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Majesta-Doré Legnini

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AN UNFULFILLED PROMISE: SECTION 1557'S FAILURE TO EFFECTIVELY CONFRONT DISCRIMINATION IN HEALTHCARE

Abstract

When the Patient Protection and Affordable Care Act passed, it offered a broad promise to provide access to quality care on a nondiscriminatory basis.[1] To achieve nondiscrimination, Congress included Section 1557, which integrated the nondiscrimination protections granted under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments, Section 504, and the Age Discrimination Act. The language of the statute has proved that the section cannot achieve its broad promise. Covering only intentional discrimination and usually interpreted to divide the standard so that intersectional discrimination cannot be redressed, Section 1557 fails to address discrimination in a way that could effectively reduce health disparities and improve overall health outcomes. While it is possible to interpret the statute to provide for an intersectional claim, the limit to only intentional discrimination narrows the scope such that expanding Section 1557's reach is *necessary but not sufficient* to improve the health of marginalized communities. As evidenced during the COVID-19 pandemic, implicit bias and disparate impact discrimination has a real impact in actual life and death healthcare decisions, for which the consequences must have an available remedy. Section 1557 opens the door to a broader approach but remains passive as a 'nondiscrimination' clause. Any further efforts to improve health outcomes and reduce health discrimination must take an active and intersectional 'antidiscrimination' approach.

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INTRODUCTION

The Affordable Care Act (ACA) brought many changes to healthcare in the United States.[2] Not only enabling over twenty million more people to access health insurance in 2016,[3] the ACA guaranteed coverage for preventive services, expanded coverage for young adults, and set new expectations of transparency.[4] In addition to these groundbreaking reforms, the ACA brought an opportunity to combat health discrimination and the resulting health disparities with new force in Section 1557.[5] Section 1557 states that "an individual shall not . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance" on the basis of race, color, national origin, sex, disability, or age.[6] Modeled after the prohibition against discrimination in Title VI of the Civil Rights Act of 1964, this nondiscrimination clause extended protection to four protected classes in a single swoop.[7] But the reality of Section 1557's impact on healthcare discrimination has been underwhelming.

The statute provided the opportunity to consider the healthcare experiences of four protected classes in one action. It appeared to recognize the complex reality of healthcare and human nature: that a single person can occupy all four of those protected classes at once

2. *Summary of Coverage Provisions in the Patient Protection and Affordable Care Act*, KAISER FAM. FOUND. (July 17, 2012) [hereinafter *Summary of Coverage*], https://www.kff.org/health-costs/issue-brief/summary-of-coverage-provisions-in-the-patient [https://perma.cc/3EV3-SGQ6].

3. *The Uninsured and the ACA: A Primer—Key Facts About Health Insurance and the Uninsured Amidst Changes to the Affordable Care Act*, KAISER FAM. FOUND. (Jan. 25, 2019), https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-many-people-are-uninsured [https://perma.cc/M7M4-NGW8].

4. *Summary of Coverage*, *supra* note 2.

5. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016).

6. 42 U.S.C. § 18116(a) (2010) (codifying Section 1557 of the ACA in the United States Code).

7. *See id.*

and be targeted for any and all of those identities in a given healthcare encounter.[8] Section 1557 has failed to successfully address these kinds of discrimination, though. Key to understanding the way Section 1557 has failed in fulfilling its goal of nondiscrimination in healthcare is understanding the principles behind identity and the power principles at play when marginalized communities experience discrimination.[9]

Intersectionality guides understanding the whole person and the privileges and challenges with which they live.[10] It is a powerful tool for interpreting human dynamics and is vital to understanding the social structures behind health disparity data.[11] Sociologist and lawyer, Kimberlé Crenshaw, derived the theory from dynamic Black, Indigenous, and "third-world" feminist and queer theories to foster a "post-colonial" way of thinking about identity and society.[12] Rather than merely considering singular characteristics, such as one's race, sex, or socioeconomic status, intersectionality recognizes the composite result of all such factors.[13] Intersectionality allows a level of nuanced discussion that is often left out of conversations on injustice.[14]

Crenshaw's theory recognizes that the experience of a white woman is different from the experience of a Black woman, and that where a white woman faces gender discrimination, she does not *also* face race-based discrimination, and a Black woman likely faces both.[15] Intersectionality embraces a person's whole experience and limits population homogenization.[16] The theory further embraces a more complex understanding of the balance of power within society itself.[17] Social structures distribute power and our interactions with those structures determine our experiences.[18] These social structures could be as near as the make-up of the family or as distant as the laws passed by governments.[19]

If those institutions foster discrimination, the consequences will pervade the whole society as power gets distributed across those who are bound to that institution.[20] Each person's composite identity

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8. *See* Anuj Kapilashrami & Olena Hankivsky, *Intersectionality and Why it Matters to Global Health*, 391 THE LANCET: COMMENT 2589, 2589 (2018).
9. *See id.*
10. *Id.*
11. *Id.*
12. *Id.*
13. *Id.*
14. Kapilashrami & Hankivsky, *supra* note 8, at 2589.
15. *Id.*
16. *Id.*
17. *Id.*
18. *Id.*
19. *See id.*
20. *See* Kapilashrami & Hankivsky, *supra* note 8, at 2589.

determines how severely a discriminatory policy will impact their lives and that power dynamic determines future policies.[21] Although recent years have brought more awareness to cultural differences and attempted to reduce barriers, the result has often been a shallow rise of cultural competency, rather than full-throttle attempts to address the deep-seated institutional issues that perpetuate discrimination in the long term.[22] For example, the 2019 National Healthcare Quality and Disparities Report provides important insight into the disparities between races in areas such as patient safety, effectiveness of care, and patient-centered care, but it lacks the deeper analysis of how those health disparities reflect larger social inequality.[23] The report includes some measures that impact women and other vulnerable populations, and looks at each care measure based on geography and income.[24] It remains unidimensional; it fails to look at how each of these factors overlay with the others to reflect the shameful and compounding realities of subjugation and oppression in this country which perpetuate these health disparities.

Although Section 1557 does afford some additional legal protection and remedy for those who experience discrimination in healthcare, the recent COVID-19 pandemic demonstrates how much work remains in healthcare reform to truly combat health discrimination and disparities.[25] Both implicit and explicit discrimination pervade the pandemic experience; from the infection and death rates, to the day-to-day encounters of patients whose doctors refuse to believe them, even to the ways that states across the country prepared for crisis care.[26] Continuing on in a system that perpetually fails to

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21. *See id.* at 2590.

22. *Id.*

23. *See, e.g.*, AGENCY FOR HEALTHCARE RSCH. & QUALITY, NAT'L HEALTHCARE QUALITY & DISPARITIES REP., at Table 1: Patient Safety Measures Black vs. White (2019) [hereinafter AGENCY FOR HEALTHCARE].

24. *See, e.g.*, *id.* at Table 1: Patient Safety Measures Black vs. White, Table 8: Person-Centered Care Asian vs. White, Table 15: Care Coordination Measures NPHI vs. White, Table 30: Patient Safety Measures for Poor vs. High Income, Table 62: Affordable Care Measures for Large Central Metro Area vs. Large Fringe Metro Area.

25. Tonya Russell, *Racism in Care Leads to Health Disparities, Doctors and Other Experts Say as They Push for Change*, WASH. POST (July 11, 2020, 10:00 AM), https://www.washingtonpost.com/health/racism-in-care-leads-to-health-disparities-doctors-and-other-experts-say-as-they-push-for-change/2020/07/10/a1a1e40a-bb9e-11ea-80b9-40ece9a701dc_story.html [https://perma.cc/YSM5-JGK9]; *Racial Data Dashboard*, THE COVID TRACKING PROJECT AT THE ATLANTIC [hereinafter THE COVID TRACKING PROJECT], https://covidtracking.com/race/dashboard [https://perma.cc/9ZLD-S45T] (last visited Dec. 6, 2021).

26. Joseph Shapiro, *People with Disabilities Fear Pandemic Will Worsen Medical Biases*, NPR (Apr. 15, 2020, 5:00 AM) [hereinafter Shapiro I], https://www.npr.org/2020/04/15/828906002/people-with-disabilities-fear-pandemic-will-worsen-medical-biases [https://perma.cc/N4TD-TU29].

recognize and actively uproot discrimination in healthcare disregards the depth of disparity that multiple marginalized patients face.[27]

Part I considers how Section 1557 has been interpreted since it passed in 2010. First without supporting regulations as courts attempted to piece together the statutory intent, then with regulations that changed between the Obama and Trump Administrations. Part II discusses the need for a single healthcare discrimination standard, and how an intersectional approach is the most appropriate way to combat discrimination that creates poorer health outcomes for marginalized patients in health systems across the United States. Finally, Part III discusses discrimination during the coronavirus pandemic. Addressing both state initiatives and doctor-patient interactions to demonstrate the inadequacy of the current system, this section concludes that any further efforts toward healthcare reform must reach much further than Section 1557.

I. APPLICATIONS OF SECTION 1557 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Congress enacted the Patient Protection and Affordable Care Act (ACA) in 2010.[28] Section 1557 is one of the provisions within the ACA that became effective even before HHS promulgated regulations.[29] HHS did not release final rules regarding Section 1557 until 2016.[30] These regulations clarified the scope of the statute's reach and how the HHS Office of Civil Rights would interpret and enforce Section 1557.[31] While important to defining the boundaries of the law, the regulations cannot define whether a private right of action exists under the statute.[32] To enforce Section 1557 on an individual level, there must be congressional intent to create a private right of action paired with a private remedy.[33] Where there is no congressional intent, "a cause of action does not exist and courts may not create one, no matter how desirable that might be as a policy matter, or

27. *See* Kapilashrami & Hankivsky, *supra* note 8, at 2590.

28. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1557 (2010).

29. MaryBeth Musumeci, Jennifer Kates, Lindsey Dawson, Alina Salganicoff, Laurie Sobel & Samantha Artiga, *The Trump Administration's Final Rule on Section 1557 Non-Discrimination Regulations Under the ACA and Current Status*, KAISER FAM. FOUND. (Sept. 18, 2020), https://www.kff.org/racial-equity-and-health-policy/issue-brief/the-trump-administrations-final-rule-on-section-1557-non-discrimination-regulations-under-the-aca-and-current-status [https://perma.cc/7C53-CUP4].

30. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,376 (May 18, 2016).

31. *Id.* at 31,376.

32. Alexander v. Sandoval, 532 U.S. 275, 286–87 (2001).

33. *See id.* at 286.

how compatible with the statute."[34] This section explores whether a private right of action exists under Section 1557, how courts interpreted the section before regulations, and, finally, how the Obama and Trump Administrations interpreted the section differently.

A. Is There a Private Right of Action Under Section 1557?

The restriction of creative power to Congress does not preclude implied causes of action.[35] For example, in *Alexander v. Sandoval*, the Court determined that there is no private right of action to enforce discrimination that disparately impacts certain racial groups under Title VI, but the Court simultaneously reaffirmed Title VI's implied right of action against intentional discrimination on the basis of race.[36] An indicator for Congressional intent is whether the language of the statute "mak[es] the would-be plaintiff 'a member of the class for whose benefit the statute was enacted'" or whether the language suggests that enforcement lies in the hands of a government agency.[37]

Section 1557, like many nondiscrimination clauses, mimics the language used in Title VI of the Civil Rights Act of 1964.[38] It grounds the right with the person experiencing discrimination, with language of "an individual shall not . . . be excluded from participation in, be denied the benefits of, or be subject to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance."[39] This language anchors the right with the individual and places the potential plaintiff in a series of protected

34. *Id.* at 286–87.

35. *See, e.g.*, *id.* at 297 (reaffirming a previous holding that there was no doubt whether Congress intended to create an implied private cause of action under Title VI).

36. *Id.* at 281, 293 (holding that private rights of action exist against the specifically proscribed discrimination and limiting interpretations to intentional discrimination).

37. *See id.* at 290.

38. *Compare* 42 U.S.C. § 2000d et seq. (1964) ("No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance"), *with* 20 U.S.C. § 1681 (1986) ("No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance"), *and* 29 U.S.C. § 794 (2015) ("No otherwise qualified individual with a disability in the United States . . . shall, solely by reason of his or her disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service"), *and* 42 U.S.C. § 6102 (1975) ("[N]o person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance").

39. 42 U.S.C. § 18116(a) (2010).

classes.[40] Where Section 1557 differs from other nondiscrimination statutes, is where it integrates "the ground[s] prohibited under" four pre-existing nondiscrimination statutes (Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments, Section 504, and the Age Discrimination Act) to define the contours of nondiscrimination in healthcare.[41]

In some ways, Section 1557 merely reflects the current state of nondiscrimination law in the United States,[42] wherein the integrated statutes reflect the implied right of action derived from the language in Title VI.[43] From that existing framework, Courts have developed the boundaries of each protected class' enforcement mechanisms.[44] Section 1557 creates an implied right of action that integrates existing systems to reach a new realm of protection—health programs and activities.[45] Where the pre-existing statutes are integrated, both procedure and remedies are incorporated.[46] This means that there are limits imposed on what a plaintiff can bring based on what bases of discrimination they allege, and also limits on what kinds of remedies they may seek.[47] It is beyond the scope of this Note to review all rights and burdens under each integrated statute. Importantly, though, the four pre-existing statutes predominantly require a showing of intentional discrimination.[48]

Considering that the overarching purpose of the ACA is "to ensure that health services are available broadly on a nondiscriminatory basis,"[49] interpreting Section 1557 to merely extend existing law to the healthcare arena is not sufficient to combat pervasive health disparities, which can result from both intentional and disparate impact discrimination.[50]

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40. *See* Southeastern Pa. Transp. Auth. v. Gilead Sci. Inc., 102 F. Supp. 3d 688, 698 (2015).

41. *See* 42 U.S.C. § 18116(a) (2010).

42. *See* Briscoe v. Health Care Serv. Corp., 281 F. Supp. 3d 725, 727 (N.D. Ill. 2017).

43. *See Gilead*, 102 F. Supp. 3d at 698.

44. *See id.*; *see, e.g.*, Alexander v. Choate, 469 U.S. 287, 292–99 (1985).

45. 42 U.S.C. § 18116(a) (2010).

46. *See Gilead*, 102 F. Supp. 3d at 698.

47. *See id.*

48. *See, e.g.*, Alexander v. Sandoval, 532 U.S. 275, 281 (2001) ("Title VI itself reach[es] only instances of intentional discrimination" and "Title IX created a private right of action to enforce a ban on intentional discrimination") (internal quotations omitted). *But see Choate*, 469 U.S. at 299 ("While we reject the boundless notion that all disparate-impact showings constitute prima facie cases under § 504, we assume without deciding that § 504 reaches at least some conduct that has an unjustifiable disparate impact upon the [disabled][.]").

49. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,379 (May 18, 2016).

50. *See, e.g.*, AGENCY FOR HEALTHCARE, *supra* note 23, at Table 20: Care Coordination Measures for AI/AN vs. White (showing that American Indian/Alaska Natives experience

B. Application of Section 1557 Before the 2016 Final Regulations

After finding that there is a private right of action, HHS had to promulgate regulations to assist in interpreting how integrated the existing statutes would be, and defining the terms that Congress left to the agency.[51] Initially, HHS moved slowly, so courts interpreted the ambiguous section on their own and found divergent applications.[52] The confusion over the extent to which the ACA established a single 'health discrimination' test that applies to discrimination on the basis of any grounds identified in the integrated civil rights legislation has dulled the clause's promise.[53]

The ACA promised to bring nondiscriminatory healthcare to the United States,[54] but failed to recognize just how common those experiences are, and how much they contribute to health disparities. Discrimination permeates all elements of healthcare and is reflected in basic health statistics: the Black infant mortality rate is twice that of white infants, there is a lack of referrals to specialists for Black patients, and Black women's pain is regularly ignored even though it may be indicative of more serious diseases.[55]

Under the divided readings, the protections against discrimination differed depending on which court the plaintiff brought their lawsuit in.[56] For example, in 2015, a Black woman whose pain was ignored may, or may not, have been able to redress the full extent of her injury under Section 1557 depending on her jurisdiction. If the court followed the reasoning in the unreported *Rumble v. Fairview Health Services* opinion, the woman could enforce the nondiscrimination law on the grounds that she experienced discrimination based on her race *and* her sex.[57] If the court followed the reasoning in *Briscoe v. Health Care Service Corporation*, on the other hand, a Black woman might be forced to select between her two identities, even though

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poorer care-coordination, including poorer communication of discharge instructions and staff disregarding preferences for treatment upon discharge).

51. *See* OFF. OF C.R., *supra* note 1.

52. *Compare* Rumble v. Fairview Health Services, No. 14-CV-2037, 2015 WL 1197415, at *2 (D. Minn. 2015) (finding a single intersectional health discrimination claim, that integrates only the grounds for discrimination that are prohibited in the statutes integrated into Section 1557, and subjects the claim to a single test), *with Briscoe*, 281 F. Supp. 3d at 728 (finding that each statute integrated into Section 1557 also brings its own tests, remedies, burdens, and procedures).

53. *Compare Rumble*, 2015 WL 1197415, at *2, *with* Briscoe v. Health Care Serv. Corp., 281 F. Supp. 3d 725, 738 (N.D. Ill. 2017).

54. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,376 (May 18, 2016).

55. Russell, *supra* note 25.

56. *Compare Rumble*, 2015 WL 1197415, at *10, *with Briscoe*, 281 F. Supp. 3d at 738.

57. *See Rumble*, 2015 WL 1197415, at *12.

each played a part in the discriminatory denial of appropriate medical care.[58] Such a division of herself is impossible and is not truly reflective of the treatment she received, particularly considering that the end result of the discriminatory treatment is the same: she experiences poorer health outcomes after being denied care or after care is delayed.

Understanding how discrimination results in poorer health outcomes is vital to addressing health disparities, but that by no means makes it a simple task. There are several layers to the analysis, as *Rumble* indicates.[59] Before *Rumble*, no other court interpreted the integration language within Section 1557.[60] Section 1557 sets out that "an individual shall not [be discriminated against] on the ground prohibited under [T]itle VI of the Civil Rights Act of 1964 . . . [T]itle IX of the Education Amendments of 1972 . . . the Age Discrimination Act of 1975 . . . or [S]ection 504 of the Rehabilitation Act of 1973."[61] Each of the integrated statutes provides distinct grounds for which discrimination is prohibited.[62] The court, recognizing the ambiguity in the integration of the four statutes, questioned how a plaintiff could use the statutes under Section 1557 where each uses a different standard for liability, causation, and different burdens of proof.[63] The court determined that Section 1557 must be interpreted as a whole, and that Congress intended to create a single health-specific nondiscrimination standard.[64]

The judge in *Rumble*, Judge Susan Nelson, recognized that any reading providing multiple standards would diffuse Section 1557's impact on discrimination in healthcare.[65] In particular, Judge Nelson noted that "different enforcement mechanisms and standards would apply to a Section 1557 plaintiff depending on whether the plaintiff's claim is based on her race, sex, age, or disability."[66] Such a reading would mean that the ignored Black woman from above would have different requirements under the law than a white woman who experienced discrimination based on her sex and sexual orientation, despite both women filing claims under Section 1557.[67] Finding that an interpretation that retains each statute's standards precludes

58. *Briscoe*, 281 F. Supp. 3d at 738.
59. *Rumble*, 2015 WL 1197415, at *9–19.
60. *Id.* at *9.
61. 42 U.S.C. § 18116(a) (2010).
62. *Rumble*, 2015 WL 1197415, at *10.
63. *Id.*
64. *See id.* at *11.
65. *See id.*
66. *Id.*
67. *See id.*

intersectional claims and leaves the court with little guidance, Judge Nelson held that the four laws provide only *the bases* for the prohibition on discrimination, but that one standard of proof applied to all Section 1557 plaintiffs.[68]

By contrast, the District Court in *Briscoe* considered the reasoning in *Rumble* and rejected the single standard reading.[69] Despite the HHS Office of Civil Rights' (OCR) support for the *Rumble* interpretation of Section 1557, the *Briscoe* court found more persuasive those cases that held that retention of the distinct enforcement mechanisms of each statute is more aligned with Congressional intent.[70] The court found that "[i]f Congress intended for a single standard . . . [then] repeating the references to the civil-rights statutes and expressly incorporating their distinct enforcement mechanisms would have been a pointless (and confusing) exercise."[71] Indeed, the court recognized that the incorporation established the perimeter of prohibited discrimination, but extended it "to establish the enforcement mechanisms available under the ACA for different discrimination claims."[72] This holding is logical to an extent, but is hindered where plaintiffs generally could already reach intentional discrimination in many healthcare settings—even if the ACA did not exist—by virtue of the "any program or activity receiving Federal funds" language in each integrated statute.[73] So, a Black disabled[74] individual facing intentional healthcare discrimination could have sought redress under the Civil Rights Act of 1964 or Section 504.[75]

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68. *Rumble*, 2015 WL 1197415, at *12.

69. Briscoe v. Health Care Serv. Corp., 281 F. Supp. 3d 725, 738 (N.D. Ill. 2017).

70. *Id.*

71. *Id.*

72. *See id.*

73. Some of the statutes do have limiting language that restricts the areas in which they are active. For example, Title VI of the Civil Rights Act of 1964 is active in employment only on rare occasions, even if the employer receives federal funding, because of language that ultimately directs potential plaintiffs to Title VII to resolve disputes via the Equal Employment Opportunity Commission (EEOC). *See* Lynn Ridgeway Zehrt, *Title IX and Title VII: Parallel Remedies in Combatting Sex Discrimination in Educational Employment*, 102 MARQUETTE L. REV. 701, 714 (2019). Some circuits follow similar reasoning in interpreting Title IX, which is already limited to education, and find that although it may operate in employment, Title VII procedures are more appropriate because otherwise Title IX can serve as a bypass to the administrative requirements under Title VII. *Id.* at 715–17.

74. There is some discussion over whether person-first or identity-first language is most appropriate when discussing a disability. This Note uses identity-first language, including the term "disabled." Understanding the argument against using identity-first language and the preconceptions that it may bring, any stigmas or harms attached to the term "disabled" are based on society's own stereotyping of disabled individuals. Since "disabled" is merely a descriptive term and any connotation assigned to it is assigned from the reader, this Note uses identity-first language.

75. *See* Alexander v. Choate, 469 U.S. 287, 293–98 (1985) (holding that Title VI reached only intentional discrimination and that Section 504 could reach disparate impact

It is merely repetition of existing law to place a list of civil rights statutes within the ACA *without* an active intention of integration to create an intersectional cause of action that operates under a single standard. Though it may clarify applicability, the practical effect of such a repetition is essentially null. Those people who would have brought claims able to withstand the existing challenging tests, presumably, would have brought and succeeded on their cases, ACA or no ACA. Applying Section 1557 as the *Briscoe* court commands adds little to the fight against health disparities.

C. Administrative Battles: Which Interpretation Fits Best?

The conflicting interpretations seen in the courts above, are also present in regulations. The Obama Administration's initial regulations clearly addressed a single right of action for plaintiffs seeking to redress discrimination in a healthcare setting.[76] The final regulations, released in 2016, interpreted the statute to integrate each of the civil rights statutes' enforcement mechanisms, stating that the "mechanisms provided for and available under" each of the incorporated statutes "shall apply for purposes of . . . Section 1557."[77] The regulations further provide that "[c]ompensatory damages for violations of Section 1557 are available in appropriate administrative and judicial actions."[78] This combination of statements settled the question of whether any of the enforcement opportunities available outside of Section 1557 litigation could be available to the Section 1557 plaintiff.[79]

The regulations did not interpret the section without limitation, though, because they did not go so far as *Rumble* to apply a single burden to discrimination in healthcare on the different prohibited bases of discrimination.[80] Rather, the regulations aligned with *Briscoe*, which retained the standards under each individual law while attempting to combine them into a single Section 1557 claim.[81] The rule established that nothing in Section 1557 or the regulations "shall be construed to apply a lesser standard for the protection of individuals

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discrimination; requiring the defendants be recipients of federal funds and explaining that the promise of nondiscrimination law is not the same outcome, but the same opportunities).

76. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,376 (May 18, 2016).

77. *Id.*

78. *Id.*

79. Allison M. Tinsey, *Regulating Relief: Private Right of Action Jurisprudence in Healthcare Discrimination Cases*, 20 RICH. PUB. INT. L. REV. 305, 312 (2017).

80. *See id.*

81. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,472 (May 18, 2016).

from discrimination than the standards applied" under the four integrated statutes.[82] Under this interpretation, the Section 1557 plaintiff would bring a single claim under 1557.[83] If the individual faced intersectional discrimination during a single health encounter, the individual's age discrimination evidence would have to meet the standard under the Age Discrimination Act, and the individual's race discrimination evidence would have to meet the Title VI standards.[84] These rules caused terrible confusion and led to overly complex and ineffective litigation.[85]

The overarching mission of the ACA is to increase access to *quality* healthcare.[86] While nondiscrimination protections make no guarantee to the same outcomes, as Justice Marshall explained in *Alexander v. Choate*, they do guarantee the *opportunity to attain* those outcomes.[87] Access is *not* improved if marginalized and multiple marginalized individuals across the nation still distrust medical providers, avoid healthcare, or fear seeking treatment because of discrimination.[88] Such avoidance only further perpetuates severity of illness and increases disparities.[89] Restructuring institutions to facilitate more diverse patients is a complex process, but one of those steps should be nondiscrimination protections *with teeth*, particularly considering the severe consequences often at stake in a healthcare setting.[90]

The Trump Administration promulgated its own rules interpreting Section 1557 and removed many of the protections enforced by the previous administration.[91] Where the Obama Administration included gender identity and sexual orientation as protected from discrimination on the basis of sex, the Trump Administration excluded those identities from protection.[92] The new regulations also moved

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82. *Id.* at 31,466.

83. Tinsey, *supra* note 79, at 314.

84. *See id.* at 312.

85. *See* OFF. OF C.R., *supra* note 1.

86. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,462 (May 18, 2016).

87. Alexander v. Choate, 469 U.S. 287, 305 (1985).

88. *See* April Dembosky, *'All You Want Is to Be Believed': Sick with COVID-19 and Facing Racial Bias in the ER*, NPR (Oct. 21, 2020, 5:01 AM), https://www.npr.org/sections/health-shots/2020/10/21/915084127/all-you-want-is-to-be-believed-sick-with-covid-19-and-facing-racial-bias-in-the-#:~:text=From-,'All%20You%20Want%20Is%20To%20Be%20Believed'%3A%20Sick%20With,Racial%20Bias%20In%20The%20ER&text=Kenneth%20Eke%2FCode2040-,Karla%20Monterroso%20says%20after%20going%20to%20Alameda%20Hospital%20in%20May [https://perma.cc/6GMJ-AE6K].

89. *See id.*

90. Kapilashrami & Hankivksy, *supra* note 8, at 2590–91.

91. *See* Nondiscrimination Requirements, 45 C.F.R. § 92.2 (2020); OFF. OF C.R., *supra* note 1.

92. OFF. OF C.R., *supra* note 1.

further away from an interpretation that allows for intersectional claims.[93] The new rules required courts to follow "the longstanding enforcement structure for each civil rights statute identified in Section 1557."[94] Such an interpretation removes the partially integrated system established under the 2016 regulations, and instead substitutes a mere recitation of the applicability of prior civil rights laws in the healthcare setting.[95] The Biden Administration has announced that these rules will not continue during his term.[96]

Still, Section 1557 protection greatly diminished under the Trump Administration's enforcement approach because it removed new protections for some patient-plaintiffs and effectively extinguished the possibility of an intersectional claim.[97] Given that "a fundamental purpose of the ACA is to ensure that health services are available broadly on a nondiscriminatory basis," such curtailing of patient rights cannot conform with the law's purpose nor achieve much progress reducing health disparity.[98]

II. Why A New, Single Health Discrimination Standard Is Necessary

There is no doubt that the simplest solution to the ambiguity in Section 1557 is essentially what the Trump Administration did: interpret it as merely extending the domain of each pre-existing statute into healthcare.[99] Such an interpretation, however, is inappropriate and does not conform with the intent behind Section 1557 or the ACA as a whole.[100] This intent, to improve healthcare access through nondiscriminatory care,[101] is vital to improving healthcare outcomes. Section 1557, however, likely is not the vehicle to ever achieve that goal. This section assesses the ways Section 1557, currently operating as a divided standard, fails to adequately address discrimination

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93. *See id.*

94. *Id.*

95. *See id.*; Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,472 (May 18, 2016).

96. MaryBeth Musumeci, Lindsey Dawson, Laurie Sobel & Jennifer Kates, *Recent and Anticipated Actions to Reverse Trump Administration Section 1557 Non-Discrimination Rules*, KFF (June 9, 2021), https://www.kff.org/racial-equity-and-health-policy/issue-brief/recent-and-anticipated-actions-to-reverse-trump-administration-section-1557-non-discrimination-rules [https://perma.cc/T4F8-WVBV].

97. *See* OFF. OF C.R., *supra* note 1.

98. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,379 (May 18, 2016).

99. *See* OFF. OF C.R., *supra* note 1.

100. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,410, 31,462 (May 18, 2016).

101. *Id.*

taking place in healthcare settings today. It goes on to assess the value of an intersectional approach, and how a single, intersectional health discrimination standard built on the foundations of Section 1557 is more appropriate for modern needs.

A. A Divided Section 1557 Does Not Adequately Address Real-Life Healthcare Experiences

Broadly, Congress framed Section 1557 with language similar to that within the pre-existing statutes.[102] The pre-existing nondiscrimination statutes state that "no person shall be . . . discriminated against . . . [in] any program or activity . . . receiving Federal financial assistance."[103] It is true that even with such a broad statement, there are some limitations on each statutes' reach. For example, there is dispute over whether Title IX *always* reaches employment situations, because of its crossover with Title VII of the Civil Rights Act of 1964.[104] If Title IX reaches all employment situations, then a plaintiff could bypass administrative exhaustion and caps on damages.[105] Some argue that since Title IX came after Title VII, Congress would have stated if it intended there to be any preemptive effect.[106] This logic implies that Congress's *not* stating a preemptive effect means that Title IX is intended to have *some* different application and interpretation than Title VII.[107] This argument can extend to the question of whether Section 1557 integrates only the broader concepts of the integrated statutes and creates a single, intersectional health discrimination cause of action.

First, the inclusion of the disclaimer in Section 1557(b), that nothing in Section 1557 is intended to alter the interpretation of the original pre-existing statutes, implies that the statute is intended to pave its own way in nondiscrimination law.[108] Second, Section 1557 came *after* each of the incorporated civil rights statutes, and uses language that both creates its own implied private right of action[109] and limits the impact of the new right of action on the interpretation of the existing laws in other contexts.[110] If Congress intended Section 1557

102. *See supra* note 38.
103. *See id.*
104. Zehrt, *supra* note 73, at 715–17.
105. *Id.* at 716–17.
106. *Id.* at 724.
107. *See id.* at 723–24.
108. *See* 42 U.S.C. § 18116(b) (2010).
109. *See* Southeastern Pa. Transp. Auth. v. Gilead Sci. Inc., 102 F. Supp. 3d 688, 698–99 (2015).
110. *See* 42 U.S.C. § 18116(b) (2010).

to merely be an add-on to the existing laws, it would not have included such language that triggers an intent to establish stronger protections on their own path in American nondiscrimination law.[111] By the same reasoning that supports the argument that Title IX is intended to have *some* different application in employment than Title VII, it is logical that Section 1557 must have *some* different application than the integrated statutes operating on their own, namely, the creation of an intersectional plaintiff.[112]

Next, the 2016 regulations partially integrated the civil rights legislation into a single claim but maintained different burdens for each aspect of that claim.[113] Requiring different burdens for a single integrated claim in such a way is illogical. It forces selection of legal and factual theories that may not be fully reflective of the discrimination that the individual faced to avoid compromising the burden under one standard or another.[114] This pressure is particularly inappropriate because failure to meet either burden could potentially defeat the entire Section 1557 claim.[115] It is unreasonable that Congress would have intended that the Section be so self-defeating.

Moreover, despite different bases for discrimination, or cumulative and intersectional discrimination, in healthcare the total discrimination that a person experiences during an encounter has the same result: deficient provision of care resulting in poorer health outcomes.[116] And poorer health outcomes resulting from discrimination perpetuates and widens health disparities.[117] Applying different tests for the different ways in which someone faces discrimination in healthcare is inefficient and ineffective toward the ACA's goals.[118] In fact, applying different tests would likely reduce a patient-plaintiff's ability to give evidence on each basis of discrimination, given likely challenges of relevance or issues with variable burdens of proof.[119] Section 1557 prohibits discrimination on the basis of age, disability, sex, race, color, or national origin in health programs that operate in organizations receiving federal funding.[120] A patient-plaintiff who

111. *See* Zehrt, *supra* note 73, at 724.
112. *Id.*
113. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,466 (May 18, 2016).
114. *See* Rumble v. Fairview Health Services, No. 14-CV-2037, 2015 WL 1197415, at *11 (D. Minn. 2015).
115. *See id.*
116. *See* Russell, *supra* note 25.
117. *See id.*
118. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,466 (May 18, 2016).
119. *See Rumble*, 2015 WL 1197415, at *10–11.
120. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1557 (2010).

faces discrimination in such a setting is entitled to seek redress for discrimination on *any and all* of those discriminatory experiences, and should not have to face the unnecessary legal barrier of having to 'pick an identity' for a more successful claim.[121]

Health disparities are highly reflective of an individual's social identities, but data can be slow to catch up.[122] Despite the constant lag in data, in part because of physicians' own hesitance to take steps that would enable such monitoring,[123] the impact of these characteristics on physician-patient interactions cannot be ignored. For example, considering the measure "adults who had a doctor's office or clinic visit in the last 12 months whose health providers sometimes or never spent enough time with them," the rate for white patients in 2019 was 8.5% compared to 28.0% for American Indian/Alaska Natives.[124] The maternal mortality rate is a shocking example of how race and gender intersect and how our current health system handles compounding marginalization.[125] Based on data from 2014–2017, the maternal mortality rate for white women was 13.4%.[126] The rates for Black women and American Indian/Alaska Native women were 41.7% and 28.3%, respectively.[127] Healthcare providers cannot divorce these women's individual social identities from each other, so much so that the combination of their identities may determine the future of their families. If the providers responsible for the discrimination cannot divorce the identities from each other, the system responsible for enforcing the remedy against that discrimination should not divorce them either.

Finally, the very nature of Section 1557's implied right of action[128] creates a barrier that limits its ability to fully redress discrimination

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121. *See id.*

122. *See, e.g.*, Jan Hoffman, *Gay and Transgender Patients to Doctors: We'll Tell. Just Ask.*, N.Y. TIMES (May 29, 2017), https://www.nytimes.com/2017/05/29/health/lgbt-patients-doctors.html [https://perma.cc/GZS3-5M7D]; Perri Klass, *The Impact of Disparities on Children's Health*, N.Y. TIMES (June 15, 2020), https://www.nytimes.com/2020/06/15/well/family/the-impact-of-disparities-on-childrens-health.html [https://perma.cc/L4Q6-KQW7]; Jill Cowan, *Californians Support Black Lives Matter and Wearing Masks*, N.Y. TIMES (July 29, 2020), https://www.nytimes.com/2020/07/29/us/california-coronavirus-demographics.html [https://perma.cc/5NQ6-Y7PH].

123. *See* Hoffman, *supra* note 122.

124. AGENCY FOR HEALTHCARE, *supra* note 23, at Table 19: Person-Centered Care Measures for AI/AN vs. White.

125. *See Pregnancy Mortality Surveillance System*, CTRS. FOR DISEASE CONTROL & PREVENT.: REPROD. HEALTH, https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm [https://perma.cc/B5GQ-NQHN] (last visited Dec. 6, 2021).

126. *Id.*

127. *Id.*

128. *See* Southeastern Pa. Transp. Auth. v. Gilead Sci. Inc., 102 F. Supp. 3d 688, 698–99 (2015).

in healthcare and achieve its goals as set forth in the ACA.[129] In modeling Section 1557 after Title VI of the Civil Rights Act of 1964,[130] the implied right of action is likely limited only to instances of *intentional* discrimination.[131] Each of the integrated statutes is modeled after Title VI,[132] and each requires a showing of intentional discrimination before a plaintiff can recover.[133] The exception is a claim for disability discrimination under Section 504, for which there *may* be times that disparate impact claims are permitted.[134] As such, if a disabled patient brought a Section 1557 claim alleging discrimination on the basis of disability and race, despite being permitted to show disparate disability discrimination, that intersectional claim would likely collapse under the weight of the intentional discrimination burden.

B. Intersectionality and a Single Health Antidiscrimination Standard

Nondiscrimination clauses will not be effective in combating the daily discrimination that marginalized communities face until they recognize and enforce against the multiple ways institutions perpetrate discrimination.[135] The law must equip multiple marginalized communities with the tools to fight against such oppression, otherwise, the "daily problems associated with intersectionality across any combination of racial, class, gender, sexual orientation, language, or disability systemic oppressions and discrimination, may . . . [be] daunting."[136] Kimberlé Crenshaw is credited with exposing the ways in which progress in the law has moved nondiscrimination forward, while still holding it back.[137] For example, at its core, the law operates within strict definitions, and American nondiscrimination laws have defined sex discrimination and race discrimination around

129. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,379 (May 18, 2016).

130. *See* C.R. DIV., DEP'T OF JUST., TITLE VI LEGAL MANUAL IV.1 (2021).

131. *See, e.g.*, Alexander v. Sandoval, 532 U.S. 275, 280 (2001).

132. *See* C.R. DIV., DEP'T OF JUST., TITLE VI LEGAL MANUAL; *Introduction to the ADA*, U.S. DEP'T OF JUST. CIV. RTS. DIV. IV.1, https://www.ada.gov/ada_intro.htm [https://perma.cc/6ZMM-3V9F] (last visited Dec. 6, 2021).

133. *See* Southeastern Pa. Transp. Auth. v. Gilead Sci. Inc., 102 F. Supp. 3d 688, 701 (2015); C.R. DIV., DEP'T OF JUST., TITLE VI LEGAL MANUAL IV.1, IX.1 (2021).

134. Alexander v. Choate, 469 U.S. 287, 299 (1985).

135. *See* Devon W. Carbado, Kimberlé Williams Crenshaw, Vickie M. Mays & Barbara Tomlinson, *Intersectionality: Mapping the Movements of a Theory*, 10 DU BOIS REV. 303, 304 (2013).

136. Nancy Lopez & Vivian L. Gadsden, *Health Inequities, Social Determinants, and Intersectionality*, NAT'L ACAD. OF MED. 1, 3 (2016).

137. *Id.* at 5; Carbado et al., *supra* note 135, at 303–04.

"prototypical representatives."[138] These representatives, white women and Black men, respectively, focus advocacy and change around patriarchal and racist understandings of discrimination, thus limiting the extent to which nondiscrimination can achieve its goal.[139]

In reality, people are much more complicated than is represented in much of the current nondiscrimination law. Until nondiscrimination law recognizes and adopts the nuances that exist within society, the notion of more active 'antidiscrimination' will remain aspirational.[140] Enforcement mechanisms like Section 1557 hold promise to open the door to such intersectional application but will hold no teeth if people are still forced to select single-identity enforcement.

C. Intersectionality in Healthcare

Health status is dependent upon both biological factors and social determinants of health.[141] Recently, there has been more research that parses the two: what was once believed to be a biological factor (e.g., race) is now understood to be a social construct that influences biology only after a series of environmental and social exposures, rather than a default biological difference.[142] Despite this growing understanding that these identity-based interruptions to our underlying biology are actually man-made,[143] the information "has not always shifted paradigms sufficiently to either disentangle intersectional inequities or tease apart the ways in which social factors and structural barriers at once interlock to prevent meaningful and sustainable change."[144] Despite knowing that it is people's attitudes and people-built institutions that are perpetuating discrimination and harm, and thus the corollary that *change* in people's attitudes and *change* in people-built institutions could prevent that same discrimination and harm, we *choose* to perpetuate morally reprehensible behavior and policies. These choices prevent actively combatting issues, such as health disparity, that are truly life and death decisions.

In healthcare, it is easy to blame poor health outcomes on something the patient did (or did not do) against medical advice.[145]

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138. Carbado et al., *supra* note 135, at 304.
139. *See id.*
140. *See id.*
141. *See* Lopez & Gadsden, *supra* note 136, at 1.
142. Vivian Chou, *How Science and Genetics are Reshaping the Race Debate of the 21st Century*, HARV. BLOG (Apr. 17, 2017), http://sitn.hms.harvard.edu/flash/2017/science-genetics-reshaping-race-debate-21st-century [https://perma.cc/T49K-3TTE]; Sarah McAfee, *Race Is a Social Construct*, CTR. FOR HEALTH PROGRESS: BLOG (Oct. 24, 2017), https://centerforhealthprogress.org/blog/race-social-construct [https://perma.cc/8FSN-956Q].
143. Chou, *supra* note 142; McAfee, *supra* note 142.
144. Lopez & Gadsden, *supra* note 136, at 1.
145. *See id.* at 2–3.

However, this "blame the victim" strategy avoids the tough questions and reflection on how providers may have adjusted their instructions to be more feasible considering that patient's situation, or even to merely reflect on the outright inequality that exists in the United States.[146] Focusing on an intersectional approach in health equity forces providers and others in positions of power to "understand that every person's experience is fundamentally different than the experience of others, based on their unique identit[ies] and structural positions within systems of inequality."[147]

It is well-known that some healthcare providers still struggle to distinguish biological difference and socially constructed difference, and the result is poor outcomes for marginalized communities.[148] In fact, many medical and nursing textbooks present racial or religious difference in demeaning ways that may discourage providers from asking pertinent diagnostic questions.[149] Consequently, patients who do not fit the archetype of the patient in whom the provider learned to diagnose a disease or condition struggle to obtain an accurate diagnosis.[150] The time has come to enable patients to redress the negative outcomes that result from such misapplication of health principles.

Section 1557 opens the door to address these disparities using an intersectional approach. As shown in *Rumble*, it is *possible* to interpret the ambiguity in the statute to incorporate the basis of discrimination, but not the processes or procedures of the integrated statutes.[151] No one holds only one identity. Rather, humans are composite creatures and harms in healthcare should be treated as such. A uniform standard across Section 1557 would provide a vehicle for plaintiffs to redress their harms and could serve as an incentive for institutions to work proactively to minimize discrimination before it happens. This is a necessary *but not sufficient* step to the change needed to move the U.S. system toward the ACA's promise of healthcare equality.[152] Though an intersectional interpretation of Section 1557 would move us closer to course-correction, the recent data on the impact of

146. *See id.*

147. *Id.* at 5.

148. Russell, *supra* note 25.

149. *See* Rozina Sini, *Publisher Apologises for 'Racist' Text In Medical Book*, BBC (Oct. 20, 2017), https://www.bbc.com/news/blogs-trending-41692593 [https://perma.cc/5URP-4ZQN].

150. Rose Eveleth, *Medical Textbooks Overwhelmingly Use Pictures of Young White Men*, VICE (May 9, 2019, 9:30 AM), https://www.vice.com/en/article/3k3kkn/medical-textbooks-overwhelmingly-use-pictures-of-young-white-men [https://perma.cc/2Q2S-HVM7].

151. Rumble v. Fairview Health Services, No. 14-CV-2037, 2015 WL 1197415, at *11 (D. Minn. 2015).

152. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,3179 (May 18, 2016).

COVID-19 illustrates the dire need for sweeping systemic change beyond a broad application of Section 1557.[153]

III. THE CORONAVIRUS PANDEMIC

The coronavirus pandemic drastically altered the world and what many people thought possible. Not only did many people transition to remote-only working and learning in a matter of weeks,[154] but we recently saw record-time approval of highly effective mRNA vaccines to accelerate reaching herd immunity.[155] While such an accomplishment should be celebrated, the damage from the virus in the year leading to vaccination is one that will shape history.[156] It took months after the initial detection[157] for the World Health Organization (WHO) to officially declare COVID-19 a global pandemic, in March 2020.[158] From the start, patients with the condition filled intensive care units (ICUs), while experts scrambled to determine exactly how the virus spread.[159] In the time since, the disease has forever left its mark on the U.S. healthcare system.

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153. For state-by-state COVID-19 data, see THE COVID TRACKING PROJECT, *supra* note 25.

154. Philippa Fogarty, Simon Frantz, Javier Hirschfeld, Sarah Keating, Emmanuel Lafont, Bryan Lufkin, Rachel Mishael, Visvak Ponnavolu, Maddy Savage & Meredith Turits, *Coronavirus: How the World of Work May Change Forever*, BBC, https://www.bbc.com/worklife/article/20201023-coronavirus-how-will-the-pandemic-change-the-way-we-work [https://perma.cc/P7J6-UG3R] (last visited Dec. 6, 2021).

155. *See* Pritish K. Tosh, *Coronavirus: What is it and how can I protect myself?*, MAYO CLINIC (Dec. 22, 2020), https://www.mayoclinic.org/diseases-conditions/coronavirus/expert-answers/novel-coronavirus/faq-20478727 [https://perma.cc/3QMN-FX99]; Katie Thomas, Sharon LaFraniere, Noah Weiland, Abby Goodnough & Maggie Haberman, *With F.D.A. Approval, Pfizer Will Ship Millions of Vaccine Doses Immediately*, N.Y. TIMES (last updated Dec. 15, 2020, 8:22 AM), https://www.nytimes.com/2020/12/11/world/millions-of-pfizer-vaccine-doses-to-be-shipped-immediately-after-fda-approval.html [https://perma.cc/U6WF-8968].

156. For data reflecting both COVID-19 infections and deaths, see THE COVID TRACKING PROJECT, *supra* note 25.

157. For information regarding initial discovery of the novel coronavirus, see Chris Buckley, David D. Kirkpatrick, Amy Qin & Javier C. Hernández, *25 Days That Changed the World: How Covid-19 Slipped China's Grasp*, N.Y. TIMES (Dec. 30, 2020), https://www.nytimes.com/2020/12/30/world/asia/china-coronavirus.html [https://perma.cc/EYF7-RBW8].

158. For information regarding the World Health Organization declaring a global pandemic, see Tosh, *supra* note 155.

159. *See* Liz Kowalczyk, *Who Gets a Ventilator? New Gut-Wrenching State Guidelines Issued on Rationing Equipment*, BOS. GLOBE (last updated Apr. 7, 2020, 2:49 PM), https://www.bostonglobe.com/2020/04/07/metro/massachusetts-officials-release-plan-ration-ventilators-icu-beds-if-need-arises [https://perma.cc/JYT6-S4W2]; Lauren Leatherby, John Keefe, Lucy Tompkins, Charlie Smart & Mathew Conlen, *'There's No Place for Them to Go': I.C.U. Beds Near Capacity Across the U.S.*, N.Y. TIMES (Dec. 9, 2020), https://www.nytimes.com/interactive/2020/12/09/us/covid-hospitals-icu-capacity.html?action=click&module=RelatedLinks&pgtype=Article [https://perma.cc/M4VP-QKLH].

First, this section discusses how discrimination manifested during the pandemic. This section first looks at discrimination through non-binding guidance documents, called Crisis Standards of Care. Many states put these documents into place in case their hospitals reached maximum capacity but had to revise their guidance on account of discrimination. Second, this section assesses discrimination taking place in stressed, but not rationing, hospitals. This section discusses how the COVID-19 pandemic merely revealed the depth and severity of healthcare discrimination. The pandemic highlights the need for a strong *antidiscrimination* statute that addresses intersectional discrimination to confront both intentional and disparate impact discrimination.

A. Discrimination by Design: Crisis Standards of Care

Discrimination has taken many forms throughout the coronavirus pandemic.[160] Black Lives Matter protests throughout the summer of 2020 made history fighting rampant police brutality and racial disparity in police killings.[161] White Americans blamed Asian Americans for the spread of the coronavirus, which included not only verbal threats, but often violence.[162] All while healthcare professionals, saddled with the burden of overflowing ICUs, attempted to sort out what to do if they needed to ration care.[163] Many states turned to 'Crisis Standards of Care' (CSC).[164]

These documents intended to provide a guide for healthcare rationing during the pandemic in a fair, nondiscriminatory manner.[165] Many missed the mark.[166] Most have never been implemented, and thus their protective provisions never put to the test.[167] Rather,

160. Larry Buchanan, Quoctrung Bui & Jugal K. Patel, *Black Lives Matter May Be the Largest Movement in U.S. History*, N.Y. TIMES (July 3, 2020), https://www.nytimes.com/interactive/2020/07/03/us/george-floyd-protests-crowd-size.html [https://perma.cc/PM3V-HKME]; Anna Purna Kambhampaty, *'I Will Not Stand Silent.' 10 Asian Americans Reflect on Racism During the Pandemic and the Need for Equality*, TIME (June 25, 2020, 6:32 AM), https://time.com/5858649/racism-coronavirus [https://perma.cc/3W2T-NNA4]; Elizabeth Pendo, *COVID-19 and Disability-Based Discrimination in Health Care*, AM. BAR ASS'N (May 22, 2020), https://www.americanbar.org/groups/diversity/disabilityrights/resources/covid19-disability-discrimination [https://perma.cc/8V9F-UHUU].

161. Buchanan et al., *supra* note 160.

162. Kambhampaty, *supra* note 160.

163. Pendo, *supra* note 160.

164. *Evaluation Framework for Crisis Standard of Care Plans*, CTR. FOR PUB. REPRESENTATION (updated Nov. 30, 2020), https://www.centerforpublicrep.org/wp-content/uploads/Updated-evaluation-framework.pdf [https://perma.cc/9NDQ-VMYD].

165. *Id.*

166. For a compilation of HHS OCR complaints, advocacy letters, and other advocacy efforts against discriminatory crisis standards of care, see CTR. FOR PUB. REPRESENTATION: COVID-19, https://www.centerforpublicrep.org/covid-19 [https://perma.cc/KD7P-XYBF] (last visited Dec. 6, 2021).

167. While many ICUs reached maximum capacity, most did not begin implementing crisis care standards. At the end of 2020, though, Los Angeles and the surrounding

decisions about day-to-day treatment have been left to physicians' best judgment, without the nondiscriminatory CSC schema to guide their triage.[168]

Crisis Standard of Care documents are protocols to assist physicians in the event that they must begin rationing life-saving treatment.[169] The logic of these plans is to ensure that patients who are most likely to survive the life-saving treatment are the ones who receive the treatment, ultimately aiming to ensure appropriate use of limited resources.[170] Early on, however, Disability Rights Washington recognized that the State of Washington built its rationing plan from disability-based distinctions, and that the plan was therefore illegally discriminatory.[171] More and more advocates across the country confronted their states' rationing plans for the discrimination both explicit and implicit within the plan, discriminating on the basis of disability, race, age, and, in some cases, sex.[172]

In response, HHS Office of Civil Rights (OCR) released a bulletin announcing that it will enforce Section 1557 against covered entities that discriminate in rationing plans and has since adjudicated many complaints.[173] The strength of this statement has changed over the course of the pandemic. When the novel coronavirus first arrived in the United States, healthcare systems operated under the

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counties' health systems faced so much strain they began rationing care. For more information on L.A.'s decision to ration care, see Leila Fadel, *LA County Hospitals Begin to Ration Care Amid Coronavirus Surge*, NPR (Jan. 6, 2021, 5:08 AM), https://www.npr.org/2021/01/06/953857303/la-county-hospitals-begin-to-ration-care-amid-coronavirus-surge [https://perma.cc/GP9G-FDH2]. For more information about which ICUs reached maximum capacity and rationing in general, see Leatherby et al., *supra* note 159, and Will Stone, *What It Means When Hospitals Say They Have to Ration Care*, NPR (Nov. 23, 2020, 3:53 PM), https://www.npr.org/2020/11/23/938131284/what-it-means-when-hospitals-say-they-have-to-ration-care [https://perma.cc/5EYU-FBJT].

168. Kowalczyk, *supra* note 159 ("'These [guidelines] are obviously only used in disaster situations—situations we hope—and are working to ensure—do not happen,'" Massachusetts Department of Public Health spokeswoman Ann Scales told the Boston Globe in an email).

169. *See* CTR. FOR PUB. REPRESENTATION, *supra* note 164.

170. *See* CAL. DEP'T OF PUB. HEALTH, CALIFORNIA SARS-COV-2 PANDEMIC CRISIS CARE GUIDELINES, 5 (June 2020), https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/COVID-19/California%20SARS-CoV-2%20Crisis%20Care%20Guidelines%20-June%208%202020.pdf [https://perma.cc/JZY2-VV5W].

171. Disability Rts. Wash., Self Advocs. in Leadership, The Arc of the U.S., & Ivanova Smith, Complaint Against the Wash. State Dep't of Health, the N.W. Healthcare Response Network and the Univ. of Wash. Med. Ctr. to the Off. for Civ. Rts. (Mar. 23, 2020), https://www.disabilityrightswa.org/disability-discrimination-complaint-filed-over-covid-19-treatment-rationing-plan-in-washington-state [https://perma.cc/S5TE-WQ28].

172. For a compilation of HHS OCR complaints, advocacy letters, and other advocacy efforts against discriminatory crisis standards of care, see CTR. FOR PUB. REPRESENTATION, *supra* note 164.

173. *See* DEP'T OF HEALTH & HUM. SERVS., NON-DISCRIMINATION IN CRISIS STANDARDS OF CARE, https://www.hhs.gov/civil-rights/for-providers/civil-rights-covid19/index.html [https://perma.cc/CNQ6-LFJG].

semi-integrated regulations that remained in place since the end of the Obama Administration.[174]

Under these regulations, patients could bring a single 'health discrimination claim' under Section 1557, but all procedures and remedies under the integrated laws applied to whatever basis of discrimination the patient-plaintiff claimed.[175] Therefore, a patient-plaintiff denied the use of a ventilator because of their pre-existing disability, would be permitted to bring a health discrimination claim, however, they would have to meet the burdens already provided under Section 504.[176] As the pandemic raged, however, the protections and meaning of Section 1557 changed.[177] The Trump Administration regulations offered no protections for individuals who face discrimination based on their sexual orientation or gender identity, and the law acted as a mere extension of the pre-existing protections, provided in the integrated statutes, into the healthcare arena.[178] While Section 1557, as it stands, does offer *some* additional protections than would have already been available, it is not as powerful a tool as it could be in battling rampant discriminatory COVID-19 care.[179] Moreover, discrimination is taking place in healthcare systems across the country, without the rationing plans ever being invoked.[180]

B. Discrimination Without Direction

It is no secret that the coronavirus pandemic in the United States has disproportionately impacted Black and Brown communities.[181] Delayed data reporting on the disproportionate impact led to an

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174. The novel Coronavirus was first officially detected in the United States on January 22, 2020, so health systems operated under the Obama-era regulations for approximately seven months before the Trump Administration released its changes. For information about early COVID-19 detection in the United States, see Erin K. Stokes, Laura D. Zambrano, Kayla N. Anderson, Ellyn P. Marder, Kala M. Raz, Suad El Burai Felix, Yungfeng Tie & Kathleen E. Fullerton, *Coronavirus Disease 2019 Case Surveillance—United States, January 22–May 30, 2020*, CTR. FOR DISEASE CONTROL & PREVENT.: MORBIDITY & MORTALITY WEEKLY REP. (June 19, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6924e2.htm [https://perma.cc/SN63-MAXQ] (reporting that the CDC recorded the first laboratory confirmed case of the novel coronavirus in the United States on January 22, 2020). To evaluate the changes to the 1557 regulations during the summer of 2020, compare 45 C.F.R. Subpart A with Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,375 (May 18, 2016).

175. *See supra* notes 91–96 and accompanying text.

176. *Id.*

177. *See supra* note 174 and accompanying text.

178. *See* OFF. OF C.R., *supra* note 1.

179. For a summary of advocates' strategies in fighting COVID care discrimination, see Pendo, *supra* note 160.

180. *See supra* note 160 and accompanying text.

181. THE COVID TRACKING PROJECT, *supra* note 25.

incomplete picture of the damage the virus inflicted across the country.[182] Even when demographic data rolled in, recognizing disparity is challenging when it is "subtle and/or systemic resulting in *under-reporting* of cases."[183] On several occasions, the differential treatment that COVID-19 patients received made national headlines.[184]

In summer of 2020, while many disability advocates challenged discriminatory CSC guidelines,[185] Michael Hickson died of COVID-19 in Texas.[186] Mr. Hickson was a forty-six-year-old quadriplegic man, and his death made headlines because his wife recorded a doctor explaining to her that the reason they did not pursue more intense treatment was her husband's "quality of life—he doesn't have much of one."[187] This is a medical provider making a decision about treatment, on the basis of his patient's existing disability.[188] The hospital explained that the doctor misused the phrase "quality of life," including that the medical team actually based the treatment decision on existing sepsis and organ failure, neither of which the doctor in the recording mentioned to Mrs. Hickson.[189] Indeed, Mrs. Hickson claimed that her husband had a quality of life; if anyone had asked him, he would have wanted the intensive treatment so that he could live.[190] Mrs. Hickson believed the doctors placed, "less value on her husband's life because he was a [B]lack man who was disabled."[191] Complicating matters, Mr. Hickson's sister, herself a physician, agreed with the decision that the hospital and Mr. Hickson's medical guardian made about treatment.[192] She believes the doctors did all they could, and

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182. Selena Simmons-Duffin, *White House: Data on COVID-19 and Race Still Weeks Away*, NPR (Apr. 20, 2020, 1:36 PM), https://www.npr.org/sections/coronavirus-live-updates/2020/04/20/838745546/white-house-data-on-covid-19-and-race-still-weeks-away [https://perma.cc/LM98-VPS9].

183. Isaac Yeboah Addo, *Double Pandemic: Racial Discrimination Amid Coronavirus Disease 2019*, 2 SOC. SCI. & HUMANITIES OPEN 1, 2 (2020) (emphasis added).

184. *See, e.g.*, Joseph Shapiro, *One Man's COVID-19 Death Raises the Worst Fears of Many People with Disabilities*, NPR (July 31, 2020, 3:29 PM) [hereinafter Shapiro II], https://www.npr.org/2020/07/31/896882268/one-mans-covid-19-death-raises-the-worst-fears-of-many-people-with-disabilities [https://perma.cc/MU6H-ZZVV]; John Eligon, *Black Doctor Dies of COVID-19 After Complaining of Racist Treatment*, N.Y. TIMES (last updated Dec. 25, 2020), https://www.nytimes.com/2020/12/23/us/susan-moore-black-doctor-indiana.html [https://perma.cc/9KWN-3VZD].

185. *See* Pendo, *supra* note 160.

186. Shapiro II, *supra* note 184; Ariana Eunjung Cha, *Quadriplegic Man's Death from COVID-19 Spotlights Questions of Disability, Race and Family*, WASH. POST (July 5, 2020, 9:40 AM), https://www.washingtonpost.com/health/2020/07/05/coronavirus-disability-death [https://perma.cc/RQ2E-MYLN].

187. Shapiro II, *supra* note 184.

188. *See id.*

189. *Id.*

190. *Id.*

191. Cha, *supra* note 186.

192. *Id.*

that they did not make decisions based on her brother's race or disabilities.[193]

This disagreement between medical providers, and even within Mr. Hickson's own family, draws attention to the areas where implicit bias may be at play within the medical profession.[194] While Mr. Hickson's providers may have done everything they could to treat him appropriately, disabled patients consistently fight a system that seems intent on dismissing them.[195] In 2019, the National Council on Disability found that one of the primary ways that healthcare providers and insurance companies discriminate against disabled patients is in using 'quality of life' scores to determine whether a treatment is appropriate—the exact method that the doctor expressed to Mrs. Hickson.[196] Mr. Hickson's death is currently under investigation.[197]

In addition to disability fears, there are many instances in which doctors have denied patients of color, particularly women of color, appropriate COVID-19 care.[198] In December 2020, Dr. Susan Moore died of COVID-19 after raising alarms of her discriminatory treatment from white doctors at a hospital in Indianapolis.[199] Dr. Moore, a Black female physician, complained of intense pain to her white male physician, who dismissed her complaints and mentioned discharging her.[200] She explained in a Facebook post to a physicians' group, "[h]e made me feel like I was a drug addict. . . . I put forth and I maintain if I was white . . . I wouldn't have to go through that."[201] Dr. Moore wrote that she had to beg for the antiviral drug remdesivir,[202] and that she told her physician about her shortness of breath but he did not believe her until he scanned her neck and lungs.[203] In a heartbreaking post, Dr. Moore explained, "[t]his is how Black people get killed, when you send them home and they don't know how to fight for themselves."[204] Dr. Moore died two weeks after she posted her initial video detailing her discrimination after acquiring bacterial pneumonia in addition to her COVID-19 pneumonia.[205]

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193. *Id.*
194. *See* Shapiro I, *supra* note 26.
195. *See id.*
196. *Id.*
197. Shapiro II, *supra* note 184.
198. *See, e.g.*, Eligon, *supra* note 184; Dembosky, *supra* note 88.
199. Eligon, *supra* note 184.
200. *Id.*
201. *Id.*
202. *Id.* For information about the effectiveness of antiviral drug remdesivir on the duration of COVID-19 infection, see J.H. Beigel et al., *Remdesivir for the Treatment of COVID-19—Final Report*, 383 NEW ENG. J. MED. 1813, 1816 (2020).
203. Eligon, *supra* note 184.
204. *Id.*
205. *Id.*

These stories of discriminatory COVID-19 care abound. By December 2020, Black and Latinx people died of COVID-19 infection at 3.6 times and 2.5 times the rate of white people, respectively.[206] Karla Monterroso, a Latina woman who left the hospital initially treating her COVID-19 infection for fear that the providers' biases would escalate her condition, explained, "[a]s women of color, you get questioned a lot about your emotions and the truth of your physical state. You get called an exaggerator a lot throughout the course of your life . . . So there was this weird, 'I don't want to go and use resources for nothing' feeling."[207] It is in times of crisis that we discover where our true values lie. For some, the Crisis Standards of Care process and the data of racial disparity in COVID infections and deaths are a revelation to the implicit and systemic discrimination in place throughout society. For the populations who live under the stress of discrimination every day, the vulnerability accompanying the pandemic is distressing, but not a surprise.[208]

This is a problem that has always been present in the healthcare system, but never appropriately addressed in the legal system.[209] The coronavirus pandemic offers an opportunity to turn a new corner and embrace the full promise of *antidiscrimination* in healthcare. Here, we learn not only from history, but also from the present. It is time to accept full responsibility for the system's failures up to this point. At minimum, Section 1557 provides the building blocks to move toward an *antidiscrimination* system that allows for intersectional claims that will provide accountability to health systems that enable providers who make women like Ms. Monterroso and Dr. Moore fear for their lives.[210]

The most effective interpretation of the statute, as written, would be that of *Rumble*, in which the Court found prohibition on intersectional discrimination on the basis of race, national origin, language, sex, age, and disability.[211] This creates a new 'health discrimination' claim, that has all of the remedies available to the patient-plaintiff that would be available to a plaintiff under the integrated statutes.[212]

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206. *Id.*

207. Dembosky, *supra* note 88.

208. *See, e.g.*, Scott D. Halpern, Robert D. Truog & Franklin G. Miller, *Cognitive Bias and Public Health Policy During the COVID-19 Pandemic*, 324 J. AM. MED. ASS'N 337, 337 (2020); Shapiro I, *supra* note 26; Julie Onos, *Race and Medicine: The Cost of Medical Bias When You're Sick, Black, and Female*, HEALTHLINE (Sept. 30, 2020), https://www.healthline.com/health/the-cost-of-medical-bias-when-youre-sick-black-and-female#1 [https://perma.cc/C865-DBH9].

209. *See supra* notes 122–25 and accompanying text.

210. *See, e.g.*, Eligon, *supra* note 184; Dembosky, *supra* note 88.

211. *See* Rumble v. Fairview Health Services, No. 14-CV-2037, 2015 WL 1197415, at *11 (D. Minn. 2015).

212. *See id.*

This approach is still limited, however, in that under *Alexander v. Sandoval*, it is likely restricted only to 'intentional discrimination.'[213] Since healthcare discrimination, in crisis and out of crisis, is more likely to be implicit than explicit, there must be an arm of health *antidiscrimination* that applies to disparate-impact claims.[214]

As written, Section 1557 integrates the structure of Title VI, in a way that is unlikely to be able to meet this requirement.[215] Instead, as the United States continues to reflect on healthcare access and learn from the pandemic, the goals must include more than insurance access issues, and rather dive deeper to challenge settled assumptions about healthcare behavior and uproot implicit biases to truly combat health disparity.[216] While issues of cost and insurance are areas that need reform to improve access and remove barriers to care, those reforms are *necessary but not sufficient* to see change in the quality of healthcare provided in the United States to multiple marginalized populations. The new grace of being able to see a physician does not improve health if that physician does not treat their patient with the equal respect as their less marginalized patients.

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213. *See supra* note 38 and accompanying text.

214. For information about how implicit health bias contributes to health disparities, *see* William J. Hall, Mimi V. Chapman, Kent M. Lee, Yesenia M. Merino, Tainayah W. Thomas, B. Keith Payne, Eugenia Eng, Steven H. Day & Tamera Coyne-Beasley, *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systemic Review*, 105 AM. J. PUB. HEALTH e60, e60 (2015); Tori DeAngelis, *How Does Implicit Bias by Physicians Affect Patients' Health Care?*, 50 AM. PSYCH. ASS'N (March 2019).

215. *Compare supra* text accompanying note 38, *with* 42 U.S.C. § 18116(a) (2010) ("an individual shall not . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance . . . .").

216. These goals did not significantly appear in conversations about healthcare reform during the 2020 presidential election cycle. *See* Samantha Artiga, Kendal Orgera & Olivia Pham, *Disparities in Health and Health Care: Five Key Questions and Answers*, KAISER FAM. FOUND. (Mar. 4, 2020), https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers [https://perma.cc/VJC5-ZEJ6] (finding that many Democratic candidates for president in the 2020 election cycle proposed healthcare reform options that further expanded coverage gap, addressing access issues, and where they targeted racial and ethnic health disparities, candidates focused namely on maternal health); *see also* JOE BIDEN: HEALTHCARE, https://joebiden.com/healthcare [https://perma.cc/4R77-JVPZ] (last visited Dec. 6, 2021) (supporting the Affordable Care Act and hoping to build on it, President Biden offers a 'public option' that would expand access to those Americans whose incomes land them in Medicaid coverage gaps. Focusing more specifically on the financial aspects of healthcare reform, the President does address health equity for women's access to reproductive medicine, plans to expand California's strategies for reducing the high maternal mortality rate for women of color, and seeks to reintegrate nondiscrimination protections for gender identity and sexual orientation).

CONCLUSION

The Affordable Care Act took on comprehensive healthcare reform in the United States.[217] With it, many health measures have improved, including access, guarantees of preventive health benefits, and better access to care for young adults.[218] Each one of these improvements has contributed to the overall improvement of health disparity in the United States.[219] But ten years from passage and six years since implementation, the health disparities continue, and they are shocking.[220]

The promise of accountability for differential treatment between providers and patients with marginalized identities has yet to be fulfilled. Section 1557 is but one step closer to the greater structural reform necessary to begin recognizing the depth of discrimination's impact on healthcare provision.[221] No person's life experience can be captured with a one-word identity label.[222] How each person interacts with the power structures surrounding them is dependent upon the different oppressions that person has had to endure throughout the different stages of their life.[223] Rather than placing an expectation on patients to only combat intentional discrimination,[224] the model must evolve to recognize disparate impact discrimination as well. These disparately impacted patients are complex people who deserve to make their *whole* case, and show how it is the harms in response to the combination identities that make their experience 'different' that deserves remedy.[225]

To do this, there must be a single, intersectional health discrimination standard.[226] Such a standard will force health providers and systems to address deeper issues in diagnosis and treatment, and incentivize greater institutional change to move beyond their mere superficial and passive acknowledgment of *'nondiscrimination'*, toward

217. *Summary of Coverage*, *supra* note 2.
218. *Id.*
219. *See, e.g.*, *Health Coverage by Race and Ethnicity: The Potential Impact of the Affordable Care Act*, KAISER FAM. FOUND., https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity-the-potential-impact-of-the-affordable-care-act [https://perma.cc/JYC7-TS4P] (last visited Dec. 6, 2021).
220. *See, e.g.*, *Pregnancy Mortality Surveillance System*, *supra* note 125.
221. *See, e.g.*, text accompanying Russell, *supra* note 25; text accompanying Shapiro II, *supra* note 184; text accompanying Eligon, *supra* note 184.
222. Kapilashrami & Hankivsky, *supra* note 8, at 2589.
223. *Id.*
224. *See* Southeastern Pa. Transp. Auth. v. Gilead Sci. Inc., 102 F. Supp. 3d 688, 698 (2015).
225. Kapilashrami & Hankivsky, *supra* note 8, at 2589–90.
226. Rumble v. Fairview Health Services, No. 14-CV-2037, 2015 WL 1197415, at *11 (D. Minn. 2015).

a more active '*antidiscrimination.*'[227] It is only when the legal structure established to enforce against these discriminatory harms reflects upon the ways in which it itself perpetuates discrimination that we can achieve successful change.[228] In healthcare, that begins with recognizing that Section 1557's expanded coverage of the pre-existing nondiscrimination statutes to healthcare arenas is *necessary but by no means sufficient* to tackle the shambolic attempts to combat health disparities in the United States. Looking no further than the outright devastation that the novel coronavirus has wrought on marginalized communities during 2020[229] and beyond, it is clear that shallow acknowledgment can no longer stand in the place of active accountability structures and intersectional progress.

MAJESTA-DORÉ LEGNINI[*]

227. *See* Kapilashrami & Hankivsky, *supra* note 8, at 2590–91.
228. *See id.*
229. *See* THE COVID TRACKING PROJECT, *supra* note 25.

* Majesta-Doré is a JD candidate at William & Mary Law School and Editor-in-Chief of Volume 28 of the *Journal of Race, Gender & Social Justice*. She has a BA in Political Science, and a BS in Health, Physical Education, and Exercise Science, concentrating in health sciences, both from Virginia Commonwealth University. Thank you to Stacy Kern-Scheerer and Joann Richardson for their feedback and enthusiasm for this Note. A prepublication draft of this Note placed second in the American University, Washington College of Law Sixth Annual National Health Law Writing Competition. Majesta-Doré dedicates this Note to Barbara Gwilliams.