THE WAR ON MEDICAL DEBT

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I support the goals of Single Payer Health Care…...but sometimes Single Payer feels like a pipe dream – or at worst, an indulgent fantasy.

There is no conceivable Congress in the next ten years that could impose the Medicare fee schedule on all doctors and hospitals.

There is no conceivable Congress in the next ten years that could negotiate lower prices for all specialty drugs.

There is no conceivable Congress that could design a National Sales tax, or a Value-Added tax, or a Gross Receipts tax large enough to fund Single Payer.

There is no conceivable Congress that could enact a 4%, 6%, or 8% income tax surcharge to help fund Single Payer.

There might be a Congress that could enact higher capital gains taxes…..but there is no assurance that this would provide significant revenue for healthcare. I consider wealth taxes, estate taxes, and financial transaction taxes to be largely "aspirational revenue."

Instead of these noble - but doomed – designs for healthcare transformation…... I am promoting patient civil rights and "The War on Medical Debt." This consists of targeted, limited reforms – with a focus on patients who are needlessly harmed and impoverished by health care.

The War on Medical Debt is meant to plug the holes in the safety net. It would provide extra protection for millions, until more comprehensive reform is enacted.

Just consider these ugly aspects of American health care:

- Denied insurance claims
- High deductibles and co-pays
- Prescription Drug prices
- Emergency Room charges
- Price gouging for medical tests and equipment
- Medical debt collectors charging 10 per cent interest, and garnishing wages

All these can be addressed without full Single Payer! In many instances, we can find relief from:

a. the modest expansion of public programs like Medicaid; and

b. courageous legislation that defies industry lobbyists.

No single enhancement proposed here should cost over $15 billion a year, and most reforms will cost the taxpayers nothing.

These reforms would not be achieving free health care in the Canadian model –but they would create a much better country.

Unregulated health care can cause economic pain; legal safeguards and public benefits are needed, to relieve the pain.

The poor and near-poor are protected by Medicaid, at least in the non-Southern states.
The elderly are largely protected by Medicare;
The wealthy can afford to protect themselves.

However, the broad middle class is often on their own. They are open prey for inflated medical billing.

Wherever we lack social insurance – such as in emergency rooms– ordinary people can go broke, just trying to do what is right.

We could in theory eliminate all medical debt. If we had complete Single Payer with no deductibles, no co-pays, all doctors on salary, and global budgets for hospitals….. therefore, no money changing hands at the point of care, like the British NHS……..then yes, medical debt would disappear.

(We could also erase debt if people learned how to save, like the Amish, and paid for their medical care up front, in cash. We could even learn to save like the Germans, or the residents of Singapore. That however would be a slow, and very painful cultural change.)

Full Single Payer right now would require at least $2 trillion in new government spending a year--- and that is on top of Medicare, Medicaid, et. al. This is a lot more money than Bernie Sanders or any other Democrat is proposing or able to raise.

Sanders and his allies claim that their new taxes will be a lot less than the premiums and co-pays which people are paying today…..and for modest-income households, that is largely correct.

But people who have high incomes would need to pay more – often a lot more --in new taxes. People who today have low insurance premiums – granted, it is a minority – would pay a lot more in new taxes. Some businesses would face dramatically higher payroll taxes with Single Payer.

Consider the impact of higher income taxes:

Household Size	**Annual Income**	**Average family spend on health care today (premiums, deductibles)**	**New Income surtax of 8% over Medicaid eligibility limits $37,000 *for a 4-person household***
Married, two kids	$25,000	$0 in the 38 Medicaid	$0
		expansion states	
Married, two kids	$50,000	$7,619	$1,040
		(typical worker expenses)	
Married, two kids	$75,000	$7,619	$3,040
		(typical worker expenses)	
Married, two kids	$100,000	$7,619	$5,840
Married, two kids	$125,000	$7,619	$6,960
Married, two kids	$150,000	$7,619	$9,040
Married, two kids	$175,000	$7,619	$11,040
Married, two kids	$200,000	$7,619	$13,240
Married, two kids	$300,000	$7,619	$21,040
Married, two kids	$500,000	$7,619	$37,040

(Single-person households would have more dramatic disadvantages -- because their health insurance costs are generally much lower than shown here, while their new taxes would be about the same as above.

About ten per cent of households do not pay $7,619 for health insurance or even close to that. Their employer – or the government, for military service members -- overs all or nearly all of their health costs.)

Some progressives are undaunted by these tax numbers, and would say:

"Let the wealthy squirm a little --they have had things their way for decades now. The person who makes $500,000 a year should be paying much more for health care than someone who makes only $50,000 …..We've had enough of working people being slammed with higher premiums, higher deductibles, and forced into health care bankruptcies. The wealthy should just suck it up and go with the program."

However, the issue is not justice -- it is what can pass Congress.

The wealthy are indeed a minority……. but they are not a tiny minority.

The 131 million taxpayer households in America are divided by income as follows:

Under $15,000	9.3	million
$15,000 to $25,000	8.1	million
$25,000 to $35,000	7.8	million
$35,000 to $50,000	10.9	million
$50,000 to $75,000	16.2	million
$75,000 to $100,000	11.9	million
$100,000 to $150,000	15.9	million
$150,000 to $200,000	8.3	million
$200,000 and over	11.6	million

If $150,000 is the "crossover point" for being worse off from Single Payer -- this means about one-sixth of households would be immediately opposed. They will not see a surtax of $10,000 or more as their "fair share" at all. (This group is essentially paying for Medicaid already.) Every single member of Congress would face higher taxes personally.

Large new taxes would pose a real risk of recession. High-income families take a lot of trips, buy most of the new cars, and go to expensive restaurants. Their purchases sustain the jobs of millions of workers.

It is worth remembering the yacht tax in 1990. The motivation behind the tax was to target the rich, in order to reduce the national deficit. Well-meaning politicians thought that rich people would just simply pay more for their fancy toys.

Unfortunately the rich responded by buying far fewer yachts. The additional 10 percent tax on yachts caused American boat builders to shutter operations and cut jobs as the rich either skipped out on yachts, or bought them cheaper from overseas. The tax did not raise money for public programs; instead, it actually created a revenue loss as a result of the industry layoffs. *(Raheem Williams)*

Some doctors and hospitals would reject Single Payer, and establish their own cash prices. They will operate without insurance, or contract with private insurers who pay them higher fees. If wealthy, demanding patients have to pay new taxes **and** still maintain private insurance, their resistance could prove overwhelming.

The only way out of this dilemma is for Single Payer to offer a much higher fee schedule – and then virtually all its proposed savings would disappear.

If you add together:

- all the wealthy;
- those who pay very little for health care today;
- conservatives who oppose 'big government' and higher taxes on principle…..

…….Single Payer has too rough a political hill to climb.

This is where The War on Medical Debt comes in……..

Consider the following "new rules" that we could impose right now --- for a vastly smaller cost than Single Payer.

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

Right now, patients are legally forced to pay disputed medical bills, when they are caught between insurers and providers. Some charges are written off –but if the patient does not pay promptly, they can legally be turned over to collections.

This must end! Under Medicare, patients are not responsible when a claim is denied. The entire U.S. population should have the protections that exist in Medicare.

Old debts that arose from denied claims can be extinguished by law.

In the future, providers and insurers will have to work out any disputes, and the patient must not be harmed.

This new law may be disruptive at first. It may lead to more pre-authorizations, which inevitably add to administrative overhead. In extreme cases, hospitals or doctors may refuse to take a patient whose insurance is with a company that frequently denies claims.

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.

Cost to taxpayers of cancelling debts that arise from claim denials*: $0*

Attack #2 - The federal government can buy off medical debts owned by collection agencies.

Doctors and hospitals can now sell medical debts for pennies on the dollar to collection agencies --who aggressively harass 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 may even sell the debts to someone else.

This business practice has allowed RIP Medical Debt, a New York-based non-profit, to also buy up medical debt-- but in order to extinguish it. The organization, which was founded in 2014, has so far bought debt worth more than $4.5 billion, freeing over 2.7 million people from the burden of unpaid medical bills. On average, RIP Medical Debt is able to buy $100 of debt for $1.

RIP tries to screen for debtors who best meet the criteria for forgiveness: i.e. individuals earning less than two times the federal poverty level, with debts that are five percent or more of their annual income.

We should start federal buyouts, where the vulture collection firms would be paid no more than what they paid themselves for old debts.

We could also buy out some of the medical debts that are still held in “soft collections” by hospitals and clinics. Toledo and Chicago have recently used unspent COVID-relief funds to do exactly this; other cities and philanthropies can participate as well.

This is actually very modest spending…just compare it to the trillions spent by the Federal Reserve, in order to buy out mortgage-related debt for its book value after 2008. Bailouts and debt forgiveness are extremely popular among millionaires; we can afford to do essentially the same for anyone.

All cancellations of medical debt must be income-tax free.

Cost to taxpayers of buying out old medical debts: estimated $5 -$10 billion a year

Attack #3. Create new limits on Medical Debt collection practices

1. Garnishment of wages for medical debts would never be permitted.
2. No liens may be placed on a primary residence to collect medical debt.
3. Interest and penalty fees may never be attached to medical debt.

The entire nation should adopt the recent New York state law S.6522A. California, Maine, and Maryland have also taken action to control medical debt collectors. The government itself must ease up on debt collections from veterans.

We need to help the debtors -- who are generally unsophisticated. They can easily get trapped by collectors who, in fact, never expect to be fully repaid and are just nickel-and-diming them for life.

The principal amounts for medical debts are often based on "fake prices" -- which are inflated so that health insurers can claim to achieve 60 to 80 per cent discounts. These prices also make hospitals appear more charitable when the debts are written off.

If new rules cause medical collection firms to lose money… and some attorneys to lose their jobs….good riddance! The brutal skills of medical debt collection are of no value to society.

Cost to taxpayers of regulating medical debt collections: $0

Attack #4. Charge Medicare rates to the uninsured

The Affordable Care Act of 2010 requires tax-exempt hospitals to limit what they charge to uninsured patients who are eligible for financial assistance.

However – the process of qualifying patients for discounts is very cumbersome, and it is tempting for a hospital to just ignore the rules. Hospitals can also impose heavy paperwork requirements on low-income applicants. Some hospitals demand tax returns, pay stubs, bank statements showing all withdrawals, and monthly costs for cars, utilities and cable TV. No other business in this country has to perform a financial audit on each customer.

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."

It would be much simpler for hospitals to just charge Medicare rates to the uninsured.
For example, a brief emergency room visit would cost about $250. (These are "Level One" Medicare rates, not the 'Level Five' rates of almost $12,000.)

The amounts of money that hospitals now collect from uninsured patients –even after letters, phone calls, lawsuits, and wage garnishments – is normally less than the hospitals pay their CEO's. They are pounding on patients for money they don't really even need. They use the very modest losses from non-paying patients to justify their tax exemptions….while many hospitals are rolling in money.)

Eventually Americans will realize that hospitals are partly public goods – and therefore need explicit public funding. We do not expect the victims of fires to pay $10,000 each to the fire department – we collect broad-based taxes instead.

Virtually all European and Asian nations provide straightforward taxpayer support to hospitals. America pretends that charity care and strategic over-charging can replace actual taxes.

Cost to taxpayers of charging Medicare rates to the uninsured: $0

Attack #5 - If a price quote is requested before a procedure --and the quote is not provided – then the patient has no liability.

if a procedure can be scheduled – i.e., it is not an emergency – then the procedure can also be quoted.

If the patient requests an estimate, they must be responded to in writing at least seven days in advance of the care. This would allow the patient to request a different provider, or to investigate other alternatives.

Today, the patient usually has no advanced notice of the price before receiving the service. Often the doctor doesn't know the price that will be charged either.

If an estimate is requested but never produced, the patient would have no liability. The risk of not getting paid will achieve provider compliance very quickly. Providers who make their money today on upcoding will suffer, and deservedly so.

(The recent Surprise Billing law has some provisions of this nature –the challenge will be enforcement.)

Cost to taxpayers of tying price quotes and patient liability: $0

Attack #6 --The "Out-of-pocket" clauses in health insurance policies must be regulated.

Patients who assume they have an "Out-of-pocket" maximum of perhaps $8,000 can easily wind up owing $15,000 or more from an episode of care, due to:

– their deductible not counting as 'out of pocket'
– their co-pays not counting as 'out of pocket'
- some drug expenses not counting as 'out of pocket'
-- balance bills and out-of-network fees not counting as 'out of pocket'
– physical therapy and mental health treatments not being covered at all

These secretive and harmful clauses must be outlawed. **All** of a patient's uncovered expenses must count toward their out-of-pocket limits. If you spent it, then it is out-of-pocket.

Over the next few years, patient complaints against their insurers can be processed in the Health Courts described in Section 8 below. These Courts will force insurance companies to honor common-sense out-of-pocket limits.

Cost to taxpayers of enforcing true "out-of-pocket" limits: slightly higher subsidies for ACA policies, and for government employee health insurance.

Attack #7 -- Establish the $5,000 subsidies, first proposed by Hillary Clinton in 2016.

This program would provide up to $5,000 to anyone whose health care expenses exceeded 5% of their annual income.

The patient would have to request the award. They would turn in a copy of their current bills, along with last year's tax return or a simple proof of current income.

The government would send a voucher to the patient that can only be spent on health care.
These funds could be used to pay down smaller medical debts, or offered as a lump sum to cancel larger obligations.

Medical debt has exploded in America with the increase in high-deductible health insurance. We cannot reverse this overnight…however, we can help the patients who have no savings available.

We should make these awards into outright grants– as opposed to the gobbledygook about refundable tax credits. These awards will be pure, justifiable, on-budget government spending.

Cost to taxpayers: A rough estimate from the Kaiser Foundation is that three million households will have debts in excess of 5% of their income. If every such household received a $5,000 award, this would cost $15 billion in the first year…again, a very modest amount of spending by federal health care standards.

Attack #8 -- Allow patients to challenge their medical bills in new 'Health Courts.'

The Health Courts will be staffed by ex-physicians and active judges. All court costs including salaries will be paid by the government, and the patient will not need an attorney.

Judges and arbitrators can cite numerous rulings that require providers to accept 'reasonable charges.' Dr. Martin Makary – a prominent health care expert -- today defends any patient who is sued by their hospital. His students come with him, and they tell the judges, "We can't show up and mow your lawn and send you a bill for $10,000. Where's the contract? Show me an informed contract that this person signed."' Dr. Makary wins 100% of these cases.

We would essentially be creating a new small claims court, just for patients. Here is a sample of potential Health Court cases :

- Outlandish charges for simple diagnostic tests (i.e. $5000 for an echocardiogram)
- $50,000 for an air ambulance trip
- $35,000 for an artificial knee that costs about $700 to produce
- $20,000 for a pacemaker that costs about $6,000 in the US, and $1,000 in India
- $14,000 for a drug infusion that costs $500 in Britain, France, or Germany
- $12,000 for the use of an "operating room" to conduct a 20 minute surgery
- $15,000 for a 'Trauma Activation Team" to help with an ER admission

- $20,000 for an anti-venom inoculation that costs the hospital about $200.
- $35,000 for resolving an ectopic pregnancy; $9,000 for a miscarriage
- $10,000 for one hour in the emergency room for back pain
- $40,000 to resolve kidney stones
- $1,500 for toenail fungus cream

Providers now claim that these bills are just "an opening bid for negotiation"…but that is a predatory, adversarial way of doing business. The recipients of these bills take them very seriously, and endure agony even if some charges are later reduced or forgiven. We do not need to negotiate with the fire department after they save our house….we just pay our taxes.

We understand that hospitals are frightfully expensive to maintain…. and they do need more money than most patients can afford to pay. But for heaven's sake, let hospitals get this money from the taxpayers -- not by financially attacking one helpless patient at a time.

Meanwhile, all bill collections will be suspended while a patient is waiting for a hearing in health courts. If thousands of medical bills now get sidetracked in health courts and become uncollectible – too bad. Let that be an incentive not to overbill in the first place.

Price gouging will not go away overnight — there are always loopholes, and some providers will always persist in exploitation. Some insurers will profit from larger and larger claims. Both parties may figure they have nothing to lose by overbilling.

In any other industry, these practices would have long ago resulted in multiple antitrust suits. If hospitals and other providers are forced to go to court to justify their charges on a systematic basis, pricing sanity may eventually prevail. For now, we need the constant interventions of special courts.

Contract law works reasonably well in every other aspect of American life. It is time to bring true consumer protection into health care.

Cost of Health Courts to taxpayers: $2 billion for salaries and court administration

SUMMARY OF "THE WAR ON MEDICAL DEBT"

Cancel any debts that arise from a denied insurance claim.
Government can buy off old medical debts
Limit the business practices of medical debt collectors
Charge Medicare rates to the uninsured
If a price quote is requested, but not provided – the patient has no liability.
The "Out-of-pocket" clauses in health insurance policies must be regulated.
Enact the $5,000 tax credits proposed by candidate Hillary Clinton in 2016.
Allow patients to challenge their medical bills in expanded 'Health courts.'
Comments and corrections are always welcome…Bob.Hertz@frontiernet.net

You are welcome to publish part or all of this essay in your own blog or magazine. You can also provide your readers with a link to my blog, The Anti-Debt Agenda……https://theantidebtagenda.com/

For a more detailed exposition of all the themes discussed here, consider ordering my book "Social Insurance vs. Medical Darwinism." It costs just $4,95 and can be ordered from Amazon at: https://www.amazon.com/Social-Insurance-vs-Medical-Darwinism/dp/B09YRZN49T

Line and paragraph