The health equity mandate

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ABSTRACT
People of color and the poor die younger than the White and prosperous. And when they are alive, they are sicker. Health inequity is morally tragic. But it is also economically inefficient, raising the nation’s healthcare bill and lowering productivity. The COVID pandemic only, albeit dramatically, highlights these pre-existing inequities. COVID sufferers of color die at twice the rate of Whites. The cause, in large part, is structural inequality and racism. Neither the popular nor the scholarly discussion of healthcare inequity, while robust, has translated into palpable and rapid progress. This article describes why health inequity has so far proven intractable. In the healthcare system, no one actor has both adequate incentive and adequate wherewithal to create progress. The healthcare system cannot solve the problem alone. To jumpstart reform, the article suggests a new regulatory approach, grounded in principles of democratic experimentalism and cooperative federalism. It draws inspiration from the examples that the Health Insurance Portability and Accountability Act (HIPAA) and the Clean Air Act provide. A federal health equity mandate, with funding and penalties for state non-compliance, will spur collaboration between federal, state, local, public, and private entities and start the USA on the path to remediating healthcare’s inequities.

KEYWORDS: collaboratives, health inequity, legal mandate, pandemic, social determinants, structural racism
The pandemic has brought into sharp focus a reality that has long been true—health inequity in the USA is tragic and trending in the wrong direction. Life expectancy varies considerably by wealth and geography. In some affluent counties, a person lives on average 20 years longer than in comparable poor counties. Life expectancy also varies starkly by skin color and education.

Even before the pandemic, other metrics were similarly troubling. Black Americans were more likely to have multiple chronic illnesses than White Americans. Racial and ethnic disparities in maternal and child health outcomes were significant, with Black women three times more likely to die of pregnancy-related causes than White women. And Black infants were twice as likely to die as White infants.

The pandemic has further illustrated the consequences of these pre-existing inequities. Black Americans have contracted COVID-19 at three times the rate of White Americans. Adjusted for age, Pacific Islanders, Latinos, Blacks, and Indigenous people are all more than twice as likely to die of COVID than White and Asian people. There is nothing about the mechanism of the virus that causes these disparate results.

These inequities are a moral wrong—under any theory of morality. But health inequity is not just a social justice issue. It is also an economic one. Eliminating race-
based health disparities would save $230 billion in direct medical expenditures and more than $1 trillion in indirect costs.\textsuperscript{11}

The causes of health inequity are complicated. Policy focus has centered squarely on differences in access to care—the actual ability to see a doctor for diagnosis and treatment.\textsuperscript{12} But while access to quality healthcare is an important part of the puzzle, fixing access to care will not solve health inequity.

The Affordable Care Act proves the point. The only major, coordinated health policy initiative in the last decade, it was primarily designed to increase access to hospitals and practitioners by expanding eligibility for Medicaid and creating subsidized private insurance. While it did significantly\textsuperscript{13} reduce the number of uninsured Americans, and notably helped nearly three million Black Americans gain health insurance coverage,\textsuperscript{14} health inequity has persisted.\textsuperscript{15}

Instead, there is nearly uniform agreement from those who study the health equity problem: it takes root long before people get sick. Good health has more to do with safe housing, access to healthy food, environmental factors, and so forth—the social determinants of health. Structural inequities cause disparate experiences with these social determinants of health, which then drive health inequity.\textsuperscript{16} In fact, studies have shown that social determinants may account for 80–90 per cent of the modifiable contributors to healthy outcomes.\textsuperscript{17}

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\textsuperscript{10} See Cynthia Jones, \textit{The Moral Problem of Health Disparities}, 100 \textit{Am. J. Public Health} S47 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837423/.

\textsuperscript{11} See Thomas LaVeist, Darrell Gaskin & Patrick Richard, \textit{Estimating the Economic Burden of Racial Health Inequalities in the United States}, 41 \textit{Int’l J. Health Serv.} 231 (2011).

\textsuperscript{12} See, eg, Karen E. Joynt Maddox et al., \textit{US Health Policy—2020 and Beyond: Introducing a New JAMA Series}, 321 JAMA 1670 (2019); Allison K. Hoffman, \textit{Health Care’s Market Bureaucracy}, 66 \textit{UCLA L. Rev.} 1926 (2019); Abbe R. Gluck & Nicole Huberfeld, \textit{What Is Federalism in Healthcare for?}, 70 \textit{Stan. L. Rev.} 1689, 1780 (2018); Christopher T. Robertson, \textit{Exposed: Why Our Health Insurance Is Incomplete and What Can Be Done About It} (2019); Wendy N. Epstein, \textit{Private Law Alternatives to the Individual Mandate}, 104 \textit{Minn. L. Rev.} 1429 (2020).

\textsuperscript{13} Although the ACA led to 20 million previously uninsured Americans getting coverage, subsequent Trump Administration policies weakening ACA protections and pandemic-related job loss has caused uninsured numbers to rise again. See Rachel Garfield & Jennifer Tolbert, \textit{What We Do and Don’t Know About Recent Trends in Health Insurance Coverage in the US}, KFF (Sept. 17, 2020), https://www.kff.org/policy-watch/what-we-do-and-dont-know-about-recent-trends-in-health-insurance-coverage-in-the-us/.

\textsuperscript{14} See ACA Implementation-Monitoring and Tracking: Who Gained Health Insurance Coverage Under the ACA and Where Do They Live?, \textit{Urban Institute} (Dec. 2016), https://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-the-y-live.pdf; Yet, this population is still more likely to be uninsured than white Americans. See Thomas C. Buchmueller & Helen G. Levy, \textit{The ACA’s Impact on Racial and Ethnic Disparities in Health Insurance Coverage and Access to Care}, 39 \textit{Health Affairs} 395 (2020); Edward R. Berchick, Jessica C. Barnett, & Rachel D. Upton, \textit{Health Insurance Coverage in the United States: 2018}, \textit{United States Census Bureau} 1, 14 (Nov. 2019), https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.

\textsuperscript{15} Omolola E. Adepoju, Michael A. Preston & Gilbert Gonzales, \textit{Health Care Disparities in the Post-Affordable Care Act Era}, 105 \textit{Am. J. Public Health} S665 (2015) (noting ‘nearly 5 years after the ACA was signed into law, researchers are still finding a wide chasm in healthcare access, quality, and outcomes’).

\textsuperscript{16} Social Determinants of Health, 3 \textit{NEJM Catalyst} (Dec. 1, 2017), https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0312; see also William Sage, \textit{Adding Principle To Pragmatism: The Transformative Potential of Medicare-for-All} 28 (May 13, 2019). SSRN: https://ssrn.com/abstract=3387120.

\textsuperscript{17} See L. DeMolto & M. Nakashian, \textit{Using Social Determinants of Health Data to Improve Health Care and Health: A Learning Report}, \textit{Robert Wood Johnson Foundation} (July 26, 2016), https://www.rwjf.org/content/dam/farm/reports/reports/2016/rwjf428872; see also Samantha Artiga and Elizabeth Hinton, \textit{Beyond Healthcare: The Role of Social Determinants in Promoting Health and Health Equity}, KFF
Policymakers have known for decades that social determinants drive health inequity. Nonetheless, only limited progress has been made.

It is not hard to see why the problem has proven so intractable. In a highly fragmented healthcare system, no one actor—not the government, not payers, and not providers—has both adequate incentive and adequate wherewithal to address social determinants.

Private payers, motivated by profit maximization, make decisions to increase revenue and decrease cost. Economically rational payers will invest in social determinants of health if the savings in claims costs resulting from the investment exceed the cost of the investment. But with churn between plans and high rates of Medicaid coverage and uninsurance in the most at-risk populations (rather than coverage by private payers), it is hard and maybe impossible for any individual private insurer to prove the value proposition. Not surprisingly, private insurance has historically focused on reimbursing for the provision of clinical healthcare, narrowly defined, and has not reimbursed for mold remediation in an asthmatic’s apartment or for the delivery of healthy food to a diabetic living in a food desert.

Government payers have more motivation to address the problem, as healthier Americans mean fewer who require government subsidy or Medicaid coverage. Yet the nation’s public health system is chronically underfunded. And the compartmentalized government infrastructure has historically meant that health funding is siloed. Medicare, for instance, does not typically spend funds on addressing housing crises, even if housing is a key driver of health outcomes. Additionally, the federal

2018, https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/; Communities in Action: Pathways to Health Equity, National Academies of Sciences, Engineering, and Medicine (National Academic Press 2017); Carlyn M. Hood et al., County Health Rankings: Relationships Between Determinant Factors and Health Outcomes, 50 Am. J. Prev. Med. 129 (2016).

18 See Alan Nelson, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, 94 J. NATL. MED. ASSOC. 666 (2002) (finding that even with equal access to healthcare, racial minorities suffer differences in quality of health); COMMITTEE ON UNDERSTANDING AND ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, INSTITUTE OF MEDICINE, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, Washington, D.C.: The National Academies Press (Brian D. Smedley et al. eds., 2003).

19 See Michele K. Evans, Health Equity—Are We Finally on the Edge of a New Frontier?, 383 N. ENGL. J. MED. 997 (2020) (‘[T]he United States, the world’s richest country, has failed to achieve health equity.’).

20 See Rachel Sachs, Integrating Health Innovation Policy, HARVARD J. L. & TECH. (forthcoming 2020) (discussing fragmentation of United States healthcare system).

21 In this way, access and social determinants of health are inextricably intertwined. Payers only pay for those who are insured.

22 Part II.C., infra, discusses how the cost of Medicaid and uninsurance is born, in part, by private insurers and how that should factor in the calculus.

23 Government actors may have insufficient incentive to save the government money as they don’t personally have skin in the game and may not be in their roles long enough to be praised for successes or blamed for failures.

24 See Jeffery Levi et al., Investing in America’s Health: A State-By-State Look at Public Health Health Funding and Key, TRUST FOR AMERICA’S HEALTH (2013), https://www.tfah.org/report-details/investing-in-americas-health-a-state-by-state-look-at-public-health-funding-and-key-health-facts/.  

25 Jessica Mantel, Tackling the Social Determinants of Health: A Central Role for Providers, 33 GA. ST. U.L. REV. 217 (2017).

26 Id.; see also Levi, supra note 24; Govind Persad, Choosing Affordable Health Insurance, 88 GEO. WASH. L. REV. 819 (2020).
government has insufficient means of coordinating efforts with local entities that can tailor interventions to the unique needs of each community.

Finally, although much faith has been put in providers—who have perhaps the best sense of patient needs—to drive health equity improvements, their efforts also have important limitations. Providers are trained to provide clinical care and not to address the social determinants of health.\textsuperscript{27} They cannot adopt and create public health policies.\textsuperscript{28} And particularly now, as the world is fighting COVID-19, providers are facing unprecedented financial and other pressures.\textsuperscript{29}

This is not to say that health inequity is being ignored by the industry. Efforts to address social determinants of health are being made by the government, payers, and providers, particularly in recent years. Still, these efforts continue to fall short of what is needed.

Even a move to a system of universal coverage—while impactful—would not be enough to fix the problem. Social determinants have a larger impact on health outcomes than the care provided once people become sick. A new regulatory approach to addressing health equity must therefore look beyond just the healthcare system. It will require collaboration not only among industry actors but also outside the healthcare system—to improve housing and access to education, infrastructure, poverty, and the environment.

This article finds inspiration in the principles of democratic experimentalism\textsuperscript{30} and the related approaches of cooperative federalism\textsuperscript{31} and adaptive management.\textsuperscript{32} It draws specific lessons from two ongoing regulatory experiments that provide instructive analogies—the health industry’s experience with HIPAA and environmental regulators’ use of the Clean Air Act.\textsuperscript{33}

Democratic experimentalism addresses the ‘master problem of organizing decentralized, collaborative design and development under conditions of volatility and diversity.’\textsuperscript{34} It envisions an important role for the federal government in goal-setting and coordination, but an equally if not more important role for autonomy to be given to local units to experiment and share knowledge with others facing similar problems. Relatedly, the hallmark of cooperative federalism is a flexible relationship between the federal and state governments, where the federal government sets policy goals and

\begin{thebibliography}{9}
\bibitem{27} Health Care’s Blind Side: The Overlooked Connection Between Social Needs and Good Health, PRINCETON: ROBERT WOOD JOHNSON FOUNDATION (Dec. 2011), http://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2011/rwjf71795.
\bibitem{28} Id.
\bibitem{29} Leif I. Solberg, Theory vs Practice: Should Primary Care Practice Take on Social Determinants of Health Now? No., 14 ANN FARM MED. 102 (2016).
\bibitem{30} See Michael C. Dorf & Charles F. Sabel, A Constitution of Democratic Experimentalism, 98 COLUM. L. REV. 267 (1998).
\bibitem{31} See, eg, Robert L. Fischman, Cooperative Federalism and Natural Resources Law, 14 N.Y.U. ENVTL. L.J. 179, 190 (2005). (defining cooperative federalism by the hallmark of state implementation of federal standards).
\bibitem{32} See, eg, Robin Kundis Craig & J.B. Ruhl, Designing Administrative Law for Adaptive Management, 67 VAND. L. REV. 1, 3–4 (2014). (defining adaptive management on the basis of continuous learning and adjusting policy implementation in response to data).
\bibitem{33} See also Hannah J. Wiseman & Dave Owen, Federal Laboratories of Democracy, 52 U.C. DAVIS L. REV. 1119 (2018) (describing how U.S. agricultural policy, federal policies on wildfire management and the United States Department of Education’s Race to the Top, provide other examples of similar techniques).
\bibitem{34} Dorf & Sabel, supra note 30, at 286.
\end{thebibliography}
often provides funding but leaves implementation flexibility to the states. Adaptive management focuses on the need for continuous learning and adjustment in policy implementation in response to data collection.

HIPAA, in key respects, is a democratic experimentalism success story. Today, HIPAA is known mostly for its standards on privacy and security. But HIPAA also addressed another entrenched health industry problem: fragmented technology infrastructure. Lack of standardization meant billions of dollars in unnecessary inefficiency costs for the industry and high rates of error. The industry could not seem to address the problem itself, in part because of the sheer complexity of the problem, but also because it could not solve the collective action problem.

These hurdles were largely (although not perfectly) overcome, with a combination of top-down regulation and bottom-up collaboration. The HIPAA statute created a binding legal mandate that lit the fire for change. And HIPAA collaboratives—where covered entities voluntarily chose to work together to implement the HIPAA mandate—figured out best practices for implementing the new legal requirements.

Environmental regulatory approaches are illustrative of similar principles. For instance, with the Clean Air Act, the federal government sets air quality standards and then gives responsibility to the states to develop their own implementation plans, reserving the authority to step in and implement a federal plan if state governments fall short. The federal government also provides funding and takes an active role in reviewing, amending, and approving plans. This regulatory regime—an example of cooperative federalism—enables state and local solutions to vary according to differing circumstances but also promotes learning at the federal level.

These examples suggest a regulatory regime with the promise of addressing health inequity—a federal mandate that requires states achieve certain metrics of health equity or face civil monetary penalties and federal funding to spur collaboration between federal and local, public and private entities. A model like this could be applied to many health industry problems. The recent experience with a failed COVID vaccine distribution bears some similar hallmarks. It also could have been vastly improved with standard-setting and funding from the federal government that left states room to make adjustments for local circumstances.

35 See M. J. Friedrich, Health Care Practitioners and Organizations Prepare for Approaching HIPAA Deadlines, 286 JAMA 1563 (2001); Mary Beth Johnston & Leighton Roper, HIPAA Becomes Reality: Compliance with New Privacy, Security, and Electronic Transmission Standards, 103 W. VA. L. REV. 541, 569 (2000). Although note that there is some controversy about how much spending HIPAA required to get the savings.

36 See Wendy N. Epstein, Bottoms Up: A Toast to the Success of Health Care Collaboratives...What Can We Learn?, 56 ADMIN. L. REV. 739 (2004).

37 Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104–191, tit. II, 110 Stat. 1936, 1991.

38 See supra note 31.

39 See, eg, Kirsten H. Engel, Democratic Environmental Experimentalism, 35 UCLA J. ENVTL. L. & POL’Y 57, 58 (2017), Robin Kundis Craig & J.B. Ruhl, Designing Administrative Law for Adaptive Management, 67 VAND. L. REV. 1 (2014), David L. Markell & Robert L. Glicksman, Dynamic Governance in Theory and Application, Part I, 58 ARIZ. L. REV. 563, 611–14 (2016).

40 See 42 U.S.C. § 1857c–5(c) (1970).

41 See Charles F. Sabel, Dewey, Democracy, and Democratic Experimentalism, 9(2) CONTEMPORARY PRAGMATISM 35, 44 (2012).
Part I of this article describes the health inequity problem and its complicated causes. It focuses on the large role that social determinants of health play in creating disparities in health outcomes. Given the widespread recognition that social determinants of health are a key driver of health inequity, Part II then describes efforts by key health industry players (state and federal government, private payers, providers, and charities) to address social determinants. But it also explores why current mechanisms are insufficient, with particular focus on the structural impediments to success and the need to look beyond the confines of the healthcare system. Part III introduces the theory of democratic experimentalism and related regulatory approaches. It then explores two examples of those regulatory approaches in action: HIPAA collaboratives and environmental regulations. Finally, Part IV concludes with the promise of a mandate-driven, funded, collaborative, public–private model to address social determinants of health.

Fixing the health inequity problem in the USA is both a moral and a financial imperative. Success could mean saving millions of lives and billions of dollars.

II. UNCONSCIONABLE HEALTH INEQUITY AND WHAT CAUSES IT

According to the World Health Organization, health equity means that ‘everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.’ In the real world, however, health equity does not exist. Rather, there are systematic differences in the opportunities that certain groups have, leading to differences in social determinants of health like education and housing. As a result, disadvantaged groups suffer worse health outcomes. The gap between those achieving full health potential and those who cannot is the health disparities that lead to unnecessary deaths, disease burden, and cost to our healthcare system.

A key assumption of this article is that most health inequities are avoidable. Racial and ethnic health inequities do not fundamentally stem from biological differences. They stem from structural inequities, social determinants of health, and racism. And while health inequity is an international problem facing every country, disparities are more acute in the USA than in any other developed country.

II.A. Evidence of Health Inequity

Over the last several decades, health outcomes in the USA have generally improved. If you look at average life expectancy and infant mortality across the population, you feel
The health equity mandate encouraged by the progress that has been made. But that progress all but disappears for populations that are low income; less educated; Black or Native American; or who live in certain parts of the country. During the pandemic, millions have lost their jobs and their health insurance. They have quit school to support their families. And they are living in conditions that make it difficult to social distance, leading to higher rates of infection. The pandemic has only served to exacerbate health inequity in the USA.

II.A.i Pre-COVID Data

Income is the greatest predictor of health inequity. The poor in America disproportionately suffer from health disparities. The gap between life expectancy for the rich and life expectancy for the poor is increasing. In 1920, a wealthy man could expect to live, on average, 5 years longer than a poor man. Now the divide is more than 12 years.

There is a gradient of health that runs parallel to the socioeconomic spectrum—the poorer you are, the worse your health outcomes are—at least until you reach a certain income. It holds true even if you consider mortality rates for children under the age of five. The poorest quintile has the highest mortality rates, followed by

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48 See Jeffery Selberg et al., A Generation of Healthcare in the United States: Has Value Improved in the Last 25 years?, Peterson-KFF Health System Tracker (Dec. 6, 2018), https://www.healthsystemtracker.org/brief/a-generation-of-healthcare-in-the-united-states-has-value-improved-in-the-last-25-years/ (but note that this is also a recent downward trend due to ‘suicide, opioid overdose and alcohol cirrhosis of the liver’); Ron Manderscheid, Take Steps to Address Health Inequity and Other Social Justice Issues, Psychiatry & Behavioral Health Learning Network (Sept. 9, 2020), https://www.psychcongress.com/article/take-steps-address-health-inequity-and-other-social-justice-issues.
49 See Max Roser, It’s Not Just About Child Mortality, Life Expectancy Improved at All Ages, Our World IN Data (Sept. 23, 2020), https://ourworldindata.org/its-not-just-about-child-mortality-life-expectancy-improved-at-all-ages.
50 See Douglas C. Dover & Ana Paula Belon, The Health Equity Measurement Framework: A Comprehensive Model to Measure Social Inequities in Health, 18 Int’l J. Equity Health 1, 8 (2019), https://equityhealth.biomedcentral.com/articles/10.1186/s12939-019-0935-0.
51 See Steffie Woolhandler & David U. Himmelstein, Intersecting U.S. Epidemics: COVID-19 and Lack of Health Insurance, Ann. Intern. Med. (July 7, 2020), DOI: 10.7326/M20-1491; Sumit Agarwal & Sommers Benjamin, Insurance Coverage after Job Loss—The Importance of the ACA during the Covid-Associated Recession, 383 N. Eng. J. Med. 1603 (2020).
52 See Stephen W. Patrick et al., Well-being of Parents and Children during the COVID-19 Pandemic: A National Survey, 146 Pediatrics 4 (2020); Abbey R. Masonbrink & Hurley Emily, Advocating for Children During the COVID-19 School Closures, 146 Pediatrics 3 (2020).
53 See Alvin Powell, The Costs of Inequality: More Money Equals Better Health Care and Longer Life, U.S. News & World Report (Feb. 23, 2016), https://www.usnews.com/news/articles/2016-02-23/the-costs-of-inequality-more-money-equals-better-health-care-and-longer-life.
54 Raj Chetty et al., The Association between Income and Life Expectancy in the United States, 2001–2014, 315 JAMA, 1750 (Apr. 10, 2016), https://scholar.harvard.edu/files/cutler/files/jsc160006_01.pdf.
55 Barry P. Bosworth, Gary Burtless & Kan Zhang, What Growing Life Expectancy Gaps Mean for the Purpose of Social Security, Brookings Inst. (Feb. 12, 2016), https://www.brookings.edu/research/what-growing-life-expectancy-gaps-mean-for-the-purpose-of-social-security/#recent/.
56 Id.
57 See Social Determinants of Health: Key Concepts, World Health Organization, https://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/ (last accessed Oct. 28, 2020).
58 Id. (‘For example, if you look at under-5 mortality rates by levels of household wealth you see that within counties the relation between socioeconomic level and health is graded.’).
the second highest quintile, and so forth. Even comparing the wealthiest quintile and second wealthiest, the health gradient holds true.\textsuperscript{59}

Because racial and ethnic minorities are disproportionately low income, it might not be surprising that the evidence of health disparities by race is also strong.\textsuperscript{60} And yet it isn’t only the correlation between race and poverty that is predictive of inequity—wealthier Black Americans have worse health outcomes when compared to comparably wealthy White Americans.\textsuperscript{61} Indeed, ‘in terms of health, there’s approximately a five-year penalty for being African-American compared to being a white male[.]’\textsuperscript{62}

African Americans, Latinx, and Native American populations also have greater maternal and infant mortality rates than White Americans and higher rates of chronic disease.\textsuperscript{63} Even as the overall death rates from heart disease in Black populations and diabetes in Native American populations have decreased, the gap in rates when compared to Whites has increased.\textsuperscript{64} And it is striking to consider that in the USA, African Americans make up only 13 per cent of the population but account for almost half of all new HIV infections.\textsuperscript{65}

Geography is another key divide in health equity. Southern states tend to have poorer health outcomes than northern ones.\textsuperscript{66} Rates of obesity and other non-communicable diseases are also higher in the South.\textsuperscript{67} Finally, lack of education is correlated with more deaths a year than smoking. One study estimated that almost 240,000 annual deaths are attributable to lack of a high school education compared to 160,000 deaths attributed to smoking.\textsuperscript{68}

\textbf{II.A.ii COVID Data of Health Inequity}

COVID-19 has further exposed these pre-existing inequities but also exacerbated them.\textsuperscript{69} People of color are getting COVID-19 at higher rates than Whites, and they...
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are also dying at higher rates than Whites.\textsuperscript{70} Because COVID-19 has only served to worsen the social determinants of health of the most vulnerable populations,\textsuperscript{71} it will likely increase health inequity going forward.

In Pennsylvania, Black people make up 11 per cent of the population but account for 23 per cent of COVID-19 diagnoses.\textsuperscript{72} The situation is similar in Michigan and Ohio.\textsuperscript{73} In California, Hispanics make up 39 per cent of the population but account for 61 per cent of COVID cases.\textsuperscript{74} A similar divide for Hispanics is found in Utah, Oregon, Illinois, and Nebraska.\textsuperscript{75}

Rates of hospitalization and death from COVID-19 are also eye-opening. According to the Centers for Disease Control, Black people are almost five times as likely to be hospitalized from COVID as Whites and two to three times as likely to die from the virus—although in some places, five to seven times as likely.\textsuperscript{76} Native Americans and Latinx populations are also close to five times more likely to be hospitalized from COVID.\textsuperscript{77} When adjusted for age, Pacific Islanders, Latinos, Blacks, and Indigenous people are all more than twice as likely to die of COVID than White and Asian people.\textsuperscript{78}

The pandemic has also unevenly impacted Americans’ economic status by race and ethnicity. Black and Hispanic households have been more likely to suffer pandemic-related job loss.\textsuperscript{79} And Hispanic and Latino households in particular have the greatest inequity among historically marginalized groups and low-income populations).\textsuperscript{80} Ruqaijah Yearby & Seema Mohapatra, Law, Structural Racism, and the Covid-19 Pandemic, 7 J.L. & BIOSCIENCES 1 (2020).

\textsuperscript{70} Id.; see also COVID-19 Hospitalization and Death by Race/Ethnicity, CENTERS FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html (last accessed Aug. 18, 2020); Eddie Bernice Johnson & Lawrence J. Trautman, The Demographics of Death: An Early Look at Covid-19, Cultural and Racial Bias in America, 48 HASTINGS CONST. L.Q. 357 (2021).

\textsuperscript{71} See Bo Burstrom & Wenjing Tao, Social Determinants of Health and Inequalities in COVID-19, 30 EUR. J. PUBLIC HEALTH 617 (2020); Patricia J. Perez et al., Community Health Workers and Covid-19—Addressing Social Determinants of Health in Times of Crisis and Beyond, 383 NEW ENG. J. MED. e108 (2020); Sravani Singu et al., Impact of Social Determinants of Health on the Emerging COVID-19 Pandemic in the United States, 8 FRONT. PUBLIC HEALTH 406 (2020).

\textsuperscript{72} See COVID-19 Cases by Race/Ethnicity, KFF, https://www.kff.org/other/state-indicator/covid-19-cases-by-race-ethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22%2C%22sort%22:%22asc%22%7D (last accessed Oct. 25, 2020).

\textsuperscript{73} Id.

\textsuperscript{74} Id.

\textsuperscript{75} Id.

\textsuperscript{76} See supra note 24.

\textsuperscript{77} Id; see also Hon. Adriano Espaillat (NY) ‘Hope and Health Equity for Communities of Color,’ Congressional Record 166:157 E830 (Sept. 11, 2020), https://www.congress.gov/congressional-record/2020/09/11/extensions-of-remarks-section/article/E830-2.

\textsuperscript{78} The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S. (data as of Jan. 7, 2021), A.P. RESEARCH LAB, https://www.apmresearchlab.org/covid/deaths-by-race; see also Mary T. Bassett et al., The Unequal Toll of COVID-19 Mortality by Age in the United States: Quantifying Racial/Ethnic Disparities, 19 HARV. CENT. POPUL. DEV. STUD. WORK PAP. SER. (June 12, 2020), https://cdn1.sph.harvard.edu/wp-content/uploads/sites/1266/2020/06/20_Bassett-Chen-Krieg_Covid-19_plus_age_working-paper_0612_Vol-19_No-3_with-cover.pdf; Richard A. Oppel et al., The Fullest Look Yet at Racial Inequity of Coronavirus, N.Y. TIMES (July 5, 2020), https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html; See Daniel Wood, As Pandemic Deaths Add Up, Racial Disparities Persist—And In Some Cases Worsen, NPR (Sept. 23, 2020), https://www.npr.org/sections/health-shots/2020/09/23/914427907/as-pandemic-deaths-are-also-dying-at-higher-rates-than-whites-because-covid-19-has-only-served-to-worsen-the-social-determinants-of-health-of-the-most-vulnerable-populations-it-will-likely-increase-health-inequity-going-forward-in-pennsylvania-black-people-make-up-11-per-cent-of-the-population-but-account-for-23-per-cent-of-covid-19-diagnoses-the-situation-is-similar-in-michigan-and-ohio-in-california-hispanics-make-up-39-per-cent-of-the-population-but-account-for-61-per-cent-of-covid-cases-a-similar-divide-for-hispanics-is-found-in-utah-oregon-illinois-and-nebraska-rates-of-hospitalization-and-death-from-covid-19-are-also-eye-opening.-according-to-the-centers-for-disease-control-black-people-are-almost-five-times-as-likely-to-be-hospitalized-from-covid-as-whites-and-two-to-three-times-as-likely-to-die-from-the-virus-although-in-some-places-five-to-seven-times-as-like-native-americans-and-latinx-populations-are-also-close-to-five-times-more-likely-to-be-hospitalized-from-covid-when-adjusted-for-age-pacific-islanders-latinos-blacks-and-indigenous-people-are-all-more-than-twice-as-likely-to-die-of-covid-than-white-and-asian-people-the-pandemic-has-also-unevenly-impacted-americans-economic-status-by-race-and-ethnicity-black-and-hispanic-households-have-been-more-likely-to-suffer-pandemic-related-job-loss-and-hispanic-and-latino-households-in-particular-have-the-greatest-inequity-among-historically-marginalized-groups-and-low-income-populations)
concerns about income stability as a result. This trend is not specific to this pandemic. In 2009, the H1N1 influenza pandemic led to racial minorities suffering higher rates of hospitalization than Whites. Even going all the way back to the 1918 Spanish influenza pandemic, racial minorities suffered higher mortality rates.

The next section will consider what causes health inequity and what has caused the pandemic in particular to disproportionately affect groups by income and race.

II.B. Causes of Health Inequity

The causes of health inequity are complicated and discussed in depth in other work. The following, however, presents a high-level overview of the most consequential factors. It draws on a robust body of literature that describes how social, political, economic, and environmental conditions lead to health inequity. Many of the disadvantages that vulnerable groups face today result from historical policies and practices that have created an unequal distribution of resources among communities. These structural inequities manifest in differential social determinants of health.
The housing example is illustrative. The process of ‘redlining,’ which began during the New Deal, prevented African Americans from obtaining mortgages while simultaneously providing White Americans funding to become homeowners.\(^{88}\) That funding allowed White people to purchase homes in the suburbs, where their growing wealth was then used to set up better schools. Meanwhile, resources were drained from city schools. The process resulted in the sorting of people into class-differentiated, resource-rich and resource-poor neighborhoods.\(^{89}\)

This history manifests, today, in racial minorities continuing to have lesser access to safe housing and to quality education.\(^{90}\) And the fact of poorer housing conditions and inferior educational opportunities ultimately leads to disadvantages in achieving full health potential.\(^{91}\) This section focuses on how the social determinants of health—income, education, housing, access to healthy food, and public safety—cause health inequity.\(^{92}\)

II.B.i. Social Determinants of Health and Health Inequity
To understand how social determinants of health disadvantage marginalized groups from achieving their full health potential, it is helpful to begin with a discussion of stress. Stress is a well-established predictor of poor health.\(^{93}\) Prolonged, chronic stress can bring about wear and tear on the body and ultimately cause premature death. But stress also harms health in other ways.\(^{94}\) It can negatively impact mental health\(^{95}\) and lead people to self-harming behaviors such as drug, alcohol, or tobacco abuse.\(^{96}\) It can prevent positive sleep habits that are essential for good health.\(^{97}\) And it can lead to a decrease in healthy activities such as exercise.\(^{98}\) ‘The unequal distribution of stressors is believed to be a key mechanism that explains health disparities among socially disadvantaged communities.’\(^{99}\)

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87 See Social Justice and Health, AMERICAN PUBLIC HEALTH ASSOCIATION, https://apha.org/what-is-public-health/generation-public-health/our-work/social-justice (last accessed Oct. 28, 2020) (describing unequal distribution of resources based on ‘race, class, gender, place and other factors.’).
88 See supra note 2 (describing how historical patterns continue to affect present day health disparities between groups).
89 Id. (noting how ‘the quality of neighborhoods and schools significantly shapes the life trajectory and the health of the adults and children... and is an important factor in producing health inequity.’).
90 Michele K. Evans, Health Equity-Are We Finally on the Edge of a New Frontier?, 383 N. ENGL. J. MED 997 (Sept. 10, 2020) (describing how recent work suggests that political actions set the stage for today’s health inequities).
91 See Ruqaijah Yearby, Breaking The Cycle of ‘Unequal Treatment’ with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias, 44 CONN. L. REV. 1281, 1294 (2012).
92 See supra note 36; see also Michael Marmot, The Status Syndrome: How Social Standing Affects Our Health and Longevity 1–2 (2004).
93 Abiola Keller et al., Does the Perception that Stress Affects Health Matter? The Association with Health and Mortality, 31 HEALTH PSYCHOL. 677 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3374921/pdf/nihms357494.pdf.
94 Id.
95 Id.
96 Id.
97 Id.
98 Id.
99 See supra note 42.
A lot of things cause health-harming stress. Living in unsafe housing conditions or not having sufficient employment income to cover the costs of living creates stress. Fear of discrimination by police is a tremendous source of stress.

Being the victim of discrimination is strongly linked to stress\(^\text{100}\) and ultimately to poorer health outcomes.\(^\text{101}\) A lot of groups feel the stress of discrimination in our society. A recent national poll found that 92 per cent of Black Americans believe that Black people are discriminated against in America.\(^\text{102}\) Seventy-eight per cent of Latinx respondents said that Latinx people were discriminated against in America,\(^\text{103}\) and 75 per cent of Native American respondents reported discrimination against Native Americans.\(^\text{104}\) The poll also found that 90 per cent of LGBTQ individuals felt there was discrimination against them,\(^\text{105}\) and 68 per cent of women felt there was discrimination in America on the basis of gender.\(^\text{106}\)

But it is not just stress that creates health inequity. Consider how environmental factors like poor air and water quality directly impact health. Poor air leads to ‘premature death, cancer, and long-term damage to respiratory and cardiovascular systems.’\(^\text{107}\) Although the U.S. Environmental Protection Agency (EPA) reports positive trends in improving air quality and reducing air pollution, it reports that nonetheless, ‘[a]pproximately 82 million Americans lived in counties with air quality concentrations above the level of one or more [National Ambient Air Quality Standards] in 2019.’\(^\text{108}\) Also, the EPA estimates that in 2017, 22 million people drank water from systems that did not meet public health standards.\(^\text{109}\) Living in substandard housing conditions with mold or lead paint or other hazards including inadequate heating and sanitation also negatively impact health.\(^\text{110}\) Those who are subjected to such health-

\(^{100}\) Brigette A. Davis, *Discrimination: A Social Determinant of Health Inequities*, Health Affairs (Feb. 25, 2020), [https://www.healthaffairs.org/do/10.1377/hblog20200220.518458/full/](https://www.healthaffairs.org/do/10.1377/hblog20200220.518458/full/) (finding discrimination to be associated with mental illness and worse mental health outcomes).

\(^{101}\) David R. Williams et al., *Racial Differences in Physical and Mental Health: Socioeconomic Status, Stress, and Discrimination*, 2 J. Health Psych. 335 (1997) (linking experience of discrimination with worse health outcomes).

\(^{102}\) See *Discrimination in America: Experiences and Views of African Americans*, Robert Wood Johnson Foundation (Oct. 2017), [https://www.rwjf.org/content/dam/farm/reports/reports/2017/rwjf441128](https://www.rwjf.org/content/dam/farm/reports/reports/2017/rwjf441128).

\(^{103}\) See *Discrimination in America: Experiences and Views of Latinos*, Robert Wood Johnson Foundation (Oct. 2017), [https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2017/rwjf444102](https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2017/rwjf444102).

\(^{104}\) See *Discrimination in America: Experiences and Views of Native Americans*, Robert Wood Johnson Foundation (Nov. 2017), [https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2017/rwjf4441678](https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2017/rwjf4441678).

\(^{105}\) See *Discrimination in America: Experiences and Views of LGBTQ Americans*, Robert Wood Johnson Foundation (Nov. 2017), [https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2017/rwjf4441734](https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2017/rwjf4441734).

\(^{106}\) See *Discrimination in America: Experiences and Views of American Woman*, Robert Wood Johnson Foundation (Dec. 2017), [https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2017/rwjf4441994](https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2017/rwjf4441994).

\(^{107}\) See *Environmental Health*, Office of Disease Prevention and Health Promotion, [https://www.healthypeople.gov/2020/topics-objectives/topic/environmental-health](https://www.healthypeople.gov/2020/topics-objectives/topic/environmental-health) (last accessed Oct. 8, 2020).

\(^{108}\) Environmental Protection Agency, [https://gispub.epa.gov/air/trendsreport/2020/#home](https://gispub.epa.gov/air/trendsreport/2020/#home) (last accessed Oct. 28, 2020).

\(^{109}\) Report on the Environment: Drinking Water, U.S. Environmental Protection Agency, [https://www.epa.gov/report-environment/drinking-water](https://www.epa.gov/report-environment/drinking-water) (last accessed Nov. 1, 2020).
reducing environments are disproportionately poor, less educated, and from certain racial groups.\textsuperscript{111}

Education is commonly regarded as another major factor in health inequity. There are many theories about why lower levels of education are so closely correlated with worse health outcomes. Some posit that lower education can mean worse employment prospects, lower earning potential, and less likelihood of good insurance coverage and that lower education is really a proxy for poverty.\textsuperscript{112} While studies have confirmed that to be true, others have found that even when controlling for income and employment, less education is still correlated with worse health.\textsuperscript{113} One possibility is that education imparts values and skills that are important to attaining good health\textsuperscript{114} or that psycho-social factors associated with lower education levels also lead to health harms.\textsuperscript{115} What is clear is that those with lower educational attainment have higher rates of most major diseases, including diabetes, circulatory diseases, and several forms of mental illness.\textsuperscript{116}

Inability to access healthy food or transportation that would allow access to health-improving resources also produces health inequity. These basic services, outside the realm of clinical healthcare, make a tremendous impact at the individual and the community-level on health outcomes.\textsuperscript{117}

Finally, it is important to note that because many of these problems are structural in nature and driven in particular by structural racism,\textsuperscript{118} problems carry over from generation to generation and impact even attempts to improve health equity through clinical care.\textsuperscript{119} For instance, with lesser educational opportunities, fewer Black Amer-
icans become healthcare professionals. 'Underrepresentation further intensifies health disparities by limiting the pool of culturally competent clinicians who can offer appropriate leadership in both academia and patient care' or who can combat both explicit and implicit racism in clinical care.\footnote{See \textit{supra} note 2 ('Such structural inequities give rise to large and preventable differences in health metrics such as life expectancy, with research indicating that one’s zip code is more important to health than one’s genetic code.').}

These social determinants of health all give rise to large (and preventable) differences in health outcomes.\footnote{See \textit{supra} note 71 ('Hispanic workers in families with noncitizens were far less likely to have the ability to work from home than those in families where all members are citizens (14.6\% compared with 31.4\%)[;]' ); Denise N. Obinna, \textit{Essential and Undervalued: Health Disparities of African American Women in the COVID-19 Era}, \textit{Ethnicity & Health}, DOI: 10.1080/13557858.2020.1843604 ('Given the disproportionate representation of African American workers in frontline jobs which put them at greater risk of exposure to COVID-19, it is not unsurprising that a greater \%age of mortalities are found among African Americans and their families.'); Ruqaiijah Yearby & Seema Mohapatra, \textit{Systemic Racism, the Government’s Pandemic Response, and Racial Inequities in COVID-19}, EMORY L. J. (forthcoming 2021) (describing how employment policies contributed to pandemic inequities).}

\textbf{II.B.ii. Why the Pandemic Has Resulted in Disparate Health Outcomes}

Given the discussion in the prior section, the fact that certain disadvantaged groups have fared worse during the pandemic than more privileged groups is not surprising. But also, because of the nature of transmission of the virus, it is also worth noting that more people of color are essential workers who were not able to shelter at home or social distance to avoid getting sick.\footnote{See \textit{supra} note 71; Denise N. Obinna, \textit{Essential and Undervalued: Health Disparities of African American Women in the COVID-19 Era}, \textit{Ethnicity & Health}, DOI: 10.1080/13557858.2020.1843604 ('Given the disproportionate representation of African American workers in frontline jobs which put them at greater risk of exposure to COVID-19, it is not unsurprising that a greater \%age of mortalities are found among African Americans and their families.'); Ruqaiijah Yearby & Seema Mohapatra, \textit{Systemic Racism, the Government’s Pandemic Response, and Racial Inequities in COVID-19}, EMORY L. J. (forthcoming 2021) (describing how employment policies contributed to pandemic inequities).}

Racial minorities tend to live in more population dense areas, and with more residents living in a single home, the virus spread more easily.\footnote{See \textit{supra} note 71; Denise N. Obinna, \textit{Essential and Undervalued: Health Disparities of African American Women in the COVID-19 Era}, \textit{Ethnicity & Health}, DOI: 10.1080/13557858.2020.1843604 ('Given the disproportionate representation of African American workers in frontline jobs which put them at greater risk of exposure to COVID-19, it is not unsurprising that a greater \%age of mortalities are found among African Americans and their families.'); Ruqaiijah Yearby & Seema Mohapatra, \textit{Systemic Racism, the Government’s Pandemic Response, and Racial Inequities in COVID-19}, EMORY L. J. (forthcoming 2021) (describing how employment policies contributed to pandemic inequities).}

Among those who are not essential workers, Black and Latinx Americans lost their jobs at higher rates than the rest of the population, contributing to higher rates of poverty and all of the risk factors that come with that.\footnote{See \textit{supra} note 71; Denise N. Obinna, \textit{Essential and Undervalued: Health Disparities of African American Women in the COVID-19 Era}, \textit{Ethnicity & Health}, DOI: 10.1080/13557858.2020.1843604 ('Given the disproportionate representation of African American workers in frontline jobs which put them at greater risk of exposure to COVID-19, it is not unsurprising that a greater \%age of mortalities are found among African Americans and their families.'); Ruqaiijah Yearby & Seema Mohapatra, \textit{Systemic Racism, the Government’s Pandemic Response, and Racial Inequities in COVID-19}, EMORY L. J. (forthcoming 2021) (describing how employment policies contributed to pandemic inequities).}

Unemployment rates during the pandemic are higher for both Black Americans and Latinx Americans than White Americans.\footnote{See \textit{supra} note 71; Denise N. Obinna, \textit{Essential and Undervalued: Health Disparities of African American Women in the COVID-19 Era}, \textit{Ethnicity & Health}, DOI: 10.1080/13557858.2020.1843604 ('Given the disproportionate representation of African American workers in frontline jobs which put them at greater risk of exposure to COVID-19, it is not unsurprising that a greater \%age of mortalities are found among African Americans and their families.'); Ruqaiijah Yearby & Seema Mohapatra, \textit{Systemic Racism, the Government’s Pandemic Response, and Racial Inequities in COVID-19}, EMORY L. J. (forthcoming 2021) (describing how employment policies contributed to pandemic inequities).}

Black Americans and Latinx Americans have also lost health insurance at
The health equity mandate

higher rates than White Americans. In turn, rates of homelessness increased among those populations. In other words, the pandemic both exemplifies structural health inequity that has always existed, but it also amplified those problems.

II.C. Costs of Health Inequity

The costs of health inequity lie not only in loss of life and quality of life, but also in societal productivity and economic loss.

The social justice case for addressing health inequity is clear. In a just and ethical society, everyone deserves equal rights and opportunities. If there are structural and social barriers to achieving optimal health, that is an injustice that must be remedied.

Health inequity in the USA has resulted in a striking number of premature deaths. One study calculated that in a single year, approximately 245,000 American deaths could be attributed to low education, 176,000 to racial segregation, 172,000 to poverty, 162,000 to low social support, and 119,000 to income inequality. These are deaths that could have been avoided in just 1 year if inequity could be eliminated.

Another study comparing premature death rates between races found that during the pandemic, ‘[r]even though mortality in 2020 reached levels that Black people experienced outside of pandemics, current COVID-19 mortality levels would need to increase by a factor of nearly 6.’ These costs in loss of life do not even account for losses in quality of life for those who do not suffer early mortality.

The economic costs of inequity are also tremendous. Overall healthcare costs in the USA are high—in fact higher than any other industrialized country. Even without

125 See The Employment Situation—July 2020, U.S. Bureau of Labor Statistics (Aug. 7, 2020), https://www.bls.gov/news.release/archives/empsit_08072020.htm ('A July 2020 report from the U.S. Bureau of Labor Statistics documents unemployment rates of 16.1% among Black Americans and 16.7% among Latinx Americans—significantly higher than the 12.0% rate among White Americans.').
126 See supra note 111; Anuj Gangopadhyaya et al., As the COVID-19 Recession Extended into the Summer of 2020, More than 3 Million Adults Lost Employer-sponsored Health Insurance Coverage and 2 Million Became Uninsured, URBAN INSTITUTE (Sept. 18, 2020), https://www.urban.org/sites/default/files/publication/102852/as-the-covid-19-recession-extended-into-the-summer-of-2020-more-than-3-million-adults-lost-employer-sponsored-health-insurance-coverage-and-2-million-became-uninsured.pdf.
127 See Courtney Anderson, Covid, Eviction and Homelessness, St. Thomas L.J. (forthcoming 2021).
128 See supra note 4. ('Many studies show how shortfalls in health are associated with low economic productivity and reduced quality of life.')
129 See Dayna Bowen Matthew, Structural Inequality: The Real Covid-19 Threat to America’s Health and How Strengthening the Affordable Care Act Can Help, 108 GEO. L.J. 1679, 1711 (2020).
130 See Arline T. Geronimus, To Mitigate, Resist, or Undo: Addressing Structural Influences on the Health of Urban Populations, 867 AM. J. PUBLIC HEALTH 867 (2000).
131 Sandra Galea et al., Estimated Deaths Attributable to Social Factors in the United States, 101 AM. J. PUBLIC HEALTH 1456 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3134519/pdf/1456.pdf; see also Michael Marmot, Social justice, epidemiology, and health inequalities, 32 EUR. J. EPIDEMIOLOG 537 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5570780/.
132 See also John N. Newton, Counting Early Deaths Due to Socioeconomic Inequality, 5 THE LANCET PUBLIC HEALTH E6 (2020), https://www.thelancet.com/action/showPdf?pii=S2468-2667%2819%2930242-7 (counting early deaths due to inequity in Europe).
133 See Elizabeth Wrigley-Field, US racial Inequality May be as Deadly as COVID-19, 117 PROC. NATL. ACAD. SCI. U.S.A 21854 (2020), https://www.pnas.org/content/117/36/21854.
134 See Yongwen Jiang & Jana Earl Hesser, Associations Between Health-related Quality of Life and Demographics and Health Risks. Results from Rhode Island’s 2002 Behavioral Risk Factor Survey, 4 HEALTH QUAL. LIFE OUTCOMES 1 (2006), https://hqlo.biomedcentral.com/articles/10.1186/1477-7525-4-14.
a promise of universal healthcare, the USA already spends almost one-fifth of its gross domestic product on healthcare costs. That is almost 50 per cent more than comparable countries.

There are many drivers of this high cost, but certainly inequity is an important one. One study determined that over 30 per cent of healthcare costs for racial and ethnic minorities were a result of structural inequity. It estimated that eliminating racial health disparities could result in savings as high as $230 billion. According to another analysis, health disparities cost the USA $93 billion in excess medical care costs and $42 billion in lost productivity.

With racial and ethnic minorities predicted to become a majority of the U.S. population by 2050, the economic costs of inequity will only continue to increase. And it is a vicious cycle. If those who live in poverty have poor health, they are less likely to be able to rise out of poverty and contribute to the US’ economic output.

III. INITIATIVES TO ADDRESS HEALTH INEQUITY AND WHY THEY ARE NOT ENOUGH

There is no doubt that the healthcare industry recognizes the health inequity problem. All major industry actors are now making at least some attempt to address it. This

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135 Roosa Tikkanen & Melinda K. Abrams, U.S. Healthcare from a Global Perspective, 2019: Higher Spending, Worse Outcomes?, The COMMONWEALTH FUND (Jan. 30 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019.

136 Id.

137 See Irene Papanicolas et al., Health Care Spending in the United States and Other High-income Countries, 319 JAMA 1024 (2018) (‘The United States spent approximately twice as much as other high-income countries on medical care.’); Gerard F. Anderson et al., It’s the Prices, Stupid: Why the United States is So Different from Other Countries, 22 HEALTH AFFAIRS 89 (2003) (‘U.S. per capita health spending was... 44% higher than Switzerland’s, the country with the next-highest expenditure per capita; 83% higher than neighboring Canada; and 134% higher than the [Organization for Economic Cooperation and Development (OECD)] median.’).

138 William Reilly, Health Disparities are Costly for (U.S.) All, NATIONAL INSTITUTES OF HEALTH (Apr. 1, 2016), https://obssr.od.nih.gov/health-disparities-are-costly-for-u-s-all-think-about-it-in-april-and-beyond/; see also Dana Brown, Single Payer would be a Good Start, but Real Health Equity Means Tackling Economic Disparities, DEMOCRACY COLLABORATIVE (Aug. 14, 2017), https://thenextsystem.org/learn/stories/single-payer-would-be-good-start-real-health-equity-means-tackling-economic (‘Not only are countless lives needlessly lost because of these inequities, but they come at a price of $300 billion a year in lost wages, healthcare costs and premature death, making a pretty good business case for addressing these harmful disparities.’).

139 Id.

140 Ani Turner, The Business Case for Racial Equity, A Strategy for Growth, W.K. KELLOGG FOUNDATION (Apr. 2018), https://altarum.org/publications/the-business-case-for-racial-equity-a-strategy-for-growth; See The Economic Case for Health Equity, ASTHO, https://www.astho.org/Programs/Health-Equity/Economic-C-Case-Issue-Brief/ (last accessed Nov. 1, 2020).

141 See Jeffry S. Passel & D’Vera Cohn, U.S. Populations Projections: 2005–2050, PEO RESEARCH CENTER (Feb. 11, 2008), https://www.pewresearch.org/hispanic/2008/02/11/us-population-projections-2005-2050.

142 See Jessica Mantel, Tackling the Social Determinants of Health: A Central Role for Providers, 33 GA. ST. U.L. REV. 217 (2016); see also Tuberculosis, WORLD HEALTH ORGANIZATION, https://www.who.int/newsroom/fact-sheets/detail/tuberculosis (last accessed Nov 2, 2020). (‘Take deaths from TB as an example—hits young adults in developing countries who then cannot contribute to improving the economic condition of their families’).
part describes those efforts. But it also details the hurdles facing current initiatives and makes the case for why current efforts alone will not adequately address the problem.

III.A. Current Efforts to Address Health Inequity

Fixing health inequity requires addressing access, quality, and the structural and social determinants of health. The ACA focused its efforts primarily on improving access and quality.143

It succeeded, at least in the short term, in reducing rates of uninsurance by allowing states to expand Medicaid coverage and by offering subsidies to allow lower income Americans to purchase policies on state exchanges—subsidies that the Biden Administration temporarily expanded with the American Rescue Plan Act (ARPA).144 But while 20 million previously uninsured Americans gained coverage because of those reforms, and perhaps even more with the ARPA, over 10 per cent of the population is still uninsured.145 Also, the ACA did little to address the problem of underinsurance, most notably in the private market, which prevents insured individuals from seeking care because they cannot afford the out-of-pocket expenses.146 Work to improve access must continue.

The ACA also attempted to legislate quality improvements by moving toward payment methodologies that rewarded good health outcomes, by requiring public reporting of quality metrics, and by incentivizing new care delivery models that rewarded quality. Healthcare quality still, however, lags behind comparable countries.147

Aside from addressing access and quality, the ACA did make some changes in furtherance of health equity. It devoted resources through entities like the Agency for Healthcare Research and Quality (AHRQ) and the Patient Centered Outcomes Research Institute (PCORI) to track patient outcomes by race and other variables of equity.148

143 While access was the primary focus, the ACA did also make some structural changes in aid of health equity, including the addition of ‘minority health offices’ within the Department of Health and Human Services and data-collection efforts. See Gwendolyn Roberts Majette, Striving for the Mountaintop—the Elimination of Health Disparities in A Time of Retrenchment (1968–2018), 12 GEO. J.L. & MOD. CRITICAL RACE PERSP. 145, 151–52 (2020) (describing the ACA as ‘framework legislation’).

144 See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111–148, 124 Stat. 119 (2010), (codified as amended at 42 U.S.C. § 18001).

145 See Rachel Garfield, Kendal Orgera & Anthony Damico, The Uninsured and the ACA: A Primer- Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act, KFF (Jan. 25, 2019). Trump Administration efforts to sabotage the ACA and the intervening COVID-19 pandemic have certainly contributed to increased rates.

146 See Christopher Robertson, Exposed: Why Our Health Insurance is Incomplete and What Can Be Done About It (Harvard Univ. Press, 2019).

147 The ACA also contains provisions to develop comparative research models to study the effectiveness of medical treatments and various other projects to reduce medical error and improve health outcomes. It also requires collection of race and ethnicity data and training of a diverse workforce. See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111–148, 124 Stat. 119 (2010), (codified as amended at 42 U.S.C. § 18001). The ACA also reauthorizes the Indian Health Care Improvement Act, designed to address health disparities by investing in preventive health and wellness to benefit American Indians and Alaska Natives. See Affordable Care Act, INDIAN HEALTH SERVICE, https://www.ihs.gov/aca/ (last accessed Oct. 21, 2020).

148 See Gwendolyn Roberts Majette, Striving for the Mountaintop—the Elimination of Health Disparities in A Time of Retrenchment (1968–2018), 12 GEO. J.L. & MOD. CRITICAL RACE PERSP. 145, 151–52 (2020).
It also implemented some structural changes in creating a Deputy Assistant Secretary for Minority Health and created six minority health offices within Health and Human Services (HHS). And it started the process of looking beyond just the traditional healthcare sector to solve the health equity problem by creating entities like the Federal Interagency Health Equity Team and the National Prevention Council, which brings together senior leadership from various federal agencies and offices.

Other preliminary efforts are also underway—by government agencies, private insurers, providers, and charitable organizations—to address the structural and social determinants of health. These innovations are important and many provide direction for the future. But they are not enough.

### III.A.i Government Efforts to Address Social Determinants of Health

The government is the most obvious entity to address the social determinants of health. Government assistance programs—both at the state and federal levels—are designed to address most of the major categories of need that ultimately contribute to disparate health outcomes. The Temporary Assistance for Needy Families (TANF) program provides temporary funding to families in poverty through a federal–state collaboration model. The Supplemental Nutrition Assistance Program (SNAP) supplements the food budget of needy families. The U.S. Department of Housing and Urban (HUD) provides funding to states, which in turn provide access to low-income housing. The U.S. Department of Labor provides unemployment benefits to eligible workers through a joint state–federal program. To the extent that poverty, food insecurity, homelessness, and unemployment are the implicated needs, there are government programs responsible for addressing all of these issues.

Historically, these assistance programs have had little to no interaction with the Department of Health and Human Services and the Centers for Medicare and Medicaid Services, which have focused narrowly on providing access to clinical healthcare. Over the last decade, however, HHS, as well as CMS in particular, has started to grapple with the role it can play outside of the strict provision of clinical care. In 2010, in ‘Healthy People 2020’—a set of goals and benchmarks that HHS hoped to achieve in the decade to follow—it first committed to: ‘Emphasizing ideas of health equity that address social determinants of health and promote health across all stages of life.’

HHS followed up in 2011 with an ‘action plan’ to eliminate racial and ethnic health disparities. That plan committed HHS not only to improve access and quality but

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149 Id.
150 See Artiga and Hinton, supra note 17. Arguably, Section 1557 of the ACA, the civil rights provision in the Act could also be used to promote health equity, although it has not been effectively used for such purposes, yet. See Dayna Bowen Matthew, Structural Inequality: The Real Covid-19 Threat to America’s Health and How Strengthening the Affordable Care Act Can Help, 108 Geo. L.J. 1679, 1711 (2020).
151 See Policy Basics: Temporary Assistance for Needy Families, CENTER ON BUDGET AND POLICY PRIORITIES, https://www.cbpp.org/research/family-income-support/temporary-assistance-for-needy-families (last accessed Feb. 6, 2020).
152 See Nutrition Assistance, FOOD AND NUTRITION SERVICE, U.S. DEPARTMENT OF AGRICULTURE, https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program (last accessed Oct. 21, 2020).
153 See Resources for Individuals, U.S. DEPARTMENT OF HOUSING AND HUMAN DEVELOPMENT, https://www.hud.gov/program_offices/administration/grants/grantssrc (last accessed Oct. 21, 2020).
154 See Health Disparities Data, HealthyPeople.gov, https://www.healthypeople.gov/2020/data-search/health-disparities-data (last accessed Oct. 21, 2020).
The health equity mandate

also to provide better data about disparities, increasing the number of health professionals from racial and ethnic minority populations, engaging in cultural competency training of health professionals, and supporting research and innovation efforts to address disparities. Notably, the plan did not involve agencies outside the HHS ‘family’ of agencies.

HHS has since undertaken a number of initiatives to implement the action plan. Alex Azar, Secretary of HHS for the Trump Administration, repeatedly confirmed the agency’s ‘deep interest’ in addressing social determinants of health. And President Biden’s Secretary of HHS, Xavier Becerra, was chosen for the role partly because of his commitment to health equity.

III.A.i.a. Medicaid

Medicaid’s efforts are the furthest along. Medicaid, a federal/state collaboration that pays the medical costs for people of limited means, serves the greatest population of individuals for whom social determinants of health affect health outcomes. Because Medicaid is administered at the state level, it also provides the greatest opportunity for state- and local-level experimentation.

First, Medicaid programs in some states are requiring insurers to screen for social and environmental determinants that could lead to poorer health outcomes. Certain programs are using that information to refer beneficiaries to social service agencies that can help to address those problems. For instance, L.A. Care, the largest publicly operated Medicaid plan in the USA, identifies beneficiaries who require access to healthy foods and then refers those beneficiaries to other government programs to meet those needs (eg, to CalFresh, which provides financial assistance to purchase healthy foods).

Second, CMS has issued waivers allowing some state Medicaid programs to reimburse for services aimed at addressing social determinants of health. Typically, this

155 See HHS Action Plan to Reduce Racial and Ethnic Health Disparities, Department of Health and Human Services, https://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf (last accessed Oct. 21, 2020).

156 See Department of Health and Human Services Sets Public Health Objectives for the next Decade in Healthy People 2030, National Institutes of Health, https://orwh.od.nih.gov/in-the-spotlight/all-articles/department-health-and-human-services-sets-public-health-objectives (last accessed Oct. 21, 2020).

157 See Leora I. Horwitz et al., Quantifying Health Systems’ Investment Determinants of Health, By Sector, 2017–19, 39 HEALTH AFFAIRS 1 (Feb. 2020), DOI: 10.1377/hlthaff.2019.01246.

158 See Sheryl Gay Stolberg and Michael D. Shear, Biden Picks Xavier Becerra to Lead Health and Human Service, NY Times (Dec. 6, 2020), https://www.nytimes.com/2020/12/06/us/politics/xavier-becerra-hhs-health-secretary.html.

159 Although some do not yet have that capacity. See Samantha Artiga & Elizabeth Hinton, Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity, KFF (May 10, 2018), https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/.

160 See Shelby Livingston, In Depth: Payers Can’t Control Costs Without Social Determinants of Health Model Modern Healthcare (Aug. 25, 2018, 1:00 AM), https://www.modernhealthcare.com/article/20180825/NEWS/180829956/in-depth-payers-can’t-control-costs-without-social-determinants-of-health-model.

161 Elizabeth Hinton et al., A first look at North Carolina’s Section 1115 Medicaid waiver’s Healthy Opportunities Pilots, Henry J. Kaiser Family Foundation (May 15, 2019), https://www.kff.org/report-section/a-first-look-at-north-carolinas-section-1115-medicaid-waivers-healthy-opportunities-pilots-issue-brief/.
means working with the Medicaid-managed care organizations that finance and deliver care to integrate benefits outside the traditional clinical domain into their contracts.\textsuperscript{162} For instance, Oregon and Colorado have integrated physical and behavioral care and social services into the benefits their Medicaid programs offer.\textsuperscript{163} North Carolina and Louisiana have obtained Section 1115 Medicaid waivers under the ACA to invest in supportive housing.\textsuperscript{164} These approaches are consistent with the results of at least one study that found low-income urban residents prioritized interventions addressing social determinants of health such as housing vouchers and job training.\textsuperscript{165}

Third, in 2018, CMS launched accountable health communities (AHC).\textsuperscript{166} AHCs build on the Accountable Care Organization (ACO) model, where, in an attempt to improve care coordination and collaboration, networks of providers agree to provide care for patients and are reimbursed in part on patient outcomes.\textsuperscript{167} ACOs tended to focus on improving clinical care coordination. AHCs, on the other hand, are designed to also address social determinants of health. CMS is providing funding so that AHCs can enroll high-risk individuals and help them to navigate the social services available to them. The 5-year AHC experiments will assess both health outcomes achieved and associated cost.\textsuperscript{168}

\textit{III.A.i.b. Medicare}

Fewer efforts have been made by the other major government payer, Medicare. Traditional Medicare still limits reimbursement to clinical care and does not have any major initiatives aimed at addressing social determinants.

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\textsuperscript{162} See \textit{Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations}, \textit{Association for Community Affiliated Plans} (Dec. 2018), \url{https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf}.

\textsuperscript{163} See Logan Kelly & Allison Hamblin, \textit{Making Integration Work: Key Elements for Effective Partnerships Between Physical and Behavioral Health Organizations in Medicaid}, \textit{California Health Care Foundation} (Feb. 2020), \url{https://www.chcf.org/wp-content/uploads/2020/02/MakingIntegrationWorkElementsEffectivePartnerships.pdf}.

\textsuperscript{164} Dayna Bowen Matthew, \textit{Structural Inequality: The Real Covid-19 Threat to America’s Health and How Strengthening the Affordable Care Act Can Help}, 108 Geo. L.J. 1679, 1711 (2020).

\textsuperscript{165} See Marion Danis et al., \textit{Priorities of Low-Income Urban Residents for Interventions to Address the Socio-Economic Determinants of Health}, 21 J. HEALTH CARE FOR POOR & UNDERSERVED 1318, 1328 (2010).

\textsuperscript{166} See Dora Hughes & Cindy Mann, \textit{Financing the Infrastructure of Accountable Communities For Health is Key to Long-Term Sustainability}, 39 HEALTH AFFAIRS 1 (Apr. 2020), \url{https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01581}.

\textsuperscript{167} Id.

\textsuperscript{168} See \textit{Accountable Health Communities Model}, \textit{Centers for Medicaid and Medicare Services}, \url{https://innovation.cms.gov/innovation-models/ahcm#text=The%20Accountable%20Health%20Communities%20Model,%20through%20screening%20referral%20and%20(last%20accessed%20Oct.%202%020);SanneMagnan, Social Determinants of Health 101 for Healthcare: Five Plus Five, NATIONAL ACADEMY OF MEDICINE} (Oct. 9, 2017), \url{https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/#!text=The%20Centers%20for%20Medicare%20%26%20Medicaid%20%5B Baton Rouge, %20C25%5D}.  

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In 2018, however, Congress enacted the Chronic Care Act legislation. Under the authority of that statute, CMS issued new rules in 2020 permitting Medicare Advantage plans to offer reimbursement for non-clinical care that impacts health outcomes. Medicare Advantage plans are private plans offering Medicare benefits. MA plans are permitted to offer a wider range of benefits than traditional Medicare (often including options such as dental and eye care). Now MA plans have been given additional flexibility to reimburse for a broader range of services addressing social determinants. For instance, an MA plan can now offer to pay for transportation to medical appointments, to install a ramp to make a home more accessible, or for adult day care. This is a major change and most of the large insurers have jumped at the opportunity. If private plans prove successful at addressing social determinants through benefit changes, it could pressure traditional Medicare to follow suit.

III.A.i.c. State Efforts

Because of funding opportunities, the largest state-level efforts to address social determinants are being conducted in partnership with the Medicaid program. But it is worth noting that almost half of all states have strategic plans to address health equity. State innovation models have focused on public health–driven community health assessments and at outreach and education efforts aiming to ensure that eligible residents understand the social services available to them. Public health efforts at the state level also focus on monitoring disease burden, ensuring safe conditions and sanitation, and overseeing the quality of clinical healthcare provided in a community. States are also working to address social determinants of health outside of the healthcare system. Early, state-level efforts to combat environmental inequities are one example. Communities of color are at a heightened risk of having their health negatively impacted by poor environmental conditions. They are more likely to suffer

169 Martha Hostetter & Sarah Klein, In Focus: CHRONIC Care Act Prompts Some Medicare Advantage Plans to Incorporate Social Services, THE COMMONWEALTH FUND (Jan. 9, 2020), https://www.commonwealthfund.org/publications/2020/jan/focus-chronic-care-act-prompts-some-medicare-advantage-plans-incorporate?redirect_source=/publications/newsletter-article/2020/jan/focus-chronic-care-act-prompts-some-medicare-advantage.
170 Id.
171 See Gretchen Jacobson et al., A Dozen Facts About Medicare Advantage in 2019, KFF (June 6, 2019), https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/.
172 'Companies who have taken advantage of this include Aetna, Anthem, Cigna, Humana, and UnitedHealth Group.' See Insurance Companies are Investing in the Social Determinants of Health, But Widespread Changes in Benefits Remain to be Seen, CENTER ON HEALTH INSURANCE REFORMS (May 7, 2020), http://chirblog.org/insurance-company-investments-social-determinants-of-health/.
173 As with Medicaid, Medicare beneficiaries appear interested in having coverage that would reimburse for social determinants. See Govind Persad, Choosing Affordable Health Insurance, 88 GEO. WASH. L. REV. 819, 854 (2020).
174 See Samantha Artiga, Kendal Orgera & Olivia Pham, Disparities in Health and Health Care Key Questions and Answers, KFF (Mar. 4, 2020), https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/.
175 James A. Hester et al., Opportunity Knocks Again for Population Health: Round Two in State Innovation Models, NAM PERSPECTIVE (Apr. 16, 2015), https://doi.org/10.31478/201504i; State Approaches to Reducing Health Disparities, NATIONAL CONFERENCE OF STATE LEGISLATURES, https://www.ncsl.org/Portals/1/HTML_LargeReports/HealthDisparity_1.htm (last accessed Oct. 21, 2020).
176 The Future of the Public’s Health of the 21st Century, INSTITUTE OF MEDICINE (2003), https://www.ncbi.nlm.nih.gov/books/n/nap10548/pdf/.
from lead exposure and to be negatively impacted by poor air quality. Asthma induced by poor air quality has led to more COVID deaths in Black populations. State efforts to address environmental racism are in their infancy. New Jersey just passed a law in 2020 that requires regulators to deny permits to industry if a project will burden communities of color or low-income communities already facing health and environmental threats. A bill is being proposed in Illinois that would fund $27 million annually to go toward clean energy and climate initiatives in communities of color.

Some states are also engaged in other efforts, such as to provide for paid family leave and to improve educational equity, just to name some. These efforts are new and promising but in their infancy and not yet widespread.

### III.A.ii. Private Payer Efforts

While Medicaid provides coverage for much of the most vulnerable populations, private payers also have incentive to make efforts to address the social determinants of health, particularly if doing so can reduce claims costs. Most large private insurers either offer plans on healthcare exchanges that cater to individuals who qualify for subsidized premiums or are involved in offering Medicaid Managed Care. As such, private payers do also serve vulnerable populations. In addition to having incentive to address the underlying causes of health equity, private payers also have the financial means to do so. This section details major efforts payers have made in recent years. It will be interesting to track payer efforts in the near term, as well, as the pandemic has simultaneously led payers to recognize unprecedented profits but caused poverty among vulnerable populations to increase.

In June 2019, America’s Health Insurance Plans (AHIP), a national association representing the interests of private insurers, launched Project Link—an initiative that brings together health insurers to discuss ‘how to effectively address social barriers for the people we serve.’ It’s a signal that health insurers are motivated and, in fact have already, started experimenting with how they can address social determinants.

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177 See Justin Worland, *Why the Larger Climate Movement Is Finally Embracing the Fight Against Environmental Racism*, TIME (July 19, 2020), https://time.com/5864704/environmental-racism-climate-change/. See also *Toxic Wastes and Race in the United States*, Commission for Racial Justice (1987), https://d3n8a8pro7vhmx.cloudfront.net/unitedchurchofchrist/legacy_url/13567/toxwrace87.pdf?1418439935 (finding race to be the best predictor of who lives near a hazardous waste site).

178 Id.

179 N.J.S.A.S-232 (2020), https://www.njleg.state.nj.us/2020/Bills/S0500/232_I1.pdf.

180 See Kari Lydersen, *In Illinois energy bill negotiations, equity is taking center stage*, ENERGY NEWS NETWORK (Oct. 27, 2020), https://energynews.us/2020/10/27/midwest/in-illinois-energy-bill-negotiations-equity-is-taking-center-stage/ (describing state and local efforts to expand paid family leave) and https://www.nashp.org/nashp-identifies-state-strategies-to-address-mental-health-and-education-inequities/ (describing state efforts to improve educational equity).

181 See *Project Link*, AMERICA’S HEALTH INSURANCE PLANS, https://www.ahip.org/project-link/ (last accessed Oct. 21, 2020).

182 Id.

183 Id.

184 See supra note 22.
A few examples are instructive. The Blue Cross Blue Shield Institute was established by the Blue Cross Blue Shield Association in 2018. Its mission is to address the ‘zip code effect’, the idea that certain neighborhoods can be “transportation, pharmacy, nutrition and fitness deserts,” impacting overall health. A for-profit benefit corporation, the Institute has pledged to use technology and strategic alliances to address social determinants. So far, it has collaborated with Lyft to bring patients to doctors’ appointments and with Walgreens and CVS to improve access to medications in rural areas. In the Chicago area, the Blue Cross Blue Shield Institute partnered with Health Care Service Corporation to deliver healthy meals to food deserts.

Another example of a private insurer attempting to address social determinants of health is United Health Care’s Housing Initiative. UHC offers Medicaid Managed Care plans. Its data from those plans showed that access to stable housing decreased health costs. Since 2011, UHC has invested over $400 million in affordable housing initiatives.

Insurers are strategically using charitable donations in other ways, too. For instance, Aetna’s charity, Building Healthier Communities, invested $100 million in activities designed to address social determinants of health. Insurers are also starting to make efforts to track social determinants of health through better data collection. United Health Group has created new ICD-10 codes related to social determinants of health that can trigger referrals to social service organizations. And Blue Cross Blue Shield of Rhode Island has deployed a life index survey to compile data on the social factors influencing health outcomes.

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185 5 Ways Health Insurers are Addressing the Social Determinants of Health, MEDIA LOGIC (Jan. 14, 2019), https://www.medialogic.com/blog/healthcare-marketing/5-ways-health-insurers-are-addressing-the-social-determinants-of-health/.
186 Id.
187 Id.
188 Id.
189 See Jacqueline Renfrow, Why Blues Plans, Health Care Service Corporation are Team Up Fight to Hunger, FIERCE HEALTHCARE (Mar. 4, 2019, 8:37 AM), https://www.fiercehealthcare.com/payer/bcbs-hcsc-deliver-food-delivery-service-as-preventative-measure (describing FoodQ program).
190 See supra note 22.
191 Aetna made similar investments in 2019. CVS Health Announces "Destination: Health," A New Platform Addressing Social Determinants of Health, CVS HEALTH (July 24, 2019), https://cvshealth.com/news-and-insights/press-releases/cvs-health-announces-destination-health-a-new-platform-addressing (describing a $50 million investment in housing services for its Medicaid and Dual-Eligible Special Needs Plan (DSNP) members.).
192 See supra note 22 (noting insurer focus on charitable grant programs rather than ‘changing benefit designs, reimbursement policies, or other business practices.’).
193 See also Florida Blue Foundation Awards $9 Million in Health Care Grants to Nonprofits Statewide, BLUE CROSS BLUE SHIELD (Oct. 9, 2019), https://www.bcbs.com/press-releases/florida-blue-foundation-awards-9-million-health-care-grants-nonprofits-statewide%09. Charities unconnected to payers are similarly funding efforts to address health inequity. See, eg, Faith A. Mitchell, Innovations in Health Equity and Health Philanthropy, 14 STANFORD SOC. INNOV. REV. 3 (Spring 2016), https://ssir.org/articles/entry/innovations_in_health_equity_and_health Philanthropy; FORD FOUNDATION, https://www.fordfoundation.org/ (last accessed Oct. 21, 2020); Patricia Doykos, Kristina Gray-Akpa & Faith Mitchell, New Directions for Foundations In Health Equity, 35 HEALTH AFFAIRS 1 (Aug. 2016), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0256.
194 See United Healthcare and the AMA Collaborate to Understand and Address Social Barriers Preventing People’s Access to Better Health, UNITEDHEALTH GROUP (Apr. 2, 2019), https://www.unitedhealthgroup.com/pressroom/2019/2019-04-02-uhc-ama-social-barriers.html.
With the exception of insurers starting to experiment with strategic reimbursement through their Medicare and Medicaid offerings, however, most are focusing their efforts on strategic use of charitable donations rather than adding benefits that address social determinants.

### III.A.iii. Provider-Driven Interventions

While payers are best situated to finance social determinants of health, providers have the most direct access to the patients that need help.\[^{196}\] Hospital systems also have valuable data that can help identify social needs and their effect on health outcomes. Historically, providers have lacked both the financial incentive to improve social determinants—as they were paid on a fee-for-service basis to narrowly deliver clinical care\[^{197}\]—and the expertise to do so. But there have been some notable changes that have led providers to engage with the drivers of health inequity, including new payment models and sources of funding.\[^{198}\] Hospitals are now engaging in direct financing to address social benefits; conducting needs assessments; and funding and participating in medical–legal partnerships, patient-centered medical homes, and ACOs.

First, while U.S. health systems have historically invested little in addressing social determinants,\[^{199}\] recent years have seen a marked increase in activity. One study of public announcements of health system efforts found 78 unique programs, pledging a total of over $2.5 billion in health system funds, announced between January 2017 and November 2019.\[^{200}\] This is a small amount relative to overall spending but is still a significant step. The majority of these programs were focused on housing interventions, but others aim to address food security, employment, and transportation.\[^{201}\]

Increasingly, health systems are collaborating to address community needs. In Chicago, for instance, Rush, Lurie Children’s Hospital, Amita Health, Cook County Health, Sinai Health System, and the University of Illinois Hospital are working together through a group called West Side United. Their goal is to use their combined economic power to revitalize the community through increasing hiring in surrounding communities and expanding local sourcing of supplies and services.\[^{202}\] Nationally, the efforts of (mostly large) hospital systems to address social determinants of health are

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195 See BCBSRI launches the Rhode Island Life Index as a Measure of Rhode Islanders’ Perceptions of the Social Factors Influencing Health and Well-being in the State, BLUE CROSS BLUE SHIELD (Oct. 23, 2019), https://www.bcbs.com/press-releases/bcbsri-launches-the-rhode-island-life-index-measure-of-rhode-islanders-perceptions.

196 See Dayna Bowen Matthew, Structural Inequality: The Real Covid-19 Threat to America’s Health and How Strengthening the Affordable Care Act Can Help, 108 GEO. L.J. 1679, 1680 (2020) (describing provider innovators).

197 See Jessica Mantel, Tackling the Social Determinants of Health: A Central Role for Providers, 33 GA. ST. U.L. REV. 217 (2016) (describing how FFS rewarded quantity of care and not health outcomes).

198 See Marcus Plescia & Michael Dulin, Accountable Care Communities, N.C. MED. J. (July 2017), https://doi.org/10.18043/ncm.78.4.238.

199 See supra note 5.

200 Id.

201 Id.

202 See Harris Meyer, As Health Inequities Mount, Hospitals Step Up Economic Development Initiatives, MODERN HEALTHCARE (Dec. 14, 2019, 1:00 AM), https://www.modernhealthcare.com/providers/health-inequities-mount-hospitals-step-up-economic-development-initiatives; Kaiser Permanente has also been a leader in this space, ‘spearheading investments and partnerships in affordable housing, job-creating economic development, education, nutrition, healthy behaviors, and other social determinants of health.’
being coordinated by the Healthcare Anchor Network, which now includes over 50 large healthcare systems. But as payers have seen record profits during the pandemic, health systems have struggled financially. It remains to be seen what effect the pandemic will have on these efforts.

Second, health systems are collecting data on social determinants through patient-level screening mechanisms and community needs assessments. Indeed the ACA requires tax-exempt hospitals to conduct regular needs assessments, which must consider non-clinical factors impacting health. Hospitals are also required to adopt a plan for meeting the needs identified in such assessments.

Third, providers are key participants, and often the financial sponsors, of medical–legal partnerships (MLPs). An MLP works by embedding lawyers into healthcare settings to work in collaboration with providers. Providers are trained to identify impediments to healthy outcomes that lie outside the clinical domain and that lawyers can help patients to resolve. For instance, lawyers can help patients address housing issues like illegal evictions and unsafe housing conditions that landlords are required to remediate and benefits issues like navigating Medicaid and social security, and they can even help resolve legal issues stemming from debt and bankruptcy. Payment models that reward healthy outcomes have incentivized provider participation in MLPs. And recent years have seen an expansion of such efforts.

Fourth, providers are addressing social determinants of health through patient-centered medical homes—a model where a provider takes responsibility for stewarding a patient’s care both clinically and out in the community. The ACA promises federal funding for medical homes that serve Medicaid beneficiaries, which has increased the attractiveness of the model for some providers. Rather than focusing on legal needs, as the MLP does, the medical home design puts providers in charge of advocating for the patient to receive community resources necessary to improve health outcomes.

Finally, as precipitated by the ACA, providers now find themselves organizing as accountable care organizations. While ACOs originally focused on coordination of clinical care and were criticized for failing to look beyond the hospital walls, ACOs have started to respond to patients’ needs for transportation, housing, and food, prompted by the realization that improved outcomes and reduced costs will be rewarded financially. With CMS’s investment, ACOs have started to transition into...
Accountable Health Communities, even more focused on drivers of health outcomes outside of the clinical domain.

III.B Why Current Efforts Won’t Be Enough
As the last section detailed, many efforts are under way to address the social and structural determinants of health. The breadth of the efforts gives reason for optimism. All sorts of different entities are committing an increasing amount of resources to better understanding, and then better addressing, the problems that lead to health inequity.

Despite this optimism, current efforts are not likely to be enough. A lack of coordination between health industry players and government entities, and perhaps most important, beyond the healthcare sector, will hinder progress. Relatedly, a mechanism for scaling promising initiatives and for collaborating across geographic boundaries is lacking. Funding is still woefully insufficient and dwarfed by spending on clinical care. And proving the success of different interventions with data has been difficult. These obstacles need to be overcome before real progress will be made.

II.B.i. The Challenges of Fragmentation and Scalability
Solving the health inequity problem is complicated by the fact that it is multi-causal and implicates all different services—housing, transportation, food, the environment, and so forth. It is further complicated by the fact that problems vary considerably with geography.211

Although government programs exist to address most of the social determinants of health, there has been limited attempt to collaborate across the responsible governmental entities and no setting of goals or metrics that must be met across agency domains.212 For instance, HHS’s efforts to address health inequity do not implicate the work being done through other federal agencies such as HUD (on housing) or the Department of Labor (on unemployment benefits).213

Expertise needs to be shared between agencies or must be reported to an entity charged with addressing health equity across sectors.214 The budgeting process does not support such collaboration. Notably, budgeting doesn’t consider cross-sector cost–benefit calculations.215 If HUD accrues extra cost that results in improvements to health outcomes, that health benefit does not factor into the calculation of HUD’s budget.216

211 See Kurt C. Stange, The Problem of Fragmentation and the Need for Integrative Solutions, 7 ANN FARM MED. 100, (2009), https://doi.org/10.1370/afm.971.
212 See Managing for Results: Key Considerations for Implementing Interagency Collaborative Mechanisms, U.S. Gov. ACCOUNTING OFFICE (Sept. 2012), https://www.gao.gov/assets/650/648934.pdf. But see President Biden Announces Members of the Biden-Harris Administration COVID-19 Health Equity Task Force (Feb. 10, 2021), https://www.whitehouse.gov/briefing-room/press-briefings/2021/02/10/president-biden-announces-members-of-the-biden-harris-administration-covid-19-health-equity-task-force/.
213 See David Zuckerman, Violeta Duncan & Katie Parker, Building a Culture of Health Equity at the Federal Level, NATIONAL ACADEMY OF MEDICINE (Mar. 1, 2016), https://nam.edu/building-a-culture-of-health-equity-at-the-federal-level/ (discussing how ‘the elimination and reduction of health disparities is contingent on concerted federal action.’); see also The War on Poverty: 50 Years Later, HOUSE BUDGET COMMITTEE REPORT (Mar. 3, 2014), https://cryptome.org/2014/03/war-on-poverty-50.pdf.
214 See Livingston, supra note 141 (noting that providers know how to reduce hospital-acquired infections but not how to ensure patients have access to healthy food).
215 See supra note 40.
But it is not just a siloed federal administrative structure that challenges solutions. Insufficient collaboration within the health industry itself, across players, is also problematic and is driven by a form of collective action problem. While both private and government payers are increasingly giving providers incentives to address social determinants of health by tying reimbursement rates to health outcomes, most of the initiatives to address health inequity are sector-specific. For instance, providers may be collaborating to revitalize the job market on the West side of Chicago, but payers are not involved in that effort. Or payers may be using philanthropic funds to invest in housing in low-income areas, but providers are not involved in that initiative. Even within the healthcare community, there is insufficient collaboration across sectors.\(^{217}\) And yet no one sector can solve health inequity on its own. Any entity making an investment has to rely on other entities following suit if progress is to be made.

Consider that providers might be best positioned to identify social needs that impact health outcomes, but they aren’t trained in how to assess the causes of the health outcomes they are seeing or in addressing those issues.\(^{218}\) Or payers could provide necessary funding to address social determinants, but they lack the infrastructure to directly implement solutions.

Relatedly, there is not enough sharing of data occurring.\(^{219}\) Payers and providers have access to different data sets that could aid in addressing the causes of health inequity but are not collaborating to use that data in ways that ultimately benefit everyone.\(^{220}\)

The local nature of many of the causes of health disparities also complicates solutions. While local-level experimentation is desirable, there is no mechanism for sharing results with other geographic areas that might be similarly situated or for scaling solutions in a way that ensures fit of the solution with local considerations.

It is frequently said that the US’ healthcare system is the most fragmented in the world. Typically, that is a reference to all of the different sources of payment for care: Medicaid, Medicare, employer-sponsored insurance, ACA policies, VA insurance, etc. But the fragmentation afflicting health inequity runs even deeper than payment sources. Even outside the health sector, the US’ federalist and fragmented system challenges a coordinated response to such a widespread problem. A path forward would have to address the dire need for collaboration.

II.B.ii. Underfunding

Even though government agencies exist to address the underlying social and structural determinants of health, those agencies are chronically underfunded. Most developed
countries spend far more on social services than the USA does.\textsuperscript{221} The investments being made, here, dwarf the kinds of investments necessary to truly address health inequity.

Similarly, it has come to light particularly as the USA fights COVID-19 that public health and social services are also severely underfunded. According to one report, $5,000 positions with local health departments were eliminated in the last decade.\textsuperscript{222} And of the $3.5 trillion spent on healthcare, only 2.5 per cent went to public health spending.\textsuperscript{223} Indeed, funds from the Prevention and Public Health Fund established by the ACA have consistently been redirected to other purposes.\textsuperscript{224}

The evidence is strong that improving social and environmental factors would have a much greater impact on health outcomes than improving quality of clinical care. While funding by industry players has certainly increased over the last decade—one study found that health systems had invested $2.5 billion between 2017 and 2019, of which $1.6 billion was directed to housing-focused interventions\textsuperscript{225}—and charitable organizations continue to fund programs to address social determinants of health;\textsuperscript{226} it is not even close to what is needed. Still, 95 per cent of all health expenditures are spent on clinical care.\textsuperscript{227} And even so, improving the social and environmental factors might not be best done through changes to the clinical care delivery system, even if that system would arguably see the greatest benefit.

II.B.iii. Even with Funding, Questions Remain about What To Do

There is no playbook, yet, for how to address the causes of health inequity. And in a world of limited resources, there is inadequate guidance on where to make investments to get the greatest return in improved health outcomes. Experimentation and data collection are needed to answer those questions.

Although the last decade has brought much innovation, it has not yet brought a lot of answers. For instance, it seems that value-based payment methods should incentivize providers to address social determinants of health, but there is little evidence, yet, that these new payment models are translating to reduced health disparities.\textsuperscript{228}

Similarly, a promising initiative in Camden, New Jersey, assigned ‘super-utilizer’ patients who were frequently hospitalized and faced significant social barriers like homelessness to a special program where they worked directly with doctors, social workers, and nurses for individualized help. The program spawned many similar programs across the country. But an initial study in the New England Journal of Medicine

\begin{enumerate}
\item See supra note 18.
\item Steve Ross Johnson, \textit{Report: Public Health Funding Falls Despite Increasing Threats}, MODERN HEALTHCARE (Apr. 24, 2019), https://www.modernhealthcare.com/government/report-public-health-funding-falls-despite-increasing-threats (linked to report by Trust for America’s Health).
\item Id.
\item Id.; see also Peter D. Jacobson & Wendy E. Parmet, \textit{Public Health and Health Care: Integration, Disintegration, or Eclipse}, 46 J.L. Med. & Ethics 940 (2018) (arguing for an integration of the healthcare and public health systems).
\item Leora I. Horwitz et al., \textit{Quantifying Health Systems’ Investment In Social Determinants of Health, By Sector, 2017–19}, 39 Health Aff. 192 (2020), DOI: 10.1377/hlthaff.2019.01246.
\item Lee L. Prina, \textit{Funding To Improve Social Determinants Of Health}, 38 HEALTH AFF. 1589 (2019), https://doi.org/10.1377/hlthaff.2019.01013.
\item See supra note 56.
\item Id.
\end{enumerate}
found that the group receiving the individualized attention did not reduce hospitalizations any more than a control group.\textsuperscript{229}

This does not mean hope is lacking. Other programs that assigned navigators to high-need patients in an attempt to bridge the gap on health disparities did find improved health outcomes.\textsuperscript{230}

Some of what needs to be accomplished—particularly changing entrenched practices, addressing implicit bias and structural racism, changing the makeup of the health workforce, effecting cultural change, and earning trust\textsuperscript{231}—is just hard. Experts don’t yet agree on the best, fastest, most cost-effective way to accomplish the desired ends.

IV. DEMOCRATIC EXPERIMENTALISM AND LESSONS FROM HIPAA AND ENVIRONMENTAL REGULATIONS

The hurdles to addressing health inequity are reminiscent of other significant regulatory challenges. This part starts by describing the hallmarks of related regulatory approaches: democratic experimentalism, cooperative federalism, and adaptive management. It then considers the examples of HIPAA administrative simplification and the Clean Air Act through the lens of these approaches.\textsuperscript{232} While neither HIPAA nor the Clean Air Act is an example of regulatory perfection, successes in both suggest a new regulatory approach to health equity, laid out in Part V.

IV.A. Democratic Experimentalism, Cooperative Federalism, and Adaptive Management

A traditional account of federalism is based on a constitutional division of power between the states and the federal government. States are to act as laboratories of democracy that will innovate to solve policy problems.\textsuperscript{233} In reality, there are impediments to this type of decentralized experimentation occurring and to its success.\textsuperscript{234} A variety of new governance models build on and attempt to improve traditional federalism. These models theorize approaches to prompting innovation and experimentation, but then also to the data collection, learning, and coordination across geography and sectors that are necessary to solve the most difficult policy problems.\textsuperscript{235}

\textsuperscript{229} Amy Finkelstein et al., Health Care Hotspotting—A Randomized, Controlled Trial, 382 N. ENG. J. MED. 152 (2020), https://www.nejm.org/doi/full/10.1056/NEJMsa1906848.

\textsuperscript{230} See Ana Natale-Pereira, The Role of Patient Navigators in Eliminating Health Disparities, 117 CANCER 3541 (2011), DOI: 10.1002/cncr.26264; Katherine Sharpe & Kathy Scheid, The Benefits of Patient Navigation, 9 J. ONCOL. NAVIG. SURVIV. (Oct. 2018), http://www.jons-online.com/issues/2018/october-2018/2018-09-navigators-benefits-of-patient-navigation; Kerry A. McBrien et al., Patient Navigators for People with Chronic Disease: A Systematic Review, 13 PLoS ONE e0191980 (2018), DOI: 10.1371/journal.pone.0191980.

\textsuperscript{231} See Leveraging Culture to Address Health Inequities: Examples from Native Communities: Workshop Summary (Steve Olson & Karen M. Anderson, eds., 2013).

\textsuperscript{232} See also Barak D. Richman & Steven L. Schwarz, Macromedical Regulation, OHIO ST. L. REV. (forthcoming 2022) (drawing an analogy between financial regulation and health policy regulation and coining the term ‘macromedical regulation’ that regulates “the healthcare system as a system that can systematically respond to spreading health crises”).

\textsuperscript{233} See New State Ice Co. v. Liebmann, 285 U.S. 262 (1932).

\textsuperscript{234} See, eg, Joshua D. Sarnoff, The Continuing Imperative (but Only from A National Perspective) for Federal Environmental Protection, 7 DUKE ENVTL. L. & POL’Y F. 225, 257 (1997) (explaining why ‘states may be unable or unwilling to expend the resources needed to conduct meaningful experiments’).
IV.A.i. Democratic Experimentalism

The governance model coined ‘democratic experimentalism’ was first described by Charles Sabel and Michael Dorf in the late 1990s. A wide-ranging regulatory model, it builds on traditional federalism in three key ways. It contemplates (i) a three-tiered decentralized structure, with (ii) flexibility but also accountability, and (iii) an important role for collaboration and coordination.

The three-tiered decentralized structure is comprised of three main bodies: the governance council, service providers, and citizen users. The governance council engages in goal setting and then empowers service providers to determine the best mechanism for achieving those goals in the interests of citizen users.

The three-tiered model is not hierarchical in the traditional sense. Citizen users are expected to provide data that is fed back up through the tiers to assess progress toward achieving the goals. In this way, there is accountability, but also the prospect for learning and adapting in response to data collection. The model expects that coordinating bodies will share successes and failures so that service providers and the governance council can learn from the subnational experiments. At base, ‘governance occurs through continuous processes of goal setting, policy innovation, measurement, reexamination, and adjustment.’

In practical terms, Dorf and Sabel explain that “[t]he chief role of Congress in such a system would be to authorize and finance experimental reform by states and other subnational jurisdictions.” The experiments are then actually conducted by state and local governments, which often collaborate with or regulate private industry to achieve the defined goals. Federal agencies are responsible for data collection and dissemination and facilitating coordination.

Dorf and Sabel argue that the democratic experimentalist model is uniquely situated to solve complex problems for which a one-size-fits-all approach is not well-suited. It attempts to capture the benefits of collective problem-solving and stakeholder engagement. At the core of the model is its ability to simultaneously provide flexibility and accountability.

But democratic experimentalism is not without critics, who argue that the model is too vague, envisions too narrow of a role for the federal government in conducting its own experimentation, and does not do enough to recognize the messiness and complexity of the real world.
IV.A.ii. Cooperative Federalism

Cooperative federalism, while a distinct regulatory approach, is related in key ways to democratic experimentalism. A cooperative federalist model envisions state implementation of federal standards.\textsuperscript{243} States have discretion in how to achieve the goals set by the federal government. Typically, the federal government maintains authority to step in and regulate if the state government falls short or refuses to act. Often, but not always, the federal government provides funding.

As a model, cooperative federalism is distinct from democratic experimentalism in not explicitly envisioning a role for horizontal collaboration or knowledge-sharing.\textsuperscript{244} Cooperative federalism is praised, however, for the flexibility it gives to states to solve local problems and for the capacity to reduce the costs of dual regulation. It also can create an important limitation on state discretion where states fail to act in the greater public good.

On the other hand, cooperative federalism can force uneasy partnerships.\textsuperscript{245} A particular challenge of cooperative federalism is how to deal with states that do not buy into the federal government’s selection of a policy goal—an issue that has come up with environmental regulation in particular. Jessica Bulman-Pozen and Heather K. Gerken termed the active opposition to federal government standard-setting concerning the Clean Air Act to be ‘uncooperative federalism.’\textsuperscript{246}

IV.A.iii. Adaptive Management

Finally, ‘adaptive management’ shares some attributes with both democratic experimentalism and cooperative federalism. Its main characteristic is the idea of learning by doing, particularly in the face of uncertainty.\textsuperscript{247} All policies are considered experiments, and governing bodies engaging in policymaking are expected to collect data and continuously adjust the approach. Adaptive management, however, is less about federalism and the interactions between different levels of government and more about how a single policymaker should approach the task.\textsuperscript{248}

IV.B. The HIPAA Mandate

The implementation of HIPAA illustrates how these new governance models can work in practice.

\textsuperscript{243} Supra note 31.

\textsuperscript{244} But see Felix Mormann, Clean Energy Federalism, 67 FLA. L. REV. 1621, 1679 (2015) (describing the related concept of dynamic federalism ‘draw[ing] on multilayered, interdependent models of governance to incorporate interactions both between and among various levels of government.’).

\textsuperscript{245} See, eg, No Child Left Behind and the Political Safeguardsof Federalism, 119 HARV. L. REV. 885, 889 (2006) (discussing a criticism of the cooperative federalism model in the context of the No Child Left Behind Act—that it masks a substantive directive and imposes a uniform philosophy of education on the states); Joshua D. Sarnoff, The Continuing Imperative (but Only from A National Perspective) for Federal Environmental Protection, 7 DUKE ENVTL. L. & POL’Y F. 225, 261–62 (1997).

\textsuperscript{246} Jessica Bulman-Pozen & Heather K. Gerken, Uncooperative Federalism, 118 YALE L. J. 1256, 1276 (2009) (discussing cooperative federalism under the CAA); see also Daniel P. Selmi, Federal Implementation Plans and the Path to Clean Power, 28 GEO. ENVTL. L. REV. 637, 650–51 (2016).

\textsuperscript{247} Supra note 32.

\textsuperscript{248} See Hannah J. Wiseman & Dave Owen, Federal Laboratories of Democracy, 52 U.C. DAVIS L. REV. 1119, 1133–34 (2018) (describing the main tenets of adaptive management but also summarizing scholarly critique).
In the 1990s, many industries already had sophisticated frameworks for transmitting business-to-business data. The healthcare industry, however, lagged far behind.²⁴⁹ Experts estimated that improving business-to-business electronic communications would save the industry billions of dollars in administrative simplification.²⁵⁰

Like other industries, the provision of healthcare requires many discrete entities to exchange information.²⁵¹ Take the claims reimbursement process as an example. Prior to HIPAA, a health system that provided a service to a patient and sought reimbursement had to fill out different forms for different payers, each of which had a different set of instructions and different codes²⁵² and had to be submitted over a different proprietary platform (sometimes via electronic submission, sometimes by facsimile, and sometimes even by mail).²⁵³ To give a sense of the order of magnitude of the problem, an estimated 33,000 proprietary codes were in use just by Medicaid agencies alone.²⁵⁴

Hospitals and many physicians’ offices had come to employ large staffs of individuals who spent their days learning each payer’s systems, processes, and codes, and filling out reimbursement forms and transmitting them. Not only was the process highly inefficient and very costly, but it was also prone to error.

The claims reimbursement process from the payers’ side was equally flawed. Claims processing was, by necessity, highly manual.²⁵⁵ Payers had to confirm patient eligibility for reimbursement, check patient deductibles, and confirm whether the procedure was eligible to be reimbursed and at what rate. Errors were frequent, driven in large part by a lack of standardized code sets across the industry.²⁵⁶

IV.B.i. Why the Industry Had Failed To Fix the Problem on Its Own
If the system was costly, inefficient, and error prone for providers, payers, and even patients, and if costs were high, payers and providers should have had the incentive to solve the problem on their own. To be sure, there was a desire to improve the state of technology, and some efforts were underway, but there were considerable hurdles.

²⁴⁹ See Wendy J. Netter, Comment, Curing the Unique Health Identifier: A Reconciliation of New Technology and Privacy Rights, 43 JURIMETRICS 165, 167–69 (2003) (discussing massive inefficiencies in the healthcare industry caused by outdated technology in the context of lauding the advances a universal health identifier would provide).
²⁵⁰ See David C. Kibbe, What the HIPAA Transactions and Code Source Standards Will Mean for Your Practice, 8 FAM PRACT MANAG. 28, 31 (Nov/Dec 2001), https://www.aafp.org/fpm/2001/1100/fpm20011100p28.pdf.
²⁵¹ See Beth M. Harrison, Internet and Health Care: DHHS Releases Final Rule on Electronic Transactions Standards, 28 J.L. MED. & ETHICS 415, 415 (2000).
²⁵² See Code Sets, CENTERS FOR MEDICARE AND MEDICAID SERVICES, https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code-Sets (last accessed Jan. 28, 2021) (describing the various code sets in use prior to HIPAA standardization).
²⁵³ See Dawn Burriss, Moving From HIPAA Compliance to an Electronic Transaction Strategy, Advance for Health Information Executives (Jan. 27, 2004), http://news.trizetto.com/articles/2004.02.01BurrissEditorial.pdf (noting that before HIPAA, some large employer groups used proprietary formats to exchange information electronically with health plans, but usually, health plans opted for manual data entry of transactions).
²⁵⁴ See Jacob Kuriyan, Impact of HIPAA on the Business of Health Care, HealthLeaders.com (Oct. 12, 2001), www.healthleaders.com/news/feature (stating translators and clearinghouses face a huge obstacle of matching thousands of proprietary codes with HIPAA standard code sets).
²⁵⁵ See Id.
²⁵⁶ See supra note 7.
The first major impediment was cost. Replacing legacy systems is expensive and resource-intensive. Even where sufficient cost savings realized over a number of years could have justified the investment, the large upfront cost still made changing systems undesirable or even impossible.257

The collective action problem exacerbated the situation. While any one entity could conceivably have made the decision to update its technology and standardize codes and information exchange platforms, true return on investment could not be achieved absent changes also being made across all other entities. A payer needed to standardize transmission across all providers, but then providers needed standardization across all payers.

The requirement of both horizontal and vertical coordination was unprecedented. Payers, used to being strict competitors with each other, had no model for negotiating and collaborating. Vertical coordination was similarly fraught. While payers and providers had to work together to deliver patient care, they also had an adversarial posture, negotiating over fees in what was viewed as a zero-sum game.

While all entities ultimately benefited from systems standardization, the practical impediments to coordination and agreement with competitors were strong, not to mention just the sheer complexity of the technical task that had to be accomplished. One industry expert described the process of standardizing to be ‘a thousand times more complicated than what we faced with Y2K.’258

Nonetheless, some early efforts were underway prior to HIPAA’s passage. In 1994, for instance, the North Carolina Health Care Information and Communications Alliance (NCHICA) was established by Executive Order of the Governor of North Carolina. NCHICA was an early ‘collaborative’—named for its intention to bring together actors across sectors to solve the technology coordination problem.259 It had more than 275 member organizations that paid a fee to the collaborative hoping that their membership in NCHICA would benefit their own organizations.260

NCHICA and other similar collaboratives were early innovators, experimenting on both local and state levels with ways to standardize and simplify transactions. But work progressed slowly. And although membership in NCHICA was broad, it was not broad enough to achieve the goal of standardization. The passage of HIPAA proved essential

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257 See M.J. Friedrich, Health Care Practitioners and Organizations Prepare for Approaching HIPAA Deadlines, 286 JAMA 1563 (2001). Although some experts believe that cost savings as a result of HIPAA could be as much as $30 billion, there is dispute over how much will have to be spent to get the savings. See also Tod Newcombe, Calming the HIPAA Hiccups, GOVERNMENT TECHNOLOGY (Apr. 16, 2002), https://www.govtech.com/security/Calming-the-HIPAA-Hiccups.html (last accessed Jan. 28, 2021) (“The U.S. Department of Health and Human Services (HHS) puts the HIPAA price tag at a modest $6 billion. However, private healthcare organizations peg the final bill as high as $42 billion. Hospitals alone are expected to fork out $22 billion just to comply, according to the American Hospital Association.”)

258 See supra note 2.

259 See NCHICA Annual Report 2001, http://www.nchica.org/Archives/Annual/01annualreport.pdf [hereinafter Annual Report] (detailing the founding of NCHICA); see also Exec. Order No. 54: To Create the North Carolina Health Care Information and Communications Alliance, James B. Hunt Jr., Governor of North Carolina (July 1, 1994), http://www.nchica.org/AboutNCHICA/CorpInfo/ExecOrder.htm [hereinafter Exec. Order] (detailing the reasoning underlying the creation of NCHICA).

260 See North Carolina Health Care Information & Communications Alliance [NCHICA], What’s New, http://www.nchica.org [hereinafter NCHICA Website] (“[A] nonprofit consortium of over 250 organizations dedicated to improving healthcare through information technology and secure communications.”).
to enabling the work of NCHICA and helping it to receive the buy-in necessary to accomplish its goals.

IV.B.ii. What Worked

Despite the hurdles, standardization was ultimately achieved.²⁶¹ Two components of the process were essential to its success: a legal mandate with deadlines and the threat of monetary penalties, and the work of collaboratives to bootstrap local successes to meet the requirements of federal rules.

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA).²⁶² HIPAA—a comprehensive regulatory strategy—is now best known for its privacy and security protections. However, HIPAA also directed the Secretary of Health and Human Services to adopt standards for the electronic exchange of financial and administrative transactions.²⁶³ In 2000, the Department of Health and Human Services published a final rule governing ‘Standards for Electronic Transactions.’²⁶⁴ That rule adopted ‘standards for eight electronic transactions and for code sets to be used in those transactions.’²⁶⁵ It also contain[ed] requirements concerning the use of these standards by health plans, healthcare clearinghouses, and certain healthcare providers.²⁶⁶

HIPAA and the HHS rules that followed are binding law. They came with both deadlines and the threat of legal sanction. HIPAA required that health plans conduct transactions according to the standards set by HHS rules.²⁶⁷ And it created a timetable for compliance—large plans had 24 months to comply and small plans had 36 months.²⁶⁸ It also established civil monetary penalties for failure to comply.²⁶⁹

The mandate is what lit the fire that prompted covered entities to solve a problem they already knew they had to solve. But all it did was define the desired end-state. It did little to help payers and providers figure out how to comply—how to get from where they were to where HIPAA required that they be 24 months later. Indeed HIPAA was strongly criticized at the time for its failure to provide enough detail or to specify how the standards should be operationalized.²⁷⁰ That is where the collaboratives came in.²⁷¹

²⁶¹ To be sure, the process was not perfect and the results are not perfect. Subsequent legislation has attempted to further address ongoing health technology and connectivity issues. But still, the accomplishments are notable given where the industry began prior to HIPAA.
²⁶² Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 201 (2000).
²⁶³ 42 U.S.C. § 1320d-2(a)(2) (2000) (stating “transactions” meant to be covered by the statute include: health claims or equivalent encounter information, health claims attachments, enrollment and disenrollment in a health plan, eligibility for a health plan, healthcare payment and remittance advice, health plan premium payments, first report of injury, health claim status, and referral certification and authorization).
²⁶⁴ See Health Insurance Reform: Standards for Electronic Transactions; Announcement of Designated Standard Maintenance Organizations, 65 Fed. Reg. 50,311 (Aug. 17, 2000), http://aspe.hhs.gov/admsimp/finaltxfinal.pdf.
²⁶⁵ Id.
²⁶⁶ Id.
²⁶⁷ 42 U.S.C. § 1320d-4(a).
²⁶⁸ Id.
²⁶⁹ 42 U.S.C. § 1320d-5(a).
²⁷⁰ See Elizabeth Wikler et al., Paper Cuts Reducing Health Care Administrative Costs, CENTER FOR AMERICAN PROGRESS (June 2012), https://dash.harvard.edu/bitstream/handle/1/17190515/33796/papercuts_final.pdf?sequence=1. HIPAA was also strongly criticized for its lack of funding.
Collaboratives were a voluntary coming together of entities covered by HIPAA. Membership was voluntary; both public and private entities joined. Collaboratives did not have the power of legal sanction, but members needed to work together—the whole point of the rules was to get their systems to communicate with each other more effectively. The existence of the HHS rules and deadlines gave the collaboratives the mandate to facilitate non-hierarchical negotiation. In this way, collaboratives like NCHICA took the HHS standards and filled in the regulatory gaps so that covered entities could comply with the complex standards as efficiently as possible.272

IV.B.iii. The Role of Federal and Local Feedback Mechanisms

The mandate and the collaboratives were essential to solving the technology standardization problems of the late 1990s and early 2000s, but the process was successful for another reason: reciprocal feedback mechanisms between the federal and the local level.

One of the complexities in technological standardization was the multitude of different systems and processes that existed throughout the country. At the federal level, HHS could create a set of requirements, but it needed feedback on feasibility from the local level.273 HHS came up with its initial set of rules, taking into account the experience of the early collaboratives that had already experimented and innovated at the state and local levels.

Once HHS passed the rules, covered entities took that mandate back to the local level to try to implement the requirements against the backdrop of their own unique situations.274 In trying to do so, entities discovered many challenges that HHS, from its vantage point at the federal level, could not have predicted. Collaboratives then brought feedback back to HHS through the notice and rulemaking process, eventually leading to an amendment of the federal rules in 2003.275

Networking among local collaboratives was similarly an important key to the success of the endeavor. As a local coordinating body, the North Carolina collaborative could share its experience with collaboratives located elsewhere in the country and when NCHICA encountered problems, it could look to solutions discovered elsewhere.276 It was a bit like the laboratory of the states, except that regional and national coordinating bodies facilitated knowledge-sharing. With the end goal being standardization in an industry that was more frequently crossing state lines, this bootstrapping process allowed incremental change to help different entities converge on a coordinated plan.

271 See Physmark, http://www.physmark.com/index.htm (last accessed June 27, 2004) (“Physmark, Inc., develops and markets software for healthcare delivery organizations.”).
272 Interview with Holt Anderson, Executive Director, NCHICA (Oct. 8, 2002) [hereinafter Anderson Interview].
273 NCHICA’s response to the Notice of Proposed Rule Making for Standards for Privacy of Individually Identifiable Health Information (on file with author).
274 An example of proposed changes submitted by NCHICA to HHS concerning the HIPAA privacy rules are on file with the author.
275 See Health Insurance Reform: Modifications to Electronic Data Transaction Standards and Code Sets, Federal Register (Feb. 20, 2003), https://www.federalregister.gov/documents/2003/02/20/03-3876/health-insurance-reform-modifications-to-electronic-data-transaction-standards-and-code-sets.
276 See HealthKey, http://www.healthkey.org (last accessed Aug. 12, 2004).
IV.C. The Clean Air Act

HIPAA illustrates how some of the key principles of democratic experimentalism and adaptive management can work in practice. The Clean Air Act provides another example of a similar governance approach.

The Clean Air Act is credited with considerable improvement in air quality and is held up as a successful example of cooperative federalism in particular. Like HIPAA, it started with a federal statute and a commitment to federal goal-setting. But it also relies heavily on the states to innovate and determine how best to meet the goals.

It is important to note up front, however, that the Clean Air Act is not without critics. As described in Part I(B)(1), a lot of Americans still live in areas with air quality that falls below federal standards. The Act has also been the subject of significant litigation. And the 2015 issuance of the Clean Power Plan (CPP) under the Act never got off the ground after it was challenged in Congress, in court, and by a subsequent administration.

Nonetheless, the Clean Air Act merits close examination for the progress it has spurred in an area with similar challenges to health equity—it is a highly complex problem requiring experimentation and learning to solve. There was no single, agreed-upon approach to fixing air quality when it was passed. Solving the problem required engagement from multiple stakeholders, many of whom were not bearing the cost of the negative externalities they imposed. Against the backdrop of those challenges, the Clean Air Act is an instructive model.

IV.C.i. The Problem and the Clean Air Act’s Solution

In the 1960s, visible smog filled many of the nation’s cities. State and local governments were not adequately equipped to respond to the growing environmental crisis. The modern Clean Air Act was enacted in 1970, following broad bipartisan support for strict environmental regulation.

The Clean Air Act has been amended several times since 1970, but the basic governance model established in 1970 remains, even as the rules and regulations associated with the Act have proliferated.

Under that model, the EPA sets national ambient air quality standards (NAAQS) for identified pollutants. Then states develop implementation plans—which include regulating private industry—intended to meet the goal set by the EPA.

277 See, eg, Dave Owen, Cooperative Subfederalism, 9 Uc Irvine L. Rev. 177, 186 (2018).
278 See, eg, Jesse M. Cross & Shelley Welton, Making Federalism Work: Lessons from Health Care for the Green New Deal, 55 U. Rich. L. Rev. 765, 820 (2021) (deeming the CAA an ‘unreliable vehicle for delivering climate policy’).
279 See David M. Driesen et al., Half A Century of Supreme Court Clean Air Act Interpretation: Purposivism, Textualism, Dynamism, and Activism, 75 Wash. & Lee L. Rev. 1781, 1786 (2018) (noting that the Supreme Court alone has decided 20 cases interpreting the CAA).
280 See Denise A. Grab, Michael A. Livermore, Environmental Federalism in A Dark Time, 79 Ohio St. L.J. 667, 672 (2018) (describing why absent regulations, rational, self-interested jurisdictions ‘will release levels of emissions that are sensible from a local perspective but inefficiently high from a global perspective’).
281 Id.
282 The CAA has several other provisions, but for simplicity, this article focuses on the NAAQS approach.
The model has been called a prototype for cooperative federalism because the federal government set goals and monitors for compliance, but states determine what must be done at a state and local level to meet those goals.

The Clean Air Act prompts experimentation and innovation using both carrots and sticks. First, the Clean Air Act includes provisions for state matching grants. Section 105 of the Act authorizes the EPA to award funds to states to pay 60 per cent of the cost of state and local programs that address ambient air quality standards. Section 103 of the Act authorizes grants to support research into how to control air pollution.

Second, the Act sets deadlines for compliance and empowered the EPA to issue monetary sanction for non-compliance. In anticipation that some states would refuse to act, it also provided that the EPA could step in and establish its own implementation plan if the state would not.

The Act has been amended several times as new air pollution problems have been identified. Amendments have also strengthened the Act’s enforcement provisions.

**IV.C.ii. What Works**

By some metrics, the Clean Air Act has been quite successful in addressing air pollution. A 2018 study found a 60 per cent decline in pollution emissions by the manufacturing industry between 1990 and 2008 despite an increase in output, which it attributes to the Clean Air Act. A 2017 study found that it led to an over 10 per cent reduction in pollution over 3 years for counties that were exceeding thresholds set by the Act.

Atmospheric lead and mercury pollution have been drastically reduced. And a quarter of ground-level ozone has been cut. Improvement in air quality has also prevented an estimated 205,000 premature deaths and millions of other respiratory complications.

The cooperative federalism model is credited for the decentralization and preference diversity it enables, as well as political responsiveness and experimentation. In particular, the leeway given to states in implementation created strong incentives for innovation and learning.

But there are also challenges to concede. The EPA has, at times, been unable to closely control state compliance with Clean Air Act standards or to effectively issue sanctions. And air pollution remains a health risk in the United States, with its consequences felt unevenly. Disadvantaged communities are more likely to experience ‘hot spots’—areas facing elevated health risks from localized air pollution. Some blame the framework of the Clean Air Act for failing to address this issue. As a result,
some states have recently passed companion bills meant to work with the Clean Air Act to promote accountability for addressing these localized problems and to bring marginalized communities into the policy-making process.\textsuperscript{292} California’s AB 617 is one example.\textsuperscript{293}

While there continues to be work to do in addressing air pollution in both minority and low-income communities, at least one recent study reports encouraging news, concluding that “[t]he gap between Black and white Americans’ particulate exposure has declined over the past two decades, due largely to enforcement of the Clean Air Act in the country’s most polluted areas.”\textsuperscript{294}

Perhaps most telling is the failure of the CPP implemented under the Clean Air Act. The CPP was unveiled in 2015. Its goal was to reduce power sector emissions to shift utilities to cleaner sources to address global warming.\textsuperscript{295}

Like the Clean Air Act, the CPP utilized a model of federal standard-setting with state implementation. There was initially great optimism around the plan, which was projected to reduce carbon emissions from electricity generation 32 per cent by 2030 relative to 2005 levels.

But the CPP never took effect after it was temporarily blocked by the Supreme Court and then repealed by the Trump Administration in 2019, which serves to highlight the challenges that a cooperative model faces.

V. ADDRESSING HEALTH INEQUITY REQUIRES A BREAKTHROUGH
The prior part described two complicated policy problems and the new governance approaches that have been used to address them. There is near consensus that health inequity is also a dire problem. A growing commitment has emerged to address it and the pandemic might prove the right political moment to further spur action. But current methods are not enough, and a clear path forward has not emerged.

A single-payer system could help\textsuperscript{296} in that it would ensure that everyone has access to clinical healthcare.\textsuperscript{297} And it would have a positive effect on rates of poverty, which

\textsuperscript{291} Meredith Fowlie, Reed Walker & David Wooley, Climate Policy, Environmental Justice, and Local Air Pollution, BROOKINGS ECONOMIC STUDIES (2020), https://www.brookings.edu/wp-content/uploads/2020/10/E S-10.14.20-Fowlie-Walker-Wooley.pdf.

\textsuperscript{292} Id.

\textsuperscript{293} Nonvehicular—Air Pollution—Reduction, 2017 Cal. Legis. Serv. Ch. 136 (A.B. 617).

\textsuperscript{294} Morgan Foy, Evidence Shows the Clean Air Act Has Reduced Racial Disparities in Exposure to Pollution, BERKELEY RESEARCH (Oct. 9, 2020), https://vresearch.berkeley.edu/news/evidence-shows-clean-air-a ct-has-reduced-racial-disparities-exposure-pollution (last accessed Dec. 13, 2021); Janet Currie, John Voorheis & Reed Walker, What Caused Racial Disparities in Particulate Exposure to Fall? New Evidence from the Clean Air Act and Satellite-Based Measures of Air Quality (NBER Working Paper Series No. 26659, 2020), https://www.nber.org/system/files/working_papers/w26659/w26659.pdf.

\textsuperscript{295} See Jessica Bulman-Pozen, Administrative States: Beyond Presidential Administration, 98 TEX. L. REV. 265, 268 (2019).

\textsuperscript{296} See, eg, Medicare for All Act of 2019, S.1129, 116th Cong. (2019); Medicare for All Act of 2019, H.R. 1384, 116th Cong. (2019); see also Sage, supra note 16, at 45 (arguing that “With sufficient political will, Medicare-for-All could help public policy turn the corner toward substantially greater non-medical social investment.”).

\textsuperscript{297} See About Single Payer, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM, https://pnhp.org/what-is-si ngle-payer/ (last accessed Nov. 5, 2020), (noting that, ‘under a single-payer system, all residents of the United States would be covered for all medically necessary services including doctor, hospital, preventive, long-term care, mental health, reproductive healthcare, dental vision, prescription drug and medical supply
in turn is a predictor of worse health outcomes, particularly if the single payer model had low out-of-pocket costs. And perhaps most importantly, a move to a single payer system would remove the payer fragmentation and collective action hurdles to addressing health inequity. Countries with single payer models, while not perfect, are all doing better on equity than the USA. And yet Medicare-for-All would not address the underlying differences in educational opportunities, housing, and safe communities that are at the heart of the health equity problem.

Something more is needed. This part makes the case for an approach grounded in the new governance techniques employed by HIPAA and the Clean Air Act—a health equity mandate supported by health equity collaboratives.

**V.A. A Mandate + Health Equity Collaboratives**

HIPAA and the Clean Air Act both began with a federal mandate defining a policy goal. Finding a path to achieving the goal was left to those closer to the problems that were in need of solving. HIPAA and the Clean Air Act prompted progress because federal law provided the necessary motivation for change—a legal requirement with penalties for lack of compliance. And then particularly in the case of HIPAA, the federal law prompted widespread (non-binding) collaboration.

The health equity problem has some important attributes in common with both the health technology problem of the 1990s and the need for environmental regulation. The first commonality is a collective action problem with a public good aspect.

In the HIPAA context, no one entity wanted to bear the cost without assurance that other entities would do the same. Similarly, no one state alone can ensure clean air for its population because of externalities imposed from the choices of neighboring states. There is also a public good aspect—too few incentives to produce it, even though everyone would be better off. With the health equity problem, entities also hope that the

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298 See Poverty, Office of Disease Prevention and Health Promotion, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/poverty (last accessed Oct. 8, 2020).

299 See Ed Weisbart, *A Single-Payer System Would Reduce U.S. Health Care Costs*, 14 AMA J. Ethics 897 (2012), https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-05/operand1-1211.pdf.

300 See Laura Joszt, *Learning From Other Countries and Dispelling Myths of a Single-Payer System*, Am. J. Manag. Care (May 9, 2019), https://www.ajmc.com/view/learning-from-other-countries-and-dispelling-myths-of-a-single-payer-system.

301 See The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104–191, 110 Stat. 56 (1996).

302 See Jessica Kent, *Top 3 Data Challenges to Addressing the Social Determinants of Health*, Health IT Analytics (Feb. 17, 2020), https://healthitanalytics.com/news/top-3-data-challenges-to-addressing-the-social-determinants-of-health (noting the difficulty of sharing information and the unstandardized data collection methods).

303 See Jacqueline LaPointe, *How Addressing Social Determinants of Health Cuts Healthcare Costs*, RevCycle Intelligence (June 25, 2018), https://revcycleintelligence.com/news/how-addressing-social-determinants-of-health-cuts-healthcare-costs (noting providers are not equipped to address social determinants because ‘fee-for-service payments do not reimburse providers for extending care beyond the practice’s or hospital’s wall and even some alternative payment models have yet to branch out into integrating medical, social, and behavioral services.’).
majority of the effort and necessary investment will be borne by others either inside of or external to the healthcare delivery system. Although health entities feel the economic consequences of inequity, they do so to varying degrees and with varying abilities to affect positive change absent contribution from others.

Second, all three problems are complicated to address, with considerable geographical variation. Technology standardization may, in retrospect, be the simplest to solve, but at the time, there was so much variability in how payers and providers interacted that it was hard to see the way forward. Even more so, solving climate change is incredibly multi-faceted and the science and technology, while progressing in important ways, does not yet hold all of the answers. The health inequity problem is arguably similar, with just as much if not more local variation in the problems that need to be addressed and in the solutions available to address them. The health equity problem is also further complicated in that it involves many entities and government agencies situated outside the healthcare universe.

Third, all three problems require significant financial investment to solve and require investment now for benefits later. In this sense, however, HIPAA is an outlier because it was an unfunded mandate. Aspects of environmental regulation are the same, but the federal government does contribute funding to the states to support state-level experimentation and implementation. Addressing health inequity is more similar in this vein to environmental regulation, because it will require financial investment, now, with the hope that reducing inequity will yield significant, industry-wide cost savings in years to come.

This section borrows from both analogies and suggests a regulatory framework to mitigate health inequity. It also argues that the time is right to act. President Biden’s administration has publicly committed to advancing racial equity and support for underserved communities, in general, signing an Executive Order memorializing that commitment on his very first day in office. Biden’s Executive Order acknowledges ‘[o]ur country faces converging economic, health, and climate crises that have exposed and exacerbated inequities, while a historic movement for justice has highlighted the unbearable human costs of systemic racism.’ It goes on to commit: ‘Our

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304 See Guidance for the National Healthcare Disparities Report (Elaine K. Swift Ed., 2002), https://www.ncbi.nlm.nih.gov/books/NBK221046/pdf/Bookshelf_NBK221046.pdf.

305 See Michael K. Evans, Health Equity—Are We Finally on the Edge of a New Frontier?, 383 N. ENGL. J. MED. 997 (2020), (noting, ‘health equity is a simple concept, but it is difficult to achieve.’).

306 See Rose M. Martinez & Joe Alper, Investing in Interventions That Address Non-Medical, Health-Related Social Needs, National Academies of Sciences, Engineering, Medicine (2019), https://www.ncbi.nlm.nih.gov/books/NBK549452/pdf/Bookshelf_NBK549452.pdf (noting there are fairly significant economic impediments in addressing social determinants); see also Kim-Lien Nguyen, HIPAA: At what cost?, MEDICAL ECONOMICS (Sept. 9, 2019), https://www.medicaledconomics.com/view/hipaa-wha t-cost (noting the estimated costs of HIPAA compliance are estimated to be about $8.3 billion a year).

307 The entities covered by the HIPAA legislation had to spend their own funds to realize savings from standardization down the road. Some entities were better situated to the bear the cost than others.

308 See Sara Heath, Proving ROI for Social Determinants of Health Interventions, PATIENT ENGAGEMENT HIT (Oct. 14, 2020), https://patientengagementhit.com/news/proving-roi-for-social-determinants-of-health-interventions.

309 President Joseph R. Biden, Jr., Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government” (Jan. 20, 2021), https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.
Nation deserves an ambitious whole-of-government equity agenda that matches the scale of the opportunities and challenges that we face. This section explores what that agenda should look like in promotion of health equity.

**V.A.i. The Case for a Legal Mandate and Why It Must Be Funded**

As Part II detailed, work is already underway on many fronts to address health inequity. But it is not enough. The health equity crisis requires a federal mandate, along with other attributes of a democratic experimentalism model, to overcome current barriers to progress.

The mandate would serve several purposes. It would add an urgency that doesn’t exist without it by including realistic goals and timelines. It would force the involvement of currently resistant yet essential entities (including some state and local governments). It would fund state experimentation and require the collection of reliable data to inform solutions. And it would also include mechanisms for fines and sanctions for non-complying states. If done correctly, it could spur collaboration across sectors, both inside and outside the healthcare delivery system.

Several bills have been introduced in Congress with the goal of addressing health inequity. None have yet made significant progress toward passage. But common attributes of proposed laws are (i) a focus on data collection, (ii) a determination to set up task forces, and (iii) funding. What they do not do is identify concrete outcomes, set timelines, and define penalties for lack of compliance.

This is not surprising. It is challenging to determine what a health equity mandate should look like. HIPAA focused on achieving an identified outcome (for instance, standardized code sets) and charged covered entities with complying by a deadline, threatening punishment for those who did not comply. The Clean Air Act empowered the EPA to set measurable air quality standards and provided funding for states to implement plans to meet those goals.

For health equity, a comparable outcome-focused goal might be to reduce the gap in disease burden or mortality that currently exists between White populations and communities of color and also along the income spectrum. There are also ways...
to measure equity in ‘equity scores’ that could be used as the target metric.316 These metrics are analogous to the air quality standards set by the federal government for the states under the Clean Air Act.

Whatever metric of equity is chosen, it would be the state that is responsible for implementing a plan to meet the described goal. Regulators cannot simply task health system actors with meeting these goals because the inputs (the social determinants) are so far removed from the results. Hospitals or health insurers cannot fix the housing crisis or poverty or food deserts. States could, however, require that they contribute to solutions by committing to payment models that prioritize good outcomes. Or insurers could be required to reimburse for some of the costs in addressing social determinants of health.317 It would be up to states to experiment with how to achieve the health equity goal, learning from experiments along the way.

State experiments would have to be multi-faceted. The Clean Air Act is similar in many ways. It also touches the work of several different agencies, from the Environmental Protection Agency, which is required to work with states to reduce greenhouse gas emissions, to the Department of Transportation, which must set standards to improve the fuel economy of vehicles, to the Department of Defense, which has to plan for security consequences of climate change.318 And it regulates private industry. Although much of the work that ultimately needs to be done on climate change happens at the state, local, and private industry level, a federal law helps to accelerate progress and coordinate work.319

A health equity mandate could work similarly and would need to enlist work from the entities responsible for building infrastructure where it is lacking, addressing inferior housing, educational opportunities, and employment opportunities, to name some.

The equity mandate would include a threat of civil monetary penalties for non-compliance, just as HIPAA and the Clean Air Act contain. As in both those cases, the federal agency would determine compliance and assess fines.

315 The mandate would need to be carefully worded to ensure that gaps are narrowed by improving health outcomes of communities of color and lower income individuals and not by worsening health outcomes of white and high-income patients. In light of Supreme Court precedent, it would also need to be articulated in a manner that advances equity on a race-neutral basis. See, e.g. Richard A. Primus, Equal Protection and Disparate Impact: Round Three, 117 Harv. L. Rev. 493, 496 (2003) (“equal protection has become hostile to government action that aims to allocate goods among racial groups, even when intended to redress past discrimination.”); Kim Forde-Mazrui, Why the Equal Rights Amendment Would Endanger Women’s Equality: Lessons from Colorblind Constitutionalism, 16 Duke J. Const. L. & Pub. Pol’y 1, 2 (2021) (the Court has essentially imposed on states and the federal government a constitutional rule of “colorblindness,” a rule that prohibits state-sponsored decisions that take account of race even when aimed at reducing racial inequality and even when pursued through laws that employ race-neutral means).
316 See Climate Equity Act of 2020, H.R. 8019, 116th Cong. (2020) (describing a requirement of an equity score).
317 This, too, is not guaranteed to promote progress toward equity. Officials would need to closely monitor the extent to which premiums increase as a result, which could further exacerbate rather than remediate inequalities. It would also increase inequity between the uninsured and the insured.
318 Clean Air Act, 42 U.S.C. §§ 7401-7671q (2000).
319 Of course this approach is not without controversy, with many arguing that a more market-based approach should be the centerpiece of climate reform. At least in the healthcare sector, however, leaving a remediation of health inequity to market sources is highly unlikely to be effective. This is particularly the case since healthcare markets are already so highly regulated.
With a stick, however, there must also be a carrot. The health equity problem will not be solved absent financial investment from the federal government, as democratic experimentalism also contemplates. State and local governments that need to make serious investments to address social determinants of health lack the necessary funding. Here, the COVID vaccine distribution analogy is apt. President Trump blamed the states for botching distribution, but the states simply did not have the necessary financial resources or available personnel to develop a quick, large-scale operation.\(^{320}\) The same is true of health inequity.\(^{321}\)

Matthew Lawrence describes how liquidity-constrained states may be unable to make investments even where cost saving will result in the longer term:

If, for example, a state invests in housing for individuals in recovery from substance use disorder and thereby reduces relapse rates, its investment will reduce Medicaid costs and Medicare hospitalization costs while increasing federal and state tax revenues. [citation omitted] But states do not have the luxury of considering all those savings in deciding whether they can afford the reform; they must balance their budget within existing, narrow budgetary categories.\(^{322}\)

This is perhaps why investment in health equity so far has primarily come from philanthropic organizations, health systems, and insurers.\(^{323}\) While government should collaborate with charitable foundations for funding, the magnitude of what is needed is great.\(^{324}\) The majority of funding should be reserved to build up programs directly addressing the social determinants of health, both at the individual level—for instance for better SNAP funding—and at the collective levels—for instance for rerouting a freeway, reducing pollution, or building housing.

Making fiscal waiver dollars available, in and of itself, could be an important stimulant of state and local experimentation. This sort of innovation incentive is consistent with what Dorf and Sabel envisioned of democratic experimentalism.\(^{325}\)

The Biden Administration has already indicated a willingness to fund efforts to combat systemic inequities, stating: ‘The Federal Government should, consistent with applicable law, allocate resources to address the historic failure to invest sufficiently, justly, and equally in underserved communities, as well as individuals from those communities.’\(^{326}\)

\(^{320}\) See Lisa Larrimore Ouellette et al., *What Can Policymakers Learn from the Disastrously Slow COVID-19 Vaccine Rollout?*, Written Description (Jan. 12, 2021), https://writendescription.blogspot.com/2021/01/what-can-policymakers-learn-from.html.

\(^{321}\) See Shannon Brownlee et al., *Health Conundrum: How State Budgets Can Find The Balance Between Social Versus Medical Services*, Health Aff. Blog (Dec. 12, 2019), https://www.healthaffairs.org/do/10.1377/hblog20191212.170322/full/(noting that “States are the principal spenders when it comes to social factors, and without raising taxes, state and local budgets simply don’t have the money to invest more in public welfare.”).

\(^{322}\) Id.

\(^{323}\) See generally Part II(A).

\(^{324}\) See Zuckerman et al., *supra* note 200 (‘95% of all U.S. health expenditures are still spent on direct medical services. The availability of funds to address broader population-wide public health improvement is, thus, quite meager for the scale of the challenge...’).

\(^{325}\) See Matthew B. Lawrence, *Fiscal Waivers and State “Innovation” in Health Care*, 62 WM. & MARY L. REV. 1477, 1501 (2021).

\(^{326}\) Executive Order, *supra* note 279.
V.A.ii. An Important Role for Collaboratives

Although a legal mandate will be essential, the real boots on the ground work will require collaboration between both public and private industry players (payers, providers, social service agencies, government agencies, and charities) and between local, state, and federal agencies outside the healthcare delivery realm. There must be a mechanism for knowledge learned at the local level and across various sectors to be shared across networks. This is what collaboratives do and do well. Learnings would then be incorporated into federal guidance and regulations to be effectively shared throughout the country. Just as in the HIPAA context, collaboration between public actors and private industry and even across governmental sectors will be essential to addressing health inequity.

Other scholars and policy advocates have been strongly making the case for industry collaboration for years. Even just within the healthcare industry itself—and to clear, this article thinks collaboration must extend beyond the healthcare industry—meaningful collaboration has been stymied by cost and collective action concerns. The legal mandate would have to get essential participants past that hurdle.

And just as with HIPAA, where collaboratives formed prior to the statute passing, early-stage health equity collaboratives already exist. There is already a framework that can therefore be expanded and catalyzed.

First, the case for collaboration is strong. As Lawrence Gostin and Eric Friedman put it, addressing the ‘immense injustices’ of health inequity will require ‘new forms of government operations—working with communities and civil society as equal partners, as well as extensive multisector collaboration . . .’

Jessica Mantel agrees, arguing that while provider-driven work is essential to improving social determinants of health, providers need to work with other sectors to achieve community health goals. She envisions ‘Population Health Partnerships’ where organizations would coordinate activities to achieve both single, specific goals and broader-range goals.

And Jacob Reider, in making the case for why payer philanthropy cannot alone solve health inequity, argues for ‘on-the-ground, collaborative, accountable networks of medical providers, CBOs, and MCOs’ to deliver the greatest benefits for social determinants of health.

Second, early-stage collaboratives of varying degrees and scope already exist. For instance, the National Collaborative for Health Equity was formed in 2014 as a product of the New Venture Fund. Its stated goal is to ‘promote health equity by harnessing data, developing leaders, and catalyzing partnerships across the many different sectors that share responsibility for creating a more equitable and just society.’

It looks

327 See Lawrence O. Gostin & Eric A. Friedman, Imagining Global Health with Justice: Transformative Ideas for Health and Well-Being While Leaving No One Behind, 108 Geo. L.J. 1535, 1587 (2019).
328 See Mantel, supra note 25.
329 Id. (envisioning members of PHPs to include health providers, local public health departments, governmental agencies, social services organizations, faith-based groups, academics, payers, and business groups).
330 Jacob Reider, Payer Philanthropy Won’t Improve Social Determinants of Health, HEALTHPAYERINTELLIGENCE (Nov. 19, 2019), https://healthpayerintelligence.com/news/payer-philanthropy-wont-improve-social-determinants-of-health
331 History & Mission, NATIONAL COLLABORATIVE FOR HEALTH EQUITY, https://www.nationalcollaborative.org/about-us/history-mission/ (last accessed Jan. 28, 2021).
to bring together ‘policymakers, researchers, industry, community groups, and others necessary to create just and equitable opportunities for all people to lead healthier lives.’

The Democracy Collaborative also brings together actors across sectors, naming ‘non-profits, public sector, financial institutions, healthcare institutions, and philanthropy,’ with a goal of community wealth-building in underserved areas. While not explicitly focused on health equity as an underlying goal, it is an example of how a collaborative is working to address a key social determinant of health that impacts health equity.

California, for instance, passed a ‘Racial Equity Resolution’ in 2020. The resolution resulted from the work of the Capitol Collaborative on Race and Equity (CCORE), which is a partnership between the Public Health Institute (PHI), Race Forward, the California Strategic Growth Council, philanthropic partners, and various state agencies. One of the goals of the collaborative is to assist government by sharing lessons from systems change work. It promotes cross-sector learning and networking opportunities.

Efforts are still in the early stages. It is the first example of a collaborative focused on racial equity with participation by multiple agencies at the state-government level.

Health in All Policies (HiAP) is another example. HiAPs are described as ‘a collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people.’ HiAPs are particularly encouraging in their recognition that ‘health is created by a multitude of factors beyond healthcare and, in many cases, beyond the scope of traditional public health activities.’

HiAPs have tended to start out small but have worked toward multilateral collaboration and toward either achieving grant funding or government-level financial support. But HiAPs are still not widespread and lack coordination at the national level. Data as to their success in reducing health disparities is so far limited.
And yet HiAPs do illustrate what is possible. In particular, their focus on fashioning local-level solutions to local problems, with the involvement of both the public and private sector, is a model that could be both expanded and improved.

**V.A.iii. Why It Could Work**

Shocks to the system can motivate structural change. The pandemic might be the shock needed to spur action and the passage of a federal health equity mandate.

The new governance approach described in this part borrows the most successful elements of democratic experimentalism, cooperative federalism, and adaptive management. It provides the legal motivation needed to spur progress and overcome the collective action problem in the name of the public good, with timelines and the threat of monetary sanction to ensure compliance. But it also reserves the most important role for state and local governments to experiment and find the right approach given local variations in circumstances. It contemplates an essential role for all stakeholders and that lessons from state and local experiments will be shared across networks and with the federal government. There is not yet a clear path to solving health inequity. Learning and adapting as experiments progress will be essential to success.

Finally, this is not the command-and-control, top-down regulation of the past. This is goal-setting, funding, and coordination at the level of the federal government, but solutions catered to the unique challenges of smaller communities.

**V.B. Challenges**

There are challenges to implementing this model, but they are not insurmountable.

**V.B.i. Defining the Desired Outcome and the Path to Achieving It, Supported by Data**

The most difficult challenge, as discussed earlier, may be defining an outcome. There are many categories of outcome data that we might care about, some more proximate than others. This is a very similar problem as measuring healthcare quality more generally.

Nonetheless, options exist even if imperfect. If a mandate succeeded in closing the gap in disease burden or in mortality, that would be substantial progress.

Second, even if we could define a goal, there is not yet a clear path to achieving that goal. While data improves to identify disparities, data on the effectiveness of interventions is still in its early stages. Some studies have found that policy interventions targeted at education, housing, urban planning, income, and employment supports have both reduced health disparities and were cost-effective. In general, there is

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341 Michele K. Evans, *Health Equity—Are We Finally on the Edge of a New Frontier?*, 383 N. ENG. J. MED. 997 (2020), DOI: 10.1056/NEJMp2005944 (noting that ‘World War II, for instance, both empowered women and propelled the fight for racial equality, initiating military desegregation that energized the evolution of the Civil Rights movement.’).

342 For instance, Chicago’s HiAP requires that standardized indicators be used in data collection efforts so that data can be more easily shared and compared between the City and sister agencies. See Shah and Kamensky, *supra* note 7, at 769.

343 See, eg, Rachel Thornton et al., *Evaluating Strategies For Reducing Health Disparities By Addressing The Social Determinants Of Health*, 35 HEALTH AFF. (Aug. 2016), https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1357 (discussing study results and ‘the need for long-term financing to scale up effective interventions for implementation at the local, state, and national levels’).
evidence that investments in addressing social determinants of health and structural inequities can improve morbidity and mortality.\textsuperscript{344} For other programs that have reported data, results are mixed.\textsuperscript{345}

But although many programs to try to address health inequity are underway around the country, data on the impact of those programs on outcomes is still insufficient. Data on cost-effectiveness is also essential but so far lacking.

More data will come with time, however, and more robust experimentation will speed up the process of identifying what works and what does not work. The building blocks for collecting data already exist, at least at a foundational level. This is a central conceit of the adaptive management approach.

In terms of government data collection, the Biden Administration recently acknowledged that federal data sets are often not disaggregated by relevant demographic variables and ‘[a] first step to promoting equity in Government action is to gather the data necessary to inform that effort.’\textsuperscript{346} In turn, the Biden Administration ordered the head of each agency to conduct an equity assessment and established an Interagency Working Group on Equitable Data to inform those efforts.

Also at the federal level, the Patient-Centered Outcomes Research Institute established by the ACA is authorized to collect data to assess effectiveness of interventions to address disparities.\textsuperscript{347} It has so far funded over a hundred clinical trials to that end.\textsuperscript{348} Although insufficient tracking of non-clinical barriers to health remains a challenge, this is one of the tremendous benefits of the collaborative model. It provides the opportunity for local experimentation and collection of data. Then collaboratives can enable the networking of positive results to be implemented where those solutions may also be effective.\textsuperscript{349}

\textbf{V.B.ii. Cost and Funding}

A large investment—much larger than funds already committed—will be needed to address health inequity. An unfunded legal mandate has the potential to further stress financially vulnerable entities. In the healthcare system alone, the pandemic has had a disparate impact on entities, with many providers struggling financially.

Unlike with HIPAA, where an unfunded mandate required covered entities to make costly investment in administrative simplification, with a promise of savings down the road, the entities that need to invest in health equity will not necessarily be the same ones, directly, to reap financial rewards.

Cost savings will also not accrue equally to all. For instance, a payer that is forced to incur higher reimbursement costs to cover social determinants of health will likely

\begin{footnotes}
\footnotetext[344]{Horwitz, supra note 139.}
\footnotetext[345]{Horwitz, supra note 139 (reporting mixed success of interventions).}
\footnotetext[346]{See Executive Order, supra note 279.}
\footnotetext[347]{See Gwendolyn Roberts Majette, Striving for the Mountaintop-the Elimination of Health Disparities in A Time of Retrenchment (1968–2018), 12 GEO. J.L. & MOD. CRITICAL RACE PERSP. 145, 152 (2020).}
\footnotetext[348]{Patient-Centered Outcomes Research Institute, \url{https://www.pcori.org/topics/addressing-disparities} (last accessed Feb. 15, 2021).}
\footnotetext[349]{Matt Kuhrt, \textit{Just How Much are Health Systems Spending on Social Determinants? A New Study Put a Number on It}, Fierce Healthcare (Feb 10, 2020), \url{https://www.fiercehealthcare.com/hospitals-health-systems/health-systems-direct-substantial-funds-toward-social-determinants-health}}
\end{footnotes}
raise premium costs to cover the expense. Wealthier insureds who might not benefit from the new reimbursement policies would just see the higher cost of care.

One option would be for Congress to provide matching funds to states for health equity initiatives. This is the way the Medicaid program works and is the bedrock of other cooperative federalism approaches, such as the former Aid to Families with Dependent Children program.

But budgetary concerns have been the nail in the coffin of many other health reform proposals throughout history.\(^3\)\(^5\)\(^0\) For instance, the Clinton Administration failed in its attempt at health reform in part because it could not demonstrate the budget neutrality of the reform proposal.\(^3\)\(^5\)\(^1\)

Overtime, a successful closing of health inequity gaps will result in lower costs, but necessary short-term tax increases would likely be met with political resistance.\(^3\)\(^5\)\(^2\)

Another option for funding would be to utilize waiver provisions. Section 1332 of the Affordable Care Act specifically contemplates that the federal government can return savings in federal funds back to the state. For example, Alaska’s reinsurance program resulted in lower premiums, saving the federal government money on statutory premium subsidies. Alaska was able to fund its reinsurance costs using those cost savings that were returned to it.\(^3\)\(^5\)\(^3\) Improvements in health equity could also lead to savings for the federal government in Medicare and ACA subsidy costs, money that could be returned to the state to fund equity initiatives.

Medicaid has an even broader waiver provision in Section 1115 that is not statutorily limited to pass-through funds. Subject to state matching, Medicaid can reimburse for ‘costs . . . which would not otherwise be included as expenditures’ as long as they are part of an ‘experimental, pilot, or demonstration project’ that is ‘likely to assist in promoting the objectives’ of the Medicaid statute.\(^3\)\(^5\)\(^4\) HHS has imposed a budget neutrality provision on itself, making Medicaid fiscal waivers function similar to § 1332 waivers. But successful health equity efforts would also promote the health of the Medicaid population and reduce expenses for that population, both in improved health and even in movement off of Medicaid and into private insurance.\(^3\)\(^5\)\(^5\)

These options are limited by the narrow ways in which waivers have been interpreted and executed. Medicaid fiscal waivers, for instance, can only be based on Medicaid savings and not savings of federal funds outside the Medicaid program. Also, cru-

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350 See Matthew B. Lawrence, Fiscal Waivers and State “Innovation” in Health Care, 62 WM. & MARY L. REV. 1477, 1518 (2021) (‘Statutes and congressional rules make it difficult to pass legislation that scorekeepers predict will increase expenditures more than it increases revenues.’).

351 See William Sage, Adding Principle To Pragmatism: The Transformative Potential of ‘Medicare-for-All’ (May 13, 2019). SSRN: https://ssrn.com/abstract=3387120 (‘The need for a benign budgetary evaluation was an absolute bar to the Clintons pursuing a single-payer program. [citation omitted] CBO scoring remains a major consideration to this day...’).

352 See William M. Sage, No, the ACA Isn’t ‘Unconstitutional’: Ends and Means in a Dysfunctional Democracy, HEALTH AFFS. BLOG (Dec. 19, 2018), https://www.healthaffairs.org/do/10.1377/hblog20181219.912615/full/ (describing tyranny of the budget in health reform efforts).

353 See Matthew B. Lawrence, Fiscal Waivers and State “Innovation” in Health Care, 62 WM. & MARY L. REV. 1477, 1518 (2021)

354 See Matthew B. Lawrence, Fiscal Waivers and State “Innovation” in Health Care, 62 WM. & MARY L. REV. 1477, 1493 (2021).

355 Id. (arguing that Medicaid could more expansively use fiscal waiver authority to fund substance use disorder treatment or medical-legal partnerships, but it has not yet done so).
cially, savings are returned to the states only as they accrue, making waivers a difficult mechanism to jump start reform.356

V.B.iii. Federalism and Coercion

A related concern is that any solution grounded in the need for state and local action is subject to the criticism that socio-political dynamics will hinder progress. A collaborative model of the sort envisioned, here, depends on states working to meet health equity goals.357 It is reasonable to assume that states will differ in their ideological commitment to addressing inequities.358

Certain states have fought the Clean Air Act and the CPP.359 While most states have generally made progress in improving air quality under the Clean Air Act program, many have not met the defined standards.360

A central criticism of democratic experimentalism is that decentralization can exacerbate inequalities—that centralized solutions better account for redistribution of resources.361

There are options. Congress can threaten to entirely take over regulation and remove authority from the states. The Clean Air Act explicitly provides for this possibility.362 It can assess penalties under the terms of the mandate or take away future funding. In the face of state non-compliance, the agency may also issue sanctions. The EPA has under-used this option in promoting state compliance with air quality standards.363

The experience with Medicaid expansion provides additional reason for caution. Despite large financial incentives, 12 states have chosen not to accept significant federal funding to provide Medicaid to all citizens who make under 138 per cent of the federal poverty level. And the Supreme Court struck down a provision in the ACA as unconstitutionally coercive that would have taken away existing Medicaid funding as a penalty to states that chose not to take the expansion option.364

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356 Id. (arguing that these ‘limitations bias state innovation toward disentitlement and privatization, and away from investment in improving residents’ health or healthcare.’).
357 See Jessica Bulman-Pozen, Administrative States: Beyond Presidential Administration, 98 Tex. L. Rev. 265, 271 (2019).
358 It is dangerous to assume, however, that conservative-leaning Southern states will fight the premise of a health equity mandate. Notably, states such as Tennessee, North Carolina, Mississippi, and Alabama made particular efforts to address racial inequity in COVID vaccine roll-out. See Nambi Ndugga, Samantha Artiga, and Olivia Pham, How are States Addressing Racial Equity in COVID-19 Vaccine Efforts?, KAISER FAM. FOUND (Mar. 10, 2021), https://www.kff.org/racial-equity-and-health-policy/issue-brief/how-are-states-addressing-racial-equity-in-covid-19-vaccine-efforts/.
359 States have challenged the Clean Power Plan as infringing on 10th amendment rights. See also David L. Markell & Robert L. Glicksman, Dynamic Governance in Theory and Application, Part I, 58 ARIZ. L. REV. 563, 591 (2016) (noting that states often fail to meet national goals and EPA’s oversight of state enforcement has been problematic).
360 Id.
361 See, eg, David A. Super, Laboratories of Destitution: Democratic Experimentalism and the Failure of Antipoverty Law, 157 U. PA. L. REV. 541 (2008); Katharine G. Young, Adjudicating Social and Economic Rights: Can Democratic Experimentalism Help? in Social and Economic Rights in Theory and Practice: Critical Inquiries (Helena Alviar Garcia et al. Eds., Routledge, 2015).
362 See Daniel P. Selmi, Federal Implementation Plans and the Path to Clean Power, 28 GEO. ENVTL. L. REV. 637, 639–40 (2016).
363 Id.
Although the parameters of the coercion doctrine remain murky, however, it should not come into play with respect to federal health equity grants to states. As long as provisions of a grant are clear in advance, and prospective, offers of new funding with conditions are not coercive. States cannot be forced to accept federal grants. But the scenario does differ from Medicaid where taking federal money also means taking on a state obligation to pay some of the costs.

V.B.iv. Limits of Regulation

It might seem odd to apply a traditional mandate and aspects of conventional regulation to a problem like health inequity. Conventional regulation can be clumsy and inefficient. And the HIPAA process was not without hiccups. Deadlines were delayed and missed. Expenses were high and pushback from industry was strong.

On the other hand, markets alone do not hold the solution. Left to their own devices, markets have contributed to the sharp inequalities that underlie the health equity problem. Markets in the health sector in particular are flawed, despite regulation aiming to support their functioning.

The paradigm this article suggests, however, is not traditional, hierarchical regulation. Rather, it is a model that not only has an important role for a mandate but also for government contributions at all levels and for contributions by industry. It envisions a cooperative network with widespread knowledge-sharing and data from both public and private sources being used to improve regulation. This is the model that was successful in HIPAA and has also been successful in addressing other complicated policy problems.

V.B.v. Politics

Finally, there is likely to be significant political push back about mandate-driven efforts to address health inequity, in particular from conservative and libertarian groups committed to the use of market principles. There will also be opposition from groups who currently benefit from the existence of marginalized populations or who perceive no direct benefit from attempts to address health inequity but would still bear the costs.

For this reason, the economic inefficiencies of health inequity must be emphasized. In the current system, affluent, privately insured individuals still bear the costs of health inequity. The potential for industry-level cost savings that will ultimately lower costs for everyone must be part of the framing of this initiative.

Also, it is important to emphasize that the goal of health equity is not to make all social determinants of health equal. Rather it is to raise those determinants (such as income, clean air and water, and access to education) to a level that allows an equal opportunity to lead a healthy life. That does not mean that everyone must make the same amount of money, but it does mean that people should have enough money that their poverty won’t predetermine a less healthy life.

Finally, there might be no better political climate to address health inequity than the present. The pandemic has just illustrated its dire consequences, and an administration supportive of addressing the problems is newly elected.
VI. CONCLUSION

Health inequity must be addressed. There is wide agreement on this point. And yet health reform efforts have focused on improving access and not health inequity. Remediating health inequity requires coordination across public and private, local to federal, and health sector to housing to the environment. It requires combatting racism, and it requires considerable funding.

As daunting as the task is, it must be done. Millions of lives depend on it. And the economy, to the tune of $230 billion, depends on it. Slow progress with little to show in terms of results must give way to something better.

This article made the case for what that better approach is. Drawing parallels to HIPAA’s successful use of a federal legal mandate and collaboratives, and the Clean Air Act’s use of cooperative federalism, it argued for a comparable approach to achieving health equity.

The paradigm must include a formal legal mandate that defines achievable outcomes, sets deadlines, includes sanctions for non-compliance, and incorporates a mechanism for funding. But there is also an essential role for more informal mechanisms—the work of collaboratives, which will experiment and network and bootstrap their successes and failures.

Health inequities are worsening, spurred in part by the effects of the pandemic. Narrowing the chasm will not be easy. But a mandate that catalyzes a collaborative, data-driven approach is the path forward.