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Health Reform Reconstruction

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This Article connects the failed, inequitable U.S. coronavirus pandemic response to conceptual and structural constraints that have held back U.S health reform for decades and calls for reconstruction. For more than a half-century, a cramped "iron triangle" ethos has constrained health reform conceptually. Reforms aimed to balance individual interests in cost, quality, and access to health care, while marginalizing equity, solidarity, and public health. In the iron triangle era, reforms unquestioningly accommodated four legally and logistically entrenched fixtures — individualism, fiscal fragmentation, privatization, and federalism — that distort and diffuse any reach toward social justice. The profound racial disparities and public health failures of the U.S. pandemic response have agonizingly manifested the limitations of pre-2020 health reform and demand a reconstruction.

Health reform reconstruction begins with a new conceptual framework that aims to realize health justice. Health justice requires commitments to anti-racism, equitable distribution of the burdens and benefits of public investments in health care and public health (for which health care access, quality, and cost are useful, but not exhaustive, metrics), and community empowerment. These commitments put health justice on a collision course

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with the fixtures of individualism, fiscal fragmentation, privatization, and federalism. Thus, incremental reforms must be measured by the extent to which they confront these fixtures. This Article describes how health reform reconstruction can chart the path for legal change and proposes "confrontational incrementalism" as a method for recognizing the necessity of reconstructive reform, along with its near impossibility.

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INTRODUCTION

Post-2020, it is no longer tenable for health care reform to accommodate the individualistic, fragmented, privatized mess that passes for a health system in the United States.[1] The conscience-shocking scale of death and devastation wrought by the COVID pandemic in the wealthiest country in the world is a fiasco — a consequence of human failures compounding a natural disaster.[2] Governments at every level failed to discharge their core obligations to protect the people's health and welfare.[3] Worse, communities of color bore the brunt of death and suffering, due to the existential failure of past reforms to rectify the racism, economic injustice, and other forms of subordination (the systematic oppression of one social group to the benefit of another) baked into the American legal and health systems.[4]

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[1] *See* Erin C. Fuse Brown, Matthew B. Lawrence, Elizabeth Y. McCuskey & Lindsay F. Wiley, *Social Solidarity in Health Care, American-Style*, 48 J.L. MED. & ETHICS 411, 411 (2020) (describing four fixtures of the US legal and health care systems that have prevented the achievement of social solidarity: federalism, fiscal pluralism, privatization, and individualism). In this Article, we use the term "health system" to describe the ideal in which public health and health care are integrated into a single system, "[t]he defining goal" of which "is to improve the health of the population." Christopher J.L. Murray & Julio Frenk, *A Framework for Assessing the Performance of Health Systems*, 78 BULL. WORLD HEALTH ORG. 717, 719 (2000). We use the term "health care system" to describe the current U.S. system of health care financing and delivery, in which health care providers, insurers, financers, and regulators are largely insulated from being measured according to their ability to improve the public's health. *See* WILLIAM L. KISSICK, MEDICINE'S DILEMMA'S: INFINITE NEEDS VERSUS FINITE RESOURCES 2-3 (1994).

[2] *See* Alexandra Ellerbeck, *The Health 202: Here's How the U.S. Compares to Other Countries on the Coronavirus Pandemic*, WASH. POST (Apr. 12, 2021, 7:52 AM EDT), https://www.washingtonpost.com/politics/2021/04/12/health-202-here-how-us-compares-other-countries-coronavirus-pandemic/ [https://perma.cc/A53K-VV45] (surveying statistical measures of COVID-19 impacts in the US and comparing them to measures from similarly situated countries).

[3] *See* Lindsay F. Wiley, *Democratizing the Law of Social Distancing*, 19 YALE J. HEALTH POL'Y., L. & ETHICS 50, 68-79 (2020) [hereinafter *Social Distancing*] (documenting the U.S. response to the COVID pandemic); Elisabeth Rosenthal, *Some Said the Vaccine Rollout Would Be a 'Nightmare.' They Were Right.*, N.Y. TIMES (Dec. 23, 2020), https://www.nytimes.com/2020/12/23/opinion/vaccine-distribution.html [https://perma.cc/XG4H-UTDF] ("[I]t turns out that getting fuel, tanks and tents into war-torn mountainous Afghanistan is in many ways simpler than passing out a vaccine in our privatized, profit-focused and highly fragmented medical system.").

[4] *See* Emily A. Benfer, Seema Mohapatra, Lindsay F. Wiley & Ruqaiijah Yearby, *Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Disparities During and After COVID-19*, 19 YALE J. HEALTH POL'Y, L. & ETHICS 122, 124-27, 129-35 (2020) (surveying literature on disparities in COVID infection, severe illness and death and connecting disparities to racism, poverty, and other forms of

The health care system was not the only — or even the most important — social determinant of the failed pandemic response in the United States.[5] Risks associated with employment, housing, and other factors were critical,[6] as were failures of leadership, law, and policy. An equitable system for health care delivery and financing is thus a necessary but insufficient requirement for a successful pandemic response.

It has been clear for decades that the U.S. health system is broken, but the sheer scale of injustice during the pandemic has made it impossible to pretend that haphazardly incremental reforms will be adequate. With

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subordination); Angela P. Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758, 762 (2020) (arguing that "[s]ubordination based on markers of social stigma such as race, gender, sexuality, and class is chief among the structural forces creating unjust access to health-promoting opportunities and resources" and explaining choice to use the term *subordination* rather than *oppression* "in recognition of the legal literature distinguishing antisubordination from anticlassification approaches to the Equal Protection Clause"); Ruqaiijah Yearby & Seema Mohapatra, *Systemic Racism, the Government's Pandemic Response, and Racial Inequities in COVID-19*, 70 EMORY L.J. 1419, 1428-31 (2021) (describing the influence of systemic racism on racial inequities during the COVID pandemic).

[5] *See* Benfer et al., *supra* note 4, 130-36 (describing the impact of health care and other social determinants of health on racial disparities during the COVID pandemic).

[6] Access to health care is "one among many social determinants of health." Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J.L. & PUB. POL'Y 47, 53 (2014) [hereinafter *Social Justice*]. The social determinants of health "encompass[] the full set of social conditions in which people live and work" including both the "structural determinants of health inequities" and "the more immediate determinants of individual health." ORIELLE SOLAR & ALEC IRWIN, WORLD HEALTH ORG., A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 9 (2010), https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf [https://perma.cc/AT3W-JKSU]. The structural determinants of health inequities include "social and political mechanisms that generate, configure and maintain social hierarchies," while the more immediate determinants of individual health include "material circumstances; psychosocial circumstances; behavioral and/or biological factors; and the health system itself." *Id.* at 5-6; *see* UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 35 (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., 2003), https://doi.org/10.17226/12875 [https://perma.cc/7TRU-YE7P] [hereinafter UNEQUAL TREATMENT] (noting that universal health care is "necessary but insufficient in and of itself to address racial and ethnic disparities in healthcare"); William M. Sage & Jennifer E. Laurin, *The Medicalization of Poverty: If You Would Not Criminalize Poverty, Do Not Medicalize It*, 46 J.L. MED. & ETHICS 573, 573 (2018) ("Both federal and state actors under-invest in education and neglect non-medical social services while massively indulging in overpriced, often ineffective medical care—a skew that is particularly bad for the poor. . . . [L]aw helped create and now perpetuates this gross misallocation of social resources."); *see, e.g.*, Benfer et al., *supra* note 4 (tracing racial, ethnic, and socioeconomic disparities in COVID to disparities in housing, employment, and health care).

this knowledge, it is not enough to renew our commitment to pre-2020 health reform principles. The "iron triangle" — health care access, cost, and quality — that has informed a half-century of reforms lacks the ambition and scope to guide our next steps. We must reconstruct health reform, and ultimately the health system, using new principles and a new method. Incremental reforms may be unavoidable but they must be designed to be *intentionally confrontational*, with an eye toward their place in the broader project of upending or transcending the legal structures that undermine public health and propagate subordination and inequity.

The thesis of this Article is that decades of reforms failed to prepare the United States for 2020 because health reform has been conceptually and structurally constrained and to transcend these constraints requires nothing short of reconstruction.[7]

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[7] Casting the project of overcoming and replacing the conceptions and structures that have defined and constrained health reform as a *reconstruction* recognizes three dimensions of the term: first, its definition, "to construct again" especially after severe damage, captures our argument that the U.S. system is even more damaged after the pandemic and requires rebuilding with a new ethos for a new age. *See Reconstruct*, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/reconstruct (last visited Aug. 21, 2021) [https://perma.cc/BU2Q-AX5L]. Second, its medical meaning contemplates surgical restoration of function in a body part, also after damage or to correct structural defects. *See, e.g.*, *Reconstructive Surgery*, WEBMD, https://www.webmd.com/a-to-z-guides/reconstructive-surgery (last visited Aug. 24, 2021) [https://perma.cc/C67M-P9KG] (describing reconstructive surgery in the clinical sense). Third, the anti-subordination valence of our argument makes normative claims about the transformative reforms necessary to address the effects of systemic racism. It thus draws normative perspective from the post-Civil War Reconstruction period and Civil Rights movement (often referred to as the Second Reconstruction), as well as the laws and critical theory that have grown out of them. *Cf., e.g.*, Rhonda V. Magee Andrews, *The Third Reconstruction: An Alternative to Race Consciousness and Colorblindness in Post-Slavery America*, 54 ALA. L. REV. 483, 486 (2003) ("A fully reconstructed America must necessarily commit to redressing the myriad present-day harms that result from the legacy and contemporaneous manifestations of racialist thought and policy."); Richard Thompson Ford, *Rethinking Rights After the Second Reconstruction*, 123 YALE L. J. 2942, 2949-50 (2014) (describing civil rights and anti-discrimination law as part of the Second Reconstruction); Angela P. Harris, *Foreword: The Jurisprudence of Reconstruction*, 82 CALIF. L. REV. 741, 765 (1994) (describing "reconstruction jurisprudence" as "committed to transforming . . . paradigms as well as criticizing them," and embodying reference to "the legacy of slavery in the New World and the unfinished revolutions of the First and Second Reconstructions"); Jeneen Interlandi, *Why Doesn't the United States Have Universal Health Care? The Answer Has Everything to Do with Race*, N.Y. TIMES (Aug. 14, 2019) https://www.nytimes.com/interactive/2019/08/14/magazine/universal-health-care-racism.html [https://perma.cc/RY8U-NSGS] (tracing the history of the U.S. health system from the post-Civil War Reconstruction era to the present day and noting that "[d]isparity is built into the system"); Vann R. Newkirk II, *America's Health Segregation Problem*, ATLANTIC (May 18,

We develop the project of health reform reconstruction by drawing four vital lessons from the pandemic — a pair of normative lessons bookending a pair of constructive lessons. First, health justice must replace the long-dominant but conceptually blinkered iron triangle. Second, legally and logistically entrenched fixtures of individualism, fiscal fragmentation, federalism, and privatization constrain health reform even when it reaches toward health justice, as it has done at times during the pandemic. Third, each of these fixtures reinforces and stems from racism and other forms of social subordination. Fourth, to make meaningful progress toward health justice, even incremental reforms must confront or transcend the fixtures that have constrained reform for decades.

The first lesson we draw from the pandemic is that health reform requires new principles rooted in solidarity, equity, and justice. In Part I, we argue that 2020 should mark the end of what we call "the iron triangle era" of health reform, dating back to the 1960s, in which reforms sought to balance three points: access to, quality of, and costs of medical care. Over time, the iron triangle's mode of pragmatic tradeoffs created a piecemeal approach to health care regulation that culminated in the Affordable Care Act.

2016), https://www.theatlantic.com/politics/archive/2016/05/americas-health-segregation-problem/483219/ [https://perma.cc/PJA4-KM5G] (tracing the history of de facto and de jure racial segregation in health care from the Jim Crow era to today). We recognize that reconstruction efforts come with trenchant backlash. *See generally* Keith Aoki, *The Scholarship of Reconstruction and the Politics of Backlash*, 81 IOWA L. REV. 1467, 1468 (1996) (describing backlash as "vituperative and largely unconscious reaction to the social progress" of marginalized communities); Ford, *supra*, at 2949 ("The Supreme Court has used individual rights to undermine much of the practical work of the Second Reconstruction . . . ."); Harris, *supra*, at 758 (noting the "political backlash against feminism and civil rights"). In health reform, even the modest, market-based ACA has already sparked backlash. *See, e.g.*, Jonathan Cohn, *The ACA, Repeal, and the Politics of Backlash*, HEALTH AFFS. BLOG (Mar. 6, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200305.771008/full/ [https://perma.cc/A22T-TWRD] (tracing the political backlash during the first decade after the ACA's enactment). So acknowledging that the backlash to health reform is inevitable, we argue that such reform should at least aim for a reconstruction. For an early use of "reconstruction" with respect to health reform, see Ed Sparer, *Fundamental Human Rights, Legal Entitlements, and the Social Struggle: A Friendly Critique of the Critical Legal Studies Movement*, 36 STAN. L. REV. 509, 551 (1984) ("[T]he very struggle to reconstruct health care, organized along mutual aid lines which stress cooperative and caring relations, helps to provide a grace . . . and character to society and to each person who struggles for it."). Harris & Pamukcu, *supra* note 4. On the legacies of slavery, segregation, and civil rights in health care, consider DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE 9-32 (NYU Press 1st ed. 2015).

To guide post-2020 health reform, we propose a new set of principles oriented toward realizing health justice and social solidarity in health care.[8] Justice and social solidarity have long been core values of *public health* law, policy, practice, and ethics[9] — albeit "still largely aspirational" ones.[10] We aim to integrate them as core values of *health care* law and policy. Health justice demands that reformers address the role of health care laws and policies in reinforcing — or, alternatively, dismantling — racism, economic injustice, and other forms of social subordination. Reformers must ensure equitable distribution of the benefits and burdens of robust public investments in health care and public health, measured in terms of population-level health outcomes and community wellbeing, in addition to the intermediate indicators of health care access, quality, and cost. Decision-making processes related to health must ensure recognition, representation, and empowerment of subordinated individuals and communities. In short, health care regulation should embrace *public health* principles and strive for anti-subordination, equity, and community empowerment, expanding far beyond the cramped iron triangle.

The second, related lesson we draw from the pandemic is that health reform has been structurally constrained by fixtures that impede solidarity and egalitarian justice. In Part II, we describe how the U.S. response to the COVID pandemic was stymied by four fixtures: individualism, fiscal fragmentation, federalism, and privatization. These fixtures, which we identified in a prior collaboration,[11] hold back mutual aid in the U.S. health care system, causing the system to function particularly poorly under the stress of a national public health crisis. Our individualistic, multi-payer, state-by-state, privately-administered health care system, in which health care entities are insulated from

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[8] *See* WILLIAM M. SAGE, SOLIDARITY: UNFASHIONABLE, BUT STILL AMERICAN 10 (2009); Fuse Brown et al., *supra* note 1, at 411-12; Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 CONN. INS. L.J. 199, 205 (2008); Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287, 290 (1993); Lindsay F. Wiley, *From Patient Rights to Health Justice: Securing the Public's Interest in Affordable, High-Quality Health Care*, 37 CARDOZO L. REV. 833, 859 (2016) [hereinafter *Health Justice*].

[9] *See, e.g.*, Lawrence O. Gostin & Madison Powers, *What Does Social Justice Require for the Public's Health? Public Health Ethics and Policy Imperatives*, 25 HEALTH AFFS. 1053, 1053 (2006) ("Justice is viewed as so central to the mission of public health that it has been described as the field's core value . . . .").

[10] Lindsay F. Wiley & Samuel R. Bagenstos, *The Personal Responsibility Pandemic: Centering Social Solidarity in Public Health and Employment Law*, 52 ARIZ. STATE L.J. 1235, 1237 (2020).

[11] Fuse Brown et al., *supra* note 1, at 414-17.

public health responsibilities, failed to support the medical countermeasures that are critical in a communicable disease crisis — including testing, therapeutics, and vaccination.[12] Our inability to distribute scarce resources in ways that maximize collective benefits has undermined the effectiveness of the pandemic response, representing a functional failure of the health care system.

An embedded lesson here is that individualism, fiscal fragmentation, federalism, and privatization are more than mere features of American health law. They are gravitational. We describe these structures conceptually as *fixtures* because they are legally and logistically entrenched. They are rooted in a constellation of constitutional provisions, laws, institutions, economic arrangements, and cultural and ideological commitments, rather than a single law.[13] Agencies, companies, workforces, relationships, and economies are built around the fixtures.

The third lesson we draw from the pandemic is that the fixtures of individualism, fiscal fragmentation, federalism, and privatization have contributed to a failure of American health care so profound we describe it as existential: stark racial inequity in the burden of disease. In Part III, we describe how each of the fixtures is historically rooted in and perpetuates racism, thereby subverting health equity and community empowerment. Because the fixtures have played historic and inherent roles in creating and reinforcing subordination, reforms accommodating them will continue to perpetuate racial injustice. The

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[12] Medical countermeasures have a dual purpose. They are used for clinical purposes (diagnosis and treatment of individuals), distinguishing them from "non-pharmaceutical interventions" such as mask mandates, school closures, and business restrictions. But medical countermeasures also serve public health purposes. For example, testing is both a tool for individual diagnosis as well as a tool of public health surveillance and disease control. Vaccination has benefits for the vaccinated individual as well as for others who may be protected by reduced transmission. A robust and comprehensive pandemic response requires both clinical interventions for the benefit of individuals and public health interventions for the common good. LAWRENCE O. GOSTIN & LINDSAY F. WILEY, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 346, 392 (3d. ed. 2016) (describing the role of medical countermeasures in public health surveillance and disease control, and contrasting medical countermeasures for pandemic response with non-pharmaceutical interventions). As this Article focuses on the failures of the U.S. health care system, our analysis focuses on the medical interventions that system is expected to deliver, rather than on non-pharmaceutical interventions.

[13] The concept of a *fixture* is thus related to the concept of "super-statutes" in its description of entrenchment, but distinct in the origins and effects of that entrenchment. *See generally* William N. Eskridge, Jr. & John Ferejohn, *Super-Statutes*, 50 DUKE L.J. 1215, 1215, 1230-37 (2001) (describing "super-statutes" as singular statutory enactments that "successfully penetrate public normative and institutional culture in a deep way").

accommodative stance of iron-triangle reforms has become untenable for reformers who are committed to anti-racism. The existential failures during the pandemic thus demand a more confrontational approach to the fixtures in future reforms.

The fourth lesson we draw from the pandemic is that implementing reform requires a new method. In Part IV, we offer an approach for operationalizing our bolder health justice reform principles within a system still constrained by the fixtures. We call this method *confrontational incrementalism*. Its end goal is to reconstruct health reform by dismantling the legal structures that hold it back. Its approach acknowledges the difficulty of that task, owing to the fixtures' entrenchment.

Reforms can reconcile ambition with pragmatism by identifying whether an incremental policy change serves as a stepping stone or stumbling block for confronting the fixtures that stymie health justice. Although incremental, this approach to the fixtures promotes vigilance about the accumulated effects of reforms that accommodate, rather than confront them. It provides an assessment of each incremental reform's confrontation with the fixtures based on its contribution to anti-racism, equitable distribution, and community empowerment. Ultimately, confrontational incrementalism demands more attention to the tradeoffs and accumulated accommodations that come with incrementalism, as well as to the ways that incremental accommodations to the fixtures perpetuate subordination. Confrontational incrementalism thus offers a navigational tool for getting us closer to realizing the ambitious goals of health justice. By elucidating the concept of *fixtures* and providing a method for health reforms to confront them, we hope to provide reformers who focus on other areas — the criminal justice system, drug policy, environmental regulation, the education system, housing, and employment, to name a few — with a navigational tool for crafting and assessing anti-racist reform efforts rooted in solidarity and community empowerment.

The project of health reform reconstruction may seem overwhelming, especially because it starts with a recognition of the potency and stickiness of obstacles to health justice in the United States. We draw hope, however, in the fact that scholars and advocates are already laying the groundwork for reconstruction as we understand it. Angela Harris's & Aysha Pamukcu's recent call for the development of a civil rights of health, rooted in health justice, is a bold example of confrontational incrementalism targeted directly at individualism and its perverse

implications for both health and subordination.[14] In prior work, each of us has proposed pragmatic reforms that, upon reflection, also show particular promise in the ways they confront the structural fixtures of individualism, fragmentation, privatization, or federalism.[15] Some policymakers have shown nascent interest in such proposals.[16] Linking together these efforts as part of the larger project of health reform reconstruction provides new direction, motivation, and a framework for not only recognizing structural bias in our law but doing something about it.

I. LESSON 1: HEALTH REFORM RECONSTRUCTION REQUIRES A NEW ETHOS

Generations of health reform advocates and health care scholars across disciplines have warned that the U.S. health care system has serious deficiencies.[17] Many have acknowledged that it is, more

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[14] Harris & Pamukcu, *supra* note 4, at 765.

[15] *See* Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. PA. L. REV. 389, 452-59 (2020) (proposing ERISA waiver that would erode federalism and privatization); Matthew B. Lawrence, *Fiscal Waivers and State "Innovation" in Health Care*, 62 WM. & MARY L. REV. 1477, 1544-47 (2021) (proposing waiver pathway to facilitate sharing of federal savings between states and federal government, bridging fragmented fiscal categories); Lindsay F. Wiley, *Medicaid for All?: State-Level Single-Payer Health Care*, 79 OHIO STATE L.J. 843, 889 (2018) (exploring state-based single payer reforms with potential to erode individualism and privatization).

[16] *E.g.*, Press Release, Nat'l Council of Ins. Legislators, NCOIL Passes Resolution to Amend ERISA (Mar. 28, 2019), http://ncoil.org/2019/03/28/ncoil-passes-resolution-to-amend-erisa [https://perma.cc/NS5C-QSGT] (adopting McCuskey and Fuse Brown's proposal to create and ERISA waiver for state health reform).

[17] *See* Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 UC DAVIS L. REV. 255, 258 (1990) ("The health care system in the United States is plagued with serious distributional inequalities . . . ."). *See generally, e.g.*, STEPHEN M. DAVIDSON, STILL BROKEN: UNDERSTANDING THE U.S. HEALTH CARE SYSTEM 10 (2010) (saying, "the U.S. health care system is broken"); LAWRENCE R. JACOBS & THEDA SKOCPOL, HEALTH CARE REFORM AND AMERICAN POLITICS: WHAT EVERYONE NEEDS TO KNOW 17-30 (2010) (same); TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK 1 (2007) (describing the U.S. health care system as "broken"); UWE E. REINHARDT, PRICED OUT: THE ECONOMIC AND ETHICAL COSTS OF AMERICAN HEALTH CARE, at XXVIII (2019) (describing the U.S. system of health care financing system as the "bogeyman of health policy — as an example of how *not* to structure a nation's health system"); ELISABETH ROSENTHAL, AN AMERICAN SICKNESS: HOW HEALTHCARE BECAME BIG BUSINESS AND HOW YOU CAN TAKE IT BACK 8 (2017) (calling the health care market "dysfunctional").

accurately, a *non*-system.[18] The stress of the COVID pandemic revealed the depth of these failures to a broader audience.[19] We argue that the magnitude of failure — both functional and existential — flows from decades of reforms under an intellectually-cramped ethos. Thus, the first lesson we draw from the pandemic is that the gestalt of health reform itself demands reconstruction, jettisoning the old "iron triangle" ethos and embracing a new era of health justice.

A. The Iron Triangle Era

The U.S. health care system that met the pandemic is a patchwork product of more than half a century of reforms driven by incrementalism, individualism, and commitment to private ordering.

The prevailing ethos of this half-century of health reforms has sought to balance (1) access to, (2) the quality of, and (3) the costs of medical care, famously dubbed the "iron triangle" by William Kissick in 1994.[20] The iron triangle accepts as a fundamental starting point that these three priorities are the most important and that there are unavoidable trade-offs between them.[21] Kissick's iron triangle described the thrust behind

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[18] *See, e.g.*, Lawrence D. Brown, *The Amazing Noncollapsing U.S. Health Care System — Is Reform Finally at Hand?*, 358 NEW ENG. J. MEDICINE 325, 325 (2008) ("a nonsystem, an incoherent pastiche that has long repulsed reforms sought by private and public stakeholders"); Isaac D. Buck, *Affording Obamacare*, 71 HASTINGS L.J. 261, 305 (2020) ("a bloated and under-regulated non-system"); Walter B. Maher, *Health Care in America: Implications for Business and the Economy*, 3 STAN. L. & POL'Y REV. 55, 55 (1991) (referencing the term "nonsystem").

[19] The failure of the U.S. health care system to cope with the stress of a pandemic was tragically predictable. *See, e.g.*, WENDY E. PARMET, POPULATIONS, PUBLIC HEALTH, AND THE LAW 193 (2009) ("By ignoring the interdependency of health and the importance of populations, American health law has helped establish a health care system that is unprepared both for public health emergencies and the more common, everyday threats that populations face."); William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497, 522 (2008) [hereinafter *Relational Duties*] ("It may indeed take a public health crisis—pandemic influenza, natural disaster, or bioterrorism—to dislodge health law from its relational roots, but progress without panic is preferable.").

[20] KISSICK, *supra* note 1, at 2-3. Over the course of his career in health policy, Dr. Kissick shaped multiple reforms characteristic of the era we borrow his phrase to label. As a White House staffer, he participated in a task force launched in 1964 that led to the proposal for Medicare, among other reforms. The book in which he coined his most famous phrase focused on Clinton-era health reform proposals, which culminated (somewhat disappointingly) in the Health Insurance Portability and Accountability Act ("HIPAA").

[21] *Id.* at 2 ("[I]n what I call the iron triangle of health care . . . access, quality, and cost containment have equal angles, representing identical priorities, and an expansion of any one angle compromises one or both of the other two. All societies confront the

reforms of the prior three decades and became the prevailing frame for assessing every health reform effort in the ensuing twenty-five years, setting up the dominant narrative that U.S. efforts to expand access and quality come with inevitable and substantial cost increases.[22] Kissick treated public health as ancillary to the health care system and equity concerns as answered through universal access to medical care, which he assumed would be too expensive to be feasible.[23] The iron triangle ethos guided the advent of Medicare and Medicaid in the 1960s, managed care cost-containment practices in the 1970s and 80s, the failed Clinton-era health security proposal in the 1990s, and the ACA's vision of fragmentary-but-universal coverage in the 2010s.[24]

Some health-system reformers have pursued a sublimated version of the iron triangle, called the "triple aim," which retooled the triangle into three new points: (1) improving the patient experience of care (a patient-service approach to quality), (2) improving the health of populations (blending access, quality, and "population health," though not necessarily *public* health), and (3) reducing per capita costs of care.[25] Pointing to the "unacceptable social cost" of health care that is

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equal tensions among access to health services, quality of health care, and cost containment. Trade-offs are inevitable . . . .").

[22] *See id.*

[23] *Id.* at 38, 50, 159 (contrasting the U.S. with the U.K. or Canada, which have "demonstrated the priority of equity through universality of access," noting that it is improbable that the U.S. would ever achieve equity of access because of the cost, and describing the medical and public health systems as fundamentally distinct).

[24] *Id.* at 80-83 (describing six eras of health reform in the U.S.); *see* Sylvia Mathews Burwell, *Preface*, *in* THE TRILLION DOLLAR REVOLUTION 1, 2 (Ezekiel J. Emanuel & Abbe R. Gluck eds., 2020) (framing the ACA in terms of the iron triangle).

[25] Donald M. Berwick, Thomas W. Nolan & John Whittington, *The Triple Aim: Care, Health, And Cost*, 27 HEALTH AFFS. 759, 760 (2008). While the triple aim is sometimes described as a framework for "[i]mproving the U.S. health care system," *id.* at 759, comprehensively reforming the U.S. system also involves "the realms of ethics and policy," which Berwick, Nolan, and Whittington characterize as *external* to the triple aim, *id.* at 760. The triple aim is perhaps more comprehensible as a tool for improving the functioning of any one of the many discrete "health systems" that make up the U.S. health care system — integrated networks of hospitals and physician practice groups, serving patient populations defined by geographic areas, and relying on capitated payment from third-party payers. *See Achieving the IHI Triple Aim: Summaries of Success*, INST. FOR HEALTHCARE IMPROVEMENT, http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/ImprovementStories.aspx (last visited Aug. 25, 2021) [https://perma.cc/7ANK-HXJT] (describing the success of "sites participating in the IHI Triple Aim Initiative," including "organizations providing health care services"). Relatedly, the triple aim's focus on "the health of populations" is not synonymous with "public health." *See* Ana V. Diez Roux, *On the Distinction—or Lack of Distinction—Between Population Health and Public Health*, 106 AM. J. PUB. HEALTH 619, 619 (2016) (lamenting how "[t]he recent explosion of the use of the term [population health] in

"overpriced, wasteful, useless, or harmful," Bill Sage has argued that the triple aim allows reformers to pursue all points of the access-quality-cost triad simultaneously, rather than viewing them as inherently in conflict.[26] Don Berwick and his fellow originators of the triple aim gestured toward "population health" and "health equity."[27] But they ultimately rooted the triple aim in a medicalized model (focusing exclusively on the delivery of medical care to individual patients), leaving public health and solidarity to ethicists and future policymakers.[28]

Health law scholars have advanced competing models for how the points of the iron triangle should be balanced or how the triple aim should be achieved — by securing the professional autonomy of physicians, the rights of patients, or the competitiveness of health care markets.[29] These models have been united by a foundational focus on

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the medical world . . . has unfortunately narrowed the concept" by focusing on "groups of patients, receiving care with a certain provider, covered by a certain health plan, sharing a certain health condition, or living in a certain geographic area" and emphasizing "improving the outcomes of care and reducing costs").

[26] William Sage, *Fracking Health Care: How to Safely De-Medicalize America and Recover Trapped Value for Its People*, 11 N.Y.U. J.L. & LIBERTY 635, 637, 662-63 (2017) [hereinafter *Fracking Health Care*]. For a version of this argument that pre-dates the triple aim, see Rand E. Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243, 244-45 (1978) ("The absence of effective regulation to increase access to health care services, ensure quality, and control costs has . . . contributed to . . . severe inflation of health care costs, maldistribution of facilities and personnel, gross profiteering from public and private funds, and unnecessary, deficient, and often harmful care. Perhaps equally important, if less obvious, has been the impact of government passivity on the experience of citizenship itself.").

[27] Berwick et al., *supra* note 25, at 760 ("The most important of all such [policy] constraints, we believe, should be the promise of equity; the gain in health in one subpopulation ought not to be achieved at the expense of another subpopulation. But that decision lies in the realms of ethics and policy; it is not technically inherent in the Triple Aim.").

[28] *See* Sage, *Fracking Health Care*, *supra* note 26, at 664 ("Where the Triple Aim may fall short is in its expectation that population health can be substantially improved within a medical framework.").

[29] *See* Wiley, *Health Justice*, *supra* note 8 (describing professional autonomy, patient rights, market power, and health consumerism as the four main models); *see also* PARMET, *supra* note 19, at 196-98 (tracing health law from its initial stage reflecting "the prestige and influence of the medical profession" to the "patients' rights paradigm" of the late 1960s and 1970s, to the most recent paradigm "emphasizing the role and values of the market"); Maxwell Gregg Bloche, *The Invention of Health Law*, 91 CALIF. L. REV. 247, 253, 256, 271 (2003) (contrasting the "economic paradigm for health care law" with "the informed consent model" and arguing for an alternative approach that "takes a pragmatic account of Americans' conflicting expectations of medicine"); James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State*

meeting individual health care needs and regulating individual relationships in the clinical context.[30] Solidarity (interdependence among individuals and groups),[31] mutual aid (reciprocity of support),[32] communitarianism (connectedness between individuals and their communities),[33] and equity (the absence of systematic disparities in

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Provider Cooperation Legislation, 79 CORNELL L. REV. 1459, 1459 (1994) (describing "the competing visions of medical care represented by the professional paradigm and the market-based economic paradigm"); Einer Elhauge, *Allocating Health Care Morally*, 82 CALIF. L. REV. 1449, 1452 (1994) (identifying four resource-allocation paradigms in health law: market, professional, moral, and political); Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 465-66 (2002) (identifying social justice and economic efficiency as competing "unifying themes" for health law, and advocating for "therapeutic jurisprudence"); Mark A. Hall & Carl E. Schneider, *Where Is the "There" in Health Law? Can It Become a Coherent Field?*, 14 HEALTH MATRIX 101, 102-04 (2004) (describing the "patient's rights" and "law and economics" approaches as the two "competing paradigms" of health law); David A. Hyman, *Getting the Haves to Come Out Behind: Fixing the Distributive Injustices of American Health Care*, 69 LAW & CONTEMP. PROBS. 265, 265 (2006) (contrasting "market-oriented policy scholars" with "collectivist-oriented policy scholars" in the health law field).

30 Wiley, *Health Justice*, *supra* note 8, at 107-20 (describing the individualistic bias of the professional autonomy, patient rights, and market power models); *see also* NORMAN DANIELS, JUST HEALTH CARE 2 (1985) (linking individualistic bias in health law and policy to the bioethics tradition, which "has focused heavily on . . . the dyadic relationship between doctors and patients or research subjects, or on the potential benefits and risks for those individuals that can arise from new [medical] technologies"); Sage, *Relational Duties*, *supra* note 19, at 500 ("[P]oliticians and policymakers apply the mental construct of the specific patient, and that patient's therapeutic relationship with a specific physician, to problems of collective costs and benefits for which such a starting point . . . is not appropriate.").

31 *See, e.g.*, Françoise Baylis, Nuala P. Kenny & Susan Sherwin, *A Relational Account of Public Health Ethics*, 1 PUB. HEALTH ETHICS 196, 198 (2008) ("[I]ssues of trust, neighborliness, reciprocity and solidarity must be made central [to public health ethics]."); Angus Dawson & Bruce Jennings, *The Place of Solidarity in Public Health Ethics*, 34 PUB. HEALTH REV. 65, 76-77 (2012) ("[S]olidarity is and ought to be at the heart of ethical thinking about public health. It does not only come into existence or prove relevant at times of grave 'threats' to a nation state, such as when a major pandemic hits the population."); Ryan M. Melnychuk & Nuala P. Kenny, Commentary, *Pandemic Triage: The Ethical Challenge*, 175 CANADIAN MED. ASS'N J. 1393, 1394 (2006) (noting that "solidarity (we are all in this together, and protecting the public and hence ourselves will require society-wide collaborations)" is highly relevant to pandemic planning).

32 *See, e.g.*, Bruce Jennings, *Relational Liberty Revisited: Membership, Solidarity and a Public Health Ethics of Place*, 2015 PUB. HEALTH ETHICS 1, 1 ("[T]he practical success of public health policies and programs and their capacity to gain normative legitimacy and trust rely on the presence of a cultural sense of obligation and mutual aid in a world of common vulnerability.").

33 *See, e.g.*, Dan E. Beauchamp, *Community: The Neglected Tradition of Public Health*, 15 HASTINGS CTR. REP. 28, 34 (1985) ("By ignoring the communitarian language of public health, we risk shrinking its claims... [and] undermining the sense in which

health outcomes based on social hierarchies)[34] are critical to securing the public's health. But in the iron triangle era, few reformers have dreamed of incorporating a public health ethos into the financing and regulation of the U.S. health care system.[35]

The ACA was the apotheosis of the iron triangle era.[36] Its boldest aim was "universal coverage" — affordable health insurance for 100 percent of Americans — under a multi-payer system heavily dependent on

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health and safety are a signal commitment of the common life—a central practice by which the body-politic defines itself and affirms its values.").

[34] *See, e.g.*, Paula Braveman & Sofia Gruskin, *Defining Equity in Health*, 57 J. EPIDEMIOLOGY & CMTY. HEALTH 254, 254 (2003) ("For the purposes of operationalisation and measurement, equity in health can be defined as the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage—that is, different positions in a social hierarchy."); Diez Roux, *supra* note 25, at 619 (advocating for a "conceptual approach to understanding the drivers of health and consequently the strategies most useful to improve health" that involves "integrating social and biologic processes" and "an explicit concern with health equity because we cannot substantially improve the health of the population as a whole without addressing health inequities and because the drivers of health inequities are often the drivers of the health the population generally").

[35] *See, e.g.*, Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155, 191 (2004) (describing the divide "between hyper-individualism and unrestrained competition" and "some way of reconstituting solidarity and associated social policies"); Sage, *Relational Duties*, *supra* note 19, at 507, 519 (noting "access to health care for economically disadvantaged groups has been 'fiscalized' as a problem of allocating scarce tax dollars rather than as a source of social solidarity and future stability," and "public health law represents the paradigm case for a regulatory, collective approach to health policy, but has been marginalized both legally and financially compared with the diagnosis and treatment of individual patients"); Stone, *supra* note 8, at 290 ("The private insurance industry . . . is organized around a principle profoundly antithetical to the idea of mutual aid . . . ."). For a discussion of emerging efforts to incorporate a public health ethos into the health care system, see Wiley, *Social Justice*, *supra* note 6, at 52 ("[T]he convergence of three distinct social movements (environmental justice, reproductive justice, and food justice) on health disparities as a central focus; the growing prominence of health disparities as a focus of health reform efforts; the recent boom in "health and social justice" monographs by political philosophers and ethicists; and the growing emphasis on social consciousness (as opposed to distinctly individualistic values like patient autonomy) in health law scholarship might together indicate the beginnings of a loosely defined "health justice" movement.").

[36] *See* Burwell, *supra* note 24, at 2 ("[A]ccessibility, affordability and quality . . . are the through-line of the history of the ACA . . . ."); Timothy Stoltzfus Jost & John E. McDonough, *The Path to the Affordable Care Act*, *in* THE TRILLION DOLLAR REVOLUTION, *supra* note 24, at 28 (noting that the ACA is "the only federal law in US history" that seeks to improve "all 3 essential components of health policy: access, quality, and costs.").

employers to provide coverage.[37] Those who accept that goal as an endpoint (which we do not) assume modest reforms further that goal as long as they increase the sheer number of insured Americans.[38] On this common and influential view, the ACA has been a positive incremental step simply because it led to coverage for an additional twenty million Americans.[39] This approach can mislead because it makes these ostensible gains while reinforcing the divisions of multi-payer coverage, amplifying some states' cries for flexibility to erode coverage gains, and increasing the stealth subsidization of private markets with public funds. The coverage gains are not, in some important respects, "universal." Worse, they have the potential to further entrench the fixtures that make truly transformative reforms so difficult in the first place.

Even the public option — arguably the most radical proposal to gain much traction during the iron triangle era — sought to "accommodate[e] the path-dependent history of American health insurance" by limiting access to individuals who did not have the option of purchasing affordable employer-based coverage.[40] And the public option was ultimately left out of the ACA in spite of its proponents' accommodating stance.[41]

In the ACA's first decade, Republican-led legal challenges and political sabotage have significantly undermined its ability to achieve its central aim of universal (but fragmented) coverage.[42] While the ACA

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[37] *See* OFF. OF MGMT. & BUDGET, EXEC. OFF. OF THE PRESIDENT, A NEW ERA OF RESPONSIBILITY: RENEWING AMERICA'S PROMISE 27 (2009), https://www.govinfo.gov/content/pkg/BUDGET-2010-BUD/pdf/BUDGET-2010-BUD.pdf [https://perma.cc/KXS7-6N7L] (noting eight goals for health reform, including universal coverage, choice of health plans, and the option of keeping one's employer-based health plan); Peter Orszag & Rahul Rekhi, *Policy Design: Tensions and Tradeoffs*, *in* THE TRILLION DOLLAR REVOLUTION, *supra* note 24, at 53 (recalling the reform imperatives of the ACA included universality but also to "do no harm" to employer-sponsored insurance coverage); Theodore R. Marmor & Jonathan Oberlander, *Paths to Universal Health Insurance: Progressive Lessons from the Past for the Future*, 2004 U. ILL. L. REV. 205, 225-26 (describing focus of health reform efforts on expanding coverage and endorsing "pragmatic universalism").

[38] *E.g.*, Marmor & Oberlander, *supra* note 37, at 215-16.

[39] *See* David Orentlicher, *Health Care Reform: What Has Been Accomplished? What Comes Next?*, 44 OHIO N.U. L. REV. 397, 401 (2018) (describing universal coverage goal).

[40] *See* Jacob S. Hacker, *From the ACA to Medicare for All?*, *in* THE TRILLION DOLLAR REVOLUTION, *supra* note 24, at 346 (describing the public option proposals that were part of Democratic reform plans in the 2008 election).

[41] *Id.*

[42] *See* Abbe R. Gluck, Mark Regan & Erica Turret, *The Affordable Care Act's Litigation Decade*, 108 GEO. L.J. 1471, 1473 (2020); Thomas Rice, Lynne Y. Unruh,

nudged the U.S. health care system in the direction of solidarity and reduced racial disparities in health insurance coverage,[43] large gaps remain. Health and life expectancy continue to be powerfully correlated with socio-economic status, race, and ethnicity.[44]

Ewout van Ginneken, Pauline Rosenau & Andrew J. Barnes, *Universal Coverage Reforms in the USA: From Obamacare Through Trump*, 122 HEALTH POL'Y 698, 699 (2018).

[43] *See, e.g.*, Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1579-80 (2011) ("The [ACA] embodies a social contract of health care solidarity through private ownership, markets, choice, and individual responsibility."); Thomas C. Buchmueller, Zachary M. Levinson, Helen G. Levy & Barbara L. Wolfe, *Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage*, 106 AM. J. PUB. HEALTH 1416, 1420 (2016) (concluding that the ACA "led to a slight reduction in coverage disparities related to race and ethnicity" but noting that "racial and ethnic minorities make up a disproportionate share" of the remaining uninsured); Molly Frean, Shelbie Shelder, Meredith Rosenthal, Thomas D. Sequist & Benjamin D. Sommers, *Health Reform and Coverage Changes Among Native Americans*, 176 JAMA INTERNAL MED. 858, 860 (2016) ("The ACA was associated with significant coverage increases for Native Americans, primarily in Medicaid expansion states, consistent with national trends for all racial ethnic groups"); Sergio Gonzales & Benjamin D. Sommers, *Intra-Ethnic Coverage Disparities Among Latinos and the Effects of Health Reform*, 53 HEALTH SERVS. RSCH. 1373, 1381 (2018) (finding that the "ACA has increased coverage by three additional percentage points among all Latinos compared to whites" but also noting significant heterogeneity among Latino subgroups); Nan D. Hunter, *Health Insurance Reform and Intimations of Citizenship*, 159 U. PA. L. REV. 1955, 1996 (2011) ("[T]he [ACA] will strengthen social norms of solidarity and responsibility . . . ."); John J. Park, Sarah Humble, Benjamin D. Sommers, Graham A. Colditz, Arnold M. Epstein & Howard K. Koh, *Health Insurance for Asian Americans, Native Hawaiians, and Pacific Islanders Under the Affordable Care Act*, 178 JAMA INTERNAL MED. 1128, 1128 (2018) ("Our findings document AANHPI coverage gains that essentially eliminated pre-ACA coverage disparities relative to whites").

[44] *See, e.g.*, Jermane M. Bond & Allen A. Herman, *Lagging Life Expectancy for Black Men: A Public Health Imperative*, 106 AM. J. PUB. HEALTH 1167, 1167 (2016) (documenting persistent disparities in mortality and health outcomes for Black males compared to white males); Thomas A. LaVeist, *Disentangling Race and Socioeconomic Status: A Key to Understanding Health Inequalities*, 82 J. URB. HEALTH iii26, iii27 (2005) (examining the inter-relationships among race, socio-economic status, and health disparities); Thomas A. LaVeist, Mindy Fullilove & Robert Fullilove, *400 Years of Inequality Since Jamestown of 1619*, 109 AM. J. PUB. HEALTH 83, 83 (2019); Yin Paradies, *Colonisation, Racism and Indigenous Health*, J. POPULATION RSCH. 83, 87-88 (2016) (discussing health disparities among colonized indigenous populations); John M. Ruiz, Belinda Campos & James J. Garcia, *Special Issue on Latino Physical Health: Disparities, Paradoxes, and Future Directions*, 4 J. LATINA/O PSYCH. 61, 64 (2016) (describing disparities in Latino "income, education, employment opportunities, discrimination, and access to health insurance and access to quality care"); Linda R. Stanley, Randall C. Swaim, Joseph Keawe'aimoku Kaholokula, Kathleen J. Kelly, Annie Belcourt & James Allen, *The Imperative for Research to Promote Health Equity in Indigenous Communities*, 21 PREVENTION SCI. 13, 19 (2020) (noting persistent disparities in life expectancy, disease morbidity, chronic disease risk factors, and quality of life among indigenous

The COVID pandemic has simultaneously exposed the systemic failure of the U.S. health care system to secure the public's health and the limitations of the iron triangle framework. Growing awareness of structural racism and other forms of subordination as determinants of health has made the iron triangle's neglect of health equity untenable. It is time to turn the page. The year 2020 should mark the end of what we term the *iron triangle era* of health policy and usher in a new era focused on realizing health justice.

B. Pandemic Failures, Functional & Existential

The COVID pandemic has subjected the iron triangle health care system to a stress test, revealing the magnitude of weaknesses and inequities that were baked in from the start. The pandemic revealed how functionally ineffective a diffuse, multi-payer, largely privatized health care system is at protecting individual and public health. And it reveals how, existentially, such a system is built on and perpetuates subordination.

Of the numerous functional weaknesses exacerbating the public health and economic harms of the pandemic, the lack of universal coverage, the linkage between employment and coverage, and the fragmentary and inefficient financing of basic services like disease testing and vaccination have been especially glaring. A narrow focus on meeting the needs of individuals has stymied our public health response to the pandemic. Moreover, the diffusion of authority between levels of government, fragmented fiscal supports, and the many diverse providers in our largely privatized health care system have led to a U.S. failure to fairly allocate, adequately supply, or constrain prices for essential testing, therapeutics, and vaccines. Widespread public health measures may be delivered more effectively in countries with a centralized and unified public health care delivery system.[45] Future reform must reflect what we are learning from these functional failures.

U.S. populations); Ruqaiijah Yearby, *Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause*, 48 J.L. MED. & ETHICS 518, 518 (2020) ("As of 2018, racial health disparities continue and are estimated to cost the United States $175 billion in lost life years (3.5. million lost years times $50,000 per life year) and $135 billion per year in excess health care costs and untapped productivity"). *But see* Raj Chetty, Michael Stepner, Sarah Abraham, Shelby Lin, Benjamin Scuderi, Nicolas Turner, Augustin Bergeron & David Cutler, *The Association Between Income and Life Expectancy in the United States, 2001-2014*, 315 JAMA 1750, 1763 (2016).

[45] *See infra* Part II.B ("Our individualistic, fragmented, diffuse, private-industry health care system has failed us in the COVID pandemic.").

More fundamentally, the pandemic has tragically amplified the most profound failure of the U.S. health care system: its unjust and inequitable burdens on communities of color, which health care and public health scholars have recognized for decades.[46] Although the uninitiated claimed COVID was "the great equalizer,"[47] it was clear to public health experts from the early days of the pandemic that it would disproportionately ravage low-income, Black and Brown communities.[48]

Due to structural racism and economic injustice, people of color and people living in low-income households and neighborhoods are more likely to be exposed to infection through their working and living conditions.[49] They are less likely to have ready access to testing, less

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[46] *See infra* Part III (discussing the four fixtures "broader existential failure illuminated by the pandemic").

[47] Bethany L. Jones & Jonathan S. Jones, *Gov. Cuomo Is Wrong, Covid-19 Is Anything but an Equalizer*, WASH. POST (Apr. 5, 2020), https://www.washingtonpost.com/outlook/2020/04/05/gov-cuomo-is-wrong-covid-19-is-anything-an-equalizer/ [https://perma.cc/FJY2-WLWH]; Tim Molloy, *Madonna's COVID-19 Bathtub Message: 'It's the Great Equalizer'*, SPIN (Mar. 22, 2020, 4:05 PM), https://www.spin.com/2020/03/madonnas-covid-19-bathtub-message-its-the-great-equalizer/ [https://perma.cc/4SLU-HXLM].

[48] *See, e.g.*, Samrachana Adhikari, Nicholas P. Pantaleo & Justin M. Feldman, Olugbenga Ogedegbe, Lorna Thorpe & Andrea B. Troxel, *Assessment of Community-Level Disparities in Coronavirus Disease 2019 (COVID-19) Infections and Deaths in Large US Metropolitan Areas*, 3 JAMA NETWORK (2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2768723 [https://perma.cc/Z2FF-2AQ8] (study finding higher cumulative COVID infections and deaths in counties with substantially non-White or more diverse populations as of May 11, 2020); Jarvis T. Chen & Nancy Krieger, *Revealing the Unequal Burden of COVID-19 by Income, Race/Ethnicity, and Household Crowding: US County vs. ZIP Code Analyses*, 27 J. PUB. HEALTH MGMT. & PRAC. S43 (study finding that as of May 5, 2020, COVID death rates per 100,000 person-years were correlated at the county level with the percentage of persons living below poverty, the percentage of persons experiencing household crowding, and the percentage of persons who are not identified as White and non-Hispanic); Cary P. Gross, Utibe R. Essien, Saamir Pasha, Jacob R. Gross, Shi-yi Wang & Marcella Nunez-Smith, *Racial and Ethnic Disparities in Population-Level Covid-19 Mortality*, 35 J. GEN. INTERNAL MED. 3097, 3097 (2020) (study finding that in states that reported race- and ethnicity-stratified COVID mortality data as of April 21, 2020, age-adjusted COVID mortality rates were significantly higher for Black versus White populations and for Latinx versus White populations); Lonnae O'Neal, *Public Health Expert Says African Americans are at Greater Risk of Death from Coronavirus*, UNDEFEATED (Mar. 13, 2020), https://theundefeated.com/features/public-health-expert-says-african-americans-are-at-greater-risk-of-death-from-coronavirus/ [https://perma.cc/K7TA-38AL] (interview with Dr. Georges Benjamin, Executive Director of the American Public Health Association warning of the likelihood that, upon exposure to the coronavirus, African Americans would be at greater risk of death and severe illness due to disparities in chronic conditions, health care access, employment protections, and other factors).

[49] Benfer et al., *supra* note 4, at 133-34, 148, 154, 163-164.

likely to have the financial resources and employment protections required to stay home when they test positive, and less likely to be able to safely isolate from others within their homes.[50] Black, Indigenous, and Latino and Latina patients are more likely to become severely ill or die from COVID.[51] Due to environmental factors, access to health care, and social subordination, people who are racialized or ethnicized as part of a minority group are more likely to have underlying chronic conditions that COVID preys upon.[52] They may be more likely to be treated in hospitals with fewer resources and lower quality of care.[53] They are more likely to experience institutional and interpersonal discrimination in health care delivery.[54] Moreover, Black, Indigenous, Latino and Latina communities and low-income communities across the country are disproportionately harmed by the economic impacts of the pandemic, including job loss and eviction.[55]

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[50] *Id.*; Wiley & Bagenstos, *supra* note 10, at 1263.

[51] *See* Gross et al., *supra* note 48, at 3097.

[52] *See* CTRS. FOR DISEASE CONTROL & PREVENTION, SUMMARY HEALTH STATISTICS: NATIONAL HEALTH INTERVIEW SURVEY, at Table A-1a (2018) https://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2018_SHS_Table_A-1.pdf [https://perma.cc/9PAC-XTFR] (age-adjusted percentages of U.S. adults with circulatory diseases, by race, ethnicity, income, poverty status, and health insurance coverage status); CTRS. FOR DISEASE CONTROL & PREVENTION, *supra*, at Table A-2a (emphysema, asthma, and chronic bronchitis); CTRS. FOR DISEASE CONTROL & PREVENTION, NATIONAL DIABETES STATISTICS REPORT, at Figure 2 (type-2 diabetes) (2020), https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf [https://perma.cc/Z7K3-EYDT]; Shreya Rao, Matthew W. Segar, Adam P. Bress, Pankaj Arora, Wanpen Vongpatanasin, Vijay Agusala, Utibe R. Essien, Adolfo Correa, Alanna A. Morris, James A. de Lemos & Ambarish Pandey, *Association of Genetic West African Ancestry, Blood Pressure Response to Therapy, and Cardiovascular Risk Among Self-Reported Black Individuals in the Systolic Blood Pressure Reduction Intervention Trial (SPRINT)*, 6 JAMA CARDIOLOGY 368, 389 (2020) ("highlight[ing] the greater importance of nonbiological risk factors—including socioeconomic status, environmental factors, educational attainment, behavioral characteristics, structural racism, and access to health care—in existing disparities in hypertension control"); CTRS. FOR DISEASE CONTROL & PREVENTION, *Evidence Used to Update the List of Underlying Medical Conditions that Increase a Person's Risk of Severe Illness from COVID-19*, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/evidence-table.html (last updated Nov. 2, 2020) [https://perma.cc/6SLD-V252] (surveying studies associating various chronic conditions with COVID severity).

[53] *See* Brian M. Rosenthal, Joseph Goldstein, Sharon Otterman & Sheri Fink, *Why Surviving the Virus Might Come Down to Which Hospital Admits You*, N.Y. TIMES (July 1, 2020), https://www.nytimes.com/2020/07/01/nyregion/Coronavirus-hospitals.html [https://perma.cc/9QEM-YJBT].

[54] *See* Héctor E. Alcalá, Amanda E. Ng, Sujoy Gayen & Alexander N. Ortega, *Insurance Types, Usual Sources of Health Care, and Perceived Discrimination*, 33 J. AM. BD. FAM. MED. 580, 588-89 (2020).

[55] *See* GREGORY ACS & MICHAEL KARPMAN, URB. INST., EMPLOYMENT, INCOME, AND UNEMPLOYMENT INSURANCE DURING THE COVID-19 PANDEMIC 3-7 (June 2020),

The pandemic has amplified the scale and visibility of this tragic failure. U.S. health care's racial injustice is a failure on an existential scale, with effects that ripple throughout all aspects of American life. Future reforms must confront this existential failure with a bolder ethos that expands far beyond the iron triangle of quality, cost, and access – to eradicate subordination and its health effects.

C. Health Reform Reconstruction: The Health Justice Era

The COVID pandemic hit at a moment when the U.S. was in the early stages of what may prove to be a major shift in ethos — from distributing costs associated with sickness based on the principle of actuarial fairness toward a social solidarity principle premised on the "goals of mutual aid and support."[56] The pandemic also coincided with growing support for the Black Lives Matter movement in response to systemic police violence against Black people.[57] The public health and economic devastation wreaked by the virus and the growing awareness among white people of the role of structural racism in American law and society have highlighted our fundamental interdependence, while also putting our emerging commitments to mutual aid and solidarity to the test. The pandemic is teaching us that twenty-first century health reform demands attention to more than the iron triangle of quality, cost, and access. At this critical juncture, we must more explicitly center anti-

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https://www.urban.org/sites/default/files/publication/102485/employment-income-and-unemployment-insurance-during-the-covid-19-pandemic.pdf [https://perma.cc/E2R6-75EF]; Emily Benfer, David Bloom Robinson, Stacy Butler, Lavar Edmonds, Sam Gilman, Katherine Lucas McKay, Lisa Owens, Neil Steinkamp, Diane Yentel & Zach Neumann, *The COVID-19 Eviction Crisis: An Estimated 30-40 Million People in America Are at Risk*, ASPEN INST. (Aug. 7, 2020), https://www.aspeninstitute.org/blog-posts/the-covid-19-eviction-crisis-an-estimated-30-40-million-people-in-america-are-at-risk/ [https://perma.cc/6C7X-8693].

[56] Mariner, *supra* note 8, at 205; Stone, *supra* note 8, at 289-90 (contrasting actuarial fairness, which holds that "each person should pay for his own risk," with the principle of mutual aid, whereby "sickness is widely accepted as a condition that should trigger" a social solidarity response); Wiley, *Health Justice*, *supra* note 8, at 859 ("[T]he ACA represents a major shift from an actuarial fairness approach to health care financing to one premised largely on mutual aid.").

[57] *See* Tasnim Motala, *"Foreseeable Violence" & Black Lives Matter: How Mckesson Can Stifle a Movement*, 73 STAN. L. REV. ONLINE 61, 64 (2020) ("The events of the last three months have galvanized Americans across the political spectrum to demand accountability for police brutality and racial justice."); Michael Tesler, *The Floyd Protests Will Likely Change Public Attitudes About Race and Policing. Here's Why.*, WASH. POST (June 5, 2020), https://www.washingtonpost.com/politics/2020/06/05/floyd-protests-will-likely-change-public-attitudes-about-race-policing-heres-why/ [https://perma.cc/H72G-2F4Z].

racism, equity, and community empowerment in the criteria by which we evaluate our health care system and proposed reforms.

We identify three core criteria for evaluating health reforms in the post-2020 era: anti-subordination, equitable distribution, and community empowerment. We draw these criteria from works by public health ethicists and critical race feminists, and from the health justice model developed in our prior work and in conversation with others.[58]

First, *anti-subordination*: reforms must address the role of health laws and policies in reinforcing — or, alternatively, dismantling — structural racism, economic injustice, and other forms of social subordination.[59] As Angela Harris and Aysha Pamukcu have argued, "[r]ecognizing subordination as a driver of health is essential to solving the puzzle of persistent health disparities linked to group status."[60]

Second, *equitable distribution*: health laws and policies must ensure just distribution of the burdens and benefits of public investments in health care and public health.[61] Access to health care, its quality, and its

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[58] *See* Benfer et al., *supra* note 4, at 141-51; Matthew B. Lawrence, *Against the "Safety Net"*, 72 FLA. L. REV. 49, 65 (2020) (applying the health justice framework and vulnerability analysis to critique the safety net metaphor for public benefits); Wiley, *Health Justice*, *supra* note 8, at 864; Wiley, *Social Justice*, *supra* note 6, at 53; *see also* Emily A. Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice*, 65 AM. U. L. REV. 275, 277-78 (2015) ("[H]ealth justice requires that all persons have the same chance to be free from hazards that jeopardize health, fully participate in society, and access opportunity."); Harris & Pamukcu, *supra* note 4, at 758 (arguing that "a civil rights of health initiative built on a health justice framework can help educate policymakers and the public about the health effects of subordination, create new legal tools for challenging subordination, and ultimately reduce or eliminate unjust health disparities"); Yearby & Mohapatra, *supra* note 4, at 13-15.

[59] *See* Harris & Pamukcu, *supra* note 4, at 763 ("Recognizing subordination as a driver of health is essential to solving the puzzle of persistent health disparities linked to group status."); Yearby, *supra* note 44, at 524 ("To achieve racial health equity, government and public health officials must aggressively work to end structural racism and . . . ensure that racial and ethnic minorities are not only treated equally, but also receive the material support they need to overcome the harms they have already suffered."); *see also* Benfer et al., *supra* note 4, at 137 ("[L]egal and policy interventions must address the structural determinants of health inequities."); Wiley, *Social Justice*, *supra* note 6, at 95 ("[By] prob[ing] the influence of class and racial bias on the goals and processes adopted by progressive reformers[, social justice movements] . . . have particularly highlighted the importance of collective responsibility for assuring healthy living conditions . . . .").

[60] Harris & Pamukcu, *supra* note 4, at 763.

[61] *See* GOSTIN & WILEY, *supra* note 12, at 19 ("Distributive justice—which stresses the fair disbursement of common advantages and sharing of common burdens—requires government to limit the extent to which the burden of disease falls unfairly on

affordability are important metrics for assessing distributive justice, but they are not the *only* important metrics. Health care is not the only resource that determines health outcomes.[62] Individual access to health care may or may not correlate with improvements in financial security, community wellbeing, and population-level health outcomes.[63] Distributive justice must also be responsive to the ways in which individuals are interconnected within groups — from families and households, to racial and ethnic groups, to schools, workplaces, and neighborhoods.

Third, *community empowerment*: Decision-making processes related to health must ensure recognition, representation, and empowerment as means for collective self-determination, particularly for subordinated groups.[64] Realizing health justice requires a "probing inquiry into the effects of social and cultural bias on the design and implementation of measures to reduce health disparities."[65] Emily Benfer and other health justice scholars have argued, "[t]hese efforts cannot be led by

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the least advantaged, and to ensure that the burdens and benefits of interventions are distributed equitably."); Lindsay F. Wiley, *Privatized Public Health Insurance and the Goals of Progressive Health Reform*, 54 UC DAVIS L. REV. 2149, 2192-203 (2021) [hereinafter *Privatized Public Health Insurance*] (assessing progressive health reform proposals in terms of fair distribution of health benefits and financial burdens). Of course, egalitarian distributive justice is not the only understanding of what justice requires with regard to health. *See, e.g.*, Paul T. Menzel, *Justice and Fairness: Mandating Universal Participation*, 2009 HASTINGS CTR. 4, 4 (contrasting the egalitarian sense of justice that "pushes toward universal [health care] access and its equitable financing" with "libertarian views of justice, [which] contend that those who have no contractual or special relationship with the unlucky victim of disease—and have not themselves exacerbated her plight—have no obligation to assist her"); Stone, *supra* note 8 (contrasting mutual aid and actuarial fairness as competing visions of what fairness requires in health care financing).

[62] *See* WORLD HEALTH ORG., A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 1, 9 (2010), https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf [https://perma.cc/L8YM-QZM8].

[63] *See* Murray & Frenk, *supra* note 1, at 719; *cf.* Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873, 1945 (2011) (discussing health promotion and financial security as competing conceptions of what health insurance coverage should achieve).

[64] *See* GOSTIN & WILEY, *supra* note 12, at 19 ("Social justice thus encompasses participatory parity: equal respect for all community members and recognition, participatory engagement, and voice for historically underrepresented groups."); Harris & Pamukcu, *supra* note 4, at 780 (identifying "collective agency and self-determination" as an important form of empowerment to further health justice); Wiley, *Social Justice*, *supra* note 6, at 101 ("[T]he health justice framework might root ongoing efforts to ensure access to health care and healthy living conditions more firmly in community engagement and participatory parity.").

[65] Wiley, *Social Justice*, *supra* note 6, at 53.

communities who have benefited from the very forms of subordination that must be dismantled if health justice is to be achieved. Empowerment of affected communities in decision-making processes helps ensure that the design and implementation of interventions intended to benefit them are actually tailored to their needs."[66]

The points of the iron triangle will certainly remain relevant in the post-2020 era, but they should be encompassed within a more expansive conceptual framework that centers equity, solidarity, and public health, rather than marginalizing them. In the post-pandemic era, "the goals of public health (what we as a society do collectively to ensure the conditions for people to be healthy) and health care reform (efforts to improve systems for health care financing and delivery) should be more fully integrated within a communitarian ethic."[67] "Rather than merely adopting social justice as the 'core value' of *public health* as . . . others have done," we argue that social justice should be embraced as "a core value of health law and policy *writ large*."[68] Using new criteria rooted in health justice, we can evaluate both the functional failures of the pandemic response and the broader existential failure to secure racial justice in health.

II. LESSON 2: FOUR FIXTURES CONTRIBUTE TO FUNCTIONAL FAILURES

The second lesson we draw: the failed U.S. response to the COVID pandemic highlights the role of four fixtures — individualism, fiscal fragmentation, federalism, and privatization — as structural constraints on health reform.[69] Precisely because the criteria we propose are rooted in anti-subordination, equity, and community empowerment, they inevitably collide with the fixtures, which are legally and logistically entrenched and have crippled the health care system's ability to meet public health needs.

A. Fixtures

A reconstruction project initially must survey the structures to be confronted and reconstructed. For health reform reconstruction, we begin with the concept of *fixtures*: forces whose "structural and political entrenchment, as well as longstanding normative commitments, make

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66 Benfer et al., *supra* note 4, at 139.

67 Wiley, *Privatized Public Health Insurance*, *supra* note 61, at 2160 n.40.

68 Wiley, *Social Justice*, *supra* note 6, at 52 (emphasis added); *see also* Wiley, *Health Justice*, *supra* note 8, at 881.

69 Fuse Brown et al., *supra* note 1, at 411.

them difficult to displace."[70] Recent scholarship has highlighted problems wrought by the forces of individualism, fiscal fragmentation, federalism, and privatization in American health care.[71] This literature has largely treated these concepts singly and as if they were ordinary policy choices that might simply be accepted or rejected by policymakers.[72] We have posed, however, that individualism, fiscal fragmentation, federalism, and privatization are more aptly described as "fixtures of American law" that reform cannot simply "turn off" without paying a steep price.[73] Their entrenchment means that fixtures operate not as mere policy options, but instead as forces that must be accommodated or confronted.

Our concept of fixtures begins with their *legal entrenchment*. Similar to "super-statutes," the fixtures "exhibit . . . normative gravity" and "bend and reshape the surrounding landscape."[74] Unlike super-statutes, fixtures are not embodied in one statute — or even one field of law. Instead, the fixtures we describe are embodied in a constellation of legal and regulatory provisions. This makes the fixtures more diffuse in their entrenchment than super-statutes, and thus harder to overcome.[75] Consider the Affordable Care Act ("ACA"), a plausible super-statute.[76]

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[70] *Id.* at 414.

[71] *See, e.g.*, Fuse Brown & McCuskey, *supra* note 15, at 443 (describing federalism); Allison K. Hoffman, *The ACA's Choice Problem*, 45 J. HEALTH POL., POL'Y & L. 501, 508 (2020) (describing individual choice); Nicole Huberfeld, Sarah H. Gordon & David K. Jones, *Federalism Complicates the Response to the COVID-19 Health and Economic Crisis: What Can Be Done?*, 45 J. HEALTH POL., POL'Y & L. 951, 952 (2020) (describing federalism); Craig Konnoth, *Privatization's Preemptive Effects*, 134 HARV. L. REV. 1937, 1951 (2021) (describing privatization); David A. Super, *Privatization, Policy Paralysis, and the Poor*, 96 CALIF. L. REV. 393, 461 (2008) (describing fiscal fragmentation).

[72] *See, e.g.*, Huberfeld et al., *supra* note 71, at 958-61 (suggesting policy options to "mitigate federalism's harmful side effects"); Konnoth, *supra* note 71, at 1990 (describing policy limitations due to privatization). *But see* Hoffman, *supra* note 71, at 508-09 (describing individual choice in health insurance as embodying and propagating an underlying normative commitment).

[73] Fuse Brown et al., *supra* note 1, at 414.

[74] Eskridge, Jr. & Ferejohn, *supra* note 13, at 1215-16 (describing "super-statutes" as singular statutory enactments that "successfully penetrate public normative and institutional culture in a deep way").

[75] *See id.*

[76] The ACA's status as super-statute is debatable and debated. *E.g.*, Eric C. Fuse Brown, *Developing a Durable Right to Health Care*, 14 MINN. J.L. SCI. & TECH. 439, 443-44 (2013) (arguing that while "[t]he ACA has the pedigree of a superstatute" in its ambition and breadth, the fragility of its right to health care places it in the category of "quasi-superstatutes" whose entrenchment remains in doubt); Abbe R. Gluck & Thomas Scott-Railton, *Affordable Care Act Entrenchment*, 108 GEO. L.J. 495, 516-17 (2020) (arguing that the "ACA's staying power has . . . come from more diffuse and

The ACA was a single enactment that touched hundreds of existing laws, spawned innumerable regulations, and significantly altered the landscape of health insurance regulation.[77] Its legal entrenchment in a single statute means that it can, in theory, be repealed in a single piece of legislation or struck down by Supreme Court in a single decision.[78] By contrast, the fixture of federalism, for example, is legally entrenched through the Constitution, countless federal and state statutes, and two centuries of jurisprudence on comity and deference to state authority.[79]

Beyond their legal manifestations, fixtures exhibit a form of entrenchment not previously explored in legal scholarship: *logistical entrenchment*. Institutions are built around the fixtures, as are workforces and bodies of expertise. These logistical considerations make it difficult to implement any reform that confronts the fixtures. For example, the administrative apparatus for our health care system is heavily dependent on private insurers and private health care providers, which means it would be practically difficult for a single-payer reform to switch entirely to government administration and rate setting.[80] Reliance on existing private structures would almost be compelled as a logistical matter, owing to the privatization fixture's logistical entrenchment. Moreover, the fixtures reinforce and further entrench each other, as seen in the deeply individualistic orientation of medical ethics, which entwines with private-law regulation of relationships

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multi-modal factors that are mostly unaccounted for by super-statute theorists," particularly its "specific statutory design choices — the structural features of a law that entrench it — [and] the federalist architecture").

77 *See generally* Gluck et al., *supra* note 42, at 1473 ("The ACA is the most significant healthcare legislation in recent American history . . . ."); Gluck & Scott-Railton, *supra* note 76, at 498 ("[T]he ACA has not only endured, but it has changed the way many Americans and the political arena think about healthcare and the entitlement to it."); Miriam Reisman, *The Affordable Care Act, Five Years Later: Policies, Progress, and Politics*, 40 PHARMACY & THERAPEUTICS 575, 575 (2015) ("The ACA . . . is one of the most complex and comprehensive reforms of the American health system ever enacted.").

78 *See, e.g.*, Timothy Jost, *Examining the House Republican ACA Repeal and Replace Legislation*, HEALTH AFFS. BLOG (Mar. 7, 2017) https://www.healthaffairs.org/do/10.1377/hblog20170307.059064/full/ [https://perma.cc/EN35-BWNW] (describing proposed legislation in Congress that would repeal the ACA); Pratik Shah, *Symposium: Severability Poses a High-stakes Question with (What Should Be) an Easy Answer*, SCOTUSBLOG (Nov. 9, 2020, 12:00 PM), https://www.scotusblog.com/2020/11/symposium-severability-poses-a-high-stakes-question-with-what-should-be-an-easy-answer/ [https://perma.cc/WJ69-D8VU] (arguing the ACA can function without the individual mandate and should not be fully unenforceable).

79 *See infra* Parts II.B.3, III.C.

80 *E.g.*, Wiley, *Privatized Public Health Insurance*, *supra* note 61, at 2162.

among private providers and insurers.[81] Fiscal fragmentation (with multiple, segregated sources of unequal payments to physicians and hospitals depending on the patient's source of coverage) and federalism (with health care providers regulated largely at the state level) further entrench the individualistic, privatized nature of health care financing and delivery in the United States.

Recognizing individualism, fragmentation, federalism, and privatization as fixtures forces attention not only to the ubiquity of their impacts but also to strategies for overcoming them. They may not be as concrete as individual laws (whether super-statutes or regular ones), but neither are they as amorphous as purely abstract cultural norms or ideologies. Their legal and logistical entrenchment makes them more stubborn in some ways, but, as Part IV elaborates, more vulnerable in others.

These four fixtures shape law and policy in fields beyond health care. And our conception of a *fixture* applies to forces beyond the four we highlight here. For example, the sovereignty of professional control over medicine could be a fixture, though professional autonomy arguably manifests individualism and privatization.[82] By elucidating the concept of *fixtures* here and applying it to health reform, we hope to provide reformers across disciplines with a navigational tool for crafting and assessing comprehensive reform efforts in other fields in which reconstruction is needed.[83]

B. Fixtures' Functional Failures

Our individualistic, fragmented, diffuse, private-industry health care system has failed us in the COVID pandemic. We focus this critique on the medical countermeasures that the health care system is responsible for delivering: testing, treatment, and vaccination, each of which has public health benefits in addition to the benefits they confer on individual patients. Our inability to distribute scarce supplies in a way

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[81] *See, e.g.*, William M. Sage, Adding Principle to Pragmatism: The Transformative Potential of "Medicare-for-All" 1, 33 (Feb. 2020) (unpublished draft), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3387120 [https://perma.cc/UL6P-SJSK] [hereinafter Adding Principle to Pragmatism] (arguing that individualistic professional ethics for physicians and pro-physician sentiment undermine the political viability of single-payer health reform proposals).

[82] For a historical account of the rise of professional medical control and corporate dominance of the health system, see PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY 28 (1982).

[83] *See infra* Part IV.

that maximizes collective benefits has undermined the effectiveness of the pandemic response.

1. Individualism

Individualism is a defining fixture of American cultural norms, policy, and law.[84] Without a sufficient communitarian counterweight[85] it manifests in three distinct, but interconnected ways that impede the realization of health justice. First, the individual — rather than the family, household, or community — is prioritized as the most important unit of inquiry, intervention, welfare maximization, and responsibility.[86] Second, regulating discrete interpersonal relations among atomistic individuals — rather than identifying and implementing structural solutions to structural problems — is prioritized as the aim of laws and policies.[87] Third, individual autonomy is prioritized over social values.[88]

Individualism is legally entrenched in our Constitution's emphasis on securing rights to be left alone and in health law's historical grounding in private law (generally) and freedom of contract (in particular).[89] It is

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[84] *See, e.g.*, Salter Storrs Clark, *Individualism and Legal Procedure*, 14 YALE L.J. 263, 263 (1905) ("American individualism . . . is the most important factor in American liberty, and . . . also, perhaps, a large factor in our material prosperity. . . . [It] marks the highest tide of political progress in the world.").

[85] *See* THE ESSENTIAL COMMUNITARIAN READER, at xi (Amitai Etzioni ed., 1998) (describing "new" or "responsive communitarianism" in terms of "balance between individual rights and social responsibilities, between autonomy and the common good").

[86] *See* Nancy Krieger, *Theories for Social Epidemiology in the 21st Century: An Ecosocial Perspective*, 30 INT'L J. EPIDEMIOLOGY 668, 670 (2001).

[87] *See, e.g.*, Samuel R. Bagenstos, *The Structural Turn and the Limits of Antidiscrimination Law*, 94 CALIF. L. REV. 1, 3-4 (2006) (arguing that a structural approach is necessary to address workplace inequities); Sage, *Relational Duties*, *supra* note 19, at 500 ("[F]ar more legal issues in health care are approached as relational than as regulatory problems, making it very difficult for law to serve truly 'public' policy.").

[88] *See, e.g.*, Martha Albertson Fineman, *Vulnerability and Inevitable Inequality*, 4 OSLO L. REV. 133, 140-41 (2017) ("[A]n emphasis on personal liberty and autonomy was combined with an assertion of equality or impartiality and used to argue against directing law and policy to address existing inequalities. . . . [A]rguments for a collective ideal of justice were beaten back by reference to the ideal of individual, not institutional, responsibility.").

[89] *See e.g.*, Larry A. DiMatteo, *The History of Natural Law Theory: Transforming Embedded Influences into a Fuller Understanding of Modern Contract Law*, 60 U. PITT. L. REV. 839, 884 (1999) ("The norms of *justice* and *fairness* are seen as competitors to the formalistic use of contract rules to promote *certainty* in contractual transactions. The latter is individualistic in its perspective and incorporates notions of freedom, security, and efficiency. The former is communitarian centered in its focus."); Wiley, *Health*

logistically entrenched in the individualistic professional ethics of medicine and our political and legal system's emphasis on personal responsibility for misfortune.[90] Iron-triangle reforms have been remarkably accommodating of individualism. So much so that "choice" is often treated as a fourth pillar of health law.[91] Moreover, the iron triangle's emphasis on meeting individual needs for health care embraces a fundamentally individualistic orientation toward solving social problems.

Many commentators have pointed to the focus of American cultural norms on the interests and rights of individuals as the key to explaining our failed pandemic response.[92] Some have specifically noted the individualistic focus of American law on personal responsibility as an impediment.[93] These criticisms have focused on individual resistance to, and inability to comply with, community mitigation measures (also known as non-pharmaceutical interventions): isolation of the infected, quarantine of the exposed, and social distancing and face-covering among the general population.[94] But individualism also pervades our

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Justice, *supra* note 8, at 835-36 (discussing how the individualistic bias of health care models is marked by private law regimes and relational professional ethics).

[90] *See* Wiley & Bagenstos, *supra* note 10, at 1241-42; Sage, Adding Principle to Pragmatism, *supra* note 81, at 33-34.

[91] *See, e.g.*, BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY STOLTZFUS JOST, ROBERT L. SCHWARTZ, BRIETTA R. CLARK, ERIN C. FUSE BROWN, ROBERT GATTER, JAMIE S. KING & ELIZABETH PENDO, HEALTH LAW: CASES, MATERIALS AND PROBLEMS 1 (8th ed. 2018) ("Cost, quality, access, and choice are the chief concerns of the health care system . . . .").

[92] *See, e.g.*, Meghan O'Rourke, *The Shift Americans Must Make to Fight the Coronavirus*, ATLANTIC (Mar. 12, 2020), https://www.theatlantic.com/ideas/archive/2020/03/we-need-isolate-ourselves-during-coronavirus-outbreak/607840/ [https://perma.cc/6EY2-GZCX] ("[Flattening the curve] requires a radical shift in Americans' thinking from an individual-first to a communitarian ethos . . . "); Edward D. Vargas & Gabriel R. Sanchez, *American Individualism Is an Obstacle to Wider Mask Wearing in the US*, BROOKINGS (Aug. 31, 2020), https://www.brookings.edu/blog/up-front/2020/08/31/american-individualism-is-an-obstacle-to-wider-mask-wearing-in-the-us/ [https://perma.cc/5HJD-LL4K] ("[T]he number one reason given by Americans who are not wearing a mask is that it is their right as an American to not have to do so.").

[93] *See, e.g.*, Wiley & Bagenstos, *supra* note 10, at 1235-36 (describing the emphasis on personal responsibility in public health and employment law as a factor in the failed U.S. response to the COVID pandemic).

[94] *Id.* at 1243. Lawsuits challenging coronavirus emergency orders on the grounds that they violate individual rights have been largely unsuccessful, except for claims that orders discriminate based on religion. *See* Wiley, *Social Distancing*, *supra* note 3, at 85-94. Outside of the courts, opposition to and defiance of public health emergency orders and guidelines have undermined the effectiveness of community mitigation measures in the United States and in several other countries. The relationship between cultural norms and compliance with social distancing is as yet unclear. *See, e.g.*, Toan Luu Duc

health care system in ways that have stymied the effectiveness of medical countermeasures for pandemic response. Diagnostic tests, therapeutic treatments, and vaccinations are the foundations of a modern public health response. Our strong orientation toward viewing these tools through a clinical lens that centers individual patients and the providers who care for them has undermined our ability to deploy them as public health interventions.

Disease testing is "the foundation of modern pandemic prevention and response," particularly for a virus that can be transmitted by asymptomatic or pre-symptomatic individuals.[95] When public health infrastructure is adequate, a positive test result should prompt health officials to provide social supports for isolation of the infected individual, investigation to trace their contacts, and quarantine of those contacts to disrupt onward transmission. Testing is also essential for disease surveillance purposes. To be effective and sustainable, public health orders closing schools and businesses should be tailored to local conditions. Without a carefully designed disease surveillance program based on random sampling and carefully defined parameters, the sheer number of reported cases is an unreliable indicator for comparing the scale of outbreaks from place to place and time to time. Recognizing the importance of testing as a public health tool, several countries quickly ramped up public health infrastructure for screening, isolation, contact tracing, quarantine, and disease surveillance.[96]

Huynh, *Does Culture Matter Social Distancing Under the COVID-19 Pandemic?*, 130 SAFETY SCI. 1 (2020) (analyzing different countries' responses to curbing the pandemic); Neha Deopa & Piergiuseppe Fortunato, *Coronagraben. Culture and Social Distancing in Times of COVID-19*, at 4-5 (U.N. Conf. on Trade & Dev., Research Paper No. 49, 2020), https://unctad.org/system/files/official-document/ser-rp-2020d8_en.pdf [https://perma.cc/D4WV-QEV4] (using Switzerland as a case study example of cultural compliance with social distancing requirements); Hohjin Im & Chuansheng Chen, Social Distancing Around the Globe: Cultural Correlates of Reduced Mobility 2-5 (June 2020) (unpublished manuscript) (on file with author), https://www.researchgate.net/profile/Hohjin_Im/publication/342507715_Social_Distancing_Around_the_Globe_Cultural_Correlates_of_Reduced_Mobility/links/5f01063d92851c52d619ab8c/Social-Distancing-Around-the-Globe-Cultural-Correlates-of-Reduced-Mobility.pdf [https://perma.cc/5CL4-8CLC] (describing how collectivist nations dealt with social distancing compared to more individualistic countries).

[95] Lindsay F. Wiley, *Federalism in Pandemic Prevention and Response*, *in* 2 COVID-19 POL'Y PLAYBOOK: ASSESSING LEGAL RESPONSES TO COVID-19, at 65, 66 (Scott Burris, Sarah de Guia, Lance Gable, Donna Levin, Wendy E. Parmet & Nicolas P. Terry eds., 2020), https://www.publichealthlawwatch.org/covid19-policy-playbook [https://perma.cc/5GHD-5LM6] [hereinafter *Federalism*].

[96] Parinaz Tabari, Mitra Amini, Mohsen Moghadami & Mahsa Moosavi, *International Public Health Responses to COVID-19 Outbreak: A Rapid Review*, 45 IRAN J. MED. SCI. 157, 159-60 (2020); *see* Thomas Hale, Noam Angrist, Beatriz Kira, Anna

In contrast, in the U.S., coronavirus testing has been driven by a focus on the clinical significance of results for individuals.[97] Testing was slow to ramp up, supplies were scarce,[98] and early criteria for allocation of scarce resources focused almost exclusively on patient care.[99] The emphasis was on testing to inform clinical decisions about the care of individual patients. In halting an early disease surveillance program in the Seattle area, the FDA disregarded the importance of monitoring trends at the population level — a purpose for which lower accuracy would be acceptable if carefully communicated to test subjects.[100] Lack of access to testing and the failure of the Centers for Disease Control and Prevention ("CDC") to implement a rational disease surveillance system has left people unsure about whether they pose a risk of transmitting the virus to others and state and local leaders ill-equipped to deploy targeted disease control strategies.

The same focus on individualism undermined early vaccination efforts. A rationally designed, carefully implemented public health vaccination campaign can support sustainable suppression of disease transmission. Even without enough vaccine supply to achieve suppression, a vaccination campaign can dramatically reduce hospitalizations and deaths by prioritizing groups for vaccination based on factors such as residential and workplace exposure, age, and underlying medical vulnerabilities.[101] Careful prioritization maximizes

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Petherick, Toby Phillips & Samuel Webster, *Variation in Government Responses to COVID-19*, at 9, 17-18 (Univ. Oxford Blavatnik Sch. Gov't, Working Paper No. BSG-WP-2020/032, version 6.0, 2020).

97 Joshua M. Sharfstein & Melissa A. Marx, Opinion, *Testing Is Just the Beginning in the Battle Against Covid-19*, N.Y. TIMES (Mar. 30, 2020), https://www.nytimes.com/2020/03/30/opinion/coronavirus-testing.html [https://perma.cc/SHP3-53MX] ("Our national tendency is to see testing, and all health care, as being about the individual. But in this crisis, the primary purpose of testing is not self awareness; it is disease control.").

98 Michael D. Shear, Abby Goodnough, Sheila Kaplan, Sheri Fink, Katie Thomas & Noah Weiland, *The Lost Month: How a Failure to Test Blinded the U.S. to Covid-19*, N.Y. TIMES (Mar. 28, 2020), https://www.nytimes.com/2020/03/28/us/testing-coronavirus-pandemic.html [https://perma.cc/8J8G-T3UM].

99 *See* CDC HEALTH ALERT NETWORK, *Update and Interim Guidance on Outbreak of 2019 Novel Coronavirus (2019-nCoV)*, CDC (Feb. 1, 2020, 9:00 AM ET), https://emergency.cdc.gov/han/HAN00427.asp [https://perma.cc/9UT2-SCPD].

100 *See* Erin Brodwin, *Experts Decry FDA's Halting of a High-Profile Covid-19 Study Over Approvals*, STAT (May 27, 2020), https://www.statnews.com/2020/05/27/coronavirus-testing-seattle-bill-gates-fda/ [https://perma.cc/L6GD-42AF].

101 *See, e.g.*, Bruce Y. Lee, Shawn T. Brown, George W. Korch, Philip C. Cooley, Richard K. Zimmerman, William D. Wheaton, Shanta M. Zimmer, John J. Grefenstette, Rachel R. Bailey, Tina-Marie Assi & Donald S. Burke, *A Computer Simulation of Vaccine Prioritization, Allocation, and Rationing During the 2009 H1N1 Influenza Pandemic*, 28

public health benefits by recognizing that some individuals' vaccination will have a greater impact than others. Alternatively, haphazard distribution of scarce supplies based on passive "you come to us" systems results in disproportionately allocating scarce resources to people who are healthier and have greater resources. Without careful planning, reductions in hospitalizations and deaths take longer than necessary and health equity suffers.[102]

In late 2020 and early 2021, underfunded state and local public health departments had insufficient capacity to administer or even oversee distribution,[103] leaving the vaccination campaign largely in the hands of large hospital systems and pharmaceutical chains.[104] Privately administered vaccination clinics had little incentive to engage in active outreach to particularly vulnerable communities where many do not have the resources or time to aggressively pursue vaccination opportunities. Commentators attacked prioritization schemes as a waste of time.[105] Many governors rapidly abandoned CDC prioritization guidelines. Some states supplemented or replaced CDC guidelines with

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VACCINE 4875, 4878 (2010) (explaining the relationships among vaccination prioritization, public health benefit, virus characteristics and vaccine scarcity); *see also* Kathleen Dooling, Mona Marin, Megan Wallace, Nancy McClung, Mary Chamberland, Grace M. Lee, H. Keipp Talbot, José R. Romero, Beth P. Bell & Sara E. Oliver, *The Advisory Committee on Immunization Practices' Updated Interim Recommendation for Allocation of COVID-19 Vaccine — United States, December 2020*, 69 MORTALITY & MORBIDITY WKLY. REP. 1657, 1659 (2021) (explaining the role of ethical criteria in prioritization).

102 *See* Ian Millhiser, *Florida County Has Elderly Residents Camp Out Overnight to Get Covid-19 Vaccine*, VOX (Dec. 29, 2020, 3:50 PM EST), https://www.vox.com/2020/12/29/22205031/florida-covid-vaccine-camp-out-lee-county-ron-desanis-estero [https://perma.cc/KAE6-AZ3L].

103 Abby Goodnough & Sheila Kaplan, *Missing from State Plans to Distribute the Coronavirus Vaccine: Money to Do It*, N.Y. TIMES (Nov. 14, 2020), https://www.nytimes.com/2020/11/14/health/covid-vaccine-distribution-plans.html [https://perma.cc/22B7-74NM].

104 Rebecca Robbins, Frances Robles & Tim Arango, *Here's Why Distribution of the Vaccine Is Taking Longer Than Expected*, N.Y. TIMES (Dec. 31, 2020), https://www.nytimes.com/2020/12/31/health/vaccine-distribution-delays.html [https://perma.cc/2S74-EYQF]; *see* Lena H. Sun & Frances Stead Sellers, *Now Comes the Hardest Part: Getting a Coronavirus Vaccine from Loading Dock to Upper Arm*, WASH. POST (Nov. 23, 2020, 6:06 PM EST), https://www.washingtonpost.com/health/2020/11/23/covid-getting-vaccine/ [https://perma.cc/CW3Z-CFF8].

105 *See, e.g.*, Jessie Hellmann, *Frustration Builds Over Slow Pace of Vaccine Rollout*, THE HILL (Jan. 5, 2021, 5:22 PM EST) https://thehill.com/policy/healthcare/532792-frustration-builds-over-slow-pace-of-vaccine-rollout [https://perma.cc/P9HF-X2B3] (discussing numerous criticisms of the vaccine rollout).

more targeted strategies that enhanced equity,[106] but many governors expanded access to too-large groups while dumping scarce doses into a small number of difficult-to-access sites.[107]

By mid-March 2021, the speed of the U.S. vaccination effort had rapidly increased as doses became more widely available.[108] Rather than administer vaccinations through the existing health care system, however, federal-state partnerships relied heavily on mass vaccination sites, including many run by the Federal Emergency Management Agency and National Guard troops.[109] The vast majority of U.S. residents have been vaccinated outside of the systems where they ordinarily receive medical care.[110] This "bypass" of our individualistic, fragmentary, privatized health care system was remarkably effective at ramping up the pace of vaccination, but it was expensive and may not have been a good fit for vaccine-hesitant people in vulnerable communities. Vaccine demand peaked in April 2021 and many mass vaccination sites began to draw down their operations.[111] Meanwhile, surveys indicated that many unvaccinated people would be more likely

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[106] *See, e.g.*, Deanna Pan, *Should Residents of Hard-Hit Cities and Towns Be Vaccinated Before Other Groups? Some Epidemiologists Think So*, BOS. GLOBE (Dec. 24, 2020, 4:28 AM), https://www.bostonglobe.com/2020/12/23/nation/should-residents-hard-hit-cities-towns-be-vaccinated-before-other-groups-some-epidemiologists-think-so/ [https://perma.cc/5DWX-9UR9] (discussing state strategies for prioritizing vulnerable populations).

[107] *See, e.g.*, Jen Christensen, *As 'Messy' Vaccine Rollout Continues, States Begin to Prioritize More People for Vaccination*, CNN (Jan. 6, 2021, 9:28 PM ET), https://www.cnn.com/2021/01/06/health/covid-19-messy-roll-out-state-expand-priorities/index.html [https://perma.cc/43DN-EXF5] (describing Florida Governor Ron Desantis's expansion of eligibility criteria to anyone over age 65, resulting in demand "so high that some seniors camped out overnight to get one."); Hellmann, *supra* note 105 ("Frustrated by the slow pace of vaccination, governors are . . . questioning the priority guidelines adopted by the CDC for who should receive the first doses of the vaccines.").

[108] *See* Eileen Sullivan, *COVID-19: Pace of U.S. Vaccinations Accelerates*, N.Y. TIMES (Mar. 12, 2021), https://www.nytimes.com/live/2021/03/12/world/covid-19-coronavirus [https://perma.cc/32XQ-YQLU].

[109] *Federally Supported Community Vaccination Centers*, FEMA https://www.fema.gov/disasters/coronavirus/vaccine-support/vaccine-center# (last updated July 6, 2021) [https://perma.cc/L722-L6AG].

[110] *See* CTRS. FOR DISEASE CONTROL & PREVENTION, EXPANDING COVID-19 VACCINE DISTRIBUTION TO PRIMARY CARE PROVIDERS TO ADDRESS DISPARITIES IN IMMUNIZATION: GUIDE FOR JURISDICTIONS 2 (2021), https://www.cdc.gov/vaccines/covid-19/downloads/Guide-for-Jurisdictions-on-PCP-COVID-19-Vaccination.pdf [https://perma.cc/29YB-JQQ8].

[111] Meghann Myers, *Troops Heading Home as COVID-19 Mass Vaccination Sites Close Up Shop*, MILITARY TIMES (June 8, 2021), https://www.militarytimes.com/news/your-military/2021/06/08/troops-heading-home-as-covid-19-mass-vaccination-sites-close-up-shop/ [https://perma.cc/GR87-KD2J].

to accept vaccination if offered by their regular health care provider, who could answer their questions and discuss risks and benefits.[112]

A key insight of public health is that "health is not just an individual good; it is a distinctly public good, too."[113] In contrast, the iron triangle ethos is individualistic at its core. It guides evaluation of our health care system based on individual access to high-quality health care and the costs associated with it, not on public health outcomes or equity. Deeper commitment to solidarity prompts us to assess the system in terms of its ability to serve "uniquely public — as opposed to the mere aggregation of private — interests."[114] The COVID pandemic has amply demonstrated our health care system's catastrophic failures by these criteria.

2. Fiscal Fragmentation

Fiscal fragmentation is the "tendency to divide costs associated with Americans' sickness and health into separate, fiscally disintegrated categories."[115] Public health programs aimed at community prevention are financed separately from health care at a rate of pennies on the dollar.[116] The costs of health care for individuals who become sick are divided between the health care provider, the patient, the taxpayer, and the patient's insurer, if she has one.[117] Costs borne by insurers are pooled across all enrollees, but fragmented among somewhat arbitrary actuarial groups based on payer, region, employer, age, and other categories. Insurance risk pools are divided by design.[118] Fiscal

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[112] Scott Ratzan, Eric C. Schneider, Hilary Hatch & Joseph Cacchione, *Missing the Point — How Primary Care Can Overcome Covid-19 Vaccine "Hesitancy"*, 384 NEW ENG. J. MEDICINE e100(1), e100(2)-(3) (2021).

[113] Harris & Pamukcu, *supra* note 4, at 792.

[114] Wiley, *Health Justice*, *supra* note 8, at 855 (emphasis omitted).

[115] Fuse Brown et al., *supra* note 1, at 415. The law's focus on individualism does not mean that persons are seen in their fullness and inter-connectedness. Instead, persons are fragmented into categories — employee, mother, child, consumer — and regulated one piece at a time. *See* Ani B. Satz, *Overcoming Fragmentation in Disability and Health Law*, 60 EMORY L.J. 277, 281 (2010) (suggesting "that an individual must be viewed holistically, across the full range of environments in which she functions").

[116] *See* David U. Himmelstein & Steffie Woolhandler, *Public Health's Falling Share of US Health Spending*, 106 AM. J. PUB. HEALTH 56, 56-57 (2016); *see also* Nason Maani & Sandro Galea, *COVID-19 and Underinvestment in the Health of the U.S. Population*, 98 MILBANK Q. 239, 240 (2020).

[117] *See* Fuse Brown et al., *supra* note 1, at 415.

[118] *See* Stone, *supra* note 8, at 290 ("Actuarial fairness . . . is a method of organizing mutual aid by fragmenting communities into ever-smaller, more homogeneous groups . . . that leads ultimately to the destruction of mutual aid. This fragmentation must be

fragmentation manifests most noticeably in our splintered multi-payer system of federal (e.g., Medicare) and state (e.g., Medicaid) public programs, and employer-based group and individual insurance plans. The result is a bewildering assortment of fiscal categories, overseen by different entities, each incentivized to reduce its own costs, but not others'.

Fragmentation impedes health justice in three ways. First, the legal division of responsibility for costs and benefits gives individuals, agencies, and programs an economic incentive to think only of themselves or the costs within their charge. In economic terms, this means that negative externalities (including harms to the public's health) will be over-produced, positive externalities (including public health benefits) will be under-produced, and equitable distribution will be marginalized.[119] Second, the logistical division of costs and benefits obscures health care's true costs and makes it easier to neglect those outside one's group — by ignoring the fiscal categories to which they are assigned or failing to account for costs in certain categories altogether.[120] The invisibility of care work provided by loved ones — especially by women to children, the elderly, and the sick — is a prime example.[121] Third, in a world of scarcity, the division of costs and benefits poses an additional challenge, making marshaling resources for significant investments in public goods with dispersed benefits difficult, susceptible both to coordination failures and collective action problems. Fragmentation it exacerbates the scarcity of resources needed to support a modern public health response.[122]

In the U.S. pandemic response, fiscal fragmentation shifted and hid costs and forced false, tragic choices. These effects began years before the pandemic. Fiscal fragmentation impeded efforts to invest in public

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accomplished by fostering in people a sense of their differences, rather than their commonalities . . . .").

[119] *See* WALLACE E. OATES, FISCAL FEDERALISM 66-67 (William J. Baumol ed., 1972) (discussing externalities and subsidies to counteract them).

[120] *See* PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 11 (2011) ("Every aspect of this financing system serves to obscure its true costs. So when people who have good health benefits evaluate reforms, they do so from a standpoint shielded from the full realities of the problem.").

[121] Allison K. Hoffman, *Reimagining the Risk of Long-Term Care*, 16 YALE J. HEALTH POL'Y, L., & ETHICS 147, 184 (2016) ("[D]amage to intimate relationships or health and an inability to pursue life goals" for caretakers are "the invisible copayment of current long-term care social insurance programs").

[122] *See* Len M. Nichols & Lauren A. Taylor, *Social Determinants As Public Goods: A New Approach to Financing Key Investments in Healthy Communities*, 37 HEALTH AFFS. 1223, 1225 (2018) (describing lack of community public health investment and coordination challenges in financing such investment).

health infrastructure for pandemic prevention and response. Section 4002 of the Affordable Care Act created an 18.75 billion dollar Prevention and Public Health Fund "to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs."[123] Unfortunately, however, the fund was a sitting duck because it counts as "mandatory" federal spending within our fragmented financing system. Budget rules push Congress to cut mandatory funding in existing law whenever it wants to pass a statute that cuts taxes or creates new mandatory spending, but mandatory funding programs are usually protected by powerful interest groups.[124] Public health is a rare exception — it tends to benefit the public generally, not particular interest groups — so Congress repeatedly (and tragically) raided the fund in the years leading up to 2020 to offset costly changes in federal law benefiting discrete interests, including the "doc fix" and the 2017 tax cuts.[125]

It is reasonable to presume that CDC's funding challenges in the years before the pandemic contributed to the agency's testing missteps. Indeed, as early as 2018, observers expressed fear that raiding the Prevention and Public Health Fund would render CDC unable to respond quickly and effectively to a pandemic. "[W]ithout funding, the CDC won't be able to protect us," former CDC Director Tom Frieden observed after one of Congress's raids on the fund in 2018.[126] As a result, he said, "[w]e're more likely to have to fight dangerous organisms here in the U.S."[127]

Fiscal fragmentation has also stymied investments in the quality of nursing home care and coordination between acute hospital care and long-term care. The perverse game of "hot potato" between families, states, providers, and the federal government over elderly Americans'

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123 42 U.S.C. § 300u-11 (2018); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4002, 124 Stat. 119 (2010).

124 *See* William M. Sage & Timothy M. Westmoreland, *Following the Money: The ACA's Fiscal-Political Economy and Lessons for Future Health Care Reform*, 48 J.L. MED. & ETHICS 434, 436 (2020) (describing PAYGO, a rule adopted by Congress to prohibit mandatory spending or revenue legislation if it would worsen the deficit).

125 Michael R. Fraser, *A Brief History of the Prevention and Public Health Fund: Implications for Public Health Advocates*, 109 AM. J. PUB. HEALTH 572, 573-74 (2019) (discussing the "doc fix"); Sage & Westmoreland, *supra* note 124, at 440 (discussing the removal of funds because of the 2017 tax cuts and other funding decisions).

126 Ashley Yeager, *Cuts to Prevention and Public Health Fund Puts CDC Programs at Risk*, THE SCIENTIST (Feb. 9, 2018), https://www.the-scientist.com/daily-news/cuts-to-prevention-and-public-health-fund-puts-cdc-programs-at-risk-30298 [https://perma.cc/ULV7-7ANQ].

127 *Id.*

care offers a stark illustration. In the U.S., much of the cost of daily care for the elderly is borne, by default, by themselves or their loved ones.[128] Medicare, which is federally financed, only pays for one hundred days of nursing home or home health care after an enrollee is hospitalized for 3-days.[129] The reason for these arbitrary cutoffs is fiscal fragmentation: Medicare's designers worried about tapping the Medicare trust fund for nursing home care, and opted to shift the cost to families and states.[130] Medicaid, which is jointly financed by states and the federal government, is the largest payer of long-term care; about half of nursing home residents either satisfy Medicaid's indigence requirement for coverage or else spend down their assets paying for care until Medicaid kicks in.[131] The arbitrary limits on Medicare-financed nursing home care cause perverse behavioral effects, as families conspire to get their loved ones admitted to hospitals in order to trigger nursing home coverage, or struggle once the 100 days are up to find alternative arrangements.[132]

A pandemic that threatens the elderly in particular is a terrible time for families to navigate the fragmented churn through hospitalization, long-term care, and home health. By mid-March of 2020, the Department of Health and Human Services ("HHS") realized that the 3-day rule and 100-day limit threatened to exacerbate the pandemic.[133] It issued an emergency waiver, purporting to relax the 3-day rule and 100-day limit for COVID patients.[134] But fiscal fragmentation is more stubborn: these costs are first born by providers who then seek reimbursement. With a long history of being denied reimbursement, providers continued to apply the old limits, despite the waiver. As Adam Zimmerman described, providers were either ignorant about the last-

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128 *See* METLIFE MATURE MKT. INST., THE METLIFE STUDY OF CAREGIVING COSTS TO WORKING CAREGIVERS: DOUBLE JEOPARDY FOR BABY BOOMERS CARING FOR THEIR PARENTS 15 (2011) (estimating costs to family caregivers approaching $3 trillion).

129 *See* Richard L. Kaplan, *Reflections on Medicare at 50: Breaking the Chains of Path Dependency for a New Era*, 23 ELDER L.J. 1, 9-10 (2015).

130 *See* Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid's History*, 26 GA. STATE U. L. REV. 937, 956 (2010) ("Wilbur Cohen, President Johnson's chief strategist on the Medicare bill, was concerned that nursing home coverage would open up a bottomless pit of demand that would destroy the delicate political budgetary balance needed to support Medicare through mandatory payroll deductions.").

131 *Id.* at 939, 952.

132 *Id.* at 956-57.

133 DEP'T OF HEALTH & HUM. SERVS., FINDINGS CONCERNING SECTION 1812(F) OF THE SOCIAL SECURITY ACT IN RESPONSE TO THE EFFECTS OF THE 2019-NOVEL CORONAVIRUS (COVID-19) OUTBREAK 1-2 (2020).

134 *Id.*

minute waiver or fearful it would be applied strictly, a fear that was bolstered by early-summer guidance describing the waiver in limited terms.[135] Thus, Medicare enrollees and their families continued to struggle to access care.[136]

The fragmentation of financing mechanisms also plagued testing. Workplaces and schools had reason to push their employees and students to get tested — for the good of other employees, customers, teachers, and students, and so they could remain open. This was easier said than done, however. The $100 to $199 cost of a COVID test for an asymptomatic person typically has been worth it, in terms of the protective interventions a positive test enables and the assurance a negative test provides.[137] But fiscal fragmentation produced a legal and logistical mismatch between those who benefit from such a test and those in a position to pay.[138] At the start of the pandemic, Congress mandated that insurers pay for coronavirus testing without cost-sharing.[139] But insurers argued that precautionary tests were not covered by insurance contracts to cover "medically necessary" care.[140] Workplaces and schools, in turn, usually declined to mandate testing

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135 *See* Adam S. Zimmerman, *Medicare's Broken Promise to People in Nursing Homes*, THE HILL (June 27, 2020), https://thehill.com/opinion/healthcare/504830-medicares-broken-promise-to-people-in-nursing-homes [https://perma.cc/2A7Y-XJJ7].

136 Chuck Buck, *Amid Confusion, the SNF 3-Day Waiver Remains Intact Nationally*, RAC MONITOR (July 8, 2020), https://www.racmonitor.com/amid-confusion-the-snf-3-day-waiver-remains-intact-nationally [https://perma.cc/TB8B-WE2M] (describing widespread reluctance by skilled nursing facilities to accept Medicare patients lacking prior 3-day inpatient admission despite waiver).

137 *See* Nisha Kurani, Karen Pollitz, Dustin Cotliar, Giorlando Ramirez & Cynthia Cox, *COVID-19 Test Prices and Payment Policy*, PETERSON-KFF HEALTH SYS. TRACKER, https://www.healthsystemtracker.org/brief/covid-19-test-prices-and-payment-policy/ (Apr. 28, 2021) [https://perma.cc/WV5N-398Z].

138 The benefit of avoided exposures justifies the cost from the perspective of those saved from the virus, but they lack any way to pay for the test. The individual's insurer has the capacity to pay for a test, but is unlikely to derive any benefit from avoiding a COVID case only if the patient happens to be one of its beneficiaries.

139 Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116-127, § 6001, 134 Stat. 178 (2020) (to be codified at 42 U.S.C.A. §§ 1320b-5, 1395l, 1396d(a)(3)); Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136, § 3202(a), 134 Stat. 281 (2020).

140 U.S. DEP'T OF HEALTH & HUMAN SERVS., FAQS ABOUT FAMILIES FIRST CORONAVIRUS RESPONSE ACT AND CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT IMPLEMENTATION Part 42, at 6 (2020) (requiring coverage applies only where the test is "medically appropriate for the individual . . . in accordance with current accepted standards of medical practice"); *see* Julie Appleby, *For COVID Tests, the Question of Who Pays Comes Down to Interpretation*, KAISER HEALTH NEWS (July 20, 2020), https://khn.org/news/for-covid-tests-the-question-of-who-pays-comes-down-to-interpretation/ [https://perma.cc/5ZJ7-Q6AP].

not due to a lack of availability, but due to the cost and administrative complexity,[141] and individuals found themselves unexpectedly being billed for coronavirus tests,[142] or delayed or refused tests for fear of that result.[143]

After approval of the first vaccines, frustrating and deadly delays in their distribution evidenced fiscal fragmentation's logistical entrenchment. The federal government had an acute fiscal interest in promptly vaccinating residents in long-term care facilities ("LTCF"), including skilled nursing facilities, assisted living facilities, and residential care homes. When COVID outbreaks hit nursing homes, the resulting hospital treatment expenses are borne primarily by Medicare (which covers hospital care costs without regard to whether a person was previously in a nursing home).[144] Unsurprisingly, then, the federal government aspired to provide and pay for vaccination for all LTCF residents and staff.

Fragmentation's logistical entrenchment proved an impediment to this public health intervention, however. While the federal government found itself with the will to finance a public health intervention, it failed to create a way — an apparatus to administer vaccinations to skilled nursing facility residents and workers as rapidly as possible.[145] After

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[141] NATHANIEL L. WADE & MARA G. ASPINALL, ASU COLLEGE OF HEALTH SOLS., FACING UNCERTAINTY: THE CHALLENGES OF COVID-19 IN THE WORKPLACE 6-7 (2020), https://issuu.com/asuhealthsolutions/docs/asu_workplace_commons_nov2020?fr=sYjhjZjE5NTg1NjM [https://perma.cc/5968-X99F] (noting in survey of more than 1100 employers, vast majority declined to test asymptomatic employees; cost was cited as number one impediment and complexity as number two); Elissa Nadworny, *Many Colleges Aren't Aggressively Testing Students for Coronavirus*, NPR, at 1:01 (Oct. 6, 2020, 5:04 AM ET), https://www.npr.org/2020/10/06/920642789/many-colleges-arent-aggressively-testing-students-for-coronavirus [https://perma.cc/3PUD-JGF3] (noting in survey of more than 1400 colleges with in-person classes, vast majority declined to test asymptomatic students; lack of CDC recommendation and cost were top two reasons).

[142] Donna Rosato, *How 'Free' Coronavirus Testing Has Become the New Surprise Medical Bill*, CONSUMER REPS. (July 27, 2020), https://www.consumerreports.org/coronavirus/how-free-coronavirus-testing-has-become-new-surprise-medical-bill/ [https://perma.cc/5V3P-7RU2].

[143] *See* Brendan Keefe, *Where to Get Free COVID-19 Test if You Have No Symptoms*, 11ALIVE (May 20, 2020, 10:55 PM EDT) https://www.11alive.com/article/news/health/coronavirus/georgia-testing-lack-of-free-accessibility/85-ce70d88b-17a8-4819-9a5b-792710212caf [https://perma.cc/5FKD-27SZ] (reporting examples of patients told they would be billed for tests despite coverage requirements and encouraging readers afraid of cost to seek tests from particular sites).

[144] 42 U.S.C. § 1395(d)(a) (2018) (describing Medicare coverage of inpatient hospital costs).

[145] Noam N. Levey, *Vaccine Rollout Relies Heavily on CVS and Walgreens*, DAILY HAMPSHIRE GAZETTE (Dec. 5, 2020, 1:25 PM), https://www.gazettenet.com/COVID-19-

months of failed legislative efforts to fund vaccine distribution by state and local health departments,[146] Operation Warp Speed (the joint HHS and Department of Defense effort to develop and deploy COVID vaccines) could not simply stand up a public health apparatus overnight. In the absence of publicly financed infrastructure, Operation Warp Speed contracted with private companies to provide immunizations: CVS, Walgreens, and a handful of smaller pharmacy chains.[147] Under the Pharmacy Partnership for Long-Term Care Program, Operation Warp Speed shipped millions of doses to pharmacies in mid-December 2020 and instructed them to bill Medicare, Medicaid, or private insurance for each vaccine administered to an LTCF resident or worker.[148]

This workaround, touted by federal officials as not imposing any additional cost on the federal government to send mobile vaccination teams directly to facilities, was "a fiasco."[149] Experts predicted that the pharmacies' profit motive would undermine their interest in active outreach to vulnerable populations, particularly since the pharmacies were paid no more for the effort of staffing mobile teams than they would have been for passively administering them at their own retail clinics.[150] Millions of doses were held in storage while the pharmacies

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vaccine-rollout-relies-heavily-on-CVS-and-Walgreens-37625338 [https://perma.cc/S5QR-WCQ9] ("We're in a situation where we don't have a public sector that's able to do something like this.").

[146] Nicholas Florko, *Trump Officials Actively Lobbied to Deny States Money for Vaccine Rollout Last Fall*, STAT (Jan. 31, 2021), https://www.statnews.com/2021/01/31/trump-officials-lobbied-to-deny-states-money-for-vaccine-rollout/ [https://perma.cc/F5JA-G2F4].

[147] Press Release, U.S. Dep't of Health and Hum. Servs., Trump Administration Partners with CVS and Walgreens to Provide COVID-19 Vaccine to Protect Vulnerable Americans Living in Long-Term Care Facilities (Oct. 16, 2020) https://www.hhs.gov/about/news/2020/10/16/trump-aministration-partners-cvs-walgreens-provide-covid-19-vaccine-protect-vulnerable-americans-long-term-care-facilities-nationwide.html [https://perma.cc/U9KR-G6ZJ]; Florko, *supra* note 146.

[148] Press Release, U.S. Dep't of Health and Hum. Servs., *supra* note 147.

[149] Rachel Bluth & Lauren Weber, *CVS and Walgreens Under Fire for Slow Pace of Vaccination in Nursing Homes*, KAISER HEALTH NEWS (Jan. 15, 2021), https://khn.org/news/article/cvs-and-walgreens-under-fire-for-slow-pace-of-vaccination-in-nursing-homes/ [https://perma.cc/YJ4D-Q84D] (quoting Mississippi's state health offer, who also stated that Mississippi pharmacies had administered only five percent of the doses committed to the program as of January 14); John Pacenti, *"Time Is of the Essence" for COVID Vaccine: Gov. DeSantis Frustrated with CVS and Walgreens*, PALM BEACH POST (Dec. 16, 2020, 4:40 PM ET), https://www.palmbeachpost.com/story/news/coronavirus/2020/12/16/covid-desantis-expresses-frustration-cvs-and-walgreens/3925203001/ [https://perma.cc/R5PS-466S].

[150] Levey, *supra* note 145; *see* Sarah Mervosh, *How West Virginia Became a U.S. Leader in Vaccine Rollout*, N.Y. TIMES (Jan. 24, 2021), https://www.nytimes.com/

imposed burdensome consent paperwork requirements on facilities. Efforts to secure hard-copy consent forms from residents and their family members do not appear to have been motivated by the threat of liability (vaccine administrators are shielded from liability). Rather, the deadly delays caused by consent paperwork appear to have been motivated by third-party billing requirements.[151] Vaccine administration fell far short of projections, except in the one state that declined to rely on the federal program.[152]

The fragmentation of responsibility for health costs has contributed to a lack of pandemic preparedness, impeding public health investments. Once the pandemic hit, fragmentation stood in the way of critical interventions with collective benefits. The federal government had the resources to implement a modern public health response but it lacked both the administrative capacity and the political will to displace our fragmented status quo.

3. Federalism

Federalism further divides authority for legal interventions in the pandemic response among federal, state, and local governments. It is legally entrenched in the Constitution's enumeration of federal regulatory powers in Article I and its reservation of non-enumerated powers for states in the Tenth Amendment, establishing dual sovereignty.[153] It extends to states' conferral of regulatory power on local authorities via home rule doctrine, creating a second layer of sub-national regulatory power, but one heavily dependent on state sovereign authority.[154] The legal pecking order establishes federal law as supreme

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2021/01/24/us/west-virginia-vaccine.html [https://perma.cc/UZ6W-MFC2]; Yuki Noguchi, *Why West Virginia's Winning the Race to Get COVID-19 Vaccines Into Arms*, NPR (Jan. 7, 2021, 4:16 PM ET), https://www.npr.org/sections/health-shots/2021/01/07/954409347/why-west-virginias-winning-the-race-to-get-covid-19-vaccine-into-arms [https://perma.cc/3UQW-L3P8].

[151] Bluth & Weber, *supra* note 149.

[152] Noah Higgins-Dunn, *Operation Warp Speed Chief Says Covid Vaccine Distribution 'Should Be Better' as U.S. Misses Goal*, CNBC (Dec. 30, 2020, 2:30 PM EST) https://www.cnbc.com/2020/12/30/covid-vaccine-operation-warp-speed-chief-says-distribution-should-be-better-.html [https://perma.cc/SB8W-BZ6F].

[153] *See generally* Heather K. Gerken, *Foreword: Federalism All the Way Down*, 124 HARV. L. REV. 4, 11-12 (2010) [hereinafter *All the Way Down*] (presenting the conventional account of sovereignty in federalism).

[154] *Id.* at 22-25 (extending federalism principles to local governments); Heather K. Gerken, *Federalism 3.0*, 105 CALIF. L. REV. 1695, 1722 (2017) [hereinafter *Federalism 3.0*]; *cf.* Richard Briffault, *The Challenge of the New Preemption*, 70 STAN. L. REV. 1995

but somewhat limited in scope, state law as subordinate to conflicting federal law but otherwise plenary in scope, and local law as subordinate to both federal and state laws and dependent on state authorization for its scope.[155]

Federalism's logistical entrenchment is more complex. It is found in the political and jurisprudential narratives of comity and deference to state sovereignty and the practical devolution to state authority.[156] Federalism embraces the normative values of state experimentation and local variation within an overarching national system of uniform priorities.[157] Practically, however, the logistical entrenchment of state influence on federal policy — despite the breadth and supremacy of federal regulatory power — means that deference to states characterizes federalism as a fixture.[158]

Health care federalism has an inconsistent and often ineffective legacy: federal authority dominates the field of regulating medical products, establishing nationwide standards for safety and efficacy and serving as a singular clearinghouse for scientific knowledge on diseases and their diagnosis, treatment, mitigation, and cures.[159] States, however,

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(2018) (describing a trend of "aggressive" and even "punitive" trend in state preemption of local laws, as a backlash to local progressive regulation and a violation of home rule).

155 *See, e.g.*, Lauren E. Phillips, Note, *Impeding Innovation: State Preemption of Progressive Local Regulations*, 117 COLUM. L. REV. 2225 (2018) (discussing states' reassertion of sovereignty through preemption of local laws).

156 Fuse Brown et al., *supra* note 1, at 414; *e.g.*, Bridget A. Fahey, *Federalism by Contract*, 129 YALE L. J. 2326, 2331-32 (2020); Abbe R. Gluck, *Our [National] Federalism*, 123 YALE L.J. 1996, 1997-2000 (2014); *cf.* Gerken, *Federalism 3.0*, *supra* note 154, at 1722 (arguing that a state's "democratic role is just as important as its regulatory one" because states serve as "the front lines for national debates, the key sites where we work out our disagreements before taking them to a national stage").

157 Erwin Chemerinsky, *The Values of Federalism*, 47 FLA. L. REV. 499, 525 (1995); Gluck, *supra* note 156, at 1999, 2020.

158 *See* Fuse Brown et al., *supra* note 1, at 414; *see also* Nicole Huberfeld, *Federalism in Health Care Reform*, *in* HOLES IN THE SAFETY NET: FEDERALISM AND POVERTY 198 (Ezra Rosser ed., 2019) [hereinafter *Federalism in Health Care Reform*] (noting that "federalism tends to be understood to mean that states are in charge").

159 Elizabeth Y. McCuskey, *Body of Preemption: Health Law Traditions and the Presumption Against Preemption*, 89 TEMPLE L. REV. 95, 135 (2016) (concluding that "[r]egulation of medical products is thus heavily and historically federal" considering the involvement of FDA, NIH, Medicare, and Medicaid regulation); Patricia J. Zettler, *Pharmaceutical Federalism*, 92 IND. L.J. 845, 851 (2017) ("[T]he federal government rigorously regulates drugs—drugs generally cannot be sold, prescribed, or dispensed to patients until the federal government determines that they are safe and effective"). *See generally* ROBERT I. FIELD, MOTHER OF INVENTION: HOW THE GOVERNMENT CREATED "FREE-MARKET" HEALTH CARE 24-28, 48-84 (2014) (explaining how the NIH, FDA, and federal Patent and Trademark Office "created the pharmaceutical industry"). CDC supplements all of these federal functions.

retain primary authority over regulating medical facilities and practitioners who prescribe and administer these products.[160] When it comes to the practical dimensions of accessing health care, federalism has stymied normatively desirable health care financing and payment reforms and perpetuated interstate inequities.[161] The ACA's design accommodated states by offering them Spending Clause enticements for Medicaid expansion and operating insurance exchanges, and relying on them to implement federal policy priorities and standards.[162] States responded in polarized and polarizing ways, with conservative-led states refusing to cooperate and attempting to use federal waivers to fund "experiments" that undermine the core protections in those

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[160] Zettler, *supra* note 159, at 885 (acknowledging and questioning the "[c]onventional wisdom in health law and policy . . . that states regulate the practice of medicine, while the federal government—specifically the FDA — regulates drugs").

[161] *See, e.g.*, Huberfeld, *Federalism in Health Care Reform*, *supra* note 158, at 197-98 ("States generally cannot and do not act alone" in health reform); Fuse Brown & McCuskey, *supra* note 15, at 443-47 (describing the "pitfalls" of federalism in health care as enabling states to undermine federal protections, while preempting states from enacting further protections); Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Healthcare For?*, 70 STAN. L. REV. 1689, 1698 (2018) ("[H]ealth policy that allows for interstate variation might be a benefit of federalism, but it also leads to significant inequality when it comes to healthcare access across the country."); Scott L. Greer & Peter D. Jacobson, *Health Care Reform and Federalism*, 35 J. HEALTH POL., POL'Y & L. 203, 206 (2010) (recognizing "that the distressing litany of historical failure at both the state and federal levels provides no guidance in answering the question of federalism in health care reform"); Jerry L. Mashaw & Theodore R. Marmor, *The Case for Federalism and Health Care Reform*, 28 CONN. L. REV. 115, 116-17 (1995) (outlining the potential for state reform to produce "workable and acceptable" changes that respond to local preferences, but also the "serious and plausible objections to leaving much of health planning to the states"); McCuskey, *supra* note 159, at 97-100 (tracing the growing ratio of federal-to-state health laws); Richard P. Nathan, *Federalism and Health Policy*, 24 HEALTH AFFS. 1458, 1461 (2005) (explaining that "richer states have richer [Medicaid] programs; hence, the federalism state-push factor for Medicaid is primarily from liberal states"); Wendy E. Parmet, *Regulation and Federalism: Legal Impediments to State Health Care Reform*, 19 AM. J.L. & MED. 121, 130 (1993) (identifying "a variety of federal statutes, all of which raise potential impediments to would-be state reformers").

[162] *See, e.g.*, Fahey, *supra* note 156, at 2362 (highlighting the Supreme Court's anti-coercion holding in *NFIB v. Sebelius* as part of a broader phenomenon of intergovernmental agreements); Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 534, 582-90 (2011) (cataloging the many different versions of federalism in the ACA, and explaining that the statute "requires elaborate infrastructures to be created and implemented at the state and local levels"); *see also* Nicholas Bagley, *Federalism and the End of Obamacare*, 127 YALE L.J.F. 1, 15 (2017); Fuse Brown et al., *supra* note 1, at 414-15; Gluck et al., *supra* note 42, at 1473.

federal programs.[163] As Abbe Gluck and Nicole Huberfeld have observed, "the ACA's federalism served state power," but did not necessarily "produce[] better health policy outcomes."[164] As a final federalism trap, ERISA preempts states and localities from enforcing their own protective laws against most employer-sponsored health insurance plans.[165] Federalism's dysfunction cuts in multiple directions simultaneously, but mostly against solidarity-enhancing policies.

The U.S. response to the COVID pandemic was dependent on an incoherent and inequitable state-by-state patchwork approach to distributing the burdens and benefits of public investments in health. In theory, the deft division of labor among different levels of government[166] could benefit health care[167] and public health[168] responses by tailoring regulatory authority and responsibility for execution to the particular strengths of each level. In practice, however, federalism has sowed dysfunction in testing, treatment, and vaccination policy — compounding its crippling disruption of community mitigation measures like masking and social distancing.[169]

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163 *E.g.*, Elizabeth Y. McCuskey, *Big Waiver Under Statutory Sabotage*, 45 OHIO N.U. L. REV. 213, 233 (2019); Jonathan Oberlander, *The End of Obamacare*, 376 NEW ENG. J. MEDICINE 1, 3 (2017); Sara Rosenbaum, *The (Almost) Great Unraveling*, 43 J. HEALTH POL., POL'Y & L. 579, 595 (2018).

164 Abbe R. Gluck & Nicole Huberfeld, *The New Health Care Federalism on the Ground*, 15 IND. HEALTH L. REV. 1, 3 (2018) ("We can say more assuredly that the ACA's federalism served state power than we can say that its federalism produced better health policy outcomes . . . .").

165 *See* Fuse Brown & McCuskey, *supra* note 15, at 389.

166 *See generally* Jenna Bednar, *The Political Science of Federalism*, 7 ANN. REV. L. & SOC. SCI. 269, 270 (2011) (explaining dual sovereignty principles of federalism theory).

167 *E.g.*, Kristin Madison, *Building a Better Laboratory: The Federal Role in Promoting Health System Experimentation*, 41 PEPP. L. REV. 765, 766 (2014); Michael Serota & Michelle Singer, *Maintaining Healthy Laboratories of Experimentation: Federalism, Health Care Reform, and ERISA*, 99 CALIF. L. REV. 557, 600-04 (2011).

168 *E.g.*, Lawrence O. Gostin & Lindsay F. Wiley, *Governmental Public Health Powers During the COVID-19 Pandemic Stay-at-Home Orders, Business Closures, and Travel Restrictions*, 323 J. AM. MED. ASS'N 2137, 2137 (2020) (explaining the legal powers of federal, state, and local governments to implement public health interventions).

169 *See, e.g.*, Rebecca L. Haffajee & Michelle M. Mello, *Thinking Globally, Acting Locally – the U.S. Response to Covid-19*, 382 NEW ENG. J. MEDICINE e75, 1 (2020) ("COVID-19 has exposed major weaknesses in the United States' federalist system of public health governance . . . ."); Huberfeld et al., *supra* note 71, at 956-57; Nancy J. Knauer, *The COVID-19 Pandemic and Federalism: Who Decides?*, 23 N.Y.U. J. LEGIS. & PUB. POL'Y 1, 5 (2020) ("The varying state and local responses to the pandemic underscore both the promise and the limitations of federalism."); Nicolas Terry, *COVID-19 and Healthcare Lessons Already Learned*, 7 J.L. & BIOSCI. 1, 1 (2020) (using "COVID-19 as a frame on the . . . flaws inherent in healthcare federalism," among other longstanding problems); Wiley, *Federalism*, *supra* note 95, at 69 (explaining how

First, on the aspects of pandemic response that demand economies of scale and interstate coordination, the federal government abdicated its role.[170] When it came to funding and supply-chain preparations for the crucial pandemic-response tools of tests, medical equipment, therapeutics, and vaccine doses, the federal government shunted to states responsibilities that they neither asked for nor could bear — functionally or financially.[171] A functional response to the pandemic would have harnessed the power of FDA's longstanding role as medical innovation intermediary, and the equally longstanding power of federal funding for "research, development, stockpiling, and distribution of critical supplies."[172] Yet FDA initially flexed its regulatory power to *prevent* the dissemination of local lab-developed testing protocols from the University of Washington.[173] HHS later rescinded FDA's authority to clear lab-developed tests before use,[174] but not until after missteps

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federalism "stymied the U.S. coronavirus response" on public health mitigation measures, and offering recommendations for how a deft division of federal and state powers should work).

170 Haffajee & Mello, *supra* note 169, at 2 (noting that "the federal government has done too little").

171 *See* Sheila Grigsby et al., *Resistance to Racial Equity in U.S. Federalism and Its Impact on Fragmented Regions*, 50 AM. REV. PUB. ADMIN. 658, 660 (2020) ("Even before COVID-19, studies have shown that state and county governments were neither prepared nor resourced to implement strategic plans to address global health crises."); Huberfeld et al., *supra* note 71, at 955 ("States have been the primary payer for the majority of the response, including purchasing personal protective equipment . . . increasing charity care payments to hospital . . . . The lack of federal coordination and funding leaves states scrambling to pay for an emergency that far outpaces what they could have budgeted for . . . .").

172 Wiley, *Federalism*, *supra* note 95, at 66.

173 *See* Sheri Fink & Mike Baker, *'It's Just Everywhere Already': How Delays in Testing Set Back the U.S. Coronavirus Response*, N.Y. TIMES (Mar. 10, 2020), https://www.nytimes.com/2020/03/10/us/coronavirus-testing-delays.html [https://perma.cc/S7Q9-84CK]; Atul Gawande, *We Can Solve the Coronavirus-Test Mess Now—If We Want To*, NEW YORKER (Sept. 2, 2020) https://www.newyorker.com/science/medical-dispatch/we-can-solve-the-coronavirus-test-mess-now-if-we-want-to [https://perma.cc/34ZP-9927] ("In fact, the United States has stymied rather than accelerated the ability of laboratories to develop testing capacity. [The labs of . . . hospital system[s] [and] other academic and commercial labs . . . began developing a coronavirus test in January, concerned that the outbreak in Asia could become a danger here. But, through February, the F.D.A. authorized only the C.D.C.'s coronavirus test.").

174 *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., RESCISSION OF GUIDANCES AND OTHER INFORMAL ISSUANCES CONCERNING PREMARKET REVIEW OF LABORATORY DEVELOPED TESTS 1 (2020).

and contamination had frustrated the rollout of CDC-developed federal test kits.[175]

States, as co-equal sovereign governments in the federalist system, sometimes sought to work together to secure needed supplies, and other times competed with each other for the scarce resources, rather than benefitting from a centralized supply chain that could distribute testing supplies based on pandemic conditions in each state.[176] Federal abdication of supply and distribution authority put states in competition with each other for other needed supplies. In short, as Atul Gawande has argued, "[w]e have no national grid for the generation, transmission, or distribution of our testing supply — or, for that matter, the supply of ventilators, masks, intensive-care beds, or almost any other health care resources. Now we're paying the price."[177]

Federal funding, accelerated approval pathways, and supply-chain coordination of Operation Warp Speed helped private companies develop COVID vaccines with astonishing speed and ensured that the United States, unlike most other countries in the world, could quickly procure more than enough doses for its entire population.[178] But the distribution problems that flowed from federal shirking on testing and treatments have also undermined the effectiveness of a nationwide vaccination campaign.[179] The Trump administration's Operation Warp Speed deferred to state officials to determine, implement, and enforce prioritization schemes to allocate doses that (in the early months) were far too scarce for herd immunity to be achievable.[180] When the initial

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175 *See* Sheila Kaplan, *C.D.C. Labs Were Contaminated, Delaying Coronavirus Testing, Officials Say*, N.Y. TIMES (Apr. 18, 2020), https://www.nytimes.com/2020/04/18/health/cdc-coronavirus-lab-contamination-testing.html [https://perma.cc/2HT7-82SG].

176 *See* Terry, *supra* note 169, at 5 ("[T]he federal government has eschewed its leadership role . . . seem[ing] to favor a Darwinian competition among states for scarce resources, or worse, [] blocking state access to some supplies."); Wiley, *Federalism*, *supra* note 95, at 66.

177 Gawande, *supra* note 173.

178 The first vaccine to receive emergency use authorization was developed by Pfizer outside of the federally-funded Operation Warp Speed program, but federal authorities provided critical supply-chain support for raw materials to speed up the manufacturing of Pfizer doses.

179 *See* Wiley, *Federalism*, *supra* note 95, at 66; *see also* Isaac Stanley-Becker, *Shots Are Slow to Reach Arms as Trump Administration Leaves Final Steps of Mass Vaccination to Beleaguered States*, WASH. POST (Dec. 30, 2020, 9:30 AM EST), https://www.washingtonpost.com/health/2020/12/30/covid-vaccine-delay/ [https://perma.cc/ALV7-S7HR].

180 *See* Caroline Chen, Isaac Arnsdorf & Ryan Gabrielson, *How Operation Warp Speed Created Vaccination Chaos*, PROPUBLICA (Jan. 19, 2021, 10:27 A.M. EST)

months of the vaccine roll-out were predictably disastrous, federal officials blamed state leaders, essentially arguing that their work was done the moment doses were shipped.[181] Eligibility criteria varied widely from state to state, though the Biden administration occasionally stepped in to direct state and local officials to expand eligibility to include educators and eventually all adults.[182] The lack of a nationally coordinated vaccination strategy mirrored the lack of a nationally coordinated strategy for non-pharmaceutical interventions, including school closures, restrictions on businesses and travel, and mask mandates.[183] "This is the dark side of federalism: it encourages a patchwork response to epidemics" which are inherently borderless in character.[184]

Second, an entire era of devolution to state power produced an unstable and inequitable system for ensuring that people can afford access to medical countermeasures.[185] As unemployment skyrocketed, many households lost employer-sponsored health insurance.[186] While

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https://www.propublica.org/article/how-operation-warp-speed-created-vaccination-chaos [https://perma.cc/X9ZE-64S5].

[181] Elizabeth Crisp, *HHS Secretary Alex Azar Blames States for Slow Rollout of COVID-19 Vaccines*, NEWSWEEK (Jan. 12, 2021), https://www.newsweek.com/hhs-secretary-alex-azar-blames-states-slow-rollout-covid-19-vaccines-1560981 [https://perma.cc/XR6T-VGT5]; Will Feuer & Kevin Stankiewicz, *Trump Blames States as He Faces Criticism for Slow Covid Vaccine Rollout*, CNBC (Dec. 30, 2020) https://www.cnbc.com/2020/12/30/trump-blames-states-as-he-faces-criticism-for-slow-covid-vaccine-rollout.html [https://perma.cc/J87E-2LTF].

[182] CDC relied on the fact that doses were federally procured and owned to impose conditions on recipients of doses. *See CDC COVID-19 Vaccination Program Provider Requirements and Support*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/vaccines/covid-19/vaccination-provider-support.html#:~:text=At%20this%20time%2C%20all%20COVID,administered%20to%20the%20vaccination%20recipient (last reviewed Aug. 26, 2021) [https://perma.cc/K7GH-ASEC].

[183] *See* Wiley, *Social Distancing*, *supra* note 3, at 110-13.

[184] Haffajee & Mello, *supra* note 169, at 5 ("The defining feature of the U.S. response to Covid-19 continues to be localized action against a threat that" is "highly transmissible, crosses borders efficiently, and threatens our national infrastructure and economy."); *accord* Huberfeld et al., *supra* note 71, at 952 ("This fragmented and disjointed response has undoubtedly cost time and lives.").

[185] *See* Karyn Schwartz, Karen Pollitz, Jennifer Tolbert & MaryBeth Musumeci, *Gaps in Cost Sharing Protections for COVID-19 Testing and Treatment Could Spark Public Concerns About COVID-19 Vaccine Costs*, KFF (Dec. 18, 2020) https://www.kff.org/health-costs/issue-brief/gaps-in-cost-sharing-protections-for-covid-19-testing-and-treatment-could-spark-public-concerns-about-covid-19-vaccine-costs/ [https://perma.cc/M27Q-NKNE].

[186] *See* Terry, *supra* note 169, at 7-9; Huberfeld et al., *supra* note 71, at 956 ("As a countercyclical program, enrollment in Medicaid increases when the economy declines . . . .").

some could still afford COBRA or subsidized insurance on the ACA exchanges,[187] the majority were left to rely on Medicaid.[188] But twelve states have refused to expand Medicaid eligibility to all low-income, childless, non-disabled adults.[189] Thus, even when the federal Families First Coronavirus Response Act added COVID testing without a copay to Medicaid coverage,[190] individuals and communities in non-expansion states could not benefit from this enhanced safety net for access to testing. Thanks to federalism, a person's ability to afford a COVID test could depend on whether she lives in North Dakota (which expanded Medicaid) or South Dakota (which did not),[191] despite the enhancement of federal funding.

To make matters worse, it is not simply the variation in state Medicaid programs that complicates the pandemic response. It is also the fact that "many states with the deepest needs" for safety-net programs "are also least equipped to respond" to public health crises "due to a culture of low taxes and distrust of government," which "often means an inadequate infrastructure of funds, people, and institutions to implement an emergency response."[192]

A health system that replaced knee-jerk deference to states with an allocation of responsibility among governmental units according to their legal and logistical capacities to improve public health would harness the power of federalism for good. At the federal level, we should expect a consistent, stable, nationwide public health infrastructure, coupled with durable federal baselines for financing equitable access to

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187 Which also have significant state-by-state variations.

188 *See* Rachel Garfield, Gary Claxton, Anthony Damico & Larry Levitt, *Eligibility for ACA Health Coverage Following Job Loss*, KFF (May 13, 2020) https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/ [https://perma.cc/4ATL-JCM7]; Press Release, CMS, New Medicaid and CHIP Enrollment Snapshot Shows Almost 10 Million Americans Enrolled in Coverage During the COVID-19 Public Health Emergency (June 21, 2021) https://www.cms.gov/newsroom/press-releases/new-medicaid-and-chip-enrollment-snapshot-shows-almost-10-million-americans-enrolled-coverage-during [https://perma.cc/ZU89-TC5W].

189 *E.g.*, Nicole Huberfeld, Elizabeth Weeks Leonard & Kevin Outterson, *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U. L. REV. 1, 76 (2013); *Status of State Medicaid Expansion Decisions: Interactive Map*, KFF (Aug. 10, 2021), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ [https://perma.cc/XBA4-6BPF] (at the end of 2020, 12 states had refused to expand Medicaid); *see also* Huberfeld et al., *supra* note 71, at 956 ("Medicaid's countercyclical effects will be severely limited in nonexpansion states . . . .").

190 FFCRA, Pub. L. No. 116-127, § 6004, 134 Stat. 178 (2020).

191 *See Status of State Medicaid Expansion Decisions*, *supra* note 189.

192 Huberfeld et al., *supra* note 71, at 952.

health care. Federal financing and support flowing to states for implementation should not empower resistant states to engage in a race-to-the-bottom, eroding public health measures. Federal authorities should stop shirking in the name of state deference and start assisting states in a race-to-the-top of evidence-based policy and social supports.

4. Privatization

The country's longstanding preference for private markets rather than government programs to finance and deliver health care means most people are covered by private health insurance.[193] The privatized nature of the U.S.'s health care system has hampered the COVID pandemic response. A system that depends on private health financing lacks the breadth, capacity, and financial incentives to deliver widespread public health measures, such as testing or vaccination, at levels necessary to be effective and equitable. Instead, our private health insurance system creates cost-barriers to basic public health measures at every step.

First, the reliance on employer-based coverage is a significant vulnerability when millions lose their job-based insurance due to the pandemic's economic recession.[194] During the early phase of the pandemic, at least twenty million people lost their jobs,[195] which translated to approximately ten million workers and dependents losing their employer-sponsored health coverage,[196] 3.5 million of whom

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[193] *See* Fuse Brown et al., *supra* note 1, at 416.

[194] *See* Stuart M. Butler, *Four COVID-19 Lessons for Achieving Health Equity*, 324 JAMA 2245, 2246 (2020).

[195] *See* David Blumenthal, Elizabeth J. Fowler, Melinda Abrams & Sara R. Collins, *Covid-19 – Implications for the Health Care System*, 383 NEW ENG. J. MED. 1483, 1483 (2020). In the months that followed, approximately half of those who initially lost jobs were able to return to work. *See* Jeanna Smialek, Ben Casselman & Gillian Friedman, *Workers Face Permanent Job Losses as the Virus Persists*, N.Y. TIMES (Oct. 3, 2020), https://www.nytimes.com/2020/10/03/business/economy/coronavirus-permanent-job-losses.html [https://perma.cc/5FNA-VZ46].

[196] There are a variety of estimates of the numbers who lost employer-sponsored insurance ("ESI") coverage. *See, e.g.*, JESSICA BANTHIN & JOHN HOLAHAN, MAKING SENSE OF COMPETING ESTIMATES: THE COVID-19 RECESSION'S EFFECTS ON HEALTH INSURANCE COVERAGE 2 (2020), https://www.urban.org/research/publication/making-sense-competing-estimates-covid-19-recessions-effects-health-insurance-coverage [https://perma.cc/RMK3-RW4M] (comparing several studies' estimating 21.9-31 million lost ESI); Josh Bivens & Ben Zipperer, *Health Insurance and the COVID-19 Shock*, ECON. POL'Y INST. (Aug. 26, 2020), https://www.epi.org/publication/health-insurance-and-the-covid-19-shock/ [https://perma.cc/L5CL-FR3W] (estimating that 6.2 million workers lost access to employer-sponsored coverage in the first few months of the pandemic, but noting many of these may have gained other forms of coverage).

became uninsured.[197] America's reliance on job-based coverage means that in an economic recession caused by a public health crisis, many are vulnerable to coverage loss, churn from switching to other sources of coverage, and disruption to their health care.[198] People in states that did not expand Medicaid and thus had a higher rate of uninsurance were more likely to contract and die of COVID.[199] The U.S.'s reliance on job-based insurance and lack of universal health care made it more vulnerable to the pandemic and weakened the country's response compared to other countries.[200] The CARES Act created a Provider Relief Fund that allocated $175 billion to providers to compensate them for providing COVID testing, treatment, and vaccination to uninsured patients.[201] Yet the funding is not a benefit that uninsured patients can access directly and does not bar providers from charging patients for their COVID care; rather, coverage depends on their provider

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197 Some of those who lost employer-sponsored insurance coverage were able to be covered by another family member's health plan or by Medicaid, CHIP, or ACA marketplace coverage. JESSICA BANTHIN, MICHAEL SIMPSON, MATTHEW BUETTGENS, LINDA J. BLUMBERG & ROBIN WANG, CHANGES IN HEALTH INSURANCE COVERAGE DUE TO THE COVID-19 RECESSION: PRELIMINARY ESTIMATES USING MICROSIMULATION 1-3 (2020), https://www.urban.org/sites/default/files/publication/102552/changes-in-health-insurance-coverage-due-to-the-covid-19-recession_4.pdf [https://perma.cc/73Y8-334H]. An additional 3.3 million lost their employer-sponsored coverage between mid-May and mid-July 2020, 2 million of whom became uninsured. ANUJ GANGOPADHYAYA, MICHAEL KARPMAN & JOSHUA AARONS, URB. INST., AS THE COVID-19 RECESSION EXTENDED INTO THE SUMMER OF 2020, MORE THAN 3 MILLION ADULTS LOST EMPLOYER-SPONSORED HEALTH INSURANCE COVERAGE AND 2 MILLION BECAME UNINSURED 1 (2020), https://www.urban.org/sites/default/files/publication/102852/as-the-covid-19-recession-extended-into-the-summer-of-2020-more-than-3-million-adults-lost-employer-sponsored-health-insurance-coverage-and-2-million-became-uninsured.pdf [https://perma.cc/4K2U-6SZL].

198 *See* Terry, *supra* note 169, at 3.

199 Tarun Ramesh, Emily Gee & Maura Calsyn, *The Pandemic and Economic Crisis Are Wake-Up Call for State Medicaid Expansion*, CTR. FOR AM. PROGRESS (Nov. 9, 2020), americanprogress.org/issues/healthcare/news/2020/11/09/492808/pandemic-economic-crisis-wake-call-state-medicaid-expansion/ [https://perma.cc/C82A-VBP4].

200 Dylan Scott, *Coronavirus Is Exposing All of the Weaknesses in the US Health System*, VOX (Mar. 16, 2020), https://www.vox.com/policy-and-politics/2020/3/16/21173766/coronavirus-covid-19-us-cases-health-care-system [https://perma.cc/DV8V-DNK6]; Ed Yong, *How the Pandemic Defeated America*, THE ATLANTIC (Aug. 4, 2020), https://www.theatlantic.com/magazine/archive/2020/09/coronavirus-american-failure/614191/ [https://perma.cc/4QH3-WBUX].

201 Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136, § 5001, 134 Stat. 281 (2020); *Covid-19 Claims Reimbursement*, HEALTH RES. & SERVS. ADMIN., https://coviduninsuredclaim.linkhealth.com/ (last visited Sept. 4, 2021) [https://perma.cc/5AJ9-TAS8]; *Provider Relief Fund*, HEALTH RES. & SERVS. ADMIN., https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html (last visited Sept. 26, 2021) [https://perma.cc/Z75Y-RCYX].

submitting a claim for reimbursement to the government.[202] Moreover, the Provider Relief Fund was distributed according to entities' revenues, which means that providers in predominantly Black communities received disproportionately smaller allocations than others despite their higher COVID-related burden and financial need.[203] Thus, the risk that an uninsured patient could be charged for their COVID care remained, along with the barriers to care that threat carried.

Even for those with coverage, several features of private health insurance (cost-sharing, limited enrollment periods, limited provider networks) work against an effective pandemic response because they create barriers to the widespread testing and vaccination needed to stem the spread. Thus, even for those who maintained their insurance coverage in the pandemic, the coverage itself contains significant holes that expose them to financial shocks. Legal measures were rushed into place by the CARES Act and Families First Coronavirus Response Act ("FFCRA") to patch some of these holes in the private health insurance system, namely by prohibiting most types of health coverage from imposing patient cost-sharing for COVID testing or vaccination.[204] Despite these patches, holes remained — they did not prohibit cost-sharing for COVID treatment, they did not protect against out-of-network charges or cost-sharing for related services (e.g., flu tests, chest x-rays, facility fees, ambulance rides), and services were not covered unless they were deemed medically appropriate by a provider.[205]

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[202] Julie Appleby, *Trump's COVID Program for Uninsured People: It Exists, but Falls Short*, KHN (Oct. 2, 2020), https://khn.org/news/fact-check-president-trump-executive-order-covid-program-for-uninsured-people-falls-short/ [https://perma.cc/G8C7-UNUQ].

[203] Pragya Kakani, Amitabh Chandra, Sendhil Mullainathan & Ziad Obermeyer, *Allocation of COVID-19 Relief Funding to Disproportionately Black Counties*, 324 JAMA 1000, 1001-02 (2020).

[204] Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116-127, §§ 6001 - 6004, 134 Stat. 178 (2020) (to be codified at 42 U.S.C. §§ 1320b–5, 1395l, 1396d(a)(3)); CARES Act § 3201 (amending FFCRA § 6001 to apply coverage without cost-sharing to out-of-network rests), § 3203 (to be codified at 42 U.S.C. § 300gg-13, covering COVID-19 vaccines); *see also* Rachel Fehr, Cynthia Cox, Karen Pollitz, Jennifer Tolbert, Juliette Cubanski & Robin Rudowitz, *Five Things to Know About the Cost of COVID-19 Testing and Treatment*, KFF (May 26, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/five-things-to-know-about-the-cost-of-covid-19-testing-and-treatment/ [https://perma.cc/89QZ-JU4U].

[205] Loren Adler & Christen Linke Young, *The Laws Governing COVID-19 Test Payment and How to Improve Them*, BROOKINGS (July 13, 2020), https://brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/07/13/the-laws-governing-covid-19-test-payment-and-how-to-improve-them/ [https://perma.cc/LZM5-UHEH].

Patients were right to worry, as stories mounted of both legal and illegal billing for COVID testing and care.[206]

The private insurance and medical model of care is fundamentally ill-suited to deployment of public health measures for mitigating or suppressing transmission of a highly communicable disease: testing for surveillance and disease-control purposes and mass vaccination. In a pandemic of a highly contagious virus with asymptomatic transmission, widespread screening of asymptomatic persons is critical to prevent spread.[207] Yet Trump administration guidance on the CARES Act and FFCRA resorted to a private medical model, only requiring insurers to cover the costs of COVID testing for "diagnostic purposes" and when deemed "medically appropriate" by an individual's attending medical provider.[208]

Sabrina Corlette and others argued forcefully that relying upon an insurance model that limits access to diagnostic or medically indicated situations is inadequate because widespread testing for public health purposes is required to track and slow the spread of asymptomatic transmission, particularly in the context of employment or education.[209] To put a finer point on it, widespread testing is necessary for employers, such as nursing homes or meat-packing plants, or schools or universities to carry on their activities safely, but the costs of such testing fall on the institution or individual because they would not be

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206 *See* Sarah Kliff, *A $52,112 Air Ambulance Ride: Coronavirus Patients Battle Surprise Bills*, N.Y. TIMES (Oct. 13, 2020), https://www.nytimes.com/2020/10/13/upshot/coronavirus-surprise-medical-bills.html [https://perma.cc/94R9-G2S8]; Sarah Kliff, *Coronavirus Tests Are Supposed to Be Free. The Surprise Bills Come Anyway.*, N.Y. TIMES (Sept. 9, 2020), https://www.nytimes.com/2020/09/09/upshot/coronavirus-surprise-test-fees.html [https://perma.cc/A2CU-7F7C]; Sarah Kliff, *How to Avoid a Surprise Bill for Your Coronavirus Test*, N.Y. TIMES (Nov. 13, 2020), https://www.nytimes.com/2020/11/13/upshot/coronavirus-surprise-bills-guide.html [https://perma.cc/2CMQ-3KRJ].

207 *See* Caroline Chen, *America Doesn't Have a Coherent Strategy for Asymptomatic Testing. It Needs One.*, PROPUBLICA (Sept. 1, 2020), https://www.propublica.org/article/america-doesnt-have-a-coherent-strategy-for-asymptomatic-testing-it-needs-one [https://perma.cc/VW3Q-5WJU].

208 FAQS ABOUT FAMILIES FIRST CORONAVIRUS RESPONSE ACT AND CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT IMPLEMENTATION PART 43, at 3-6 (2020) (interpreting FFCRA to cover COVID-19 testing only if medically appropriate and diagnostic, excluding "testing conducted to screen for general workplace health and safety (such as employee 'return to work' programs), for public health surveillance . . . , or for any other purpose not primarily intended for individualized diagnosis or treatment of COVID-19"); *see also* Adler & Linke Young, *supra* note 205.

209 Sabrina Corlette, *I've Been Calling for Greater Private Insurance Coverage of COVID-19 Testing. I've Been Wrong*, HEALTH AFFS. BLOG (May 18, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200513.267462/full/ [https://perma.cc/UUG6-BC9F].

considered diagnostic or medically appropriate under the medical-insurance model.[210] If the individual, the employer, or even the health insurer is forced to bear the cost, then the burden will disproportionately fall on lower-income and minority populations and may serve as a barrier to employment, education, or the ability to control disease.[211] A better approach would be for the government to arrange for the direct provision of COVID testing and vaccine, free to all, and provided where the population is (grocery stores, workplaces, schools, parking lots, community centers) rather than just in medical care settings.[212]

Our privatized and fragmented health care system does a terrible job of constraining prices for health care services and leads to wild and inexplicable price discrimination.[213] Though one of main theoretical advantages of a private health care system is the ability to harness the salutary effects of competition, in reality the lack of centralized governmental rate controls means U.S. health care prices are far higher than anywhere else.[214] In the case of coronavirus, this means the prices of testing and vaccines were left to the wildly unpredictable and undisciplined private market. The price of a COVID test varied forty-fold, from $20 to $850 at hospitals, and into the thousands of dollars at private, labs.[215] The CARES Act required insurers to pay for COVID tests but didn't limit the amount providers can charge for the tests,

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[210] Linda J. Blumberg, Sabrina Corlette & Michael Simpson, *Imposing the Costs of Workplace Coronavirus Testing on Group Plan Coverage Would Place an Excessive Burden on Essential Workers*, HEALTH AFFS. BLOG (July 28, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200727.300119/full/ [https://perma.cc/D4S4-GZPQ].

[211] *See id.*; Noam Scheiber, *Many Employers Avoid Coronavirus Tests Over Cost, Not Availability*, N.Y. TIMES (Nov. 19, 2020), https://www.nytimes.com/2020/11/19/business/virus-testing-companies.html [https://perma.cc/FP72-UN99].

[212] *See* Butler, *supra* note 194, at 2245; Corlette, *supra* note 209.

[213] *See* Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind the Veil of Secrecy*, 25 HEALTH AFFS. BLOG 57, 63 (2006).

[214] Gerard F. Anderson, Peter Hussey & Varduhi Petrosyan, *It's Still the Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt*, 38 HEALTH AFFS. 87, 93 (2019).

[215] Sarah Kliff, *Most Coronavirus Tests Cost About $100. Why Did One Cost $2,315?*, N.Y. TIMES (June 16, 2020), https://www.nytimes.com/2020/06/16/upshot/coronavirus-test-cost-varies-widely.html [https://perma.cc/XP3L-QK6A]; Nisha Kurani, Karen Pollitz, Dustin Cotliar, Giorlando Ramirez & Cynthia Cox, *COVID-19 Test Prices and Payment Policy*, HEALTH SYS. TRACKER (Apr. 28, 2021), https://www.healthsystemtracker.org/brief/covid-19-test-prices-and-payment-policy/ [https://perma.cc/QZ24-HZFH].

which invited price gouging.[216] In the absence of a contractual price, the provider could charge whatever it wanted and the insurer had to pay. For new vaccines and therapeutics, there are no price constraints because without competition from generics, the manufacturer can unilaterally set its price.[217] The cost of COVID vaccine doses in the U.S. has been borne largely by the federal government and left to negotiation with the manufacturers, including billions in government aid for research, development, and manufacturing costs.[218] Fundamental public health measures like testing and vaccine should be free to the public at the point of service to eliminate barriers to these generally low-cost, high-value measures, and the prices for these measures should be capped by the government to eliminate price gouging, price discrimination, and waste.

Finally, our private and fragmented health care system failed to provide a mechanism for public decision-making over the distribution of therapeutics to treat COVID, thwarting nimble, need-based allocations of critical therapies. For example, the process for distributing the antiviral remdesivir[219] was driven by private industry and lacked transparency.[220] Even when HHS assumed responsibility for allocation over the summer of 2020, the process remained confusing

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216 Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136, § 3202, 134 Stat. 281 (2020) (to be codified at 42 U.S.C. § 256b); Loren Adler, *How the Cares Act Affects Covid-19 Test Pricing*, BROOKINGS (Apr. 9, 2020), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/04/09/how-the-cares-act-affects-covid-19-test-pricing/ [https://perma.cc/G252-R7RS].

217 *See, e.g.*, Matthew Herper, *Gilead Announces Long-Awaited Price for Covid-19 Drug Remdesivir*, STAT (June 29, 2020), https://www.statnews.com/2020/06/29/gilead-announces-remdesivir-price-covid-19/ [https://perma.cc/TYZ3-V5N3] (describing how Gilead set the initial price for its COVID-19 drug, remdesivir).

218 *See* Sydney Lupkin, *Novavax Posts Coronavirus Vaccine Contract That Government Didn't Disclose*, NPR (Nov. 11, 2020, 1:10 PM ET), https://www.npr.org/sections/health-shots/2020/11/11/933864908/novavax-posts-coronavirus-vaccine-contract-that-government-didnt-disclose [https://perma.cc/4YXU-NRDS] (noting that Operation Warp Speed limited the government's "march-in" rights to curtail price gouging by recipients of federal funding); Schwartz, *supra* note 185.

219 FDA authorized remdesivir, an investigational drug not approved for any indication, under an emergency use authorization ("EUA") for use in hospitalized patients with severe COVID-19 on May 1, 2020. Letter from RADM Denise M. Hinton, Chief Scientist, FDA, to Ashley Rhoades, Manager of Regul. Affs., Gilead Sciences, Inc. (Oct. 22, 2020) https://www.fda.gov/media/137564/download [https://perma.cc/CV58-DJ6X].

220 Sydney Lupkin, *Remdesivir Distribution Causes Confusion, Leaves Some Hospitals Empty-Handed*, NPR (May 14, 2020, 11:12 AM ET), https://www.npr.org/sections/health-shots/2020/05/14/855663819/remdesivir-distribution-causes-confusion-leaves-some-hospitals-empty-handed [https://perma.cc/QY8X-QAP6].

and seemingly unresponsive to need.[221] To the extent there has been public guidance and deliberation on the ethical distribution of scarce therapeutics, ventilators, ICU beds, or critical care staff, the guidance focused on private decisions *within* a hospital, but did not meaningfully grapple with the allocation of the resources *between* hospitals or among states.[222] When there was a shortage of ventilators, the lack of a centralized distribution plan meant that ventilators did not go to states, regions, or hospitals that need them the most but rather to those who were able to pay and who had existing transactional connections to the suppliers.[223] Without a centralized governmental payer or publicly accountable system to distribute health care resources, private actors make distributional decisions that are opaque, tend to follow existing well-greased supply chains,[224] and bid up the cost of the scarce resource.[225]

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[221] Sydney Lupkin, *How Feds Decide on Remdesivir Shipments to States Remains Mysterious*, NPR, (Aug. 19, 2020, 4:21 PM ET), https://www.npr.org/sections/health-shots/2020/08/19/903946857/how-feds-decide-on-remdesivir-shipments-to-states-remains-mysterious [https://perma.cc/37FC-6GHM].

[222] *See* Colette DeJong, Alice Hm Chen & Bernard Lo, *An Ethical Framework for Allocating Scarce Inpatient Medications for COVID-19 in the US*, 323 JAMA 2367, 2367 (2020); Ezekiel J. Emanuel, Govind Persad, Ross Upshur, Beatriz Thome, Michael Parker, Aaron Glickman, Cathy Zhang, Connor Boyle, Maxwell Smith & James P. Phillips, *Fair Allocation of Scarce Medical Resources in the Time of Covid-19*, 382 NEW ENG. J. MED. 2049, 2053 (2020); *Strategies to Allocate Ventilators from Stockpiles to Facilities*, CTRS. FOR DISEASE CONTROL & PREVENTION https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/ventilators.html (last updated Mar. 20, 2020) [https://perma.cc/VHE6-GA88]; *see, e.g.*, *Strategies to Mitigate Healthcare Personnel Staffing Shortages*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html (last updated Mar. 10, 2021) [https://perma.cc/8X88-NBCS] (providing guidance on how health facilities can mitigate staffing shortages within a facility).

[223] Nathan Layne, *Outbid and Left Hanging, U.S. States Scramble for Ventilators*, REUTERS (Apr. 10, 2020, 12:32 PM) https://www.reuters.com/article/us-health-coronavirus-usa-ventilators/outbid-and-left-hanging-u-s-states-scramble-for-ventilators-idUSKCN21S20D [https://perma.cc/RHK6-DQRE]; *see* Megan L. Ranney, Valerie Griffeth & Ashish K. Jha, *Critical Supply Shortages — The Need for Ventilators and Personal Protective Equipment During the Covid-19 Pandemic*, 382 NEW ENG. J. MEDICINE e41(1), e41(2) (2020).

[224] *See e.g.*, Press Release, Gilead, Gilead Sciences Update on Supply and Distribution of Veklury® (remdesivir) in the United States (Oct. 1, 2020), https://www.gilead.com/news-and-press/press-room/press-releases/2020/10/gilead-sciences-update-on-supply-and-distribution-of-veklury-remdesivir-in-the-united-states [https://perma.cc/992S-K9AH] (announcing that remdesivir's manufacturer, Gilead, would supply the drug directly to hospitals via its sole distributor, Amerisourcebergen).

[225] *Price Gouging in a Public Health Crisis: Out-of-Network COVID-19 Test Costs Continue to Far Exceed In-Network Costs*, AM. HEALTH INS. PLANS (Nov. 2020), https://www.ahip.org/wp-content/uploads/202008-AHIP_COVID-PriceGouging.pdf

Our reliance on private health insurance in the U.S. stymied our pandemic response in critical ways. The economic unemployment crisis left millions uninsured in the height of a public health crisis; those who kept their coverage still faced risks of unexpected costs for testing and treatment; our reliance on private markets meant the prices of these services were uncontrolled and wildly variable; and the system failed to provide for public decision-making about the fair allocation and efficient distribution of scarce resources in the pandemic.[226] The pandemic revealed in stark terms that our privatized health care system suffers from a profound cost and affordability crisis while it lacks incentives and the coordination needed to provide for public goods. The fear of the cost of services creates barriers to widespread testing and vaccination, which foment disease spread; burdens government, private payers, and individuals; and crowds out resources for other social goods needed to address the pandemic's economic and societal dislocation — such as housing, education, food, or income maintenance. Our private health care system is bad for public health and well-being.

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Inadequate and inequitable access to COVID testing, treatments, and vaccinations has compounded the economic and health harms caused by the pandemic. Individualism, fiscal fragmentation, federalism, and privatization have each played a role in these failures. To reconstruct a functional system, future reforms must confront the fixtures.

III. LESSON 3: RACISM AND SUBORDINATION ARE FOUNDATIONAL TO THE FOUR FIXTURES

The fixtures play an abiding role in the broader existential failure illuminated by the pandemic: racial inequity in the burden of disease. The iron triangle ethos gestured toward equity as a worthy but ultimately unattainable goal. That simply isn't good enough in a post-2020 world. "Racism is a fundamental determinant of health."[227] It

[https://perma.cc/B68V-W2UV] (reporting that out-of-network providers charged significantly higher prices for COVID-19 tests forty percent of the time).

226 *See* Terry, *supra* note 169, at 10 ("COVID-19 not only illustrates how private actors failed to invest in prophylactic structures but also their relatively poor performance once the pandemic arrived.").

227 RUQAIIJAH YEARBY, CRYSTAL N. LEWIS, KEON L. GILBERT & KIRA BANKS, THE JUST. COLLABORATIVE INST., RACISM IS A PUBLIC HEALTH CRISIS. HERE'S HOW TO RESPOND. 7 (2020), https://www.filesforprogress.org/memos/racism-is-a-public-health-crisis.pdf; Roland J. Thorpe, Jr., Keith C. Norris, Bettina M. Beech & Marino A. Bruce, *Racism*

includes, and extends far beyond, interpersonal racism experienced by many patients in clinical encounters.[228] Racism is foundational to "the political, social, and economic environments that influence access to resources necessary to prevent, manage, or overcome disease."[229] Realizing health justice demands that health reform grapple with the racist foundations of the American legal and health care systems and embrace an anti-subordination agenda. It demands equitable distribution of the benefits and burdens of public investments in health care and public health. It demands empowerment and self-determination for Black and Brown communities.

The third lesson we draw: All four fixtures are rooted in and perpetuate structural racism and subordination based on socioeconomic class, thereby subverting equity and community empowerment. The fixtures' historic and inherent roles in inequity and subordination mean that reforms accommodating them will continue to accommodate inequity and subordination. To begin to address the existential failures, future reforms must confront the fixtures with unswerving resolve.

A. Individualism

The "you're on your own" ethos of individualism has provided a superficially neutral ideological mask for racist cultural norms and ideological notions of deservingness and blame throughout American history. "American individualism, a philosophy deeply imbedded in the American psyche, prevents whites from seeing themselves as a privileged racialized group."[230] To resist structural change, white people in power may claim that the goal of racial justice is for everyone to be treated as individuals. "When white people insist on Individualism in discussions about racism, they are in essence saying, . . . 'It is talking about race as if it mattered that divides us . . . . Generalizing discounts

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Across the Life Course, *in* RACISM: SCIENCE & TOOLS FOR THE PUBLIC HEALTH PROFESSIONAL 1, 209 (2019).[https://perma.cc/3HTW-2JP4]; *see also* Yearby, *supra* note 44, at 518.

[228] *See* Yearby, *supra* note 44, at 524.

[229] Ronald J. Thorpe, Jr., Derek M. Griffith, Marino A. Bruce & Lawnrece Brown, *Racism as a Fundamnetal Determinant of Health for Black Boys* in NADINE M. FINIGAN-CARR, ED., LINKING HEALTH AND EDUCATION FOR AFRICAN AMERICAN STUDENTS' SUCCESS 13 (2017).

[230] Taunya Lovell Banks, *Exploring White Resistance to Racial Reconciliation in the United States*, 55 RUTGERS L. REV. 903, 912 (2003).

my individuality . . . . Further, as an individual I am objective and view others as individuals and not as members of racial groups."[231]

Rhetoric about health disparities often shifts blame to individuals, adopting the view that "the most important determinants of health are the catastrophes, genetic inheritances, and disease agents that cause illness or injury, and the individual patient's responsible or irresponsible reaction to these challenges."[232] As "[i]n all matters of Black disadvantage, the first question is often, 'What is wrong with Black people?' [instead of asking,] 'What is wrong with the policies and institutions?'"[233] Mary Bassett and Jasmine Graves have argued that individualistic explanations for public health problems are a "litmus test" for anti-racism.[234] Their focus is on the particularities of anti-Black racism in the United States, but their insights may be applicable to racism and other forms of subordination more broadly: "Any framework that identifies the problem as people should be challenged. Communities are vulnerable because of bad policies and disinvestment, not because of the people who live in them."[235] In the ethos of individualism, health disparities ranging from heart disease, diabetes, and cancer to sexually transmitted infections, and now COVID, are attributed to "lack of knowledge and flawed decision-making . . . . This 'lifestyle hypothesis' assigns responsibility to individuals without reference to the context of their lives. In addition to dismissing racial patterning of power and opportunity, it ignores the toll of daily and lifelong experiences of discrimination. [Like the hypothesis that Black-white disparities in health are genetically based], it is a racist idea."[236]

Implicitly racist, classist, and xenophobic notions of deservingness and individualism have permeated US health reform debates. Actuarial fairness and mutual aid offer "competing visions" of "how Americans should think about what ties them together and *to whom* they have

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231 Robin J. DiAngelo, *Why Can't We All Just Be Individuals?: Countering the Discourse of Individualism in Anti-Racist Education*, 6 INTERACTIONS: UCLA J. EDUC. & INFO. STUDS. 1, 1 (2010).

232 Harris & Pamukcu, *supra* note 4, at 767.

233 Mary T. Bassett & Jasmine D. Graves, *Uprooting Institutionalized Racism as Public Health Practice*, 108 AM. J. PUB. HEALTH 457, 458 (2018).

234 *Id.*

235 *Id.*; *see* MATTHEW, *supra* note 7, at 10 ("Throughout most of our country's history, the rule of law has been perversely instrumental in enabling the racism...that has produced, and continues to exacerbate, the unjust distribution of health care, as well as the resources that permit people to live healthy lives, such as property, wealth, income, housing, food, employment, and education.").

236 Bassett & Graves, *supra* note 233, at 457.

ties."[237] In its efforts to undermine progressive health reform, the health insurance industry has attempted to "persuade the . . . public that 'paying for someone else's risks' is a bad idea."[238] Attribution of premature death and morbidity to personal failures "[s]erves a symbolic, or value expressive function . . . , reinforcing a world view consistent with a belief in a just world, self-determination, the Protestant work ethic, self-contained individualism, and the notion that people get what they deserve."[239] Individualism and notions of personal responsibility give privileged people a free pass to ignore their role in subordinating others and to disregard the needs of subordinated people and the inequitable burdens they bear. Individualism erodes the social solidarity that underpins mutual aid and community empowerment.

Notions of individualism and deservingness have reared their heads again and again in the design and implementation of the ACA. Expansion of Medicaid eligibility beyond the "deserving poor" triggered rhetoric reminiscent of Reagan's dog whistles about social welfare programs.[240] The mutual aid principles reflected in guaranteed issue and community rating requirements for private insurers were undercut by a "personal responsibility" amendment adopted in the name of giving people incentives for "wellness."[241] Waivers granted by the Trump administration permitting states to impose work requirements as a condition of Medicaid eligibility further entrenched an individualistic ethic of deservingness even as more states have opted into the ACA's Medicaid expansion.[242] Litigation challenging the ACA's individual mandate and Medicaid expansion pressed the limits of majoritarian rule and the communitarian ethos.[243] Challengers asked what individuals can be required by the majority to do for the benefit of the community and what states can be required by the national community to do for those residing within their borders.

In the pandemic, these themes have been repeated with even more devastating consequences. Federal, state, and local officials have urged

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237 Stone, *supra* note 8, at 289 (emphasis added).

238 *Id.* at 287 (quoting an advertising campaign in the late 1980s).

239 Christian S. Crandall & Rebecca Martinez, *Culture, Ideology, and Antifat Attitudes*, 22 PERSONALITY & SOC. PSYCH. BULL. 1165, 1166 (1996).

240 *See* Lindsay F. Wiley, *Access to Health Care as an Incentive for Healthy Behavior? An Assessment of the Affordable Care Act's Personal Responsibility for Wellness Reforms*, 11 IND. HEALTH L. REV. 635, 707 (2014).

241 *Id.* at 679.

242 *See* Sidney D. Watson, *Medicaid, Work, and the Courts: Reigning in HHS Overreach*, 46 J.L. MED. & ETHICS 887, 889 (2018).

243 *See* Fuse Brown et al., *supra* note 1, at 416-17 (discussing Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012)).

personal responsibility while failing to protect and support people who are required to report for duty in high-exposure workplaces, those who live in crowded, multi-generation homes, and those who are exposed in institutions like jails, prisons, and detention centers.[244] "Infectious disease pandemics are fueled by the connection of people to one another in society. The same human interconnectedness demands prevention and response measures grounded in mutual aid . . . Public health emergency prevention and response measures are meant to benefit society as a whole. The burdens should also be shared."[245]

As Harris and Pamukcu argue, "[o]ur health is not just an individual matter; it is deeply influenced by institutional and structural forces that shape who has access to the opportunities and resources needed to thrive."[246] Viewing health through an individualistic lens obscures the root causes of racial disparities and the structural interventions necessary to realize health justice. Health reforms that go too far in accommodating the fixture of individualism will have limited impact on injustice because, at root, "social problems need social or collective, not just individual, solutions."[247] Deeper commitment to solidarity prompts us to assess the system in terms of its ability to serve "uniquely public — as opposed to the mere aggregation of private — interests."[248] To serve solidarity, health reform must embrace collective problem-solving to meet collective needs. To do so justly, it must ensure that the benefits and burdens of public investments in health and public health are equitably distributed and that communities are empowered to protect themselves and others. To realize health justice, health reform must be both universalist *and* anti-subordinationist.[249]

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[244] *See, e.g.*, Wiley & Bagenstos, *supra* note 10, at 1235-36 ("Elected officials have asked each of us to take personal responsibility for weathering this crisis rather than providing community supports and legal protections that would cushion the blow, spread the costs more widely, and enable everyone to abide by and benefit from public health recommendations.").

[245] *Id.* at 1236-37.

[246] Harris & Pamukcu, *supra* note 4, at 762.

[247] Fineman, *supra* note 88, at 141; *see* Wiley, *Health Justice*, *supra* note 8, at 874 (describing "collective action grounded in community engagement and participatory parity" as a core commitment of health justice); *see also* Wiley, *Social Justice*, *supra* note 6, at 95 (highlighting "collective responsibility for assuring healthy living conditions, rather than reinforcing individualistic assumptions about personal responsibility for health").

[248] Wiley, *Health Justice*, *supra* note 8, at 855.

[249] Lindsay F. Wiley, Universality, Vulnerability, and the Goals of Twenty-First Century Health Reform 2 (2019) (unpublished manuscript) (on file with author) ("the universalization of social supports for access to health care and healthy living conditions can and should be antisubordinationist").

B. Fiscal Fragmentation

At the most basic level, fiscal fragmentation is a product of two complexes of laws that divide up control over resources within the United States: property laws and fiscal (spending and tax) laws. Both bodies of law have been used as tools of structural racism and subordination. Property laws assign control and ownership of existing and newly generated resources of all types, including land, capital, ideas, and labor.[250] Tax and spending laws, in turn, alter this baseline allocation of resources from the default set by property law, creating additional fragmented pots of money.[251]

Tax laws create revenue for government redistribution, and spending laws re-allocate resources or commit resources for future allocation. For example, the Medicare statute commits to Medicare beneficiaries and the providers who serve them reimbursement for covered services, in perpetuity, and funds that entitlement largely by directing payroll taxes into the Medicare trust fund.[252] It thereby creates a discrete pot of national resources that serve a distinct constituency of Medicare beneficiaries[253] — just as property laws create millions of pots of resources that serve distinct constituencies of property owners. The higher reimbursement rates paid to providers for services rendered to patients covered by Medicare (including for COVID testing and vaccination) incentivize more outreach to those patients than to Medicaid beneficiaries, whose coverage is more precariously financed and whose providers receive substantially less generous reimbursement rates.[254]

The fragmentation of the nation's wealth and redistributive programs is not random; it creates, perpetuates, and reflects subordination. The baseline of property ownership locks in and carries forward any unaddressed inequity in wealth or the means to generate it. Thus, Black Americans today control less, and have less, because their ancestors

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250 *See generally* David A. Super, *A New New Property*, 113 COLUM. L. REV. 1773, 1778-80 (2013) (describing nature and purposes of property law).

251 *See* Daniel Shaviro, *Rethinking Tax Expenditures and Fiscal Language*, 57 TAX L. REV. 183, 191 (2003) ("The distinction between taxes and spending [] depends on pure form.").

252 *See* Matthew B. Lawrence, *Medicare Bankruptcy*, 63 B.C. L. Rev. (forthcoming 2022) (manuscript at 6-12) (draft Sept. 13, 2021) (on file with authors) (describing Medicare financing structure).

253 *Id.*

254 *See* Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855, 868 (2012) ("Physicians tend to avoid Medicaid patients primarily, but not exclusively, because reimbursement rates are often lower than for privately insured and Medicare patients.").

were able to pass less on to them — at first because they were prohibited from owning property, even their own labor, and then because of systematic discrimination in access to education, jobs, equal pay, housing, and health care.

Similarly, the creation and separation of spending programs through which the nation alters the baseline distribution of property has not been neutral to subordination, either. It has favored powerful groups and disfavored the powerless.[255] Thus, programs like Medicare and Social Security that benefit the middle class are sturdy, with permanent federal funding flows protected from disruption — government "shutdowns" do not hurt Medicare beneficiaries.[256] Meanwhile, programs that predominantly benefit the poorest Americans and communities, like Medicaid and the Supplemental Nutrition Assistance Program ("SNAP"), are fiscally fragile. They require annual appropriations just to keep operating and, therefore, are susceptible to sabotage or hostage-taking by the House, Senate, and President — as the weeks-long lapse in SNAP benefits during the 2019 government shutdown illustrated.[257]

Because fiscal fragmentation reflects subordination, it propagates it. Fiscal fragmentation makes inequity durable. There are many good arguments in favor of durability in property ownership and spending programs like Medicare, but that durability comes at the cost of entrenching inequity.[258] Furthermore, fiscal fragmentation facilitates the nation's failure to offer a robust response to all its residents' health needs. It allows us to conceptualize poverty, want of health care, and want of health investment as individual or community failures, what economists call "wealth effects," rather than as the societal choices they ultimately are.

C. Federalism

The concept of shared sovereignty is not unavoidably racist. But the historical and political manifestations of deference to state authority in American federalism are racist in origin and perpetuate

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255 DANIEL E. DAWES, THE POLITICAL DETERMINANTS OF HEALTH 143 (2020).

256 *See* Matthew B. Lawrence, *Subordination and Separation of Powers*, 131 YALE L.J. 87, 107-13 (2021) (describing privileged financial status of spending programs that benefit middle class).

257 *See id.* at 23.

258 *See id.*

subordination.[259] States' rights in American federalism have long been the rallying cry for proponents of slavery and racial segregation — from the drafting of the Tenth Amendment, to the Civil War, through Reconstruction and the Civil Rights movement, to the "Contract for America," and the resistance to the Affordable Care Act.[260] "People of color have long been disproportionately disadvantaged by federalism,"[261] and the "core problems of racial inequality" still find their "core . . . in questions of federalism.[262]

In health care, devolution to state authority has been most visible in health care infrastructure investments and the Medicaid safety net — so-called "cooperative federalism" and spending clause programs.[263] Historically, when federal reforms have extended the reach of public programs, legal and political concessions to former Confederate states in the South have allowed for the continued exclusion or subordination of Black and Brown people from the health care system.[264] For example, in the 1945 Hill-Burton Act, representatives from Southern states

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[259] *See* Peggy Cooper Davis, Anderson Francois & Colin Starger, *The Persistence of the Confederate Narrative*, 84 TENN. L. REV. 301, 302-03 (2017) ("The Confederate narrative . . . . is a story grounded in the assumption that People's rights are best protected by limiting federal power and protecting the power and independence of states . . . . [It] is notoriously significant for having protected slave power, undermined the Civil War Amendments, and justified Jim Crow subordination."); *see, e.g.*, Grigsby et al., *supra* note 171, at 659 ("The real failure of our federalist system is rooted in systemic racism and a resistance to racial equity.").

[260] Gerken, *All the Way Down*, *supra* note 153, at 48 ("Federalism has often been a code-word for letting racists be racists."); *e.g.*, Jamila Michener, *Race, Politics, and the Affordable Care Act*, 45 J. HEALTH POLS., POL'Y & L. 547, 550 (2020); Denise C. Morgan & Rebecca E. Zietlow, *The New Parity Debate: Congress and Rights of Belonging*, 73 U. CIN. L. REV. 1347, 1369-70 (2005); *cf.* Paul D. Moreno, *"So Long as Our System Shall Exist": Myth, History, and the New Federalism*, 14 WM. & MARY BILL RTS. J. 711, 714 (2005) (noting "the devolution of power from Washington to the states is a cause championed today most often by the right").

[261] Michener, *supra* note 260, at 550.

[262] Robert C. Lieberman & John S. Lapinski, *American Federalism, Race, and the Administration of Welfare*, 31 BRIT. J. POL. SCI. 303, 303-04 (2001); *accord* Gerken, *All the Way Down*, *supra* note 153, at 49 ("those interested in racial justice have long been skeptical of federalism"); Medha D. Makhlouf, *Laboratories of Exclusion: Medicaid, Federalism & Immigrants*, 95 N.Y.U. L. REV. 1680, 1752 (2020).

[263] *See* Ava Ayers, *Discriminatory Cooperative Federalism*, 65 VILL. L. REV. 1, 11-12 (2020) (explaining that "cooperative-federalism schemes" such as Medicaid "are another important tool Congress can use to support state discrimination against noncitizens."); Gluck & Huberfeld, *supra* note 161, at 1711 (arguing that deference to state authority in implementing federal law has often served to entrench rather than transcend interstate disparities).

[264] Interlandi, *supra* note 7.

demanded local control of hospital construction funds, which allowed many hospitals in rural and Southern areas to be segregated.[265]

State control of federal funds likewise allows opportunistic states to dis-invest in health care for their Black and Brown residents, perpetuating disparities in health care access. Medicaid serves as a prime example. Congress enacted Medicaid in 1965 as part of the Great Society reforms targeting discrimination and poverty.[266] Since then, a series of legislative waivers and administrative policies have ceded control of program design increasingly to the states.[267] Southern states and those politically aligned with them have frequently wielded this "flexibility" to exclude and subordinate people of color from the program's reach, eroding the federal floor of protection.[268] This "fend-for-yourself" federalism and policy devolution "has led to states developing welfare sanctions that disproportionately harm low-income Blacks . . . ."[269]

The Supreme Court's decision in 2012 to make the ACA's Medicaid expansion subject to states' discretion has meant that a similar grouping of states have refused to expand Medicaid, allowing racial disparities in coverage to persist in non-expansion states while narrowing disparities in expansion states.[270]

In addition to eroding nationwide protections for subordinated populations, the devolution to state sovereignty treads on the abilities of local communities to protect their own populations through state preemption of local government action.[271] Preemption, as Harris and Pamucku have argued, is "[a] potential danger to [the] innovations in

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265 *Id.*

266 *See generally* Dayna Bowen Matthew, *The "New Federalism" Approach to Medicaid: Empirical Evidence that Ceding Inherently Federal Authority to the States Harms Public Health*, 90 KY. L.J. 973, 978-80 (2002) (tracing the 1965 origins and evolution of "Medicaid and the 'New' Legislative Federalism").

267 *See generally* Edward H. Stiglitz, *Forces of Federalism, Safety Nets, and Waivers*, 18 THEORETICAL INQUIRIES LAW 125, 129 (2017) (arguing that "waivers represent a form of managed devolution, and that forces that operate at the level of state implementation *generally*, even if not *uniformly*, move toward retrenchment").

268 *See id.*

269 Grigsby et al., *supra* note 171, at 658.

270 Michener, *supra* note 260, at 549-51. All but four of the twelve remaining states that have refused the Medicaid expansion were part of the Confederate States of America during the Civil War. Interlandi, *supra* note 7 ("Several states, most of them in the former Confederacy, refused to participate in Medicaid expansion.").

271 *See* Briffault, *supra* note 154, at 1998-2000 (explaining that preemption denies "legal space for local self-determination concerning problems that arise at the local level").

collective self-determination" that further health justice.[272] Local governments are not insulated from racism, but to the extent that local governments take discriminatory actions, federal and state preemption helpfully invalidates them.[273] On the other hand, when localities want to adopt anti-racist or other protective policies, state governments may preempt them from doing so, which exposes the subordinating influence of state sovereignty.[274] This is particularly true because local governments often are "the very sites where racial minorities are empowered to rule."[275]

In a pandemic, local governments have the least political power and fewest resources to effectuate public health measures.[276] But, if allowed, they also can be nimble and highly-responsive to local needs, especially to the manifestations of health disparities among their Black and Brown residents. For example, when COVID infections and deaths spiked in the Atlanta region, Mayor Keisha Lance Bottoms implemented policies for face-covering and restricting business openings to stanch the trend.[277] Georgia Governor Brian Kemp sued her, asserting that state-level policy of *not* requiring masks and *not* requiring public accommodation closures preempted these local public health measures.[278] Other conservative states entertained similar arguments to

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272 Harris & Pamukcu, *supra* note 4, at 827.

273 Derek Carr, Sabrina Adler, Benjamin D. Winig & Jennifer Karas Montez, *Equity First: Conceptualizing a Normative Framework to Assess the Role of Preemption in Public Health*, 98 MILLBANK Q. 131, 127 (2020); *e.g.*, Briffault, *supra* note 154, at 2021-22.

274 Kim Haddow, Derek Carr, Benjamin D. Winig & Sabrina Adler, *Preemption, Public Health, and Equity in the Time of COVID-19*, ASSESSING LEGAL RESPONSES TO COVID-19, at 71, 73-74 (2020); *see also* HUNTER BLAIR, DAVID COOPER, JULIA WOLFE & JAIMIE WORKER, ECON. POL'Y INST., PREEMPTING PROGRESS 1, 4-6, (2020), https://files.epi.org/pdf/206974.pdf [https://perma.cc/5GQ8-B959] ("[State p]reemption [of local ordinances] is more prevalent in the South and is embedded in a racist history," and also limited "cities' ability to protect their residents from the pandemic.").

275 Gerken, *All the Way Down*, *supra* note 153, at 59 ("If we eliminate opportunities for local governance to protect racial minorities from discrimination, we also eliminate the very sites where racial minorities are empowered to rule.").

276 *Cf.* Gostin & Wiley, *supra*, note 168, at 394 ("Since the mid-twentieth century, the federal government has assumed responsibility for financing disaster recovery efforts that overwhelm local resources, thus spreading the economic burden of disasters."); Haddow et al., *supra* note 274, at 70 ("In many states . . . statewide orders prevented local governments from imposing stricter requirements than the state [during the COVID pandemic].").

277 Ben Nadler, Jeff Amy & Kate Brumback, *Georgia Governor to Drop Lawsuit over Atlanta Mask Mandate*, ASSOCIATED PRESS (Aug. 13, 2020), https://apnews.com/article/virus-outbreak-georgia-lawsuits-local-governments-keisha-lance-bottoms-7c220bed26f611dcf6ea57af94d516d9 [https://perma.cc/BM5L-LJYG].

278 *Id.*

try to preempt protective measures taken by cities, many of which had majority-minority populations.[279]

The manifestations of structural racism and subordination already put low-income and racial minority populations at greater risk of contracting and dying from COVID.[280] They have also suffered from a lack of equitable access to testing and vaccination.[281] "[F]ederalism exacerbates these inequities, as some states have a particularly deep history of under-investing in social programs, especially in certain communities."[282] The federal government's tepid response and shirking of responsibility surely contribute to the racial disparities in the virus's toll by implicitly delegating power to the states who wish to undermine equity efforts, and failing to fund those states that wish to expand them.[283]

D. Privatization

Racism is a key historical reason the U.S. has a predominantly private health care system rather than a national, universal health system that integrates health care and public health.[284] From the inferior health care provided to enslaved people dating back to the 17th century, through the post-Civil War reconstruction period, the New Deal, the mid-20th century Hill-Burton Act's investments in hospital infrastructure, Great Society reforms in the 1960s (adding Medicare and Medicaid), to the ACA, reformers have entrenched the dominant role of privately

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279 Haddow et al., *supra* note 274, at 70-71 (surveying preemption by state executive order in those states, as well as West Virginia and Iowa); Brooks Rainwater, *States Are Abusing Preemption Powers in the Midst of a Pandemic*, BLOOMBERG (July 1, 2020, 3:00 AM PDT) https://www.bloomberg.com/news/articles/2020-07-01/how-states-co-opted-local-power-during-coronavirus [https://perma.cc/VE7G-6QAU] (reporting on similar efforts in Nebraska, Texas, Florida, Mississippi, Arizona, and North Carolina).

280 *See* Grigsby et al., *supra* note 171, at 659 ("[M]any have concluded U.S. federalism is unfit to respond to a pandemic").

281 *See, e.g.*, Scott Dryden-Peterson, Gustavo E. Velásquez, Thomas J. Stopka, Sonya Davey, Shahin Lockman & Bisola O. Ojikutu, *Disparities in SARS-CoV-2 Testing in Massachusetts During the COVID-19 Pandemic*, 4 JAMA NETWORK OPEN 1, 3-4 (2021) (finding that "despite programs to promote equity and enhance epidemic control in socioeconomically vulnerable communities, testing resources across Massachusetts have been disproportionately allocated to more affluent communities." (citations omitted)).

282 Huberfeld et al., *supra* note 71, at 1.

283 *See, e.g.*, Grigsby et al., *supra* note 171, at 661 ("[T]he lack of coordination and consistent messaging in a decentralized system contributed to unacceptable delays in testing sites in . . . municipalities with a high proportion of Black residents.").

284 *See* Interlandi, *supra* note 7 ("In the United States, racial health disparities have proved as foundational as democracy itself.").

financed health care, which has permitted *de jure* and *de facto* segregation and tiering of health care along racial, ethnic, geographic, and socioeconomic lines, and separated health care and public health into separate silos.[285] The fragmentation of the U.S. health care system tracks these demographic characteristics — with wealthier, mostly white people covered by private insurance and poorer people, and more non-whites, covered by public programs or not at all.[286]

David Barton Smith documented how racial subordination prevented the establishment of universal social insurance in the U.S.[287] The ascendance of private, voluntary health insurance as a benefit tied to employment largely benefitted whites, and opposition to a broader, more inclusive system from trade unions, private hospitals, and the white medical profession blocked the establishment of a national public insurance system like those in other countries.[288] The American Medical Association and hospitals excluded Black people as members or patients until the Civil Rights era, few Black people had jobs with employer-health benefits, and even if they did, they couldn't use the coverage in white-only facilities.[289] The divisions between the two-tiered publicly and privately financed health care systems in the U.S. were racialized from the beginning of the nation and continue through this day.[290]

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285 W. MICHAEL BYRD & LINDA A. CLAYTON, AN AMERICAN HEALTH DILEMMA—RACE, MEDICINE, AND HEALTH CARE IN THE UNITED STATES 1900-2000, at 9-18 (2002); DAVID BARTON SMITH, HEALTH CARE DIVIDED—RACE AND HEALING A NATION, ch. 5 (1999) (describing how Southern states threatened to stop Medicare's passage if it meant they would be required to desegregate hospitals under Title VI of the Civil Rights Act, and secured an exception for physicians).

286 BYRD & CLAYTON, *supra* note 285, at 17 ("[T]he majority of African Americans remained demographically, economically, and socially segregated and isolated within our nation's depressed inner cities. These areas continue their history of being medically underserved and being provided substandard healthcare by the underfinanced, inferior public tier of the nation's dual unequal health system."); SMITH, *supra* note 285, at 29-30 ("Public programs were for Blacks; private ones for whites."); *Uninsured Rates for the Nonelderly by Race/Ethnicity, Timeframe: 2019*, KFF, https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Sept. 10, 2021) [https://perma.cc/C7SL-2NRD] (finding 7.8% of whites, 11.4% of Blacks, 20% Hispanics, 7.4% of Asian-Pacific Islanders, 21.7% of Native Americans, and 8.2% of multi-racial persons being uninsured).

287 SMITH, *supra* note 285, at 28-29.

288 BYRD & CLAYTON, *supra* note 285, at 16; Interlandi, *supra* note 7 (contrasting the opposition of the white-only AMA with the Black National Medical Association, which advocated for national health insurance system).

289 Interlandi, *supra* note 7.

290 BYRD & CLAYTON, *supra* note 285, at 17.

Racial subordination was key to the ascendance of the private tier of the U.S. health care system, and the persistence of the private health insurance model stands in stark opposition to health justice. In the words of Deborah Stone, the market-based logic of the private health insurance system is "profoundly antithetical to the idea of mutual aid."[291] Private insurance market principles are based on actuarial fairness, where each person pays for his own risk, and the insurance profit model depends on fragmenting the risk pool into ever smaller, more homogenous groups.[292] Moreover, the actuarial methodology of insurance historically incorporated the social biases and subordination of people of color, who tend to be poorer and live and work in communities designated as higher risk.[293] The U.S.'s private insurance system treats health care as a market good — allocated based on the ability to pay — which means poorer communities, which are disproportionately Black and Brown, always have worse health care access and quality.[294] By contrast, other developed countries treat health care as a public good, to be distributed based on need and funded collectively.[295] It is this organizing market-principle of actuarial fairness and its rejection of mutual aid principles, not the mere presence of private insurance companies (which many countries with universal social insurance programs have)[296] that connect the U.S. private health insurance system with its racially inequitable outcomes.[297]

The nail in the inequitable coffin is that the two-tiered U.S. health care system pays providers less to care for patients with public insurance than those with private insurance.[298] Price discrimination,

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[291] Stone, *supra* note 8, at 290.

[292] *Id.*

[293] *Id.* at 296-97 (describing how underwriting methodology tracks social class, stereotypes, and occupational categories).

[294] *See* Thomas Rice, *The Impact of Cost Containment Efforts on Racial and Ethnic Disparities in Healthcare: A Conceptualization*, *in* UNEQUAL TREATMENT, *supra* note 6, 699-70 (concluding that the U.S. approach to cost containment exacerbates racial disparities, particularly by allocating services based on the ability to pay).

[295] SMITH, *supra* note 285, at 28.

[296] Roosa Tikkanen, *Variations on a Theme: A Look at Universal Health Coverage in Eight Countries*, THE COMMONWEALTH FUND (Mar. 22, 2019), https://www.commonwealthfund.org/blog/2019/universal-health-coverage-eight-countries [https://perma.cc/8FJT-4ZJA].

[297] *See* Stone, *supra* note 8, at 291.

[298] *See* UNEQUAL TREATMENT, *supra* note 6, at 190 ("Low payment rates inhibit the supply of . . . provider[] services to low-income groups, disproportionately affecting ethnic minorities. Inadequate supply takes the form of too few providers participating in plans serving the poor, and provider and unwillingness to spend adequate time with patients.").

which is the practice of providers charging different prices depending on the patient's/payer's ability to pay, is an economic principle that maximizes profits for the provider.[299] Health care is rife with price discrimination. Health care price discrimination translates into racial discrimination, because a patient's coverage type maps onto a patient's racial, economic, and social status.[300]

In the U.S. health care system, lower provider payments by public payers translate to reduced access, particularly in Medicaid, the public program for the poor and the principal source of coverage for minorities.[301] Everyone knows that Medicaid is a poor payer, Medicare slightly better, and private coverage the most lucrative.[302] Price discrimination means providers are always more willing and eager to serve a privately insured patient (including for COVID testing and vaccination) than a publicly insured one and validates negative attitudes against minority, low-income communities.[303] Low reimbursement rates depress provider participation in Medicaid, and Medicaid beneficiaries have far worse access to health care than privately insured patients.[304] This explains the paradox of how Medicare, Medicaid, and

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299 Rice, *supra* note 294, at 712; Uwe E. Reinhardt, *The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for a More Rational All-Payer System?*, 30 HEALTH AFFS. 2125, 2128-29 (2011).

300 Rice, *supra* note 294, at 712 (describing how a system that permits price discrimination will lead providers to preferentially serve privately-insured patients and avoid serving less lucrative publicly-insured or uninsured patients).

301 Sara Rosenbaum, *Racial and Ethnic Disparities in Healthcare: Issues in the Design, Structure, and Administration of Federal Healthcare Financing Programs Supported Through Direct Public Funding*, *in* UNEQUAL TREATMENT, *supra* note 6, at 664, 679.

302 MATTHEW FIEDLER, USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POL'Y, CAPPING PRICES OR CREATING A PUBLIC OPTION: HOW WOULD THEY CHANGE WHAT WE PAY FOR HEALTH CARE? 1, 14 (2020), https://www.brookings.edu/wp-content/uploads/2020/11/Price-Caps-and-Public-Options-Paper.pdf [https://perma.cc/T9FV-44H6]; Rosenbaum, *supra* note 301, at 687 ("It is perhaps safe to say that the best-known problem plaguing the Medicaid program is its notoriously low payment rates."); Leila Fadel, *'The Separate and Unequal Health System' Highlighted By COVID-19*, NPR (Jan. 21, 2021, 4:27 PM), https://www.npr.org/2021/01/21/959091838/the-separate-and-unequal-health-system-highlighted-by-covid-19 [https://perma.cc/K8D3-HNJQ] (quoting the CEO of a safety-net hospital, "We've created a tiered financing system for health care with commercial at the top and Medicaid and uninsured at the bottom . . . where many of our Black and brown communities are. And that's why they're being harder hit by something like COVID. We need to fix it.").

303 *See* Rosenbaum, *supra* note 301 (quoting a 2001 GAO Report, in which a consultant advised a physician practice to "ration your Medicaid, and if anyone calls from Blue Cross/Blue Shield, you say, 'When do you want to come in? We'll come and get you,'" and to give Medicaid patients the most inconvenient appointment times").

304 UNEQUAL TREATMENT, *supra* note 6, at 147-48 (describing how "Medicaid's low reimbursement rates for doctors and hospitals" make the program's "poor,

the ACA reduced racial disparities in health care while perpetuating them.[305] And this is why universal coverage is necessary but insufficient to achieve equitable access to health care. So long as private payers pay more than public ones and people's source of coverage is correlated with their social, economic, and racial status, simply giving everyone an insurance card will not achieve equity.[306]

Empirically, privatized health care systems perpetuate and are characterized by greater inequality.[307] Privatized health care systems underperform publicly financed systems in terms of health outcomes, and they are correlated with higher levels of economic and health inequality. According to one study, the level of health care system privatization in a country significantly increased COVID incidence and mortality, even controlling for other variables.[308] A review study found that greater health care privatization was associated with worse patient outcomes and quality than public health care systems across a number

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disproportionately minority beneficiaries [] subject to largely separate, often segregated systems of hospital and neighborhood clinics" and "drastically restrict Medicaid beneficiaries' ability to access private physicians" and hospitals") (internal citations omitted)).

305 Rosenbaum, *supra* note 301, at 664; LaShyra T. Nolen, Adam L. Beckman & Emma Sandoe, *How Foundational Moments in Medicaid's History Reinforced Rather Than Eliminated Racial Health Disparities*, HEALTH AFFS. BLOG (Sept. 1, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200828.661111/full/ [https://perma.cc/HZ5K-6CXJ].

306 Note the distinction between *paying providers equally* to see all patients and *charging patients equally* for their coverage. Equal provider payment is necessary to promote equality of treatment and access. An equity-maximizing system would scale individuals' costs of coverage and care according to their ability to pay, with wealthier individuals paying more for their coverage than poorer individuals but the coverage would pay providers the same rate for all patients. *See* Rice, *supra* note 294, at 712-13 (advocating for an all-payer system to eliminate price discrimination); Stone, *supra* note 8, at 291 (describing how social insurance breaks the linkage between the amount one pays for care and one's ability to pay).

307 WORLD HEALTH ORG., CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 95 (2008) https://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf;jsessionid=59F070C281D0321A383E27BD94057FD6?sequence=1 [https://perma.cc/3TYJ-S7M8] ("Runaway commodification of health and commercialization of health care are linked to increasing medicalization of human and societal conditions, and the stark and growing divide of over- and under-consumption of health-care services between the rich and the poor worldwide.").

308 JACOB ASSA & CECILIA CALDERON, PRIVATIZATION AND PANDEMIC: A CROSS-COUNTRY ANALYSIS OF COVID-19 RATES AND HEALTH-CARE FINANCING STRUCTURES 14-15 (2020) (estimating the magnitude of this effect of privatization to conclude that "a 10% increase in private health expenditure results in a 4.85% increase in COVID-19 cases" and "a 6.91% increase in COVID-19 deaths").

of low- and middle-income countries.[309] This is because health care privatization has distributional effects. A privatized system generally does a worse job of fairly distributing health care resources across the population — by favoring the wealthy and disadvantaging the poor, and charging fees that deter poorer patients from seeking or continuing care — and these distributional inequities translate to greater disparities in health outcomes.[310] Privatized health care tends to be more inequitable. Thus, even if everyone has coverage, a private health care system will perpetuate inequality along racial and socioeconomic lines unless it is heavily regulated to resemble a public system of coverage with standardized provider payment rates and benefits.

Even in countries with universal public coverage systems, where providers typically are not paid more to serve rich patients than poor ones, there is an observed social gradient in health status.[311] A universal single-payer health care system does not fully eliminate the health effects of income inequality, structural racism, and other social determinants of health.[312] But health inequalities and disparities cannot be addressed without a universal system of coverage under which providers are paid the same amounts to treat all persons.[313] Moreover,

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309 Sanjay Basu, Jason Andrews, Sandeep Kishore, Rajesh Panjabi & David Stuckler, *Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review*, 9 PLOS MED. e1001244, at 1, 5-8 (2012).

310 ASSA & CALDERON, *supra* note 308, at 6 ("Privatization also has distributional effects, . . . [and the] positive relationship between private health-care provision and health inequality is confirmed by the latest data for 147 countries on inequality in life-expectancy [] and the ratio of private to public health expenditures . . . ."); Basu et al., *supra* note 309, at 8 ("private sector health services tend to cater more greatly to groups with higher income and fewer medical needs . . . resulting in disparities in coverage") (internal citations omitted)).

311 Michael Marmot, *The Health Gap: The Challenge of an Unequal World*, 46 INT'L J. EPIDEMIOLOGY 1312, 1313 (2017) (calling the linking of social position with health – higher rank, better health – the "social gradient in health"); M. G. Marmot, George Davey Smith, Stephen Stansfeld, Chandra Patel, Fiona North, Jenny Head, Ian White, Eric Brunner & Amanda Feeney, *Health Inequalities Among British Civil Servants: The Whitehall II Study*, 337 LANCET 1387, 1391-92 (1991). *See generally* Roosa Tikkanen, Robin Osborn, Elias Mossialos, Ana Djordjevic & George A. Wharton, *International Health Care System Profiles: England*, THE COMMONWEALTH FUND (June 5, 2020), https://www.commonwealthfund.org/international-health-policy-center/countries/england [https://perma.cc/W3TZ-ZLBN] (describing England's National Health Service, which served the populations Marmot studied when he described the social gradient).

312 UNEQUAL TREATMENT, *supra* note 6, at 34; Rosenbaum, *supra* note 301, at 665.

313 WORLD HEALTH ORG., *supra* note 307 at 8 ("Universal coverage requires that everyone . . . can access the same range of (good quality) services according to needs and preferences, regardless of income level, social status, or residency, and that people are empowered to use these services. It extends the same scope of benefits to the whole population.").

single-payer health care systems may be more likely to integrate public health goals into their operations.[314]

In the iron triangle era, the holy grail of health policy was universal access to high-quality, affordable health insurance. However, the iron triangle ethos equated access with coverage and was not particularly concerned whether the coverage was equal or the benefits and burdens of such health care were justly distributed. A health justice framework would not be satisfied with universal coverage if it perpetuated a fragmented health care system where wealthier, socially dominant groups benefit from generous private coverage with broad access to enthusiastic providers and poorer, socially subordinated groups are covered by public programs with constrained access to reluctant providers.

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Individualism, fiscal fragmentation, federalism, and privatization perpetuate inequity and subordination in our health care system on a tragic scale. To reconstruct a system on the health justice model, future reforms must confront the fixtures.

IV. LESSON 4: HEALTH REFORM RECONSTRUCTION REQUIRES CONFRONTATIONAL INCREMENTALISM

The pandemic has instructed us that health reform needs nothing short of a reconstruction in ethos, centered on health justice criteria. We have learned that the entrenched fixtures of individualism, fiscal fragmentation, federalism, and privatization sow dysfunction in our health care system and tragically perpetuate inequitable burdens of disease. The health justice ethos — with its commitments to anti-racism, equitable distribution of burdens and benefits, and community empowerment — demands confrontation with these fixtures. But their logistical entrenchment may practically compel an incremental method. We must dig deep for our concluding lesson about *how* health reform might reconcile bolder goals with sharper pragmatism about the fixtures' obstruction of those goals: confrontational incrementalism offers an agenda that makes health reform reconstruction possible.

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[314] *See, e.g.*, Wiley, *supra* note 15, at 891 ("By eliminating (or dramatically reducing) fragmentation in health care financing, single-payer health care could better align incentives between the health care and public health systems. . . . Under a single-payer system, there would be near-total overlap between the primary payer for health care goods and services (taxpayers) and those who exercise control over the most crucial social determinants of health (voters).")

A. *Envisioning a Just U.S. Health System*

Applying the bolder criteria of health justice, what would an anti-racist, equitable, empowering, and solidarity-enhancing health system look like? Such a transformed U.S. health system would eliminate, displace, or transcend the four legally and logistically entrenched fixtures that have led to the functional and existential failures laid bare by the COVID pandemic. The lessons of the pandemic have strengthened the case for a single-payer health care system in the U.S. — a universal social insurance program that is grounded in solidarity, distributes its benefits based on need, allocates its financing burdens by the ability to pay, and empowers affected communities in decision-making processes.[315]

Such a single-payer system would displace the fixture of individualism within health care by enrolling everyone into a shared program from cradle to grave, providing every person in the country the same right to a comprehensive array of health care services.[316] It could also embrace public health principles, strengthening the recognition of health as a public good and prioritizing resources toward the enhancement of the population's health, including addressing systemic racial and social inequities that are themselves a public health crisis.[317] Adopting a universal, single-payer system in the U.S. would eradicate the ethos of actuarial fairness, under which everyone pays for their own risk, and move decisively toward social solidarity where health care and public health are public goods, not commodities.[318]

A universal, single-payer system would also collapse the fixtures of fiscal fragmentation and privatization by combining all participants in

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[315] *See* Bloche, *supra* note 29, at 300 (arguing that "in a democracy," the "principle function" of health law should be to manage conflicting "hopes and expectations for the health care system" we have "as individuals and as public-regarding citizens"); Fuse Brown et al., *supra* note 1, at 419-23 (describing how national single-payer proposals confront the fixtures more directly than the ACA did); Hunter, *supra* note 43, at 1959 (arguing that practices arising out of health reform "have the potential to lead to new discourses and understandings about the interrelationship between individualism and collectivity, and about the public and private dimensions of the health system"); Stone, *supra* note 8, at 291 ("Under a social insurance scheme, individuals are entitled to receive whatever care they need, and the amounts they pay to finance the scheme are totally unrelated to the amount or cost of care they actually use."); Wiley, *Privatized Public Health Insurance*, *supra* note 61 (discussing the role of democratic deliberation in the design and administration of public insurance programs).

[316] *See* Fuse Brown et al., *supra* note 1, at 422; *see, e.g.*, Medicare for All, H.R. 1384, 116th Cong. (2019–2020) (proposing a national single-payer health system that would cover all U.S. residents automatically at birth or upon residency in the U.S.).

[317] *See* YEARBY ET AL., *supra* note 227, at 7-8.

[318] BYRD & CLAYTON, *supra* note 285, at 585.

a single, unified risk pool.[319] With a single payer rather than fiscal diffusion across multiple payers, the system could coordinate and marshal resources in times of emergency. It could provide the "national grid for the generation, transmission, or distribution" of supplies that Atul Gawande has argued that the US lacks.[320]

A single-payer system could also confront fiscal fragmentation by applying administratively set payment rates across the population, eliminating unjust payment differentials so that providers would no longer be paid more to care for wealthier patients than poorer ones. Importantly, a universal system would eliminate the segmentation of the population into tiers of unequal private and public coverage that reify existing racial and socioeconomic disparities in health care access and outcomes.[321] Publicly financed health systems are more equitable and produce better outcomes than privatized systems. Health care user fees and lack of access to a private health plan would no longer be a barrier for disadvantaged people to access needed care, whether in a public health emergency or in more routine circumstances.

Likewise, a single nationwide single-payer program would confront federalism. It could flatten many of the state-by-state disparities that flow from federalism's deference to state flexibility.[322] A federal program could advance health justice by redistributing the burdens and benefits of public investments in health care at a national level — rather than relying on state financing that varies widely.

Other countries offer a variety of visions for what a single-payer, universal health care system looks like.[323] Some have greater reliance on private health insurance contractors to administer the benefits, others retain more federalist flexibility.[324] We do not have to invent our

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319 *See* Fuse Brown et al., *supra* note 1, at 419-21.

320 Gawande, *supra* note 173.

321 *See* SMITH, *supra* note 285, at 29-30.

322 *See generally* JAMILA MICHENER, FRAGMENTED DEMOCRACY: MEDICAID, FEDERALISM, AND UNEQUAL POLITICS (Cambridge Univ. Press 2018) (documenting disparities associated with Medicaid policies that vary from state to state).

323 *See* Tikkanen, *supra* note 296.

324 *See, e.g.*, *How Does Universal Health Coverage Work?*, THE COMMONWEALTH FUND, https://www.commonwealthfund.org/international-health-policy-center/system-features/how-does-universal-health-coverage-work (last visited Aug. 27, 2021) [https://perma.cc/MA4C-BXJH] (describing Germany's health care system that shares powers between the federal government and the states); Dylan Scott, Ezra Klein & Tara Golshan, *Everybody Covered: What the US Can Learn from Other Countries' Health Systems*, VOX (Feb. 12, 2020, 10:28 AM EST), https://www.vox.com/2020/1/13/21055327/everybody-covered [https://perma.cc/5AAV-X9ZG] (describing how the Netherlands has private, universal coverage).

universal, single-payer health care system from whole cloth — though achieving a system that counters rather than propagates the legacy of subordination in upstream determinants of health will be a particular challenge for the United States. We benefit from being the last wealthy country on earth without such a system.[325] The difficulty lies not with a lack of blueprints or models, but rather from the fact that *no country has ever gotten there from here.* The prospect of overcoming the fixtures in the U.S. to achieve this transformed, universal, single-payer health care system seems daunting and possibly even naïve.

B. Health Reform Is Hard

Perhaps COVID will usher in a new era in which the U.S. finds the will to begin the dramatic transformation it needs. Because access to health care is one among many social determinants of health, realizing health justice will also require action in other sectors. But a more just health system, integrating public health and health equity goals into legal frameworks for health *care* financing and delivery, is an important pre-condition for health justice. The pandemic undeniably affects the political and economic climate for health reform and therefore may affect the feasibility of pursuing bolder reforms based on health justice. The public health and economic crises of the pandemic may have accelerated the public's embrace of a greater government role in health care, untethered from employment, and willingness to confront structural inequalities of a fragmented, privatized, "you're on your own" non-system.[326]

Moreover, while we argue for a more principled ethos in which solidarity supports health justice, interest-convergence theory[327] also suggests that the pandemic may have added to the utility of social solidarity. That is, the pandemic may have made it more obvious to dominant racial and social groups in the U.S. that empowering subordinated populations aligns with their own interests. Interest-

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[325] *See* JACOBS & SKOCPOL, *supra* note 17, at 3 ("Universal health care was established in one way or another in every other industrial or industrializing nation. But in the United States, health care reformers (as advocates of universal coverage are labeled) have run into bitter political opposition and, every time, fall short of achieving guaranteed coverage or all citizens.").

[326] *See* Victor R. Fuchs & Ezekiel J. Emanuel, *Health Care Reform: Why? What? When?*, 24 HEALTH AFFS. 1399, 1412 (2005) (predicting that the will for comprehensive health reform may require major upheaval such as a "national health crisis, such as a flu pandemic").

[327] *See* Mary Crossley, *Black Health Matters: Disparities, Community Health, and Interest Convergence*, 22 MICH. J. RACE & L. 53, 58 (2016).

convergence does not make health justice more normatively desirable, but it does suggest that it might be more feasible.

With all of that said, such transformational health reform may seem hopeless or at least unimaginably hard.[328] The pandemic has vitiated any pretense that our current health care financing and delivery system is effective or just — it is profoundly ineffective and unjust. And it has shown that what is needed is not just the will for health justice, but a way. Substantial fixtures are blocking the path toward health system transformation.[329] So long as the blinkered "iron triangle" approach remains dominant in law and policy analysis, reform will not even *aspire* to a just health system, guaranteeing we will not actualize it.[330] And in the political realm, the prospect of a dramatic change brought about through federal legislation like "Medicare for All" has seemingly receded, once again, into the future — as it has been doing for decades.[331]

At the same time, even if a bolder vision of a just health system gains steam in policy and political circles, the road to creating such a system in the United States is difficult because of the structural impediments we have described.[332] As this Article has demonstrated, the distance

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328 *See* JACOBS & SKOCPOL, *supra* note 17, at ch. 5 (asking whether the more modest reforms of the ACA will survive special interest lobbying by the powerful industry groups, whether federalism will undermine implementation, and whether it will collapse under budgetary pressures).

329 *See, e.g.*, Patrice A. Harris, *Health Reform: How to Improve U.S. Health Care in 2020 and Beyond*, AM. MED. ASS'N. (Aug. 13, 2019), https://www.ama-assn.org/about/leadership/health-reform-how-improve-us-health-care-2020-and-beyond [https://perma.cc/T39W-SX3K] (stating the AMA's opposition to single-payer reforms, and its commitment to universal "coverage" by "build[ing] on our current" multi-payer system, pursuant to the values of "choice," "competition," and "pluralism").

330 *See supra* Part I.A.

331 *See* Rachel Cohrs, *Medicare for All Champion Bernie Sanders Drops Out of Presidential Race*, MOD. HEALTHCARE (Apr. 8, 2020, 1:10 PM), https://www.modernhealthcare.com/politics-policy/medicare-all-champion-bernie-sanders-drops-out-presidential-race [https://perma.cc/5FB3-THSD]; Tucker Higgins, *Biden Suggests He Would Veto 'Medicare for All' over Its Price Tag*, CNBC (Mar. 10, 2020, 4:17 PM EDT), https://www.cnbc.com/2020/03/10/biden-says-he-wouldd-veto-medicare-for-all-as-coronavirus-focuses-attention-on-health.html [https://perma.cc/F2FZ-HUV6].

332 *See* Anup Malani & Michael Schill, *Introduction*, *in* THE FUTURE OF HEALTHCARE REFORM IN THE UNITED STATES 9 (Anup Malani & Michael H. Schill eds., 2015) (highlighting that health reforms are difficult because they "directly implicate many of the most sensitive ideological cleavages in our society"); Gabriel Scheffler, *Equality and Sufficiency in Health Care Reform*, 81 MD. L. REV. (forthcoming 2021) (on file with authors) (comparing the normative principles underlying differing conceptions of a "right to health care" in single-payer or more incremental reforms).

between conception and execution is great, and the law is often a barrier to reform, not a facilitator. When the country musters the impulse for solidarity in health care as it did in the spring of 2020, that impulse crashes against entrenched, isolating, dispersive fixtures — individualism, fiscal fragmentation, federalism, and privatization — and stalls. These quasi-legal structures ensure that the solidarity impulse does not translate into solidarity in practice. We have focused on COVID and racial disparities here, but history offers other examples, including the ACA itself.[333]

C. Confrontational Incrementalism

To achieve anything approaching health justice, reform must overcome the fixtures that constrain it. This will require transformation, which may ultimately require a single-payer health system. Incremental reforms that fall short of transformation must be evaluated not based on their marginal progress on quality-cost-access metrics or some proxy endpoint like "universal coverage," but instead on the extent to which they reinforce or undermine the fixtures. Incremental reforms that reinforce the fixtures are counter-productive even if they entail modest coverage gains. But, incremental reforms that undermine or transform fixtures could be a step forward, perhaps regardless of their immediate impacts on coverage.

To deal with both the necessity of transforming our health care system and the apparent impossibility of doing so, we believe health law and policy must develop a strategy for *confrontational incrementalism* — a method for identifying incremental reforms that challenge, displace, or transcend the regressive fixtures we have described and, so, plant the seeds for future transformation.

Confrontational incrementalism begins by distinguishing conceptually between incremental reforms that serve as stepping stones (which represent progress toward fundamental change) and those that serve as stumbling blocks (which distract from fundamental change). Crucially, confrontational incrementalism also requires frank assessment of the extent to which incremental reforms confront legally and logistically entrenched structures that prevent transformation. Incremental reforms that tend to dismantle those structures are stepping stones and reforms that accommodate those structures are

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[333] *See* Fuse Brown et al., *supra* note 1, 414-17.

stumbling blocks. Examples from past health reforms inform this approach.[334]

Our call for confrontational incrementalism traces an agenda for health reform reconstruction. It does not conclude the project. This methodological focus reveals the value of further research into the way fixtures are created and, more importantly, how they may be dismantled — not only in health reform but also in other legal fields where reconstruction is necessary.

1. Stepping Stones or Stumbling Blocks

The COVID pandemic has revealed just how far the United States is from a just and equitable health care system. This leaves a fundamental question for reform — should we accept incremental reforms or hold out for transformation? If, for example, we accept that modest coverage expansions like a "public option" in the Affordable Care Act marketplaces would fall far short, what should we make of such reforms? Are they to be avoided as a distraction from the transformation that must take place, or embraced as a step in the right direction?

Incrementalism is not a question merely for health policy. In drug policy, scholars and policymakers must decide whether to seek reform through the criminal justice system, or hold out to decriminalize substance use disorder.[335] In policing, scholars and policymakers must decide between fundamental reform (or abolition) or modest gains.[336] And in environmental policy, scholars and policymakers must decide whether to accept modest reforms if they fail to fully mitigate and prepare for climate change.[337]

Unpacking incrementalism in environmental policy, Rachel Brewster distinguishes among different incremental reforms based on whether they are "stepping stones" or "stumbling blocks."[338] Stumbling blocks turn out to be "a barrier that make advancement more difficult."[339]

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[334] *See, e.g.*, Fuchs & Emanuel, *supra* note 326, at 1408 (comparing incremental versus comprehensive reform).

[335] John Kip Cornwell, *Opioid Courts and Judicial Management of the Opioid Crisis*, 49 SETON HALL L. REV. 997, 1005 (2019) (discussing controversy surrounding whether to employ drug courts or abandon them as "fundamentally incompatible with the disease model of addiction").

[336] *See* Dorothy E. Roberts, *Foreword: Abolition Constitutionalism*, 133 HARV. L. REV. 1, 11-12 (2019) (describing abolition movement in criminal justice reform).

[337] Rachel Brewster, *Stepping Stone or Stumbling Block: Incrementalism and National Climate Change Legislation*, 28 YALE L. & POL'Y REV. 245, 246 (2010).

[338] *Id.*

[339] *Id.*

Stepping stones "eas[e] the way to climbing higher."[340] In assessing the difference, Brewster stresses the importance of considering not only the static effects of a reform ("what the immediate and direct effects of the policy are") but also its dynamic effects ("how the measure will affect the system," including "longer-term and indirect effect[s]" and alterations to "incentives for private and public actors").[341]

This is an essential framework and an important, partial defense of incrementalism. Yes, we should not accept any *goal* short of transformation to a just and equitable health system. But that alone does not render reforms short of that goal undesirable. To realize health justice, the confrontational incrementalist approach to health reform must be anti-subordinationist.[342] Assessing whether any particular incremental reform is a stepping stone or a stumbling blocks is key to this effort.

In some sense, whether an incremental reform is a stepping stone or a stumbling block is a political judgment for elected officials and movement leaders. Will implementing a modest reform use up political energy that could eventually be channeled into transformation? Or will it demonstrate the success that will both maintain a movement's momentum and make the next step forward a smaller one? That said, the relevance of such political judgments may be overstated, as shifting political dynamics make any prediction about how choices today will impact the will of the voters (or the politicians they elect) in some future year inaccurate indeed.

Differentiating stepping stones and stumbling blocks is also a legal question. Because the fixtures we have identified impede social solidarity and propagate subordination in health care, the question of whether to pursue reforms that fall short of the needed transformation depends on how those reforms interact with the legal entrenchment of individualism, fiscal fragmentation, federalism, and privatization.

2. Applying Confrontational Incrementalism to Pre-pandemic Reforms

Measuring incremental reforms' degree of confrontation with the fixtures will be hard work. As a starting place, we can find historical examples of health reforms that, on an impressionistic basis, appear positive or negative from the standpoint of confrontational incrementalism.

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340 *Id.*

341 *Id.* at 250-51.

342 *See* Harris & Pamukcu, *supra* note 4, at 762.

Medicare's enactment in 1965 may be an example of a stepping stone. The law partially confronted privatization (established as a public program), individualism (automatic enrollment), fiscal fragmentation (federally-financed without segmentation), and federalism (federally administered).[343] Not surprisingly, the law is today understood as a template for universal, single-payer, federally-run health care.[344] Given Medicare's success in confronting the fixtures, it is no wonder that "Medicare for All" has become the shorthand for such a system.[345] It's worth remembering, however, that Medicare's confrontations, while substantial, were *partial*. Medicare preserved a role for private contractors in benefits administration (in addition to preserving private health care delivery systems).[346] It also preserved fiscal fragmentation to some degree by segregating eligible enrollees from other risk pools.

By this same analysis, Medicare Part D, which added pharmaceutical coverage to the program, was more of a stumbling block. The program, spearheaded by the George W. Bush Administration, changed a largely government-run program into a fully-privatized program by relying on private insurers to administer virtually every aspect of it.[347] This private insurance model meant individual premiums, significant cost-sharing, and risk selection — importing an ethic of individualism and actuarial fairness into Medicare. Moreover, by explicitly keeping the Medicare program out of drug pricing, it failed to leverage administrative rate setting to keep drug prices (and costs to enrollees) in check.[348] Thus, Medicare Part D invites Medicare enrollees to see themselves as individual consumers rather than participants in a public program. In this sense, Medicare Part D was a stumbling block because it primarily accommodated rather than confronted the fixtures that constrain reform.

Under this analysis, the ACA was a mixed bag. The law's coverage gains themselves actually came through designs that, because they tried

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343 *See* Timothy Stoltzfus Jost, *Governing Medicare*, 51 ADMIN. L. REV. 39, 44-45 (1999) (describing the Medicare program).

344 *Id.*

345 *See* Nicole Huberfeld, *Is Medicare for All the Answer? Assessing the Health Reform Gestalt as the ACA Turns 10*, 20 HOUS. J. HEALTH L. & POL'Y 69, 70-72 (2020).

346 Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn't Worked*, 101 GEO. L.J. 519, 527-28 (2013) (describing reliance on private claims administration in Medicare program).

347 42 U.S.C. § 1395w-101(a) (2012); *see* Fox Ins. Co. v. Ctrs. for Medicare & Medicaid Servs., 715 F.3d 1211, 1214 (9th Cir. 2013) (describing Medicare Part D enrollment process).

348 42 U.S.C. § 1395ww-111(i) (2012) (Medicare "may not interfere with the negotiations between drug manufacturers and pharmacies[.]").

to accommodate the fixtures, reinforced them, featuring further fiscal fragmentation, individualism, and state administration. The law did, however, directly attack the individualism fixture in two ways: the individual mandate (requiring everyone to purchase insurance) and community rating coupled with the ban on preexisting condition exclusions (requiring everyone to share in the costs of one another's illness).[349]

Though the individual mandate did not endure,[350] the ACA's ban on preexisting condition exclusions won the confrontation with individualism, shifting the public's view on preexisting conditions.[351] That reform — and not the law's coverage gains — is perhaps the clearest example of an incremental stepping stone, precisely because it confronted a fixture of American law.

Confrontational incrementalism can be applied to assess proposed reforms. It does not necessarily provide definitive answers, but it does reframe the debate around the extent to which trade-offs among the four fixtures progress toward health justice or further entrench the status quo.[352] Consider public option reforms. A federal public option plan could extend eligibility to everyone, create a large and unified risk pool of previously fragmented ones, offer broad benefits and provider participation, improve affordability through aggressive rate setting, and offer additional financial supports for low-income and high-cost patients.[353] Such a public option reform would confront all four fixtures to some extent and likely be a stepping-stone toward health justice. If politics require accommodations to certain fixtures — to federalism by allowing states to pursue a public option first, or to privatization by

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[349] *See* Fuse Brown et al., *supra* note 1, at 414-17; Hunter, *supra* note 43, at 1959 (arguing that practices arising out of the individual mandate and health insurance exchanges "have the potential to lead to new discourses and understandings about the interrelationship between individualism and collectivity, and about the public and private dimensions of the health system").

[350] *See* Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, 131 Stat. 2054 (2017) (reducing the individual mandate penalty to zero).

[351] *See* Gluck & Scott-Railton, *supra* note 76, at 560 ("Virtually no Republican is now willing to state a desire to return to the pre-ACA landscape of discrimination based on health status.").

[352] Fuse Brown et al., *supra* note 1, at 423.

[353] *See, e.g.*, Matthew Yglesias, *Joe Biden's Health Care Plan, Explained*, VOX (July 16, 2019, 11:30 AM EDT), https://www.vox.com/2019/7/16/20694598/joe-biden-health-care-plan-public-option [https://perma.cc/SNY6-F9A8] (describing candidate Biden's public option plan as containing all these features and noting that if implemented, it would be "the most dramatic piece of new social legislation since the Great Society.").

using commercial carriers to administer public option plans[354] — these accommodations should be offset by confrontations to other fixtures. For example, the policy could grant states the ability to combine their Medicaid population with their public option plan, equalizing payment rates and unifying the inequitable two-tiered public-private health care system that pays more to providers for seeing privately insured patients than publicly insured. Overall such a plan could be a stepping-stone toward a just and equitable health system, even if it did not confront all the fixtures simultaneously.

For contrast, consider a public option that is only offered on the marketplaces (and is thus unavailable to Medicaid beneficiaries and undocumented immigrants), leaves untouched most employer-based coverage, is administered and financed by private health insurers, and applies modest provider rate controls with correspondingly modest effects on the market. A public option thus designed would accommodate the fixtures and would not move us any closer to the goal of a just health care system, even if it provided more choices and modest cost savings to some enrollees.[355] Such an accommodating public option could constitute a stumbling block if it consumes all the political capital and energy for reform, but merely reinforces the fixtures and all their attendant problems.

3. Applying Confrontational Incrementalism During the Pandemic

Realizing health justice — especially during a pandemic — requires legal protections and supports that extend well beyond access to medical countermeasures, including measures to secure safe and healthy housing, worker protections, basic income support, food security, and more. Here, our focus is on medical countermeasures. Although testing and vaccination campaigns have been plagued by inadequacies and inequities, there are examples of interventions that incrementally confront the fixtures we have described.

Some of the most successful approaches from a health justice perspective have been place-based interventions that inherently confront the fixture of individualism. By prioritizing access to scarce resources for testing and vaccination based on census tracts, worksites, and other institutional settings, place-based strategies recognize the

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354 Wiley, *Privatized Public Health Insurance*, *supra* note 61, at 2161 (discussing potential political expedience of private provision of public coverage).

355 Jaime S. King, Katherine L. Gudiksen & Erin C. Fuse Brown, *Are State Public Option Health Plans Worth It?*, 59 HARV. J. ON LEGIS. (forthcoming 2022).

importance of individuals' connections with the communities where they live and work.

The Pharmacy Partnership for Long-Term Care Program is an example of a place-based approach.[356] It confronts federalism by creating a nationwide distribution mechanism, but its hands-off approach to privatization and its failure to confront fiscal fragmentation left it poorly coordinated and underfunded.[357] Depending exclusively on third-party reimbursement based on the insurance status of each individual resident or worker who receives a vaccination was a major stumbling block. Relying on profit-motivated pharmacy chains to mobilize vaccination teams without public oversight contributed to failures of coordination, transparency, and accountability. Ironically, state governors were blamed for "doses sitting on shelves" at a point when most of those doses appeared to be sitting on shelves owned by CVS and Walgreens. While the pharmacy chains held up vaccine administration to obtain hard-copy consent forms for billing purposes, state government officials were being criticized for the deficits between doses shipped and doses administered.

A better example (though one that benefits from state flexibility under a federalism framework, rather than confronting it) was West Virginia's program for vaccinating nursing home residents and staff. West Virginia was the only state to entirely opt-out of the federal program for vaccinating long-term care residents and workers.[358] The state's governor and health department opted to launch their own program. Well-funded state and local health departments played match-maker between individual long-term care facilities and local pharmacies and provided ongoing guidance and oversight to ensure smooth administration.[359] The state was the first in the nation to offer full vaccination to all residents of nursing homes and assisted living facilities.[360]

Rhode Island has pioneered a place-based approach to prioritization for COVID vaccines and to ensuring just distribution of the benefits of

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356 *See* Press Release, U.S. Dep't of Health and Hum. Servs., *supra* note 147.

357 *See supra* Part II.B.2.

358 Noguchi, *supra* note 150.

359 *Id.*

360 Press Release, W. Va. Off. of the Governor, COVID-19 Update: Gov. Justice: West Virginia Becomes First State in Nation to Complete Vaccinations at All Nursing Homes, Assisted Living Facilities (Jan. 29, 2021), https://governor.wv.gov/News/press-releases/2021/Pages/COVID-19-UPDATE-Gov.-Justice-West-Virginia-becomes-first-state-in-nation-to-complete-vaccinations-at-all-nursing-homes.aspx [https://perma.cc/U8GC-YTEC].

public investments in health. The governor and health department designated entire "hard-hit" communities for the first phase of vaccine distribution based exclusively on geography.[361] Place-based prioritization — based on pandemic-related indicators like test positivity and hospitalization rate, as well as pre-pandemic tools like CDC's social vulnerability index[362] — directly confronts the structural racism and economic subordination that have driven COVID disparities by actively prioritizing communities where higher-risk workplaces and crowded multi-generation homes contribute to high exposure.[363] After prioritizing entire communities, the state health department partnered with local housing authorities, employers, and civil society groups to send mobile teams and pop-up vaccination sites directly to the places where people live and work and vaccinate anyone on-site who's willing, without asking for documentation of individual eligibility factors or insurance information.[364]

These partnerships focused on empowering local communities. They confronted individualism by focusing on neighborhood-level factors and the interconnectedness between individuals and the communities where they live, work, shop, and attend school. They confronted privatization (incrementally, but also intentionally) by ensuring strong public coordination and oversight. They failed to confront federalism, but in this case, state-level experimentation and on-the-ground implementation may have had some advantages.

Another incremental approach is to confront fiscal fragmentation by equalizing reimbursement rates for Medicare, Medicaid, and private insurance. In March 2021, amid criticism that white and wealthier

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361 Pan, *supra* note 106.

362 The social vulnerability index is a tool for identifying communities likely to be hit particularly hard by disasters. It uses fifteen variables to rate census tracts based on socioeconomic indicators, household composition, racial and ethnic composition, English language skills, housing type, and access to transportation. *CDC/ATSDR SVI Frequently Asked Questions*, AGENCY FOR TOXIC SUBSTANCES & DISEASE REGISTRY, https://www.atsdr.cdc.gov/placeandhealth/svi/faq_svi.html (last visited Sept. 15, 2020) [https://perma.cc/VZY9-B9HG].

363 Govind Persad, *Allocating Medicine Fairly in an Unfair Pandemic*, 2021 U. ILL. L. REV 1085, 1131 (2021); *see* William F. Parker, Govind Persad & Monica E. Peek, *Four Recommendations to Efficiently and Equitably Accelerate the COVID-19 Vaccine Rollout*, HEALTH AFFS. BLOG (Feb. 10, 2021), https://www.healthaffairs.org/do/10.1377/hblog20210204.166874/full/ [https://perma.cc/75NN-HSUH].

364 E-mail Communication from Julian Drix, Co-Lead, Health Equity Inst., R.I. Health Dep't, to authors (Feb. 5, 2021, 8:14 AM) (on file with authors).

residents were receiving the lion's share of vaccine doses in his state,[365] Massachusetts Governor Charlie Baker announced that the state's Medicaid program would increase reimbursement for COVID vaccination to twice the level of Medicare rates and mandated that private insurers pay at least the same rate.[366] Shortly after that, CMS announced a substantial increase in the reimbursement rate Medicare would pay to providers for administering vaccines.[367] Equalizing rates reflects a more passive approach than place-based prioritization efforts, and it fails to confront individualism, federalism, or privatization. But rate equalization's confrontation of fiscal fragmentation marks a significant, stepping-stone improvement.

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Successful examples of confrontational incrementalism within the pandemic point to important lessons of their own. It may well be that *accommodating* one fixture as part of a trade-off that allows for greater *confrontation* with other fixtures provides an important path forward. Vaccination programs in West Virginia and other states took advantage of federalism and public-private partnerships to confront individualism and fiscal fragmentation. Similarly, Washington's public option reform accommodates federalism and privatization while confronting individualism and fiscal fragmentation. These trade-offs among the four fixtures merit further attention in follow-up projects. Here, our point is simply that examining trade-offs among individualism, fiscal fragmentation, federalism, and privatization offers a new framework for evaluating health reforms aimed at anti-subordination, just distribution of the benefits and burdens of public investments in health care and public health, and community empowerment. Trade-offs among health care access, quality, and cost are insufficient to explain or inform the next steps in health reform reconstruction.

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365 Philip Marcelo, *2 Hard-Hit Cities, 2 Diverging Fates in Vaccine Rollout*, WBUR NEWS (Feb. 24, 2021), https://www.wbur.org/commonhealth/2021/02/24/central-falls-chelsea-coronavirus-vaccine-access [https://perma.cc/TML6-JFRA].

366 Priyanka Dayal McCluskey, *In Surprise Move, Baker Administration Sets High Insurance Payments for Vaccinations*, BOS. GLOBE (Mar. 8, 2021, 6:51 PM), https://www.bostonglobe.com/2021/03/08/metro/surprise-move-baker-administration-sets-high-insurance-payments-vaccinations/ [https://perma.cc/E3FD-KTHQ].

367 Press Release, Ctrs. for Medicare & Medicaid Servs., Biden-Harris Administration Increases Medicare Payment for Life-Saving COVID-19 Vaccine (Mar. 15, 2021), https://www.cms.gov/newsroom/press-releases/biden-harris-administration-increases-medicare-payment-life-saving-covid-19-vaccine [https://perma.cc/UD6K-8WTF].

CONCLUSION

The COVID pandemic is what John Kingdon has described as a "focusing event."[368] Reflecting on the failures of the U.S. pandemic response may create an opening to start building a better health system oriented toward public health and equity. The lessons of the pandemic have made the case for reconstructing health reform to confront the four fixtures in ways that realize health justice. Reformers should seize the moment — the public health, racial, and economic crises of the pandemic have accelerated the public's embrace of a greater government role in health care and bolstered our willingness to confront the structural inequities of a fragmented, privatized, "you're on your own" system. But it is critical for reformers to ensure that they do no further harm by entrenching the fixtures we have identified here. Regardless of whether reformers seek to realize health justice in one leaping transformation or tack toward it incrementally, we provide a methodology — confrontational incrementalism — to chart the course.

The post-pandemic period will be a critical inflection point. The COVID pandemic offers lessons about the *what*, the *how*, and the *why* of future reforms to the U.S. health system. Similar lessons will also guide reforms in other spheres implicated in pandemic devastation. The deep entrenchment and path-dependent reification of individualism, fiscal fragmentation, federalism, and privatization make it nearly impossible to displace these fixtures wholesale. But abandoning the haphazard accommodation of the fixtures, which fatally constrained pre-2020 health reform, is a critical step in the right direction.

Given the enormity of the U.S. health system's failures during the pandemic, we put forth an ambitious proposal. It is time to exit the iron triangle era in which health reforms are assessed solely in terms of health care access, quality, and costs. We must work toward a bolder goal of realizing health justice by centering anti-subordination, equitable distribution of burdens and benefits (for which access, quality, and cost are useful, but not exhaustive, metrics), and community empowerment. This will require confronting the structural fixtures that have hobbled the country's pandemic response and reinforced racial and social subordination in our health care system. Armed with a new conceptual framework (health justice), the diagnosis (the four fixtures) and the treatment (confrontational incrementalism), health reform reconstruction is possible.

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[368] JOHN W. KINGDON, AGENDAS, ALTERNATIVES, AND PUBLIC POLICIES 98 (1995).