

3-2021

Health Care Civil Rights Under Medicare for All

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Health Care Civil Rights Under Medicare for All

VALARIE K. BLAKE[†]

The passage of Medicare for All would go a long way toward curing the inequality that plagues our health care system along racial, sex, age, health status, disability, and socioeconomic lines. Yet, while laudably creating a universal right to access to health care, Medicare for All may inadvertently dampen civil rights protections that are necessary to ensure equality in health care delivery, an outcome its creators and supporters surely would not intend.

Federal money is typically requisite for civil rights enforcement. Title VI, Title IX, and the Age Discrimination Act of 1975 all apply to recipients of federal financial assistance. Under Medicare for All, the federal government becomes the payer, not recipient, of federal funds, leaving it outside civil rights enforcement unlike private insurers. Additionally, because of historic quirks in how we interpret civil rights law, Medicare for All may leave health care providers outside of nondiscrimination mandates altogether.

Medicare for All creates a vacuum in civil rights applicability—one that lawmakers will have to fill if we want nondiscrimination by doctors and health benefits administrators—but it also creates an opportunity for lawmakers to reimagine the possibilities of civil rights in health care. Lawmakers have been none too deliberate about this process in the past, with civil rights being a byproduct rather than a goal of health reform. With careful planning, Medicare for All can go beyond retaining the status quo and become a meaningful and intentional civil rights movement in health care, providing greater access to health care in our country as well as more robust civil rights protections for patients in the future.

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INTRODUCTION

The passage of Medicare for All, or a single-payer style health plan of a similar variety, would be the most significant health policy achievement in this nation's history.¹ Lives have been lost as a direct result of our broken health care system.² Millions of Americans struggle to obtain affordable health care when they need it.³ Costly care eats up wage growth, leaving a stagnant middle class.⁴ Each year, American households go into bankruptcy because of unpaid medical bills, even after the passage of the Affordable Care Act (ACA).⁵

Medicare for All would grant Americans a universal right to access care. This would go a long way toward curing the inequality that plagues our health care system along racial, sex, age, health status, disability, and socioeconomic lines. After all, health care is no more immune from the harmful effects of discrimination than education, employment, or other critical domains. The segregation of American hospitals during the era of Jim Crow, the flight of hospitals out of minority neighborhoods, provider refusals to treat patients because of skin color or HIV status, refusals of health care entities to provide translators for non-English speakers or auxiliary aids for the deaf, health care plans designed to deter enrollment by the sick or by pregnant women—all are very real examples of the discrimination that many populations have faced or continue to face in obtaining even basic medical care.

Medicare for All might render our health care system more equal in some ways, by providing universal access to health benefits. At the same time, Medicare for All may inadvertently dampen civil rights protections that are necessary to ensure equality in health care delivery, an outcome its creators and supporters surely would not intend.

How could it be so that Medicare for All would be less protective of our civil rights in health care? Federal money is typically requisite for civil rights

1. "Medicare for All" and "single-payer" are used interchangeably in this Article. The analysis is not meant to be confined to any particular bill, although Senator Bernie Sanders's bill in the Senate (S. 1129) and Representative Pramila Jayapal's bill in the House (H.R. 1384) may serve as useful examples. See Medicare for All Act of 2019, S. 1129, 116th Cong. (2019); Medicare for All Act of 2019, H.R. 1384, 116th Cong. (2019).

2. For a summary of studies demonstrating how health insurance reduces mortality, see Steffie Woolhandler & David U. Himmelstein, *The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?*, 167 ANNALS INTERNAL MED. 424 (2017).

3. Uninsured rates have been steadily rising since 2016, with an uninsured rate of 13.7% at the end of 2018. Dan Witters, *U.S. Uninsured Rate Rises to Four-Year High*, GALLUP (Jan. 23, 2019), <https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx>.

4. *Benchmark Employer Survey Finds Average Family Premiums Now Top \$20,000*, KAISER FAM. FOUND. (Sept. 25, 2019), <https://www.kff.org/health-costs/press-release/benchmark-employer-survey-finds-average-family-premiums-now-top-20000/> ("Since 2009, average family premiums have increased 54% and workers' contribution have increased 71%, several times more quickly than wages (26%) and inflation (20%).").

5. David U. Himmelstein, Steffie Woolhandler, Robert M. Lawless, Deborah Thorne & Pamela Foohey, *Medical Bankruptcy: Still Common Despite the Affordable Care Act*, 109 AM. J. PUB. HEALTH 431 (2019).

enforcement.⁶ Title VI,⁷ Title IX,⁸ and the Age Discrimination Act of 1975,⁹ which collectively ban discrimination based on race, color national origin, sex, and age, all only apply to recipients of federal financial assistance. Federal money is at the center of all health reforms; each proposal varies based on how much or how little health care services are subsidized by the federal government and for whom. Thus, each effort at health reform and each pour of the federal coffers into health care services has cemented some forms of civil rights protections for patients (or potentially reduced them). Medicare brought in hospitals, Medicaid brought in state agencies and their benefit design, and the ACA brought in private insurers and nondiscrimination based on sex.¹⁰

By design, in Medicare for All and plans like it, all health care payments stem from a single payer, the federal government. But the federal government as the administrator of those benefits would not automatically be held to account for civil rights violations, in the way that Medicaid and private insurers currently are.¹¹ Additionally, because of historic quirks in how we interpret civil rights laws, even though most doctors and other providers are currently held accountable under civil rights law, Medicare for All money might actually free them from accountability.¹² Sex discrimination protections could also be lost.¹³

Medicare for All would create a vacuum in civil rights applicability, one that lawmakers will have to fill if only to retain the status quo. But this also makes Medicare for All an opportunity for lawmakers to reimagine the possibilities of civil rights in health care. In every other health reform in the past, civil rights laws automatically attached. As a result, lawmakers did not think about how civil rights *should* operate in health care. Under Medicare for All, civil rights inclusion will not be automatic, forcing lawmakers to have a conversation about how they best are incorporated. As we as a nation embark in this presidency or the next on still another major effort to reform our health care system—one that brings federal money exclusively or almost exclusively to the fore—we have an opportunity to plan for civil rights enforcement at the outset in a way that not just retains the status quo but improves upon civil rights protections for all patients.

This Article begins in Part I with the story of civil rights in health care, which is really the story of major federal health care reforms and their impact

6. For instance, see Title VI's language: "[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 42 U.S.C. § 2000d. There are some exceptions, like the Americans with Disabilities Act, which governs specifically enumerated private entities even when they do not accept federal money under Congress's Commerce powers. *See id.* § 12182.

7. *Id.* § 2000d.

8. 20 U.S.C. § 1681.

9. 42 U.S.C. § 6101.

10. *See infra* Part I.C–E.

11. *See infra* Part II.B.2.

12. *See infra* Part II.B.1.

13. *See infra* Part II.B.4.

on civil rights. The mechanics of civil rights laws are briefly overviewed before discussing civil rights implications of Medicare, Medicaid, and the ACA. This functions as an overview of the status quo of civil rights protections as they currently exist in our health care system, and the level of safeguards needed to keep the status quo. Part II explores the implications of Medicare for All and public options for civil rights enforcement in health care. It introduces the concepts of single-payer and public option models and provides examples of such legislation introduced in the 116th Congress. This Part then considers how Medicare for All, or bridges to it, will change the applicability of civil rights laws. In this Part, the Article also explains what legislative changes are needed to a Medicare for All bill to retain existing civil rights protections in health care. Part III dreams bigger; it considers what it may look like not just to maintain the status quo but to leverage Medicare for All into a meaningful and intentional civil rights movement in health care. This Part suggests ways that a Medicare for All bill could improve upon existing systems to create robust civil rights protections for patients in the future, while acknowledging the political challenges of such sweeping reforms.

I. THE STORY OF CIVIL RIGHTS IN HEALTH CARE

The history of civil rights in health care is one of passivity. Despite widespread systemic racism in medicine, health care was not a major focus of the passage of the Civil Rights Act of 1964 which, instead, addressed discrimination by employers, by recipients of federal funds, and in educational settings and public accommodations.¹⁴ Civil rights were an added bonus, but not the intention, of the government-financed behemoths that were Medicare and Medicaid. A steady flow of federal money into hospitals meant the return of a promise not to discriminate, at first, on the basis of race and, later, on the basis of other protected statuses. This Part discusses the evolution of civil rights in health care to date, or how we got to where we are, before turning in the next Part to how Medicare for All changes this status quo.

A. BRIEF OVERVIEW OF CIVIL RIGHTS LAW

This Subpart provides a general overview of how civil rights laws apply: who they protect, who they govern, what discrimination they prohibit, and how they are enforced both privately and governmentally. Title VI of the Civil Rights Act of 1964, which bans race, color, and national origin discrimination in programs and activities of recipients of qualifying federal financial assistance,¹⁵

14. Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241 (1964). For instance, see Title II (public accommodations), Title IV (public education), Title VI (discrimination in entities receiving federal financial assistance), and Title VII (employment).

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

has since become a model for most other civil rights statutes. Title IX, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and section 1557 of the ACA all prohibit discrimination by recipients of qualifying federal financial assistance. Title IX prohibits sex discrimination;¹⁶ the Rehab Act addresses disability discrimination;¹⁷ the Age Discrimination Act prohibits age discrimination;¹⁸ and section 1557 prohibits all of these forms of discrimination by health care entities.¹⁹ Other civil rights statutes may govern health care entities, irrespective of whether they receive federal funds, but these will not be the focus of this Article as they are not directly impacted by federal health reform and federal spending.²⁰ Notably, this Subpart uses Title VI for many examples, because it functions as the model for most other civil rights laws.

1. *Protected Classes*

Civil rights laws prohibit discrimination by covered entities on the basis of designated protected traits. While this may vary by statute, generally these laws prohibit discrimination on the basis of race, color, national origin, age, sex, or disability. Some statutes forbid discrimination on the basis of religion or exercise of conscience,²¹ genetic traits,²² health status,²³ or other factors.

Sometimes who qualifies as a protected group is complicated and subject to interpretation by the courts. For instance, courts and rule-makers alike have had to interpret whether Title VII's sex discrimination ban extends to sexual orientation and gender identity.²⁴

16. "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance" 20 U.S.C. § 1681.

17.

No otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency

29 U.S.C. § 794.

18. The statute prohibits "discrimination on the basis of age in programs or activities receiving Federal financial assistance." 42 U.S.C. § 6101.

19. 42 U.S.C. § 18116.

20. Some civil rights statutes have been passed under Congress's commerce authority, rather than spending power. These types of statutes prohibit discrimination by enumerated parties, whether they accept federal money or not. One example is the Americans with Disabilities Act, which regulates public accommodations including hospitals, doctors' offices, and insurance offices. 42 U.S.C. § 12181(7). Such laws would presumably be untouched by Medicare for All, or similar legislation.

21. See, for example, the Church Amendments, which prohibit the conditioning of federal funds on willingness to perform abortions or sterilizations. 42 U.S.C. § 300a-7.

22. Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, 122 Stat. 881 (2008) (barring genetic discrimination in employment and health insurance).

23. See, for example, the Health Insurance Portability and Accountability Act (HIPAA), which bars some forms of health status discrimination by group health insurers. 29 U.S.C. § 1182(a).

24. See, for example, *Price Waterhouse v. Hopkins*, 490 U.S. 228, 256-58 (1989), where the Supreme Court interpreted Title VII to apply to sex stereotyping as a form of sex discrimination. More recently, see *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1753-54 (2020), where Justice Gorsuch held that the plain language meaning of Title VII must encompass gender identity and sexual orientation discrimination by employers.

2. Covered Parties

Most civil rights statutes are passed under Congress's spending authority and apply to entities that receive federal financial assistance. President John F. Kennedy, when speaking in favor of the passage of the Civil Rights Act, insisted that tying nondiscrimination to federal spending was a critical issue of fairness:

Simple justice requires that public funds, to which all taxpayers of all races contribute, not be spent in any fashion which encourages, entrenches, subsidizes or results in racial discrimination. Direct discrimination by Federal, State or local governments is prohibited by the Constitution. But indirect discrimination, through the use of Federal funds, is just as invidious; and it should not be necessary to resort to the courts to prevent each individual violation.²⁵

Using Title VI as an example, the statute defers to each respective agency to define federal financial assistance for purposes of its own funding streams.²⁶ The Department of Health and Human Services (HHS), the primary agency to regulate health care, defines federal financial assistance as:

(1) grants and loans of Federal funds, (2) the grant or donation of Federal property and interests in property, (3) the detail of Federal personnel, (4) the sale and lease of, and the permission to use (on other than a casual or transient basis), Federal property or any interest in such property without consideration or at a nominal consideration, or at a consideration which is reduced for the purpose of assisting the recipient, or in recognition of the public interest to be served by such sale or lease to the recipient, and (5) any Federal agreement, arrangement, or other contract which has as one of its purposes the provision of assistance.²⁷

Meanwhile, licenses, statutory programs or regulations, programs owned and operated by the federal government, guaranty and insurance contracts, procurement contracts, and assistance to ultimate beneficiaries have all generally not been considered forms of federal financial assistance.²⁸

Additionally, most civil rights statutes only apply to “programs and activities” of the covered entities. Title VI’s definition of “programs and activities” is quite expansive and includes operations of departments, agencies, and local and state governments, as well as corporations, partnerships, private organizations, and solo proprietorships.²⁹ In the context of health care, the

25. Special Message to Congress on Civil Rights and Job Opportunities, 1 PUB. PAPERS 483, 492 (June 19, 1963).

26. 42 U.S.C. § 2000d-1.

27. 45 C.F.R. § 80.13(f) (2019).

28. C.R. DIV., U.S. DEP’T OF JUST., TITLE VI LEGAL MANUAL sec. V, at 7–11, <https://www.justice.gov/crt/book/file/1364106/download>.

29. HHS rules for Title VI define “program” and “activity” as:

all of the operations of—

(1)(i) A department, agency, special purpose district, or other instrumentality of a State or of a local government; or

definition is typically not limiting; instead, it is a question of whether the respective entity accepts federal financial assistance.

3. *Discrimination Prohibited*

Civil rights statutes generally prohibit intentional discrimination, which requires a showing that the discrimination was at least partially motivated by the protected status.³⁰ The protected status need not be the only reason for the discriminatory conduct, but the discrimination needs to be because of, not in spite of, its adverse effects on the protected group.³¹ Disparate impact claims are also often implicitly recognized in most civil rights statutes.³² These types of claims require a showing that a facially neutral practice or policy has a statistically significant discriminatory effect on the protected class.³³ Lastly, claims of retaliation for reporting discrimination are also typically implicitly recognized, as a form of intentional discrimination.³⁴

(ii) The entity of such State or local government that distributes such assistance and each such department or agency (and each other State or local government entity) to which the assistance is extended, in the case of assistance to a State or local government;

(2)(i) A college, university, or other postsecondary institution, or a public system of higher education; or

(ii) A local educational agency (as defined in 20 U.S.C. 7801), system of vocational education, or other school system;

(3)(i) An entire corporation, partnership, or other private organization, or an entire sole proprietorship—

(A) If assistance is extended to such corporation, partnership, private organization, or sole proprietorship as a whole; or

(B) Which is principally engaged in the business of providing education, health care, housing, social services, or parks and recreation; or

(ii) The entire plant or other comparable, geographically separate facility to which Federal financial assistance is extended, in the case of any other corporation, partnership, private organization, or sole proprietorship; or

(4) Any other entity which is established by two or more of the entities described in paragraph (g)(1), (g)(2), or (g)(3) of this section; any part of which is extended Federal financial assistance.

45 C.F.R. § 80.13(g).

30. See C.R. Div., *supra* note 28, sec. VI, at 2.

31. *Id.* at 3.

32. See, e.g., *Cannon v. Univ. of Chi.*, 441 U.S. 677, 696–98 (1979) (“Neither [Title VI nor Title IX] expressly mentions a private remedy for the person excluded from participation in a federally funded program. The drafters of Title IX explicitly assumed that it would be interpreted and applied as Title VI had been during the preceding eight years. In 1972 when Title IX was enacted, the critical language in Title VI had already been construed as creating a private remedy. . . . It is always appropriate to assume that our elected representatives, like other citizens, know the law; in this case, because of their repeated references to Title VI and its modes of enforcement, we are especially justified in presuming both that those representatives were aware of the prior interpretation of Title VI and that that interpretation reflects their intent with respect to Title IX.”) (footnote omitted).

33. See C.R. Div., *supra* note 28, sec. VII, at 2, 18–19.

34. See, e.g., *Jackson v. Birmingham Bd. of Educ.*, 544 U.S. 167, 173 (2005) (“Retaliation against a person because that person has complained of sex discrimination is another form of intentional sex discrimination encompassed by Title IX’s private cause of action.”).

4. Government Enforcement

Enforcement of civil rights laws come in two forms: government enforcement and private rights of action in the courts. In the context of health care, most civil rights violations are handled by HHS's Office for Civil Rights (herein referred to as OCR).³⁵ Most statutes require assurances by recipients of federal funds that they will comply with these laws as a condition of receiving funds.³⁶ OCR can monitor covered entities for compliance and can also receive and investigate complaints of civil rights violations.³⁷

When there are violations of civil rights laws, OCR typically seeks informal resolution, meaning that it does not publicly declare that the entity violated the law. As part of this process, OCR will often generate a Voluntary Resolution Agreement, in which the covered party agrees to make certain changes to come into and maintain compliance with the civil rights law, and to be monitored by OCR with respect to that compliance.³⁸ Where informal resolution fails, OCR has the ability to formally resolve violations of the law. They may issue a Letter of Findings that publicly sets forth the violation by the covered entity.³⁹ OCR may also terminate or freeze federal financial assistance, though this is typically reserved for more extreme cases of noncompliance.⁴⁰ For formal resolution, covered parties are given an opportunity for a hearing before an administrative law judge with procedural safeguards from the Administrative Procedures Act.⁴¹

5. Private Enforcement

Private rights of action are also available in civil rights law, but typically only for claims of disparate treatment or retaliation. Private rights of action were dramatically reduced by *Alexander v. Sandoval*, in which the Supreme Court held that litigants cannot bring suits alleging disparate impact under Title VI.⁴²

35. See *About Us*, OFF. FOR C.R., U.S. DEP'T OF HEALTH & HUM. SERVS. (Oct. 8, 2019), <https://www.hhs.gov/ocr/about-us/index.html>.

36. For example, see HHS rules governing Title VI assurances. 45 C.F.R. § 80.4 (2019).

37. For HHS requirements related to Title VI's complaint process, see 45 C.F.R. § 80.7.

38. For an example of a Voluntary Resolution Agreement, see RESOLUTION AGREEMENT BETWEEN U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE FOR CIVIL RIGHTS AND THE UNIVERSITY OF PITTSBURGH MEDICAL CENTER (2010), <https://www.hhs.gov/sites/default/files/ocr/civilrights/activities/agreements/upmcra.pdf>.

39. See, e.g., *OCR Letter of Findings*, OFF. FOR C.R., U.S. DEP'T OF HEALTH & HUM. SERVS., <https://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/examples/aids/at-associates-closure-letter/index.html> (July 26, 2013).

40. See 45 C.F.R. § 80.8.

41. *Id.* § 80.9.

42. *Alexander v. Sandoval*, 532 U.S. 275, 293 (2001). The Supreme Court held that Title VI does not permit a private right of action alleging disparate impact, reasoning that while Title II of the Act could be read to allow for disparate impact claims, Title II lacks rights bearing language in contrast to Title I which clearly permits private rights for disparate treatment. *Id.* at 288–93.

Other courts have since reasoned that the same limitation applies to analogous civil rights statutes as well.⁴³

When private litigation is available, plaintiffs may seek monetary damages, declaratory relief, or injunctions; as a general rule, punitive damages are typically not permitted in civil rights suits.⁴⁴

Absent clear congressional authorization, lawsuits are generally not permitted against the federal government, either for its actions or its failure to enforce civil rights.⁴⁵ Most civil rights statutes only apply to programs and activities receiving federal financial assistance, which does not include the federal government.⁴⁶ There are a few exceptions. The Rehab Act expressly applies to recipients of federal financial assistance as well as “any program or activity conducted by any Executive agency,” which includes programs conducted by HHS or Centers for Medicare and Medicaid Services.⁴⁷ Likewise, section 1557 of the ACA applies to recipients of federal financial assistance as well as “any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments).”⁴⁸

State actors can also be sued under civil rights laws. The Eleventh Amendment provides sovereign immunity to insulate states from lawsuits, but there are exceptions if the state consents to be sued or if Congress clearly abrogates the state’s immunity under valid powers.⁴⁹ Congress has been interpreted to have abrogated state immunity with respect to Title VI, for example.⁵⁰

Individuals can also be sued under civil rights statutes, whether private or public, but generally only in their official capacity.⁵¹

43. For the impact of *Sandoval* on civil rights litigation, see Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v. Sandoval*, 3 YALE J. HEALTH POL’Y, L. & ETHICS 215 (2003).

44. See C.R. DIV., *supra* note 28, sec. IX, at 3–5.

45. *Id.* at 2–3.

46. For example, Title VI’s definition of “programs and activities” refers to state and local government periodically, but never to the federal government or federal agencies. See 45 C.F.R. § 80.13(g) (2019).

47. 29 U.S.C. § 794.

48. 42 U.S.C. § 18116.

49. C.R. DIV., *supra* note 28, sec. IX, at 7.

50. See 42 U.S.C. § 2000d–7(a) (“(1) A State shall not be immune under the Eleventh Amendment of the Constitution of the United States from suit in Federal court for a violation of . . . title VI of the Civil Rights Act of 1964, or the provisions of any other Federal statute prohibiting discrimination by recipients of Federal financial assistance. (2) In a suit against a State for a violation of a statute referred to in paragraph (1), remedies (including remedies both at law and in equity) are available for such a violation to the same extent as such remedies are available for such a violation in the suit against any public or private entity other than a State.”) (citations omitted).

51. See C.R. DIV., *supra* note 28, sec. IX, at 2.

B. THE IMPORTANCE OF CIVIL RIGHTS FOR PATIENTS

At the time of passage of the Civil Rights Act of 1964, health care entities were still widely segregated. Professor David Barton Smith provides a vivid depiction of what segregation in American medicine looked like at the time:

In many areas, blacks were excluded from the community's hospitals altogether. For example, in the 1940s, Broward County Florida had two hospitals—one municipal and one private—and both excluded the county's more than 30,000 black residents from any care. Blacks were also excluded from white areas of the county by vagrancy laws that permitted local police to arrest them and put them on work gangs to harvest crops if they could not pay the heavy fines for violating such laws. In 1940, a gang of white youth bent on more aggressively policing the streets shot a young black man in the abdomen. He died without access to hospital care, and an outraged black community pulled together to create Provident Hospital, a modest thirty-five-bed cottage hospital for blacks. . . .

In the North . . . care could be just as separate and unequal as in the South, [though] the way this was achieved in the North was more subtle. In Chicago, Illinois, for example, almost all black hospitalizations took place either at Cook County Hospital (Cook County) or the historically black, Provident Hospital, bypassing many voluntary hospitals that were closer in proximity to most black neighborhoods. . . . The segregation resulted from the exclusion of black physicians from the privileges of admitting patients to these hospitals and the informal understanding of white physicians, who did have such privileges, about where it was acceptable to admit their black patients. In 1951, a black patient with a skull fracture was turned away from Woodlawn Hospital in a racially mixed neighborhood, only to die several hours later. This incident sparked the creation of the Committee to End Discrimination and a ten-year battle to open staff privileges at the voluntary hospitals to black doctors.⁵²

Health care, in short, was not immune from discrimination and segregation, any more than other important areas of life. Even today, decades since the passage of the Civil Rights Act, discrimination in health care remains. Hospitals notoriously flee minority neighborhoods, setting up shop in white suburbs and leaving minority patients without easy access to either acute or primary care.⁵³ Nursing homes remain segregated along racial and socioeconomic lines, with minorities often residing in lower-resource, lower-quality institutions.⁵⁴

52. David Barton Smith, *Healthcare's Hidden Civil Rights Legacy*, 48 ST. LOUIS U. L.J. 37, 39–41 (2003) (footnotes omitted).

53. See generally Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn't Be So Easy*, 58 FORDHAM L. REV. 939 (1990); Brietta R. Clark, *Hospital Flight from Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023 (2005); Dayna Bowen Matthew, *A New Strategy to Combat Racial Inequality in American Health Care Delivery*, 9 DEPAUL J. HEALTH CARE L. 793 (2005).

54. Ruqaiyah Yearby, *Striving for Equality, but Settling for the Status Quo in Health Care: Is Title VI More Illusory than Real?*, 59 RUTGERS L. REV. 429, 454–58 (2007) (detailing ongoing segregation in nursing homes).

Providers have refused to treat patients because of their HIV status,⁵⁵ and refused to use patients' gender-affirming pronouns, causing them severe psychological distress.⁵⁶ Patients with disabilities encounter a health care system that does not always accommodate their needs, such as being denied access to auxiliary aids, like American Sign Language interpreters.⁵⁷ Insurers, before and after the ACA, have sought to minimize benefits for mental health and substance abuse or other costly conditions, or ones perceived as costly.⁵⁸

These are health inequalities, or avoidable, unnecessary, and unjust⁵⁹ differences in access to and quality of health care. Over time, they can contribute to health and health care disparities for certain populations. Such disparities are well documented in the health policy literature. Take the alarming statistic that Black women are 2.5 to 3.1 times more likely to die during childbirth than white or Hispanic women,⁶⁰ or that racial minorities generally have poorer outcomes and higher mortality from heart disease, diabetes, breast cancer, stroke, and other diseases.⁶¹ Take the fact that women's pain is undertreated when compared to men and discounted as deriving from emotional rather than physical origins,⁶² or that LGBT individuals are two to three times as likely to attempt suicide and experience higher rates of substance use and psychiatric disorders.⁶³ Imagine the barriers for people with disabilities who receive fewer necessary preventative

55. See, e.g., *Howe v. Hull*, 874 F. Supp. 779, 783 (N.D. Ohio 1994) (alleging disability discrimination on the basis of HIV where a physician refused to treat the patient, stating that "if you get an AIDS patient in the hospital, you will never get him out"); *Bragdon v. Abbott*, 524 U.S. 624, 628–29 (1998) (alleging that a dentist refused to treat an HIV-positive patient in a regular office setting for fear of infection).

56. *Prescott v. Rady Children's Hosp.*, 265 F.Supp.3d 1090, 1097 (S.D. Cal. 2017) (suing a hospital under a section 1557 claim where hospital workers refused to use male pronouns and one worker stated "Honey, I would call you 'he,' but you're such a pretty girl"); *Rumble v. Fairview Health Servs.*, No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, at *18 (D. Minn. Mar. 16, 2015) (finding plaintiff had successfully alleged sex discrimination under section 1557 where defendant refused to use preferred pronouns and subjected the patient to repeated, unnecessary, and painful genital examinations); see also INST. OF MED., *THE HEALTH OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PEOPLE: BUILDING A FOUNDATION FOR BETTER UNDERSTANDING* 62 (2011) (reporting on "refusal of treatment by health care staff, verbal abuse, and disrespectful behavior" against LGBT patients).

57. *Loeffler v. Staten Island Univ. Hosp.*, 582 F.3d 268, 275–76 (2d Cir. 2009) (finding a successful claim of disability discrimination where a hospital failed to provide ASL translation to a deaf patient and wife during course of surgery and post-recovery, forcing minor children to interpret).

58. See generally Valarie K. Blake, *Seeking Insurance Parity During the Opioid Epidemic*, 2019 UTAH L. REV. 811 (2019) (cataloguing ways that insurers continue to provide drug treatment below the standards required by federal laws).

59. Margaret Whitehead, *The Concepts and Principles of Equity and Health*, 22 INT'L J. HEALTH SERVS. 429, 431 (1992).

60. Donna L. Hoyert & Arialdi M. Miniño, *Maternal Mortality in the United States: Changes in Coding, Publication, and Data Release, 2018*, 69 NAT'L VITAL STAT. REPS., Jan. 30, 2020 (rev. July 15, 2020), at 1, 5.

61. Martha Hostetter & Sarah Klein, *In Focus: Reducing Racial Disparities in Health Care by Confronting Racism*, COMMONWEALTH FUND (Sept. 27, 2018), <https://www.commonwealthfund.org/publications/newsletter-article/2018/sep/focus-reducing-racial-disparities-health-care-confronting>.

62. Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29 J. L., MED. & ETHICS 13, 13 (2001).

63. *Lesbian, Gay, Bisexual, and Transgender Health*, OFF. OF DISEASE PREVENTION & HEALTH PROMOTION, U.S. DEP'T OF HEALTH & HUM. SERVS., <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health> (last visited Feb. 25, 2021).

screenings for conditions like breast cancer and cervical cancer⁶⁴ or the under-treatment of older persons because of misperceptions and generalizations about their age.⁶⁵ Now, imagine the care received by individuals who may occupy more than one of these categories, say a woman of color who is LGBTQ and has a disability.⁶⁶

Health and health care disparities are not solely driven by health care discrimination; broader structural inequalities, unequal access to the social determinants of health, health care choices, and other factors matter too.⁶⁷ But inequalities in our health care system, driven by discrimination, are certainly a critical component. This discrimination is intolerable in and of itself for the pain and suffering it unnecessarily generates, by making people less healthy than they otherwise would be. It is made more so by the reality that health care is so important for ensuring equal opportunity in our ability to work, to learn, to engage meaningfully in society.⁶⁸ Additionally, sociology literature suggests that individuals who encounter broader societal discrimination are generally sicker;⁶⁹ an equal health care system may be important to offset the health harms of wider systemic injustices in housing, employment, education, and other areas of life. Given these considerations, civil rights are important for our health and for equality.

C. MEDICARE AS THE FIRST HEALTH CARE CIVIL RIGHTS BILL

The story of civil rights in health care is told through the various federal health reform bills that have expanded federal spending into health care and, in doing so, expanded civil rights protections for patients.

Prior to Medicare, few federal dollars flowed into health care.⁷⁰ This was all to change one year after the passage of the Civil Rights Act with the adoption

64. *Disability and Health*, OFF. OF DISEASE PREVENTION & HEALTH PROMOTION, U.S. DEP'T OF HEALTH & HUM. SERVS., <https://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health> (last visited Feb. 25, 2021).

65. See Joel B. Teitelbaum, *Health Care and Civil Rights: An Introduction*, 15 ETHNICITY & DISEASE S2-27, S2-29 (2005).

66. See Chien-Ching Li, Alicia K. Matthews, Frances Aranda, Chirag Patel & Maharshi Patel, *Predictors and Consequences of Negative Patient-Provider Interactions Among a Sample of African American Sexual Minority Women*, 2 LGBT HEALTH 140, 142-44 (2015) (finding that one-third of Black sexual minority women report a negative experience with a healthcare provider in the last five years and, of these, one-third of women responded by not seeking medical care when needed the next time).

67. Nancy E. Adler, M. Maria Glymour & Jonathan Fielding, *Addressing Social Determinants of Health and Health Inequalities*, 316 JAMA 1641, 1642 (2016).

68. Norman Daniels, *Justice, Health, and Healthcare*, 1 AM. J. BIOETHICS 2, 3 (2001).

69. See Mark L. Hatzenbuehler, Jo C. Phelan & Bruce G. Link, *Stigma as a Fundamental Cause of Population Health Inequities*, 103 AM. J. PUB. HEALTH 813, 819 (2013).

70. Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOWARD L.J. 855, 864 (2012). One exception was the Hill-Burton Act, which provided federal funds to hospitals to modernize facilities, in return for agreeing not to discriminate on the basis of race, color, national origin, or creed. 42 U.S.C. § 291e (1946) (current version at 42 U.S.C. § 291e (2018)). However, there was an important exception: "an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services

of Medicare, the federally-funded and administered health care program that reimburses private providers to deliver care to people aged sixty-five and older.⁷¹ Medicare became the necessary precondition for civil rights to apply in health care to prohibit racial, and later, other forms of discrimination by some health care entities.

1. Medicare's History

With the passage of Medicare, the Johnson Administration and the Department of Health, Education, and Welfare (HEW), the predecessor of HHS, made clear that at least some Medicare payments would be viewed as a form of federal financial assistance for purposes of Title VI.⁷² Although Medicare had not been designed specifically as a civil rights bill for health care, it led to the first application of civil rights to health care entities anyway. Legislators and the Administration understood that federal money extended into health care would have a happy consequence of requiring covered entities to comply with civil rights law. As Senator Philip Hart stated during debates over Medicare:

In addition to the new economic independence it will create, I am hopeful that the bill will promote first-class citizenship in another fashion also. We decided last year, and wrote into law, that Federal tax funds collected from all the people may not be used to provide benefits to institutions or agencies which discriminate on the grounds of race, color, or national origin. This principle will, of course, apply to hospital and extended care and home health services provided under the social security system, and will require institutions and agencies furnishing these services to abide by title 6 of the Civil Rights Act of 1964.⁷³

On the eve of Medicare's implementation, the significance of Title VI enforcement was on President Johnson's mind: "Medicare will succeed—if hospitals accept their responsibility under the law not to discriminate against any patient because of race This program is not just a blessing for older Americans. It is a test for all Americans—a test of our willingness to work together."⁷⁴

of like quality for each such group." *Id.* § 291e(f). This exception to permit "separate but equal" health care facilities was ruled unconstitutional in *Simkins v. Moses H. Cone Mem'l Hosp.*, 323 F.2d 959, 969 (4th Cir. 1963). Even so, Hill-Burton funds were limited in duration, not every entity accepted them, and some health care entities even considered returning them in order to avoid having to comply with non-discrimination mandates. Smith, *supra* note 52, at 49. In short, they did not achieve the same desegregation efforts that Medicare was to later attain.

71. *An Overview of Medicare*, KAISER FAM. FOUND. (Feb. 13, 2019), https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/?gclid=Cj0KCQiAtmuBRDXARIsABiN-7CnTTQMeXGuOxPfeG7VMAj-16ZL5X_iW0yzvwlajgNcAEWVBTKyYaAg9KEALw_wcB.

72. See Watson, *supra* note 70, at 860–70 (providing an overview of this history).

73. 111 CONG. REC. 15,813 (1965). Senator Abraham Ribicoff also expressly contemplated that hospitals would need to comply with Title VI after the passage of Medicare. 111 CONG. REC. 15,803 (1965).

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

Though at times victory seemed uncertain, by the time Medicare was up and running, “more than 1,000 hospitals had quietly and uneventfully integrated their medical staffs, waiting rooms and hospital floors.”⁷⁵ The same activists who had fought for civil rights had fought for Medicare, in the name of social progress, and now, with the passage of Medicare, civil rights had some meaning in the context of health care too.⁷⁶ The money was too great, the bargain too good. Suddenly, large swaths of the health care industry were willing to accept federal funds, even if it came with a requirement to comply with the Civil Rights Act and to desegregate along with the rest of American society.⁷⁷

2. *Medicare Brings Health Care Entities Under Civil Rights Laws, with Less Clarity Regarding Providers and Benefits*

Medicare has become the primary vehicle to bring health care entities under compliance with civil rights laws. Medicare clearly extends civil rights laws to hospitals and other institutions that accept those funds, but there is less clarity around discrimination by health care providers, or in health benefits. The issue turns on whether the party involved counts as a recipient of federal financial assistance.

a. *Health Care Entities*

Medicare Part A, or hospital coverage, is the primary form of payment for health care provided by institutions.⁷⁸ Part A covers 100% of the cost of inpatient hospital care, skilled nursing facility care, inpatient care in a skilled nursing facility, hospice care, and home health care.⁷⁹ Medicare Part A applies to any such providers including hospitals, hospices, and skilled nursing facilities. Medicare notoriously does not cover custodial care or long-term nursing home care, which has been left to the means-tested Medicaid program.⁸⁰

Shortly after the passage of Medicare, HEW made clear that Medicare Part A would count as federal financial assistance in the context of health care.⁸¹ Moreover, though redundant given that the laws obligate these entities already, Medicare regulations require that Part A providers agree to comply with civil rights laws.⁸²

75. Smith, *supra* note 52, at 52.

76. *Id.* at 50.

77. *Id.* (calling Medicare “in a very real sense, the major unacknowledged gift to the American people of the Civil Rights Movement”).

78. *An Overview of Medicare*, *supra* note 71.

79. *What Part A Covers*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/what-part-a-covers> (last visited Feb. 25, 2021).

80. *Id.*

81. OFF. FOR C.R., *What Qualifies as “Federal Financial Assistance” for Purposes of Civil Rights Complaints Handled by OCR?*, U.S. DEP’T OF HEALTH & HUM. SERVS., <https://www.hhs.gov/civil-rights/for-individuals/faqs/what-qualifies-as-federal-financial-assistance/301/index.html?language=es> (Nov. 19, 2015).

82. Section 489.10 reads:

b. Health Care Providers

While HEW was happy to dub Medicare Part A payments a form of federal financial assistance, it pulled back the reins on doing the same for Part B payments. Part B payments are those payments paid to individual providers for services.⁸³ Part B covers only 80% of the cost of individual provider services, with individual Medicare beneficiaries paying the other 20% in the form of a premium.⁸⁴

It remains true to this day, even after the passage of the ACA, that individual providers that accept Medicare Part B payments only, and no other form of federal money, are not governed by civil rights laws.⁸⁵ The failure to include individual providers was significant as segregation and inequality in medicine was at least in part a function of individual providers, as well as institutions.⁸⁶

The Agency's reasoning behind excepting Part B from civil rights enforcement is convoluted and has changed over time. Right after the passage of Medicare, HEW's general counsel published an opinion supporting the stance that Part B payments are not federal financial assistance by arguing that Part A payments are federal financial assistance because they pay providers for 100% of the service, while Part B payments are not because they only pay for a portion of services.⁸⁷ HEW's general counsel described Part B payments as creating a

(b) In order to participate in the Medicare program, the provider must meet the applicable civil rights requirements of:

(1) Title VI of the Civil Rights Act of 1964, as implemented by 45 CFR part 80, which provides that 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 subject to discrimination under, any program or activity receiving Federal financial assistance (section 601);

(2) Section 504 of the Rehabilitation Act of 1973, as implemented by 45 CFR part 84, which provides that no qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination under any program or activity receiving Federal financial assistance;

(3) The Age Discrimination Act of 1975, as implemented by 45 CFR part 90, which is designed to prohibit discrimination on the basis of age in programs or activities receiving Federal financial assistance. The Age Discrimination Act also permits federally assisted programs and activities, and beneficiaries of Federal funds, to continue to use certain age distinctions, and factors other than age, that meet the requirements of the Age Discrimination Act and 45 CFR part 90; and

(4) Other pertinent requirements of the Office of Civil Rights of HHS.

42 C.F.R. § 489.10 (2019); *see also* Dean M. Harris, *Beyond Beneficiaries: Using the Medicare Program to Accomplish Broader Public Goals*, 60 WASH. & LEE L. REV. 1251, 1273 n.114 (2003) (observing that the regulations are duplicative, as institutions are governed by civil rights statutes by virtue of receiving the Part A funds).

83. *What Part B Covers*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/what-part-b-covers> (last visited Feb. 25, 2021).

84. *An Overview of Medicare*, *supra* note 71.

85. OFF. FOR C.R., *supra* note 81.

86. *See* Smith, *supra* note 52, at 53.

87. *See* Memorandum from Alanson W. Willcox, Gen. Couns., Dep't of Health, Educ. & Welfare, to Robert M. Ball, Comm'r, Soc. Sec. (Oct. 18, 1965), in U.S. COMM'N ON C.R., CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY 867, 868–71 (1980).

right of the ultimate beneficiary of Medicare services to receive at least 80% of their services covered, as compared with Part A where the right accrues to the providers to have all of their costs of delivering care reimbursed.⁸⁸

HEW reasoned that because Title VI does not apply to the ultimate beneficiaries of federal financial assistance, for instance those who receive social security payments, then Title VI should not apply to Part B recipients.⁸⁹

Additionally, HEW justified the difference in treatment because Part B is sometimes provided directly to the beneficiary, unlike other forms of federal financial assistance.⁹⁰ However, as these payments are also sometimes provided directly to health care providers, just like Part A, the distinction seemed tenuous at best.

In a 1966 memo, HEW's general counsel moved away from its overly narrow earlier rationale, but still maintained that Part B payments are not federal financial assistance.⁹¹ HEW rejected its earlier stance, stating "[t]here is no basis in the text of [Title VI] for an assumption that net economic benefit to the payee of the Federal funds is a necessary or even relevant factor in determining what is 'Federal financial assistance.'"⁹² Instead, HEW reasoned, Part A payments should be considered federal financial assistance because they are designed to finance the program or activity of a non-Federal institution or agency; thus they should be within the scope of Title VI even if there is no element of financial benefit to the recipients.⁹³

In a brief footnote, HEW precluded Part B payments from federal financial assistance, arguing that Part B payments are contracts of insurance, unlike Part A payments.⁹⁴ Title VI exempts from federal financial assistance "contract[s] of insurance or guaranty."⁹⁵ The opinion provided no rationale for the distinction between Parts A and B in this manner other than that Part B is a "voluntary insurance system" and "is truly contractual in nature."⁹⁶ This argument is particularly weak given that the legislative history of Title VI clearly states that in including the term "contracts of insurance" it meant to exclude home mortgages obtained from federally insured institutions from civil rights enforcement, such as mortgages one would obtain through Fair Housing

88. *Id.* at 869.

89. *Id.*

90. *Id.* at 870 n.2.

91. Memorandum from Alanson W. Willcox, Gen. Couns., Dep't of Health, Educ. & Welfare, to Robert M. Ball, Comm'r, Soc. Sec. (Dec. 30, 1966), in U.S. COMM'N ON C.R., *supra* note 87, at 872, 872-80.

92. *Id.* at 873.

93. *Id.* at 874.

94. *Id.* at 879 n.10.

95. 42 U.S.C. § 2000d-1.

96. Memorandum, *supra* note 91, at 879 n.10. In the 1966 memorandum, HEW's general counsel discusses in more detail what HEW considers "contractual" in the context of Part A. Specifically, HEW states that rights to Part A funds are statutory, not contractual, and that statutory social insurance is not a "contract of insurance" as determined by the Supreme Court in *Flemming v. Nestor*, 363 U.S. 603 (1960). HEW contrasts Part B as truly contractual, akin to war risk insurance policies that were held to be contracts in *Lynch v. United States*, 292 U.S. 571 (1934). *See id.* at 877-79.

Administration loans.⁹⁷ Moreover, Medicare payments of any kind could not have been in the minds of the legislators, as Medicare was passed a year later.⁹⁸

Ultimately, Medicare officials were seeking to steer clear of allegations that they were interfering in the practice of medicine. Hospitals were different but the practice of medicine was clearly a state-governed function, as well as a matter for professional self-regulation.⁹⁹ As Smith puts it:

[T]he reality was that it would have been almost impossible to define what Title VI compliance meant for physician practices, and it would have been impossible to enforce. Nevertheless, Title VI compliance for hospitals would be meaningless without the ability to exert some control over the referral patterns of physicians. Physicians could, as they had done in Chicago, simply selectively refer their white and black patients to different hospitals maintaining de facto segregation.¹⁰⁰

Unlike Medicare Conditions of Participation that require hospitals to attest to compliance with civil rights laws,¹⁰¹ no such obligation is present in the provision of the Medicare Act that applies to individual providers.¹⁰² It would take enforcement of Medicaid, and other federal programs, to bring providers under the umbrella of civil rights.¹⁰³

c. Health Care Benefits

Public health insurance programs, just like any other health insurance benefits, can sometimes raise issues of discrimination. Discrimination is much more common in private, for-profit health insurance however, where insurers' profits and need to compete by price drive a need for classification. Insurers, absent regulation, may be prone to discriminate when deciding whether to enroll a certain individual into insurance, what premiums they charge the individual, and what benefits are offered to that individual.¹⁰⁴ Some of these forms of discrimination are inapplicable in public programs. Public programs generally cannot discriminate when deciding who to enroll, the cost of premiums, and

97. Letter from Eileen M. Stein, Gen. Couns., U.S. Cmm'n on C.R., to Louis Nunez, Staff Dir., U.S. Cmm'n on C.R. (Oct. 7, 1980), in U.S. COMM'N ON C.R., *supra* note 87, at 851, 855–57 (citing testimony of Senator John Pastore explaining the “contracts of insurance” amendment to Title VI, 110 CONG. REC. 13,435–36 (1964)).

98. *Id.* at 855.

99. Smith, *supra* note 52, at 53.

100. *Id.* Smith adds to this rationale elsewhere. SMITH, *supra* note 74, at 162 (“As to the political realities at the time of the passage of Medicare, imposing any kind of Title VI requirements on medical practices was inconceivable. Local medical societies, state societies, and the AMA were powerful political forces and reluctant, if not openly hostile, participants in the Medicare program.”).

101. *See supra* note 82.

102. *See* 42 U.S.C. § 1395cc.

103. *See supra* Part III.D.

104. For examples of discrimination in individual private insurance markets, see KAREN POLLITZ, RICHARD SORIAN & KATHY THOMAS, KAISER FAM. FOUND., HOW ACCESSIBLE IS INDIVIDUAL HEALTH INSURANCE FOR CONSUMERS IN LESS-THAN-PERFECT HEALTH? (2001), <https://www.kff.org/wp-content/uploads/2013/01/how-accessible-is-individual-health-insurance-for-consumer-in-less-than-perfect-health-report.pdf>.

what benefits to offer, as these standards are set forth by statute. However, insurance benefit design can still sometimes operate in ways that disadvantage protected classes. For instance, a public program might choose not to cover a benefit in a way that arguably treats a group differently based on protected status, such as choosing not to cover gender transition therapies¹⁰⁵ or limiting eligibility for a certain medical procedure to people below a certain age.

Medicare itself, as an administrator of health benefits, is not accountable to nondiscrimination mandates and aims, though. Many of the federal civil rights statutes do not govern the federal government; instead they only apply to recipients of federal financial assistance.¹⁰⁶ The Centers for Medicare and Medicaid Services (CMS) indicates that it complies with nondiscrimination mandates for race, color, national origin, sex, age, and disability, though it is unclear how to legally hold the agency accountable for this promise.¹⁰⁷ Lawsuits are generally not permitted against the federal government, either for its actions or its failure to enforce civil rights.¹⁰⁸ The Rehab Act and section 1557 govern programs and activities conducted by HHS (thus including activities of the CMS).¹⁰⁹ However, the former is limited to disability claims and the latter only applies so long as the ACA is the governing law.

Instead, Medicare is held accountable for discriminatory benefit design in two ways that are outside the scope of civil rights laws. One, injured parties may make constitutional claims, where applicable.¹¹⁰ Two, Medicare, as a provider of health benefits, is subject to an inter-agency appeals process over its benefits determinations.¹¹¹ What benefits Medicare covers are determined by National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs) that consider medical effectiveness and other factors.¹¹² Through this process,

105. See *infra* notes 108–113 and accompanying text.

106. For example, Title VI, Title IX, and the Age Discrimination Act all only apply to recipients of federal financial assistance. See *supra* notes 15–19, 25 and accompanying text.

107. CMS's nondiscrimination notice provides that

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally facilitated Marketplace. CMS doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

Accessibility & Nondiscrimination Notice, MEDICARE.GOV, <https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice> (last visited Feb. 25, 2021).

108. See C.R. DIV., *supra* note 28, sec. IX, at 2–3.

109. See *supra* notes 17, 19 and accompanying text.

110. For example, a litigant might sue the federal government if the litigant believed a Medicaid benefit coverage violated the Equal Protection clause for, say, treating people of varied races or sexes differently.

111. See generally CTRS. FOR MEDICARE & MEDICAID SERVS., U.S DEP'T OF HEALTH & HUM. SERVS., MEDICARE APPEALS (2020), <https://www.medicare.gov/Pubs/pdf/11525-Medicare-Appeals.pdf>.

112. For more on the process of national coverage determination appeals, see *National Coverage Determination Complaints*, U.S DEP'T OF HEALTH & HUM. SERVS., <https://www.hhs.gov/about/agencies/dab/>

complainants can sometimes reach benefits exclusions that are discriminatory. For instance, until 2014, Medicare had a NCD that banned coverage of “transsexual surgery.”¹¹³ The NCD was based on medical evidence compiled in 1981 that determined the procedure to be “experimental” with high rates of serious complications.¹¹⁴ The exclusion was overturned by the recommendation of the HHS Departmental Appeals Board (DAB) after the DAB found the exclusion to be based on outdated science.¹¹⁵ Experts presented evidence that the treatment was no longer experimental, that the surgery is generally safe, and that the surgery is an important treatment for some patients experiencing gender identity disorder. CMS agreed, lifting the national ban on coverage and making gender transition surgery now available on a case-by-case basis.¹¹⁶ Notably, though, this effort was made successful by framing the NCD as outdated science though. This may not always be an available approach for benefit determinations that differentially harm a protected group.

While CMS generally is not covered by civil rights laws, Medicare has, over time, developed roles for private insurers, who are covered by these laws. In Medicare Part C (or the managed care arm of Medicare), Medicare beneficiaries have the option to enroll in private insurance plans to receive their Medicare Parts A, B, and D services.¹¹⁷ Additionally, Medicare Part D covers prescription drugs and is also managed through contracts with private insurers.¹¹⁸ Insurers that provide Medicare Part C or Part D plans are recipients of federal financial assistance. As such, they must also comply with civil rights laws.¹¹⁹

The importance of Medicare to civil rights in health care cannot be overstated. Medicare was the bait that caught hospitals, long term acute care facilities, community hospitals, and other health care entities, and holds them responsible for protecting civil rights of all patients, whether Medicare recipients or not. Other laws, including Medicaid and the ACA, have built on Medicare’s foundation.

different-appeals-at-dab/appeals-to-board/national-coverage-determination-complaints/index.html (Oct. 2, 2016).

113. *Access to Healthcare: Non-Discrimination*, U.S. DEP’T OF HEALTH & HUM. SERVS., <https://www.hhs.gov/programs/topic-sites/lgbt/accesstohealthcare/nondiscrimination/index.html> (Aug. 15, 2017).

114. *Id.*

115. *Id.*

116. *Id.*

117. *An Overview of Medicare*, *supra* note 71.

118. *Id.*

119. OFF. FOR C.R., *supra* note 81.

D. MEDICAID BUILDS ON MEDICARE'S PROGRESS

Medicaid was passed at the same time as Medicare but, from its passage, it has always been under greater threat than Medicare.¹²⁰ A means-tested program, the original Medicaid program provided health care to the “deserving poor,” or individuals who were income eligible and satisfied other statutory mandates like being blind or deaf, or having children.¹²¹ Medicaid is a federal and state funded program, administered by the states.¹²²

1. *Medicaid Expands Civil Rights Laws' Reach over Health Care Providers and Medicaid Benefits*

Medicaid adds two distinct and additional layers of civil rights protection to health care apart from that offered by Medicare: (1) application to providers and (2) the ability to challenge discrimination in benefit design. However, Medicaid is limited, too, in that it offers lower reimbursement rates than Medicare so more providers and entities may participate in Medicare than Medicaid.¹²³

a. *Health Care Providers*

While Medicare Part B payments are not viewed as federal financial assistance for the purposes of civil rights laws, Medicaid payments (as well as some other federal programs like Children's Health Insurance Program (CHIP)) are.¹²⁴ Thus, individual providers that choose to accept Medicaid payments are governed by civil rights statutes. HHS, when promulgating rules for section 1557 of the ACA in 2016, nonetheless estimated that most health care providers are covered under civil rights laws because, even though Medicare Part B does not count as federal financial assistance, most providers accept Medicaid or some other form of federal financial assistance.¹²⁵ HHS made this estimate based on the fact that about 614,000 physicians accept Medicaid payments (based on 2010 Medicaid Statistical Information System data). This accounts for about 72% of the licensed physicians in the country.¹²⁶ HHS also noted that physicians might participate in other programs that constitute federal financial assistance, like CHIP.¹²⁷ Taking these physicians into account, HHS estimated that “almost

120. See generally Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL'Y L. & ETHICS 67 (2015).

121. *Id.* at 69–70.

122. See *id.* at 71, 78.

123. See *id.* at 71.

124. See OFF. FOR C.R., *supra* note 81.

125. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,445–46 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92).

126. They estimated there were 850,000 licensed physicians in the United States at the time. *Id.* at 31,446.

127. Examples HHS provided of other federal financial assistance that health providers accept include funding from: National Health Service Corps, HRSA-funded community health centers, National Institutes of Health (NIH) research grants, Substance Abuse and Mental Health Services Administration (SAMHSA) funded programs, and Centers for Medicare and Medicaid Services (CMS) gain-sharing demonstration projects. *Id.*

all practicing physicians in the United States are reached by [civil rights laws] because they accept some form of Federal remuneration or reimbursement apart from Medicare Part B.”¹²⁸ Medicaid, as the next most common federal funding program, is the primary vehicle to hold providers accountable under civil rights laws.

b. States as Providers of Health Care Benefits

Medicaid and its administrators, unlike Medicare, are subject to civil rights laws. First, they are recipients of federal financial assistance, in that they receive funds from the government to pay for Medicaid services.¹²⁹ Second, civil rights laws abrogate state immunity with respect to Title VI, Title IX, and the Rehabilitation Act, allowing state Medicaid agencies to be sued under civil rights laws.¹³⁰

For one example of the benefits of such litigation, see *Alexander v. Choate*, where the Supreme Court reviewed the actions of a state Medicaid agency after it decided to cut annual covered inpatient hospital stays from twenty days to fourteen days.¹³¹ Medicaid beneficiaries with disabilities sued the state, arguing that the cuts would have a disparate impact on people with disabilities who disproportionately rely on hospital care when compared to the non-disabled.¹³² The plaintiffs were ultimately unsuccessful in part because the Court was hesitant to conclude that the Rehab Act allows for challenges related to the content of the benefits, as opposed to just access; however, the claim and ones like it are nonetheless important.¹³³ Instead, the Court was highly deferential to the state, in accordance with the Medicaid Act, to have “substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in ‘the best interests of the recipients.’”¹³⁴ While the challenge was ultimately unsuccessful, at least it was permitted. Litigants were able to bring the action and ask the Court to decide if the state actions were unlawful. Plaintiffs could have been successful, for instance, if they could show that the discrimination was intentional or had a disparate impact on people with disabilities.¹³⁵ The same type of claim would not be possible against Medicare as a provider of benefits, as it is not a recipient of federal financial assistance and is insulated from litigation.

128. *Id.*

129. See OFF. FOR C.R., *supra* note 81.

130. See *supra* notes 48–49 and accompanying text.

131. *Alexander v. Choate*, 469 U.S. 287, 289–90 (1985).

132. *Id.* at 290–91.

133. *Id.* at 292–300.

134. *Id.* at 303 (quoting 42 U.S.C. § 1396a(a)(19) (1976)).

135. *Id.* at 297 (observing that the Rehab Act would “ring hollow if the resulting legislation could not rectify the harms resulting from action that discriminated by effect as well as by design” but concluding that discrimination was not present in this case because people with disabilities and people without are given the same exact benefit—fourteen covered hospital days).

Olmstead v. L.C. ex rel. Zimring provides another example.¹³⁶ In *Olmstead*, two Medicaid recipients with intellectual disabilities and psychiatric disorders were institutionalized in a psychiatric unit in a hospital in Georgia, despite their health care providers believing they were better suited to receive treatment in community-based programs.¹³⁷ The plaintiffs sued state officials for failing to place them in community-based programs, arguing the state agency had discriminated against them on the basis of disability.¹³⁸ State officials defended that their actions were motivated by a tight budget rather than disability discrimination.¹³⁹ The Court ultimately decided that segregation of individuals in institutionalized settings when community-based integration is possible is discrimination on the basis of disability in violation of the ADA.¹⁴⁰ The Court required state Medicaid agencies to offer “a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace.”¹⁴¹ The litigation produced tangible benefits for patients who were now much more likely to be able to obtain community-based services. Subsequent plaintiffs have successfully analogized from this case in order to secure rights to some forms of home-based and community-based Medicaid services that are necessary to prevent them from becoming institutionalized.¹⁴² For instance, plaintiffs have successfully challenged limits on prescription drug offerings¹⁴³ and adult day care offerings¹⁴⁴ by arguing that failure to adequately cover these benefits places individuals at risk of institutionalization, in violation of disability antidiscrimination laws.

Medicaid benefit challenges are much more robust than challenges to benefit design under Medicare because of the availability of civil rights laws. In Medicare, patients are limited to framing discrimination through a lens of outdated medical evidence, which may not always capture all forms of discrimination, or through a constitutional challenge. In contrast, Medicaid litigants are able to use the full sweep of civil rights to challenge discriminatory benefit design.

136. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).

137. *Id.* at 593.

138. *Id.* at 593–94.

139. *Id.* at 594–95.

140. *Id.* at 601–04.

141. *Id.* at 605–06.

142. “[W]hile it is true that the plaintiffs in *Olmstead* were institutionalized at the time they brought their claim, nothing in the *Olmstead* decision supports a conclusion that institutionalization is a prerequisite to enforcement of the ADA’s integration requirements.” *Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1181 (10th Cir. 2003).

143. *Id.* at 1182.

144. *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161, 1171 (N.D. Cal. 2009).

E. SECTION 1557 OF THE AFFORDABLE CARE ACT AS THE LATEST CIVIL RIGHTS ACHIEVEMENT

If Medicare and Medicaid created the conditions necessary to bring civil rights into the field of health care, then the Affordable Care Act serves to fill in many of the important gaps that remained.

The ACA, unlike Medicare and Medicaid, has an express civil rights provision, section 1557. Section 1557 provides that:

(a) In general—Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection.¹⁴⁵

1. Section 1557 Expands Civil Rights Enforcement to Private Insurers

Perhaps most significantly, the ACA extends federal money to private insurers through subsidies to income-qualifying individuals to offset the cost of premiums and copays. Section 1557 expressly applies to recipients of “credits, subsidies, or contracts of insurance.”¹⁴⁶ With these subsidies and section 1557, private insurers who were traditionally left out of civil rights enforcement are now considered recipients of federal financial assistance.

Private insurers were a particular source of discrimination prior to the ACA, especially in individual markets where insurers might outright exclude individuals from coverage on the basis of health status, or might subject them to harsh benefit restrictions or sky-high premiums.¹⁴⁷ The ACA imposed a number of market-based reforms aimed at eliminating health status discrimination in insurance markets. For instance, the ACA banned discrimination on the basis of pre-existing conditions in enrollment, leveling premiums across the insureds except in a few limited instances and providing a baseline level of benefits that all insurers must offer.¹⁴⁸

Section 1557 has proven a powerful tool, as well, in tackling insurance discrimination that is rooted in protected class discrimination. The Obama-era

145. 42 U.S.C. § 18116(a) (footnotes omitted) (citations omitted).

146. *Id.*

147. See POLLITZ ET AL., *supra* note 104, at iii–iv.

148. *Summary of the Affordable Care Act*, KAISER FAM. FOUND. (Apr. 25, 2013), <https://www.kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/>.

rule interprets section 1557 to apply to all offerings of an insurer if the insurer receives any federal subsidies.¹⁴⁹ Thus, if an insurer offers even one plan on the federal or state ACA insurance exchanges, it is accountable to civil rights laws for all of the plans it offers or administers on or off the exchanges. The Trump Administration rolled this back in its section 1557 rule by taking the position that the language in section 1557 only permits it to apply to insurers' plans offered on the exchanges, while any plans they offer or administer outside of the exchanges are not accountable for complying with section 1557.¹⁵⁰

Section 1557 also allows enforcement of civil rights laws against Medicare and CMS, as a public insurance plan. Section 1557 covers "any program or activity that is administered by an Executive Agency or any entity established under [Title I of the ACA]."¹⁵¹ Obama-era rulemakers concluded that HHS "is not covered as a federally assisted program, although the Department is covered by the rule as an administrator of health programs and activities. . . . [A]ll parts of the Medicare program are a health program or activity."¹⁵² Section 1557 thus reached any program that HHS administered, including public insurance programs under CMS like Medicare, Medicaid, CHIP, and the Indian Health Service.¹⁵³ Under the Trump Administration, officials excluded these public insurance programs by reading section 1557's language to include only programs established or administered under Title I of the ACA or, basically, just the insurance marketplaces.¹⁵⁴

149. "For an entity principally engaged in providing or administering health services or health insurance coverage or other health coverage, all of its operations are considered part of the health program or activity, except as specifically set forth otherwise in this part." 45 C.F.R. § 92.4 (2016) (emphasis added).

150. 45 C.F.R. § 92.3(b) (2019) ("[H]ealth program or activity' encompasses all of the operations of entities principally engaged in the business of providing healthcare that receive Federal financial assistance as described in paragraph (a)(1) of this section. For any entity not principally engaged in the business of providing healthcare, the requirements applicable to a 'health program or activity' under this part shall apply to such entity's operations only to the extent any such operation receives Federal financial assistance as described in paragraph (a)(1) of this section."); see also *id.* § 92.3(c) ("[A]n entity principally or otherwise engaged in the business of providing health insurance shall not, by virtue of such provision, be considered to be principally engaged in the business of providing healthcare.")

151. 42 U.S.C. § 18116(a).

152. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,383–85 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92).

153. See MaryBeth Musumeci, Jennifer Kates, Lindsey Dawson, Alina Salganicoff, Laurie Sobel & Samantha Artiga, *The Trump Administration's Final Rule on Section 1557 Non-Discrimination Regulations Under the ACA and Current Status*, KAISER FAM. FOUND. (Sept. 18, 2020), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/the-trump-administrations-final-rule-on-section-1557-non-discrimination-regulations-under-the-aca-and-current-status/>. The rule also includes Title I entities, like the insurance exchanges. See *id.*

154. 45 C.F.R. § 92.3 (2019). The new rule states that it applies to: "(2) Any program or activity administered by the Department under Title I of the Patient Protection and Affordable Care Act; or (3) Any program or activity administered by any entity established under such Title." *Id.* In the preamble, the Agency argues that the language of the statute is unclear and has to be narrowed, so as to not sweep up Agency action beyond the field of health care.

In resolving the sentence's ambiguity, however, the Department no longer agrees with the 2016 Rule's decision to add a limiting modifier (*i.e.*, "health") that Congress did not include in the statutory text. Instead, the Department concludes that Congress had already placed a limitation in

The Obama-era rule specifically forbade discriminatory insurance design, stating that covered insurers must not:

Deny, cancel, limit, or refuse to issue or renew a health-related insurance plan or policy or other health-related coverage, or deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, or disability.¹⁵⁵

The Obama-era rule warned that blanket exclusions of particular benefits may be discriminatory.¹⁵⁶ Rulemakers also provided examples of potentially discriminatory benefit design, for instance a “plan that covers inpatient treatment for eating disorders in men but not women” or “a plan that covers bariatric surgery in adults but excludes such coverage for adults with particular developmental disabilities.”¹⁵⁷

The Obama-era rule also provided concrete protections against discrimination by insurers on the basis of gender identity. The rule forbade insurers from denying or limiting “health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual’s sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.”¹⁵⁸ For instance, an insurer could not justifiably deny coverage of cervical cancer screening to a transgender male. Additionally, the rule forbade categorical exclusions of gender transition services,¹⁵⁹ based on the idea that such limits are rooted in bias and old studies that have been proven incorrect.¹⁶⁰ Notably, the safeguards for gender identity

the text of Section 1557 by applying the statute to any program or activity administered by an Executive Agency “under this title” (meaning Title I of the ACA), as well as to any program or activity administered by an entity established under such title. The Department believes that either this interpretation of the statutory text, or the 2016 Rule’s addition of the modifier “health,” is necessary in order to make sense of the statutory text; this final rule offers a technical reading of the text that is at least as reasonable as the 2016 Rule’s addition of a word not present in the text of the statute.

Nondiscrimination in Health and Health Care Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160, 37,170 (June 19, 2020) (to be codified at 42 C.F.R. pt. 438, 440, 460; 45 C.F.R. pt. 86, 92, 147, 155, 156).

155. 45 C.F.R. § 92.207(b)(1) (2016). Additionally, covered insurers must not use marketing practices or benefit designs that discriminate. *Id.* § 92.207(b)(2).

156. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,429.

157. *Id.*

158. 45 C.F.R. § 92.206 (2016).

159. *Id.* § 92.207(b)(4)–(5).

160.

[M]any health-related insurance plans or other health-related coverage, including Medicaid programs, currently have explicit exclusions of coverage for all care related to gender dysphoria or associated with gender transition. Historically, covered entities have justified these blanket exclusions by categorizing all transition-related treatment as cosmetic or experimental. However, such across-the-board categorization is now recognized as outdated and not based on current standards of care.

Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,429 (footnotes omitted).

discrimination were uncertain, even while the Obama-era rules applied, as a court vacated the part of the rule that considers gender identity a form of sex discrimination.¹⁶¹ The meaning of sex discrimination under section 1557 has been a point of controversy.¹⁶² The Trump-era draft rule eliminated all of the specific guidance on what counts as insurance discrimination, leaving the issue to OCR and the courts.

2. *Section 1557 Stops Short of Covering Medicare Part B Providers*

Section 1557 applies to health care entities in much the same way as Medicare and Medicaid. Again, the rule makers have stopped short of applying civil rights laws to providers that are recipients of Medicare Part B payments. Commenters to the Obama-era rulemaking process asked HHS to reverse this historical position, given that section 1557 expressly includes recipients of “contracts of insurance” under its covered parties.¹⁶³ Recall that one of the bases for why HEW had historically excluded Part B Medicare payments from the definition of federal financial assistance was because they considered Part B payments to be contracts of insurance.¹⁶⁴ In section 1557, rulemakers declined to change this position, stating that this rule was not the time to overturn the long-held position held by HHS while offering no further substantive rationale for this stance.¹⁶⁵

However, the section 1557 rulemakers argued this would have a de minimis impact on the issue of provider discrimination, as most providers accept some other form of federal financial assistance, whether Medicaid or CHIP payments, or special federal grant programs.¹⁶⁶ Rulemakers stressed that insurers that are covered parties under section 1557 have an obligation to ensure compliance with the civil rights law with respect to the treatment of their enrollees.¹⁶⁷ However, it is unclear how or if insurers enforce civil rights protections against health care providers.

The Trump-era draft rule also failed to include Medicare Part B as a form of federal financial assistance while also offering minimal rationale, thus leaving

161. *Franciscan All., Inc. v. Azar*, 414 F. Supp. 3d 928, 928 (N.D. Tex. 2019); see *supra* Part I.E.3.

162. See *supra* Part I.E.3.

163. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,383.

164. See *supra* notes 91–97 and accompanying text.

165. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,383.

166. See *supra* notes 124–128 and accompanying text. For instance, at the time of the Obama-era rule, many doctors accepted meaningful use payments to help develop their use of electronic medical records and this counted as federal financial assistance. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,445. The meaningful use program ended in 2018, however, and Centers for Medicare and Medicaid renamed the program and changed the focus to different measurements related to electronic health records. *Interoperability Programs, CTRS. FOR MEDICARE & MEDICAID SERVS.*, <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms> (last visited Feb. 25, 2021).

167. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,383.

health care providers out of civil rights enforcement unless they accept other forms of federal financial assistance.¹⁶⁸

3. *Section 1557 Prohibits Sex Discrimination*

Almost fifty years after the passage of the Civil Rights Act of 1964, sex finally became a form of prohibited discrimination in health care. Section 1557 of the ACA achieves this by expressly extending Title IX to health programs and activities.¹⁶⁹ Title IX previously did not extend to health care entities as it only prohibits sex discrimination by “any education program or activity receiving Federal financial assistance.”¹⁷⁰

Section 1557 prohibits “under . . . title IX of the Education Amendments of 1972 . . . be[ing] excluded from participation in, [] denied the benefits of, or [] subjected to discrimination” by covered health programs, including providers and insurers.¹⁷¹

The Obama-era rule defined “on the basis of sex” broadly, including “discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity.”¹⁷² The rule failed to expressly cover discrimination on the basis of sexual orientation, however, but noted this type of conduct should be considered a form of sexual stereotyping.¹⁷³ The Northern District of Texas vacated the Obama-era rule with respect to its ban on discrimination based on gender identity and termination of pregnancy.¹⁷⁴ The court held that to include these issues as forms of sex discrimination was a

168. Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160, 37,174 (June 19, 2020) (to be codified at 42 C.F.R. pt. 438, 440, 460; 45 C.F.R. pt. 86, 92, 147, 155, 156) (“As for Medicare Part B, it is not Federal financial assistance. This remains unchanged from the 2016 Rule, which also determined that Medicare Part B was not Federal financial assistance under Section 1557.”) (footnote omitted).

169. 42 U.S.C. § 18116.

170. 20 U.S.C. § 1681(a).

171. 42 U.S.C. § 18116.

172. 45 C.F.R. § 92.4 (2016). Gender identity is defined as:

an individual’s internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual’s sex assigned at birth. The way an individual expresses gender identity is frequently called “gender expression,” and may or may not conform to social stereotypes associated with a particular gender.

Id. Sex stereotypes means:

stereotypical notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics. These stereotypes can include the expectation that individuals will consistently identify with only one gender and that they will act in conformity with the gender-related expressions stereotypically associated with that gender. Sex stereotypes also include gendered expectations related to the appropriate roles of a certain sex.

Id.

173. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,389 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92).

174. *Franciscan All., Inc. v. Azar*, 414 F. Supp. 3d 928, 928 (N.D. Tex. 2019).

violation of both the Administrative Procedure Act and Religious Freedom Restoration Act.¹⁷⁵ The Trump Administration repealed the Obama-era rule's definition of "on the basis of sex," and instead said it took "on the basis of sex" to mean what they called "the biological binary of male and female that human beings share with other mammals."¹⁷⁶ Legal challenges to the Trump rule argued it was contrary to *Bostock v. Clayton County*, which held that Title VII sex discrimination protections necessarily encompass LGBTQ discrimination.¹⁷⁷ A judge in the Eastern District of New York has issued a stay on the Trump Administration's rule with respect to its definition of sex, as contrary to *Bostock* and arbitrary and capricious for having been finalized prior to the Supreme Court's *Bostock* opinion.¹⁷⁸

What this long and winding history reveals is a body of civil rights law continually developing and growing, and sometimes stagnating or regressing, with each advancement in health reform. As the next Part demonstrates, the next stages of health reform threaten this progress. Medicare for All, and proposals similar to it, may create a civil rights vacuum and the legislation will need to be designed to expressly guarantee at least the status quo with respect to civil rights, if not to argue for more protective laws. As the final Part suggests, however, this may create an opportunity for lawmakers to revisit what civil rights in health care should look like.

II. MEDICARE FOR ALL, HEALTH REFORM, AND THE IMPACT ON CIVIL RIGHTS LAWS AS THEY APPLY IN HEALTH CARE

Roughly a decade since the passage of the ACA, naturally the focus has turned to the next stages of health reform. The ACA has had innumerable positive effects on the health of Americans, driving down uninsured rates and making health insurance more affordable and accessible for all, but especially for the sick.¹⁷⁹ Yet, the ACA was never designed to be the end point for a number of reasons, one being that the legislation is not a guarantee of universal care for all and, even at its best, still approximately ten percent of the population remain uninsured.¹⁸⁰ Moreover, the ACA retains a fragmented health care financing

175. *Id.* at 944–47.

176. Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160, 37,178 (June 19, 2020) (to be codified at 42 C.F.R. pt. 438, 440, 460; 45 C.F.R. pt. 86, 92, 147, 155, 156).

177. *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1754 (2020).

178. *Walker v. Azar*, No. 20-CV-2834 FBSMG, 2020 WL 4749859 (E.D.N.Y. Aug. 17, 2020). For arguments as to why *Bostock*'s reasoning necessitates the view that Title IX and section 1557 forbid LGBTQ discrimination, see Amy Post, Ashley Stephens & Valarie Blake, *Sex Discrimination in Healthcare: Section 1557 and LGBTQ Rights After Bostock*, CAL. L. REV. ONLINE (Jan. 2021), <https://www.californialawreview.org/sex-discrimination-in-healthcare-after-bostock/>.

179. Sherry A. Glied, Stephanie Ma & Anaïs Borja, *Effect of the Affordable Care Act on Health Care Access*, COMMONWEALTH FUND (May 8, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/may/effect-affordable-care-act-health-care-access>.

180. See Witters, *supra* note 3.

system that does little to tackle the inefficiencies that contribute to outsized health care spending.

A debate has sprung up, on the liberal-leaning side, over whether a single-payer system or a public option is the preferred next step given that the Democratic party captured the presidency in 2020. Single-payer systems, now colloquially referred to as “Medicare for All” after Senator Bernie Sanders’s bill of that name, typically guarantee health care to all residents of a country, or perhaps all citizens.¹⁸¹ The government, or some other entity, pools all health care finances, traditionally through a tax, and pays for all services through a single, universal program.¹⁸² Private insurance is often rendered unnecessary, or retained only as a supplemental benefit to address any gaps left by the government plan.¹⁸³ In contrast, public buy-ins or public options are plans where the government offers a public insurance plan alongside private insurance and individuals have the choice whether to purchase one or the other.¹⁸⁴ The government plan is likely to be chosen by those individuals whose needs are not well met in the private market, but the public option’s rates may still be competitive with private insurance given low overhead and a large market share that can bargain down reimbursement rates.¹⁸⁵

Medicare for All, and to a lesser degree any plan that move us toward universal or near-universal federal funding, threatens to wipe out civil rights as we currently know them in health care. As the brief history of civil rights in health care suggests, Medicare was the earliest and least protective civil rights “bill,” but this may be all we are left with after reforms. Medicaid may no longer exist, and neither may the ACA, though the two undeniably brought additional, necessary civil rights protections to patients that Medicare did not.

As this Part will demonstrate, civil rights protections may inadvertently drop out with Medicare for All legislation and will need to be deliberately drafted back in to any health reform proposal.

First, this Part describes some possible designs of single-payer and public option proposals, using examples of current legislation introduced to the 116th Congress. Second, it examines how these proposals will affect the applicability of civil rights laws to health care settings, all with an aim of ensuring that future

181. See Andrea S. Christopher, *Single Payer Healthcare: Pluses, Minuses, and What It Means for You*, HARV. HEALTH PUBL’G, <https://www.health.harvard.edu/blog/single-payer-healthcare-pluses-minuses-means-201606279835> (June 23, 2020) (discussing Jonathan Oberlander, *The Virtues and Vices of Single-Payer Healthcare*, 374 NEW ENG. J. MED. 1401 (2016)); Selena Simmons-Duffin, *Medicare for All? A Public Option? Health Care Terms, Explained*, NPR (Jan. 14, 2020, 12:38 PM), <https://www.npr.org/sections/health-shots/2020/01/14/796246568/medicare-for-all-a-public-option-health-care-terms-explained>.

182. See Oberlander, *supra* note 181, at 1403; Simmons-Duffin, *supra* note 181.

183. See Oberlander, *supra* note 181, at 1401–02 (discussing the Canadian single-payer healthcare system and how private insurance polices are “supplemental services not covered by the governmental plan”); Simmons-Duffin, *supra* note 181.

184. See Simmons-Duffin, *supra* note 181.

185. See *id.*

legislation can offset for any unanticipated and unintended erosion of these safeguards.

A. HEALTH REFORM PROPOSALS

1. *Medicare for All*

There were two single-payer proposals introduced in the 116th Congress. The most well-known is Medicare for All (S. 1129) introduced by Senator Bernie Sanders.¹⁸⁶ The plan ends Medicare, Medicaid, CHIP, TRICARE, the federal employee health benefit plan, and all private insurance and introduces the new Medicare for All plan, providing universal health coverage for all United States residents.¹⁸⁷ All United States residents are automatically enrolled for life at birth, or are enrolled upon eligibility.¹⁸⁸ The plan covers comprehensive health benefits in thirteen categories: inpatient and outpatient hospital care; ambulatory patient care; primary and preventive care including care for chronic disease; drugs, devices, and biologics; mental health and substance abuse treatment; laboratory and diagnostic services; reproductive, maternity, and newborn care; pediatric care; oral health; short-term rehabilitative and habilitative services; emergency care and transport; transport to services for people with disabilities and individuals with low incomes; and some home and community-based long-term care.¹⁸⁹ Medicare for All does not cover all forms of long-term nursing home care; instead this function remains with Medicaid and the federal government will provide some matching funds to the states similar to what it currently does for such services.¹⁹⁰

States can provide supplemental benefits at their own expense.¹⁹¹ Private insurance and employer benefits may also be permitted for benefits not covered by the universal Medicare for All plan.¹⁹² Payments for delivery of services are made directly from the federal government to the providers.¹⁹³

S. 1129 dedicates a section to antidiscrimination. It provides that:

(a) IN GENERAL.—No person shall, on the basis of race, color, national origin, age, disability, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions (including termination of pregnancy), be excluded from participation in, be denied the benefits of, or be subjected to discrimination by any participating provider as

186. Medicare for All Act of 2019, S. 1129, 116th Cong. (2019).

187. *Id.* §§ 701(b)(2) (discussing replacement of public plans), 901 (discussing replacement of private plans).

188. *Id.* § 105(a).

189. *Id.* § 201(a).

190. *Id.* § 204.

191. *Id.* § 201(d).

192. *Id.* § 107(b) (“Nothing in this Act shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by this Act, including additional benefits that an employer may provide to employees or their dependents, or to former employees or their dependents.”).

193. *Id.* § 611.

defined in section 301, or any entity conducting, administering, or funding a health program or activity, including contracts of insurance, pursuant to this Act.

(b) CLAIMS OF DISCRIMINATION.—

(1) IN GENERAL.—The Secretary shall establish a procedure for adjudication of administrative complaints alleging a violation of subsection (a).

(2) JURISDICTION.—Any person aggrieved by a violation of subsection (a) by a covered entity may file suit in any district court of the United States having jurisdiction of the parties.

(3) DAMAGES.—If the court finds a violation of subsection (a), the court may grant compensatory and punitive damages, declaratory relief, injunctive relief, attorneys' fees and costs, or other relief as appropriate.¹⁹⁴

This express protection for civil rights in S. 1129 will be discussed in more detail in Part III.

A second Medicare for All plan (H.R. 1384) was introduced by Representative Pramila Jayapal.¹⁹⁵ H.R. 1384 is very similar to Senator Sanders's plan but departs in a few signature ways. One significant difference is that Representative Jayapal's plan covers long-term care services under the federal plan, rather than by retaining Medicaid.¹⁹⁶

Specifics may ultimately vary but, generally, a Medicare for All or single-payer type of proposal will confine all or almost all health care spending to a single program. Such a plan is likely to end private insurance, or reduce it to a supplemental role, free of any federal subsidies. Such a program might also maintain private insurance for some managed care functions.

2. Public Option Proposals

Public options, or public buy-ins, are plans run through a public program that individuals have the option to purchase, as opposed to purchasing private insurance. Most of the proposals put forth in the 116th Congress leave all of the public programs like Medicare, Medicaid, TRICARE, and CHIP intact and simply designate one that individuals have the option to purchase into.¹⁹⁷ Some plans allow automatic enrollment in which individuals can opt out of the public insurance; most are opt-in.¹⁹⁸ These plans often vary in which market is used to create the public option. For instance, plans might expand the Affordable Care Act's marketplace, Medicare Part C plans, Medicare, Medicaid, or create

194. *Id.* § 104.

195. Medicare for All Act of 2019, H.R. 1384, 116th Cong. (2019).

196. *Id.* § 204.

197. *Compare Medicare-for-All and Public Plan Proposals*, KAISER FAM. FOUND., <https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals/> (May 15, 2019).

198. *See id.* For example, Medicare for America Act of 2019, H.R. 2452, 116th Cong. § 101 (2019) is an opt-out model of a public option.

entirely new public plans for individuals to buy into.¹⁹⁹ Plans also may vary in who can purchase into them, whether only individuals or also small groups and employers.²⁰⁰ These plans are more modest than Medicare for All-style plans, but they have the same general effect of increasing public payments to health care providers. Individuals or groups pay into the government, and then the government pays providers for health care services.

These types of plans have received support from some Democratic leaders on the basis that they represent a more modest reform over single-payer options, but still expand beyond the reaches of the ACA. Some politicians see such plans as a bridge between the ACA and single payer, believing that a public option will prove so successful at competing with private insurers that it may effectively end private insurance by the public voting with its wallets.²⁰¹ President Biden is a supporter of a public option, as opposed to Medicare for All.²⁰² With Democrats currently lacking a filibuster-proof majority, it is unclear that either a public option or Medicare for All can pass, absent filibuster reform.²⁰³ The two models remain the short- and long-term health reform strategies of the Democratic party, however, so they must be examined for their impact on the larger health care system.

B. THE EFFECTS OF SINGLE-PAYER AND PUBLIC OPTION PROPOSALS ON CIVIL RIGHTS APPLICABILITY

Single-payer and public option proposals may have an unanticipated and undesirable effect that will need to be planned for in the legislation. Without clear legislation stating otherwise, these proposals may roll back protections for patients from discrimination by providers, from health benefit discrimination, and from discrimination specifically on the basis of sex. This Subpart discusses how these new health reform bills could impact the flow of federal financial

199. See *Compare Medicare-for-All and Public Plan Proposals*, *supra* note 197.

200. *Id.*

201. For instance, Senator Elizabeth Warren proposed a public option in her presidential campaign platform as a bridge to Medicare for All. She noted in an explanation of her approach that

I will fight to pass legislation that would complete the transition to full Medicare for All. By this point, the American people will have experienced the full benefits of a true Medicare for All option, and they can see for themselves how that experience stacks up against high-priced care that requires them to fight tooth-and-nail against their insurance company.

My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All, WARREN DEMOCRATS, <https://elizabethwarren.com/plans/m4a-transition> (last visited Feb. 25, 2021). For ways that a public option operates as a bridge to Medicare for All, see Sally C. Pipes, Opinion, *Fans of Medicare for All Have an Ally in Biden*, BOS. HERALD (Sept. 18, 2020, 5:43 AM), <https://www.bostonherald.com/2020/09/18/fans-of-medicare-for-all-have-an-ally-in-biden/> (“Biden might present himself as an opponent of Medicare for All. But his policy proposals would pave the way for single-payer in the very near future, whether his fellow Democrats realize it or not.”).

202. See *Health Care*, JOE BIDEN, <https://joebiden.com/healthcare/> (last visited Feb. 25, 2021).

203. Dylan Scott, *The Senate’s Rules Will Make It Really Hard to Pass Medicare-For-All*, VOX (Mar. 8, 2019, 10:30 AM), <https://www.vox.com/policy-and-politics/2019/3/8/18251707/medicare-for-all-bill-senate-filibuster-budget-reconciliation-byrd-rule>.

assistance into health care and what this means for civil rights applicability to health care. Particularly, this Subpart proposes legislative fixes for how to ensure that any new reforms at least maintain the status quo with respect to civil rights enforcement.

1. Implications for Nondiscrimination and Health Care Providers

Perhaps most dramatically, a transition to a single-payer or Medicare for All-type model could effectively end all civil rights obligations for individual health care providers. Both single-payer plans currently proposed in Congress expand Medicare and appear to retain the Medicare Parts A through D framework, or at least some delimitation between provider payments and institutional care payments via Part A and Part B.

Part B payments, those made to individual providers, continue to be deemed by HHS not to count as federal financial assistance for purposes of civil rights statutes.²⁰⁴ This has been the consistent position of HHS almost since Medicare's passage.²⁰⁵ When HHS promulgated the section 1557 rule under the Obama Administration, the Agency admitted that this may not be good policy but it failed to change it, in part, because it believed nearly all providers would be covered through other funding streams and, in part, because it did not believe that the rulemaking process was the appropriate mechanism to overturn its own long-standing position.²⁰⁶

Indeed, HHS was correct at the time of the implementation of section 1557 that most providers are covered by a form of federal financial assistance, whether Medicaid, CHIP, or some other federal program.²⁰⁷ The trouble is that with Medicare for All proposals, all other funding streams would drop off, leaving only Medicare and thus potentially removing providers from any civil rights accountability. This is more than a little ironic given that the government would be funding nearly one hundred percent of all provider services, even more than it does now, but with zero percent of the civil rights accountability by providers.

The same effect would likely not be seen with public option plans, since many of the proposals introduced in the 116th Congress retain Medicare, Medicaid, and private insurance (including government subsidies to purchase private insurance on the exchanges for the income-eligible).²⁰⁸ Under these plans, there is still plenty of other federal financial assistance floating around, aside from Medicare Part B, to bring providers under civil rights enforcement.²⁰⁹ However, many proponents of these types of proposals tout them as a bridge to single-payer plans, either legislatively or by reason that the public option plan

204. See *supra* notes 84–97 and accompanying text.

205. See *supra* notes 84–97 and accompanying text.

206. See *supra* notes 158–163 and accompanying text.

207. See *supra* notes 158–163 and accompanying text.

208. See *Compare Medicare-for-All and Public Plan Proposals*, *supra* note 197.

209. *Id.*

will be so competitive that it ultimately drives out private payers. To the extent that any of these proposals create a single federal payer by design or effect, they may present the same challenge as Medicare for All.

The issue should be planned for at the time of drafting the legislation, whether Medicare for All or a public option, as health reform, especially in the current political climate, can make amending laws *ex post facto* nearly or totally impossible. The most logical fix would be for any proposals to expressly state that all funds stemming from the proposal count as federal financial assistance for purposes of civil rights laws. This is best done in the statute. If the statute is silent, there is the possibility that rulemakers and the courts could construe the law in a way that leaves patients unprotected from provider discrimination. Or, even if the rulemakers try to define those federal funds as federal financial assistance for purposes of civil rights laws in a rule, they risk being overruled in a *Chevron* challenge.²¹⁰ A court is likely to find the statute as clearly not including Medicare for All funds as federal financial assistance or see the statute as ambiguous and find that the agency oversteps because of HHS's long history of considering Part B payments to not be federal financial assistance.

2. *Implications for Nondiscrimination and Health Care Benefits*

Another implication of single-payer or public option proposals is that civil rights laws may not apply to the government, as the designer and administrator of health benefits. Admittedly, Medicare for All-style proposals do much to remove discrimination from the insurance market. There is no cherry-picking in enrollment, and premiums and cost-sharing, if present, would not vary (except perhaps by income). Still, what benefits get covered or not could have disparate effects on certain groups. For instance, a failure of Medicare for All to cover some forms of gender transition therapy could be viewed as a form of sex discrimination, or cuts to community-based care could differentially harm the elderly or people with disabilities.

Medicare as a program, and CMS as the agency administering it, are not recipients of federal financial assistance for purposes of civil rights laws. Therefore, Medicare and CMS are not governed by Title IV, Title IX, or the Age Discrimination Act. The Rehab Act applies to agencies, but it only addresses disability discrimination.²¹¹ Section 1557 of the ACA extends age, race, disability, and sex antidiscrimination obligations to health programs and activities including to government agencies like CMS,²¹² but this law would seemingly no longer apply once the ACA has been repealed and replaced with a single-payer system.

210. See *Chevron U.S.A. Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843 (1984). In *Chevron*, the Supreme Court created a deference framework for agency interpretations of statutes: first, a statute that is clear controls; second, a statute that is ambiguous allows for an agency's reasonable interpretation of Congressional intent.

211. 29 U.S.C. § 794.

212. 42 U.S.C. § 18116.

If civil rights laws are to be applicable to Medicare for All legislation, there are several possible solutions. Probably the best approach is to adopt the model of section 1557 and clearly state that civil rights laws will apply to “any program or activity that is administered by an Executive Agency”²¹³ or some similar language. This would likely be satisfactory to bring in CMS and its Medicare for All plan; HHS interpreted it to do just that in its Obama-era rule interpreting section 1557.²¹⁴ Shy of that, Congress could leave the issue to the regulators or the courts, but that would be risky, as without expressly stating that CMS is covered by civil rights laws, the agency or courts are free (and justifiably based on the text of the law) to find that civil rights laws do not apply to CMS as an administrator of benefits.²¹⁵

Alternatively, Medicare for All could continue to rely mainly on Medicare’s agency process of national and local benefit determinations.²¹⁶ This is a proposal worth considering in more detail, but notably civil rights laws do not foreclose this; they are an extra safeguard and one better designed to reach claims rooted in discrimination based on protected class.

A Medicare for All style of proposal is also likely to end private insurance in health care, or to reduce it to a supplemental role.²¹⁷ Discrimination in this market is highly probable, absent regulation, as was the case prior to the ACA’s robust consumer and civil rights protections.²¹⁸ Any private insurance that functions like Medicare Parts C or D would continue to be governed by civil rights law, as a recipient of federal financial assistance.²¹⁹ However, without express protections in the law, other forms of private insurance may go unchecked by civil rights law, as any remaining role of private insurers is likely to be supplemental and not subsidized by the federal government.²²⁰ Lawmakers will need to consider whether they want to retain any of the ACA market protections, or civil rights protections that currently apply to the private market in the absence of receipt of federal funds.

213. *Id.*

214. “[HHS] is not covered as a federally assisted program, although the Department is covered by the rule as an administrator of health programs and activities. . . . [A]ll parts of the Medicare program are a health program or activity. . . .” Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,383–85 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92).

215. Note that while the Author believes the language of 42 U.S.C. § 18116 to be clear in extending to agencies like CMS, the rule under the Trump Administration disagreed and argued that section 1557 only applied to Title I entities. *See* Nondiscrimination in Health and Health Education Programs or Activities, 85 Fed. Reg. 37,160, 37,161–62 (June 19, 2020) (to be codified at 42 C.F.R. pt. 438, 440, 460; 45 C.F.R. pt. 86, 92, 147, 155, 156).

216. *See supra* Part I.C.2. **Error! Reference source not found.**

217. Medicare for All Act of 2019, S. 1129, 116th Cong. § 901 (2019) (discussing replacement of private plans).

218. *See* POLLITZ ET AL., *supra* note 104, at iii–v.

219. OFF. FOR C.R., *supra* note 81.

220. This is in contrast to private insurers under section 1557, which were expressly governed as recipients of subsidies. 42 U.S.C. § 18116.

With public option programs, the same issues may be raised, though the matter will vary greatly based on the design of the public option. Many public option proposals offered in the most recent Congress allow for subsidies to purchase private insurance alongside a public plan.²²¹ In these models, private insurers would be retained and would be governed by civil rights law, just as is the case now with the ACA and section 1557 (presuming that the ACA remains intact and lawmakers simply amend the law to add a public option).²²² Any public options that would remove federal subsidies from private insurance would remove civil rights applicability, however. Additionally, if the public option is Medicare or some other federal public program (as opposed to a Medicaid buy-in), then civil rights laws may not apply to the program as the administrator of benefits if the ACA is repealed.²²³ Any proposal should consider civil rights protections for the beneficiaries who buy into the public plan, as well as the individuals who remain in private plans. If the public option proves popular, some providers may find themselves only providing care to Medicare beneficiaries, effectively freeing those providers from antidiscrimination mandates, unless the law anticipates and preempts this issue.

3. *Implications for Nondiscrimination and Health Care Entities*

A shift to Medicare for All is unlikely to significantly change the civil rights obligations of Part A recipients or hospitals and other health care institutions. Medicare Part A counts as federal financial assistance in the context of health care.²²⁴ Most hospitals, community health centers, and hospices have historically been governed by these laws as recipients of Part A funds.²²⁵ If Medicare is expanded, it should leave these obligations unsettled, or else expand them even further to the rare institution that does not currently accept Medicare but might be enticed to do so in a Medicare for All system. Public option proposals would also likely do little to disturb civil rights laws; if anything they might expand the number of entities receiving federal financial assistance.

4. *Implications for Claims Based on Sex Discrimination*

Protections against sex discrimination in health care came only with the adoption of the Affordable Care Act and section 1557. Since then, there has been a wave of cases challenging discriminatory conduct in health care by providers and insurers on the basis of sex.²²⁶ These protections, however, are purely

221. See *Compare Medicare-for-All and Public Plan Proposals*, *supra* note 197.

222. See *supra* Part I.E.1.

223. See *supra* Part I.E.1.

224. OFF. FOR C.R., *supra* note 81.

225. *Id.*

226. See, e.g., *Prescott v. Rady Children's Hosp.*, 265 F. Supp. 3d 1090, 1097 (S.D. Cal. 2017) (using section 1557 to challenge lack of preferred pronoun use and other discrimination against a transgender teenager); *Rumble v. Fairview Health Servs.*, No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, at *15–17 (D. Minn. Mar. 16, 2015) (challenging lack of preferred pronoun use and inappropriate genital examinations as discrimination

derived from the statutory text of section 1557. Absent that, Title IX does not otherwise apply to health care; it expressly applies only to “any education program or activity receiving Federal financial assistance.”²²⁷ Moreover, other protections from sex discrimination only derive from the text of the ACA, such as its ban on gender rating by health insurers.²²⁸ These protections must be transferred to any reforms that repeal or alter the ACA. For instance, a Medicare for All bill would not implicitly bring Title IX protections into health care. The statute would need to expressly provide for these same or greater protections.

None of these issues are insurmountable; most simply require thoughtful foresight and a Congress that, in passing major health reform, is amenable to taking minor, proactive steps in the legislation to maintain the status quo with respect to civil rights laws and their application to health care settings. Absent these safeguards, though, Medicare for All might mean a health care system that is more discriminatory than the one that predates it. Moreover, because lawmakers have to be intentional in including civil rights protections in the legislation, this is an opportunity for lawmakers to do more, to create a civil rights provision that reflects historical failings of civil rights in health care and prepares for better enforcement in the future.

III. LEARNING FROM PAST MISTAKES AND USING MEDICARE FOR ALL AS THE VEHICLE FOR A MEANINGFUL CIVIL RIGHTS MOVEMENT FOR PATIENTS

Ultimately, the uncertainty of civil rights under Medicare for All or other versions of health reform can be turned into an opportunity for positive legal reforms. Lawmakers will need to address these issues during the drafting of the legislation, or risk creating a regulatory vacuum where much of the progress of civil rights in health care is undone.

In prior health reforms, civil rights were an afterthought at best. Civil rights laws followed from health reform, rather than being considered independent of it and goals unto themselves. For both Medicare and Medicaid availability of federal money was simply expanded, and regulators acted in response. The ACA did contain a health care specific civil rights bill in section 1557 and the provision did expand protections some, by expressly including agencies and specifying that subsidies are a form of federal financial assistance.²²⁹ Otherwise,

on the basis of sex); *Flack v. Wis. Dep’t of Health Servs.*, 328 F. Supp. 3d 931, 934 (W.D. Wis. 2018) (challenging an insurer’s ban on gender affirming surgery as sex discrimination under section 1557); *Boyden v. Conlin*, 341 F. Supp. 3d 979, 993–94 (W.D. Wis. 2018) (challenging a ban on gender affirming surgery by an employer-sponsored plan as violating section 1557 and Title VII).

227. 20 U.S.C. § 1681.

228. Note that the ACA does not explicitly ban gender rating. It imposes community ratings except with respect to a couple of attributes: family size, geography, age, and whether one smokes. In this way, it indirectly bans premium differentiation based on sex. 42 U.S.C. § 300gg.

229. *See supra* Part I.E.

section 1557 of the ACA said very little beyond the fact that the four relevant civil rights statutes would apply.²³⁰

Legislators have the opportunity to be the architects of this new civil rights bill, as they have no choice but to consider deliberately what counts as federal financial assistance, who the covered entities should be, and what groups warrant protection. Legislators thus have the opportunity to grapple with how civil rights *should* apply in a health care setting.

This Part first considers whether legislation should adopt a traditional civil rights framework or venture beyond. It also clarifies the importance of designating the civil rights provision of the law as unique to health care, as this may be important for enforcement where the law is unclear. Lastly, it provides specific areas where the legislation may enhance civil rights protections beyond their current reach, as well as acknowledging some political pitfalls.

A. ADOPTING A TRADITIONAL CIVIL RIGHTS FRAMEWORK OR TRYING SOMETHING NEW?

One notable aspect of section 1557 was that it simply extended existing civil rights jurisprudence into health care, rather than creating a new framework for health care nondiscrimination. Take section 1557's prohibition on sex discrimination as one example of the issue. It stated that Title IX would now apply to health care programs that were recipients of federal financial assistance.²³¹ In doing so, it brought in all of Title IX's statutory, regulatory, and case law meaning to bear in considering what constitutes sex discrimination under the ACA.

In contrast to this, consider S. 1129's antidiscrimination provision, which instead specifies which groups of people will be protected from discrimination, without any reference to specific civil rights laws.²³² For instance, S. 1129 bans discrimination based on sex, gender identity, and sexual orientation.²³³ This may leave an opening for regulators or the courts to decipher whether or not Title IX applies, or whether the law forbids sex discrimination in some different and unique way that is divorced from the body of law that interprets Title IX.

Now of course this may simply be a mistake of the drafters, and one that can easily be remedied by the time such a law would be passed. However, it does

230. *See supra* Part I.E.

231. 42 U.S.C. § 18116.

232. *See* Medicare for All Act of 2019, S. 1129, 116th Cong. § 104(a) (2019).

No person shall, on the basis of race, color, national origin, age, disability, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions (including termination of pregnancy), be excluded from participation in, be denied the benefits of, or be subjected to discrimination by any participating provider as defined in section 301, or any entity conducting, administering, or funding a health program or activity, including contracts of insurance, pursuant to this Act.

Id.

233. *Id.*

represent a real choice for lawmakers. Do they want to create a truly health-specific brand of nondiscrimination or do they want to apply traditional civil rights to health care? And if the latter, are there aspects of traditional civil rights laws they want to reject when it comes to health care for discrete health policy reasons?

Creating a new brand of nondiscrimination law seems frighteningly complicated and, absent clear direction, rulemakers and the courts are likely to simply apply traditional civil rights norms anyway. But on the other hand, one advantage is the opportunity to argue for a rationale of greater safeguards when civil rights laws fall short. For instance, section 1557 ties its ban on sex discrimination to Title IX and, in doing so, it is at the mercy of the courts whether the law encompasses gender identity discrimination or not.²³⁴ Of course rulemakers may interpret broadly but, absent congressional guidance, this can be subject to change from administration to administration. Even the Obama-era rulemakers who sought expansive protections under section 1557 would not state that the rule categorically reached sexual orientation discrimination *per se*, as they felt they were reaching beyond Title IX case law, likely subjecting themselves to legal challenge.²³⁵ Their inclusion of gender identity and pregnancy determination in the definition of “on the basis of sex” was challenged and ultimately vacated on Administrative Procedure Act and Religious Freedom Restoration Act grounds.²³⁶ In contrast, S. 1129 simply proscribes gender identity discrimination;²³⁷ it is not reliant on what sex discrimination means in Title IX or Title VII contexts and so can be more protective and more certain of how the law will be interpreted in future.

Perhaps the safest course is a compromise tying the statute to traditional civil rights laws but clearly identifying areas where there is a departure. For instance, in order to define in the statute what sex discrimination means for purposes of that law, the statute might state that Title IX applies. But, it could also state that discrimination is prohibited on the basis of sex, sex stereotyping, sexual orientation, gender identity, pregnancy termination, and so on.

B. MAKING MEDICARE FOR ALL A HEALTH CARE-SPECIFIC CIVIL RIGHTS BILL

No matter how clear and specific the statute may be, there will always be room for interpretation by agencies and by the courts. How the courts responded to section 1557 may be informative for this issue. Particularly, in interpreting unclear provisions, the courts seemed concerned with whether section 1557 was meant to be a health care-specific civil rights bill—that is, did Congress intend

234. *See supra* notes 168–173 and accompanying text.

235. *See supra* notes 168–173 and accompanying text.

236. *Franciscan All., Inc. v. Azar*, 414 F. Supp. 3d. 928, 945–46 (N.D. Tex. 2019).

237. S. 1129 § 104.

the statute to play by its own rules, or did Congress intend for civil rights in this context to be treated like civil rights in any other context?

Take the question of whether there is a private right of action under section 1557. Section 1557, in its framing, gave courts and rule makers the opportunity to consider it as a unique and health care specific civil rights bill. In stating that four different civil rights laws all applied to health care programs and activities, it left courts to untangle whether the enforcement mechanisms for each of these civil rights statutes applied or whether there was one single enforcement scheme for section 1557, regardless of whether the underlying claim was based in race, age, sex, or disability discrimination. The statute itself was not particularly helpful, with vague and confusing language: “The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection.”²³⁸

Professor Sidney Watson argued effectively that section 1557 creates a new health-specific anti-discrimination prohibition that reaches further than Title VI, prohibiting discrimination not only in federally funded health programs but also federally administered health programs and new ACA-authorized entities like Exchanges. Section 1557 does not merely extend Title VI to additional health programs; it creates a new civil right and remedy while leaving in place Title VI and other existing civil rights laws. Section 1557 relies on familiar language from Title VI and other federal civil rights statutes that have established legal meanings, which is evidence of the Congressional intent that this new civil rights statute is to prohibit both intentional and disparate impact discrimination.²³⁹

Particularly, Watson argued that because section 1557 is health care specific, and independent of other civil rights, this should have implications for how it is enforced, including whether it permits a private right of action and when other applications of civil rights laws may not.²⁴⁰

Courts were split on this issue of whether section 1557 effectively overrode *Alexander v. Sandoval* for purposes of health care discrimination, allowing private rights of action alleging disparate impact for each of the underlying grounds that section 1557 reached.²⁴¹ At least one court was compelled by the narrative that the law meant for health care to be treated differently, observing that “it appears that Congress intended to create a new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff’s protected class status.”²⁴² In contrast, another court did not

238. 42 U.S.C. § 18116.

239. Watson, *supra* note 70, at 870.

240. *Id.*

241. See *supra* notes 42–43 and accompanying text.

242. Rumble v. Fairview Health Servs., No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, at *11 (D. Minn. Mar. 16, 2015) (footnote omitted).

conclude that Congress clearly demonstrated such intent, noting instead that “[Section 1557] does not change the nature of those grounds any more than it adds a new form of discrimination.”²⁴³ The rulemakers under the Obama Administration ultimately interpreted section 1557 as:

authorizing a private right of action for claims of disparate impact discrimination on the basis of any of the criteria enumerated in the legislation. At the same time, OCR is incorporating its existing procedures for its administrative processing of complaints; thus, we will use our current processes to address age discrimination on the one hand and race, color, national origin, sex, or disability on the other hand. This approach will enable us to be consistent in our processing of complaints under OCR’s other authorities in instances where we have concurrent jurisdiction under Section 1557 and the other civil rights laws it references.²⁴⁴

In essence, the regulation permitted a single, health care specific standard for private rights of action. For purposes of agency enforcement, HHS retained the enforcement mechanisms for each of the four statutes, as it is responsible for enforcing section 1557 and the other underlying civil rights laws.²⁴⁵ HHS under the Trump Administration stated it would not take a position on whether section 1557 permits private rights of action or not, effectively leaving the matter to the courts.²⁴⁶

All of this serves as a useful example of the importance of Congress designating whether it wants special rules to apply in health care. Of course, ideally, if Congress does, it will explicitly state what those rules are. But short of that, Congress can express a clear intent in the purpose, findings, and even text of the statute to demonstrate that the civil rights provision is unique from traditional civil rights law and designed to be protective of patients.

Reading Section 1557 otherwise would lead to an illogical result, as different enforcement mechanisms and standards would apply to a Section 1557 plaintiff depending on whether the plaintiff’s claim is based on her race, sex, age, or disability. For instance, a plaintiff bringing a Section 1557 race discrimination claim could allege only disparate treatment, but plaintiffs bringing Section 1557 age, disability, or sex discrimination claims could allege disparate treatment or disparate impact.

Id.

243. *Doe v. BlueCross BlueShield of Tenn., Inc.*, 926 F.3d 235, 238–40 (6th Cir. 2019) (applying *Chevron* deference and concluding that HHS overreached in permitting a private right of action for all four grounds pursuant to section 1557 under prong 1 of *Chevron* because the original statute was clear; then holding that whether there is a private right of action depends on the jurisprudence of each of the four grounds as section 1557).

244. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,440 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92).

245. *See id.* at 31,378.

246. *See* Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160, 37,203 (June 19, 2020) (to be codified at 42 C.F.R. pt. 438, 440, 460; 45 C.F.R. pt. 86, 92, 147, 155, 156).

C. CONSIDERING SPECIFIC PROTECTIONS FOR CIVIL RIGHTS UNDER
MEDICARE FOR ALL

In Part II.B, this Article explored the ways that Medicare for All and other reforms could unravel existing civil rights protections and how to retain the status quo in drafting the legislation. This Subpart provides some examples of opportunities where Medicare for All could build on and go beyond the status quo, to continue in the tradition of other health reforms in expanding civil rights for patients one bill at a time. Many of these issues have been briefly touched on earlier, as they represent current weaknesses in the existing applicability of civil rights law to health care.

1. *Protected Classes*

A civil rights provision under Medicare for All is free to define who it intends to shield from discrimination in health care.

As discussed in Part III.A, this may include enumerating what specific classes are covered by the law; for instance, not just listing sex discrimination, but defining what sex discrimination encompasses, such as gender identity and sexual orientation.

Lawmakers also have a decision to make about whether to include more groups of people than have traditionally been protected in the past. For example, Professors Jessica Roberts and Elizabeth Weeks have detailed discrimination by employers, health providers, insurers and others on the basis of health status, a form of discrimination not typically protected by civil rights laws.²⁴⁷ Likewise, scholars point to obesity as a condition that drives discrimination and for which legal protections are absent.²⁴⁸ Currently, health care providers are free to refuse to treat patients on these bases: a surgeon may object to treating a particularly difficult case for fear of a bad outcome hurting the surgeon's reputation or a primary care physician might refuse to treat an obese patient because of outright prejudice.

This creates an opportunity to match civil rights protections with the literature on who suffers from discrimination in health care settings. Of course, there may be tradeoffs with this approach and there may be good reason to stick to the conventional protected classes. For one, these groups and others do not have civil rights laws that apply to them, leaving uncertainty about how to enforce laws to protect them.²⁴⁹ Still, this is a matter that lawmakers can consider. As a single-payer system, the federal government has the prerogative

247. See generally JESSICA L. ROBERTS & ELIZABETH WEEKS, HEALTHISM: HEALTH-STATUS DISCRIMINATION AND THE LAW (2018) (establishing a framework for considering when discrimination based on health status should and should not be permitted under the law).

248. Rebecca M. Puhl & Chelsea A. Heuer, *The Stigma of Obesity: A Review and Update*, 17 OBESITY 941, 944 (2009) ("In a study of over 620 primary care physicians, >50% viewed obese patients as awkward, unattractive, ugly, and noncompliant. One-third . . . characterized obese patients as weak-willed, sloppy, and lazy.").

249. See *supra* Part III.A.

to design the health care system in the way it sees fit. If it is to finance all health care, it might be concerned with making sure that care is equal, of high quality, and does not further health and health care disparities that ultimately become the problem of the federal government.

2. Covered Parties

Lawmakers also have the opportunity to revisit which parties must comply with civil rights laws under a Medicare for All bill. Section 1557 expressly included recipients of federal subsidies in the statute to guarantee that subsidies would be considered a form of federal financial assistance, such that private insurers would be governed by civil rights.²⁵⁰ A Medicare for All bill also has the opportunity to plan for broader reach of civil rights laws. Indeed, as Part II.B demonstrates, lawmakers must expressly enumerate some groups like providers and CMS, clarify what counts as federal financial assistance, or risk that these groups will not be captured by civil rights laws at all.

The current version of nondiscrimination in S. 1129 broadly applies to “any participating provider . . . or any entity conducting, administering, or funding a health program or activity, including contracts of insurance.”²⁵¹ Participating providers are defined in the statute to mean any individual or entity that provides covered services (and meets other administrative criteria like being party to a participation agreement under Medicare for All).²⁵² The requirement to comply with nondiscrimination laws appears to attach to the individual or entity by virtue of being a participating provider, rather than a recipient of federal financial assistance.²⁵³ Again, this is a departure from traditional civil rights laws.

Another issue will be whether and to what extent a public insurance program should be held to account for complying with civil rights laws. S. 1129’s nondiscrimination mandate applies to those that administer or fund programs, likely capturing CMS, or whatever agency is tasked with designing health benefits.²⁵⁴ Likewise, section 1557 applies to agencies.²⁵⁵ However, other civil rights laws like Title IV and Title IX do not apply to agencies, only recipients of federal funds. A program like Medicare for All will have to balance equality, cost-savings, and other factors. Certainly, while civil rights laws

250. 42 U.S.C. § 18116; *see supra* Part I.E.1.

251. Medicare for All Act of 2019, S. 1129, 116th Cong. § 104 (2019).

252. *Id.* § 301.

253. Note that the bill includes recipients of “contracts of insurance” as covered parties. *Id.* This is likely not clear enough language to guarantee that health care provider receiving Part B are covered under the law, since section 1557 also included this language and still the regulators excluded Part B payments for enforcement. *See* 45 C.F.R. § 92.1 (2019); *see also supra* Part I.E.2. The issue is more critical here, though, where they may be no other funds that bring providers under government enforcement.

254. S. 1129 § 104 (the nondiscrimination provision applies to “any entity conducting, administering, or funding a health program or activity, including contracts of insurance”).

255. 42 U.S.C. § 18116 (explaining that the nondiscrimination mandate applies to “any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)”).

clearly extend to Medicaid as an administrator of benefits, courts have been reluctant to be overly proscriptive in how this influences health benefit design. For instance, in *Alexander v. Choate*, the Court, even while worrying about the disparate impact of budget cuts on people with disabilities, was hesitant to tell Medicaid officials that they must entirely counter this in their administration of health benefits.²⁵⁶ The Court noted that:

But nothing in the pre- and post-1973 legislative discussion of § 504 suggests that Congress desired to make major inroads on States' longstanding discretion to choose the proper mix of amount, scope, and duration limitations on services covered by state Medicaid. And more generally, we have already stated that § 504 does not impose a general NEPA-like requirement on federal grantees. . . . On the contrary, to require that the sort of broad-based distributive decision at issue in this case always be made in the way most favorable, or least disadvantageous, to the handicapped, even when the same benefit is meaningfully and equally offered to them, would be to impose a virtually unworkable requirement on state Medicaid administrators.²⁵⁷

Likewise, *Olmstead* was largely a victory for people with disabilities as the Court held that states had to find ways to ensure that individuals were given access to home- and community-based care.²⁵⁸ However, even there the Court gave states space to achieve the goal over time, within their discretion and budget:

Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities.²⁵⁹

This Article reserves this weighty question for another day and simply suggests that Medicare for All will change applicability of civil rights to health benefits. However, it is worth emphasizing that if the goal of civil rights law is, as President Kennedy intended, not to use federal money to further discrimination,²⁶⁰ then it seems unwise to allow the whole of health care financing in the United States to go entirely unchecked by civil rights, especially given the significant health and health care disparities that persist over time for so many vulnerable groups.²⁶¹ Civil rights likely should play some role in ensuring equality in access to health benefits. Lawmakers may want to consider how the courts have responded to this issue in the past and whether they need to provide more guidance in the law for how the courts and regulators should approach this issue when interpreting and applying the law.

256. See *Alexander v. Choate*, 469 U.S. 287, 298–99, 302–04 (1985).

257. *Id.* at 307–08 (footnote omitted) (citations omitted).

258. See *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 587 (1999).

259. *Id.* at 604.

260. See *supra* note 24 and accompanying text.

261. See *supra* Part I.B.

3. Government Enforcement

Medicare for All may require the government to also rethink how it enforces civil rights laws.

If Congress believes that civil rights should apply within benefit design, a bill would need to consider the best way to address nondiscrimination here. One idea is a complaint process that could be preserved for individuals who believe that benefits determinations discriminate against them on the basis of protected class.²⁶² Additionally, a Medicare for All bill might establish an administrative process whereby the original benefit design offered by Medicare and any changes are scrutinized by a designated committee made up of physicians, civil rights experts, government officials, and patient advocates including representatives from protected classes. This may help to cut down on complaints about inequities in benefits if the benefit design is evaluated, at the outset and periodically, for inequalities.

A Medicare for All bill can also reconsider traditional enforcement strategies under civil rights. S. 1129's nondiscrimination provision does not clearly adopt HHS's enforcement of other civil rights laws.²⁶³ Other civil rights laws, to the extent federal financial assistance derives from the Agency, are enforced by HHS's OCR and involve a complaint process, investigations, the opportunity for informal or formal resolution, and the possibility of terminating federal financial assistance for noncompliance.²⁶⁴ S. 1129 instead provides deference to the Secretary to "establish a procedure for adjudication of administrative complaints alleging a violation of [the nondiscrimination provision]."²⁶⁵ The Secretary, likely, would model agency enforcement off of other civil rights laws and delegate the enforcement of HHS's OCR, although there may be merits to considering new models of enforcement.

If lawmakers are compelled by the idea that Medicare for All can be a true reset for civil rights in health care, then they might also consider how active the government should be in enforcing civil rights laws, and whether this requires a redesign of the existing civil rights agency under HHS, or at least its funding. Professor David Barton Smith recalls the era immediately after the passage of Medicare when civil rights enforcement by HHS seemed unstoppable.²⁶⁶ Important lessons from the time can inform the next chapter of civil rights in health care.

In a rapid clip, the Office of Equal Health Opportunity (OEHO) was established under the Surgeon General's Office of the Public Health Service to manage enforcement of Title IV in the rollout of Medicare certification of

262. This is similar to current enforcement of civil rights laws. *See supra* Part I.A.

263. *See* Medicare for All Act of 2019, S. 1129, 116th Cong. § 104 (2019).

264. *See supra* Part I.A.4.

265. S. 1129 § 104(b)(1).

266. SMITH, *supra* note 74, at 96–126.

hospitals.²⁶⁷ Seven hundred and fifty employees from other parts of HEW were diverted to OEHO; they faced a daunting task of enrolling twenty million seniors into Medicare while ensuring that hospitals racially integrated.²⁶⁸

What ensued was a game of chicken: the Surgeon General published standards in the American Hospital's Associations' journal and mailed forms to every hospital, asking them to fill out an assurance of compliance with Title VI—while genuinely not knowing whether hospitals would comply or not.²⁶⁹ The team tirelessly plugged away, giving guidance to hospital after hospital about how to comply with the new Title IV.²⁷⁰ When two hospitals in a town in North Carolina, one white and one black, telegraphed asking how to comply with Title VI, they received a one-word telegram in response: "Merge."²⁷¹

In contrast with the enforcement of civil rights laws by OCR today, OEHO sent boots on the ground to see that hospitals were integrating and built relationships with employees and community members who would report back on progress when agency officials left.²⁷²

OEHO was to later run up against significant roadblocks.²⁷³ By the time the Agency got around to desegregation efforts in nursing homes, most of the workers who had been loaned to OEHO had been sent back to their original assignments, and President Johnson seemed satisfied with nursing homes providing paper reassurances, with no on-the-ground enforcement to ensure that the nursing homes were doing what they promised.²⁷⁴ Then, DHEW's general counsel interpreted the law so as not to apply to the some 150,000 office-based physicians who received Medicare funds, both because the agency did not know how to handle the sheer volume of enforcement, and because it feared a fight with organized medicine.²⁷⁵ De-centralization of funds, in particular, had protected the OEHO from budget cuts by members of Congress that would have preferred to slow or stop the civil rights agenda.²⁷⁶ But eventually southern Congressmen that were opposed to civil rights and fed up with OEHO's agenda pushed to dissolve it and to form the more centralized and more toothless Office

267. As Smith notes, OEHO's

life would be a remarkably short one for a bureaucratic agency, less than two years, but long on accomplishments. For many of the civil servants who worked for the Office of Equal Health Opportunity during this period, it was the high point of their careers and a period that they looked back to with pride and more than a little nostalgia.

Id. at 128.

268. This occurred during a time when desegregation was facing hurdles in other areas of American life. Lunch counters had yet to be fully desegregated and the government had been exhausting resources waging a war with schools in the South. *See id.* at 128–32.

269. *Id.* at 129–32.

270. *Id.* at 135–40.

271. *Id.* at 137.

272. *Id.* at 135–40.

273. *Id.* at 143–87.

274. *Id.* at 160.

275. *See supra* Part I.C.2.b.

276. SMITH, *supra* note 74, at 164–66.

of Civil Rights.²⁷⁷ Everyone involved knew that a centralized OCR could be more easily controlled by Congress, through reduced appropriation.²⁷⁸ Since then, civil rights enforcement has declined and some lay the blame at the feet of an understaffed and under-resourced OCR.²⁷⁹ OCR has also been tasked with HIPAA enforcement, which diverts critical resources away from civil rights.²⁸⁰

The lessons of OEHO for a Medicare for All bill are at least threefold. One, special times call for special measures. The government was able to go almost overnight from no civil rights enforcement to deploying a fully staffed department dedicated to civil rights enforcement.²⁸¹ They would achieve what became the most aggressive enforcement ever in the history of health care civil rights in this country; no later measures were to match that earliest and best accomplishment.²⁸² It shows how much progress can be attained when the government prioritizes civil rights. Two, Smith observes that the story of OEHO also shows that it is far easier to refuse to give money in the first place than to take it away later.²⁸³ The government set forth clear terms in how it would interpret Title VI for Medicare-participating hospitals, and no hospital would receive the money until it demonstrated its compliance.²⁸⁴ What was far more challenging was when a hospital later lagged in its compliance.²⁸⁵ Then, the agency got tangled up in the administrative processes of investigating, seeking informal or formal resolution, participating in hearings, and terminating funds.²⁸⁶ Three, OEHO didn't solve every problem. Instead, it focused on some specific inequalities that it believed it could immediately budge.²⁸⁷

What this may signal to lawmakers is that now is the time, at the brainstorming and drafting and passage of the law stage, to place strict expectations on participants. Now is the time to be robust about civil rights protections, to adopt a take-it-or-leave-it approach. Moreover, it suggests that to see meaningful change in civil rights there may need to be a stronger effort on the part of the government with respect to enforcement than currently exists. This may require a reconfiguration of OCR or, at minimum, an increase of

277. *Id.*

278. *Id.*

279. Louise G. Trubek & Maya Das, *Achieving Equality: Healthcare Governance in Transition*, 29 AM. J. L. & MED. 395, 398–99 (2003) (criticizing OCR over the decades for failing to build on its enforcement procedures for Title VI).

280. HIPAA complaints number in the tens of thousands per year. *Health Information Privacy Complaints Received by Calendar Year*, U.S. DEP'T OF HEALTH & HUM. SERVS., <https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/data/complaints-received-by-calendar-year/index.html> (Mar. 30, 2020).

281. SMITH, *supra* note 74, at 128–29.

282. Matthew, *supra* note 53, at 806–14 (characterizing Title VI enforcement as on a backslide after desegregation of hospitals).

283. SMITH, *supra* note 74, at 159.

284. *Id.* at 128–29.

285. *Id.* at 159.

286. *Id.* at 96–142 (profiling the narrow focus on desegregation of hospitals, before turning to other entities and other discriminatory practices).

287. *Id.* at 128–29.

funding and staff to that agency to achieve these important aims and to strike while the iron is hot. Lastly, under a Medicare for All system, regulators should be prepared to think about what the greatest inequities currently are in the system. That is where the battle for civil rights enforcement under Medicare for All should begin (but not end).

4. *Private Enforcement*

It is impossible to discuss civil rights without mentioning the erosion the courts have had on their enforcement, particularly by the limiting of private rights of action under *Alexander v. Sandoval*.²⁸⁸ Ultimately, it made civil rights claims much more challenging for litigants and left a number of discriminatory behaviors to the whims of enforcement by a federal government that has fluctuated in its dedication to civil rights enforcement from administration to administration.²⁸⁹

Medicare for All is an opportunity to specifically outline greater rights for litigants. Section 1557 was not very clear about this matter. Rulemakers under the Obama Administration first interpreted the law robustly as allowing private rights of action for all four civil rights laws, but the Trump Administration eroded this in its rule.²⁹⁰ This shows the risk of leaving the matter to the rulemaking process. With Medicare for All, lawmakers can be clear that, whatever the civil rights protections are, private rights of action (including for disparate impact) are permitted. Lawmakers can also be explicit in whether certain types of damages should or should not be allowed under private claims.

For instance, S. 1129 expressly details private rights and provides greater protection than traditional civil rights law.²⁹¹ The provision is silent on private rights of action alleging disparate impact, except to say that individuals will have jurisdiction in federal courts—but this is a matter the lawmakers can easily amend to clarify the issue by statute.²⁹² S. 1129 also expressly permits “compensatory and punitive damages, declaratory relief, injunctive relief, attorneys’ fees and costs, or other relief as appropriate,”²⁹³ expanding damages beyond those that are traditionally allowed under civil rights laws.²⁹⁴

In short, lawmakers have the opportunity with a Medicare for All bill, or public option, to remake civil rights in a way that is more protective of patients. They can be informed by past failures of civil rights laws and by the gaps in

288. See *Alexander v. Sandoval*, 532 U.S. 275, 293 (2001); see also Rosenbaum & Teitelbaum, *supra* note 43, at 238–39, 244 (depicting a limited reach for civil rights in the aftermath of *Sandoval*).

289. Rosenbaum & Teitelbaum, *supra* note 43, at 243–44.

290. See *supra* Part III.B.

291. Medicare for All Act of 2019, S. 1129, 116th Cong. § 104 (2019).

292. See *id.*

293. *Id.*

294. Civil rights laws typically permit monetary damages with a showing of deliberate indifference. They typically do not permit punitive damages, however, so this represents a greater remedy for plaintiffs. See *supra* Part I.A.4.

Medicare, Medicaid, and section 1557 in drafting a civil rights bill that is finally crafted with the unique needs of patients and health care in mind.

D. POLITICAL REALITIES

There may be significant pushback to the inclusion of robust civil rights protections in a Medicare for All bill. Smith details similar pushback during the early enforcement of Title VI after the passage of Medicare and Medicaid, noting that “imposing any kind of Title VI requirements on medical practices was inconceivable. Local medical societies, state societies, and the AMA were powerful political forces and reluctant, if not openly hostile, participants in the Medicare program.”²⁹⁵ However, such pushback may take a different shape and may be less significant than in the 1960s.²⁹⁶ For one, under Medicare, individual providers at least had a choice and could forgo those funds in favor of private pay if they did not want to be held to account for complying with civil rights laws. Hospitals found the money too enticing not to take the bargain.²⁹⁷ Providers today, in the face of a Medicare for All, may be more like hospitals, so they will have to choose to work within the Medicare for All system or select a perhaps very small or nonexistent private system. It certainly would not be a sympathetic or popular position for any organized medical group or provider to take today to be opposed to the robustness of civil rights protections, as compared with the political and social climate of the mid-1960s.

Of course, this could translate into greater pushback from providers against the adoption of Medicare for All or public option generally. Early evidence suggests that there may be growing support among health care providers for such reforms. The American Medical Association (AMA) was virulently opposed to single-payer health care for almost a century.²⁹⁸ They were credited with destroying Franklin D. Roosevelt’s push for a single-payer system as part of the New Deal.²⁹⁹ In the 1960s they organized the major opposition to Medicare, even having Ronald Reagan record an LP opposing it.³⁰⁰ The AMA eventually came out in support of the ACA, however, losing a number of conservative

295. SMITH, *supra* note 74, at 162 (discussing how this became the basis for HEW’s tortured rationale to exclude Part B from the definition of federal financial assistance).

296. *See id.* at 96–142 (discussing different health care actors’ responses to civil rights enforcement in the aftermath of the passage of Medicare).

297. *See id.*

298. Susannah Luthi, *AMA Exits Partnership Fighting Medicare for All, Public Options*, MOD. HEALTHCARE (Aug. 15, 2019, 5:55 PM), <https://www.modernhealthcare.com/medicare/ama-exits-partnership-fighting-medicare-all-public-options>.

299. *Id.*

300. Avik Roy, *Ronald Reagan’s Advice on Health Reform*, FORBES (Feb. 6, 2011, 9:29 AM), <https://www.forbes.com/sites/theapothecary/2011/02/06/ronald-reagans-advice-on-health-reform/#5dbfa4f09a8f>. The recording was designed for Operation Coffee Cup, a movement led by the AMA in which doctors’ wives held coffee meetings “in order to persuade their friends to write letters to Congress in opposition” to Medicare. *Id.*

members in that process.³⁰¹ At the AMA's last annual meeting, the AMA's house of delegates (its policy-making branch) almost voted to overturn the AMA's position opposing single-payer health care, with 47% voting to end it and 53% voting to retain it.³⁰² The organization also withdrew from the Partnership for America's Health Care Future, the lobbying group that runs opposition ads against single-payer health reform.³⁰³ The American College of Physicians, meanwhile, has come out in support of a Medicare for All plan.³⁰⁴ Couple this with single-payer type systems enjoying wider public support than in the past:³⁰⁵ a majority of the American public (56%) favors a Medicare for All plan, and an even larger portion (68%) favors a public option.³⁰⁶ Likely one of the greatest forces in opposition to Medicare for All or a public option would be insurers, and these insurers would not be focused on civil rights enforcement but, instead, the legislation itself and its implications for their services.

Undeniably, civil rights movements often encounter pushback,³⁰⁷ but here the greater controversy is likely to be a Medicare for All or public option bill itself, not any civil rights protections it brings with it. If Medicare for All or a public option can overcome the obstacles that they will undoubtedly face, it seems of little risk to ensure that the legislation brings with it the most robust civil rights protections possible.

CONCLUSION

Medicare for All would represent unprecedented progress for patients in accessing the health care system, but the law could leave us with fewer civil rights protections, absent careful planning to bake safeguards into the legislation. By requiring lawmakers to deliberately assure civil rights protections, Medicare for All enables a conversation and a rethinking of what civil rights health care can achieve and how lawmakers can draft a law that is protective of all patients, including members of protected classes. Opportunities for health reform the likes of Medicare for All may never come again. That bill

301. Harris Meyer, *AMA Conservatives Revolt Against the Individual Mandate*, HEALTH AFFS. BLOG (Nov. 30, 2010), <https://www.healthaffairs.org/doi/10.1377/hblog20101130.008103/full/>. For more on the history of the AMA and health reform, see *id.*

302. Dylan Scott, *The Nation's Most Prominent Doctors Group Almost Dropped Its Opposition to Medicare-for-All*, VOX (June 12, 2019, 11:40 AM), <https://www.vox.com/policy-and-politics/2019/6/12/18662722/ama-medicare-for-all-single-payer-vote-2020>.

303. Luthi, *supra* note 298. While the President of the AMA stated that this was not a reversal of the organization's opposition to single payer health care, it nevertheless suggests that the AMA may at minimum not be strongly opposed to such reforms. See *id.*

304. Steffie Woolhandler & David U. Himmelstein, *The American College of Physicians' Endorsement of Single-Payer Reform: A Sea Change for the Medical Profession*, 172 ANNALS INTERNAL MED. S60, S60 (2020).

305. Lunna Lopes, Liz Hamel, Audrey Kearney & Mollyann Brodie, *KFF Health Tracking Poll—January 2020: Medicare-for-All, Public Option, Health Care Legislation and Court Actions*, KAISER FAM. FOUND. (Jan. 30, 2020), <https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2020/>.

306. *Id.*

307. See SMITH, *supra* note 74, at 143–87.

could be the chance to ensure that the civil rights of patients are respected and protected well into the future.
