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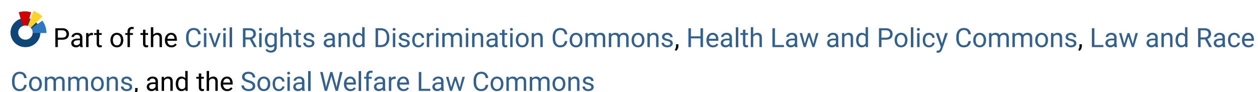
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Striving for the Mountaintop – The Elimination of Health Disparities in a Time of Retrenchment (1968 – 2018)

GWENDOLYN ROBERTS MAJETTE*

ABSTRACT

Health disparities in the United States are real. People of color are the adverse beneficiaries of these facts—lower life expectancy, higher rates of morbidity and mortality, and poorer health outcomes in general. This Article analyzes the laws and policies that improve and create barriers to improving people of color's health since the death of Reverend Martin Luther King, Jr. in 1968. The Article builds upon my earlier scholarship and considers the effectiveness of the "PPACA Framework to Eliminate Health Disparities" since the Patient Protection and Affordable Care Act (PPACA) was enacted in 2010.

The Article also explores the impact of constitutional challenges to the PPACA, President Trump's executive orders, and other regulatory changes on the continued reduction of health care disparities. It analyzes legal retrenchment from the PPACA through Professor Derrick Bell's critical race theory scholarship, in particular his theory of interest convergence. Following the works of Dr. King and Prof. Bell, it proposes a "Mountaintop Solution" to eliminate health disparities for people of color in the United States.

The Mountaintop Solution recognizes the importance of health and human rights norms to protect the rights of marginalized groups. Normatively, the Article argues that the United States should act justly and comply with its treaty obligations under the International Convention on the Elimination of All Forms of Racial Discrimination and the first United States National Action Plan for Responsible Business Conduct. The Article also argues that businesses in the U.S. health care industry should adhere to the United Nations Framework and Guiding Principles for Business and Human Rights in their response to the promulgation of laws designed to undermine the effectiveness of the PPACA. Specifically, the health care industry should engage in health promoting activities that create conditions that will ensure that people of color have the highest level of physical and mental health.

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I. INTRODUCTION – THE MOUNTAINTOP: REVEREND MARTIN LUTHER KING JR.'S ADVICE TO LEADERS

On April 3, 1968, the night before he died, Dr. Martin Luther King, Jr. delivered his *I've Been to the Mountaintop* speech at a church in Memphis, Tennessee.[1] In that speech, he provided advice to three categories of leaders—ministers, government officials, and businesspeople. He described what they should do to end the racial subordination of people of color. He advised the ministers to have a "relevant ministry" that focuses on ensuring that life on earth meets the needs of the congregation—to be able to live lives where they can afford clothing, food, and housing. He advised government leaders at home (mayors and judges) and abroad (leaders of African countries) to abandon the laws that oppress people of color. He also reminded government officials that the legal system, particularly injunctions, should not be used to prevent people from protesting to protect their rights given the First Amendment rights to free speech, association, and assembly. Lastly, he admonished the business leaders to treat people of color fairly with respect to hiring and to affirmatively pressure their local government to treat its colored workers fairly.

Since 1968, the state of race relations has improved in the United States and so has the health status of people of color. Several laws have been passed that create conditions to improve the health of people of color. An important piece of legislation is the Patient Protection and Affordable Care Act of 2010 (PPACA)[2] and its creation of what I call the *PPACA Framework to Eliminate Health Disparities.* Under the *PPACA Framework to Eliminate Health Disparities,* health inequity became a priority issue at the highest level within the United States Department of Health and Human Services; federal health policy shifted to make elimination of health disparities and addressing social determinants of health a priority; insurance coverage was expanded; and steps were taken to begin to monitor social determinants of health and health

1. Martin Luther King, Jr., I've Been to the Mountaintop, Address Delivered at Bishop Charles Mason Temple (Apr. 3, 1968).

2. Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). Subsequent references in this Article to the Patient Protection and Affordable Care Act (PPACA) refer to the Act as amended. Thus, PPACA and ACA are synonymous terms that refer to the amended legislation.

inequity. Unfortunately, the campaign, election, and presidency of Donald Trump has begun to undermine the progress made. Dr. King's 1968 summary of the state of affairs in 1968 is apropos today. He said, "The world is all messed up. The nation is sick, there is trouble in the land, and confusion all around."[3]

This Article will proceed in six parts. Following the introduction, part II identifies the laws and policies that demonstrate progress in promoting the health of people of color since the death of Dr. Martin Luther King, Jr. Part III discusses the positive impact of the "*PPACA Framework to Eliminate Health Disparities*" since PPACA was enacted in 2010. Part IV provides context exemplifying the deteriorating race relations in 2017 and 2018. This section also discusses the retraction of rights by analyzing the constitutional challenges to the PPACA and President Trump's executive orders and regulatory changes on the continued reduction of health care disparities through the critical race theory scholarship of Professor Derrick Bell, in particular his theory of interest convergence. Part V concludes the article by recommending a Mountaintop Solution to further reduce health care disparities for people of color in the United States. The Mountaintop Solution seeks to achieve the following: (1) provide a message to Christian leaders, Evangelicals, and the Religious Right; (2) create a just United States government at the federal level based on human rights treaty obligations and commitments under the International Convention on the Elimination of all Forms of Racial Discrimination (ICERD) and the first U.S. National Action Plan for Responsible Business Conduct; and (3) encourage businesses in the U.S. health care industry to engage in health-promoting behavior that is consistent with the PPACA by complying with the United Nations Framework for Business and Human Rights and the United Nations Guiding Principles for Business and Human Rights.

II. PROGRESS IN PROMOTING THE HEALTH OF PEOPLE OF COLOR

In 1968, when Dr. King made his *I've been to the Mountaintop* speech, African American infants were 1.9 times more likely to die at birth than White infants. While infant mortality for African American infants has improved over the last 50 years from 34.9 deaths per 1,000 live births in 1968 to 11.4 deaths per 1,000 live births in 2018, in relative terms, African Americans have fallen behind. "Today, the rate is 2.3 times higher for African-American" infants compared to White infants. The infant mortality rate for white infants has fallen from 18.8 to 4.9 deaths per 1,000 live births.[4] There has also been significant progress with respect to life expectancy. African Americans' life expectancy at birth has increased from 64 years in 1968 to 75.5 in 2018. In contrast, White life expectancy has improved from 71.5 years to 79 years in 2018. This means that an African American in 2018 will still on average

3. King, *supra* note 1.

4. Janelle Jones, John Schmitt & Valerie Wilson, *50 Years after the Kerner Commission: African Americans Are Better Off in Many Ways but Are Still Disadvantaged by Racial Inequality*, ECON. POL'Y INST. (Feb. 26, 2018), https://www.epi.org/publication/50-years-after-the-kerner-commission [https://perma.cc/ZZ3R-WUJM].

live 3.5 fewer years than a White person.[5] In 1968, the maternal mortality rate was 16.6 deaths per 100,000 live births for White women and 63.6 per 100,000 live births for "all other[s]."[6] Thus women of color were 3.8 times more likely to die from childbirth than White women. In 2018, African American women had the highest maternal mortality rate at 47.2 in contrast to the rate for white women, which was 18.1.[7]

There are several laws and significant health care policies that have improved the health of people of color and helped to reduce health care disparities. Three major laws were passed while Dr. King was alive—Title VI of the Civil Rights Act of 1964, Medicare, and Medicaid. Title VI provides that "no person shall on the grounds 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 [that receives] federal financial assistance."[8] Title VI thus prevents discrimination in the provision of health care services by health care providers and facilities. Medicare and Medicaid were passed in 1965. These federal programs in general provide health care financing to the elderly (age 65 and older) and poor.[9] Passage of these laws improved access to care for people of color by helping them pay for medical care and also helped to desegregate hospitals across the United States.[10]

Since Dr. King's death in 1968, the following laws and policies have been implemented to improve the health of people of color:

- Report of the Secretary's Task Force on Black and Minority Health (Heckler Report) (1985)[11]
- Health and Human Services creates the Office of Minority Health (1986)[12]

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5. *Id.*

6. HEALTH SERVS. & MENTAL HEALTH ADMIN., NAT'L CTR. HEALTH STATS., U.S. DEP'T HEALTH, EDUC. & WELFARE, VITAL STATISTICS OF THE UNITED STATES, 1968, VOLUME II – MORTALITY, PART A, SECTION 1 – GENERAL MORTALITY, page 1-52, TABLE 1–17, MATERNAL MORTALITY RATES BY COLOR: BIRTH-REGISTRATION STATES OR UNITED STATES, 1915-68 (1972), https://www.cdc.gov/nchs/data/vsus/mort68_2b.pdf [https://perma.cc/WGR7-PS7A].

7. AMERICA'S HEALTH RANKINGS, *Subpopulations: Maternal Mortality, United States, Race/Ethnicity* (2018), https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality_a/population/maternal_mortality_a_aian/state/ALL [https://perma.cc/AXX2-4F2U]. The maternal mortality rate for American Indian/Alaska Native women is also high at 38.8. Hispanics and Asian Pacific Islanders have lower rates of maternal mortality, 12.2 and 11.6 respectively. *Id.*

8. 42 U.S.C.A. § 2000(d) (Westlaw through Pub. L. No. 116-5).

9. 42 U.S.C.A. § 1395 (Westlaw through Pub. L. No. 116-5); 42 USC § 1396 (Westlaw through Pub. L. No. 116-5).

10. Gwendolyn Roberts Majette, *Global Health Law Norms – A Coherent Framework to Understand PPACA's Approach to Eliminate Health Disparities and Address Implementation Challenges*, *in* LAW AND GLOBAL HEALTH – CURRENT LEGAL ISSUES 441 (2014) [hereinafter LAW AND GLOBAL HEALTH].

11. Howard K. Koh et al., *Reducing Racial and Ethnic Disparities: The Action Plan from the Department of Health and Human Services*, 30 HEALTH AFF. 1822, 1822 (2011).

12. "The mission of this office is to improve the health of racial and ethnic minorities through the development of health policies and programs that will eliminate health disparities." U.S. DEP'T HEALTH & HUM. SERVS., OFF. MINORITY HEALTH, REPORT TO CONGRESS ON MINORITY HEALTH ACTIVITIES FOR FISCAL YEARS 2013 AND 2014 12 (2015) [hereinafter 2015 REPORT TO CONGRESS ON MINORITY HEALTH ACTIVITIES FY 2013 & 2014].

- Presidential Initiative to Eliminate Racial and Ethnic Disparities in Health (1998)
- Congressional Funding for an Institute of Medicine study reporting on the Prevalence and Impact of Racial and Ethnic Bias (1999)
- Title VI of the Civil Rights Act of 1964, Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency (Health and Human Services 2000)
- National Standards for Culturally and Linguistically Appropriate Services (CLAS) (2000)[13]
- Institute of Medicine Report Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2003)
- Patient Protection and Affordable Care Act 2010 (PPACA)
- HHS Plan to Eliminate Health Care Disparities (April 2011)[14]
- National Partnership for Action - National Stakeholder Strategy for Achieving Health Equity (2011)[15]
- Secretary Sebelius of the US Department of Health and Human Services speaks at the 2011 World Health Organization's World Conference on Social Determinants of Health[16]
- PPACA Section 1557 Final Rule – Nondiscrimination in Health Programs and Activities (2016)[17]

These laws and policies begin to recognize the significant health and health care disparities for people of color and the conditions creating that poor health. Some of those conditions were laws and policies that legalized and promoted discrimination in the receipt and payment for quality health care, and other areas that impact health such as education, housing, and employment. The laws and policies also begin to recognize the need for structural changes to the laws themselves and to the health and

13. The CLAS Standards were developed for individual providers and health care organizations to help ensure that individuals/patients receive equitable and effective treatment that is culturally and linguistically appropriate. U.S. DEP'T HEALTH & HUM. SERVS., OFF. MINORITY HEALTH, NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE: FINAL REP. 3 (2001), https://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf [https://perma.cc/6DP8-T68P]. The CLAS Standards were revised in 2013. U.S. DEP'T HEALTH & HUM. SERVS., *Health Equity Timeline*, https://thinkculturalhealth.hhs.gov/clas/health-equity-timeline [https://perma.cc/UMC4-WNCJ] (last visited Aug. 1, 2020).

14. This department wide initiative was designed to move the US to be a nation free of disparities in health and health care.

15. This was an initiative of the Office of Minority Health and the private sector. It is a comprehensive, "collaborative effort between the government, civil society, and private business to reduce health disparities and improve the health of the nation and its most vulnerable citizens." Majette, LAW AND GLOBAL HEALTH, *supra* note 10, at 448.

16. Secretary Sebelius' participation in the conference is important from a social learning theory perspective. Social learning theory "recognizes the process of interaction and deliberation among political leaders, thought leaders, and ordinary citizens as a mechanism to create or confirm societal and political support for action." Secretary Sebelius' participation, the US service on the WHO conference advisory planning group, and submission of case studies reinforces the idea that equity is an important tool nationally and globally to eliminate health disparities. Majette, LAW AND GLOBAL HEALTH, *supra* note 10, at 449.

17. The HHS, Office of Civil Rights issued the final rule. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31375 (May 18, 2016) (codified at 45 C.F.R. pt. 92).

welfare agencies to focus their attention on eliminating health disparities for people of color. The legal shift to focus on eliminating health disparities continued with passage of the Patient Protection and Affordable Care Act in 2010.

III. IMPACT OF THE PPACA FRAMEWORK TO ELIMINATE HEALTH DISPARITIES

In an earlier work, I argued that PPACA constituted framework legislation to eliminate health disparities for people of color.[18] This conclusion was based on viewing the ACA through the lens of global health law norms. And in particular, Professor Larry Gostin's and Allyn Taylor's definition of global health law, which is the norms, processes, and institutions designed to create conditions so that people throughout the world can attain the highest level of physical and mental health.[19] That earlier work identified the global health law norms that imposed an obligation on the United States to eliminate health disparities for people of color.[20] I also identified *"the PPACA Framework to Eliminate Health Disparities"* by explaining how PPACA constituted framework legislation.

A. PPACA Framework – PPACA constitutes Framework Legislation to eliminate health care disparities

Framework legislation is a human rights concept. It describes a law that operationalizes a national strategy that is designed to ensure equal access to health care facilities, goods, and services for everyone in the country.[21] PPACA constitutes framework legislation, because it shifts the United States health care system to make health and health inequity a priority at the highest levels of government through the creation of a Deputy Assistant Secretary for Minority Health and six minority health offices within Health and Human Services (HHS). Also, government policy for the health sector begins to focus on disparities and social determinants of health. Examples include requiring the creation of a national quality strategy and a national prevention strategy. PPACA takes a multi-sectoral approach to health (health-in-all-policies), through entities like the National Prevention, Health Promotion and Public Health Council, and the Federal Interagency Health Equity Team. Universal coverage is a priority and achieved through the creation of state insurance exchanges, the expansion of Medicaid to individuals below 135% of poverty,

18. Gwendolyn Roberts Majette, *Global Health Law Norms and the PPACA Framework to Eliminate Health Disparities*, 55 HOW. L.J. 887 (Spring 2012) [hereinafter *PPACA Framework*].

19. *Id.*

20. *Id.*

21. For example, General Comment 14: The Right to the Highest Attainable Standard of Health, is the seminal interpretive document for the International Covenant on Economic, Social and Cultural Rights (ICESCR) explicating the meaning of the right to health. International Covenant on Economic, Social and Cultural Rights General Comment 14, Dec. 16, 1966, 1966 U.S.T. 521, 993 U.N.T.S. 3 [hereinafter ICESCR]. ICESCR has the most comprehensive right to health provision among human rights treaties. General Comment 14 requires governments that have ratified ICESCR to implement a national strategy to ensure equal access to health care and it urges countries to operationalize the strategy through a framework law. The United States has signed, but not ratified ICESCR. Majette, *PPACA Framework*, *supra* note 18, at 910.

and insurance market reforms.[22] Structures are created to monitor the reduction of health disparities and health inequity. An emphasis is also made to improve the quality of care provided in health care generally and for people of color through entities like the Agency for Healthcare Research and Quality (AHRQ) and the Patient Centered Outcomes Research Institute (PCORI).[23] PCORI is authorized to seek data to help with disparities in health care delivery and patient outcomes.

B. Effectiveness of the Framework to Eliminate Health Care Disparities – Assessing health outcomes

The *PPACA Framework to Eliminate Health Disparities* is effective. Consistent with the *PPACA Framework to Eliminate Health Disparities*, health and health inequity was a priority at the highest levels of the Department of Health and Human Services. Structural changes were made as required by the PPACA Sec. 10334. As of 2015, all of the Offices of Minority Health were created within the six HHS Agencies (Center for Medicare and Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), Agency for Healthcare Research and Quality (AHRQ), Health Resources Services Administration (HRSA), and Substance Abuse and Mental Health Services Administration (SAMHSA)).[24] In addition, the National Institute on Minority Health and Health Disparities (NIMHD) was elevated from being a center inside the National Institute of Health (NIH).[25]

1. Government Health Policy – Focuses on Health Care Disparities

a. CMS – Center for Medicare and Medicaid Services

CMS sought to transform health care financed through Medicare, Medicaid, and CHIP by focusing on reducing disparities in health insurance coverage; providing access to care, especially primary care and care coordination; and reducing disparities in the quality of health care.[26] Some examples include the *Improving Cardiovascular Health and Reducing Cardiac Disparities program.* Here, quality improvement organizations work with clinical providers and beneficiaries in collaboration with partners and stakeholders to improve the cardiovascular health of racial and ethnic beneficiaries of the Million Heart initiative.[27] The program sought to reduce one million heart attacks and strokes by 2017. The program focused on Medicare and dually eligible African American, Hispanic, Latino, Asian, and Pacific Islander beneficiaries.[28] A 2017 CMS report estimated that half a million events may have been prevented

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22. Majette, *PPACA Framework*, *supra* note 18, at 911–23.
23. *Id.* at 924.
24. 2015 REPORT TO CONGRESS ON MINORITY HEALTH ACTIVITIES FY 2013 & 2014, *supra* note 12, at 2.
25. *Id.*
26. *Id.* at 38.
27. *Id.* at 39.
28. *Id.*

from 2012 – 2016.[29] Another initiative is the Partnership for Patients (Hospital Engagement Network – "HEN Contracts"). This program encourages hospital networks to adopt effective quality improvement approaches to reduce disparities in patient health outcomes and readmissions. This is done through contract terms. In 2013, the Hospital Engagement Network required hospitals to adopt approaches such as use of the Culturally and Linguistically Appropriate Services (CLAS) Standards, patient data collection standardization, the use of data to identify disparities in patient outcomes, and leadership engagement. Partnership for Patients also created an internal Health Equity Team.[30]

Additionally, in 2015, the CMS Office of Minority Health published *The CMS Equity Plan for Improving Quality in Medicare*. Three of the six plan priorities are especially relevant. The first priority is to "expand the collection, reporting, and analysis of standardized data."[31] The second priority is to "evaluate disparities' impact and integrate equity solutions across CMS programs."[32] The third priority is to "develop and disseminate promising approaches to reduce health disparities."[33] The plan also acknowledged that CMS did not have a consistent way to assess the Medicare programs' impact on health equity and that its future goal was to gain a better understanding and not exacerbate disparities with new programs.[34]

During 2015, CMS worked with awardees of the Quality Innovation Networks—Quality Improvement Organizations, HENs, and Transforming Clinical Practice Initiative on identifying the requirements to address health disparities in their scope of work agreements.[35] Additionally, health equity was added as a clinical practice improvement activity of the Merit-based Incentive Payment System.[36] CMS also worked with the Center for Medicare and Medicaid Innovation (CMMI) on several demonstration models to incorporate health equity assessment. For example, in the Accountable Health Community Model application package, applicants were assessed on their health equity resources and the model was designed to consider social determinants of health. The CMS Office of Minority Health also worked with several CMMI teams (Health Care Innovation, Population Health, and Accountable Care) to build a health equity lens into their model designs.[37] CMS also completed a

29. CTRS. MEDICARE & MEDICAID SERVS., MILLION HEARTS: MEANINGFUL PROGRESS 2012-2016, A FINAL REPORT (May 2017), https://millionhearts.hhs.gov/files/MH-meaningful-progress.pdf [https://perma.cc/SKA7-XU66]. The final report was scheduled to be published in 2019 when the necessary data was available, but it has not yet been published.

30. 2015 REPORT TO CONGRESS ON MINORITY HEALTH ACTIVITIES FY 2013 & 2014, *supra* note 12, at 39.

31. CTRS. MEDICARE & MEDICAID SERVS., OFF. MINORITY HEALTH, THE CMS EQUITY PLAN FOR IMPROVING QUALITY IN MEDICARE 2 (2015), https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf [https://perma.cc/E7KW-H4YC].

32. *Id.*

33. *Id.* The other priorities include increasing the ability of the health care workforce to meet the needs of vulnerable populations; improving communication and language access for individuals with limited English proficiency and persons with disabilities; and increasing the physical accessibility of health care facilities.

34. *Id.* at 9.

35. *Id.* at 7.

36. *Id.* at 6.

37. *Id.*

Mapping Medicare Disparities Tool based on fee-for-service data for nineteen chronic diseases. The interactive map displays disparities based on prevalence, utilization, and costs by race, ethnicity, sex, and disability. CMS also established a CMS Technical Assistance team for Health Equity to help health care providers implement health equity initiatives.[38]

Between 2013 and 2015, CMS began efforts to develop CLAS measures and refine existing data sets for health plans and systems and explore disparities in quality. The office also began an important project, the Stratified Analysis and Reporting of Racial and Ethnic Disparities. The project "focus[ed] on analysis, reporting, display, and dissemination of existing Medicare Healthcare Effectiveness Data and Information Set [HEDIS] and the Consumer Assessment of Healthcare Providers and Systems [CAHPS] quality measures stratified by race and ethnicity."[39] This initiative will help CMS, stakeholders, and partners target quality improvement activities, monitor plan performance, and advance culturally and linguistically appropriate quality improvement interventions and strategies.[40] In 2015, data was released for Medicare Part C and D at the contract level for Medicare Advantage Plans.

b. AHRQ – Agency for Healthcare Research and Quality

In addition to establishing an office of minority health within AHRQ, AHRQ has established a Minority Health Network across the agency composed of experts on minority health to ensure consideration of minority health issues in research, programming, and budgets. AHRQ also conducts and supports research to inform disparities reduction initiatives.[41] A recent primary care initiative is the personalized health care approach to treat patients at federally qualified health centers that suffer from daily headaches. "Personalized health care is a coordinated, strategic approach to patient care that broadly applies the concepts of systems biology and P4 medicine (personalized, predictive, preventive, and participatory care)."[42] Another initiative is a study with Wayne State University on the use of Text Messaging to Improve Hypertension Medication Adherence in African Americans. This study targets African Americans, racial and ethnic minorities, and the elderly throughout Michigan. A final example is the Virtual Patient for Improving Quality of Care in Primary Healthcare study. This partnership with Massachusetts General Hospital will use computer simulations to help train health care providers to accurately diagnose and treat patients from traumatized refugee, disadvantaged, and racial and ethnic minority populations.[43]

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38. *Id.* at 4.
39. 2015 REPORT TO CONGRESS ON MINORITY HEALTH ACTIVITIES FY 2013 & 2014, *supra* note 12, at 41.
40. *Id.*; THE CMS EQUITY PLAN FOR IMPROVING QUALITY IN MEDICARE: ACCOMPLISHMENTS REPORT, *supra* note 31, at 4, 12.
41. 2015 REPORT TO CONGRESS ON MINORITY HEALTH ACTIVITIES FY 2013 & 2014, *supra* note 12, at 30.
42. *Id.*
43. *Id.*

AHRQ – National Healthcare Quality and National Health Disparities Report.

One of the most significant disparities reduction tools is the Agency for Healthcare Research and Quality's (AHRQ) publication of the National Healthcare Quality and National Health Disparities report since 2003 and the combined report since 2013. The annual report measures trends in disparities and the components of quality: effectiveness of care, patient safety, timeliness of care, patient-centeredness, and efficiency of care. In 2014, the report concluded that "the nation had made clear progress in improving the health care delivery system to achieve the three aims of better care, smarter spending, and healthier people."[44] However, the report also noted that there is more work to do to address disparities in care because "few disparities were eliminated, and many challenges remain to improve quality and reduce disparities."[45] In 2015, AHRQ incorporated the National Quality Strategy update in the report.[46] The 2015 report addressed access, quality, and disparities. The most significant improvement occurred with respect to access to health care which improved dramatically due to the coverage provisions of the PPACA.[47] Not only did individuals secure coverage, but their access to a usual source of medical care improved. With respect to the priorities in the National Quality Strategy, measures improved for overall performance, but wide variation remains. However, challenges remain for care coordination. Additionally, while patient safety, person-centered care, and healthy living have improved, few disparities have been reduced. The report specifically notes that "disparities persist with respect to race and social economic status among measures of access and all National Quality Strategy priorities, despite progress in some areas."[48] The 2016 Healthcare Quality and Disparities report concludes that "while 20% of measures show disparities getting smaller for Blacks and Hispanics, most disparities have not changed significantly for any racial and ethnic group."[49] Unfortunately, the most recent National Healthcare Quality and Disparity

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44. AGENCY HEALTHCARE RSCH. & QUALITY, 2014 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT 2 (May 2015), https://archive.ahrq.gov/research/findings/nhqrdr/nhqdr14/2014nhqdr.pdf [https://perma.cc/5GKE-XCX3].

45. *Id.*

46. AGENCY HEALTHCARE RSCH. & QUALITY, 2015 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT AND 5TH ANNIVERSARY UPDATE ON THE NATIONAL QUALITY STRATEGY (2016), https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/nhqdr15/2015nhqdr.pdf [https://perma.cc/P34M-9FCW] [hereinafter 2015 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT].

47. *Id.* at v.

48. *Id.* Areas of progress for reduction of disparities for people of color include measures regarding access to insurance and having a usual source of care. *Id.* at 6-7. For patient safety, effective treatment, and healthy living priorities, the disparities were present for 30% of the measures. In contrast, disparities existed for 60% of the care coordination and person-centered care measures. *Id.* at 11.

49. AGENCY HEALTHCARE RSCH. & QUALITY, 2016 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT 1, 23 (Oct. 2017), https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/nhqdr16/final2016qdr-cx.pdf [https://perma.cc/2F24-2555] [hereinafter 2016 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT]. Quality of care in the United States is continuing to improve with respect to the National Quality Strategy priorities. Of the 250 measures, person-centered care measures improved 80%, two-thirds of the patient safety measures improved, 60% of the healthy living measures improved, more than 50% of the effective treatment measures improved, 50% of the care coordination measures improved, and 70% of the care affordability measures improved. *Id.* at 1.

Report for 2017 continues to show disparities for people of color. "Overall some disparities were getting smaller from 2000 through 2015, but disparities persist."[50]

c. National Prevention, Health Promotion & Public Health Council, Strategy, & Fund

In 2011, the prevention strategy was released, and one priority is eliminating racial and ethnic disparities.[51] Numerous health care providers and facilities received funding from the PPACA to expand public health capacity: Federally Qualified Health Centers, state Health Clinics, and the National Health Service Corps.[52] The Prevention Council was successful in getting the Department of Housing and Urban Development (HUD) to enact a public housing smoking ban in 2016.[53] These resources are likely used by poor people of color and other vulnerable groups and thus expands their access to care and reduces their exposure to hazardous living environments. However, the full import of the prevention strategy was not achieved because funding for the Prevention and Public Health Fund was "not appropriated, not fully allocated, or misallocated."[54]

d. PCORI – Patient-Centered Outcomes Research Institute

PCORI created the Addressing Disparity Program that was designed to fund and manage projects to reduce or eliminate disparities with a focus on care delivery and health outcomes. Only three studies were funded during 2018. As of August 2018, a total of $252 million dollars was spent to fund eighty-one studies. From November 2017 to August 2018, three disparities studies were funded, and an additional $14 million dollars was invested in disparities research. By November 2017, over $238 million dollars was provided to fund 78 studies.[55]

50. AGENCY HEALTHCARE RSCH. & QUALITY, 2017 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT 1, 26 (Sept. 2018), https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2017nhqdr.pdf [https://perma.cc/UQ67-CQNA]. While 55% of quality measures improved overall for African Americans, 40% of the quality measures were worse compared to Whites. For Asian, 60% of quality measures improved overall, while only 20% were worse when compared to Whites. Quality measures for Hispanics also improved 60%, yet 33% were worse compared to Whites. American Indians/Alaska Natives experienced fewer quality improvements at 35%, and their quality was worse for 30% of the quality measures compared to Whites. For Native Hawaiians/Pacific Islanders, trends show 25% of the quality measures improved, while 33% were worse compared to Whites. *Id.* at 1, 26-35.

51. Gwendolyn Roberts Majette, *PPACA and Public Health: Creating a Framework to Focus on Prevention and Wellness and Improve the Public's Health*, 39 J.L. MED. & ETHICS 366, 373 (2011).

52. Nadia Chait & Sherry Glied, *Promoting Prevention Under the Affordable Care Act*, 39 ANN. REV. PUB. HEALTH 507 (2018).

53. *Id.*

54. Majette, LAW AND GLOBAL HEALTH, *supra* note 10, at 446; Nancy E. Adler & Howard K. Koh et al., Discussion Paper, *Addressing Social Determinants of Health and Health Disparities, A Vital Direction for Health and Health Care* at 3 (Sept. 19, 2016), https://nam.edu/addressing-social-determinants-of-health-and-health-disparities-a-vital-direction-for-health-and-health-care/ [https://perma.cc/6QBN-7Y6J].

55. PATIENT-CENTERED OUTCOMES RSCH. INST., RESEARCH SPOTLIGHT ON ADDRESSING DISPARITIES (Aug. 2018), https://www.pcori.org/sites/default/files/PCORI-Research-Spotlight-Addressing-Disparities.pdf [https://perma.cc/8E92-WZG2]; PATIENT-CENTERED OUTCOMES RSCH. INST., RESEARCH SPOTLIGHT ON ADDRESSING DISPARITIES (Nov. 2017), https://www.pcori.org/sites/default/files/PCORI-Research-Spotlight-Addressing-Disparities.pdf [https://perma.cc/Y5RD-PSYF].

2. Monitoring and Measuring Health Disparities - HHS funding to the National Quality Forum

In November 2017, the National Quality Forum ("NQF") released its final *Framework to Achieve Health Equity and Eliminate Disparities.* The framework was funded by HHS and provides a systematic approach that uses measures to reduce disparities and advance health equity.[56] The four-part framework requires organizations to identify and prioritize reducing health disparities. Organizations should then implement evidence-based interventions to reduce disparities. The third step requires organizations to invest in the development and use of health equity performance measures. The final step organizations should take is to incentivize the reduction of health disparities and achievement of health equity. The health equity performance measures should be created using a five-domain framework.

The five domains of health equity measurement reflect the goals that must be met to ensure that the health care system achieves health equity. The first domain includes establishing "partnerships and collaborations" with those outside the health care system to work on social determinants of health.[57] Another domain is the creation of a "culture of equity." This culture of equity seeks to establish genuine respect, fairness, cultural competency, and a safe environment where marginalized groups can discuss difficult topics like racism and propose solutions.[58] This domain encompasses bias and structural racism.[59] The next domain establishes a structure for equity. The structure promotes equity through policies, procedures, and institutions. The structure also has money and data to monitor outcomes and continuously adapt as knowledge advances and the needs of marginalized communities' change.[60] The fourth domain is easy access to care that is affordable and convenient. The final domain is the provision of quality care that continuously reduces disparities, stratifies data where necessary, and includes measures to hold providers, payers, and regulators accountable to reduce health care disparities.[61]

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56. NAT'L QUALITY F., A ROADMAP FOR PROMOTING HEALTH EQUITY AND ELIMINATING DISPARITIES: THE FOUR I'S FOR HEALTH EQUITY 6 (Sept. 14, 2017), https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities__The_Four_I_s_for_Health_Equity.aspx [https://perma.cc/8XLL-PTUU].

57. *Id.* at 12.

58. *Id.*

59. *Id.* at 15.

60. *Id.* at 13.

61. The Institute for Healthcare Improvement ("IHI") created a similar equity structure in 2016. The one major difference in structures is that IHI adds a component to address institutional racism. It contains five pillars for health care to advance equity: (1) Make equity a strategic priority, (2) create infrastructures that support equity, (3) impact multiple determinants of health over which health care can have an impact (i.e. improve clinical processes or improve the SES of employees), (4) address institutional racism, and (5) form community partnerships to improve health and facilitate equity. Similar to the National Stakeholders Strategy for Achieving Health Equity, IHI defines institutional racism as "differential access to the goods, services, and opportunities of society by race." Ronald Wyatt et al., White Paper, *Achieving Health Equity: A Guide for Health Care Organizations*, INST. HEALTHCARE IMPROVEMENT 11 (2016), http://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx [https://perma.cc/2V4U-Q2W9] Institutional racism includes implicit bias within policies, structures, norms, and patient care. *Id.*; Majette, *PPACA*

As previously discussed in Section III (A), in 2012, I argued that PPACA constituted framework legislation to eliminate health care disparities. I discussed the need to follow the recommendations of the Commission on Social Determinants of Health to improve the daily living conditions of individuals to advance health and lower health inequity. I also recommended that the United States should periodically create a national strategy to eliminate health care disparities and change the Medicare reimbursement regulations that govern physicians to incentivize them to eliminate health disparities in the provision of care.[62] Five years later, NQF has created an equity framework that actualizes my recommendation.

3. Universal Coverage

A seminal part of the *PPACA Framework to Eliminate Health Disparities* makes universal insurance coverage a priority. As a result of the statutory focus, 20 million adult Americans were covered from 2011 to 2016. This includes 8.9 million White, 4 million Hispanic, and 3 million Black adults ages 18 to 64.[63] Additionally, under the PPACA, from 2010 to 2016, the uninsured rate dropped most significantly for Hispanics from 42.4% to 25.9%, for African Americans it dropped from 27.9% to 14.6%, and for Whites from 15.6% to 8.9%.[64]

Not only did health care become more accessible and more affordable, but individual health outcomes improved. The expansion of Medicaid has had a positive impact on health. A 2017 study showed that cardiac surgery patients with Medicaid experienced improved health by lowering significantly their predicted preoperative risk of morbidity or mortality and a decrease in their postoperative major morbidity.[65] Moreover, a January 2018 study on the effects of coverage showed reduced infant mortality rates among African Americans in expansion states during the 2014 to 2016 timeframe compared to non-expansion states.[66]

The provision of health insurance has increased the diagnosis and treatment of chronic diseases and cancer.[67] Patient use of diabetes medication increased. Better coverage has also led to improved outcomes for people diagnosed with depression.

Framework, supra note 18, at 934 (quoting the National Stakeholder Strategy's definition of institutional racism).

62. Majette, *PPACA Framework*, *supra* note 18, at 905-10, 927-32.

63. 2015 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT, *supra* note 46, at vii.

64. 2016 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT, *supra* note 49, at 17. In 2016, the uninsured rate for Native Americans/Alaska Indians was 22% and 11% for Native Hawaiians/other Pacific Islanders. Samantha Artiga, Kendal Orgera & Anthony Damico, *Changes in Health Coverage by Race and Ethnicity since Implementation of the ACA, 2013-2017*, KAISER FAM. FOUND. (Feb. 2019), https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/ [https://perma.cc/BE4Z-FYX5].

65. Eric Charles et al., *Impact of Medicaid Expansion on Cardiac Surgery Volume and Outcomes*, 104 ANNALS THORACIC SURGERY 1251 (June 2017).

66. Chintan Bhatt & Consuelo Beck-Sague, *Medicaid Expansion and Infant Mortality in the United States*, 108 AM. J. PUB. HEALTH 565 (Jan. 2018).

67. Benjamin D. Sommers, Atul A. Gawande & Katherine Baicker, *Health Insurance Coverage and Health – What the Recent Evidence Tells Us*, 377 NEW ENG. J. MED 586 (Aug. 10, 2017).

The PPACA allowed for dependents to be covered up to the age of 26 which resulted in the earlier diagnosis and treatment of cervical cancer.[68]

The provision of coverage has also resulted in the improvement of patients' perspective on their well-being and self-reported health. This is important because "people who [report] their health as poor have mortality rates two to ten times as high as those who report being in the healthiest category."[69] A reduction of insurance coverage can significantly harm health, especially among people who suffer from chronic diseases and those with lower incomes.[70]

Access to coverage has improved health through the increased use of preventative care by low-income childless adults.[71] And as expected, access to insurance has provided financial protection and stability to millions of individuals who have had fewer medical bills sent to collections and who have filed fewer bankruptcies.[72]

In conclusion, the evidence to date shows that the *PPACA Framework to Eliminate Health Disparities* has had a positive impact on the lives of people of color. Unfortunately, the progress made is in jeopardy because of the efforts to dismantle PPACA.

IV. STATE OF THE WORLD – RETRACTION OF RIGHTS

When analyzing Dr. King's, *I've been to the Mountaintop* speech, it is evident that he views the acknowledgement and protection of the rights of people of color as advancing or progressing as we move forward in time, not retrenchment. He references oppressed people being freed around the world by using examples from the Old Testament in the Bible (Israelites leaving Egypt and crossing the Red Sea), President Lincoln freeing the slaves through the Emancipation Proclamation, and the Civil Rights Movement in the 1950s and 1960s.

Dr. King's perspective contrasts with Professor Derrick Bell's expectation of retrenchment. In an earlier work, *And We are Not Yet Saved*, Professor Bell describes the Civil Rights Movement as a "spiritual manifestation of the continuing faith of a people who have never truly gained their rights in a nation committed by the basic law to the freedom of all."[73] The book uses metaphorical tales (chronicles) based on the heroine Geneva Crenshaw to describe the "phenomenon *of rights gained, then lost, then gained again* – a phenomenon that continues to surprise even though the *cyclical experience* of blacks in this country predates the Constitution by more than one hundred years."[74]

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68. *Id.* at 589.

69. *Id.*

70. *Id.* at 591.

71. Kosali Simon, Soni Aparna & John Cawley, *Affordable Care Act*, 36 J. POL'Y ANLYS & MGMT. 390, 390 (2017).

72. Sommers, Gawande & Baicker, *supra* note 67, at 586.

73. DERRICK BELL, AND WE ARE NOT SAVED: THE ELUSIVE QUEST FOR RACIAL JUSTICE xi (1987) (emphasis added) [hereinafter AND WE ARE NOT SAVED].

74. *Id.* at xi, 6 (emphasis added). Derrick Bell reiterates this idea in *Law as a Religion*, which was published posthumously based on the original April 15-16, 2010 manuscript. Derrick Bell, *Law as a Religion*, 69 CASE W. RES. L. REV. 265, 272 (2018). [hereinafter *Law as a Religion*].

Professor Bell explains the cause of the cyclical experience through his theory of *interest convergence.* Essentially, racial progress, as reflected through laws and policies, occurs when they are consistent with the self-interest of segments of the dominant society or the country as a whole.[75] Sometimes the laws and policies lose support, are minimized, or reversed because the conditions causing an alignment of interest dissipates, and implementation becomes difficult, reflecting what Professor Lani Guinier calls *interest divergence.*[76]

This same phenomenon of rights gained, lost, then gained again is also reflected in the area of health care. Thus, once I identified that PPACA constituted framework legislation to eliminate health care disparities for people of color in 2012, I became concerned about the permanence of the legal framework. In 2014, I wrote, "the use of . . . . 'rights' in the US to reduce health care disparities is controversial. . . . The US approach to addressing racial inequality [through civil and human rights] is inconsistent. It waxes and wanes."[77]

I then made four recommendations on what could be done to ensure that the United States continued to comply with its global health law obligation to adhere to the *PPACA Framework to Eliminate Health Disparities.*[78] First, we secure continuous compliance by identifying and using the structures created by PPACA to ensure a permanent focus on minority health such as restructuring the Office of Minority Health, creating six offices throughout the Department of Health and Human Services, and including congressional oversight mechanisms. Second, we integrate health and human rights treaty obligations into federal and state bureaucracies. Third we comply with General Comment 14: The Right to the Highest Attainable Standard of Health and develop collaborative partnerships to protect the right to health with civil society and private businesses.[79] Finally, we secure compliance by using global health law norms as a conceptual framework to develop, identify, and coordinate legal and non-legal structures designed to reduce health disparities and inequality in the United States.[80]

Several years later in 2017 and 2018, the state of race relations in America began to deteriorate and is similar to Dr. King's description of the United States in 1968. Dr. King said, "the world is all messed up. The nation is sick, there is trouble in the land, and confusion all around."[81]

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75. BELL, AND WE ARE NOT SAVED, *supra* note 73, at 10; Bell, *Law as a Religion, supra* note 74, at 272.

76. Bell, *Law as a Religion, supra* note 74, at 273; Lani Guinier, *From Racial Liberalism to Racial Literacy:* Brown v. Board of Education *and the Interest-Divergence Dilemma,* 91 J. AM. HIST. 92, 98 (2004).

77. Majette, LAW AND GLOBAL HEALTH, *supra* note 10, at 444.

78. *Id.* at 445-50.

79. *Id.* at 448-49.

80. *Id.* at 450.

81. King, *supra* note 1.

A. Rights and Racial Progress are undermined by Racial and Ethnic Intolerance & Violence

Racial violence and government neglect undermine health outcomes, especially for racial minorities. The Presidency of Donald Trump has been marred by racial and ethnic intolerance and violence. This environment undermines individual rights and racial progress achieved to date, and as envisioned by Dr. King. It also adversely impacts health. In 2017, White supremacists and neo-Nazis held a rally in Charlottesville, Virginia, at which a white female counter-protester was killed. President Trump responded to the tragedy by saying, "there were very fine people on both sides." The comment caused several business people on presidential advisory boards to resign and his Chief Economic Advisor for the White House Economic Council, Gary Cohn, a Jewish member of the administration to draft a resignation letter.[82] Also in 2017, while there were several severe hurricanes that caused unprecedented damage and flooding in Texas, Florida, and Puerto Rico, the President did not respond to them equally. The Trump administration's response to Hurricane Maria that hit Puerto Rico was delayed, his conduct while visiting the victims was dismissive, and he later discounted the number of deaths that researchers concluded were attributable to the storm (64 compared to 2, 975). The category 4 storm devastated the island's infrastructure, leaving 3.4 million residents without power for weeks, disrupted communications by knocking out ninety five percent of cell phone towers, created shortages of clean water, and severely limited access to medical care.[83] The mayor of San Juan was forced to go on television in order to provide an accurate picture of the level of devastation and to plead for assistance from the federal government. She stated, "we are dying, and you are killing us with the inefficiency, and the bureaucracy."[84]

Racially charged incidents continued into 2018. On October 25, 2018, in Louisville, Kentucky a White man killed two innocent African Americans shopping at a Kroger's grocery store because of their race. Prior to going to the grocery store, he attempted to enter a historically Black church. Kentucky Senator Mitch McConnell called the killing a hate crime.[85] In 2018, US Attorney General Sessions began a no tolerance immigration policy where Homeland Security separated Hispanic children, including infants and toddlers, from their parents who were attempting to cross the southern border of the United States. Some of the children

82. Kate Kelly & Maggie Haberman, *Gary Cohn, Trump's Adviser, Said to Have Drafted Resignation Letter After Charlottesville*, N.Y. TIMES (Aug. 25, 2017), https://www.nytimes.com/2017/08/25/us/politics/gary-cohn-trump-charlottesville.html [https://perma.cc/E36E-FSSS].

83. Lia Eustachewich, *Trump Rejects Puerto Rico Hurricane Death Toll*, N.Y. POST (Sept. 13, 2018), https://nypost.com/2018/09/13/trump-rejects-puerto-rico-hurricane-death-toll/ [https://perma.cc/X3RG-9497].

84. Phil Helsel & Saphora Smith, *Puerto Rico Crisis: San Juan Mayor Pleads for Federal Aid, Trump Hits Back*, NBC NEWS (Updated Sept. 30, 2017), https://www.nbcnews.com/storyline/puerto-rico-crisis/san-juan-s-mayor-pleads-trump-you-are-killing-us-n806116 [https://perma.cc/A2P9-7CU5].

85. Laurel Wamsley, *Killing of 2 at Kentucky Supermarket is Being Investigated as a Hate Crime*, NPR (Oct. 29, 2018), https://www.npr.org/2018/10/29/661834642/killing-of-2-at-kentucky-supermarket-is-being-investigated-as-hate-crime [https://perma.cc/9CV4-BJYY].

were placed in inhumane facilities. The Trump administration did not have a reasonable plan to reunite the 2,342 children.[86] Lawsuits were filed to force the administration to reunite the families and 542 children were not reunited with their parents by the court's deadline.[87] Additionally in December 2018, several children died unnecessarily in these detention facilities because of the failure to appropriately assess and address the children's health.[88] Finally on October 27, 2018, eleven Jewish congregants were killed and four policemen were injured during Saturday services at the Tree of Life Synagogue in Pittsburg, Pennsylvania. The White assailant used anti-Semitic slurs. The killing is the deadliest of its kind in the United States. Moreover, according to the Anti-defamation League, the number of reported anti-Semitic incidents in the United States surged fifty seven percent in 2017.[89] This larger social context of divisiveness is the backdrop in which one must assess the continued challenges to the PPACA and its impact on people of color. The increase in racial intolerance and hatred translates into disregard of the *effects* of constitutional challenges and administrative action.

B. *Constitutional Challenges*

The PPACA framework to eliminate health care disparities has been repeatedly threatened because of constitutional challenges, reflecting interest divergence.[90] From 2010 to 2018, there were several challenges to numerous provisions that sought to expand insurance coverage. In *National Federation of Independent Business v. Sebelius* (2012), the plaintiffs challenged the constitutionality of the shared responsibility clause, the provision expanding Medicaid, and the constitutionality of PPACA in its entirety.[91] The Supreme Court held that the shared responsibility clause was constitutionally enacted under Congress' power to tax and thus there was no need to strike the entire statute.[92] The Court also held that the Medicaid expansion provision was unconstitutional under the spending clause but saved the statute

86. Camila Domonoske & Richard Gonzales, *What We Know: Family Separation and 'Zero Tolerance' At the Border*, NPR (June 19, 2018), https://www.npr.org/2018/06/19/621065383/what-we-know-family-separation-and-zero-tolerance-at-the-border [https://perma.cc/BUE3-P7FU].

87. Order Granting Plaintiffs' Motion for Classwide Preliminary Injunction, Ms. L v. U.S. Immigration and Customs Enforcement, 310 F. Supp.3d. 1133 (S.D. Ca. June 26, 2018) (18cv0428 DMS (MDD)); Lee Gelerent, *The Battle to Stop Family Separation*, NYR DAILY (Dec. 19, 2018), https://www.nybooks.com/daily/2018/12/19/the-battle-to-stop-family-separation [https://perma.cc/U9RG-GQFQ]. By December 2018, 130 children remained separated from their parents. And "many of the children, especially the young, are exhibiting mental health problems and trauma," as predicted by the health care providers that warned the administration about the consequences of their actions. *Id.*

88. Francesca Paris, *8-Year-Old Migrant Boy Dies in Government Custody in New Mexico Hospital*, NPR (Dec. 25, 2018), https://www.npr.org/2018/12/25/680066848/8-year-old-migrant-boy-dies-in-government-custody-in-new-mexico-hospital [https://perma.cc/VZ59-4D2Y].

89. Campbell Robertson, Christopher Mele & Sabrina Tavernise, *11 Killed in Synagogue Massacre: Suspect Charged With 29 Counts*, N.Y. TIMES (Oct. 27, 2018), https://www.nytimes.com/2018/10/27/us/active-shooter-pittsburgh-synagogue-shooting.html [https://perma.cc/GG6N-S6WX].

90. *See* Guinier, *supra* note 76, at 98.

91. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

92. *Id.*

by severing the statutory mandate that states expand.[93] Thus, states are allowed to choose whether to expand Medicaid to their citizens.[94] In *King v. Burwell* (2015), there was a constitutional challenge to the availability of advanced premium tax credits ("APTC") in states that operate on the federal exchange.[95] Advanced premium tax credits are important because they make the purchase of insurance affordable by providing a subsidy to those individuals between 100% to 400% of poverty. In its opinion, the Supreme Court noted that eighty-seven percent of the individuals that purchased insurance on the federal exchange in 2014 received an APTC.[96] The Court held that the phrase, "exchange established by the state," must be read in light of the context and structure of the PPACA.[97] PPACA made the purchase of insurance affordable by providing subsidies to "qualified individuals." The individuals would purchase insurance on state exchanges unless a state decided not to establish an exchange. Then a federal exchange would be created by the Secretary of Health and Human Services for that state.[98]

In 2016, a district court decision threatened the continuation of cost sharing reductions which PPACA provides to low income individuals between 100% to 250% of poverty when they purchase insurance on the exchange.[99] The cost-sharing reductions make the cost of health care services affordable. In *U.S. House of Representatives v. Burwell*, Judge Collier agreed with the House of Representatives and held that the Department of Health and Human Services reimbursements to health insurance companies pursuant to Section 1402 of PPACA was impermissible because Congress had not appropriated funds for the reimbursement as required by Article 1, Section 9, Clause 7 of the U.S. Constitution.[100] While the Obama administration appealed this decision, the Trump administration stopped payment in October and settled the case with the House of Representatives in December 2017. The most recent challenge to the insurance coverage provisions in PPACA was filed in February 2018, *Texas v. United States*.[101] Here, Texas and nineteen other

93. *Id.*
94. *Id.*
95. King v. Burwell, 135 S. Ct. 2480, 2485 (2015).
96. *Id.* at 2493.
97. *Id.* at 2492.
98. *Id.* at 2494.
99. U.S. House of Representatives v. Burwell, 130 F. Supp.3d. 53 (D.D.C 2015).
100. *Id.*
101. Texas v. United States, 340 F. Supp.3d. 579 (N.D. Tex. 2018), *rev'd*, 945 F.3d 355 (5th Cir. 2019). This lawsuit was filed by 18 states, 2 governors, and 2 individuals. The states represented are similar to the original states that challenged the constitutionality of the PPACA in 2010 in *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012). The 20 states that are represented include Texas, Wisconsin, Alabama, Arkansas, Arizona, Florida, Georgia, Tennessee, Kansas, Louisiana, Missouri, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Utah, and West Virginia, and the Governors of Maine and Mississippi. In April, sixteen states and the District of Columbia intervened in the litigation to uphold the constitutionality of PPACA. Those states are California, Connecticut, Delaware, Hawaii, Illinois, Kentucky, Massachusetts, Minnesota, New Jersey, New York, North Carolina, Oregon, Rhode Island, Vermont, Virginia, and Washington. Intervenor-Defendants' Brief in Opposition to Plaintiffs' Application for a Preliminary Injunction, Texas v. United States, 340 F. Supp.3d. 579 (N.D. Tex. 2018) (4:18 Civ. Act. No. 00167). Subsequently on September 13, 2018, Maryland filed its own lawsuit in the Maryland District Court which seeks a declaratory judgment that PPACA is constitutional or that the Tax Cuts and Jobs Act provision

republican governed states seek a declaratory judgment and preliminary injunction that PPACA's shared responsibility payment (28 USC § 5000A) and the entire statute is unconstitutional.[102] The plaintiffs argue that Section 11081 of the Tax Cuts and Jobs Act of 2017 eliminates the shared responsibility payment for individuals failing to maintain minimum essential coverage.[103] As such, the plaintiffs argue that the provision is no longer constitutional as a permissible exercise of Congress' taxing power under *NFIB v. Sebelius.* Moreover, since the shared responsibility payment is inseverable from the rest of PPACA, the entire statute must be invalidated.[104]

Many argue that the latest lawsuit, *Texas v. United States*, is meritless.[105] The lawsuit is especially problematic in light of the Supreme Court's repeated decisions upholding the constitutionality of PPACA. In *NFIB v. Sebelius*, Justice Roberts writing for the majority stated, "it is well established that if a statute has two possible meanings, one of which violates the Constitution, *courts should adopt the meaning that does not do so.*"[106] Justice Roberts reiterated that idea in 2015, when writing for the 6-3 majority in *King v. Burwell* he stated the following:

> [I]n a democracy, the power to make the law rests with those chosen by the people. . . . In every case we must respect the role of the Legislature, and take care not to undo what it has done. A fair reading of legislation demands a fair understanding of the legislative plan. *Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them.* If at all possible, we must interpret the Act in a way that is consistent with the former and avoids the latter.[107]

Despite the weakness of the legal arguments, in December, Judge O'Connor of the Northern District Court of Texas accepted the plaintiffs' arguments and held that the individual mandate was unconstitutional after Congress zeroed out the tax penalty in 2017.[108] Additionally, the district court concluded that "the individual mandate is so interwoven [with the ACA regulations] and they cannot be separated.

amending the shared responsibility payment (26 U.S.C. § 5000A) is unconstitutional. Complaint, Maryland v. United States, (D. Md. Sept. 13, 2018) (Civ. Act. No. ELH-18-2849). On February 1, 2019, the District Court dismissed Maryland's lawsuit without prejudice based on its acceptance of the Department of Justice's argument that Maryland lacked legal standing to sue because the Trump administration continues to enforce the ACA. Memorandum Opinion and Order, Maryland v. United States, Civ. Act. No. ELH- 18-2849 (D. Md. Feb. 1, 2019).

102. *Texas v. United States*, 340 F. Supp.3d. at 579. (N.D. Tex. 2018) (4:18 Civ. Act. No. 00167).

103. *Id.*

104. *Id.*

105. Brief of Amici Curiae Jonathan H. Adler, Nicholas Bagley, Abbe R. Gluck, Ilya Somin & Kevin C. Walsh In Support of Intervenors-Defendants' Opposition to Plaintiffs' Application for Preliminary Injunction, Texas v. United States, 340 F. Supp.3d. 579 (N.D. Tex. 2018) (4:18 Civ. Act. No. 00167); Brief of Amici Curiae for Economic Scholars in Support of the Intervenor-Defendants, Texas v. United States, 340 F. Supp.3d. 579 (N.D. Tex. 2018) (4:18 Civ. Act. No. 00167); Maryland v. United States, 360 F. Supp.3d. 288 (D. Md. 2019).

106. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. at 562 (2012) (quoting Justice Story from 180 years ago (1830) and Justice Holmes from nearly a century later (1927)) (emphasis added).

107. King v. Burwell, 135 S. Ct. 2480, 2496 (2015) (emphasis added).

108. Memorandum Opinion and Order at 50, Texas v. United States, 340 F. Supp.3d. 579 (N.D. Tex. 2018) (4:18 Civ. Act. No. 00167); Texas v. United States, 340 F. Supp.3d. 579, 605 (N.D. Tex. 2018).

None of them can stand."[109] The district court issued a stay and the constitutionality and severability of the individual mandate was appealed to the Fifth Circuit Court of Appeals.[110]

C. *Trump Presidency – Administrative Actions*

Interest divergence is also reflected in the administrative actions of the Trump administration. Efforts by the Trump administration to repeal PPACA adversely impact the *PPACA Framework to Eliminate Health Disparities.* Many of the Trump administration's policies are directed at undermining PPACA's expansion of insurance coverage, which will increase the number of uninsured and raise the cost of health insurance. And all of these actions have taken place with President Trump periodically using racialized rhetoric that devalues the lives of some groups of color.

Since he took office in 2017, President Trump has consistently tried to undermine the PPACA. In his first Executive Order addressing health care, the President stated

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109. Memorandum Opinion and Order at 50, Texas v. United States, 340 F. Supp.3d. 579 (N.D. Tex. 2018) (4:18 Civ. Act. No. 00167); *Texas v. United States*, 340 F. Supp.3d. at 615.

110. In February 2019, the Fifth Circuit Court of Appeals ruled that the Democratic House of Representatives of the United States and four states, Colorado, Iowa, Michigan, and Nevada could intervene in support of the ACA. Order, Texas v. United States, 945 F.3d 355 (5th Cir. 2019) (No. 19-10011). The plaintiffs-appellees also filed an unopposed motion to dismiss the new Governor of Maine, a democrat, on February 6, 2019. Unopposed Motion to Dismiss Janet Mills, Governor of Maine, Texas v. United States, 945 F.3d 355 (5th Cir. 2019) (No. 19-10011). In December 2019, the Fifth Circuit issued a divided decision with a strong dissent (2-1). Texas v. United States, 945 F.3d 355 (5th Cir. 2019). The Fifth Circuit affirmed the lower court opinion in part. *Id.* at 403. The Fifth Circuit held that the individual mandate was no longer constitutional under Congress' power to tax as construed in *NFIB v. Sebelius. Id.* at 387.The court reasoned that when Congress amended the shared responsibility payment by setting the penalty to zero, it eliminated the features that made the provision a tax. The amended shared responsibility payment would no longer produce revenue; it would not be paid to the United States Treasury; it would not be calculated according to taxable concepts; and it would no longer be collected by the Internal Revenue Service. The Fifth Circuit vacated and remanded the lower court's decision on severability. The Fifth Circuit concluded that that the district court's severability rational lacked the careful, precise analysis necessary for an "extensive, complex, and oft-amended statutory scheme." *Id.* at 397. The Fifth Circuit instructed the district court to carefully analyze each provision of the ACA and explain how it is inextricably tied to the individual mandate. The Fifth Circuit highlighted several provisions where it was not clear how they tied to the mandate, as well as insurance reforms that went into effect before the individual mandate became effective in 2014. The court also directed the lower court to consider the intent of the 2017 Congress with respect to individual mandate and the hindsight that it had to see the mandate implemented. Court Opinion - Appeals from the United States District Court for the Northern District of Texas – Texas v. United States, Case 19-10011 (5th Cir. Dec. 18, 2019). The Dissent disagreed with the majority's analysis regarding the individual mandate. The Dissent concluded that the individual mandate remained constitutional under the constitutional construction provided in NFIB. It reasoned that once the Court construes a statute that interpretation "becomes part of the statutory scheme." *Id.* at 392 (internal marks omitted). Additionally, the coverage requirement was not amended by Congress in 2017. Instead only the shared responsibility provision was amended by reducing the penalty to zero. The Dissent interpreted Congress's action as an act to reduce the burden of the coverage requirement on individuals. *Id.* at 417 (King, C.J., dissenting). Second, the Dissent agreed with most of the majority opinion that the lower court's severability analysis was flawed and should be vacated. However, the dissenting justice disagreed with the decision to remand since severability is an issue of law which appellate courts' review de novo. *Id.* at 416. The intervening states, represented by several attorney generals and governors, and the United States House of Representatives appealed the Fifth Circuit's opinion to the United States Supreme Court. On March 2, 2020, the Supreme Court granted certiorari and the case will be heard during its next term which begins in October 2020. California v. Texas, 140 S. Ct. 1262 (Mar. 2, 2020).

that it was the policy of his administration to seek the "prompt repeal of the Patient Protection and Affordable Care Act."[111] Executive Order 13765 enabled federal agencies to grant exemptions and waivers or otherwise delay implementation of PPACA requirements.[112] Several other administrative actions undermined the PPACA features that sought to provide universal coverage. On March 14, 2017, Secretary Price of Health and Human Services and CMS Administrator Verma wrote a letter to state governors encouraging them to seek Medicaid waivers for work requirements.[113] To grant a section 1115 demonstration waiver, the Secretary of Health and Human Services must determine that the demonstration is likely "to assist in promoting the objectives" of the Medicaid program which was created "to furnish medical assistance" to the people entitled to its benefits.[114] As Professor Sara Rosenbaum states, this requires the Secretary to make a decision based on a record that demonstrates the "potential coverage gains flowing from the experiment, as designed, appear to outweigh the risks of coverage losses (and their attendant effects)."[115] The concern with this policy is that large numbers of individuals that need health care will not receive that care. This is especially true given the repeated studies that show the discouraging effect of cost-sharing on poor individuals' access to necessary health care. In the six months that Arkansas began to implement its work requirements in 2018, 18,000 enrollees lost their coverage.[116] And in Kentucky's waiver application, the state predicted that 95,000 enrollees would lose their coverage.[117]

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111. Presidential Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal, Exec. Order No. 13765, 82 Fed. Reg. 8351 (Jan. 20, 2017).

112. *Id.*

113. Letter from Thomas E. Price, Secretary of the Department of Health and Human Services, and Seema Verma, Administrator of Centers for Medicare & Medicaid Services, to Governors (Mar. 14, 2017), https://www.hhs.gov/healthcare/empowering-patients/providing-relief-right-now-for-patients/making-medicaid-work-for-patients-and-states/index.html [https://perma.cc/DYB7-57YX].

114. *Id.*

115. Sarah Rosenbaum, *Medicaid Work Demonstration Legal Developments:* Stewart v Azar; Bevin v Stewart; Gresham v Azar, HEALTH AFF. BLOG (Sept. 24, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180914.426396/full/ [https://perma.cc/C4X8-LNNP].

116. Robin Rudowitz, MaryBeth Musumeci & Cornelia Hall, *January State Data for Medicaid Work Requirements in Arkansas*, KAISER FAM. FOUND. (Feb. 25, 2019), https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/ [https://perma.cc/682H-D9RS]. On February 14, 2020, the D.C. Circuit Court of Appeals unanimously affirmed the lower court decisions by Judge Boasberg that found the decisions of the Secretary of Health and Human Services to grant state waivers imposing Medicaid work requirements were arbitrary and capricious. Gresham v. Azar, No. 19-5094 (D.C. Cir. Feb. 14, 2020).

117. Memorandum Opinion, Stewart v. Azur, CA 18-152 (D.D.C. June 29, 2018) (Judge Boasberg cites Kentucky's waiver application in his decision to vacate and remand the Secretary of Health and Human Services decision granting Kentucky's waiver with instructions that the Secretary consider whether the waiver will help the state furnish medical assistance.) Initially, Kentucky and the United States Secretary for Health and Human Services appealed the district court decision. However, once a democratic governor was elected near the end of 2019, he withdrew from the lawsuit and ended the state's work requirements. Press Release, *Governor Beshear Ends Medicaid Waiver, Protects Health Care for Nearly 100,000 Kentuckians*, (Dec. 16, 2019), https://kentucky.gov/Pages/Activity-stream.aspx?n=GovernorBeshear&prId=7 [https://perma.cc/69XG-4EPH]; Executive Order Relating to the Kentucky Medicaid Expansion, Exec. Order No. 2019-005

In October 2017, the administration decided not to reimburse insurance companies for the cost-sharing subsidies that PPACA section 1402 required to be paid on behalf of individuals whose income was between 100% to 250% of poverty.[118] This increased insurance premiums. The higher premium was not problematic for those individuals entitled to an advanced premium tax credit (100% to 400% of poverty) under the PPACA, which covered the higher premium; however, it was a problem for those who were not entitled to a subsidy and purchased insurance on and off the marketplaces.[119] The administration's decision, as predicted by the Congressional Budget Office, also significantly increased the cost of advanced premium tax credits that the federal government paid in 2018 and is predicted to increase the federal deficit by $194 billion dollars over ten years.[120] On October 12, 2017, the administration also sought to undermine the purchase of insurance in the individual markets through a second executive order.[121] Executive Order 13813 was designed to attract young, healthy consumers out of the marketplace by loosening the consumer protections on insurance product designs for short-term health insurance and expanding access to Association Health Plans contrary to PPACA implementing regulations.[122] These policies are predicted to fragment the insurance risk pools on the individual and small group marketplaces and increase the cost of insurance for those individuals with pre-existing conditions.

The Trump administration continued its efforts to undermine the PPACA in June 7, 2018 when Attorney General Jefferson Sessions took a rare position by asserting that the Justice Department would not defend the legality of PPACA in *Texas v. United States*, the previously discussed lawsuit filed by 20 Republican-governed states.[123] Attorney General Sessions agreed with Texas that the shared responsibility payment under 26 U.S.C. § 5000 A (a), coupled with guaranteed issue (42 U.S.C. § 300gg-1, 42 U.S.C. § 300gg-3, 42 U.S.C. § 300gg-4), and the prohibitions on discriminatory premium rates (42 U.S.C. § 300gg(a)(1), § 300gg-4(b)) are unconstitutional.[124] The full harm of the Attorney General's letter is masked by the text's

(Dec. 16, 2019), https://governor.ky.gov/attachments/20191216_Executive-Order_2019-005.pdf [https://perma.cc/85SA-XLXA].

118. U.S. DEP'T HEALTH & HUM. SERVS., Press Release, *Trump Administration Takes Action to Abide by the Law and Constitution, Discontinue CSR Payments* (Oct. 12, 2017), https://www.hhs.gov/about/news/2017/10/12/trump-administration-takes-action-abide-law-constitution-discontinue-csr-payments.html [https://perma.cc/RY7B-7EBU].

119. Katie Keith, *New Guidance Encourages States To Allow Non-CSR-Loaded Off-Marketplace QHPs*, HEALTH AFF. BLOG (Aug. 6, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180805.711405/full/ [https://perma.cc/92CR-L5Z5].

120. CONG. BUDGET OFF., THE EFFECTS OF TERMINATING PAYMENT FOR COST-SHARING REDUCTIONS (Aug. 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf [https://perma.cc/34FX-8U3P].

121. Presidential Executive Order Promoting Healthcare Choice and Competition across the United States, Exec. Order No. 13813, 82 Fed. Reg. 48385 (Oct. 12, 2018).

122. *Id.*

123. Letter from Attorney General Jefferson B. Sessions III, Department of Justice, to The Honorable Paul Ryan, Speaker of the House (June 7, 2018), http://www.justice.gov/file/1069806/download [https://perma.cc/HP6C-LZTT].

124. *Id.* (citing 42 U.S.C. 300gg-1, 300gg-3, 300gg-4(a) (guaranteed issue); 300gg(a)(I), 300gg-4(b) ("prohibiting discriminatory premium rates," "community rating")).

failure to disclose the true character of the PPACA provisions at risk: the prohibition of preexisting condition exclusions (42 U.S.C. § 300gg-3) and the prohibition of discrimination based on health status (42 U.S.C. § 300gg-4) are merely characterized as "guaranteed issue."[125]

Other actions by the Trump administration that directly affect the *PPACA Framework to Eliminate Health Disparities* include the failure to produce reports designed to hold the federal government accountable for continuing its efforts to reduce health care disparities for people of color. PPACA section 10334(a)(3) requires the Secretary of the Department of Health and Human Services to publish a bi-annual report to Congress on the minority health activities that it has conducted. The last three reports produced in 2011, 2013, and 2015 were all published in March. However, the fourth report which was due March 2017 has not been submitted to the U.S. Congress.[126] The Periodic Report of the United States to the United Nations Committee on the Elimination of Racial Discrimination, another outstanding report, was due to the State Department over a year ago on November 20, 2017. Submission of this report complies with the United States' duty to "identify the legislative, judicial, administrative or other measures" adopted to give effect to the treaty.[127] While the United States has traditionally filed this report late, it has not reversed course on actions the Committee on the Elimination of Racial Discrimination ("CERD") recommended the United States take to comply with this treaty. In prior reports, CERD concluded that the United States was not complying with the treaty because of the disproportionate number of people of color who were uninsured and in poor health.[128] In 2014, CERD praised the U.S. for passing the PPACA and noted its positive effect on reducing the number of uninsured people of color.[129]

As expected, the constitutional and administrative attacks on the PPACA coverage provisions have resulted in an increase in the number of uninsured. The overall uninsured rate in the U.S. has increased from 12.7% in April 2016 to 15.5% in March of 2018 for adults ages 19 to 64.[130] For this same period, the rate of uninsured Whites

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125. Letter from Attorney General Sessions, *supra* note 123.

126. As of August 1, 2020, this report is not on the United States Department of Health and Human Services, Office of Minority Health webpage (see "Report to Congress" hyperlink), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=57#:~:text=The%20biennial%20Report%20to%20Congress,minority%20health%20and%20health%20disparities [https://perma.cc/22WT-AYYC].

127. International Convention on the Elimination of All Forms of Racial Discrimination art. 9 (1), Dec. 21, 1965, 660 U.N.T.S. 195; Majette, *PPACA Framework*, *supra* note 18, at 896.

128. U.N. Comm. on the Elimination of Racial Discrimination, 72d Sess., *Consideration of Reports Submitted by States Parties Under Article 9 of the Convention: Concluding Observations of the Committee on the Elimination of Racial Discrimination, United States of America*, 10 - 11, ¶ 32, U.N. Doc. CERD/C/USA/CO/6 (Feb. 2008) [hereinafter *CERD 2008 Concluding Observations on U.S. Reports*]; *see also*, Majette, *PPACA Framework*, *supra* note 18, at 897.

129. U.N. Comm. on the Elimination of Racial Discrimination, 85th Sess., *Concluding Observations on the Combined Seventh to Ninth Periodic Reports of United States of America*, 7, para 15, U.N. Doc. CERD/C/USA/CO/7-9 (Aug. 2014) [hereinafter *CERD 2014 Concluding Observations on U.S. Reports*].

130. Sara R. Collins, Munira Z. Gunja, Michelle M. Doty & Herman K. Bhupal, *First Look at Health Insurance Coverage in 2018 Finds ACA Gains Beginning to Reverse, Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, Feb. – Mar. 2018*, TO THE POINT (BLOG), COMMONWEALTH FUND

increased 2% from 9% to 11%. The rate of uninsured Asian/Pacific Islanders remained the same at 9%. For Hispanics and African Americans, the uninsured rate remains much higher at 32% and 14% respectively. This is an increase of 3% for Hispanics and 1% for African Americans since April 2016.[131]

V. RECOMMENDATIONS – A MOUNTAINTOP SOLUTION

A Mountaintop Solution is needed to continue to reduce health and health care disparities for people of color in a time of retrenchment. Consistent with the architecture of Dr. King's *I've been to the Mountaintop* speech, this solution addresses three audiences—the religious leaders of the time, governmental leaders, and business leaders.[132] Each of these types of leaders is important because each represents an institution and/or social construct that has an influence on health, and each has the ability to influence other sectors of society.

A. A Message to Christian Leaders, Christians, Evangelicals, and the Religious Right

In America, the Christian Church has been an anchor in the community, a place of refuge, and an advocate for the humanity of people. This has been especially true for African Americans. But the Christian Church has also been a source of oppression. Both Dr. King and Professor Bell were critical of the role of the White Christian Church in supporting racist political, social, and economic ideas. In *Law and Religion* written in 2010, Professor Bell expresses his concern about the rising race-based opposition to President Barack Obama and its impact on his ability to keep the promises that he made as a political candidate. Professor Bell also notes that "both major parties [have a history of] exploiting the racist faith of their Christian White constituencies."[133] Citing Professor and Theologian George D. Kelsey, he discusses how the White Christian Church inculcated the idea of a superior race; and that, for some, racism is a faith.[134] For Bell, religion is a *double-edged sword*, it can be used for evil and to foment racism or it "can proffer inspirational guidelines for honorable and ethical living."[135] The racist concerns noted by Professor Bell in 2010 are also reflected in the Trump presidency.[136]

Dr. King used Christian principles to call his brethren, other religious leaders, and the nation to love and value individuals regardless of their skin color.[137] He sought to recognize the dignity and worth of human beings. Those Christian principles command Christians to teach and manifest love toward mankind. To achieve this we

(May 1, 2018), https://www.commonwealthfund.org/blog/2018/first-look-health-insurance-coverage-2018-finds-aca-gains-beginning-reverse [https://perma.cc/L7L8-E59X].

131. *Id.*

132. While the Mountaintop Solution focuses on three types of leaders, this does not exclude other groups' roles in helping to reduce health care disparities for people of color.

133. Bell, *Law as a Religion*, *supra* note 74, at 271.

134. *Id.* at 269 (citing George D. Kelsey, RACISM AND THE CHRISTIAN UNDERSTANDING: AN ANALYSIS AND CRITICISM OF RACISM AS AN IDOLATROUS RELIGION (1965)).

135. *Id.* at 267, 271.

136. *See supra* Part IV and *infra* Part V.B.2.

137. King, *supra* note 1; Martin Luther King, Jr., Letter from a Birmingham Jail (Apr. 16, 1963), available at https://www.africa.upenn.edu/Articles_Gen/Letter_Birmingham.html [https://perma.cc/7528-2XU3].

must first, acknowledge that God created one race, the human race.[138] Second, we must follow what Jesus tells us is the greatest and second greatest commandments. Jesus said the first and greatest commandment requires that we should love the Lord our God with all our heart, with all our soul, and with all our mind.[139] The second greatest commandment is like the first, that we love our neighbor as we love our self. The Bible further explains that children of God show their love to God by obeying his commandments.[140] And the beloved are exhorted to love one another. "For love is of God and everyone that loves is born of God and knows God. *He who does not love does not know God, for God is love.*"[141] Third, we must not be a hypocrite or act like a pharisee or a scribe.[142] Jesus rebukes the pharisees and scribes for engaging in conduct that makes them appear righteous, but inside they are "full of hypocrisy and lawlessness."[143] As a result, their actions do not reflect the weightier matters of God's law: *justice, mercy, and faith.*[144]

The above biblical scriptures lay the foundation to challenge ideas of racial or ethnic superiority and inferiority in oneself (self-examination) or when expressed by others (friends, teachers, religious leaders, or political leaders). They also compel Christian church leadership to create environments where all human lives are valued equally, and conditions are created to promote the health and well-being of all individuals. More importantly, Christian leaders should call out and condemn racist comments, discriminatory political rhetoric, discriminatory policies, and hate crimes; and encourage their followers to do the same.

B. Forging A Just United States Government at the Federal Level

The United States government is just when it complies with its human rights treaty obligations and commitments. The Mountaintop Solution relies on at least two human rights norms to encourage the United States to protect the health of people of color: the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) and the United Nations Framework for Business and Human Rights (UNBHR), which is implemented through the United States National Action Plan for Responsible Business Conduct. In 1996, the United States ratified the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD).

138. *Acts* 17:26 says "and he has made from *one blood every nation of men* to dwell on all the face of the earth and has determined their pre-appointed times and the boundaries of their dwellings." *Acts* 17:26 (New King James) (emphasis added).

139. *Matthew* 22:36-40 (New King James).

140. "For this is the love of God, that we keep His commandments." *I John* 5:3 (New King James).

141. *I John* 4:7-8 (New King James) (emphasis added).

142. *Matthew* 23:23 (New King James) ("Woe to you scribes and Pharisees, hypocrites! For you pay tithe of mint and anise and cumin, and have neglected the weightier matters of the law: justice and mercy and faith. These you ought to have done, without leaving the others undone.").

143. *Matthew* 23:28 (New King James).

144. *Matthew* 23:23 (New King James) (emphasis added).

1. ICERD – International Convention on the Elimination of All Forms of Racial Discrimination

ICERD prohibits racial discrimination, which the treaty defines as any distinction, exclusion, restriction, or preference based on prohibited grounds (race, colour, descent, national or ethnic origin) with the intent or effect of impairing enjoyment of a covenant right.[145] Governments must also prohibit racial discrimination by others through appropriate means.[146] Governments must take effective measures to review, amend, rescind, and nullify laws that have the effect of creating or perpetuating racial discrimination.[147] Governments are also encouraged to take special measures "for the sole purpose of securing adequate advance of certain racial or ethnic groups" requiring protection as necessary to ensure the "equal enjoyment or exercise of human rights and fundamental freedoms."[148]

In 2011, the international community celebrated the International Year for People of African Descent.[149] During that year, the Committee to Eliminate Racial Discrimination (CERD) had a day-long meeting with the countries that ratified ICERD, "United Nations organs and specialized agencies, special rapporteurs . . ., and non-governmental organizations to clarify some aspects of discrimination and further support the struggle to overcome this discrimination worldwide."[150] CERD also reached some troubling conclusions based on its review of all of the mandatory periodic reports submitted by countries that had ratified ICERD. CERD's analysis revealed "that people of African descent continue to experience racism and racial discrimination."[151] Thus around the world, "millions of people of African descent live in societies where racial discrimination places them in the *lowest* positions in social hierarchies."[152]

Accordingly, in 2011, CERD adopted General Comment 34, which is an interpretive document of ICERD. General Comment 34 identifies forms of discrimination to include racism and structural discrimination.[153] The Comment concludes that "racism and structural discrimination against people of African descent [is] rooted in the infamous regime of slavery and [is manifested] in the situations of *inequality* facing them."[154]

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145. International Convention on the Elimination of All Forms of Racial Discrimination, *supra* note 127, at art. 1.

146. *Id.* at art. 2(1)(d).

147. *Id.* at art. 2(1)(c).

148. *Id.* at art. 1(4). The treaty also notes that special measures should be time limited and discontinued once the objectives for which they are created have been achieved. *See* art. 2(2).

149. United Nations, Comm. on the Elimination of Racial Discrimination, General Recommendation No. 34 adopted by the Committee at 1, U.N. CERD Doc. C/GC/34 (Oct. 3, 2011) [hereinafter CERD General Comment 34].

150. *Id.*

151. *Id.*

152. *Id.* at ¶ 2 (emphasis added).

153. *Id.* at ¶¶ 5-6.

154. *Id.*

a. Measures – General & Special

Consistent with the text of ICERD, General Comment 34 recommends that countries (which includes public institutions and authorities at the national and local level) take steps to eliminate discrimination against people of African descent by doing the following:

- Reviewing, enacting, or amending legislation;
- "Review[ing], adopt[ing], and implement[ing] national strategies and programs [to] improv[e] the situation of people of African descent and [to] protect them against discrimination by State agencies, public officials, . . . groups or organizations;"[155]
- "Fully implement[ing] legislation and other measures already in place;"[156]
- "Strengthen[ing] existing institutions or creating specialized institutions to promote respect for equal human rights;"[157] and
- Conducting periodic surveys to assess the discrimination against people of African descent and disaggregate the data to provide information on the economic and social conditions, including a gender perspective.[158]

The countries should "effectively acknowledge in their policies and actions the negative effects of past wrongs [committed] against people of African descent, chief among them being colonialism and the transatlantic slave trade."[159] These effects continue to disadvantage people of African descent.

To overcome structural discrimination, CERD recommends the "*urgent adoption*" of special measures (affirmative action) pursuant to ICERD.[160] CERD also recommends that the special measures be a part of a comprehensive national strategy designed to eliminate all forms of racial discrimination against people of African descent. These policies should be implemented by educating the public about the importance of using these policies to address the "historical" effects of discrimination.[161]

b. Economic, Social and Cultural Rights – Access to Health Care

General Comment 34 also expounds on ICERD's requirement that countries:

> "guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law . . . [in e]conomic, social and cultural rights, . . . [like t]he right to public health, [and] medical care."[162]

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155. *Id.* at ¶¶ 10-12.
156. *Id.* at ¶ 11.
157. *Id.* at ¶ 15.
158. *Id.* at ¶ 16.
159. *Id.* at ¶ 17.
160. *Id.* at ¶ 7; *see also* International Convention on the Elimination of All Forms of Racial Discrimination, *supra* note 127, at arts. 1(4), 2(2).
161. CERD General Comment 34, *supra* note 149, at ¶ 20.
162. International Convention on the Elimination of All Forms of Racial Discrimination, *supra* note 127, at art. 5 (e)(iv); Majette, *PPACA Framework*, *supra* note 18, at 895.

General Comment 34 recommends that countries do the following:

- "Take steps to remove obstacles that prevent the enjoyment of economic, social and cultural rights by people of African descent, especially in the areas of education, housing, employment and *health*;"[163]
- "Ensure equal access to *health care* . . . for people of African descent;"[164] and
- "Involve people of African descent in *designing* and *implementing health-based* programs and projects."[165]

c. Protection against hate speech and racial violence

ICERD article 7 also urges countries to promote understanding, tolerance, and friendship among nations and racial or ethnic groups.[166] Similarly, ICERD article 4 requires countries to prohibit dissemination of ideas based on theories of racial superiority, racial discrimination, hatred, or acts of violence against any race, or group.[167] General Comment 34 recommends that countries take measures to prevent dissemination of ideas of *racial superiority and inferiority* or ideas that attempt to justify violence, hatred, or discrimination against people of African descent.[168] It also recommends that countries take resolute action to *counter* any tendency to *target, stigmatize, stereotype*, or profile people of African descent on the basis of race by law enforcement officials, *politicians*, and educators.[169]

2. The Trump Administration's policies undermine ICERD & General Comment 34

The Trump administration's policies, which attack the PPACA, as previously discussed in part IV, violate the United States' obligations under ICERD, especially article 5(e)(iv).[170] Instead of adhering to the CERD's 2008 and 2014 recommendations to the United States,[171] the Trump administration is undermining and reversing governmental actions, creating obstacles and denying equal access to health care for people of color. The administration is not continuing to implement national strategies, programs, and legislation already in place as recommended in General Comment 34. The Trump administration has also undermined the United States' efforts to expand coverage, which has a disproportionate effect on people of color.

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163. CERD General Comment 34, *supra* note 149, at ¶ 50 (emphasis added).

164. *Id.* at ¶ 55 (emphasis added); International Convention on the Elimination of All Forms of Racial Discrimination, *supra* note 127, at art. 5(e)(4).

165. CERD General Comment 34, *supra* note 149, at ¶ 56 (emphasis added).

166. International Convention on the Elimination of All Forms of Racial Discrimination, *supra* note 127, at art. 7.

167. *Id.* at art. 4.

168. CERD General Comment 34, *supra* note 149, at ¶ 27; International Convention on the Elimination of All Forms of Racial Discrimination, *supra* note 127, at art. 5(e) (emphasis added).

169. CERD General Comment 34, *supra* note 149, at ¶ 31 (emphasis added).

170. International Convention on the Elimination of All Forms of Racial Discrimination, *supra* note 127, at art. 5(e)(iv).

171. *See* Majette, *PPACA Framework*, *supra* note 18, at 896-97.

In the 2014 CERD Concluding Observations on the combined seventh to ninth periodic reports of the United States, the committee commended the United States on passage of the Patient Protection and Affordable Care Act in March 2010. It also noted several areas of concern. The first is the previously discussed 2012 Supreme Court decision in *NFIB v. Sebelius*, which enabled "many states with substantial numbers of racial and ethnic minorities" to opt out of Medicaid expansion.[172] As a result, the United States is unable to "fully address racial disparities in access to affordable and quality care."[173] Additionally, CERD was concerned about inadequate access to health care facilities in racially segregated neighborhoods with concentrated poverty (example of "substandard conditions and services").[174] Accordingly, CERD recommended that the United States take concrete measures to ensure that individuals, racial/ethnic minorities, and immigrants have effective access to affordable and adequate health care services.[175]

Instead of encouraging states to maximize the expansion of Medicaid, President Trump's first HHS Secretary and CMS Administrator urged and granted state requests for Medicaid work requirements. As discussed previously in Section IV, the work requirements create an unnecessary impediment to poor individuals' entitlement to and receipt of health care.[176] Additionally, the term "able-bodied," which is used by federal and state governments[177] to describe the individuals to whom the work requirements apply, stigmatizes the poor and has a racialized historical meaning. The American colonies adopted the Elizabethan policy, which did not provide care to the "able-bodied" poor.[178] Additionally, the term "able-bodied" "was used to

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172. *CERD 2014 Concluding Observations on U.S. Reports*, *supra* note 129, at 7, ¶ 15; *see also supra* Part IV.B.

173. *CERD 2014 Concluding Observations on U.S. Reports*, *supra* note 129.

174. *Id.* at 6, ¶ 13. CERD also expressed concerns about the exclusion of immigrants and children from health care coverage and those lawfully present for less than 5 years. Further, CERD repeated its 2008 concern about the significant health disparities in reproductive health and infant mortality. CERD recommended that the US standardize data collection for maternal and infant mortality to facilitate identification of the causes of the disparities and to develop solutions. It also recommended that the US monitor these areas and ensure that state maternal mortality review boards have sufficient resources and capacity. *Id.* at 7, ¶ 15.

175. *Id.* at 7, ¶ 15.

176. *See supra* Part IV. C (footnotes 113 to 117).

177. Seema Verma, Remarks by Administrator Seema Verma at the National Association of Medicaid Directors (NAMD) 2017 Fall Conference (Nov. 7, 2017), https://www.cms.gov/newsroom/fact-sheets/speech-remarks-administrator-seema-verma-national-association-medicaid-directors-namd-2017-fall [https://perma.cc/9YER-PMKK]; ARKANSAS DEP'T HUM. SERVS., ARKANSAS WORKS, WORK AND COMMUNITY ENGAGEMENT REQUIREMENTS, MEDICAID SECTION 1115 DEMONSTRATION PROJECT WORK REQUIREMENT EVALUATION DESIGN & STRATEGY (Amended Submission August 2018, Original Submission May 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-cmmnty-engagement-draft-eval-dsgn-20180813.pdf [https://perma.cc/E8YC-XWDQ]; COMMONWEALTH OF KENTUCKY, KENTUCKY HEALTH MODIFICATION REQUEST (July 3, 2017). As of March 18, 2019, CMS has approved 9 state requests for work requirements – Indiana, Kentucky, Arizona, Arkansas, Michigan, New Hampshire, Wisconsin and Ohio. KAISER FAM. FOUND., *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State* (Mar. 15, 2019), https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table2 [https://perma.cc/NH5P-5GKE].

178. Nicole Huberfeld, *Federalism in Health Care Reform*, *in* HOLES IN THE SAFETY NET: FEDERALISM AND POVERTY 199 (Ezra Rosser ed., 2019).

classify slaves as healthy, especially adult males who promised more laboring power and thus commanded higher prices."[179] It was also used in the southern penal system to "funnel criminally convicted "able-bodied" freedman to "convict lease" programs that provided involuntary, free labor to private industry."[180]

The actions of candidate and President Trump, as well as his administration, also raise concerns about hate speech, racial violence, and the devaluation of lives of people of color. The protections against hate speech and racial violence as prohibited in General Comment 34 and ICERD articles 7 and 4 are critical to protecting the health and safety of racial and ethnic minorities in the United States. The scientific literature shows that dramatic societal events such as the recent presidential elections can affect health. President Trump's election has created fear and anxiety in many Americans. Additionally, his candidacy stoked preexisting hostile attitudes toward racial and ethnic minorities. Thus, surveys of elementary and high school teachers "show that many of their students have been emboldened to use slurs and name calling and to say bigoted and hostile things about minorities, immigrants, and Muslims."[181] There has also been a proliferation of hate websites. Additionally, the "Southern Poverty Law Center has documented an increase in incidents of harassment and hateful intimidations since President Trump's election."[182] Studies also show that "living in communities with high levels of racial prejudice is associated with an elevated risk of disease and death."[183] Adverse health effects also result from racial and ethnic hostility in both the media and society.

3. The Trump Administration's policies create *weak governance zones* and undermine the U.S. National Action Plan for Responsible Business Conduct

United Nations Special Representative to the Secretary General for Business and Human Rights John Gerard Ruggie, created two accountability structures to advance corporate and business entities' compliance with human rights norms in the global market place.[184] Both structures were endorsed *unanimously* by the United Nations Human Rights Council.[185] The first structure is the United Nations Framework for Business and Human Rights, which was endorsed by the Human Rights Council in 2008. The framework contains three parts: Protect, Respect, and Remedy. The government has a duty to protect its citizens from human rights violations by corporate

179. *Id.* at 201.

180. *Id.*

181. David R. Williams & Morgan M. Medlock, *Health Effects of Dramatic Societal Event—Ramifications of the Recent Presidential Election*, 376 NEW ENG. J. MED. 2295, 2296 (June 8, 2017).

182. *Id.* at 2296. The mere election of an African American, Barack Obama to be President of the United States also helped create an opposition movement with antiminority rhetoric, the Tea Party. *Id.* at 2295.

183. *Id.* at 2296.

184. Ruggie's official title was the Special Representative of the Secretary-General on the issue of human rights and transnational corporations and other business enterprises. OFF. U.N. HIGH COMM'R HUM. RTS., GUIDING PRINCIPLES ON BUSINESS AND HUMAN RIGHTS: IMPLEMENTING THE UNITED NATIONS 'PROTECT, RESPECT AND REMEDY' FRAMEWORK iv, U.N. Doc. HR/PUB/11/04 (2011) [hereinafter UNGP]; JOHN GERARD RUGGIE, JUST BUSINESS, MULTINATIONAL CORPORATIONS AND HUMAN RIGHTS xviii (2013) [hereinafter JUST BUSINESS].

185. RUGGIE, JUST BUSINESS, *supra* note 184, at 102.

entities; corporations must respect human rights, and those who suffer from human rights abuses must have access to a remedy.[186] The second structure is the United Nations Guiding Principles for Business and Human Rights, which was endorsed by the Human Rights Council in 2011. The Guiding Principles provide guidance on how to implement the Protect, Respect, and Remedy Framework.[187] The Framework "rests upon three pillars:"

1. the [government] duty to protect against human rights abuses by third parties, including business enterprises, through appropriate policies, regulation, and adjudication;
2. an independent corporate responsibility to respect human rights, which means that business enterprises should act with due diligence to avoid infringing on the rights of others and address the adverse impacts with which they are involved;
3. the need for greater access by victims to effective remedy, both judicial and nonjudicial.[188]

United Nations Guiding Principle (UNGP) 3 provides guidance on how countries like the United States should protect Business and Human Rights (BHR).[189] It states that countries should enforce laws, and periodically inspect laws that require business enterprises to respect human rights.[190] Additionally, countries should ensure that policies governing business operations "do *not* constrain but enable" businesses to respect human rights.[191] The commentary makes it clear that regulation can be beneficial to businesses and society. "[Countries] should not assume that businesses invariably prefer, or benefit from [government] inaction, and [countries] should consider a smart mix of measures—national and international, mandatory and voluntary—to foster business respect for human rights."[192]

At a minimum, the corporate responsibility to respect human rights is understood to include the human rights in the International Bill of Human Rights.[193] The commentary to UNGP 12 lists the core internationally recognized human rights as those contained in the International Bill of Human Rights to include the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights (ICESCR).[194] ICESCR is important because it is the leading treaty that has a

186. *Id.* at 82.

187. UNGP, *supra* note 184, at 1; RUGGIE, JUST BUSINESS, *supra* note 184, at 106-07. The Guiding Principles were endorsed by the American Bar Association House of Delegates in 2012. The ABA urged "governments, the private sector, and the legal community to integrate the GPs into their respective operations and practices." Ruggie, JUST BUSINESS, *supra* note 184, at 150.

188. Ruggie, JUST BUSINESS, *supra* note 184, at xx-xxi; *see also* UNGP, *supra* note 184, at page 3, para. 1; page 13, para 11; page 27, para. 25.

189. UNGP, *supra* note 184, at page 3.

190. *Id.* at page 4, para. 3(a).

191. *Id.* at page 4, para. 3(b).

192. *Id.* at page 5, para. 3, commentary.

193. *Id.* at page 13, para. 12.

194. *Id.* at page 14, para. 12, commentary.

comprehensive right to health provision. ICESCR article 12(2) requires countries to address the "reduction of the stillbirth-rate and of infant mortality," promote the healthy development of children, and create conditions to "assure to all medical service and medical attention in the event of sickness."[195] General Comment 14 of the ICESCR encourages countries to take steps to make the civil society and the private sector aware of the right to health and to collaborate with these entities in implementing national plans to protect the right to health.[196] Moreover, as I argued in an earlier work, ICESCR is also a soft (non-binding) global health law norm that imposes an obligation on the United States to eliminate health care disparities for people of color.[197]

National Action Plan for Responsible Business Conduct.

In 2016, the United States developed its *National Action Plan for Responsible Business Conduct* to implement the previously discussed United Nations Guiding Principles on Business and Human Rights.[198] The United States' first National Action Plan for Responsible Business Conduct defines *responsible business conduct* as the idea that "businesses can perform well while doing good, and that governments should facilitate such conduct."[199] The plan also describes U.S. companies as global leaders in responsible business conduct who are widely recognized as "committed to promoting human rights, respecting the rule of law, engaging in fair play, and strengthening local community through long-term investments and corporate social responsibility."[200] The U.S. is committed to its leadership role in working with business and other stakeholders to implement responsible business conduct.[201] The content of the U.S. National Action Plan for Responsible Business Conduct is in part based on the United Nations Framework and Guiding Principles for Business and Human Rights. The U.S. views those principles as a floor, not a ceiling, to guide implementation of responsible business conduct.[202] It also acknowledges that responsible business conduct should not only apply to U.S. companies acting globally, but also to domestic companies.[203]

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195. ICESCR, *supra* note 21, at art. 12(2).

196. *Id.* at General Comment 14, paras. 55-56, U.N. Doc. E/C.12/2000/4; Majette, LAW AND GLOBAL HEALTH, *supra* note 10, at 448-49 (providing a detailed discussion on how the United States should collaborate with a broad array of actors to engage in health promoting activities that advance health equity for people of color (i.e. the role of the National Stakeholder Strategy for Achieving Health Equity; the impact of social learning theory as applied to the U.S. participation in the World Conference on Social Determinants of Health; and a recommendation that health professionals receive health and human rights training))

197. Majette, *PPACA Framework*, *supra* note 18, at 894.

198. In 2014 the Human Rights Council passed a resolution urging countries to create a national action plan to implement the United Nations Framework on Business and Human Rights. United Nations Human Rights Council, *Human Rights and Transnational Enterprises and Other Business Enterprises*, UN Resolution 26/L.1, UN Doc. A/HRC/26/L.1 (June 23, 2014).

199. U.S. SEC'Y OF STATE, RESPONSIBLE BUSINESS CONDUCT, UNITED STATES FIRST NATIONAL ACTION PLAN 4 (Dec. 16, 2016), https://2009-2017.state.gov/documents/organization/265918.pdf [https://perma.cc/89JK-VKTT].

200. *See id.*

201. *Id.*

202. *Id.* at 17.

203. *Id.* at 6.

Special Representative Ruggie and other scholars warn against the harms that result from human rights violations in *weak governance zones.*[204] Weak governance zones exist when "governments are unable or unwilling to assume their responsibilities."[205] This results in a lack of accountability, failure of the rule of law, corruption, and sometimes violent conflict.[206] While the U.S. is typically viewed as the international standard bearer protecting the "rule of law," its actions to undermine the PPACA demonstrate an abandonment of that role. Moreover, as discussed further in section C, promulgation of regulations and policies that discourage health companies from engaging in best practices and harm health does not promote *responsible business conduct.*

C. Health Care Businesses should adhere to Global Health Law Norms and the United Nations Framework and Guiding Principles for Business and Human Rights

Normatively, not only should human rights norms guide the United States in encouraging it to preserve the *PPACA Framework to Eliminate Health Disparities*, these ethical principles should also guide businesses in their response to the promulgation of government regulations that seek to undermine the effectiveness of the PPACA. Specifically, businesses in the U.S. health care sector should be encouraged to adhere to global health law norms and the United Nations Framework and Guiding Principles for Business and Human Rights to facilitate their engagement in health-promoting activities.

As previously stated, according to Professors Gostin and Taylor global health laws are designed to create conditions so people throughout the world can attain the highest level of physical and mental health.[207] Global health law achieves this end by seeking to facilitate health promoting behavior among the key actors that impact health like governments, international organizations, businesses, foundations, and civil society. The leading framework in global health law to address inequities is human rights.[208] Thus, I argue that the framework that should guide the health care industry and its businesses in promoting health and human rights is the United Nations Framework on Business and Human Rights ("UNBHR") and the United Nations Guiding Principles on Business and Human Rights ("UNGP"). Leading legal

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204. *See* John G. Ruggie, *Protect, Respect and Remedy: A Framework for Business and Human Rights*, 3 INNOVATIONS 189, 192 (Spr. 2008), https://www.mitpressjournals.org/doi/pdf/10.1162/itgg.2008.3.2.189 [https://perma.cc/LGU9-YK2A]; Larry Cata Backer, *Corporate Social Responsibility in Weak Governance Zones*, 14 SANTA CLARA J. INT'L L. 297 (2016).

205. ORG. FOR ECON. CO-OPERATION & DEV., *OECD Risk Awareness Tool for Multinational Enterprises in Weak Governance Zones* (2006), http://www.oecd.org/daf/inv/corporateresponsibility/36885821.pdf [https://perma.cc/JRA2-D4UG].

206. INT'L ORG. EMPLOYERS, BUS. & HUM. RIGHTS, THE ROLE OF BUSINESS IN WEAK GOVERNANCE ZONES: BUSINESS PROPOSALS FOR EFFECTIVE WAYS OF ADDRESSING DILEMMA SITUATIONS IN WEAK GOVERNANCE ZONES 3-4 (2006), https://www.business-humanrights.org/sites/default/files/media/bhr/files/Role-of-Business-in-Weak-Governance-Zones-Dec-2006.pdf [https://perma.cc/GN6N-F9SR].

207. *See* Majette, *PPACA Framework*, *supra* note 18.

208. *See* Majette, LAW AND GLOBAL HEALTH, *supra* note 10, at 422.

scholars with an expertise in human rights and the rights and obligations of corporations and business entities describe the UNBHR Framework and UNGP as innovative.[209]

Corporate Responsibility to Respect Human Rights.

Corporations and other business entities have a corporate responsibility to respect human rights by acting with due diligence to avoid infringing on the rights of others and address any adverse impacts. The corporate duty to respect human rights through due diligence is explained in UNGP 17. Businesses should assess actual and potential human rights impacts, act on the findings, track responses, and communicate how the impact was addressed.[210] According to Special Representative Ruggie, due diligence moves beyond "identif[ication] and manage[ment] of corporate risks" to a risk assessment of the impact on affected individuals and communities.[211]

Global health law norms require that the U.S. health care industry and individual health care companies should engage in health-promoting behavior that creates conditions to assure people the highest level of health. Thus, these companies should abide by the UN Framework on Business and Human Rights and its Guiding Principles. This means that corporations should respect human rights that society views as a basic social norm.[212] Second, corporations must recognize that their duty to respect human rights is an independent duty that is not conditioned on a country's willingness or capacity to protect human rights.[213] Finally, health care business entities should not be complicit in host government (United States) activities that violate individual human rights.[214] As applied to U.S. businesses, they should not create products or provide services that undermine the *PPACA Framework to Eliminate Health Disparities*, as previously discussed in part III. Thus for example, despite President Trump's October 12, 2017 executive order[215] that permits individuals and small businesses to join together to buy coverage through Association Health Plans and extends the availability of Short-term, Limited-Duration Insurance, insurance companies would not design insurance products that fragment the insurance risk pool in the individual and small group markets or exclude essential health benefits from short-term plans.

Today, some U.S. health care companies are engaging in health-promoting behavior by operating their businesses in a manner consistent with global health law norms and

209. *See* Anita Ramastry, *Corporate Social Responsibility versus Business and Human Rights: Bridging the Gap Between Responsibility & Accountability*, 14 J. HUM. RTS. 237 (2015).

210. UNGP, *supra* note 184, at page 17, para. 17.

211. RUGGIE, JUST BUSINESS, *supra* note 184, at 99; *see also* Jena Martin, *Business and Human Rights: What's the Board Got to Do With it?*, 2013 U. ILL. L. REV. 959 (2013).

212. Ruggie, JUST BUSINESS, *supra* note 184, at 82.

213. *Id.* at 124.

214. *Id.* at 100. The former Special Representative further warns that compliance with the UNBHR might mean that a corporation *severs* its ties with the host country. *Id.*

215. Presidential Executive Order Promoting Healthcare Choice and Competition across the United States, Exec. Order No. 13813, 82 Fed. Reg. 48385 (proposed Oct. 12, 2018). CMS proposed a rule to implement the executive order in February and the Final Rule was published on August 3, 2018. Proposed Rule, Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 7437 (Feb. 21, 2018); Final Rule, Short-Term, Limited Duration Insurance, 33 Fed. Reg. 38,212, 38,213 (Aug. 3, 2018).

the UN Framework and the Guiding Principles on Business and Human Rights. For example, Medica, a non-profit insurer is partnering with the Nebraska Farm Bureau to offer AHP plans.[216] Their product will not discriminate against those with pre-existing conditions in eligibility or premium rates. The premium will be based on PPACA standards that only allow rate differentials for age and geographic area. Medica's premiums will be lower because it expects that the ranchers and farmers will be a healthier risk pool.[217] In contrast, the Iowa Farm Bureau in collaboration with Wellmark Blue Cross Blue Shield will sell "self-funded health benefit plans," which are a special product that the state legislature created and is not insurance.[218] Eligibility to purchase a self-funded health benefit will be based on an individual's pre-existing conditions, which can serve as the basis to deny coverage or charge a higher premium.[219] However, the policy will include some essential health benefits like maternity care, mental health treatment, addiction treatment, and prescriptions.[220]

Some insurance companies are also engaging in health-promoting behavior in their decision to not sell insurance products based on the more lenient short-term, limited duration rules. After CMS proposed regulations in February 2018 that would extend Short-Term, Limited Duration plans from nonrenewable, three-month plans to 364 days with unlimited renewal periods up to thirty-six months, United Healthcare planned to continue selling short-term plans, and Aetna's CEO expressed an interest in entering the market.[221] However, by October 1, 2018, Aetna stated that it would not sell short term plans.[222] United Healthcare plans to offer short-term plans in several states. United Healthcare's policies range from an $12,500 annual deductible for $80 per month to $1000 annual deductible with limited

216. Kimberly Leonard, *Nebraska Unveils Trump-backed Health Plans for Farmers, Ranchers*, WASH. EXAMINER (Sept. 20, 2018), https://www.washingtonexaminer.com/policy/healthcare/nebraska-unveils-trump-backed-health-plans-for-farmers-ranchers [https://perma.cc/4VXT-X3CE].

217. *Id.*

218. Nathaniel Weixel, *Iowa to Sell Health Plans that can Disqualify People Based on Pre-existing Conditions*, HILL (Oct. 4, 2018), https://thehill.com/policy/healthcare/409956-iowa-to-begin-selling-health-plans-that-can-discriminate-on-applicants-pre [https://perma.cc/BDA7-UZY9].

219. *Id.*

220. *Id.*

221. Carolyn Y. Johnson, *Trump Proposal Could Mean Healthy People Save on Insurance while Others Get Priced Out*, WASH. POST (Apr. 23, 2018), https://www.washingtonpost.com/news/wonk/wp/2018/04/23/trump-proposal-could-mean-healthy-people-save-on-insurance-while-sick-middle-class-people-get-priced-out/?utm_term=.2e26a8ad6dab [https://perma.cc/YP3V-6XAG].

222. Alison Kodjak, *Buyer Beware: New Cheaper Insurance Policies May Have Big Coverage Gaps*, NPR (Oct. 1, 2018), https://www.npr.org/sections/health-shots/2018/10/01/652141154/buyer-beware-new-cheaper-insurance-policies-may-have-big-coverage-gaps [https://perma.cc/8XTT-QNQX]. While the ACA created some national consumer protection rules (3 months, nonrenewable), the short-term policy rules are state based. On September 14, 2018, a lawsuit was filed challenging the Short-Term, Limited Duration regulation as contrary to law and arbitrary and capricious in violation of the Administrative Procedures Act. Complaint, Ass'n for Community Affiliated Plans v. U.S. Dep't of Treasury, 392 F. Supp.3d. 22 (D.D.C. 2019) (Civ. Act. No. 18-2133). On July 26, 2018, a lawsuit was filed by the attorney generals for 12 states challenging the Association Health Plan regulations as violative of the Employment Retirement Income Security Act, the Affordable Care Act, and the Administrative Procedures Act. Complaint, New York v. U.S. Dep't of Labor, Civ. Act. No 18-1747 (D.D.C. opinion issued July 26, 2018).

benefits – no prescription coverage and covers 60% of hospital costs.[223] Short-term policies with limited benefits are also sold online. A policy on eHealthInsurance.com does not cover prescription drugs unless the patient is hospitalized, and does not cover prenatal care, mental health care, or annual physicals.[224]

In the United States, the providers, payers, and regulators in the health care industry should continue to comply with the dictates of the Patient Protection and Affordable Care Act and its framework to eliminate health disparities for people of color.[225]

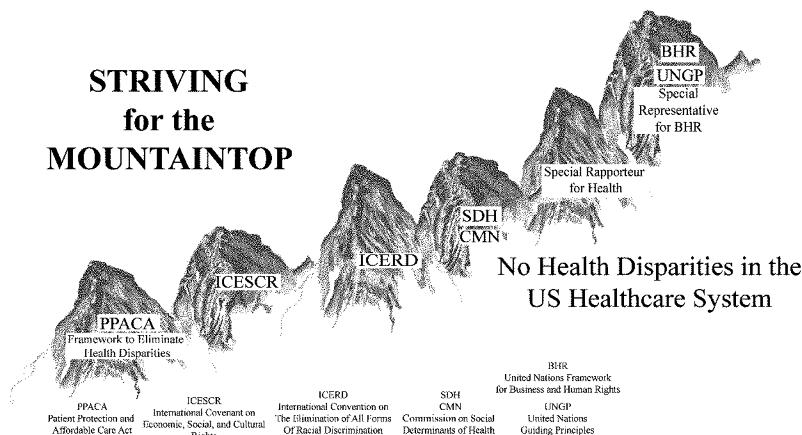

FIGURE 1. – *Global Governance Structure Designed to Eliminate Health Disparities*

VI. CONCLUSION

Passage of the Patient Protection and Affordable Care Act created a framework to develop a system to eliminate health disparities in the United States, the *PPACA Framework to Eliminate Health Disparities*. From 2010 to 2016, the infrastructure was laid as articulated in the Framework. Leadership was provided at the highest levels from President Obama and the Secretary of Health and Human Service (Sebelius and Burwell) to the Deputy Assistant Secretary for Minority Health. Financial resources were provided to the Department of Health and Human Services to fund numerous initiatives to develop and begin testing new health care delivery models to improve the health of people of color. The CMS Office of Minority Health began to use equity-focused tools, and measures were created to track the effectiveness and

223. Alison Kodjak, *Buyer Beware: New Cheaper Insurance Policies May Have Big Coverage Gaps*, NPR (Oct. 1, 2018), https://www.npr.org/sections/health-shots/2018/10/01/652141154/buyer-beware-new-cheaper-insurance-policies-may-have-big-coverage-gaps [https://perma.cc/8XTT-QNQX].

224. *Id.*

225. Majette, LAW AND GLOBAL HEALTH, *supra* note 10, at 421; NAT'L ACADS. OF SCIS., ENGINEERING & MED., ACHIEVING HEALTH EQUITY VIA THE AFFORDABLE CARE ACT: PROMISES, PROVISIONS, AND MAKING REFORM A REALITY FOR DIVERSE PATIENTS: WORKSHOP SUMMARY (2015), https://www.nap.edu/catalog/18551/achieving-health-equity-via-the-affordable-care-act-promises-provisions [https://perma.cc/3EXM-V3JH].

progress of initiatives to reduce health disparities. Several stakeholders in the health care industry and some states also began earnestly working on initiatives to reduce health care disparities.

Since 2017, there has been a period of retrenchment at the federal level. Professor Derrick Bell's interest convergence theory and Professor Lani Guinier's interest divergence theory remind us to expect some backward progress on initiatives designed to improve the lives of people of color. The lessons from human rights violations around the world tell a global story that the marginalized populations in a society suffer. Some of the attacks on the PPACA are intentional and others reflect neglect. President Trump ran on a promise to repeal Obamacare; and he is trying to fulfill that promise by signing executive orders to enable federal agencies to grant exemptions and waivers or otherwise delay implementation of PPACA requirements, passing regulations allowing the Department of Health and Human Services to stop paying cost-sharing reductions, and supporting the Department of Justice's refusal to defend the constitutionality of the PPACA in a lawsuit that seeks to invalidate the entire statute.

There have been leadership challenges at the Department of Health and Human Services. The United States has had two Secretaries of Health in two years. The Office of Minority Health (OMH) has not consistently had a permanent Deputy Assistant Secretary for Minority Health. OMH did not have a permanent secretary for eight months when physician Matthew Yuan Ching Lin was appointed on August 20, 2017. After a year, he left the department in October 2018. Another secretary was not appointed until January 31, 2019. The administration has also not produced mandated reports that are necessary to hold the government accountable like the Report to Congress on the Minority Health Activities of the Department of Health and Human Services or the Periodic Report of the United States to the United Nations Committee on the Elimination of Racial Discrimination. And all of these actions took place while President Trump consistently used racialized rhetoric in his addresses to the nation.

The good news is that there is resistance to efforts to undermine the PPACA, and the *PPACA Framework to Eliminate Health Disparities* is resilient. The United Nations human rights legal system of treaties, treaty bodies, courts, commissions, international organizations, special rapporteurs/representatives, and soft law instruments are an essential bulwark to protect marginalized groups. For health matters, global health law norms provide another avenue and lens to resist retrenchment and regression. Arguments can be made that the United States has violated its obligations under ICERD to protect the health of people of color; violated its duty under the United Nations Framework for Business and Human Rights by not protecting some of its citizens against abuses by third parties by its acts to sabotage the PPACA; and not abiding by the commitments made in the first U.S. National Action Plan for Responsible Business Conduct to play a leadership role in working with business and other stakeholders to implement the plan. In contrast, many players in the health care industry including insurers, health care providers, think tanks, and researchers are continuing their initiatives to reduce health care disparities consistent with the

PPACA Framework to Eliminate Health Disparities. It is the health care industry that is protecting and promoting the health of people of color consistent with the United Nations Framework and Guiding Principles on Business and Human Rights.

The *PPACA Framework to Eliminate Health Disparities* and the infrastructure it created is strong and resilient. Early evidence shows the framework is improving the health of people of color:

- In 2012, Oregon received finding from the NIH National Institute on Minority Health to transform its Medicaid program providing coverage through sixteen coordinated care organizations. The coordinated care organizations provide care that coordinates physical, behavioral, and oral health with social services. Oregon's multi-pronged approach included strategic planning, community health workers, and Regional Health Equity Coalitions. A March 2018 evaluation concludes that the early evidence shows the effort has been successful in reducing disparities for African Americans and American Indian/ Alaska Natives in utilization and quality of care.[226]
- Since 2014, Maryland has required qualified health plans sold on its state exchange to collect and report quality data and Race, Ethnicity, Language, Interpreter Need, and Cultural data (RELIC) on its physicians to the Maryland Health Care Commission (MHCC).[227] Also, as a model for the Center for Medicare and Medicaid Innovation, the state made reduction of health disparities a goal in its All Payer Model Plan that began in 2014 and the Total Cost of Care Model that began in 2019. The All Payer Model Agreement focused on hospital care and required the state to continue to collect and use discharge and quality data to incentivize hospitals to reduce race and ethnic disparities.[228] As part of the Total Cost of Care Model, the Maryland Primary Care program "will identify and reduce disparities in care delivery and health outcomes."[229]
- In 2016, *Achieving Health Equity: A Guide for Health Care Organizations* was published by the world respected think tank, the Institute for Health Care Improvement. The report provides a framework for health care organizations to work on reducing health disparities. The report provides an example of

226. *See* K. John McConnel, Christina J. Charlesworth & Thomas Mearth et al., *Oregon's Emphasis on Equity Shows Signs of Early Success for Black and American Indian Medicaid Enrollees*, 37 HEALTH AFF. 386 (Mar. 2018).

227. MARYLAND HEALTH BENEFIT EXCHANGE, *2018 Letter to Issuers Seeking to Participate in Maryland Health Connection* (Jan. 24, 2017), https://www.marylandhbe.com/wp-content/uploads/2013/05/2018-Final-Letter-to-Issuers.pdf [https://perma.cc/3YXP-Q3EL]; MARYLAND HEALTH BENEFIT EXCHANGE, *Carrier and Qualified Plan Certification, Interim Procedures* (Oct. 23, 2012), https://www.marylandhbe.com/wp-content/uploads/2013/05/MHBE-QHP-Interim-10-23-20121.pdf [https://perma.cc/EEJ7-95A9].

228. MARYLAND HEALTH SERVS. COST REV. COMMISSION, MARYLAND ALL-PAYER MODEL AGREEMENT 38 (Feb. 11, 2014), https://hscrc.maryland.gov/documents/md-maphs/stkh/MD-All-Payer-Model-Agreement-(executed).pdf [https://perma.cc/2YNA-3F4W].

229. MARYLAND DEP'T HEALTH & MENTAL HYGINE, THE MARYLAND ALL-PAYER MODEL PROGRESSION PLAN: UPDATE TO THE DECEMBER 2016 PROPOSAL TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (May 2018), https://hscrc.maryland.gov/Documents/Modernization/05-30-18%20Maryland%20All-Payer%20Model%20Progression%20Plan%27.pdf [https://perma.cc/SE4F-J3XL]; MARYLAND DEP'T HEALTH & MENTAL HYGIENE, THE MARYLAND ALL-PAYER MODEL PROGRESSION PLAN (Dec. 16, 2016), https://hscrc.maryland.gov/documents/md-maphs/pr/Maryland-All-Payer-Model-Progression-Plan.pdf [https://perma.cc/C7MS-WCKA].

hospital initiatives to work on social determinants of health by providing transportation to patients, working with state and local agencies to provide healthy housing, and working with food banks to provide food. Beginning in 2017, the Institute for Health Care Improvement has also been working to help eight organizations implement the guide.

- The National Quality Forum published the *Framework to Achieve Health Equity and Eliminate Disparities* in 2017. This framework provides a systematic approach to develop and use measures to monitor the reduction in disparities and to assess health equity performance; it also recommends incentivizing this work. The framework is broad and applies to providers, payers, and regulators. It also encourages collaboration with those outside the health care system to focus on social determinants of health.

We need more time for additional evidence to develop on the effectiveness of the *PPACA Framework to Eliminate Health Disparities.* Dr. King's *I've Been to the Mountaintop* speech encourages us to resist government and individual efforts to treat people of color as inferior and to resist actions that undermine activities designed to improve their health.