INTRODUCTION
A Bold Agenda for the Next Steps in Health Reform

Brietta R. Clark, Erin C. Fuse Brown, and Lindsay F. Wiley

This symposium issue is the product of the 2019 Next Steps in Health Reform Conference. American University Washington College of Law launched the Next Steps in Health Reform conference in 2012 with a reprise in 2015. Beginning in 2017, the American Society of Law, Medicine and Ethics (ASLME) partnered with American University's Washington College of Law, School of Public Affairs, and Kogod School of Business to expand the event to a three-day conference bringing together speakers and attendees from multiple disciplines, from the academy and practice, and from across the U.S. and Canada.

ASLME committed to continuing the conference on a biannual basis, alternating with our other flagship biannual gathering, the Public Health Law Conference. Our carefully organized rotation has been disrupted by the coronavirus pandemic and both conferences have been postponed for the time being. Nonetheless, plans for Next Steps in Health Reform 2022 are already underway. For updates, please visit https://www.wcl.american.edu/impact/initiatives-programs/health/healthreform.

Brietta R. Clark, J.D., *is a Professor of Law and J. Rex Dibble Fellow, Loyola Law School, Loyola Marymount University, Los Angeles.* **Erin C. Fuse Brown, J.D., M.P.H.**, *is an Associate Professor of Law and Director of the Center for Law, Health & Society at Georgia State University College of Law.* **Lindsay F. Wiley, J.D., M.P.H.**, *is a Professor of Law and Director of the Health Law and Policy Program at American University Washington College of Law, and is a former President of the American Society of Law, Medicine & Ethics.*

In the aftermath of the largely failed Clinton-era health reform push and the build-up to Obama-era reforms, experts worried that another failed effort could cast a ten-year shadow. The tenth anniversary of the Affordable Care Act offered an opportunity for participants in the 2019 Next Steps in Health Reform conference to reflect. If the ACA proves resilient, what paths will it have paved for the next decade of reforms?

Policy Perspectives

Our fragmented, inequitable health care system is the product of iterative reform efforts and the market forces that often counter them. The durability of the Affordable Care Act (ACA) through multiple battles in the courts and the Senate floor throughout the 2010s has paved the way for bigger, bolder ideas about what the next steps in health reform might accomplish in the 2020s. A groundswell of deep democratic engagement on the core policy issues of universality, equity, and accountability could push reform efforts in new directions.[1] The orientation of these efforts is far from certain. While some reformers push proposals rooted in solidarity and mutual aid,[2] others embrace the vision of personal responsibility and actuarial fairness embodied in the Trump administration's regressive Medicaid policies.[3]

The drafters of the next wave of national health reform proposals must learn from the ACA, whether they seek to build on its foundation or leave it behind. Legal battles over the ACA are far from over, with the Supreme Court poised to hear yet another existential challenge as soon as this fall and a decision expected sometime after the momentous elections of November 2020.[4] Unless policymakers can broaden the metrics by which legislation is rated primarily in terms of

The Journal of Law, Medicine & Ethics, 48 (2020): 390-392. © 2020 The Author(s)
DOI: 10.1177/1073110520958793

budgetary impacts, big, bold health reform proposals will fall into the same fiscal traps and congressional gridlock that left the ACA particularly vulnerable to litigation.[5] Congress's inability to fulfill its policymaking role has opened up a policy void within which executive branch officials assert expanding power. The resulting clashes over separation of powers and administrative law have contributed to the emergence of litigation as an important vehicle for interested parties to advance their vision of health policy.[6] Whether sweeping, modest, or regressive, the next wave of health reforms signed into federal law are likely to follow the ACA's path and be hashed out in the courts.

Congressional inaction means that states are the engines of health policy innovation. Federal preemption of state health reform looms large. States' innovations in health regulation — whether broad single-payer plans or narrower efforts to curb abusive out-of-network surprise medical bills — are hampered by federal preemption that walls off entire market segments from state regulation.[7] To unshackle states' role as innovators of health reform, Congress should revisit ERISA's broad preemption that shields self-funded employer-based health plans beyond all manner of state health regulation. Similarly, states have a narrow set of policy tools to protect consumers from out-of-network air ambulance bills due to a double-dose of federal preemption by ERISA and the Airline Deregulation Act.[8] If Congress cannot muster the will to enact broad national health reforms, then it ought to remove the barriers to state action posed by excessive federal preemption.

Beyond Access and Affordability to Health Equity

Health reforms must contend with perennial questions of access and affordability and yet recognize that advancing these policy goals is no substitute for pursuing health equity as an end in itself. To do so, health policymakers must simultaneously think of the forest and be intimately aware of the trees. Broad reforms must attend to the organization and reimbursement of primary care, which, due to its close proximity to patients, has untapped potential to promote care integration and address unmet social needs.[9] In other areas, such as mental health care, we need strategies to shore up the ACA's protections where they have proven inadequate. Here, too, states have experimented with novel ways to use Medicaid managed care plans to fill gaps left by federal mental health parity requirements.[10] It is not enough to give everyone a health insurance card — the health care itself must be accessible, affordable, and responsive to the social, economic, and cultural context in which patients make decisions about their health.

It is perhaps this failure to fully account for the social, economic, and cultural context in which patients seek care and manage their health that makes health equity such an elusive goal. Indeed, despite the fact that concerns about health disparities animated many provisions in the ACA — including its coverage mandates, guarantee issue and pricing reforms, and antidiscrimination protections — significant health disparities persist. Disparities persist, in part, because of Congressional inaction that empowers states as crucial drivers of health reform. This means that state law can be a powerful determinant of health, especially in the absence of clear federal guardrails. This is particularly pronounced in the context of women's reproductive health care. Although the ACA has been touted for advancing gender equity in its private insurance reforms, there is a federal regulatory void in the area of reproductive health, which states can fill with actions that either undermine or advance health equity goals.[11] Abortion is one example. A federal policy that exceptionalizes abortion — that is, fails to protect and regulate it like other health care services — emboldens states that want to regulate providers of abortion care out of existence. This depletion of resources is occurring, even when it means losing providers who provide other crucial health care for women and without any regard for the potential harm to women's health. Maternal health care is another example. Despite protections for pregnancy coverage, inattention to the quality of care women receive during and after pregnancy has allowed problems of maternal mortality

Health reforms must contend with perennial questions of access and affordability and yet recognize that advancing these policy goals is no substitute for pursuing health equity as an end in itself. To do so, health policymakers must simultaneously think of the forest and be intimately aware of the trees.

The Journal of Law, Medicine & Ethics, 48 (2020): 390-392. © 2020 The Author(s)
https://doi.org/10.1177/1073110520958793 Published online by Cambridge University Press

and morbidity to persist — a problem which becomes even more stark when considering the intersection of sex and race.[12] Some states have enacted reforms to improve maternal health care, while others have failed to act.

Disparities also persist because federal and state health policy has largely neglected the social forces that have an outsized impact on health. These social or structural determinants of health include employment, housing, nutrition, education, neighborhood and the built environment, and other social or community conditions. Reforms addressing these non-medical determinants of health are increasingly viewed as important to improving health among low-income and rural communities,[13] as well as to reducing racial and other health disparities. But such reforms tend to focus on discrete areas that are poverty-related and perceived as relatively easy to remediate, such as food or housing insecurity. Discrimination — a powerful determinant of health that contributes to health disparities — is often not addressed in these reform efforts.[14] For example, it is often assumed that addressing access and poverty-related factors will reduce racial disparities, despite ample evidence of race discrimination in health care, housing, employment, and policing. While the ACA should be seen as laying a crucial foundation for the path toward health equity, disparities will persist unless the next wave of health reforms create more meaningful standards for ensuring health equity and do more to address the social determinants of health, including interpersonal, institutional, and structural discrimination.

Conclusion

Since the 2019 conference that spawned these articles and commentaries, the global COVID-19 pandemic, its disproportionate toll on communities of color, the brutal killings of Black Americans by the police, and subsequent anti-racist protests have highlighted systemic vulnerabilities, failures, and inequities of our current U.S. health care system. Thus, the year 2020 has underscored the urgency and necessity of continuing to work toward the next steps in health reform, building on the lessons of the first decade of the ACA and grappling with the challenges we face in the coming decade.

References

1. B. Palmquist, "Equity, Participation, and Power: Achieving Health Justice Through Deep Democracy," *Journal of Law, Medicine & Ethics* 48, no. 3 (2020): 393-410.
2. E. Fuse Brown, M. Lawrence, E. McCuskey, and L. Wiley, "Social Solidarity in Health Care, American Style," *Journal of Law, Medicine & Ethics* 48, no. 3 (2020): 411-428.
3. N. Huberfeld, S. Watson, and A. Barkoff, "Struggle for the Soul of Medicaid," *Journal of Law, Medicine & Ethics* 48, no. 3 (2020): 429-433.
4. *Texas v. U.S.*, 945 F.3d 355 (5th Cir. 2019), cert. granted, rev'd sub nom. *California v. Texas* (No. 19-840).
5. W. Sage and T. Westmoreland, "Following the Money: The ACA's Fiscal-Political Economy and Lessons for Future Health Care Reform," *Journal of Law, Medicine & Ethics* 48, no. 3 (2020): 434-442.
6. K. Keith and J. McElvain, "Health Policy by Litigation," *Journal of Law, Medicine & Ethics* 48, no. 3 (2020): 443-449.
7. E. McCuskey, "ERISA Preemption Reform as Health Reform," *Journal of Law, Medicine & Ethics* 48, no. 3 (2020): 450-461.
8. E. Fuse Brown, A. McDonald, and N. Nguyen, "What States Can Do to Address Out-of-Network Air Ambulance Bills," *Journal of Law, Medicine & Ethics* 48, no. 3 (2020): 462-473.
9. J. Jacobi, "Payment Theory and the Last Mile Problem," *Journal of Law, Medicine & Ethics* 48, no. 3 (2020): 474-479.
10. M. Lawrence, "Parity is Not Enough! Mental Health, Managed Care, and Medicaid," *Journal of Law, Medicine & Ethics* 48, no. 3 (2020): 480-484.
11. V. Blake and M. McGowan, "Filling a Federal Void: Promises and Perils of State Law in Addressing Women's Health Disparities," *Journal of Law, Medicine & Ethics* 48, no. 3 (2020): 485-490.
12. J. Taylor, "Structural Racism and Maternal Health Among Black Women," *Journal of Law, Medicine & Ethics* 48, no. 3 (2020): 506-517.
13. S. Vorha, C.A. Pointer, A. Fogleman, T. Albers, A. Patel, and E. Weeks, "Designing Policy Solutions to Build a Healthier Rural America," *Journal of Law, Medicine & Ethics* 48, no. 3 (2020): 491-505.
14. R. Yearby, "Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause," *Journal of Law, Medicine & Ethics* 48, no. 3 (2020): 518-526.

The Journal of Law, Medicine & Ethics, 48 (2020): 390-392.