



## Health Matrix: The Journal of Law-Medicine

---

Volume 25 | Issue 1

---

2015

# Race and Rationing

Rene Bowser

Follow this and additional works at: <https://scholarlycommons.law.case.edu/healthmatrix>

 Part of the [Health Law and Policy Commons](#)

---

### Recommended Citation

Rene Bowser, *Race and Rationing*, 25 Health Matrix 87 (2015)

Available at: <https://scholarlycommons.law.case.edu/healthmatrix/vol25/iss1/6>

This Symposium is brought to you for free and open access by the Student Journals at Case Western Reserve University School of Law Scholarly Commons. It has been accepted for inclusion in Health Matrix: The Journal of Law-Medicine by an authorized administrator of Case Western Reserve University School of Law Scholarly Commons.

# RACE AND RATIONING

*Rene Bowser*<sup>†</sup>

## CONTENTS

INTRODUCTION .....	87
I. HEALTH CARE SCARCITY AND RATIONING.....	91
II. SCARCITY, QUEUES, AND HEALTH DISPARITIES.....	95
III. RATIONING BY PRICE AND ABILITY TO PAY .....	98
IV. RACE, RATIONING, AND THE AFFORDABLE CARE ACT .....	101
CONCLUSION .....	106

## INTRODUCTION

During the recent battle over health care reform, “rationing” became a dirty word. Republicans asserted that Americans would not put up with limits on health care, while Democrats vigorously denied that the United States rations health care or that health care reform would result in rationing.<sup>1</sup> For instance, former U.S. vice presidential candidate Sarah Palin warned that the reforms would bring “rationing” into the American health care system, a result that she described as “evil” and “un-American.”<sup>2</sup> “And who will suffer the most when they ration care?” she asked, to which she immediately responded: “[t]he sick, the elderly, and the disabled, of course,”<sup>3</sup> During the summer of 2010, President Obama even urged Democratic governors to avoid using the term “rationing,” presumably because it invokes strong feelings and has a negative connotation for most Americans.<sup>4</sup>

---

† Associate Professor of Law, University of St. Thomas School of Law. B.A. 1985, University of Maryland, College Park; M.A., 1987, Northwestern University (Economics); J.D. 1994, Stanford University Law School; LL.M. 1999, Georgetown University Law Center.

1. Peter Singer, *Why We Must Ration Health Care*, N.Y. TIMES MAG., July 15, 2009, <http://www.nytimes.com/2009/07/19/magazine/19healthcare-t.html?pagewanted=all>.
2. See BEATRIX HOFFMAN, HEALTH CARE FOR SOME: RIGHTS AND RATIONING IN THE UNITED STATES SINCE 1930 ix (2012).
3. Sarah Palin, *Statement on the Current Health Care Debate*, FACEBOOK.COM\_\_\_\_(posted Aug. 7, 2009, 1:26 PM), [https://www.facebook.com/note.php?note\\_id=113851103434\\_](https://www.facebook.com/note.php?note_id=113851103434_).
4. Singer, *supra* note 1.

Health care is a scarce resource and all scarce resources are rationed in one way or another.<sup>5</sup> Neither the United States nor any other society can afford to provide to every individual the health care services that each citizen needs or wants.<sup>6</sup> As a result, in some circumstances we cannot provide health care services that would yield positive benefits to patients.

In 2000, U.S. Supreme Court Justice David Souter firmly rejected the false notion that the United States does not ration health care: “[W]hatever the HMO, there must be rationing and inducement to ration . . . inducement to ration care goes to the very point of any HMO scheme.”<sup>7</sup> Regardless of the organizational form, executives of health plans and provider organizations operating within a budget must set limits on the amount of medical services produced and the acquisition of resources such as health care professionals, facilities, drugs, and equipment.

Rationing has always been present in the American health care system. Physicians have, in effect, always rationed care by exercising clinical discretion about marginal benefits by asking, for instance, whether a patient should receive therapy that may provide the patient only minimal benefits.<sup>8</sup> Limiting the patient’s choice of physician and hospital, requiring copays and deductibles, and demanding preauthorization for certain procedures are all forms of rationing.<sup>9</sup> Health insurers have used a person’s health—in the form of preexisting conditions, current health status, family history, or previous claims—to differentiate among insureds in both pricing and coverage.<sup>10</sup> Although the Affordable Care Act (ACA) does not state it

- 
5. Steven Teutsch & Bern Rechel, *Ethics of Resource Allocation and Rationing Medical Care in a Time of Fiscal Restraint – US and Europe*, 34 PUB. HEALTH REV. 2 (2012).
  6. In 2013, the last year for which data are available, the United States spent \$2.9 trillion, 17.4% of the Gross Domestic Product, \$9,255 per man, woman and child on health care. *National Health Expenditure Data – Historical*, CTRS FOR MEDICARE & MEDICAID SERV. (Dec. 9, 2014, 6:26 AM), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>.
  7. *Pegram v. Hendrich*, 530 U.S. 211, 221 (2000).
  8. See generally ROBERT A. BLANK, *THE PRICE AND FUTURE OF AMERICAN HEALTH CARE XII* (1997) (explaining that “we ration through physician discretion, public relations campaigns, litigation, an array of mechanisms that put people in categories that compete for resources.”).
  9. *Id.*
  10. See Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 74 (2005) (“Discrimination against unhealthy persons is deeply ingrained in the health insurance industry

that way, the health insurance reforms contained within the legislation seek to put an end to insurance companies rationing by health status and gender.<sup>11</sup> Still, the ACA permits insurers to charge more based on age, geographic location, and tobacco use.<sup>12</sup>

The largest and clearest example of rationing is American society's willingness to allow 40 to 50 million individuals to be uninsured in order to conserve our scarce health care resources.<sup>13</sup> Even in emergency rooms, evidence suggests that people without health insurance may receive less health care than those with insurance.<sup>14</sup>

Rationing by race is a particularly pernicious method of allocating health care resources. Health care has been rationed by race in the Jim Crow system of a segregated health care system and through structural, institutional and interpersonal racial bias.<sup>15</sup> For instance, African American patients were not admitted to hospitals and clinics in many parts of the country during the twentieth century, giving whites exclusive use of those scarce resources.<sup>16</sup> Racist policies endorsed by the American Medical Association (AMA) prevented African American physicians from joining state and county medical societies, a precursor to admitting and caring for patients at local hospitals.<sup>17</sup>

The federal government gave express approval to the practice of rationing by race with the passage of the Hill-Burton Act of 1946,<sup>18</sup>

---

and traditionally has been generally accepted as a legitimate application of underwriting and risk-classification principles.”).

11. Patient Protection and Care Act, Pub. L. No. 111-148, §1201, 124 Stat. 119, 154 (2010) (prohibiting discrimination based on a preexisting condition or health status and prohibiting discrimination against individual participants based on health status).
12. *Id.* at 154-56.
13. Richard M. Friedenber, *Rationing in Health Care: Changing the Patterns of Health Care*, 227(1) RADIOLOGY 5, 5-6 (2003).
14. See Joseph J. Doyle Jr., *Health Insurance, Treatment and Outcomes: Using Auto Accidents as Health Shocks*, 87 REV. ECON. & STAT. 256 (finding that automobile accident victims who lack health insurance receive 20% less treatment in hospitals and are 37% more likely to die of their injuries than victims with health coverage).
15. See Hoffman, *supra* note 2, at x.
16. See *id.* at 64.
17. See generally Harriet A. Washington et al., *Segregation, Civil Rights and Health Disparities: The Legacy of African American Physicians and Organized Medicine, 1910-1968*, 101 J. NAT'L MED. ASS'N. 513-537 (finding that the American Medical Association refused to take action against racial barriers imposed by its constituent state and county medical societies during the civil rights era).
18. Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946) (codified as amended at 42 U.S.C. §§ 291-291o-1 (2000)).

which provided federal funding to segregated hospital facilities.<sup>19</sup> More recently, the “hospital flight” movement of the 1970s rationed health care by race as hospitals relocated some or all of their services from inner city areas to more affluent white suburbs.<sup>20</sup> Even today, African Americans disproportionately reside in poor quality nursing homes compared to whites, a result researchers attribute to discrimination, in the form of both disparate treatment and disparate impact.<sup>21</sup>

Even during national tragedies, race (and class) affects the health care allocation decision. Compare the government’s response to the terrorist attacks on 9/11 to its response to Hurricane Katrina: In the aftermath of both events, survivors faced obstacles in obtaining health care because of job loss and displacement.<sup>22</sup> As Beatrix Hoffman astutely observed, “Congress agreed to expand Medicaid to temporarily cover survivors of 9/11, but refused to do the same for victims of Katrina. These contrasting experiences add another chapter to the history of rationing and denial of health care rights in the United States.”<sup>23</sup>

Rationing by race is one of the many factors that have historically contributed to health disparities.<sup>24</sup> Facially neutral resource allocation methods such as leveraging physician status to get to the head of a line to see a specialist (rationing by physician status), or rationing based on the ability to pay are both problematic because they bring larger societal race-based inequalities and disadvantages into the health care system. These and other implicit rationing schemes permeate the health care system and continue to generate racial and ethnic health care disparities.<sup>25</sup> Because these implicit rationing

---

19. See Hoffman, *supra* note 2, at 76.

20. See *id.* at 151-52.

21. See Ruqaiyah Yearby, *Litigation, Integration and Transformation: Using Medicaid to Address Racial Inequities in Health Care* 13 J. HEALTH CARE L. & POL’Y 325, 328-30 (2010); see also, DAVID BARTON SMITH, *HEALTH CARE DIVIDED: RACE AND HEALING A NATION: RACE AND LONG-TERM CARE* 243-75 (1999).

22. Hoffman, *supra* note 2, at 198.

23. See *id.*

24. See Kevin Outterson, *Tragedy and Remedy: Reparations for Disparities in Black Health*, 9 DEPAUL J. HEALTH CARE L. 735, 736 (2005) (arguing that black health disparities are rooted in state sponsored discrimination).

25. The Institute of Medicine Report, *Unequal Treatment: Confronting Racial and Ethnic Disparities*, affirms in its first finding: “Racial and ethnic disparities in healthcare exist and, because they are associated with worse outcomes in many cases, are unacceptable.” INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES* 6 (Smedley, et al. eds., 2002). The mechanisms that generate racial and ethnic disparities in medical care operate at the levels of the health care

schemes are so prevalent, they are not seen as rationing but as “the nature of everyday life.”<sup>26</sup> The disproportional burden shouldered by people of color, however, remains hidden.

This Article does not attempt to exhaustively catalogue all forms of rationing. Indeed, health care is implicitly rationed in myriad ways, across numerous settings, and within all clinical institutions. The purpose of this Article is to add the voices and concerns of patients of color to the rationing dialogue.

The Article is divided into four parts. Part I explains the problem of health care scarcity and defines rationing. Part II establishes that scarcity leads to queues for health care services and waitlists. Part II goes on to assert that physician status and power determines who gets to the head of the queue in clinically ambiguous situations, and it argues that this resource allocation method disadvantages patients of color and produces health care disparities. Part III examines rationing based on price and ability to pay and concludes that this manner of allocating scarce resources is unjust and is a subtle form of structural racial bias. Finally, Part IV examines rationing under the Affordable Care Act with a focus on the burdens and potential benefits to communities of color.

## I. HEALTH CARE SCARCITY AND RATIONING

From an economic perspective, scarcity results from a disparity between the demand for health care services and the supply.<sup>27</sup> Demand for health care is vast. Indeed, as Reinhart Priester eloquently explained, “The appetite for healthcare is infinitely expandable, since it is almost always possible to secure some small benefit from additional treatment.”<sup>28</sup> Even if we could eliminate the

---

system and the clinical encounter. Research demonstrates the role of health care system factors, including differences in insurance coverage and other determinants of health care access, in producing disparities. Research also shows, however, that even when insurance status and other measures of access are controlled for by statistical methods, racial and ethnic disparities persist. These disparities remain when researchers try by various methods to control for patients’ clinical characteristics. Disparities are especially well documented through comparisons among white patients, African Americans, and Latinos, but they are believed to affect other minority groups as well. As a result, many members of minority racial and ethnic groups receive less or inferior care. For a comprehensive review of these findings, *see id.* 160-79.

26. *See Hoffman, supra* note 2, at xv.

27. *See Maxwell G. Bloche, Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL’Y L. & ETHICS 95, 107 (2001).

28. REINHARD PRIESTER, TAKING VALUES SERIOUSLY: A VALUES FRAMEWORK FOR THE U.S. HEALTH CARE SYSTEM 29 (1992). A French study asked how much it would cost to give all the health care that is

considerable amount of health care resources spent wastefully and inefficiently, health care would remain scarce, in the sense that choices among competing health needs would still have to be made.<sup>29</sup> And although we could increase the expenditures devoted to healthcare, we still could not provide services to everyone who needs them due to the continued development of newer and more costly technologies, an aging population, and other factors fueling the demand for health care.

On the supply side, the legal and regulatory environment, as well as organizational design and economic incentives, act to lower the amount of health care services produced. Doctors are highly regulated and in that manner, they are restricted in supply.<sup>30</sup> State regulatory requirements such as certificate of need (CON) constrain new investments in hospitals, services, and equipment.<sup>31</sup> Scope of practice regulations prevent non-physician providers from performing primary care functions that many are well-qualified to do.<sup>32</sup> A number of overlapping regulations restrict the number of foreign doctors, bar nurse practitioners from performing traditional doctor duties, and keep telemedicine from replacing in-person doctor visits.<sup>33</sup> The regulation of the pharmaceutical market and medical technologies also limits the supply of scarce health care resources to clinical care institutions.

---

“beneficial” to each citizen. The answer was five-and-one-half times the French gross national product. If that number is indicative of how much such health care would cost in other countries, then no modern society can afford to give all the health care that is “beneficial.”

29. See generally Nicole C. Lallemand, *Health Policy Brief: Reducing Waste in Health Care*, HEALTH AFF. (Dec. 13, 2012), available at [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=82](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=82).
30. See, e.g., Shirley Svorny, *Licensing Doctors: Do Economists Agree?*, 1 ECON. J. WATCH 279, 279 (2004) (finding that economists view licensing as a constraint on the efficient combination of health care inputs).
31. See *Certificate Of Need: Health Laws and Programs*, NAT'L CONF. OF ST. LEGISLATURES (July 2014), <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx> (finding that 36 states currently maintain some form of CON program, and that the 14 states that repealed their CON laws still retain some mechanisms intended to regulate costs and duplication of services).
32. See Barbara J. Safriet, *Closing the Gap between Can and May in Health-Care Providers' Scopes of Practice: A Primer for Policymakers*, 19 YALE J. REG. 301, 308-09 (2002).
33. See, e.g., Robert Koch, *Doctors Without State Borders: Practicing Across State Lines*, HEALTH AFF. BLOG (Feb. 28, 2014), <http://healthaffairs.org/blog/2014/02/18/doctors-without-state-borders-practicing-across-state-lines>.

As Maynard aptly described it, the scarcity in healthcare means that “choices have to be made about who will be given the ‘right’ of access to care and who, as a result of denial, will be left in pain and discomfort, and, in the limit, to die.”<sup>34</sup> The essential question then is not will we ration health care, or even should we ration health care; rather, the question is *how* will we ration health care services.<sup>35</sup>

Because of the tension between the demand for health services and the supply and cost of providing them, rationing can be found in all health care systems.<sup>36</sup> Nations such as Canada with a publicly funded health care system reject price rationing and instead ration health care at two levels:<sup>37</sup> At the macro level, rationing is performed through governmental decisions about the overall size of the global health care budget.<sup>38</sup> At the micro level, health care is expressly or implicitly ranked and rationed by the degree of “need” or “medical necessity.”<sup>39</sup> Available data on the costs and benefits of alternative treatments, despite its flaws and incompleteness, is used by providers to ration care at the micro level and by policy makers in defining covered benefits at the macro level.<sup>40</sup>

For purposes of this article, health care rationing is the allocation of health care services under conditions of scarcity.<sup>41</sup> According to distinguished medical ethicist Dan Brock, this definition “necessarily implies that some who want and could be benefited by that good will not receive it.”<sup>42</sup> There are two types of rationing: implicit and explicit. One example of implicit rationing is rationing done at the individual clinical level—the level of physician and patient.<sup>43</sup> Other

- 
34. Alan Maynard, *Rationing Health Care: An Exploration*, 49 HEALTH POL’Y 5, 5 (1999).
35. See Lanis L. Hicks, *Making Hard Choices: Rationing Health Care Services*, 32 J. LEGAL MED. 27, 28 (2011).
36. David Mechanic, *Dilemmas in Rationing Health Care Services: The Case for Implicit Rationing*, 310 BMJ 1655, 1655 (1995).
37. Murray G. Brown, *Rationing Health Care in Canada*, 2 ANNALS HEALTH L. 101, 105 (1993).
38. *Id.* at 105-6.
39. *Id.* at 108.
40. *Id.*
41. See Dan Brock, *Rationing: Why it is Ethical*, HEALTH CARE COST MONITOR ONLINE 1 (July 17, 2009), <http://healthcarecostmonitor.thehastingscenter.org/danbrock/why-it-is-ethical>.
42. See *id.*
43. See Daniel Strech et al., *Are Physicians Willing to Ration Healthcare? Conflicting Findings in a Systematic Review of Survey Research*, 90 HEALTH POL’Y 113, 114 (2009).



examples of implicit rationing include preauthorization requirements and high patient copayment requirements.<sup>44</sup> This form of rationing occurs frequently in our health care system. On the other hand, in explicit rationing, medical services are distributed or denied based on an official set of rules.<sup>45</sup> This would include drug formularies that list the drugs that an insurer will cover and official criteria for priority on an organ transplant waitlist.<sup>46</sup> Friedenberg distinguishes between explicit and implicit methods of rationing when he lists a few ways of rationing health care:

The method of rationing can be based on rationing the physician's time, rationing new technologies, rationing by gatekeepers, rationing by limiting referrals, or rationing by limiting expensive procedures. Other more indirect methods of rationing include rationing by inconvenience (*i.e.* requiring excessive paperwork or making patients wait an exceptionally long time for an appointment), rationing by policy (*i.e.* declaring that a service is not covered), or rationing by contract (*i.e.* stating within the contract what services are covered at each level, with the patient deciding which level and amount he or she wishes to pay).<sup>47</sup>

The recent public outcry over the Veterans Affairs (VA) "waitlist" scandal provides an extreme and scary example of the injustices that can occur when scarce health care resources are

---

44. KEITH SYRETT, LAW, LEGITIMACY, AND THE RATIONING OF HEALTH CARE: A CONTEXTUAL AND COMPARATIVE PERSPECTIVE 45-50 (2007). There are many different ways of rationing:

- (1) To ration by price ("restricting medical services to those with the ability to pay for them");
- (2) To ration by denial ("[T]his consists of a decision not to approve a particular beneficial medical treatment either to an individual . . . or to a group . . . .");
- (3) To ration by selection (which "amounts to an outright exclusion for access to a particular treatment"), or to ration by delay ("This technique finds expression in one of the most common features of publicly funded health systems, the waiting list, which applies particularly, though not exclusively, to cases of elective surgery.");
- (4) To ration by dilution ("which consists of a reduction in the quantity and/or quality of services provided");
- (5) To ration by termination ("which refers simply to the premature withdrawal of treatment, for example by discharge from hospital earlier than might be thought to be medically advisable").

45. See Friedenberg *supra* note 13, at 6.

46. See *id.*

47. See *id.*

rationed because demand far exceeds supply. The *New York Times* reported that VA administrators used artifices to cloak long waiting times for veterans seeking care and manipulated waitlists at the Veterans Medical Center in Phoenix such that “1,700 patients . . . were not placed on the official waiting list for doctors appointments and may have never received care.”<sup>48</sup> The scandal’s major underlying causes were supply and demand mismatches, including a lack of physicians and nurses, a shortage of space in hospitals and clinics, an outdated computer scheduling system, and a rise in demand due to use of the VA system by veterans of the wars in Iraq and Afghanistan.<sup>49</sup>

## II. SCARCITY, QUEUES, AND HEALTH DISPARITIES

A physician trying to book time for a patient to have a CAT scan or an MRI (medical technologies that help physicians diagnose a range of conditions) is likely to find a waiting list.<sup>50</sup> A patient trying to make an appointment to see a specialist, schedule a follow-up visit, or arrange a date for elective surgery will typically find a waiting list.<sup>51</sup> Within hospitals, periods of permanent or temporary excess demand for hospital services create multiple internal “queues” for services.<sup>52</sup> Economists often criticize the Canadian system for forcing people to wait for care (queuing). But it is not at all clear that Canadians wait longer for medical care than Americans because the statistics do not include those Americans with high copays and deductibles who are waiting to sign up for health care procedures until they have enough money to pay.

While waiting lists and queuing for services may appear democratic in theory, this rationing strategy “risks allocating resources in a piecemeal, unfair fashion with those ‘shouting the

---

48. See Richard Oppel, Jr. & Michael Shear, *Severe Report Finds V.A. Had Waiting Lists at Hospitals*, N.Y. TIMES, May 28, 2014, <http://www.nytimes.com/2014/05/29/us/va-report-confirms-improper-waiting-lists-at-phoenix-center.html>.

49. See Richard Oppel, Jr., *V.A. Official Says Fixing Issues at Root of Wait-List Scandal Will Cost Billions*, N.Y. TIMES, July 16, 2014, <http://www.nytimes.com/2014/07/17/us/va-official-says-fixing-issues-at-root-of-waiting-list-scandal-will-cost-billions.html>.

50. See, e.g., *Transcript of the 2008 Live Symposium Panel Discussion, Healthcare Reform in America: Getting Beyond Ideology to True Reform*, 5 IND. HEALTH L. REV. 463, 467 (2008) (remarks by Dr. Carroll).

51. See *id.*

52. See Bloche, *supra* note 27, at 107.

loudest,' or those with the most money and/or influence gaining privileged access to the goods."<sup>53</sup>

Implicit rationing by queue occurs across the health care system in the absence of bright line rules for allocating scarce resources.<sup>54</sup> Which patient gets to the head of the line is often decided not on the basis of "need" or "medically necessity," but through "the politics of personal influence and professional hierarchy;" indeed, these positional and personal power relationships shape the health care allocation decision and prioritize the patients within a queue.<sup>55</sup> But this allocation method has the potential to generate great disparities in health care because of the race- and ethnicity-based disadvantages patients of color face within the health care system.<sup>56</sup>

As M. Gregg Bloche explained, patients cared for by "high status" physicians have privileged access to health care services and can more easily push their patients to the head of the queue.<sup>57</sup> Those physicians lower in the professional hierarchy—interns, residents, junior attending physicians, and more senior physicians with less prestigious credentials and appointments—face more difficulty in pushing their patients to the front of the line.<sup>58</sup>

The wealthy and powerful tend to seek care from elite academic and private physicians, cultivate relationships with these physicians, and benefit from their personal advocacy in hospitals and other clinical settings.<sup>59</sup> Many wealthy patients also gain an advantage from concierge medicine, a growing subset of medicine where patients pay doctors an annual retainer of anywhere from \$1,500 to \$25,000, and they expect that in an emergency their concierge doctor will push them to the front of the line to see a top specialist.<sup>60</sup>

African Americans and other people of color enter the health care system at a lower level of sponsorship and advocacy for a variety of reasons. The racially discriminatory practices of the AMA and its constituent medical societies badly undermined confidence in black physicians and contributed to a perception that they were less

---

53. Paquita de Zueueta, *Sharing the Health: Rationing in General Practice*, 5(3) *NEW GENERALIST* 50, 52 (2007).

54. See Bloche, *supra* note 27, at 107.

55. See *id.*

56. *Id.* at 107-08.

57. *Id.* at 107.

58. See *id.*

59. *Id.* at 108.

60. See Paul Sullivan, *Putting Your Doctor, or a Whole Team of Them on Retainer*, N. Y. TIMES, Apr. 29, 2011, <http://www.nytimes.com/2011/04/30/your-money/30wealth.html?pagewanted=all>.

competent than their white peers.<sup>61</sup> And the devaluation of black physicians has proven strongly resistant to change. Racial discrimination and differential treatment within the medical profession reemerged as a major problem in the 1980s. Allegations that white-run hospitals were purging black physicians from hospital staffs surfaced in Detroit, Chicago, Fort Worth, and Houston, among other places.<sup>62</sup> The charge was that under the guise of “quality assurance,” professional peer review was being used in a racially discriminatory manner to drive out physicians of color.<sup>63</sup>

Black, Latino/a and Asian American physicians are much less likely to report that their financial status as good or excellent.<sup>64</sup> African American physicians are also strongly overrepresented in HMO settings,<sup>65</sup> which “are often considered less desirable practice locations, with lower remuneration and prestige.”<sup>66</sup> HMO physicians are generally less satisfied with their jobs and more likely to leave their practices than physicians in many other practice settings.<sup>67</sup> Many of the physicians serving communities of color work in public clinics, small private practices, public hospitals, community health centers, and emergency rooms. They frequently have rapid staff turnover and have far less ability to steer their patients through clinical bureaucracies.<sup>68</sup> Physicians of color provide care for over half of minority patients and over 70 percent of care for non-English speaking patients.<sup>69</sup> These physicians report greater difficulties

- 
61. The AMA passed weak resolutions in 1950 and 1952, but did nothing to prevent its local and state medical societies from excluding blacks from membership, with full knowledge that such membership was necessary to be appointed to the medical staffs of most hospitals. See HERBERT M. MORAIS, *THE INTERNATIONAL LIBRARY OF NEGRO LIFE AND HISTORY: THE HISTORY OF THE NEGRO IN MEDICINE* 134 (1967). For instance, a 1950 resolution urged that “constituent and component societies that have restrictive membership provisions based on race study this question in light of prevailing conditions, with the view to taking steps as they may elect to eliminate such restrictive provisions.” *Resolution on Restrictive Membership Provisions*, 143 JAMA 1086 (1950).
  62. See, e.g., W. MICHAEL BYRD & LINDA A CLAYTON, *AN AMERICAN HEALTH DILEMMA: RACE, MEDICINE AND HEALTH CARE IN THE UNITED STATES 1900-2000* (2002).
  63. See *id.* at 415.
  64. Forest Briscoe & Thomas R. Kondrad, *HMO Employment and African-American Physicians*, 98 J. NAT’L MED. ASSOC. 1318, 1324 (2006).
  65. *Id.* at 1319.
  66. *Id.*
  67. *Id.* at 1318.
  68. Bloche, *supra* note 27, at 107.
  69. Lyndonna M. Marrast et al., *Minority Physicians Role in the Care of Underserved Patients: Diversifying the Physician Workforce May Be*

accessing high-quality specialists, diagnostic imaging, and nonemergency admission of their patients to the hospital than physicians serving predominantly nonminority patients.<sup>70</sup>

Any healthcare system that implicitly connects a patient's ability to securely access clinical resources to her physician's power and prestige is fundamentally undemocratic and unjust. Status rationing is little more than a proxy for race and income. More importantly, racial disparities are likely to result from these "status disparities" because lower levels of patient sponsorship and advocacy mean less access to health care resources already in short supply.<sup>71</sup> A fair system of rationing will have to set some priorities and be transparent about them. Our current system falls way short in this regard.

### III. RATIONING BY PRICE AND ABILITY TO PAY

Market justice and social justice are two competing theories about how scarce health care resources should be produced and distributed.<sup>72</sup> Market justice places the responsibility on market forces for the fair distribution of health care resources. Health care is then allocated based on price and the willingness and ability of patients to pay. In other words, patients are entitled to purchase a share of the medical services that they value. Social justice, in contrast, emphasizes the well-being of the community over the individual. Under this view, health care is regarded as a social good (as opposed to an economic good) that should be collectively financed and available to everyone regardless of ability to pay.<sup>73</sup>

The United States rations chiefly by price and the ability to pay,<sup>74</sup> though, in underserved medical communities, access may be limited by the lack of providers and health care facilities.<sup>75</sup> Allocating scarce health care resources by ability to pay and price means that in some instances low-income individuals cannot get health care at all; it also means that they might get a different (inferior) kind of care because the American health care system treats people differently based on

---

*Key in Addressing Health Disparities*, 174 JAMA INTERN. MED. 290 (Feb. 2014) (stating that higher proportions of African American physicians' patients were obese, on Medicaid, and sicker than patients treated by white physicians).

70. *See id.*

71. Bloche, *supra* note 27, at 107-08.

72. LEIGH SHI & DOUGLAS A. SINGH, *ESSENTIALS OF THE U.S. HEALTH CARE SYSTEM* 17 (3rd ed. 2013).

73. *Id.*

74. *See* Richard D. Lamm, *Rationing of Health Care: Inevitable and Desirable*, 140 U. PA. L. REV. 1511, 1518 (1992).

75. *See id.*

whether and how much they can pay.<sup>76</sup> It also leads to people choosing to go without health insurance because they cannot afford it.<sup>77</sup> Over forty million Americans have no access to health care except in an emergency.<sup>78</sup>

This rationing method disproportionately hurts low-income families and communities of color in no small part because health insurance in the United States remains linked to employment. Persons of color comprise about one-third of the nation's population; however, they make up over half of the millions of uninsured.<sup>79</sup> In 2005, nearly two-thirds of Hispanic adults (fifteen million) and one-third of African Americans (six million) were uninsured compared to 20 percent of white adults.<sup>80</sup> People of color are less likely to have health coverage through an employer, in part because they are more likely to be unemployed; however, when employed, they are more likely to work low-wage jobs, which rarely offer coverage.<sup>81</sup>

The uninsured often postpone health care, which is one reason people of color are diagnosed at more advanced stages of diseases and

---

76. See Hoffman, *supra* note 2, at x.

77. See *id.*

78. While no official figures have been released, a Gallup survey finds that “the uninsured rate has dropped by 3.7 points since the fourth quarter of 2013, when it averaged 17.1 percent.” Jenna Levy, *In U.S. Uninsured Rate Sinks to 13.4% in Second Quarter*, GALLUP (July 10, 2014), <http://www.gallup.com/poll/172403/uninsured-rate-sinks-second-quarter.aspx>. Moreover, the Gallup survey found that the uninsured rate declined significantly more in the states that chose to expand Medicaid and set up their own state exchange in the health insurance marketplace than in the states that have not done so. “The uninsured rate declined 4.0 points in the 21 states that have implemented both of these measures, compared with a 2.2-point drop across the 29 states that have implemented only one or neither of these actions.” Dan Witters, *Arkansas, Kentucky Report Sharpest Drops in Uninsured Rate*, GALLUP (Aug. 5, 2014), <http://www.gallup.com/poll/174290/arkansas-kentucky-report-sharpest-drops-uninsured-rate.aspx>.

79. Brian D. Smedley, *Moving Beyond Access: Achieving Equity in State Health Care Reform*, 27 HEALTH AFF. 447, 448 (2008).

80. Michelle M. Doty & Alyssa L. Holmgren, *Health Care Disconnect: Gaps in Coverage and Care for Minority Adults*, COMMONWEALTH FUND (Aug. 2006) available at [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2006/aug/health-care-disconnect--gaps-in-coverage-and-care-for-minority-adults--findings-from-the-commonwealth/941\\_doty\\_hlt\\_care\\_disconnect\\_disparities\\_issue\\_brief.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2006/aug/health-care-disconnect--gaps-in-coverage-and-care-for-minority-adults--findings-from-the-commonwealth/941_doty_hlt_care_disconnect_disparities_issue_brief.pdf).

81. *Health Reform and Communities of Color: Implications for Racial and Ethnic Health Disparities*, FACTS ON HEALTH REFORM (Kaiser Family Found., Menlo Park, CA), Sept. 2010, available at <http://www.kff.org/healthreform/upload/8016-02.pdf>.

thus receive poorer care. Many more of these Americans lack a usual source for health care, have substantially higher unmet health needs, and have high out-of-pocket costs.<sup>82</sup> Compared to the insured, a larger percentage of the uninsured report problems paying medical bills. They also report relying on home remedies rather than seeking the care of a doctor, skipping dental care, and not filling a prescription due to cost.<sup>83</sup> Compared to whites, African Americans and Latino/as are more likely to report experiencing these problems.<sup>84</sup>

Moreover, racial and ethnic minorities are disproportionately dependent on public insurance sources such as Medicaid. While Medicaid has been vital for expanding access to health insurance, its low reimbursement rates have a dampening effect on health care access and quality among its beneficiaries. While varying from state to state, Medicaid physician payment rates have traditionally trailed those of both Medicare and employer-sponsored insurance. After controlling for inflation, Medicaid physician fees declined from 2003 through 2008.<sup>85</sup> Because reimbursement is lower, many doctors do not participate in the program or greatly limit the number of Medicaid patients they treat.<sup>86</sup> As a result, Medicaid enrollees often seek care

- 
82. See THOMAS A. LAVEIST ET AL., JOINT CENTER FOR POLITICAL AND ECONOMIC STUDIES, *THE ECONOMIC BURDEN OF HEALTH INEQUALITIES IN THE UNITED STATES* 4 (2009); see Megan Thomas & Cara James, *The Role of Health Coverage for Communities of Color*, KAISER FAMILY FOUND. (Nov. 2009) available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8017.pdf>.
83. See *Health Security Watch*, KAISER FAMILY FOUND. (June 2012) available at [http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8322\\_hsw-may2012-update.pdf](http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8322_hsw-may2012-update.pdf).
84. *Id.* For example, 31 % of Hispanics compared to 25 % of whites reported having a problem paying medical bills in the past year, and more than half of Hispanics reported relying on home remedies in the past year instead of going to the doctor because of cost compared to almost one-third of whites. Moreover, about one in three blacks and Hispanics reported not filling a prescription in the past year due to costs compared to about one in four whites. *Id.* at 9.
85. Stephen Zuckerman et al., *Trends in Medicaid Physician Fees, 2003-2008*, 28 HEALTH AFF. w511, w514 (2009).
86. See KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *PHYSICIAN WILLINGNESS AND RESOURCES TO SERVE MORE MEDICAID PATIENTS: PERSPECTIVES FROM PRIMARY CARE PHYSICIANS 3* (Apr. 2011), <http://www.kff.org/medicaid/upload/8178.pdf>. The study found that primary care physicians that restrict Medicaid patients also cite additional reasons including difficulty in arranging for specialty care, the high clinical burden of Medicaid patients, and administrative burdens such as billing and paperwork. As a result, Medicaid enrollees often seek care from hospital emergency rooms, federally qualified health centers, or other safety-net institutions. *Id.* at 2.

from hospital emergency rooms, federally qualified health centers, or other safety-net institutions.<sup>87</sup>

Finally, as Ruqaiijah Yearby persuasively argues, rationing by price and ability to pay is a subtle form of structural racial bias.<sup>88</sup> Structural racial bias, she argues, operates at the societal level and privileges some groups while denying other groups access to the goods and resources of society.<sup>89</sup> Allocating scarce health care resources by ability to pay rather than through some other criteria such as need privileges wealthy whites and allows them to obtain the highest quality health care available.<sup>90</sup> Those without privilege, such as people of color (who are disproportionately poor), have limited access to health care resources because they lack health insurance and cannot afford to pay for it.<sup>91</sup>

#### IV. RACE, RATIONING, AND THE AFFORDABLE CARE ACT

While the ACA is expected to significantly reduce the number of uninsured Americans, it does not provide a right to health care or guarantee universal access to coverage.<sup>92</sup> The law is projected to extend health insurance to an estimated 32 million people in two ways.<sup>93</sup> First, the ACA expands Medicaid to provide coverage to all families and individuals with incomes below 133 percent of the federal poverty level, no matter the state they live in.<sup>94</sup> Second, the law establishes a health insurance marketplace (health exchange) that includes security provisions that end insurers' ability to ration on the basis of health status condition and gender. To make private insurance coverage affordable in the health exchange, the law provides for upfront subsidies and tax credits.<sup>95</sup> Even though there is no right to health insurance, the ACA does confer a right to a subsidy to purchase insurance within the health exchange that alleviates, to

---

87. *See id.*

88. *See* Ruqaiijah Yearby, *Racial Inequities in Mortality and Access to Health Care*, 32 J. LEGAL MED. 77, 86-89 (2011).

89. *See id.* at 87.

90. *Id.*

91. *Id.*

92. *See* Hoffman, *supra* note 2, at 214-15.

93. *See* Letter from Douglas W. Elmendorf, Dir., Cong. Budget Off. to Nancy Pelosi, Speaker, House of Rep. 9 (Mar. 20, 2010), *available at* <https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf>.

94. 42 U.S.C. § 1396w-3 (2010).

95. 26 U.S.C. § 36B (2010).



some extent, rationing by income. This will be especially beneficial to low- and middle-income persons of color.<sup>96</sup>

The ACA also has the potential to alleviate some forms of rationing by race. Influential scholars like Sidney Watson and Sara Rosenbaum argue that the ACA creates a broad new health care-specific federal civil rights mandate whose purpose is to overcome the shortcomings in previous civil rights laws that dealt with discrimination on the basis of race, sex, disability, or age.<sup>97</sup> This new mandate not only prohibits intentional discrimination in health care (as does current law), but also prohibits some forms of institutional bias,<sup>98</sup> particularly facially neutral policies and practices that have an unjustifiably disproportionate racial impact, including those that segregate along racial lines.<sup>99</sup> The U.S. Department of Health and Human Services should move quickly to publish standards and regulations to ensure early compliance by health plans and providers<sup>100</sup>

The U.S. health care system has always been tiered by income, race, and class.<sup>101</sup> For instance, health insurance and health care remain racially and ethnically divided: A higher tier of care disproportionately serves white patients with private insurance while a lower tier “safety net” system of care serves both minority patients with Medicaid and the uninsured.<sup>102</sup> From a social justice perspective, the problem with a tiered health care system is that it imposes severe rationing at the bottom tiers where people of color are disproportionately represented while little or no rationing occurs at the top.<sup>103</sup> For instance, the lowest tier, which includes Medicaid beneficiaries and the uninsured, has never had much of a political

---

96. See Hoffman, *supra* note 2, at 214.

97. Sarah Rosenbaum, *Section 1557 of the ACA and Non-Discrimination: The HHS Request for Information*, HEALTHREFORMGPS (2010), available at <http://www.healthreformgps.org/wp-content/uploads/Rosenbaum-1557-PDF1.pdf>; Sidney D. Watson, *Section 1557 of the Affordable Care Act: Race and Equity*, 55 HOWARD L. J. 855, 859 (2012).

98. See Watson, *supra* note 97, at 859.

99. Watson, *supra* note 97, at 859.

100. See *id.* at 884.

101. See Uwe E. Reinhardt, *The Economics of Being Kinder and Gentler in Health Care*, N.Y. TIMES, Dec. 20, 2013, <http://economix.blogs.nytimes.com/2013/12/20/the-economics-of-being-kinder-and-gentler-in-health-care/>.

102. See Watson, *supra* note 97, at 857.

103. See Uwe E. Reinhardt, *Rationing Health Care: What It Is, What It Is Not, and Why We Cannot Avoid It*, 2 BAXTER HEALTH POL'Y REV. 63 (1996).

voice, and politicians are able to ration health care for Medicaid beneficiaries and the uninsured without admitting that they are doing it merely by placing restraints on the budget.<sup>104</sup>

The ACA appears to provide official sanction to a three-tier health care system. For high-income groups in the upper tier, health care consists of concierge medicine and Cadillac health insurance plans.<sup>105</sup> For the employed and middle- to lower-income groups in the second tier, health care is a mixed system of employer sponsored insurance and health exchanges with defined contributions by employers and government subsidies.<sup>106</sup> Nearly half of those uninsured adults eligible for subsidies are people of color.<sup>107</sup> For the poor and the uninsured in the bottom tier, the health care system consists of Medicaid, hospital emergency rooms, community health centers, and free clinics.<sup>108</sup> Moreover, in the lower tiers, especially for those purchasing cheaper “Bronze” plans in the health exchange or receiving care through Medicaid and hospital emergency rooms, health care is rationed by long waits, high patient copayment requirements, high deductibles, low payments to doctors that discourage some from serving patients, and limits on payments to hospitals.<sup>109</sup> By permitting a tiered health system where rationing occurs at the lower levels, the ACA may unwillingly “serve to reinforce and further segregate patients along racial lines.”<sup>110</sup>

---

104. Reinhardt, *supra* note 101.

105. *Id.*

106. *Id.*

107. DENNIS P. ANDRULIS ET AL., JOINT CTR FOR POL. & ECON. STUDIES, PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010: ADVANCING HEALTH EQUITY FOR RACIALLY AND ETHNICALLY DIVERSE POPULATION 9 (2010), *available at* <http://jointcenter.org/sites/default/files/Patient%20Protection%20and%20Affordable%20Care%20Act.pdf>.

108. *See id.*

109. 42 U.S.C. § 18022 (2010) (explaining that health plans offered in the individual and small group markets must cover specific percentages of actuarial value and are arrayed in “precious metal” categories: bronze plans must cover 60% of actuarial value, silver plans must cover 70% of actuarial value, gold plans must cover 80% of actuarial value, and platinum plans must cover 90% of actuarial value. Insurers may also offer a catastrophic plan to subscribers under thirty years of age, which has been referred to as the “young invincibles” plan because it is aimed at attracting younger subscribers inclined to doubt they need health insurance).

110. *See Watson, supra* note 97, at 857.

Although undocumented immigrants represent about 15 percent of the nation's 47 million uninsured,<sup>111</sup> the ACA maintains the status quo; these individuals can get emergency care through Medicaid, but they cannot receive nonemergency care unless they pay.<sup>112</sup> Here again, people of color are allowed to receive minimal health care so that the rest of society can conserve and consume health care resources. Presumably, undocumented immigrants will receive the bulk of primary care at community health centers (CHCs), which charge based on a sliding scale. While CHCs are able to provide primary care, they report difficulty in connecting their patients to diagnostic testing and specialty care, even when patients are insured.<sup>113</sup>

Also included in the bottom tier are the almost five million uninsured poor adults who fall into a coverage gap because their state of residence chose not to expand Medicaid.<sup>114</sup> The U.S. Supreme Court ruled in June 2012 that states may opt out of Medicaid expansion,<sup>115</sup>

- 
111. Richard Wolf, *Rising Health Care Costs Put Focus on Illegal Immigrants*, USA TODAY, Jan. 21, 2008, [http://usatoday30.usatoday.com/news/washington/2008-01-21-immigrant-healthcare\\_N.htm](http://usatoday30.usatoday.com/news/washington/2008-01-21-immigrant-healthcare_N.htm); see also Jeffrey S. Passel & D'Vera Cohn, *A Portrait of Unauthorized Immigrants in the United States*, PEW HISP. CTR. 18 (Apr. 14, 2009), available at <http://pewhispanic.org/files/reports/107.pdf> (noting that most undocumented adults had no health insurance during all of 2007, more than double the uninsured share among authorized immigrants and four times the uninsured share among U.S.-born adults).
112. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1312(f)(3), 124 Stat. 119, 184 (2010).
113. MICHELLE M. DOTY, ENHANCING THE CAPACITY OF COMMUNITY HEALTH CENTERS TO ACHIEVE HIGH PERFORMANCE: FINDINGS FROM THE 2009 COMMONWEALTH FUND NATIONAL SURVEY OF FEDERALLY QUALIFIED HEALTH CENTERS 15 (2010), available at [http://www.commonwealthfund.org/~media/files/publications/fund-report/2010/may/1392\\_doty\\_enhancing\\_capacity\\_community\\_hlt\\_ctr\\_s\\_2009\\_fqhc\\_survey\\_v5.pdf](http://www.commonwealthfund.org/~media/files/publications/fund-report/2010/may/1392_doty_enhancing_capacity_community_hlt_ctr_s_2009_fqhc_survey_v5.pdf).
114. *A Closer Look at the Impact of State Decisions Not to Expand Coverage for Uninsured Adults*, KAISER FAMILY FOUND. (Apr. 24, 2014), <http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/>.
115. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012). Twenty-six states led by their Republican-dominated governments sued HHS. The plaintiffs raised many challenges to the ACA, contesting the constitutionality of the so-called "individual mandate" (requiring most people to purchase insurance or pay a tax penalty for failure to do so), as well as the portion of the ACA requiring states to expand Medicaid eligibility to include all adults below 138% of the FPL or risk losing federal funding for their existing Medicaid programs. Although the Court upheld the constitutionality of the individual mandate by finding it to be a permissible exercise of Congress' taxing authority, it found the Medicaid expansion unconstitutionally coercive of states, holding that

and as of September 2014, twenty-five states have chosen to do so. Without the Medicaid expansion, these poor and low income adults are ineligible for financial assistance to obtain health coverage under the ACA and are likely to remain uninsured.<sup>116</sup>

The decision not to expand Medicaid in those states will have adverse health and financial consequences for those poor, uninsured black adults residing in the South, where most states are not moving forward with the expansion.<sup>117</sup> In several of the states that refuse to expand such as Alabama, Georgia, and South Carolina, at least 45 percent of those in the program in 2011 were black, according to the Kaiser Family Foundation. In Louisiana, 57 percent of Medicaid beneficiaries were black; in Mississippi it was 67 percent. As noted by a Kaiser Family Foundation report, “Four in ten uninsured Blacks with incomes low enough to qualify for the Medicaid expansion fall into the gap, compared to 24% of uninsured Hispanics and 29% of uninsured Whites.”<sup>118</sup>

Whether the decision to opt-out of the Medicaid expansion is yet another example of rationing by race is open for debate. One of the key purposes of the Medicaid expansion was to reduce racial and ethnic health disparities.<sup>119</sup> Congress was well aware that the Medicaid expansion would be an important mechanism for increasing the access to medical care of people of color, and for many members, the fact that it would reduce racial and ethnic disparities was a key reason for

---

the Secretary could not threaten the loss of existing Medicaid funding to incentivize states to participate in the Medicaid expansion. *Id.* at 2598, 2607. The Court’s ruling essentially converted the Medicaid expansion into an optional program in which states could choose to participate but would incur no penalty for opting out.

116. *See id.* at 2665.

117. *The Impact of the Coverage Gap in States not Expanding Medicaid by Race and Ethnicity*, KAISER FAMILY FOUND. (Dec. 7, 2013), <http://kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity/>.

118. *Id.*

119. This understanding that the Medicaid expansion would help ameliorate racial health disparities has also been articulated by the Executive Branch. For example, HHS has created an action plan to reduce racial and ethnic health disparities. *See generally* U.S. DEP’T OF HEALTH & HUMAN SERV., HHS ACTION PLAN TO REDUCE RACIAL AND ETHNIC HEALTH DISPARITIES: A NATION FREE OF DISPARITIES IN HEALTH AND HEALTH CARE (2011), *available at* [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf) (proposing to “reduce disparities in health insurance coverage and access to care,” and stating that the Medicaid expansion, among other ACA measures, “will have a focus on reducing disparities in coverage for racial and ethnic minorities.”).

their vote.<sup>120</sup> Further, some opponents of the Medicaid expansion have nasty racial dog whistles and ugly-coded language to defeat it.<sup>121</sup>

Regardless of the intent, the rationing decision made by these Republican governors will generate racial and ethnic health disparities. A recent study estimates that the number of deaths attributable to the lack of Medicaid expansion in opt-out states at between 7,115 and 17,104.<sup>122</sup> The study also estimates that “Medicaid expansion in these states would have resulted in 422,553 more diabetics receiving medication for their illness, 195,492 more mammograms among women age 50-64 years, and 443,677 more pap smears among women ages 21-64.”<sup>123</sup> Without action to rectify this unintended consequence of the ACA, the United States seems likely to consign its poorest and most vulnerable residents to a continued tenuous health status in which the only options for care are emergency rooms and those institutions that are willing to provide free or nearly free health services.

### CONCLUSION

Rationing by race has its origins in intentional discriminatory practices that denied people of color access to health care recourses. It continues today in the form of political decisions and facially neutral policies and practices that, while not called rationing, still allocate resources away from communities of color and toward more affluent whites. The ACA’s provisions expanding access to affordable health insurance offer a critical tool to improve minority access to health insurance and reduce inequities both in the health care system and among communities of color. But other consequences—namely, a three-tiered healthcare system that rations severely at the bottom and

---

120. See 155 CONG. REC. H8397 (daily ed. July 20, 2009) (statement of Rep. Fudge) (discussing that “nearly half—or 48%—of black adults suffer from some form of chronic condition compared to 39% of all adults,” yet “one in every five black Americans lack health insurance compared to one in every eight whites” and that “[c]onsidering the statistics that [Fudge] mentioned, [Fudge was] glad to report that affordability and access to quality health care are two problems that are addressed” by the Medicaid expansion provision of the then-pending health care reform bill).

121. See, e.g., Robert Mann, *Jindal’s No Racist, But When it Comes to Medicaid He Whistles Their Tunes*, SOMETHING LIKE THE TRUTH BLOG (Apr. 25, 2013), <http://bobmannblog.com/2013/04/25/stopping-medicaid-expansion-the-uses-and-abuses-of-racial-code-words/>.

122. Sam Dickman et al., *Opting out of Medicaid: The Health and Financial Impacts*, HEALTH AFF. BLOG (Jan. 30, 2014), <http://healthaffairs.org/blog/2014/01/30/opting-out-of-medicaid-expansion-the-health-and-financial-impacts/>.

123. *Id.*

the Medicaid opt-out—are anathema to those strongly committed to the principles of equal access to necessary healthcare services for all Americans, including people of color.

