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Teneille R. Brown

University of Utah, S.J. Quinney College of Law, teneille.brown@law.utah.edu

Leslie Francis

University of Utah, S.J. Quinney College of Law, francisl@law.utah.edu

James Tabery

University of Utah, S.J. Quinney College of Law, james.tabery@utah.edu

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SHOULD WE DISCRIMINATE AMONG DISCRIMINATIONS?

TENEILLE R. BROWN,* LESLIE P. FRANCIS** & JAMES TABERY***

ABSTRACT

The COVID-19 pandemic has demonstrated the complexities of rationing needed health care in a pandemic. It has also revealed deep, structural inequities in health care systems and societies, with certain disadvantaged groups experiencing alarmingly disproportionate rates of infection. A number of anti-discrimination statutes exist to ameliorate some of these historical inequities in the United States. Under federal law, health care facilities receiving federal funding may not discriminate on the basis of race, color, or national origin; disability; age; or sex. Three of these forms of discrimination were already prohibited by statutes that have been in effect for nearly fifty years: Title VI of the Civil Rights Act of 1964 (race, color, and national origin), the Rehabilitation Act of 1973 (disability), and the Age Discrimination Act of 1975 (age). In 2010, Section 1557 of the Affordable Care Act (ACA) referenced these three statutes and a fourth, Title IX of the Education Amendments of 1972 (sex), in a prohibition of all of these forms of discrimination by health care facilities receiving federal funding.

Substantially different bodies of case law have been developed for each statute, spanning the fifty years these statutes have been in effect. The ACA's juxtaposition of the four presents a puzzle with profound legal, policy, social, and ethical implications: Does Section 1557 bring these four anti-discrimination statutes together in order to harmonize them, offering a common approach to anti-discrimination in health care for all categories? Or should there continue to be differences among how discrimination is understood for these different protected categories? Using the examples of crisis care standards and vaccine allocation, this Article explores this puzzle in interpreting Section 1557. To do so, this Article details important differences among the statutes, including their approach to disparate impact discrimination and whether they have been

* Teneille R. Brown, JD, is a Professor of Law at the University of Utah S.J. Quinney College of Law.

** Leslie P. Francis, JD, PhD, is the Distinguished Alfred C. Emery Professor of Law and Distinguished Professor of Philosophy at University of Utah.

*** James Tabery, MA, PhD, is a Professor of Philosophy at the University of Utah. We are grateful to Darian Hackney (2L) and Diana Alfonso Olmedo (2L) for research assistance with this article and to the Program in Medical Ethics and Humanities for funding support.

interpreted to permit suits by private individuals for damages. This Article also explores the legislative histories of the Age Discrimination Act and the ACA itself. This Article concludes that Section 1557 reveals but does not resolve important questions about whether there are legally relevant reasons to discriminate among discriminations.

I. INTRODUCTION

The COVID-19 pandemic has exposed deep, structural inequities in our health care systems and society, with certain disadvantaged groups experiencing alarmingly disproportionate rates of infection, hospitalization, and death.¹ Thankfully, a number of federal anti-discrimination statutes exist to ameliorate some of these historical inequities. The statutes respond to different types of discrimination and have generated diverse bodies of case law. While these statutes prohibit discrimination in places like education, employment, and housing, for decades there were gaps remaining.

In 2010, Congress sought to address one of these gaps in Section 1557 of the ACA (Section 1557), which prohibits discrimination in health care programs and activities that receive federal funds.² Rather than creating new protected classes of individuals, Section 1557 incorporates the protected classes from four pre-existing civil rights statutes. These statutes are: Title VI of the Civil Rights Act of 1964 (Title VI), which protects against discrimination on the basis of race, color, and national origin in federally funded programs;³ Title IX of the Education Amendments of 1972 (Title IX), which protects against discrimination on the basis of sex in educational programs receiving federal funding;⁴ Section 504 of the Rehabilitation Act of 1973 (Section 504), which protects against discrimination on the basis of disability in federally funded programs;⁵ and the Age Discrimination Act of 1975 (Age Act), which protects against discrimination on the basis of age in federally funded programs.⁶

When referencing these four statutes, Section 1557 states that it prohibits discrimination “on the *ground* prohibited under” and then lists each statute.⁷ This use of the singular “ground” creates a puzzle: Does Section 1557 simply refer to each of the statutes separately, incorporating the separate statutory language and case law that has developed with respect to each of the four? Or does Section 1557 create an anti-discrimination standard in federally funded health care that is, to at least some extent, uniform across these categories?

The difference between “disparate treatment” and “disparate impact” discrimination illustrates the importance of answering this question about the interpretation of Section 1557. Disparate treatment involves intentional discrimination against disadvantaged people in protected groups, while disparate

1. Leonard E. Egede & Rebekah J. Walker, *Structural Racism, Social Risk Factors, and Covid-19 — A Dangerous Convergence for Black Americans*, 383 NEW ENG. J. MED. e77(1), e77(2) (2020); Sravani Singu et al., *Impact of Social Determinants of Health on the Emerging COVID-19 Pandemic in the United States*, FRONTIERS PUB. HEALTH, July 2020, at 1, 5.

2. Patient Protection and Affordable Care Act, 42 U.S.C. § 18116.

3. The Civil Rights Act of 1964, 42 U.S.C. § 2000(d).

4. Title IX of The Education Amendments of 1972, 20 U.S.C. § 1681(a).

5. Rehabilitation Act of 1973, 29 U.S.C. § 794(a).

6. Age Discrimination Act of 1975, 42 U.S.C. § 6102.

7. 42 U.S.C. § 18116(a) (emphasis added).

impact involves discriminatory *outcomes*, even if unintentional.⁸ To illustrate this point, consider a policy that locates COVID-19 testing centers in areas of a city that are predominantly inhabited by White people and that cannot readily be accessed by public transit. If the decision was made intentionally to make it more difficult for communities of color to access the testing centers, then it would amount to disparate treatment. On the other hand, if the decision was made without any consideration of race, and yet still disproportionately affected the ability of people of color to successfully receive testing, then it could amount to disparate impact.⁹ The disparate impact would be discriminatory if other approaches to locating test centers were reasonably available and there were no overriding justifications for the location of the centers. While all of the four referenced statutes prohibit disparate treatment discrimination, the extent to which disparate impact discrimination claims are permitted under these statutes is unresolved.¹⁰ As a result, controversies have emerged about whether Section 1557 endorses disparate impact discrimination claims for all the classes it incorporates by reference or defers to case law under each of the four referenced statutes on this question.

The interpretation of Section 1557 is legally contested. The rulemaking completed by the Department of Health and Human Services (HHS) under the Obama administration adopted a standard that would permit individuals to bring claims for all of the protected categories based upon disparate impact discrimination.¹¹ However, the final rule promulgated by the Trump administration's HHS rejected this uniformity.¹² Instead, it defers to the four, separate, referenced statutes on this point, supposedly to eliminate redundancy and "to align it more closely with the statutory text."¹³ Courts, for their part,

8. *Ricci v. DeStefano*, 557 U.S. 557, 577 (2009) (explaining the difference between disparate treatment and disparate impact as forms of discrimination prohibited under Title VII of the Civil Rights Act).

9. Racial disparities in availability of COVID-19 testing were identified by reporters early in the pandemic. *See, e.g.*, Soo Rin Kim et al., *Which Cities Have the Biggest Racial Gaps in COVID-19 Testing Access?*, FIVETHIRTYEIGHT (July 22, 2020), <https://fivethirtyeight.com/features/white-neighborhoods-have-more-access-to-covid-19-testing-sites/> (identifying problems with access to testing in Black and Hispanic neighborhoods).

10. *See infra* Section III.A.

11. Nondiscrimination in Health Programs and Activities; Final Rule, 81 Fed. Reg. 31,376, 31,440 (May 18, 2016) (codified at 45 C.F.R. § 92).

12. Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160, 37,162 (June 19, 2020) (to be codified at 42 C.F.R. pt. 438, 440, 460; 45 C.F.R. pt. 86, 92, 147, 155, 156).

13. *Id.*

have also been divided on how to interpret the statute.¹⁴ In May 2021, the Biden administration announced plans to reassess the Section 1557 regulations.¹⁵

These interpretive distinctions have real-world consequences. A few examples come into sharp relief in the context of the COVID-19 pandemic, as many health care prioritization policies have been developed by programs that accept federal funds. Consider the following examples from vaccine allocation programs and care referrals.

A. Vaccine Allocation

People who live in congregate settings such as long-term care (LTC) facilities or prisons are at far greater risk of COVID-19 exposure than people who live in single-family homes.¹⁶ This is because they share air ventilation systems, staff, and communal eating environments.¹⁷ Indeed, the infection and mortality rates among people living in these settings are several times higher than the national average.¹⁸ Most vaccine allocation decisions prioritize nursing home residents on this basis.¹⁹ The prioritization of prisoners has been much more politically charged.²⁰ Nursing home residents in the United States are 77.9% White, 5.3% Hispanic or Latino, 14.2% Black, and 1.7% Asian.²¹ In state prisons, by contrast, 35% are White, 38% are Black, and 21% are Hispanic or

14. See, e.g., *Doe v. BlueCross BlueShield*, 926 F.3d 235, 239 (6th Cir. 2019); *Schmitt v. Kaiser*, 965 F.3d 945, 953, 954 (9th Cir. 2020).

15. Joint Status Report at 2–3, *Whitman-Walker Clinic, Inc. v. U.S. Dep’t Health & Hum. Servs.*, No. 20-5331 (D.C. Cir. May 14, 2021). See also MaryBeth Musumeci et al., *Recent and Anticipated Actions to Reverse Trump Administration Section 1557 Non-Discrimination*, KAISER FAM. FOUND. (June 9, 2021), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/recent-and-anticipated-actions-to-reverse-trump-administration-section-1557-non-discrimination-rules/>.

16. See Beth Schwartzapfel et al., *1 in 5 Prisoners in the U.S. Has Had COVID-19*, THE MARSHALL PROJECT (Dec. 18, 2020, 6:00 AM), <https://www.themarshallproject.org/2020/12/18/1-in-5-prisoners-in-the-u-s-has-had-covid-19>.

17. *Id.*

18. See Priya Chidambaram et al., *COVID-19 Has Claimed the Lives of 100,000 Long-Term Care Residents and Staff*, KAISER FAM. FOUND. (Nov. 25, 2020), <https://www.kff.org/policy-watch/covid-19-has-claimed-the-lives-of-100000-long-term-care-residents-and-staff/>; see also Schwartzapfel et al., *supra* note 16.

19. Larry Levitt et al., *Estimates of the Initial Priority Population for COVID-19 Vaccination by State*, KAISER FAM. FOUND. (Dec. 10, 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/estimates-of-the-initial-priority-population-for-covid-19-vaccination-by-state/>.

20. Isaac Stanley-Becker, *Early Vaccination in Prisons, a Public Health Priority, Proves Politically Charged*, WASH. POST (Jan. 2, 2021, 4:30 PM) <https://www.washingtonpost.com/health/2021/01/02/covid-vaccine-prisons/>.

21. *Share of Nursing Home Residents U.S. 2014, by Ethnicity*, STATISTA, <https://www.statista.com/statistics/717618/percent-of-nursing-home-residents-in-us-by-ethnicity/> (last visited Mar. 1, 2021).

Latino.²² The decision to allocate vaccines to nursing homes before prisons will have a disparate impact by race, even if that was not the intention. If disparate impact claims are not available in this kind of situation, predictable racial disparities such as this cannot be addressed through federal anti-discrimination law.

B. Care Referrals

People in nursing homes have been disproportionately impacted by COVID-19.²³ According to the Kaiser Family Foundation, forty percent of all COVID-19 deaths have been among LTC facility residents and staff.²⁴ There may be many reasons for this difference, including the preferences of patients or family members or concerns that the residents are too frail to be transferred. However, more sinister forms of rationing may also be occurring if overcrowded hospitals express reluctance to take patients from nursing homes, patients are diagnosed later in the disease course, facilities caring for older patients face equipment shortages, or nursing homes are reluctant to transfer patients to other facilities for ageist or financial reasons.²⁵ These are all forms of “soft rationing,” in that they do not explicitly apply a formal standard or rubric, but nonetheless adversely affect individuals’ access to care as a result of their age.²⁶ Very high percentages of residents of LTC facilities are elderly (eighty-five percent over sixty-five, forty-three percent over eighty-five).²⁷ Over seventy percent of LTC

22. ASHLEY NELLIS, THE SENT’G PROJECT, *THE COLOR OF JUSTICE: RACIAL AND ETHNIC DISPARITY IN STATE PRISONS* 4 (2016). The percentages in the general population, by contrast, are 60.1% non-Hispanic White, 18.5% Hispanic and Latino, and 13.4% Black or African American. *Quick Facts*, U.S. CENSUS BUREAU (July 1, 2019), <https://www.census.gov/quickfacts/fact/table/US/PST045219>.

23. See Chidambaram et al., *supra* note 18.

24. *Id.*

25. The surge in Los Angeles may have resulted in these forms of soft rationing. See, e.g., Rong-Gong Lin II et al., *Ambulance Crews Told Not to Transport Patients Who Have Little Chance of Survival*, L.A. TIMES (Jan. 4, 2021, 4:57 PM), <https://www.latimes.com/california/story/2021-01-04/los-angeles-hospitals-cannot-keep-up-covid-19-surge-illness>; see also Catherine R. Butler et al., *US Clinicians’ Experiences and Perspectives on Resource Limitation and Patient Care During the COVID-19 Pandemic*, JAMA NETWORK OPEN, Nov. 6, 2020, at 6, 8, doi:10.1001/jamanetworkopen.2020.27315 (describing physicians’ experiences with rationing care due to equipment shortages during COVID-19); Timothy R. Farrell et al., *Rationing Limited Healthcare Resources in the COVID-19 Era and Beyond: Ethical Considerations Regarding Older Adults*, 68 J. AM. GERIATRICS SOC’Y 1143, 1145 (2020) (criticizing age rationing during COVID-19); Teneille R. Brown, Leslie P. Francis, & James Tabery, *When Is Age Choosing Ageist Discrimination?*, 51 HASTINGS CTR. REP. 13, 13 (2021).

26. See Julia Belluz, *No ICU Beds? Expect Double the Number of Covid-19 Deaths.*, VOX (Jan. 13, 2021, 9:00 AM), <https://www.vox.com/2021/1/13/22224445/covid-19-deaths-in-us-hospital-beds-icu>.

27. LAUREN HARRIS-KOJETIN ET AL., NAT’L CTR. FOR HEALTH STAT., *LONG-TERM CARE PROVIDERS AND SERVICES USERS IN THE UNITED STATES, 2015–2016*, at 19 (2019).

residents are women.²⁸ Over forty-seven percent of LTC residents have a diagnosis of dementia, forty-six percent have a diagnosis of depression, and thirty-two percent have a diagnosis of diabetes.²⁹ Cumulative patterns of non-referral decisions from LTC facilities can thus have disparate impacts based on age, sex, and disability.

If disparate impact discrimination protections vary by the protected class in question, some of these effects could be judged discriminatory on the part of health care entities receiving federal funding, but others would not be. Can this divergence be justified by different features of the categories of race, color, national origin, sex, age, or disability, or by their historical treatment? If so, what might it look like to implement different anti-discrimination rules in health care for different groups of people? This Article explores whether categories (i.e., age, disability, race, and sex) legally and ethically warrant separate or universal treatment from the perspective of achieving non-discrimination in health care. That is, if we think it is wrong to adopt policies with the effect of deprioritizing people for health care because of their race or sex, should we think that it is similarly wrong to adopt policies with the effect of deprioritizing people for health care on the basis of their age or disability? Or do the differences among the statutes capture features of the categories that are of relevant legal or ethical significance?

This Article begins the exploration of these difficult questions with a brief overview of Section 1557 and what little can be gleaned from its legislative history in Part II. This Article then describes several important differences among the referenced statutes in Part III, followed by accounts of the conflicting rulemakings and decisions in the case law in Part IV.

II. QUESTIONS REGARDING INTERPRETATION OF SECTION 1557 OF THE ACA

Section 1557 of the ACA consists of only two sentences. As described briefly above, the first sentence states that individuals shall not “be excluded from participation in, be denied the benefits of, or be subjected to discrimination under” health programs or activities receiving federal funding “on the ground prohibited under” the four referenced statutes.³⁰ The second sentence states that the “enforcement mechanisms provided for and available under such title VI, title IX, [Section 504], or such Age Discrimination Act shall apply for purposes of violations of this subsection.”³¹ Neither of these sentences resolve whether Section 1557 adopts a uniform anti-discrimination standard, as explained in what follows.

28. Ari Houser, *Women & Long-Term Care*, AARP PUB. POL’Y INST. (2007), https://assets.aarp.org/rgcenter/il/fs77r_ltc.pdf.

29. LAUREN HARRIS-KOJETIN ET AL., *supra* note 27, at 23.

30. 42 U.S.C. § 18116(a).

31. *Id.*

A. *Ways of Reading the Text of Section 1557*

The first sentence of Section 1557 prohibits discrimination in federally funded health care on the “ground” prohibited in the four other statutes.³² “Ground” is explicitly singular in this sentence. As such, it might mean each of the categories: race, color, and national origin; sex; disability; or age. If so, it would refer to the categories but not the substantive types of forbidden discrimination in the four referenced statutes. Alternatively, “ground” might mean the unique body of law that has developed for each of the four statutes referenced.

The first interpretation would create a universal anti-discrimination standard for all protected classes. This could be referred to as a “universal” interpretation of the first sentence. The discrimination prohibited by Section 1557 would thus apply in the same way whether the protected category was race, sex, disability, or age. A less complete form of universal interpretation would apply Section 1557 in the same way to all categories for some legal issues but not for others.

The second interpretation of this sentence would simply bring the four separate prohibitions of discrimination together in one location, with each maintaining their separate case law doctrines and rules. This could be called a “separate” interpretation of the first sentence. This separate interpretation may violate the rule against surplusage,³³ a common precept of statutory interpretation, as Title VI, Section 504, and the Age Act already prohibited discrimination in federally funded health care in virtue of prohibiting discrimination in federally funded programs or activities for the classes they protected.³⁴ Thus, if Section 1557 merely incorporates the standards of prior laws, it will be redundant and unnecessary for all categories but sex.

However, on the separate interpretation of the first sentence, the additional function of Section 1557 for sex would be to bring the standards of non-discrimination developed in the realm of education into health care. At a minimum, this interpretation would raise questions about whether the law that has developed for education is a good fit for the kinds of discrimination expected in health care. Much of the litigation under Title IX has involved secondary school and college sports, asking questions such as whether the athletic opportunities for girls and boys are sufficiently equivalent in light of the respective interests of boys and girls in playing sports.³⁵ Whether the approaches found in such litigation should carry over to health care is, at best, questionable. For example, would a health care system that offers special services for men’s

32. *Id.*

33. See Charlie D. Stewart, *The Rhetorical Canons of Construction: New Textualism’s Rhetoric Problem*, 116 U. MICH. L. R. 1485, 1496 (2018).

34. See *supra* notes 3–6 and accompanying text.

35. See, e.g., Samuel R. Bagenstos, *Legitimacy and Agency Implementation of Title IX*, 43 HARV. J. L. & GENDER 301, 304–05 (2020).

health (say, prostate cancer or male infertility care) but that does not offer services specifically directed to women (say, breast cancer care or in vitro fertilization) be now held to violate Section 1557? Is this question analogous to whether a school discriminates if it offers baseball for boys but not fast pitch softball for girls?³⁶ If a condition disproportionately affects men—as COVID-19 may³⁷—would it be discrimination to prioritize men for a vaccine, or would a facility need to consider whether to allocate a vaccine proportionately to the desires of men and women to receive it?

The second sentence of Section 1557 presents additional interpretive problems. This sentence states, “[t]he enforcement mechanisms provided for and available under such title VI, title IX, section [504], or such Age Discrimination Act shall apply for purposes of violations of this subsection.”³⁸ Of note, unlike “ground” in the first sentence, “enforcement mechanisms” is plural. This could suggest a separate interpretation of the second sentence: that people should use the enforcement mechanism associated with the referenced statute (i.e. Title VI, Title IX, Section 504, Age Act) for the category (i.e., race, color, national origin; sex; disability; age) claimed as the basis of discrimination. Several courts have adopted this separate interpretation of the enforcement sentence.³⁹ These courts have reasoned in addition that this sentence functions to reinforce the separate interpretation of the first sentence.⁴⁰

Alternatively, the second sentence might be given a universal interpretation allowing any of the available enforcement mechanisms to apply to any of the categories. A point in favor of this reading is that the sentence does not specify that only the enforcement mechanism from a specific protected category or statute shall be used for that category or statute. It simply says that “the enforcement mechanisms provided for and available under...shall apply.”⁴¹ Perhaps Congress meant for people complaining of discrimination on any of the grounds to have the same enforcement mechanisms available to them. Many anti-discrimination claimants assert that they have suffered discrimination based on more than one of the categories; for example, people claiming age discrimination may also claim disability discrimination. It could seem

36. *See, e.g.*, *Horner v. Ky. High Sch. Athletic Ass’n*, 206 F.3d 685 (6th Cir. 2020) (concluding that female high school athletes had not provided evidence to show a violation of Title IX).

37. *See* Derek M. Griffith et al., *Men and COVID-19: A Biopsychosocial Approach to Understanding Sex Differences in Mortality and Recommendations for Practice and Policy Interventions*, PREVENTING CHRONIC DISEASE, July 2020, at 1, 1–2, https://www.cdc.gov/pcd/issues/2020/pdf/20_0247.pdf.

38. 42 U.S.C. § 18116(a).

39. *E.g.*, *Doe v. BlueCross BlueShield of Tenn., Inc.*, 926 F.3d 235, 238–39 (6th Cir. 2019); *Doe v. CVS Pharmacy, Inc.*, 982 F.3d 1204, 1210 (9th Cir. 2020).

40. *BlueCross BlueShield of Tenn., Inc.*, 926 F.3d at 239; *CVS Pharmacy, Inc.*, 982 F.3d at 1209.

41. 42 U.S.C. § 18116(a).

problematic to be able to get different remedies depending on which category is the ground of the claimed discrimination. The rule against surplusage is a further argument in favor of the universal interpretation of the second sentence. Otherwise, the second sentence adds nothing, and simply restates what the enforcement mechanisms already are for each of the referenced statutes.

On the other hand, the idea that the second sentence of Section 1557 is meant to permit any type of enforcement that would be allowed under any of the four incorporated statutes has been roundly criticized by some courts. This universal interpretation, courts have said, would make Section 1557 a “[pick] your own adventure” from which plaintiffs may choose their favorite anti-discrimination theories and methods to enforce them.⁴² A further argument in favor of the separate interpretation of the second sentence is that it is institutionally more streamlined to defer to existing enforcement mechanisms when cases might allege violations of both Section 1557 and the underlying statute. Someone might, for example, claim discrimination under both Section 1557 and Title VI; having different enforcement mechanisms for the two could create confusion about which mechanism to use. It would be more streamlined to use the enforcement mechanism for Title VI in suits claiming discrimination under both Section 1557 and Title VI. Reasoning in this way, however, potentially creates the problem mentioned in the preceding paragraph, of the availability of different enforcement mechanisms depending on the category claimed. Just as it might seem problematic for someone claiming discrimination on the basis of race to get different remedies if they use Section 1557 than if they use Title VI, it also might seem problematic for someone claiming discrimination on the basis of race and age to receive different remedies depending on whether they prevail on their claim of race discrimination or their claim of age discrimination. This difference could seem especially troubling if the same set of facts give rise to a successful claim of discrimination on the basis of both of the categories of race and age. [Otherwise, people might be confused by the availability of different enforcement processes when they claim violations of Section 1557 and, say, discrimination on the basis of race under Title VI. In response, it could also be pointed out that there is no obvious justification for someone claiming discrimination on the basis of more than one category in the same case—say, age and disability—to get different remedies depending on the category.]

Unfortunately, the legislative history does not answer these interpretive questions for us. There is no record of discussion or debate on Section 1557,

42. *BlueCross BlueShield of Tenn., Inc.*, 926 F.3d at 239. A reply to this criticism could be that Section 1557 was intended to permit claimants to select the anti-discrimination theory to use, particularly if they were claiming discrimination on the basis of more than one category, such as age and disability.

which was part of the ACA from its initial introduction.⁴³ This could be due to inartful drafting of Section 1557, for the ACA itself has many drafting issues.⁴⁴ Also, not surprisingly, the Obama administration and the Trump administration have interpreted Section 1557 differently in successive rulemaking.⁴⁵ As mentioned above, the Biden administration has indicated that it will review the rulemaking changes introduced by the Trump administration.

B. Different Administrations, Different Interpretative Rules

The Obama administration and the Trump administration took different approaches to interpreting Section 1557. Here, we outline a few of those important differences.

The Obama administration issued its final rule implementing Section 1557 in May 2016.⁴⁶ That rule contained three provisions relevant to our discussion. First, it recognized disparate impact as a form of prohibited discrimination for all categories.⁴⁷ Second, it stated that individuals in all of the protected categories could bring private suits for disparate impact discrimination under Section 1557.⁴⁸ Thus, it interpreted the second sentence of Section 1557 as referring only to administrative processes of enforcement, such as the time period within which claims must be brought, rather than to the remedies that could be available, such as damages.⁴⁹

Finally, the four referenced statutes in Section 1557 contain explicit exceptions to the anti-discrimination requirements they impose.⁵⁰ The Obama administration rulemaking adopted these exceptions without change.⁵¹ These exceptions all concern entitlement benefits specifically limited by federal law.

43. We have searched the Bluebook database for “Section 1557,” Medicare, “age discrimination,” and “discrimination.” References to “discrimination” are either to discrimination in the insurance industry or to the need for people to be protected against discrimination on the basis of sex. Full information about our search is on file with the authors.

44. *See, e.g.*, Robert Pear, *Four Words That Imperil Health Care Law Were All a Mistake, Writers Now Say*, N.Y. TIMES (May 25, 2015), <https://www.nytimes.com/2015/05/26/us/politics/contested-words-in-affordable-care-act-may-have-been-left-by-mistake.html> (discussing “exchange established by a state”).

45. *See infra* Section II.B.

46. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31375 (May 18, 2016) (codified at 45 C.F.R. pt. 92).

47. *Id.* at 31440.

48. *Id.*

49. *See id.*

50. *E.g.*, 45 C.F.R. § 80.3(d) (2019) (creating an exception under Title VI for the exclusion of non-qualifying individuals for Indian Health and Cuban Refugee Services); 45 C.F.R. § 84.4(c) (2019) (creating an exception under the Rehab Act for the exclusion of non-qualifying individuals for benefits); 45 C.F.R. § 91.13 (2019) (creating an exception under the Age Act for age consideration if reasonably necessary for the normal operation or achievement of the statutory objective of a program).

51. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31470.

For example, the Indian Health Service is established by statute, and Title VI of the Civil Rights Act states that having this program available to a limited group is not prohibited discrimination based on race, color, or national origin.⁵² Under Section 504, benefits programs for people with specific disabilities, such as the inclusion of people with end-stage renal disease in the Medicare program, are not disability discrimination.⁵³ Similarly, that people must reach the age of sixty-five to become eligible for Medicare is not Age Discrimination under the Age Act.⁵⁴ The only additional referenced exception concerns age. Under Section 1557, age may be used when it is needed for the normal operation of a program or to achieve a program's statutory objectives.⁵⁵

In incorporating these explicit exceptions in the four referenced statutes in Section 1557, this rulemaking from the Obama administration recognized some differences among Title VI, the Rehab Act, and the Age Act.⁵⁶ These differences among exceptions in the underlying statutes might lend support for interpreting Section 1557 as less than fully universal. Importantly, however, these differences all involve benefits or programmatic objectives recognized by statutes enacted by a general-purpose legislative body.⁵⁷ In these respects, recognition of these differences in statutory exceptions might not provide support for adopting a fully separate interpretation of Section 1557. Consider as an example, standards for allocating crisis care during COVID-19. Some have argued that disability and age are different, and that while it is a violation of Section 1557 to allocate crisis care during COVID-19 based on disability, it may not be a violation to allocate the same care based on age because older people may have shorter life expectancies.⁵⁸ The interpretation of Section 1557 in the Obama administration rule-making would require determining whether the life expectancies of older people fall within a specific Age Act exception. However, COVID-19 care crisis standards may have been adopted by non-legislative advisory bodies, rather than being program objectives recognized by a general purpose legislative body, and thus arguably would not be like the statutory

52. 45 C.F.R. § 80.3(d) (2019).

53. 45 C.F.R. § 84.4(c) (2019); 45 C.F.R. § 85.21(c) (2019).

54. 45 C.F.R. § 91.17 (2019).

55. 45 C.F.R. § 91.13 (2019) (creating the exception for age consideration if reasonably necessary for the normal operation or achievement of the statutory objective of a program). *See also* 45 C.F.R. § 91.12 (2019) (defining normal operation and statutory objective); 45 C.F.R. § 91.15 (2019) (stating the burden of proving an age distinction falls within the exception is on the recipient); 45 C.F.R. § 91.18 (2019) (stating any age distinction contained in a rule or regulation promulgated by HHS is presumed to qualify for the exception).

56. Nondiscrimination in Health Programs and Activities; Final Rule, 81 Fed. Reg. 31376, 31378 (May 18, 2016) (codified at 45 C.F.R. § 92).

57. *See id.*

58. *See* David Wasserman et al., *Setting Priorities Fairly in Response to Covid-19: Identifying Overlapping Consensus and Reasonable Disagreement*, J. L. & BIOSCIENCES, June 28, 2020, at 1, 6 (2020).

exceptions recognized in the Obama administration rule-making.⁵⁹ We return in the final Part of this Article to whether these differences should matter to our understanding of differentiating among the types of discrimination referenced in Section 1557.

The Trump administration issued its final Section 1557 rule in June 2020.⁶⁰ The stated goal of this rulemaking was to eliminate unnecessary duplication, redundancy, or confusion by instituting specific deference to each of the statutes referenced in Section 1557.⁶¹ As the agency explained:

[T]he final rule will defer to the relevant existing regulations and the relevant case law with respect to each of the underlying civil rights statutes, as applied to the health context under Section 1557. It will not create, as the 2016 Rule did, a new patchwork regulatory framework unique to Section 1557 covered entities.⁶²

On disparate impact causes of action, the 2020 rule defers to the referenced statutes. Stating the judgment that disparate impact suits are authorized by Title VI and Section 504, but not by Title IX or the Age Act, the rulemaking states:

[T]he Department believes it is necessary to revert to the underlying statutes and their implementing regulations. As a result, to the extent any of the underlying statutes authorize disparate impact claims, this final rule will recognize such claims by virtue of its reliance on the governing statutes, regulations, guidance and case law applicable to such claims without needing to delineate the availability or lack of availability of all possible claims in this final rule.⁶³

Finally, although the rule as proposed had planned to repeal the provision authorizing private rights of action, the final rule took no position on this issue for Section 1557.⁶⁴

III. IMPORTANT DIFFERENCES AMONG TITLE VI OF THE CIVIL RIGHTS ACT, TITLE IX OF THE EDUCATION AMENDMENTS, SECTION 504 OF THE REHABILITATION ACT, AND THE AGE ACT

This section outlines several doctrinal differences that have developed for the four statutes referenced in Section 1557, with the goal of deepening understanding of the challenges presented in interpreting Section 1557, rather than the goal of resolving the differences. Perhaps most striking is the earlier

59. See, e.g., *COVID-19 Medical Rationing & Facility Visitation Policies*, CTR. FOR PUB. REPRESENTATION, <https://www.centerforpublicrep.org/covid-19-medical-rationing/> (last updated Mar. 31, 2021) (discussing how medical professionals developed protocols to ration care that discriminated against people with disabilities).

60. Nondiscrimination in Health and Health Education Programs and Activities, Delegation of Authority, 85 Fed. Reg. 37160, 37160 (June 19, 2020) (to be codified at 45 C.F.R. pt. 86, 92, 147, 155, and 156).

61. *Id.* at 37163.

62. *Id.* at 37162.

63. *Id.* at 37195.

64. *Id.* at 37203.

observation that three of the statutes already prohibited discrimination in federally funded health care—Title VI, Section 504, and the Age Act—whereas the fourth, Title IX, prohibited discrimination in federally funded educational programs on the basis of sex, but not in the health care arena.⁶⁵ Other differences among the statutes have also developed through the case law, although these lines of case law continue to generate controversy. This Article considers two particularly important areas where the statutes may diverge: recognizing disparate impact as a form of actionable discrimination and allowing individuals to bring causes of action on their own behalf.⁶⁶

A. *Disparate Impact Discrimination*

As highlighted above, disparate impact discrimination occurs when facially neutral policies or practices have significantly different effects on people in specified categories.⁶⁷ This type of discrimination may be proved through statistical evidence showing that protected classes are negatively impacted in ways that others are not, and the effects could be avoided by reasonable changes in the harmful policies or practices.⁶⁸ Disparate impact discrimination was formally recognized by the Supreme Court in an early decision interpreting the employment discrimination section of the Civil Rights Act, Title VII.⁶⁹ This case involved an apparently neutral rule—requiring employees to have a high school diploma or pass an intelligence test—that had been adopted as a thinly-veiled effort to avoid Title VII's prohibition of discrimination on the basis of race.⁷⁰ In *Griggs v. Duke Power Co.*, the Court struck down the power company's use of these requirements as a condition of certain higher-status jobs in its generating plant.⁷¹ The employer had adopted the requirement after the enactment of Title VII, without any validation of its need.⁷² Instead, the motivation for its adoption was apparently to keep Blacks from attaining non-custodial jobs in the plant.⁷³

As the *Duke Power* facts illustrate, recognition of disparate impact as a form of discrimination may be critical when actors avoid explicitly mentioning protected categories yet enact policies that function in similarly exclusionary

65. See *supra* Section II.A.

66. Other differences might also be important, but we set them aside for reasons of space.

67. See *supra* note 8 and accompanying text.

68. See, e.g., *Tex. Dep't of Hous. & Cmty. Affs.*, 576 U.S. at 538, 543. See generally *Title VI Legal Manual, Section VII: Proving Discrimination – Disparate Impact*, U.S. DEP'T OF JUST., <https://www.justice.gov/crt/fcs/T6Manual7> (last visited June 11, 2021).

69. *Griggs v. Duke Power Co.*, 401 U.S. 424, 429–30 (1971).

70. *Id.* at 425–26.

71. *Id.* at 425–26, 436. For the history of disparate impact discrimination, see generally Susan D. Carle, *A Social Movement History of Title VII Disparate Impact Analysis*, 63 FLA. L. REV. 251 (2011).

72. *Griggs*, 401 U.S. at 431.

73. *Id.* at 426–27.

ways. As employers became aware of their Title VII obligations, direct evidence of intentional disparate treatment discrimination became increasingly rare.⁷⁴ Employment policies or decisions rarely mention the categories themselves, making it necessary for claimants to prove that the employer acted with animus.⁷⁵ However, employers can usually offer a reason for not hiring or firing someone in a protected class, and it may be difficult to prove that the offered reason was not the employer's real motive.⁷⁶ This makes disparate impact claims essential as they may reach beyond thinly veiled overt discrimination to situations in which there are differential outcomes that could reasonably be avoided.⁷⁷ Policies with such impacts may be the result of histories of implicit bias or social inequality.⁷⁸

Because of this, disparate impact claims recognize the influence of structural factors in ways that individualized disparate treatment analyses cannot.⁷⁹ They can address many forms of systemic discrimination that might be unintentional but no less harmful to protected classes. Policies with significantly different impacts may have originated in the context of earlier injustices, while not being directly linked to those injustices. For example, the federal tax policy of permitting homeowners to sell their primary residence exempt from some capital gains tax allows people to accumulate wealth from their homes.⁸⁰ However, this facially race neutral policy has had a disparate impact over the years on minorities who were unable to purchase homes in the first place due to discriminatory redlining.⁸¹ Still other policies are simply longstanding practices that have never been examined in light of whether they are necessary or whether their utility might be outweighed by the disadvantages they impose on others. Here, an example might be the design of mammography machines to require

74. Jason R. Bent, *The Telltale Sign of Discrimination: Probabilities, Information Asymmetries, and the Systemic Disparate Treatment Theory*, 44 UNIV. MICH. J. L. REFORM 797, 803–04 n.17 (2011).

75. See Laina Rose Reinsmith, *Proving an Employer's Intent: Disparate Treatment Discrimination and the Stray Remarks Doctrine After Reeves v. Sanderson Plumbing Products*, 55 VAND. L. REV. 219, 225–26 (2002).

76. See *id.* at 232–33.

77. See Susan D. Carle, *A Social Movement History of Title VII Disparate Impact Analysis*, 63 FLA. L. REV. 251, 258 (2011). But see Michael Selmi, *Was the Disparate Impact Theory a Mistake?*, 53 UCLA L. REV. 701, 767–75 (arguing that disparate impact theory has proved unsuccessful and created a misunderstanding of disparate treatment theory as solely about animus).

78. See Angela P. Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758, 784 (2020).

79. See *id.* at 788; Dayna Bowen Matthew, *Structural Inequality: The Real Covid-19 Threat to America's Health and How Strengthening the Affordable Care Act Can Help*, 108 GEO. L.J. 1679, 1687–88 (2020).

80. See *Topic No. 701 Sale of Your Home*, IRS (Jan. 25, 2021), <https://www.irs.gov/tax-topics/tc701>.

81. BRUCE MITCHELL & JUAN FRANCO, NCRC RSCH, HOLC “REDLINING” MAPS: THE PERSISTENT STRUCTURE OF SEGREGATION AND ECONOMIC INEQUALITY 5 (2018).

patients to stand and lean forward for optimal imaging.⁸² Without modification, this design renders mammography inaccessible for many patients with disabilities who could not easily maintain a standing position.⁸³

Whether to recognize disparate impact as a form of discrimination, and what standards to use in so doing, is legally and ethically contentious. Opponents of disparate impact as a theory of discrimination argue that anti-discrimination law should address individual, intentional acts of prejudice rather than social inequalities or social structures more generally.⁸⁴ Opponents also question whether current disparate impacts, even when correlated with historically disfavored groups, are unjust.⁸⁵ Despite the importance of disparate impact theory in addressing difficulties in proving covert discrimination, the Court has increasingly suggested limiting the scope of claims of disparate impact discrimination.⁸⁶ These limitations also have been a theme in rulemaking under the Trump administration.⁸⁷

Significant complexities in understanding Section 1557, with respect to disparate impact discrimination, have been created by the times when the referenced statutes were adopted and interpreted by the Court. Title VI was adopted in 1964, Title IX in 1972, the Rehab Act in 1973, and the Age Act in 1975.⁸⁸ Title VI, coming first, was in some respects the model for the later statutes.⁸⁹ An early Supreme Court decision interpreting Title VI, handed down in 1974, had suggested a broad scope for disparate impact theory under that statute.⁹⁰ Seminal Supreme Court decisions then were handed down regarding Title IX in 1979⁹¹ and Section 504 in 1985.⁹² In the background of these decisions was the Court's apparently broad reading of Title VI in 1974.

82. Lisa I. Iezzoni & Elizabeth Pendo, *Accessibility of Medical Diagnostic Equipment — Implications for People with Disability*, 378 NEW ENG. J. MED. 1371, 1372 (2018).

83. *Id.*

84. Susan D. Carle, *A Social Movement History of Title VII Disparate Impact Analysis*, 63 FLA. L. REV. 251, 254 (2011).

85. Justice Scalia raised this concern in his concurrence in *Ricci v. DeStefano*, 557 U.S. 557, 594 (Scalia, J., concurring) (“Title VII’s disparate-impact provisions place a racial thumb on the scales, often requiring employers to evaluate the racial outcomes of their policies, and to make decisions based on (because of) those racial outcomes. That type of racial decisionmaking is, as the Court explains, discriminatory.”).

86. *See, e.g., Tex. Dep’t of Hous. & Cmty. Affs. v. Inclusive Cmty. Project, Inc.*, 576 U.S. 519, 525, 543, 544 (2015) (analyzing disparate impact claims under the Fair Housing Act).

87. *See, e.g., HUD’s Implementation of the Fair Housing Act’s Disparate Impact Standard*, 85 Fed. Reg. 60288 (Sept. 24, 2020) (to be codified at 24 C.F.R. pt. 100).

88. 42 U.S.C. § 2000d (2018); 20 U.S.C. § 1681(a) (2018); 29 U.S.C. § 794 (2018); 42 U.S.C. § 6101 (2018).

89. *E.g., Cannon v. Univ. of Chi.*, 441 U.S. 677, 694 (1979) (“Title IX was patterned after Title VI of the Civil Rights Act of 1964.”)

90. *Lau v. Nichols*, 414 U.S. 563, 568, 569 (1974).

91. *See generally Cannon*, 441 U.S. at 677, 680.

92. *See generally Alexander v. Choate*, 469 U.S. 287, 289 (1985).

However, in 2001, the Court specifically limited the scope of disparate impact discrimination for Title VI.⁹³ As discussed below, the implications of this decision for the interpretation of the Rehab Act and Title IX are not fully resolved. In what follows, this Article considers the status of disparate impact theory under the four referenced statutes, with the aim of exploring what is at stake in incorporating these different histories into Section 1557, or in choosing to take a uniform approach to disparate impact under Section 1557.

1. Title VI

Section 601 of Title VI of the Civil Rights Act, prohibiting discrimination based on race, color, or national origin, simply reads: “No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”⁹⁴ The Court has interpreted Section 601 of Title VI to prohibit only intentional discrimination based on race, color, or national origin.⁹⁵

However, Section 602 may give some scope for addressing disparate impact discrimination under Section 1557, because Section 1557’s reference to Title VI explicitly includes all of Title VI.⁹⁶ Under Section 602 of Title VI, federal agencies have authority to issue rules implementing the objectives of Title VI with the approval of the President.⁹⁷ The Court has assumed that agency rules under Title VI may prohibit practices with disparate impacts, but it has also held that there are no private rights of action to enforce these rules insofar as they involve disparate impact discrimination, which will be discussed below.⁹⁸

For COVID-19 allocation decisions, the upshot of this legal assumption governing Title VI would be that categorization on the basis of race is strictly prohibited, whether intentional or not. This prohibition would apply even if the categorization is intended to *benefit* someone based on race. Thus interpreted, Title VI would prohibit any vaccine allocation programs that prioritize Blacks or Hispanics, even if the prioritization is because of their higher mortality from

93. *Alexander v. Sandoval*, 532 U.S. 275, 281, 293 (2001).

94. 42 U.S.C. § 2000d (2020).

95. *Alexander*, 532 U.S. at 275, 280, 303, 307 n. 14 (2001). This interpretation followed the Court’s interpretation of the Fourteenth Amendment. An earlier decision involving a claim by non-English-speaking Chinese students that the San Francisco school system’s policy of refusing bilingual or remedial English instruction was discriminatory had seemed to countenance disparate impact discrimination under § 601, *Lau v. Nichols*, 414 U.S. 563, 564–65 (1974). See generally S. HSIN, CONG. RSCH. SERV., R45665, CIVIL RIGHTS AT SCHOOL: AGENCY ENFORCEMENT OF TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, 7 (2019).

96. Section 1557 says “Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.)” 42 U.S.C. 18116(a).

97. 42 U.S.C. § 2000d-1 (2020). An executive order has since delegated this approval authority to the Attorney General. Exec. Order No. 12250, 45 Fed. Reg. 72995 (Nov. 2, 1980).

98. *Alexander*, 532 U.S. at 293.

the virus. On the other hand, a completely neutral vaccine allocation policy that failed to consider the disparate impact such policies might have on racial groups especially hard-hit by the virus might be thought to have a discriminatory disparate impact on these groups. This presents a conundrum.

The ultimate interpretation of Title VI for allocation policies that have disparate impacts based on race, color, or national origin remains unclear, as the Court has not ruled definitively on whether the Title VI regulations prohibiting disparate impact provide a way to enforce the Title VI prohibition on disparate treatment based on race.⁹⁹ An example of what might be considered disparate impact discrimination based on race or color is the use of pulse oximetry readings to decide whether someone's oxygenation is sufficiently compromised to require hospitalization for COVID-19.¹⁰⁰ Recent evidence suggests that oximetry readings may give inflated results for people with darker skin and thus result in inaccurate assessments and undertreatment of people of color.¹⁰¹ A program's reliance on these oximetry readings for treatment decisions might therefore be questioned as having a disparate impact on people of color. If the Section 602 regulations are determined to properly interpret Title VI, this would be prohibited disparate impact discrimination. If Title VI only prohibits intentionally disparate treatment, it would not be covered by Title VI. If disparate impact discrimination is prohibited under any of the other statutes referenced in Section 1557, this would mean less robust protection against discrimination based on race, color, or national origin than against discrimination based on at least one of the other categories.

2. Section 504 of the Rehabilitation Act

Early interpretations of Section 504 permitted claims of disparate impact as a form of discrimination based on disability. These interpretations, as noted above, came at a time when it was thought that Section 601 of Title VI prohibited disparate impact discrimination. In the leading case introducing disparate impact theory under Section 504, *Alexander v. Choate*, people with disabilities challenged a Tennessee Medicaid policy limiting hospital stays to fourteen days annually.¹⁰² Although the challengers lost the case, the ruling was based on the Court's determination that both disabled and non-disabled Medicaid recipients had access to the same benefit—fourteen hospital days—rather than on rejection

99. *Alexander* ruled only on whether there is a private right of action to enforce §2000d-1, 532 U.S. at 279 (“We do not inquire here whether the DOJ regulation was authorized by § 602 . . .”).

100. Sonia Shah et al., *Novel Use of Home Pulse Oximetry Monitoring in COVID-19 Patients Discharged from the Emergency Department Identifies Need for Hospitalization*, 27 ACAD. EMERGENCY MED. 681, 682 (2020).

101. Michael W. Sjöding et al., *Letter to the Editor: Racial Bias in Pulse Oximetry Measurement*, 383 NEW ENG. J. MED. 2477, 2478 (2020).

102. *Alexander v. Choate*, 469 U.S. 287, 289 (1985).

of disparate impact as a potential form of discrimination under Section 504.¹⁰³ This decision in *Alexander v. Choate* predates, by over fifteen years, the determination that parallel language in Title VI does not encompass disparate impact discrimination.¹⁰⁴ Later interpretations of Section 504 are less clear on whether it includes disparate impact as a form of prohibited discrimination. Some subsequent court decisions have understood *Alexander v. Choate* to mean that disparate impact discrimination is addressed under Section 504 as the failure to provide “meaningful access” to the federally funded program at issue.¹⁰⁵ In contrast, other courts have questioned reading Section 504 to permit disparate impact discrimination in the context of cases discussing the interpretation of Section 1557.¹⁰⁶ The Trump administration Section 1557 rulemaking also opined that Section 504 does not encompass disparate impact discrimination.¹⁰⁷

Whether Section 504 applies to disparate impact discrimination has important implications for policies adopted during COVID-19. Many COVID-19 allocation decisions can be anticipated to have differential impacts on people with disabilities. Initial crisis standards of care singled out specified disabilities for deprioritization, such as neuromuscular diseases and conditions with respiratory complications like cystic fibrosis.¹⁰⁸ These standards were considered discriminatory by the Office for Civil Rights at HHS.¹⁰⁹ As they refer specifically to disabilities, they would be considered discriminatory disparate treatment. However, protocols now in effect in various states rely on physiological measures judged to be predictive of the likely impact of therapy based on the best available evidence.¹¹⁰ Whether these standards are also discriminatory because of the likelihood that they will have a disparate impact on people with disabilities remains contested.¹¹¹ Answering this question under disability anti-discrimination law depends on whether Section 504 is judged to prohibit disparate impact discrimination and, if so, what forms this might take.

103. *Id.* at 309.

104. *Alexander v. Sandoval*, 532 U.S. 275, 280, 285 (2001).

105. *Doe v. CVS Pharmacy, Inc.*, 982 F.3d 1204, 1210 (9th Cir. 2020).

106. *See, e.g., Doe v. BlueCross BlueShield of Tenn., Inc.*, 926 F.3d 235, 238 (6th Cir. 2019).

107. Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37160, 37195, 37202 (June 19, 2020).

108. *E.g.*, Press Release, U.S. Dep’t of Health & Hum. Servs., OCR Resolves Complaint with Utah After it Revised Crisis Standards of Care to Protect Against Age and Disability Discrimination (Aug. 20, 2020), <https://www.hhs.gov/about/news/2020/08/20/ocr-resolves-complaint-with-utah-after-revised-crisis-standards-of-care-to-protect-against-age-disability-discrimination.html> [hereinafter OCR Resolves Complaint].

109. *Id.*

110. *E.g.*, STATE OF UTAH, UTAH STANDARDS OF CRISIS CARE GUIDELINES 5 (Nov. 12, 2020).

111. *See, e.g., Ari Ne’eman, When It Comes to Rationing, Disability Rights Law Prohibits More Than Prejudice*, THE HASTINGS CTR. (Apr. 10, 2020), <https://www.thehastingscenter.org/when-it-comes-to-rationing-disability-rights-law-prohibits-more-than-prejudice/>.

3. Title IX of the Education Amendments

Title IX, prohibiting discrimination based on sex, was modeled after Title VI of the Civil Rights Act.¹¹² Court decisions typically treat Title IX as analogous to Title VI with respect to disparate treatment discrimination.¹¹³ The Court decision regarding private rights of action under Title IX involved a challenge to medical school admission policies that deprioritized or automatically rejected older applicants, but did not reach the issue of whether such policies with a disparate impact on women applicants were prohibited disparate impact discrimination.¹¹⁴ Just as for Title VI, it is disputed whether the non-discrimination provision of Title IX may be interpreted to prohibit disparate impact discrimination. The Trump administration rulemaking for Section 1557 stated explicitly that Title IX does not cover disparate impact discrimination.¹¹⁵ Court decisions have also rejected the contention that Title IX addresses disparate impact discrimination, holding that Section 1557 by reference to Title IX does not address disparate impact discrimination on the basis of sex.¹¹⁶ Other courts seem to assume that Title IX does permit recognizing disparate impact as a form of discrimination, although it does not allow individuals to sue for money damages on this theory.¹¹⁷

By referencing Title IX, Section 1557 incorporates a statute into the realm of health care that was designed for, and has been interpreted in, the realm of education.¹¹⁸ There may be problems with whether the forms discrimination takes in education resemble the forms that it takes in health care. Many of the court decisions interpreting Title IX involve school or college athletic programs.¹¹⁹ These decisions apply standards developed under regulations to determine whether programs are adequately accommodating of the respective

112. *Cannon v. Univ. of Chi.*, 441 U.S. 677, 694 (1979).

113. *Id.* at 696 n.19.

114. *Id.* at 680 n.2.

115. *Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority*, 85 Fed. Reg. 37160, 37196 (June 19, 2020).

116. *See, e.g., Doe v. BlueCross BlueShield of Tenn., Inc.*, 926 F.3d 235, 240 (6th Cir. 2019).

117. *See, e.g., Horner v. Ky. High Sch. Athletic Ass'n*, 206 F.3d 685, 692 (6th Cir. 2020). Title IX regulations also prohibit actions that constitute disparate impact discrimination, although the Court has not explicitly upheld these regulations. An example is the use of admissions criteria with a “disproportionately adverse effect on persons on the basis of sex unless the use of such test or criterion is shown to predict validly success in the education program or activity in question and alternative tests or criteria which do not have such a disproportionately adverse effect are shown to be unavailable.” 34 C.F.R. § 106.21(b)(2) (2020).

118. *See* 20 U.S.C. § 1681(a) (2020); *see also* *Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority*, 85 Fed. Reg. at 37207.

119. *See, e.g., Diane Heckman, The Glass Sneaker: Thirty Years of Victories and Defeats Involving Title IX and Sex Discrimination in Athletics*, 13 *FORDHAM INTELL. PROP., MEDIA, & ENT. L.J.* 551, 561 (2003) (“Title IX has become synonymous with expanding participation opportunities for female student-athletes.”).

levels of interest of girls and boys in playing sports.¹²⁰ Whether standards based on levels of interest in this way are appropriate to health care is questionable, given ethical obligations to do patient education and outreach; obligations that do not exist for sports. For example, suppose the levels of interests of men in receiving a therapy were much higher than the levels of women in receiving the same therapy, but the evidence indicated that the therapy was as effective in women as in men. It seems unlikely that it would be judged non-discriminatory to allocate a greater proportion of the therapy to men.

4. The Age Act

The Age Act has explicit provisions about disparate treatment and disparate impact that are not found in the other three statutes. This raises questions about whether age discrimination is different in kind from discrimination against people falling into other protected categories. As for disparate treatment, the Age Act specifically states that it does not apply to programs or activities established under law to provide benefits or assistance based on age, or which establish criteria for participation in age-related terms.¹²¹ Federal or state statutes, such as Medicare, that provide health benefits based on age are examples. Under the Age Act regulations, these programs must be in federal, state, or local statutes or ordinances “adopted by an elected, general purpose legislative body.”¹²² Otherwise, these programs would not be protected by this safe harbor and could be found to constitute disparate treatment discrimination. Crisis standards of care committees composed to address shortages during a pandemic, such as those found in many states for influenza and COVID-19 planning, would not meet this standard of a general-purpose legislative body.¹²³

The Age Act further states that it is not violated if a program acts in a way that “reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of such program or activity; or the differentiation made by such action is based upon reasonable factors other than age.”¹²⁴ Reasonably taking age into account means that at least

120. 34 C.F.R. § 106.41(c)(1) (2020) (“In determining whether equal opportunities are available, the Director will consider, among other factors . . . [w]hether the selection of sports and levels of competition effectively accommodate the interests and abilities of both sexes . . .”). *See, e.g., Ollier v. Sweetwater Union High Sch. Dist.*, 768 F.3d 843, 855 (9th Cir. 2014) (applying effective accommodation of interests standard).

121. 42 U.S.C. § 6103(b)(2) (2018).

122. 45 C.F.R. § 91.3(b)(1) (2020). The legislative history of the Age Act makes clear that Congress was referring to benefit programs with age-related eligibility criteria. 121 CONG. REC. 9212 (1975).

123. *See, e.g.,* UTAH HOSP. ASS’N CRISIS STANDARDS OF CARE WORKGROUP, UTAH CRISIS STANDARDS OF CARE GUIDELINES 3 (Nov. 12, 2020) (listing membership of Utah Hospital Association Crisis Standards of Care Workgroup).

124. 42 U.S.C. § 6103(b)(1)(A)–(B) (2020). This provision was added to the legislation explicitly to take reasonableness into account. *See* H.R. 1230, 116th Cong. (2019).

some additional forms of disparate treatment based on age are regarded as non-discriminatory if they are necessary to achieve statutory objectives. For COVID-19, a vaccination program that aims to protect those most likely to become seriously ill might take age into account, if evidence shows that people over a given age are at a significantly elevated mortality risk, protecting those at highest risk of serious illness is a statutory objective of the vaccination program, and vaccinating the elderly is necessary to achieve this protection. Likewise, a statutory objective of ensuring vaccine safety would allow setting a minimum age threshold if the evidence is as yet insufficient to demonstrate that a vaccine is safe in younger children.

The use of “reasonable factors other than age” permits policies that, if reasonable, might also disproportionately affect the elderly. That is, it permits some policies with disparate impact on the elderly, if necessary to achieve the stated policy goal. For example, a policy requiring visual acuity in order to drive would be permissible if it were considered necessary for public safety. However, the Age Act regulations further clarify that “an action may be based on a factor other than age only if the factor bears a direct and substantial relationship to the normal operation of the program or activity or to the achievement of a statutory objective.”¹²⁵ A driver licensing requirement that required the ability to walk or run a mile in twelve minutes or less would likely have a disparate impact on the elderly, and it would be discriminatory under the regulation unless it could be shown to bear a direct and substantial relationship to the furtherance of driving safety. A similar requirement for public safety officers might not be considered discriminatory, if it bore a direct relationship to the officers’ job responsibilities. In health care, factors such as renal function might be relevant to the statutory objectives for organ allocation, for example, but taking renal function into account might have a disparate impact on persons who are older if age is correlated with differences in renal function.¹²⁶ Determining whether these impacts are discriminatory is a challenge, and critical to understanding whether age is or should be different than the other categories referenced in Section 1557.

B. *Private Rights of Action*

As described above, the second sentence of Section 1557 states that “the enforcement mechanisms provided for and available under such title VI, title IX, section [504], or such Age Discrimination Act shall apply for purposes of

125. 34 C.F.R. § 110.13 (2020).

126. See Roy D. Bloom, *Kidney Function and Non-Kidney Solid Organ Transplantation*, UPTODATE, <https://www.uptodate.com/contents/kidney-function-and-non-kidney-solid-organ-transplantation/print> (last updated Nov. 9, 2018) (describing how kidney function is part of preoperative evaluation prior to non-kidney solid organ transplantation). See, e.g., A. Clara Drenth-van Maanen et al., *Renal Function Assessment in Older Adults*, 76 BJCP 616, 617 (2013) (discussing the fact that older adults are more vulnerable to adverse drug reactions due to an increased prevalence of kidney function impairment).

violations of this subsection.”¹²⁷ Understanding this sentence depends on understanding what is meant by “enforcement mechanisms” and how the relevant provisions of the four referenced statutes have been interpreted to differ. These mechanisms might include who may pursue enforcement, what procedures must be used, and what remedies are available for violations. One particularly contested question is whether enforcement mechanisms include what are called private rights of action.¹²⁸

Private rights of action enable private individuals to bring suit to enforce their rights under a statute.¹²⁹ They reflect determinations that statutes are designed to provide individuals with rights and remedies.¹³⁰ Sometimes a statute explicitly permits private rights of action and damage remedies for individuals; courts have also determined that the right is implied in some circumstances.¹³¹ Without private rights of action, individuals must rely on the federal government, or other designated entities, for enforcement.¹³² But even the federal government’s enforcement capabilities are limited, especially when the statute does not provide for damages for individuals. When the federal government believes that a state program such as Medicaid is out of compliance, the ultimate remedy is to withhold federal funding for the program from the state.¹³³ This is a drastic and overly broad remedy to ensure state compliance

127. 42 U.S.C. § 18116(a).

128. Other questions include the processes they must use and the remedies they may receive. *See, e.g., Palacios v. MedStar Health, Inc.*, 298 F. Supp. 87, 91 (D.D.C. 2018) (considering statute of limitations).

129. For a discussion of standards used by courts to determine whether to imply private rights of action under a statute, see Caroline Bermeo Newcombe, *Implied Private Rights of Action: Definition, and Factors to Determine Whether a Private Action Will Be Implied from a Federal Statute*, 49 LOY. U. CHI. L.J. 117, 120 (2017). Newcombe argues that statutes enacted under the spending clause—such as the statutes under consideration here—are unlikely to be found to imply private rights of action. *Id.* at 126.

130. *See id.* at 120 n.9.

131. *See id.* In the background is that as the Court has become increasingly conservative, its decisions have insisted on explicit statutory authorization or clear recognition of individual rights under the statute in order to allow private rights of action. For example, in *Armstrong v. Exceptional Child Center, Inc.*, the Court held that the section of the Medicaid statute requiring states to set reimbursement levels for providers at a point sufficient to ensure availability of services comparable to that available to others in the community could not be enforced by private individuals, 575 U.S. 320, 331–32 (2015). The statute at issue was § 20 of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A) (2020), which provides for payment “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”

132. *See generally Section IX- Private Right of Action & Individual Relief Through Agency Action*, U.S. DEP’T OF JUST., <https://www.justice.gov/crt/fcs/T6Manual9> (last updated Feb. 3, 2021).

133. *Conditional Grants-in-Aid*, LEGAL INFO. INST., <https://www.law.cornell.edu/constitution-conan/article-1/section-8/clause-1/conditional-grants-in-aid> (last visited Feb. 25, 2021).

with statutory standards.¹³⁴ If Medicaid funds are withheld, the entire Medicaid population may suffer. By contrast, when the funding goes to federal contractors, the consequences of enforcement may be less widespread public harm. The harm of the ultimate remedy of contract termination or debarment from government contracts will fall most directly on the contractor,¹³⁵ but there may also be indirect harms if the contractor was serving members of the public. Additionally, if the actors charged with enforcing these rights are not politically motivated to do so, this leaves injured parties without legal redress.¹³⁶

The upshot of a failure to recognize private rights of action is that individuals who are concerned that they have been subjected to discrimination would not be able to bring suit on their own behalf.¹³⁷ Without a private right of action, an individual would be unable to go to court to obtain an order for the funding agency to require changes in funded programs.¹³⁸ So too, would they be unable to obtain an injunction to confront agency approval of state pandemic crisis standards that discriminate on the basis of the protected categories of Section 1557. Instead, they would be dependent on the federal funding agency to take action against the state, as HHS did with crisis plans that allegedly discriminated on the basis of disability or age.¹³⁹ Nor would individuals who suffer personal harm be able to sue for damages.¹⁴⁰ Each of the four statutes referenced in Section 1557 has a complex history with respect to the recognition of private rights of action. These complex histories are intertwined with whether disparate impact is recognized as a form of discrimination under each of the referenced statutes.

1. Title VI

The Supreme Court's initial decision involving private rights of action under Title VI appeared to signal that individuals could bring suit for violations of both

134. See *Spending for the General Welfare*, LEGAL INFO. INST., <https://www.law.cornell.edu/constitution-conan/article-1/section-8/clause-1/spending-for-the-general-welfare> (last visited Feb. 25, 2021).

135. See *Federal Contract Compliance Manual: 8A01 Remedies*, OFF. OF FED. CONT. COMPLIANCE, <https://www.dol.gov/agencies/ofccp/manual/fccm/chapter-8-resolution-noncompliance/8a-introduction> (last updated Dec. 23, 2019).

136. See Newcombe, *supra* note 129, at 132.

137. Christine H. Monahan, *Private Enforcement of the Affordable Care Act: Toward an "Implied Warranty of Legality" in Health Insurance*, 126 YALE L.J. 1118, 1123 (2017) (arguing for implied private rights of action under state insurance law). See also Newcombe, *supra* note 129, at 131.

138. See Monahan, *supra* note 137, at 1124, 1139.

139. E.g., OCR Resolves Complaint, *supra* note 108 (noting that this was the seventh such complaint resolved by OCR).

140. Amitabh Chandra et al., *Challenges to Reducing Discrimination and Health Inequity Through Existing Civil Rights Laws*, 36 HEALTH AFFS. 1041, 1044 (2017), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1091>.

Section 601 and Section 602.¹⁴¹ To recall, Section 601 prohibits discrimination on the ground of race, color or nation origin, while Section 602 grants the authority to issue regulations enforcing Section 601.¹⁴² Twenty-six years later, the Court explicitly rejected private rights of action under Section 602.¹⁴³ In this decision, however, the Court did not determine whether the Section 602 regulations addressing disparate impact as a form of discrimination could stand. The result is that the regulations under Section 602 prohibit disparate impact discrimination, but individuals may not bring private suits to enforce these regulations.

2. Section 504 of the Rehabilitation Act

Private rights of action are permitted under Section 504 at least for allegations of disparate treatment. Section 504 states specifically that the remedies of Title VI of the Civil Rights Act are to be available to any person aggrieved by any recipient of federal funds under the Rehabilitation Act.¹⁴⁴ This has been the case from the very first decision under Section 504 of the Rehabilitation Act.¹⁴⁵ The availability of private rights of action under Section 504 for disparate impact has been assumed,¹⁴⁶ but this has been disputed by some courts recently interpreting Section 1557.¹⁴⁷

3. Title IX

Title IX has been held to imply private rights of action.¹⁴⁸ The leading case, *Cannon v. University of Chicago*, involved a female applicant to medical schools who alleged she was denied admission on the basis of her sex.¹⁴⁹ Cannon was a

141. This signal came from a 1974 decision, which recognized a challenge by Chinese-language speaking school children in San Francisco against the school district's failure to provide them with supplemental instruction. *Lau v. Nichols*, 414 U.S. 563, 564, 568–69 (1974).

142. *Supra* Section III.A.1.

143. *Alexander v. Sandoval*, 532 U.S. 275, 293 (2001). The case involved a state's administration of driver's license tests in English only. The Court stated as given that Title VI Section 601 permits individuals to sue for both injunctive relief and damages when they allege discriminatory treatment on the basis of race, color, or national origin, and that Section 601 extends only to such intentional discrimination. *Id.* at 281.

144. 29 U.S.C. § 794a(a)(2).

145. *See Se. Cmty. Coll. v. Davis*, 442 U.S. 397, 402, 405 (1979) (permitting a disabled person's claim against a federally funded college to proceed under Section 504 in a case of first impression).

146. *Alexander v. Choate*, 469 U.S. 287, 309 (1985).

147. *Compare Doe v. BlueCross BlueShield of Tenn., Inc.*, 926 F.3d 235, 242 (6th Cir. 2019) (holding that individuals cannot recover under a disparate impact theory as applied to the Rehabilitation Act), *with Doe v. CVS Pharmacy, Inc.*, 982 F.3d 1204, 1211–12 (9th Cir. 2020) (explaining that a disparate impact claim may be brought based on lack of meaningful access).

148. *Cannon v. Univ. of Chi.*, 441 U.S. 677, 717 (1979).

149. *Id.* at 680.

thirty-nine-year-old woman who contended that although her academic credentials were similar to those of admitted students, she had been disfavored by policies disqualifying older students for admission and that such policies adversely affected women who were more likely to experience interruptions in their educations.¹⁵⁰ Lower courts had dismissed her suit on the ground that Title IX did not grant a private right of action.¹⁵¹ The Court, however, construed Title IX as granting an implied private right of action, noting that it had been modeled on Title VI.¹⁵² In 1972, when Title IX was passed, many federal courts of appeals had already held that Title VI permitted a private right of action; this was the context in which Congress had enacted Title IX.¹⁵³ In addition, the package of statutes that included Title IX authorized attorney fees for private individuals claiming violations of Title IX in public education, thereby implying the anticipation of private rights of action.¹⁵⁴ According to the Court, Congress wanted both “to avoid the use of federal resources to support discriminatory practices” and to “provide individual citizens effective protection against those practices.”¹⁵⁵

4. Age Discrimination Act

Both federal enforcement and private rights of action for injunctive disparate impact relief are permitted under the Age Act. The relevant Age Act provision reads: “When any interested person brings an action in any United States district court . . . to enjoin a violation of this act by any program or activity receiving Federal financial assistance”¹⁵⁶ Thus the Age Act explicitly recognizes private rights of action. An example of such individual action under the Age Act was the unsuccessful effort by older residents of the western part of Contra Costa County to challenge closure of a hospital in their area that received federal funds.¹⁵⁷ The residents contended that the closure was discriminatory because of its impact on the poor, African-American, and elderly who made up a disproportionate share of the residents in this portion of the county.¹⁵⁸ The court found that they were unlikely to succeed in their suit and thus could not obtain a preliminary injunction against the closure because the explanation for the closure was the failure to pass a parcel tax measure needed to raise funds for the

150. *Id.* at 680 n.2.

151. *Id.* at 683.

152. *Id.* at 703, 717.

153. *Cannon*, 441 U.S. at 696.

154. *Id.* at 699.

155. *Id.* at 704.

156. 42 U.S.C. § 6104(e) (2020) (“When any interested person brings an action . . . to enjoin a violation of this Act”).

157. *DMC Closure Aversion Committee v. Goia*, No. 14-cv-03636-WHO, 2014 WL 4446831, at *11–12 (N.D. Cal. 2014) (not reported).

158. *Id.* at *1.

hospital.¹⁵⁹ Even so, the court recognized the availability of injunctive relief in cases like these.

IV. ARE THE CATEGORIES NORMATIVELY DIFFERENT?

The preceding sections have outlined two important differences among the four statutes brought together in Section 1557. The following table summarizes these differences.

SELECTED DIFFERENCES IN THE STATUTES REFERENCED BY SECTION 1557

<i>Statute</i>	<i>Disparate Impact?</i>	<i>Implied Private Right?</i>
Title VI (race, color, national origin)	No under § 601; yes under § 602 regulations; unclear whether these regulations will stand	Yes under § 601; no under § 602
Rehab Act (disability)	Assumed in <i>Alexander v. Choate</i> ; currently disputed	Yes
Title IX (sex)	Disputed	Yes
Age Act (age)	Not discriminatory to use “reasonable factors other than age” to achieve statutory objectives or normal operation of a program	Explicit private right to sue; no need to imply a private right

The puzzle we have presented in this Article is whether these differences should be replicated in the interpretation of Section 1557. This interpretive ambiguity in Section 1557 is more than just an academic puzzle. It reveals deeper normative questions that demand scrutiny. To motivate this, consider the following scenario: Anette, Theresa, Susan, and Gill are all eagerly awaiting access to a COVID-19 vaccine. What factors should (or shouldn’t) be used when deciding whom to prioritize? The fact that Anette is Black while the other three people are White (Black patients have higher COVID-19 mortality than White patients¹⁶⁰)? The fact that Theresa has diabetes while the other three don’t (patients with diabetes have higher COVID-19 mortality than patients without

¹⁵⁹ *Id.*

¹⁶⁰ *The COVID Racial Data Tracker*, THE ATLANTIC, <https://covidtracking.com/race> (last visited Feb. 23, 2021).

diabetes¹⁶¹)? The fact that Susan is eighty-five while the other three individuals are in their forties (older patients have higher COVID-19 mortality than younger patients¹⁶²)? The fact that Gill is male while the other three are female (males have higher COVID-19 mortality than females¹⁶³)? Is one of these factors more (or less) legitimate for basing a prioritization decision than the others? Should we avoid considering any of the factors? Should we consider all four factors and just look to the epidemiological evidence to determine who is *most* at risk in this particular scenario? Does it matter what specific types of historical discrimination the anti-discrimination statutes were developed to correct, and which types are most exacerbated by COVID-19 or lack of vaccine access?

Our purpose is not to offer a normative account that definitively answers these questions. We are incapable of doing so for two reasons. First, it would require selecting one distributive justice theory as “best,” which is far beyond the scope of this Article. Second, precisely because Black people, women, older adults, and people with disabilities have experienced different and complex histories of discrimination in health care,¹⁶⁴ members of each of these groups could be legitimately prioritized based on multiple theories of equity, corrective justice, and need.

But even more important to our thesis is that we also cannot turn to anti-discrimination law for guidance in answering these questions. Far from providing a meta-framework for coordinating the diverse legal requirements of the four anti-discrimination statutes it references, Section 1557 of the ACA instead raises even more questions. The legal ambiguity in its interpretation challenges the very idea of using individual categories to address widespread discrimination.¹⁶⁵

161. Matthew C. Riddle et al., *COVID-19 in People with Diabetes: Urgently Needed Lessons from Early Reports*, 43 *DIABETES CARE* 1378, 1378 (2020).

162. *Id.*

163. *The COVID-19 Sex-Disaggregated Data Tracker*, THE SEX, GENDER, & COVID-19 PROJECT (Feb. 22, 2021), <https://globalhealth5050.org/the-sex-gender-and-covid-19-project/the-data-tracker/?explore=country&country=USA#search>.

164. See, e.g., Leslie P. Francis & Anita Silvers, *Bringing Age Discrimination and Disability Discrimination Together: Too Few Intersections, Too Many Interstices*, 11 *MARQ. ELDER'S ADVISOR* 139, 140, 148–49 (2009) (exploring differences and similarities between discrimination based on age, disability, sex, and race); Stephanie E. Rogers et al., *Discrimination in Healthcare Settings Is Associated with Disability in Older Adults: Health and Retirement Study 2008-2012*, 30 *J. GEN. INTERNAL MED.* 1413, 1417 (discussing the commonplace issue of age discrimination in health care settings, as one in five adults over the age of fifty experience it); SCOTT BURIS ET AL., *ACCESSING LEGAL RESPONSES TO COVID-19*, at 247 (2020) (noting the history of health disparities experienced by those who are disabled).

165. See *Section 1557 of the Patient Protection and Affordable Care Act*, U.S. DEP'T OF HEALTH & HUM. SERVS. (Feb. 1, 2021), <https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html> (discussing how Section 1557 is an amalgamation of four longstanding anti-discrimination laws, and the interpretation of it remains unclear as various final rules are disputed in court).

As a threshold point, this approach leads to legal protections only for those groups who have overcome collective action problems and gained sufficient political power to have their concerns addressed through legislation.¹⁶⁶ This leaves behind many groups that experience widespread discrimination in health care, such as the poor, the undocumented, and the unhoused.¹⁶⁷ Second, and more important to our inquiry, the separate development of case law and remedies in the four anti-discrimination statutes leads to competition between vulnerable groups and the essentializing of protected classes.¹⁶⁸

Given the different legal remedies available to them based upon the statute under which they typically sue, this itself generates disparities. Without private rights of action and disparate impact claims, some groups will struggle much more than others to tackle systemic discrimination.¹⁶⁹ Importantly, reliance on protected categories can also lead to vulnerable groups and their advocacy organizations being pitted against one another when lobbying for important concerns like prioritizing vaccine distribution during a pandemic.¹⁷⁰ For example, disability groups might be placed in a position to need to fight against policies that are meant to counter ageism, or racial justice groups might need to fight against policies that dilute their cause. This presents challenges to developing overarching anti-discrimination policies that do not result in one marginalized group succeeding at the expense of another.

Additionally, the fractured use of different anti-discrimination statutes may inadvertently essentialize the protected categories of race, sex, disability, and

166. See, e.g., Maura Calsyn et al., *For the Insurance Lobby, Old Habits Are Hard to Break*, CTR. FOR AM. PROGRESS (Feb. 15, 2017, 1:10 PM), <https://www.americanprogress.org/issues/healthcare/news/2017/02/15/415237/for-the-insurance-lobby-old-habits-are-hard-to-break/> (discussing how policymakers were successfully encouraged to include protections for transgender people's care and coverage in the ACA).

167. See April Z. Dawson et al., *Relationship Between Social Determinants of Health and Systolic Blood Pressure in United States Immigrants*, INT'L J. CARDIOLOGY HYPERTENSION, Aug. 2019, at 1, 2 (noting that life course socioeconomic status, immigrant status, and homelessness history can all act as social determinants of health, leading to disparate health outcomes in affected individuals).

168. See MaryBeth Musumeci et al., *The Trump Administration's Final Rule on Section 1557 Non-Discrimination Regulations Under the ACA and Current Status*, KAISER FAM. FOUND. (Sept. 18, 2020), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/the-trump-administrations-final-rule-on-section-1557-non-discrimination-regulations-under-the-aca-and-current-status/> (detailing that federal courts have awarded relief under Section 1557 based on one of the four comprising statutes itself and this, combined with administrative changes to Section 1557's interpretation, can lead to the inconsistent protections for many groups, such as those who are transgender, those seeking abortions, and those with limited English proficiency).

169. See MARIE MERCAT-BRUNS, *DISCRIMINATION AT WORK* 92 (2016); Musumeci et al., *supra* note 168.

170. E.g., Isaac Stanley-Becker & Lena H. Sun, *Covid-19 Is Devastating Communities of Color. Can Vaccines Counter Racial Inequity?*, WASH. POST (Dec. 18, 2020, 12:00 PM), <https://www.washingtonpost.com/health/2020/12/18/covid-vaccine-racial-equity/>.

age. Despite remarkable differences among individuals, a poor Black woman with asthma may just be treated as “Black,” a mother with an immune-compromised child who is uninsured as “female,” and an active, healthy seventy-five-year-old man as simply “old.” The protected classes create important legal entitlements, but the way they are operationalized may lead to reducing individuals to features of their personality that ignore intersectionalities, unique personal histories, and other important clinical factors.

Finally, many different considerations must come into play when considering whether the categories protected from discrimination under Section 1557 do or should protect from discrimination in the same ways. Some health care programs provide funding benefits.¹⁷¹ Others impose burdens or may exclude people from access to care, as crisis care standards might do in the circumstances in which they are invoked.¹⁷² Some forms of health care such as donated organs may be ineluctably scarce, others such as intensive care unit beds may be expanded in dire circumstances, and still others such as funding may require reallocation of resources.¹⁷³ As for the categories, some such as disability will have fluctuating membership, others such as age occur to everyone over the life cycle, and still others such as national origin are immutable.¹⁷⁴ Definitions of some of the categories, such as race, disability, and sex, are contested with social, personal, and biological components.¹⁷⁵ Different histories and experiences of discrimination attend the categories too, as do differences in social structures.¹⁷⁶

171. See generally *What Marketplace Health Insurance Plans Cover*, HEALTHCARE.GOV, <https://www.healthcare.gov/coverage/what-marketplace-plans-cover/> (last visited Feb. 25, 2021).

172. See Catherine L. Auriemma et al., *Eliminating Categorical Exclusion Criteria in Crisis Standards of Care Frameworks*, AM. J. BIOETHICS, 2020, at 28, 31.

173. See *Steep Decline in Organ Transplants Amid COVID-19 Outbreak*, PENN MED. NEWS (May 12, 2020), <https://www.pennmedicine.org/news/news-releases/2020/may/steep-decline-in-organ-transplants-amid-covid19-outbreak>; *How to Increase Hospital Bed Capacity by 20-30 Percent*, GE HEALTHCARE (Apr. 2, 2020), <https://www.gehealthcare.com/article/how-to-increase-hospital-bed-capacity-by-20-30-percent>; Eike-Henner W. Kluge, *Resource Allocation in Healthcare: Implications of Models of Medicine as a Profession*, MEDSCAPE GEN. MED. (2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1925021/>.

174. See *Disability Statistics in the United States*, BUREAU OF INTERNET ACCESSIBILITY (Nov. 29, 2018), <https://www.boia.org/blog/disability-statistics-in-the-united-states>; *Eight Demographic Trends Transforming America's Older Population*, POPULATION REFERENCE BUREAU (Nov. 12, 2018), <https://www.prb.org/eight-demographic-trends-transforming-americas-older-population/>; Sharona Hoffman, *The Importance of Immutability in Employment Discrimination Law*, 52 WM. & MARY L. REV. 1483, 1508 (2011).

175. Helen Meekosha, *What the Hell Are You? An Intercategorical Analysis of Race, Ethnicity, Gender, and Disability in the Australian Body Politic*, 8 SCANDINAVIAN J. DISABILITY RSCH. 161, 172 (2006).

176. ROBERT WOOD JOHNSON FOUND., DISCRIMINATION IN AMERICA 19 (2018).

The pertinent question raised by the interpretation of Section 1557 is whether such differences *should* shape protections against discrimination in health care. For example, should we say that protections against racial discrimination must be more robust than protections against age discrimination because only some members of society bear the burdens of racism, while everyone has the potential to live long enough to bear the burdens of ageism? Or should we say that protections against age discrimination must be less robust than protections against sex discrimination because women bear the burdens of exposure to sexism across a lifetime, while ageism only plays out for a portion of it?

We do not think so. There are, of course, meaningful differences between types of discrimination and even different degrees of exposure to discrimination. But we reject pitting one type of discrimination against another because discrimination by its very nature is wrong regardless of the type or degree. The person with a recent spinal cord injury who must now navigate the world with a wheelchair does not experience “discrimination-lite” compared to someone born with achondroplasia, just because she has not been exposed to discrimination for as long. Likewise, an older patient in a long-term care facility who is not transferred to a hospital despite suffering from symptoms of COVID-19 and a Black man who suffers from a severe case of COVID-19 due to having his diabetes ignored both bear the burdens of harms associated with being a member of a marginalized group. The fact that the older patient’s variant of discrimination only came later in life should not imply that it is ethically or legally more tolerable.

There are certainly normative arguments for discriminating among discriminations. One could advocate for prioritization of vaccine access based on either race, sex, disability, or age, or some combination of these. The groups chosen for prioritization might in turn reflect the outcome that we think most unacceptable—the exacerbation of historical inequities, the creation of new disparate impacts, increased population mortality, or increased transmission of COVID-19. Preventing any of these outcomes would be a worthy goal. However, it is beyond the scope of this Article to identify which outcome would be most deplorable, and then advocate for a policy that mitigates it.

In this Article, we merely seek to highlight uncertainties regarding the current interpretation of Section 1557 of the ACA. These uncertainties have real-world consequences, as some forms of discrimination might be allowed, some might provide private rights of action, and some might require proof of disparate treatment rather than impact. There are many thorny ethical and legal questions that must be addressed in any policy that prioritizes one group’s health at the expense of others.¹⁷⁷ Unfortunately, the existing case law interpreting Section 1557 of the ACA does not answer many of these normative questions for us.

177. See generally Brown, Francis, & Tabery, *supra* note 25, at 13–15.

