Health Reform Reconstruction

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

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

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

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INTRODUCTION

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

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


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

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

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

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

Access to health care is “one among many social determinants of health.” Lindsay F. Wiley, Health Law as Social Justice, 24 CORNELL J.L. & PUB. POLY 47, 53 (2014) [hereinafter Social Justice]. The social determinants of health “encompass[] the full set of social conditions in which people live and work” including both the “structural determinants of health inequities” and “the more immediate determinants of individual health.” ORIELLE SOLAR & ALEC IRWIN, WORLD HEALTH ORG., A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 9 (2010), https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf [https://perma.cc/AT3W-JKSU]. The structural determinants of health inequities include “social and political mechanisms that generate, configure and maintain social hierarchies,” while the more immediate determinants of individual health include “material circumstances; psychosocial circumstances; behavioral and/or biological factors; and the health system itself.” Id. at 5-6; see UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 35 (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., 2003), https://doi.org/10.17226/12875 [https://perma.cc/TRU-YETP] [hereinafter UNEQUAL TREATMENT] (noting that universal health care is “necessary but insufficient in and of itself to address racial and ethnic disparities in healthcare”); William M. Sage & Jennifer E. Laurin, The Medicalization of Poverty: If You Would Not Criminalize Poverty, Do Not Medicalize It, 46 J.L. MED. & ETHICS 573, 573 (2018) (“Both federal and state actors under-invest in education and neglect non-medical social services while massively indulging in overpriced, often ineffective medical care—a skew that is particularly bad for the poor. . . . [L]aw helped create and now perpetuates this gross misallocation of social resources.”); see, e.g., Benfer et al., supra note 4 (tracing racial, ethnic, and socioeconomic disparities in COVID to disparities in housing, employment, and health care).
this knowledge, it is not enough to renew our commitment to pre-2020 health reform principles. The “iron triangle” — health care access, cost, and quality — that has informed a half-century of reforms lacks the ambition and scope to guide our next steps. We must reconstruct health reform, and ultimately the health system, using new principles and a new method. Incremental reforms may be unavoidable but they must be designed to be intentionally confrontational, with an eye toward their place in the broader project of upending or transcending the legal structures that undermine public health and propagate subordination and inequity.

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

7 Casting the project of overcoming and replacing the conceptions and structures that have defined and constrained health reform as a reconstruction recognizes three dimensions of the term: first, its definition, “to construct again” especially after severe damage, captures our argument that the U.S. system is even more damaged after the pandemic and requires rebuilding with a new ethos for a new age. See Reconstruct, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/reconstruct (last visited Aug. 21, 2021) [https://perma.cc/BU2Q-AX5L]. Second, its medical meaning contemplates surgical restoration of function in a body part, also after damage or to correct structural defects. See, e.g., Reconstructive Surgery, WebMD, https://www.webmd.com/a-to-z-guides/reconstructive-surgery (last visited Aug. 24, 2021) [https://perma.cc/C67M-P9KG] (describing reconstructive surgery in the clinical sense). Third, the anti-subordination valence of our argument makes normative claims about the transformative reforms necessary to address the effects of systemic racism. It thus draws normative perspective from the post-Civil War Reconstruction period and Civil Rights movement (often referred to as the Second Reconstruction), as well as the laws and critical theory that have grown out of them. Cf., e.g., Rhonda V. Magee Andrews, The Third Reconstruction: An Alternative to Race Consciousness and Colorblindness in Post-Slavery America, 54 ALA. L. REV. 483, 486 (2003) (“A fully reconstructed America must necessarily commit to redressing the myriad present-day harms that result from the legacy and contemporaneous manifestations of racialist thought and policy.”); Richard Thompson Ford, Rethinking Rights After the Second Reconstruction, 125 YALE L. J. 2942, 2949-50 (2014) (describing civil rights and anti-discrimination law as part of the Second Reconstruction); Angela P. Harris, Foreword: The Jurisprudence of Reconstruction, 82 CALIF. L. REV. 741, 765 (1994) (describing “reconstruction jurisprudence” as “committed to transforming . . . paradigms as well as critiquing them,” and embodying reference to “the legacy of slavery in the New World and the unfinished revolutions of the First and Second Reconstructions”); Jeneen Interlandi, Why Doesn’t the United States Have Universal Health Care? The Answer Has Everything to Do with Race, N.Y. TIMES (Aug. 14, 2019) https://www.nytimes.com/interactive/2019/08/14/magazine/universal-health-care-racism.html [https://perma.cc/RY8U-NSGS] (tracing the history of the U.S. health system from the post-Civil War Reconstruction era to the present day and noting that “[d]isparity is built into the system”); Vann R. Newkirk II, America’s Health Segregation Problem, ATLANTIC (May 18,
We develop the project of health reform reconstruction by drawing four vital lessons from the pandemic — a pair of normative lessons bookending a pair of constructive lessons. First, health justice must replace the long-dominant but conceptually blinkered iron triangle. Second, legally and logistically entrenched fixtures of individualism, fiscal fragmentation, federalism, and privatization constrain health reform even when it reaches toward health justice, as it has done at times during the pandemic. Third, each of these fixtures reinforces and stems from racism and other forms of social subordination. Fourth, to make meaningful progress toward health justice, even incremental reforms must confront or transcend the fixtures that have constrained reform for decades.

The first lesson we draw from the pandemic is that health reform requires new principles rooted in solidarity, equity, and justice. In Part I, we argue that 2020 should mark the end of what we call “the iron triangle era” of health reform, dating back to the 1960s, in which reforms sought to balance three points: access to, quality of, and costs of medical care. Over time, the iron triangle’s mode of pragmatic tradeoffs created a piecemeal approach to health care regulation that culminated in the Affordable Care Act.
To guide post-2020 health reform, we propose a new set of principles oriented toward realizing health justice and social solidarity in health care.\(^8\) Justice and social solidarity have long been core values of public health law, policy, practice, and ethics\(^9\) — albeit “still largely aspirational” ones.\(^10\) We aim to integrate them as core values of health care law and policy. Health justice demands that reformers address the role of health care laws and policies in reinforcing — or, alternatively, dismantling — racism, economic injustice, and other forms of social subordination. Reformers must ensure equitable distribution of the benefits and burdens of robust public investments in health care and public health, measured in terms of population-level health outcomes and community wellbeing, in addition to the intermediate indicators of health care access, quality, and cost. Decision-making processes related to health must ensure recognition, representation, and empowerment of subordinated individuals and communities. In short, health care regulation should embrace public health principles and strive for anti-subordination, equity, and community empowerment, expanding far beyond the cramped iron triangle.

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

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\(^9\) See, e.g., Lawrence O. Gostin & Madison Powers, What Does Social Justice Require for the Public’s Health? Public Health Ethics and Policy Imperatives, 25 Health Affs. 1053, 1053 (2006) (“Justice is viewed as so central to the mission of public health that it has been described as the field’s core value . . . .”).


\(^11\) Fuse Brown et al., supra note 1, at 414-17.
public health responsibilities, failed to support the medical countermeasures that are critical in a communicable disease crisis — including testing, therapeutics, and vaccination. Our inability to distribute scarce resources in ways that maximize collective benefits has undermined the effectiveness of the pandemic response, representing a functional failure of the health care system.

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

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

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

13 The concept of a fixture is thus related to the concept of “super-statutes” in its description of entrenchment, but distinct in the origins and effects of that entrenchment. See generally William N. Eskridge, Jr. & John Ferejohn, Super-Statutes, 50 DUKE L.J. 1215, 1215, 1230-37 (2001) (describing “super-statutes” as singular statutory enactments that “successfully penetrate public normative and institutional culture in a deep way”).
accommodative stance of iron-triangle reforms has become untenable for reformers who are committed to anti-racism. The existential failures during the pandemic thus demand a more confrontational approach to the fixtures in future reforms.

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

Reforms can reconcile ambition with pragmatism by identifying whether an incremental policy change serves as a stepping stone or stumbling block for confronting the fixtures that stymie health justice. Although incremental, this approach to the fixtures promotes vigilance about the accumulated effects of reforms that accommodate, rather than confront them. It provides an assessment of each incremental reform's confrontation with the fixtures based on its contribution to anti-racism, equitable distribution, and community empowerment. Ultimately, confrontational incrementalism demands more attention to the tradeoffs and accumulated accommodations that come with incrementalism, as well as to the ways that incremental accommodations to the fixtures perpetuate subordination.

Confrontational incrementalism thus offers a navigational tool for getting us closer to realizing the ambitious goals of health justice. By elucidating the concept of *fixtures* and providing a method for health reforms to confront them, we hope to provide reformers who focus on other areas — the criminal justice system, drug policy, environmental regulation, the education system, housing, and employment, to name a few — with a navigational tool for crafting and assessing anti-racist reform efforts rooted in solidarity and community empowerment.

The project of health reform reconstruction may seem overwhelming, especially because it starts with a recognition of the potency and stickiness of obstacles to health justice in the United States. We draw hope, however, in the fact that scholars and advocates are already laying the groundwork for reconstruction as we understand it. Angela Harris's & Aysha Pamukcu's recent call for the development of a civil rights of health, rooted in health justice, is a bold example of confrontational incrementalism targeted directly at individualism and its perverse
implications for both health and subordination. In prior work, each of us has proposed pragmatic reforms that, upon reflection, also show particular promise in the ways they confront the structural fixtures of individualism, fragmentation, privatization, or federalism. Some policymakers have shown nascent interest in such proposals. 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.

1. 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. Many have acknowledged that it is, more

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14 Harris & Pamukcu, supra note 4, at 765.
The stress of the COVID 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.

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. The iron triangle accepts as a fundamental starting point that these three priorities are the most important and that there are unavoidable trade-offs between them. Kissick’s iron triangle described the thrust behind

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

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

21 Id. at 2 (“[I]n what I call the iron triangle of health care . . . access, quality, and cost containment have equal angles, representing identical priorities, and an expansion of any one angle compromises one or both of the other two. All societies confront the
reforms of the prior three decades and became the prevailing frame for assessing every health reform effort in the ensuing twenty-five years, setting up the dominant narrative that U.S. efforts to expand access and quality come with inevitable and substantial cost increases. 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. 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 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. Pointing to the “unacceptable social cost” of health care that is equal tensions among access to health services, quality of health care, and cost containment. Trade-offs are inevitable . . . .”.

22 See id.

23 Id. at 38, 50, 139 (contrasting the U.S. with the U.K. or Canada, which have “demonstrated the priority of equity through universality of access,” noting that it is improbable that the U.S. would ever achieve equity of access because of the cost, and describing the medical and public health systems as fundamentally distinct).

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

25 Donald M. Berwick, Thomas W. Nolan & John Whittington, The Triple Aim: Care, Health, And Cost, 27 HEALTH AFFS. 759, 760 (2008). While the triple aim is sometimes described as a framework for “[i]mproving the U.S. health care system,” id. at 759, comprehensively reforming the U.S. system also involves “the realms of ethics and policy,” which Berwick, Nolan, and Whittington characterize as external to the triple aim, id. at 760. The triple aim is perhaps more comprehensible as a tool for improving the functioning of any one of the many discrete “health systems” that make up the U.S. health care system — integrated networks of hospitals and physician practice groups, serving patient populations defined by geographic areas, and relying on capitated payment from third-party payers. See Achieving the IHI Triple Aim: Summaries of Success, INST. FOR HEALTHCARE IMPROVEMENT, http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/ImprovementStories.aspx (last visited Aug. 25, 2021) [https://perma.cc/7ANK-HXJT] (describing the success of “sites participating in the IHI Triple Aim Initiative,” including “organizations providing health care services”). Relatedly, the triple aim’s focus on “the health of populations” is not synonymous with “public health.” See Ana V. Diez Roux, On the Distinction—or Lack of Distinction—Between Population Health and Public Health, 106 AM. J. PUB. HEALTH 619, 619 (2016) (lamenting how “[t]he recent explosion of the use of the term [population health] in
“overpriced, wasteful, useless, or harmful,” Bill Sage has argued that the triple aim allows reformers to pursue all points of the access-quality-cost triad simultaneously, rather than viewing them as inherently in conflict. Don Berwick and his fellow originators of the triple aim gestured toward “population health” and “health equity.” But they ultimately rooted the triple aim in a medicalized model (focusing exclusively on the delivery of medical care to individual patients), leaving public health and solidarity to ethicists and future policymakers.

Health law scholars have advanced competing models for how the points of the iron triangle should be balanced or how the triple aim should be achieved — by securing the professional autonomy of physicians, the rights of patients, or the competitiveness of health care markets. These models have been united by a foundational focus on the medical world . . . has unfortunately narrowed the concept” by focusing on “groups of patients, receiving care with a certain provider, covered by a certain health plan, sharing a certain health condition, or living in a certain geographic area” and emphasizing “improving the outcomes of care and reducing costs”).

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

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

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

29 See Wiley, Health Justice, supra note 8 (describing professional autonomy, patient rights, market power, and health consumerism as the four main models); see also Parmet, supra note 19, at 196-98 (tracing health law from its initial stage reflecting “the prestige and influence of the medical profession” to the “patients' rights paradigm” of the late 1960s and 1970s, to the most recent paradigm “emphasizing the role and values of the market”); Maxwell Gregg Bloche, The Invention of Health Law, 91 CALIF. L. REV. 247, 253, 256, 271 (2003) (contrasting the “economic paradigm for health care law” with “the informed consent model” and arguing for an alternative approach that “takes a pragmatic account of Americans’ conflicting expectations of medicine”); James F. Blumstein, Health Care Reform and Competing Visions of Medical Care: Antitrust and State
meeting individual health care needs and regulating individual relationships in the clinical context.\(^{30}\) Solidarity (interdependence among individuals and groups),\(^{31}\) mutual aid (reciprocity of support),\(^{32}\) communitarianism (connectedness between individuals and their communities),\(^{33}\) and equity (the absence of systematic disparities in

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

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

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

\(^{33}\) See, e.g., Dan E. Beauchamp, *Community: The Neglected Tradition of Public Health*, 15 HASTINGS CTR. REP. 28, 34 (1985) (“By ignoring the communitarian language of public health, we risk shrinking its claims… [and] undermining the sense in which
health outcomes based on social hierarchies)\textsuperscript{34} are critical to securing the public's health. But in the iron triangle era, few reformers have dreamed of incorporating a public health ethos into the financing and regulation of the U.S. health care system.\textsuperscript{35}

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

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

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

\textsuperscript{36} See Burwell, supra note 24, at 2 ("[A]ccessibility, affordability and quality . . . are the through-line of the history of the ACA . . . ."); Timothy Stoltzfus Jost & John E. McDonough, The Path to the Affordable Care Act, in THE TRILLION DOLLAR REVOLUTION, supra note 24, at 28 (noting that the ACA is "the only federal law in US history" that seeks to improve "all 3 essential components of health policy: access, quality, and costs.").
employers to provide coverage.\textsuperscript{37} Those who accept that goal as an endpoint (which we do not) assume modest reforms further that goal as long as they increase the sheer number of insured Americans.\textsuperscript{38} On this common and influential view, the ACA has been a positive incremental step simply because it led to coverage for an additional twenty million Americans.\textsuperscript{39} This approach can mislead because it makes these ostensible gains while reinforcing the divisions of multipayer coverage, amplifying some states’ cries for flexibility to erode coverage gains, and increasing the stealth subsidization of private markets with public funds. The coverage gains are not, in some important respects, “universal.” Worse, they have the potential to further entrench the fixtures that make truly transformative reforms so difficult in the first place.

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

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

\begin{footnotes}
\footnote{See Off. of Mgmt. & Budget, Exec. Off. of the President, A New Era of Responsibility: Renewing America’s Promise 27 (2009), https://www.govinfo.gov/content/pkg/BUDGET-2010-BUD/pdf/BUDGET-2010-BUD.pdf [https://perma.cc/KXS7-6N7L] (noting eight goals for health reform, including universal coverage, choice of health plans, and the option of keeping one’s employer-based health plan); Peter Orszag & Rahul Rekhi, Policy Design: Tensions and Tradeoffs, in The Trillion Dollar Revolution, supra note 24, at 53 (recalling the reform imperatives of the ACA included universality but also to “do no harm” to employer-sponsored insurance coverage); Theodore R. Marmor & Jonathan Oberlander, Paths to Universal Health Insurance: Progressive Lessons from the Past for the Future, 2004 U. Ill. L. Rev. 205, 225-26 (describing focus of health reform efforts on expanding coverage and endorsing “pragmatic universalism”).}

\footnote{E.g., Marmor & Oberlander, supra note 37, at 215-16.}


\footnote{See Jacob S. Hacker, From the ACA to Medicare for All?, in The Trillion Dollar Revolution, supra note 24, at 346 (describing the public option proposals that were part of Democratic reform plans in the 2008 election).}

\footnote{Id.}

\footnote{See Abbe R. Gluck, Mark Regan & Erica Turret, The Affordable Care Act’s Litigation Decade, 108 Geo. L.J. 1471, 1473 (2020); Thomas Rice, Lynne Y. Unruh,
nudged the U.S. health care system in the direction of solidarity and reduced racial disparities in health insurance coverage, large gaps remain. Health and life expectancy continue to be powerfully correlated with socio-economic status, race, and ethnicity.


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

B. Pandemic Failures, Functional & Existential

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

Of the numerous functional weaknesses exacerbating the public health and economic harms of the pandemic, the lack of universal coverage, the linkage between employment and coverage, and the fragmentary and inefficient financing of basic services like disease testing and vaccination have been especially glaring. A narrow focus on meeting the needs of individuals has stymied our public health response to the pandemic. Moreover, the diffusion of authority between levels of government, fragmented fiscal supports, and the many diverse providers in our largely privatized health care system have led to a U.S. failure to fairly allocate, adequately supply, or constrain prices for essential testing, therapeutics, and vaccines. Widespread public health measures may be delivered more effectively in countries with a centralized and unified public health care delivery system.\footnote{See infra Part II.B (“Our individualistic, fragmented, diffuse, private-industry health care system has failed us in the COVID pandemic.”).}

Future reform must reflect what we are learning from these functional failures.

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

Due to structural racism and economic injustice, people of color and people living in low-income households and neighborhoods are more likely to be exposed to infection through their working and living conditions. They are less likely to have ready access to testing, less accessible health care, and less ability to work remotely. As a result, they are more likely to contract COVID and have more severe outcomes if they do get infected. This is particularly true for Black and Brown communities, who have higher rates of underlying health conditions such as diabetes, hypertension, and obesity, which increase the likelihood of severe illness and death from COVID. In addition, they have less access to personal protective equipment, hand sanitizers, face masks, and other means of protection.

46 See infra Part III (discussing the four fixtures “broader existential failure illuminated by the pandemic”).


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

49 Benfer et al., supra note 4, at 133-34, 148, 154, 163-164.
likely to have the financial resources and employment protections required to stay home when they test positive, and less likely to be able to safely isolate from others within their homes.\(^{50}\) Black, Indigenous, and Latino and Latina patients are more likely to become severely ill or die from COVID.\(^{51}\) Due to environmental factors, access to health care, and social subordination, people who are racialized or ethnicized as part of a minority group are more likely to have underlying chronic conditions that COVID preys upon.\(^{52}\) They may be more likely to be treated in hospitals with fewer resources and lower quality of care.\(^{53}\) They are more likely to experience institutional and interpersonal discrimination in health care delivery.\(^{54}\) Moreover, Black, Indigenous, Latino and Latina communities and low-income communities across the country are disproportionately harmed by the economic impacts of the pandemic, including job loss and eviction.\(^{55}\)

\(^{50}\) Id.; Wiley & Bagenstos, supra note 10, at 1263.

\(^{51}\) See Gross et al., supra note 48, at 3097.


\(^{55}\) See GREGORY ACS & MICHAEL KARPMAN, URB. INST., EMPLOYMENT, INCOME, AND UNEMPLOYMENT INSURANCE DURING THE COVID-19 PANDEMIC 3-7 (June 2020),
The pandemic has amplified the scale and visibility of this tragic failure. U.S. health care’s racial injustice is a failure on an existential scale, with effects that ripple throughout all aspects of American life. Future reforms must confront this existential failure with a bolder ethos that expands far beyond the iron triangle of quality, cost, and access – to eradicate subordination and its health effects.

C. Health Reform Reconstruction: The Health Justice Era

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

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

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

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

Second, equitable distribution: health laws and policies must ensure just distribution of the burdens and benefits of public investments in health care and public health. Access to health care, its quality, and its
affordability are important metrics for assessing distributive justice, but they are not the only important metrics. Health care is not the only resource that determines health outcomes.\(^{62}\) Individual access to health care may or may not correlate with improvements in financial security, community wellbeing, and population-level health outcomes.\(^{63}\) Distributive justice must also be responsive to the ways in which individuals are interconnected within groups — from families and households, to racial and ethnic groups, to schools, workplaces, and neighborhoods.

Third, community empowerment: Decision-making processes related to health must ensure recognition, representation, and empowerment as means for collective self-determination, particularly for subordinated groups.\(^{64}\) Realizing health justice requires a “probing inquiry into the effects of social and cultural bias on the design and implementation of measures to reduce health disparities.”\(^{65}\) Emily Benfer and other health justice scholars have argued, “[t]hese efforts cannot be led by the least advantaged, and to ensure that the burdens and benefits of interventions are distributed equitably.”; Lindsay F. Wiley, Privatized Public Health Insurance and the Goals of Progressive Health Reform, 54 UC DAVIS L. REV. 2149, 2192-203 (2021) [hereinafter Privatized Public Health Insurance] (assessing progressive health reform proposals in terms of fair distribution of health benefits and financial burdens). Of course, egalitarian distributive justice is not the only understanding of what justice requires with regard to health. See, e.g., Paul T. Menzel, Justice and Fairness: Mandating Universal Participation, 2009 HASTINGS CTR. 4, 4 (contrasting the egalitarian sense of justice that “pushes toward universal [health care] access and its equitable financing” with “libertarian views of justice, [which] contend that those who have no contractual or special relationship with the unlucky victim of disease—and have not themselves exacerbated her plight—have no obligation to assist her”); Stone, supra note 8 (contrasting mutual aid and actuarial fairness as competing visions of what fairness requires in health care financing).

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


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

\(^{65}\) Wiley, Social Justice, supra note 6, at 53.
communities who have benefited from the very forms of subordination that must be dismantled if health justice is to be achieved. Empowerment of affected communities in decision-making processes helps ensure that the design and implementation of interventions intended to benefit them are actually tailored to their needs.\textsuperscript{66}

The points of the iron triangle will certainly remain relevant in the post-2020 era, but they should be encompassed within a more expansive conceptual framework that centers equity, solidarity, and public health, rather than marginalizing them. In the post-pandemic era, “the goals of public health (what we as a society do collectively to ensure the conditions for people to be healthy) and health care reform (efforts to improve systems for health care financing and delivery) should be more fully integrated within a communitarian ethic.”\textsuperscript{67} “Rather than merely adopting social justice as the ‘core value’ of public health as . . . others have done,” we argue that social justice should be embraced as “a core value of health law and policy \textit{writ large}.”\textsuperscript{68}

Using new criteria rooted in health justice, we can evaluate both the functional failures of the pandemic response and the broader existential failure to secure racial justice in health.

II. LESSON 2: FOUR FIXTURES CONTRIBUTE TO FUNCTIONAL FAILURES

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

A. Fixtures

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

\begin{itemize}
  \item \textsuperscript{66} Benfer et al., \textit{supra} note 4, at 139.
  \item \textsuperscript{67} Wiley, \textit{Privatized Public Health Insurance}, \textit{supra} note 61, at 2160 n.40.
  \item \textsuperscript{68} Wiley, \textit{Social Justice}, \textit{supra} note 6, at 52 (emphasis added); \textit{see also} Wiley, \textit{Health Justice}, \textit{supra} note 8, at 881.
  \item \textsuperscript{69} Fuse Brown et al., \textit{supra} note 1, at 411.
\end{itemize}
them difficult to displace.”

Recent scholarship has highlighted problems wrought by the forces of individualism, fiscal fragmentation, federalism, and privatization in American health care. This literature has largely treated these concepts singly and as if they were ordinary policy choices that might simply be accepted or rejected by policymakers. 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. Their entrenchment means that fixtures operate not as mere policy options, but instead as forces that must be accommodated or confronted.

Our concept of fixtures begins with their legal entrenchment. Similar to “super-statutes,” the fixtures “exhibit . . . normative gravity” and “bend and reshape the surrounding landscape.” Unlike super-statutes, fixtures are not embodied in one statute — or even one field of law. Instead, the fixtures we describe are embodied in a constellation of legal and regulatory provisions. This makes the fixtures more diffuse in their entrenchment than super-statutes, and thus harder to overcome.

Consider the Affordable Care Act (“ACA”), a plausible super-statute.


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

72 See id.

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

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

75 See id.

76 The ACA’s status as super-statute is debatable and debated. E.g., Eric C. Fuse Brown, Developing a Durable Right to Health Care, 14 MINN. J.L. SCI. & TECH. 439, 443-44 (2013) (arguing that while “[t]he ACA has the pedigree of a superstatute” in its ambition and breadth, the fragility of its right to health care places it in the category of “quasi-superstatutes” whose entrenchment remains in doubt); Abbe R. Gluck & Thomas Scott-Railton, Affordable Care Act Entrenchment, 108 GEO. L.J. 495, 516-17 (2020) (arguing that the “ACA’s staying power has . . . come from more diffuse and
The ACA was a single enactment that touched hundreds of existing laws, spawned innumerable regulations, and significantly altered the landscape of health insurance regulation.\(^7\) Its legal entrenchment in a single statute means that it can, in theory, be repealed in a single piece of legislation or struck down by Supreme Court in a single decision.\(^7\) By contrast, the fixture of federalism, for example, is legally entrenched through the Constitution, countless federal and state statutes, and two centuries of jurisprudence on comity and deference to state authority.\(^7\)

Beyond their legal manifestations, fixtures exhibit a form of entrenchment not previously explored in legal scholarship: logistical entrenchment. Institutions are built around the fixtures, as are workforces and bodies of expertise. These logistical considerations make it difficult to implement any reform that confronts the fixtures. For example, the administrative apparatus for our health care system is heavily dependent on private insurers and private health care providers, which means it would be practically difficult for a single-payer reform to switch entirely to government administration and rate setting.\(^7\)

Reliance on existing private structures would almost be compelled as a logistical matter, owing to the privatization fixture’s logistical entrenchment. Moreover, the fixtures reinforce and further entrench each other, as seen in the deeply individualistic orientation of medical ethics, which entwines with private-law regulation of relationships.

\(^7\) See generally Gluck et al., supra note 42, at 1473 (“The ACA is the most significant healthcare legislation in recent American history . . . .”); Gluck & Scott-Railton, supra note 76, at 498 (“The ACA has not only endured, but it has changed the way many Americans and the political arena think about healthcare and the entitlement to it.”); Miriam Reisman, The Affordable Care Act, Five Years Later: Policies, Progress, and Politics, 40 PHARMACY & THERAPEUTICS 573, 573 (2015) (“The ACA . . . is one of the most complex and comprehensive reforms of the American health system ever enacted.”).


\(^7\) See infra Parts II.B.3, III.C.

\(^8\) E.g., Wiley, Privatized Public Health Insurance, supra note 61, at 2162.
among private providers and insurers. Fiscal fragmentation (with multiple, segregated sources of unequal payments to physicians and hospitals depending on the patient’s source of coverage) and federalism (with health care providers regulated largely at the state level) further entrench the individualistic, privatized nature of health care financing and delivery in the United States.

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

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

B. Fixtures’ Functional Failures

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


83 See infra Part IV.
that maximizes collective benefits has undermined the effectiveness of the pandemic response.

1. Individualism

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

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

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

\textsuperscript{85} See The Essential Communitarian Reader, at xi (Amitai Etzioni ed., 1998) (describing “new” or “responsive communitarianism” in terms of “balance between individual rights and social responsibilities, between autonomy and the common good”).


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

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

\textsuperscript{89} See e.g., Larry A. DiMatteo, The History of Natural Law Theory: Transforming Embedded Influences into a Fuller Understanding of Modern Contract Law, 60 U. PITT. L. REV. 839, 884 (1999) (“The norms of justice and fairness are seen as competitors to the formalistic use of contract rules to promote certainty in contractual transactions. The latter is individualistic in its perspective and incorporates notions of freedom, security, and efficiency. The former is communitarian centered in its focus.”); Wiley, Health
logistically entrenched in the individualistic professional ethics of medicine and our political and legal system’s emphasis on personal responsibility for misfortune. Iron-triangle reforms have been remarkably accommodating of individualism. So much so that “choice” is often treated as a fourth pillar of health law. Moreover, the iron triangle’s emphasis on meeting individual needs for health care embraces a fundamentally individualistic orientation toward solving social problems.

Many commentators have pointed to the focus of American cultural norms on the interests and rights of individuals as the key to explaining our failed pandemic response. Some have specifically noted the individualistic focus of American law on personal responsibility as an impediment. 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.

Lawsuits challenging coronavirus emergency orders on the grounds that they violate individual rights have been largely unsuccessful, except for claims that orders discriminate based on religion. See Wiley, Social Distancing, supra note 3, at 85-94. Outside of the courts, opposition to and defiance of public health emergency orders and guidelines have undermined the effectiveness of community mitigation measures in the United States and in several other countries. The relationship between cultural norms and compliance with social distancing is as yet unclear. See, e.g., Toan Luu Duc
health care system in ways that have stymied the effectiveness of medical countermeasures for pandemic response. Diagnostic tests, therapeutic treatments, and vaccinations are the foundations of a modern public health response. Our strong orientation toward viewing these tools through a clinical lens that centers individual patients and the providers who care for them has undermined our ability to deploy them as public health interventions.

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


96 Parinaz Tabari, Mitra Amini, Mohsen Moghadami & Mahsa Moosavi, International Public Health Responses to COVID-19 Outbreak: A Rapid Review, 45 IRAN J. MED. SCI. 157, 159-60 (2020); see Thomas Hale, Noam Angrist, Beatriz Kira, Anna
In contrast, in the U.S., coronavirus testing has been driven by a focus on the clinical significance of results for individuals.\textsuperscript{97} Testing was slow to ramp up, supplies were scarce,\textsuperscript{98} and early criteria for allocation of scarce resources focused almost exclusively on patient care.\textsuperscript{99} The emphasis was on testing to inform clinical decisions about the care of individual patients. In halting an early disease surveillance program in the Seattle area, the FDA disregarded the importance of monitoring trends at the population level — a purpose for which lower accuracy would be acceptable if carefully communicated to test subjects.\textsuperscript{100} Lack of access to testing and the failure of the Centers for Disease Control and Prevention ("CDC") to implement a rational disease surveillance system has left people unsure about whether they pose a risk of transmitting the virus to others and state and local leaders ill-equipped to deploy targeted disease control strategies.

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

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


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

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


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


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


to accept vaccination if offered by their regular health care provider, who could answer their questions and discuss risks and benefits.\(^{112}\)

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

2. Fiscal Fragmentation

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


\(^{113}\) Harris & Pamukcu, supra note 4, at 792.

\(^{114}\) Wiley, Health Justice, supra note 8, at 855 (emphasis omitted).

\(^{115}\) Fuse Brown et al., supra note 1, at 413. The law’s focus on individualism does not mean that persons are seen in their fullness and inter-connectedness. Instead, persons are fragmented into categories — employee, mother, child, consumer — and regulated one piece at a time. See Ani B. Satz, Overcoming Fragmentation in Disability and Health Law, 60 EMORY L.J. 277, 281 (2010) (suggesting “that an individual must be viewed holistically, across the full range of environments in which she functions”).


\(^{117}\) See Fuse Brown et al., supra note 1, at 415.

\(^{118}\) See Stone, supra note 8, at 290 (“Actuarial fairness . . . is a method of organizing mutual aid by fragmenting communities into ever-smaller, more homogeneous groups . . . that leads ultimately to the destruction of mutual aid. This fragmentation must be
fragmentation manifests most noticeably in our splintered multi-payer system of federal (e.g., Medicare) and state (e.g., Medicaid) public programs, and employer-based group and individual insurance plans. The result is a bewildering assortment of fiscal categories, overseen by different entities, each incentivized to reduce its own costs, but not others'.

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

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

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


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

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

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

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

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

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

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


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

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

\textsuperscript{131} Id. at 939, 952.

\textsuperscript{132} Id. at 956-57.

\textsuperscript{133} Dep’t of Health & Hum. Servs., Findings Concerning Section 1812(f) of the Social Security Act in Response to the Effects of the 2019- Novel Coronavirus (COVID-19) Outbreak 1-2 (2020).

\textsuperscript{134} Id.
minute waiver or fearful it would be applied strictly, a fear that was bolstered by early-summer guidance describing the waiver in limited terms.\textsuperscript{135} Thus, Medicare enrollees and their families continued to struggle to access care.\textsuperscript{136}

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

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\textsuperscript{135} See Adam S. Zimmerman, Medicare’s Broken Promise to People in Nursing Homes, \textit{The Hill} (June 27, 2020), https://thehill.com/opinion/healthcare/504830-medicare’s-broken-promise-to-people-in-nursing-homes [https://perma.cc/2A7Y-XJJ7].

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


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


not due to a lack of availability, but due to the cost and administrative complexity,\footnote{NATHANIEL L. WADE & MARA G. ASPINALL, ASU COLLEGE OF HEALTH SOLS., FACING UNCERTAINTY: THE CHALLENGES OF COVID-19 IN THE WORKPLACE 6-7 (2020), https://issuu.com/asuhealthsolutions/docs/asu_workplace_commons_nov2020?fr=sYjhjZjE5NTg1NjM [https://perma.cc/5968-X99F] (noting in survey of more than 1100 employers, vast majority declined to test asymptomatic employees; cost was cited as number one impediment and complexity as number two); Elissa Nadworny, Many Colleges Aren’t Aggressively Testing Students for Coronavirus, NPR, at 1:01 (Oct. 6, 2020, 5:04 AM ET), https://www.npr.org/2020/10/06/920642789/many-colleges-arent-aggressively-testing-students-for-coronavirus [https://perma.cc/3PUD-JGF3] (noting in survey of more than 1400 colleges with in-person classes, vast majority declined to test asymptomatic students; lack of CDC recommendation and cost were top two reasons).} and individuals found themselves unexpectedly being billed for coronavirus tests,\footnote{Donna Rosato, How ‘Free’ Coronavirus Testing Has Become the New Surprise Medical Bill, CONSUMER REP’S. (July 27, 2020), https://www.consumerreports.org/coronavirus/how-free-coronavirus-testing-has-become-new-surprise-medical-bill/ [https://perma.cc/5V3P-7RU2].} or delayed or refused tests for fear of that result.\footnote{See Brendan Keefe, Where to Get Free COVID-19 Test if You Have No Symptoms, 11ALIVE (May 20, 2020, 10:55 PM EDT) https://www.11alive.com/article/news/health/coronavirus/georgia-testing-lack-of-free-accessibility/83-cc70d88b-17a8-4819-9a5b-792710212caf [https://perma.cc/5FKD-27SZ] (reporting examples of patients told they would be billed for tests despite coverage requirements and encouraging readers afraid of cost to seek tests from particular sites).}

After approval of the first vaccines, frustrating and deadly delays in their distribution evidenced fiscal fragmentation’s logistical entrenchment. The federal government had an acute fiscal interest in promptly vaccinating residents in long-term care facilities (“LTCF”), including skilled nursing facilities, assisted living facilities, and residential care homes. When COVID outbreaks hit nursing homes, the resulting hospital treatment expenses are borne primarily by Medicare (which covers hospital care costs without regard to whether a person was previously in a nursing home).\footnote{42 U.S.C. § 1395(d)(a) (2018) (describing Medicare coverage of inpatient hospital costs).} Unsurprisingly, then, the federal government aspired to provide and pay for vaccination for all LTCF residents and staff.

Fragmentation’s logistical entrenchment proved an impediment to this public health intervention, however. While the federal government found itself with the will to finance a public health intervention, it failed to create a way — an apparatus to administer vaccinations to skilled nursing facility residents and workers as rapidly as possible.\footnote{Noam N. Levey, Vaccine Rollout Relies Heavily on CVS and Walgreens, DAILY HAMPSHIRE GAZETTE (Dec. 5, 2020, 1:25 PM), https://www.gazettenet.com/COVID-19-}
months of failed legislative efforts to fund vaccine distribution by state and local health departments.\textsuperscript{146} Operation Warp Speed (the joint HHS and Department of Defense effort to develop and deploy COVID vaccines) could not simply stand up a public health apparatus overnight. In the absence of publicly financed infrastructure, Operation Warp Speed contracted with private companies to provide immunizations: CVS, Walgreens, and a handful of smaller pharmacy chains.\textsuperscript{147} Under the Pharmacy Partnership for Long-Term Care Program, Operation Warp Speed shipped millions of doses to pharmacies in mid-December 2020 and instructed them to bill Medicare, Medicaid, or private insurance for each vaccine administered to an LTCF resident or worker.\textsuperscript{148}

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


\textsuperscript{148} Press Release, U.S. Dep’t of Health and Hum. Servs., supra note 147.


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

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

3. Federalism

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

\footnotetext[151]{Bluth & Weber, \textit{supra} note 149.}
\footnotetext[153]{See generally Heather K. Gerken, \textit{Foreword: Federalism All the Way Down}, 124 HARV. L. REV. 4, 11-12 (2010) [hereinafter \textit{All the Way Down}] (presenting the conventional account of sovereignty in federalism).}
but somewhat limited in scope, state law as subordinate to conflicting federal law but otherwise plenary in scope, and local law as subordinate to both federal and state laws and dependent on state authorization for its scope.\footnote{155}

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

Health care federalism has an inconsistent and often ineffective legacy: federal authority dominates the field of regulating medical products, establishing nationwide standards for safety and efficacy and serving as a singular clearinghouse for scientific knowledge on diseases and their diagnosis, treatment, mitigation, and cures.\footnote{159} States, however,
retain primary authority over regulating medical facilities and practitioners who prescribe and administer these products.\footnote{Zettler, supra note 159, at 885 (acknowledging and questioning the “[c]onventional wisdom in health law and policy . . . that states regulate the practice of medicine, while the federal government—specifically the FDA — regulates drugs”).} When it comes to the practical dimensions of accessing health care, federalism has stymied normatively desirable health care financing and payment reforms and perpetuated interstate inequities.\footnote{See, e.g., Huberfeld, Federalism in Health Care Reform, supra note 158, at 197-98 (“States generally cannot and do not act alone” in health reform); Fuse Brown & McCuskey, supra note 15, at 443-47 (describing the “pitfalls” of federalism in health care as enabling states to undermine federal protections, while preempting states from enacting further protections); Abbe R. Gluck & Nicole Huberfeld, What Is Federalism in Healthcare For?, 70 STAN. L. REV. 1689, 1698 (2018) (“[H]ealth policy that allows for interstate variation might be a benefit of federalism, but it also leads to significant inequality when it comes to healthcare access across the country.”); Scott L. Greer & Peter D. Jacobson, Health Care Reform and Federalism, 35 J. HEALTH POL’Y & L. 203, 206 (2010) (recognizing “that the distressing litany of historical failure at both the state and federal levels provides no guidance in answering the question of federalism in health care reform”); Jerry L. Mashaw & Theodore R. Marmor, The Case for Federalism and Health Care Reform, 28 CONN. L. REV. 115, 116-17 (1995) (outlining the potential for state reform to produce “workable and acceptable” changes that respond to local preferences, but also the “serious and plausible objections to leaving much of health planning to the states”); McCuskey, supra note 159, at 97-100 (tracing the growing ratio of federal-to-state health laws); Richard P. Nathan, Federalism and Health Policy, 24 HEALTH AFFS. 1458, 1461 (2005) (explaining that “richer states have richer [Medicaid] programs; hence, the federalism state-push factor for Medicaid is primarily from liberal states”); Wendy E. Parmet, Regulation and Federalism: Legal Impediments to State Health Care Reform, 19 AM. J.L. & MED. 121, 130 (1993) (identifying “a variety of federal statutes, all of which raise potential impediments to would-be state reformers”).} The ACA’s design accommodated states by offering them Spending Clause enticements for Medicaid expansion and operating insurance exchanges, and relying on them to implement federal policy priorities and standards.\footnote{See, e.g., Fahey, supra note 136, at 2362 (highlighting the Supreme Court’s anti-coercion holding in NFIB v. Sebelius as part of a broader phenomenon of intergovernmental agreements); Abbe R. Gluck, Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond, 121 YALE L.J. 534, 582-90 (2011) (cataloging the many different versions of federalism in the ACA, and explaining that the statute “requires elaborate infrastructures to be created and implemented at the state and local levels”); see also Nicholas Bagley, Federalism and the End of Obamacare, 127 YALE L.J.F. 1, 15 (2017); Fuse Brown et al., supra note 1, at 414-15; Gluck et al., supra note 42, at 1473.} States responded in polarized and polarizing ways, with conservative-led states refusing to cooperate and attempting to use federal waivers to fund “experiments” that undermine the core protections in those
federal programs. As Abbe Gluck and Nicole Huberfeld have observed, “the ACA’s federalism served state power,” but did not necessarily “produce[] better health policy outcomes.” As a final federalism trap, ERISA preempts states and localities from enforcing their own protective laws against most employer-sponsored health insurance plans. Federalism’s dysfunction cuts in multiple directions simultaneously, but mostly against solidarity-enhancing policies.

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


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


First, on the aspects of pandemic response that demand economies of scale and interstate coordination, the federal government abdicated its role. 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. 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.” Yet FDA initially flexed its regulatory power to prevent the dissemination of local lab-developed testing protocols from the University of Washington. HHS later rescinded FDA’s authority to clear lab-developed tests before use, but not until after missteps federalism “stymied the U.S. coronavirus response” on public health mitigation measures, and offering recommendations for how a deft division of federal and state powers should work.

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

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

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


and contamination had frustrated the rollout of CDC-developed federal test kits.\textsuperscript{175}

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

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

\begin{footnotesize}
\begin{enumerate}
\item See Terry, \textit{supra} note 169, at 5 (“[T]he federal government has eschewed its leadership role . . . seem[ing] to favor a Darwinian competition among states for scarce resources, or worse, [] blocking state access to some supplies.”), Wiley, \textit{Federalism, supra} note 95, at 66.
\item Gawande, \textit{supra} note 173.
\item The first vaccine to receive emergency use authorization was developed by Pfizer outside of the federally-funded Operation Warp Speed program, but federal authorities provided critical supply-chain support for raw materials to speed up the manufacturing of Pfizer doses.
\item See Wiley, \textit{Federalism, supra} note 95, at 66; see also Isaac Stanley-Becker, \textit{Shots Are Slow to Reach Arms as Trump Administration Leaves Final Steps of Mass Vaccination to Beleaguered States}, \textit{WASH. POST} (Dec. 30, 2020, 9:30 AM EST), https://www.washingtonpost.com/health/2020/12/30/covid-vaccine-delay/ [https://perma.cc/ALV7-S7HR].
\end{enumerate}
\end{footnotesize}
months of the vaccine roll-out were predictably disastrous, federal officials blamed state leaders, essentially arguing that their work was done the moment doses were shipped. Eligibility criteria varied widely from state to state, though the Biden administration occasionally stepped in to direct state and local officials to expand eligibility to include educators and eventually all adults. The lack of a nationally coordinated vaccination strategy mirrored the lack of a nationally coordinated strategy for non-pharmaceutical interventions, including school closures, restrictions on businesses and travel, and mask mandates. “This is the dark side of federalism: it encourages a patchwork response to epidemics” which are inherently borderless in character.

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


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


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


186 See Terry, supra note 169, at 7-9; Huberfeld et al., supra note 71, at 956 (“As a countercyclical program, enrollment in Medicaid increases when the economy declines . . . .”).
some could still afford COBRA or subsidized insurance on the ACA exchanges, the majority were left to rely on Medicaid. But twelve states have refused to expand Medicaid eligibility to all low-income, childless, non-disabled adults. Thus, even when the federal Families First Coronavirus Response Act added COVID testing without a copay to Medicaid coverage, individuals and communities in non-expansion states could not benefit from this enhanced safety net for access to testing. Thanks to federalism, a person’s ability to afford a COVID test could depend on whether she lives in North Dakota (which expanded Medicaid) or South Dakota (which did not), despite the enhancement of federal funding.

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

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

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187 Which also have significant state-by-state variations.
191 See Status of State Medicaid Expansion Decisions, supra note 189.
192 Huberfeld et al., supra note 71, at 952.
health care. Federal financing and support flowing to states for implementation should not empower resistant states to engage in a race-to-the-bottom, eroding public health measures. Federal authorities should stop shirking in the name of state deference and start assisting states in a race-to-the-top of evidence-based policy and social supports.

4. Privatization

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

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

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193 See Fuse Brown et al., supra note 1, at 416.
became uninsured. 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. The U.S.’s reliance on job-based insurance and lack of universal health care made it more vulnerable to the pandemic and weakened the country’s response compared to other countries. The CARES Act created a Provider Relief Fund that allocated $175 billion to providers to compensate them for providing COVID testing, treatment, and vaccination to uninsured patients. Yet the funding is not a benefit that uninsured patients can access directly and does not bar providers from charging patients for their COVID care; rather, coverage depends on their provider


198 See Terry, supra note 169, at 3.


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

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

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

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

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


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

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

Our privatized and fragmented health care system does a terrible job of constraining prices for health care services and leads to wild and inexplicable price discrimination. 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. In the case of coronavirus, this means the prices of testing and vaccines were left to the wildly unpredictable and undisciplined private market. The price of a COVID test varied forty-fold, from $20 to $850 at hospitals, and into the thousands of dollars at private labs. The CARES Act required insurers to pay for COVID tests but didn’t limit the amount providers can charge for the tests.


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


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

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

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

\textsuperscript{216} Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-
136, § 3202, 134 Stat. 281 (2020) (to be codified at 42 U.S.C. § 256b); Loren Adler,
How the Cares Act Affects Covid-19 Test Pricing, BROOKINGS (Apr. 9, 2020),
https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/04/09/

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

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

\textsuperscript{219} FDA authorized remdesivir, an investigational drug not approved for any
indication, under an emergency use authorization (“EUA”) for use in hospitalized
patients with severe COVID-19 on May 1, 2020. Letter from RADM Denise M. Hinton,
Chief Scientist, FDA, to Ashley Rhoades, Manager of Regul. Affs., Gilead Sciences, Inc.
(Oct. 22, 2020) https://www.fda.gov/media/137564/download [https://perma.cc/CV38-
DJ6X].

\textsuperscript{220} Sydney Lupkin, Remdesivir Distribution Causes Confusion, Leaves Some Hospitals
health-shots/2020/05/14/85566819/remdesivir-distribution-causes-confusion-leaves-
some-hospitals-empty-handed [https://perma.cc/QY8X-QAP6].
Our reliance on private health insurance in the U.S. stymied our pandemic response in critical ways. The economic unemployment crisis left millions uninsured in the height of a public health crisis; those who kept their coverage still faced risks of unexpected costs for testing and treatment; our reliance on private markets meant the prices of these services were uncontrolled and wildly variable; and the system failed to provide for public decision-making about the fair allocation and efficient distribution of scarce resources in the pandemic.\textsuperscript{226} The pandemic revealed in stark terms that our privatized health care system suffers from a profound cost and affordability crisis while it lacks incentives and the coordination needed to provide for public goods. The fear of the cost of services creates barriers to widespread testing and vaccination, which foment disease spread; burdens government, private payers, and individuals; and crowds out resources for other social goods needed to address the pandemic’s economic and societal dislocation — such as housing, education, food, or income maintenance. Our private health care system is bad for public health and well-being.

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

\section*{III. Lesson 3: Racism and Subordination Are Foundational to the Four Fixtures}

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

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

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

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

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

A. Individualism

The “you’re on your own” ethos of individualism has provided a superficially neutral ideological mask for racist cultural norms and ideological notions of deservingness and blame throughout American history. “American individualism, a philosophy deeply imbedded in the American psyche, prevents whites from seeing themselves as a privileged racialized group.”\textsuperscript{230} To resist structural change, white people in power may claim that the goal of racial justice is for everyone to be treated as individuals. “When white people insist on Individualism in discussions about racism, they are in essence saying, . . . ‘It is talking about race as if it mattered that divides us . . . . Generalizing discounts across the life course, in Racism: Science & Tools for the Public Health Professional 1, 209 (2019). [https://perma.cc/3HTW-2JP4]; see also Yearby, supra note 44, at 518.

\textsuperscript{228} See Yearby, supra note 44, at 524.


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

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.” 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?’”

Mary Bassett and Jasmine Graves have argued that individualistic explanations for public health problems are a “litmus test” for anti-racism. Their focus is on the particularities of anti-Black racism in the United States, but their insights may be applicable to racism and other forms of subordination more broadly: “Any framework that identifies the problem as people should be challenged. Communities are vulnerable because of bad policies and disinvestment, not because of the people who live in them.”

In the ethos of individualism, health disparities ranging from heart disease, diabetes, and cancer to sexually transmitted infections, and now COVID, are attributed to “lack of knowledge and flawed decision-making . . . . This ‘lifestyle hypothesis’ assigns responsibility to individuals without reference to the context of their lives. In addition to dismissing racial patterning of power and opportunity, it ignores the toll of daily and lifelong experiences of discrimination. [Like the hypothesis that Black-white disparities in health are genetically based], it is a racist idea.”

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

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

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


234 Id.

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

236 Bassett & Graves, supra note 233, at 457.
ties.” 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.” 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.” Individualism and notions of personal responsibility give privileged people a free pass to ignore their role in subordinating others and to disregard the needs of subordinated people and the inequitable burdens they bear. Individualism erodes the social solidarity that underpins mutual aid and community empowerment.

Notions of individualism and deservingness have reared their heads again and again in the design and implementation of the ACA. Expansion of Medicaid eligibility beyond the “deserving poor” triggered rhetoric reminiscent of Reagan’s dog whistles about social welfare programs. 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.” 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. Challengers asked what individuals can be required by the majority to do for the benefit of the community and what states can be required by the national community to do for those residing within their borders.

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

237 Stone, supra note 8, at 289 (emphasis added).
238 Id. at 287 (quoting an advertising campaign in the late 1980s).
241 Id. at 679.
personal responsibility while failing to protect and support people who are required to report for duty in high-exposure workplaces, those who live in crowded, multi-generation homes, and those who are exposed in institutions like jails, prisons, and detention centers.244 Infectious disease pandemics are fueled by the connection of people to one another in society. The same human interconnectedness demands prevention and response measures grounded in mutual aid . . . Public health emergency prevention and response measures are meant to benefit society as a whole. The burdens should also be shared.”245

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

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

245 Id. at 1236-37.

246 Harris & Pamukcu, supra note 4, at 762.

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

248 Wiley, Health Justice, supra note 8, at 855.

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

At the most basic level, fiscal fragmentation is a product of two complexes of laws that divide up control over resources within the United States: property laws and fiscal (spending and tax) laws. Both bodies of law have been used as tools of structural racism and subordination. Property laws assign control and ownership of existing and newly generated resources of all types, including land, capital, ideas, and labor. 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 higher reimbursement rates paid to providers for services rendered to patients covered by Medicare (including for COVID testing and vaccination) incentivize more outreach to those patients than to Medicaid beneficiaries, whose coverage is more precariously financed and whose providers receive substantially less generous reimbursement rates.

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

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

253 Id.

254 See Sidney D. Watson, Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity, 55 HOW. L.J. 855, 868 (2012) (“Physicians tend to avoid Medicaid patients primarily, but not exclusively, because reimbursement rates are often lower than for privately insured and Medicare patients.”).
were able to pass less on to them — at first because they were prohibited from owning property, even their own labor, and then because of systematic discrimination in access to education, jobs, equal pay, housing, and health care.

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

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

\textbf{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

\textsuperscript{255} \textsc{Daniel E. Dawes}, \textit{The Political Determinants of Health} 143 (2020).

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

\textsuperscript{257} \textit{See id.} at 23.

\textsuperscript{258} \textit{See id.}
subordination. 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. “People of color have long been disproportionately disadvantaged by federalism,” and the “core problems of racial inequality” still find their “core . . . in questions of federalism.”

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. Historically, when federal reforms have extended the reach of public programs, legal and political concessions to former Confederate states in the South have allowed for the continued exclusion or subordination of Black and Brown people from the health care system. For example, in the 1945 Hill-Burton Act, representatives from Southern states

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

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

261 Michener, supra note 260, at 550.


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

264 Interlandi, supra note 7.
demanded local control of hospital construction funds, which allowed many hospitals in rural and Southern areas to be segregated.265

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

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

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

265 Id.
267 See generally Edward H. Stiglitz, Forces of Federalism, Safety Nets, and Waivers, 18 THEORETICAL INQUIRIES LAW 125, 129 (2017) (arguing that “waivers represent a form of managed devolution, and that forces that operate at the level of state implementation generally, even if not uniformly, move toward retrenchment”).
268 See id.
269 Grigsby et al., supra note 171, at 658.
270 Michener, supra note 260, at 549-51. All but four of the twelve remaining states that have refused the Medicaid expansion were part of the Confederate States of America during the Civil War. Interlandi, supra note 7 (“Several states, most of them in the former Confederacy, refused to participate in Medicaid expansion.”).
271 See Briffault, supra note 154, at 1998-2000 (explaining that preemption denies “legal space for local self-determination concerning problems that arise at the local level”).
collective self-determination” that further health justice.272 Local governments are not insulated from racism, but to the extent that local governments take discriminatory actions, federal and state preemption helpfully invalidates them.273 On the other hand, when localities want to adopt anti-racist or other protective policies, state governments may preempt them from doing so, which exposes the subordinating influence of state sovereignty.274 This is particularly true because local governments often are “the very sites where racial minorities are empowered to rule.”275

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

272 Harris & Pamukcu, supra note 4, at 827.
273 Derek Carr, Sabrina Adler, Benjamin D. Winig & Jennifer Karas Montez, Equity First: Conceptualizing a Normative Framework to Assess the Role of Preemption in Public Health, 98 MILLBANK Q. 131, 127 (2020); e.g., Briffault, supra note 154, at 2021-22.
274 Kim Haddow, Derek Carr, Benjamin D. Winig & Sabrina Adler, Preemption, Public Health, and Equity in the Time of COVID-19, ASSESSING LEGAL RESPONSES TO COVID-19, at 71, 73-74 (2020); see also Hunter Blair, David Cooper, Julia Wolfe & Jamie Worker, Econ. Pol’y Inst., PREEMPTING PROGRESS 1, 4-6, (2020), https://files.epi.org/pdf/206974.pdf [https://perma.cc/5GQ8-B959] (“[State p]reemption [of local ordinances] is more prevalent in the South and is embedded in a racist history,” and also limited “cities’ ability to protect their residents from the pandemic.”).
275 Gerken, All the Way Down, supra note 153, at 59 (“If we eliminate opportunities for local governance to protect racial minorities from discrimination, we also eliminate the very sites where racial minorities are empowered to rule.”).
276 Cf. Gostin & Wiley, supra note 168, at 394 (“Since the mid-twentieth century, the federal government has assumed responsibility for financing disaster recovery efforts that overwhelm local resources, thus spreading the economic burden of disasters.”); Haddow et al., supra note 274, at 70 (“In many states . . . statewide orders prevented local governments from imposing stricter requirements than the state [during the COVID pandemic].”).
278 Id.
try to preempt protective measures taken by cities, many of which had majority-minority populations.  

The manifestations of structural racism and subordination already put low-income and racial minority populations at greater risk of contracting and dying from COVID.  

They have also suffered from a lack of equitable access to testing and vaccination.  

“[F]ederalism exacerbates these inequities, as some states have a particularly deep history of under-investing in social programs, especially in certain communities.”  

The federal government’s tepid response and shirking of responsibility surely contribute to the racial disparities in the virus’s toll by implicitly delegating power to the states who wish to undermine equity efforts, and failing to fund those states that wish to expand them.  

D. Privatization  

Racism is a key historical reason the U.S. has a predominantly private health care system rather than a national, universal health system that integrates health care and public health.  

From the inferior health care provided to enslaved people dating back to the 17th century, through the post-Civil War reconstruction period, the New Deal, the mid-20th century Hill-Burton Act’s investments in hospital infrastructure, Great Society reforms in the 1960s (adding Medicare and Medicaid), to the ACA, reformers have entrenched the dominant role of privately

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

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

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

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

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

284 See Interlandi, supra note 7 (“In the United States, racial health disparities have proved as foundational as democracy itself.”).
financed health care, which has permitted *de jure* and *de facto* segregation and tiering of health care along racial, ethnic, geographic, and socioeconomic lines, and separated health care and public health into separate silos. The fragmentation of the U.S. health care system tracks these demographic characteristics — with wealthier, mostly white people covered by private insurance and poorer people, and more non-whites, covered by public programs or not at all.

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

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

287 Smith, supra note 285, at 28-29.

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

289 Interlandi, supra note 7.

290 Byrd & Clayton, supra note 285, at 17.
Racial subordination was key to the ascendance of the private tier of the U.S. health care system, and the persistence of the private health insurance model stands in stark opposition to health justice. In the words of Deborah Stone, the market-based logic of the private health insurance system is “profoundly antithetical to the idea of mutual aid.”

Private insurance market principles are based on actuarial fairness, where each person pays for his own risk, and the insurance profit model depends on fragmenting the risk pool into ever smaller, more homogenous groups. Moreover, the actuarial methodology of insurance historically incorporated the social biases and subordination of people of color, who tend to be poorer and live and work in communities designated as higher risk.

The U.S.’s private insurance system treats health care as a market good — allocated based on the ability to pay — which means poorer communities, which are disproportionately Black and Brown, always have worse health care access and quality.

By contrast, other developed countries treat health care as a public good, to be distributed based on need and funded collectively. 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) that connect the U.S. private health insurance system with its racially inequitable outcomes.

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

Price discrimination,

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291 Stone, supra note 8, at 290.
292 Id.
293 Id. at 296-97 (describing how underwriting methodology tracks social class, stereotypes, and occupational categories).
294 See Thomas Rice, The Impact of Cost Containment Efforts on Racial and Ethnic Disparities in Healthcare: A Conceptualization, in UNEQUAL TREATMENT, supra note 6, 699-70 (concluding that the U.S. approach to cost containment exacerbates racial disparities, particularly by allocating services based on the ability to pay).
295 SMITH, supra note 285, at 28.
297 See Stone, supra note 8, at 291.
298 See UNEQUAL TREATMENT, supra note 6, at 190 (“Low payment rates inhibit the supply of . . . provider[] services to low-income groups, disproportionately affecting ethnic minorities. Inadequate supply takes the form of too few providers participating in plans serving the poor, and provider and unwillingness to spend adequate time with patients.”).
which is the practice of providers charging different prices depending on the patient’s/payer’s ability to pay, is an economic principle that maximizes profits for the provider. Health care is rife with price discrimination. Health care price discrimination translates into racial discrimination, because a patient’s coverage type maps onto a patient’s racial, economic, and social status.

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

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


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

304 UNEQUAL TREATMENT, supra note 6, at 147-48 (describing how “Medicaid’s low reimbursement rates for doctors and hospitals” make the program’s “poor,
the ACA reduced racial disparities in health care while perpetuating them. And this is why universal coverage is necessary but insufficient to achieve equitable access to health care. So long as private payers pay more than public ones and people’s source of coverage is correlated with their social, economic, and racial status, simply giving everyone an insurance card will not achieve equity.

Empirically, privatized health care systems perpetuate and are characterized by greater inequality. Privatized health care systems underperform publicly financed systems in terms of health outcomes, and they are correlated with higher levels of economic and health inequality. According to one study, the level of health care system privatization in a country significantly increased COVID incidence and mortality, even controlling for other variables. A review study found that greater health care privatization was associated with worse patient outcomes and quality than public health care systems across a number
disproportionately minority beneficiaries [] subject to largely separate, often segregated systems of hospital and neighborhood clinics” and “drastically restrict Medicaid beneficiaries’ ability to access private physicians” and hospitals”) (internal citations omitted)).

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

World Health Org., CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 95 (2008) https://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf?sequence=1 (“Runaway commodification of health and commercialization of health care are linked to increasing medicalization of human and societal conditions, and the stark and growing divide of over- and under-consumption of health-care services between the rich and the poor worldwide.”).

Jacob Assa & Cecilia Calderon, PRIVATIZATION AND PANDEMIC: A CROSS-COUNTRY ANALYSIS OF COVID-19 RATES AND HEALTH-CARE FINANCING STRUCTURES 14-15 (2020) (estimating the magnitude of this effect of privatization to conclude that “a 10% increase in private health expenditure results in a 4.85% increase in COVID-19 cases” and “a 6.91% increase in COVID-19 deaths”).
of low- and middle-income countries. This is because health care privatization has distributional effects. A privatized system generally does a worse job of fairly distributing health care resources across the population — by favoring the wealthy and disadvantaging the poor, and charging fees that deter poorer patients from seeking or continuing care — and these distributional inequities translate to greater disparities in health outcomes. Privatized health care tends to be more inequitable. Thus, even if everyone has coverage, a private health care system will perpetuate inequality along racial and socioeconomic lines unless it is heavily regulated to resemble a public system of coverage with standardized provider payment rates and benefits.

Even in countries with universal public coverage systems, where providers typically are not paid more to serve rich patients than poor ones, there is an observed social gradient in health status. A universal single-payer health care system does not fully eliminate the health effects of income inequality, structural racism, and other social determinants of health. 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. Moreover,

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


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

313 WORLD HEALTH ORG., supra note 307 at 8 (“Universal coverage requires that everyone . . . can access the same range of (good quality) services according to needs and preferences, regardless of income level, social status, or residency, and that people are empowered to use these services. It extends the same scope of benefits to the whole population.”).
single-payer health care systems may be more likely to integrate public health goals into their operations.\textsuperscript{314}

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

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

IV. \textsc{Lesson 4: Health Reform Reconstruction Requires Confrontational Incrementalism}

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

\textsuperscript{314} See, e.g., Wiley, \textit{supra} note 15, at 891 (“By eliminating (or dramatically reducing) fragmentation in health care financing, single-payer health care could better align incentives between the health care and public health systems. . . . Under a single-payer system, there would be near-total overlap between the primary payer for health care goods and services (taxpayers) and those who exercise control over the most crucial social determinants of health (voters).”)}
A. Envisioning a Just U.S. Health System

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

Such a single-payer system would displace the fixture of individualism within health care by enrolling everyone into a shared program from cradle to grave, providing every person in the country the same right to a comprehensive array of health care services.\(^\text{316}\) It could also embrace public health principles, strengthening the recognition of health as a public good and prioritizing resources toward the enhancement of the population’s health, including addressing systemic racial and social inequities that are themselves a public health crisis.\(^\text{317}\)

Adopting a universal, single-payer system in the U.S. would eradicate the ethos of actuarial fairness, under which everyone pays for their own risk, and move decisively toward social solidarity where health care and public health are public goods, not commodities.\(^\text{318}\)

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

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

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

\(^{317}\) See Yearby et al., supra note 227, at 7-8.

\(^{318}\) Byrd & Clayton, supra note 285, at 585.
a single, unified risk pool.\textsuperscript{319} With a single payer rather than fiscal diffusion across multiple payers, the system could coordinate and marshal resources in times of emergency. It could provide the “national grid for the generation, transmission, or distribution” of supplies that Atul Gawande has argued that the US lacks.\textsuperscript{320}

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

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

Other countries offer a variety of visions for what a single-payer, universal health care system looks like.\textsuperscript{323} Some have greater reliance on private health insurance contractors to administer the benefits, others retain more federalist flexibility.\textsuperscript{324} We do not have to 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.325 The difficulty lies not with a lack of blueprints or models, but rather from the fact that no country has ever gotten there from here. The prospect of overcoming the fixtures in the U.S. to achieve this transformed, universal, single-payer health care system seems daunting and possibly even naïve.

B. Health Reform Is Hard

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

Moreover, while we argue for a more principled ethos in which solidarity supports health justice, interest-convergence theory327 also suggests that the pandemic may have added to the utility of social solidarity. That is, the pandemic may have made it more obvious to dominant racial and social groups in the U.S. that empowering subordinated populations aligns with their own interests. Interest-

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

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

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. The pandemic has vitiated any pretense that our current health care financing and delivery system is effective or just — it is profoundly ineffective and unjust. And it has shown that what is needed is not just the will for health justice, but a way. Substantial fixtures are blocking the path toward health system transformation. So long as the blinkered “iron triangle” approach remains dominant in law and policy analysis, reform will not even aspire to a just health system, guaranteeing we will not actualize it. 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.

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

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


330 See supra Part I.A.


332 See Anup Malani & Michael Schill, Introduction, in The Future of Healthcare Reform in the United States 9 (Anup Malani & Michael H. Schill eds., 2015) (highlighting that health reforms are difficult because they “directly implicate many of the most sensitive ideological cleavages in our society”); Gabriel Scheffler, Equality and Sufficiency in Health Care Reform, 81 Md. L. Rev. (forthcoming 2021) (on file with authors) (comparing the normative principles underlying differing conceptions of a “right to health care” in single-payer or more incremental reforms).
between conception and execution is great, and the law is often a barrier to reform, not a facilitator. When the country musters the impulse for solidarity in health care as it did in the spring of 2020, that impulse crashes against entrenched, isolating, dispersive fixtures — individualism, fiscal fragmentation, federalism, and privatization — and stalls. These quasi-legal structures ensure that the solidarity impulse does not translate into solidarity in practice. We have focused on COVID and racial disparities here, but history offers other examples, including the ACA itself.

C. Confrontational Incrementalism

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

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

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

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333 See Fuse Brown et al., supra note 1, 414-17.
stumbling blocks. Examples from past health reforms inform this approach.334

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

1. Stepping Stones or Stumbling Blocks

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

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

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

334 See, e.g., Fuchs & Emanuel, supra note 326, at 1408 (comparing incremental versus comprehensive reform).
335 John Kip Cornwell, Opioid Courts and Judicial Management of the Opioid Crisis, 49 SETON HALL L. REV. 997, 1005 (2019) (discussing controversy surrounding whether to employ drug courts or abandon them as “fundamentally incompatible with the disease model of addiction”).
338 Id.
339 Id.
Stepping stones “eas[e] the way to climbing higher.”\(^{340}\) In assessing the difference, Brewster stresses the importance of considering not only the static effects of a reform (“what the immediate and direct effects of the policy are”) but also its dynamic effects (“how the measure will affect the system,” including “longer-term and indirect effect[s]” and alterations to “incentives for private and public actors”).\(^{341}\)

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

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

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

2. Applying Confrontational Incrementalism to Pre-pandemic Reforms

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

\(^{340}\) \textit{Id.}.

\(^{341}\) \textit{Id.} at 230-51.

\(^{342}\) See Harris & Pamukcu, \textit{supra} note 4, at 762.
Medicare's enactment in 1965 may be an example of a stepping stone. The law partially confronted privatization (established as a public program), individualism (automatic enrollment), fiscal fragmentation (federally-financed without segmentation), and federalism (federally administered). Not surprisingly, the law is today understood as a template for universal, single-payer, federally-run health care. Given Medicare's success in confronting the fixtures, it is no wonder that "Medicare for All" has become the shorthand for such a system. It's worth remembering, however, that Medicare's confrontations, while substantial, were partial. Medicare preserved a role for private contractors in benefits administration (in addition to preserving private health care delivery systems). It also preserved fiscal fragmentation to some degree by segregating eligible enrollees from other risk pools.

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

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

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344 Id.
348 42 U.S.C. § 1395ww-111(i) (2012) (Medicare “may not interfere with the negotiations between drug manufacturers and pharmacies”).
to accommodate the fixtures, reinforced them, featuring further fiscal fragmentation, individualism, and state administration. The law did, however, directly attack the individualism fixture in two ways: the individual mandate (requiring everyone to purchase insurance) and community rating coupled with the ban on preexisting condition exclusions (requiring everyone to share in the costs of one another’s illness).349

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

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

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


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

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

353 See, e.g., Matthew Yglesias, Joe Biden’s Health Care Plan, Explained, Vox (July 16, 2019, 11:30 AM EDT), https://www.vox.com/2019/7/16/20694598/joe-biden-health-care-plan-public-option [https/perma.cc/SNY6-F9A8] (describing candidate Biden’s public option plan as containing all these features and noting that if implemented, it would be “the most dramatic piece of new social legislation since the Great Society.”).
using commercial carriers to administer public option plans\textsuperscript{354} — these accommodations should be offset by confrontations to other fixtures. For example, the policy could grant states the ability to combine their Medicaid population with their public option plan, equalizing payment rates and unifying the inequitable two-tiered public-private health care system that pays more to providers for seeing privately insured patients than publicly insured. Overall such a plan could be a stepping-stone toward a just and equitable health system, even if it did not confront all the fixtures simultaneously.

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

3. Applying Confrontational Incrementalism During the Pandemic

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

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

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

\textsuperscript{355} Jaime S. King, Katherine L. Gudiksen & Erin C. Fuse Brown, \textit{Are State Public Option Health Plans Worth It?}, 59 HARV. J. ON LEGIS. (forthcoming 2022).
importance of individuals’ connections with the communities where they live and work.

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

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

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

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357 See supra Part II.B.2.
358 Noguchi, supra note 150.
359 Id.
public investments in health. The governor and health department designated entire “hard-hit” communities for the first phase of vaccine distribution based exclusively on geography. Place-based prioritization — based on pandemic-related indicators like test positivity and hospitalization rate, as well as pre-pandemic tools like CDC’s social vulnerability index — directly confronts the structural racism and economic subordination that have driven COVID disparities by actively prioritizing communities where higher-risk workplaces and crowded multi-generation homes contribute to high exposure. After prioritizing entire communities, the state health department partnered with local housing authorities, employers, and civil society groups to send mobile teams and pop-up vaccination sites directly to the places where people live and work and vaccinate anyone on-site who’s willing, without asking for documentation of individual eligibility factors or insurance information. These partnerships focused on empowering local communities. They confronted individualism by focusing on neighborhood-level factors and the interconnectedness between individuals and the communities where they live, work, shop, and attend school. They confronted privatization (incrementally, but also intentionally) by ensuring strong public coordination and oversight. They failed to confront federalism, but in this case, state-level experimentation and on-the-ground implementation may have had some advantages.

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

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361 Pan, supra note 106.
362 The social vulnerability index is a tool for identifying communities likely to be hit particularly hard by disasters. It uses fifteen variables to rate census tracts based on socioeconomic indicators, household composition, racial and ethnic composition, English language skills, housing type, and access to transportation. CDC/ATSDR SVI Frequently Asked Questions, AGENCY FOR TOXIC SUBSTANCES & DISEASE REGISTRY, https://www.atsdr.cdc.gov/placeandhealth/svi/faq_svi.html (last visited Sept. 15, 2020) [https://perma.cc/VZY9-B9HG].
364 E-mail Communication from Julian Drix, Co-Lead, Health Equity Inst., R.I. Health Dep’t, to authors (Feb. 5, 2021, 8:14 AM) (on file with authors).
residents were receiving the lion’s share of vaccine doses in his state.\footnote{Philip Marcelo, 2 Hard-Hit Cities, 2 Diverging Fates in Vaccine Rollout, WBUR NEWS (Feb. 24, 2021), https://www.wbur.org/commonhealth/2021/02/24/central-falls-chelsea-coronavirus-vaccine-access [https://perma.cc/TML6-JFRA].} Massachusetts Governor Charlie Baker announced that the state’s Medicaid program would increase reimbursement for COVID vaccination to twice the level of Medicare rates and mandated that private insurers pay at least the same rate.\footnote{Priyanka Dayal McCluskey, In Surprise Move, Baker Administration Sets High Insurance Payments for Vaccinations, BOS. GLOBE (Mar. 8, 2021, 6:51 PM), https://www.bostonglobe.com/2021/03/08/metro/surprise-move-baker-administration-sets-high-insurance-payments-vaccinations/ [https://perma.cc/E3FD-KTHQ].} Shortly after that, CMS announced a substantial increase in the reimbursement rate Medicare would pay to providers for administering vaccines. Equalizing rates reflects a more passive approach than place-based prioritization efforts, and it fails to confront individualism, federalism, or privatization. But rate equalization’s confrontation of fiscal fragmentation marks a significant, stepping-stone improvement.

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

CONCLUSION

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

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

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