HEALTH REFORM RECONSTRUCTION

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ABSTRACT

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, an intellectually cramped "iron triangle" ethos has constrained health reform conceptually. The iron triangle centered individual interests in access to, quality of, and cost of medical care, while marginalizing equity and public health. In the iron triangle era, reforms unquestioningly accommodated four entrenched fixtures of American law—individualism, fiscal fragmentation, privatization, and federalism—that distort and diffuse any reach toward justice and solidarity. The profound racial disparities and public health failures of the U.S. pandemic response in 2020 agonizingly manifested the limitations of pre-2020 health reform and demand a reconstruction.

Health reform reconstruction begins with the replacement of the iron triangle era with a new era in which reforms aim to realize health justice. Health justice does not itself overcome the fixtures of American law that constrain reform and propagate subordination. But it reveals the importance of doing so, despite the fixtures' stubborn legal and logistical entrenchment. Because health reformers can no longer accept any conceptual goal short of health justice, incremental reforms must be measured chiefly by whether they confront or accommodate individualism, fiscal fragmentation, privatization, and federalism in health care. Through an uncompromising conceptual aspiration and a method of confrontational incrementalism focused on dismantling the legal structures that stand in the way of health justice, health reform reconstruction is possible. The Article describes how health reform reconstruction can chart the path of legal change and reflects on the usefulness of its methodology of confrontational incrementalism in other fields which recognize the necessity of reconstructive reform, along with its near impossibility, such as policing and drug policy.

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CONTENTS

Introduction ... 3
I. Lesson 1: Health Reform Reconstruction Requires a New Ethos ... 7
A. The Iron Triangle Era ... 8
B. Pandemic Failures, Functional & Existential ... 12
C. Health Reform Reconstruction: The Health Justice Era ... 15
II. Lesson 2: Four Fixtures Contribute to Functional Failures ... 17
A. Fixtures ... 17
B. Fixtures' Functional Failures ... 19
1. Individualism ... 20
2. Fiscal Fragmentation ... 23
3. Federalism ... 29
4. Privatization ... 36
III. Lesson 3: Racism and Subordination Are Foundational to The Four Fixtures ... 41
A. Individualism ... 42
B. Fiscal Fragmentation ... 44
C. Federalism ... 46
D. Privatization ... 48
IV. Lesson 4: Health Reform Reconstruction Requires Confrontational Incrementalism ... 53
A. Envisioning a Just U.S. Health System ... 54
B. Health Reform is Hard ... 55
C. Confrontational Incrementalism ... 57
1. Stepping stones or stumbling blocks ... 58
2. Dismantling structures ... 59
3. Applying confrontational incrementalism ... 60
Conclusion ... 62

INTRODUCTION

In the aftermath of 2020, it is no longer tenable for health 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 coronavirus pandemic in the United States was a fiasco—a consequence of human failures—not merely a natural disaster. In one of the richest nations on earth, governments at every level failed to discharge their core obligations to protect the people's health and welfare.[2] Worse, communities of color bore the brunt of death and suffering, due to the existential failure of past reforms to rectify the systemic racism and other forms of subordination baked into the American legal and health systems from the start.[3] It has been clear for decades that the U.S. health system is broken, but the sheer scale of injustice in 2020 has made it impossible to pretend that haphazard incremental reforms will be adequate. With this knowledge, it is not enough to renew our commitment to pre-2020 health reform principles. We must reconstruct health reform, and ultimately the health care system, using new principles and a new method. Incremental reforms may be unavoidable but they must be adopted intentionally, with an eye toward their place in the broader project of upending or transcending the legal structures that propagate subordination.

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 that what is necessary to transcend these constraints is nothing short of reconstruction.[4] The Article develops the project of health reform

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[1] 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 (2020) (describing four legal fixtures of the health care system that have prevented the achievement of social solidarity: federalism, fiscal pluralism, privatization, and individualism); 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 ("[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.").

[2] *See* Lindsay F. Wiley, *Democratizing the Law of Social Distancing*, 19 YALE J. HEALTH POL'Y, L. & ETHICS 50, 68-79, (2020) (documenting the U.S. response to the 2020 coronavirus pandemic) [hereinafter *Social Distancing*].

[3] *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 __, 2-5 (forthcoming 2021) (surveying literature on racial, ethnic, and socioeconomic disparities in SARS-CoV-2 infection and severe illness and death from COVID-19); *id.* at 7-13 (connecting disparities to racism, poverty, and other forms of subordination).

[4] 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. health care system is even more damaged after the pandemic and requires rebuilding with a new ethos for a new age. *See* RECONSTRUCT, MERRIAM-WEBSTER.COM. 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.COM. Third, the anti-

reconstruction by drawing four vital lessons from the pandemic – a pair of normative lessons bookending a pair of constructive lessons. First, a new ethos for health reform rooted in solidarity, equity, and justice must replace the long-dominant but conceptually blinkered iron triangle. Second, entrenched legal 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 legal fixtures reinforces and stems from racism and other forms of social subordination. Fourth, to make meaningful progress reforms must confront or transcend the legal fixtures that have reinforced subordination and constrained reform for decades.

The first lesson we draw from the pandemic is that post-2020 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 balancing and rebalancing created a piecemeal approach to health care regulation that culminated in the Affordable Care Act.

To guide post-2020 health reform, we propose a new set of principles oriented toward social solidarity and health justice. Social solidarity in health care is rooted in the principle of mutual aid, as contrasted with actuarial fairness principles where everyone pays for their own risk.[5] Health justice demands that reformers address the role of health laws and policies in reinforcing—or, alternatively, dismantling—racism, economic injustice, and other forms of social subordination. Reformers must ensure just distribution of the burdens and benefits of robust public investments in health care. Decision-making processes related to health must ensure recognition, representation, and empowerment of marginalized

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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.*, Richard Thompson Ford, *Rethinking Rights After the Second Reconstruction*, 123 YALE L. J. 2574 (2014); 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."). 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 (2015); Angela Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. Rev. 758 (2020); Sidney D. Watson, *Minority Access and Health Reform: A Civil Right to Health Care*, 22 J. L. MED. & ETHICS 127 (1994); Jeneen Interlandi, *Why Doesn't the United States have Universal Health Care? The Answer has Everything to Do with Race*, N.Y. TIMES MAG. (Aug. 24, 2019); and Vann R. Newkirk II, *America's Health Segregation Problem*, THE ATLANTIC (May 18, 2016).

[5] Fuse Brown, Lawrence, McCuskey & Wiley, *supra* note 1, at 411-412; Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 CONN. INS. L. J. 199, 205 (2008); Lindsay F. Wiley, *From Patient Rights to Health Justice*, 37 CARDOZO L. REV. 833, 859 (2016) [hereinafter *Health Justice*]; Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & LAW 287, 290 (1993).

groups. In short, health care regulation should embrace public health principles and strive for health justice and solidarity, leaving the iron triangle era in the rearview.

The second, related lesson we draw from the pandemic is that health reform has been structurally constrained by legal fixtures that impede solidarity and justice. In Part II, we describe how the U.S. response to the 2020 coronavirus pandemic was stymied by four legal fixtures: individualism, fiscal fragmentation, federalism, and privatization. These fixtures, which we described in a prior collaboration,[6] 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 failed to support the medical countermeasures that are critical in a communicable disease crisis—including testing, therapeutics, and vaccination.[7] 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 logistically and politically entrenched. They are rooted in a constellation of constitutional provisions, laws, legal institutions, economic arrangements, and cultural commitments, rather than a single law.[8] Agencies, companies, work forces, relationships, and economies are built around the fixtures. The iron triangle era accommodated these four fixtures unquestioningly.

The third lesson we draw from the pandemic is that the fixtures of individualism, fiscal fragmentation, federalism, and privatization have contributed to a more profound existential failure of American health care: racial inequity in the burden of disease. In Part III, we describe how each of the fixtures is historically rooted in and perpetuates subordination, thereby subverting health equity and health justice. Because the fixtures have played historic and inherent roles in creating and reinforcing subordination, reforms accommodating them will continue to perpetuate racial injustice. The accommodative stance of iron-triangle reforms has become untenable for reformers who are committed to anti-subordination. The

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[6] Fuse Brown, Lawrence, McCuskey & Wiley, *supra* note 1, at 414-417.

[7] *See* U.S. CTRS. DISEASE CONTROL, VACCINE AND OTHER MEDICAL COUNTERMEASURES, CDC.GOV (Apr. 28, 2020), https://www.cdc.gov/flu/pandemic-resources/planning-preparedness/vaccine-medical-countermeasures.html#:~:text=Safe%2C%20effective%2C%20and%20readily%20available,society%20during%20a%20future%20pandemic.

[8] 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, as described in Part II.A., *infra*. *See generally* William N. Eskridge, Jr. & John Ferejohn, *Super-Statutes*, 50 DUKE L.J. 1215 (2001) (describing "super-statutes" as singular statutory enactments that "successfully penetrate public normative and institutional culture in a deep way").

existential failures of 2020 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.

How can reforms reconcile ambitious goals with pragmatism about their feasibility? They may do so initially by identifying whether an incremental policy change serves as a stepping stone, stumbling block, or springboard for confronting the fixtures that stymie health justice and solidarity. Although incremental, this approach to the fixtures promotes vigilance about the accumulated, functional effects of reforms that accommodate, rather than confront them. It provides an assessment of each incremental policy's confrontation with the fixtures based on its contribution to equity, anti-subordination, and solidarity. Ultimately, confrontational incrementalism demands more attention to the tradeoffs and accumulated accommodations which 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 a health justice endpoint. 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-subordinationist reform efforts.

The project of health reform reconstruction may seem overwhelming, especially because it starts with a recognition of the potency and stickiness of conceptual and structural obstacles to health justice in the United States. We draw hope, however, in the fact that reconstruction as we understand it is already beginning. Professor Harris's & 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.[9] 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

[9] Harris & Pamukcu, *supra* note 4.

federalism.[10] Policymakers have shown nascent interest in such proposals.[11] 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.[12] Many have acknowledged that it is, more accurately, a *non*-system.[13] The stress of the 2020 coronavirus pandemic revealed the depth of these failures to a broader audience. 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.

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[10] *See* Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. PA. L. REV. (2019) (proposing ERISA waiver that would erode federalism and privatization); Lindsay F. Wiley, *Medicaid for All?: State-Level Single-Payer Health Care*, 79 OHIO ST. L.J. 843 (2018) (exploring paths to state-based single payer reforms with potential to erode individualism and privatization); Matthew B. Lawrence, *Fiscal Waivers and State "Innovation" in Health Care*, ___ WM. & MARY L. REV. (forthcoming 2021) (proposing waiver pathway to facilitate sharing of federal savings between states and federal government, bridging fragmented fiscal categories).

[11] *E.g.*, NAT'L COUNCIL OF INS. LEGISLATORS, *Press Release: NCOIL Passes Resolution to Amend ERISA*, (Mar. 28, 2019) (adopting McCuskey and Fuse Brown proposal to create and ERISA waiver for state health reform), http://ncoil.org/2019/03/28/ncoil-passes-resolution-to-amend-erisa.

[12] *See generally, e.g.*, UWE E. REINHART, PRICED OUT: THE ECONOMIC AND ETHICAL COSTS OF AMERICAN HEALTH CARE (2019); Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255, 258 (1990) ("The health care system in the United States is plagued with serious distributional inequalities"); TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK 1 (2007) (calling the health care system "broken"); STEPHEN M. DAVIDSON, STILL BROKEN: UNDERSTANDING THE U.S. HEALTH CARE SYSTEM xii-xiv (2010) (same); LAWRENCE R. JACOBS & THEDA SKOCPOL, HEALTH CARE REFORM AND AMERICAN POLITICS 17-30 (2010) (same); ELISABETH ROSENTHAL, AN AMERICAN SICKNESS 8 (2017) (calling the health care market "dysfunctional").

[13] *See, e.g.*, Isaac D. Buck, *Affording Obamacare*, 71 HASTINGS L. J. 261, 305 (2020) (describing it as both "a bloated and underregulated non-system"); George B. Moseley III, *History of Medicine: The U.S. Health Care Non-System, 1908-2008*, 10 AM. MED. ASS'N J. ETHICS, *Virtual Mentor*, 324-31 (2008); Lawrence D. Brown, *The Amazing Noncollapsing U.S. Health Care System — Is Reform Finally at Hand?*, 358 N. ENGL. J. MED. 325, 325 (2008) ("[T]the U.S. system is in fact a nonsystem, an incoherent pastiche that has long repulsed reforms sought by private and public stakeholders"); Walter B. Maher, *Health Care in America: Implications for Business and the Economy*, 3 STAN. L. & POL'Y REV. 55, 55 (1991) (critiquing the U.S. "health care system or, more accurately, nonsystem").

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.[14] The iron triangle accepts as a fundamental starting point that these three priorities are the most important and that there are unavoidable tradeoffs between them.[15] Kissick's iron triangle described the thrust behind reforms of the prior three decades and became the prevailing frame for assessing every health reform effort in the ensuing 25 years, setting up the dominant narrative that U.S. efforts to expand access and quality come with inevitable and substantial cost increases.[16] 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.[17] 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.

Some health-system reformers have pursued a sublimated version of the iron triangle, called the "triple aim," which retooled the iron 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.[18] Alluringly, the triple aim sought to avoid the tragic tradeoffs of the

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[14] WILLIAM L. KISSICK, MEDICINE'S DILEMMA'S: INFINITE NEEDS VERSUS FINITE RESOURCES 2-3 (1994). 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).

[15] *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 equal tensions among access to health services, quality of health care, and cost containment. Trade-offs are inevitable regardless of the size of the triangle.")

[16] *Id.*

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

[18] Donald M. Berwick, Thomas W. Nolan, & John Whittington, *The Triple Aim: Care, Health, And Cost,* 27 HEALTH AFF. 759, 760 (2008). The triple aim is sometimes described as a framework for "improving the U.S. health care system." *Id.* at 759. But reforming the U.S. system writ large involves many decisions and actions in "the realms of ethics and policy," which Berwick et al., characterize as external to the triple aim. *Id.* at 760. The triple aim is perhaps more comprehensible

iron triangle, promising that all points of the triad could be pursued simultaneously.[19] Recognizing the limitations of the access-quality-cost framework, the originators of the triple aim gestured toward "population health" and "health equity."[20] But they ultimately rooted the triple aim in a medicalized model (focusing exclusively on delivery of medical care) and left public health and social justice concerns to ethicists and future policymakers.[21] Troublingly, the iron triangle treats individuals' access to needed medical care as something to be balanced against other forces.

Health law scholars have also advanced competing models for how the points of the iron triangle should be balanced—by securing the professional autonomy of physicians, the rights of patients, or the market power of payers.[22]

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as a tool for improving the individual functioning of any one of the many discrete health care systems that are components of the U.S. system—integrated networks of hospitals and physician practice groups that serve patient populations defined by geographic catchment area and capitated payment arrangements with third-party payers. *See* Institute for Healthcare Improvement, Achieving the IHI Triple Aim: Summaries of Success, http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/ImprovementStories.aspx (describing the success of "sites participating in the IHI Triple Aim Initiative," including "organizations providing health care services" and highlighting several case studies, all of which center health care providers and third-party payers).

[19] William Sage, *Fracking Health Care: How to Safely De-Medicalize America and Recover Trapped Value for Its People*, N.Y.U. J. L. & LIBERTY 635, 662-663 (2017).

[20] Berwick, Nolan, & Whittington, *supra* note 18, at 760 ("The most important of [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.").

[21] Sage, *supra* note 19, at 664 ("Where the Triple Aim may fall short is in its expectation that population health can be substantially improved within a medical framework."). 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 (2016) ("The recent explosion of the use of the term [population health] in the medical world, in phrases like 'population health management,' has unfortunately narrowed the concept in two important ways. First, 'population' refers to 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. Second, the emphasis is on improving the outcomes of care and reducing costs."); Berwick, Nolan, & Whittington, *supra* note 18, at 762-63 ("What best defines a population, as we use the term, is probably the concept of enrollment. (This is different from the prevailing meaning of the word enrollment in U.S. health care today, which denotes a financial transaction, not a commitment to a healing relationship.").

[22] *See* Wiley, *Health Justice*, *supra* note 5 (surveying the relevant literature and describing professional autonomy, patient rights, market power, and health consumerism as the four main models); *see also* Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1452 (1994) (identifying four paradigms used in health law to allocate resources: market, professional, moral, and political); James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State 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"); 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 an alternative concept of "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" approach, which "at heart hopes that medicine can be regulated by endowing patients with rights of autonomy to

These models have been united by a foundational focus on meeting individual needs and regulating individual relationships.[23] They have assumed that private employer-based health insurance will remain the default, supplemented by fragmentary public subsidization that varies from state to state. Solidarity (interdependence among individuals and groups),[24] mutual aid (reciprocity of support),[25] and communitarianism (connectedness between individuals and their communities)[26] are critical to securing the public's health, particularly in a

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which medical professionals and institutions must defer" and the "law and economics approach," which "at heart hopes that medicine can be regulated in the market, by consumers making purchasing decisions that discipline medical institutions, as the two "competing paradigms" of health law); Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155, 155 (2004) (contrasting the "modestly egalitarian social contract" paradigm in which the role of law is "to achieve a fair resolution of conflicting interests, especially in the light of highly unequal information and power between patients and [physicians and other stakeholders with interests in the health care system]" with the "market competition" paradigm, in which the role of law "is to ensure that choices about health insurance and health services are made by individuals based on their own financial resources (assuming them to be above some specified minimum), and . . . to eliminate as much as possible hidden 'cross-subsidies.'"); WENDY E. PARMET, POPULATIONS, PUBLIC HEALTH, AND THE LAW 196-98 (2009) ("Initially, the laws relating to health care reflected the prestige and influence of the medical profession . . . . Then, in the late 1960s and 1970s, a new patients' rights paradigm developed . . . . In the last twenty-five years, another perspective emphasizing the role and values of the market has gained prominence.").

[23] Wiley, *Health Justice*, *supra* note 5 at 107-120 (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, since its inception "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."); William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497, 500 (2008) [hereinafter *Relational Duties*] ("politicians 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").

[24] *See, e.g.*, Ryan M. Melnychuk & Nuala P. Kenny, *Pandemic Triage: The Ethical Challenge*, 175 CANADIAN MED. ASS'N J. 1393, 1394 (2006) 1394 ("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]"); 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.").

[25] *See, e.g.,* Bruce Jennings, *Relational Liberty Revisited: Membership, Solidarity and a Public Health Ethics of Place*, 8 PUB. HEALTH ETHICS 7, 7 (2015) ("[B]oth the 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.").

[26] *See, e.g.*, Dan E. Beauchamp, *Community: The Neglected Tradition of Public Health*, 15 HASTINGS CTR. REP. (no. 6) 28 (1985) ("By ignoring the communitarian language of public health, we risk shrinking its claims. We also risk undermining the sense in which 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.").

pandemic. But in the iron triangle era, few reformers have dreamed of incorporating a solidarity ethos into regulation of the U.S. health care system.[27]

The ACA was the apotheosis of the iron triangle era.[28] Its boldest aim was "universal coverage" under a multi-payer system heavily dependent on employers to provide coverage.[29] 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.[30] And the public option was ultimately left out of the ACA in spite of its proponents' accommodating stance.[31] 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 (if fragmented) coverage.[32] While the ACA nudged the U.S. health care system in the direction of solidarity and reduced racial

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[27] *See, e.g.*, Stone, *supra* note 5, at 290 ("The private insurance industry . . . is organized around a principle profoundly antithetical to the idea of mutual aid, and indeed, the growth and survival of the industry depends on its ability to finance health care by charging the sick and to convince the public that 'each person should pay for his own risk.'"); Rosenblatt, *supra* note 22, at 191 (describing "[t]he sense of a great fork in the road between hyper-individualism and unrestrained competition, on the one hand, and some way of reconstituting solidarity and associated social policies, on the other"); Sage, *Relational Duties, supra* note 23, at 500 ("An obligation to further the interest of a something rather than a someone—perhaps an aggregate of persons, perhaps an ideal—I call a 'regulatory duty.' The thesis of this Essay is that far 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."); *id.* at 507 ("[A]ccess 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.").

[28] Sylvia Matthews Burwell, *Preface* to THE TRILLION DOLLAR REVOLUTION 2 (Ezekiel J. Emanuel & Abbe R. Gluck eds. 2020) ("Those 3 aspects—accessibility, affordability and quality—and their impact on the health of the American people 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 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.")

[29] OFFICE OF MGMT. & BUDGET, EXEC. OFFICE OF THE PRESIDENT, A NEW ERA OF RESPONSIBILITY: RENEWING AMERICA'S PROMISE, BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 2010 at 27 (2009), https://www.govinfo.gov/content/pkg/BUDGET-2010-BUD/pdf/BUDGET-2010-BUD.pdf (noting eight goals for health reform, including aiming for universal coverage and guaranteeing choice of health plan 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 50 (recalling the reform imperatives of the ACA included universality but also to "do no harm" to employer-sponsored insurance coverage.)

[30] Jacob S. Hacker, *From the ACA to Medicare for All?* in THE TRILLION DOLLAR REVOLUTION: HOW THE AFFORDABLE CARE ACT TRANSFORMED POLITICS, LAW, AND HEALTH CARE IN AMERICA 336 (Ezekiel J. Emanuel & Abbe R. Gluck eds., 2020) (describing the public option proposals that were part of Democratic reform plans in the 2008 election).

[31] *Id.*

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

disparities in health insurance coverage,[33] large gaps remain. Health and life expectancy continue to be powerfully correlated with socio-economic status, race, and ethnicity.[34]

The 2020 coronavirus pandemic has simultaneously exposed the systemic failure of the U.S. health care system to secure the public's health and welfare 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 social justice 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 health justice and solidarity.

B. Pandemic Failures, Functional & Existential

The 2020 coronavirus 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 is revealing how functionally ineffective a diffuse, multi-payer, largely privatized health care system is at actually protecting individual and population health. And it is revealing how, existentially, such a system is built on and perpetuates subordination and marginalization.

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[33] *See* 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 and extend a deeper consciousness of these norms to public discourse related to the health care system."); 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. Public ownership and pure, tax-based financing are technically easier and almost certainly cheaper routes to health care solidarity, but they come at a cost to the status quo that Congress was not prepared to pay."); Molly Frean, Shelbie Shelder, Meredith Rosenthal, et al., *Health Reform and Coverage Changes Among Native Americans*, 176 JAMA INTERNAL MED. 858 (2016); John J. Park, Sarah Humble, Benjamin Sommers et al., *Health Insurance for Asian Americans, Native Hawaiians, and Pacific Islanders under the Affordable Care Act*, 178 JAMA INTERNAL MED. 1128 (2018); Sergio Gonzales and Benjamin D. Sommers, *Intra-Ethnic Coverage Disparities Among Latinos and the Effects of Health Reform*, 53 HEALTH SVCS. RES. 1373 (2017); Thomas C. Buchmueller, Zachary Levinson, Helen Levy, Barbara Wolfe, *Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage*, 106 AM. J. PUB. HEALTH 1416 (2016).

[34] *See e.g.*, Thomas A. LaVeist, *Disentangling Race and Socioeconomic Status: A Key to Understanding Health Inequalities*, 82 J. URBAN HEALTH iii26 (2005); John M. Ruiz, Belinda Campos & James J. Garcia, *Special Issue on Latino Physical Health: Disparities, Paradoxes, and Future Directions*, 4 J. LATINA/O PSYCH. 61-66 (2016); Jermane M. Bond & Allen A. Herman, *Lagging Life Expectancy for Black Men: A Public Health Imperative*, 106 AM. J. PUB. HEALTH 1167 (2016); Raj Chetty, Michael Stepner & Sarah Abraham, *The Association between Income and Life Expectancy in the United States, 2001-2014*, 315 JAMA 1750 (2016); Yin Paradies, *Colonisation, Racism, and Indigenous Health*, J. POP. RESEARCH 83 (2016); Thomas A. LaVeist, Mindy Fullilove & Robert Fullilove, *400 Years of Inequality Since Jamestown of 1619*, 109 AM. J. PUB. HEALTH 83 (2019); Linda R. Stanley, Randall C. Swaim, Joseph Keawe'aimoku Kaholohula, Kathleen J. Kelly, Annie Belcourt & James Allen, *The Imperative for Research to Promote Health Equity in Indigenous Communities*, 21 PREVENTION SCIENCE 13 (2020); 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 (2020).

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 delivered more effectively in countries with a centralized and unified public health care delivery system.[35] Future reform must reflect what we are learning from these functional failures.

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. Although the uninitiated claimed COVID-19 was "the great equalizer,"[36] 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.[37]

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

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[35] *See, infra*, Part II.B.

[36] *See* Tim Molloy, *Madonna's COVID-19 Bathtub Message: 'It's the Great Equalizer'*, SPIN (Mar. 22, 2020), https://www.spin.com/2020/03/madonnas-covid-19-bathtub-message-its-the-great-equalizer/; 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/.

[37] *See, e.g.*, Lonnae O'Neal, *Public Health Expert Says African Americans are at Greater Risk of Death from Coronavirus*, THE UNDEFEATED (Mar. 13, 2020), https://theundefeated.com/features/public-health-expert-says-african-americans-are-at-greater-risk-of-death-from-coronavirus/ (interview with Dr. Georges Benjamin, Executive Director of the American Public Health Association); Emily A. Benfer & Lindsay F. Wiley, *Health Justice Strategies to Combat COVID-19: Protecting Vulnerable Communities During a Pandemic*, HEALTH AFF. BLOG (Mar. 19, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200319.757883/full/; Ruqaiijah Yearby & Seema Mohapatra, *Structural Discrimination in COVID-19 Workplace Protections*, HEALTH AFF. BLOG (May 29, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200522.280105/full/; 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 (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*, J. PUBLIC HEALTH MANAGEMENT & PRACTICE (published online ahead of print, Sept. 9, 2020); Clyde W. Yancy, *COVID-19 and African Americans*, 323 JAMA 1891 (2020); W. Holmes Finch & Maria E. Hernandez Finch, *Poverty and Covid-19: Rates of Incidence and Deaths in the United States During the First 10 Weeks of the Pandemic*, 5 FRONTIERS IN SOCIOLOGY 47 (2020); Samrachana Adhikari, Nicholas P. Pantaleo & Justin M. Feldman, *Assessment of Community-Level Disparities in Coronavirus Disease 2019 (COVID-19) Infections and Deaths in Large US Metropolitan Areas*, 3 JAMA Network Open e2016938 (2020).

to infection through their working and living conditions.[38] They are less likely to have ready access to testing, less 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.[39] Black, Indigenous, and Latino and Latina patients are more likely to become severely ill or die from COVID-19.[40] 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-19 preys upon.[41] They may be more likely to be treated in hospitals with fewer resources and lower quality of care.[42] They are more likely to experience institutional and interpersonal discrimination in health care delivery.[43] 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.[44]

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[38] 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*, 20 YALE J. HEALTH POL'Y, L. & ETHICS __ (forthcoming 2020).
[39] *Id.*; Lindsay F. Wiley & Samuel R. Bagenstos, *The Personal Responsibility Pandemic: Centering Social Solidarity in Public Health and Employment Law*, 52 ARIZ. ST. L.J. __ (forthcoming 2021).
[40] *See* Gross, et al., *supra* note 37.
[41] *See* Ctrs. for Disease Control and Prevention, Summary Health Statistics—National Center for National Health Interview Survey—2018, Table A-1a, https://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2018_SHS_Table_A-1.pdf (age-adjusted percentages of people with coronary heart disease, hypertension, and stroke among U.S. adults by race, ethnicity, income, poverty status, and health insurance coverage status); Ctrs. for Disease Control and Prevention, Summary Health Statistics—National Center for National Health Interview Survey—2018, Table A-2a, https://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2018_SHS_Table_A-2.pdf (emphysema, asthma, and chronic bronchitis); Ctrs. for Disease Control and Prevention, National Diabetes Statistics Report (2020) at Figure 2 (type-2 diabetes); Shreya Rao, Matthew W. Segar & Adam P. Bress, *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)*, JAMA CARDIOLOGY (published Nov. 13, 2020 online ahead of print) (finding that Global West African ancestry proportion was not significantly associated with blood pressure control, "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"); CDC, *Evidence Used to Update the List of Underlying Medical Conditions that Increase a Person's Risk of Severe Illness from COVID-19* (last updated Nov. 2, 2020), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/evidence-table.html (surveying studies associating various chronic conditions with COVID-19 severity).
[42] *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.
[43] *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. FAMILY MED. 580 (2020).
[44] *See* GREGORY ACS & MICHAEL KARPMAN, EMPLOYMENT, INCOME, AND UNEMPLOYMENT INSURANCE DURING THE COVID-19 PANDEMIC, URBAN INSTITUTE (June 2020), https://www.urban.org/sites/default/files/publication/102485/employment-income-and-

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 2020 coronavirus 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."[45] The pandemic also coincided with growing support for the Black Lives Matter movement in response to systemic police violence against Black people.[46] The public health and economic devastation wreaked by a novel, serious, and highly infectious virus and 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. 2020 has taught 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 solidarity and social justice 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. We draw these criteria from works by public health ethicists and critical race feminists, and from the health justice model two of us have developed and

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unemployment-insurance-during-the-covid-19-pandemic.pdf; EMILY BENFER, DAVID BLOOM ROBINSON, STACY BUTLER, LAVAR EDMONDS, SAM GILMAN, KATHERINE LUCAS MCCAY, ZACH NEUMANN, LISA OWENS, NEIL STEINKAMP & DIANE YENTEL, THE COVID-19 EVICTION CRISIS: AN ESTIMATED 30-40 MILLION PEOPLE IN AMERICA ARE AT RISK, ASPEN INSTITUTE (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/.

[45] *See* Mariner, *supra* note 5, at 205; Wiley, *supra* note 5, 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."); Stone, *supra* note 5, at 289-290 (contrasting the individualistic principle of actuarial fairness in health policy, 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).

[46] *See* Tasnim Motala, *'Foreseeable Violence & Black Lives Matter: How Mckesson Can Stifle a Movement*, 73 STANFORD L. REV. 61 (2020) ("The events of the last three months have galvanized Americans across the political spectrum to demand accountability for police brutality and racial justice. The phrase 'Black Lives Matter' has gone from a polarizing rhetorical boogeyman to a relatively uncontroversial rallying cry, taken up by politicians, celebrities, and corporations regardless of their political affiliation."); 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/.

applied in our prior work.[47] First, 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.[48] Second, to secure collective interests in public health and social justice, health laws and policies must ensure just distribution of the burdens and benefits of public investments in health care.[49] Third, decision-making processes related to health must ensure recognition, representation, and empowerment of marginalized groups.[50] These criteria, which

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[47] *See* Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J. L. & PUB. POL'Y 47, 52 (2014) [hereinafter *Social Justice*] ("I describe social justice as a communitarian approach (in its emphasis on collective problems and collective problem-solving) to ensuring the essential conditions for human well-being, including redistribution of social and economic goods and recognition of all people as equal participants in social and political life. Rather than merely adopting social justice as the 'core value' of public health as . . . others have done, I argue that social justice is emerging as a core value of health law and policy *writ large*."); Matthew B. Lawrence, *Against the Safety Net*, 72 FLA. L. REV. 49 (2020) (applying the health justice framework and vulnerability analysis to critique the safety net metaphor for public benefits); *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) ("Premised on fundamental principles of equity, health 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 ("This Article argues 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.").

[48] *See* Harris & Pamukcu, *supra* note 4, at 762-63 ("Subordination [defined as a set of policies, practices, traditions, norms, definitions, cultural stories, and explanations that function to systematically hold down one social group to the benefit of another social group] 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. . . . Recognizing subordination as a driver of health is essential to solving the puzzle of persistent health disparities linked to group status".); *see also* Yearby, *supra* note 34, at 524 ("To achieve racial health equity, government and public health officials must aggressively work to end structural racism and revamp all of our systems, especially the public health system, to 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."); Wiley, *Social Justice*, *supra* note 47, 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, rather than reinforcing individualistic assumptions about personal responsibility for health.").

[49] *See* LAWRENCE O. GOSTIN & LINDSAY F. WILEY, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 19 (3d. ed. 2016) ("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 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. __ (forthcoming 2021) [hereinafter *Privatized Public Health Insurance*] (assessing progressive health reform proposals in terms of fair distribution of health benefits and financial burdens).

[50] Wiley, *Social Justice*, *supra* note 47, 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."); GOSTIN & WILEY, *supra* note 49, at 19 ("Social justice encompasses participatory parity: equal respect for all community members and recognition, participatory engagement, and voice for historically underrepresented groups."); Harris & Pamukcu,

are rooted in social justice, are more likely to promote an ethos of solidarity in health care law and policy. The solidarity ethos that characterizes public health as a field distinct from medicine can and should be more fully integrated into health reform proposals in the post-pandemic era.[51] While cost, quality, and access will remain relevant to the operation of particular reforms, they can no longer sustain a centrality to the ethos of that reform.

Using new criteria rooted in solidarity and 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

Precisely because the equity-based criteria we propose are rooted in solidarity, they inevitably collide with four legal fixtures in the U.S. health care system: individualism, fiscal fragmentation, federalism, and privatization.[52] These four fixtures are legally and logistically entrenched and have crippled the health care system's ability to meet public health needs.

The second lesson we draw: the failed U.S. response to the 2020 coronavirus pandemic highlights the role of four fixtures – individualism, fiscal fragmentation, federalism, and privatization – as structural constraints on health reform. The fixtures' legal and logistical entrenchment make them difficult to dismantle in reconstructive reforms. Yet the health care system's failure to provide widespread and equitable access to medical countermeasures in the pandemic should prompt more direct confrontation with these fixtures in future reforms.

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 legal *fixtures*: forces whose "structural and political entrenchment, as well as longstanding normative commitments, make them difficult to displace."[53]

Recent scholarship has highlighted problems wrought by the forces of individualism, fiscal fragmentation, federalism, and privatization in American health care.[54] This recent literature has largely treated these concepts as if they

supra note 4, at 765 ("[Health justice is] a framework that places the empowerment of marginalized populations at the center of the action").

[51] *See* Wiley, *Social Justice*, *supra* note 47, at 88 ("[H]ealth care is a component of the broader public health system—rather than the other way around, as many health law scholars assume"); Wiley, *Health Justice*, *supra* note 5 at 881 (arguing that integration of health care and public health goals should be a core focus of the health justice model).

[52] Fuse Brown, Lawrence, McCuskey & Wiley, *supra* note 1, at 411.

[53] *Id.* at 414.

[54] *See, e.g.*, Allison K. Hoffman, *The ACA's Choice Problem*, 45 J. HEALTH POL. POL'Y & L. 501 (2020) (individual choice); David A. Super, *Privatization, Policy Paralysis, and the Poor*, 96 CALIF. L. REV. 393 (2008) (fiscal fragmentation); Nicole Huberfeld, Sarah Gordon, & David K. Jones, *Federalism Complicates the Response to the COVID-19 Health and Economic Crisis: What Can Be Done?*, J. HEALTH POLITICS, POL'Y, & L. (2020) (federalism); Fuse Brown & McCuskey, *supra* note

were ordinary policy choices that might simply be accepted or rejected by policymakers writing future health reform legislation.[55] 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.[56] Their entrenchment means that fixtures operate not as mere policy options, but instead as forces that must be accommodated, confronted, or even leveraged.

Our concept of legal fixtures begins with their *legal entrenchment.* Similar to "super-statutes," the fixtures "exhibit . . . normative gravity" and "bend and reshape the surrounding landscape."[57] 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 which may, or may not, be directly related to each other. This makes the fixtures both more diffuse in their legal entrenchment than super-statutes, and also harder to overcome.[58] Consider the Affordable Care Act, a plausible super-statute.[59] The ACA represents a single enactment that touched hundreds of existing laws, spawned innumerable regulations, and significantly altered the landscape of health insurance regulation.[60] The ACA's 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.[61] By contrast, the fixture of *federalism*, for example, finds its legal

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10 (federalism); Craig Konnoth, *Preemption Through Privatization*, 134 Harv. L. Rev. __ (forthcoming 2021) (privatization); Craig Konnoth, *Privatized Preemption*, 45 ABA ADMIN. & REG. L. NEWS 10 (Spring 2020) (same).

[55] *See, e.g.*, Jones, *supra* note 54; Konnoth, *supra* note 54. *But see* Hoffman, *supra* note 54 (describing individual choice in health insurance as embodying and propagating an underlying normative commitment).

[56] Fuse Brown, Lawrence, McCuskey, & Wiley, *supra* note 1, at 5.

[57] Eskridge & Ferejohn, *supra* note 8, at 1216 (describing "super-statutes" as singular statutory enactments that "successfully penetrate public normative and institutional culture in a deep way.").

[58] *See id.*

[59] The ACA's status as super-statue is debatable and debated. *E.g.*, Abbe R. Gluck & Thomas Scott-Railton, *Affordable Care Act Entrenchment*, 108 GEO. L. J. 495 (2020) (arguing that the "ACA's staying power has … come from more diffuse and 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"); Erin 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).

[60] *See generally* Gluck & Scott-Railton, *supra* note 59; Gluck, Regan, & Turret, *supra* note 32, at 1473 ("The ACA is the most significant healthcare legislation in recent American history."); 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.").

[61] *See* Timothy S. Jost, *Examining The House Republican ACA Repeal And Replace Legislation*, HEALTH AFFAIRS (Mar. 7, 2017); Pratik Shah, *Symposium: Severability poses a high-stakes question with (what should be) an easy answer*, SCOTUSBLOG.COM (Nov. 9, 2020), https://www.scotusblog.com/2020/11/symposium-severability-poses-a-high-stakes-question-with-what-should-be-an-easy-answer/; Reed Abelson & Abby Goodnough, *If the Supreme Court Ends*

entrenchment in health care through the Constitution, countless federal and state statutes over the past century, and two centuries of jurisprudence on comity and deference to state authority.[62]

Beyond their legal origins, fixtures exhibit a form of entrenchment not previously explored in legal scholarship: *logistical entrenchment*. Institutions are built around the fixtures, as are work forces and bodies of expertise. These logistical considerations make it difficult to actually implement any reform that wishes to confront the fixtures. For example, the administrative apparatus for our health care system is concentrated in private insurers, which means it would be practically difficult for a single payer reform to switch entirely to government administration.[63] Reliance on existing private structures would almost be compelled as a logistical matter, owing to the *privatization* fixture's logistical entrenchment.

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 concepts or ideologies. Their legal and logistical entrenchment makes them more stubborn in some ways than mere ideas, but, as Part IV elaborates, more vulnerable in others.

These four fixtures shape law and policy in fields beyond health care. Further, our conception of a *fixture* applies to forces beyond the four we highlight here.[64] While there is benefit to focusing on each fixture in isolation, stepping back to look at the fixtures as a category is essential both to see how they interact and to chart a path forward for reform. 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 warranted.[65]

B. Fixtures' Functional Failures

Our individualistic, fragmented, diffuse, private-industry health care system failed us in the 2020 pandemic. We focus this critique on the medical countermeasures that the health care system is responsible for disseminating, which

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Obamacare, Here's What It Would Mean, N.Y. TIMES (Dec. 4, 2020), https://www.nytimes.com/article/supreme-court-obamacare-case.html. [62] *See* Parts II.B.3. and II.C., *infra*.

[62] *See* Parts II.B.3. and II.C., *infra*.

[63] *E.g.*, Wiley, *Privatized Public Health Insurance, supra* note 49.

[64] For example, the sovereignty of professional control over medicine could be a fixture, but arguably professional autonomy is a form of individualism or privatization. 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 28 (1982).

[65] *See* Part IV, *infra*.

include testing, therapeutics, and vaccination.[66] These countermeasures have collective benefits in addition to the benefits they confer on individual patients. But our inability to distribute scarce supplies with an eye toward maximizing collective benefits has undermined the effectiveness of the pandemic response, in addition to exacerbating social injustice. Inequitable access to testing and treatments for COVID-19 has the compounded economic and health harms caused by the pandemic, while the development and distribution of vaccines has thus far insufficiently addressed health equity issues. In short, the fixtures make our health care system function especially poorly under the stress of a public health crisis.

1. Individualism

As a political ideology, individualism is a defining fixture of American culture, policy, and law.[67] It is embodied in our Constitution's emphasis on securing rights to be left alone and our political and legal system's emphasis on personal responsibility for misfortune. Iron-triangle reforms have been remarkably accommodating toward the ideology of individualism. 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 foundational focus of American cultural norms on the interests, rights, and personal responsibilities of individuals as the key to explaining our failed pandemic response.[68] Some have specifically

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[66] Medical countermeasures have a dual purpose. They are used for clinical purposes (diagnosis and treatment of individuals), distinguishing them from community mitigation measures such as mask mandates and stay-at-home orders. 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. Currently available treatments for COVID-19 have individual benefits, but in the future, antiviral therapies that reduce infectiousness (such as those used for tuberculosis and HIV) could be developed for COVID-19 A robust and comprehensive pandemic response requires both clinical interventions for the benefit of individuals and public health interventions for the common good. *See* GOSTIN & WILEY, *supra* note 49, at 15-16 (describing the "continuum [from primordial to tertiary prevention] in which public health and medicine, prevention and amelioration are intertwined"); *id.* at 346 (describing the role of medical countermeasures in public health surveillance and disease-control strategies); *id.* at 392 (contrasting medical countermeasures for pandemic response with community mitigation strategies). As this Article focuses on reforms for the health care system, our analysis focuses on the medical interventions that system is expected to deliver.

[67] *See, e.g.,* Salter Storrs Clark, *Individualism and Legal Procedure*, 14 YALE L. J. 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.");

[68] *See, e.g.*, Meghan O'Rourke, *The Shift Americans Must Make to Fight the Coronavirus*, THE ATLANTIC (Mar. 12, 2020), https://www.theatlantic.com/ideas/archive/2020/03/we-need-isolate-ourselves-during-coronavirus-outbreak/607840/ ("[Flattening the curve] requires a radical shift in Americans' thinking from an individual-first to a communitarian ethos—and it is not a shift that is coming easily to most, especially in the absence of clear federal guidelines); 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-

noted the individualistic focus of American law on personal responsibility as an impediment.[69] 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.[70] But individualism also pervades our 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 a critical public health tool, particularly for a virus that can be transmitted by asymptomatic or pre-symptomatic individuals. 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

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individualism-is-an-obstacle-to-wider-mask-wearing-in-the-us/ ("[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.").

[69] *See, e.g.*, Wiley & Bagenstos, *supra* note 39.

[70] *Id.* Lawsuits challenging coronavirus emergency orders on the grounds that they violate individual rights have been largely unsuccessful, except for claims that orders discriminate on the basis of religion. Wiley, *Social Distancing*, *supra* note 2, at 85-93. Although individual rights challenges have mostly failed in the courts, opposition to and defiance of public health emergency orders and guidelines have undoubtedly undermined the effectiveness of community mitigation measures. This problem is not unique to the United States, however. In several countries throughout the world, efforts to tighten restrictions in response to a fall resurgence of the novel coronavirus have triggered large protests. The relationship between cultural norms and compliance with social distancing is unclear. *See, e.g.*, Neha Deopa & Piergiuseppe Fortunato, CORONAGRABEN. CULTURE AND SOCIAL DISTANCING IN TIMES OF COVID-19, UNITED NATIONS CONFERENCE ON TRADE & DEVELOPMENT RESEARCH PAPER NO. 49 (June 2020), https://unctad.org/system/files/official-document/ser-rp-2020d8_en.pdf (finding a negative correlation between reductions in individual mobility and societal level of trust in other people); Toan Luu Duc Huynh, *Does Culture Matter: Social Distancing Under the COVID-19 Pandemic?* 130 SAFETY SCIENCE 104872 (2020) (finding larger reductions in mobility in countries that rate high on the Uncertainty Avoidance Index, but finding no correlation between mobility reduction and how a country rates on the Individualism Versus Collectivism Index); Hohjin Im & Chuansheng Chen, *Social Distancing Around the Globe: Cultural Correlates of Reduced Mobility* (unpublished preprint), 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 (finding more rapid reductions in mobility in countries that rate high on uncertainty avoidance, collectivism, and tightness (versus looseness) in the earliest weeks of the pandemic, but not at the later stages).

testing as a public health tool, several countries quickly ramped up public health infrastructure for screening, isolation, contact tracing, quarantine, and disease surveillance.[71]

In contrast, in the U.S., coronavirus testing has been driven by a focus on the clinical significance of results for individuals.[72] Testing was slow to ramp up, supplies were scarce,[73] and early criteria for allocation of scarce resources focused almost exclusively on patient care.[74] 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.[75] Lack of access to testing and the failure of the 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 individual health is undermining our vaccination strategy. A rationally designed, carefully implemented public health vaccination campaign can support sustainable suppression of disease transmission. Even when supplies are too scarce to vaccinate enough of the population to achieve suppression, hospitalizations and deaths can be dramatically reduced if groups are prioritized based on factors such as residential and workplace exposure, age, and underlying medical vulnerabilities.[76] Alternatively, if scarce supplies are

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[71] Parinaz Tabari, Mitra Amini, Mohsen Moghadami, Mahsa Moosavi, *International Public Health Responses to COVID-19 Outbreak: A Rapid Review*, 45 IRAN J. MED. SOC. 157, 159-60 (2020); Thomas Hale, Noam Angrist, Beatriz Kira, Anna Petherick, Toby Phillips, Samuel Webster, *Variation in Government Responses to COVID-19* (U. Oxford Blavatnik Sch. Gov't, Working Paper No. BSG-WP-2020/-32 v. 6.0, May 2020).

[72] Joshua M. Sharfstein & Melissa A. Marx, 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 ("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.").

[73] Michael D. Shear et al., *The Lost Month: How a Failure to Test Blinded the U.S. to Covid-19* (Mar. 28, 2020), https://www.nytimes.com/2020/03/28/us/testing-coronavirus-pandemic.html.

[74] CDC, *Update and Interim Guidance on Outbreak of 2019 Novel Coronavirus (2019-nCoV)* (CDC Health Alert Network – 00427) (Feb. 1, 2020), https://emergency.cdc.gov/han/HAN00427.asp.

[75] 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/#:~:text=Regulators%20at%20the%20Food,failed%20to%20secure%20needed%20approval.

[76] Which groups should be prioritized to achieve the greatest public health benefit and the tipping point at which prioritization should give way to offering vaccination to the general population regardless of priority-group status depends on characteristics of the targeted virus and the affected population and the degree of scarcity. *See, e.g.*, Bruce Y. Lee et al., *A Computer Simulation of Vaccine Prioritization, Allocation, and Rationing during the 2009 H1N1 Influenza Pandemic*, 28 VACCINE 4875 (2010). In addition to public health impact, ethical criteria play a role in prioritization criteria. *See, e.g.*, Kathleen Dooling et al., *The Advisory Committee on Immunization Practices' Updated Interim Recommendation for Allocation of COVID-19 Vaccine — United States, December*

haphazardly distributed based on ability to pay and ability to wait, vaccinations will disproportionately be administered to people who are healthier and have greater resources at their disposal, mitigation and suppression will take longer to achieve, and health equity will suffer.[77] Privately administered clinics may limit access to those who are already connected to a regular source of care or charge out-of-network fees to administer the vaccine even if the doses themselves are paid for by the federal government. Underfunded state and local public health departments may have insufficient capacity to administer or even oversee distribution,[78] leaving the vaccination campaign largely in the hands of large hospital systems.[79]

A key insight of public health is that "health is not just an individual good; it is a distinctly public good, too."[80] In contrast, the iron triangle ethos is individualistic at its core. It guides evaluation of our health 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."[81] The 2020 coronavirus pandemic has amply demonstrated our health system's catastrophic failures by these criteria.

2. *Fiscal Fragmentation*

A second fixture of American law that continues to impede the country's COVID-19 response is fiscal fragmentation, that is, the "tendency to divide costs associated with Americans' sickness and health into separate, fiscally disintegrated categories."[82]

Fragmentation divides along many dimensions. The costs of health care for individuals who become sick are divided between the health care provider, the

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2020, 69 MORTALITY & MORBIDITY WEEKLY REPORT 1657 (2021). Our point is simply that prioritization has benefits for public health and equity and our broken health care system is poorly suited to implement it.

[77] *See*, *e.g.*, Ian Millhiser, *Florida County Has Elderly Residents Camp Out Overnight to Get Covid-19 Vaccine,* Vox (Dec. 29, 2020), https://www.vox.com/2020/12/29/22205031/florida-covid-vaccine-camp-out-lee-county-ron-desanis-estero.

[78] 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.

[79] 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), https://www.washingtonpost.com/health/2020/11/23/covid-getting-vaccine/; Rebecca Robbins Frances Robles and 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.

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

[81] Wiley, *From Patient Rights to Health Justice*, at 855.

[82] *See* Fuse Brown, Lawrence, McCuskey, Wiley, *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) ("I suggest . . . that an individual must be viewed holistically, across the full range of environments in which she functions").

patient, the taxpayer, and the patient's insurer, if she has one.[83] Costs borne by insurers are pooled across all members of the insurance plan, but fragmented among somewhat arbitrary and actuarially-based groups based on payer, region, employer, age, and various other categories. Insurance risk pools are divided by design.[84] Fiscal fragmentation manifests most noticeably as the multi-payer health system, where coverage is splintered between public payers and private, federal (Medicare) and state (Medicaid), and employer-based groups and individuals. 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 solidarity 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 and positive externalities (including public health benefits) will be under-produced.[85] Second, the logistical division of costs and benefits, and accounting for costs and benefits, obscures the true costs of health care 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.[86] The invisibility of care work provided by loved ones—especially by women to children, the elderly, and the sick—is a prime example.[87] Third, in a world of scarcity, the division of costs and benefits poses an additional logistical challenge, making marshaling resources for significant investments in public goods with dispersed benefits difficult, susceptible both to coordination failures and collective action problems—it exacerbates the scarcity of resources needed to support a modern public health response.[88]

In the U.S. pandemic response, fiscal fragmentation shifted and hid costs and forced false, tragic choices. These effects began years before the pandemic.

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[83] *See* Fuse Brown, Lawrence, McCuskey, Wiley, *supra* note 1, at 415.

[84] *See* Stone, *supra* note 5, 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 accomplished by fostering in people a sense of their differences, rather than their commonalities,").

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

[86] PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 10 (2011). ("[People] think the company is paying for most of their health insurance and often have no idea how much the total bill is. Nor do they recognize that their insurance is substantially subsidized by the government because the employer's share is excluded from taxable income. Every aspects 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.")

[87] Allison K. Hoffman, *Reimagining the Risk of Long-Term Care*, 16 Yale J. Health Pol'y, Law, and Ethics 2 (2016) ("damage 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").

[88] 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 (2018) (describing lack of community public health investment and coordination challenges in financing such investment).

Fiscal fragmentation impeded efforts to invest in public health infrastructure to better prepare to mitigate the pandemic. Public health garners pennies on the dollar compared to health care subsidies.[89] Section 4002 of the Affordable Care Act created an $18.75 billion dollar Prevention and Public Health Fund with the express purpose of preparing for public health crises, including pandemics.[90] 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 entrenched interest groups. 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 in order to offset costly changes in federal law benefiting discrete interests, including the "doc fix" and the 2017 tax cuts.[91]

In the years to come, we will surely learn more about the early testing missteps at the Centers for Disease Control that first setback U.S. coronavirus response, but it is reasonable to presume that the agency's funding challenges in the years prior to the pandemic contributed. Indeed, concerned observers as early as 2018 expressed fear that the raiding of the Public Health Services Fund would render the 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.[92] As a result, he said, "[w]e're more likely to have to fight dangerous organisms here in the U.S."[93]

Fiscal fragmentation continued to act as an impediment to public-minded responses once the pandemic hit. Again, the nation's failure to implement the surveillance testing necessary to stem the pandemic—a massive and tragic collective action problem—was the most stubborn and problematic example. As just mentioned, individualism prevented testing from being conceived and implemented as a public rather than a personal good. Nonetheless workplaces and schools had reason to push their employees and students to obtain tests out of

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[89] *See* Expenditures for Public Health: Assessing Historical and Prospective Trends, 99 Am. J. Pub. Health 1780 (2009) (analysis showing federal public health expenditures represented 1.1% of federal expenditures on health care).

[90] ACA § 4002; 42 U.S.C. § 300u-11.

[91] 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, 440 (2020) ("successive pieces of essentially bipartisan legislation raided the PPHF for other purposes"); Michael R. Fraser, *A Brief History of the Prevention and Public Health Fund: Implications for Public Health Advocates*, 109 Am. J. Public Health 109, 572 (2019) https://doi.org/10.2105/AJPH.2018.304926 https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2018.304926?casa_token=0v8zgOdGCsgAAAAA:GDHPZMM7uWkqRfR-USRmjVJ1JQcZqfQf6ZtVkn8t70b6PajdPy6fiE7bK-rXzd82rGJHPWiz5WV7

[92] Ashley Yeager, *Cuts to Prevention and Public Health Fund Puts CDC Programs at Risk*, The Scientist (Feb. 9, 2018).

[93] *Id.*

institutional self-interest—for the good of other employees, customers, teachers, and students, and so that they might remain open. This was easier said than done, however.

During the pandemic it has usually been worth the $100 to $199 a coronavirus test typically costs for an asymptomatic person to obtain assurance she is negative before returning to work at a restaurant or office, to being a student at school, and so on.[94] But fiscal fragmentation meant there was a legal and logistical mismatch between those who benefit from such a test and those in a position to pay.[95] At the start of the pandemic, Congress mandated that insurers pay for coronavirus testing, without cost sharing.[96] But, as discussed further *infra*, insurers' contracts with their insureds take on responsibility only for their insureds' "medically necessary" care,[97] which led them to refuse to pay for employer and school surveillance testing.[98] Workplaces and schools, in turn, usually declined to mandate testing not due to a lack of availability, but due to the cost and

[94] *See* Nisha Kurani *et al.*, *COVID-19 Test Prices and Payment Policy*, Kaiser Family Foundation, kff.org (July 15, 2020).

[95] The benefit of avoided exposures certainly 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 administrative capacity to pay for a test, but is unlikely to derive any benefit—in our pluralist financing system, an insurer gets the financial benefit from avoiding a COVID case only if the patient happens to be one of its beneficiaries—depending on the market, an unlikely proposition. The cost may be "worth it" to the individual because of the benefit she receives by not unwittingly infecting others, and she has the administrative capacity to pay for her own test (of course). But, on the other hand, the benefit may not be worth the cost to such a person and, in any case, she may not have the financial wherewithal to pay, especially for multiple tests over a period of months. Finally, the cost may be worth it to an individual's employer if preventing exposures means staying in business, or staying in school, but logistically fragmentation leaves employers without the administrative apparatus to pay for employees' tests and legally fragmentation leaves them with the expectation that someone else should pay.

[96] Families First Coronavirus Response Act (FFCRA), Pub. L. 116–127, § 60001, 134 Stat. 178 (2020) (to be codified at 42 USC §§ 1320b–5, 1395l, 1396d(a)(3); Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. 116-136, § 3202(a), 134 Stat. 281 (2020).

[97] U.S. DEP'T OF HEALTH AND HUMAN SERVS., FAQS ABOUT FAMILIES FIRST CORONAVIRUS RESPONSE ACT AND CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT IMPLEMENTATION Part 42 (June 23, 2020) (requirement of coverage applies only where "the test is medically appropriate for the individual in accordance with current accepted standards of medical practice").

[98] Julie Appleby, *For COVID Tests, the Question of Who Pays Comes Down to Interpretation*, KAISER HEALTH NEWS (July 20, 2020), khn.org.

administrative complexity,[99] and individuals found themselves unexpectedly being billed for coronavirus tests,[100] or delayed or refused tests for fear of that result.[101]

Later, once a vaccine was developed and approved, frustrating and deadly delays in its distribution evidenced fiscal fragmentation's logistical entrenchment. When it came to vaccine distribution, the federal government had an acute fiscal interest in ensuring that residents in skilled nursing facilities were promptly vaccinated. Medicare pays for hospital care, not (ordinarily) nursing home care. Therefore, when one nursing home resident gives coronavirus to another, the "cost" of the resulting hospital treatment is born by the federal government. Unsurprisingly, then, the federal government aspired to provide and pay for vaccines for all Medicare-eligible skilled nursing facility residents by tapping into the Medicare trust fund.[102]

Fragmentation's logistical entrenchment proved an impediment to this public health intervention, however. While it found itself with a will to finance a public health intervention, it lacked a way, that is, it lacked an administrative apparatus actually to distribute and physically pay for vaccines for skilled nursing facility residents.[103] It could not simply stand up such a public health apparatus overnight, so it contracted with private companies with the experience and personnel to provide immunizations: CVS and Walgreens.[104] Under these contracts, CVS and Walgreens were to be provided with hundreds of thousands of vaccines and be able to bill Medicare for each vaccine distributed to a skilled

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[99] Nathaniel L. Wade & Mara G. Aspinall, Facing Uncertainty: The Challenges of COVID-19 in the Workplace, ASU College of Health Solutions (2020) at , 6-7, https://issuu.com/asuhealthsolutions/docs/asu_workplace_commons_nov2020?fr=sYjhjZjE5NTg1NjM (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 Morning Edition, Oct. 6, 2020, https://www.npr.org/2020/10/06/920642789/many-colleges-arent-aggressively-testing-students-for-coronavirus (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).

[100] Donna Rosato, *How 'Free' Coronavirus Testing Has Become the New Surprise Medical Bill*, Consumer Reports, consumerreports.org (July 27, 2020).

[101] *See* Brendan Keefe, *Where to get free COVID-19 test if you have no symptoms*, 11alive.com (May 20, 2020) (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).

[102]HHS.gov, *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.

[103] Noam M. Levey, *Vaccine Rollout Relies Heavily on CVS and Walgreens*, LA Times (Dec. 5, 2020), https://www.gazettenet.com/COVID-19-vaccine-rollout-relies-heavily-on-CVS-and-Walgreens-37625338 ("We're in a situation where we don't have a public sector that's able to do something like this.").

[104] *Id.*; HHS.gov, *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.

nursing facility resident.[105] This workaround is proving problematic, however. Experts predicted that the pharmacies' profit motive would undermine their interest in outreach to vulnerable populations.[106] While it is too early to assess the rollout across the board, it proved troublesome in its early days, as Republican Florida Governor Desantis complained about delays and a lack of communication from the pharmacies,[107] and vaccine administration fell far short of projections by year's end.[108]

The perverse game of "hot potato" between families, states, providers, and the federal government over elderly Americans' care offers a stark illustration of how fragmentation impeded the health care system's ability to cope with the coronavirus. In the U.S., much of the cost of daily care for the elderly is borne, by default, by themselves or loved ones.[109] Medicare, which is federally financed, only pays for one-hundred days of nursing home or home health care after an elderly person is hospitalized for 3-days.[110] The reason for these arbitrary cutoffs is fiscal fragmentation: Medicare's designers worried about tapping the Medicare trust fund for nursing home care, opting to shift the cost to families and the states. Medicaid, which is jointly financed by the state and 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.[111] The arbitrary limits on Medicare-financed nursing home care causes perverse behavioral effects, as families conspire to get their loved ones admitted to hospitals in order to trigger nursing home care, or struggle once the 100 days are up to find alternative care arrangements.[112]

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 realized that the 3-day rule and 100-day limit threatened to exacerbate the pandemic. It issued an emergency waiver, purporting to relax the 3-day rule and

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[105] *Id.*

[106] Noam M. Levey, *Vaccine Rollout Relies Heavily on CVS and Walgreens*, LA Times (Dec. 5, 2020), https://www.gazettenet.com/COVID-19-vaccine-rollout-relies-heavily-on-CVS-and-Walgreens-37625338 (describing concerns).

[107] John Pacenti, "*Time is of the Essence*," *for COVID Vaccine; DeSantis Frustrated with CVS and Walgreens*, Palm Beach Post (Dec. 16, 2020), https://www.palmbeachpost.com/story/news/coronavirus/2020/12/16/covid-desantis-expresses-frustration-cvs-and-walgreens/3925203001/

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

[109] *See* MetLife Mature Market 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).

[110] Richard L. Kaplan, *Reflections on Medicare at 50: Breaking the Chains of Path Dependency for a New Era*, 223 ELDER L.J. 1, 9-10 (2015).

[111] *Id.*

[112] *Id.*

100-day limit in the case of patients impacted by coronavirus.[113] But fiscal fragmentation is more stubborn: these costs are first born by providers who then seek reimbursement by Medicare. With a long history of being denied reimbursement, providers continued to apply the three-day rule and 100-day limit, despite the waiver. As Professor Zimmerman described, providers were either ignorant about the last-minute waiver or fearful that it would be applied strictly in practice, a fear that was bolstered by early-summer guidance describing the waiver in limited terms.[114] Thus, for the duration of 2020, elderly persons and families continued to struggle with finding loved ones care, despite the waiver.[115]

The fragmentation of responsibility for health costs in the United States contributed to the country's lack of preparation for the pandemic, impeding public health investment and promoting the raiding of those dollars the country did devote to public health through the Prevention and Public Health Fund. Then, once the pandemic hit, it stood in the way of critical interventions with broadly distributed benefits, like surveillance testing in schools and workplaces. The pandemic posed new costs across society, and desirable medical interventions to prevent or reduce the costs of the pandemic inevitably fell on different actors then the costs themselves. An entity (or entities) with an incentive to serve the public interest and both the financial means and administrative capacity to do so could have taken steps both to mitigate the pandemic's effects in the United States in the years prior to 2020 and to better manage the pandemic once it hit. But only the federal government had the resources, and it lacked both the administrative capacity and the political will to displace our fragmented status quo all at once.

3. Federalism

Federalism further divides authority for legal interventions in the pandemic response among federal, state, and local governments. In theory, the deft division of labor among different levels of government that federalist systems contemplate[116] could benefit governmental pandemic prevention and responses.[117] In practice, however, federalism operating as a fixture in health care regulation has

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[113] DEP'T OF HEALTH & HUMAN SERVS., FINDINGS CONCERNING SECTION 1812(F) IN RESPONSE TO THE EFFECTS OF THE 2019-NOVEL CORONAVIRUS (COVID-19) OUTBREAK (Mar. 13, 2020).

[114] 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.

[115] Chuck Buck, *Amid Confusion, the SNF 3-Day Waiver Remains Intact Nationally*, RAC MONITOR (July 9, 2020), https://www.racmonitor.com/amid-confusion-the-snf-3-day-waiver-remains-intact-nationally (describing widespread reluctance by skilled nursing facilities to accept Medicare patients lacking prior 3-day inpatient admission despite waiver).

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

[117] *See, e.g.*, Lindsay F. Wiley, "Federalism in Pandemic Prevention and Response" in SCOTT BURRIS, SARAH DE GUIA, LANCE GABLE, DONNA E. LEVIN, WENDY E. PARMET, & NICHOLAS P. TERRY, EDS. ASSESSING LEGAL RESPONSES TO COVID-19, 65, 69 (2020), https://www.publichealthlawwatch.org/covid19-policy-playbook [hereinafter Wiley, *Federalism*] (explaining how 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).

sewed dysfunction in testing, therapeutics, and vaccination policy – compounding its crippling disruption of public health mitigation measures like masking and distancing.

In our definition of *fixture*, federalism's *legal entrenchment* follows the conventional account of 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 in federal and state governments.[118] 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.[119] The legal pecking order establishes federal law as supreme 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, as well as dependent on state authorization for its scope.[120]

Federalism's *logistical entrenchment* is more complex than these legal boundaries of sovereignty. Federalism, as a fixture and a force, refers to the political and jurisprudential narratives of comity and deference to state sovereignty and the practical devolution to the state authority that has characterized the negotiation and implementation of federalism.[121] It is about the way that these authorities relate to each other, within and despite the legal framework of their boundaries.[122] Federalism thus embraces the normative values of state experimentation and local variation within an overarching national system of uniform priorities.[123] Practically, however, the logistical entrenchment of state influence on federal policy – despite the breadth and supremacy of federal

[118] *See generally* Heather K. Gerken, *The Supreme Court 2009 Term—Foreword: Federalism All the Way Down*, 124 HARV. L. REV. 9, 11-12 (2010) [hereinafter *All the Way Down*] (presenting the conventional account of sovereignty in federalism).

[119] *See generally* Gerken, *All the Way Down*, 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 (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).

[120] *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).

[121] Fuse Brown, Lawrence, McCuskey & Wiley, *supra* note 1, at 414. *E.g.*, Bridget A. Fahey, *Federalism by Contract*, 129 YALE L. J. 2326, 2332 (2020); Abbe R. Gluck, *Our [National] Federalism*, 123 YALE L. J. 1996, 1997-2000 (2014); Erin Ryan, *Negotiating Federalism*, 52 B.C. L. REV. 1, 10 (2011). *Cf.* Gerken, *Federalism 3.0*, *supra* note 119, at 1722 (arguing that states' "democratic role is just as important as its regulatory one" because they serve as "the front lines for national debates, the key sites where we work out our disagreements before taking them to a national stage").

[122] *E.g.*, Fahey, *supra* note 121, at 2334 ("One of the disruptive contributions of recent federalism scholarship is its reorientation away from drawing boundaries between domestic governments and toward thinking about federalism as a system of integrated governance. …[Federalism's] potential and its puzzle are not in keeping our domestic governments separate but in guiding how they act together.").

[123] *See* Gluck, *Our [National] Federalism*, *supra* note 121, at 1999, 2020; Erwin Chemerinsky, *The Values of Federalism*, 47 FLA. L. REV. 499, 525 (1995).

regulatory power – means that deference to states characterizes federalism as a fixture.[124]

Distributing political power among federal, state, and local authorities theoretically could benefit health care regulation[125] and public health responses[126] by tailoring policies and execution roles to the particular strengths of each level of authority. In practice, however, 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.[127] States may supplement the federal safety and efficacy standards set by the FDA and enforce parallel state regimes.[128] States retain primary authority over regulating medical facilities and practitioners who prescribe and administer these products.[129]

When it comes to the practical dimensions of access those products – the insurance funding to pay for access to these doctors, facilities, and products– federalism's legacy for health care regulation is one of fragmentation and inefficacy, detailed in Part II.B.2, above, and Part II.B.4, below. Throughout the iron triangle era, federalism has stymied normatively desirable payment and access reforms and perpetuated interstate inequities.[130] The ACA's design accommodated

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[124] *See* Fuse Brown, Lawrence, McCuskey & Wiley, *supra* note 1, at 414. *See also* Nicole Huberfeld, "Federalism in Health Care Reform," in EZRA ROSSER, ED., HOLES IN THE SAFETY NET: FEDERALISM AND POVERTY 198 (2020) ("federalism tends to be understood to mean that states are in charge").

[125] *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).

[126] *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 (2020) (explaining the legal powers of federal, state, and local governments to implement public health interventions).

[127] Patricia J. Zettler, *Pharmaceutical Federalism*, 92 IND. L. J. 845, 850 (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"); 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). *See generally* ROBERT I. FIELD, MOTHER OF INVENTION: HOW THE GOVERNMENT CREATED "FREE-MARKET" HEALTH CARE 24-28, 48-84 (2014) (explaining how the federal government "created the pharmaceutical industry" through the workings of the NIH, FDA, and federal Patent and Trademark Office). The CDC supplements all of these federal functions.

[128] Zettler, *supra* note 127, at 859-61.

[129] *Id.* 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.").

[130] *See, e.g.*, Huberfeld, *Federalism in Health Care Reform*, *supra* note 124, at 197-98 ("States generally cannot and do not act alone" in health reform); Abbe R. Gluck & Nicole Huberfeld, *What is Federalism in Healthcare For?*, 70 STAN. L. REV. 1689, 1696-99 (2018); Fuse Brown &

states by offering them Spending Clause enticements for Medicaid expansion and operating insurance exchanges, as well as relying on them to implement federal policy priorities and standards.[131] States responded in polarized and polarizing ways, with conservative-led states refusing to expand Medicaid and establish insurance exchanges, as well as attempting to use federal waivers to fund state "experiments" that undermine the core protections in those federal programs.[132] As Abbe Gluck and Nicole Huberfeld observed, "the ACA's federalism served state power," but did not necessarily "produce[] better health policy outcomes."[133] And, as a final federalism trap, ERISA preempts states and localities from enforcing their own protective laws against most employer-sponsored health insurance plans.[134] Federalism's dysfunction cuts in multiple directions simultaneously, but mostly against solidarity-enhancing policies.

The 2020 pandemic thus landed in a regulatory landscape characterized by federal dominance in medical product innovation and safety, federal funding as the chief source of health care infrastructure investments, and an overriding deference to state power, which has contributed to an incoherent and inequitable state-by-state patchwork of health insurance. Under the stress of the pandemic, health care regulation's federalism dysfunction has been more dramatically revealed and contributed to functional failures on testing, equipment, therapeutics, and vaccination.[135]

McCuskey, *supra* note 54, at 443-48; McCuskey, *Body of Preemption, supra* note 127, at 96-100 (tracing the growing ratio of federal-to-state health laws); 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 (1995); Richard P. Nathan, *Federalism and Health Policy*, 24 HEALTH AFF. 1458 (2005); Wendy E. Parmet, *Regulation and Federalism: Legal Impediments to State Health Care Reform*, 19 AM. J.L. & MED. 121 (1993).

[131] *See, e.g.*, Fahey, *supra* note 121, at 2332 (2020) (highlighting the Supreme Court's anti-coercion holding in *NFIB v. Sebelius* as part of a broader phenomenon of intergovernmental agreements, many of which are rooted in the Spending Clause); Samuel R. Bagenstos, *The Anti-Leveraging Principle and the Spending Clause After NFIB*, 101 GEO. L.J. 861, 916-20 (2013); Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 534, 582 (2011). *See also* Fuse Brown, Lawrence, McCuskey & Wiley, *supra* note 1, at 414-15; Gluck, Regan, & Turret, *supra* note 32; Nicholas Bagley, *Federalism and the End of Obamacare*, 127 YALE L. J. F. 1 (2017);

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

[133] Abbe R. Gluck & Nicole Huberfeld, *The New Health Care Federalism on the Ground*, 14 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….").

[134] Fuse Brown & McCuskey, *supra* note 54.

[135] *See, e.g.*, Rebecca L. Haffajee & Michelle M. Mello, *Thinking Globally, Acting Locally – the U.S. Response to Covid-19*, 382 N. ENGL. J. MED. e75, (1) (2020) ("COVID-19 has exposed major weaknesses in the United States' federalist system of public health governance…."); Nicholas Terry, *COVID-19 and healthcare lessons already learned*, J. L. & BIOSCI. 1 (2020) (using "COVID-19 as

First, on the aspects of pandemic response that demand economies of scale and interstate coordination, the federal government abdicated its role.[136] 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.[137] Take for example COVID-19 testing, "the foundation of modern pandemic prevention and response."[138] 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."[139] Yet the FDA initially flexed its regulatory power to *prevent* the dissemination of local lab-developed testing protocols from the University of Washington.[140] The Department of Health and Human Services later rescinded FDA's authority to clear lab-developed tests before use,[141] but not until after missteps and contamination had frustrated the rollout of the CDC-developed federal test kits.[142]

Even worse, the federal government's failure to develop a coordinated approach and funding to secure the testing supplies left state governments in the lurch at a time when widespread testing could have been most effective at

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a frame on the … flaws inherent in healthcare federalism," among other longstanding problems); Huberfeld, Gordon, & Jones, *supra* note 54, at *6-7; Nancy J. Knauer, *The COVID-19 Pandemic and Federalism: Who Decides?*, 23 N.Y.U. J. LEGIS. & PUBLIC POL'Y __ (forthcoming 2020) ("The varying state and local responses to the pandemic underscore both the promise and the limitations of federalism.").

[136] Haffajee & Mello, *supra* note 135, at (2) ("the federal government has done too little").

[137] *See* Huberfeld, Gordon, & Jones, *supra* note 54, at *6-7 ("States are largely responsible for coordinating and financing pandemic response efforts because of the federalist structure of the American public health system. States have been the primary payer for the majority of the response, including purchasing personal protective equipment, …increasing charity care payments to hospitals …. The lack of federal coordination leaves states scrambling to pay for an emergency that far outpaces what they could have budget for . . . ."); Sheila Grigsby, Alicia Hernandez, Sara John, Desiree Jones-Smith, Katie Kaufmann, Cordaryl Patrick, Christopher Prener, Mark Tranel, & Adriano Udani, *Resistance to Racial Equity in U.S. Federalism and Its Impact on Fragmented Regions*, 50 AM. REV. OF PUBLIC 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.").

[138] Wiley, *Federalism*, *supra* note 117, at 66.

[139] *Id.*

[140] *See* Sheri Fink & Mike Baker, "*It's Just Everywhere Already": How Delays in Testing Set Back the U.S. Coronavirus Response*, N.Y. TIMES (March 10, 2020), https://nyti.ms/39SdV3K; Atul Gawande, *We Can Solve the Coronavirus-Test Mess Now—If We Want To*, NEW YORKER (Sept. 2, 2020) ("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.").

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

[142] *See* Sheila Kaplan, "C.D.C. Labs Were Contaminated, Delaying Coronavirus Testing, Officials Say," N.Y. TIMES (Apr. 18, 2020), https://nyti.ms/34KnBf0.

containment.[143] 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.[144] Federal abdication of supply and distribution authority put states in competition with each other for other needed supplies. In short, "We 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."[145]

The federal funding and accelerated approval pathways in Operation Warp Speed helped private companies develop COVID-19 vaccines astonishingly quickly.[146] But the supply-chain, stockpiling, and distribution problems that flowed from federal shirking on testing and treatments also threaten to undermine the effectiveness of a nationwide vaccination campaign.[147] "This is the dark side of federalism: it encourages a patchwork response to epidemics" which are inherently borderless in character.[148]

Second, an entire era of devolution to state power produced an unstable and inequitable system for ensuring the practical dimension of access medical countermeasures – that people can pay for them using one of the fragments of the multi-payer insurance model described in the previous section.[149] A person's ability to pay for medical countermeasures depends on her source of insurance (or uninsurance). Her eligibility and coverage for that insurance depends in large part on the state in which she lives, which has nothing to do with health needs or effective practices, and everything to do with federalism.

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[143] *See* Wiley, *Federalism*, *supra* note 117, at 66.
[144] *See id.* at 66; Terry, *supra* note 135, at 5 (2020) ("[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.").
[145] Gawande, *supra* note 140 ("In fact, we don't have a technological problem; we've got an implementation problem. We could have the testing capacity we need within weeks. The reason we don't is not simply that our national leadership is unfit but also that our health-care system is dysfunctional.") (at 2).
[146] But note that the first vaccine to receive emergency use authorization was developed by Pfizer outside of the federally-funded Operation Warp Speed program.
[147] *See* Wiley, *Federalism*, *supra* note 117, 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), https://www.washingtonpost.com/health/2020/12/30/covid-vaccine-delay/.
[148] Haffajee & Mello, *supra* note __, at (1)-(2) ("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, Gordon, & Jones, *supra* note 54, at *1 ("This fragmented and disjointed response undoubtedly cost time and lives.").
[149] *See* Karyn Schwartz, Karen Pollitz, Jennifer Tolbert, and MaryBeth Musumeci, *Gaps in Cost Sharing Protections for COVID-19 Testing and Treatment Could Spark Public Concerns About COVID-19 Vaccine Costs*, KFF.org (Dec. 19, 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/.

The pandemic increased reliance on Medicaid, as unemployment skyrocketed and people lost the employer-sponsored health insurance that came with their jobs.[150] While some could still afford subsidized insurance on the ACA exchanges,[151] the majority were left to rely on Medicaid. But, based on the narratives of state deference and "non-coercion" imposed on the ACA by the Supreme Court in *NFIB v. Sebelius*, twelves states have refused to expand their Medicaid programs to all low-income, childless, non-disabled adults.[152] Thus, even when the federal Families First Coronavirus Response Act added COVID-19 testing without a copay to Medicaid coverage,[153] those folks in non-expanding states could not benefit from this safety net of financial access to testing. Thanks to federalism, a person's ability to afford a COVID-19 test could depend on whether she lives in North Dakota (which expanded Medicaid) or South Dakota (which did not),[154] despite the provision of federal funding.

To make matters worse, it is not simply the variation in state Medicaid programs that complicates the pandemic response, but 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."[155]

Narratives of deference to state sovereignty thus burden the current system and result in dysfunction, felt acutely during a communicable disease pandemic. A health system that instead allocated 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 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 to engage in a race-to-the-top of evidence-based policy and social supports.

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[150] Terry, *supra* note 135, at 7-9; Huberfeld, Gordon, & Jones, *supra* note 54, at *8 ("As a countercyclical program, enrollment in Medicaid increases when the economy declines.").
[151] Which also have significant state-by-state variations.
[152] *E.g.*, Nicole Huberfeld, Kevin Outterson, & Elizabeth Weeks Leonard, *Plunging into Endless Difficulties: Medicaid and Coercion in* National Federation of Independent Business v. Sebelius, 93 B.U. L. REV. 1 (2013); KAISER FAMILY FOUNDATION, *Status of State Medicaid Expansion Decisions: Interactive Map*, KFF.ORG (Nov. 2, 2020), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ (at the end of 2020, 12 states had refused to expand Medicaid). *See also* Huberfeld, Gordon, & Jones, *supra* note 54, *8 ("Medicaid's countercyclical effects will be severely limited in nonexpansion states….").
[153] FFRA § 6004 (2020).
[154] KAISER FAMILY FOUNDATION, *Status of State Medicaid Expansion Decisions: Interactive Map*, KFF.org (Nov. 2, 2020).
[155] Huberfeld, Gordon, & Jones, *supra* note 54, at *2.

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.[156] The privatized nature of the U.S.'s health care system has hampered the coronavirus pandemic response. In particular, 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 vaccine, at levels necessary to be effective. 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.[157] During the early phase of the 2020 pandemic, at least 20 million people lost their jobs,[158] which translated to approximately 10 million workers and dependents losing their employer-sponsored health coverage,[159] 3.5 million of whom became uninsured.[160] 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.[161] People in states that did not expand Medicaid and thus had a

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[156] *See* Fuse Brown, Lawrence, McCuskey & Wiley, *supra* note 1, at 416.
[157] *See* Stuart Butler, *Four COVID-19 Lessons for Achieving Health Equity*, 324 JAMA 2245, 2246 (Dec. 8, 2020).
[158] *See* David Blumenthal, Elizabeth J. Fowler, Melina Abrams, Sara Collins, *Covid-19 – Implications for the Health Care System*, 383 N. ENGL. J. MED. 1483, 1483 (Oct. 8, 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 and Gillian Friedman, *Workers Face Permanent Job Losses as the Virus Persists* (Oct. 3, 2020), https://www.nytimes.com/2020/10/03/business/economy/coronavirus-permanent-job-losses.html.
[159] There are a variety of estimates of the numbers who lost employer-sponsored insurance (ESI) coverage. *See e.g.,* Jessica Banthin and John Holahan, Urban Institute, Making Sense of Competing Estimates: The COVID-19 Recession's Effects on Health Insurance Coverage 2 (Aug. 28, 2020), https://www.urban.org/research/publication/making-sense-competing-estimates-covid-19-recessions-effects-health-insurance-coverage (comparing several studies' estimating 21.9 - 31 million lost ESI); Josh Bivens & Ben Zipperer, Economic Policy Institute, *Health Insurance and the COVID-19 Shock* (Aug. 26, 2020), https://www.epi.org/publication/health-insurance-and-the-covid-19-shock/.
[160] Not all of those who lost employer-sponsored insurance coverage became uninsured because many 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, URBAN INSTITUTE, CHANGES IN HEALTH INSURANCE COVERAGE DUE TO THE COVID-19 RECESSION: PRELIMINARY ESTIMATES USING MICROSIMULATIOn 1-3 (July 2020), https://www.urban.org/sites/default/files/publication/102552/changes-in-health-insurance-coverage-due-to-the-covid-19-recession_4.pdf. Later analyses estimated that 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, and Joshua Aarons, Urban Institute, 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 (Sept. 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.
[161] Terry, *supra* note 135, at 3.

higher rate of uninsurance were more likely to contract and die of COVID-19.[162] The U.S.'s reliance on job-based insurance and lack of a universal health care made it more vulnerable to the pandemic and weakened the country's response compared to other countries.[163] The CARES Act created a Provider Relief Fund that allocated $175 billion to providers to compensate them for providing COVID-19 testing, treatment, and vaccination to uninsured patients.[164] Yet the funding is not a benefit that uninsured patients can access directly and does not bar providers from charging patients for their COVID-19 care; rather, coverage depends on their provider submitting a claim for reimbursement to the government.[165] Thus, the risk that an uninsured patient could be charged for their COVID-19 care remains, along with the barriers to care that threat carries.

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-19 testing or vaccine.[166] Despite these patches, holes remain—they do not prohibit cost-sharing for COVID-19 treatment, 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 are not covered unless they are deemed

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[162] Tarun Ramesh, Emily Gee, Maura Calsyn, The Pandemic and Economic Crisis Are Wake-Up Call for State Medicaid Expansion, (Nov. 9, 2020), americanprogress.org/issues/healthcare/news/2020/11/09/492808/pandemic-economic-crisis-wake-call-state-medicaid-expansion/.

[163] 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; Ed Yong, *How the Pandemic Defeated America*, THE ATLANTIC (Aug. 4, 2020), https://www.theatlantic.com/magazine/archive/2020/09/coronavirus-american-failure/614191/.

[164] Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. 116-136, § 5001, 134 Stat. 281 (2020). U.S. Dep't of Health & Human Svcs., CARES Act Provider Relief Fund (Sept. 29, 2020), https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html; U.S. Health Resources & Svcs. Admin., Covid-19 Claims Reimbursement, https://coviduninsuredclaim.linkhealth.com/,

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

[166] Families First Coronavirus Response Act (FFCRA), Pub. L. 116—127, §§ 6001 - 6004, 134 Stat. 178 (2020) (to be codified at 42 USC §§ 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, and Robin Rudowitz, Five Things to Know about the Cost of COVID-19 Testing and Treatment, Kaiser Family Found, (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/.

medically appropriate by a provider.[167] Patients are right to worry, as stories mount of both legal and illegal billing for COVID-19 testing and care.[168]

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.[169] 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-19 testing for "diagnostic purposes" and when deemed "medically appropriate" by an individual's attending medical provider.[170]

Sabrina Corlette and others argue 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.[171] 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 considered diagnostic or medically appropriate under the medical-insurance model.[172] If the individual, the employer, or even the health insurer is forced to bear the cost, then the burden will

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[167] Loren Adler & Christen Linke Young, The Brookings Institution, *The Laws Governing COVID-19 Test Payment and How to Improve Them* (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/.

[168] *See* 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; 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; 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.

[169] 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-I-have-a-coherent-strategy-for-asymptomatic-testing-it-needs-one.

[170] Centers for Medicare & Medicaid Services, FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 43, at Qs. 3, 5 (June 23, 2020) (interpreting Section 6001 of the FFCRA to not cover COVID-19 testing unless medically appropriate and diagnostic and excluding "testing conducted to screen for general workplace health and safety (such as employee 'return to work' programs), for public health surveillance for SARS-CoV-2, or for any other purpose not primarily intended for individualized diagnosis or treatment of COVID-19"); *see also*, Adler & Linke Young, *supra* note 167.

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

[172] 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 AFF. BLOG (Jul. 28, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200727.300119/full/.

disproportionately fall on lower-income and minority populations and may serve as a barrier to employment or education or to the control of the disease.[173] A better approach would be for the government to arrange for the direct provision of COVID-19 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.[174]

Our privatized and fragmented health system does a terrible job of constraining prices for health care services and leads to wild and inexplicable price discrimination. 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.[175] In the case of coronavirus, this means the prices of testing and vaccines are left to the wildly unpredictable and undisciplined private market. The price of a COVID-19 test can vary forty-fold, from $20 to $850 at hospitals, and into the thousands of dollars at private labs.[176] The CARES Act required insurers to pay for COVID-19 tests but didn't limit the amount providers can charge for the tests, which essentially invites price gouging.[177] In the absence of a contractual price, the provider can charge whatever it wants and the insurer would have to pay. For new vaccines and therapeutics, there are no price constraints because without competition from generics, the manufacturer can unilaterally set its price.[178] The cost of COVID-19 vaccines in the U.S. will be borne largely by the federal government and left to negotiation with the manufacturers, including billions in government aid for research, manufacturing, and development.[179]

[173] *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.
[174] *See* Corlette, *supra* note 171; Butler, *supra* note 157, at 2245.
[175] Gerard 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 AFF. 87 (2019).
[176] NISHA KURANI, KAREN POLLITZ, DUSTIN COTLIAR, NICOLAS SHANOSKY, AND CYNTHIA COX, HEALTH SYSTEM TRACKER, COVID-19 TEST PRICES AND PAYMENT POLICY (July 15, 2020), https://www.healthsystemtracker.org/brief/covid-19-test-prices-and-payment-policy/; 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.
[177] Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. 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* (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/.
[178] Matthew Herper, *Gilead announces long-awaited price for Covid-19 drug remdesivir*, STAT (Jun. 29, 2020), https://www.statnews.com/2020/06/29/gilead-announces-remdesivir-price-covid-19/ .
[179] *See* Karyn Schwartz, Karen Pollitz, Jennifer Tolbert, & MaryBeth Musumeci, KFF, *Gaps in Cost Sharing Protections for COVID-19 Testing and Treatment Could Spark Public Concerns About COVID-19 Vaccine Costs* (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/; Sydney Lumpkin, *Novavax Posts Coronavirus Vaccine Contract That Government Didn't Disclose*, NPR (Nov. 11, 2020), https://www.npr.org/sections/health-shots/2020/11/11/933864908/novavax-posts-coronavirus-vaccine-contract-that-government-didnt-disclose (describing how many COVID-19 vaccine manufacturers' contracts under Operation Warp

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 decisionmaking over the distribution of therapeutics to treat COVID-19, thwarting nimble, need-based allocations of critical therapies. For example, the process for distributing the antiviral remdesivir[180] was driven by private industry and lacked transparency. Even when HHS assumed responsibility for allocation over the summer of 2020, the process remained confusing and seemingly unresponsive to need.[181] 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.[182] 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 were able to pay and who had existing transactional connections to the suppliers.[183] Without a centralized governmental payer or publicly accountable system to distribute health care resources, private actors make distributional decisions that are opaque, tend to

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Speed limited the government's "march-in" rights to curtail price gouging by recipients of federal funding).

[180] 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. https://www.fda.gov/media/137564/download

[181] Sydney Lupkin, *How Feds Decide On Remdesivir Shipments To States Remains Mysterious*, NPR, (Aug. 19, 2020), https://www.npr.org/sections/health-shots/2020/08/19/903946857/how-feds-decide-on-remdesivir-shipments-to-states-remains-mysterious; Sydney Lupkin, *Remdesivir Distribution Causes Confusion, Leaves Some Hospitals Empty-Handed*, NPR (May 14, 2020), https://www.npr.org/sections/health-shots/2020/05/14/855663819/remdesivir-distribution-causes-confusion-leaves-some-hospitals-empty-handed.

[182] *See, e.g.,* CDC, COVID-19, Strategies to Mitigate Healthcare Personnel Staffing Shortages (updated July 17,2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html; CDC, COVID-19, Strategies to Allocate Ventilators from Stockpiles to Facilities (updated Mar. 20,2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/ventilators.html; Ezekiel Emanuel, Govind Persad, Ross Upshur, et al., *Fair Allocation of Scarce Medical Resources in the Time of Covid-19*, 382 N. ENG. J. MED. 382 (2020); Colette DeJong, Alice Hm Chen, Bernard Lo, *An Ethical Framework for Allocating Scarce Inpatient Medications for COVID-19 in the US*, 323 JAMA 2367 (2020).

[183] *See* Megan Ranney, Valerie Griffith, & Ashish Jha, *Critical Supply Shortages — The Need for Ventilators and Personal Protective Equipment during the Covid-19 Pandemic*, 382 N. ENG. J. MED. e41 (2020); Nathan Layne, Outbid and left hanging, U.S. states scramble for ventilators, REUTERS (Apr. 11, 2020) https://www.reuters.com/article/us-health-coronavirus-usa-ventilators/outbid-and-left-hanging-u-s-states-scramble-for-ventilators-idUSKCN21S20D ;

follow existing well-greased supply chains,[184] and bid up the cost of the scarce resource.[185]

Our reliance on a 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 decisionmaking about the fair allocation and efficient distribution of scarce resources in the pandemic.[186] The pandemic reveals 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 in a pandemic. The fear of the cost of services creates barriers to widespread testing and vaccine, 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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Individualism, fiscal fragmentation, federalism, and privatization hindered our health care system from delivering the basic medical countermeasures of in a pandemic. 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

[184] Gilead Sciences, Press Release: 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 (describing how starting Oct. 1, 2020, remdesivir manufacturer, Gilead, would begin supplying the drug directly to hospitals via its sole distributor, Amerisourcebergen).

[185] America's Health Insurance Plans, Price Gouging in a Public Health Crisis: Out-of-Network COVID-19 Test Costs Far Exceed In-Network Charges (Aug. 2020), https://www.ahip.org/wp-content/uploads/202008-AHIP_COVID-PriceGouging.pdf (reporting that out-of-network providers charged significantly higher prices for COVID-19 tests 40% of the time).

[186] *See* Terry, *supra* note 161, at 10 ("[P]rivate healthcare entities (be they nonprofits or for-profits) lack incentives to address the social determinants of health, to build community resilience, to construct wraparound service, or to invest in healthcare solidarity to achieve herd-based improvements to the health of all. . . . COVID-19 not only illustrates how private actors failed to invest in prophylactic structures but also their relatively poor performance once the pandemic arrived.")

determinant of health."[187] Racism is foundational to "the political, social, and economic environments that influence access to resources necessary to prevent, manage, or overcome disease."[188] Realizing health justice demands that health reform grapple with the racist foundations of the American legal and health care systems. It demands just 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 health equity and solidarity. 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 and social 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."[189] 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 my individuality. . . . Further, as an individual I am objective and view others as individuals and not as members of racial groups."[190]

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."[191]

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[187] Roland J. Thorpe, Jr., Keith C. Norris, Bettina M. Beech & Marino A. Bruce, *Racism Across the Life Course* in CHANDRA L. FORD, DEREK M. GRIFFITH, MARINO A. BRUCE & KEON L. GILBERT, EDS., RACISM: SCIENCE & TOOLS FOR THE PUBLIC HEALTH PROFESSIONAL 209 (2019); *see also* 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 (2020); RUQAIIJAH YEARBY, CRYSTAL N. LEWIS, KEON L. GILBERT & KIRA BANKS, RACISM IS A PUBLIC HEALTH CRISIS. HERE'S HOW TO RESPOND (2020), https://tjcinstitute.com/wp-content/uploads/2020/09/Racism-is-a-Public-Health-Crisis.pdf.

[188] Roland J. Thorpe, Jr., Keith C. Norris, Bettina M. Beech & Marino A. Bruce, *Racism Across the Life Course* in CHANDRA L. FORD, DEREK M. GRIFFITH, MARINO A. BRUCE & KEON L. GILBERT, EDS., RACISM: SCIENCE & TOOLS FOR THE PUBLIC HEALTH PROFESSIONAL 209 (2019).

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

[190] Robin J. DiAngelo, Why Can't We All Just Be Individuals?: Countering the Discourse of Individualism in Anti-racist Education, 6 INTERACTIONS (2010), https://escholarship.org/uc/item/5fm4h8wm.

[191] Harris & Pamukcu, supra note 4, at 767.

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?'"[192] Mary Bassett and Jasmine Graves have argued that individualistic explanations for public health problems are a "litmus test" for antiracism: "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."[193] In the ethos of individualism, health disparities ranging from heart disease, diabetes, and cancer to sexually transmitted infections and now COVID-19 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."[194]

Implicitly racist, classist, and xenophobic notions of deservingness and individualism have permeated American 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 ties."[195] 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."[196] 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."[197] Individualism and notions of personal responsibility give privileged people a free pass to ignore their role in subordinating others and to disregard subordinated people's needs. Individualism erodes the social solidarity that underpins mutual aid.

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

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[192] Mary T. Bassett & Jasmine D. Graves, *Uprooting Institutionalized Racism as Public Health Practice*, 108 AM. J. PUB. HEALTH 457, 458 (2018).
[193] Mary T. Bassett & Jasmine D. Graves, *Uprooting Institutionalized Racism as Public Health Practice*, 108 AM. J. PUB. HEALTH 457, 458 (2018); see also Dayna Bowen Matthew, Just Medicine: A Cure for Racial Inequality in American Health Care 10 (2015) ("Throughout most of our country's history, the rule of law has been perversely instrumental in enabling the racism—both conscious and unconscious—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.").
[194] *Id.* at 457.
[195] Stone, supra note 5, at 289 (emphasis added).
[196] *Id.* at 287 (quoting an advertising campaign in the late 1980s).
[197] Christian S. Crandall & Rebecca Martinez, *Culture, Ideology, and Antifat Attitudes*, 22 PERSONALITY & SOCIAL PSYCH. BULL. 1165, 1166 (1996)..

dog whistles about social welfare programs.[198] 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."[199] 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. Litigation challenging the ACA's individual mandate and Medicaid expansion pressed the limits of majoritarian rule and the communitarian ethos.[200] 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.

"Our 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."[201] 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 health justice because, at root, "social problems need social or collective, not just individual, solutions."[202] 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."[203] To serve solidarity, health reform must embrace collective responses to collective needs. To do so justly, it must ensure that the benefits and burdens of public investments in health are fairly distributed and that communities are empowered to protect themselves and others.

To realize health justice, health reform must be both universalist *and* anti-subordinationist.[204]

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

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[198] 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 INDIANA HEALTH L. REV. 642, 707 (2014).
[199] *Id.* at 679.
[200] Nat'l Fed'n of Indep. Bus. v. Sebelius, 573 U.S. 682 (2014); *see* Fuse Brown, Lawrence, McCuskey & Wiley, *supra* note 1, at 416-17.
[201] Harris & Pamukcu, *supra* note 4, at 762.
[202] Fineman, *Inevitable Inequality*, at 142; see also Wiley, *Social Justice*, *supra* note 5, at 95 (highlighting "collective responsibility for assuring healthy living conditions, rather than reinforcing individualistic assumptions about personal responsibility for health"); Wiley, *Health Justice*, *supra* note 5at 874 (describing "collective action grounded in community engagement and participatory parity" as a core commitment of health justice).
[203] Wiley, *Health Justice*, *supra* note 5, at 855.
[204] Lindsay F. Wiley, *Universality, Vulnerability, and the Goals of Post-2020 Health Reform* (draft on file with author).

of existing and newly generated resources of all types, including land, capital, ideas, and labor. 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.

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. It thereby creates a discrete pot of national resources that serve a distinct constituency of Medicare beneficiaries—just as property laws create millions of pots of resources that serve distinct constituencies of property owners.

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 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, and equal pay.

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.[205] 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.[206] Meanwhile, programs that predominantly benefit the poorest Americans and communities, like Medicaid and the Supplemental Nutrition Assistance Program ("SNAP"), are fiscally fragile, requiring annual appropriations just to keep operating and 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.[207]

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 in spending programs like Medicare, but that durability comes at the cost of entrenching inequity. 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.

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[205] DANIEL E. DAWES, THE POLITICAL DETERMINANTS OF HEALTH (2020).

[206] *See* Matthew Lawrence, *The Real Imbalance in the Balance of Powers* (unpublished manuscript) (describing privileged financial status of spending programs that benefit middle class).

[207] *Id.*

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 subordination.[208] 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.[209] "People of color have long been disproportionately disadvantaged by federalism,"[210] and the "core problems of racial inequality" still find their "core … in questions of federalism.[211]

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.[212] Historically, even when reforms have enacted or expanded public programs to cover more people, 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.[213] For example, in the 1945 Hill-Burton Act, representatives from Southern states demanded local control of hospital construction funds, which allowed many hospitals in rural and Southern areas to be segregated.[214]

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.[215] Since then, a series of legislative waivers and administrative policies have ceded control of program design increasingly to the states. Southern states

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[208] *See, e.g.*, Grigsby, Hernandez, John, Jones-Smith, Kaufmann, Patrick, Prener, Tranel, & Udani, *supra* note 137, at 659 ("The real failure of our federalist system is rooted in systemic racism and a resistance to racial equity.").

[209] *See* Gerken, *All the Way Down*, *supra* note 118, at 48 ("Federalism has often been a code-word for letting racists be racists."). *E.g.*, Denise C. Morgan & Rebecca E. Zietlow, *The New Parity Debate: Congress and Rights of Belonging*, 73 U. CIN. L. REV. 1347, 1369-70 (2005); Jamila Michener, *Race, Politics, and the Affordable Care Act*, 45 J. HEALTH POLITICS, POL'Y & L. 547, 550 (2020). *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).

[210] Michener, *supra* note 209, at 550.

[211] Robert C. Liberman & John S. Lapinski, *American Federalism, Race, and the Administration of Welfare*, 31 BRIT. J. POL. SCI. 303, 303 (2001). *Accord* Gerken, *All the Way Down*, *supra* note 118, at 49 ("those interested in racial justice have long been skeptical of federalism"); Medha A. Makhlouf, *Laboratories of Exclusion: Medicaid, Federalism & Immigrants*, 95 N.Y.U. L. REV. __ (forthcoming 2020).

[212] *See* Gluck & Huberfeld, *supra* note 130, at 1711 (arguing that deference to state authority in implementing federal law has often served to entrench rather than transcend interstate disparities). *Cf.* Ava Ayers, *Discriminatory Cooperative Federalism*, 65 VILL. L. REV. 1 (2020).

[213] Interlandi, *supra* note 4.

[214] *Id.*

[215] *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 (2002).

and those politically aligned with them have frequently wielded this "flexibility" to marginalize and exclude people of color from the program's reach, eroding the federal floor of protection.[216] This "fend-for-yourself" federalism and policy devolution "has led to states developing welfare sanctions that disproportionately harm low-income Blacks …."[217]

The Supreme Court's decision in 2012 to make the ACA's Medicaid expansion subject to states' discretion has meant that many 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.[218]

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.[219] Local governments are not insulated from racism, but to the extent that local governments take discriminatory actions, federal and state preemption helpfully invalidates them.[220] 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.[221] This is particularly true because local governments often are "the very sites where racial minorities are empowered to rule."[222]

In a pandemic, local governments have the least political power and fewest resources to effectuate public health measures. 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-19 infections and deaths spiked in the Atlanta region, Mayor Keisha Lance Bottoms implemented policies for face-covering and restricting business openings to staunch the trend. Georgia Governor Brian Kemp sued her, asserting that state-level policy of *not* requiring masks and *not* requiring public accommodation

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[216] *Id.*

[217] Grigsby, Hernandez, John, Jones-Smith, Kaufmann, Patrick, Prener, Tranel, & Udani, *supra* note 137, at 658.

[218] Michener, *supra* note 209, at 549-51. All but 4 of the 12 remaining states that have refused the Medicaid expansion were part of the Confederate States of America during the Civil War. *See* Interlandi, *supra* note 4 ("Several states, most of them in the former Confederacy, refused to participate in Medicaid expansion.").

[219] *See generally* Briffault, *supra* note 119, at 2000-2001.

[220] *E.g.*, *id.*, at 2021-22; Derek Carr, Sabrina Adler, Benjamin D. Winig, & J.K. Montez, *Equity First: Conceptualizing a Normative Framework to Assess the Role of Preemption in Public Health*, 98 MILBANK Q. 131 (2020).

[221] *See* Kim Haddow, Derek Carr, Benjamin D. Winig, & Sabrina Adler, *Preemption, Public Health, and Equity in the Time of COVID-19*, in ASSESSING LEGAL RESPONSES TO COVID-19 AT 71, 73-74 (Aug. 2020). *See also* Hunter Blair, David Cooper, Julia Wolfe, & Jaimie Worker, *Preempting Progress*, ECON. POL'Y INST. (Sept. 30, 2020), https://files.epi.org/pdf/206974.pdf ("State interference in local policymaking prevents people of color, women, and low-income workers from making ends meet in the South").

[222] *See* Gerken, *All the Way Down*, *supra* note 118, 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.").

closures preempted these local public health measures.[223] Other conservative states entertained similar arguments to try to preempt protective measures taken by cities, many of which had majority-minority populations.[224]

The manifestations of structural racism and subordination already put low-income and racial minority populations at greater risk of contracting and dying from COVID-19.[225] "[F]ederalism exacerbates these inequities, as some states have a particularly deep history of under-investing in social programs, especially in certain communities."[226] The federal government's tepid response and shirking of responsibility surely contributes 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.[227]

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.[228] 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, all these reforms have entrenched the dominant role of privately financed health care and the permitted *de jure* and *de facto* segregation and tiering of health care along racial, ethnic, geographic, and socioeconomic lines.[229] The fragmentation of the U.S. health care system tracks these demographic characteristics—with wealthier, mostly white

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[223] Ben Nadler, Jeff Amy, and Kate Brumback, *Georgia governor to drop lawsuit over Atlanta mask mandate*, ASSOC. PRESS (Aug. 13, 2020), https://apnews.com/article/virus-outbreak-georgia-lawsuits-local-governments-keisha-lance-bottoms-7c220bed26f611dcf6ea57af94d516d9.

[224] Brooks Rainwater, *States Are Abusing Preemption Powers in the Midst of a Pandemic*, BLOOMBERG CITYLAB (Jul. 1, 2020) https://www.bloomberg.com/news/articles/2020-07-01/how-states-co-opted-local-power-during-coronavirus (reporting on similar efforts Nebraska, Texas, Florida, Mississippi, Arizona, and North Carolina); Haddow, *et al.*, *supra* note 221, at 72-73 (surveying preemption by state executive order in those states, as well as West Virginia and Iowa)..

[225] *See* Grigsby, et al., *supra* note 137217, at 659 ("many have concluded U.S. federalism is unfit to respond to a pandemic").

[226] Huberfeld, Gordon, & Jones, *supra* note 54, at 1.

[227] *E.g.*, Harris & Pamukcu, *supra* note 4, at 252 ("many government entities particularly at the federal level, have been slow to measure – let alone address – the racialized consequences of COVID-19"); Grigsby, et al., *supra* note 137217, at 661 ("the 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").

[228] Interlandi, *supra* note 4 ("In the United States, racial health disparities have proved as foundational as democracy itself.")

[229] 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); W. MICHAEL BYRD & LINDA A. CLAYTON, AN AMERICAN HEALTH DILEMMA--RACE, MEDICINE, AND HEALTH CARE IN THE UNITED STATES 1900-2000, 9-18 (2002).

people covered by private insurance and poorer people, and more non-whites, covered by public programs or not at all.[230]

David Barton Smith documented how racial subordination prevented the establishment of universal social insurance in the U.S.[231] 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 national public insurance system like those in other countries.[232] The American Medical Association and hospitals excluded Blacks as members or patients until Civil Rights era, few Blacks had jobs with employer-health benefits, and even if they did, they couldn't use the coverage in white-only facilities.[233] The divisions between the two-tiered publicly and privately financed health systems in the U.S. were racialized from the beginning of the nation and continue through this day.[234]

Racial subordination was key to the ascendance of the private tier of the U.S. health system, and the persistence of the private health insurance model stands in stark opposition to both solidarity and health justice. In the words of Professor Deborah Stone, the market-based logic of the private health insurance system is "profoundly antithetical to the idea of mutual aid."[235] 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 tinier, more homogenous groups.[236] Moreover, the actuarial methodology of insurance historically incorporated the social biases and subordination of non-whites, who tend to be poorer and live and work in higher-risk areas.[237] 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

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[230] SMITH, *supra* note 229, at 29-30 ("Public programs were for Blacks; private ones for whites."); Byrd & Clayton, *supra* note 229, 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.") Kaiser Fam. Fdn., Uninsured Rates for the Nonelderly by Race/Ethnicity (Time frame: 2019), 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 (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).
[231] SMITH, *supra* note 229,at 28-29; *see also*
[232] Interlandi, *supra* note 4(contrasting the opposition of the white-only AMA with the Black National Medical Association, which advocated for national health insurance system); BYRD & CLAYTON, *supra* note 229, at 16.
[233] Interlandi, *supra* note 4.
[234] BYRD & CLATYON, *supra* note 229, at 17.
[235] Stone, *supra* note 5, at 290.
[236] *Id.*
[237] *Id.* at 296-297 (describing how underwriting methodology tracks social class, stereotypes, and occupational categories).

Brown, always have worse health care access and quality.[238] By contrast, other developed countries treat health care as a public good, to be distributed based on need and funded collectively.[239] 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)[240] that connect the U.S. private health insurance system with its racially inequitable outcomes.[241]

The nail in the inequitable coffin is that the two-tiered U.S. health care system pays providers less to care for publicly insured patients than those with private insurance.[242] Price discrimination, 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.[243] Health care is rife with price discrimination. Health care price discrimination translates into racial and ethnic discrimination, because a patient's coverage type maps onto a patient's racial, economic, and social status. [244]

In the U.S. health system, lower provider payments by public payers translates to reduced access, particularly in Medicaid, the public program for the poor and the principal source of coverage for minorities.[245] Everyone knows that Medicaid is a poor payer, Medicare only slightly better, and private coverage the most lucrative.[246] Price discrimination means providers are always more willing

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[238] Thomas Rice, *The Impact of Cost Containment Efforts on Racial and Ethnic Disparities in Healthcare: A Conceptualization*, *in* INSTITUTE OF MEDICINE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 664 (Brian D. Smedley, Adrienne Y. Stith, Alan R. Nelson eds. 2003) (concluding that the U.S. approach to cost containment makes racial disparities worse, particularly by allocating services based on the ability to pay).

[239] SMITH, *supra* note 229, at 28.

[240] Roosa Tikkanen, The Commonwealth Fund , *Variations on a Theme: A Look at Universal Health Coverage in Eight Countries* (Mar. 22, 2019), https://www.commonwealthfund.org/blog/2019/universal-health-coverage-eight-countries.

[241] Stone, *supra* note 5, at 291.

[242] INSTITUTE OF MEDICINE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 190 (Brian D. Smedley, Adrienne Y. Stith, Alan R. Nelson eds. 2003), ("Low payment rates inhibit the supply of physician (and other health care 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.").

[243] Rice, *supra* note 238, at 712; Uwe 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 AFF. 2125, 2128-29 (2011).

[244] Rice, *supra* note238, at 712. (describing the result of a system that permits price discrimination is that providers will preferentially serve the most lucrative privately insured patients and avoid serving less lucrative publicly insured or uninsured patients).

[245] 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* INSTITUTE OF MEDICINE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 664, 679 (2003), https://doi.org/10.17226/12875.

[246] *Id.* at 687 ("It is perhaps safe to say that the best-known problem plaguing the Medicaid program is its notoriously low payment rates."); Matthew Fiedler, *Capping Prices or Creating a Public*

and eager to serve a privately insured patient than a publicly insured one and validates negative attitudes against minority, low-income communities.[247] Low reimbursement rates depress provider participation in Medicaid, and Medicaid beneficiaries have far worse access to health care than privately insured patients.[248] This explains the paradox of how Medicare, Medicaid, and the ACA reduced racial disparities in health care while perpetuating them.[249] And this is why universal coverage is necessary but insufficient to achieve health equity. 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.[250]

Empirically, privatized health systems perpetuate and are characterized by greater inequality.[251] Privatized health systems underperform publicly financed

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Option: How Would They Change What We Pay for Health Care?, USC-Brookings Schaeffer Initiative for Health Policy at 1, 14 (Nov. 2020), https://www.brookings.edu/wp-content/uploads/2020/11/Price-Caps-and-Public-Options-Paper.pdf ("Commercial health insurers pay much higher prices for health care services than public insurance programs like Medicare or Medicaid.").

[247] Rosenbaum, *supra* note 245 (quoting a 2001 GAO Report, which included this advice a consultant gave to a physician practice, "you have 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.'" The consultant said that one way of discouraging Medicaid patients while welcoming private pay patients whose insurance policies often reimburse at higher rates, is to give Medicaid patients the most inconvenient appointment times while saving the most popular appointment slots for private pay patients.")

[248] INSTITUTE OF MEDICINE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 143 (Brian D. Smedley, Adrienne Y. Stith, Alan R. Nelson eds. 2003), https://doi.org/10.17226/12875. ("Because of Medicaid's low reimbursement rates for doctors and hospitals, its poor, disproportionately minority beneficiaries are subject to largely separate, often segregated systems of hospital and neighborhood clinics. . . In addition, Medicaid low reimbursement rates drastically restrict Medicaid beneficiaries' ability to access private physicians and prevents many Medicaid patients from being admitted to hospitals in the absence of a private doctor with hospital admitting privilege") (internal citations omitted).

[249] Rosenbaum, *supra* note 245, 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 AFF. BLOG (Sept. 1, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200828.661111/full/.

[250] Note there is a distinction between paying providers equally to see all patients and charging patients/individuals equal amounts for their coverage. The former is necessary to promote equality of treatment and access, whereas a system that maximizes health equity would scale individuals' costs of coverage and care (whether in taxes, premiums, or cost-sharing) according to their ability to pay, with wealthier individuals paying more for their coverage than poorer individuals. But the coverage itself and the amounts it pays to providers would be equal. *See* Stone, *supra* note 5, at 291 (describing how social insurance breaks the linkage between the amount one pays for care and one's ability to pay); Rice, *supra* note 238 (advocating for an all-payer system to eliminate price discrimination).

[251] WORLD HEALTH ORG., COMM'N ON SOCIAL DETERMINANTS OF HEALTH, CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 94 (2008) https://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf;jsessionid=59F070C281D0321A383E27BD94057FD6?sequence=1 ("Runaway commodification of health and

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 system privatization in a country significantly increased COVID-19 incidence and mortality, even controlling for other variables.[252] A review study found that greater health care privatization was associated with worse patient outcomes and quality than public health systems across a number of low- and middle-income countries.[253] Why would this be? In short, health care privatization has distributional effects. A privatized health system generally does a poorer job of fairly distributing health care resources across the population—the fees charged for health care create barriers to access and disruptions to care among poorer parts of the population and the incentives of private health systems tend to favor the wealthy and disadvantage the poor—and these distributional inequities translate to greater disparities in health outcomes.[254] In short, for privatized health care tends to be more inequitable. Thus, even if everyone had coverage, a private health system will perpetuate inequality along racial and socioeconomic lines unless it were heavily regulated to resemble a public system of coverage with standardized provider payment rates and benefits.

To be sure, even countries with universal public coverage systems, where generally providers are not paid more to serve rich patients than poor ones, there is an observed social gradient in health status.[255] The health effects of income inequality, structural racism, and other social determinants are not eliminated by a

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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.")

[252] Jacob Assa & Ceclia Calderon, *Privatization and Pandemic: A Cross-Country Analysis of COVID-19 Rates and Health-Care Financing Structures* 14-15 (United Nations Devel Prog., Human Devel. Rsrch. Off., preprint May 30, 2020), DOI: 10.13140/RG.2.2.19140.65929 (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.").

[253] 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 MEDICINe e1001244 at 5, 8 (2012).

[254] Assa & Calderon, *supra* note 252, at 6 ("Privatization also has distributional effects, as private clinics and doctors often charge user fees which the poor cannot pay, a situation which deters some people from seeking medical testing and treatment . . . This positive relationship between private health-care provision and health inequality is confirmed by the latest data for 147 countries on inequality in life-expectancy (UNDP 2019) and the ratio of private to public health expenditures (WHO 2020)"); Basu et al., *supra* note 253, at 8 ("private sector health services tend to cater more greatly to groups with higher income and fewer medical needs (an illustration of the ''inverse care law''), resulting in disparities in coverage,") (internal citations omitted).

[255] MICHAEL MARMOT, THE HEALTH GAP: CHALLENGE OF AN UNEQUAL WORLD ___ (2014) ("This linking of social position with health – higher rank, better health – I call the social gradient in health."); Michael Marmot et al., *Health inequalities among British civil servants: the Whitehall II study*, 337 THE LANCET 1387 (1991); Roosa Tikkanen, Robin Osborn, Elias Mossialos, Ana Djordjevic, and George A. Wharton, The Commonwealth Fund, *International Health Care System Profiles: England* (June 5, 2020), https://www.commonwealthfund.org/international-health-policy-center/countries/england (describing England's National Health Service, which served the populations Marmot studied when he described the social gradient.

universal single-payer health system.[256] 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.[257]

In the iron triangle era, the holy grail of health policy was universal access to high-quality, affordable health care. 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 system where wealthier, socially dominant groups benefit from more generous private coverage with broad access to enthusiastic providers and poorer, marginalized 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 just and equitable system, 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 sew dysfunction in our health care system and tragically perpetuate subordination in the burden of disease. The health justice ethos thus demands confrontation with these fixtures. But their logistical entrenchment may practically compel some version of incrementalism in approach. We must dig deep for our concluding lesson about *how* health reform might reconcile bolder anti-subordination 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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[256] INSTITUTE OF MEDICINE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 34 (Brian D. Smedley, Adrienne Y. Stith, Alan R. Nelson eds. 2003), https://doi.org/10.17226/12875 (noting that providing universal health care "is necessary but insufficient in and of itself to address racial and ethnic disparities in healthcare,"); Rosenbaum, *supra* note 245, at 665.

[257] WORLD HEALTH ORG., COMM'N ON SOCIAL DETERMINANTS OF HEALTH 8 ("The Commission considers health care a common good, not a market commodity. Virtually all high-income countries organize their health-care systems around the principle of universal coverage (combining health financing and provision). Universal coverage requires that everyone within a country 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.").

A. Envisioning a Just U.S. Health System

Applying the bolder criteria of health justice, what would a fair, equitable, and solidarity-enhancing health system look like? Such a transformed U.S. health system would eliminate, displace, or transcend the four legal fixtures that have led to the functional and existential failures laid bare by the coronavirus pandemic. The lessons of 2020 have strengthened the case for single-payer health system in the U.S.—a universal social insurance program that is grounded in solidarity, distributes its benefits on the basis of need, allocates its financing burdens by the ability to pay, and empowers affected communities to participate in decision-making processes.[258]

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.[259] It would 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.[260] 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 is a public good, not a commodity.[261] By so doing, it would lay bare health inequities stemming from forms of subordination in marginalized communities that exist upstream from the health care system and provide a vehicle to respond to those communities' distinctive health care needs.

A universal, single-payer system would also collapse the fixtures of fiscal fragmentation and privatization by combining all participants in a single, unified risk pool.[262] With a single payer rather than fiscal diffusion across multiple payers, the system could coordinate and marshal resources in times of emergency. It would also control costs by applying administratively set payment rates across population, eliminating unjust payment differentials so that providers would no longer be paid more to care for wealthier patients than poor 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

[258] *See* Stone, *supra* note 5, 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."); Fuse Brown, Lawrence, McCuskey, Wiley, *supra* note 1, at 419-23 (describing how national single-payer proposals like Medicare for All confront the fixtures more directly than the ACA did); Wiley, *Privatized Public Coverage*, *supra* note 45 (discussing the role of democratic deliberation in the design and administration of public insurance programs).

[259] *See* Fuse Brown, Lawrence, McCuskey & Wiley, *supra* note 1, at 422; *see, e.g.* Medicare for All, H.R. 1384, 116th Cong. (2019-2020).

[260] *See* YEARBY, LEWIS, GILBERT & BANKS, *supra* note 187, at 7-8.

[261] BYRD & CLAYTON, *supra* note 229, at 585.

[262] *See* Fuse Brown, Lawrence, McCuskey & Wiley, *supra* note 1, at 419-21.

health care access and outcomes.[263] Publicly financed health systems (i.e. taxpayer funded) are more equitable and produce better outcomes than privatized systems.[264] 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 ordinary life. Likewise, a single nationwide payment program would flatten many of the state-by-state disparities that flow from federalism's deference to state flexibility.[265]

The vision for what a single-payer, universal health care system looks like exists in many flavors and varieties in other countries throughout the world.[266] Some have greater reliance on private health insurance contractors to administer the benefits, others retain more federalist flexibility.[267] We do not have invent our 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.[268] 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 system seems daunting and possibly even naïve.

B. Health Reform is Hard

Perhaps COVID-19 will usher in a new era in which the U.S. finds the will to begin the dramatic transformation it needs. 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 2020 pandemic may have accelerated the public's embrace of a greater government role in health care, untethered to employment, and

[263] *See* SMITH, *supra* note 229, at 29-30.
[264] *See supra* notes 251-253 and accompanying text.
[265] *See* JAMILA MICHENER, FRAGMENTED DEMOCRACY: MEDICAID, FEDERALISM, AND UNEQUAL POLITICS (2018).
[266] *See* Tikkanen, *supra* note 260.
[267] *See, e.g.*, Dylan Scott, Ezra Klein & Tara Golshan, *Everybody Covered: What the US Can Learn From Other Countries' Health Systems*, VOX (Feb. 12, 2020), https://www.vox.com/2020/1/13/21055327/everybody-covered (describing how the Netherlands has private, universal coverage); Commonwealth Fund, *International Health Care System Profiles—Germany* https://www.commonwealthfund.org/international-health-policy-center/system-features/how-does-universal-health-coverage-work (last visited Dec. 1, 2020) (describing Germany's health care system that shares powers between the federal government and the states).
[268] JACOBS & SKOCPOL, *supra* note 12, 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.")

willingness to confront structural inequalities of a fragmented, privatized, "you're on your own" version of health care.[269]

Moreover, while we argue for a more principled ethos in which solidarity supports health justice, interest-convergence theory[270] 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 protecting the health of subordinated populations aligns with their own interests. Interest-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.[271] The 2020 pandemic has vitiated any pretense that our current health care 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. There are substantial fixtures blocking the path toward health care system transformation.[272] So long as the blinkered "iron triangle" approach remains dominant in law and policy analysis, reform will not even aspire to a just health care system, guaranteeing we do not get it.[273] 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.[274]

At the same time, even if a bolder vision of a just health care system gains steam in policy and political circles, the road to actually achieving such a system in the United States is difficult because of the structural impediments we have

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[269] *See* Victor R. Fuchs & Ezekiel Emanuel, *Health Care Reform: Why? What? When?,* 24 HEALTH AFF. 1399, 1412 (2005) (predicting that to overcome he hurdles of status quo bias, it may take a major upheaval from war, depression, civil unrest or a "national health crisis, such as a flu pandemic" to precipitate comprehensive health reform).

[270] *See* Mary Crossley, *Black Health Matters: Disparities, Community Health, and Interest Convergence*, 22 MICH. J. RACE & L. 53 (2017).

[271] JACOBS & SKOCPOL, *supra* note 12, 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).

[272] *See, e.g.*, Patrice Harris, *Health reform: How to Improve U.S. Health Care in 2020 and Beyond*, AM. MED. ASSN. (Aug. 13, 2019) ("The AMA strongly believes that every American should have access to meaningful, affordable coverage. We also believe we need to build on our current system of coverage provided by employers, government, and individually selected plans so that patients can benefit from choice and competition. This fits with our long-standing policies of pluralism, freedom of both choice and practice, and universal access for patients. . . . A single-payer option is not a viable solution, because it is a one-size-fits-all approach that would ultimately reduce coverage options and eliminate patients' freedom of choice.")

[273] *See* Part I.A, *supra*.

[274] *See* Rachel Cohrs, *Medicare for All Champion Bernie Sanders Drops Out of Presidential Race*, MODERN HEALTHCARE (Apr. 8, 2020), https://www.modernhealthcare.com/politics-policy/medicare-all-champion-bernie-sanders-drops-out-presidential-race; Rucker Higgins, *Biden Suggests He Would Veto 'Medicare for All' Over Its Price Tag*, CNBC (Mar. 10, 2020), https://www.cnbc.com/2020/03/10/biden-says-he-wouldd-veto-medicare-for-all-as-coronavirus-focuses-attention-on-health.html.

described.[275] As this Article has demonstrated, the distance 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 of our law—individualism, fiscal fragmentation, federalism, and privatization—and goes nowhere (or just about nowhere). These quasi-legal structures ensure that the solidarity impulse does not translate into solidarity in practice. We have focused upon Covid-19 and racial disparities here, but history offers other examples, including the ACA itself.[276]

C. Confrontational Incrementalism

To achieve anything approaching health justice, reform must overcome the fixtures that constrain it. This will require transformation, which may mean a single payer health care 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 constraining meaningful reform 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 overall 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 – that is, a method for identifying incremental reforms that challenge, displace, or transcend the regressive structural features of American law we have described and, so, plant the seeds for future transformation.

Subsection 1 begins by distinguishing conceptually between incremental reforms that serve as stepping stones (which represent progress toward more fundamental change) or springboards (which carry the dynamic potential to trigger transformative future change) and those that serve as stumbling blocks (which distract from or hold back more fundamental change). Subsection 2 explains that in a field in which legal structures prevent necessary transformation—like health reform—legal changes that tend to dismantle those structures are stepping stones and reforms that accommodate those structures are stumbling blocks. Subsection

[275] Anup Malani & Michael Schill, *Introduction in* THE FUTURE OF HEALTHCARE REFORM IN THE UNITED STATES 9 (Anup Malani & Michael H. Schill, eds. 2015) (echoing our concerns about the difficulty of health reforms because they "directly implicate many of the most sensitive ideological cleavages in our society—ranging from the role of markets in distributing vital goods and services, to the liberty to make one's choices free of government interference, to the relationship among different levels of government, on the one hand, and between government and the individual, on the other."). As explained *supra* Part II, the project of reconstruction sees individualism, fragmentation, federalism, and privatization not merely as ideologies, but as legally and logistically entrenched fixtures of American law.

[276] *See* Fuse Brown, Wiley, McCuskey, and Lawrence, *supra* note 1, 414-17.

3 offers examples from past health reforms to inform this approach.[277] Our call for confrontational incrementalism is meant to trace an agenda for health reform reconstruction, 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 coronavirus 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.[278] In policing, scholars and policymakers must decide between fundamental reform (or abolition) or modest gains.[279] 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.[280]

In unpacking incrementalism in environmental policy, Professor Rachel Brewster distinguishes among different incremental reforms based on whether they are "stepping stones" or "stumbling blocks."[281] Stumbling blocks turn out to be "a barrier that make advancement more difficult."[282] Stepping stones "eas[e] the way to climbing higher."[283] 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").[284]

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[277] *See, e.g.*, Fuchs & Emanuel, *supra* note 269, at 1408 (comparing incremental versus comprehensive reform, and concluding that incremental reforms have rarely improved U.S. health care or would cost too much in incremental spending increases).

[278] 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").

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

[280] Rachel Brewster, *Stepping Stone or Stumbling Block: Incrementalism and National Climate Change Legislation*, 28 YALE L. & POL'Y REV. 246 (2009); .

[281] Rachel Brewster, *Stepping Stone or Stumbling Block: Incrementalism and National Climate Change Legislation*, 28 YALE L. & POL'Y REV. 246 (2009).

[282] *Id.*

[283] *Id.*

[284] *Id.*

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. Instead, incremental reforms are undesirable if they are stumbling blocks that make achieving the ultimate goal of transformation more difficult. But incremental reforms are desirable if they are stepping stones that bring us closer to that goal.

2. *Dismantling structures*

To serve solidarity, the confrontational incrementalist approach to health reform must be anti-subordinationist.[285] Assessing whether any particular incremental reform is a stepping stone or a stumbling blocks is key to this effort. This assessment is also very hard to do and legal scholarship has barely begun to attempt to do it.

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 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.

In health reform and perhaps in other fields, differentiating stepping stones and stumbling blocks is also a legal question. Because legal fixtures impede social solidarity and propagate subordination in health care, the question whether to pursue reforms that fall short of the needed transformation depends on how those reforms interact with the fixtures of American law.

Consider, for example, the ACA's progress toward the iron-triangle era goal of "universal coverage"—affordable health insurance for 100% of Americans.[286] To those who accept that goal as an endpoint (which we do not), modest reforms are assumed to be steps toward that goal as long as they increase the sheer number of insured Americans.[287] On this common and influential view, the ACA has been a positive incremental step simply because it led to coverage for an additional 20 million Americans.[288] This approach can be misleading 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

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

[286] *See* Theodore R. Marmor & Jonathan Oberlander, *Paths to Universal Health Insurance: Progressive Lessons from the Past for the Future*, 2004 U. ILL. L. REV. 205, 215-16, 226 (2004) (describing focus of health reform efforts on expanding coverage and endorsing "pragmatic universalism").

[287] *E.g. id.* at 215-16

[288] *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).

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.

Privatization, fiscal fragmentation, federalism, and individualism are fixtures of our law that block many paths to reform, and they exert a gravitational pull that divides us even within those reforms that we achieve. In assessing any particular incremental reform, it is necessary to ask: Does this reform reinforce the fixtures and their corrosive effects on health justice and solidarity? Or, on the other hand, does this reform strike a blow against the fixtures, tending to diminish them, or perhaps transform them to advance health justice and solidarity rather than work against them? Accommodating reforms that reinforce the fixtures are likely to be stumbling blocks, whatever their immediate policy effects. Confrontational reforms that diminish the fixtures, on the other hand, are likely to be stepping stones.

3. *Applying confrontational incrementalism*

Measuring incremental reforms' degree of confrontation with the fixtures will be hard work. It will require a greater understanding than we have today of how the legal fixtures are built and, more importantly, how they may be dismantled. Such an understanding is complicated by the fact that the fixtures we have described are legally and logistically entrenched. 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.

Medicare's enactment in 1965 may be an example of a stepping stone. The law directly confronted privatization (established as a public program), individualism (automatic enrollment), fiscal fragmentation (federally-financed without segmentation), and federalism (federally administered).[289] Not surprisingly, the law is today understood as a template for universal, single payer, federally-run health care.[290] Given Medicare's success in confronting the fixtures, it is no wonder that "Medicare for All" has become the shorthand for such a system.[291]

By this same analysis, Medicare Part D, which added pharmaceutical coverage to the program, was a mixed bag. The program, spearheaded by the George W. Bush Administration, changed a purely government-run program into a partially-privatized program by relying on private insurers to administer it.[292] This private insurance model meant individual premiums, significant cost-sharing, and risk selection—importing an ethic of individualism and actuarial fairness into

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[289] *See* Timothy Stolzfus Jost, *Governing Medicare*, 51 ADMIN. L. REV. 39, 44-45 (1999) (describing Medicare program).
[290] *Id.*
[291] *See* Nicole Huberfeld, *Is Medicare for All the Answer? Assessing the Health Reform Gestalt as the ACA Turns 10*, 20 HOUS. J. OF HEALTH LAW & POLY __ (forthcoming 2020)
[292] 42 U.S.C. § 1395w-101(a); *see Fox Ins. Co. v. Berwick*, 715 F.3d 1211, 1214 (9th Cir. 2013) (describing Medicare Part D enrollment process).

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. 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 accommodated rather than confronted the fixtures that constrain reform.

As another example, under this analysis the ACA was also a mixed bag. The law's coverage gains themselves actually came through designs that, because they tried to accommodate the fixtures, reinforced them, featuring further fiscal fragmentation, individualism, and state administration. That said, the law did directly attack the individualism fixture in two ways: the individual mandate (requiring everyone to purchase insurance) and the ban on preexisting condition exclusions and community rating (requiring everyone to share in the costs of one another's illness).[293]

The ACA ultimately lost its confrontation with the individualism fixture when it came to the individual mandate.[294] But at the same time, the law won its confrontation with that fixture in its ban on preexisting condition exclusions; today that ban is at least rhetorically favored across the board. Indeed, scholars have correctly pointed to the ACA's shift of the public's view on preexisting condition as its most fundamental success.[295] 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 and may tell us when the trade-offs between fixtures progress toward health justice and solidarity or further entrench the status quo.[296] Consider the public option. If a federal public option extended eligibility to everyone, created a large and unified risk pool of previously fragmented ones, offered broad benefits and provider participation, improved affordability through aggressive rate setting, and offered additional financial supports for low-income and high-cost patients, such a public option[297] would confront all four fixtures to some extent and likely be a stepping-stone toward health justice and solidarity. If politics require accommodations to certain fixtures—to federalism by allowing states to pursue a public option before the federal government, or to privatization by using commercial carriers to administer the public option plans[298]—these accommodations should be offset by confrontations to other fixtures. For example, the policy could grant states the

[293] *See* Fuse Brown, Lawrence, McCuskey & Wiley, *supra* note 1, at 414-17.
[294] *See* Tax Cuts and Jobs Act of 2017, 131 Stat. 2054, Pub. L. 115-97 (reducing the individual mandate penalty to zero).
[295] *See* Gluck & Scott-Railton, *supra* note 59, 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.").
[296] Fuse Brown, Lawrence, McCuskey, & Wiley, *supra* note 1, at 423.
[297] This is pretty similar to the health plan President Biden proposed as a candidate. *See, e.g.*, Matthew Ygelsias, *Joe Biden's Health Care Plan, Explained*, VOX (Jul. 16, 2019), https://www.vox.com/2019/7/16/20694598/joe-biden-health-care-plan-public-option.
[298] Wiley, *Privatized Public Coverage*, *supra* note 44.

ability to combine their Medicaid population with their public option plan, equalizing payment rates and unifying the inequitable two-tiered public-private health system that pays more to providers for seeing privately insured patients than publicly insured.[299] 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.

By contrast, 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, would barely confront any of the fixtures.[300] By accommodating the fixtures, such a policy 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. 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.

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The lessons of the 2020 pandemic have made the case for turning the page on the iron triangle era and reconstructing health reform to confront each of the four fixtures in service of health justice and solidarity. Reformers should seize the moment—the public health, racial, and economic crises of the 2020 pandemic have accelerated the public's embrace of a greater government role in health care untethered to employment and our willingness to confront the structural inequalities of a fragmented, privatized, "you're on your own" system of health care. The depth of the failures of the U.S. health system in 2020 may present a rare moment of reckoning and groundswell of support to pursue a universal, single-payer health system that confronts all four fixtures head-on.

Incremental reforms may be the most realistic path to getting there, but it is critical for reformers to ensure that they do no further harm by entrenching the fixtures. Regardless of whether the U.S. reaches these goals in one leaping reform effort or tacks toward them incrementally, we provide a methodology—confrontational incrementalism—to chart the course.

CONCLUSION

2021 will be a critical inflection point. The coronavirus pandemic offers deep 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

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[299] Medicaid could still provide wraparound coverage for the population with fewer means and greater needs, including cost-sharing assistance, long term services and supports, early and periodic screening, diagnostic and treatment and disability services, and transportation.

[300] Jaime S. King, Katherine L. Gudiksen, Erin C. Fuse Brown, *Are State Public Option Health Plans Worth It?* At *72-73 draft on file with authors.

impossible to displace these fixtures wholesale. But abandoning the haphazard accommodation of the fixtures, which has 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 in 2020, we put forth an ambitious proposal—it is time to exit the iron triangle era and strive toward bolder goals of health justice and solidarity by confronting the structural fixtures that have hobbled the country's pandemic response and reinforced racial and social subordination in our health system. Armed with the diagnosis (the four fixtures) and the treatment (confrontational incrementalism), health reform reconstruction is possible.