recognized Native American tribes, Indian health organizations, or other public health organizations that have a substantial Native American clientele to provide educational and public health services targeted to Native American populations.</td>
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<td>§ 85-1,130 (repealed 2012)</td>
<td>Instructed the University of Nebraska Medical Center to develop a plan to increase the number of graduates of the center who specialize in primary care fields, who take residencies in primary care fields, and who establish practices in rural areas and other medically underserved areas of the state.</td>
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<tr>
<td><strong>Nevada</strong></td>
<td>Created the Office of Minority Health in order to (1) improve the quality of health care services for members of minority groups, (2) increase access to health care services for members of minority groups, and (3) disseminate information to and educate the public on matters concerning health care issues of interest to members of minority groups. Created an Advisory Committee composed of nine members reflecting the ethnic and geographical diversity of Nevada.</td>
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<td>NEV. REV. STAT. ANN. §§ 232.467 - .484</td>
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<td>Nevada</td>
<td>§ 396.907</td>
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<tr>
<td>§ 439.362</td>
<td>Requires that the District Board of Health in counties whose population is 400,000 or more contain two physician representatives who have education, training, experience, or demonstrated abilities in the provision of health care services to members of minority groups and other medically underserved populations.</td>
</tr>
<tr>
<td>§ 439.491 –.494</td>
<td>Established the Advisory Committee for the Prevention and Treatment of Stroke and Heart Disease to, among other things, make recommendations to the Health Division for the establishment of a comprehensive plan for the prevention of stroke, heart disease and other vascular disease in this State, which includes, but is not limited to, recommendations to eliminate disparities in vascular health among populations that are disproportionately affected by stroke, heart disease, and other vascular disease.</td>
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<tr>
<td>Nevada</td>
<td>Assemb. B. 519, 76th Leg., Reg. Sess. (Nev. 2011)</td>
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<td>New Hampshire</td>
<td>None</td>
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<td>New Jersey</td>
<td>N.J. STAT. ANN. §§ 18A:71C -32 to -48 Established a Primary Care Practitioner Loan Redemption Program within the Higher Education Student Assistance Authority to provide for the redemption of a portion of the eligible qualifying loan expenses of program participants for each year of service at an approved site located within a state designated underserved area or a health professional shortage area.</td>
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<td>§§ 26:2-160 to -167.3 Established the New Jersey Office on Minority and Multicultural Health within the State Department of Health and its outlines powers and duties.</td>
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<td>§ 26:2-182 Established the Task Force on Cancer Prevention, Early Detection and Treatment in New Jersey within the Department of Health and Senior Services and outlined its powers and duties, which include, but are not limited to, closing the gap in cancer mortality rates between the total population and minorities.</td>
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<td>New Jersey</td>
<td>§ 26:2W-1</td>
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<td>§ 45:9-7.2</td>
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<td>New Mexico</td>
<td>N.M. STAT. ANN. § 9-7-4.1</td>
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<td>New Mexico</td>
<td>§ 9-7-11.1</td>
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<td>§§ 11-18-1 to -5</td>
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<td>§§ 24-ID-1 to -10</td>
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<tr>
<td>New York</td>
<td>N.Y. PUB HEALTH LAW §§ 241–243</td>
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<td>North Carolina</td>
<td>N.C. GEN. STAT. ANN. § 130A-16</td>
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<td>§§ 130A-33 .43–.44</td>
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<td>North Dakota</td>
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<td><strong>Ohio</strong></td>
<td><strong>OHIO REV. CODE ANN. § 183.18</strong></td>
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<td>Established the Public Health Priorities Trust Fund in the state treasury. Requires money credited to the fund to be used for, but not limited to, minority health programs, on which not less than twenty-five percent of the annual appropriations from the trust fund shall be expended.</td>
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<td><strong>§ 185.01 (repealed 2012)</strong></td>
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<td>Established the Patient Centered Medical Home Education Pilot Project with curricula that focuses on the special needs of patients who are part of a medically underserved population, including Medicaid recipients, individuals without health insurance, individuals with disabilities, individuals with chronic health conditions, and individuals within racial or ethnic minority groups.</td>
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<td><strong>§ 3701.78</strong></td>
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<td>Established a Commission on Minority Health to promote health and the prevention of disease among members of minority groups.</td>
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<td><strong>Oklahoma</strong></td>
<td><strong>OKLA. STAT. tit. 63, § 1-560.1</strong></td>
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<td>Created the Legislative Task Force to Eliminate Health Disparities and set goals for the task force, membership requirements, and reporting obligations.</td>
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<tr>
<td>State</td>
<td>Title and Section(s)</td>
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<tr>
<td>Oklahoma</td>
<td>Tit. 70, §§ 625.1-3</td>
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<td>Tit. 70, §§ 697.1-2</td>
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<td>Tit. 70, § 697.9</td>
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<td>Oregon</td>
<td>OR. REV. STAT. ANN. § 413.250</td>
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<td>§§ 413.550-.560</td>
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<td>§ 431.375</td>
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<td>§ 676.400</td>
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<td>Or. Exec. Order No. 99-07</td>
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<tr>
<td>Oregon</td>
<td>Requires six members of the task force to be state legislators, three of which are members of racial or ethnic groups.</td>
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<tr>
<td>Pennsylvania</td>
<td>35 PA. CONS. STAT. ANN. § 5701.901</td>
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<td>62 PA. CONS. STAT. ANN. § 5001.1301</td>
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<td>Pa. Exec. Order No. 2007-04</td>
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<tr>
<td>Rhode Island</td>
<td>R.I. GEN. LAWS ANN. § 23-1-43</td>
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<td>State</td>
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<td>Rhode Island</td>
<td>§ 23-14.1-1 Established the Health Professional Loan Repayment Program for physicians, dentists, dental hygienists, nurse practitioners, certified nurse midwives, physician assistants, and any other eligible health care professionals who desire to serve the health care needs of medically underserved individuals in Rhode Island.</td>
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<td>§ 23-64-1 Created the Minority Populations Health Promotion Act, which established the minority population health promotion program, to be funded by a tax on tobacco.</td>
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<td>§ 23-64.1-1 Established the Commission for Health Advocacy and Equity.</td>
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<tr>
<td>South Carolina</td>
<td>S.C. CODE ANN. § 11-11-170 Established the Healthcare Tobacco Settlement Trust Fund from which interest earnings may be appropriated and used for disease prevention and the elimination of health disparities, particularly in minority populations.</td>
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<tr>
<td>South Dakota</td>
<td>None</td>
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<td>State</td>
<td>Code Section Details</td>
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<tr>
<td>Tennessee</td>
<td>TENN. CODE ANN. § 3-15-401 (repealed 2011)</td>
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<td>§ 68-1-117</td>
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<td>§§ 68-1-2201 to -2204</td>
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<td>2004 Tenn. Pub. Acts ch. 564</td>
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<td>Texas</td>
<td>TEX. EDUC. CODE ANN. §§ 51.711 –.716 (repealed 2013)</td>
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<td>Texas</td>
<td>§§ 63.301 –302</td>
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<tr>
<td>TEX. GOV’T CODE ANN. §§ 487.201 –204</td>
<td>Created the Medically Underserved Community-State Matching Incentive Program where medically underserved communities may sponsor a physician by contributing start-up money for the physician and having that contribution matched wholly or partly by state money.</td>
</tr>
<tr>
<td>§§ 487.251 –256</td>
<td>Established the Texas Health Service Corps Program for Medically Underserved Areas to assist those communities in recruiting and retaining physicians.</td>
</tr>
<tr>
<td>§§ 487.451 –454</td>
<td>Created the Community Healthcare Awareness and Mentoring Program for Students to identify high school students in rural and underserved urban areas who are interested in serving those areas as health care professionals and partnering them with health care professionals to act as positive role models, mentors, and reference resources.</td>
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<tr>
<td>Texas</td>
<td>§§ 487.551 - .560</td>
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<tr>
<td>TEX. HEALTH &amp; SAFETY CODE ANN. §§ 12.081 - .084</td>
<td>Requires the Department of Health to establish and maintain an Office of Minority Health to assume a leadership role in working in developing minority health initiatives, including bilingual communications. Established the powers of the office, provided for its funding, and outlined its legislative reporting requirements.</td>
</tr>
<tr>
<td>§§ 107.001 - .009 (repealed 2011)</td>
<td>Established the Health Disparities Task Force and outlined its powers and duties.</td>
</tr>
<tr>
<td>§§ 107A.001 - .002</td>
<td>Directs the executive commissioner of the Health and Human Services Commission to maintain an office for the elimination of health disparities in the Health and Human Services Commission and sets forth the powers and duties of the office.</td>
</tr>
<tr>
<td>TEX. HUM. RES. CODE ANN. §§ 2.001 - .003</td>
<td>Established the Interagency Council for Addressing Disproportionality with one stated goal of assisting the Health and Human Services Commission in eliminating health and health access disparities in Texas among racial, multicultural, disadvantaged, ethnic, and regional populations.</td>
</tr>
<tr>
<td><strong>Texas</strong></td>
<td><strong>Utah</strong></td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>H.B. 757, 77th Leg., Reg. Sess. (Tex. 2001)</td>
<td><strong>UTAH CODE ANN. § 9-9-104.6</strong></td>
</tr>
<tr>
<td>Established the Health Disparities Task Force to eliminate health and health access disparities in Texas among multicultural, disadvantaged, and regional populations.</td>
<td>Provides that the American Indian-Alaskan Native Health Liaison may participate in at least three of the joint meetings of specified Utah tribal governments for the purpose of coordinating the efforts of state and tribal governments in meeting the needs of the Native American Indians residing in the state.</td>
</tr>
<tr>
<td>§ 26-7-2</td>
<td><strong>§ 26-7-2 to -2.5</strong></td>
</tr>
<tr>
<td>Established the Center for Multicultural Health within the Utah Department of Health to address multicultural and minority health issues in the state.</td>
<td>Established the Office of Health Disparities Reduction within the Utah Department of Health to address multicultural and minority health issues in the state. Authorizing, subject to funding, the executive director to appoint an individual as the American Indian-Alaskan Native Health Liaison.</td>
</tr>
<tr>
<td><strong>§ 26-10b-102</strong></td>
<td>Authorizing, subject to appropriations specified by the Legislature, the Department of Health to make grants to public and nonprofit entities for the cost of operation of providing primary</td>
</tr>
<tr>
<td>State</td>
<td>Requirements</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Utah</td>
<td>health care services to medically underserved populations.</td>
</tr>
<tr>
<td>Vermont</td>
<td>None</td>
</tr>
<tr>
<td>Virginia</td>
<td><strong>VA. CODE ANN. § 32.1-14</strong> Requires the State Board of Health to submit an annual report to the Governor and General Assembly that includes, but is not limited to, statistics and analysis regarding the health status and conditions of minority populations in the Commonwealth by age, gender, and locality.</td>
</tr>
<tr>
<td></td>
<td><strong>§ 32.1-19</strong> Requires the State Health Commissioner to designate a senior staff member of the Department of Health, who shall be a licensed physician, to oversee minority health efforts of the Department.</td>
</tr>
<tr>
<td></td>
<td><strong>§ 32.1-122 .6:01</strong> Established a physician loan repayment program for recent medical school graduates who agree to perform a period of medical service in the Commonwealth in a medically underserved area or a health professional shortage area</td>
</tr>
<tr>
<td></td>
<td><strong>§ 32.1-122.7</strong> Established the Virginia Health Workforce Development Authority to facilitate the development of a statewide health professions pipeline that identifies, educates, recruits, and retains a diverse, appropriately geographically distributed, and culturally competent workforce.</td>
</tr>
<tr>
<td>State</td>
<td>Code Section</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Washington</td>
<td>WASH. REV. CODE ANN. § 28B.115 .010</td>
</tr>
<tr>
<td></td>
<td>§ 43.20.270</td>
</tr>
<tr>
<td></td>
<td>§ 43.70.590</td>
</tr>
<tr>
<td></td>
<td>§ 43.70.615</td>
</tr>
<tr>
<td>West Virginia</td>
<td>None</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Wis. Stat. § 250.20</td>
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</tr>
<tr>
<td>Wyoming</td>
<td>None</td>
</tr>
</tbody>
</table>
TABLE 2: National Stakeholder Strategy for Achieving Health Equity

<table>
<thead>
<tr>
<th>GOAL #</th>
<th>GOAL DESCRIPTION</th>
<th>STRATEGIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>AWARENESS</td>
<td>1. <strong>Health Care Agenda.</strong> Ensure that ending health disparities is a priority on local, state, tribal, regional, and federal health care agendas.</td>
</tr>
<tr>
<td></td>
<td>Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations</td>
<td>2. <strong>Partnerships.</strong> Develop and support partnerships among public, nonprofit, and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to end health disparities and achieve health equity across the lifespan.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. <strong>Media.</strong> Leverage local, regional, and national media outlets using traditional and new media approaches as well as information technology to reach a multi-tier audience—including racial and ethnic minority communities, youth, young adults, older persons, persons with disabilities, LGBT groups, and geographically isolated individuals—to encourage action and accountability.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEADERSHIP</th>
<th>HEALTH SYSTEM AND LIFE EXPERIENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthen and broaden leadership for addressing health disparities at all levels</td>
<td>Improve health and health care outcomes for racial, ethnic, and underserved populations</td>
</tr>
</tbody>
</table>

| | 4. Communication. Create messages and use communication mechanisms tailored for specific audiences across their lifespan—and present varied views of the consequences of health disparities—to encourage individuals, communities, and organizations to act and to reinvest in public health. |
| 1. Capacity Building. Build capacity at all levels of decision-making in order to promote community solutions for ending health disparities. | 1. Access to Care. Ensure access to quality health care for all. |
| 2. Funding Priorities. Improve coordination, collaboration, and opportunities for soliciting community input on funding priorities and involvement in research and services. | 2. Children. Ensure the provision of needed services (e.g., mental, oral, vision, hearing, and physical health; nutrition; and those related to the social and physical environments) for at risk-children, including children in out-of-home care. |
| 3. Youth. Invest in young people to prepare them to be future leaders and practitioners by actively engaging them in the planning/execution of health, wellness, and safety initiatives. | 3. Older Adults. Enable the provision of needed services and programs to foster healthy aging. |
### Cultural and Linguistic Competency

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<table>
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<tbody>
<tr>
<td><strong>CULTURAL AND LINGUISTIC COMPETENCY</strong></td>
</tr>
<tr>
<td>Improve cultural and linguistic competency and the diversity of the health-related workforce</td>
</tr>
</tbody>
</table>

### Health Communications

4. **Health Communications.** Enhance and improve health service experience through improved literacy, communications, and interactions.

### Education

5. **Education.** Substantially increase high school graduation rates, with a goal of 100%, by working with schools, programs, community organizations, public health agencies, health plan providers, and businesses to promote the connection between educational attainment and long-term health benefits.

### Social and Economic Conditions

6. **Social and Economic Conditions.** Support and implement policies that create the social, environmental, and economic conditions required to realize healthy outcomes.

### Workforce

1. **Workforce.** Develop and support the healthy workforce and related industry workforces to promote the availability of cultural and linguistic competency training that is sensitive to the cultural and language variations of diverse communities.

### Diversity

2. **Diversity.** Increase diversity and competency of the health workforce and related industry workforces through recruitment, retention, and training of racially, ethnically, and culturally diverse individuals and through leadership action by health care organizations and systems.
### DATA, RESEARCH, AND EVALUATION

Improve data availability as well as coordination, utilization, and diffusion of research and evaluation outcomes

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<tbody>
<tr>
<td>1. <strong>Data.</strong> Ensure the availability of health data on all racial, ethnic, and underserved populations.</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Community-Based Research and Action, and Community-Originated Intervention Strategies.</strong> Invest in community-based participatory research and evaluation of community-originated intervention strategies in order to build capacity at the local level for ending health disparities.</td>
<td></td>
</tr>
<tr>
<td>3. <strong>Coordination of Research.</strong> Support and improve coordination of research that enhances understanding about, and proposes methodology for, health and health care disparities</td>
<td></td>
</tr>
<tr>
<td>4. <strong>Knowledge Transfer.</strong> Expand and enhance transfer of knowledge generated by research and evaluation for decision-making about policies, programs, and grant making related to health disparities and health.</td>
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</tr>
</tbody>
</table>

**3. Ethics and Standards, and Financing for Interpreting and Translational Services.** Encourage interpreters, translators, and bilingual staff providing services in languages other than English to follow codes of ethics and standards of practice for interpreting and translation; encourage financing and reimbursement for health interpreting services.
### TABLE 3: HHS Action Plan to Reduce Racial and Ethnic Health Disparities

#### ACTION PLAN TO REDUCE RACIAL AND ETHNIC HEALTH DISPARITIES

**OVERARCHING SECRETARIAL PRIORITIES**

1. Assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities.

2. Increase the availability, quality, and use of data to improve the health of minority populations.

3. Measure and provide incentives for better health care quality for minority populations.


#### GOAL

<table>
<thead>
<tr>
<th>I. TRANSFORM HEALTH CARE</th>
</tr>
</thead>
</table>

**STRATEGY**

| I.A. Reduce disparities in health insurance coverage and access to care. |
| I.B. Reduce disparities in access to primary care services and care coordination. |

**ACTION**

| I.A. Reduce disparities in health insurance coverage and access to care. |
| I.B. Reduce disparities in access to primary care services and care coordination. |

I.A.1. Increase the proportion of people with health insurance and provide patient protection in Medicaid, CHIP, Medicare, Health Insurance Exchanges, and other forms of insurance.

I.B.1. Increase the proportion of persons with a usual primary care provider and patient-centered health homes.

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521. Adapted from U.S. DEP’T OF HEALTH & HUMAN SERVS., supra note 450, at 12-34.
<table>
<thead>
<tr>
<th>II. STRENGTHEN THE NATION'S HEALTH AND HUMAN SERVICES INFRASTRUCTURE AND WORKFORCE</th>
<th>I.C. Reduce disparities in the quality of health care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.C.1. Improve the quality of care provided in the Health Insurance Exchanges.</td>
<td></td>
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<tr>
<td>I.C.2. Improve outreach for and adoption of certified electronic health record (EHR) technology to improve care through the Regional Extension Centers program and other federal grant programs.</td>
<td></td>
</tr>
<tr>
<td>I.C.3. Develop, implement, and evaluate interventions to prevent cardiovascular diseases and their risk factors.</td>
<td></td>
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<tr>
<td>I.C.4. Increase access to dental care for children in Medicaid and CHIP.</td>
<td></td>
</tr>
<tr>
<td>II.A. Increase the ability of all health professionals and the health care system to identify and address racial and ethnic health disparities.</td>
<td></td>
</tr>
<tr>
<td>II.A.1. Support the advancement of translational services.</td>
<td></td>
</tr>
<tr>
<td>II.A.2. Collaborate with individuals and health professional communities to make enhancements to the current National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS).</td>
<td></td>
</tr>
<tr>
<td>II.B. Promote the use of community health workers and promotoras (individuals who provide health education and support to their community members).</td>
<td>II.B.1. Increase the use of promotoras to promote participation in health education, prevention, and health insurance programs.</td>
</tr>
<tr>
<td>II.C. Increase the diversity of the health care and public health workforces.</td>
<td>II.C.1. Create a pipeline program for students to increase racial and ethnic diversity in the public health and biomedical sciences professions.</td>
</tr>
<tr>
<td>II.B.2. Promote the use of community health workers by Medicare beneficiaries.</td>
<td>II.C.2. Increase education and training opportunities for recipients of Temporary Assistance for Needy Families (TANF) and other low-income individuals for occupations in health care fields through Health Profession Opportunity Grants (HPOG) programs.</td>
</tr>
<tr>
<td></td>
<td>II.C.3. Increase the diversity and cultural competency of clinicians, including the behavioral health workforce.</td>
</tr>
<tr>
<td></td>
<td>II.C.4. Increase the diversity of the HHS workforce.</td>
</tr>
</tbody>
</table>
III. ADVANCE THE HEALTH, SAFETY, AND WELL-BEING OF THE AMERICAN PEOPLE

<p>| III.A. Reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies. |
| III.A.1. Build community capacity to implement evidence-based policies and environmental, programmatic, and infrastructure change strategies. |
| III.A.2. Implement an education and outreach campaign regarding preventive benefits. |
| III.A.3. Develop, implement, and evaluate culturally and linguistically appropriate evidence-based initiatives to prevent and reduce obesity in racial and ethnic minorities. |
| III.A.4. Reduce tobacco-related disparities through targeted evidence-based interventions in locations serving racial and ethnic minority populations. |
| III.A.5. Increase education programs, social support, and home-visitation programs to improve prenatal, early childhood, and maternal health. |
| III.A.6. Implement targeted activities to reduce disparities in flu vaccination. |</p>
<table>
<thead>
<tr>
<th></th>
<th>III.A.7. Implement targeted activities to reduced asthma disparities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>III.B.</td>
<td>III.B.1. Adopt a “health in all policies” approach.</td>
</tr>
<tr>
<td>III.B.2.</td>
<td>III.B.2. Evaluate use of health disparity impact assessments for proposed policies and programs.</td>
</tr>
<tr>
<td>IV. ADVANCE SCIENTIFIC KNOWLEDGE AND INNOVATION</td>
<td>IV.A. Increase the availability and quality of data collected and reported on racial and ethnic minority populations.</td>
</tr>
<tr>
<td>IV.A.1.</td>
<td>IV.A.1. Implement a multifaceted health disparities data collection strategy across HHS.</td>
</tr>
<tr>
<td>IV.B.</td>
<td>IV.B.1. Develop and implement strategies to increase access to information, tools, and resources to conduct collaborative health disparities research across federal departments.</td>
</tr>
<tr>
<td>IV.B.2.</td>
<td>IV.B.2. Develop, implement, and test strategies to increase the adoption and dissemination of interventions based on patient-centered outcomes research among racial and ethnic minority populations.</td>
</tr>
</tbody>
</table>
| V. INCREASE EFFICIENCY, TRANSPARENCY, AND ACCOUNTABILITY OF HHS PROGRAMS | IV.B.3. Promote community-based participatory research (CBPR) approaches to increase cancer awareness, prevention, and control to reduce health disparities.  
IV.B.4. Expand research capacity for health disparities research.  
IV.B.5. Leverage regional variation research in search of replicable success in health disparities.  
Streamline grant administration for health disparities funding.  
Monitor and evaluate implementation of the HHS Disparities Action Plan.  
Goal-level disparities monitoring and surveillance.  
Strategy-level evaluation.  
Action-level monitoring. |
### Table 4: Opportunities to Advance Health Disparities Reduction Activities at the U.S. Department of Health and Human Services

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
<th>For More Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center for Integrated Health Solutions (CIHS)</td>
<td>Dedicated to addressing the comprehensive care needs of people in or seeking long-term recovery from addiction and mental illness by improving the coordination of health care services in publicly funded community settings, and promoting whole health and recovery self-management. Recognizes that members of underserved racially and ethnically diverse communities are more likely to seek care from a primary care provider than from a community behavioral health provider.</td>
<td><a href="http://www.integration.samhsa.gov/about-us/about-cihs">http://www.integration.samhsa.gov/about-us/about-cihs</a></td>
</tr>
<tr>
<td>Communities Putting Prevention to Work (CPPW)</td>
<td>As part of the 2009 American Recovery and Reinvestment Act, with support from the Affordable Care Act, CPPW has funded fifty programs committed to reducing chronic diseases related to obesity and tobacco.</td>
<td><a href="http://www.cdc.gov/nccdphp/dch/programs/communities/puttingprevention/towork/">http://www.cdc.gov/nccdphp/dch/programs/communities/puttingprevention/towork/</a></td>
</tr>
<tr>
<td>Healthy Weight Collaborative</td>
<td>Address child and family obesity through learning collaboratives, which have shown promise for improving the quality of care and clinical outcomes of underserved populations.</td>
<td><a href="http://www.nichq.org/news%20and%20events/news/nichq%20launches%20collaborate%20for%20healthy%20weight">http://www.nichq.org/news%20and%20events/news/nichq%20launches%20collaborate%20for%20healthy%20weight</a></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Program Description</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Supported through the Public Health and Prevention Fund under the Affordable Care Act and made possible by a grant from HRSA.</td>
<td></td>
</tr>
<tr>
<td><strong>Head Start Program</strong></td>
<td>Provides grants to local public and private nonprofit and for-profit agencies to provide comprehensive child development services to economically disadvantaged children and families. Efforts include the provision of educational, health, nutritional, social, and other services.</td>
</tr>
<tr>
<td><strong>National Network to Eliminate Disparities in Behavioral Health (NNED)</strong></td>
<td>Network funded by SAMHSA, NIMHD, and other foundations to link community-based behavioral health and multi-service organizations serving racial and ethnic minority populations in order to improve access to and delivery of evidence-supported quality behavioral health care.</td>
</tr>
<tr>
<td><strong>Racial And Ethnic Approaches to Community Health (REACH)</strong></td>
<td>A national multi-level program that has developed innovative approaches that focus on racial and ethnic groups, improves people's health. REACH communities have empowered residents to seek better health, changed local health care practices, and mobilized communities to implement evidence-based public health programs that address their unique social, historical, economic, and cultural circumstance.</td>
</tr>
</tbody>
</table>
The CDC currently funds forty communities to implement best practices to reduce health disparities.

| Regional Extension Centers | Funded by the Office of the National Coordinator to (1) assist more than 100,000 primary care providers in achieving meaningful use of certified electronic health record (EHR) technology and (2) improve care by providing outreach, education, EHR support, and technical assistance. Regional Extension Centers serve local communities around the country, focusing on those health care settings that provide primary care services to those who lack adequate coverage or medical care. | http://www.healthit.gov/providers-professionals/regional-extension-centers-recs |
| Task Force on Environmental Health Risks and Safety Risks for Children | Co-Chaired by HHS and EPA, this Task Force is supported by a Senior Steering Committee constituted of senior representatives of several federal departments, agencies, and White House offices. The Steering Committee has identified asthma disparities, chemical exposures, and healthy settings (where children live, learn, and play) as the three initial priorities for improving coordination of federal efforts and developing interagency collaborations to address environmental health risks and safety risks to children. | http://www2.epa.gov/children/presidential-task-force-environmental-health-and-safety-risks-children |
A FAREWELL AND A NEW CHAPTER

Volume 41 Board of Editors

Since 1974, the William Mitchell Law Review has published legal scholarship not only for its value in ongoing academic debate, but also for its usefulness to the legal profession. The journal has served local practitioners, judges, scholars, and lawmakers since its inception by annually publishing quality articles covering a wide range of timely, relevant, interesting, and thought-provoking topics. In addition to this broad outward impact, the William Mitchell Law Review has also benefited the lives and careers of hundreds of its members over the past forty years. Alumni of the journal have gone on to accomplish great things, thanks in no small part to their Law Review experience. For many, serving on the William Mitchell Law Review was a defining aspect of their law school career.

In February 2015, William Mitchell College of Law announced its intention to merge with Hamline University School of Law, pending ABA approval. As a result of this merger, beginning next fall, the William Mitchell Law Review will join together with the Hamline Law Review under a new banner: the Mitchell | Hamline Law Review. This combination of flagship journals marks the end of an era. This year’s edition, Volume 41, will be the last published under the William Mitchell Law Review name.

Although the name may be changing, the history and tradition of the journal will remain as strong as ever. The Mitchell | Hamline Law Review will continue to serve the Minnesota legal community by publishing quality articles that are timely, relevant, interesting, and thought provoking. And, it will continue to benefit the lives and careers of both its current members and alumni. With nearly eighty years of combined experience and credibility, the Mitchell | Hamline Law Review is certain to be a great success. Although one chapter may be coming to a close, an exciting new chapter is just about to begin. On behalf of the Volume 41 Board of Editors, please enjoy this final print issue of the William Mitchell Law Review.
2015

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