



**UNITED STATES
COMMISSION ON
CIVIL RIGHTS**

624 Ninth Street, N.W.
Washington, D.C. 20425

December 11, 2009

President Barack Obama
The Honorable Harry Reid, Majority Leader
The Honorable Mitch McConnell, Republican Leader
The Honorable Richard Durbin, Senate Majority Whip
The Honorable Jon Kyl, Senate Minority Whip
The Honorable Max Baucus, Chairman, Committee on Finance
The Honorable Charles Grassley, Ranking Member, Committee on Finance
The Honorable Thomas Harkin, Chairman, HELP Committee
The Honorable Michael Enzi, Ranking Member, HELP Committee

Dear President Obama and Distinguished Senators:

We write to express our deep reservations about racially discriminatory provisions included in H.R. 3590, the Patient Protection and Affordable Health Care Act (the "Senate Health Care Bill").¹ The impetus behind such provisions appears to be the belief that racial health care disparities are caused by a shortage of medical professionals of particular races and by health workers' lack of "cultural competency." The legislation presumes that addressing those issues will help alleviate disparities. But as Dr. Amitabh Chandra of Harvard University testified at a recent briefing before the U.S. Commission on Civil Rights on health care disparities (and as we explained more fully in our October 9, 2009, letter to the President and members of the House regarding an earlier version of its health care bill),² this view is "grounded in hope more than science."³

No matter how well-intentioned, utilizing racial preferences with the hope of alleviating health care disparities is inadvisable both as a matter of policy and as a matter of law. This is not to suggest that more cannot or should not be done to attract highly qualified physicians and other health care professionals of any race to practice in underserved areas, where they are in short supply and badly needed. But any recruitment, training, or assessment of such health care

¹ The decision to send this letter was arrived at by a notational vote of the United States Commission on Civil Rights conducted on December 10, 2009. The vote was 5-1 (Melendez), with two Commissioners not voting (Thernstrom, Yaki).

The U.S. Commission on Civil Rights was established by the Civil Rights Act of 1957. Civil Rights Act of 1957, P.L. 85-315, § 101(a), 71 Stat. 634, 634 (1957). Among other things, it studies and collects information relating to discrimination or denial of equal protection because of color, race, religion, sex, age, disability or national origin; appraises the laws and policies of the federal government relating to discrimination or denials of equal protection; and serves as a national clearinghouse of information relating to discrimination or denials of equal protection on the basis of protected classifications.

² See U.S. Commission on Civil Rights, Letter to President Obama and Distinguished Members of the U.S. House of Representatives Regarding H.R. 3200, Oct. 9, 2009, which is included as an attachment to this document (hereinafter "Oct. 9, 2009 Letter").

³ A full transcript of the briefing can be found at <http://www.usccr.gov/calendar/trnsrpt/061209ccr2.pdf>.

professionals' qualifications, and any federal funding thereof, must be accomplished without regard to race. The Constitution and sound public policy demand no less.

We direct your attention to our October 9, 2009, letter regarding H.R. 3200 (which is attached) for a more thorough discussion of why smart public policy calls for a serious reassessment of many of the assumptions that underlie both the House and Senate versions of health care reform. In that letter, we cite strong support for the proposition that health care disparities stem not from a lack of medical professionals of particular races or of health professionals' levels of cultural competency, but from the fact that doctors who treat minority patients with frequency are less likely to be highly credentialed and more likely to report obstacles in gaining access to high-quality service for their patients.⁴ We supplement that letter here setting forth our specific concerns with H.R. 3590. They are threefold.

First, H.R. 3590 contains constitutionally suspect provisions similar to those we identified as problematic in H.R. 3200. For example, the bill would authorize the Secretary of Health and Human Services ("HHS") to enter into contracts with or award grants to eligible institutions of higher education that operate a range of professional training programs for medical service providers, including primary care physicians⁵ and dentists,⁶ along with social workers, psychologists and other mental health professionals.⁷ In each case, the provisions in question appear designed to ensure that the institutions of higher education that train health professionals at all levels (i.e., undergraduate, graduate, postgraduate, etc.) grant preferential treatment in admissions to members of underrepresented minorities on the basis of race (as well as national origin, sex, sexual orientation and religion, in one case).⁸ Failure to do so could hamper these institutions' ability to compete for federal grants and contracts or even render them ineligible.

For example, the Senate Health Care Bill authorizes the Secretary of HHS to make contracts with or award grants to accredited schools of medicine or osteopathic medicine that train primary care providers, giving "priority" to institutions that "have a record of training individuals who are from underrepresented minority groups or from a rural or disadvantaged background."⁹ Identical "priority" language is used elsewhere in the bill in the context of the

⁴ See Oct. 9, 2009 Letter at 2-4, nn.10-17.

⁵ Patient Protection and Affordable Health Care Act, H.R. 3590, 111th Cong. § 5301 (amending Part C of Title VII of the Public Health Service, 42 U.S.C. § 293k et seq., to include a new § 747, under the title, "Primary Care Training and Enhancement") (hereinafter referred to as "§747").

⁶ *Id.* § 5303 (amending Part C of Title VII of the Public Health Services Act, 42 U.S.C. § 293k et seq., to include a new §748, under the title, "Training in General, Pediatric, And Public Health Dentistry") (hereinafter referred to as "§ 748").

⁷ *Id.* § 5306 (amending Part D of Title VII of the Public Health Services Act, 42 U.S.C. § 294 et seq., to include a new §756, under the title, "Mental and Behavioral Health Education and Training Grants.") (hereinafter referred to as "§ 756").

⁸ See, e.g., *id.* § 756(b)(1).

⁹ *Id.* § 747(b)(3)(D).

Secretary's authorization to award grants to or make contracts with institutions that train general, pediatric and public health dentists.¹⁰ Those that train social workers, psychologists, and other behavior and mental health service providers face an even higher bar to the receipt of federal funding. Such institutions are ineligible for federal funding unless they can demonstrate "participation in the institutions' programs of individuals and groups from different racial, ethnic, cultural, geographic, religious, linguistic, and class backgrounds, and different genders and sexual orientations"¹¹ and "knowledge and understanding of the concerns" of those individuals and groups.¹²

But these terms are constitutionally suspect and ill-defined. For instance, the bill does not define what constitutes a "record of training," giving potential grantees and contractors every incentive to give preferential treatment to applicants who are members of "underrepresented minority groups." Nor does it set forth how covered institutions are to demonstrate "knowledge and understanding of the concerns" of members of the listed groups. We urge Senators to reject the view that a student's race, sex or ethnicity is a valid proxy or measure of his or her concerns, experiences, outlook or ideas, or that an individual of one race, sex or ethnicity instinctively knows or necessarily shares the same concerns of other members of his or her group. In fact, the foundation of antidiscrimination law rests on just the opposite presumption—that an individual's views, merits or qualifications cannot and should not be judged by reference to his or her group status. Likewise, a common race, gender or ethnicity does not render an individual the spokesperson for his or her respective group. Some may argue that professionals in the mental health services context, in particular, must be able to demonstrate a greater degree of empathy towards and understanding of their patients, whatever the patient's background, race, ethnicity, etc., and we do not suggest otherwise. We simply argue that shared racial, ethnic or gender identity is not a reliable indicator or predictor of these abilities.

Some of the Senate Health Care Bill's provisions with regard to protecting elders from abuse in long-term health care facilities, such as nursing homes, are equally problematic. For example, § 2046(b)(3), which adds a new section to the Social Security Act, appears to grant the HHS Secretary the discretion to penalize elder abuse and other crimes committed against residents of long-term health care facilities less stringently in rural facilities, those that serve racial and ethnic minorities, patients with limited language proficiency, and those with special needs, such as the disabled.¹³ The provisions at issue place a mandatory reporting obligation upon owners, operators, employees, managers, agents or contractors of long-term health care

¹⁰ *Id.* § 738(c)(3) ("With respect to training provided for under this section, the Secretary shall give priority in awarding grants or contracts to the following: . . . (3) Qualified applicants that have a record of training individuals who are from a rural or disadvantaged background, or from underrepresented minorities.").

¹¹ *Id.* § 756(b)(1).

¹² *Id.* § 756(b)(2).

¹³ Senate Health Care Bill § 2046(b)(3) (amending Part A of Title XI of the Social Security Act, 42 U.S.C. § 1301 et seq.) to include a new § 1150B, entitled, "Reporting Of Crimes In Federally Funded Long-Term Care Facilities.") (hereinafter referred to as "§ 1150B.").

facilities receiving \$10,000 or more in federal funds to report reasonable suspicion of crimes committed against residents or those receiving care by the facility to the appropriate law enforcement authorities within prescribed times.¹⁴

Violations of the reporting requirement subject the covered individuals to civil monetary penalties totaling anywhere from \$200,000 to \$300,000 and exclusion from federally funded health care programs, as determined by the HHS Secretary.¹⁵ Entities employing persons excluded from federally funded program participation are ineligible to receive any federal funding for health services programs themselves, until such time as the individual is no longer excluded.¹⁶ However, the HHS Secretary is granted the discretion to waive the financial burdens of the reporting requirement penalty “on providers with underserved populations.”¹⁷ “Underserved populations” are defined as those facing a lack of elder justice programs such as those living in rural areas, racial and ethnic minority populations, and those “underserved because of special needs” such as individuals or groups with language barriers, disabilities, alien status or age.¹⁸

When taken together, these provisions permit a separate and unequal operating standard for long-term health care facilities that serve racial and ethnic minorities, with the possibility that their residents will not be afforded the same levels of protection against abuse and other crimes as residents of nursing homes that have larger non-minority populations. Nursing home administrators operating in underserved areas (with racial and ethnic minority populations, financial challenges and limited resources) would have less of an incentive to enforce the strict reporting requirements set forth in this section of the bill without the threat of serious penalties for noncompliance. While it is highly unlikely that the drafters intended this result, this is a prime example of the dangers of defining the benefits or burdens of a particular piece of legislation with regard to race.

Finally, the bill creates a federally-funded and administered medical school—the United States Public Health Sciences Track (the “Track”)—and directs the Surgeon General to devise racially preferential admissions policies for the program.¹⁹ If experience is any predictable guide, both the Surgeon General administering the federal medical school program and the

¹⁴ *Id.* § 1150B(a)-(b).

¹⁵ *Id.* § 1150B(c)(1)-(2).

¹⁶ *Id.* § 1150B(c)(3).

¹⁷ *Id.* § 1150B(4).

¹⁸ *Id.* § 1150B(4)(B)(i)-(iii).

¹⁹ *Id.* § 5315 (amending Title II of the Public Health Service Act, 42 U.S.C. § 202 et seq. by adding a new Part D—United States Health Sciences Track) at §273(a)(2) (“In developing admissions procedures under paragraph (1), the Surgeon General shall ensure that such procedures give priority to applicant medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students from rural communities and underrepresented minorities.”).

medical institutions vying for federal dollars discussed earlier in this letter will likely read these “priority” provisions as a demand to apply less demanding academic standards to their minority applicants.²⁰ But race-based attempts to achieve some ill-defined “critical mass” of minority students or to demonstrate a “sufficient” record of training such students are constitutionally suspect. Furthermore, use of such procedures obscures what even proponents of racial preferences admit—that racial disparities in performance are already present at the precollege level and success at alleviating those “would eventually provide a national pool of students whose academic preparation for medical school (and health professions study) would not be distinguished by race or ethnicity.”²¹

As we noted in our October 9, 2009 letter, it is generally illegal for the government to show favoritism or even use classifications based on race, ethnicity, or sex.²² Indeed, such classifications and favoritism are “presumptively invalid.”²³ All governmentally-imposed racial classifications trigger strict scrutiny—a highly demanding standard of review. To withstand this level of review, a racial classification must be necessary to serve a compelling state interest and must be narrowly drawn to serve that end.²⁴ The standard of review under the Fifth and Fourteenth Amendments is the same regardless of the race of those burdened or benefited by a

²⁰ In *Grutter v. Bollinger*, 539 U.S. 306 (2003), the Court acknowledged that, given the widespread use of racially preferential admissions policies, the University of Michigan Law School had no choice but to engage in such policies if it wished to attract a racially diverse law school class. *Id.* at 340. Similarly, we believe that the Court would acknowledge that, given the widespread use of heavy preferences for minority students in medical schools, a medical school that wished to maintain a “record of training individuals who are from underrepresented minority groups” would have to engage in racially preferential admissions policies.

The educational benefits of diversity will likely not justify racial preferences by Congress. *Grutter* upheld the University of Michigan Law School’s ability to adopt certain, limited kinds of racially-preferential admissions policies, but cannot be relied upon to justify the Senate Health Care Bill’s racially discriminatory provisions. Although the University of Michigan was able to overcome the overwhelming presumption against state-sponsored race discrimination without concrete evidence of the benefits of diversity, it did so in the narrow context of academic freedom. Justice Sandra Day O’Connor, writing for the five-member majority, stated that “universities occupy a special niche in our constitutional tradition.” *Id.* at 329. In the majority’s view, universities are entitled to special deference in their academic judgments. As Justice O’Connor put it, “the freedom of a university to make its own judgments ... includes the selection of its student body.” *Id.* at 329 (quoting *Univ. of Calif. Regents v. Bakke*, 438 U.S. 265, 312 (Powell, J.)). Whatever the merits of this reasoning, it doesn’t apply to Congress. Congress is a political institution, not an academic one; it is not entitled to deference to its academic judgments. It cannot avoid the full burden of the strict scrutiny standard. A legislature is precisely the kind of institution academic freedom is supposed to protect colleges and universities from. If anything, *Grutter* imposes even greater burdens on non-academic entities, like Congress, who attempt to impose racial classifications on academic entities than the strict scrutiny standard alone would have imposed.

²¹ See, e.g., Jordan J. Cohen, Barbara A. Gabriel, and Charles Terrell, *The Case for Diversity in the Health Care Workforce*, 21(5) HEALTH AFF. 90, 99 (2002).

²² See *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 227 (1995) (“all racial classifications ... must be analyzed by a reviewing court under strict scrutiny”); *Mississippi Univ. for Women v. Hogan*, 458 U.S. 718 (1982) (gender classifications require an “exceedingly persuasive justification”).

²³ See *Personnel Admin. v. Feeney*, 442 U.S. 256 (1979)).

²⁴ *Adarand*, 515 U.S. at 227.

particular classification.²⁵ Furthermore, narrow tailoring requires the consideration of race-neutral means of achieving stated goals before resorting to race-conscious ones.²⁶ In the event that race-conscious means are required to eradicate the effects of past intentional discrimination, such means must last no longer than necessary to do so.²⁷

It is unlikely that the Senate Health Care bill's racial classifications, as described above, would survive legal scrutiny. The strong weight of the evidence is against the proposition that racially preferential admissions policies can help solve the health care disparity problem. Consequently, that purpose cannot fulfill the requirements of strict scrutiny. Unless Congress has concrete evidence that these provisions are likely to accomplish some other compelling purpose, they will likely be held unconstitutional.²⁸

The fact that similar preference provisions may already exist in statutes such as the Health Professions Education Partnership Act,²⁹ as some proponents of the health care legislation point out, does not place either the past legislation or current proposals on solid legal footing. On the contrary, the existence of repetitive legislation undermines both the need and rationale for these newer racially discriminatory provisions and poses serious questions about their efficacy at accomplishing the legislation's goals.³⁰

²⁵ *Id.* at 222 (citing *Richmond v. J.A. Croson Co.*, 488, U.S. 469, 494 (“[T]he standard of review under the Equal Protection Clause is not dependent on the race of those burdened or benefited by a particular classification.”)).

²⁶ *Grutter*, 539 U.S. at 339 (Narrow tailoring requires “serious, good faith consideration of workable race-neutral alternatives. . .”).

²⁷ *Adarand*, 515 U.S. at 238.

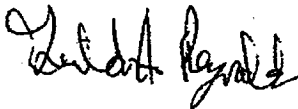
²⁸ If the point is to ensure the “right proportion” of minority health care professionals for its own sake, then it is surely unconstitutional. As Justice Lewis Powell put it in *Bakke*, that would be “discrimination for its own sake. This the Constitution forbids.” 438 U.S. at 307 (Powell, J.). Instead, the use of preferences can be justified only if there is an interest beyond the desire for a particular racial mix.

²⁹ Health Professions Education Partnership Act of 1998, 42 U.S.C. § 293 (1998). The preferences in this Act have never been challenged in court and have not been subject to judicial scrutiny.

³⁰ There is little to point to in the way of data demonstrating that health professions programs funded under Title VII of the Public Health Services Act are achieving their goals of producing more, diverse medical health professionals to serve in underrepresented areas. *See, e.g.*, General Accountability Office, GAO-06-55, Health Professions Education Programs: Action Still Needed to Measure Impact (Feb. 2006). A top official of the Health Resources and Services Administration (“HRSA”), the branch of HHS that administers Title VII programs, admitted as much during Senate testimony just last year. *See Addressing Healthcare Workforce Issues for the Future: Hearing Before the Senate Health, Education, Labor and Pensions Committee*, 110th Cong. (Feb. 13, 2008) (Statement of Marcia Brand, Ph.D., Associate Administrator, HRSA). In her testimony, Associate Administrator Brand cited GAO conclusions in both 1994 and 1997 that “the role of the Title VII Health Professions programs in improving access was unclear” and that “the large number of Title VII program objectives made evaluating the programs’ impacts difficult”; she further noted that, in its 2006 report, “GAO found that action was still needed to successfully measure the impact of Title VII programs” through the use of clear, relevant goals and performance measures backed by timely and complete data. *Id.*

Ensuring that all Americans, regardless of race, have access to quality health care requires both creativity and hard-nosed attention to data. It also requires staying within the requirements of the Constitution. The current race-based provisions of the Senate Health Care bill display none of those qualities. We urge Congress to re-examine those provisions and focus on proven methods of improving health care outcomes for minority patients and attracting the best quality health professionals to underserved communities.

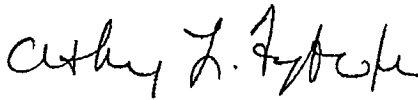
Respectfully submitted,



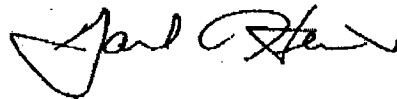
Gerald A. Reynolds
Chairman



Peter N. Kirsanow
Commissioner



Ashley L. Taylor, Jr.
Commissioner



Gail Heriot
Commissioner



Todd F. Gaziano
Commissioner

Attachment

cc: Abigail Thernstrom, Vice Chairman
Arlan Melendez, Commissioner
Michael Yaki, Commissioner