

COVID-19 Reveals the Fiscal Determinants of Health

Matthew B. Lawrence

I INTRODUCTION

This chapter describes the ways in which the US fiscal system undermined the country's preparation for and response to the COVID-19 pandemic. It emphasizes that health law scholarship can usefully treat the discovery of a lack of resources to address a particular problem in health or health care as a starting point, not an endpoint, in the identification of legal solutions to policy problems. The fiscal determinants of health – including scorekeeping, fragmentation, fiscal federalism, and forced fragility – contribute to underinvestment in health care and public health. By tracing particular examples of underinvestment back to their fiscal determinants, health law can identify and motivate necessary upstream reforms.

II HEALTH INVESTMENT AND THE PETER/PAUL QUESTION

Health law and policy scholarship are replete with calls for additional investment in health or health care, usually based on careful, persuasive analysis of how such investment would be cost-justified on many dimensions.¹ The COVID-19 pandemic has been no exception. For example, the Network for Public Health Law issued a compilation of scholarly recommendations for steps that state, local, and federal governments might take to mitigate the harms of the pandemic; the unmistakable theme of the recommendations is “more funding.”² The pervasiveness of

¹ Overall, the United Health Foundation estimates a potential, untapped savings of \$5.60 for every \$1 invested in discrete evidence-based public health programs. United Health Found. Ann. Rep. 85 (2018).

² In many cases, the recommendations are explicitly for greater funding. For example, Scott Burris et al., *Assessing Legal Responses to COVID-19*, Pub. Health L. Watch, at 7 (Aug. 2020) (“Congress should fund ... rapid testing, contact tracing, and isolation”); *id.* (“Congress should mandate and fund an effort to rebuild CDC’s information infrastructure”); *id.* at 8 (“State legislatures should fund ... ongoing contact tracing”); *id.* (“Legislators should ... provide sufficient funding to support improved data collection”); *id.* at 9 (“Local governments should enact paid sick leave policies”). In others, they are for measures that would require federal, state, local, or tribal actors to take resource-intensive actions such as hiring additional full-time employees or hiring subcontractors or consultants. For example, *id.* at

underinvestment raises the possibility of underlying, systemic causes. Why does US society fail to make worthwhile investments in health and health care?

Prominent explanations include public choice pathologies and racism.³ From the standpoint of these explanations, there is only so much that health law scholarship can do once scholars identify a particular example of underinvestment, other than to turn directly to political advocacy.

There is another explanation for the nation's tendency to underinvest in health and health care, however: the often-overlooked fiscal system through which the country makes tradeoffs concerning the allocation of its scarce resources. Any suggestion that more funding is needed for a given project will be met by policymakers with the same question: What should I cut to get the money? Just as the "Chicago question" haunts private law ("if it's such a good idea, why aren't private entities already doing it?"), this Peter/Paul question haunts health law. Should policymakers rob Peter to pay Paul? If the country spends too much on treating sickness and not enough on preventing it, should health care entitlements be cut to fund public health investments? If not, where should the money come from: Should it be borrowed? Should taxes be raised – and if they are, will that stifle economic growth and, with it, the revenues available in the future?

The debate over additional pandemic funding in the 2022 Consolidated Appropriations Act illustrated the potency of the Peter/Paul question. In March of 2022, as the pandemic entered its third year, the Biden Administration sought \$22.5 billion in additional funding to pay for continued response efforts, including testing, treatment, and vaccination.⁴ Congress initially included \$15 billion in an omnibus appropriations package to meet this request, but Republicans insisted that any additional funds be offset by reductions elsewhere.⁵ A plan to draw such offsets from pandemic funds that had already been appropriated for states, but not yet spent, created controversy and opposition.⁶ As a result, the pandemic relief was pulled from the omnibus funding package, which was enacted in March 2022 without it, despite the Administration's predictions of immediate adverse impacts for

7 (recommending that the Department of Health and Human Services develop guidance on the spread of communicable disease); id. ("[The] CDC should develop rigorous ... guidance for safe operation of schools [and] businesses"); id. ("Congress should require the Department of Health and Human Services to collect and publicly report standardized data"); id. ("Agencies ... should coordinate and standardize data collection"); id. at 8 (suggesting that states should "use their police power to promote physical distancing"); id. (recommending that state health departments "seek to identify and address unique barriers and concerns [for] immigrant and migrant populations"); id. at 9 ("Local health departments should collect detailed data on the populations and geographies most affected by COVID-19").

³ Daniel E. Dawes, *The Political Determinants of Health* (2020); Paul A. Diller, Why Do Cities Innovate in Public Health? Implications of Scale and Structure, 91 *Wash. Univ. L. Rev.* 1219 (2014) (discussing public choice explanations).

⁴ See Cheyenne Haslett & Ben Gittleson, White House Says 1st Cuts to COVID Efforts Will Hit Americans Next Week as Funding Stalls in Congress, ABC News (Mar. 15, 2022).

⁵ Id.

⁶ Id.

the nation's pandemic response.⁷ At the time of writing, it is not clear whether or when Congress will ever provide the funding, but if it does, it will at least be delayed long enough to cause some of the predicted adverse impacts. As this sequence of events reveals, the question that proved determinative for inclusion of additional pandemic funding in the 2022 Consolidated Appropriations Act was not whether such funding was necessary. The determinative question was how additional funding would be acquired.

As this example makes clear, the Peter/Paul question tends to defuse calls for greater investment by highlighting the tradeoffs forced by such calls. But objections based on tradeoffs are only as good as our system for making them – for deciding where to direct scarce resources. That is not only a story about politics. It is also a story about the complicated system of revenues, expenditures, estimates, and budgets that society uses to make “fiscal” decisions.⁸

III THE FISCAL DETERMINANTS OF HEALTH

The laws, rules, and practices that comprise the US fiscal system load the dice against public health, contributing to the country's failure to make tradeoffs correctly – its failure to allocate resources appropriately for public health and health care. As Professor Westmoreland, whose scholarship has done much to uncover such distortions, put it, “the process is the policy.”⁹

The parts that follow elaborate upon how the nation makes tradeoffs about how to allocate scarce resources using a complex fiscal system that: (1) ignores long-term and secondary costs and benefits in estimating the effects of policy; (2) fragments choices into largely arbitrary but outcome-determinative fiscal categories; (3) leaves a flawed federal fiscal apparatus as the main source of essential investments; and (4) forces fragility on public goods. It is useful to think of these tendencies – score-keeping distortions, fiscal fragmentation, fiscal federalism, and forced fragility – as the “fiscal determinants of health.” While the point can be overdone, it highlights the fact that these are distinct causes of unnecessary sickness and suffering embedded in a particular area of law, and that they therefore offer legal levers we might pull to improve outcomes.

The fiscal determinants of health are a promising avenue for legal reform because they are themselves partially the product of law, as described later. Health law scholarship can productively approach individual cases of scarcity it discovers not as an

⁷ Id. (quoting letter from Shalanda D. Young, Acting Director, OMB & Jeffrey D. Zients, Secretary of the Treasury, to Speaker Nancy Pelosi, Mar. 15, 2022).

⁸ Fiscal, Merriam-Webster Dictionary 271 (2016) (deriving from Latin, “basket,” often government revenue/expenditure, but also, more broadly, budgeting; “of or relating to taxation, public revenues, or public debt”).

⁹ Timothy Westmoreland, Standard Errors: How Budget Rules Distort Lawmaking, 95 *Geo. L. J.* 1555, 1557 (2007).

ending, but as a beginning, tracing them back to underlying fiscal law rules to motivate reform. Moreover, this work offers opportunities for engagement with other fields that depend heavily on social ordering through spending, such as education, childcare, and transportation, because fiscal determinants can act as obstacles to investment across these contexts.

The discussion here is not intended to be a comprehensive accounting of the interaction between fiscal determinants and the nation's preparation for, or response to, the COVID-19 pandemic. Instead, it is intended to illustrate how fiscal rules and practices can undermine health policymaking, drawing on examples from this pandemic.

IV SCOREKEEPING

Scorekeeping is the first fiscal determinant that undermined the country's management of the pandemic. Estimating the costs and benefits of potential policy choices is an essential step in deciding how to allocate scarce resources – without an estimate, there is no way either to assess which allocations are worthwhile or, where many potential allocations seem worthwhile, to make comparisons between them. In a series of articles, Professor Westmoreland has problematized the rules that Congress uses to estimate the costs and benefits of legislation in the budget process.¹⁰ The closest formal congressional equivalent to cost-benefit analysis of regulations, scorekeeping, is the process by which the Congressional Budget Office and the House and Senate Budget Committees estimate the effects of legislation and track its effects for purposes of various budget statutes and points of order.¹¹

The scores produced in this process can be incredibly influential. Professor Westmoreland has described how the goal of gaming the “score” distorted a range of health care policies.¹² Professors Westmoreland and William Sage have described how scoring considerations doomed President Clinton's health reform plan and shaped that of President Obama.¹³ And Professor Sage has described the importance of scorekeeping considerations for the design of single-payer health reforms such as Medicare for All.¹⁴

Prophetically, Professor Westmoreland explained how these biases would leave the country unprepared for a viral pandemic years before COVID-19. He pointed out that “[t]he budget process discourages long-term investments” by measuring

¹⁰ Id.; Timothy Westmoreland, *Invisible Forces at Work: Health Legislation and Budget Processes*, in *The Oxford Handbook of U.S. Health Law* 873 (I. Glenn Cohen et al., eds., 2017); Timothy Westmoreland, *Can We Get There from Here? Universal Health Insurance and the Congressional Budget Process*, 96 *Geo. L. J.* 523 (2008).

¹¹ Allen Schick, *The Federal Budget: Politics, Policy, Process* (3d ed. 2007).

¹² Westmoreland, *supra* note 10, at 1574.

¹³ William M. Sage & Timothy M. Westmoreland, *Following the Money: The ACA's Fiscal-Political Economy and Lessons for Future Health Care Reform*, 48 *J. L. Med. Ethics* 434, 437–40 (2020).

¹⁴ William M. Sage, *Adding Principles to Pragmatism: The Transformative Potential of “Medicare-for-All,”* 14–15, 23–24 (Feb. 2020) (unpublished manuscript) (available at <https://perma.cc/TT5D-FSBT>).

both costs and benefits within narrow windows of, at most, ten years.¹⁵ Moreover, estimates exclude so-called “secondary” (dynamic) effects of spending, such as the benefit of reduced Medicare hospital costs associated with measures that promote health or prevent chronic illness.¹⁶ This exclusion is the result of a facially neutral desire for certainty in predictions, but because both costs and market effects are easier to predict than secondary benefits, the facially neutral criterion of certainty in estimates depresses investments in public goods. Furthermore, in what Professor Westmoreland calls an example of “solipsism,” federal scorekeeping estimates “place no value on non-federal savings,”¹⁷ “resulting in an underappreciation of public value and public improvement.”¹⁸ Because the “widely dispersed benefits of preventing an epidemic would ... remain unscored,”¹⁹ Professor Westmoreland predicted in 2007 that the federal government would fail to invest adequately in pandemic preparedness. Of course, that is precisely what happened.²⁰

Scorekeeping most directly undermines health investment when it prevents a bill from being passed or distorts its design. But even when a bill passes, scorekeeping’s solipsism and limited time horizons can undermine investment because of the way it interacts with deficit control statutes, such as the Statutory Pay-As-You-Go Act of 2010. When COVID-19 struck, Congress passed major spending legislation to address it, including the Coronavirus Aid, Relief, and Economic Security Act and the American Recovery Plan. It overcame negative scores in doing so, but the Senate refused a permanent exemption from the Pay-As-You-Go Act, instead deferring impacts. The result is that the Act will require a mandatory across-the-board sequestration cut in spending programs in late 2024 or early 2025, unless addressed by Congress through legislation.²¹ Even if Congress enacts a measure averting these cuts, their threat, and the votes they force, will increase the fragility of social programs.

Finally, the COVID-19 pandemic also illustrated a blind spot in the US fiscal system: the invisibility of unpaid care work. Some of the most critical work done in this country is the work of caring for those in positions of acute vulnerability, including children and elderly people.²² Yet, as Professor Noah Zatz points out, this work tends to be ignored in making policy because it is often unpaid and done by women.²³

¹⁵ Westmoreland, *supra* note 10, at 1590.

¹⁶ Scott Levy, Spending Money to Make Money: CBO Scoring of Secondary Effects, 127 *Yale L. J.* 936 (2018).

¹⁷ Westmoreland, *supra* note 10, at 1593.

¹⁸ *Id.* at 1592.

¹⁹ *Id.* at 1593.

²⁰ Sage & Westmoreland, *supra* note 14, at 435.

²¹ Ctr. for a Responsible Federal Budget, Upcoming Fiscal Policy Deadlines (Dec. 22, 2021), www.crfb.org/blogs/upcoming-congressional-fiscal-policy-deadlines; S. 610, Protecting Medicare and American Farmers from Sequester Cuts Act, Pub. L. 117–71 (Dec. 10, 2021).

²² Martha Albertson Fineman, The Nature of Dependencies and Welfare “Reform,” 36 *Santa Clara L. Rev.* 287 (1996).

²³ Noah Zatz, Supporting Workers by Accounting for Care, 5 *Harv. L. Pol’y Rev.* 45 (2011).

The COVID-19 response illustrated this blind spot for unpaid care work. Nurses and doctors in hospitals and clinics are usually described as working on the “front lines” of the COVID-19 pandemic,²⁴ but this framing ignores the fact that most COVID-19 treatment took place in homes across the country and was provided unpaid by family members and loved ones.²⁵ While the goal of protecting “front-line” professional health care workers from exposure through the provision of personal protective equipment was a leading one throughout the pandemic, protecting home-front health workers was an afterthought.

This oversight proved costly. Household spread appears to have been a key fuel in the COVID-19 pandemic in the United States. While data is still emerging, one study showed that across the country, when symptomatic coronavirus patients were sent home after diagnosis, cohabitating family members quickly contracted the virus (usually within a week) more than 50 percent of the time.²⁶ This was much higher than results reported in other countries, where the rate was 30 percent or lower.²⁷ Even congressional efforts to address home care work focused only on workers pulled from the full-time workforce, rather than on those not in that workforce because of their commitment to care work. In the Coronavirus Aid, Relief, and Economic Security Act passed in March 2020, Congress attempted to partially reimburse some home care work, mandating that employers provide their full-time employees with up to six weeks of paid time off to care for dependent children. The measure excluded employees who needed to take time to care for loved ones other than dependent children, including parents and partners,²⁸ care workers who lacked qualifying full-time employment,²⁹ and for half of 2020, employees unable to work due to lockdown because of an unlawfully cramped Department of Labor interpretation (which was ultimately overturned).³⁰

V FISCAL FRAGMENTATION

The fragmentation of health care costs and benefits into discrete fiscal categories also undermined the nation’s handling of the pandemic. Through a dense, interconnected web of property law, contract law, and fiscal law, responsibility for costs associated with sickness and health care in the United States is segmented into

²⁴ Emily Palmer, *Voices from the Pandemic’s Front Lines*, NY Times (May 11, 2020), www.nytimes.com/2020/05/11/reader-center/coronavirus-healthcare-workers.html.

²⁵ Kate Power, *The COVID-19 Pandemic Has Increased the Care Burden of Women and Families*, 16 *Sustainability: Sci., Prac. & Pol’y* 67 (2020).

²⁶ Carlos G. Grijalva et al., *Transmission of SARS-COV-2 Infections in Households – Tennessee and Wisconsin, April-September 2020*, 69 *Morbidity & Mortality Wkly. Rep.* 1631 (2020).

²⁷ Jake Lowary, *VUMC Study Finds Faster, Wider Spread of COVID-19 in US Households*, *Vand. Univ. Med. Ctr.* (Oct. 30, 2020), [https://news.vumc.org/2020/10/30/vumc-study-finds-faster-wider-spread-of-covid-19-in-u-s-households/#:~:text=COVID%2D19%20spreads%20faster%20and,Control%20and%20Prevention%20\(CDC\).](https://news.vumc.org/2020/10/30/vumc-study-finds-faster-wider-spread-of-covid-19-in-u-s-households/#:~:text=COVID%2D19%20spreads%20faster%20and,Control%20and%20Prevention%20(CDC).)

²⁸ *Families First Coronavirus Response Act (FFCRA)*, Pub. L. No. 116–127, 134 Stat. 178 (2020).

²⁹ *Id.*

³⁰ *New York v. US Dep’t of Lab.*, 477 F.Supp.3d 1 (SDNY 2020).

categories, such as “public” and “private” and “federal” and “state.”³¹ They are then further segmented within each category into subcategories – at the federal level, these include “mandatory” expenditures (such as Medicare and Medicaid) and “discretionary” expenditures (most public health funding),³² and then into programs (Medicare Part A or Medicaid), and so on. Similarly, state spending is separated by department and program; for example, Professor Elizabeth Weeks’s recent work has shown the many different components of states and localities that have been impacted financially by the opioid crisis – and the hard work that can be entailed in stitching these segregated categories together to reveal the true costs of the crisis.³³ And, of course, within the private sector, costs are fragmented between and among providers, payers, and patients.³⁴

The fragmentation of costs into disparate categories prevents needed investment in public goods by limiting reforms enacted to those that are cost-justified within a given narrow fiscal category or, put differently, by impeding investments that pose costs within one fiscal category but create benefits within another category.³⁵ At the same time, it facilitates costly and wasteful behaviors that increase overall costs – but create savings for the actor. Take Medicare’s readmission penalty. The penalty is an attempt to respond to a problematic phenomenon: fragmentation gives hospitals an economic incentive to discharge patients prematurely because they do not bear the cost of readmissions. In response, Medicare penalizes those hospitals whose patients have the highest readmission rates.³⁶ In economic terms, fragmentation leads to overproduction of negative externalities and underproduction of positive externalities, necessitating either the coordination required for Coasian bargaining of a Pigouvian subsidy or sanction.³⁷ In plain English, because decisionmakers may lack either the means or the stakes to take costly actions that reduce health care costs for which they are not responsible, even when those actions are worthwhile from the overall standpoint of the community, such actions will not be taken unless, by contract or government fiat, the benefits of the investment (or costs of foregone investment) are shared with them.

³¹ See Erin C. Fuse Brown, Matthew B. Lawrence, Elizabeth Y. McCuskey & Lindsay F. Wiley, *Social Solidarity in Health Care, American-Style*, 48 *J. L. Med. Ethics* 411, 415 (2020).

³² Federal budgeting laws and rules treat “mandatory” expenditures on programs such as Medicare and Medicaid as distinct from “discretionary” expenditures on annual programs, requiring that increases in mandatory spending be offset by decreases in mandatory spending and that increases in discretionary spending similarly be offset by discretionary decreases. Allen Schick, *The Federal Budget: Politics, Policy, Process* (3d ed. 2007).

³³ Elizabeth Weeks & Paula Sanford, *Financial Impact of the Opioid Crisis on Local Government: Quantifying Costs for Litigation and Policymaking*, 67 *U. Kan. L. Rev.* 1061 (2019).

³⁴ Fuse Brown et al., *supra* note 32.

³⁵ *Id.*; see also Fineman, *supra* note 23 (“It is widely understood that the social safety net is being torn apart by the rhetoric of budget necessity and professed American moral values”).

³⁶ Jordan Rau, *Look Up Your Hospital: Is It Being Penalized by Medicare?*, Kaiser Health News (Nov. 2, 2020), <https://khn.org/news/hospital-penalties>.

³⁷ Wallace E. Oates, *Fiscal Federalism* 66–67 (William J. Baumol ed., 1972) (describing A.C. Pigou’s proposed subsidy to counteract positive externalities).

Scholars have noted that an individualized, medical approach to health care does not facilitate the measures needed to address a viral pandemic, such as surveillance testing, quarantine, and expeditious vaccination.³⁸ The issue is one of means as well as motivation: even if actors might want to further collective interests for the good of society, fiscal fragmentation means they often lack the means: the money to do it.

Through much of the pandemic, the lack of surveillance testing through employers and schools illustrated this problem. From a collective perspective, it makes sense for asymptomatic employees, teachers, and students to be tested before returning to work or school. Doing so can prevent exposure – and cases – for other employees and students, their families, and the broader community. Congress mandated that insurers cover COVID-19 testing, but insurers were able to refuse such testing for employers and schools on the grounds that surveillance testing for an individual was not a “medically necessary” intervention under the insurance contracts.³⁹ They did so.⁴⁰ Workplaces and schools, for their part, refused to pay for such testing themselves in the vast majority of cases. They cited the cost and administrative burden of testing as the primary barriers.⁴¹

Why would insurers not pay for surveillance testing for employees and schools themselves – indeed for everyone – as a means to curb the pandemic? Why did Congress even have to mandate that insurers cover tests sought by their beneficiaries? In the fragmented US health care system, any one insurer is financially responsible for the medical costs of only a small fraction of the full patient population. Insurers bear 100 percent of the costs of testing their beneficiaries and only a small fraction of the savings (in terms of health care costs) created by preventing viral spread, which are shared among all other insurers: Medicare, Medicaid, and so on.

VI FISCAL FEDERALISM

Fiscal fragmentation can be overcome on issues such as surveillance testing and vaccines by collective action, as it was, to an incomplete extent, by the mandate that insurers cover medically necessary tests. The Coase theorem would predict that community members could bargain with each other to prompt measures in their

³⁸ Example, Emily A. Benfer, Seema Mohapatra, Lindsay F. Wiley & Ruqaiyah Yearby, Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Disparities during and after COVID-19, 19 *Yale J. Health Pol’y, L. Ethics* 122, 138 (2020).

³⁹ Julie Appleby, For COVID Tests, the Question of Who Pays Comes Down to Interpretation, Kaiser Health News (July 20, 2020), <https://khn.org/news/for-covid-tests-the-question-of-who-pays-comes-down-to-interpretation/>.

⁴⁰ Id.

⁴¹ Nathaniel L. Wade & Mara G. Aspinall, Facing Uncertainty: The Challenges of COVID-19 in the Workplace, ASU Workplace Commons (Nov. 2020), www.rockefellerfoundation.org/wp-content/uploads/2020/11/ASU_Workplace_Commons_Nov2020_FINAL.pdf (showing that a significant majority of more than 1,100 employers surveyed refused to test asymptomatic employees, citing cost and administrative complexity as reasons).

collective self-interest.⁴² And while ordinarily the coordination entailed in such an effort might itself be a barrier to such collective effort,⁴³ for a universal threat such as COVID-19, government can be the vehicle for compromise and collective choices.

Fiscal federalism is an impediment to many collective responses to fiscal fragmentation.

As Professor David Super has pointed out, states and localities themselves are tightly limited as a source of costly, collective interventions. Not only are most constitutionally prohibited from deficit spending,⁴⁴ but during a recession (such as the one brought on by the pandemic), their revenues decrease (due to reduced spending and income), while their expenditures increase (due to heightened demand for social services, such as unemployment benefits).⁴⁵

That leaves the federal government as the primary source for high-cost collective measures. But, as the pandemic revealed, the risk that the federal government will fail to make appropriate interventions is significant. This is in part a question of leadership,⁴⁶ of course, but scorekeeping distortions (discussed earlier) also hamper federal investment, even where it is an essential backstop, as does forced fragility (discussed later).

Personal protective and medical equipment offer one example of the federal government's limitations. The George W. Bush Administration's influenza pandemic plan acknowledged that the federal government is best positioned to supply sufficient stock of these measures to respond quickly to a pandemic.⁴⁷ The federal government fell short in doing so, however, due to both a lack of preparation and a lack of leadership.⁴⁸ States then demonstrated the challenges of fiscal federalism in real time. They competed over scarce supplies, driving up prices, creating an appearance of chaos, and channeling supplies to the best-resourced and best-connected states, rather than those that most needed it.⁴⁹

⁴² R.H. Coase, *The Problem of Social Cost*, 3 *J.L. & Econ.* 1 (1960).

⁴³ *Id.*

⁴⁴ David A. Super, *Rethinking Fiscal Federalism*, 118 *Harv. L. Rev.* 2544, 2616 (2005).

⁴⁵ *Id.* at 2611–14.

⁴⁶ See David Pozen & Kim Lane Scheppele, *Executive Underreach*, in *Pandemics and Otherwise*, 114 *Am. J. Int'l L.* 608 (2020).

⁴⁷ Homeland Sec. Council, *National Strategy for Pandemic Influenza: Implementation Plan 10* (2005) (indicating that the federal government would “[s]tockpil[e] and coordinat[e] the distribution of necessary countermeasures, in concert with states and other entities”).

⁴⁸ See Scott Burris et al., *The Legal Response to COVID-19: Legal Pathways to a More Effective and Equitable Response*, 27 *J. Pub. Health Mgmt. Prac.* S72 (2020) (arguing that the federal government “encouraged a Darwinian competition among states for scarce resources”).

⁴⁹ See *Examining the National Response to the Worsening Coronavirus Pandemic: Hearing Before the H. Comm. on Homeland Sec.*, 116th Cong. (2020) (statement of Hon. Jay Robert Pritzker, Governor of Illinois) (indicating that the state “paid \$5 for masks that usually cost 85 cents”); *Reviewing Federal and State Pandemic Supply Preparedness and Response: Hearing Before H. Comm. on Homeland Sec.*, 116th Cong. (2020) (statement of Xochitl Torres Small, Subcommittee Chairwoman) (stating that “[t]he competition for limited resources [among states] drove up prices and attracted new brokers into the marketplace that were inexperienced and unreliable”).

VII FORCED FRAGILITY

A fourth aspect of the fiscal system that undermines health investment has to do not with who makes decisions (the domain of fragmentation and fiscal federalism) or how they make them (the domain of scorekeeping), but with how durable those decisions are once made – an intertemporal question. As used here, fragility refers to a program’s susceptibility to disruption or abandonment; it is the inverse of durability (sometimes known as entrenchment). Laws, rules, and norms force fragility even when substantive policy considerations counsel stability.

A critical choice in policymaking is how resistant to change to make a decision – how durable or fragile. Flexibility is often desirable, as it permits change with circumstances or new information (though Professor Super has pointed out that flexibility’s benefits are often overstated).⁵⁰ On the other hand, stability can often be desirable, too, to engender reliance and long-term investment.⁵¹ The appropriate balance between these considerations depends, of course, on the circumstances.

Several aspects of the US fiscal system interfere with decisions about whether to make a decision flexible or stable. The Constitution interferes with balancing by policymakers of the benefits of stability versus those of flexibility over a wide range of subjects. The Takings and Due Process Clauses insist on stability for resource commitments that trigger their protections, such as ownership of real property.⁵² Meanwhile the Appropriations Clause encourages fragility for resource commitments that take the form of government spending, encouraging Congress to leave those commitments dependent on annual appropriations, whether stability is warranted or not, in order to secure the “power of the purse” for itself and its committees.⁵³ Congressional rules carry forward this encouragement of temporary spending enactments.⁵⁴ Separation of powers norms endorsed by courts, commentators, and legislators further encourage Congress to fund spending programs annually to preserve power.⁵⁵ And federal statutes, including the debt ceiling and the Pay-As-You-Go-Act, threaten disruption to spending programs across-the-board, serving as a blanket source of instability in service of fiscal or separation of powers goals.

These laws, rules, and norms motivated by fiscal concerns and the separation of powers force fragility in federal public good investments – such as pandemic

⁵⁰ See David A. Super, *Against Flexibility*, 96 *Cornell L. Rev.* 1375, 1411 (2011).

⁵¹ See *id.*

⁵² Matthew B. Lawrence, *Subordination and the Separation of Powers* (unpublished manuscript) (on file with author).

⁵³ Matthew B. Lawrence, *Congress’s Domain: Appropriations, Time, and Chevron*, 70 *Duke L. J.* 1057, 1072 (2021).

⁵⁴ Congressional Budget and Impoundment Control Act of 1974, H.R. 7130, 93rd Cong. § 401 (1973–74); 2 U.S.C. 651 (points of order for mandatory spending or budget authority beyond control of appropriations committees).

⁵⁵ See Lawrence, *supra* note 54.

preparedness – even when the goals of such investments would be better served by stability. As a result, public health programs in the United States are less able to engender meaningful health investment because of constant threats to funding and recurrent disruptions.⁵⁶

Again, the nation’s preparation for coronavirus was undermined by forced fragility.

Senator Clinton recognized the problem posed by a lack of stable public health funding in the United States, proposing with Jeanne Lambrew a “wellness trust” as a permanent public health funding source.⁵⁷ These efforts culminated in the Prevention and Public Health Fund (PPHF) in the Patient Protection and Affordable Care Act (ACA) of 2010. Section 4002 of the ACA created the \$18.75 billion PPHF in mandatory, permanent law, with the sole purpose of preparing for public health crises, including pandemics.⁵⁸

Although Congress and the President could make the PPHF permanent, insulating it from the vicissitudes of the annual appropriations process, they could not entrench it against change in future legislation. Spending on public health is a collective benefit, not “property” that anyone owns or a contract with performance owed to any particular business – so existing avenues of constitutional entrenchment were closed.⁵⁹ Moreover, as “mandatory” spending, the PPHF was in the same fiscal category as more constitutionally and politically entrenched spending programs, such as Medicare and Social Security, as Professors Westmoreland and Sage explain.⁶⁰ That meant that when Congress wanted to make subsequent costly changes in the “mandatory” category, the PPHF was an easy target as a source of funds. Congress repeatedly raided the fund, paying for new expenditures (the Medicare “doc fix”) and reduced revenues (the 2017 Tax Cuts and Jobs Act).⁶¹

The PPHF’s fragility thus significantly limited its usefulness. As the fund was raided, fiscally aware onlookers once again made prophetic predictions. “[W]ithout funding, the CDC won’t be able to protect us,” former CDC Director Tom Frieden

⁵⁶ Example, Sage & Westmoreland, supra note 14.

⁵⁷ See Jeanne M. Lambrew, *A Wellness Trust to Prioritize Disease Prevention* 21, Brookings Inst. (Apr. 1, 2007), www.brookings.edu/research/a-wellness-trust-to-prioritize-disease-prevention/ (calling for permanent funding source); S. 3674, *Twenty-First Century Wellness Trust Act*, § 39900(c)(3), 110th Cong. (2008) (proposed legislation).

⁵⁸ Patient Protection and Affordable Care Act § 4002, Pub. L. No. 111–148, 124 Stat. 119 (2010); 42 U.S.C. § 300u–11 (purpose of “expanded and sustained national investment in public health programs”).

⁵⁹ See Christopher Serkin, *Public Entrenchment Through Private Law: Binding Local Government*, 78 *U. Chi. L. Rev.* 879, 882 (2011) (describing means of entrenchment).

⁶⁰ Sage & Westmoreland, supra note 14, at 436.

⁶¹ Id. at 441; Michael R. Fraser, *A Brief History of the Prevention and Public Health Fund: Implications for Public Health Advocates*, 109 *Am. J. Pub. Health* 572 (2019), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2018.304926?casa_token=ov8zgOdGCsgAAAAA:GDHPZ_MM7uWkqRfR-USRmjVjJQCZqfQf6ZfVkn8t7ob6PajdPy6fiE7bK-rXzd82rGJHPWiz5WV7.

observed in 2018. “We’re more likely to have to fight dangerous organisms here in the U.S.”⁶² Sadly, Director Frieden’s prognosis proved correct.

VIII CONCLUSION

Unlike other barriers to health investment, the fiscal determinants of health are largely a product of law – and so can be changed through legislative, regulatory, and litigation pathways. This effort is not hopeless. Recognizing the importance of fiscal determinants, Democrats in Congress in 2021 amended House procedures to reduce budgetary barriers to future legislation addressing COVID-19 “or public health consequences resulting from climate change.”⁶³ Representative Ocasio-Cortez described the rule change on Twitter as “a big deal – and not only on health care.” “They are structural changes in the House that level the playing field for a full SUITE of flagship legislation.”⁶⁴ This change is closely related to reforms pressed by Professor Westmoreland, discussed earlier.⁶⁵

Health law scholars and policymakers should not see scarcity as inevitable, or fiscal law as beyond health law. It is possible to identify and motivate needed fiscal system reforms by tracing particular instances of harm not only to the lack of investment that contributed to them, but also to the upstream fiscal determinants that contributed to that lack of investment.

⁶² Ashley Yeager, Cuts to Prevention and Public Health Fund Puts CDC Programs at Risk, *TheScientist* (Feb. 9, 2018), www.the-scientist.com/daily-news/cuts-to-prevention-and-public-health-fund-puts-cdc-programs-at-risk-30298.

⁶³ See H.R. Res. § 3(v)(2) (2021), www.congress.gov/bill/117th-congress/house-resolution/8/text (“The Chair of the Committee on the Budget may adjust an estimate ... to ... exempt the budgetary effects of measures” related to COVID-19 or “public health consequences resulting from climate change.”).

⁶⁴ Alexandria Ocasio-Cortez (@AOC), Twitter (Jan. 3, 2021, 9:09 PM), <https://twitter.com/aoc/status/1345190548815142918?lang=en>.

⁶⁵ Westmoreland, *supra* note 10, at 1604–10 (suggesting changes).