

RACIAL HORIZONS AND EMPIRICAL LANDSCAPES IN THE POST-ACA WORLD

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INTRODUCTION

In some legal circles, there is a popular saying that “law is too important to leave to lawyers.”¹ Socio-legal scholars often deploy this cliché in an attempt to wrestle law out of its typically doctrinal confines and justify social science explorations of law.² The idea is that subject matter expertise on law should not be limited to attorneys and J.D.-toting scholars but should be more of an interdisciplinary enterprise. I think the same could be said about another equally important field: health is too important to leave to the medical scholars and public health practitioners.³ This symposium represents a

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1. See, e.g., HAROLD J. BERMAN, ON THE TEACHING OF LAW IN THE LIBERAL ARTS CURRICULUM 28 (1956).

2. E.g., Marianne Constable, *On Not Leaving Law to the Lawyers*, in LAW IN THE LIBERAL ARTS 69 (Austin Sarat ed., 2004) (describing the usage of this saying in socio-legal research).

3. It is important to note that although medicine and public health are overlapping fields, they also have distinct differences. Public health is particularly interested in preventing individuals from risks and exposures that lead them to rely on the healthcare system, whereas medicine, although interested in prevention, is concerned with diagnoses and treatments after individuals have developed diseases or conditions.

wonderful opportunity to consider ways to wed the theoretical heft of critical race theory (CRT) with the empirical strengths of social science research in accordance with invitations made by several scholars.⁴ The former—a theoretical paradigm that emphasizes the indeterminate, intersectional, and enduring nature of racism—has been around formally for almost three decades and weathered critiques about its usefulness as well as concerns about balkanization.⁵ Law schools have incorporated CRT in their curriculums; professors have included it in their instruction; student groups have started journals in the area; and, whether explicitly announced or not, it filters into legal scholarship on social identity (e.g., race, class, gender, sexuality, citizenship) in ways that are arguably beyond measurement.⁶ Moreover, despite calls for more interdisciplinary engagement with this theory, it is not limited to the confines of law.⁷

The social sciences, on the other hand, have a much more entrenched history in the academy. Facilely broken up into two camps—the qualitative and the quantitative—this super category of

4. See, e.g., Devon W. Carbado & Daria Roithmayr, *Critical Race Theory Meets Social Science*, 10 ANN. REV. L. & SOC. SCI. 149, 151–55 (2014); Devon W. Carbado & Mitu Gulati, *The Law and Economics of Critical Race Theory*, 112 YALE L.J. 1757, 1761 (2003); Laura E. Gómez, *A Tale of Two Genres: On the Real and Ideal Links Between Law and Society and Critical Race Theory*, in THE BLACKWELL COMPANION TO LAW AND SOCIETY 453, 454 (Austin Sarat ed., 2004); Osagie K. Obasogie, *Foreward: Critical Race Theory and Empirical Methods*, 3 UC IRVINE L. REV. 183 (2013); Gregory Parks, *Toward a Critical Race Realism*, 17 CORNELL J.L. & PUB. POL'Y 683, 738–43 (2008); Kimani Paul-Emile, *Foreward: Critical Race Theory and Empirical Methods Conference*, 83 FORDHAM L. REV. 2953 (2015).

5. See KEVIN HYLTON, 'RACE' AND SPORT: CRITICAL RACE THEORY (2009); MATHIAS MÖSCHEL, LAW, LAWYERS AND RACE: CRITICAL RACE THEORY FROM THE UNITED STATES TO EUROPE (2014) (applying CRT principles to European law); Keith Aoki, *Space Invaders: Critical Geography, the "Third World" in International Law and Critical Race Theory*, 45 VILL. L. REV. 913 (2000); Michael J. Coyle, *Notes on the Study of Language: Towards Critical Race Criminology*, 11 W. CRIMINOLOGY REV. 11 (2010); Gloria Ladson-Billings, *Just What Is Critical Race Theory and What's It Doing in a Nice Field Like Education?*, 11 INT'L J. QUAL. STUDS. EDUC. 7, 10–11 (1998); Charles R. P. Pouncy, *Institutional Economics and Critical Race/LatCrit Theory: The Need for a Critical "Raced" Economics*, 54 RUTGERS L. REV. 841 (2002).

6. The sociology of citation is relevant here, as noted at CRT's outset. See Richard Delgado, *The Imperial Scholar: Reflections on a Review of Civil Rights Literature*, 132 U. PA. L. REV. 561 (1984) (critiquing mainstream civil rights scholarship for ignoring the work of minority legal scholars); Randall L. Kennedy, *Racial Critiques of Legal Academia*, 102 HARV. L. REV. 1745 (1989) (challenging Delgado's claims). Beyond the recognizable issues of under-citation and lack of acknowledgment, there are some aspects of intellectual influence that are not as readily noticeable, such as a CRT scholar providing feedback on an article, mentoring, or being referenced in non-scholarly outlets (e.g., journalism or online content).

7. See sources cited *supra* note 5.

study has been subject to internal critiques and external judgments about its troubled history as well as its contemporary posture toward race and other categories of social division.⁸ Unsurprisingly, these two large areas of study have much to offer each other.

This short essay focuses specifically on the fusion of critical race studies and public health. To be sure, I am far from the first person to situate these two fields.⁹ Many scholars have synthesized these areas ably and extensively. Moreover, my co-panelist Professor Chandra Ford and her colleague Professor Collins Airhihenbuwa persuasively articulated the necessity of linking public health and critical race theory in the beginning of this decade.¹⁰ This essay picks up the thematic baton but with addenda. Professors Ford and Airhihenbuwa focused primarily on bringing critical race theory to public health research and practice.¹¹ This essay does the opposite and highlights how public health might inform critical race studies scholarship. It does this by focusing sharply

8. See RODERICK A. FERGUSON, *ABERRATIONS IN BLACK: TOWARD A QUEER OF COLOR CRITIQUE* (2004); ALDON D. MORRIS, *THE SCHOLAR DENIED: W.E.B. DU BOIS AND THE BIRTH OF MODERN SOCIOLOGY* (2015); FRANCILLE RUSAN WILSON, *THE SEGREGATED SCHOLARS: BLACK SOCIAL SCIENTISTS AND THE CREATION OF BLACK LABOR STUDIES, 1890–1950* (2006); TUKUFU ZUBERI, *THICKER THAN BLOOD: HOW RACIAL STATISTICS LIE* (2001).

9. See KHIARA M. BRIDGES, *REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION* (2011); DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* (1997); Tony N. Brown, *Critical Race Theory Speaks to the Sociology of Mental Health: Mental Health Problems Produced by Racial Stratification*, 44 *J. HEALTH & SOC. BEHAVIOR* 292 (2003); Andrea Freeman, “*First Food*” *Justice: Racial Disparities in Infant Feeding as Food Oppression*, 83 *FORDHAM L. REV.* 3053 (2015); Louis Graham et al., *Critical Race Theory as Theoretical Framework and Analysis Tool for Population Health Research*, 21 *CRITICAL PUB. HEALTH* 81 (2011); Lisa C. Ikemoto, *In the Shadow of Race: Women of Color in Health Disparities Policy*, 39 *U.C. DAVIS L. REV.* 1023 (2006).

10. Chandra L. Ford & Collins O. Airhihenbuwa, *Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis*, 100 *AM. J. PUB. HEALTH* S30 (2010) [hereinafter *Toward Antiracism Praxis*]; Chandra L. Ford & Collins O. Airhihenbuwa, *The Public Health Critical Race Methodology: Praxis for Antiracism Research*, 71 *SOC. SCI. & MED.* 1390 (2010) [hereinafter *Praxis for Antiracism Research*].

11. *Toward Antiracism Praxis*, *supra* note 10, at S30 (“We introduce Critical Race Theory to the public health community, highlight key Critical Race Theory characteristics (race consciousness, emphases on contemporary societal dynamics and socially marginalized groups, and praxis between research and practice) and describe Critical Race Theory’s contribution to a study on racism and HIV testing among African Americans.”); *Praxis for Antiracism Research*, *supra* note 10, at 1390 (“To improve the ease and fidelity with which public health researchers can use CRT to conduct health equity research, we developed the Public Health Critical Race praxis (PHCR). PHCR maintains public health’s high standards for scientific rigor while drawing on the robust body of antiracism work that exists outside public health.”).

on areas that some might say are within the disciplinary ambit of public health and others might say are related but separate intellectual projects: medical sociology, medical anthropology, and health economics. While there are several other relevant sub-fields, this essay focuses on these areas because they are particularly relevant to the discussion of the ACA. Medical sociology and medical anthropology, I argue, offer useful empirical perspectives on the enduring roles of racial subordination, poverty, sexism, and nativism in the provision of health services. CRT's focus on law can help illuminate how the state, courts, and government agencies are implicated in categorical health inequalities; the fusion of CRT and these areas of public health can also provide insights on how law can ameliorate such disparities in ways that advance critical race theory's egalitarian vision. In each section, I highlight how critical race theory would benefit from engagement with these different brands of public health scholarship, particularly in the post-Patient Protection and Affordable Care Act (ACA or the "Act") world. I pay close attention to potential obstacles related to the ACA; some of these topics were social problems that existed before the passage of this sweeping health law and the various judicial challenges that have tested its constitutionality.¹² Other areas are tied specifically to the ACA's implementation. Nevertheless, the larger point is that the ACA, which created an improved albeit still flawed health care regime, is rife with implications that may have a productive or counterproductive impact on socially marginalized groups. Some of the potential shortcomings of the ACA might impact these communities irrespective of whether the law is here to stay, is withered away by Republicans (as is the case during the time of this writing),¹³ or is completely decimated.

The ACA requires the Secretary of Health and Human Services to ensure that federally supported health programs collect and report "data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants."¹⁴ The Act is also explicit about improving health outcomes for vulnerable populations and reducing health disparities.¹⁵ Critical race theorists in conjunction with health

12. *King v. Burwell*, 135 S. Ct. 2480 (2015); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

13. See David Ramsey, *Red States Are Reinventing Medicaid to Make It More Expensive and Bureaucratic*, NEW REPUBLIC (Jan. 18, 2015), <https://newrepublic.com/article/120781/republican-governors-accept-medicaid-expansion-make-it-costlier>.

14. 42 U.S.C. § 300kk(a)(1)(A) (2012).

15. See *id.* § 280j(a)(2)(B)(i) (stating that the Secretary of Health and Human Services shall establish a national strategy that has "the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care for all populations, including children and vulnerable populations").

social scientists can not only ensure that such data is being used exactly but are also in a position to use this information to see if the Act is living up to stated goals. To be sure, I am not advocating a kind of grab bag interdisciplinarity, where dilettantes dive into these sub-disciplines in search of convenient empirics that support their points. Instead, I'm interested in cross-disciplinary collaborations, substantive engagement with these areas, and wrestling with data that might complicate (and potentially refine) some of the central claims of critical race theory. This is an endeavor that I believe will be both intellectually and practically useful as racial subordination and entanglements with other areas of social identity continue to move in linear and unpredictable ways.

THE SUBFIELDS

At the outset, it is important to note that the different strands of health research discussed in this section often overlap. Medical anthropology and medical sociology both rely on similar qualitative methods (e.g., interviews and participant observation). Medical sociology and health economics both cohere around interests in how healthcare systems and institutions function. Medical anthropology's interest in government and socio-economic systems (e.g., capitalism and socialism) coincides with health economics' focus on how the state can use law to improve the general population's health. In short, no one field has a monopoly on health scholarship. While these distinctions might seem like I am hairsplitting, these differences are important to highlight, even if briefly (or in the eyes of provincialists, crudely), and are pertinent for operationalizing socio-medical research within critical race theory.

A. Medical Anthropology and Community Health Needs Assessments

The first sub-discipline that has practical import for critical race theory is medical anthropology. This area of study is rife with disciplinary debates about its contours and boundaries. I use medical anthropology as a broad umbrella term to describe various anthropological work that coheres around medicine, health, illness, and healing. It is similar to medical sociology but distinct in its origins, prioritization of ethnographic methods, and emphasis on international contexts and, in its applied form, is often unabashed about its goal of

addressing human suffering.¹⁶ Most notably, medical anthropologists are interested in biology and culture (e.g., diet, nutrition, how pain and sickness is experienced differently across cultural groups);¹⁷ the political economy of health (e.g., the privatization of health services, health care as a human right or as a free market commodity);¹⁸ and power (e.g., asymmetrical relationships between patients and providers or the consequences of taken-for-granted assumptions about medical knowledge and expertise).¹⁹ Critical race theory's utilization of

16. George M. Foster, *Medical Anthropology: Some Contrasts with Medical Sociology*, 9 SOC. SCI. & MED. 427 (1974); see *Mission, Vision, Values, and Goals*, SOC'Y FOR APPLIED ANTHROPOLOGY, <https://www.sfaa.net/about/governance/mission/> (last updated Oct. 1999) ("The Society for Applied Anthropology aspires to promote the integration of anthropological perspectives and methods in solving human problems throughout the world; to advocate for fair and just public policy based upon sound research; to promote public recognition of anthropology as a profession; and to support the continuing professionalization of the field.").

17. MERRILL SINGER & HANS BAER, INTRODUCING MEDICAL ANTHROPOLOGY: A DISCIPLINE IN ACTION 11–13 (2007); see also Megan Crowley-Matoka, *Desperately Seeking "Normal": the Promise and Perils of Living with Kidney Transplantation*, 61 SOC. SCI. & MED. 821 (2005) (describing how patients with kidney transplants manage being sick and healthy); Leandris C. Liburd, *Food, Identity, and African-American Women with Type 2 Diabetes: An Anthropological Perspective*, 16 DIABETES SPECTRUM 160 (2003) (describing the relationship between food consumption and diabetes).

18. Arachu Castro & Paul Farmer, *Medical Anthropology in the United States*, in MEDICAL ANTHROPOLOGY: REGIONAL PERSPECTIVES AND SHARED CONCERNS 42, 49 (Francine Saillant & Serge Genest eds., 2007); see also JESSICA M. MULLIGAN, UNMANAGEABLE CARE: AN ETHNOGRAPHY OF HEALTH CARE PRIVATIZATION IN PUERTO RICO (2014) (describing how market-based reforms impacted the health of Puerto Ricans); Deborah A. Boehm, *The Safety Net of the Safety Net: How Federally Qualified Health Centers "Subsidize" Medicaid Managed Care*, 19 MED. ANTHROPOLOGY Q. 47 (2005); Jeff Maskovsky, *"Managing" The Poor: Neoliberalism, Medicaid HMOs and the Triumph of Consumerism Among the Poor*, 19 MED. ANTHROPOLOGY 121 (2000) (describing how private sector strategies impact the health of poor people in Philadelphia); Cathleen E. Willging, *Power, Blame, and Accountability: Medicaid Managed Care for Mental Health Services in New Mexico*, 19 MED. ANTHROPOLOGY Q. 84 (2005) (describing the problems with the public-private partnership in the provision of health care in New Mexico).

19. See CAROLYN MOXLEY ROUSE, UNCERTAIN SUFFERING: RACIAL HEALTH CARE DISPARITIES AND SICKLE CELL DISEASE 7–8 (2009) (Rouse questions the categories used to identify health disparities and argues that "[t]o accept that genes are responsible for health disparities, one must accept that black people represent a distinct genetic group predisposed to certain health conditions, and that they (perhaps) have on average lower IQs. To accept that culture is responsible for health disparities, one must accept that black people share cultural beliefs and practices that differ significantly from those of the mainstream."); Khiara M. Bridges, *Wily Patients, Welfare Queens, and the Reiteration of Race in the U.S.*, 17 TEX. J. WOMEN & L. 1 (2007) (describing the fraught interactions between poor patients of color and hospital staff and how they are influenced by assumptions about race, class, and gender and impact the provision of healthcare); Duana Fullwiley, *The Biological Construction of Race: 'Admixture' Technology and the New Genetic Medicine*, 38 SOC. STUD. SCI. 695 (2008) (studying

narratives, skepticism of doctrinal dogma, and “desire not merely to understand the vexed bond between law and racial power but to *change it*” make it particularly amenable to engagement with medical anthropology.²⁰

One specific area where these two fields can interface is the Affordable Care Act’s requirements for hospitals seeking federal tax-exemption.²¹ The ACA requires hospitals to conduct a “community health needs assessment” (CHNA) every three years to retain their tax-exempt status.²² The CHNA requires hospitals to “take[] into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.”²³ Its purpose is to ensure that hospitals service the communities in which they are located. This requires hospitals to adopt “an implementation strategy to meet the community health needs identified through such assessment”²⁴ and make it “widely available to the public.”²⁵ Hospitals that fail to meet this requirement are subject to a \$50,000 tax.²⁶

Critical race theory and medical anthropology are well positioned to examine local hospitals’ fidelity to this requirement. There are several questions for both fields to consider: what are the specific medical needs of impoverished localities and is the CHNA, in its novelty, a mechanism that can scratch the surface of these biocultural nuances? These questions are important because some critics have argued that the CHNA standards are too vague and make hospital compliance difficult.²⁷ Others argue that such ambiguity, coupled with

two medical genetics laboratories and highlighting how health disparities researchers bracket environmental factors “while privileging racialized genetic variance as the primary source of health disparities for common disease”).

20. CRITICAL RACE THEORY: THE KEY WRITINGS THAT FORMED THE MOVEMENT, at xiii (Kimberlé Crenshaw et al. eds., 1995); *see also* CRITICAL RACE THEORY: THE CUTTING EDGE 3 (Richard Delgado & Jean Stefancic eds., 3d ed. 2013).

21. 26 U.S.C. § 501(r)(1) (2012).

22. § 501(r)(3)(A)(i).

23. § 501(r)(3)(B)(i).

24. § 501(r)(3)(A)(ii).

25. § 501(r)(3)(B)(ii).

26. *Id.* § 4959.

27. *See, e.g.,* Mary Crossley, *Tax-Exempt Hospitals, Community Health Needs and Addressing Disparities*, 55 *How. L.J.* 687, 694, 701–02 (2012) (arguing that IRS regulatory guidance does not address how the CHNA would impact health care disparities or vulnerable populations and suggesting that “without meaningful prodding by the IRS, most hospitals may be unlikely to do more than the bare minimum identified as needed to satisfy the new requirement, particularly when it comes to the possibility of widening their focus to include not only individual patients but population-level health needs”).

hospitals' discretion during the assessment-development phase, might make it difficult for the IRS to meaningfully evaluate the assessments.²⁸ These potential problems provide an opportunity for medical anthropology (with its focus on discourse and political economy) and critical race theory (with its focus on indeterminacy and eschewal of mechanical understandings of law) to evaluate the ways the CHNA works in practice and in different communities. In the worst case scenario, are hospitals using this ambiguity and discretion to evade legal responsibilities while still receiving tax benefits? In the best case scenario, are hospitals, in concert with community members, using this ambiguity to go beyond the ACA's directives? In either instance, the oft-criticized consumer-driven understandings of health care that animate the ACA could be better explicated and ameliorated.²⁹

More micro-level questions abound: Are hospitals substantively engaging community members and local expertise or is the CHNA a mere bureaucratic ritual? For hospitals that are meaningfully engaging local residents, are they implementing their needs and recommendations or using medical expertise and their positions of power to minimally respond to their suggestions? Such inquiries address concerns about the discordance between government rules on one hand and the quotidian impact of such rules on marginalized groups on the other; both are issues that are central to critical race theory's and medical anthropology's focus on power. Finally, there could be jurisprudential and policy gains from this fusion, especially considering the pre-ACA challenges to hospitals' tax-exemptions on state grounds,³⁰ post-ACA

28. See, e.g., Roger Colinviaux, *Charity in the 21st Century: Trending Toward Decay*, 11 FLA. TAX. REV. 1, 52 (2011) ("Because there is no actionable definition of charity, or community benefit, however, there is likely to be frustration on both sides: how is a hospital to know whether its 'community benefit activities' are sufficient; and how is the IRS to prove that a hospital is not discharging its obligations, whatever they may be?"); Daniel B. Rubin, Simone R. Singh & Gary J. Young, *Tax-Exempt Hospitals and Community Benefit: New Directions in Policy and Practice*, 36 ANN. REV. PUB. HEALTH 545, 546 (2015) (providing an overview of federal and state-level exemptions and arguing that "current tax exemption standards for nonprofit hospitals, both federal and local, are beset by certain inherent ambiguities" which create "compliance challenges for hospitals" and "fail to ensure that hospitals provide adequate benefits to the communities they serve").

29. See Adam Gaffney, *The Neoliberal Turn in American Health Care*, 45 INT'L J. HEALTH SERVS. 33 (2015) (describing how neoliberalism has shaped the ACA); Sarah Horton et al., *Critical Anthropology of Global Health "Takes a Stand" Statement: A Critical Medical Anthropological Approach to the U.S.'s Affordable Care Act*, 28 MED. ANTHROPOLOGY Q. 1 (2012) (describing how medical anthropologists can contribute to research on the ACA and its privileging of market-based logics).

30. See *Greater Anchorage Area Borough v. Sisters of Charity of the House of Providence*, 553 P.2d 467, 469–70 (Alaska 1976); *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 925 N.E.2d 1131, 1135–36 (Ill. 2010); *Wexford Med. Grp. v. City*

challenges,³¹ and concerns about the IRS's ability and willingness to enforce its regulations. Scholars in both fields, along with public interest organizations, might capture the CHNA's effectiveness (or lack thereof) as well as potential policy strategies that might keep hospitals accountable.³² Again, such an endeavor would not only advance academic debates but would also attend to the social justice concerns that drive many scholars' work.

B. Medical Sociology

1. SOCIOLOGY IN MEDICINE AND ACCOUNTABLE CARE ORGANIZATIONS

Medical sociology, like medical anthropology, belies a simple description or classification. I use this categorization capaciously with the clear recognition that there are internecine debates within the larger discipline of sociology about how to research and write about health, illness, and medicine. But again, there are important differences for critical race theorists seeking to engage this brand of public health work. The first two versions of medical sociology were roughly sketched by Robert Straus in 1957, who delineated between sociology *in* medicine and sociology *of* medicine.³³ Sociology in medicine is interested in problems *within* medical practice, somewhat accepting of medical categories, and focused on improving the effectiveness of medical and health care professions through evidence-based work.³⁴ Such work might include understanding patient compliance, managerial

of Cadillac, 713 N.W.2d 734, 746 (Mich. 2006); *Hosp. Utilization Project v. Commonwealth*, 461 A.2d 894, 895 (Pa. Commw. Ct. 1983), *aff'd*, 487 A.2d 1306 (Pa. 1985); *Utah Cnty. v. Intermountain Health Care*, 709 P.2d 265 (Utah 1985).

31. See Moriah Balingit, *Pittsburgh Lawsuit Challenges UPMC's Tax Status*, PITTSBURGH POST-GAZETTE (Mar. 21, 2013), <http://www.post-gazette.com/local/city/2013/03/21/Pittsburgh-lawsuit-challenges-UPMC-s-tax-status/stories/201303210210>; Peyton M. Sturges, *Complaint Filed With IRS by Advocacy Groups Charges Hospital Shuns Charity Obligations*, BLOOMBERG BNA (Sept. 3, 2014), <http://www.bna.com/complaint-filed-irs-n17179894336/> (describing a complaint filed against a Miami hospital for its failure to meet its CHNA requirement).

32. See Lynn D. Lu, *Standing in the Shadow of Tax Exceptionalism: Expanding Access to Judicial Review of Federal Agency Rules*, 66 ADMIN. L. REV. 73 (2014) (criticizing the lack of judicial review as it relates to federal tax regulation that impacts members of historically or politically marginalized populations and stakeholders of federal public charities regulation).

33. See generally Robert Straus, *The Nature and Status of Medical Sociology*, 22 AM. SOC. REV. 200 (1957).

34. Clive Seale, *Mapping the Field of Medical Sociology: A Comparative Analysis of Journals*, 30 SOC. HEALTH & ILLNESS 677, 677-78 (2008).

effectiveness within medical institutions, or evaluation of health care provisions. In this context, sociologists work as “applied investigators” or “technicians” and attempt to solve problems that are of interest to various sponsors such as government agencies, foundations, or medical institutions.³⁵

One relevant area for critical race theorists and sociologists in medicine is the proliferation of Accountable Care Organizations (ACOs). These “are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to [elderly] Medicare patients.”³⁶ The purpose of ACOs is to reduce health care costs by incentivizing coordinated care amongst these entities; ACOs that keep their patients healthy and do so efficiently are eligible for bonuses.³⁷ ACOs are a response to Medicare’s fee-for-service model, which provides payments to providers based on the quantity of care (e.g., treatments and procedures) as opposed to the quality of care. In theory, the fee-for-service model incentivizes unnecessary care; although ACOs retain fee for service, ACOs encourage more efficient care by offering bonuses to providers who keep costs down, meet specific bench marks, and focus on prevention.³⁸ The veracity of ACOs’ cost-savings will be determined over time, but this model is not without its critics. Many see ACOs as just another healthcare “fad” that fails to confront the need for universal health care;³⁹ others worry that ACOs’ focus on coordination could raise antitrust concerns about consolidation and hospital monopolies, both of which could lead to higher health care costs in the long run.⁴⁰

35. David Mechanic, *The Role of Sociology in Health Affairs*, 87 HEALTH AFF. 85, 87 (1990).

36. *Accountable Care Organizations (ACO)*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html> (last modified Jan. 6, 2015).

37. Jenny Gold, *Accountable Care Organizations, Explained*, KAISER HEALTH NEWS (Sept. 14, 2015), <http://khn.org/news/aco-accountable-care-organization-faq/>.

38. See Jenny Gold, *Accountable Care Organizations, Explained*, NPR (Jan. 18, 2011, 8:21 AM), <http://www.npr.org/2011/04/01/132937232/accountable-care-organizations-explained>.

39. Theodore Marmor & Jonathan Oberlander, *From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy*, 27 J. GEN. INTERNAL MED. 1215 (2012).

40. Mark McClellan et al., *A National Strategy to Put Accountable Care into Practice*, 29 HEALTH AFF. 982, 987 (2010); Avik Roy, *FTC Commissioner: Accountable Care Organizations Will Likely Lead to ‘Higher Costs and Lower Quality Health Care,’* FORBES (Nov. 21, 2011, 6:24 PM), <http://www.forbes.com/sites/aroy/2011/11/21/ftc-commissioner-accountable-care-organizations-will-likely-lead-to-higher-costs-and-lower-quality-health-care/>.

In addition to these concerns, one particular area of inquiry for critical race theory and sociologists in medicine is how ACO's impact minority elders. Since older racial minorities tend to be sicker, are more likely to be in poverty, are less likely to have employer-sponsored health care, and report higher rates of access problems than Whites, this development could be beneficial for them.⁴¹ Are ACOs mitigating the disparate health outcomes for minority elders or adding to the problem? Are there any specific aspects of medical care to minority patients that might implicate the seldom litigated but potentially useful Age Discrimination Act of 1975⁴² or the new civil rights provisions of the ACA?⁴³ Is the concern about ACOs leading to greater consolidation empirically verifiable, and if so, how do they impact existing concerns about the various barriers minority elders encounter in healthcare?⁴⁴ These inquiries are especially important because all non-white racial groups are projected to see an increase in their share of elderly population (sixty-five years or older) in the next four decades.⁴⁵

41. THE HENRY J. KAISER FAMILY FOUND., *MEDICARE AND MINORITY AMERICANS* (1999), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/medicare-and-minority-americans-fact-sheet.pdf>; NARI RHEE, UNIV. OF CAL., BERKELEY, CTR. FOR LABOR RESEARCH & EDUC., *BLACK AND LATINO RETIREMENT (IN)SECURITY* (2012), http://laborcenter.berkeley.edu/pdf/2012/retirement_in_security2012.pdf.

42. 42 U.S.C. § 6101 (2012); *see also* Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 *HOW. L.J.* 855, 870 (2012) (describing how the Age Discrimination Act of 1975 allows for administrative enforcement and a private right of action in federal court to review agency adjudication, unlike Title VI, which provides expressly only for administrative enforcement); Phoebe Weaver Williams, *Age Discrimination in the Delivery of Health Care Services to Our Elders*, 11 *MARQ. ELDER'S ADVISOR* 1, 29–33 (2009) (describing the litigation landscape of the Age Discrimination Act of 1975 and arguing that the law may be useful for discrimination in healthcare contexts).

43. Section 1557 of the ACA, 42 U.S.C. § 18116, creates a new health-specific anti-discrimination prohibition that reaches further than Title VI and forbids discrimination based on race, ethnicity, and national origin but also sex, age, or disability. *See* Watson, *supra* note 42, at 870 (describing the statutory reach of Section 1557).

44. *See* Arturo Vargas Bustamante & Jie Chen, *Physicians Cite Hurdles Ranging from Lack of Coverage to Poor Communication in Providing High-Quality Care to Latinos*, 30 *HEALTH AFF.* 1921 (2011) (describing challenges in the provision of care to Latinos).

45. According to the U.S. Census Bureau, 8.6% of the African American population was sixty-five or older in 2010, which is projected to increase to 15.2% in 2030 and 18.5% in 2050; 5.7% of the Hispanic population was sixty-five or older in 2010, which is projected to increase to 10% in 2030 and 13.2% in 2050; and 9.3% of the Asian American population was sixty-five or older in 2010, which is projected to increase to 16.5% in 2030 and 21.9% in 2050. *See* GRASON K. VINCENT & VICTORIA A. VELKOFF, U.S. CENSUS BUREAU, *THE NEXT FOUR DECADES: THE OLDER*

Moreover, in addition to addressing the typically covered categories in critical race theory (e.g., race, class, gender), it would also provide an opportunity for a deeper engagement with age and the less discussed topics of elder law and geriatric studies—all of which implicate racial subordination in undertheorized ways.⁴⁶

2. SOCIOLOGY OF MEDICINE AND WORKFORCE DIVERSITY

Sociology of medicine, like medical anthropology, is less accepting of medical categories and takes a more critical stance by questioning the functional roles of medical and health institutions in society. It is interested in organizational issues, the social construction of medical knowledge, the professionalization of medical bureaucrats (e.g., doctors and nurses), health care managerialism, and health social movements.⁴⁷ This version of sociology has affinities with critical race theory. It is understood as best “carried out by persons operating from independent positions outside the formal medical setting”⁴⁸ and has “a critical and unmasking orientation” that is “meant to expose dysfunctions in medicine and in its formal institutions.”⁴⁹

POPULATION IN THE UNITED STATES: 2010 TO 2050, at 7 (2010), <https://www.census.gov/prod/2010pubs/p25-1138.pdf>.

46. Dawn Klein et al., *Elders Who Delay Medication Because of Cost: Health Insurance, Demographic, Health, and Financial Correlates*, 44 GERONTOLOGIST 779 (2004) (describing how African American elders are significantly likely to delay medication); Nina A. Kohn, *A Civil Rights Approach to Elder Law*, in BEYOND ELDER LAW: NEW DIRECTIONS IN LAW AND AGING 19, 19 (Israel Doron & Ann M. Soden eds., 2012) (arguing for a civil rights understanding of gerontology as opposed to a strictly social welfare perspective); Valentine M. Villa et al., *Hispanic Baby Boomers: Health Inequities Likely To Persist in Old Age*, 52 GERONTOLOGIST 166 (2014) (demonstrating how elderly individuals of Mexican origin—United States-born Mexicans, naturalized Mexican immigrants, and noncitizen Mexican immigrants—have disadvantageous health outcomes *vis-à-vis* non-Hispanic whites); Ruqaiyah Yearby, *African Americans Can't Win, Break Even, or Get Out of the System: The Persistence of 'Unequal Treatment' in Nursing Home Care*, 82 TEMP. L. REV. 1177, 1178 (2010) (describing racial disparities in access to and the provision of quality nursing home care).

47. Seale, *supra* note 34, at 678; *see also* ALONDRA NELSON, *BODY AND SOUL: THE BLACK PANTHER PARTY AND THE FIGHT AGAINST MEDICAL DISCRIMINATION* (2011); Armando Lara-Millán, *Public Emergency Room Overcrowding in the Era of Mass Imprisonment*, 79 AM. SOC. REV. 866 (2014); Celeste Watkins-Hayes, *Intersectionality and the Sociology of HIV/AIDS: Past, Present, and Future Research Directions*, 40 ANN. REV. SOC. 431 (2014).

48. Robert Straus, *The Nature and Status of Medical Sociology*, 22 AM. SOC. REV. 200, 203 (1957).

49. Włodzimierz Piątkowski & Michał Skrzypek, *To Tell the Truth. A Critical Trend in Medical Sociology – An Introduction to the Problems*, 20 ANNALS AGRIC. & ENVTL. MED. 613, 613 (2013).

The ACA's treatment of workforce diversity as one mechanism to address health inequality is relevant for sociologists of medicine and critical race theory. There is an abundance of scholarship written by doctors, social scientists, and government agencies that unsurprisingly documents the role of racial bias in the treatment of minority patients.⁵⁰ The ACA seeks to diversify the medical and health professions in a few ways. Section 5207 allocated approximately \$4 billion in funding between 2010 and 2015 for the National Health Service Corps program, which provides scholarships and loan repayments to professionals who work in poor rural and urban areas; amounts after 2015 are based on the previous year's funding and subject to adjustment.⁵¹ Section 5401 authorized \$50 million per year in funding for Centers of Excellence from 2010 through 2015,⁵² which supports the training, recruitment, and retention of underrepresented minority students and faculty. There is a pending \$25 million request for 2016.⁵³ Section 5402 authorized up to \$51 million per year for the Scholarships for Disadvantaged Students program, which supports students from disadvantaged backgrounds in

50. See INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* (2003); DAYNA ROWEN MATTHEW, *JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE* (2015); DAMON TWEEDY, *BLACK MAN IN A WHITE COAT: A DOCTOR'S REFLECTION ON RACE AND MEDICINE* (2015); U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. NO. 15-0007-3-EF, 2014 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT (2015); AUGUSTUS A. WHITE & DAVID CHANOFF, *SEEING PATIENTS: UNCONSCIOUS BIAS IN HEALTH CARE* (2009); Elizabeth N. Chapman et al., *Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*, 28 J. GEN. INTERNAL MED. 1504 (2013); Carmen R. Green et al., *The Unequal Burden of Pain: Confronting Racial and Ethnic Disparities in Pain*, 4 PAIN MED. 277 (2003).

51. Patient Protection and Affordable Care Act § 5207, 42 U.S.C. § 254q (2012).

For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

(A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and

(B) one plus the average percentage change in the number of individuals residing in health professions shortage areas designated under section 333 during the prior fiscal year, relative to the number of individuals residing in such areas during the previous fiscal year.

§ 254q(a)(7).

52. *Id.* § 293(i).

53. See STEPHEN REDHEAD ET AL., CONG. RESEARCH SERV., R41390, *DISCRETIONARY SPENDING UNDER THE AFFORDABLE CARE ACT (ACA)*, at CRS 19 (2016), <https://www.fas.org/sgp/crs/misc/R41390.pdf>.

health professions and disciplines;⁵⁴ approximately \$43 million in funding is expected per year from 2016 through 2019.⁵⁵

This emphasis on bureaucratic diversity could be instructive for critical race theory and sociology of medicine in a variety of ways. Optimistically, the ACA's focus on the workforce addresses enduring criticisms of the medical professions' jarring homogeneity.⁵⁶ Considering medical claims that suggest that more heterogeneity would lead to better health outcomes,⁵⁷ these portions of the ACA provide an opportunity to empirically test the accuracy of such arguments. Moreover, in the opinion of some, proving these claims might provide the kind of narrowly tailored compelling interest for affirmative action in medical education that was rejected in *Regents of the University of California v. Bakke*.⁵⁸ At the same time, empirical examinations of this diversification might provide fodder to or complicate critical race

54. 42 U.S.C. § 293d(a).

55. U.S. DEP'T OF HEALTH & HUMAN SERVS., CFDA No. 93.925, SCHOLARSHIPS FOR DISADVANTAGED STUDENTS: FUNDING OPPORTUNITY ANNOUNCEMENT 4 (2015), <http://apply07.grants.gov/apply/opportunities/instructions/oppHRSA-16-069-cfda93.925-cidHRSA-16-069-instructions.pdf>.

56. David M. Carlisle, Jill E. Gardner & Honghu Liu, *The Entry of Underrepresented Minority Students into US Medical Schools: An Evaluation of Recent Trends*, 88 AM. J. PUB. HEALTH 1314 (1998); Liliana M. Garces & David Mickey-Pabello, *Racial Diversity in the Medical Profession: The Impact of Affirmative Action Bans on Underrepresented Student of Color Matriculation in Medical Schools*, 86 J. HIGHER EDUC. 264 (2015); Joan Y. Reede, *A Recurring Theme: The Need for Minority Physicians*, 22 HEALTH AFF. 91, 92 (2003). See generally Sandra Daley, Deborah L. Wingard & Vivian Reznik, *Improving the Retention of Underrepresented Minority Faculty in Academic Medicine*, 98 J. NAT'L MED. ASS'N 1435, 1435 (2006).

57. E.g., Lisa Cooper-Patrick et al., *Race, Gender, and Partnership in the Patient-Physician Relationship*, 282 J. AM. MED. ASS'N 583, 583 (1999) (finding that patients who see physicians of their own race rate physicians decision-making styles as more participatory); Thomas A. LaVeist & Amani Nuru-Jeter, *Is Doctor-Patient Race Concordance Associated with Greater Satisfaction with Care?*, 43 J. HEALTH & SOC. BEHAV. 296, 303 (2002) (finding that patients reported greater satisfaction with physicians of the same race than with a physicians of a different race).

58. 438 U.S. 265 (1978); see Kenneth DeVille & Loretta Kopelman, *Diversity, Trust, and Patient Care: Affirmative Action in Medical Education 25 Years after Bakke*, 28 J. MED. & PHIL. 489, 489 (2003) (DeVilleville and Kopelman discuss *Bakke* and argue that, despite trends in affirmative action jurisprudence, "the framework sketched by Powell can be used to defend diversity in medical education both morally and legally as a 'compelling state interest.' Because trust is a central component of the physician-patient relationship and a prerequisite to the profession's ability to provide effective medical care, the state has a compelling interest in training physicians with whom patients can feel comfortable and safe if the population is (1) distrustful; (2) underserved; (3) faces significant discrimination in the allocation of benefits, goods and services and (4) affirmative action programs would be likely to promote their trust in the system.").

theory's suspicion of diversity rhetoric⁵⁹ as well as its skepticism of tokenistic integration as a solution to bureaucratic racism.⁶⁰ It could also demonstrate how these sections of the ACA flatten racial identity and presume a kind of solidarity that is at tension with intersectionality and contributed to health inequality in the past.⁶¹ Investigations of the ACA's workforce diversity emphasis might also highlight factors within medical education and socialization that inhibit better health outcomes and cannot be solved purely by diversity. Finally, a focus on professional diversity might provide alternative insights into the statutory elephant in the room: interpersonal racial bias (whether explicit, implicit, or unconscious). As Professor Ruqaiijah Yearby notes, the ACA makes no mention of this problem in its framework, despite being on notice about this problem from its own government reports.⁶² Critical race theory has paid significant attention to implicit and unconscious bias;⁶³ sociology of medicine has documented the professionalization process of health practitioners;⁶⁴ both offer the tools to evaluate how diversification either tempers or fails to account for racial bias in the provision of health care.

59. See, e.g., Derrick Bell, *Diversity's Distractions*, 103 COLUM. L. REV. 1622, 1622 (2003).

60. See Liyah Kaprice Brown, *Officer or Overseer?: Why Police Desegregation Fails as an Adequate Solution to Racist, Oppressive, and Violent Policing in Black Communities*, 29 N.Y.U. REV. L. & SOC. CHANGE 757 (2005); Paul Butler, *How Can You Prosecute Those People?*, in HOW CAN YOU REPRESENT THOSE PEOPLE 15, 24–25 (Abbe Smith & Monroe H. Freedman eds., 2013).

61. CATHY J. COHEN, BOUNDARIES OF BLACKNESS: AIDS AND THE BREAKDOWN OF BLACK POLITICS 8, 24–25, 33–35, 37 (1999) (describing how African American leadership failed to respond quickly to the AIDS epidemic because of homophobia, sexism, and classism).

62. Ruqaiijah Yearby, *Breaking the Cycle of "Unequal Treatment" with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 CONN. L. REV. 1281, 1286–87 (2012).

63. See generally Jerry Kang, *Trojan Horses of Race*, 118 HARV. L. REV. 1489 (2005); Charles Lawrence III, *The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism*, 39 STAN. L. REV. 317 (1987); L. Song Richardson, *Police Racial Violence: Lessons from Social Psychology*, 83 FORDHAM L. REV. 2961 (2015).

64. See HOWARD S. BECKER ET AL., BOYS IN WHITE: STUDENT CULTURE IN MEDICAL SCHOOL 4–5 (2d ed. 1965); Paul Atkinson & Lesley Pugsley, *Making Sense of Ethnography and Medical Education*, 39 MED. EDUC. 228 (2005); Samuel W. Bloom, *Structure and Ideology in Medical Education: An Analysis of Resistance to Change*, 29 J. HEALTH & SOC. BEHAV. 294 (1988).

3. SOCIOLOGY OF HEALTH, THE EMPLOYER MANDATE, AND COVERAGE GAPS

The third branch of work in this field is referred to as the sociology of health. This subfield emerged from the belief that medical sociology has focused too much attention on the medical profession to the neglect of social institutions that also impact health such as families, schools, and labor markets. To that end, sociologists of health look outside the walls of medical institutions and pay close attention to issues such as poverty, social mobility, lifestyle choices, occupational constraints, and environmental factors.⁶⁵ The ACA's employer mandate, which is often overshadowed by the individual mandate but at the center of a number of federal appellate lawsuits,⁶⁶ is a fruitful area of inquiry for this field and critical race theory.

The employer mandate requires employers with fifty or more full-time employees to provide these employees (and their dependents) with the opportunity to enroll in minimum essential health coverage under an eligible employer-sponsored plan or face a penalty.⁶⁷ "Full-time" consists of individuals who have worked for more than thirty hours per week on average in a given month.⁶⁸ This is a definition that some fear will incentivize employers to cut the hours of their employees in the larger labor market.⁶⁹ Notwithstanding these concerns, seasonal

65. See generally ANNE-MARIE BARRY & CHRIS YUILL, UNDERSTANDING THE SOCIOLOGY OF HEALTH: AN INTRODUCTION (3d ed. 2012); KEVIN WHITE, AN INTRODUCTION TO THE SOCIOLOGY OF HEALTH & ILLNESS (2d ed. 2009).

66. See *Hotze v. Burwell*, 784 F.3d 984 (5th Cir. 2015) (rejecting an Origination Clause challenge to the employer mandate); *Kawa Orthodontics, LLP v. Sec'y, U.S. Dep't of the Treasury*, 773 F.3d 243, 245 (11th Cir. 2014) (finding that the plaintiff lacked Article III standing to challenge the Department of the Treasury's decision to postpone enforcement of the employer mandate); *Liberty Univ., Inc. v. Lew*, 733 F.3d 72 (4th Cir. 2013) (holding that the employer mandate was a valid exercise of Congress's Commerce Clause power to regulate existing economic activity); *Baldwin v. Sebelius*, 654 F.3d 877 (9th Cir. 2011) (holding that one of the plaintiffs did not sufficiently plead standing to challenge the employer shared-responsibility provision); *N.J. Physicians, Inc. v. President of the U.S.*, 653 F.3d 234, 239 (3d Cir. 2011) (holding that a physician lacked standing to challenge the constitutionality of the ACA's employer responsibility provision); *Ass'n of Am. Physicians & Surgeons v. Sebelius*, 901 F. Supp. 2d 19, 38–39 (D.D.C. 2012), *aff'd*, 746 F.3d 468 (D.C. Cir. 2014) (rejecting Origination Clause, Takings Clause, Due Process, and Equal Protection challenges to the employer mandate).

67. 26 U.S.C. § 4980H(a)–(b)(1), (c)(2)(A) (2012).

68. § 4980H(c)(4)(A).

69. See Tami Luhby, *No, Obamacare Is Not Reducing Employees' Hours*, CNN (June 25, 2015, 9:29 AM), <http://money.cnn.com/2015/06/25/news/economy/obamacare-employees-hours/>; Reid Wilson, *Local Governments Cutting Hours over Obamacare Costs*, WASH. POST (Aug. 22, 2013), <https://www.washingtonpost.com/>

workers, who provide services temporarily and non-continuously, do not fall within the statutory ambit.

There are several areas of investigation here. Consider the case of domestic workers, who are disproportionately foreign-born women of color⁷⁰ and, like with other landmark federal legislation,⁷¹ are relatively overlooked by the ACA. Almost two-thirds of these workers do not have health insurance and only four percent receive employer-provided insurance.⁷² These women encounter a myriad of circumstances that can detrimentally impact their health. They are more likely to receive lower wages; work with toxic products; have difficulty paying other bills (which can induce stress); and work while sick, injured, or in pain.⁷³ Despite some of these working conditions, these women, like their male counterparts, are unlikely to quit or complain.⁷⁴ Future research might

blogs/govbeat/wp/2013/08/22/local-governments-cutting-hours-over-obamacare-costs/. The problem that is sometimes missed by supporters of the ACA and its proponents is that the proliferation of contingent work predated the ACA and is part of larger global trends predating the ACA. See ROBERT E. PARKER, *FLESH PEDDLERS AND WARM BODIES: THE TEMPORARY HELP INDUSTRY AND ITS WORKERS* 1–3 (1994); CHRIS TILLY, *HALF A JOB: BAD AND GOOD PART-TIME JOBS IN A CHANGING LABOR MARKET* 1–2, 6 (1996); Arne L. Kalleberg, *Nonstandard Employment Relations: Part-Time, Temporary and Contract Work*, 26 ANN. REV. SOC. 341, 341–42 (2000); Jamie Peck & Nik Theodore, *Flexible Recession: The Temporary Staffing Industry and Mediated Work in the United States*, 31 CAMBRIDGE J. ECON. 171, 171–72 (2007).

70. According to a study from the National Domestic Workers Alliance, 54% of domestic workers identify as Black, Latina, Asian, Pacific Islander, or some race other than white, 46% are foreign born, and 95% are women. LINDA BURNHAM & NIK THEODORE, *HOME ECONOMICS: THE INVISIBLE AND UNREGULATED WORLD OF DOMESTIC WORK* 11 (2012), <http://www.domesticworkers.org/sites/default/files/HomeEconomicsEnglish.pdf>.

71. Domestic workers are excluded from the National Labor Relations Act, 29 U.S.C. § 152(3) (2012) (protecting rights of employees to organize and bargain collectively), and generally excluded from Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e (2012) (prohibiting employment discrimination for employers who employ fifteen or more individuals for each working day); the Occupational Safety and Health Act, 29 U.S.C. § 651 (creating health and safety standards for workers); 29 C.F.R. § 1975.6 (2015) (excluding domestic workers); and the Family and Medical Leave Act, 29 U.S.C. §§ 2611(2)(A)–(B), 2691(b)(2) (allowing employees to take 12 weeks of unpaid leave for the birth of a child or to take care of a child, parent, or spouse but only for employees who work for at least 12 months, for at least 1250 hours, and at worksites with more than 50 employees).

72. BURNHAM & THEODORE, *supra* note 70, at 30.

73. *Id.* at 20.

74. *Id.*; see also Nicholas Walter et al., *Social Context of Work Injury Among Undocumented Day Laborers in San Francisco*, 17 J. GEN. INTERN. MED. 221, 221 (2002) (describing how male laborers encounter a high incidence of work injuries and work-related injuries but are reluctant to use health services because of anxieties about economic pressures and immigration status).

consider challenges to employment regulations that might temper these occupational hazards in ways that might improve health outcomes.

Moreover, since the Supreme Court held that the ACA's Medicaid expansion was unconstitutionally coercive and therefore optional,⁷⁵ close attention should be paid to states that have declined to opt into the expansion. These states have created a coverage gap, where people make too much for Medicaid eligibility but do not make enough to qualify for Marketplace premium tax credits. In these predominantly red, non-expansion states, Blacks and Latinos comprise almost half of the estimated 2.9 million non-elderly adults who are in coverage gaps.⁷⁶ Almost half (forty-eight percent) of workers in non-expansion states are employed by small firms (less than fifty employees) that are not subject to ACA penalties.⁷⁷ Health sociologists and critical race theorists might empirically document how the ACA's employer-based health insurance regime contributes to health disparities comparatively (e.g., across racial groups in these non-expansion states as well as in expansion states). Moreover, such scholarship might contribute to litigation strategies that challenge the boundaries and judicial constructions of state laws that mandate care for the medically indigent⁷⁸ as well as policy proposals for state laws that go beyond the ACA's employer mandate.⁷⁹ Overall, the need for work on the intersection of labor market disadvantages, health outcomes, and law is abundant and exigent.

C. Health Economics and Hospital Funding

Health economics is concerned generally with the efficient allocation, delivery, and consumption of health resources. The efficiency focus is interested in the relationship between costs and benefits (e.g., whether a treatment generates more benefit at less cost)

75. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2608 (2012) (upholding the individual mandate of the Affordable Care Act under Congress's taxing power).

76. Rachel Garfield & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update*, HENRY J. KAISER FAMILY FOUND. (Jan. 21, 2016), <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/>.

77. *Id.*

78. Several non-expansion states have such laws. *See, e.g.*, IDAHO CODE ANN. § 31-3501 (2006 & Supp. 2015); S.C. CODE ANN. § 44-6-150 (2002 & Supp. 2015); TEX. HEALTH & SAFETY CODE ANN. § 61.022 (West 2010).

79. Hawai'i, for example, has the Hawai'i Prepaid Health Care Act, which requires employers to provide health insurance to employees who work twenty hours or more per week for four consecutive weeks. *See* HAW. REV. STAT. § 393-1 (1993).

as opposed to focusing on costs or benefits in isolation.⁸⁰ Health economists are also interested in opportunity costs, the value of a good compared to the next best alternative.⁸¹ In their evaluations, health economists are often concerned with analyzing the cheaper options between goods (cost minimization); the most cost effective option (cost effectiveness); options that maximize both quantity and quality of life (cost utility); and the value, cost, and benefits in monetary terms (cost benefit analysis).⁸² Like other branches of economics (e.g., law and economics) and the larger discipline, health economics is seemingly incompatible with critical race theory. As some have noted, quantitative disciplines like economics tend to use race as an independent variable that is static, fixed, and easily measurable, whereas critical race theory understands race as fluid, interactive, and relational.⁸³ Some critical race theorists might reject the understanding of health care as a “good,” “product,” or something that can be measured in isolation.⁸⁴ Others might reject the premises that people act rationally or respond to certain kinds of incentives. But these challenges, amongst others, are not insurmountable nor prohibitive. In addition to the tax exemptions that come with community health benefits assessments discussed earlier, the ACA’s treatment of public hospitals is an illustrative space for health economics–critical race theory engagement.

The federal government provides funding, known as Disproportionate Share Hospital (DSH) payments, to hospitals that serve a disproportionate number of low-income patients. Public and non-profit hospitals that serve racial minorities rely heavily on DSH payments to offset the costs of uncompensated care. For example,

80. MARILYN JAMES & ELIZABETH STOKES, *HARNESSING INFORMATION FOR HEALTH ECONOMICS ANALYSIS* 4 (2006). There is also technical efficiency, which focuses on choices made within goods and services (e.g., an open versus closed laparoscopy), and allocative efficiency, which focuses on choices made between goods and services (e.g., cholesterol-lowering drugs versus cardiac care). *Id.*

81. *Id.* at 5.

82. In some instances, health economists evaluate multiple outcomes (cost consequences analysis). See David Kernick & Ruth McDonald, *Using Health Economics to Facilitate Decision Making: The Basics of Economic Evaluation*, in *GETTING HEALTH ECONOMICS INTO PRACTICE* 30, 31–32 (David Kernick ed., 2002).

83. See Carbado & Gulati, *supra* note 4, at 1758–59; Gómez, *supra* note 4, at 453.

84. Lisa C. Ikemoto, *The Fuzzy Logic of Race and Gender in the Mismeasure of Asian American Women’s Health Needs*, 65 U. CIN. L. REV. 799, 807–09 (1997) (arguing that Asian and Pacific American women’s health should be measured in the context of structures such as relevant labor markets, amongst others, which would show that they may be susceptible to certain work-related injuries and illnesses but also that addressing health means addressing problems outside the body and beyond the medical profession).

during the fiscal years of 2011–13, DSH payments for Medicaid amounted to an average of approximately \$11 billion.⁸⁵ The ACA originally mandated \$18 billion in DSH cuts from 2014–20 but this was delayed and modified to \$35 billion from 2017–24. This equates to about \$4.3 billion in cuts per year, or a little more than one third of what the federal government previously dispensed.⁸⁶ These cuts were premised on the understanding that the ACA would lead to a decrease in the amount of uninsured patients, which would reduce the amount of uncompensated care hospitals provided and, as a result, decrease hospitals' need for DSH payments. But insurance enrollment has not corresponded with expected cuts.⁸⁷ Moreover, the Supreme Court's ruling in *NFIB v. Sebelius*⁸⁸ that Medicaid expansion was optional put a wrinkle in this plan and is leaving hospitals in expansion and non-expansion states with gaping holes in their future budgets.⁸⁹

Accordingly, there are several lingering questions that will be examined by health economists and some that will not; many questions in both categories will be of interest to critical race theory. In regards to DSH funds, how should we understand this trade off of increased healthcare coverage and reduced funding to public hospitals? Since the ACA is a moving target for Democrats (who hope to embolden the law) and Republicans (who hope to temper it), such research may help shape

85. ALISON MITCHELL, CONG. RESEARCH SERV., R42865, MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS 6–7 (2013), <https://www.fas.org/sgp/crs/misc/R42865.pdf>.

86. Protecting Access to Medicare Act of 2014, H.R. 4302, 113th Cong. (2014), <http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302eh/pdf/BILLS-113hr4302eh.pdf>.

87. For example, in New York, which has opted into the Medicaid expansion, the New York City Health and Hospitals Corporation (“HHC”) is the municipal healthcare provider and is scheduled for a 24% reduction in DSH revenue in 2019. It reported that “the number of uninsured patients dropped by only 1.3% from FY 2013 to FY 2014. Going forward, HHC only predicts an additional drop of 7.2% in its uninsured patient pool by 2019.” OFFICE N.Y.C. COMPTROLLER, HOLES IN THE SAFETY NET: OBAMACARE AND THE FUTURE OF NEW YORK CITY'S HEALTH & HOSPITALS CORPORATION 4 (2015), http://comptroller.nyc.gov/wp-content/uploads/documents/Holes_in_the_Safety_Net.pdf. In Georgia, which has not opted in the Medicaid expansion, there is also concern. Grady Memorial Hospital is the largest safety-net provider in Atlanta and received about \$90 million annually in DSH funding, but the state's refusal to opt into Medicaid expansion will leave them with a \$45 million hole in their budget in 2018. This gap could cause the hospital to potentially close its mental health and gynecology units. See Max Blau, *This Georgia Hospital Shows Why Rejecting Medicaid Isn't Easy*, WASH. POST (June 26, 2013), <http://www.washingtonpost.com/news/wonkblog/wp/2013/06/26/this-georgia-hospital-shows-why-rejecting-medicare-isnt-easy/>.

88. 132 S. Ct. 2566 (2012).

89. *Id.* at 2608.

unfolding debates around the law amidst budget cuts and illustrate how less funding is impacting hospital efficiency. Relatedly, the relationship between DSH funding and hospital closures may also be of interest. The shuttering of hospitals has been a problem since before the ACA, and the empirical data on whether hospital closures impact residential health is mixed.⁹⁰ Nevertheless, critical race theorists could not only provide qualitative texture to these quantitative accounts⁹¹ but also tie the DSH funding gap to potential policy fixes or statutory remedies.⁹² On a more general level, what has been the overall cost-benefit of the ACA before and after its implementation? Is the ACA delivering on promises of lower health care costs for the country and the under- and uninsured? How might this vary across race, gender, and place? Since the ACA now requires the collection of data on race, critical race theorists are in a position to engage health economists in ways that may ensure that such data is used responsibly⁹³ and in conjunction with other

90. Thomas C. Buchmueller, Mireille Jacobson & Cheryl Wold, *How Far to the Hospital? The Effect of Hospital Closures on Access to Care*, 25 J. HEALTH ECON. 740, 759 (2006) (finding that most residents are unaffected by hospital closures but also finding that seniors perceive more difficulty accessing care); Ashley Hodgson et al., *The Financial Impact of Hospital Closures on Surrounding Hospitals*, 4 J. HOSP. ADMIN. 25, 33–34 (2015) (finding that hospital closures are shifting high-cost patients to open hospitals but not improving efficiency in the market); Karen E. Joynt et al., *Hospital Closures Had No Measurable Impact On Local Hospitalization Rates or Mortality Rates, 2003–11*, 34 HEALTH AFF. 765, 772 (2015) (finding that hospital closures were not associated with worse outcomes for patients living in those communities); Richard C. Lindrooth et al., *The Effect of Urban Hospital Closure on Markets*, 22 J. HEALTH ECON. 691, 710 (2003) (finding that hospital closure led to an evolutionary increase in efficiency in urban markets).

91. If health is not affected, critical race theorists might consider how other areas of life are affected (or not affected); if health is affected, then these researchers might document how that is the case beyond epidemiological outcomes.

92. As Professor Brietta Clark has shown, Title VI has not prevented the large number of hospital closures in minority communities. See Brietta R. Clark, *Hospital Flight from Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023, 1026 (2005). Professor Ruqaiyah Yearby argues that the government should use sections 10302, 10303, 1303, 1557, 1946, and 4302 to require health providers to prepare health disparities impact statements prior to hospital closures and relocations; if the closures would disproportionately harm a minority community, Professor Yearby suggests that the provider should be required to provide services that would limit the disparate impact by providing transportation to the new facility, coordinating care with the remaining facilities, or improving the provision of care. See Yearby, *supra* note 62, at 1321–22. Professor Sidney Watson argues that section 1557 of the ACA could go further than other anti-discrimination and civil rights laws. See Watson, *supra* note 42, at 884–85.

93. This might include making sure the data is used in ways that reduce disparities, monitor progress, ascertain health needs, and do not infringe on privacy or reify notions of racial inferiority. See Allen Fremont & Nicole Lurie, *The Role of*

kinds of knowledge production (e.g., qualitative interviews and narratives) that might challenge assumptions about health inequality and identity.

CONCLUSION

Despite the Affordable Care Act's many limitations and shortcomings, it is a remarkable legislative achievement. Critical race theory collaboration and engagement with various branches of public health has the potential to enrich the latter's understanding of how the state uses law (e.g., constitutional, administrative, tax, tort) to shape health outcomes for marginalized groups. At the same time, CRT also offers a useful framework for understanding the regulatory inertia and hesitance of federal courts when it comes to addressing healthcare discrimination against vulnerable groups.⁹⁴ At the same time, CRT would benefit from deeper engagements with public health in light of the ACA's new healthcare regime, its rocky implementation, and the current attempts to scale it back. No doubt, such interdisciplinarity is not without its problems; different fields are premised on certain (and sometimes diametrically opposed) premises and have varying approaches to studying social identity, power, and the law. For critical race theorists, engagement with social science should not supplant their understanding of law but serve as a methodological and empirical companion. Existing scholarship at the intersection of critical race theory and social science suggests that this is possible,⁹⁵ and the current state of health disparities suggests that such collaboration is imperative.

Racial and Ethnic Data Collection in Eliminating Disparities in Health Care, in *ELIMINATING HEALTH DISPARITIES: MEASUREMENT AND DATA NEEDS* 202, 202, 223–24 (Michele Ver Ploeg & Edward Perrin eds., 2004).

94. See DAVID BARTON SMITH, *HEALTH CARE DIVIDED: RACE AND HEALING A NATION* 312–26 (1999); Clark, *supra* note 92, at 1099–100; Dayna Bowen Matthew, *Health Care, Title VI, and Racism's New Normal*, 6 *GEO. J. L. & MOD. CRITICAL RACE PERSP.* 3, 64–65 (2014); Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn't Be So Easy*, 58 *FORDHAM L. REV.* 939, 978 (1990); Yearby, *supra* note 62, at 1323–24.

95. See *supra* notes 4–5 and accompanying text.