SINGLE PAYER HEALTH CARE

SOCIAL INSURANCE vs. MEDICAL DARWINISM

By Bob Hertz
Editor, New Laws for America.com

HOW MUCH WOULD SINGLE PAYER REALLY COST?

A Single-Payer health system has undeniable attractions.

Nobody would ever lose coverage again.

You could change jobs, start a new business, or retire, and not disturb your insurance coverage.

Seniors have this kind of protection today. With Single Payer, everyone would have it.

Racial and rural health discrepancies should be greatly reduced.

Equity

The cost of care would be spread across all taxpayers. No one would endure financial hardship because they needed a specialty drug or a hospital stay. The cost of health care would vary by household income, not by medical need.

There would be no surprise billings and no medical debt. Every provider would be paid promptly-- with no confusing networks, or deductibles, or coinsurance.

Personal Viewpoint

I have been on Medicare Advantage in Minnesota for 9 years. I have had two major surgeries, but have never paid more than $250 out of pocket. I pay the normal Part B premium, and $76 per month for my MA contract. It has meant a richer life than I had before age 65. With virtually no deductible, my healthcare is better and my finances are far better. Perhaps I am just another spoiled senior, in a well-regulated state, living longer thanks to Medicare's generosity. Nevertheless, I want to see what can be done for all Americans.

I want Single Payer to succeed.

The goal of Single Payer is to pay for health care with taxes, not user fees. Once you paid your taxes, you would have nothing to worry about – no bills and no debts. Paying for health care collectively would remove financial fear from our medical lives. Progressive public taxes would replace the unequal user fees and private insurance premiums that most of us face today.

But I am concerned over the financing, and I see huge hurdles in any transition.

For example, Single Payer advocates are reluctant to propose new taxes that affect the middle class. That is felt to be a "third rail" in American politics.

Benjy Shaylin comments:
"For months, Elizabeth Warren faced constant attacks over her embrace of Bernie Sanders' single-payer health care plan, then further attacks after she released her own plans on how to pass, finance and implement it. Her campaign was dragged down and never fully recovered. Meanwhile, the Vermont senator, who "wrote the damn bill" on Medicare For All while offering fewer details on how it would operate, surged and is now in a two-way race with former Vice President Joe Biden."[1]

When Gov. Peter Shumlin of Vermont introduced Single Payer in 2011, he did not discuss the financing until after the initial bill had been passed. Unfortunately, his later announcement of new payroll taxes of 11% and new income taxes of 4 to 9% caused the plan to be abandoned.

The state of Colorado included a 10% income tax hike on all residents in its single-payer initiative in 2016 -- and the proposition was resoundingly defeated.

Hillary Clinton unveiled a well-researched, intricate plan to pay for her smaller health care reforms, versus Trump and Sanders offering huge and supposedly painless reforms – and how well did she do?

<u>Would we actually raise enough taxes to cover the cost of Single Payer?</u>

Possibly not. Traditional Medicare now spends hundreds of billions of dollars more than it collects in dedicated tax revenue -- and has done so for years.

Premiums from seniors were originally intended to cover half the cost of Medicare Part B. But today the premiums cover only 25%, which alone creates over $100 billion a year in deficit spending. Congress regularly ignores Medicare's growing reliance on general revenue.

The Bush White House pushed through the Medicare Part D Drug benefit in 2003 -- costing $95 billion a year today—with less than $10 billion of annual new tax revenues. We basically "put it on the card" with deficit financing.

Americans resist any cuts to middle-class benefits, while embracing all forms of tax relief. In the words of George Will, "We're happy because we're getting a dollar's worth of government for eighty cents." Borrowing money seems to make us feel richer – at least at first – while even the thought of new taxes makes us feel poorer. American fiscal policy sometimes appears almost childlike.

Note that when Germany offered public coverage for long-term care, they immediately raised taxes by about 2%. All their union pension plans are fully funded, by law. The German healthcare tax of 8% on employers and 8% on employees applies to every single workplace; there are no exceptions for part-timers or small firms.

If we establish Northern-European-level benefits, will we also impose Northern-European taxes? These welfare states do not just tax the rich – they tax everyone. The European Union requires a minimum sales tax of 15% for all members, and payroll taxes are often higher than that. They believe that actually paying for benefits is part of honest government.

Meanwhile let's look at the details.

The full Single Payer plan described in the Medicare for All Act of 2021 (Senate Bill 107 and H.R. Bill 1384) would first replace employer insurance, ACA exchange policies, and any other individual private coverage.

Adults age 21-64	**136 Million**
Children aged 1-20	**58 Million**

Cost estimate per person:
$ 7,464 per adult
$ 3,986 per young person

(This estimate is based on the average cost today for new enrollees to Medicaid, which has no deductibles or co-pays. I have added 12%, on the assumption that provider fees in Single Payer would have to be increased from Medicaid's current levels.)

Estimated total cost: $1.015 trillion for adults 21+
$232 billion for children 0-20
$1.247 trillion per year

This number should not be surprising. Today, corporations pay about $950 billion a year in premiums; individuals under 65 pay another $300 billion in premiums; and families pay at least $150-$200 billion in deductibles, co-pays, and other out-of-pocket costs.

Ideally this current spending could be captured as taxes and devoted to Single Payer. Many families who are now tormented by health costs would have no more premiums, out-of-pocket costs, or medical debts. Their new taxes for public health care should be much smaller than their payments for health care today.

For now, let's move on to the rest of the program.

The full Single Payer plan would enhance Medicare for seniors:

Add dental, vision, and hearing benefits…....$34 billion
Remove all deductibles and coinsurance….....$90 billion
Remove all monthly Part B and D premiums… $91 billion
Add long term care coverage….....$315 billion

$531 billon per year

Single Payer would also enhance Medicaid-- increasing physician fees by $87 billion a year.

Based on the steps above, here is the total first-year cost of Single Payer:

Under age 65……. $1.247 trillion
Enhanced Medicare…….$1.332 trillion
Enhanced Medicaid……. $707 billion
Veterans Administration…… $345 billion
Other federal programs…… $348 billion

$3.9 trillion

We can subtract any savings that will reduce the total cost.

For example, these federal programs could be terminated after a single-payer plan is installed:

A. ACA subsidies…….....$68 billion
B. SCHIP (children's health insurance).$14 billion
C. Disproportionate Share Payments
to hospitals……$20 billion
D. Tax deductions for cafeteria plans,
health savings accounts, et al……$88 billion
E. Medicaid payments for nursing home care
(now covered by Single Payer).. $100 billion

$290 billion expense reductions

(Note: We do not "plug in" any administrative savings for the first year.)

This leaves us with:

$3.90 trillion total cost
Less $290 billion savings =

$3.61 trillion first/yr

Some opponents of Single Payer stop here, and ask: how we can ever pay $3.6 trillion in new taxes? That question is intended to stop all discussion.

Instead, we assume that most existing federal programs will continue, and would provide:

Medicare funding……..... $800 billion
Medicaid (federal revenue only) …..$400 billion
Veteran's Administration funding… .$200 billion
Other federal programs….....$308 billion
$1.708 trillion

Thus, we can estimate the new taxes required:

$3.90 trillion total cost
-$290 billion savings
-$1.7 trillion ongoing revenue
$1.9 trillion new taxes needed first-year

BEWARE OF ILLUSORY SAVINGS

Many Single Payer advocates say that we only need about $1 trillion in new taxes per year for the full Sanders plan --about half as large as my estimate. Over a ten-year period, this creates a gap of at least $15 trillion in favor of their plans.

I can understand why they push in this direction. Any large increase in new taxes moves millions of voters from being clear financial winners to potential losers.

However, the advocates' scenarios don't always add up. I see too many "magic asterisks," where questionable savings and revenue are relied upon to balance the books.

#1. They overestimate the amount of savings that would be realized, and how fast this could occur.

Examples:

The Political Economy Research Institute (PERI) assumes annual savings of 19% overall with Single Payer, from a combination of:

- administrative efficiencies from having one non-profit insurer
- lower drug prices
- Medicare rates for all providers
- reducing inefficient and unnecessary services

Prof. Gerald Friedman - writing for the Bernie Sanders campaign - projects savings of $592 billion on the "costs of care and insurance."

Drs. Steffie Woolhandler and David Himmelstein estimate that we currently spend $1.1 trillion on health care administration; and of that amount, they feel that $504 billion is "excess" --attributable to having multiple insurers, multiple fee schedules, getting pre-authorizations, and pursuing patients and/or insurers over unpaid bills.

"Excess administration" also includes utilization management, risk-adjustment systems, and managing provider networks.

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Medical billing is undoubtedly a wasteful practice. However -- I estimate that about 1.5 million persons work on all aspects of medical billing, either in providers' offices or at insurance companies. That would be about $75 billion in salaries – and some of those employees would still be needed to help manage Single Payer. I am skeptical about a $504 billion "pot of gold."

The costs of hiring and training staff, and of maintaining health records, will not go away with Single Payer. We would initially use the Medicare claims system – logistically there is no other choice --and Medicare is not claims heaven. Medicare has its own complex fee schedule, and demands time-consuming reports. Its instructions for office-visit claims alone are sixty pages long. Its appeal process for denied claims is very cumbersome. Using thousands of CPT codes, with modifiers for each, invites fraud and requires constant audits -- in any public or private system.

Administrative savings are to some extent the "lure", being touted to help providers accept lower payment rates. The assumption is that clinics can easily see more patients at less cost, if they are freed up from the endless hassle of pre-approvals, dishonest insurers, and the need for patient collections. It is a very fetching scenario, but far, far from a certainty.

A Lancet-Yale report on Single Payer promises that "$284 billion in annual administrative savings would more than compensate for the $100 billion revenue loss from applying the Medicare fee schedules."[2]

This is a very large stretch; administrative savings would be gradual and uncertain. Even now, an office of specialists in a prepaid health plan has much lower billing costs than an independent general practitioner.

Given the troubled history of recent federal insurance rollouts, we might initially see an actual increase in providers' staffs, just to make sure this goes well.

Meanwhile, the revenue losses to some providers could be profound. If anesthesiologists or orthopedic surgeons have been collecting 300% of Medicare rates from private payers, or a hospital is charging 250% of Medicare today, laying off a few billing clerks might not keep them solvent. The infrastructure of facilities, doctors, and nurses may depend on high prices being continued – at least for several years.

Charles Silver reminds us: "The medical establishment has a long history of lobbying aggressively to reverse even the threat of a modest reduction in the rate of increase in health care spending. If threatened with an actual reduction in revenue, it will go ballistic."[3]

#2. They overestimate ongoing federal revenue.

Most Single Payer advocates assume a full "Maintenance of Effort" from state and local governments.

In other words, the individual states would keep sending over $280 billion per year to Washington for Medicaid -- which legally would no longer exist.

The former state contributions to Medicaid would supposedly be "repurposed" into Single Payer funds.

This is another large stretch. Kenneth Thorpe was very skeptical, noting that "The Supreme Court in 2012 said that we could not force states to contribute to the ACA's expansion of Medicaid. How in the world can we now force states to contribute toward a program that has been eliminated?"[4]

Maintenance of Effort also calls for federal, state, and local governments to continue paying over $350 billion for employee health insurance premiums -- even if a payroll tax is much cheaper. (Prof. Gerald Friedman even assumes that the continuing Maintenance payments would grow by 6.5% per year. State legislators will likely say otherwise.)

These assumptions create about $600 billion a year in very questionable new revenue.

#3. They overestimate the funding that will come from new taxes.

Prominent advocates such as Matt Bruenig of the People's Policy Project, Physicians for a National Health Plan, Sen. Sanders, and Robert Pollin's PERI study group all assume that a "reversal of federal tax expenditures" will create new revenue for Single Payer.

This convoluted phrase refers to $1 trillion in current employer-paid premiums, which they assume will be converted into taxable income for all affected workers. This would theoretically create at least $300 billion in new annual tax revenue – another pot of gold to be uncovered.

Their proposed scenario is certainly attractive……

- Assume a worker with family income of $80,000 who receives generous employer insurance. Their take-home pay today after income taxes, FICA taxes, state taxes, et.al, is probably about $60,000.

- If the employer premium of $20,000 is transferred to them instead…and even if all of it is taxable… and even if tax rates are increased for single payer… the employee would have take-home pay close to $70,000, plus no more deductibles or self-pay premiums.

This would be the greatest mass pay raise in history! Higher tax rates would be forgotten in this avalanche of higher salaries. Single Payer would pass tomorrow if workers were sure this would happen.

But many Americans are cautious about this:

- The average employer-paid premium is a lot less than $20,000.

- Non-union employees might get no extra wages at all. For example, the businesses that received Trump's 2017 tax cuts spent the money on stock buybacks, helping shareholders and not workers.

- If a worker turns down employer health insurance today, for any reason, they do not normally get higher wages in return. Jobs which offer health insurance generally pay higher salaries than those which offer no benefits. All this would not be the case if the premiums were really the workers' money. Most employers look on health insurance as a regrettable bonus, which they would stop paying in any form just as soon as they could.

Besides - most single-payer proposals include new payroll taxes, at least in the early years of the program.

For example, the proposals from Elizabeth Warren and PERI would tax employers at about 90% of their current insurance outlay. This is probably unconstitutional, but the relevant point is that it leaves essentially no money for an increase in taxable payroll.

Employers cannot be expected to pay out the same money twice -- both as additional payroll tax to the government, and then as a taxable raise for their employees. Single Payer plans are not likely to let corporations totally "off the hook" for the financing of health insurance.

<u>There are other over-estimates of new tax revenue:</u>

The PERI proposal counts on $458 billion new revenue annually from:

- Capital gains taxes.....$69 billion

- Sales taxes on non-necessities…. $196 billion

- A wealth tax……. $193 billion[5]

Prof. Friedman assumes $442 billion in annual revenue from a tax on stock and bond transactions alone.[6]

Matt Bruenig estimates $133 billion annually from taxing capital gains as ordinary income, $45 billion from ending the step-up in basis at death on capital gains, and $81 billion from eliminating itemized deductions.[7]

Elizabeth Warren assumes $200 billion of new corporate taxes by ending accelerated cost recovery.

Warren also proposes taxing capital gains for the top 1 percent on an annual basis, rather than just when a sale is made. That theoretically raises $150 billion a year.

She proposes a corporate foreign-earning tax, with a minimum of 35%, to generate $130 billion in the first year.

She also proposes a massive increase in IRS enforcement aimed at reducing tax avoidance. If successful, this could supposedly raise $200 billion a year.[8]

My new-taxes equation for the full Single-Payer package was this:

$3.9 trillion total cost-$290 billion savings -$1.7 trillion ongoing federal revenue =
$1.9 trillion new taxes

Their new-taxes equations run approximately like this:

$3.9 trillion total cost -$900 billion savings -$2.2 trillion ongoing federal revenue =
$1 trillion new taxes

Whichever figure is correct, the question remains:

Can we actually raise taxes by $2 trillion, or even by $1 trillion per year?

BEWARE OF ASPIRATIONAL TAX REVENUE

Consider the following legislative options to cover the cost of Single Payer…….

Option #1. Add a 10 % Payroll Tax on top of the current levy for Social Security and Medicare

The current payroll tax is 12.5% for Social Security plus 2.90% for Medicare ---a total tax of 15.4%.

The current tax is split 50-50 between employers and employees.

A new 10% tax for Single Payer would be collected through this same Social Security system -- which has the highest compliance rate of all national taxes.

The new tax would apply to all W-2 income. There would be no exemptions for small firms or low-income or part-time employees - just like Social Security works today.

Estimated Collections…….10% from all employers ……. $870 billion a year

However:

- A new tax would be hard on small businesses that do not offer health insurance now.

There are about 3 million such firms, nearly all with fewer than 25 employees. Some will resist paying even five dollars in new taxes, much less 10% of payroll. Remember, it was small businesses who led the fight against Bill Clinton's health reforms in 1994.

- The tax would be hard on firms with mainly part time employees.

For example, a large McDonald's restaurant could have 100 part time employees, with a total payroll of $2 million a year, and minimal spending today for health insurance. A new 10% payroll tax would cost the firm $200,000.

If this new payroll tax is split 50-50 with employees, then any part-time and lower-wage workers who now get Medicaid or a low-premium ACA plan would be worse off financially; they are paying virtually nothing today. That means at least 50 million adults who effectively cannot be taxed in this manner.

In addition:

- The wealthy who live on dividends, interest, and Sub-S profits would face no new tax at all.

- The owners of "Gig economy" firms like Uber, Lyft, and Doordash would be undisturbed. The avoidance of payroll taxes would remain central to their business model.

- Self-employed persons would assumedly pay the full 10% on their net income, as with Social Security taxes today.

That could be a big increase over what some of them are paying now.

Option #2. Same tax as above, but with an exemption for the first $1 million of payroll

Estimated collections from a 10% tax with a $1 million exemption …….$572 billion

This would be a smart move politically. A tax that starts at $1 million of payroll would exempt at least 80-90% of American business firms. Virtually all self-employed persons would be exempt as well.

But there is a big impact in revenue.

Plus, there would be constant maneuvering by medium-sized firms to stay under the million-dollar ceiling. *(When the ACA created a 30-hour-per-week cutoff, millions of workers saw a decrease in pay.)*

Firms would re-organize, subdivide, subcontract, etc. just to avoid the tax. (If the tax was 10 per cent and a company grew from a $990,000 payroll to $1 million, suddenly a firm would owe $100,000!) The IRS could never keep up with this.

A better alternative would be to start the new tax lower for small businesses, and then have a gradual increase. For example:

- 4% on payrolls up to $500,000
- 6% on payrolls $500,000 to $1,000,000
- 8% on payrolls $1,000,000 to $2,000,000
- 10% on payrolls $2,000,000 and more

For most large firms, this tax level would be close to what they are paying now, or even less.

I am assuming that the entire tax would be paid by the employer. The tax must be applied to 1099 contractor payments as well as traditional W-2 wages.

Estimated collections from a graduated payroll tax ……....$620 billion annually

Option #3. A general increase in income taxes

This is a better way to share the cost burden with business owners and investors.

We could start the rate increases at the 22% tax bracket --$81,051 income on a joint return. Each bracket over that amount would go up by one-fourth -- i.e. 22% would become 27.4%.

No household earning less than $81,000 would be impacted at all.

Estimated collections from a increase in higher tax brackets…....$334 billion

A household earning $200,000 would see their basic federal income taxes go from $33,000 to almost $39,000. Households with a $400,000 AGI would go from an $86,000 tax up to $106,000. (FICA taxes, state taxes, and property taxes are on top of this.)

Of course, this would be a major shift for Congress -- we have been cutting income tax rates for the last 50 years. Conservatives even promised to pay for wars with tax cuts -- in 1972, 1980, and 2001. Anyone like Walter Mondale who proposed higher taxes was shunted aside.

Both parties now propose ‘tax credits’ or ‘future entitlement reforms’ to pay for new programs. Both parties work hard to keep federal spending off-budget and less visible. Tax credits are easier for Congress

to pass, and much harder for the public to understand. Americans don't want to pay more directly out of their own pocket– even for programs they say they favor.

The Affordable Care Act did raise a few small explicit taxes on tanning beds, cosmetic surgery, medical devices, 1099 receipts down to $600, FSA's, and 'Cadillac' health plans. It counted future Medicare cuts – some of which never happened -- as a supposed source of new revenue.

Democrats even applied $9 billion in excess interest on student loans to help pay for ACA subsidies.

We were scraping the bottom of the tax barrel, plus legislative trickery, all to avoid a straightforward increase in federal rates.

There is always a "break point" or "cliff", where new income taxes on upper-income households would cause them to lose money under Single Payer.

Let's say that the cliff is $200,000. One can argue that these families should be paying more for health care, and that they can easily afford it. But this still means a tax increase for at least 15 million households. They will not be convinced that Single Payer will be cheaper for America.

Senior citizens will also object to any new income taxes. They feel that they already have "paid their dues" for single payer. One might recall the bitter resistance from wealthy seniors to new taxes in the Medicare Catastrophic Care Act of 1988.

Single Payer would actually be a great deal for seniors. It would eliminate their deductibles and co-pays. Retirees would no longer pay the Medicare Part B premiums now subtracted from their Social Security. They would no longer need Medigap or Part D drug insurance. They would also receive extra coverage, such as dentistry and long-term care.

In any event, exempting senior citizens from any tax increase would lower projected revenues by 16%. That means another 60 million persons who effectively cannot be taxed more for this purpose.

Options #4-#12. Add Additional taxes on corporations and the rich

4. Special 70 per cent income tax bracket for $400,000+ annual income

Rosy-Scenario Revenue estimate…. $39 billion per year

Likely Revenue……. $20 billion per year

5. Increase capital gains taxes to ordinary-income levels

Rosy-Scenario Revenue estimate… $137 billion per year

Likely Revenue……. $40 billion a year

6. Impose a Transactions tax on stock and bond trades

Rosy-Scenario Revenue estimate… $80 billion per year

Likely Revenue…….$20 billion per year

7. Impose a Wealth Tax on any estate over $50 million

Rosy-Scenario Revenue estimate… $275 billion per year

Likely Revenue……...$60 billion per year
(or $0 revenue, if the tax is ruled unconstitutional)

8. **Increase estate taxes**

Rosy-Scenario Revenue estimate… $30 billion/yr

Likely Revenue……... $10 billion/yr

9. Increase corporate income taxes on profits exceeding $100 million

Rosy-Scenario Revenue estimate…$80 billion/yr

Likely Revenue……... $40 billion/yr

10. Double the existing ACA taxes on investment income

Rosy-Scenario Revenue estimate…...$30 billion/yr

Likely Revenue…… $30 billion/yr

11. Impose the Social Security tax of 12.4% on all income, both wages and Sub-S profits, rather than stopping at $142,800 as we do today.

Rosy-Scenario estimate… $110 billion/yr

(These increased revenues would flow to the Social Security Trust Fund, thus technically unavailable for health care.)

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12. Reduce military spending, especially for overseas bases and buildups

Rosy-Scenario Revenue estimate… $80 billion per year

Likely Revenue……. $0

"Taxing the Rich Won't Pay for Politician's Promises,"
Brian Liedl, Manhattan Institute Journal, 10/17/19

Most of these estimates rely on "aspirational revenue." Single-payer advocates presume that Americans will pay all new taxes obediently.

This will not happen, because rich people have uncommon flexibility. A millionaire can postpone any activities that incur capital gains; a stock or bond trader can move to Ireland, if transaction taxes are imposed in New York; a billionaire can hire a small army of attorneys to contest their own wealth tax, and will effectively hire Congressmen to fight the tax legislatively. The rich can manipulate the timing of their income, and re-direct their wealth into foundations and other shelters which are endemic in the tax code.

Note:

Some commentators have proposed a Value Added Tax.

A 10% VAT on every product and service would theoretically produce $75 billion in new revenue. A 40% to 50% VAT might pay for the whole single payer plan – and people would pay it with every purchase, rather than writing a check on April 15.

However, I am skeptical that any such tax can be operational in America.

- Many states have their own sales taxes today and will be loath to give them up.
- Some firms would collect the VAT and not send in the money. The IRS would need a whole new compliance police.[9]
- A VAT would be paid by everyone, including senior citizens who already have Medicare. For non-elderly Americans, the offer would be higher prices in exchange for free health insurance; but elderly Americans would feel they are paying higher prices in exchange for nothing.

It would be much simpler to increase the existing sales taxes on alcohol and tobacco, and add a tax on all sugary products. This could bring in an extra $40 billion per year, and might even improve national health in the bargain.

Can't we just tax the rich for Single Payer?

- The total income of the top 5% of households—i.e., incomes over $200,000 -- is about $4.3 trillion.

- These twelve million households pay about $1.1 trillion in federal income taxes right now. It would require a 50% increase in their income taxes, to raise about $500 billion a year.

- Could we really do this? The top 5% includes many Democrats, many doctors, and the entire U.S Senate– so resistance would be bipartisan.

A wealth tax alone is also insufficient.

The six hundred American billionaires have about $3 trillion in net worth today; a 3% wealth tax would bring in only $90 billion a year.

A wealth tax which started at $50 million in net worth could theoretically raise $250 billion a year…but again this is an aspirational amount. The IRS would need to quadruple its staff for annual audits, and even then could never collect all that was owed.

Voters have been told that the rich, as well as greedy corporations, are an untapped renewable resource that can pay for everything and anything. That is false.

None of the wealth taxes proposed so far would even pay the interest on the current national debt.

For example, here is one package of new taxes to consider for Single Payer:

Graduated Payroll Tax ……. $620 billion
Increase the five highest Income Tax brackets by 25% (seniors exempt) …$271 billion
Increase corporate income taxes ……$40 billion
Double the existing Obamacare taxes on investment income…….. $30 billion
Double the taxes on alcohol, tobacco, and sugary food …….. $40 billion

This would only pay for ‘Single Payer Lite’ – i.e., replacing individual and employer coverage with zero-deductible federal insurance. Medicare and Medicaid would have to be left alone, and long-term care would still be uncovered.

These increases would arouse serious opposition from small businesses, the wealthy, and conservatives in general. It is not 1932 or1965, when the Democrats had huge legislative majorities.

The $2 trillion full Sanders agenda would require large and perpetual budget deficits, given the resistance to new taxes.

The advocates of Modern Monetary Theory – including Sanders – do have an answer for this. They would advise us to just forget about full funding. They believe that “If we can do it, then we can pay for it.”

In this view, if new taxes are not enough to cover the program, we should just plunge ahead anyways. This worked during the Depression and World War II, and would assumedly work again. The government

can print money to cover the extra cash flow of Single Payer, and we would never need to re-balance the budget.

Professor Stephanie Kelton remarks: “If we had had CBO in 1935, we wouldn’t have had Social Security. If we had it in 1964, we wouldn’t have Medicare. Progressives need to be willing to disregard CBO scores, and quit presenting their policies as a two-step process: Tax the bad --like offshore corporate profits – to pay for the good, be it health care or free college.”[10]
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In the short run, deficits do appear to make the country richer. Federal health spending has created millions of good jobs – for doctors and nurses, drug and equipment makers, insurance workers, hospital construction companies, et al.

MMT advocates believe that the federal debt will not bankrupt the country now or in the future. In their view, taxes do not pay for government spending; nor does debt. New revenue is actually not required for new programs. (After all, Congress never asks what taxes should go up to cover defense spending.)

Anyone who talks as if “taxpayer dollars” must be collected to “pay for” government programs is seen as undermining Medicare-for-all --and every other progressive policy initiative.

In MMT’s theory, the federal government cannot default on obligations denominated in its own currency. It can and will create all the dollars needed to pay interest on the national debt.

However, MMT is not completely a free lunch; even its staunchest advocates admit that printing money can cause inflation.

Right now in America, inflation is running at 6.8%, over three times higher than the Fed’s stated 2% objective. Under MMT theory, the government should be raising taxes to reduce consumption to fight inflation.

Will either political party entertain raising taxes on the middle class today? Absolutely not!

My own major concern is ‘tax capacity’.

We might only get one “bite at the apple” in terms of expanding social welfare. We might not want to spend all the new tax money on just replacing employer premiums. Job-based health insurance has many flaws, but it is not the greatest evil in American life. We need to save some tax capacity for student loan forgiveness, climate change, criminal justice reform, and many other areas.

LEGAL ROADBLOCKS FOR SINGLE PAYER

Challenge #1.

Could a corporation keep its own self-funded health plan?

The Sanders Single Payer plan would prohibit such workplace self-insurance. Under Section 107 - Title I of House Bill #1384, it would be unlawful for any private plan to duplicate the coverage of the government health insurance program.

However, the 1974 ERISA employee-benefits law has prevented states from regulating self-funded plans. Would it also prevent the federal government from interfering here? Corporations will claim a legal right to opt-out of health care mandates – and this will not be settled overnight.

Some employers will be glad to take Single Payer to court. They may like providing their own employees with generous benefits; they may be proud of their own health plan efficiencies; and they will distrust what they see as a 'slippery slope' of future tax increases. A new payroll tax on part-timers and contract workers might hit some of them particularly hard.

It is impossible to design a new national health plan that appeals equally to all employers. General Motors might be spending 20% of payroll on health insurance, so Single Payer with a 10% payroll tax sounds fantastic. Dunkin' Donuts or Subway or the Dollar Stores may be spending 2% of payroll currently, so their attitude will be very different.

Two industrial firms on the same street and of the same size may have widely differing health costs today. Older employees vs. younger, family coverage vs. single, union vs. non-union -- all these factors are in play.

(For that matter, two households on the same street may have very different current costs. Insurance status can vary even in the same household if there are two working adults.)

In any event -- Single Payer will not survive if large employers can replace it and not be subject to payroll taxes.

Challenge #2.

What if a doctor or hospital will not accept the Single Payer fee schedule?

Could they balance bill their patients? This is greatly restricted in Medicare today.

Could they practice totally outside the federal system? They will argue that this is a constitutional right.

If a patient uses only 'non-participating providers,' will they still be required to pay any new income taxes? Can they still buy private health insurance policies, which only cover independent providers? What if a voter really likes the concept of Single Payer, but their doctor is not going to participate?

Some providers feel they will be busy enough with private-pay patients; in that case, public-plan patients would have longer wait times for specialist care. This is exactly what has happened in England.

The zero deductibles in Single Payer will bring thousands of patients "out of the woodwork" with requests for expensive dental care, orthopedic care, et. al. There may not be enough providers available – and it will take years, not months, to meet the new demand. Judged by their waiting lists, England and Canada have never met the new demand.

Challenge #3.

What if drug makers refuse to negotiate prices?

At least one hundred specialty drugs now cost over $300,000 a year. In some countries such drugs might not be purchased at all, or a much lower price would be enforced.

Up until now Medicare has been a price taker, not a price setter. (In fact there are six classes of drugs which Medicare Part D plans are forced to cover drugs regardless of their price.)

The FDA does not regulate the launch prices of new drugs, nor does it review annual increases for older drugs. There is effectively no sheriff in town, and price competition is very rare.

This would change under a law like the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3), --passed in the House in December 2019 -- which would require the Department of Health and Human Services (HHS) to negotiate prices for selected drugs that have little competition.

Negotiations between HHS and drug manufacturers would set prices, which would have to fall within 120 percent of the average price across six reference countries. Manufacturers' compliance would be enforced through a substantial excise tax.

Additional new rules would limit prescription drug prices increases to inflation, where drug companies currently have monopolies; this would cover "all brand, biotech, and abusively priced generic drugs."

We may also need to look at U.S.C. Section 1498… under this law, the federal government has the power to take away a patent for price-gouging. The government can then find another manufacturer to produce a cheap generic version, or even produce the drug itself.[11]

Challenge #4.

What happens to health plans such as Kaiser?

HMO plans like Kaiser and Geisinger combine the direct provision of medical care along with the role of insurer. They are virtually a single payer plan in themselves; actually, they have had streamlined billing, data analytics, no claims filing, and doctors on salary for over fifty years.

It seems pointless to close them down; but how would they be paid? What if they also refuse to negotiate? They have millions of loyal members who might resist any changes – i.e., Kaiser with one-third of all residents of California.

The same is true for the military's Tricare plan, with nine million insureds who pay very low premiums for comprehensive coverage. Over five million workers in private industry and government still have a zero-deductible plan; single payer might not feel like an improvement for them.

And what about Medicare Advantage and Medigap plans?

A full Single Payer plan would make these policies unnecessary. There would be no deductibles or copays remaining to cover.

However, seniors may not trust a drastic change like this. Also, the health insurance industry derives most of its profits from these Advantage plans, and will be vigorously opposed to Single Payer.

Challenge #5.

Will hospitals be moved onto federally funded global budgets, as described by single payer advocates?

Virtually all hospitals and clinics rely on user fees today. This means creating millions of individual bills, and then trying to collect from devious insurers and resentful patients, who all pay as slowly as possible. Doctors hate to act as bill collectors, understandably. Some hospitals have become financial predators -- attacking any patient who is uninsured or out of network, squeezing out whatever dollars they can, and then backing off only if a journalist exposes them.

Dr. Adam Gaffney describes it brilliantly:

> Imagine if we funded public schools the way we funded hospitals. Instead of giving schools a lump sum global budget to take care of all their students, we required them to issue per-student bills that were to reflect each student's unique educational needs, and the precise mix of services they received.
>
> Assume also that teachers had to issue bills for every episode of instruction provided to each pupil daily, using a complex fee schedule incorporating the length, complexity, and/or intensity of every interaction.
>
> Finally, imagine that the tsunami of resultant bills went not just to the local government, but to a welter of different "educational insurance" plans, with varying rules and requirements; that these insurers frequently contested the charges; and that schools were required to collect co-pays and deductibles from parents, which varied depending on how much education a child consumed and the rules of their particular insurance plan.

> The waste would be colossal: large bureaucracies would be needed to issue and process the bills, and the paperwork would suck up large amounts of teachers' time, taking them away from, say, teaching.[12]

In theory it would be much cheaper for hospitals to have an annual government budget like the fire department, with no need for individual billing or collections. Hospital care would not have individual 'prices' -- just like police, libraries, public parks, and interstate highways. Most medical debt would disappear. An America without large hospital bills is well worth exploring.

The single payer approach gets credit for being far more direct. The state levies a hospital tax, paid by the rich and middle class according to their incomes. No one needs to do laborious audits of patients, any more than a library or fire station needs to find out the incomes of its users. Payments to the hospital have already been adjusted for wealth, before a single bill is created.

But frankly, I do not know how we "get there from here."

- Would we need to set over 5,000 individual hospital budgets? Who would do that? No one has great confidence in the competence of federal health agencies – and whoever runs the national hospital budgets will be administering over $1 trillion a year.

- Would 35,000 ambulatory care clinics each need their own federal budget?

- Who would decide which hospitals have too much expensive equipment (and want more of it)? What about hospitals that are locked into union labor contracts? What about hospitals that have massive debt service?

- Some doctors and investors now share in the profits of clinics and private hospitals. They too would be quick to go to court. A buy-out of these private facilities would be incredibly costly.

- Canada pays hospitals with lump-sum grants, which can grow no faster than nominal GNP. Canada strives for a balanced federal budget, so its mechanisms for cost containment can be harsh --- i.e., limiting the supply of physicians (which creates waiting lists); restricting what is spent on hospital equipment; and imposing much higher staffing ratios for nurses. In England, years of skimping on teaching hospitals has created a serious shortage of doctors.

Paying for hospitals is a complex challenge in every country; there are many combinations of taxes, social insurance, private insurance, charity, and outright cash.

America's full-service hospitals are frightfully expensive, for many historical reasons, and the pandemic has made this worse. Federal aid to hospitals is already increasing, and for reasons having nothing to do with Single Payer. The suddenly huge costs of hiring nurses can only be met with public spending. The labor expense per patient is going through the roof.

A somewhat crude example may be instructive here.

Picture a smaller hospital with an annual budget of $20 million, which cares for 2,000 full-service patients a year.

The average cost is $10,000 per patient.

However, Medicare and Medicaid pay less than $10,000, and most uninsured patients pay next to nothing. So the actual average for everyone else might actually be $13,000.

This is a genuine fiscal challenge. Here are four possible approaches:

#1 – The entire $20 million could be loaded onto the local budget, creating a free public institution. Hospitals would be like the fire department; no one would know or even care what the cost was for an individual patient.

Taxes would go way up, but insurance premiums would disappear. This may work on paper, but it is an enormous hurdle politically. New York City once had true public hospitals, but they have largely disappeared. Tax-funded county hospitals have been sold off and privatized as well.

#2 – Insurance markets could be regulated and subsidized, so that everyone has fairly complete coverage. This is basically the Affordable Care Act – call it backdoor socialism.

This also works on paper, but is difficult to impose. Mandates are resisted, and aid programs are frequently sabotaged.

#3 – Leave insurance alone, but offer emergency assistance to any patients who get into financial trouble. This article will propose several such programs.

#4 – Do nothing. People with poor coverage can be harassed and sued, until they go to GoFundMe and/or bankruptcy court. Hospitals are allowed to overcharge where they can, to make up the inevitable funding gaps. Charity will have to help individual patients.

But hey, we haven't raised taxes or lost our precious freedoms. Long live medical Darwinism!

Challenge #6.

Will abortion be covered?

The Colorado single payer proposal was defeated in 2017 in part because abortion was not covered.

However, in some states, a plan would be defeated if it **did** cover abortion.
So far as Bernie Sanders and other advocates are concerned, abortion is just a part of health care and must be covered in full. This issue alone could delay single payer for years.[13] The Hyde Amendment that prohibits federal funds from paying for abortions will not go quietly.

Challenge #7.

Will undocumented immigrants be covered?

HR 676 appears to promise this. In fact, a single payer plan might be defeated in California if it did not cover the undocumented.

However, even the liberal European nations are concerned about generous benefits for immigrants. Canada keeps out unskilled immigrants in the first place.

The Affordable Care Act only covered full citizens. Can Single Payer afford to go further? There are over 10 million persons involved here. Some are included in employer plans, but many are uninsured.

Covering them under Single Payer might make sense economically, but it will be very controversial. The Congressman who called out "You lied!" to Obama in 2009 was referring to this issue.

Challenge #8.

Will a financial reserve be established for Single Payer?

If there is no reserve, what happens if claims exceed premiums? Even in good years, it is common to see health costs rise 3 to 5 per cent.

It is challenging, even exhilarating, to design an attractive health plan for the first year.

The real test is what happens when claims go up.

Future-year increases were a major consideration in Vermont and Colorado, where single-payer initiatives were on the ballot. Advocates claimed that Single Payer reforms would actually reduce future costs, but voters and politicians were understandably skeptical.

(States do not have the ability to run large deficits; in that respect, Single Payer would probably never work at the state level. State-based plans would likely contract, crash, and burn in the wake of the first serious economic recession, when claims rise and tax revenues fall. Gov. Shumlin in Vermont realized this danger in 2014, and had the humility to pull his proposal.)

When commercial insurers face higher claims, they respond by denying coverage, raising rates, increasing deductibles, or just leaving the market. Naturally, this makes insurance companies unpopular.

When employers see insurance costs go up, they accept high deductibles and take other unpopular steps. Employers cannot (or had better not) go into debt over health costs.

This is because insurers, employers and states have "hard budgets." They cannot absorb relentlessly higher costs without taking painful actions.[14] A classic example was Medicaid in Missouri, which stopped paying for any adult dental care, in order to cover the expensive drug that cures Hepatitis C. In a hard-budget environment, the needs of the frailest and sickest essentially have to compete with all other state spending. And the frailest can actually lose.

By contrast, Medicare can rely on federal general revenue to cover cash flow shortages. If the so-called Medicare "trust fund" is exhausted, general revenue will be there once more.

Medicare does not reduce payments to doctors if the program is running a deficit.

(German doctors only get about 90% of their expected fees if their program is in deficit. The U.S. Congress declined to take similar steps for 15 straight years.)

Medicare has essentially had an unlimited ability to lose money. This is a key reason for its popularity.

Medicare has quietly relied on what James K. Galbraith calls "soft budgets" ---where costs can exceed revenues year after year, but without panic or cutbacks.[15]

The greatest enemy of Single Payer would be a balanced budget amendment. This condition would make us far more cautious about expensive medical miracles. In a balanced-budget world, the millions of dollars spent on premature infants or children with hemophilia is seen as reducing the normal care for everyone else.

At this time, a new single payer plan would likely be classified as mandatory spending, and would go onto budget autopilot like Medicare today. A Medicare "public option" would probably work the same way.

That removes the need to pass tax increases every year. Given that Congress has never made significant cuts to Medicare, this is effectively a guarantee of future deficits.

Challenge #9.

Is there any role for state governments in Single Payer?

America's broad deference to state governments has been a constant problem for the ACA and for Medicaid.

Meanwhile, Medicare runs much smoother because it has no state discretion whatsoever.

Medicare (and Social Security) are purely federal --so a senior citizen can move from Vermont to Florida and still get full benefits. They are not forced to live in the North, where they spent their working lives and paid their taxes.

Uninterrupted federal coverage has been an enormous benefit to Sunbelt states -- even while they boast about states' rights and low taxes. Federal programs like have alleviated their endemic rural poverty. Their greatest actual friends have been Democrats like Roosevelt and Johnson.

In any event ---if Single Payer is going to be subject to state-level subversion, it may never get off the ground.

Neither Canada nor northern Europe has any political equivalent to our deep red states, and their desire to punish the poor. After the ACA was passed, "these states deprived millions of their poorest citizens of Medicaid coverage, out of sheer racial prejudice and partisan spite."[16]

According to Thom Hartmann, the phrase “skin in the game” actually comes from the high co-payments in Medicare -- which were intended to keep Southern blacks from fully participating.[17]

State governments are theoretically the “laboratories of democracy.” Well, in labor history, rights history, and health history, they have sometimes been more like the cesspools of reaction.

Challenge #10.

Will anything be done about upcoding?

The Medicare fee schedule can already be stretched to get higher reimbursements from coding manipulations.

Secondary conditions are added to raise the cost of claims. Hospitals make extra money by coding pneumonia as sepsis, or by adding “acute heart failure” as a secondary condition. The national claims expense for emergency care is up almost 99 percent over ten years, but on a static volume of cases -- a clear sign of upcoding.

The ‘growing cost of health care’ may not be a medical phenomenon at all. It is not all due to patients getting older or sicker.

It can come from taking advantage of overly detailed codes, and thereby extracting more money from payers

Providers do not even need to be deceptive. Just look at one small item from Medicare’s own fee schedule:

Medicare fee for CPT code 64510, Stellate Ganglion Block (2013 Medicare Rates):

Hospital Outpatient Department: $826
Ambulatory Surgery center: $531
Office site of care: $221

When Medicare last tried to reform this, a lawsuit brought by the American Hospital Association preserved these “site of service” differentials. By contrast, the renowned efficiency of the European health systems comes from having a single, agreed-upon national fee schedule.

TIME FOR AN ASSAULT ON MEDICAL DEBT

Maybe we cannot achieve Single Payer at this time…but what if we aimed at these goals instead?

- Enforcing the existing laws against medical price-gouging
- Reducing or even cancelling millions of medical debts
- Expanding Medicare and Medicaid to help the most vulnerable

Background

Over 40 million American households have less than $2,000 in liquid assets. Why are so many of them walking around with deductibles they cannot afford?

If their auto or homeowner's insurance policies had a $7,000 deductible, we'd all say that was way too high. Banks might even refuse to make mortgages and car loans to people with that large a deductible.

Note that most unionized workplaces provide affordable health insurance. (This is true even in relatively low-wage occupations such as hotels and restaurants.) Labor unions have always opposed high deductibles and co-payments.

In non-union shops, however, limited insurance may be the only coverage that workers can afford. They go along with a high deductible, because it is the only way to avoid an unaffordable premium. Their choices might be limited to a high-deductible plan for $300 a month, versus a zero-deductible plan for $700 a month. High premiums hurt everyone, every month -- whereas a high deductible only hurts those who get sick. Most employees at any firm are relatively healthy, so the deductibles are grudgingly accepted. The calculation is painful, but understandable.

Some workers then refuse to buy any health insurance, gambling that they will not have any illnesses in the coming year. Americans do have a high tolerance for risk-taking with health, and not everyone who goes uninsured loses the bet, either…but it is a childish way to run a national health system.

Too many households are living right on the edge financially, and they have trouble with all their debts, not just medical. Default rates are growing on car loans and credit cards as well. They might be trying to pay off student loans, and medical bills just have to wait their turn. Paying for car repairs or home heating oil is more urgent – compared to a medical bill for some condition that has resolved. Debtors may be seeking fresh sources of credit, simply to service their existing debt. One of the popular bumper sticker states: "I use MasterCard to pay Visa." For the working poor, this has long been a familiar arrangement.

A tax-favored health savings account is not much help to families who barely pay income taxes in the first place. A family might get by – barely -- with a used car, old house, and re-used clothes; but there are no bargain-basement hospitals, or surgeons, or specialty drugs.

A medical debt explosion – where over 5 million persons have medical debts in excess of $10,000 -- was conveniently not mentioned in the propaganda for high-deductible plans. In theory, employers would get large savings on premiums, and the savings would be deposited into employee Health Savings Accounts (HSA's) to help cover the deductibles.[18]

Providers would theoretically start competing on price, because people would be spending their own money. Patients would shop for health care, compare prices, and decrease consumption of unnecessary medical services. (Assuming they actually knew what is unnecessary.) Deductibles would nudge Americans into self-rationing, unlike the crude shortages and waiting lists of socialist countries. Price-gouging providers would presumably be driven out of business, by price competition and bad Yelp reviews.

It is easy to see how this idea took hold. Americans are the bargain hunters of the world for consumer goods, so why not in medicine as well? Competition could lower the prices for simpler diagnostic tests and for low-risk, voluntary procedures like Lasik eye surgery. We could invite foreign competition as well, through medical tourism.

Unfortunately, these reforms have not reduced the costs of transplants, heart attacks, and cancer treatments. Saving $500 on lab tests and MRI's is fine…….but insurance costs are mainly driven by involuntary cases like the $200,000 ICU patient or premature baby, or the $60,000 cancer drug.

Free markets will not deliver low prices unless the average consumer refuses to pay higher prices. In much of health care, that rarely happens. (For many prescription drugs, that never happens.) When people face a serious medical crisis, they go wherever their doctor practices and where their family can easily visit them. Insured patients rarely choose the lowest-cost provider.[19]

The high-deductible-plus-HSA approach still looks attractive to households with higher incomes, good health, and good savings habits. It works well today for state employees in Indiana -- the state covers the full insurance premium and gifts the deductible of $2,850 into each employee's HSA every year.

HSA's also work in Singapore, where everyone is legally required to save seven per cent of salary for their HSA account. Unfortunately, Americans resist saving up for health care expenses. We are not likely to pass a law that automatically deducts a per cent of each paycheck, to create a valuable savings account for health care.

Today, about half the employers offering high-deductible coverage do not make any contributions toward their workers' HSAs.

Dr. Sean Masaki Flynn is a fervent advocate of HSA's, but even he admits:

"Putting people into these plans without ensuring that they are going to have enough money to pay their deductibles creates a medically-underserved group, which will demand traditional insurance instead. They will probably feel that the medical system is hideously costly and unfair….and they will find themselves favoring Canadian-style Single Payer."[20]

Too many workers do not “shop around” for the most efficient care -- they may just go without any treatment, until they are forced to use the hospital. Then they may get a bill for $5,000 or more as their share – a bill they often do not pay, either out of poverty or just anger. The bill eventually goes to a collection agency, with more negative consequences for the patient.

Patients can face severe debt if they use credit cards to pay for treatment. This may be their only option, but high interest rates from 13 to 29% can create many years of financial hardship. It is a hideous way to run any part of our health system.

Their final step may be bankruptcy, unless they have generous extended families. If they need ongoing care and specialty drugs, they may have to beg for help on GoFundMe – where fewer than ten per cent of requests are fully funded.

I consider medical begging to be the shame of the nation.

Note: There is a libertarian viewpoint that private charity is not shameful at all. The theory is that if hospitals, doctors, and drug companies can pursue maximum profits, and face low taxes, this will produce superior health care in a booming economy. The cost of health care will go down overall due to innovation; and the needy can be cared for by generous donations and generous physicians, as supposedly occurred before Medicare.

Price-gouging is seen as unfortunate, but necessary to promote product innovation. Charity is considered preferable to new taxes. Plus, the donors get to choose who are the worthiest recipients. According to conservative economist Michael Strain, “A slightly higher mortality rate is an acceptable price to pay for certain goals – including…less government coercion and more individual liberty.”

I doubt that anyone who holds this view has ever had to rely on charity themselves. They are the proverbial rich kid who starts on third base and thinks they’ve hit a triple. Or, as described more elegantly by John Kenneth Galbraith:

“The modern conservative is engaged in one of man's oldest exercises in moral philosophy; that is, the search for a superior moral justification for selfishness.”

Here are several reforms to reduce the most burdensome medical debts.

Attack #1. Cancel any debts that arise from a denied insurance claim.

If a health insurance claim is denied, the patient would not be liable. (This has been true in Medicare for decades.)

Right now, patients can be forced to pay disputed medical bills, caught between insurers and providers. If an individual does not pay the bill during this time, it can be turned over to collections.

This must end! Any debts that have arisen from denied claims must be extinguished by law. Providers and insurers will have to work out any disputes, and the patient must not be harmed.

Individual patients cannot be expected to master all the details of insurance coverage. Patients today must sign consent forms that accept responsibility for any medical bills which their insurance company does not cover in full. These extortionate "pseudo-contracts" must disappear.

Attack #2. Cancel the oldest medical debts now owned by collection agencies.

Providers can now sell their charged-off medical debts for pennies on the dollar to collection agencies, who aggressively attempt to force patients to pay the full amount due.

The agencies try to collect more than they paid for the portfolios. After three or five years they will often sell the debts to someone else. Often, the people trying to pay off their debt have no idea that they're now paying anyone besides their hospital. All they know is that they have to keep paying.

For now, all debts over three years old must be legally cancelled right away—and in all states. (The state of Maryland bans this practice already.)[21]

Pending legislation in California would require that before selling patient debt to a debt buyer, the hospital must have found the patient ineligible for financial assistance.

All the resulting cancellations of medical debt should be income-tax free. There is a long list of persons who can be taxed before reaching down to medical debtors.

Attack #3.

A. Enforce the existing laws against price-gouging

The Affordable Care Act of 2010 required tax-exempt hospitals to limit their charges to uninsured patients who are eligible for financial assistance. They cannot be charged more than "amounts generally billed to insurers."

California's Hospital Fair Pricing Act technically limits how much can be charged to any patients whose medical bills exceed 10% of household income.[22]

Illinois, Maryland, New Jersey, New York and Washington – the usual leaders in health care reform – require hospitals to provide at least some care on a sliding-scale basis.

Unfortunately, there is broad non-compliance, and many states do nothing. The process of qualifying patients for discounts is very cumbersome, and it is tempting for a hospital to just ignore the rules. Even when hospitals do the right thing, some patients miss out on large discounts because they fail to complete financial eligibility forms.

According to Craig Antico, "More than one-third of the hospital accounts assigned for collection should have been classified as charity care."[23]

For starters, the Internal Revenue Service must add sufficient staff to audit the billing practices of all non-profit hospitals.

B. Enforce the No Surprises Act of 2020

The No Surprises Act will protect Americans from the most egregious forms of balance billing (excepting ground ambulances) beginning on January 1, 2022.

In surprise medical billing, an ER doctor or staff surgeon would stay out of all insurance networks. They could then charge unlimited fees to patients, who usually were hospitalized and could not realistically protest. No one really has a choice whether to use an anesthesiologist when hospitalized, or which one. Some insurers provide no coverage at all for out-of-network emergency care. The result for many patients has been surprise bills topping several thousand dollars.

This was the healthcare equivalent of a carjacking. Some doctors had no idea of what was being billed in their name. (*Any doctors who were aware of the price-gouging should have been sued for violation of fiduciary duty. Patients who were harmed should be able to demand compensation and punitive damages. We do this already with investment brokers - why not doctors also?)*

Under the new law, the charges for out-of-network care should come close to the "qualifying payment amount" –i.e., the median contracted rate that insurers pay to in-network providers.

But there will inevitably be violators in the next few years. We cannot go from seven million surprise bills per year down to none, overnight. (Some providers are already looking for ways to delay or sabotage the new rules.) The law as passed only appropriated funds to handle 3,600 complaints a year – which is ludicrously inadequate.

C. Expand the Consumer Finance Protection Bureau to cover health care.

Recently**,** U.S. Senators Chris Van Hollen (D-Md) and Chris Murphy (D-Conn.) called on the Consumer Financial Protection Bureau (CFPB) to address medical debt.

The Senators requested that the CFPB oversee collectors' practices regarding medical debt, and must ensure that their calls include information on financial assistance.[24]

This is not enough expansion, however. This agency should be empowered to enforce all the new regulations on medical debt, including:

- Cancellation of debts due to insurance denials
- Cancellation of debts beyond a national statute of limitations
- Reduction of debts caused by ignoring charity-care guidelines
- Reduction of debts incurred by surprise non-network billing

A federal agency like this would be beyond the reach of the states, which is a good thing. Profiteers have traditionally found it easier to bribe and/or evade state legislatures.

The Affordable Care Act did order each state to create an ombudsman office for aggrieved patients – but has never provided any funding for this vital task! For resolving surprise medical bills in the new law, Congress has created a single toll-free number -- which of course will be swamped on the first day.

The CFPB could eventually adopt the guidelines suggested by blogger Karl Denninger for all medical bills:

> "For a bill to be valid and collectible it must be affirmatively consented to in writing, with a disclosure of the actual price to be charged for <u>each</u> item being performed.
>
> A bill that is increased, has items added to it after consent is obtained, or which contains any open-ended promise to pay without an actual price listed, or is issued after a customer sign a consent form while under the influence of drugs, is deemed fraudulent and void."[25]

The CFPB would be given legal authority to correct price-gouging. Hospital billing especially is plagued with:

- unconscionability (based on unreasonable pricing)
- lack of mutual assent
- fraudulent nondisclosure
- unfair or deceptive trade practices

Prof. George Nation explains:

"Hospitals set their prices at an exorbitant level because their primary purpose is to create leverage in negotiations with insurers; they force insurers to agree to higher reimbursements by threatening to bill these excessive amounts if the insurer does not agree to what the hospital demands. As an additional benefit, the chargemaster prices make the final payments to the hospital look reasonable and even attractive."

And he adds:

"Hospital admission agreements are contracts of adhesion; they are written solely by the hospital, which possesses much more bargaining power and knowledge….and the patient has no meaningful ability to negotiate with the hospital."[26]

When a hospital bills $5,000 for ten minutes of patient triage, or $10,000 for an anti-rabies inoculation that costs the hospital $200, the CFPB should be authorized to step in and reduce the charges. When an insurer pays $800 for a short ER visit but the hospital adds a charge of $4,500, again the CFPB could step in and cancel the hospital's extortion.

Some hospitals charge a $15,000-$25,000 "trauma activation fee" – even when the patient goes home the same day. This too should be outlawed, and existing debts in this area should be extinguished.

We have never had full consumer protections for healthcare. This stands in stark contrast to less prestigious fields, such as motor vehicle repairs -- which requires detailed written estimates, special procedures where a repair charge exceeds the estimate by more than 10 percent, and penalties if a provider makes any statement which is untrue or deceptive.

The CFPB will need thousands of new employees – attorneys, investigators, et al. There should be physical offices in every medium sized city, just like Social Security; not everyone with crippling medical debt can work online.

Debtors would need time to make their case about the size and/or injustice of their debts. We may need a federally funded expansion of small claims courts, in order to handle all the refunds and appeals. We also need a health-care oriented Legal Services Corporation, providing free representation in medical debt cases.

The fact remains: any industry which makes its profits from persons who are vulnerable must be regulated. Any industries and investors who sell to (and can exploit) desperate people must be subject to constant legal scrutiny.

Most people who need hospital care are suffering; to compound their suffering by demanding excessive payments feels immoral.

(And hospitals are not the only pigs at the trough. "Free-standing emergency rooms" were supposed to be a cheaper alternative to hospitals. But many of these places have also price-gouged for years, especially in western states…..essentially because they could.)

D. End all lawsuits over medical debt

Hospitals and doctors usually lose money when suing patients -- they tend to collect very little -- and our civil courts have too many medical debt cases already.

(In Connecticut alone, between 2011 and 2016, physician practices, hospitals or collection agencies combined initiated 81,136 lawsuits in small claims courts to recover outstanding medical debts. Virginia hospitals were also bringing over 20.000 lawsuits a year. Community Health Systems has brought 19,000 suits throughout the South just since March 2020. Some hospitals cruelly sue their own employees.)[27]

Due to outdated rules around service of process, defendants may not actually know that they have been sued. In one study, fewer than 10% of defendants in medical debt collections cases had legal counsel. Defendants may also have trouble taking time off to appear in court. (U.S. defendants only have a right to legal representation in criminal cases, not in civil lawsuits.)

Lawsuits also inflate the costs of the original debt by tacking on court costs, attorney's fees, and interest. Collectors can use various tools to enforce settlements, including garnishing wages and seizing assets.

Congress has not always helped. It ordered hospitals to aggressively seek bill payment from any recipient of emergency care. Squeezing the poor was described by GOP leaders at the time as "forcing individual responsibility." Congress also ordered all subsidies for charity care and non-payment to be eliminated from bills paid by government – classic Republican penny-pinching.

However, hospitals do need to get paid something on each patient…they need to meet their own payrolls. High levels of bad debt can put financial strain on hospitals — particularly for rural facilities that have a less profitable mix of payers. This can contribute to hospital closures that affect entire communities.

Full-service hospitals require a tremendous amount of money, given the costs of:
- 24 hour staffing – doctors, nurses, technicians, etc.
- Full supplies of drugs, surgical items, and diagnostic equipment
- Perfect cleanliness and temperature controls
- Financial reserves and liability insurance

If this were Germany, the hospital CEO's would have annual bargaining sessions with the sickness fund CEO's; and eventually they would settle on a national fee schedule within a firm national budget. (Another national bargaining group would control drug prices.) Claims would be paid promptly, with little or no patient debt. Hospitals would not gain by padding each bill, and insurers would not gain by imposing high deductibles or delaying claims.

Many hospitals have fallen into the car dealer-rug merchant-real estate model of pricing – where the high first bill is just an invitation to negotiate. The beleaguered patient needs an attorney or at least a high-energy relative on their side. Americans prefer fixed prices and generally do not enjoy haggling.

According to conservative ideology, "freedom" is the key ingredient to all of our prosperity. In healthcare this is not so simple, however. The freedom of drug companies to raise prices is not helping the nation as a whole. The freedom of individuals to stay unvaccinated is costing us billions in overwhelmed hospitals and nurses. Individuals are mainly "free" to be uninsured, and small employers are "free" to provide inadequate coverage or none at all. These freedoms are pretty worthless if they are hospitalized and then sued. Meanwhile, all citizens are "free" to reject new taxes for social insurance.

Whether all these freedoms make us better off -- versus nations with mandates and price controls-- is, to put it mildly, worth debating.

In any event, suing patients is surely the least efficient way to fill the inevitable financing gaps. The median lawsuit amount in a study of Virginia cases was under $1,000. The hospitals probably lost money even on the lawsuits that they won. Why are they doing this? Debt collectors are not known for mercy or even good judgement.

One solution is for Medicare to compensate hospitals when they forgive legitimate debts. Based on 2017 data, this would require the government to pay hospitals an additional $30-40 billion a year. These payments must be set by the Medicare fee schedule for each case, rather than the hospital's chargemaster rates. Even if hospitals only get 30 cents on the dollar for old debts, that is far more than they collect today from self-pay patients or from private debt buyers. (This would also be more universal than the current Disproportionate Share Program, which gives money only to hospitals that serve a larger percentage of poor patients.)

This would not be free health care (although that in itself would not be sinful.) Many indebted patients will have already paid their deductibles and more.

Of course, this is an indirect and wasteful process, compared to having Single Payer with low deductibles. But then, Americans will always spend a lot of money to keep from being called Socialists.

The financing of modern health care inevitably requires some degree of coercion – whether payroll taxes, income taxes, sales taxes, insurance mandates, et al. The repulsive lawsuits described above are surely a

form of coercion. But Denmark and Japan garnish the wages of anyone who does not buy health insurance. The so-called libertarian havens of Singapore and Switzerland pay for their hospitals in large part through taxes; they also regulate drug prices and fees for medical devices. (Switzerland requires health insurers to pay all valid claims in ten days – we might find this a welcome form of coercion.)

Medical debt ultimately comes from these conditions:

- High prices
- Gaps in health insurance
- Patients' lack of ready cash
- Resistance to upfront public funding

(It is worth noting that Canada also has medical bankruptcies, almost always related to drug costs – which is precisely the' gap area' that their Single Payer does not cover.)

No single legislative program can cure all these conditions. There is not enough political will or tax capacity to turn us into Singapore or Germany. A forced-savings account for health care makes a lot of sense, but it would never pass Congress. The best we can do is to chip away at the problem.

Ironically, medical debt in America is due in part to our generosity. We do not require patients to pay for health care in advance – which would eliminate many debts. (When a Minneapolis hospital placed debt collectors right in the emergency room -- before the patients could "escape" without paying -- this was a public scandal, and the collection agents were quickly removed.)

Note that there is no comparable epidemic of hotel bad debt – you pay for the room when you check in. There is no epidemic of legal bad debt – lawyers stop working if they do not get paid. The Surgery Center of Oklahoma has no medical debt – here too, you pay when you check in.

But it would take a heart of stone, at least by Western standards, to run full-service hospitals on a cash basis like that. The Amish would be fine because they know how to save and bargain, but some Americans would suffer greviously (as in the Depression), until they re-learned the savings and tithing habits.

So we require hospitals to care for anyone in a crisis. (This conforms with the self-image of most doctors and nurses, so it is a popular rule.)

Unfortunately, we will not raise taxes to pay providers for doing so. The EMTALA law of 1986 --which mandated that hospitals at least stabilize any patient without upfront payment – had exactly $0 in federal spending. Medicaid and SSDI expansion have relieved this somewhat, but overall we expect providers to work out cross-subsidies behind the scenes.

We do want to provide advanced medicine for everyone – that's the generous part -- but we will not tax ourselves to cover the full price for all. Medical debt, like college debt, emerges as the ugly compromise. It is a classic American combination of good intentions and tax timidity.

America's bankruptcy laws are actually very liberal– and they need to be! Bankruptcy has been described as an 'implicit safety net', by sociologists like Monica Prasad:

"The United States offers families more sanctuary in bankruptcy —while it permits a wide-open consumer credit economy coupled with less protection from the economic consequences of other problems such as job losses, medical problems, accidents, and family breakups. … The European

and Canadian approaches, by contrast, make credit access and bankruptcy more difficult, but provide extensive social safety nets."[28]

Some medical debts are so large that even at Medicare rates there is no hope of repaying. For patients who owe more than $50,000, filing for bankruptcy may be the least harmful alternative. The following circumstances could justify a filing for Chapter 7:

- The debtor is unable to pay basic expenses each month without using credit cards, such as utility bills, transportation costs or groceries.
- They are using payday loans, cash advances on credit cards, or other forms of high interest loans to pay household bills.
- They cannot make minimum payments on credit cards and other debts.
- Their home is in foreclosure or their vehicle will be repossessed.
- They are being constantly pursued or harassed by creditors. and will not feel like a failure for filing bankruptcy.

In theory a person could stay uninsured; then get very sick and put all their bills on a credit card; and then declare bankruptcy. But this is an undependable strategy for the individual, and ludicrous for the population at large.

Under bankruptcy, it is true that medical providers get nothing. However, they are not getting very much revenue from debtors at present, and at the cost of great individual misery.

Bankruptcy is a pathetic form of last-resort health insurance, but in some cases it is all we have. It is the endpoint of a debt-financed system where hospitals borrow to build and expand, doctors borrow to get their education, and patients borrow when they cannot afford good insurance.

Attack #4. Expand Medicaid, not GoFundMe

For all its flaws, Medicaid might be the best anti-debt program in America. In the states that expanded Medicaid after 2013, medical debt fell four times faster than in non-expansion states.[29]

In the non-expansion states, childless adults are banned from the program altogether. Parents can usually earn no more than $10,000 a year to get free coverage. Virtually all the horror stories of garnished wages or jail time for unpaid debt come from these states.

Some states do have a program called Medicaid for the Medically Needy – which offers very modest benefits for anyone whose medical bills would otherwise impoverish them.

This program should be federalized and expanded. For example, a family whose ongoing medical expenses exceed 15-20% of their discretionary income could be added to Medicaid automatically. There would be no "spend-downs", which are all too common in Medicaid, and no constant checks for eligibility.

There would also be no “claw-backs” – another ugly feature of Medicaid, where benefits are subject to recovery if the recipient ever has a small amount of money in their name. This program would relieve some of the toughest GoFundMe cases, where families may have a child with permanent medical needs.

Medicare and Medicaid already serve as insurers of last resort for dialysis, nursing homes, AIDS cases, the disabled, and numerous other areas. No harm is done by expanding this function.

Attack #5. The federal government should pay the costs of ambulances and paramedics.

Ambulances should be funded primarily by the federal government, including air ambulances. The cost would be from $14 to $18 billion a year.

It is better to raise income taxes – in this case by less than one per cent – to prevent anyone being stuck with a huge ambulance bill. This service clearly should be in the public sector, no different than fire or police departments.

In libertarian theory, we could have competing ambulances and even private firefighters. A prudent homeowner would pick a firm each year and pay their fees. The employees need not be given pensions or disability plans, and this alone would make the private companies look cheaper. The company owners could get very rich – private equity investors might get involved. Rural residents would probably pay much higher rates. People who did not sign up with any company would be harassed and sued if they had a fire and got ‘charity care.’ Fire coverage could even become a tax-free employee bonus for selected workers.

Historically, most privatizations have been fraudulent. The politicians who arrange them are usually corrupt, helping friends and donors and doing well themselves from the process. The promised savings usually disappear into bloated profits and executive salaries.

Granted, ambulance care is intrinsically expensive; the ‘readiness costs’ of buying, maintaining, and staffing a vehicle for 24 hours a day are substantial. If we can afford fire and police departments, we can afford public ambulances.

Rescuing an accident victim by air from a remote location might actually cost $30,000, when you add up all the legitimate costs. The question is why we allow the victim to be billed $30,000. The ‘right price’ to the accident victim should be close to zero – the rescue should be primarily a community obligation. These services should be a publicly funded good, which does not depend upon individual access to insurance.

We need to set aside sufficient federal funds to handle this. We should not revert to charging user fees, in order to avoid broad-based taxes. We already practice this false economy with emergency rooms-- and consequently get massive personal debts.

SOCIAL INSURANCE vs. MEDICAL DARWINISM

I realize that my viewpoint is not universal. America has millions of voters who regularly oppose any taxes for expanded public services. Most of these voters are financially secure, and they may not actually know anyone who is hungry, or evicted, or jailed for debt. They are tired of paying taxes for "sob stories" from the poor and uninsured. Conservative voters are afraid that the beneficiaries of social programs are essentially freeloaders. They secretly believe that "what keeps the great majority of people well is the fact that they can't afford to be ill."

In their view, if we go on rescuing poor people --through Medicaid, SSDI, SNAP, TANF, et. al. -- all we will ultimately get is more poor people.

(If some of the poor actually die from their illnesses -- well, that kind of culls the herd. To paraphrase Donald Trump and other Darwinists, we wouldn't be losing our best people.)

These conservatives cannot imagine a world where they might be the ones who are crippled by medical debts or have no money for long-term care. Uwe Reinhardt used to say that anyone's position on health care was determined by their "distributive ethic."

Most of the proposed de-regulation in health insurance is a barely disguised effort to let healthy people avoid paying for sick people. I believe this must be balanced by what is known as The Golden Rule. I want to be free of financial worry myself in a medical crisis, and I want this for everyone.

Is this paternalistic? Absolutely, and proudly so. I prefer a health system that has more solidarity. I will gladly help pay for public services that I individually may never use – because that makes our community a better place to live. Rather than people being responsible only for their own care, those who are healthier and wealthier should take on a larger share of costs. [30]

Summary of Incremental Reforms

As described above, we can alleviate many hardship cases in American health care for a lot less than $2 trillion in annual new taxes.

It is true that these reforms are a band-aid. Obviously, it would be better to have no medical debt in the first place. The reforms we propose would reduce or cancel the most outrageous debts –but many months after the fact, i.e. after credit scores may have been ruined, resulting in higher-cost home loans, car loans, insurance premiums and rental problems for many years.

Please note these facts:

- Medicaid recipients have no medical debt.
- Medicare enrollees with full Medigap plans have no debt.
- Low-income insureds in the ACA exchanges have relatively little debt, thanks to their 'Cost Saving Reduction' benefits.
- Employees with zero-deductible insurance have little debt.
- Swedish and German citizens have very little debt, despite required co-payments. The maximum out-of-pocket expense in Germany is 2% of income – and 1% of income for chronic illnesses. The maximum in Sweden is $370 a year.
- J.P. Morgan offers a health plan with no deductibles for anyone earning less than $60,000.

- Massachusetts offers zero-deductible ACA plans to those with incomes less than 300% of poverty.
- France waives all deductibles for persons with chronic illnesses, such as diabetes.

In other words: medical debt is not inevitable!

The reforms outlined here may be the best we can do for now -- with the Congress we have, and our resistance to higher taxes. We should not let the perfect be the enemy of the good.

This would not be the first time that America pulled back from Single Payer, and downshifted to smaller but valid reforms. This is essentially what happened with Medicare and Medicaid in 1965. We took decent care of the elderly and the poor, who were expensive and unprofitable for private insurers. We expected that union benefits would protect nearly everyone else. However, labor markets have not provided universal care, so we must expand public coverage again.

Affordable health care has never been easy for lower-income Americans. That is why many doctors used to treat poor patients for free, and why many hospitals ran at a loss and relied on charity for years. We must now deal with a large population that makes too much for Medicaid, but does not earn or save enough to pay their medical bills.

Unfortunately, many Americans remain complacent about medical debt:

a) Most politicians and opinion makers are wealthy and well-insured. Doctors and nurses may understand the problem, but they alone cannot alleviate the financial struggles of patients.

b) Very few Americans understand the federal budget. They may not be aware that we spend $800 billion essentially to keep seniors out of medical debt, and $700 billion to keep poor people out of medical debt. If so, they would be less alarmed at federal spending to relieve the largest debts of working-class insureds under age 65.

c) The Affordable Care Act is under-appreciated. Families with modest incomes now fare much better under the ACA than in many workplace plans. A family of four making $50,000 can get a low-deductible health policy for about $200 a month. The “firewall” that bans such families from receiving ACA subsidies must eventually come down. This will require more tax dollars, at least $100 billion a year – but when has that not been true of successful health care reform?

To summarize our proposals for today:

1 . Cancel medical debts that are due to insurance denials…… No cost to taxpayers

2. Cancel old medical debts now held by collection agencies……No cost to taxpayers

3. Reduce or cancel medical debts from predatory pricing……No cost to taxpayers

4. Expand Medicaid to the poor in the twelve ACA-resisting states- $25 billion/year

5. Expand the ‘Medicaid for Medically Needy’ programs…...…….$20 billion/ year
.
6. The federal government pays for ambulances and paramedics…. $20 billion/ year

7. Medicare compensates hospitals to forgive patient debts……..$30-$40 billion/year

Comments and questions are welcome. For further details on any reforms described here, contact the author at:

Bob.Hertz@frontiernet.net

You might also be interested in Bob’s earlier writing, which is available at his website:

https://www.newlawsforamerica.com/

Past articles include:

- Creeping Socialism Would be Good for America
- Here Are Solutions for Student Loans
- The Anti-Debt Agenda
- The Health Care Crusade

Bob lives in Minnesota and is a retired insurance broker. He describes himself as “an unreconstructed Garrison Keillor Democrat.”

FOOTNOTES

[1] Benjy Shaylin, "Why Medicare for All Wrecked Elizabeth Warren and not Bernie Sanders," NBC News.com (blog), 3-5- 2020. https://www.nbcnews.com/politics/2020-election/why-medicare-all-wrecked-elizabeth-warren-not-bernie-sanders-n1150

[2] Gordon Misser, "A Review of Reports on the Cost and Funding of Medicare for All." June 11, 2020. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3603034

[3][3] David Hyman and Charles Silver, *Overcharged - Why Americans Pay Too Much for Health Care* (Washington, Cato Institute, 2018)

[4] Kenneth Thorpe, "An Analysis of Senator Sanders' Single Payer Plan," Emory University, 01-02-2016. https://www.healthcare-now.org/wp-content/uploads/2017/09/National-Thorpe-2016-Analysis-of-Bernie-Sanders-Single-Payer-Proposal.pdf

[5] Robert Pollin, et al. "Economic Analysis of Medicare for All," University of Massachusetts Amherst PERI, file:///C:/Users/Bob%20Hertz/Downloads/Medicare_For_All_12.5.18%20(3).pdf C:\C:\Downloads\Medicare_For_All_12.5.18 (3).pdf

[6][6]. Gerald Friedman, "Funding 676, How We Can Afford a National Health Plan," 7-31-2013. http://www.pnhp.org/sites/default/files/Funding%20HR%20676_Friedman_7.31.13_proofed.pdf

[7] Matt Bruenig, "How to Approach Medicare for All Financing, People's Policy Project," 10-30-2019 https://www.peoplespolicyproject.org/2019/10/30/how-to-approach-medicare-for-all-financing/

[8] Ezra Klein, "Elizabeth Warren's Plan to Pay for Medicare for All," Vox, 11-1-2019 (blog) https://www.vox.com/2019/11/1/20942587/elizabeth-warren-medicare-for-all-taxes-explained

[9] Katie Dore, 'The Value Added Tax Brings in Billions for Other Countries, but the U.S. Still Doesn't Have One," CNBC, 6/21/2021 https://www.cnbc.com/2021/06/21/this-tax-brings-in-billions-worldwide-why-theres-no-vat-in-the-us.html

[10] Kate Aronoff, *Overtreated – How Capital Broke the Planet and How We fight Back. (*New York, Bold Type Books, 2021.)

[11] Hannah Brennan, et al. "A Prescription for Excessive Drug Pricing: Leveraging Government Patent Uses for Health".18 Yale Journal of Law and Technology 2015.

https://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1124&context=yjolt'

[12] Adam Gaffney, "Adam Gaffney Explains Hospital Financing Under Medicare for All," Jacobin (blog) 5-10-2019 https://www.jacobinmag.com/2019/05/medicare-for-all-hospital-financing-costs

[13] Dylan Matthews, 'Single Payer health care failed miserably in Colorado last year. Here's why," Vox (blog), 2-14-2017 https://www.vox.com/policy-and-politics/2017/9/14/16296132/colorado-single-payer-ballot-initiative-failure

[14] Erin Brown and Elizabeth McCuskey, "Federalism, ERISA, and State Single Premium health care", University of Pennsylvania Law Review, Vol, 163, p. 389-465. https://www.pennlawreview.com/2020/05/01/federalism-erisa-and-state-singlepayer-health-care/

[15] James K. Galbraith, "What is the American Model all about? Soft Budgets and the Keynesian Devolution" Levy Institute, Public Policy Brief No. 72, 2003 http://www.levyinstitute.org/publications/?docid=1002

[16] Harold Meyerson. "Which Are the Real Mismanaged States," The American Prospect (blog), 5-12-2020. https://prospect.org/blogs/tap/which-are-the-real-mismanaged-states/

[17] Thom Hartmann. "The Hidden History of American Healthcare." (video) 9-12-2021 https://www.youtube.com/watch?v=E8Jdj_Wt7Ds

[18] John Goodman, "High Deductible Health Insurance, The /Good, the Bad, and the Ugly," 5- 11-2018 https://www.forbes.com/sites/johngoodman/2018/05/11/high-deductible-health-insurance-the-good-the-bad-and-the-ugly/?sh=518521277b18

[19] John A. Cogan, Jr, "The Failed Economics of Consumer-Driven Health Plans," *UC Davis Law Review, Vol. 54, 2020*https://lawreview.law.ucdavis.edu/issues/54/3/articles/files/54-3_Cogan.pdf

[20] Sean Masaki Flynn, *The Cure That Works: How to Have the World's Best Health Care -- at a Quarter of the Price. (*New York, Simon and Schuster, 2019)

[21]Nicole Dieker, "How Long Can a Debt Collector Pursue Old Debts," Bank Rate, 7-30-2021. https://www.bankrate.com/finance/credit-cards/how-long-can-a-debt-collector-pursue-old-debt/

[22] Hospital Accountability Projecthttps://www.communitycatalyst.org/initiatives-and-issues/initiatives/hospital-accountability-project/free-care/states/california

[23] Jerry Ashton, Robert Goff, Craig Antico. *End Medical Debt*, (Hoku House, 2018)

[24]https://www.vanhollen.senate.gov/news/press-releases/van-hollen-murphy-call-on-consumer-financial-protection-bureau-to-address-medical-debt-increase-transparency-as-americans-face-steep-bills-in-the-wake-of-

covid-19

[25]George A. Nation III, "Contracting for Healthcare: Price Terms in Hospital Admission Agreements." Dickinson Law Review, Vol.124 Issue 1, Fall 2019. *https://ideas.dickinsonlaw.psu.edu/dlr/vol124/iss1/4/*

[26] UConn Health Disparities Institute. Issue Brief. "When Hospitals and Doctors Sue Their Patients: The Medical Debt Crisis Through a New Lens" https://health.uconn.edu › uploads › sites › 2019/06

[27]Monica Prasad, "The Trade-Off between Social Insurance and Financialization: Is There a Better Way https://www.niskanencenter.org/wpcontent/uploads/old_uploads/2019/08/PrasadCreditWelfare_Final.pdf

[28]https://siepr.stanford.edu/news/americas-medical-debt-much-worse-we-think#:~:text=America's%20medical%20debt%20has%20been,crisis%20part%20is%20spot%20on.&text=Groundbreaking%20research%2

[29] E.C. Fuse Brown, "Social Solidarity in Health Care, American-Style" Journal of Law, Medicine, & Ethics, Vol 48, 2020 Georgia State University of Law and Legal Studies *https://journals.sagepub.com/doi/abs/10.1177/1073110520958864*

[30]