

Health Affairs

At the Intersection of Health, Health Care and Policy

Cite this article as:
Amitabh Chandra, Michael Frakes and Anup Malani
Challenges To Reducing Discrimination And Health Inequity Through Existing
Civil Rights Laws
Health Affairs 36, no.6 (2017):1041-1047
doi: 10.1377/hlthaff.2016.1091

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ANALYSIS & COMMENTARY

Challenges To Reducing Discrimination And Health Inequity Through Existing Civil Rights Laws

DOI: 10.1377/hlthaff.2016.1091
HEALTH AFFAIRS 36,
NO. 6 (2017): 1041-1047
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ABSTRACT More than fifty years after the passage of the Civil Rights Act of 1964, health care for racial and ethnic minorities remains in many ways separate and unequal in the United States. Moreover, efforts to improve minority health care face challenges that differ from those confronted during de jure segregation. We review these challenges and examine whether stronger enforcement of existing civil rights legislation could help overcome them. We conclude that stronger enforcement of existing laws—for example, through executive orders to strengthen enforcement of the laws and congressional action to allow private individuals to bring lawsuits against providers who might have engaged in discrimination—would improve minority health care, but this approach is limited in what it can achieve. Complementary approaches outside the legal arena, such as quality improvement efforts and direct transfers of money to minority-serving providers—those seeing a disproportionate number of minority patients relative to their share of the population—might prove to be more effective.

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More than fifty years have passed since the Civil Rights Act became law in 1964, yet in many ways minority health care in the United States remains separate and unequal.^{1,2} The act achieved singular success in reducing racial disparities in access and in improving outcomes during the 1960s, but the modern challenges to improving minority health care are different than those confronted during the era of de jure segregation. De facto segregation still survives: Roughly 20 percent of US hospitals treat 80 percent of all black Medicare patients with acute myocardial infarction (heart attack), and 40 percent of hospitals treat none of those patients.³ One study estimates that over half of the overall racial disparity in survival after acute myocardial infar-

tion may be attributed to the lower performance of minority-serving hospitals—that is, those that treat a disproportionate number of minority patients relative to their share of the population.⁴ Peter Bach and colleagues have noted that physicians who treat black patients are less likely to be board certified and more likely to lack access to important resources, compared to other physicians.⁵ In addition, the Institute of Medicine has drawn attention to “bias, discrimination and stereotyping”^{6(p2)} that may cause a provider to treat patients differently because of a patient’s race.⁷

The administration of President Barack Obama initiated certain measures to strengthen enforcement of Title VI of the Civil Rights Act, which prohibits discrimination on the basis of race or ethnicity, color, and national origin by all

entities that receive federal financial assistance—including hospitals, nursing homes, and long-term care facilities.^{8,9} The Affordable Care Act (ACA) also attempted to update Title VI to account for the increasing integration between the financing and delivery of health care. Specifically, section 1557 of the ACA clarified that federal civil rights protections against non-discrimination extended to individuals enrolled in Marketplace insurance plans. But many gaps remain in the protection provided by civil rights laws, and the future of the ACA has been uncertain since the November 2016 election.

We explore whether stronger enforcement of historical civil rights laws and expansion of the scope of these laws would be sufficient to improve minority health care today. We pay special attention to how the behavior of practicing physicians is evaluated by the courts.⁶ We also explore solutions outside the legal sector—such as policies that provide more resources to minority-serving providers—and conclude that a combination of the two approaches, with an emphasis on solutions outside the legal arena, would better address the challenge of improving minority health care in the twenty-first century.

The Civil Rights Act

Title VI of the Civil Rights Act is enforced by withholding federal funds from institutions that discriminate against people on the basis of race or ethnicity, color, or national origin. The Civil Rights Act applied to Medicaid *de jure* but not *de facto*, because compliance was left to states—which didn't follow through. Given that Medicare and Medicaid are federal programs, the leverage and scope of Title VI are enormous in principle. The threat of being barred from these programs encouraged more than a thousand hospitals to integrate their facilities. The salutary effect on minority health care was extraordinary: The integration of health care facilities is estimated to have saved the lives of six thousand black infants in the first five years after the Civil Rights Act's passage.^{10,11}

The integration of hospitals and facilities in the 1960s addressed only the most blatant forms of discrimination, however. Other insidious forms remained, including the denial of admitting privileges to black physicians, prepayment requirements for black patients, and the relocation of hospitals from inner cities to predominantly white suburbs.⁶ In lawsuits against hospitals for discriminatory admitting privileges and for prepayment requirements, plaintiffs challenged hospital policies that overtly distinguished between races.¹³ Civil rights lawyers called these “disparate treatment” cases and

were very successful at winning them. In suits involving hospital relocations, however, plaintiffs were challenging not overtly discriminatory behavior, but rather activities that had a “disparate impact” on members of minority groups. Here, litigation was far less successful.

The reason for the success of some lawsuits and the failure of others stems from the manner in which plaintiffs must satisfy their burden-of-proof requirement in civil rights cases. At the start, the plaintiff must present evidence suggesting discrimination. If the defendant (a physician or hospital) can then offer an explanation for the evidence that does not involve discrimination, the plaintiff must convince the court that the explanation is a pretext for discriminatory intent or—in the case of disparate-impact claims—that a reasonable result from the activity in question could have been achieved in a less discriminatory fashion. This can be a difficult challenge for plaintiffs to overcome, especially in the disparate-impact setting.^{12–14}

With disparate-treatment claims, a plaintiff must show (through direct or, more often, indirect statistical evidence) that race formed the basis of the differential treatment, as opposed to some other characteristic of the plaintiff. However, the plaintiff's ability to then show that the defendant's explanation is a pretext for discrimination is made simpler by the fact that the plaintiff has some evidence that, for example, the provider actually treated blacks and whites differently. In contrast, the evidentiary challenges facing plaintiffs in disparate-impact cases are often insurmountable, particularly in cases that involve challenges to hospital relocations. Hospitals in relocation cases often argued that they moved because they were losing money in the inner city, and plaintiffs often lost because they could not show that a hospital actually moved because it wanted to avoid minority patients or that the cost savings and quality improvements sought by the hospital could have been attained through other means. Unfortunately, obstacles to minority patients' receiving adequate health care today more closely resemble those in cases involving disparate impact than those in cases about disparate treatment.¹⁵

Limitations Of Litigation

Given this background, is greater enforcement of existing civil rights laws the solution to improving minority health care? We next discuss the limitations of litigation and point to ways in which litigation might be more successful.

LIMITED SCOPE OF THE LAW As noted above, Title VI of the Civil Rights Act applies to hospitals, nursing homes, and long-term care facilities

ties. Importantly, it does not apply to physicians, because Medicare Part B payments to physicians were not classified as federal financial assistance. Physicians receiving Medicaid payments were not specifically exempted in the act, but the prevailing opinion has been that physicians paid by either Medicaid or Medicare are not covered by the law.

Around the time that Medicaid and Medicare were enacted in 1965, this omission was minor. Even in 1970, physician and outpatient care accounted for only 5.4 percent of spending on personal health care services. By 2010, however, they accounted for 40 percent of personal health spending.¹⁶

Although the language of section 1557 of the ACA is vague, it suggests that civil rights protection under Title VI now extends to Medicaid and to Marketplace plans and other entities set up by the ACA—including Medicaid-related entities, such as state Medicaid agencies and Medicaid physicians.¹⁷ The 2016 implementing rule issued by the Department of Health and Human Services indicated that Medicare Part B payments to physicians would still not be considered federal financial assistance.¹⁸ Moreover, repeal and replacement of the ACA could make the additional authorities gained under section 1557 moot. This gap in legal coverage means that a minority patient who is a reasonable candidate for, say, an angioplasty but does not receive one for potentially discriminatory reasons can sue the hospital but not the physician—if he or she was providing care under Medicare Part B. This gap is routinely ignored in the large public health literature on racial disparities, which presupposes that the Civil Rights Act covers care delivered by physicians and that all that is required is greater enforcement.

A natural solution would be for the administration of President Donald Trump to expand Title VI or section 1557 to include physician services by defining physician payments as federal financial assistance subject to civil rights regulation. This could be accomplished through an executive order or agency regulation and would not require the support of Congress. However, the Trump administration does not appear likely to make the change, at least in the near future. Simply expanding the scope of Title VI to cover physicians would not eliminate the evidentiary obstacles discussed above, but at the very least, it would allow plaintiffs to challenge the disparate treatment of physicians.

THE GEOGRAPHY OF HEALTH CARE Title VI also cannot address the root causes of health care inequality. The disparate medical treatment of minority patients is, to a large extent, the product of geography. Black and white patients tend

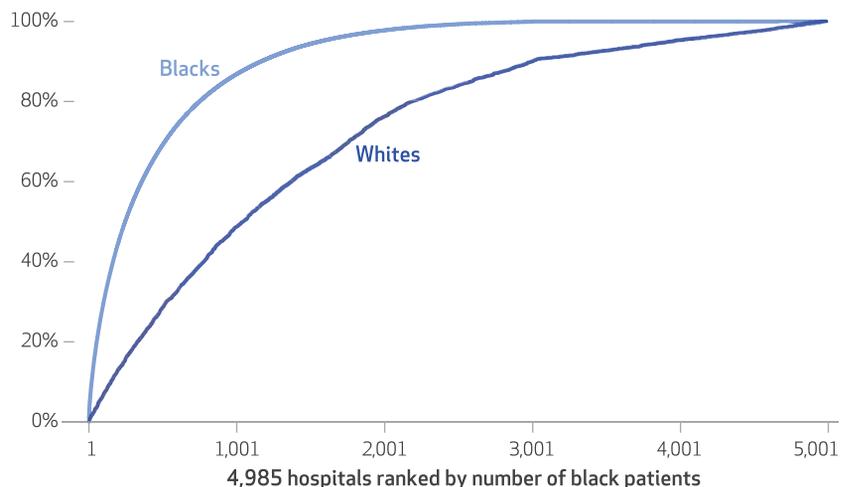
to be treated by different hospitals and physicians even for a common condition such as acute myocardial infarction (Exhibits 1 and 2). The exhibits update an earlier analysis,³ using more recent Medicare hospital data for the period 2005–13 and including an additional analysis at the physician level. As the steepness of the curves for black patients in the exhibits shows, hospital admissions and physician visits for black patients are largely concentrated among a modest number of hospitals and physicians, while the plateau of the curves near the 100 percent mark relatively close to the left side of the exhibits suggests that many hospitals and physicians serve predominantly white patients.

The fact that minority patients and white patients are treated by different providers is unsurprising, given the concentration of black populations in the southeastern United States and in highly segregated cities. But minority-serving hospitals have also been shown to have lower performance on standard Hospital Compare metrics.¹⁹ Minorities are also disproportionately treated by lower-quality providers in the outpatient setting—for example, for diabetes.²⁰

Title VI is ill suited to address these problems. First, it makes discrimination illegal only within a hospital or certain other facilities, such as nursing homes, and it cannot be used to challenge the quality of care at a minority-serving hospital that fails to perform at the same level as non-minority-serving hospitals. Second, as discussed above,

EXHIBIT 1

Cumulative percentages of black and white fee-for-service Medicare beneficiaries, by hospitals' black-patient volume, 2005–13

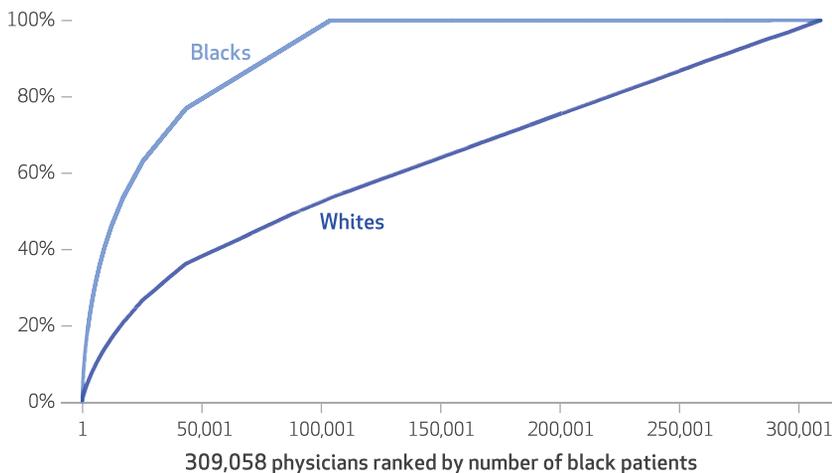


SOURCE Updated from Barnato AE et al. Hospital-level racial disparities in acute myocardial infarction treatment and outcomes (Note 3 in text), using Medicare discharge data for the period 2005–13.

NOTES Hospitals on the x axis are ranked in descending order of number of black acute myocardial infarction patients treated. The first hospital represented on that axis treated the most black patients; the last hospital treated the fewest.

EXHIBIT 2

Cumulative percentages of black and white fee-for-service Medicare beneficiaries, by physicians' black-patient volume, 2005-13



SOURCE Updated from Barnato AE et al. Hospital-level racial disparities in acute myocardial infarction treatment and outcomes (Note 3 in text), using Medicare discharge data for the period 2005-13 analyzed at the physician level. **NOTES** Treatment within thirty days of the index hospitalization is for any reason. Physicians on the x axis are ranked in descending order of number of black acute myocardial infarction patients treated. The first physician represented on that axis treated the most black patients; the last physician treated the fewest.

Title VI has limited power to force hospitals to serve minority neighborhoods. Title VI cannot improve the quality of hospitals that remain in inner cities, let alone improve the quality of care in the Deep South relative to that in higher-performing regions.

PENALTIES AND PERFORMANCE IMPROVEMENT

If a hospital violates the Civil Rights Act, the penalty of barring it from receiving federal funds is rarely enforced, and for good reason. Doing so could leave inadequately funded minority-serving hospitals with even fewer funds and adversely affect the quality of care received by all patients who are treated at such facilities, regardless of race or ethnicity. A more common penalty is an injunction that requires the hospital to reform its practices, pay a fine, or offer a financial settlement. For instance, plaintiffs with limited English proficiency have successfully secured settlements from hospitals with inadequate Spanish and other foreign-language services.²¹ Unfortunately, many of these facilities were unable to secure the funding to implement the reforms they promised to make in those settlements, in part because neither Medicare nor private insurance pays for interpretation and translation, and only a handful of Medicaid programs do.²² Thus, greater enforcement of Title VI may prove to be less transformative and more punitive than commonly believed.

PRIVATE SUITS AND COMPENSATION The US Supreme Court has limited minority access to

the protection of Title VI by preventing minority patients from suing providers directly. A 2001 decision, *Alexander v. Sandoval*, barred private individuals from filing disparate-impact lawsuits under Title VI. According to this decision, only the federal government has authority to litigate such cases. The rule of the Department of Health and Human Services (HHS) implementing section 1557(a) of the ACA appears to have reversed this Supreme Court ruling by providing a private right of action for disparate-impact claims.¹⁷ Of course, should section 1557 be eliminated in efforts to repeal and replace the law, individuals would once again not be able to bring these cases.

Private individuals can address their complaints to the HHS Office of Civil Rights, which monitors Title VI compliance and can initiate a lawsuit. However, the Office of Civil Rights is notoriously underresourced and can pursue only a fraction of cases.

Even when minority patients are permitted to bring Title VI suits, either through HHS or under section 1557 of the ACA, they are often unable to obtain compensation for the wrongs they have suffered. According to the Supreme Court's 1983 decision in *Guardians Association v. Civil Service Commission of the City of New York*, plaintiffs can obtain monetary damages under Title VI only if they can prove that they suffered intentional discrimination. However, many researchers believe that intentional discrimination is uncommon relative to the potential for implicit discrimination (of the type measured by an Implicit Association Test). Despite considerable academic research on implicit discrimination, encountering it does not make a patient eligible for compensation.^{23,24}

To compensate for these limitations and uncertainties in the private enforcement (that is, individuals bringing lawsuits) of Title VI, the Trump administration could increase funding for the HHS Office for Civil Rights so that it could bring more Title VI suits. Such suits, possibly initiated by Centers for Medicare and Medicaid Services (CMS) pilot programs that permit evaluation, could be directed toward hospital systems that put more resources into hospitals located in majority-white areas rather than majority-black areas. In addition, Congress could protect private enforcement efforts by retaining section 1557 even if it repeals other provisions of the ACA.

Congress could also broaden the scope of remedies available to wronged patients under Title VI. Specifically, it could authorize monetary compensation even in cases of implicit discrimination, including disparate-impact cases. Even if cases brought against physicians are difficult to

The disparate medical treatment of minority patients is, to a large extent, the product of geography.

win, the threat of litigation might increase diligence and reduce disparities caused by implicit discrimination. As with the penalty of withholding federal funds, care must be taken to avoid having lawsuits merely further burden under-resourced minority-serving health care providers.

Renewed Department Of Justice Enforcement

In July 2014 the Department of Justice announced a new initiative geared toward revamping Title VI enforcement.⁹ This initiative launched new Title VI training programs; created new channels of communication and coordination among relevant agencies; and expressed the department's heightened expectation that agencies would pursue litigation against hospitals, should efforts to secure voluntary compliance fail. It remains to be seen whether this initiative has improved compliance with the Civil Rights Act. It also remains to be seen whether such efforts will continue in the Trump administration.

Solutions Based Outside The Law

Complementary solutions based outside the law also hold promise for improving minority health care. The ACA's expansion of health insurance coverage disproportionately helps minority patients, who are disproportionately likely to be uninsured: Before passage of the ACA, the uninsured rate was 12 percent for non-Hispanic whites, 21 percent for non-Hispanic blacks, and 31 percent for Hispanics.²⁵ Marketplace insurance plans grant newly insured patients access to a wider network of providers than they were able to access without insurance. Moreover, the ACA's efforts to improve the quality of care—through accountable care organizations and alternative payment models—might disproportionately help patients who are being cared for by lower-quality providers, potentially curbing

the separate and unequal character of minority health care. Of course, repealing the coverage expansion provisions of the ACA could undermine much of this progress.

However, the ACA is not a panacea for eliminating racial disparities in health care. The majority of its insurance expansions come from its expansion of eligibility for the Medicaid program, but several states have chosen not to participate in that expansion. That decision disproportionately hurts members of minority groups because of their overrepresentation in lower-income groups and the populations of non-expanding states.²⁶ In addition, Medicaid offers smaller provider networks than Marketplace plans do, which could limit patient choice. Finally, while the ACA's insurance expansions provide members of minority groups with increased access to medical providers that previously served a richer, predominantly white population, patients' choice of providers remains predominantly determined by geography—that is, by the geographic distance between a provider's location and a patient's residence.

Another way to improve minority health care would be to improve the quality of care delivered by minority-serving providers. A first step could be creating report cards on disparities, with the goal of reducing disparities by relying on market learning by patients, providers, and payers.²⁷ For such report cards to be effective, they would have to measure how the same provider treated patients of different races, as opposed to reporting state- or county-level disparities in care. The latter approach confuses disparities in care with differences in where care is received. In addition, the substantial statistical challenges of robustly measuring relevant treatment rates at smaller providers would have to be addressed. A cottage-industry effort has built and is continuing to build such report cards, but their effect remains unknown. Policy makers would be wise to ascertain their effect before endorsing the use of report cards, as opposed to naively assuming that simply measuring disparities will change outcomes.¹⁹

Health services researchers, too, can play a critical role here, by moving away from a business model in which one applies for grants to document disparities to a model in which one actually evaluates what works to reduce disparities.

Report cards, which are by themselves passive, could be strengthened by active quality improvement efforts targeted at minority-serving providers. As an example, a government agency such as CMS could provide resources to elevate the performance of the twenty largest minority-serving hospitals, which are responsible for over

10 percent of all hospital discharges of black patients (a fact that is evident in Exhibit 1). This assistance would help both black and other patients treated at these hospitals, but it would disproportionately help black patients in the general population. Assistance does not have to be solely financial, but financial assistance is necessary for these hospitals to hire better physicians and purchase equipment. Such efforts are similar to those of the environmental justice movement, where the focus is on improving communities as defined by geography or race, instead of on improving outcomes for an individual.

Unfortunately, the ACA reduced disproportionate-share hospital (DSH) payments, which are additional funds allocated to hospitals that treat a large number of Medicaid and indigent patients. The rationale for the reduction was that the ACA's insurance expansion meant that such programs were not needed.

One might object that throwing money at the problem will not improve patient outcomes. However, experience with the DSH program to date gives us reason to be optimistic. There is evidence showing that the program significantly improves outcomes in neonatal health and for acute myocardial infarction patients.²⁸ The key here is not simply to increase federal DSH funding, but to ensure that state governments don't reduce their funding of minority-serving hospitals as a result. For an additional level of surety against waste, HHS could offer hospitals grants to improve outcomes or implement reforms. In contrast to the lackluster performance of pay-for-performance in health care more generally, there is evidence that pay-for-performance initiatives significantly improve the performance of hospitals that serve indigent populations.²⁹

A final non-litigation-based solution to reducing discrimination and improving minority health care would be to invest in programs that reduce implicit bias, acknowledging that the science of tracing such bias to actual treatment decisions and then reducing it is far from established. Minority-serving accountable care organizations might have strong incentives to create and evaluate such programs. Once again, however, we caution that it remains unknown whether simply measuring disparities will lead to reductions in them.

A Combined Approach

To reduce discrimination within the health care system, the choice between litigation and other strategies is a difficult one. Neither option is obviously superior to the other. As hospitals employ more physicians and consolidate with downstream providers such as nursing homes and long-term care facilities, they become responsible for a larger portion of total care, which increases the benefits of litigation directed at hospitals. Some legal solutions (such as expanding the scope of the Civil Rights Act to cover all physician services) do not require congressional approval, which is important given that body's recent paralysis. But litigation remains inherently uncertain, slow, and costly. In addition, allowing minority-serving hospitals to be sued may weaken those providers' already precarious financial situation. Any effort to reform the law would face opposition from provider groups that are unlikely to accept greater scrutiny of their practices, especially at a time when physicians are beleaguered by cuts in Medicare fees, health information technology implementation, and malpractice litigation.³⁰ Despite these concerns, strengthening the Civil Rights Act might improve minority health care by bolstering minority patients' trust in the health care system, increasing physicians' diligence, and as a result increasing the patients' willingness to seek care.

A different set of problems affects solutions outside the legal arena. They cost money, and the current focus on bending the cost curve has had a chilling effect on all increases in health care spending. Yet they are associated with less uncertainty than litigation-based solutions and can be designed in a manner that can be evaluated and scaled up or down depending on their success.

Conclusion

Litigation and other strategies to reduce discrimination and improve health equity are not mutually exclusive. While greater enforcement of existing civil rights legislation offers some promise for improving minority health care, large gains are possible with strategies not based on litigation. What is beyond doubt, however, is that persistent gaps in minority health care remain a civil rights issue. ■

Amitabh Chandra's research was funded in part by the National Institutes of Health. Chandra acknowledges support

from the National Institute on Aging (Grant Nos. P01 AG005842 and P01 AG019783). Anup Malani acknowledges

the support of the Samuel J. Kersten Faculty Fund and the Microsoft Fund at the University of Chicago.

NOTES

- 1 Jha AK, Fisher ES, Li Z, Orav EJ, Epstein AM. Racial trends in the use of major procedures among the elderly. *N Engl J Med*. 2005;353(7):683–91.
- 2 Harper S, Lynch J, Burriss S, Davey Smith G. Trends in the black-white life expectancy gap in the United States, 1983–2003. *JAMA*. 2007;297(11):1224–32.
- 3 Barnato AE, Lucas FL, Staiger D, Wennberg DE, Chandra A. Hospital-level racial disparities in acute myocardial infarction treatment and outcomes. *Med Care*. 2005;43(4):308–19.
- 4 Skinner J, Chandra A, Staiger D, Lee J, McClellan M. Mortality after acute myocardial infarction in hospitals that disproportionately treat black patients. *Circulation*. 2005;112(17):2634–41.
- 5 Bach PB, Pham HH, Schrag D, Tate RC, Hargraves JL. Primary care physicians who treat blacks and whites. *N Engl J Med*. 2004;351(6):575–84.
- 6 Institute of Medicine. *Unequal treatment: confronting racial and ethnic disparities in health care*. Washington (DC): National Academies Press; 2003.
- 7 Green AR, Carney DR, Pallin DJ, Ngo LH, Raymond KL, Iezzoni LI, et al. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *J Gen Intern Med*. 2007;22(9):1231–8.
- 8 King L. Strengthening enforcement of Title VI of the Civil Rights Act of 1964 [Internet]. Washington (DC): Department of Justice; 2009 Jul 10 [cited 2017 May 2]. Available from: <https://www.usbr.gov/cro/pdfsplus/crastrong09.pdf>
- 9 Samuels J. The 50th anniversary of the Civil Rights Act of 1964 and announcement of new government-wide Title VI coordination initiative [Internet]. Washington (DC): Department of Justice; 2014 Jul 24 [cited 2017 May 2]. Available from: https://www.justice.gov/sites/default/files/crt/legacy/2014/07/29/7_24_14_Coordination_Memo_50th_Anniv.pdf
- 10 Smith DB. Racial and ethnic health disparities and the unfinished civil rights agenda. *Health Aff (Millwood)*. 2005;24(2):317–24.
- 11 Almond D Jr, Chay KY, Greenstone M. Civil rights, the war on poverty, and black-white convergence in infant mortality in the rural South and Mississippi. Cambridge (MA): Massachusetts Institute of Technology; 2006 Dec 31. (MIT Department of Economics Working Paper No. 07-04).
- 12 Department of Justice. Title VI legal manual [Internet]. Washington (DC): DOJ; 2001 Jan 11 [cited 2017 May 2]. Available from: <https://www.justice.gov/crt/fcs/Title-6-Manual>
- 13 Rosenbaum S, Markus A, Darnell J. U.S. civil rights policy and access to health care by minority Americans: implications for a changing health care system. *Med Care Res Rev*. 2000;57(1, Suppl 1):236–59.
- 14 McDonnell Douglas Corp. v. Green, 411 US 792 (1973).
- 15 Smith DB. *Health care divided: race and healing a nation*. Ann Arbor (MI): University of Michigan Press; 1999.
- 16 CMS.gov. National health expenditure data: historical [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services. Table 6, Personal health care expenditures; levels, percent change, and percent distribution, by source of funds: selected calendar years 1970–2015; [last modified 2016 Dec 6; cited 2017 May 11]. Available for download from: <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html>
- 17 Department of Health and Human Services. Summary: final rule implementing section 1557 of the Affordable Care Act [Internet]. Washington (DC): HHS; [cited 2017 May 2]. Available from: <https://www.hhs.gov/sites/default/files/2016-06-07-section-1557-final-rule-summary-508.pdf>
- 18 45 CFR, Part 92.
- 19 Chandra A, Skinner JS. Geography and racial health disparities. In: Anderson NB, Bulatao RA, Cohen B, editors. *Critical perspectives on racial and ethnic differences in health in late life*. Washington (DC): National Academies Press; 2004. p. 604–40.
- 20 Bynum JP, Fisher ES, Song Y, Skinner J, Chandra A. Measuring racial disparities in the quality of ambulatory diabetes care. *Med Care*. 2010;48(12):1057–63.
- 21 Perez TE. The civil rights dimension of racial and ethnic disparities in health status. In: Institute of Medicine. *Unequal treatment: confronting racial and ethnic disparities in health care*. Washington (DC): National Academies Press; 2003. p. 626–63.
- 22 Ku L, Flores G. Pay now or pay later: providing interpreter services in health care. *Health Aff (Millwood)*. 2005;24(2):435–44.
- 23 Krieger LH, Fiske ST. Behavioral realism in employment discrimination law: implicit bias and disparate treatment. *California Law Review* [serial on the Internet]. 2006 Jul [cited 2017 May 2]. Available from: <http://scholarship.law.berkeley.edu/cgi/viewcontent.cgi?article=1252&context=california-lawreview>
- 24 Green AR, Carney DR, Pallin DJ, Ngo LH, Raymond KL, Iezzoni LI, et al. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *J Gen Intern Med*. 2007;22(9):1231–8.
- 25 DeNavas-Walt C, Proctor BD, Smith JC. *Income, poverty, and health insurance coverage in the United States: 2010* [Internet]. Washington (DC): Census Bureau; 2011 Sep [cited 2017 May 2]. Available from: <https://www.census.gov/prod/2011pubs/p60-239.pdf>
- 26 Kaiser Commission on Medicaid and the Uninsured. *Health coverage by race and ethnicity: the potential impact of the Affordable Care Act* [Internet]. Washington (DC): The Commission; 2013 Mar [cited 2017 May 2]. Available from: <https://kaiserfamilyfoundation.files.wordpress.com/2014/07/8423-health-coverage-by-race-and-ethnicity.pdf>
- 27 Trivedi AN, Gibbs B, Nsiah-Jefferson L, Ayanian JZ, Prothrow-Stith D. Creating a state minority health policy report card. *Health Aff (Millwood)*. 2005;24(2):388–96.
- 28 Baicker K, Staiger D. Fiscal shenanigans, targeted federal health care funds, and patient mortality. *Q J Econ*. 2005;120(1):345–86.
- 29 Jha AK, Orav EJ, Epstein AM. The effect of financial incentives on hospitals that serve poor patients. *Ann Intern Med*. 2010;153(5):299–306.
- 30 Jena AB, Seabury S, Lakdawalla D, Chandra A. Malpractice risk according to physician specialty. *N Engl J Med*. 2011;365(7):629–36.