

Distributive Justice and Racial Health Equity: What COVID-19 Teaches About Medicare’s Blanket Priority for Americans of Advanced Age

MELISSA BALLENGEE ALEXANDER*

I. INTRODUCTION	824
II. THE UNITED STATES RATIONS HEALTH CARE BASED ON ABILITY TO PAY WHILE PROVIDING SPECIAL ASSISTANCE TO INDIVIDUALS OF ADVANCED AGE	828
A. <i>A Third of Americans Lack Access to Needed, Beneficial Care Because They Cannot Afford to Pay</i>	828
B. <i>The Government Funds Care for Individuals of Advanced Age Regardless of Wealth, While Millions of Low-Income, Nonelderly Adults Do Not Qualify</i>	830
C. <i>Racial Minorities Face a Disproportionate Gap in Access to Care and Shorter Life Expectancy</i>	835
III. COVID-19 HIGHLIGHTED RACIAL HEALTH INEQUITIES AND FORCED RATIONING PLANS, PROVIDING AN IMPETUS AND FRAMEWORK FOR HEALTHCARE REFORM	837
A. <i>COVID-19 Spotlighted Racial Health Disparities That Plague the United States</i>	838
B. <i>COVID-19 Crisis Allocation Plans Reflect the Consensus that Distributive Justice Requires Utilizing Evidence-Based Measures to Maximize Benefit</i>	841

* Professor of Law, University of Wyoming College of Law. During COVID-19, Professor Alexander participated as a member of a state medical ethics committee and a hospital ethics committee addressing the just allocation of ventilators, vaccines, Remdesivir, and other critical care resources. She thanks Briana Long for her excellent research assistance

IV. LIKE RATIONING PLANS, GOVERNMENT HEALTH CARE ASSISTANCE SHOULD FOLLOW EVIDENCE TO MAXIMIZE BENEFIT, NOT UNIVERSALLY PRIVILEGE OLDER AMERICANS	846
A. <i>Blanket Advantage to Americans of Advanced Age over Nonelderly Adults Is Inefficient and Inequitable</i>	847
B. <i>Privileging Older Americans Perpetuates Racial Health Inequity</i>	853
V. IMMEDIATE SPENDING REFORM TOWARD JUSTICE AND EQUITY COULD TAKE MANY FORMS, BUT REMOVING AGE-BASED ELIGIBILITY SHOULD BE GRADUAL.....	854
VI. CONCLUSION.....	859

I. INTRODUCTION

Not a single COVID-19 crisis standard of care (“CSC”) allocation plan suggests that life-saving ventilators should go first to those able to pay or to the oldest in need.¹ Such would be unconscionable.² Yet, every day we ration health care in the United States, and with limited exceptions, care is rationed based on ability to pay, with special assistance provided to Americans of advanced age.³ This rationing scheme cannot be justified under any coherent theory of distributive justice. While it may be politically untenable to end the United States’ market-driven, ability to pay approach, the government can and should phase out its unjustified blanket preference for Americans of advanced age over nonelderly adults with equal or greater need and expected

1. See, e.g., Emily Cleveland Manchanda et al., *Crisis Standards of Care in the USA: A Systematic Review and Implications for Equity Amidst COVID-19*, J. RACIAL & ETHNIC HEALTH DISPARITIES, Aug. 13, 2020, at 6 tbl.2 (summarizing CSC plans); Armand H. Matheny Antommara et al., *Ventilator Triage Policies During the COVID-19 Pandemic at U.S. Hospitals Associated with Members of the Association of Bioethics Program Directors*, 173 ANNALS INTERNAL MED. 188 (2020) (summarizing CSC plans).

2. Ezekiel Emanuel et al., *Fair Allocation of Scarce Medical Resources in the Time of COVID-19*, 382 NEW ENG. J. MED. 2051, 2053 (2020) (stating that no crisis allocation uses or should use ability to pay as a criterion and suggesting that giving younger patients priority to curative resources may be ethically justified).

3. Roosa Tikkanen & Robin Osborn, *Does the United States Ration Health Care?*, COMMONWEALTH FUND (July 11, 2019), <https://www.commonwealth-fund.org/blog/2019/does-united-states-ration-health-care>.

benefit. The government's preference for older adults lacks normative basis, squanders resources, and perpetuates significant racial disparity in access to care, structurally reinforcing centuries of disadvantage.⁴

The United States must use what it has learned from the rigorous interdisciplinary debate surrounding COVID-19 crisis allocation to reform government healthcare spending priorities.⁵ It should allocate government-funded health care with the goal of maximizing benefit, the ethical imperative at the heart of virtually all ventilator allocation plans, while also accounting for equity.⁶ This will require that the government renounce the universal preference given to individuals age sixty-five and over at the expense of nonelderly adults.⁷ All Americans, regardless of age, should receive equal consideration for scarce resources.⁸ Medical evidence should guide the government's distribution, with cost-effectiveness and cost-benefit analysis playing a larger role, although fairness must also be taken into account.⁹ While

4. See *infra* Part III.

5. See, e.g., Emanuel et al., *supra* note 2; Manchanda et al., *supra* note 1; Antommaria et al., *supra* note 1; David Wasserman et al., *Setting Priorities Fairly in Response to COVID-19: Identifying Overlapping Consensus and Reasonable Disagreement*, 7 J.L. & BIOSCIS. 1, 3 (2020).

6. Antommaria et al., *supra* note 1, at 191 tbl.2 (showing 96.2% of triage policies allocate based on likelihood of medical benefit measured by expected increase in short-term and long-term survival). A truly equitable distribution of health care will entail remedying past inequitable distributions, even though this was not generally a factor in crisis allocations and may be difficult to administer fairly in a centralized policy. Additional reforms needed to redress past injustice are beyond the scope of this incremental solution but ending the preference for Americans of advanced age will remove one structural barrier to health equity.

7. See Paula Braveman et al., *Health Disparities and Health Equity: The Issue Is Justice*, 101 AM. J. PUB. HEALTH 149, 149–55 (2011) (asserting that distributive justice in healthcare requires considering need, benefit, efficiency, and equity).

8. See Alicia Yamin, *Shades of Dignity: Exploring the Demands of Equality in Applying Human Rights Frameworks to Health*, 11 HEALTH & HUM. RTS. 1, 1–18 (2009) (expounding on the importance that all human beings be valued equally).

9. Until Medicare can cover all “reasonable and necessary” medical expenses for *all* Americans who cannot afford them (and do not qualify for other assistance), a just distribution requires better stewardship of existing resources. This will likely require amending existing federal law to make coverage more efficient. See Social Security Act § 1862(a)(1), 42 U.S.C. § 1395(a)(1) (explaining that Medicare generally covers “reasonable and necessary” medical expenses for beneficiaries); *id.* at § 1182, 42 U.S.C. § 1320e-1 (limiting use of comparative-effectiveness research to reign in Medicare coverage); see also Nicholas Bagley, *Bedside Bureaucrats: Why Medicare*

combatting health inequity will require broader societal reform, a more just distribution of resources would be a significant first step, increasing equitable access to care and the benefits achieved thereby.¹⁰

In order to illustrate how moral imperatives apply to allocation of government healthcare spending, this Article assumes that the United States will continue to spend the *same amount* on government-funded care. This makes government-funded healthcare dollars more like ventilators in a crisis, a set quantity with need exceeding supply. It sidesteps the contentious debate about how much health care we can afford, thereby avoiding arguments from the left that the government should pay for all needed care and from the right that government should be smaller and less redistributive.¹¹ It treats healthcare as a

Reform Hasn't Worked, 101 GEO. L.J. 519, 574 (2013) (describing the interaction of Patient-Centered Outcomes Research Institute and Medicare); NORMAN DANIELS, PUBLIC HEALTH ETHICS: CASES SPANNING THE GLOBE 62–65 (Drue H. Barrett et al. eds., 2016) (“[E]fficiency has ethical and not just economic importance;” it enables a health system to meet more health needs per dollar and do more good, but how benefit are distributed must also be considered.). However, efficiency should not subsume all other ethical values. The government should work to ameliorate disadvantage and to improve equity, while also taking efficiency into account. See Derek Parfit, *Equality and Priority*, 10 RATIO 202, 213 (1997) (“[B]enefits to the worst off could be morally outweighed by sufficiently great benefits to the better off”); Govind Persad, *Evaluating the Legality of Age-Based Criteria in Health Care: From Nondiscrimination and Discretion to Distributive Justice*, 60 B.C. L. REV. 889, 928 (2019).

10. See, e.g., Norman Daniels, *Justice and Access to Health Care*, STAN. ENCYCLOPEDIA OF PHIL., <https://plato.stanford.edu/archives/win2017/entries/justice-healthcareaccess/> (last visited May 24, 2021) (asserting that as long as inequality in the social determinants of health continue, “we cannot expect health inequalities to disappear solely as a result of providing universal access to care”); Dayna Bowen Matthew, *Justice and the Struggle for the Soul of Medicaid*, 13 ST. LOUIS J. HEALTH L. & POL’Y 29, 30 (2019) (arguing that egalitarian justice compels Medicaid to address the social and environmental risk factors that impede health equity).

11. See, e.g., HOUSE GOP, OBAMACARE REPEAL AND REPLACE: POLICY BRIEF AND RESOURCES 7 (2017), https://gallery.mailchimp.com/301a28247b80ab82279e92afb/files/5c7c3226-a149-4842-ab43-707b7b4720fc/Healthcare_Policy_Brief.pdf?utm_source=HouseGOP Staff List&utm_campaign=cceeba1704-EMAIL_CAMPAIGN_2017_02_16&utm_medium=email&utm_term=0_f9e806e009-cceeba1704-132524909 (describing Medicaid growth as unsustainable and proposing to “put Medicaid on a budget”). This comparative justice approach also avoids arguments that health care spending may tradeoff with more cost-effective government spending on other determinants of health. See, e.g., Linda Diem Tran et al.,

human right, to which each individual is inherently entitled, but it does so in a way that acknowledges the right to health as intrinsically tied to resources and interdependent with other rights.¹² In this regard, this Article offers a comparative justice allocation theory.¹³

Applying lessons learned from the COVID-19 CSC allocation to create a moral framework to guide future government healthcare spending, this Article suggests a prescriptive remedy towards health justice.¹⁴ This Introduction describes how the United States rations care based on ability to pay, prioritizing the needs of Americans of advanced age over other nonelderly adults and disproportionately leaving historically marginalized racial minorities without access to care. Part II explains how COVID-19 highlighted racial health disparities and forced states to develop frameworks for rationing health care. It outlines the distributive justice principles underpinning most critical care crisis allocation plans, including such plans' approach to age. Part III applies these principles to demonstrate why the United States should abandon its preference for older Americans and instead provide healthcare funding on an equitable basis, utilizing evidence of likely benefit to determine priority, which is the approach widely adopted in crisis allocation protocols. Citing philosophical arguments and empirical evidence, this Part shows how benefit-driven allocation would improve health equity by helping more people and shifting resources

Public Health and the Economy Could Be Served by Reallocating Medical Expenditures to Social Programs, 3 SSM POPULATION HEALTH 185 (2017).

12. See U.N. Comm. on Econ., Soc., & Cultural Rts., *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12)*, U.N. DOC. E/C.12/2000/4 (Aug. 11, 2000) ("Health is a fundamental human right indispensable for the exercise of other human rights The right to health is closely related to and dependent upon the realization of other human rights").

13. To be clear, how much we should spend on health care is an important question too, but regardless of however much that might be, this Article argues that as a matter of ethics and efficiency, we should be maximizing the likely benefit from each dollar. Currently, we are not.

14. In normal times, health care providers operate under a "conventional" standard of care. *COVID-19 Crisis Standards of Care: Frequently Asked Questions for Counsel*, <https://www.aamc.org/coronavirus/faq-crisis-standards-care> (last updated Dec. 18, 2020). When the healthcare system is stressed, providers and institutions may need to shift to a "contingency" standard of care. *Id.* If conditions deteriorate further necessitating degraded services, then the focus shifts from decision-making to achieve the best outcome for each individual patient to decision-making to achieve the best outcome for the group, known as "crisis" standard of care. *Id.*

towards traditionally marginalized groups. Part IV provides guidance on how such reforms could be implemented. Specifically, it advocates gradual reallocation of age-based Medicare funds to expand coverage for cost-effective care to low-income Americans of any age. This Article concludes with a plea to emerge stronger from COVID-19 by adopting a more just distribution of government healthcare spending, guided by likely benefit, helping more individuals and reducing significant racial disparities in access to care.

II. THE UNITED STATES RATIONS HEALTH CARE BASED ON ABILITY TO PAY WHILE PROVIDING SPECIAL ASSISTANCE TO INDIVIDUALS OF ADVANCED AGE

A. *A Third of Americans Lack Access to Needed, Beneficial Care Because They Cannot Afford to Pay*

While rationing health care remains controversial, the reality is that care is rationed every day in the United States.¹⁵ In fact, one in three patients skip needed care because of cost.¹⁶ Most cannot afford to pay for health care out-of-pocket, and roughly 29 million (or 11% of nonelderly) Americans lack health insurance.¹⁷ Even among those with insurance, many are under-insured and forego care because it is

15. See, e.g., David Orentlicher, *Rationing Health Care: It's a Matter of the Health Care System's Structure*, 19 ANNALS HEALTH L. 449, 449 (2010) (discussing U.S. rationing and allocation questions stating that “rationing health care is inevitable”); Jessica Mantel, *A Defense of Physicians' Gatekeeping Role: Balancing Patients' Needs with Society's Interests*, 42 PEPP. L. REV. 633, 652–60 (2015) (describing the necessity of rationing to control health care costs); Philip G. Peters, Jr., *Health Care Rationing and Disability Rights*, 70 IND. L.J. 491, 492 (1995) (describing rationing health care as omnipresent and inevitable).

16. Tikkanen & Osborn, *supra* note 3; see also Lydia Saad, *More Americans Delaying Medical Treatment Due to Cost*, GALLUP (Dec. 9, 2019), <https://news.gallup.com/poll/269138/americans-delaying-medical-treatment-due-cost.aspx> (remarking that 33% of American households report delaying health care due to cost; 25% for a serious illness and an additional 8% for a less serious illness).

17. Jennifer Tolbert et al., *Key Facts About the Uninsured Population*, KAISER FAM. FOUND. (2020), <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/> (explaining that in 2019, 28.9 million Americans lacked health insurance and that number likely increased in 2020); *id.* (“The uninsured often face unaffordable medical bills when they do seek care.”).

uncovered or they cannot afford cost-sharing obligations.¹⁸ Without acknowledging rationing, the United States provides care primarily based on the ability to pay, not based on need or benefit, and as a result, many Americans do not receive medically necessary, beneficial care.¹⁹

While the U.S. healthcare system's main allocation principle is ability to pay, it does recognize a limited exception for emergency care.²⁰ If a patient arrives at an emergency room and is diagnosed with an "emergency medical condition," the hospital must generally stabilize the patient before transfer without regard to the patient's ability to pay.²¹ Outside of the emergency context, however, patients are not typically guaranteed access to care—even if medically necessary—unless they can afford it.²²

18. Tikkanen & Osborn, *supra* note 3.

19. *Id.* Moreover, the result of this approach for many Americans who do receive care is crippling medical debt. See Frank Griffin, *Fighting Overcharged Bills from Predatory Hospitals*, 51 ARIZ. ST. L.J. 1003, 1006 (2019) (stating that medical debt contributes to more than half of all personal bankruptcies in the United States).

20. Medical necessity also plays an important role in the distribution of care in the United States, as it often serves as a prerequisite for health insurance coverage. See, e.g., CTRS. FOR MEDICARE & MEDICAID SERVS., ITEMS & SERVICES NOT COVERED UNDER MEDICARE 5 (2018) (Medicare does not cover care deemed medically unnecessary). The federal government defines medically necessary expenses as those "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 42 U.S.C. § 1395y. Insurance frequently does not cover all medically necessary care, however. See, e.g., CTRS. FOR MEDICARE & MEDICAID SERVS., *supra*, at 2 (listing three additional categories of care not covered by Medicare, beyond care deemed medically unnecessary). Further, those without insurance are not guaranteed access to medically necessary care or recommended screening tests when they cannot pay for them. RACHEL GARFIELD ET AL., THE UNINSURED AND THE ACA: A PRIMER—KEY FACTS ABOUT HEALTH INSURANCE AND THE UNINSURED AMIDST CHANGES TO THE AFFORDABLE CARE ACT 13 (2019), <https://files.kff.org/attachment/The-Uninsured-and-the-ACA-A-Primer-Key-Facts-about-Health-Insurance-and-the-Uninsured-amidst-Changes-to-the-Affordable-Care-Act>. Accordingly, medical necessity appears to be a secondary rather than a primary ordering principle in the distribution of care.

21. 42 U.S.C. § 1395dd(a). It is worth noting, however, that while the Emergency Medical Treatment and Labor Act ensures access to stabilizing care under certain circumstances, it does not mitigate the financial repercussions of such care. *Id.*

22. Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAM. FOUND. (Jan. 21, 2021), <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

Without access to needed care, individuals die sooner and suffer greater morbidity.²³ They also often have a lower quality of life, stymied by ill health in the realization of their work and personal life goals.²⁴ Access to needed healthcare is like education; it is an essential precondition to realize full potential utility and social welfare.²⁵ Without care, both the individual and society suffer.²⁶ Yet, millions of Americans lack access to care because health care remains unaffordable in the United States.²⁷

B. The Government Funds Care for Individuals of Advanced Age Regardless of Wealth, While Millions of Low-Income, Nonelderly Adults Do Not Qualify

To offset the potential injustice of allocating health care based primarily on ability to pay, the government does fund health insurance

23. Steffie Woolhandler & David U. Himmelstein, *The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?*, 167 ANNALS INTERNAL MED. 424, 424–31 (2017) (summarizing current evidence that health insurance saves lives); INST. OF MED. (US) COMM. ON THE CONSEQUENCES OF UNINSURANCE, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE (2002); see also Timothy Stoltzfus Jost, *Private or Public Approaches to Insuring the Uninsured: Lessons from International Experience with Private Insurance*, 76 N.Y.U. L. REV. 419, 419 (2001) (“[P]ersons who are uninsured get less health care, get it later, and suffer greater mortality and morbidity because of their failure to receive health care in a timely fashion.”).

24. BARRY R. FURROW ET AL., HEALTH LAW 635 (8th ed. 2018) (describing how forgoing needed health care can result in lost income, lost productivity, diminished ability to participate in social, family and political life, and an overall loss to personal and public well-being); AMA Code of Ethics, Opinion 11.1.1 (2016) (“Health care is a fundamental human good because it affects our opportunity to pursue life goals . . .”).

25. See, e.g., WHO Guide to Identifying The Economic Consequences of Disease and Injury, WORLD HEALTH ORG. (WHO), DEPT. OF HEALTH SYS. FIN. HEALTH SYS. & SERVS. 3 (2009) (“Ill-health can contribute to losses in individual utility or social welfare in a number of defined ways, both directly (because people prefer to be more healthy than less healthy) and indirectly by reducing the enjoyment or utility associated with the consumption of goods and services unrelated to health, or by compromising other economic objectives such as producing income”); AMARTYA SEN, DEVELOPMENT AS FREEDOM 20–21 (1999) (describing health as a capability required to function in society).

26. See sources cited *supra* note 25.

27. See Tikkanen & Osborn, *supra* note 3; Saad, *supra* note 16; Tolbert et al., *supra* note 17.

and insurance subsidies for certain populations. In particular, the government provides special assistance to elderly, disabled, and certain low-income individuals and families through Medicare, Medicaid, Children's Health Insurance Program ("CHIP"), and marketplace insurance plans with premium tax credits, among others.²⁸ Unfortunately, such programs still do not reach millions of Americans in need.²⁹ Moreover, while providing unique funding assistance to low-income and disabled individuals rests on strong moral grounds, the special priority accorded to individuals of advanced age who are neither low-wealth nor high need is harder to justify as a matter of ethics or efficiency.

Medicare provides government health insurance assistance to elderly individuals regardless of wealth.³⁰ To be eligible for Medicare, an individual must generally be eligible for Social Security and age sixty-five or older or have a disability.³¹ Medicare eligibility is universal; it does not turn on income or assets.³² As a result, five percent of Medicare beneficiaries have six-figure incomes and five percent of beneficiaries have more than \$1.37 million in savings.³³

28. See *Subsidized Coverage*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/subsidized-coverage/> (last visited May 24, 2021); 42 U.S.C. § 1396a(a)(10)(A)(i); 42 U.S.C.A. § 426 (West 2015). The government also funds TRICARE, a medical benefit for the military and their dependents, and federal employee health plans. These plans are not discussed herein because they are more like employment benefits than government assistance programs.

29. See Tikkanen & Osborn, *supra* note 3; Saad, *supra* note 16; Tolbert et al., *supra* note 17. In addition to other gaps, most government health care assistance programs limit eligibility based on immigration status. See *Health Coverage of Immigrants*, KAISER FAM. FOUND., <https://www.kff.org/disparities-policy/factsheet/health-coverage-of-immigrants/> (last visited May 24, 2021). While such status limitations contribute to the coverage gap, they raise unique ethical questions and are therefore largely beyond the scope of this Article.

30. See 42 U.S.C.A. § 426 (giving entitlement to government health care benefits to individuals over the age of sixty-five).

31. See *Who Is Eligible for Medicare?*, HEALTHCARE.GOV, <https://www.hhs.gov/answers/medicare-and-medicare/who-is-eligible-for-medicare/index.html> (last visited May 24, 2021); 42 U.S.C.A. § 426.

32. FURROW ET AL., *supra* note 24, at 635. Wealth may affect Medicare premium and cost-sharing obligations. *Id.* at 636.

33. Gretchen Jacobsen et al., *Income and Assets of Medicare Beneficiaries, 2016-2035*, KAISER FAM. FOUND. (Apr. 21, 2017) <https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/>. Of course, far

Government assistance to relatively affluent individuals of advanced age likely occurs at least in part because Medicare was initially designed to be self-supporting from payroll taxes.³⁴ While there may be a lingering narrative of “earning” Medicare, payroll taxes only covered about a third of Medicare expenditures in 2019.³⁵ Even when beneficiary premiums are added, this amount only provides roughly half of Medicare costs.³⁶ The remaining half is truly a government assistance program, paid for primarily by general revenues.³⁷ In fact, most beneficiaries contribute far less to Medicare than the benefits they receive over their lifetime.³⁸ A worker with average income who turns sixty-five in 2020 is expected to receive a lifetime benefit of approximately three dollars for every one dollar that beneficiary paid in Medicare payroll taxes.³⁹ This is a significant government health care

more Medicare beneficiaries are low-income with relatively little in savings, but the lack of wealth-eligibility requirements results in considerable variability and government subsidies to many economically well-off individuals. *Id.*

34. U.S. SOC. SEC. ADMIN., FINANCING SOCIAL SECURITY AND MEDICARE 52, <https://www.ssa.gov/history/pdf/80chap4.pdf> (explaining that Medicare was “designed to be self-supporting from payroll tax contributions”) (last visited May 24, 2021).

35. *What Is the Medicare Trust Fund, and How Is It Financed?* TAX POL’Y CTR., URBAN INST. & BROOKINGS INST., <https://www.taxpolicycenter.org/briefing-book/what-medicare-trust-fund-and-how-it-financed> (last visited May 24, 2021); CONG. RSCH. SERV., R43122, MEDICARE FINANCIAL STATUS: IN BRIEF 4 (2020) (explaining that payroll taxes contributed 36% of Medicare in 2019). The one-third covered by payroll taxes actually overstates beneficiaries’ payroll contributions because Medicare follows a pay as you go approach, whereby the payroll taxes paid by today’s workers and employers are used. *Id.*

36. CONG. RSCH. SERV., *supra* note 35 (explaining that in 2019, payroll taxes and beneficiary premiums together contributed 51% of Medicare).

37. *Id.* (stating that in 2019, general revenues contributed the largest amount to Medicare, 43%, with interest, state payments, and taxes on social security benefits each adding 2-3% more); *see also* Juliette Cubanski et al., *The Facts on Medicare Spending and Financing*, KAISER FAM. FOUND. (Aug. 20, 2019), <https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/>.

38. Because the current workforce tends to be larger than the past workforce due to population growth, the payroll taxes collected in a given year are greater than the amounts the Medicare beneficiaries paid, even when adjusted to present value.

39. ERALD KOLASI & C. EUGENE STEUERLE, SOCIAL SECURITY & MEDICARE LIFETIME BENEFITS & TAXES: 2020, at 6 (Nov. 17, 2020), <https://www.taxpolicycenter.org/sites/default/files/publication/160738/social-security-and-medicare->

subsidy, and it must be evaluated in light of the government's treatment of nonelderly adults who cannot afford health care.⁴⁰

Medicaid, the primary government health insurance assistance program available to nonelderly, nondisabled Americans, limits eligibility to certain low-income individuals and families.⁴¹ Because Medicaid is a joint federal and state program, its eligibility requirements vary considerably by state, but in some states, only the “deserving poor” qualify for coverage.⁴² When Congress enacted the Affordable Care Act (“ACA”) in 2010, it sought to expand Medicaid “to cover *all* adults with income below 138% of the federal poverty level [“FPL”]” and to make health insurance more affordable to households with incomes up to 400% of the FPL by offering subsidies.⁴³ However, many states still have not adopted this expansion of Medicaid.

lifetime-benefits-and-taxes-2020.pdf (showing expected present value of lifetime Medicare benefits of \$240,000 for \$81,000 in lifetime Medicare taxes paid, which is \$2.96 for every one dollar paid). Average beneficiaries receive a greater lifetime Medicare benefit than their Medicare payroll tax contribution at every income level, but the rate of that benefit varies widely based on income, with lower-income workers receiving more benefit per dollar contributed than higher income workers. *Id.* Of course, those who die younger do not necessarily receive more in lifetime benefit than in Medicare taxes paid.

40. While Medicare ensures that 99% of Americans age sixty-five and over have health insurance, the Medicare program has significant gaps in coverage and imposes cost-sharing obligations. Katie Keith, *Uninsured Rate Rose in 2018, Says Census Bureau Report*, HEALTH AFFS. BLOG (Sept. 11, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190911.805983/full/> (“Adults aged 65 and over, due to Medicare coverage, continue to have the highest coverage rate (99.1 percent.)”); FURROW ET AL., *supra* note 24, at 637–38 (describing gaps in coverage and cost-sharing obligations). Accordingly, those on Medicare who cannot afford additional Medigap insurance and do not qualify for Medicaid may still be forced to forego needed care.

41. Compare 42 U.S.C. § 1396a(a)(10)(A)(i), with 42 U.S.C.A. § 426 (West 2015).

42. See *Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level*, KAISER FAM. FOUND. (Jan. 1, 2021), <https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel={%22colId%22: %22Location%22,%22sort%22: %22asc%22}>; Garfield et al., *supra* note 22; Matthew, *supra* note 10, at 30.

43. Affordable Care Act (ACA), HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/affordable-care-act/> (last visited May 24, 2021) (emphasis added).

In the twelve non-expansion states, Medicaid only provides assistance to “categorically eligible” individuals and families of modest economic means.⁴⁴ Eligible categories include the aged, blind, disabled, children, pregnant women, and caretaker relatives.⁴⁵ Low-income adults who do not fit within these categories, such as most childless adults, are not eligible for government-funded health care assistance even when needed care is wholly unaffordable.⁴⁶ Moreover, even for adults with children, the income limit in non-expansion states is typically so low, 40% of the FPL, that many adults with children are also ineligible for Medicaid, do not qualify for health insurance tax subsidies, and cannot afford care.⁴⁷

While the ACA sought to make access to needed care affordable to all, it currently falls well short of that goal. Millions of Americans still lack insurance or are under-insured.⁴⁸ The decision of almost a quarter of states not to expand Medicaid is one reason for this.⁴⁹ Immigration status limits on government health care assistance are another.⁵⁰ Even without these gaps, however, many Americans would lack access to affordable care as a result of unaffordable premium and cost-sharing obligations.⁵¹ Under the existing distributive approach,

44. *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Mar. 26, 2021), <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/> (showing twelve states, including Texas, Florida, Georgia, and Tennessee, have not expanded Medicaid); FURROW ET AL., *supra* note 24, at 687–88.

45. FURROW ET AL., *supra* note 24, at 687–88.

46. Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAM. FOUND. (Jan. 21, 2020), <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

47. *Id.*

48. Tolbert et al., *supra* note 17.

49. Garfield et al., *supra* note 22. In *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court held that the federal government could not compel states to expand Medicaid to cover all low-income individuals as a condition of continued participation in the Medicaid program. 567 U.S. 519, 572 (2012).

50. *Health Coverage of Immigrants*, *supra* note 29.

51. Tikkanen & Osborn, *supra* note 3.

85% of Americans without health insurance are nonelderly adults, most with incomes below 400% of the FPL.⁵²

C. Racial Minorities Face a Disproportionate Gap in Access to Care and Shorter Life Expectancy

Further, the rate of uninsured Americans with insufficient wealth to afford needed care is not uniform. People of color are significantly more likely to be uninsured.⁵³ Latinx and American Indian/Alaskan Native individuals are roughly three times more likely to be uninsured than non-Latinx Whites.⁵⁴ Black Americans are twice as likely to be uninsured as non-Latinx Whites.⁵⁵ At the same time, White families commonly enjoy eight times the wealth of Black families and five times the wealth of Latinx families.⁵⁶ In short, traditionally marginalized groups remain significantly less likely to have health insurance or to be able to pay for health care out of pocket.

In addition to higher rates of being uninsured and greater inability to afford care, some racial minorities suffer from shorter life

52. Tolbert et al., *supra* note 17 (showing 83% of uninsured adults have incomes below 400% of the FPL). Moreover, almost three-fourths of the uninsured have at least one full-time worker in the family. *Id.* The elderly fair better for coverage because of Medicare. Minors fair better because of broader eligibility for children than adults under Medicaid and CHIP. *Id.*

53. This Article focuses on funding health care to increase access to care, but to address racial health inequity, this country will also have to address the social determinants of health and the quality, availability, and acceptability of care. At present, low-quality hospitals and providers are disproportionately located where African Americans live. Evidence suggests ongoing, often unconscious bias in health care, as well as a lack of cultural competency. Racial minorities remain underrepresented as health care providers. Much work remains to be done, even after access to care is equalized.

54. Tolbert et al., *supra* note 17 (showing 20% of Hispanic, 21% of American Indian/Alaskan Native, and 11.4% of Black people lacked health insurance in 2019, as compared to 7.8% of non-Hispanic Whites).

55. *Id.*

56. Neil Bhutta et al., *Disparities in Wealth by Race and Ethnicity in the 2019 Survey of Consumer Finances*, BD. OF GOVERNORS OF THE FED. RES. SYS. (Sept. 28, 2020), <https://www.federalreserve.gov/econres/notes/feds-notes/disparities-in-wealth-by-race-and-ethnicity-in-the-2019-survey-of-consumer-finances-20200928.htm>.

expectancy on average than White Americans.⁵⁷ Black Americans' life expectancy is 3.6 years shorter than White Americans.⁵⁸ American Indian and Alaskan Natives have a life expectancy that is 5.5 years shorter than the average American.⁵⁹ So, government assistance programs that prioritize individuals based on advanced age tend to provide fewer years of assistance to these racial minorities than to their similarly situated White counterparts.⁶⁰

The difference in life expectancy based on income is even larger. The richest 1% of Americans enjoy a life expectancy that is more than a decade longer than the poorest 1%.⁶¹ Given the lower life expectancy associated with lower socio-economic status, government assistance programs like Medicare that target Americans of advanced age paradoxically provide fewer years of assistance to those who need assistance most.

In summary, under the current distributive system, Americans of advanced age are almost universally covered by government-subsidized health care, while millions of nonelderly adults, especially from traditionally marginalized groups, lack access to needed care. Because of virtually universal eligibility for Medicare, less than 1% of Americans aged sixty-five and over lack health insurance.⁶² Yet, because of stringent Medicaid eligibility requirements, 10.9% of nonelderly

57. See Elizabeth Arias et al., *United States Life Tables, 2016*, 68 NAT'L VITAL STAT. REP. 1, 3 tbl.A (May 7, 2019), https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_04-508.pdf (reporting that White Americans live an average of 3.6 years longer than Black Americans). Interestingly, Hispanic Americans live 3.2 years longer than non-Hispanic White Americans, however. *Id.*

58. *Id.*

59. *Disparities*, INDIAN HEALTH SERV. (OCT. 2019), <https://www.ihs.gov/newsroom/factsheets/disparities>.

60. Of course, total dollars of government health care assistance provided would depend on services received, but the years that such assistance was available to an individual would track years lived after age sixty-five.

61. Raj Chetty et al., *The Association Between Income and Life Expectancy in the United States, 2001–2014*, 315 J. OF AM. MED. ASS'N 1750, 1752 (2016) (finding a gap in life expectancy of 14.6 years for men and 10.1 years for women between the richest and the poorest 1%).

62. Keith, *supra* note 40 (“Adults aged 65 and over, due to Medicare coverage, continue to have the highest coverage rate (99.1 percent).”). Amongst Americans of advanced age, the people who still lack insurance are often immigrants. *See id.*

Americans lack health care coverage, and for some racial minorities, the rate is twice that high.⁶³ This significantly larger coverage gap for nonelderly Americans, with its disparate impact on historically discriminated against racial minorities, cannot be justified. The injustice is made worse by longer life expectancy for Whiter, wealthier individuals, further privileging the already privileged.⁶⁴ The special preference given to Americans of advanced age must be abandoned.

III. COVID-19 HIGHLIGHTED RACIAL HEALTH INEQUITIES AND FORCED RATIONING PLANS, PROVIDING AN IMPETUS AND FRAMEWORK FOR HEALTHCARE REFORM

While the inequitable age-preference in government-funded health care assistance has existed for decades, COVID-19 brought clearer focus to the unacceptable nature of existing health inequities and, at the same time, forced hard discussions about rationing care.⁶⁵ Utilizing lessons from such allocations and the moral outrage at health disparities, the time is ripe to begin structural healthcare reform.⁶⁶

63. Tolbert et al., *supra* note 17.

64. Arias et al., *supra* note 57; *Disparities*, *supra* note 59; Chetty et al., *supra* note 61.

65. See Merlin Chowkwanyun & Adolph Reed, Jr., *Racial Health Disparities and Covid-19—Caution and Context*, 383 NEW ENG. J. MED. 201 (2020) (“Racial disparities have thus become central in the national conversation about COVID-19.”); Leana Wen & Nakisa Sadeghi, *Addressing Racial Health Disparities in the COVID-19 Pandemic: Immediate and Long-Term Policy Solutions*, HEALTH AFFS. BLOG (July 20, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200716.620294/full/> (discussing how COVID-19 called attention to long-standing racial health disparities); Chiari Mannelli, *Whose Life to Save? Scarce Resources Allocation in the COVID-19 Outbreak*, 46 J. MED. ETHICS 364 (2020) (explaining how COVID-19 brought the ethics of resource allocation into the spotlight); Emanuel et al., *supra* note 2, at 2049 (describing how COVID-19 caused rationing discussions).

66. Of course, many state plans, studies, and articles existed on crisis allocation of ventilators prior to COVID-19 and influenced the COVID-19 response. See generally N.Y. STATE TASK DEP’T HEALTH, VENTILATOR ALLOCATION GUIDELINES (2015), https://www.health.ny.gov/regulations/task_force/reports_publications/docs/ventilator_guidelines.pdf; E. Lee Daugherty Biddison et al., *Too Many Patients . . . A Framework to Guide Statewide Allocation of Scarce Mechanical Ventilation During Disasters*, 155 CHEST 848 (2019); Bruce M. Altevogt et al., GUIDANCE FOR ESTABLISHING CRISIS STANDARDS OF CARE FOR USE IN DISASTER SITUATIONS: A

Reform efforts must lead to a fairer and more efficient distribution of government resources.

A. COVID-19 Spotlighted Racial Health Disparities That Plague the United States

This Article has already documented differences in rates of insurance and wealth along racial lines, and it now turns to differences in health outcomes. The Center for Disease Control defines health disparities as “preventable differences in the burden of disease, injury, violence or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.”⁶⁷ Unfortunately, racial health disparities have been well documented for decades.⁶⁸

Racial health inequity often begins at birth and continues through premature death.⁶⁹ Infant mortality of Black babies is twice that of White, non-Latinx babies.⁷⁰ In childhood, Black children are three times more likely to die from asthma than White children.⁷¹ By

LETTER REPORT (Natl. Aca. ed., 2009), https://www.ncbi.nlm.nih.gov/books/NBK219958/pdf/Bookshelf_NBK219958.pdf.

67. CTRS. FOR DISEASE CONTROL & PREVENTION, HEALTH DISPARITIES, <https://www.cdc.gov/healthyyouth/disparities/index.htm> (last visited May 24, 2021).

68. “Of all the forms of inequality, injustice in healthcare is the most shocking and inhuman.” Matthew, *supra* note 10 (quoting Dr. Martin Luther King, Jr.’s statement on health inequity many decades ago).

69. These overall trends are important but also an oversimplification. At times, there is considerable heterogeneity within racial and ethnic groups, with significant health differences in sub-populations. Intersectional analysis can be critical, as, for example, low-income racial or ethnic individuals may fair differently than high-income individuals or women within a group differently than men.

70. CTRS. FOR DISEASE CONTROL & PREVENTION, INFANT MORTALITY, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm> (last visited May 24, 2021) (stating that in 2018, the infant mortality rate for Non-Hispanic black infants was 10.8 compared to 4.6 for non-Hispanic White infants); Samantha Artiga et al., *Low-Income and Communities of Color at Higher Risk of Serious Illness if Infected with Coronavirus*, KAISER FAM. FOUND. (May 7, 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/low-income-and-communities-of-color-at-higher-risk-of-serious-illness-if-infected-with-coronavirus/> (discussing how differences in health insurance coverage and access to care, along with other social determinants, likely drive disparities in infant mortality).

71. *Asthma and African Americans*, U.S. DEP’T OF HEALTH & HUM. SERVS., OFF. OF MINORITY HEALTH,

adulthood, American Indians are two and half times as likely to experience serious psychological distress as their White counterparts.⁷² Latinx, American Indian, and Black adults have higher rates of HIV/AIDS, obesity, and diabetes, and overall, they self-report poorer health.⁷³ Empirically, Black and American Indian individuals fair worse than their White counterparts across most health status indicators.⁷⁴ These unjust outcomes are avoidable and result from several factors, including inadequate access to health care.⁷⁵

As a result of existing inequities, in 2020 when COVID-19 struck the United States, historically disadvantaged racial and ethnic minorities suffered at disproportionate rates that simply could no longer be ignored.⁷⁶ Black, American Indian, Alaskan Native, and

<https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=15> (last visited May 24, 2021) (“In 2019, non-Hispanic blacks were almost three times more likely to die from asthma related causes than the non-Hispanic white population.”).

72. *Mental and Behavioral Health—American Indians/Alaska Natives*, U.S. DEP’T OF HEALTH AND HUM. SERV., OFF. OF MINORITY HEALTH, <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=39> (last visited May 24, 2021).

73. SAMANTHA ARTIGA & KENDAL ORGERA, KAISER FAM. FOUND., KEY FACTS ON HEALTH AND HEALTH CARE BY RACE AND ETHNICITY, 16 fig. 24 (2019), <https://files.kff.org/attachment/Chart-Pack-Key-Facts-on-Health-and-Health-Care-by-Race-and-Ethnicity>.

74. *Id.* at 3 fig. 4 (noting that Black individuals fared worse than Whites across nineteen health indicators and better on only three; American Indian individuals fared worse on seventeen indicators and better on seven; Latinx individuals fared worse on fourteen indicators but better on eleven).

75. *Health Disparities*, *supra* note 67. While this Article focuses on access to health care, without question, other social determinants of health play a large role in health inequity. Daniels, *supra* note 10. The wage gap, discrimination, less safe and affordable housing, less access to clean air and water, and less access to high quality education, all play a significant role in diminished health and wellbeing. *See id.*; Ruqaiyah Yearby & Seema Mohapatra, *Law, Structural Racism, and the COVID-19 Pandemic*, J.L. & BIOSCIS. 1, 4–15 (2020) (describing how structural racism in employment, housing and health care contribute to racial health disparities); MICHAEL MARMOT, *THE STATUS SYNDROME: HOW SOCIAL STANDING AFFECTS OUR HEALTH AND LONGEVITY* (2004) (discussing the impact of social status on health).

76. *Health Equity Considerations & Racial & Ethnic Minority Groups*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 12, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html> [hereinafter *Health Equity*] (“Long-standing systemic health and social inequities have put many people from racial and ethnic minority groups at increased risk of getting sick and dying from COVID-19.”).

Latinx populations bore the brunt of COVID-19, contracting the disease at higher rates than their White, non-Latinx counterparts.⁷⁷ Individuals from these same groups were hospitalized at four times the rate of Whites and died from COVID-19 at almost three times the rate of White Americans.⁷⁸ The differential risk and outcomes were not due to any biological difference but rather were caused by structural racism in access to care, housing, employment, and wealth.⁷⁹ COVID-19's unequal disease burden reflects long-standing, systematic health and social injustices.⁸⁰

Health disparities have always been deeply problematic, but COVID-19 brought new salience to these inequities. It drove home the extent and impact of current disparities, as well our interconnectedness when we fail to ensure all Americans' needs are met.⁸¹ The United States cannot afford to ignore health injustices any longer. This country must begin to make reforms, in healthcare and beyond, to create

77. *COVID-19 Hospitalization and Death by Race/Ethnicity*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 12, 2021) [hereinafter *COVID-19 by Race/Ethnicity*], <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html> (last updated Apr. 23, 2021); Yearby & Mohapatra, *supra* note 75, at 19 (asserting that African Americans and other minority populations are bearing the brunt of COVID-19).

78. *COVID-19 by Race/Ethnicity*, *supra* note 77.

79. *See, e.g.*, Yearby & Mohapatra, *supra* note 75, at 4–15 (describing how structural racism in employment, housing, and healthcare caused COVID-19 racial health disparities); Gbenga Ogedegbe et al., *Assessment of Racial/Ethnic Disparities in Hospitalization and Mortality in Patients with COVID-19 in New York City*, J. OF AM. MED. ASS'N NETWORK OPEN (Dec. 4, 2020) (finding that “Black and Hispanic populations are not inherently more susceptible to having poor COVID-19 outcomes,” and suggesting that structural determinants, including access to care, may explain the poorer COVID outcomes); *see also* Samantha Artoga et al., *Communities of Color at Higher Risk for Health and Economic Challenges due to COVID-19*, KAISER FAM. FOUND. (Apr. 7, 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/> (“Communities of color will likely face increased challenges accessing COVID-19-related testing and treatment since they are more likely to be uninsured and to face barriers to accessing care than Whites.”).

80. *Health Equity*, *supra* note 76; Yearby & Mohapatra, *supra* note 75, at 3–4.

81. *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, 1679–80 (2020) (pointing to the prioritization of eliminating health inequities in the healthcare system).

equal opportunity for health, prosperity, and wellbeing for all Americans.

B. COVID-19 Crisis Allocation Plans Reflect the Consensus that Distributive Justice Requires Utilizing Evidence-Based Measures to Maximize Benefit

In addition to shining a light on health injustices, COVID-19 has demonstrated the ethical principles Americans value when they are forced to actually acknowledge rationing health care.⁸² As demand created by COVID-19 threatened to overwhelm available resources in our healthcare system, ethics committees around the nation began drafting plans to provide a framework to justly allocate scarce resources.⁸³ States, hospitals, and other organizations developed allocation criteria for scarce ventilators, intensive care unit (“ICU”) beds, vaccines, pharmaceuticals, and other equipment and services whose demand exceeded supply.⁸⁴ This Article focuses on CSC plans for critical care resources such as ventilators.⁸⁵ While such plans vary considerably,

82. While centralized government health care distributions may not involve response to a public health emergency, such allocations parallel CSC allocations in that both primarily aim to improve the well-being of populations, as opposed to focusing on individual patients the way routine clinical ethics generally does. See Auriemma et al., *Eliminating Categorical Exclusion Criteria in Crisis Standards of Care Frameworks*, 7 AM. J. BIOETHICS 28, 30 (2020) (“[P]ublic health emergencies demand a more substantial shift toward prioritizing the well-being of populations.”). Those who suggest that emergency crisis allocation is different from centralized government funding resource allocation ignore the reality that the U.S. healthcare system rations care every day.

83. See Manchanda et al., *supra* note 1, at 1.

84. *Id.*; see also Antommaria et al., *supra* note 1.

85. Some have criticized common CSC allocations on health equity grounds, arguing that allocations that take into account comorbidities and lifespan will further disadvantage already marginalized populations because of existing health inequities. See, e.g., Chiara Caraccio, et al., *No Protocol and No Liability: A Call for COVID Crisis Guidelines That Protect Vulnerable Populations*, J. COMP. EFFECTIVENESS RES., Jul. 24, 2020, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7379972/>; Manchanda et al., *supra* note 1. Without question, it is important to avoid any allocation that exacerbates disparities based on race. A just distribution requires balancing multiple ethical values, including equity. However, given lower life expectancy and higher rates of being uninsured and low-income amongst most racial minorities, any

most have key ethical principles in common. Those widely-endorsed moral values for allocating care are discussed below.⁸⁶

Almost all CSC plans utilize “benefit maximization” as the primary criteria for allocation.⁸⁷ Plans typically define benefit in terms of “saving the most lives” through discharge and often some period thereafter.⁸⁸ They follow a medical evidence-based approach to measuring likely benefit, typically relying on a patient’s sequential organ failure assessment (“SOFA”) score as a relatively reliable and fast means to assess likelihood of survival to discharge.⁸⁹ This evidence-based approach treats like alike. Prioritizing patients with the goal of saving the most lives reflects a consensus ethical value and accords with most theories of distributive justice, not merely utilitarian ones.⁹⁰

redistribution that shifts care from an age-based priority system to a poverty- and benefit-based priority system is likely to decrease inequality rather than exacerbate it.

86. While this Article references CSC plans as reflecting a shared consensus on certain foundational distributive justice principles for health care, it must be conceded that several early CSC plans unethically discriminated against patients with disabilities by using non-evidence-based exclusionary criteria. See Michelle M. Mello et al., *Respecting Disability Rights—Toward Improved Crisis Standards of Care*, 383 *NEW ENG. J. MED.* e26(1), e26(2) (2020), <https://www.nejm.org/doi/full/10.1056/NEJMp2011997> (describing Office of Civil Rights complaints against state CSC plans that discriminated against individuals with disabilities). Any reform must take care to avoid the same result. CSC plans typically reflect considerable expertise and deliberation, but they are not intrinsically ethical or unethical. To be just, they must rest on sound principles, best evidence, and fair process.

87. Antommaria et al., *supra* note 1, at 191 tbl.2 (showing that 96.2% of triage policies allocate based on likelihood of medical benefit measured by expected increase in short-term and long-term survival); see also Emanuel et al., *supra* note 2, at 2051 (describing maximizing benefit as the most important ethical value for crisis allocation).

88. Antommaria et al., *supra* note 1, at 191 tbl.2.

89. Manchanda et al., *supra* note 1, at 3 (“All 21 states with specific frameworks for allocation of critical care resources recommended SOFA”); see also Gina M. Piscitello et al., *Variation in Ventilator Allocation Guidelines by U.S. State During the Coronavirus Disease 2019 Pandemic: A Systematic Review*, 3 *J. OF AM. MED. ASS’N NETWORK* 4 tbl.2 (2020) (reflecting use of SOFA or mSOFA as the ranking tool in twenty-one states).

90. Wasserman et al., *supra* note 5, at 3. Despite significant consensus, some ethicists do contend that a lottery (equal chance) or first-come, first-served approach would be more equitable, even if it saves fewer people. See, e.g., Ari Ne’eman, Opinion, ‘I Will Not Apologize for My Needs’, *N.Y. TIMES* (Mar. 23, 2020),

Crisis allocation plans also commonly aim to “save the most life years.”⁹¹ Plans do so in two ways. First, they assess decreased priority to those likely to die within six months, one year, or five years post-discharge based on individualized assessment.⁹² This approach seeks to avoid giving scarce resources to a patient with a very short future life expectancy if another patient with a substantially longer life expectancy has equal expected benefit. Only near-term survival is (and should be) considered.⁹³ Longer-term survival predictions are too inaccurate and risk exacerbating inequalities in access to care for racial minority and disabled populations.⁹⁴

<https://www.nytimes.com/2020/03/23/opinion/coronavirus-ventilators-triage-disability.html> (advocating a first-come, first-served allocation approach).

91. Manchanda et al., *supra* note 1, at 6 tbl.2, 8 tbl.4. Some in the disability rights community have criticized assessing benefit based on quantity of life years saved because some disabilities shorten life expectancy. See Ari Ne’eman, *supra* note 90. Others have countered that, as a whole, people with disabilities would also be better off under allocation criteria that factors in quantity of life years saved. See Govind Persad, *Disability Law and the Case for Evidence-Based Triage in a Pandemic*, 26 YALE L.J. F. 26 (, 2020). Ethically, disability leading to few remaining life years is distinct from advanced age leading to the same predicted outcome. See Persad, *supra* note 9; Wasserman et al., *supra* note 5, at 6. Accordingly, a definition of maximizing benefit that accounts for quantity of life years saved should make reasonable accommodation and adjustment for shortened life expectancy due to disability. *Id.* Such an adjustment would ensure life cycle fairness and account for some duty to distribute more to the most vulnerable. *Id.* However, the scope and contours of appropriate adjustments are beyond the scope of this Article. CSC plans typically address disability rights-based concerns with saving life years, albeit not to the satisfaction of all in the disability rights community, by only decreasing priority when a patient’s expected mortality is near-term, defined as six months to five years. Manchanda et al., *supra* note 1, at 8 tbl.4 (demonstrating that a majority of plans consider life years saved, as well as lives saved); Mello et al., *supra* note 86, at e26(3) (“Consideration of near-term prognosis is accepted in medical ethics and clinical practice Allocation guidelines that ignore near-term prognosis can produce outcomes inconsistent with considered moral judgments about responsible stewardship of scarce resources.”). A more just and equitable distribution of government resources based on lessons learned from COVID-19 crisis allocation should likewise only consider near-term mortality when distinguishing between individuals based on quantity of life years saved.

92. Manchanda et al., *supra* note 1, at 8 tbl.4. In considering near-term mortality, states are following the influential recommendation made by Biddison et al., *supra* note 66, as well as others.

93. See Mello et al., *supra* note 86, at e26(3).

94. See *id.*

Second, and somewhat more controversially, many crisis allocation plans utilize “life cycle” as a tiebreaker.⁹⁵ In these plans, significant age difference may decide priority between two patients if and only if those patients have the same expected likelihood and duration of benefit.⁹⁶ So, if an eighteen-year-old and an eighty-eight-year-old have equal likelihood of survival to discharge (based on SOFA score) and shortly thereafter (based on an individualized assessment of comorbidities), the eighteen year old will receive priority.⁹⁷ Life cycle fairness considerations strive to give all individuals an equal opportunity to reach later life stages. This approach may also decrease disparity in access for individuals who are racial minorities or who have a disability, as such groups are disproportionately represented amongst

95. Antommaria et al., *supra* note 1 (50% of CSC policies utilized age); *see, e.g.*, ARIZ. DEP’T OF HEALTH SERVS., COVID-19 ADDENDUM: ALLOCATION OF SCARE RESOURCES IN ACUTE FACILITIES 7–8 (2020), <https://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/infectious-disease-epidemiology/novel-coronavirus/sdmac/covid-19-addendum.pdf> [hereinafter AZ PLAN]; PA. DEP’T OF HEALTH, INTERIM PENNSYLVANIA CRISIS STANDARDS OF CARE FOR PANDEMIC GUIDELINES VERSION 2, 35 (2020), <https://www.health.pa.gov/topics/Documents/Diseases%20and%20Conditions/COVID-19%20Interim%20Crisis%20Standards%20of%20Care.pdf> [hereinafter PA PLAN]; COMMONWEALTH OF MASS. DEP’T OF PUB. HEALTH, CRISIS STANDARDS OF CARE PLANNING GUIDANCE FOR THE COVID-19 PANDEMIC 21–22 (2020), <https://www.documentcloud.org/documents/6843353-Revised-Crisis-Standards-of-Care-Planning-Guidance.html> [hereinafter MA PLAN]; *see also* Auriemma et al., *supra* note 82, at 31 (endorsing use of age as a tiebreaker). *But see* JUSTICE IN AGING, JUSTICE IN AGING’S NATIONWIDE WORK ON CRISIS STANDARD OF CARE DURING COVID-19 1 (2021), <https://justiceinaging.org/wp-content/uploads/2021/01/Nationwide-Work-on-CSC-During-COVID-19.pdf?eType=EmailBlastContent&eId=f5803ba0-1b0c-4e60-a727-b7cd8391602e&eType=EmailBlastContent&eId=a684e210-528f-4e49-a6a5-8047c284b374> (objecting to use of age as a tie breaker as devaluing the lives of older adults).

96. *See* AZ PLAN, *supra* note 95; PA PLAN, *supra* note 95, at 35; MA PLAN, *supra* note 95, at 21–22.

97. CSC plans sometimes assign priority points based on broad age ranges for ease of priority scoring. *See, e.g.*, PA PLAN, *supra* note 95, at 35. This approach can result in patients who are only a year apart in age receiving different priority. *Id.* A better application of the life cycle fairness principle would mandate a significant age differential between patients before considering age in allocation priority. *See, e.g.*, AZ PLAN, *supra* note 95, at 8 (remarking, however, that this plan’s preference for minors over adults would still allow a nineteen-year-old to receive lower priority than an eighteen-year-old).

high acuity younger patients.⁹⁸ While not without critics, aiming to save the most life years, as well as lives, is consistent with American Medical Association guidance that instructs to “allocate limited resources first based on likelihood of benefit . . . then to promote the greatest duration of benefit after recovery.”⁹⁹

Of course, the criteria crisis allocation plans reject for allocation may be as important as the criteria they select. All such plans dismiss ability to pay as a consideration, and most forego any exclusion criteria.¹⁰⁰ Avoiding exclusionary criteria prevents categorizing any individual as not worth saving, even when a very low priority score makes access to scarce resources unlikely.¹⁰¹ Most CSC plans also repudiate “quality of life” considerations.¹⁰² This is important because existing quality of life measures tend to underestimate the value of disabled life and to conflate societal disadvantages with innate limitations.¹⁰³ CSC plans avoid ability to pay considerations, exclusionary criteria, and quality of life assessments.

In summary, crisis allocation teaches us to use evidence-based, individualized assessment criteria to rank all those needing care according to likelihood and duration of benefit.¹⁰⁴ It may allow consideration of life cycle fairness to advantage youth, but only for patients

98. Wasserman et al., *supra* note 5, at 9.

99. *Crisis Standards of Care: Guidance from the AMA Code of Medical Ethics*, AMA (April 5, 2020), <https://www.ama-assn.org/delivering-care/ethics/crisis-standards-care-guidance-ama-code-medical-ethics>.

100. Auriemma et al., *supra* note 82 (describing the shift away from exclusionary criteria and how same better accords with ethical, legal, and practical duties).

101. *See id.* (arguing that exclusionary criteria devalue certain types of lives, exacerbate social inequalities, and fail to protect patients with special needs or social disadvantages).

102. *See* Dep’t of Health & Hum. Servs., Off. for Civ. Rts. in Action, *Bulletin: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19)* (March 28, 2020), <https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf> (discussing potential legal problems with allocation plans considering perceived quality of life); Emanuel et al., *supra* note 2, at 2052 (discussing potential ethical concerns with allocation plans considering perceived quality of life).

103. *See* Wasserman et al., *supra* note 5, at 6–7.

104. *See* Manchanda et al., *supra* note 1; Antommarrina et al., *supra* note 1; Mello et al., *supra* note 86; Wasserman et al., *supra* note 5; Emanuel et al., *supra* note 2.

with equal likelihood of benefit.¹⁰⁵ It rejects consideration of ability to pay and quality of life and recognizes the expressive significance of not categorically excluding any individuals based on age, disease, or health condition.¹⁰⁶

IV. LIKE RATIONING PLANS, GOVERNMENT HEALTH CARE ASSISTANCE SHOULD FOLLOW EVIDENCE TO MAXIMIZE BENEFIT, NOT UNIVERSALLY PRIVILEGE OLDER AMERICANS

Crisis allocation suggests that the United States' market-driven, ability to pay approach to health care may be unethical, at least for essential care.¹⁰⁷ However, universal care at any level currently appears unattainable.¹⁰⁸ Until all Americans can afford medically necessary care, any government funds that subsidize access to care should provide such assistance on the most efficient and equitable basis possible.

Crisis allocation teaches that this will require that Americans of advanced age stop receiving an unjustified universal advantage in access to government-funded assistance over younger Americans with equal or greater need and likely benefit.¹⁰⁹ All individuals should receive equal consideration for scarce resources, and equity must be taken into account.¹¹⁰ Generally, age should not be the starting point for allocation, as it does not typically correlate closely to medical

105. See Auriemma et al., *supra* note 82, at 31; Emanuel et al., *supra* note 2; Antommara et al., *supra* note 1 (stating that 50% of CSC policies utilized age).

106. See generally Auriemma et al., *supra* note 82; Mello et al., *supra* note 86; Emanuel et al., *supra* note 2.

107. See Emanuel et al., *supra* note 2, at 2053 (asserting that no crisis allocation turns on ability to pay).

108. See Eric Levitz, *America's Health-Care System Has Never Looked Sicker—or Harder to Cure*, N.Y. MAG. (May 5, 2020), <https://nymag.com/intelligencer/2020/05/coronavirus-medicare-for-all-rural-hospitals-congress-employer-coverage.html>.

109. See Auriemma et al., *supra* note 82.

110. Equity must also be a central value in allocation and can sometimes be in tension with benefit maximization, as the most vulnerable are often the most expensive to help. This reality may compel some adjustment to a purely benefit maximizing framework to ensure that those with significant disabilities and those who have previously received inadequate resources are treated justly.

evidence of increased (or decreased) benefit for particular care.¹¹¹ The government's current blanket priority for older Americans through Medicare wastes resources, lacks normative basis, and perpetuates racial disparities in health.

A. Blanket Advantage to Americans of Advanced Age over Nonelderly Adults Is Inefficient and Inequitable

Using age, rather than evidence-based medical criteria, as the first grounds to allocate government healthcare assistance fails to maximize benefit.¹¹² It is inefficient and unethical.¹¹³ Good stewardship requires prioritizing cost-effective, evidence-based care in an equitable manner.¹¹⁴ Yet, Medicare universally prioritizes care for older

111. TOO OLD FOR HEALTH CARE? CONTROVERSIES IN MEDICINE, LAW, ECONOMICS, AND ETHICS I (Robert H. Binstock & Stephen G. Post eds., 1991) [hereinafter TOO OLD FOR HEALTH CARE?] (describing the heterogeneity of need and benefit from care in Americans of advanced age).

112. Evidence-based medical criteria measuring likely benefit take different forms depending on the types of care, and reliable evidence does not yet exist for all types of care. The Patient-Centered Outcomes Research Institute ("PCORI") funds comparative effectiveness research focused on patient-centered outcomes. See Methodology Comm. of the Patient-Centered Outcomes Rsch. Inst. (PCORI), *Methodological Standards and Patient-Centeredness in Comparative Effectiveness Research: the PCORI Perspective*, 307 J. OF AM. MED. ASS'N 1636–40 (2012). If free to do so, PCORI could aid in the transition toward following participant informed, evidence-based research, as the United Kingdom does through its National Institute for Health and Care Excellence. See Social Security Act § 1182 (currently limiting use of comparative-effectiveness research); Victoria Charlton, *NICE and Fair? Health Technology Assessment Policy Under the UK's National Institute for Health and Care Excellence, 1999-2018*, 28 HEALTH CARE ANALYSIS 193, 193–94 (2020) (discussing NICE allocation in the context of health technology assessment). See generally nice.org.uk (last visited May 24, 2021).

113. While rare, there are times when age correlates closely to expected benefit and advanced age correlates to increased benefit. For example, COVID-19 vaccine distribution plans typically give priority to Americans of advanced age based on empiric evidence that such priority will maximize benefit by saving more lives. This still contrasts sharply with Medicare's blanket priority to older Americans, which is not based on evidence of greater likely benefit.

114. See Richard B. Saltman & Odile Ferroussier-Davis, *The Concept of Stewardship in Health Policy*, 78 BULL. WORLD HEALTH ORG. 732 (2000) (explaining that good stewardship in health care requires a balance between economic efficiency and normatively based decision making); Emanuel et al., *supra* note 2, at 2051

Americans, with little consideration for cost-effectiveness, while millions of nonelderly adults remain uninsured and without access to care despite equal or greater need and potential benefit.¹¹⁵

This allocation approach squanders resources by failing to fund the most beneficial and cost-effective care, regardless of recipient age.¹¹⁶ It wastes resources by preferencing older Americans when, on average, *younger* individuals are more likely to benefit from care than individuals of advanced age.¹¹⁷ Of course, there are times when medical evidence indicates that Americans of *advanced age* are more likely to benefit, as in the case of COVID-19 vaccines, and when the evidence shows such efficiency, Americans of advanced age should receive priority. The key is to follow the evidence. Medicare currently fails to do this, instead relying on blanket age-based eligibility. On average, Medicare's age-biased allocation results in less benefit received from each government dollar spent.¹¹⁸

(maximizing benefit is the most important allocation value; it reflects good stewardship of resources).

115. Medicare currently spends roughly a quarter of its budget on care provided to beneficiaries ages sixty-five and older in their last year of life. *10 FAQs: Medicare's Role in End-of-Life Care*, KAISER FAM. FOUND. (Sept. 26, 2016), <https://www.kff.org/medicare/fact-sheet/10-faqs-medicare-role-in-end-of-life-care/#footnote-153315-28>. Much of this money would almost certainly provide more benefit if instead spent on currently uninsured nonelderly adults with real need and significant potential benefit.

116. Generally, age is too poor a proxy for need or benefit and should be abandoned as guiding allocation criteria. *See, e.g.*, TOO OLD FOR HEALTH CARE?, *supra* note 111 (describing the heterogeneity of need and benefit from care in Americans of advanced age).

117. *See, e.g.*, Andrew H. Smith & John Rother, *Commentaries: Older Americans and the Rationing of Health Care*, 140 U. PA. L. REV. 1847, 1852–53 (1992) (rejecting age-based rationing but conceding that “advanced age is statistically associated with reduced likelihood of a favorable medical outcome” and older persons may be less productive on average in economic terms).

118. In defining benefit, the allocation should be participant-value informed, as improvements that are scientifically measurable do not always accord with what patients value most. *See, e.g.*, Maxwell J. Mehlman, *Professional Power and the Standard of Care in Medicine*, 44 ARIZ. ST. L.J. 1165, 1214–17 (2012) (discussing mismatch between research measures and patient-centered outcome goals in the context of clinical practice guidelines).

While efficiency is important, good stewardship requires a balance between efficient and ethical decision-making.¹¹⁹ At times, there are valid ethical reasons, like historic disadvantage or significant disability, to provide special assistance to groups even when their care is less efficient.¹²⁰ Yet, neither remedying past injustice nor helping the least advantaged support a blanket priority for older Americans. As a group, Americans of advanced age have not received less than their fair share of health care resources. Moreover, while it is true on average that individuals sixty-five and older suffer from poor health and chronic conditions more than younger adults and would have higher health insurance premiums in the private market, many older Americans are not the least advantaged.¹²¹ They are healthy, affluent, and powerful.¹²² Blanket categorization based on age alone belies significant evidence of heterogeneity and instead seems to reflect stereotype and bias. Many nonelderly, low-income adults are more vulnerable than some elderly adults receiving Medicare.¹²³ Given how poorly targeted age-based criteria is when compared to individualized assessment of likely

119. Saltman & Ferroussier-Davis, *supra* note 114.

120. See Braveman et al., *supra* note 7 (describing the ethical foundation for combatting health disparities).

121. See JANET L. DOLGIN & LOIS L. SHEPHERD, *BIOETHICS AND THE LAW* 705 (4th ed. 2019) (citing U.S. DEP'T OF HEALTH & HUM. SERVS., ADMINISTRATION ON AGING, *A PROFILE OF OLDER AMERICANS: 2015*, 1 <https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2015-Profile.pdf>) (explaining how the elderly population suffers more than other age groups from poor health and chronic conditions); see also Russell Hittinger, *John Rawls, Political Liberalism*, 47 *REV. OF METAPHYSICS* 585–602 (1994) (reviewing Rawls's book and describing the difference principle, pursuant to which inequality can be justified if open to all under conditions of fair opportunity and providing the greatest benefit to the least advantaged members of society).

122. Jacobsen et al., *supra* note 33; DOLGIN & SHEPHERD, *supra* note 121 (stating that 43% of non-institutionalized elderly Americans report excellent or very good health); Chris Cillizza, *2 Charts That Show Just How Old This Congress Actually Is*, CNN: POLITICS (Jan. 29, 2021), <https://www.cnn.com/2021/01/29/politics/congress-age/index.html> (pointing out that half of the Senate is age sixty-five or older).

123. Compare DOLGIN & SHEPHERD, *supra* note 121 (43% of non-institutionalized older Americans report excellent or very good health), with Tolbert et al., *supra* note 17 (millions of uninsured adults go without needed medical care even for major health conditions). Well-paying jobs that make health care affordable are simply not always available. In fact, 75% of uninsured, nonelderly adults have a full-time worker in the family.

medical benefit and financial need, blanket prioritization of the elderly for access to healthcare is unjustifiable.¹²⁴

A more difficult question is whether the government should provide some priority to *younger* Americans over Americans of advanced age when need and likelihood of benefit is the same.¹²⁵ Crisis allocation plans suggest that age may sometimes play an appropriate role in allocation, as a secondary factor, to account for duration of benefit or life cycle fairness.¹²⁶ When all else is equal, preferencing nonelderly adults maximizes benefit by saving more life-years.¹²⁷ A nonelderly

124. Older individuals do tend to pay more than younger Americans for health insurance when purchasing insurance on the individual market, as the ACA still permits age rating of premiums. This suggests that a reformed Medicare program that allocates government spending based on likely benefit and financial need, with some equitable adjustments, would still disproportionately benefit Americans of advanced age. This result is not unethical, so long as the distribution is evidence-based, treats all with equal concern, and strives to maximize benefit and to mitigate inequality.

125. Ethicists have suggested a variety of arguments to defend prioritizing youth. For example, some scholars have also justified age-based allocation by arguing that such allocation offers greater benefit because later years of life tend to have diminished marginal utility. See FRANCES KAMM, 1 MORTALITY, MORTALITY: DEATH AND WHOM TO SAVE FROM IT 237–38 (1998). While such may be some individuals' experience and even empirically true on average if caregiving or economic contribution through taxes are the measure, the diminishing utility argument seems more subjective, variable and problematic than the other two grounds for age-weighting medically equivalent patients. See, e.g., BETTY FRIEDAN, THE FOUNTAIN OF AGE 127, 128 (1993) (describing how existing lack of purposeful roles and isolating environments influence researchers and individuals understanding of aging). Adopting such argument runs the risk of exacerbating already prevalent age discrimination, stigma, and bias.

126. See Jana Rogge & Bernhard Kittel, *Who Shall Not Be Treated: Public Attitudes on Setting Health Care Priorities by Person-Based Criteria in 28 Nations*, 11 PLOS ONE 1, 4 (2016) (finding public support for setting health allocations based on medical criteria and for using age-based criteria as a secondary factor for medically equivalent patients when the allocation is a zero-sum game).

127. Some argue that Americans of advanced age should be largely excluded from government health care assistance through age-based rationing. See, e.g., DANIEL CALLAHAN, SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY 116 (1987). This Article does not adopt Callahan's view that once society has helped an individual reach a "natural lifespan," society owes no more. Instead, it argues that medical evidence of likely benefit, not age, should primarily drive prioritization.

adult is simply more likely, on average, to live longer than an American of advanced age, thus increasing the overall benefit obtained.¹²⁸

While duration of benefit has some relevance to a just allocation, merely counting likely remaining life-years oversimplifies the ethical analysis. Any consideration of maximizing life-years saved must be tempered to avoid bias and equity concerns. Many would agree that if an individual in need of a scarce resource is likely to die from an unrelated co-morbidity within days and another with equal need is likely to live for decades, good stewardship demands giving the resource to the individual who can benefit for decades.¹²⁹ Nonetheless, in other cases, the moral authority of saving the most life-years may be thin or even non-existent.¹³⁰ People are all of equal worth and more than just the sum of their remaining life-years, which can be difficult to predict accurately in any event. Moreover, prioritizing individuals based on duration of benefit raises significant concerns about bias and exacerbating existing health disparities. Historically marginalized racial minorities, as well as individuals with certain disabilities, tend to have shorter life expectancies and disproportionately suffer from co-

128. See Emanuel et al., *supra* note 2, at 2052–53 (prioritizing the youngest can be justified as benefit maximization, saving the most life-years); Persad, *supra* note 9 (arguing for a “lifetime justice” approach that considers the duration of future life patients may gain as well as years of life they have already experienced). Recognizing, of course, that age alone is a relatively poor proxy for future life expectancy. *Id.*

129. Mello et al., *supra* note 86, at e26(3) (“Consideration of near-term prognosis in accepted in medical ethics and clinical practice Allocation guidelines that ignore near-term prognosis can produce outcomes inconsistent with considered moral judgments about responsible stewardship of scarce resources.”). In contrast, Medicare currently prohibits consideration of future life expectancy. 42 U.S.C. § 1320e-1(c)(1). Some ethicists oppose maximizing life-years saved, arguing that all individuals have equal moral worth or that both individuals stand to lose the same thing, their remaining life.

130. See, e.g., Samuel R. Bagenstos, *Who Gets the Ventilator? Disability Discrimination in COVID-19 Medical-Rationing Protocols*, 130 *YALE L.J.F.* 1, 16 (2020) (distinguishing the ethical basis for considering age based on life-cycle fairness from that based on seeking to maximize the number of life-years saved and challenging the view that health systems should seek to maximize life-years saved); Persad, *supra* note 9 (arguing in favor of a “lifetime justice” approach that takes into account future life years patients can gain and past life years already enjoyed); Smith & Rother, *supra* note 117 (criticizing treating individuals as the sum of remaining life years rather than as individual human entities).

morbidities that decrease remaining life-years.¹³¹ Government spending must take care to avoid exacerbating existing inequalities. Accordingly, to balance competing ethical imperatives, maximizing life-years saved should probably only be considered in cases of near-term mortality when stewardship considerations are strongest. Even then, it should only be taken into account after any appropriate equitable adjustments have been made for significant disadvantage or disability.¹³²

Life cycle fairness, however, provides a stronger ethical basis for prioritizing youth when need and likelihood of benefit are the same.¹³³ All people start young and, if they are lucky enough, become older. When all else is equal, younger individuals arguably should receive priority since they have enjoyed fewer years of life. This approach can be justified as a way to equalize lifespan opportunity or to assist the least advantaged (those who have enjoyed the fewest life years).¹³⁴ It explains why a young patient with a disability who has an expected future life expectancy of one year might have a stronger claim to resources than an eighty-year-old with cancer who has that same future life expectancy.¹³⁵ Life cycle fairness tends to avoid the disability and health inequity problems raised by maximizing life-years saved.¹³⁶ It may even “be an administrable and politically tenable way of ameliorating at least some disparities.”¹³⁷ While still a secondary factor, allowing significant differences in life cycle to influence allocation between medically equivalent patients seems not only ethically justified but also arguably ethically compelled.

131. See *supra* Sections II.C and III.A.

132. Age may be relevant to near-term mortality and to equitable adjustments, but it should only be one factor in such calculations.

133. See, e.g., Alan Williams, *Intergenerational Equity: An Exploration of the “Fair Innings” Argument*, 6 HEALTH ECON. 117 (1997); A. Farrant, *The Fair Innings Argument and Increasing Life Spans*, 35 J. MED. ETHICS 53 (2009).

134. See Emanuel et al., *supra* note 2, at 2051 (prioritizing the youngest can be justified as prioritizing the worst off, because the youngest will have lived the shortest lives if they die untreated).

135. See generally Persad, *supra* note 9 (arguing in favor of a lifetime justice approach that accounts future life years gained and past life years experienced).

136. Life cycle may actually ameliorate at least some inequity because those who die young are disproportionately from racial minority groups and disabled groups. However, any age-based criteria for allocation must take care to avoid bias or animus. Regardless of age, all individuals are of equal moral worth.

137. See Wasserman et al., *supra* note 5, at 9.

In conclusion, the current system for distributing government healthcare assistance, which provides a blanket privilege to older Americans through Medicare, must be reformed. It unfairly advantages adults of advanced age over nonelderly adults without evidentiary or normative basis and results in less overall benefit to those in need. As crisis allocation suggests, medical evidence of need and benefit should guide allocation decisions. All Americans should receive equal consideration for scarce government healthcare resources. If age is considered at all, it should only be as a secondary factor, when need and likely benefit are equal, to further good stewardship or life cycle fairness.

B. Privileging Older Americans Perpetuates Racial Health Inequity

Medicare's blanket preference for Americans over the age of sixty-five must also be abandoned because it structurally reinforces health disparities. As discussed previously, low-income Americans enjoy a significantly shorter life expectancy than high-income Americans. Americans who identify as Black or American Indian enjoy a shorter life expectancy than their non-Latinx White peers. In fact, only 23% of Americans age sixty-five and older are members of racial or ethnic minority populations.¹³⁸ Meanwhile, the majority of Americans under age sixteen identify as racial or ethnic minorities.¹³⁹ As a result, a distribution that favors older Americans will tend to provide more years of government assistance to White, wealthier individuals who have already been privileged. Such a distribution will perpetuate and exacerbate existing racial health disparities and cannot be ethically justified.

138. U.S. DEP'T HEALTH & HUM. SERVS., 2017 PROFILE OF OLDER AMERICANS 1 (2018), <https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2017OlderAmericansProfile.pdf> ("In 2016, 23% of persons age 65 and older were members of racial or ethnic minority populations.").

139. William Frey, *The Nation Is Diversifying Even Faster Than Predicted, According to New Census Data*, BROOKINGS (July 1, 2020), <https://www.brookings.edu/research/new-census-data-shows-the-nation-is-diversifying-even-faster-than-predicted/> ("In 2019, for the first time, more than half of the nation's population under age 16 identified as a racial or ethnic minority.").

Arguably, improving health equity and compensating for past injustice are such strong moral imperatives that reform efforts should more directly target racial minorities who have received less than their fair share in the past. More targeted efforts may be morally justified, but practically, they are complicated to administer fairly, and use of race in allocation can lead to unintended, undesirable consequences.¹⁴⁰ This Article advocates a universal, incremental reform away from unjustified prioritization of all Americans of advanced age. This reform should still provide the largest benefit to Americans from racial and ethnic minority groups, as such individuals are disproportionately younger, uninsured, and low-income.¹⁴¹ This does not discount the likelihood, however, that additional more targeted reforms may also be appropriate.

V. IMMEDIATE SPENDING REFORM TOWARD JUSTICE AND EQUITY
COULD TAKE MANY FORMS, BUT REMOVING AGE-BASED ELIGIBILITY
SHOULD BE GRADUAL

Having established the need to transition away from unfairly privileging older Americans, the question becomes how to do so. Reform should begin immediately, but ethically appropriate reform could be accomplished in many different ways.¹⁴² Consolidating Medicare and Medicaid would have the advantage of creating a single pot for most government healthcare funds, making applying evidence-based

140. See Wasserman et al., *supra* note 5, at 9.

141. See Tolbert et al., *supra* note 17 (reporting that 20% of Hispanic, 21% of American Indian/Alaskan Native, and 11.4% of Black people lacked health insurance in 2019, as compared to 7.8% of non-Hispanic Whites); Bhutta et al., *supra* note 56.

142. While intended to be cost-neutral, in some ways, the discussion of how best to transition to a system that distributes government healthcare resources more fairly, parallels the debate amongst Democratic presidential candidates regarding healthcare reform. Bernie Sanders argued for Medicare for All, a single-payer health system that would supplant Medicaid and private insurance. Stephanie Booth, *Medicare for All: What Is It and How Will It Work?*, HEALTHLINE (Aug. 26, 2020), <https://www.healthline.com/health/what-medicare-for-all-would-look-like-in-america>. Pete Buttigieg supported a plan that would allow people to keep their private insurance but add a public option for anyone. *Id.* Other candidates, including now President Biden, endorsed a more incremental approach, building off the status quo. *Id.* Reforms to increase access to care, whether to correct unethical age priority or otherwise, can follow a disruptive model or an incremental approach, and there are pros and cons of each.

medical criteria across populations easier.¹⁴³ This approach may also have the added advantage of increasing pressure on provider participation and decreasing administrative expenses.¹⁴⁴ Further, it may be more likely to achieve political support, as the government would not be “defunding” care to older Americans but simply consolidating government healthcare assistance and prioritizing all equally.

Unfortunately, consolidation would also pose unique challenges. In addition to differences in eligibility and covered benefits, Medicare and Medicaid have very different funding and payment structures.¹⁴⁵ Moreover, Medicaid represents a balance between state and federal power, likely to pose difficulties in negotiating a consolidation.¹⁴⁶ Even assuming these challenges could be overcome, consolidation would be complicated at best, and the transition could be hard on patients and providers during the first few years.¹⁴⁷

143. Medicare and Medicaid are both currently uncapped funding obligations based on coverage and eligibility rules. This could continue or be changed but thinking of them together may make it easier to make ethical healthcare allocations that treat like alike, based on best available medical evidence, do not exclude anyone, and seek to maximize benefit while also improving health equity.

144. See Caroline Brown & Anna Kraus, *Medicare and Medicaid: When Two Is Not Better Than One*, ATLANTIC (May 22, 2012), <https://www.theatlantic.com/health/archive/2012/05/medicare-and-medicare-when-two-is-not-better-than-one/257298/> (citing controlling costs, decreasing bureaucracy, and improving coordination as potential benefits of a single government program for dual eligible beneficiaries, but not arguing for the total consolidation of Medicare and Medicaid programs); David Orentlicher, *Medicare for the Poor*, BILL OF HEALTH (Mar. 3, 2020), <https://blog.petrieflom.law.harvard.edu/2020/03/03/medicare-for-the-poor/> (arguing in favor of folding Medicaid into Medicare to make access to care more uniform across states and to increase provider participation, among other reasons).

145. *What Is the Difference Between Medicare and Medicaid?*, HHS.GOV, <https://www.hhs.gov/answers/medicare-and-medicare-when-two-is-not-better-than-one-between-medicare-medicare/index.html> (last visited May 24, 2021); see also Orentlicher, *supra* note 144 (acknowledging differences in eligibility, reimbursement rates, and funding structures between Medicare and Medicaid).

146. See, e.g., Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Healthcare For?*, 70 STAN. L. REV. 1693 (2018) (analyzing implementation of the ACA through a federalism lens).

147. While significant, these challenges are likely not insurmountable. The Centers for Medicare and Medicaid Services (“CMS”) has authorized thirteen states to integrate Medicare and Medicaid benefits for dual eligibles through a demonstration known as the Financial Alignment Initiative. See Laura Keohane, *Integrating Benefits for Dually Eligible Medicare and Medicaid Beneficiaries: Early Lessons from the*

Regardless of whether or not the government consolidates programs, any significant change to Medicare will require a gradual transition. Existing Medicare stakeholders form a significant part of the U.S. economy, and a slower transition is appropriate to minimize market disruptions.¹⁴⁸ In addition, eliminating Medicare, or even dramatically changing its eligibility and coverage overnight, disturbs the reasonable expectations of workers who have planned for retirement expecting future Medicare benefits.¹⁴⁹ Most Americans of advanced age have relatively limited ability to increase their financial means to offset unexpectedly lower benefits. A phased-in approach is necessary to mitigate these concerns.

Perhaps, the best short-term way to move towards the ends suggested by this Article would be to use part of the Medicare funds that are not contributed by payroll taxes or premiums, to fund federal coverage for the so called “expansion population.”¹⁵⁰ This is the group of more than two million nonelderly adults below 138% FPL who are not

Financial Alignment Demonstration, COMMONWEALTH FUND (Apr. 25, 2019), <https://www.commonwealthfund.org/blog/2019/integrating-benefits-dually-eligible-medicare-and-medicaid-beneficiaries-early-lessons>. Some such partially combined Medicare and Medicaid demonstrations have already functioned effectively for a decade. *Id.*

148. ELIZABETH DOCTEUR ET AL., NAT’L ACAD. SOC. INSURANCE, EXAMINING APPROACHES TO EXPAND MEDICARE ELIGIBILITY: KEY DESIGN OPTIONS AND IMPLICATIONS 51, 144 (2020), https://www.nasi.org/sites/default/files/NASI_Medicare%20Report_Final_Digital.pdf.

149. Samuel C. Thompson, Jr., *A Buffett Rule for Social Security and Medicare: Phasing Out Benefits for High Income Retirees*, 50 U. LOUISVILLE L. REV. 603, 616 (2012) (endorsing a gradual phase-out of benefits for high-income retirees but recognizing the need for a delayed basis to avoid interfering with reasonable expectations regarding retirement planning). Because Medicare is more popular than Medicaid, any consolidation would likely adopt the Medicare name, but if the program determined eligibility based primarily on income and likely benefit, rather than universally at age sixty-five, to many beneficiaries, it would be seen as the elimination of Medicare.

150. See Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended (expanding Medicaid eligibility to all adults under age sixty-five with incomes below 138% of the FPL; creating a new adult “expansion population”); Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2607 (2012) (making coverage for the expansion population a state decision).

currently covered in non-expansion states.¹⁵¹ This would eliminate the exclusion criteria, barring the lowest-income nonelderly, adults from receiving government healthcare assistance. Because this population includes a disproportionately high rate of traditionally marginalized racial minorities, this incremental solution would also improve health equity.¹⁵²

The second short term target should be making federal insurance premium subsidies more generous permanently, so that more nonelderly adults can afford care. The overwhelming majority of uninsured adults report being uninsured because the cost of coverage is too high.¹⁵³ The American Rescue Plan Act of 2021 temporarily expands subsidies so that most individuals buying health insurance coverage through the Marketplace can receive a federal subsidy if their premium would otherwise be more than 8.5% of their household income.¹⁵⁴

151. See Garfield et al., *supra* note 22 (explaining that more than two million low-income adults fall into the coverage gap resulting from twelve states' decisions not to expand Medicaid). In March 2021, Congress passed the American Rescue Plan Act of 2021, providing a new temporary financial incentive to encourage states that have not yet expanded Medicaid to do so. Pub. L. No. 117-2, 135 Stat. 4. The Act increases the federal matching rate for Medicaid funds by five percent for two years for states that newly expand. *Id.* This financial incentive more than offsets the states' costs in covering the newly eligible expansion population during that two-year time period.

It is too soon to know if the new incentives will persuade any of the holdout states to expand Medicaid, but the Act will not convince all. Wyoming stood to gain \$54 million from the increased match, and with estimated expansion costs of \$20 million, was projected to have a net benefit of \$34 million. Tom Coulter, *Medicaid Expansion Bill Rejected by Senate Committee*, WYO. TRIB. EAGLE (Apr. 2, 2021), https://www.wyomingnews.com/news/local_news/medicaid-expansion-bill-rejected-by-senate-committee/article_06d332c5-3f66-50ef-8261-5d692fcf8a9f.html. Nonetheless, the Wyoming Senate has already voted against expansion. *Id.*

152. See Garfield et al., *supra* note 22.

153. See Tolbert et al., *supra* note 17 (“73.7% of uninsured adults said that they were uninsured because the cost of coverage was too high.”).

154. Matthew Rae et al., *How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured*, KAISER FAM. FOUND. (Mar. 25, 2021), <https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/>. Unfortunately, the Act leaves a coverage gap in non-expansion states for the more than two million individuals who do not qualify for Medicaid but are below 100% of the federal poverty level and therefore do not qualify for subsidies. *Id.* The

These expanded subsidies will make more than a million uninsured nonelderly adults newly eligible for assistance.¹⁵⁵ However, the expanded premium subsidies currently expire at the end of 2022.¹⁵⁶ Re-allocating government healthcare spending to make such subsidies permanent, at least until the United States achieves broader healthcare reform, would improve efficiency and equity.¹⁵⁷

To accomplish these reforms in an income-neutral, ethical manner will require eliminating Medicare coverage for the least beneficial, least cost-effective, end-of-life care, at least for Americans of advanced age.¹⁵⁸ While perhaps unpopular initially, this change should spur important discussions regarding how much the United States should spend on care and which care provides the most benefit relative to its cost. It may also force the United States to discuss what obligation we owe to those who have previously received less than their fair share of resources and to those with significant disabilities.¹⁵⁹ Only by acknowledging that rationing already occurs can the United States begin to allocate health care more justly and efficiently.

Ultimately, the exact administrative form of changes is not as important as the ethical foundation upon which such reforms are based. The administrative changes necessary to implement the proposed changes will likely be difficult, but they are possible and ethically

Act also fails to remedy unaffordable premiums for millions of individuals who are non-qualified immigrants or whose employer-based coverage is unaffordable. *Id.*

155. *Id.*

156. *Id.*

157. Health insurance subsidies improve access to care but fail to address, and may even exacerbate, underlying cost concerns. Broader healthcare reform would do well to reduce the role (and complexity) of insurance in our healthcare system.

158. *See* Peters, *supra* note 15 (recommending an allocation approach that eliminates the least beneficial or least cost-effective treatments).

159. The ethical basis for such change, maximizing benefit while treating all equitably under evidence-based medical criteria and accounting for life cycle fairness, is strong. Nonetheless, one must acknowledge not only that the public opposes incorporating cost-effectiveness considerations into healthcare allocations but also that determining cost-effectiveness is inherently complicated, especially across conditions. Moreover, because “benefit” is subjective, as well as objective, an ethical distribution must also account for participant-informed values. Finally, cost-effectiveness must find ways to account for equity, not oppose it. *See* Richard Cookson et al., *Using Cost-Effectiveness Analysis to Address Health Equity Concerns*, 20 *VALUE HEALTH* 206 (2017) (discussing tools available for equity impact analysis and equity trade-off analysis in healthcare allocations).

compelled. The health inequity highlighted by COVID-19 has provided impetus, and crisis allocation plans have offered an ethical framework. It is time to apply those teachings to eliminate the advantage given to Americans of advanced age and to create a more just, efficient, and ethical distribution of government-funded healthcare.

VI. CONCLUSION

The fundamental ethical principles embodied in most crisis allocation plans contrast with the government's routine allocation of government-subsidized health care. All Americans should be eligible for government health care assistance, regardless of age. Medical evidence of likely benefit, economic need, equity, and cost-effectiveness should guide distribution. Duration of benefit or lifecycle may be considered in at least some circumstances. The United States should transition away from the unjustified blanket priority provided to Americans of advanced age which squanders the total benefit realized from government resources, lacks ethical basis, and exacerbates health inequity. An equity-informed, evidence-based, benefit maximization approach to government spending would provide better outcomes, especially for low-income individuals and racial minorities. Ending age-based priority for government-funded healthcare would be an important first step towards distributive justice and health equity.
