

7. ASSURING MEDICAL SECURITY AND HEALTH CARE FOR ALL

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Summary

No rich democracy has effectively and durably protected all citizens against costs of health care without containing cost of care.

Similarly, no rich democracy has contained cost of care without durably protecting all citizens' financial coverage.

The U.S. has been unable and unwilling to accomplish either of the two. This manifests the anarchy that pervades our health care.

Financial coverage for all Americans is the beginning of the job of winning health security for all. It is not possible to win and sustain durable financial coverage for all Americans—and health security for all—without containing cost.²⁸⁹² Containing cost, in turn, depends heavily on paying caregivers in financially neutral ways. Good care for all also requires organizing care sensibly, configuring caregivers well, and boosting both quality and appropriateness of care.

Six complementary elements assure medical security and health care for all. Nations that build all 6 into their health care policies, finance, and delivery will more capably advance medical security and health care for all. The U.S. has paid only sparse attention to the 6 elements.

The **first** is manifest financial protection, usually signaled by issuing a plastic insurance card to each person.

The **second** is to enable citizens to afford to use their coverage by holding down out-of-pocket costs of deductibles, co-payments, and co-insurance, and by capping total yearly out-of-pocket costs.

The **third** is to prohibit payers from interposing sneaky administrative barriers between patients and their caregivers.

The **fourth** is to ensure that adequate numbers of the right types of doctors, hospitals, and other caregivers are well-distributed and readily accessible. Winning an adequate configuration of caregivers requires careful action by accountable payers and governments. Unless caregivers are available, able, and willing to redeem the promise of financial coverage, that promise is vacuous. When some payers create narrow networks of caregivers, they erect barriers of time and space between patients and needed services. Public action must prohibit narrow networks.

7. Assuring Medical security and Health care for all

The **fifth** is control over the costs of health care nationally. Holding down the costs incurred by caregivers is the only practical and durable method of making care affordable for all people. That means holding down the money available to finance care. When money is finite, waste visibly kills. Then, everyone touching health care is aware that excesses—such as giving high-cost/low value care or enriching oneself or fighting for disproportionately high incomes or tolerating caregiver malconfiguration—results in deprivation of needed patient care. To squander is to create squalor. Much of the discussion of “affordability” of U.S. health care is vacuous because it relies on higher spending to increase subsidies to allow patients to afford caregivers’ high bills. Cost control is taken up in chapter 8. Aspects of caregiver configuration are addressed in chapters 10, 11, 12, 13, and 14.

The **sixth** is an explicit or implicit understanding among citizens, payers, and caregivers about how much spending on health care is affordable nationally, how much revenue is available to pay caregivers, the location of the floor under acceptable standards of access to care, and the location of the floor under acceptable standards of appropriateness and technical quality of patient care.

This understanding can be thought of as a health care peace treaty, one in which patients, payers, and caregivers understand both one another and what’s reasonable to expect from our health care. Patients recognize that they will receive affordable and equitable care. They will have grounds to trust their doctors and other caregivers to do as much as possible with available money. All parties recognize that pathology is remorseless and resources of money and clinical time are finite. So the treaty has clinical, financial, political, legal, and ethical clauses. It is addressed in chapter 16.

Because the U.S. has refused to take any of these 6 steps, it has been unable to realize medical security and health care for all citizens.

Many Americans enjoy good care without excessive financial burden. But many live in a health care world resembling toxic medical and financial Superfund site—one plagued by insecure access, crushing costs, debt, unavailable caregivers, and low-quality care.

We see expansions in U.S. insurance coverage financed by increased spending. Many people with plastic insurance cards are often unable to afford the OOPs and debt that follow in the steps of U.S. medical care. Higher OOPs, prior authorization and other administrative barriers, narrow networks, caregiver shortages and maldistribution, and low prices paid to caregivers are 5 of the main tools used to suppress access to care.

These are ineffective in restraining health care cost and spending growth nationally. They do work to slow the rate of rise in Medicaid or ACA-subsidized private insurance. But not well enough. High and rising health care spending—\$1 trillion more every 3 years—crowds out all the other things Americans value—and makes it even harder to afford medical security and high-quality health care for all.

Assuring solid financial coverage of each American’s health care costs is the first step toward access to care and medical security for all. This chapter discusses the reasons many Americans are uninsured and many more are under-insured. It describes a range of mechanisms to improve or equalize coverage.

7. Assuring Medical security and Health care for all

It also considers other causes of unequal access. Those include the non-financial barriers to health care for all such as the radically different prices payers pay for the same care, caregiver maldistribution, narrow networks of caregivers, and administrative barriers like prior authorization requirements.

The chapter is divided into 4 main parts. The first shows that people lacking good financial coverage lack adequate health care. The second describes the very different mechanisms used by other rich democracies to protect all people against health care costs. It notes the one element shared by all those nations—the tight link between covering everyone and containing costs. The third analyzes the many different causes of the American failure to cover all people and ensure access to needed care. And the fourth considers narrow and broad paths to covering all people.

The political unwillingness to contain U.S. health care cost—discussed in chapter 8—is a main cause of weak access to care in the U.S. That's because no rich democracy has succeeded in assuring medical security and health care for all without containing costs,

Other things equal, boosting subsidies to buy solid health insurance and cutting OOPs make care more affordable for Americans. But the flow of money to pay those higher subsidies is politically unreliable.

Reducing the underlying costs of health care itself would also make care more affordable. Early in 2026, Levitt recorded pontifications about health care costs from Nixon to Obama. He then wrote that “Ultimately, the only way to achieve greater health care affordability systematically is to lower underlying health care costs, and that may be the next big health care debate.”²⁸⁹³ For the reasons discussed in chapters 4, 5, and 8, that debate—were it to materialize—is likely to be a sterile one until the financial crisis compels us to address the 4 types of waste in order to lower costs of health care.

The rapid death of business-as-usual fantasies of spending more to boost coverage

By 2024, the share of Americans aged 18-64 who lacked health insurance was about 9 to 10 percent, down markedly from 16 percent in 2010. After the ACA's Medicaid expansions, its original subsidized individual mandate to buy insurance, and subsequent boosts in subsidies, some 25-35 million people remained uninsured.

A liberal fantasy is that the U.S. could win health care for all by incrementally adding programs and benefits to the existing complicated methods of covering people. And that, over time, the jagged inequities in covered benefits, levels of payments to caregivers, and out-of-pocket costs could be filed down. This embodies the fantasy that coverage can be expanded without effective cost controls.

(A conservative fantasy is that many Americans don't deserve financial protection against health care costs. A related conservative fantasy is that health care costs do not need to be controlled or—if they do—market forces will do the job.)

Even so, a liberal like Glied could write in the early fall of 2024, with some justification, about U.S. “Health Policy in an Era of Universal Coverage.”²⁸⁹⁴ She noted that many Medicaid

7. Assuring Medical security and Health care for all

expansion states had cut their uninsured rates below 5 percent, and one apparently was below 3 percent. Those rates approach levels in rich democracies that are deemed to have achieved universal coverage. In this era, Glied thought, liberals could seek to start to move toward single payer by enacting a public option; they could cover more people through more generous subsidies to buy insurance. (She did note conservatives' opposition to the enhanced ACA subsidies.)

Glied thought that 3 steps could improve coverage further. One was to accept some variations in coverage but to put a floor under covered services and impose a ceiling on out-of-pocket costs. A second was to make it easier for Americans to transition from one type of coverage to another. The third was to end low-income patients' special reliance on safety net caregivers by requiring and paying all caregivers to serve all patients.

Some international precedents might be thought to support this view. For example, the French incremental additions to coverage, discussed later in this chapter, have proven a durably successful path to universal coverage.

But high health care costs block the U.S. from taking that path. One reason is that incremental coverage improvements do little to add political pressure to contain health care costs.

Second, U.S. health policy-makers have never acknowledged the two-way street connecting covering everyone and containing health care's cost.

And third, the U.S. has not politically embraced the notion that all people need and deserve protection against health care costs. Absent broad and deep reform, it is hard to imagine anyone writing in 2026 or soon thereafter about "health policy in an era of universal coverage."

As discussed in chapter 1, Congress and Trump cut Medicaid spending substantially in the July 2025 budget bill. They also allowed the enhanced ACA premium subsidies enacted during Covid to lapse at the end of 2025. Both retreats were prompted in part by a need to show spending cuts to offset renewed tax cuts for high-income Americans. Both also reflected beliefs that federal dollars were being wasted on people who should be working—or on crooked ACA brokers who manipulated insurance subsidies for private gain. States like California, which had expanded insurance to a wide range of immigrants using state dollars, were forced to backtrack and expel people from coverage.

Financial and non-financial barriers have long stood between insured Americans and the health care they need. Bornstein summarized these: high dollar costs of family shares of premiums, OOPs, and uncovered services; foregone income; delays in obtaining care owing to shortages of caregivers (either overall shortages or shortages of caregivers accepting particular insurance coverage); travel times to obtain care; and uncertainty about whether insurers will cover prescribed care.²⁸⁹⁵ She therefore urged building on full financial coverage by addressing all the other barriers to access.

Even as the ACA expanded insurance coverage from 2010 to 2025, the numbers of under-insured Americans continued to grow. Some 27 percent of adults under age 65 reported living in families facing high OOPs, medical debt, and other financial barriers to care. Fully 45 percent faced one of a broader set of barriers.²⁸⁹⁶

7. Assuring Medical security and Health care for all

In the summer and fall of 2025, it became clear that the numbers of uninsured and under-insured Americans would begin to rise. One reason was the political outlook of the president and of the Congressional majorities. Another reason was that U.S. efforts to finance improved coverage never (ever) have been accompanied by effective cost controls. So, when politics turn right or the economy heads south, coverage is chopped. A third reason is that, alone among rich democracies, the U.S. hasn't yet resolved to protect all people. Political and social divisions undermine reaching any such resolution—and so do the high costs and waste baked into U.S. health care. Even though the decision to cover everyone is the surest generator of effective action to contain cost.

The July 2025 federal budget act will probably cut about 10 million people from Medicaid. Expiration of the higher federal subsidies for buying insurance through the ACA in December of 2025 will lead some 5-10 million or more people to lose coverage. Others will choose flimsy see-through coverage featuring unaffordable OOPs.

Further, rising health care costs—resulting in higher insurance premiums through the job—cause some workers and families to drop coverage. Others covered privately face rising OOPs, making it harder for them to take advantage of their insurance. Others are blocked by lack of a doctor or by insurers' refusal to authorize and pay for care their doctor deems appropriate.

While focusing on financial coverage, this chapter also considers the links between medical security/health care for all and cost control, methods of paying and organizing caregivers, caregiver configuration, and quality/ appropriateness of care. Because U.S. efforts to improve financial coverage have generally ignored these four, those efforts have proven less valuable—and durable—than their supporters had hoped.

- ✓ Without cost control, actual use of needed care—notionally enabled by financial coverage—is suppressed by rising out-of-pocket (OOP) burdens and rising premiums. All of these are regressive in that they absorb a higher share of the incomes of lower-income Americans.
- ✓ Without reforming methods of paying caregivers and of organizing and orienting their work, cost control is impossible—and that undermines financial access.
- ✓ Without better caregiver configuration—the right kinds and numbers of doctors and hospitals in the right places—many people who are covered financially find it hard to get needed health care. The care we get depends heavily on the caregivers we've got. Caregivers redeem financial coverage's promise. More balanced caregiver configuration—such as more primary care and greater protections for hospitals and doctors in rural and low-income urban areas—would do double duty by boosting access and lowering cost. They smooth the road to medical security.
- ✓ Without greater attention to raising the floor under quality and appropriateness of care—the lowest levels of each that we are prepared to tolerate—many people who are covered financially actually receive care that is incompetent. Others receive unnecessary care or fail to get necessary care.

Why cover everyone?

7. Assuring Medical security and Health care for all

Equitable financial coverage for all Americans is essential for 5 ethical, political, and practical reasons. **First**, it will help to rebuild social solidarity and a shared belief that ours is a just nation.

Second, winning financial coverage for all will be widely understood as a victory for competence as well as compassion. Financial coverage improves longevity and self-reported health.²⁸⁹⁷ It is a foundation for medical security—confidence that we'll be able to get competent, appropriate, quick, and kind care—without worrying about the bill.

Third, effective cost control is not politically or practically possible unless all people enjoy solid and fairly equal financial coverage.

This will seem paradoxical to many. Without equal financial coverage, fear of further harming uninsured and under-insured people will undermine effective work to contain cost. Across nations, the obligation to afford care for all has been the most powerful political force for instituting effective cost controls. Unless all Americans are covered, the U.S. will continue to push weak private and public cost controls that are both ineffective and tolerate high levels of waste.

Current U.S. cost controls rely heavily on suppressing access to care. Widely-held but deeply-flawed bodies of opinion—such as the iron triangle fantasy discussed briefly at the end of chapter 2 or the moral hazard fantasy discussed in chapter 4—even posit that good financial protection necessarily boosts health spending. Indeed, other things equal, covering more people would boost spending. But, as usual, other things need not be equal. Other things should and can be reformed. Again, the obligation to cover all people impels slashing waste. The experience of the world's other rich democracies supports this view.

Fourth, *financial coverage for all is an essential foundation for liberating doctors and hospitals to act professionally and as trusted fiduciaries to marshal inevitably and manifestly scarce money and caregiver time to do as much clinical good as possible.*

Only then will patients, payers, and politicians have reason to believe that, even though pathology is remorseless and resources are finite, U.S. medical care is doing as much as possible to win medical security for all citizens.

Fifth, medical insecurity plagues all Americans except a small minority of very wealthy people. Writing for an audience of retirees with above-average incomes, MarksJarvis identified three very threatening types of specific health care costs: expensive meds that are not on Part D plans' formularies, geographic or social isolation, and concierge primary care physicians.²⁸⁹⁸ Affordable health care reform would address the first and third of these. It would also address a fourth threat that is even more widespread—high out-of-pocket costs.

The way to financially protect all Americans is by covering each of us completely. American citizens and even most reformers have been deceived by proposals that nominally bestow insurance coverage but then making it hard to use by imposing high OOPs, by failing to configure caregivers in alignment with patient needs, or by collectivizing Medicaid patients in for-profit managed care organizations with narrow and sparse networks of doctors and hospitals.

7. Assuring Medical security and Health care for all

Insurance coverage without cost control leads inexorably to care suppression

Well-intentioned American reformers have paid excessive attention to stapling plastic health insurance cards to the collars of as many people as possible. Surely, insurance coverage matters greatly. But it is only part of the story. Other financial forces shape actual coverage and ability to obtain medical care. As Galewitz reported in November of 2024, “In Vermont, Where Almost Everyone Has Insurance, Many Can’t Find or Afford Care.”²⁸⁹⁹

The 2006 Massachusetts c. 58 universal health care law was the model for the 2010 federal ACA. The fight to pass each was prolonged and fierce. Spending more money to cover more people was the winning political formula. Higher spending lubricated coverage improvements. Coalitions supporting either law would have been fatally weakened had meaningful cost controls—especially those targeting any of the 4 types of waste—been included.

But higher spending had its limits. Absence of forthright cost controls led to adoption of subtle ones. And then to cutting up previously-issued Medicaid and ACA-subsidized insurance cards.

Suppression of care results. It has sometimes been pursued actively through higher OOPs or work requirements or cessation of higher ACA subsidies. At other times, it has been accepted passively through narrow networks or prior authorization. It has been accepted as the price that must be paid to offer health insurance to as many Americans as possible while failing to contain costs effectively.

Bernard and colleagues examined the combined effects of high OOPs, medical debt, and other financial impediments to care. They found that over one-quarter of non-seniors lived in families facing at least one of these barriers. And almost one-half faced a broader set of financial barriers.²⁹⁰⁰

Why don’t we cover everyone well?

Why is the U.S. the only rich democracy that fails to financially protect all people reasonably well? **One reason** is that high costs make it financially and politically difficult to cover all Americans.

A second is that failure to contain costs in smart, effective, and equitable ways leaves suppression of access as the powerful default cost containment method. Flimsy coverage suppresses use of care and thereby holds down its cost.

Unwilling to adopt effective and reasonable and equitable cost controls—and continuing to tolerate high levels of waste, public and private payers—and caregivers—adopt cost control methods that suppress care. Many of these methods engender what is called “under-insurance.” Some of the explanations for the failure to adopt effective and reasonable and effective cost controls were taken up in chapters 4 and 5; the rest will be examined in chapter 8.

A third reason is that the U.S., alone among the world’s rich democracies, has not yet embraced either the principle or the practice of health care for all. Covering Americans through Medicaid, Medicare, subsidized ACA care, group insurance through the job, and various other

7. Assuring Medical security and Health care for all

methods means that caregivers are paid for different patients' care at very different prices. Moreover, different caregivers often disproportionately serve patients financed by different payers. This differentiation is no accident. It manifests weak commitment to both equity and cost control.

Why hasn't the U.S. embraced equity? Partly because our nation has not chosen to contain cost by cutting waste and thereby make health care affordable for all without boosting spending. As noted elsewhere, no rich democracy has contained cost without covering all people—nor covered all people without containing cost.

(High U.S. health spending—over \$17,000 per person in 2026—should be enough to finance solid health care for all. Average family premiums for private health insurance rose 7 percent yearly in both 2023 and 2024, and 6 percent in 2025. That made for a 2025 average total family premium of \$26,993.²⁹⁰¹ On average, the worker/family paid one-quarter of that total,²⁹⁰² a substantial regressive imposition that leads many families to decline health insurance offered by an employer owing to inability to afford the family share of premium.)

And it is partly because political pressure to cover everyone is weak while political opposition is fairly strong. Some of the opposition rests on high health costs even absent health care for all. And some rests on fear that costs would rise greatly if today's uninsured or under-insured Americans were to become fully protected via traditional public and private methods. Since income inequality in the U.S. is among the highest across the world's rich democracies, many people with money fear they will be asked to pay substantially higher taxes to cover currently uninsured or under-insured Americans. That would be true if Americans continued to tolerate wasting one-half of health care spending.

Conservatives point to Americans they consider unworthy of still higher public spending to subsidize solid health coverage. Some people suffer a generalized stunted empathy while some members of some racial or ethnic groups specifically dislike members of other groups. It is no accident that 7 of the 10 states that did not expand Medicaid under the ACA were among the 11 former Confederate states. Inequality of medical coverage, receipt of care, and health outcomes by income, race, ethnicity, and geography remain pronounced.^{2903 2904}

Other opponents worry that good coverage would mean moral hazard and unnecessary care. Some worry that health care is so wasteful that covering more people will be extraordinarily expensive. At the same time, reforms that would squeeze out waste are little understood and excite opposition from parties that see waste either as inevitable or as in their own interest.

A fourth reason is most access advocates' hope that it will be possible—even without waste-cutting or other substantial reforms—to find the added money to buy solid coverage for all Americans. The ACA cut the number of uninsured Americans. But the numbers of under-insured Americans rose. The elements of under-insurance are actively embraced by some as essential to slow cost increases by suppressing use of care, or are passively accepted by others as sad but subtle and politically acceptable tools for doing so.

The designers of the ACA relied on detailed modeling to design the complicated four-tiered insurance, complex forms of coverage, and high OOPs calibrated to hold down total incremental spending on newly-covered people.

Fifth, the ACA's designers—like those of the 2006 Massachusetts law on which it rested—knew that the ACA contained only the pretense of cost controls. Supporters of both laws recognized

7. Assuring Medical security and Health care for all

that winning political support for expanded coverage would have to rely on new money—higher public spending—not on cutting waste. Politicians, access advocates, insurance companies, hospitals, doctors, drug makers, and others could agree on spending more.

Even so, the fight to legislate higher state and federal spending to finance improved coverage was far from easy. The Massachusetts legislature debated nearly universal health care for a year before enacting it in April of 2006. Congress passed the ACA March and April of 2010 by the tightest of margins.

Higher spending lubricated passage of both laws. Expanding coverage exhausted all the political oxygen available in the Massachusetts State House or in Congress. Including effective cost controls in either law would have quickly scuttled the coverage expansions.

This approach had been recommended by many reformers. They argued for expanding access first and containing cost subsequently. It is hard to fault this view of the world of 2006 or 2010.

In those years, to demand laws that both covered more people and contained cost would have meant quick political defeat. So advocates of improved access chose the only politically feasible path available to them.

But no effective cost controls have been put in place subsequently. As a result, U.S. health care spending rose from \$2,589 billion in 2010 to a projected \$5,940 billion in 2026, a rise of 129 percent in only 16 years.²⁹⁰⁵

Further progress down the path to protecting more Americans by spending still more money is now blocked. Fantasy cost controls like addressing social determinants of life, “prevention,” and “value-based payments” are undergoing slow delegitimization. As discussed in chapter 2, addressing social determinants is valuable. But it is unattainable financially and politically owing to its high cost, lack of evidence on which social determinants should be prioritized on grounds of cost-effectiveness, and health care’s steady sponging-up of an extra one-third a trillion dollars yearly. That swollen sponge crowds out increased spending on social determinants of life.

When effective ways to prevent illness and injury exist, they should be financed. But it is self-defeating to promise that prevention will save money. It rarely does, as discussed in chapter 2. But we don’t spend \$6 trillion on health care in 2026 to save money. We spend to win better health and better, longer lives. Subjecting prevention to a money-saving standard is to establish a double-standard. That’s both foolish and wrong.

As discussed in chapter 9, “value-based payments” have done little to save money or improve health care’s quality, appropriateness, or outcomes.

Reformers will continue to suffer defeat and disappointment if they continue to bet on social determinants of life, “prevention,” or “value-based payments” to substitute for reforming health care in ways that actually squeeze out waste and use the savings to finance solid health care for all.

Access advocates must therefore identify ways to finance coverage improvements by cutting waste. They will need to make common cause with those who worry about high health care costs’ threat to economic competitiveness or the federal deficit or housing or job training or education or national/community/personal security.

7. Assuring Medical security and Health care for all

In 2026, it becomes clear that neither universal financial coverage nor health care cost controls can be attained without the other. Hard-won coverage improvements are being rolled back for political and financial reasons. Chapter 1 argued that crises outside and inside health care will soon make continued business-as-usual in health care impossible. That will offer a political and practical opportunity to win both affordable high-quality health care for all Americans and cost controls that attack waste inside health care. But seizing that opportunity demands detailed design and testing of realistic reforms.

A sixth reason is that the practical shortage of U.S. doctors, along with widespread difficulties in obtaining care in many urban and rural locations, frightens some insured patients—makes them worry that expanding access for other people will impair their own access. Sadly, Americans have accepted high-cost and low-volume patterns of care that are, in many ways, inherently unequal. And that serve as barriers to extending health care for all.

A seventh reason is the anarchy that pervades U.S. health care owing to absence of competitive free markets and competent government action. No one in health care is accountable for what happens outside the building where they work.

Today, no one is accountable for financially protecting each American against health care costs. Medicare, Medicaid, and various private insurance companies are not even accountable for protecting their own enrollees.

Today, use of words like “accountability—” and also “affordability—” typically masks their absence. Medicare multiplies the flavors of accountable care organizations. But ACOs’ incentives have not boosted accountability for giving needed care or for saving money.

Medicare Advantage is a faith-based program that rests on the paired beliefs that capitulated budgets and competition will boost both efficiency and equity.

Medicare pays huge sums to MA plans, hoping they will spend the money wisely and fairly. But this does not do enough to boost equity of care. In 2024, Medicare provided some \$67 billion in rebates to MA plans. These were intended to reduce premiums or finance supplemental benefits such as dental and vision care and hearing aids, which traditional Medicare does not cover. Unfortunately, low-income MA enrollees more often reported unmet needs for these three benefits owing to high costs, report Gupta and colleagues.²⁹⁰⁶ They urged public monitoring of the supplemental benefits’ equity and access. It is hard to understand how that could be done, in practice.

The more common complaint about MA, discussed in chapter 5, is that its risk-adjustment rules are so weak that they invite aggressive gaming by for-profit MA sponsors to boost revenue and profit. MA plans that financially pillage risk-adjustment are not accountable. For decades, congresses and presidents have unaccountably countenanced this pillaging.

The 2010 ACA has almost halved the number of uninsured Americans, but the share facing financial barriers that inhibit use of needed care has remained constant. We have fewer uninsured people but more under-insured people. But the uninsured share of our people bottomed out in 2023. Since then, resumed Medicaid eligibility recertifications, Medicaid cuts, work requirements, and expiration of higher ACA subsidies have been increasing the uninsured share.

7. Assuring Medical security and Health care for all

Fragmented care delivery and payment impair health security and cost control

Fragmenting groups of Americans by payer, by price, and by caregiver manifests weak commitment to equity. By adding complexity and also for-profit insurance and caregiving, fragmentation handicaps reform. Four types of coverage—MA, Medicaid managed care, ACA, and private through insurance through the job—typically rely on distinct narrow networks of caregivers. Doctors and hospitals often contract to participate in many of different narrow networks, but each has its own rules, payment methods, and prices. Most of the insurance companies and other entities that create the narrow networks operate for-profit. They make more money, other things equal, when patients get less care or lower-priced care.

In 1986, Rosenblatt reviewed changes in Medicaid and argued that for-profit managed care organizations needed to integrate “the patient-centered ideal into increasingly private and cost-conscious administration of medical care to the poor.”²⁹⁰⁷ Commenting on that argument, Dallek noted Reinhardt’s regretful insistence that Americans need to accept 3 classes of care. She also cited Thurow’s worry that the U.S. was headed for a “segregated three-tiered health care system.”²⁹⁰⁸

The concluding section of this chapter discusses why merging the main revenue sources advances both access and cost control, and identifies methods of undertaking that merger. Chapter 9 discusses methods of paying caregivers that support integrated care. And chapter 10 discusses commensurate changes in organization and delivery of care that would support affordable one-class care for all Americans.

Understanding the reasons for the failure to protect all Americans will suggest improved methods. As mentioned in chapters 1 and 5, some of the causes of this failure are accidental while others result from intentional political decisions, financial forces inside health care, economic forces outside health care, various geo-political threats, and the inability to forge a connection between coverage expansion and cost containment.

This chapter’s first section examines Americans lacking coverage and facing barriers to equitable care. The second section presents brief histories of coverage improvements in other rich democracies. These may help identify opportunities and strategies for progress in the U.S. The third analyzes causes of past failures to cover all Americans. The fourth considers various incremental and comprehensive paths to financial coverage for all of us.

7. Assuring Medical security and Health care for all

Key coverage terms – varieties of out-of-pocket costs

Deductible – the sum that the patient or family must pay before most insurance coverage kicks in. For example, a per-person deductible might be \$1,000 per year and the total family deductible might be \$2,500 per year. Deductibles are calculated separately for in-network and (when offered) out-of-network coverage. Sometimes, patients—like those with drug coverage through Medicare Part D—face a separate deductible for prescription drugs.

Co-payment – a fixed per-visit or per-prescription OOP fee, such as \$10 for a monthly supply of a generic drug, \$30 for a monthly supply of a drug under patent, \$30 for a primary care visit, and \$50 for a visit to a specialist. Insurance covers payments above the patient's co-payment. It generally does so even before the yearly deductible is satisfied.

Facility fee – an added and often-secret co-payment that's imposed by a hospital or other caregiver to generate revenue for itself.

Co-insurance – the patient's percentage share of a payment, such as 20 percent co-insurance for Medicare Part B services, once the patient has satisfied the yearly deductible. Co-insurance always begins after the patient satisfies the relevant deductible. Most individual services have either co-payments or co-insurance, but not both.

Annual OOP maximum – the yearly cap on OOPs for in-network care. For example, \$6,000 per year per patient and \$12,000 per year for a family. Sometimes, a distinct OOP maximum is created for prescription drugs, one that must be satisfied separately. Out-of-network care typically has no yearly OOP maximum. Ordinary Medicare has no cap on OOPs for Part B physician and other services. Payments toward uncovered services—like dental or vision care—do not apply to the OOP maximum. Nor do co-payments or facility fees.

Not premiums – employees' shares of premiums for health insurance through the job are not defined as out-of-pocket costs; rather, these shares are included in private health insurance. Similarly, Medicare patients' premiums for Part B physician care and Part D prescription drug coverage are not defined as OOP costs.

7. Assuring Medical security and Health care for all

A. People lacking good coverage face barriers to equitable care

People who are uninsured or under-insured are much less likely to obtain needed health care. Simple lack of insurance coverage is straightforward. Under-insurance is much more subtle and complicated and widespread.

1. Uninsured people

In 2010, 48 million Americans lacked health insurance coverage.²⁹⁰⁹ That number fell to 28 million in 2015. Three ACA provisions were responsible. By 2015, almost 10 million people were covered under the ACA's Medicaid expansion, almost 8 million people through its subsidized individual mandate, and about 2 million people under age 26 had been added to their parents' private health insurance.²⁹¹⁰

By 2022, owing in part to Covid-related suspensions of Medicaid recertifications, the ACA's Medicaid expansions covered 7.5 million more people than in 2015 and ordinary Medicaid covered another 8 million more.

Enrollment in the ACA's subsidized private plans grew by 4 million in 2022—and by an added 4 million in 2023—largely owing to higher federal subsidies enacted as a provision of the 2021 American Rescue Plan's responses to Covid.^{2911 2912}

In 2022, the number of uninsured Americans fell below 24 million, less than one-half the number prevailing pre-ACA, only a dozen years earlier.²⁹¹³ The share of uninsured Americans fell to an estimated 7.7 percent in the first quarter of 2023.²⁹¹⁴

As mentioned earlier, Glied noted that states that had expanded Medicaid and also mandated coverage had pushed their uninsured shares of eligible residents below 5 percent in 2022. The Massachusetts rate was said to be below 3 percent.²⁹¹⁵

Not one Congressional Republican voted for the ACA in 2010. Trump and his allies were one senator's vote away from repealing the law in 2017. Appreciation for the law's coverage improvements grew gradually.

Since then, more red states steadily accepted the ACA's generous federal financing of Medicaid expansions. This was often done in the face of elected officials' opposition. Since 2017, seven states have expanded Medicaid by popular votes on ballot questions.²⁹¹⁶ By the spring of 2024, only 10 states continued to refuse.

Eleven states' applications to add work requirements to Medicaid were approved during Trump's first presidency. States did so using the Section 1115 waiver program.²⁹¹⁷ But only three states' programs—those of Arkansas, Indiana, and Kentucky—were actually implemented. Biden withdrew all approvals early in his administration.²⁹¹⁸

States generally sought to require healthy applicants aged 18 to 64 to work or study or care for children or engage in community service at least 80 hours monthly to be eligible for Medicaid.

7. Assuring Medical security and Health care for all

Georgia, which did not expand Medicaid, had a narrow, short-lived, and low-enrollment Medicaid expansions that required work. It was very costly to administer.²⁹¹⁹

After Trump was re-elected, the July 2025 federal budget law required enforcing Medicaid work requirements in all states beginning in 2027. In the summer of 2026, Nebraska voluntarily began enforcing requirements for some 70,000 of the state's Medicaid recipients. It is surprising that one consistently objective source of health care information called that process a "purge."²⁹²⁰

Work requirements are costly to administer because they often entail review of individual cases to judge whether the obligation to work applies and, if so, whether it is being satisfied. They therefore save little money. But they do discourage applications for Medicaid. In this respect, they manifest weak commitments to extending health insurance to people considered by some to be unworthy of coverage.

California's early responses to Trump's Medicaid cuts are telling. A few years earlier, it had chosen to add people with "unsatisfactory" immigration status to state-financed Medicaid coverage. California closed its program to new entrants and required people already covered to begin paying monthly premiums in 2027.²⁹²¹

More broadly, the state's Legislative Analyst's Office projected that the number of uninsured Californians would double from 2 million in 2026 to 4 million in 2030 owing to Medicaid work requirements. Over 1 million others would lose comprehensive Medi-Cal coverage and retain only emergency coverage.²⁹²² The report also anticipated pressure on private health insurance premiums, county government finances, and caregivers such as hospitals, physicians, and community health centers.

The 2021 expansions in federal subsidies for marketplace plans meant that individuals and families paid much lower premiums. That resulted in a rise in ACA plans' enrollments from 12.0 million in 2021 to 21.4 million in 2024, a rise of over three-quarters.

By 2024, over three-fifths of Americans said they supported the ACA.²⁹²³ After 14 years, it seemed to diminish as a political issue.

Or not.

Forces suppressing insurance coverage

In most rich democracies, citizens enroll for health care coverage and retain that form of coverage for life. But over Americans' lifespans, sources of coverage change with income, location, employment, insurers' decisions to cease offering policies, and other factors. Rosenthal described the plight of a Floridian who lost ACA-subsidized insurance owing to failure to pay a 5-cent premium.²⁹²⁴

Medicaid "unwinding," 2023-2024

7. Assuring Medical security and Health care for all

The conduct and consequences of the “unwinding” of Medicaid eligibility post-Covid reveal challenges in protecting financial coverage by traditional means.

What happened? Medicaid statute requires yearly recertification of eligibility. This was suspended during the Covid public health emergency. Consequently, fully 94 million Americans were enrolled in Medicaid or CHIP in March of 2023. Yearly recertification then came back into force.²⁹²⁵ In the following 14 months, some 22.4 million (24 percent of Medicaid enrollees in March of 2023 and 6.5 percent of all Americans in 2023) were disenrolled. That number rose as other states conducted recertifications.²⁹²⁶

This was predictable for several reasons. First, it is difficult to communicate reliably with many Medicaid patients. State information on addresses, e-mail addresses, or phone/text numbers is often not current.²⁹²⁷

Second, many Americans—not only those relying on Medicaid—find that enrolling for health care coverage is unnecessarily complex, confusing, adversarial, and time-consuming. Applications are lengthy to complete and costly to review. Ofri describes her own challenges, as a physician, in re-enrolling her husband and children for coverage through her employer.²⁹²⁸ Other rich democracies treat their citizens more respectfully. Lifetime eligibility is the most common practice.

Third, states rely heavily on automated redeterminations of Medicaid eligibility. These are often inaccurate. In August of 2023, CMS wrote to all states to caution those states using automatic renewal software that such software measured family eligibility, not that of individuals. Federal law requires the latter because individuals—particularly children—might continue to be eligible for Medicaid even if the family as a whole is not.^{2929 2930} CMS also criticized states for failing to link to available income data to gauge eligibility of families that failed to re-apply by deadlines.

Fourth, the individual states recertify eligibility. State governments have varied enormously in their commitment to protect their citizens who rely on Medicaid, and also in their ability to do so.

CMS is supposed to oversee state actions to ensure compliance with Medicaid rules.²⁹³¹ That is a tough job. Its magnitude, its complexity, the states’ varying political preferences, and the federal government’s unwillingness to act forcefully to protect eligible Americans from disenrollment combined to render it impossible to do the job well. During 2023, CMS and other federal administrators pleaded with states to clean up recertification procedures, use data already available to certify continued eligibility, and conduct added outreach before disenrolling.^{2932 2933 2934 2935 2936} Neither pleas nor threats to withhold federal Medicaid matching dollars were initially effective.

Over the first 12 months of unwinding, reported Corallo and Tolbert, the share of reviewed Medicaid patients losing coverage fell from 38 percent to 23 percent. They identified three explanations. One is that a number of states chose to review more patients who seemed likelier to lose coverage during the early months of unwinding.

A second is that the share of patients reviewed via “ex parte” determinations rose from 51 percent in unwinding’s first month to 70 percent by its 12th month. Ex parte determinations, also called auto-renewals, do not require patients to submit documentation; instead, they rely on data already available to state governments.

7. Assuring Medical security and Health care for all

A third, Corallo and Tolbert believed, was that CMS's enforcement—in 29 states—of more careful redetermination procedures, including proper use of automatic determinations helped cut the rate of improper expulsions from Medicaid.²⁹³⁷

This is a more positive view of the willingness and ability of CMS to act effectively. Corallo and Tolbert also noted that, despite a net cut of over 13 million people during the first year of unwinding, enrollment in April of 2024 was one-seventh higher than it had been pre-Covid—a rise of 10 million patients.

Many states had signaled their interest in cutting the numbers and costs of their Medicaid patients. A letter from 25 Republican governors to Biden in December of 2022 asked for an end to continuous Medicaid enrollment because it was costing their states “hundreds of millions of dollars.”²⁹³⁸ It is not clear whether that sum was net of enhanced federal Medicaid matching money.²⁹³⁹

Indeed, by December 2023, three-fifths of children disenrolled from Medicaid resided in 9 states, all led by Republicans.

Over four-fifths of Texans reviewed were disenrolled.²⁹⁴⁰ Three-quarters of those losing coverage were disenrolled for administrative reasons (such as inability to contact or failure to re-apply) rather than for rise in income or other changes that would actually make a person ineligible for Medicaid.^{2941 2942}

In October 2023, Arkansas became the first state to complete review of eligibility. It removed 427,000 citizens, more than one-half of those previously covered. Alker said “Arkansas has distinguished itself by moving very rapidly to kick families off coverage, regardless of whether they are still eligible.”²⁹⁴³

Many other states, like Virginia, Arizona, Michigan, and Nebraska, found ways to re-enroll 85-90 percent of those requiring re-certification.²⁹⁴⁴

The 1,653-page Consolidated Appropriations Act of 2023, signed into law on 29 December 2022, gave CMS additional authority over Medicaid eligibility redeterminations. Only in early-December of 2023, though, did CMS promulgate an interim rule requiring states to submit corrective action plans if they had failed to comply with federal law, regulations, and reporting for redeterminations.^{2945 2946} This 81-page interim final rule seemed to be predicated on a belief that delayed, lengthy, legalistic, and probably ineffective regulations are an acceptable substitute for simple and effective action.

Lessons

What might different people learn from the “unwinding” of Medicaid coverage?

One is that use of the remarkably anodyne and neutral word, “unwinding,” signals the view that this is an ordinary, routine, and unexceptional administrative procedure. This seems to send the message that it is unremarkable to strip health insurance coverage from at least 26 million Medicaid enrollees—almost 30 percent. So public actions to deprive a large number of Americans of health insurance have not become a high-charged political issue, one that could harm elected officials and administrators who took those actions.

7. Assuring Medical security and Health care for all

A *second* is that it is hard to be confident that people who lost Medicaid coverage will either regain it or obtain substitute coverage. Some patients re-enrolled in Medicaid when they next sought care. Most hospitals facilitated re-enrollment because they didn't want to care for patients without remuneration. But unless re-enrollment procedures were streamlined and regularized, their administrative costs to many doctors and other caregivers would be high relative to the revenue to be collected.

Predictably, the share of ER visits covered by Medicaid fell by 2.8 percentage points from March to August 2023 and Medicaid's share of hospital admissions fell by 2.7 percent. Self-paying (uninsured) shares rose.²⁹⁴⁷ In May of 2024, Houghton reported that a Montana health center had to lay off about 10 percent of its workers in the face of lower revenue from Medicaid stemming from loss of eligibility. Some 134,000 were disenrolled, fully 12 percent of that state's people.²⁹⁴⁸

And the human costs could be much higher. People who lost Medicaid coverage might delay seeing the doctor, allowing serious problems to worsen. Predictably, some patients suffer highly visible and grave medical problems—or die prematurely—owing to failures to obtain administrative recertification.

Some chose to blame the patients while others blamed an unnecessarily complicated process of recertifying income eligibility. Critics noted that no other rich democracy compels large shares of its citizens to jump through complicated administrative hoops simply to retain their health insurance.

Moreover, people removed from Medicaid found it harder to renew coverage for food aid or cash assistance. Sometimes, people found eligible for one of these three forms of support are automatically enrolled in one or both of the other forms. If not, state workers engaged in unwinding Medicaid coverage and those working to re-enroll people who inappropriately lost Medicaid coverage are not available to help citizens apply or reapply for other forms of support.²⁹⁴⁹

CBO analysts predicted that, if some 15 million people lost Medicaid eligibility owing to the unwinding, just over 6 million (two-fifths) would become uninsured while the remaining 60 percent would obtain alternative coverage.²⁹⁵⁰

The CBO prediction that 60 percent of those disenrolled would obtain substitute coverage was radically optimistic. In 2018, only 3 percent of those losing Medicaid coverage were able to enroll in subsidized ACA marketplace plans.²⁹⁵¹ Even though federal subsidies improved markedly since 2018, anticipating a great rise in marketplace coverage seems unreasonable.

McIntyre and colleagues learned that six months after unwinding began, about one-half of those who'd lost Medicaid coverage became uninsured. Many of those who did find new coverage reported gaps during which they were uninsured. Unsurprisingly, people extruded from Medicaid found it harder to get care than those who continued to be covered.²⁹⁵²

In most states, subsidized ACA plans differ considerably from Medicaid in their enrollment process and caregiver networks.²⁹⁵³ They require substantially higher OOPs. Although states are supposed to coordinate their Medicaid and marketplace coverages, Rosenbaum and Musumeci assert that many states did not do so. Citizens losing Medicaid were sometimes wrongly denied insurance through ACA marketplaces.²⁹⁵⁴ This parallels many states' failures to

7. Assuring Medical security and Health care for all

follow federal rules in assessing Medicaid eligibility—failures that manifest the administrative difficulty of the job, incompetence, willful hard-heartedness, or simple discrimination.

Indeed, over one-third of people who had marketplace coverage said they found it somewhat or very hard to find a plan that met their needs.²⁹⁵⁵ Former Medicaid patients seeking subsidized plans often must weigh premiums, OOPs, caregiver networks, continuity of care, and other factors. Navigators can help, but are often unavailable, especially in rural areas. (No other nation requires use of navigators to help citizens choose health insurance coverage.)

Unwound Medicaid patients who succeeded in obtaining subsidized ACA coverage often were forced to change physicians or other caregivers. About one-half of Americans enrolled in a Medicaid managed care plan in 2021 were covered through an insurer that had an ACA plan in the same county. And about one-quarter of those enrolled a Medicaid managed care plan lived in counties whose largest Medicaid managed care plan and largest ACA plan were the same.²⁹⁵⁶ Many people losing Medicaid coverage owing to incomes above 138 percent of the FPL might, therefore, be able to retain their caregiver network after switching an ACA plan. But they might choose not to do so owing to higher family premiums, variations in network doctors or hospitals, and other factors.

Two states did use their own dollars to subsidize insurance during a short transition. And four states automatically enrolled those dropped from Medicaid in ACA plans, and then asked those citizens if they wished to retain that new coverage. Elsewhere, the picture was one of insecurity for most people losing Medicaid.²⁹⁵⁷

Given the very wide variation across the states in share of Medicaid patients expelled from the program for failure to adhere to administrative rules, it seems clear that some states were willing and able to be careful and others were not. It also seems clear that federal oversight of state actions was administratively inept and politically powerless.

Mann and Daugherty noted that disenrolling people who actually remained eligible for Medicaid worsened in 2023 but had been a problem even during ordinary times. They reported that two states already allowed continuous eligibility up to age 6, with more states requesting similar waivers.²⁹⁵⁸ This is entirely sensible but is only a small step. It is noteworthy, as discussed later in this chapter, that no other rich democracy requires burdensome periodic re-certification of protection against health care costs.

A third is that states booting two dozen million people off Medicaid—mainly for failure to follow administrative rules for recertification—faced no political consequences. So this sort of thing must not be allowed to happen again. Buettgens wrote that Congress should at minimum permit all states to allow 12 months' continuous eligibility.²⁹⁵⁹ That option became available for children beginning in 2024. More reasonably, citizens could be grandparented into Medicaid—such that, once eligible, they remain so until they obtain employer, ACA, or other health insurance.

That last provision might induce hospitals and doctors located in states with low-paying Medicaid programs to lobby legislatures to boost their Medicaid prices. States would resist and beg for federal rescue.

A fourth might be a federal take-over of Medicaid accompanied by a claw-back of state dollars paid for the program in, say, 2023, unadjusted for inflation. Clawback of state Medicaid

7. Assuring Medical security and Health care for all

payments for meds was a feature of the 2003 law creating Medicare Part D. Were the claw-back capped in nominal dollars, its real burden on states would drop each year.

Immediately, this approach would most benefit those states with low Medicaid spending. But over time, the high-spending states would enjoy substantial budgetary relief. Congress and the president would not. This should propel them to design effective ways to contain cost while protecting all citizens.

High federal deficits make this unlikely until the next deep recession and resulting state budget crises lead many states to clamor for federal take-over.

By the spring of 2024, the number of uninsured Americans had risen again by a substantial number. That was attributable mainly to disenrollments from Medicaid that were only very partly offset by rising subsidized ACA coverage. I estimate that the number of uninsured Americans rose from 26.7 million in 2022 to 29.1 million in 2023, and to 34.1 million in 2024.

Subsequently, those figures would fall somewhat as a number of people wrongly dropped from Medicaid re-enrolled successfully.

Against this, the 2025 budget law's cuts in Medicaid spending and its demand that state's require work and similar obligations when gauging Medicaid eligibility are expected to cut Medicaid enrollment by some 10 million in the next decade.

Further, the enhanced ACA subsidies expired at the end of 2025. Many millions will lose coverage. Ortaliza and colleagues noted that people below 250 percent of the FPL comprised five-sixths of the recent growth in enrollment in ACA plans. The enhanced subsidies have meant zero or very low premiums for these Americans.²⁹⁶⁰ It is all too reasonable to expect a drop in ACA enrollment of almost 10 million—back to the level prevailing before subsidies increased.

A drop of over 10 percent in ACA enrollment materialized in the first 2 months of 2026. Most of this was owing to the rise in families' premiums owing to the expiration of higher subsidies. But some followed from Trump efforts to expel fraudulent enrollees. Unfortunately, a number of brokers colluded with insurers to enroll ineligible or even ghost patients in ACA plans. Failure to fight illegal enrollment can help to delegitimize a program. That failure stemmed partly from a federal court ruling that blocked Biden administration rules aimed at combatting ACA program fraud.

Ohio and Oklahoma lost almost one-third of their ACA enrollment early in 2026. Arizona, South Carolina, Minnesota, Indiana, Michigan, Mississippi, Louisiana, and Missouri lost over one-quarter of enrollment. Florida, with some 4 million enrollees, saw the greatest drop in number of enrollees—about 440,000 or one-ninth of those in the program at the end of 2025.²⁹⁶¹

As shown in Exhibit 7 – 1, all this meant a drop in the uninsured share of Americans under age 65 from 17.3 percent in 2010 to 9.3 percent in 2022. But that share then is expected to rise from 9.3 percent in 2022 to 12.8 percent in 2026. Again, the rise is attributed to Medicaid disenrollments in 2023-2024, loss of enhanced ACA subsidies at the end of 2025, and loss of private insurance coverage owing to rising premiums. One CBO estimate has the number of uninsured Americans rising from 30 to only 37 million from 2026 to 2036. That's mainly owing to Medicaid cuts in the 2025 budget law—and also to drops in the number of children in families

7. Assuring Medical security and Health care for all

eligible for Medicaid. It assumes a drop of only 2 million in ACA coverage.²⁹⁶² That is a remarkably optimistic number. Indeed, 5 million were reported to have shed ACA coverage by mid-2026.²⁹⁶³

As always, national averages mask vast inter-state differences. Exhibit 7 – 2 displays the state-by-state shares of people under age 65 population who were uninsured in 2022.

Exhibit 7 – 1
Uninsured Share of Americans under Age 65, 2010 - 2026

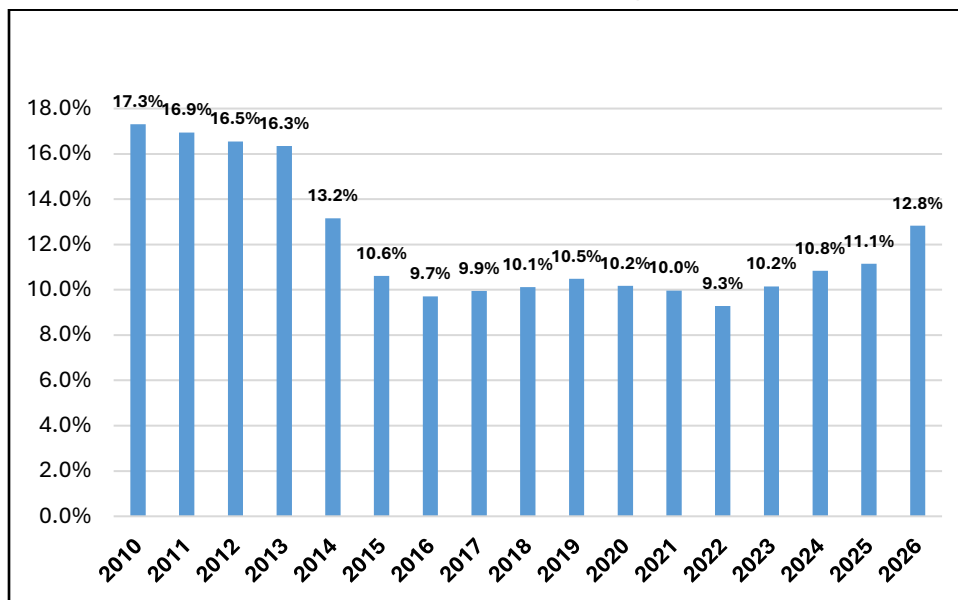
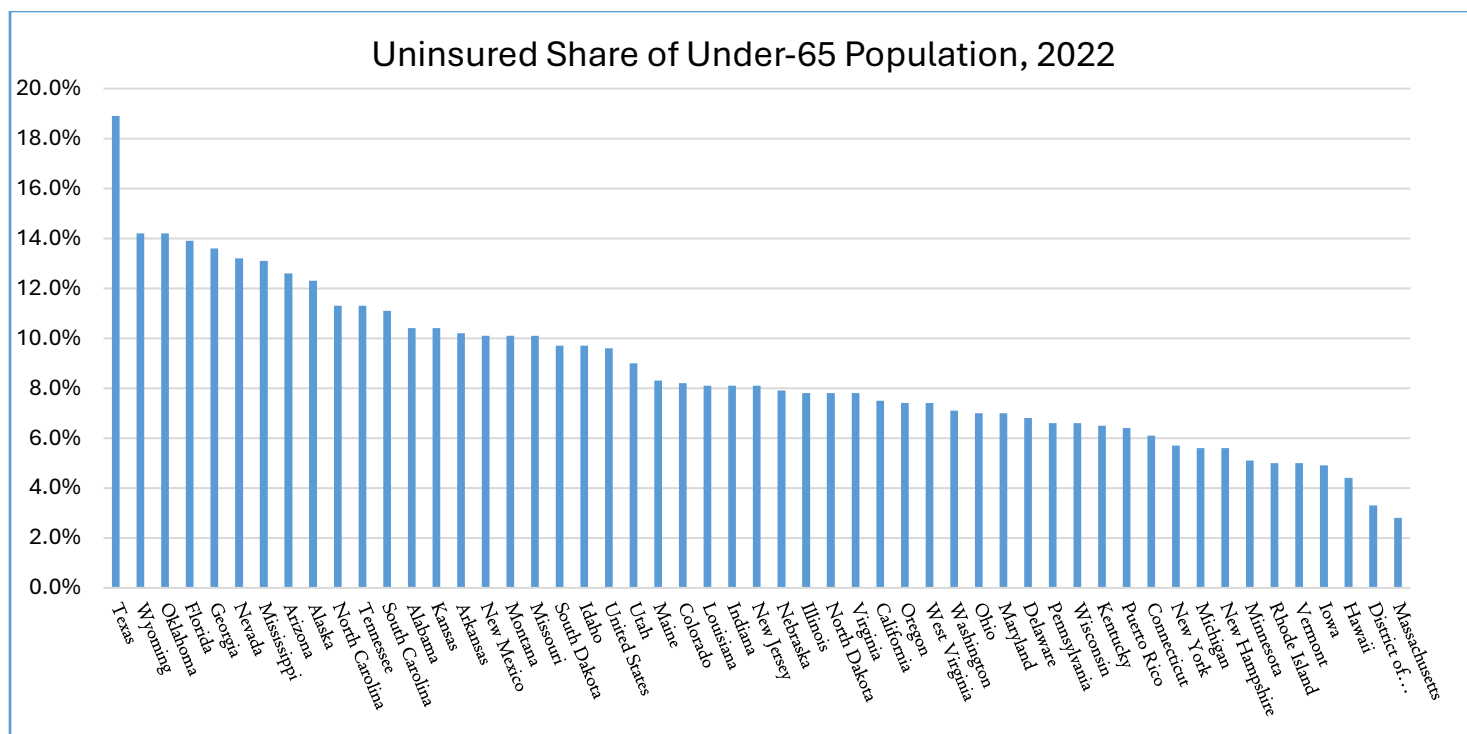


Exhibit 7 – 2

7. Assuring Medical security and Health care for all



Massachusetts's share was just under 3 percent while Texas's share was almost 19 percent. Northeast and mid-west states enjoyed lower percentages while southern and some western states fared poorly—particularly those that failed to expand Medicaid under the ACA.

Financially unprotected, uninsured Americans' medical care is as good as is allowed by their savings, their willingness or ability to borrow, and the goodwill of the caregivers from whom they seek services.

Additionally, as discussed later in this section, high shares of the 310 or so million Americans with some health insurance are under-insured in various ways.

Overall, the Gallup organization found deteriorating affordability of care between 2022 and 2024. The share of adults readily able to obtain and afford needed care fell by 6 percentage points, dropping to 55 percent.²⁹⁶⁴

This share fell further. In June of 2026, fewer than one-half of Americans said they "can consistently afford health care and prescription medications when... they need them, the lowest level recorded..." since this was first measure in 2021.²⁹⁶⁵

Private insurance gaps and weaknesses

The shares of workers offered insurance coverage through the job varies by industry. Claxton and colleagues analyzed Bureau of Labor Statistics data on private insurance coverage through the job.^{2966 2967} In 2024-2025, some three-quarters of workers were offered insurance and

7. Assuring Medical security and Health care for all

about two-thirds of those offered accepted coverage. As discussed earlier, most employers offer fixed-dollar premiums to workers—premiums that do not vary with income. As total premiums rise, lower-income workers find it harder to afford these regressive premiums.

Shares of working people lacking insurance vary by industry, occupation, and earnings. Service workers are less likely to receive offers and also less likely to accept. Only about one-half of service workers are offered coverage through the job and, of these, only about one-half accept coverage. At the other extreme, almost nine-tenths of managers and professionals are offered coverage, along with about three-quarters to four-fifths of workers in manufacturing, construction, and sales. Generally, workers earning lower incomes are less likely to be able to afford to accept offers of coverage.

Firms with fewer workers are less likely to offer coverage and employees at those firms typically pay higher shares of premiums. One reason is that smaller firms are likelier to be found in more competitive industries, making for smaller profit margins and greater difficulty in affording health insurance. If workers at these firms earn lower incomes, the fixed-dollar (regressive) costs of health insurance make for a greater percentage rise in employers' and employees' costs. Further, smaller firms are less likely to be capital-intensive; they probably employ more workers per million dollars of revenue, making health insurance costs a relatively high share of their cost of doing business.

2. Under-insured people

Going without coverage for prescription drugs is a form of under-insurance. About 10 percent of Americans lack drug coverage. And an added 30 percent with drug coverage are under-insured owing to high OOPs or financially-motivated denial of coverage of doctor-prescribed drugs.

Americans with drug coverage are effectively under-insured when their payer denies care prescribed by their physician. Levy and colleagues analyzed 1.2 million patients' attempts to fill 2 million new prescriptions for single-source brand name drugs between 2018 and 2024. They found that 68 percent were paid on initial submission, 15 percent were rejected because they were not on formulary, and 17 percent were rejected because they required step therapy or prior authorization.

Rejections varied widely by source of payment. Fully 50 percent of attempts were rejected by Medicaid managed care plans; 49 percent by ACA plans; 24 percent by Medicare Part D plans; and 20 percent by MA plans. Half of the patients whose prescriptions were initially rejected received no med in the same therapeutic class within 90 days.²⁹⁶⁸

Jaffe reported that in the spring of 2026, some 140,000 Americans lost their Medicare Part D prescription drug coverage because they accidentally did not pay their monthly premiums earlier in the year. Most would not become eligible for renewed drug coverage until the start of 2027. All would face penalty increases in premiums of 1 percent for each month they were uninsured.²⁹⁶⁹

They were some of the 6 million Medicare Part D patients covered by Wellcare, a Centene subsidiary. All had zero-premium drug plans in 2025 but did face small monthly premiums for 2026. Wellcare insists it notified these individuals about the new premiums in September of 2025. But many did not get the word. And many assumed that they had addressed the change because

7. Assuring Medical security and Health care for all

they had previously arranged for Medicare to deduct premiums from their monthly Social Security checks. Unfortunately, Social Security ends that arrangement for enrollees with zero-premium plans.

No other nation subjects its citizens to the complex eligibility, paperwork, coverage gaps, bureaucratic barriers to care, and—particularly—high out-of-pocket burdens—that cause a majority of Americans to be under-insured.

Having insurance coverage powerfully shapes actual access to care. But it does not act alone.

Fully three-quarters of uninsured Americans said it was very difficult or somewhat difficult to pay health care costs. But two-fifths of those with group insurance through the job and three-fifths of those with individual or ACA marketplace coverage said the same.²⁹⁷⁰ By these measures, a very high share of insured Americans are under-insured.

And that share is growing. Early in 2026, Long and colleagues assessed forces pushing more Americans into high-destructible, high-OOP health plans. One was the expiration of higher premium subsidies for ACA plans at the end of 2025. Another was the anticipated shift away from silver ACA plans and toward bronze plans that required higher OOPs. In light of 2027 filings from 16 states, McGough and others projected a rise of one-third in ACA premiums between 2025 and 2027.²⁹⁷¹ A third was Trump's executive order allowing more people to enroll in catastrophic, short-term, or other flimsy plans.

This further undermines the usefulness of a 0/1 split between uninsured and insured Americans. Instead, we should henceforth see a continuum from fully-protected and insured Americans to completely uninsured citizens. Most people fall into the large under-insured spread between the two ends of the distribution.

Factors closely associated with incomplete insurance coverage strongly influence actual access to care. These include:

- ✓ high and regressive premiums demanded by employers and paid by families for insurance through the job;
- ✓ the size of the three traditional OOPs—scheduled co-pays, co-insurances, and deductibles;
- ✓ the annual OOP maximum for medical services;
- ✓ whether a separate OOP maximum is imposed for meds;
- ✓ the related administrative barrier of prior authorization for many individual services;
- ✓ reliance on profit-making and risk-bearing financial intermediaries with financial incentives to hold down use of care and spending on care—including most MA plans, Medicaid managed care plans, and insurance companies;
- ✓ some payers' low prices for caregivers—which impair caregiver willingness to see patients covered by those payers;
- ✓ the financial uncertainties introduced by payers' denial of payment after care has been given;
- ✓ the financial uncertainties magnified by surprise bills;
- ✓ the narrow and shifting networks of doctors and hospitals that rend carefully woven fabrics of care—especially for people with chronic illnesses or disabilities;
- ✓ the shifting sources of insurance coverage and shifting insurer-caregiver contracts that further rend fabrics of care;

7. Assuring Medical security and Health care for all

- ✓ inadequate supply and distribution of caregivers overall—and especially of in-network caregivers, and associated long waits for appointments and long travel times to care;
- ✓ complicated and shifting formularies and step therapies for meds;
- ✓ grave and growing shortages of primary care to serve as single points of entry into care, and associated weaknesses in assuring continuity, coordination, and comprehensiveness of care;
- ✓ non-coverage of many types of needed medical or dental care; and
- ✓ other barriers to actual access to needed medical care.

All of these elements make for various degrees of incomplete insurance coverage. All of these suppress use of needed care. Access becomes more flimsy when more of these are present.

In these many ways, most Americans who are insured on paper are under-insured in practice. Under-insurance is the inability to afford or otherwise obtain needed care—care for which the patient is nominally covered financially. This matters little to most Americans, most of the time, because most of us are usually healthy. (Indeed, as discussed in chapter 11, care for fully one-half of Americans absorbs only 3 percent of health care costs.) Pryor and colleagues captured the problem of under-insurance well in a 2007 report they titled, “The Illusion of Coverage: How Health Insurance Fails People When They Get Sick.”²⁹⁷²

Barnes and colleagues found that patients with cancer enrolled in high-deductible health plans died at rates substantially higher than patients not enrolled in HDHPs.²⁹⁷³

Fortier sought to help under-insured Americans with HDHPs—including the growing number of ACA-subsidized citizens forced to choose lower-premium bronze plans—cope by urging them to sign up for health savings accounts to pay the high deductibles and other OOPs required by HDHPs.²⁹⁷⁴

While well-intentioned, this advice resembles urging lower-income Americans to swim up Niagara Falls. People who can’t afford premiums for silver ACA plans are less likely than others to be able to find substantial sums to finance HSAs.²⁹⁷⁵

Lukens found clear evidence that higher-income Americans can better afford to contribute before-tax dollars to HSAs, and also that they stand to enjoy greater financial benefits by doing so—since they face higher marginal income tax rates.²⁹⁷⁶ Households with incomes over \$100,000 in 2023 garnered 77 percent of the value of HSA contributions. One-fifth of White and Asian Americans with private insurance had HSAs in 2021, but only one-tenth of Black and Latino Americans had HSAs.

Most Americans are under-insured. High and regressive insurance premiums, unaffordable out-of-pocket costs, uncovered or badly-covered services like dental or mental health care or long-term care, financial incentives to give less care, differences in prices paid by various payers for various services, narrow or under-staffed networks, long travel or waiting times for care, refusal of some caregivers to accept patients covered by low-price payers like Medicaid or military health insurance, denials of prior authorization, denial of payment after care is given, and other gaps in coverage cause many nominally insured Americans who need medical care to go without it.

7. Assuring Medical security and Health care for all

The Massachusetts example is striking. The 2023 Massachusetts Health Insurance Survey found that over 98 percent were insured. But two-fifths of respondents reported difficulties accessing care and the same share reported problems affording needed care.²⁹⁷⁷

The shares of people with chronic illnesses or disabilities who face these problems is almost certainly much higher. That's because these individuals typically have lower incomes and, as they use more care, face greater accumulated OOP burdens. By contrast, people with no health problems seek care at much lower rates and are less likely to report difficulties in accessing or affording it.

The 2025 Massachusetts Health Insurance Survey reported that one-third of families with good or excellent health reported problems in affording health care. But 53 percent of families with one or more members in fair or poor health, or limited in mobility, reported problems in affording health care.²⁹⁷⁸

Many of these financial, bureaucratic, and other impediments to full coverage were deliberately installed to hold down spending on health care. Most of them particularly disadvantage lower-income Americans.

Glied acknowledged these difficulties but appeared to downplay their importance. She pointed to existence of supplementary private coverage in other nations as a way of saying that inequality is common.²⁹⁷⁹ But the U.S. is probably unusual among rich democracies in the level of inequality we tolerate—in financial coverage, in under-insurance, and in non-financial barriers to use of care. It's true that gaps in coverage exist elsewhere (weak public coverage of cost of meds is indeed a problem in Canada, for example—though Canada does regulate prices of costly patented meds). Moreover, high U.S. income inequality magnifies the effects on access to care of differences in coverage and payment levels here.

Dietz and Lucia concluded that “health care affordability has deteriorated over the past two decades in California” owing to higher premiums for insurance through the job, coupled with rising OOPs.²⁹⁸⁰

Altman wrote in August of 2024 that he thought Democratic presidential candidate Harris “is reframing health as an economic issue” by mentioning high OOPs, drug prices, and medical debt.²⁹⁸¹ While it may be politically advantageous for a presidential candidate to try to reframe health as an economic issue, doing so is really only one simple way to acknowledge that insurance coverage has been very incomplete. Also, most of the elements of this reframing had already been pursued during Biden's years as president.

Thirty years ago, Short and Banthin estimated that 29 million Americans under age 65 were under-insured. Their criterion was whether a person would incur very high OOPs to obtain care for a costly catastrophic illness.²⁹⁸² That remains one useful financial measure, though far from a complete one.

Under-insurance manifests itself in many other ways. In 1985, Berki and colleagues noted that even moderate or modest OOPs were unaffordable to families with low incomes, leaving them under-insured.²⁹⁸³ Schoen and colleagues concluded that nearly 12 million Medicare enrollees were under-insured in 2014.²⁹⁸⁴ And Collins and colleagues deemed fully 41 million Americans (28 percent of insured people aged 19 to 64) to be under-insured in 2016. This was double the

7. Assuring Medical security and Health care for all

2003 share. Half of the 41 million had problems with medical bills or debt; almost as many said they did not seek needed care because of cost.²⁹⁸⁵

Betancourt reported that rates of insurance coverage for Hispanic adults rose markedly after the ACA was implemented but that 55 percent remain uninsured or under-insured. A majority said they sometimes skip care or fail to fill prescriptions owing to cost.²⁹⁸⁶

Bernard and colleagues examined working aged adults in families burdened by high health insurance premiums, high accumulated medical debt, or suffer delayed care or no care owing to its cost. They found that between 27 percent and 45 percent of this group lived in families shouldering at least one of the three burdens in 2018.²⁹⁸⁷

Importantly, under-insurance is episodic. It is not manifested steadily or regularly. That's because health care costs are highly concentrated in each year: Roughly 1 percent of Americans use between one-fifth and one-quarter of all health care. And 5 percent use about one-half of all health care. Therefore, cross-sectional or 1-year survey data will predictably under-estimate under-insurance. Under-insurance is much more visible when needs for care are higher. Analyzing MEPS data over 4 years, Gaffney colleagues found that 11 percent suffered financial strain or foregone care in a given year, but that 26 percent did so during at least 1 of the 4 years examined.²⁹⁸⁸

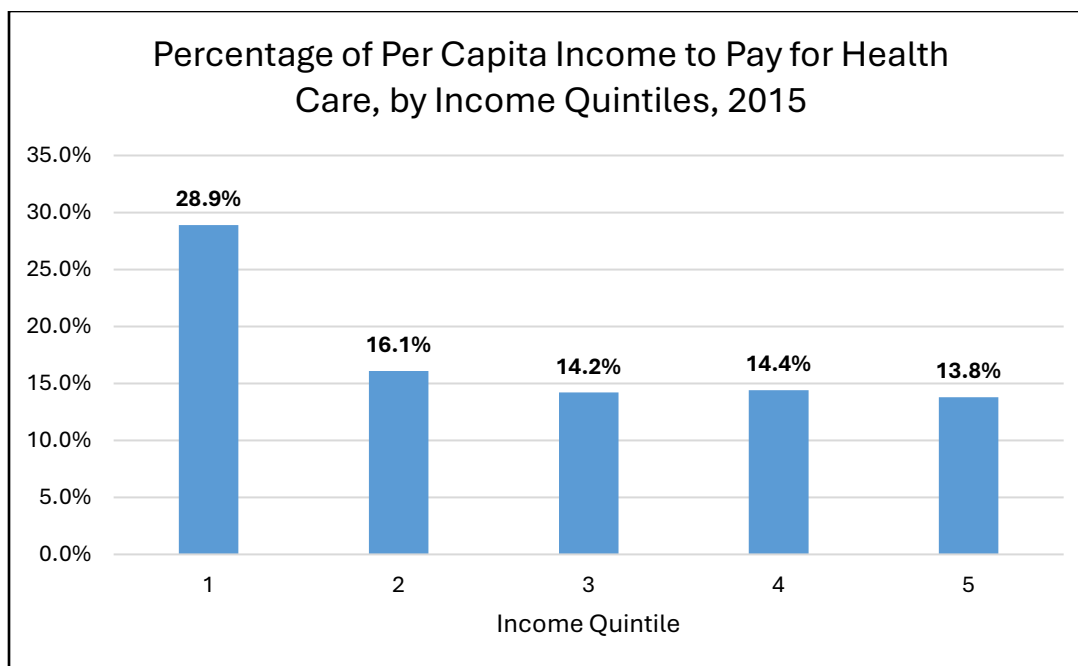
High-priced insurance premiums. Altman has highlighted the inability of many workers'—especially those employed by small businesses—to afford premiums and OOPs.²⁹⁸⁹ Since workers' increases in payments for health insurance premiums at big business lag behind increases at small business by only a few years, more and more of individuals and families covered through the job will soon become unable to afford premiums and OOPs. Some will decline coverage and others will choose plans with lower premiums and higher OOPs, hoping not to need or use medical care. Growing unaffordability of private insurance through the job parallels the steadily growing burden of health care costs on governments, employers, workers, and citizens.

Regressive premiums. A survey of adults aged 50 to 64 published in 2023 found that very large numbers said it was very or somewhat hard to afford their premiums. Because health insurance premiums through the job don't vary with income, they are much heavier burdens on lower-income Americans. Rapid rises in premiums—highlighted by Friedman in 2014²⁹⁹⁰—and employer shifts of higher shares of those premiums to workers—raise burdens on lower-income workers and their families. Most employees with low incomes were deemed under-insured owing to high OOPs as a share of income. Almost one-half of those with low incomes said that cost forced them to delay or avoid needed medical care.²⁹⁹¹

Owing to a combination of regressive premiums and even more regressive OOPs, lower-income Americans spend much higher shares of their (smaller) incomes on health care than do higher-income Americans. Examining people with private health insurance, Shashikumar and colleagues analyzed total health care spending on premiums and OOPs as a share of income (minus food spending) from 2007 to 2019. Lower-income families' health spending burden rose from 23.5 to 26.4 percent of income during those 12 years. Higher-income families' burden rose from 5.4 percent to 6.5 percent of income. Exhibit 7 – 3 depicts the share of per capita income paid for health care in the U.S., by income quintile.

Exhibit 7 – 3

7. Assuring Medical security and Health care for all



Note: These are payments by individuals. Omitted are premium payments by employers.

Source: Catherine Grace Carman, Jodi Liu, and Chapin White, "Accounting for the Burden And Redistribution of Health Care Costs," *Health Services Research*, Vol. 55, No. 2 (April 2020), pp. 224-231, <https://pmc.ncbi.nlm.nih.gov/articles/PMC7080400/>.

Nonetheless, higher-income families spent an average of \$5,239 on health care in 2019, fully three-fifths more than the average of \$3,247 spent by lower-income families that year.²⁹⁹² Since lower-income people tend to suffer more health problems, that gap in spending suggests they receive less care than they need, on average.

High OOPs. Some have long trumpeted high OOPs for the reasons discussed in chapter 4. They see high OOPs as a way to offset the notional "moral hazard" of good insurance coverage, to deter people from reckless behaviors that damage health or to recklessly use unnecessary or marginally valuable health care simply because it is free when obtained. Others suppose that higher OOPs will induce sick or injured Americans to shop for health care by price and quality. This entails drafting sick or injured citizens as kami-kaze pilots in the cost control war.

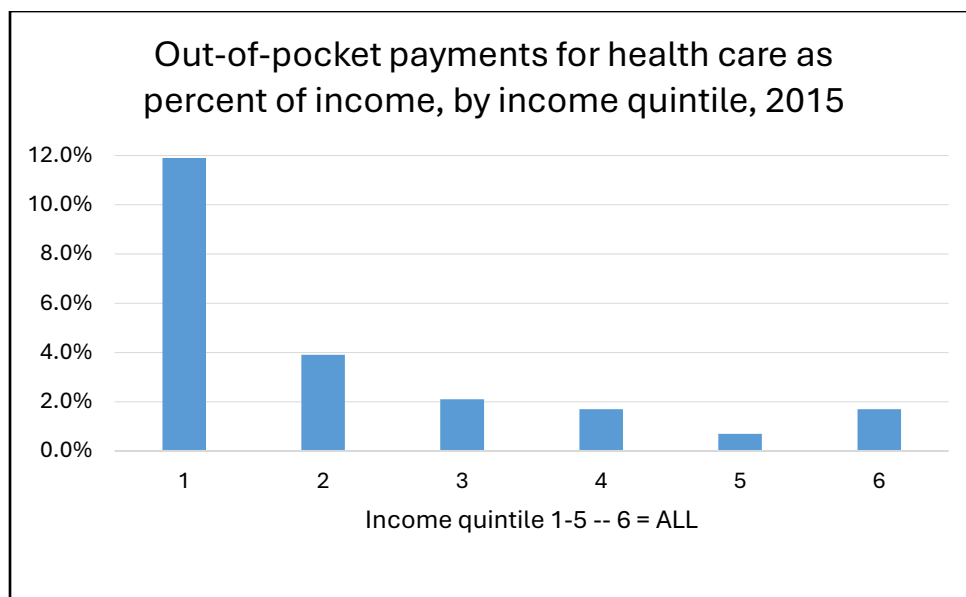
Analyzing data from the Medical Expenditure Panel Surveys from 2018 to 2022, Gaffney and colleagues concluded that "most individuals in the US will experience [high OOP] cost burdens during their lifetimes."²⁹⁹³ Such burdens don't include those shouldered by Americans who refrain from obtaining care owing to inability to afford it or for other reasons.

High OOPs are a form of under-insurance that particularly oppresses people with low incomes or ongoing health problems that require sustained care. That's because fixed-dollar OOPs are a much bigger share of the incomes—or savings—of lower-income Americans. As shown in

7. Assuring Medical security and Health care for all

Exhibit 7 – 4, OOPs took up one-eighth of the incomes of the Americans in the lowest one-fifth of the income distribution but less than 2 percent of overall incomes.

Exhibit 7 – 4



Source: Catherine Grace Carman, Jodi Liu, and Chapin White, "Accounting for the Burden And Redistribution of Health Care Costs," *Health Services Research*, Vol. 55, No. 2 (April 2020), pp. 224-231, <https://pmc.ncbi.nlm.nih.gov/articles/PMC7080400/>.

It is true that OOPs have fallen as a share of national health care spending. But, wrote Altman, that's the wrong denominator. The right one, he asserted, is income, which has not kept pace with health care costs.²⁹⁹⁴

Long and colleagues predicted that loss of enhanced ACA subsidies at the end of 2025 would probably push many people into low-premium but high-OOP bronze plans.²⁹⁹⁵ In March of 2026, Casolo reported on a report from Healthinsurance.org that indeed found enrollee downgrading to bronze plans in 9 states with state-run ACA clearinghouses.²⁹⁹⁶ The share of ACA patients in bronze plans rose from about 30 percent in 2025 to 40 percent in 2026. Unsurprisingly, Texas saw the largest increase.²⁹⁹⁷

Expiration of extra federal subsidies to buy ACA insurance at the end of 2025²⁹⁹⁸ were expected to would cause another 5 - 10 million to lose health insurance. I believe that the high end of that range is more likely. Mathews reported on a study by Lopes and others showing that one-tenth of Americans covered by ACA-subsidized plans were dropping coverage early in 2026, and that others were likely to follow in their steps.^{2999 3000} McGough and colleagues projected a drop of 5 to 6 million ACA enrollees in 2026 alone.³⁰⁰¹ One-seventh of those who signed up for subsidized coverage early in 2026—about 3 million people—failed to pay their January premiums, a rate roughly triple that of past years.³⁰⁰² Two million others, seeking slower premium increases, switched from silver to bronze plans but therefore faced much higher deductibles and other OOP burdens if they used health care.³⁰⁰³

7. Assuring Medical security and Health care for all

Hooper concluded that Republicans viewed lower-premium higher-risk plans as desirable and inevitable.³⁰⁰⁴

Trump has long sought to offset cuts in the numbers of insured Americans by making it easier for displaced patients to buy catastrophic coverage—insurance that starts after the patient has paid \$10,000 per year out-of-pocket.^{3005 3006} Trump also proposed boosting ACA plans' yearly maximum OOP costs to \$31,000 per family.³⁰⁰⁷ This might be called crypto-coverage.

Trump has also pushed shifting federal tax subsidies from subsidizing purchase of ACA coverage at lower premiums into cash donations to families' HSAs. This signals de-insurance. It will leave healthier people better off financially but it will devastate families struck by serious illness, accident, or disability.

HSAs are also financially discriminatory, as mentioned earlier. High-income Americans can set aside before-tax dollars in health savings accounts or flexible spending accounts, and use that money to pay OOPs. Lower-income Americans use HSAs and FSAs at much lower rates than do higher-income Americans. In 2017, only 4 percent of HSA contributions was made by households with incomes below \$50,000 and 77 percent was made by households with incomes above \$100,000.³⁰⁰⁸

Bush's 2003 combination of high-destructible health plans and health savings accounts meant higher OOPs plus a big, new federally-subsidized income and tax shelter for high-income Americans.

The power of high OOPs to deter lower- and middle-income Americans from seeking health care is magnified when overall increases in family incomes don't match overall increases in cost of living. Food and housing costs' shares of income are higher when income is lower. So inflated costs of food and housing particularly disadvantage lower-income Americans. And those facing these rising burdens have left less money to pay for health care, resulting in greater delays or more frequent refusals to seek health care.³⁰⁰⁹

Similarly, Americans suffering chronic illness and disabilities need more health care and, when they use it, they face higher OOPs. These Americans have lower incomes to pay those higher OOPs. Park and Stimpson found that disabled people covered by Medicare have substantially higher OOPs and must devote higher shares of their incomes to pay them.³⁰¹⁰ Under-insurance is worsened by weak financing of long-term home care and mental health services, as discussed in chapters 13 and 14.^{3011 3012}

Cliff and Dusetzina hope that employers can cut workers' OOPs by converting them to regular premium payments over time, by varying OOPs or premiums by income, or by advocating for lower caregiver prices.³⁰¹³ These hopes are unlikely to be widely realized soon. Employers see high OOPs as one of their few tools to hold down premium costs. And employers who believe in market methods of cost control typically endorse high OOPs as a way to neutralize imagined moral hazard and also to motivate sick workers and dependents to shop for health care by price. Such shopping is a fantasy cost control, but belief in its efficacy fits nicely with employers' embrace of high OOPs to win lower premiums for themselves.

Medicare's high OOPs for many services meant one-third of beneficiaries said they could not afford them. More than one if five said they delayed or skipped needed care because they

7. Assuring Medical security and Health care for all

lacked money to pay for it.³⁰¹⁴ Two-fifths of Medicare beneficiaries with incomes below twice the federal poverty level (FPL) were deemed under-insured.³⁰¹⁵

Medicaid patients typically pay no OOPs or very low ones. And caregivers may not balance bill them for any part of charges not paid by Medicaid. Nonetheless, 21 percent of Medicaid patients report medical or dental debt. These stem from non-covered care, failure to bill Medicaid, or illegal bills and other errors.³⁰¹⁶

Trump's 2025 budget scheduled cuts of about \$1 trillion in federal Medicaid spending during the following decade. This will mean fewer people on Medicaid—more uninsured people. It will also mean even less adequate rates of Medicaid payment to physicians and other caregivers in many states, cutting practical access to care. Gooch described ways in which several hospitals began planning to respond to the Medicaid cuts. One safety net hospital anticipated a greater flow of Medicaid patients turned away from nearby hospitals.³⁰¹⁷

In 2026, alleging apparently fraudulent spending on autism, home health care, and other services, Trump led federal Medicaid administrators to defer two sets of payments to both California and Minnesota until financial reviews were completed. These deferrals totaled \$2.1 billion for California and \$450 million for Minnesota.³⁰¹⁸ Three motives were possible: genuine interest in cutting theft and building program integrity, discrediting health spending, and casting blame on Democratic politicians.

Galewitz described a different federal tactic to cut Medicaid spending—tighter scrutiny of Medicaid waivers to ensure compliance with budget neutrality.³⁰¹⁹ That is, they were not to boost federal spending. Many such waivers expanded coverage, services, or prices paid to caregivers. It appears that many were not and are not budget neutral. So ratcheting back on waivers by refusing to extend them will cut federal Medicaid payments to states and erode Medicaid benefits or even eligibility.

Impaired coverage was designed into the ACA in order to hold down the federal government's cost of subsidizing insurance. One method is the high yearly out-of-pocket costs legislated into the ACA. A silver plan, for example, has an actuarial value of only 70 percent of the care costs of people enrolled in such a plan whose family incomes exceed 250 percent of the federal poverty level. Actuarial value can be thought of as a weighted average across all people with a given silver plan. Very high yearly out-of-pocket maximums for 2026--\$10,600 for individuals and \$21,200 for two or more people—mean that the share of costs paid out-of-pocket by most people with silver plans and incomes above 250 percent of poverty will substantially exceed 30 percent. That's because they won't attain solid insurance coverage until they hit their out-of-pocket maximum payments.³⁰²⁰ Holahan and colleagues explained how the ACA's low premiums were made possible by high deductibles.³⁰²¹

Even the ACA's requirement that preventive care be free to the patient (with no OOPs, that is), is often misleading. The requirement creates an artificial boundary between preventive and therapeutic care. For example, the results of a biopsy (free) can lead a conscientious doctor to excise a polyp or cancerous growth (not free).³⁰²² Patients will be surprised by resulting bills.³⁰²³

Another difficulty with preferential financial treatment of preventive care is that some groups may use their opposition to some preventive services—such as PrEP meds to prevent HIV

7. Assuring Medical security and Health care for all

transmission, the HPV vaccine, contraception, or others—to try to overthrow the ACA provision making all preventive care free to patients. Legal attacks continue.^{3024 3025} They risk gutting the ACA's requirement that certain preventive services be entirely covered by all patients' public or private insurance. By one estimate, some 150 million privately-insured Americans had benefited from this provision in 2020 alone, along with millions of Medicare and Medicaid patients.³⁰²⁶

Even the 2020 No Surprises Act was strikingly incomplete because it failed to protect Americans from surprise bills from out-of-network ground ambulance companies. This omission reveals three things. One is the lobbying power of well-organized interest groups. Many local government and non-profit ambulance operators apparently opposed inclusion of ground ambulances under the NSA's umbrella. The second is the weak financing of ambulance services. The third is the pernicious effect of narrow networks. And the fourth is the unfairness of imposing high out-of-network charges when speedy care is pressing and when low-income families are less likely to call 9-1-1 out of fear of cost. A few states have acted to protect citizens and an advisory committee recommended federal action.³⁰²⁷ But progress has been slow.

Complexities multiply as caregivers and payers play games using patients as little white ping-pong balls. One example: Insurers demand rising OOPs to deter patients from filling prescriptions for expensive meds. To offset that deterrent effect, drug makers have offered coupons to cover part or all of monthly OOPs. Long and colleagues explain that many insurers respond by refusing to count the coupons toward annual OOP payments.³⁰²⁸

The simple specific remedy to high OOPs, discussed subsequently, is to make all care free to patients—without OOPs. That remedy would require careful legislative crafting since it would doubtless spark its own legal challenges.

Medical debt: forever toxic financial effects of high OOPs. Just as forever chemicals poison air or water, high OOPs, under-insurance, and their legacy—medical debt—blight families' financial lives.

The toxic effects of debt are greatest for people lacking insurance, for those in high-OOP insurance plans, and those with grave acute or chronic illnesses whose medical costs keep accumulating. Debt often results in denial of subsequent care, garnishing of wages, liens on cars and homes, and bankruptcy.

How much medical debt is incurred? In 2021, some \$88 billion in medical debt was recorded on Americans' credit reports.³⁰²⁹ But most debt does not show up there.

That's because hospitals and doctors are still carrying most of the debt on their books as accounts receivable, usually because patients are making regular monthly payments directly to those hospitals and doctors. Collins and colleagues reported that one-third of working-age adults had medical or dental debt they were paying over time.³⁰³⁰

Suppose that accumulated medical debt is some \$200 to \$250 billion. If so, it is possible that yearly debt incurred is about \$50 billion. If that is correct, it is only about 1 percent of yearly health care spending. But debt seems to have an outsized effect in deterring Americans from obtaining needed medical care.

7. Assuring Medical security and Health care for all

Imposing remarkably high hospital and other charges on uninsured or under-insured people—those least able to pay—is a recurring national scandal. These high prices are a main cause of unaffordable medical debt. (Different recurring scandals, discussed in chapters 13 and 14, include neglectful, abusive, inadequate, or dangerous care in nursing homes or mental hospitals.) Also, I believe, a number of hospitals and doctors violate their contracts with private insurance companies and other payers by charging patients for shares of charges that insurers don't pay. I believe that practice can constitute consumer fraud.

Messac reports that Wisconsin hospitals' suits against patients rose 37 percent between 2001 and 2018.³⁰³¹ This was probably attributable in part to the rise of high-destructible health insurance plans, spurred by Bush's coupling of such plans to health savings accounts. Many employers found those HDHPs attractive because they meant lower premiums. The resulting rise in OOPs probably boosted medical debt.

Hospital actions against Americans with medical debt are well-publicized in part because some hospitals wish that. Those hospitals hope thereby to deter patients who are unable to pay for care from continuing to seek it. Fearing that "no good deed goes unpunished," they don't want to become magnets for uninsured patients seeking affordable care. Near Denver, University Hospital imposed an ER screening charge of \$292 even if patients were not treated. The hospital said it did so to keep out patients who did not need ER care. Critics said the purpose of the fee was in line with the hospital's long-term aim of keeping out uninsured patients.³⁰³²

Hospitals bring patients to court to garnishee wages or place liens on cars or homes. An Illinois hospital had 164 patients arrested over 8 years for failing to appear at court hearings on their debts.³⁰³³ Messac called this a "criminalization of debt."³⁰³⁴

Many hospitals ceased carrying medical debt on their books for many years. Instead, they turned the debts over to collections agencies (which were paid a percentage of recoveries) or sold the debt outright. By 2003, this amounted to one-third of yearly debt.³⁰³⁵ Both practices made for more aggressive—and sometimes abusive—efforts to obtain payment.

A change in New York State law allowed hospitals to electronically attach the bank accounts of thousands of former patients who owed them money.³⁰³⁶ This is another way to instill fear in those who might incur debt in the future, discouraging many from obtaining care—or from maintaining accounts at banks.

Garnisheeing wages to recover medical debts also instills fear. Bichell described legislative proposals in 8 states to prohibit or impede garnisheeing.³⁰³⁷ Sadly, well-intentioned efforts like these address only symptoms of uninsurance, under-insurance, and high OOPs, not their causes.

Some hospitals insist they will go broke if they don't hound patients. Saslow reports on the "follow-up appointment" with a judge for patients with medical debt in Popular Bluff, southeastern Missouri. From January to August of 2019, the local for-profit hospital owned by the Community Health Systems chain had filed 1,100 suits against patients owing it money. More than one-third of county residents had medical debt on their credit reports. The reporter was sympathetic to "a hospital ownership company that couldn't afford to keep losing money and patients who couldn't afford to pay."³⁰³⁸ A look at the hospital's finances for calendar year 2020, though, reveals an annual surplus of \$51 million.³⁰³⁹

7. Assuring Medical security and Health care for all

In Kansas, separate reports from Coffeyville³⁰⁴⁰ and Olathe³⁰⁴¹ describe frequent and aggressive lawsuits against patients by doctors and hospitals. These often resulted in fines or jail time when patients didn't appear for court hearings.

In Minnesota, the Mayo Clinic agreed in 2025 to cease suing patients to recover costs of charity care.³⁰⁴²

Anderson asserts that hospitals, doctors, and other caregivers typically now impose higher charges on uninsured patients. He examines hospitals' pricing more closely because far better data are available on them. Anderson also notes, citing Kessel, that, decades ago, doctors charged lower prices to lower-income patient.^{3043 3044} This was either stealing from the rich to give to the poor (Robin Hood) or garnering as much money as each patient could pay (revenue maximization).

Hospitals also charged higher prices to higher-income patients. This was done from the 1920s through at least the 1940s—at least by large non-profit urban hospitals that had high-price private rooms for wealthy people, 2- and 4-bed semi-private rooms for middle-income people, and 30-bed wards for low-income people. Surpluses on the patients in smaller rooms helped to subsidize cost of care for ward patients.³⁰⁴⁵

Today, hospitals typically demand that uninsured patients pay full charges—even though these are close to four times average cost of services. Many hospitals do this because they can, because uninsured patients have no leverage over hospitals' prices. And others do it because they somehow convince themselves that they are entitled to be paid what they charge.

Hospitals' default charge for uninsured patients has typically been just that—their charge. Charges are hospitals' fantasy prices—the maximum sums they hope to be paid. Charges are much higher even if prices paid by insurance companies, still higher than Medicare and Medicaid prices. In 2018, U.S. hospitals' charges of \$3,853 billion but expenses were \$1,010 billion—so charges were 3.8 times actual costs.³⁰⁴⁶ Hitting uninsured patients with prices that are almost 4 times average cost is hard to understand. (Charges may be as much as 10 times the actual incremental cost to the hospital—the real financial burden—of serving uninsured patients.)

In 1998, hospitals' charge-to-cost ratio nationally was 1.9, just half the level of 3.8 only two decades later. This means that uninsured patients or others hit with high OOP charges like surprise bills have faced much greater financial hardship over time.

The charge-to-cost ratios also vary very considerably across states. This means that interventions to lower the ratios will be particularly valuable to low-income and uninsured patients in states where they are high. It also means that the value of consistent national action would be considerable.

Late in February 2003, Connecticut's then-Attorney-General Blumenthal sued Yale-New Haven Hospital for failing to use its \$37-million free bed fund, established by donors, to pay bills of eligible patients.³⁰⁴⁷

In March 2003, Lagnado reported on the hospital's practice of hitting low-income uninsured patients with high charges for care, high interest rates on unpaid balances, liens, and bank account seizures. She described one patient, now late, whose care was billed at \$18,740 in

7. Assuring Medical security and Health care for all

1982. The patient's husband continued to make weekly payments on the bill but it nonetheless grew to almost \$39,000 owing to 10 percent interest charges on the unpaid balance. The hospital's chief operating officer said "I can attest vehemently to the ethics, the goodwill, and the intent of this organization."³⁰⁴⁸ In the light of Lagnado's reporting, nonetheless, the hospital chose, probably less vehemently, to wipe out the balance owed in April of 2003.³⁰⁴⁹

During the decade before passage of the ACA, lawsuits and legislative hearings sought to push non-profit hospitals to lower their prices for uninsured patients and to strongly temper their aggressive efforts to collect money they believed they were entitled to.^{3050 3051 3052}

Other evidence from Connecticut indicates that physicians and other caregivers have been suing patients more frequently in recent years than do hospitals. This was attributable mainly to a drop in the rate of hospital suits, not to a rise in other caregivers' suits. Levey and others compiled data on suits for health care debt collections in Connecticut. In 2019, Connecticut hospitals filed almost 5,000 suits—three times as many suits against medical debtors as other caregivers filed. Hospitals' suits fell to fewer than 1,000 in 2020 and to fewer than 500 in 2024. Other caregivers' suits also fell—from about 1,700 in 2019 to about 1,200 in 2024.³⁰⁵³ Because hospitals' bills are generally very high, it is likely that the total dollars sought by hospitals remains greater than that sought by other caregivers.

Uncovered organs and other gaps. Americans who enjoyed health insurance protection against costs of doctors, hospitals, or drugs often faced gaps in needed coverage.

Teeth. Perhaps 70 percent of Americans have some dental insurance, but low ceilings on yearly dollar insurance payments are very common. Crowns and root canals are often not covered. Implants are rarely covered. Many dentists responded to the arrival of private dental insurance by raising their total charges for care. Dental insurers were often unwilling or unable to negotiate lower total prices for patients they covered. Much of the payments by dental insurance companies, therefore, boosted dentists' incomes instead of cutting OOP burdens on patients.

Only about two-thirds of working-age Americans visited a dentist in 2019.³⁰⁵⁴ Despite incessant talk about the value of prevention, financing for preventive dental care is often inadequate. Even though it is demonstrably effective.

State Medicaid programs must cover dental care for children, but low payment rates impair actual access to care and use of care in many states:

In February 2007, 12-year-old, seventh grader Deamonte Driver died after complications from an abscessed tooth. His mother, Alyce, who worked a low-paying job, could not find a dentist who would accept Medicaid and perform the routine \$80 extraction to treat Deamonte's toothache. As a result, bacteria from the untreated tooth infection spread to his brain. After two surgeries and six weeks of hospital care, Deamonte died. His operations, hospital care and therapy totaled approximately \$250,000.³⁰⁵⁵

States may elect to cover dental care for adults as an optional benefit, but this coverage is often episodic--granted and then terminated. These disruptions impair both use of care and continuity of care.³⁰⁵⁶

Only some 30 to 40 percent of dentists accept Medicaid.^{3057 3058}

7. Assuring Medical security and Health care for all

The 1965 Medicare legislation explicitly denied almost all coverage of teeth.

Since 2023, as Simon and colleagues noted, Medicare will pay only for dental care that is “inextricably linked to covered medical services”. The list of such care is gradually growing so this could be a foot in the door. Unfortunately, as Simon and colleagues also noted, a 2021 proposal to add dental care to Medicare failed—even though its yearly cost was expected to be about equal to the then-estimated cost of \$24 billion for a newly approved Alzheimer’s drug of very doubtful clinical value.³⁰⁵⁹

Lee and Sutton found high shares of under-65 Medicare beneficiaries unable to afford dental, vision, and hearing care.³⁰⁶⁰

Meds. Prescription drugs pose a similar difficulty. Here, some 10 percent of Americans are uninsured and at least another 25 percent are under-insured owing to inability to afford high OOPs for meds that might be prescribed. Some employers set annual maximum OOPs for meds; these are toted up separately from other OOPs, thereby boosting the yearly OOP exposure of patients with serious illnesses. Many state Medicaid plans have not been aggressive in covering costly new meds like those for hepatitis C even though they are very effective. Medicare now caps OOP spending on covered meds at \$2,000 per person yearly. But, in the absence of effective caps on drug prices, that cap means either higher premiums or tighter formularies—formularies that exclude many high-priced drugs.

Mental health. Federal and state laws are supposed to make coverage for mental health services on a par with somatic health services. But, in practice, tight benefits administration and utilization review may impair delivery of needed care. That difficulty is compounded by substantial waiting lists. Those lists are long, in part, because too few caregivers accept various insurance plans owing to administrative annoyance or low payment rates.

And they are long, in part, owing to the shortage of mental health caregivers. That shortage means that caregivers can choose to exclusively or predominantly serve patients who can afford their high charges. As discussed in chapter 14, many insurers have established or tolerated ghost networks of mental health caregivers—people nominally in-network but actually either not in-network or willing to accept only a few low-paying patients covered by those insurers. Ramey described one patient’s decision to sue insurers for failure to redeem promised mental health care.³⁰⁶¹

Ears. Hearing aids are badly insured. Only about 1 in 6 Americans with hearing loss uses hearing aids.³⁰⁶² Reasons include high prices, stigma, and low satisfaction. The VA covers hearing aids and pays about one-third of the price imposed on non-veterans. The VA price is comparable to those negotiated in the U.K., Denmark, and Switzerland, nations that cover hearing aids.³⁰⁶³

Overall rates of financial protection are unknown. About one-half of states have some sort of mandate that insurers cover hearing aids, but these typically apply only to children. And those mandates can’t legally apply to employers that self-insure.

7. Assuring Medical security and Health care for all

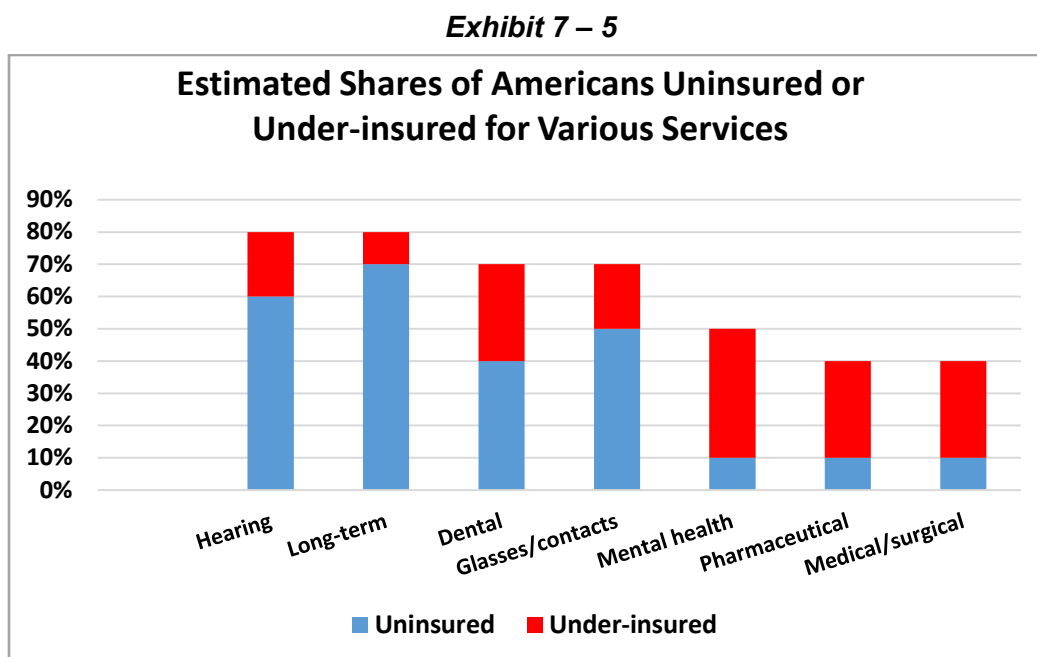
About one-half of state Medicaid plans offer some coverage. As with private insurance, help for children is generally far better than help for adults.

Almost all MA plans offer some subsidies for purchase of hearing aids, but average payment is capped at about \$1,000³⁰⁶⁴ while the average price is substantially higher. Price of over-the-counter devices has been dropping as quality improves; for many, these affordably offer substantial improvement in hearing.

Eyes. Eyeglasses and contact lenses are also badly insured. Only one-half of Americans are insured for vision care devices.³⁰⁶⁵

Long-term care is the least-well-insured set of services. People on Medicaid are covered. So are those with private long-term care insurance and those residing in retirement communities that cover LTC and have solid financial reserves. These groups total perhaps 100 million of 340 million Americans—or about 3 in 10 of us. A smaller share of elderly and disabled Americans—those of us most likely to actually need LTC—now or soon—are covered.

Exhibit 7 – 5 displays estimated shares of Americans who lack insurance entirely or who are under-insured for these different medical services.



Financial incentives. For at least 50 years, U.S. experts in health policy and finance have increasingly espoused the view that paying for doctors' care by FFS and for hospitals' care by

7. Assuring Medical security and Health care for all

the admission has led to over-service—to inappropriately high volumes of doctor visits or hospital admissions. A parallel belief has been that open-ended financing for health care is very costly.

Critics of these methods call them “pay-for-volume.” They urge switching to what they call “pay-for-value.” And they urge capping spending for various groups of Americans.

Financial incentives certainly matter. But, as was shown in chapter 3 and, as will be discussed further in chapters 8 and 9, paying doctors by the visit or hospitals by the admission—usually called pay-for-volume—has not resulted in higher U.S. volumes of doctor visits or hospital admissions. Just the opposite has long been true: our volumes of care are well below the rich democracy averages.

Still, widespread belief in the inherent evil of pay-for-volume has propelled blind acceptance that things called pay-for-value actually pay for value and are generally superior to pay-for-volume.

I think any method of payment can be corrupted by caregivers—if they are motivated to do so. Some methods are easier to undermine than others. But caregivers are capable of manipulating any rules of payment to enrich themselves. That’s because they are closest to the patient, because they make the decisions about diagnosis and treatment, and because they control the data about what care is given.

The key question is whether caregivers are willing to use their knowledge, power, and control over the data in corrupt ways. Answering this question is one of the most important jobs in designing any method of paying caregivers.

In the U.S., switching from pay-for volume to other methods could, in effect, result in under-insuring patients even more deeply. And in further suppressing use of needed care.

If patients are capitated in for-profit MA, in for-profit Medicaid managed care, and in for-profit HMOs for patients covered through employers, the operators of those plans have financial incentives to restrict volumes of care and prices they pay. They make more money when patients get less or cheaper care. The MA, Medicaid managed care, and HMO operators delude themselves when they believe that their profits are sanctified by a competitive free market. Capitated or managed care arrangements are inherently untrustworthy unless operated not-for-profit by trustworthy and financially neutral caregivers, managers, and trustees. And unless revenue is adequate.

States have long used Medicaid managed care as a tool to tightly cap spending on low-income Americans while politically diffusing accountability for doing so. Even non-profit or publicly-operated Medicaid managed care plans have sometimes behaved badly. The publicly-run Medicaid managed care plan for 2.5 million citizens of Los Angeles County was fined \$55 million by state government for delays in authorizing needed care.^{3066 3067} It’s likely that California state government’s own long-standing under-payment of doctors and hospitals serving Medicaid patients—and of Medicaid managed care plans—was in part responsible for those delays.

Differences in prices. Medicaid is the lowest-paying insurer in most states, particularly to physicians—who are important regulators of access to care—and also its potential

7. Assuring Medical security and Health care for all

guarantor.³⁰⁶⁸ On average, Medicare pays higher prices. Private insurance plans typically pay the highest prices. These differences can lead caregivers to prefer some patients over others.

This often means that fewer doctors or dentists accept new (or any) Medicaid patients. Sometimes, it means greater waiting time for an appointment. This problem may be even graver for patients covered by the military Tricare program.

In one survey, only 42 percent of doctors responded that they felt obligated to accept any Medicaid patients; 40 percent reported they felt no obligation at all; and the remaining 18 percent said they'd feel obligated if states boosted payment rates and made other reforms.³⁰⁶⁹ Zhu and colleagues found that two-thirds of doctors were enrolled to serve Medicaid patients, but that 28 percent of those nominally enrolled doctors did not serve a single Medicaid-financed patient in 2021.³⁰⁷⁰ As discussed at length in chapter 15, psychiatrists were found to be the most common ghost doctors, but ghosts were widely disseminated across various payers' directories of caregiver networks.

In most states, Medicaid's low payment rates plague doctors more than they do hospitals. Medicaid's share of hospital costs (before adding in the DSH payments) is about three-quarters of Medicare's share, but Medicaid's share of doctor costs is only about one-half of Medicare's. After accounting for Medicaid Disproportionate Share Hospital additions, average Medicaid payments to hospitals approach those of Medicare.

Because doctors are paid much lower prices by Medicaid in most states, patients who need to see a doctor are disproportionately obliged to turn to organized caregivers like community health centers, hospital outpatient departments, and hospital ERs. Visits to physicians at these sites may entail greater travel times. Continuity of care and building trusting relationships between patients and doctors will typically be harder to achieve. Those organized caregivers are paid higher prices than are doctors in private practice, pushing Medicaid's own costs higher.

A subtler but still common problem arises because all payers' average payments for some services are lower than for other services. Patients needing low-paid services may have more difficulty finding nearby care. The closing of maternity services—owing partly to declining births and partly to high shares of births paid by Medicaid—is one example of this problem. A report from the American Hospital Association asserts that hospitals are paid 34 percent below cost of care for behavioral health and nephrology, 24 percent below cost for burn and wound care, 19 percent below cost for pulmonology, and 15 percent below cost for infectious disease care.³⁰⁷¹

Hospitals hound patients. Low incomes or savings, lack of insurance, or high OOP costs leave many patients unable to pay hospitals' bills. Many non-profit hospitals have become increasingly aggressive in seeking to collect money—even from patients entitled to free care. Some hospitals cite a need to defend their finances against financial pressures that worsened during and after Covid. Others seem to imitate for-profit hospitals' pursuit of high margins.³⁰⁷²
³⁰⁷³

Some non-profit hospitals aggressively sue patients, place liens on homes or cars, or garnishee wages.³⁰⁷⁴ Some deny non-emergency care to patients who have accumulated substantial debts—³⁰⁷⁵ though they have faced pressure to cease that practice. North Carolina hospitals have sued thousands of patients, with one-third of suits initiated by the formerly public Atrium Health in Charlotte.³⁰⁷⁶ ³⁰⁷⁷ The public University of Arkansas Medical Center sued some 8,000

7. Assuring Medical security and Health care for all

patients between 2019 and 2023, including over 500 university employees. In 2016, pre-Covid, it sued only 35 patients.³⁰⁷⁸

Still other hospitals have embedded agents in emergency rooms to collect outstanding debts before new care is given.³⁰⁷⁹ A firm supplying these services was expelled from Minnesota.³⁰⁸⁰ That firm was later bought by a non-profit hospital chain's investment fund.³⁰⁸¹

A number of for-profit hospital chains aggressively sue patients for unpaid bills.³⁰⁸² They often claim this is essential to generate revenue to keep the hospital open, but hospitals involved are often much more profitable than they assert.³⁰⁸³

Another tactic hospitals employ is to market high-interest medical credit cards so patients can pay for care not covered by insurance.³⁰⁸⁴ (At least one insurer subjects doctors and their patients to parallel financial mischief.³⁰⁸⁵)

High levels of medical debt result in large part from public and private payers' high out-of-pocket obligations, under-insurance, denials of payment for claims after care is given, and surprise bills. Such debt is close to \$200 billion, with 17 percent of households facing some medical debt and 6 percent of adults in debt to doctors or other non-hospital caregivers.³⁰⁸⁶

All non-profit hospitals are required to have charity care policies, but these are inconsistent in design, unpredictable in administration, and badly enforced. Eligibility for free care varies from 41 percent of the federal poverty level (FPL) to 600 percent. It is frustrating—but understandable—that hospitals located in counties with smaller shares of poor people or people lacking health insurance had more generous income cut-offs for free care. Those hospitals were less concerned about being overwhelmed medically or financially if they were more generous.³⁰⁸⁷

Narrow and unstable networks of doctors and hospitals formed by insurance companies and other managed care operators are often not adequate or durable enough to assure timely access to needed and coordinated care. Insurers and operators form narrow networks because they believe them to be one of the few tools they can wield to leverage lower prices they pay to doctors and hospitals. Narrow networks probably also cut use of care by disrupting patients' relations with caregivers and by boosting waits for appointments and travel times.

Rayasam vividly described the plights of patients whose care was disrupted by a switch in insurance coverage.³⁰⁸⁸ State and federal regulations are supposed to protect continuity of coverage and care, but a number of patients' changes are not covered. Different payers' different rules about benefits, administrative requirements, and payment levels can impede care.

As discussed in chapter 5, the narrow networks formed by for-profit California HMOs serving Medicaid patients, when Reagan was governor, were so inadequate and denied care so often that they became a state and national scandal.

Narrow networks can result in loss or disruption of needed care by breaking ties with doctors or hospitals on which patients had long relied.³⁰⁸⁹ So can changes in insurance coverage. Insurers often promise help in finding new in-network doctors,³⁰⁹⁰ but these promises are typically meaningless in practice.

7. Assuring Medical security and Health care for all

Medicaid patients who are obliged to find new caregivers who are in their new payer's narrow network may experience particular difficulty in finding any who take Medicaid and are accepting new patients.³⁰⁹¹

Moreover, narrow networks disrupt continuity of care. Continuity with primary care doctors or with specialists treating chronic illnesses is particularly valuable. Physicians' ties to different networks change over time, compelling patients to find new primaries or specialists, or to pay OOP. And if a patient's coverage switches between Medicaid and a subsidized ACA plan, primary care doctors taking one form of insurance will often not take the other.³⁰⁹²

When insurers create networks with too few caregivers, the ensuing long waiting times for appointments and long travel times for care can deter patients from seeking or obtaining needed services. These can be particular problems in rural areas and low-income urban areas—places where total numbers of caregivers are often inadequate overall—even before narrow network are created.

Patients in Medicaid managed care plans will suffer inadequate access when those plans pay doctors, hospitals, or other caregivers at rates so inadequate they fall below even the low prices paid by conventional Medicaid fee-for-service rules—or when in-network caregivers are so sparse that it is hard to get a timely appointment or when visiting them imposes lengthy travel.³⁰⁹³

No other rich democracy oppresses its citizens, patients, or caregivers in this way.

ACA plans' narrow networks impair access and drive away patients with greater medical needs.³⁰⁹⁴ Read-Richards and Keller note the difficulties rural Americans face in several states in gaining access to in-network ACA caregivers.³⁰⁹⁵ But these narrow networks save little money overall. Premiums for ACA marketplace plans with an extra-narrow network plan—fewer than 10 percent of area physicians—were only 6.7 percent lower than for wider networks that included 40-59 percent of area physicians.³⁰⁹⁶ This apparent—and very modest—saving stems partly from patient self-sorting: patients with chronic or severe health problems disproportionately seek larger networks that include all of their trusted physicians.

ACA mispricing. Dorn and Jost explained that one-half of Americans whose premiums were subsidized by the ACA were in bronze and silver plans with very high deductibles. They claimed that insurance companies under-priced silver plans because they were highly profitable—even after Trump ended special federal payments to finance cost-sharing reductions for low-income silver plan enrollees during his first presidency.

Low-income patients have been acutely sensitive to premium differentials and appear to have been less likely to consider high OOPs associated with low premiums when choosing an ACA plan. But the high OOPs end up deterring low-income enrollees from using much health care—which helps make those silver plans so profitable to the companies.

Dorn and Jost further asserted that insurers in most states illegally set premiums to reflect risk. They contrast this with the experience in Texas and New Mexico, where state law requires ACA insurers to follow federal law and rely on a single risk pool. In New Mexico, passing that law caused the share of enrollees in high-destructible bronze or silver plans to fall from 49 to 23 percent in one year.³⁰⁹⁷

7. Assuring Medical security and Health care for all

This speaks to the difficulty of relying on traditional insurance in health care to fill gaps in coverage. The difficulty stems in part from the complexity of setting health insurance premiums. And in part from insurance companies' willingness and ability to game federal law—and even violate it—to make money for themselves.

Weak oversight. Harm to patients has been compounded by “absence of robust oversight” of availability of in-network caregivers by state Medicaid programs. State agencies setting payments to caregivers routinely violate the obligation to set rates adequate to ensure access to care.

A review by Perkins pointed to the two federal regulations that should govern state Medicaid programs' requirements for payment rates and networks sufficient to ensure equal access and reasonable promptness of care. It is 42 U.S.C. § 1396a(a)(30)(A) that requires payments that are “consistent with efficiency, economy, quality of care and assure equal access.” And it is 42 U.S.C. § 1396a(a)(8) that requires reasonably prompt care for Medicaid patients.³⁰⁹⁸

Unfortunately, the federal Centers for Medicare and Medicaid Services (CMS), which is responsible for enforcing these Medicaid provisions, has been irresponsibly lax. Many states have been allowed to set low payment rates and accept inadequate networks of caregivers. CMS has permitted this to persist owing to federal government desires to avoid fights with states, many of which are not strongly committed to access for Medicaid patients—or even to Medicaid itself.

This political and financial problem is exacerbated by the Supreme Court's 2015 decision in *Armstrong v. Exceptional Child Center, Inc.*, that neither Medicaid beneficiaries nor caregivers have standing to sue to enforce the 2 regulations in federal court. The Armstrong decision held that only CMS was authorized to enforce the regulations. It could do so by withholding federal Medicaid matching funds from states that did not comply with federal regulations.³⁰⁹⁹

The combined effect of these political and legal decisions is to nullify Congress's intent to establish a Medicaid program that would be adequate and equal in its access to care.

These effects are magnified when states delegate accountability for caregiver network and payment adequacy to Medicaid managed care operators that are paid fixed yearly sums.

Some assert that the federal government monitors Medicare Advantage plans' network adequacy more carefully than states monitor network adequacy for traditional Medicaid or private Medicaid managed care plans. Unfortunately, evidence on the adequacy of MA networks is sparse. And some reports are highly critical.³¹⁰⁰

Insurers have been accused of creating “ghost networks” by issuing directories that name “in-network” caregivers who are no longer in-network or are not taking new patients. This may result from accident, from incompetence, or from intent.³¹⁰¹ Inaccuracies seem to consistently involve over-stating the numbers of in-network caregivers. The problem is long-standing and seems to be a chronic source of pollution running downstream from use of narrow networks. In October 2025, California settled its suit against Centene for inaccurate directory information for \$40 million in penalties and remedies.³¹⁰²

Public regulation of network adequacy has been weak, transient, and—even when intentions are good—difficult to enforce effectively. These matters are addressed in chapter 9's

7. Assuring Medical security and Health care for all

examination of ways to pay caregivers and in chapter 10's discussions of reforms in the organization and delivery of care.

Prior authorization. Refusing prior authorization for care can disrupt diagnosis and delay treatment. Medicaid relies heavily on private managed care operators to form networks of doctors and hospitals and authorize needed care. The operators face financial risk. In 2022, over one-half of Medicaid managed care patients were contracted out to for-profit operators.³¹⁰³ If costs of care exceed their fixed payments from state Medicaid programs, they lose money. One-tenth of operators—those reviewed by the DHHS Office of the Inspector General for a 2023 report—refused authorization for more than one-quarter of all claims.³¹⁰⁴ The IG found that states do not sample denials to assess whether they are clinically appropriate or even legal, and that many states do not even monitor denial rates.³¹⁰⁵

A 2022 OIG report on Medicare Advantage plans that found that some MA “denials of prior authorization requests raise concerns about beneficiary access to medically necessary care.”³¹⁰⁶

Sutton wrote that MA plans denied more than 2 million prior authorization requests in 2021, some 6 percent of 31 million Medicare Advantage prior authorization requests in 2021, with some insurers denying 3 percent and others 12 percent of requests.³¹⁰⁷ In 2022, the share denied rose to 7.4 percent of 46 million prior authorization requests.³¹⁰⁸

Only 1 percent of denials were appealed and MA plans’ internal reviews over-turned three-quarters of those denials. The remaining one-quarter were automatically referred to outside qualified independent contractors (QICs). These amounted to 165,000 appeals in 2021. Only 3 percent of denials were overturned by QICs in 2022, down from 7.1 percent in 2016.³¹⁰⁹

Cuts in care resulting from prior authorization go beyond requests actually refused. A history of denials leaves a legacy of discouraged caregivers. Expectations of difficulty in obtaining prior authorization may lead physicians to refrain from ordering certain services for patients.

For-profit MA plans enrolled almost three-quarters of MA plan members in 2024, up from two-thirds in 2019.³¹¹⁰ Appeals of denied prior authorization requests may increase if enrollees fear that MA plans are refusing to pay for care—said by their doctor to be needed—in order to boost profits. This will make for greater friction and will boost administrative waste.

Prior authorization frustrates both patients and physicians. Their complaints are long-standing³¹¹¹ and widespread.^{3112 3113 3114 3115} In the face of these complaints, and of federal and state actions and proposals to constrain prior authorization,^{3116 3117 3118} some insurers have promised to cut their demands for it.

Starting in 2023, insurers like United Healthcare and Cigna promised to cut the number of services requiring prior authorization. The AMA was said to be “careful not to confuse positive developments with major progress.” Insurers lack effective tools to safely contain health care costs. So they should be expected to cling even to ineffective or unsafe tools.³¹¹⁹

Not all doctors are impressed.³¹²⁰ Some journalistic coverage balanced doctors’ own frustrations with prior approval with descriptions of harms to patients stemming from delayed care.³¹²¹

7. Assuring Medical security and Health care for all

Many doctors and hospitals—and some patients—may be frustrated by MA plans' withholding of prior approval or denying claims for care received, but rising MA enrollments testify to the plans' perceived advantages. Attractive elements include caps on OOPs, along with some coverage of hearing aids, eye care, and teeth, all at low or no cost above ordinary Part B and D monthly premiums. This game appears rigged, though. That's because MA plans have been shown to harvest undeserved revenue by making their members look needier than they really are. This is done by gaming Medicare's risk-adjustment measures and also by manipulating Medicare's star rating bonuses paid to notionally high-quality plans. Reforms to contain MA's cost will need to address resistance from enrollees who understandably fear loss of extra benefits. Simply, it is hard to take away benefits to which people have become accustomed.

CMS issued a proposed rule in December of 2022 that would require health insurers serving as financial intermediaries for public health insurance programs like Medicare, Medicaid, and ACA plans to use electronic forms of prior approval by 2026.

Kyle and Song asserted this might be helpful, or that it might lead to cursory review and denials, followed by more careful attention to the small numbers of denials that are appealed. They believe that prior approval is “one of the most enduring, infuriating, and effective tools in the United States for managing health care spending. Easing prior authorization would put even more pressure on payment policy to control spending.”³¹²²

They believed that other nations rely on government decisions that contain spending by regulating access to health care services. That counter-factual belief will be examined later in this chapter and also in chapter 8.

MA plans have also been criticized for relying on predictive software to decide whether patients need to initiate or continue various sorts of medical care. When this is done without seeing and assessing the living patient, care that's obviously needed can be denied.³¹²³

United Health was sued in November of 2023 for using an algorithm to cut short nursing home stays by its Medicare Advantage patients.³¹²⁴ In June of 2026, a report from the DHHS Office of Inspector General found that MA plans “overturned nearly all appealed prior authorization denials for skilled nursing facility admission, raising concerns about initial denials.”³¹²⁵

Since 2024, federal rules required MA plans to make coverage decisions that respect individual patients' clinical needs—and not simply ratify results of predictive software. It will not be possible to effectively enforce those rules in the face of financial incentives to deny care and the enormous volumes of individual services requiring coverage decisions by private payer-regulators.

Chino and colleagues found that roughly 7 in 10 cancer patients' treatments were delayed by prior approval processes and that 22 percent of cancer patients did not receive treatments their physicians recommended. Patients faced the double burden of worry and paperwork. The share of denials that was justified by evidence is not known.³¹²⁶

Sausser describes an example of a patient covered by the Veterans Health Administration whose cancer care was delayed by slow prior authorization of outside surgery through the VA's Community Care Program.³¹²⁷

But prior authorization persists. One reason is the widely-held over-riding belief that prior authorization saves money. Altman endorsed retaining prior authorization because he was

7. Assuring Medical security and Health care for all

persuaded that eliminating it would push up national health spending by some 5 percent. In doing so, he relied on a figure that had been estimated by a consultant's report commissioned by an insurer—Massachusetts Blue Cross.³¹²⁸

Complaints from patients, caregivers, and politicians often elicit promises from insurers, MA plans, Medicaid managed care plans, and other operators that they will trim the numbers of services requiring prior authorization. But this is little more than theater.

Interestingly, a bill filed in the Pennsylvania legislature in 2026 would hold health insurer CEOs criminally liable for aggravated assault “if a covered person gets an ‘adverse benefit determination’ of a medically necessary benefit that leads to serious bodily injury or death.”³¹²⁹ This appears to cover both denial of prior authorization and denial of payment after care is given.

Denial of claims. Effects of under-insurance are worsened by payers' high rates of denial of patient claims for payment for in-network care. ACA insurers denied 17 percent of in-network claims in 2021. Some denied only 2 percent of claims while others denied almost one-half. For almost three-quarters of denials, no specific reason was provided.³¹³⁰ Only a few tenths of one percent of patients appeal denials and, even then, insurers uphold most of the denials. These figures show little improvement from previous years. Subsequent denial rates have remained close to the 2021 levels.

As might be expected, Horny and colleagues found that low-income and disadvantaged Americans suffered disproportionately from denial of insurance claims.³¹³¹

The ACA statute obligated HHS to monitor denials of claims. This probably stemmed from a fear that the law's prohibitions of medical underwriting, annual limits, lifetime limits, and rescinding coverage might lead insurers in the ACA marketplaces to take other steps to hold down their payments for care.

HHS has refused to comply with the law's monitoring requirement.³¹³²

Is this surprising? No. Federal regulation or scrutiny of millions of claims is very difficult. (A sample of claims could be pulled and examined, but even this has apparently not been done.) Regulations, simply, try to modulate the hurricane of financial incentives. The problem is the existence of those incentives—absent a functioning free market. Failure to regulate health care competently is unsurprising. (Please recall the photo from chapter 1 of the worker with a wheelbarrow and shovel who followed the circus parade.)

Refusal to pay about one-sixth of all in-network claims—typically without a specific reason for refusing—undermines ACA patients' confidence in their health insurance—and in the federal government that heavily subsidizes that insurance. Worse, uncertainty about whether claims will be paid inevitably discourages patients from seeking needed care. And caregivers from serving patients in ACA plans.

Wide variations in denial rates across insurers suggest that payers' policies help powerfully to explain denials. At the same time, those variations indicate that patients' or caregivers' behaviors are not responsible for the bulk of denials.

7. Assuring Medical security and Health care for all

For years, the federal government has been as lax in monitoring ACA marketplace insurers as it was in 2023 and 2024 in begging or urging states not to throw patients off Medicaid purely for flimsy administrative reasons.

Patients in subsidized ACA plans are not the only victims of denials of payment. Pestaina and colleagues found that 21 percent of patients with private insurance reported claims denied during 2022, compared with 20 percent in ACA marketplace plans, 20 percent on Medicare, and 12 percent on Medicaid.³¹³³

The American Hospital Association complained that MA plans' denials of payment rose by 56 percent between January 2022 and July 2023.³¹³⁴

Possibly, health insurance companies have become more aggressive over time in denying payment for care of people covered under ordinary employer-sponsored insurance.³¹³⁵ Patients covered by Cigna have sued the company over allegations that it illegally denied caregivers' claims without reviewing them.^{3136 3137}

Miller and Fields reported that health insurance companies have long been violating state laws prohibiting wrongful denial of payment. State enforcement action has been weak. Miller and Fields found only 45 instances of state agency action to address wrongful denial of payment across the nation in five recent years. Once again, regulators are overmatched both politically and logistically.³¹³⁸ The core problem here is that insurers make more money when they deny more care. This financial incentive overwhelms potential opposition. Opposition is also suppressed by fears that approving payment for more claims would boost the insurance premiums and taxes that finance U.S. health care.

Private insurance companies aim to contain their spending for care of privately insured patients and also those companies' Medicare Advantage and Medicaid managed care patients. Narrow caregiver networks, refusal to authorize care, denial of claims for care given, and curtailing treatments prematurely all suppress access and compromise quality.

Generally, over one-half of all insured adults reported problems in using their insurance coverage. These problems included denied claims, problems with caregiver networks, and pre-authorization of care. Two-thirds of people in fair or poor health reported such problems.³¹³⁹

Efforts to address harms from narrow networks, denial of prior authorization, and denial of claims for payment have been ineffective.

One reason is that under-insurance is made more severe when two or more factors combine. Ordinary Medicaid or Medicaid managed care pays low prices for professional services in most states, such that relatively small shares of physicians or dentists agree to serve Medicaid patients. When Medicaid or its managed care plans then refuse prior authorizations or deny payment retroactively, more physicians and dentists are likely to decline to treat Medicaid patients.

A second reason is that it is very difficult for remote reviewers to oversee caregiver or managed care or payer decisions. If doctors, hospitals, or operators face financial incentives to deny care to make money (or avoid losses), many of them will do so. This is a prime example of both the danger of using financial incentives and the danger inherent in regulators' endemic inability to

7. Assuring Medical security and Health care for all

protect patients from managed care plans or caregivers who are incentivized to cut care to make money. Financial arrangements that build in rewards for bad behavior are hard to regulate or modulate.

The Biden administration's response was the traditional one: to promulgate regulations to require state-run marketplaces to adhere to federal standards for network adequacy.³¹⁴⁰ But the federal standards are themselves neither adequate nor actually enforced. It is probably not possible to enforce them effectively. The problem here is that narrow networks are one of the few means insurance companies and managed care operators can employ to try to contain use and cost of care. Few other nations rely on them. Once they are allowed, it is not feasible—politically, logistically, or legally—to set effective standards for network adequacy, to oblige insurers and managed care operators to adhere to them, or even to learn when those insurers or operators inevitably fail to follow the rules.

The main reason such regulations exist is to comfort legislators, patients, or caregivers—to reassure them that something is being done about a predictable, pervasive, and pernicious problem. That comfort is illusory. When that reality sinks in, all parties' trust in government's willingness and capacity to act competently in health care drops further. Cynicism soars.

It is a toxic combination to create mechanisms that are prone to abuse, to tolerate those abuses, and then to only pretend to address them meaningfully when the abuses are publicized. It undermines health care equity, effectiveness, and efficiency. It employs talented lawyers and administrators in futile tasks. It undermines Americans' faith in our competence and compassion. As chapters 4 and 5 describe, this pattern is the rule in U.S. health care, not the exception. Kessler suggests this pattern operates outside health care as well.³¹⁴¹

A number of hospitals have withdrawn from networks created by insurance companies sponsoring Medicare Advantage plans.³¹⁴² Emerson detailed 23 hospitals dropping various MA plans in 2026.³¹⁴³ The Senate Permanent Subcommittee on Investigations sought information from the three biggest MA plans about their methods of approving or denying care.³¹⁴⁴

In the fall of 2023, Goozner suspected that enrollment in MA plans may have peaked.³¹⁴⁵ He pointed to a growing number of hospitals and doctors—such as Scripps in San Diego, Mayo in Florida and Arizona, and Baptist Health in Louisville—terminating their MA contracts owing to low prices and fraught payments. These exits disrupt patients' care. They frighten those patients who are denied Medi-gap coverage or face high risk-rated premiums when they try to return to traditional Medicare. Only 4 states require guaranteed issue with community rating for Medi-Gap policies—and forbid medically underwriting their premiums—when patients abandon MA for traditional Medicare.

Managed care's prepaid capitation financially incentivizes operators of all for-profit plans and many non-profit plans to authorize less care and deny claims. Medicare and Medicaid apparently do as little to protect their patients as marketplaces do to protect those covered by ACA plans. Entitling patients financially with plastic insurance cards one hand, but suppressing care by incentivizing denial of care with the other hand is bound to upset patients and also frustrate doctors and hospitals. Private insurers' denials of claims for care of employees and dependents, discussed earlier, cause parallel upsets and frustrations.

Institutionalized insecurity. Patients' willingness or ability to seek care is undermined by high OOPs, loss of insurance coverage, change in insurer, severing of insurer – caregiver relations,

7. Assuring Medical security and Health care for all

loss of caregiver, change in caregiver, shortages of in-network caregivers, delays in obtaining appointments, prior authorization delays/denials, denial of payment after care is given, and other upsets. Patients with more serious medical problems and those with less money, time, self-confidence, or sense of empowerment will suffer greater harm from these disruptions. Karkowsky vividly described some of these.³¹⁴⁶

Other rich democracies do not undermine their citizens' access to care in these ways.

One persisting form of insecurity is gaining and losing insurance coverage. This particularly afflicts patients on Medicaid. They are subject to churn—going on and off Medicaid owing to changes in income or difficulty in recertifying eligibility. This problem has long been known but little was done to address it before the massive unwinding of Medicaid eligibility in 2023 and 2024.³¹⁴⁷

Many patients face—or fear—disruption of care caused by contractual fights between insurers and hospitals, doctors, and other caregivers. Most contention concerns prices to be paid and whether caregivers will be in-network. If a valued physician or the nearest hospital ceases to be in network, patients must weigh convenience, cost, and sustaining important ties to caregivers.³¹⁴⁸ Even when disputes are resolved before contracts terminate, many patients fear their care will be disrupted.³¹⁴⁹ Such fights have been publicized for years.³¹⁵⁰ They have become common.^{3151 3152 3153 3154 3155 3156 3157 3158 3159 3160 3161} And they have become more visible to the public.³¹⁶²

Examples abound. One of the most dramatic was Nemours Children's Hospital's withdrawal from New Jersey's Medicaid program. In the second half of 2023, the hospital ceased to care for 11,000 special needs children.³¹⁶³ Some 50,000 Medicaid patients in Ohio became out-of-network at Bon Secours Mercy caregivers owing to that system's disputes with Anthem Blue Cross.³¹⁶⁴ Anthem's attempt to cut payments to in-network hospitals that tolerate care of Anthem-covered patients by out-of-network doctors, discussed elsewhere, is a new type of threat to continuity of patients' care.

Private insurance companies' narrow networks, prior authorization requirements, rigid care protocols, and payment denials impair patients' access and undermine quality of care.³¹⁶⁵ In one large study, one-quarter of respondents reported that care was delayed or abandoned owing to patient/family administrative tasks.³¹⁶⁶

No other nation regards harm to patients from insurer – caregiver fights as inevitable or acceptable collateral damage.

Those fights stem from financial incentives that are untrustworthy owing to the absence of a competitive free market, the inherent incompetence and wastefulness of regulatory review of physicians' individual diagnosis and treatment decisions, shortages of primary care and other malconfigurations of caregivers, absence of effective and trustworthy cost controls, and the absence of both financial and clinical accountability in U.S. health care.

Fears that payers' efforts to constrict the flow of revenue for health care would further undermine access to care—especially for people vulnerable to deprivation of needed care—should strengthen attempts to combine cost control with access. Fears that cost controls would

7. Assuring Medical security and Health care for all

accelerate the loss of needed rural and urban doctors and hospitals highlight the need for special protections for vulnerable patients and the caregivers serving them.

3. Who gets what care?

The share of Americans with health insurance coverage has remained higher early in 2026 than it was in 2010. That is not likely to persist. Also, the shares who are under-insured for various reasons remain very high.

Because so many Americans suffer impaired access to health care—in substantial part because suppressing access to care is a mainstay of cost control efforts, six basic questions demand answers.

First, how can all Americans be fully protected financially against the costs of health care? This means first- and last-dollar coverage. It means removing financial and administrative barriers that suppress use of care.

Second, what methods of covering people are most compatible with effectively containing cost in ways that are politically acceptable—that minimize ongoing conflict or friction or litigation—and that don't drive patients and caregivers crazy? Building on chapter 3's analyses of waste, this question is addressed in part in the present chapter and in part in chapters 8 and 11.

Third, what methods of paying caregivers would reinforce patients', voters', and payers' trust that caregivers would be available, able, and willing to equitably serve all people and contain cost? This question is addressed in chapter 9.

Fourth, how to shift the configuration of caregivers to help redeem the promise of full financial coverage without administrative barriers? Because the care we get depends heavily on the caregivers we're got, this means securing the right numbers and types of doctors, hospitals, dentists, and others in the right places. Chapters 10 through 14 take up these matters.

Fifth, how to ensure that the right patients get the right care—appropriate care, and how to ensure that the technical quality of that care is high? What steps can be taken to raise the floor under care quality—such that no patients fall below that level? How to balance investments in raising the floor with investments that raise the ceiling—the best health care can do? These questions are addressed in chapter 16.

Sixth, who decides which patients get what types and amounts of care? What are the roles of physicians and other professionals? Of patients? What rights to care would patients enjoy? How can patients be confident that physicians and other caregivers are treating them fairly? These are also addressed in chapter 16.

Providing good answers to these six questions entails integrating wholesale policy decisions about coverage, cost control, and caregiver configuration with retail clinical decisions about which patients get what care.

7. Assuring Medical security and Health care for all

Looking ahead

In the future, what will be the practical meaning of “equitable first- and last-dollar coverage”?

It should mean an end to rationing by ability to pay. It is the first key step—and not the only one—toward giving care in light of patient need for care, efficacy of care, and cost of care. (Subsequent steps will be containing cost, reforming caregiver payment, reconfiguring caregiver types and numbers and locations, and boosting quality and appropriateness of care.)

It could never mean unlimited payment for all care that any doctor sought to provide or that any patient desired to receive. That indulgent approach is the enemy of equitable coverage and of cost control. It would perpetuate in health care what Hardin called “the tragedy of the commons.”³¹⁶⁷

Unlimited payment is never possible. It is always a myth. Since cost control requires yearly caps on revenue available to pay for health care, negotiating a solid prenuptial agreement is essential to a durable marriage between cost control and equitable first- and last-dollar coverage.

Coverage should entail wide and deep protection for each American. All needed and effective and affordable services should be covered. And protection should mean much more than an insurance policy with high premiums and high OOPs. OOPs should be in the minimal-to-symbolic range. Financial barriers to care should be eliminated. Along with all forces making for under-insurance or otherwise suppressing use of needed care.

The nation’s past focus on lowering shares of people entirely lacking health insurance and on highlighting some states’ progress in lowering rates of complete lack of insurance can feel good and even inspire progress.³¹⁶⁸ But they are neither sufficient nor acceptable.

Practical “equitable first- and last-dollar coverage” would begin by covering everyone for all low-cost services that are highly effective and by excluding services whose harm exceed their benefit, services that do no good, and low-value/ high-cost services. Effective and beneficial services would continue to be provided until the money runs out. The only reason to deny any care to any patient would be to make other care (and both the clinical time to give it and the money to pay for it) available to deliver more valuable care to that patient or other patients.

This would require identifying services’ effectiveness and cost. That would include recognizing that patients with different needs will benefit differently from the same care. It would continue by assuring that similar patients are treated similarly.

That would include both protections for people who are reluctant to seek needed care and protections against those who demand ineffective or unaffordable care. The former are probably much more numerous than the latter—even though the latter are more audible. These topics are addressed in chapter 16.

For the next 5-10 years, Improvements in coverage and equity should and must be financed by cutting waste. One reason is that, as argued in chapter 1, steady flows of incremental revenue into health care are unlikely. A second reason, as argued in chapter 3, is that one-half of today’s health care spending is wasted.

7. Assuring Medical security and Health care for all

Subsequently, once waste is cut to the bone, Americans will need to decide whether health spending should be allowed to remain at around 17-18 percent of GDP, or whether it should gradually subside. This decision will be made in light of health care's value, demands of other sectors, and the condition of the economy. Chapter 8 asserts this will be a political decision.

"What do patients really want from health care?"

Detsky posed this question in 2011. He offered a personal list with three categories.³¹⁶⁹

He believed the public most wants restoration of health when ill, timeliness, kindness, hope and certainty, continuity, a private room, no OOPs, the best care—from the doctors to whom trusted people refer them, and meds or surgery—not treatments obliging them to exert themselves.

Less important are efficiency, aggregate-level statistics, equity, and avoiding caregiver conflicts-of-interest.

Still less important are real cost of care or the share of GDP going to health care.

This is interesting but not entirely useful. That's because it will be impossible for health care to give patients what they say they really want unless health care pays attention to the things that patients say are less important.

Also, it is likely that different Americans seek different things from our health care. It will be important to protect ourselves financially against health care costs in ways that respect these differences.

B. How and why do other rich democracies cover all people?

None of the world's rich democracies made a jack-rabbit start and covered everyone all at once. All those outside the U.S. evolved toward financial coverage for all people over a number of decades. They made the journey by different roads. They employed different mechanisms. They were motivated by different considerations. But all ended up more or less in the same place.

As they covered all people, the world's other rich democracies found ways to contain cost of care. No nation has covered all people without containing cost—or contained cost without covering all people.

Since the 1930s, the U.S. has financed added insurance coverage incrementally, first through private insurance, and then through Medicare, Medicaid, and the ACA. Some believe the U.S. will complete the job by continuing to extend coverage at steadily higher cost.

I do not believe that will ever happen. Why not? First, because U.S. health care has become extraordinarily costly even without covering everyone. I doubt that finding enough added money to cover all people well is politically or financially feasible.

And second, because added insurance coverage in the U.S. has, for years, been accompanied by worsening under-insurance. Many people have formal coverage but can't afford the OOPs that attend obtaining care, or the medical debt that ensues. Coverage expansions have marched forward in step with care suppression.

Third, covering everyone well will need to rest on substantial reforms in cost control through capped spending and waste-cutting, in methods of paying caregivers, in caregiver configuration, and in improved quality and appropriateness of care.

Where have the world's other rich democracies have arrived? Generally, doctors, hospitals, meds, and even dentists are covered for all people. The obligation to pay for care for all people—with high shares of needed revenue raised through tax- or tax-like-financing—combine to press politicians to contain spending, leading caregivers to respect the need to contain costs of care.

No rich democracy has covered all people without containing cost, or contained cost without covering all people.

Nowhere is health care perfect. Inequalities in access and outcomes persist—often by income and usually by urban-rural locations. Payment for long-term care, dental care, or mental health services is incomplete almost everywhere.

Although the coverage for all people elsewhere is more important than the very different paths taken to reach it, those paths are worth examining because they suggest many different but rich opportunities for progress in the U.S.

7. Assuring Medical security and Health care for all

1. Different paths to covering all people

U.S.

The U.S. has advanced coverage incrementally—but incompletely. Medical care for sailors has been paid publicly since 1796, Lee reminds us.³¹⁷⁰ Union Army and Navy veterans were added during the Civil War, though surviving Confederate veterans were added only in 1958. Low-income people who were blind, disabled, dependent children, or elderly—and were receiving income supports—were covered under federally-subsidized state welfare programs to pay doctors and hospitals beginning in 1950.³¹⁷¹

The 1965 law creating Medicaid expanded and systematized these benefits considerably. The 1965 Medicare law covered people over 65 for doctor, hospital, and recuperative benefits. Younger disabled people were added in 1972, along with those suffering from chronic kidney disease. Since 2001, patients diagnosed with ALS who receive Social Security Disability Income are covered by Medicare immediately, without SSDI's customary 2-year wait.

In the years after the Second World War, private health insurance through the job boomed as non-profit Blue Cross plans were initiated by state hospital associations and Blue Shield by state medical societies. Both were usually community rated initially, charging the same premium for all groups of employees. For-profit insurance companies soon began competing with the Blues. They generally experience rated, charging lower premiums to employers with younger and healthier workers.

The 2010 ACA compelled private health insurance companies to cover children up to age 26, expanded Medicaid to all people below 138 percent of the federal poverty level—subject to state approval, and subsidized purchase of private insurance by people under 400 percent of the FPL. The American Rescue Plan of 2021 enhanced those federal subsidies and thereby reduced families' premiums. The Inflation Reduction Act of 2022 extended the higher subsidies until the end of 2025, when they lapsed.

U.S. coverage is unique in two ways. First, as discussed earlier in this chapter, a substantial share of people lack any insurance. That proportion shrank under the ACA until about 2023 or 2024; it rose subsequently as patients lost Medicaid and subsidized ACA coverage. A much greater share are under-insured.

Second, and as important, the U.S. is the only rich democracy whose payers, public or private, have not coalesced to cap spending and agree on payment rates and procedures.

Just the opposite. Instead of uniting to gain leverage over hospitals, doctors, drug makers, and other caregivers, U.S. payers have grown more and more fragmented. Anti-trust legislation prohibits private plans from jointly negotiating with caregivers. (That legislation could have been amended to allow joint negotiation—just as anti-kickback laws were amended to allow hospital purchasing cooperatives to legally accept payments from vendors. But, instead, powers of insurers to set prices were outlawed by the courts in the name of competition.)

In the public sphere, both Medicare and Medicaid payments have been fragmented. Both programs have chosen to rely increasingly on private managed care organizations to enroll capitated participants and set rates of payment to caregivers. This has happened at the same time that hospitals and doctors have consolidated to gain leverage over payers. The Medicare

7. Assuring Medical security and Health care for all

prescription drug benefit enacted in 2003 prohibited Congress from setting prices of meds and willfully fragmented Medicare's buying power by requiring that coverage be extended through notionally competing private prescription drug plans.

Experiences in other nations have been radically different.

Canada

After 15 years of Depression and war, Saskatchewan's economy revived in the mid-1940s. But the 15 years had left many hospitals with old and small buildings and inadequate revenue. Saskatchewan was the only province lacking a Blue Cross plan. Instead, individual hospitals had their own prepayment plans. A socialist provincial government enacted universal hospital insurance in 1947. Money to include physician care or meds was lacking. Gradually, all other provinces enacted similar laws.

In 1961, a new Saskatchewan law covered physician services for all residents. It led doctors to strike for three weeks. The strike was settled largely by guaranteeing doctors the right to be paid by FFS. Again, other provinces enacted similar statutes.^{3172 3173}

In 1966, Parliament passed a Medicare act to cover one-half of costs of provincial health plans that paid for hospital, physician, laboratory, and radiology services, and that satisfied a number of reasonable requirements. The last major Canadian statute, enacted unanimously in 1984, prohibited doctors from billing patients for the balance of their charges (the dollars not paid by Medicare).

Economic difficulties led subsequent federal governments to convert this match into yearly block grants that dropped from 44 percent to about 20 percent of provinces' Medicare costs.³¹⁷⁴ That obliged provinces to both raise taxes to support their Medicare plans and also to work energetically to contain costs. On average, about one-third of provincial budgets pay for health care. Consequently, though, lower-income provinces have had to devote substantially greater shares of their economies to financing health care. Contention between Ottawa and provincial governments about financing both Medicare's traditional benefits and those it does not cover has been loud and persistent.³¹⁷⁵

Provinces differ in their coverage of meds, nursing home care, and mental health services. Other services, like dental or vision care, are covered only privately. About two-thirds of Canadians have supplemental private insurance, mostly via employers. About one in ten has province-paid supplemental coverage. These pay for outpatient meds, dental care, and other items not covered under Medicare. The remaining one-quarter of people must pay OOP for these. Overall, the public share of health spending in Canada is only about 70 percent, well below the rich democracy average. The remainder is split about equally between supplementary private insurance and OOPs.³¹⁷⁶

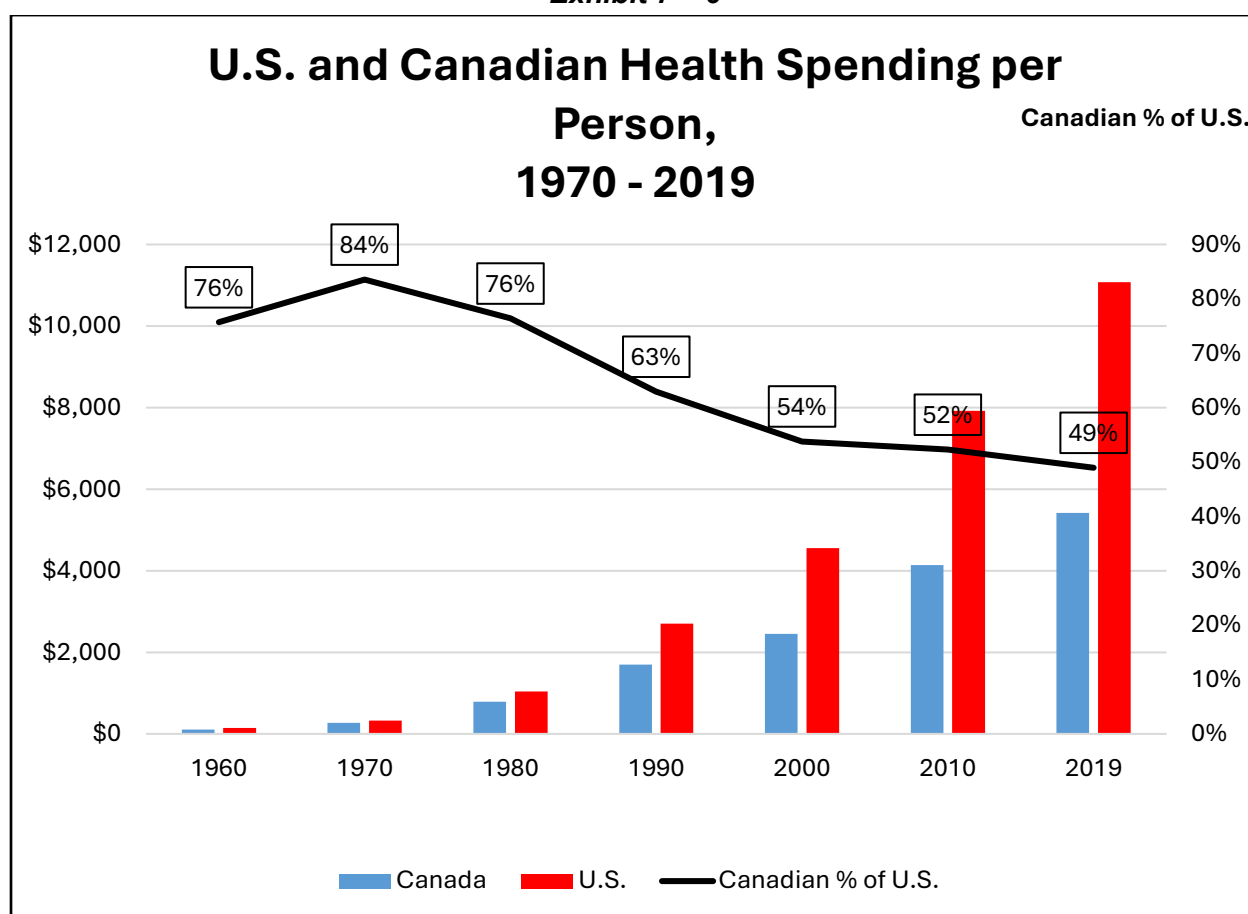
Access to hospital and doctor care is generally solid. Canadians enjoy much greater choice of hospitals or doctors than do Americans covered by various managed care plans or through narrow networks.³¹⁷⁷ Access to the services covered under Medicare appears to be fairly equitable. Decades ago, Siemiatycki and colleagues reported similar rates of use of doctor services in Montreal, regardless of income. But lower-income people did rely more heavily on hospital ERs and clinics. Also, they sought care at more advanced stages of illness, suggesting

7. Assuring Medical security and Health care for all

lower ability or willingness to seek care promptly—or greater difficulty in finding a family doctor.³¹⁷⁸ Rosser and others found that Ontario's Family Health Teams boosted both patient satisfaction with primary care and doctors' incomes.³¹⁷⁹ Some evidence suggested the teams were disproportionately formed in higher-income areas. Flood and colleagues identified ongoing shortages of primary care in Canada.³¹⁸⁰

In the years during and after Covid, a number of Canadian hospitals have suspended emergency room care for substantial periods owing to worker shortages or financial constraints.^{3181 3182} Over many decades, pressures to slow growth in health care costs and in the taxes finance Medicare have led to growing wait lists for some procedures. This is not surprising. As shown in Exhibit 7 – 6, Canadian real health spending per person fell from about 84 percent of the U.S. level to just under one-half in 2019. (It remained at that level in 2023.³¹⁸³) Overall clinical standards in the two nations are very similar.

Exhibit 7 – 6



Low administrative costs of raising money, paying caregivers, and certifying eligibility help to offset the falling ratio of Canadian to U.S. health spending per person.

Most money to pay for Canadian Medicare is raised through income and value-added (sales) taxes. A few provinces also employ employer premiums.

7. Assuring Medical security and Health care for all

Hospitals generally have fixed budgets and do not need to bill for payment for care of individual patients. Physicians are overwhelmingly still paid fee-for-service, but this is mainly automated, with some auditing to check for possible over-billing.

Applications for health care coverage in Canada are succinct, streamlined. It is necessary to substantiate that one is a citizen or permanent resident who lives in Canada for the majority of the year. The Ontario application form is presented in Exhibit 7 – 7. The form's simplicity means efficient initial enrollment. Permanent coverage saves cost of periodic re-certification of eligibility of the sort that plagued U.S. Medicaid in 2023-2024.

Exhibit 7 – 7 **Ontario's Application for Health Insurance Coverage – 1 page**

Ontario		ServiceOntario	
Registration for Ontario Health Insurance Coverage			
If you are a new or returning to Ontario, complete sections A, B and C. If you are renewing your photo Health Card, complete sections A and C.			
Refer to the Ontario Health Coverage Document List for the list of documents you will need to present with your application. Please print and use a blue or black pen.			
		Facility Use Only	
		Number Reference Number	
A. Personal Information			
Last Name		First Name	Middle Name
Date of Birth year month day		Official language preference? ☐ English ☐ French	Sex ☐ Male ☐ Female
Home Telephone Number () - -		Have you ever had an Ontario Health Number? ☐ Yes ☐ No	If yes, what was the number?
		☐ No Telephone	Work or other Telephone Number () - - Extension -
Mailing Address Apartment		Street Number and Name, R.R., P.O. Box or General Delivery	
City		Province	Postal Code Country
Residence Address (if different from above) Apartment		Street Number and Name, or lot, concession and township	
City		Province ON	Postal Code Country CANADA
		Date moved to this address year month day	
B. Section to be completed only by new or returning residents			
Where did you move from? (Apartment number, street number and name)			City
Province/State			Country
When did you arrive to Ontario? year month day			When did you leave the above address? year month day
When did you take up permanent residence in Ontario? year month day			How long do you plan to live in Ontario? ☐ permanently ☐ temporarily
If you moved from another part of Canada, were you covered by a government health plan? ☐ No ☐ Yes			If yes, what was your health number?
Are you a Canadian citizen returning to Canada? ☐ No ☐ Yes			Are you an immigrant returning to Canada? ☐ No ☐ Yes
Are you a new immigrant? ☐ No ☐ Yes			Are you a new immigrant? ☐ No ☐ Yes
Have you recently left the Canadian Forces? ☐ No ☐ Yes (date of discharge) yyyy / mm / dd			Have you recently been released from a Federal penitentiary? ☐ No ☐ Yes (date of release) yyyy / mm / dd
Are you the spouse or dependant of a Regular Force member of the Canadian Forces? ☐ No ☐ Yes			Are you a reservist returning from an out-of-country posting? ☐ No ☐ Yes (date of return) yyyy / mm / dd
			Are you the spouse or dependant of a reservist currently deployed by the Canadian Forces into active service? ☐ No ☐ Yes
C. Agreement			
I confirm that:			
- I make and intend to continue making Ontario my primary place of residence. - I will be physically present in Ontario for at least 5 months (153 days) in any 12-month period. - I must not be absent from Ontario for more than 30 days within the first 183 days immediately after establishing residency in Ontario unless I am considered by the Ministry of Health and Long-Term Care to be one of the following or I could lose my OHIP coverage: a Mobile Worker or a Mobile Student, a person who has moved to Ontario directly from another province or territory of Canada where I was insured under a publicly funded health care insurance plan, a Reservist returning from an out-of-country posting or the spouse and/or dependant of a Regular Force member of the Canadian Forces, or the spouse and/or dependant of a Reservist currently deployed by the Canadian Forces into active service. - The information I have given in this application, and in the documents I have provided, is true and accurate.			
I understand that:			
- If there is any change in my name, address, citizenship or immigration status I will inform the Ministry of Health and Long-Term Care and/or its agent ServiceOntario within 30 days. - The Ministry of Health and Long-Term Care and/or its agent ServiceOntario may check my residence status and any information I have given in this form and in the documents I have provided. - For verification this information may be collected from, and disclosed to, government and non-government organizations, if the law allows it. - It is an offence to knowingly provide false information in relation to this application.			
Signature ☐ applicant ☐ legal guardian			Date

Additionally, regionalization of costly tertiary care cuts clinical waste association with duplication of specialized equipment and training. It probably boosts quality of care as well because well-trained teams can coordinate smoothly. Morrison describes this vividly by contrasting one surgeon's experience of the high level of teamwork in a Canadian tertiary hospital with the fragmentation and inefficiency in a comparable U.S. facility.³¹⁸⁴

7. Assuring Medical security and Health care for all

U.K.

The National Insurance Act of 1911 paid GPs to care for workers, but spouses and children were uncovered so they paid OOP. Local authorities employed midwives. Specialist physicians staffed a variety of non-profit and public hospitals, high shares of which fell into poor physical condition by 1945 owing to German bombs and age.³¹⁸⁵

Younger GPs served for the 6 years of the Second World War and returned to learn that other doctors were now serving their former patients. Many doctors, soldiers, sailors, and airmen saw that the military provided better medical care in war than civilian doctors and hospitals had in peacetime.

The Labor government was elected in 1945 on a program of nationalizing industry, banks, and transport. In a nation exhausted and impoverished by war, public money was needed to finance recovery. To temper privation and to continue to express the solidarity that arose during the war, it was natural to implement a National Health Service financed by taxation. Hospitals were nationalized and clustered into regions. Hospitals paid salaries to their staffs of specialist physicians. Those doctors retained the right to admit their private patients to the NHS's hospitals. Today, GPs are paid by a mix of capitation, salary, and FFS while specialists working in hospitals are salaried. Dental care is subject to mild OOPs and a minority of patients face co-pays for outpatient meds.³¹⁸⁶

All rich democracies face various pressures to boost health care spending. The U.K. sought to focus on holding down spending mainly by creating "internal markets" comprised of separate GP or primary care fundholders that purchase hospital care from various notionally competing institutions.^{3187 3188} Many words have been devoted to debating the value of this approach. The U.K. has constrained drug spending by extracting lower prices from drug makers and by declining to pay for high-price/low-value meds.

The NHS's main problem is low revenue, not high cost. Over the decades, low spending on the NHS has led to growing concerns about adequate doctor availability, waiting lists for care, and other problems. Further, the U.K.—like the U.S.—has long trained far too few physicians. Both nations rely on importing doctors, who have often been educated at great cost in their countries of origin. Fully two-fifths of specialists and GPs practicing in Britain were trained outside the U.K.³¹⁸⁹ (The U.S. share is about one-quarter.³¹⁹⁰)

In part, these manifest political decisions about spending priorities, growing political pressure to expand other public services and supports, and a weakening economy. They also reflect, to a degree, a widespread conservative attitude toward illness and cure.³¹⁹¹

A 2013 paper asked whether the NHS could survive.³¹⁹² Post-Covid, the combined mortality and hospital capacity crises led to an emergency cash infusion and promises to train more doctors and nurses.^{3193 3194} Citizens' worries about the adequacy, capacity, and competence of the NHS have not yet been assuaged. Waiting lists for care continue to grow.

The British have, in effect, chosen to devote a small share of a relatively small economy to health care. In 2020, U.K. spending per person of \$5,019 was only 42 percent of the U.S. spending of 11,859.³¹⁹⁵ U.K. spending was also well below the western European average. Moreover, the U.K.'s physician-to-population and bed-to-population ratios are both nearly the lowest across the rich democracies of the OECD.

7. Assuring Medical security and Health care for all

France

In 1930, a social insurance law obliged employers to cover health care costs for workers earning below a certain income. By 1939, mutual benefit associations covered about two-thirds of the population.

After the Second World War, economic and social disruption, dislocation, and devastation—combined with the Red Army's role in defeating the Nazis and the communist role in the French underground—made the French Communist party attractive to many voters. It won the most votes in the 1946 election, nearly 30 percent. Communists were also strong politically elsewhere in western Europe, particularly in Italy.³¹⁹⁶

Many politicians saw public mandates for health insurance coverage as a social and political bulwark against communist influence. Doctors and hospitals saw it, in part, as a way to rebuild their revenues.

The 1945 Statutory Health Insurance (SHI) law built on pre-war coverage but applied to workers and their families in factories and commerce only. Farmers were added in 1961, self-employed workers in the late-1960s, and everyone else in 1978. Unemployed and retired people are covered also; this is done via the plans in which they enrolled initially.

Three SHI plans—for salaried workers and dependents, for farmers and others in agriculture, and for the self-employed—now protect about 95 percent of people. A single entity negotiates on behalf of the three SHI plans about payment rates with doctors and other caregivers. The health care ministry sets budgets for the public hospitals.

The remaining people are protected by 11 small plans; some of these, with older members, receive supplementary public subsidies. Curiously, a small separate plan with slightly better benefits and slightly higher taxes covers districts of Alsace and Lorraine controlled by Germany from 1871 to 1918. The survival of the various legacy plans manifests the power of custom.

By the late 1990s, about three-quarters of revenue was generated by mandatory employer and employee payroll taxes that totaled almost 20 percent of wages and salaries. The remainder was raised via general tax revenue, OOPs, and supplementary non-profit or for-profit private insurance that covers most OOPS for almost 90 percent of people. The OOPs are a prominent feature of French health care because doctors in private practice—the majority—insisted on the right to bill patients directly by FFS, including the right to balance-bill above the fee schedules negotiated with the SHI plans.³¹⁹⁷

Since the late 1990s, an earmarked tax on all income has gradually become a more important source of revenue, making the mandatory payroll taxes less important.³¹⁹⁸ In 2021, one-third of the SHI revenue came from payroll taxes, one-quarter from general income taxation, one-fifth from a value-added tax (national sales tax), and the rest from other taxes—including those on alcohol and tobacco.³¹⁹⁹

7. Assuring Medical security and Health care for all

Increasingly, the Statutory Health Insurance has come to function as a single payer when negotiating with organized physicians and with non-profit and for-profit hospitals. The Ministry of Health must approve the results of the negotiations. This holds down total spending.

Most doctors practice privately and are paid FFS; specialists in hospitals are salaried. Most hospitals are public or non-profit, but some are run for-profit.

Prices are regulated but volumes of care are not. Patients have nearly complete freedom of choice of doctors and other caregivers. Benefits are comprehensive, though dental care is less-well-covered. These help to protect access. Almost three-fourths of French GPs report they are likely to receive adequate information about their patients from hospitals or specialist doctors, the second-highest share across 11 rich democracies.³²⁰⁰ French doctors, also, were third-lowest in reporting their job was stressful in the wake of Covid.

Although the supply of doctors is strong nationally, especially in primary care, substantial geographic imbalances in physicians' and other caregivers' supply constrain access in some places. So may extra-billing by doctors. Fully one-fifth of French doctors trained outside the country.³²⁰¹ This may lead to gaps in cultural understanding between some doctors and their patients. The aging of the physician workforce has been a growing problem, as has the spread of medical deserts.

The French government has assumed some accountability for securing adequate numbers of physicians to care for under-served groups. It has paid retired doctors to work part-time in urban or rural areas with low ratios. And it has considered legislation to limit new physicians in areas of high doctor/population ratios, and to pay.³²⁰²

Despite these challenges, French health outcomes and satisfaction with care are among the world's highest. Primary care is centrally important. Coordination of services seems informal but appears to work well. Drug prices are pushed down by public action and pressure.

Germany

Germany was the first nation to start down the road to ensuring all residents financial coverage and access to care. The first health insurance law was enacted in 1883, covering some blue collar workers for occupational accidents or disease. Initially, benefits were in cash, not in guarantees to pay for health care.

Germany's rapidly growing economy made it possible to afford health benefits and complementary protections like old age pensions. Bismarck saw these elements of government-mandated social security as a way to counter growing unionization and the nation's Socialist party.³²⁰³

By 1885, 10 percent of people were covered. A 1889 law added health coverage for older or disabled people. White collar workers were covered starting in 1901. By 1913, one-third of people were insured, a share rising to one-half in 1925. Unemployed people were protected beginning in 1927. Dependents of covered workers were included in 1930.

7. Assuring Medical security and Health care for all

As elsewhere in western Europe, in the years after the Second World War, improved health insurance coverage was seen as a way to restore a sense of security—and also to pre-empt support for Communist parties anxious to undermine western democracies.

By 1960, 83 percent were covered. (This discussion of German efforts to protect citizens against health care costs rests heavily on two standard authorities.^{3204 3205})

Long-term care insurance was mandated in 1994. It is financed by a separate assessment on earned income.

And in 2007, coverage was mandated for all citizens and permanent residents.

Today, almost 90 percent of Germans are protected through Statutory Health Insurance (SHI) via non-profit sickness funds. All with incomes under \$78,000 (2019) must choose to join a sickness fund. The number of funds has declined from 18,776 in 1885 to 7,777 in 1925 to 2,028 in 1960 to 300 in 2004 to 154 in 2011 and to 105 in 2020.

SHI is financed by mandatory assessments of 14.6 percent of wages up to \$69,900 (2019). Now divided equally between employer and employee, employees long paid two-thirds of the assessments. This is probably a cosmetic or symbolic distinction.

All assessments on all people are pooled nationally and then divided among the sickness funds by risk-adjusted capitation. Sickness funds can assess their own supplementary contributions; these average about 1 percent of earned income.

Social solidarity among insured people is strong. People pay according to earned income—not predicted risk of needing care. They receive benefits in proportion to need—not ability to pay.

The remaining 11 percent of Germans are covered via private insurance. They are civil servants and higher-income people who wish to buy in. These pay risk-adjusted premiums, with risk assessed only at entry, so they tend to attract younger high-income people. Private insurers pay doctors at slightly higher rates, allowing their covered patients speedier access.

As in France, all Germans enjoy full freedom of choice of doctor, hospital, and other caregiver. Almost all caregivers serve both groups of insured people.

OOPs were about 13.5 percent of total spending in 2017. Most went to nursing home care or meds. Those OOPs can mean financial barriers to care for some. Patients pay nothing OOP for doctor visits and a nominal 10 euros per day for hospital stays.

Joint committees of sickness fund payers negotiate with doctor associations, hospital associations, and other caregivers about covered benefits and payment rates.

Doctors in ambulatory practices are paid FFS at rates negotiated between sickness funds and regional physician associations. These doctors must belong to regional associations that engage in collective bargaining with the sickness funds.

Doctors in hospitals earn salaries; these are paid from hospital budgets. Hospitals earn revenue by the DRG, which covers cost of both hospital and in-hospital physician services.

7. Assuring Medical security and Health care for all

Hospitals' capital costs are paid separately by state governments. Public money for capital investments are often inadequate because they must compete with other state government spending. Hospitals in lower-income states are more likely to suffer aging buildings and equipment. They may also lack enough money to hire the doctors they seek.

The separate mandatory LTC insurance is financed by a 3 percent tax on earned income. The benefit covers one-half of nursing home cost, so some buy supplementary private LTC insurance. About 3 million people received LTC in 2015, one-half at home from relatives (with half of costs paid by a separate public program), one-quarter at home by paid workers, and one-quarter in nursing homes. The two latter services are covered by the mandatory LTC insurance.

Very few people reported unmet needs for care in 2017. Cost is not a barrier to access.

But physician availability is. The supply of GPs is shrinking, particularly in rural areas and in the former East Germany. A 2002 study found that GP visits in Germany were shorter than in 5 other western European rich democracies, at 7.6 minutes—only two-thirds as long as the mean of 11.6 minutes elsewhere.³²⁰⁶ Doctors complain that time dealing with paperwork consumes one-quarter of their working days. German patients were second-highest (after U.S. patients) across 11 nations in complaining they had to spend time on paperwork or fights with payers.³²⁰⁷

One expert said that payment rules incentivize scheduling a patient quarterly.³²⁰⁸ Across 11 nations, German primary care doctors were least likely to report receiving adequate information about their patients from specialist physicians or hospitals.³²⁰⁹ Only about one-quarter of German GPs thought they did receive adequate information, compared with about 70 percent of British or French doctors (and one-half of U.S. doctors). Further, German GPs were second-highest in share (68 percent) reporting their jobs to be stressful during Covid. Only U.K. GPs were more likely to report stress.

Israel

Organized financial coverage began with 4 non-profit health plans. All were formed between 1920 and 1942, some by merging smaller predecessors. Initially, each resembled a European-style sickness fund. With the passage of the universal coverage mandate in 1995, the state specifies the physician, hospital, meds, and other coverage that all health plans must provide.³²¹⁰

NHE was a steady 7.4 percent of GDP in the 2 decades that followed passage of the universal insurance law. The nation enjoys high longevity for both men and women but low spending.

Dental care for children and mental health care were added to the basic package of benefits subsequently.

Public spending is financed mainly by a progressive health care tax on all income, supplemented by general revenues raised through progressive taxation. Some three-fifths of health spending was progressively tax-financed in 2015, down from three-fourths in 1995. Deductibles don't exist. No OOPs are imposed for primary care or inpatient hospital care. Some OOPs are required for specialist doctor visits and for meds.

7. Assuring Medical security and Health care for all

Tax revenue is distributed by a risk-adjusted formula to the 4 competing non-profit health plans which deliver and pay for care for all people. This capitated revenue comprises a budget for each of the 4, which they are free to spend to deliver the publicly-required benefits. Budget discipline requires careful evaluation of new health care technology and costly new meds. The 4 plans negotiate prices of each with suppliers.³²¹¹

Individuals are free to choose 1 of the 4 plans and also to switch plans.

Publicly-paid care is financed in accord with ability to pay and care is given in accord with clinical need.

14 percent of spending was financed by supplemental private health insurance in 2016. Fully 84 percent of people are covered by it. This insurance pays for dental care for adults, some meds, and faster access to care.

Doctors in outpatient practices are paid entirely by the health plans, not by patients. Various forms of capitation are used. One-third of nurses work in community settings as health plan employees. They have a substantial role in caring for patients with chronic illnesses.

Since 2008, special initiatives to cut disparities in use and outcomes of care have improved both financial access (through targeted cuts in OOPs) and actual delivery of care and its quality.

Hospitals pay their doctors from their own budgets. Hospitals are paid fees for ER visits, daily payments for routine care, and—sometimes—separately for surgical procedures. The government sets caps on total revenue each hospital may collect yearly.

Long-term care is separately financed, about two-thirds through general taxation and the rest through private long-term care insurance and OOPs. About one-half of people have private LTC insurance. Only about one-seventh of people receiving LTC were in nursing homes.

Responsibility for mental health services was transferred from the ministry of health to the 4 health plans in 2015. This has meant improved access and better integration with somatic care. But the 4 plans have substantial waiting lists for mental health services owing to shortages of professionals.

Keeping cost of care at a low share of GDP makes equity of benefits more affordable. Shares of physicians, nurses, and pharmacists—by ethnicity and religion—are in closer proportions to underlying population shares than is the case in most other rich democracies.

Demands of defense, education, and other sectors have put pressure on public spending on health care. The rise in the private insurance share of spending and the imposition of OOPs for specialist doctor visits and meds has somewhat lowered equality of access to care. Special programs have been implemented to mitigate these. Regions on the nation's periphery have faced longer travel times for specialized inpatient care but these are being addressed by constructing added hospital capacity in the north and south.

Czechia

7. Assuring Medical security and Health care for all

This brief review relies on the detailed 2023 report on Czech health care by Bryndova and colleagues.³²¹²

Independent in 1918, the former Czechoslovakia inherited Austro-German-style sickness funds that paid cash benefits. A 1924 statute converted these to health insurance funds (HIFs) that paid caregivers directly. The HIFs were mandated to collect enough money to cover protected people when they became old or disabled. In 1938, more than half of Czechoslovakians were compelled to be covered by an HIF. After the 1948 Communist coup, tax-financed universal coverage was accompanied by nationalization of all physician clinics, pharmacies, hospitals, nursing homes, and other institutional caregivers.

Restored independence after the 1989 revolution meant a return to free choice of caregivers, and to private control of physician clinics and pharmacies. Hospitals remained under public ownership.

All citizens and residents are financially protected under statutory health insurance (SHI). Benefits are very broad. 7 non-profit health insurance funds (HIFs) operated in 2023, down from 27 three decades earlier. Each person must enroll in an HIF. These are obliged to accept any applicant. People may choose a new HIF each year. Enrollees have free choice of caregivers. They may choose a new GP every three months.

All SHI revenue is pooled and then distributed across the 7 HIFs in proportion to member risk. Risk adjustment has been improved incrementally and is now believed to offer little opportunity to skim profitable patients.

The HIFs act as buyers of health care. They also pay doctors, hospitals, and other caregivers. All HIFs must offer the national standard package of very broad benefits. HIFs compete for members only in very small (nearly symbolic) ways by offering supplementary benefits like swimming lessons or vaccinations.

HIFs are accountable to their boards and to the ministry of health. Both must approve their financial and operating plans for the year ahead. HIFs that are in financial trouble can be placed in a type of receivership; this has happened only once.

Most GPs, other doctors in ambulatory care, and hospitals contract with all of the HIFs with a presence in their region of Czechia. This makes for a high level of freedom of choice of caregiver.

Initially, HIFs paid doctors by the visit and hospitals by the admission. This proved expensive. Since 1997, primary care doctors have been paid by capitation and hospitals have fixed budgets. Budgets for drug spending were also introduced. Caps on specialist physicians' volumes of care were added. Payments are negotiated between HIFs and caregiver groups. Government supervises or mediates the negotiations.

A public agency regulates prices of all meds covered under SHI. Prices are set either at the average of the three lowest prices across EU nations or at a proportion of manufacturers' prices.

70 percent of health spending is financed via SHI. Revenue is drawn from payroll taxes on employed people and their companies, a progressive income tax on self-employed people, and general public revenue paid on behalf of "economically inactive" people—students, retirees, and jobless people. The economically inactive people were one-half of all Czechs. The general

7. Assuring Medical security and Health care for all

public revenue was one-quarter of that paid to SHI in 2020. Post-Covid, these payments are being adjusted to reflect economic conditions.

Other government payments cover about 18 percent of health spending. Over one-half of this sum pays for LTC and one-quarter pays for hospital care, particularly through grants to state-owned hospitals for buildings and equipment, and partial capital subsidies to other hospitals.

OOPs comprise a little over 10 percent of health spending. Higher OOPs were imposed in 2008 and 2012 but most were abandoned in the face of strong popular opposition. Most outpatient and all inpatient services are free at point of use. Three-fifths of surviving OOPs are co-pays for meds that are not fully covered by SHI. Most of the remaining OOPs are for dental care.

Equity of access is generally high owing to high caregiver availability and strong financial coverage with few OOPs. Still, as is the case in most nations, access to care in rural areas is weaker because doctors are in shorter supply and hospitals are older and less well-equipped. Equity of access to covered services is financially sustained in part by identifying types of care for which SHI will not pay. These include cosmetic surgery, some dental treatments, and some meds.

2. Conclusions

In the nations just examined, all people enjoy broad and deep financial coverage. By law, citizens and resident aliens must be covered. This is administratively simplest in single payer nations. But the all payer nations have made mandated coverage work just as well. Consequently, uninsurance is negligible. And under-insurance is much less serious than in the U.S. In the other rich democracies, the political commitments to covering all people and promoting access to care are strong. Despite much lower spending, health outcomes are generally better than in the U.S. Costs are not contained by suppressing access to care.

The mechanisms by which people are covered vary considerably. Single payer is atypical; all payer arrangements are more common. The variations seem to matter little to equity of care. All payer arrangements vary in how money is raised: Some nations rely more on payroll taxes and others on progressive taxation of all income. In both, the crucial step is to pool all revenue. When a choice of capitated plans is available, it is the pooled revenue is apportioned by risk-adjusted capitation. That apportionment means that the rich subsidize the poor; the young subsidize the old; and the healthy subsidize the sick. Otherwise, the poor, old, or sick would find it much harder to afford care. The plans typically negotiate payments with all doctors and hospitals, allowing patients to freely choose among caregivers.

Still, coverage varies around the edges. A few examples are obvious. Canadian coverage is deeper than it is broad. Coverage of prescription drugs is incomplete.³²¹³ Higher-income Germans—about 11 percent of the population—buy into a separate insurance plan that pays higher prices and enables speedier access and longer doctor visits.³²¹⁴ In the U.K., about 11 percent of people have supplementary private insurance that can achieve similar results.³²¹⁵ The Swiss are unusual in imposing fairly high out-of-pocket (OOP) costs on patients who use ordinary doctor and hospital care.³²¹⁶ Their high average incomes and only moderately worse-than-average income inequality may mean that the high OOPs don't impair access to care at humanly or politically unacceptable rates.³²¹⁷

7. Assuring Medical security and Health care for all

Also noteworthy is that the other rich democracies achieve universal coverage at levels of real spending per person that, while highly variable, do not begin to approach U.S. spending levels. Cost control and health care for all clearly reinforce one another. They are complementary, not antagonistic.

The high public share of health spending outside the U.S. helps to assure equity of financial coverage. It also strongly spurs cost control efforts. And, by supporting concerted action by payers, it helps to make those efforts effective and successful.

Elsewhere, public or semi-public shares of payments to cover people are typically higher than in the U.S., averaging over 70 percent elsewhere versus about 50 percent in the U.S. Outside the U.S., the electoral risk associated with boosting highly visible taxes to finance higher health care spending encourages politicians to negotiate robust cost controls.

It is useful to note, in this regard, that OECD data have reclassified U.S. private health insurance through the job as “public” health spending. In doing so, it apparently relied on the ACA’s individual mandate that obliged otherwise uncovered people to buy insurance or pay a penalty. This reclassification is legalistic and also misleading.

In other rich democracies, the money raised by statutory health insurance may flow through non-government sickness funds. But the sickness funds are united when they negotiate with hospitals or doctors. Public bodies like ministries of health usually supervise the negotiations and strongly influence their results. Further, money raised through mandated universal coverage is typically pooled and then distributed by risk-adjusted capitation among health plans. In this way, money raised by statutory health insurance assessments on employers and workers closely resembles money raised via public taxation. All payers pay essentially the same price for the same care, and rules of payment are uniform. So are quality measures and data reporting requirements.

In the U.S., payers are atomized. Prices vary substantially. Out-of-pocket burdens, covered services, formularies, step therapies, quality measures, and payment rules vary just as much.

Importantly, U.S. private health insurance premiums are not meaningfully regulated by state or federal governments.

Just as the need to cover all people, combined with the high public share of health care spending, politically compel payers to contain cost of care, payers’ concentrated power enables them to hold down that cost.

These great differences between private health insurance in the U.S. and statutory health insurance in other rich democracies make it unreasonable to classify U.S. private health insurance as public spending.

Methods of paying hospitals and doctors also vary greatly. But they are designed and implemented to respect the aims of covering everyone and containing costs. Typically, payers negotiate with organized caregivers. Cost controls aim to cap revenue available to spend on health care; they generally address price before volume. Supplies and rates of use of doctors and hospital beds are, on average, substantially greater outside the U.S., as discussed in chapter 3. Canada and the U.K., though, have bed- and doctor-to-population ratios close to that of the U.S.

7. Assuring Medical security and Health care for all

The rich democracy pattern is striking. Outside the U.S., all people enjoy broad and deep and affordable financial coverage. The obligation to cover all people reinforces pressure to hold down cost increases. The high public or statutory share of revenue raised to pay for health care reminds elected officials that boosting taxes to pay for health care could cost them re-election.

Waste becomes a target, not something to which health care must be reconciled. The obligation to cover everyone with finite revenue reminds both caregivers and payers to cut waste clinical and protect access to effective services. Limited revenue for health care induces other rich democracies to regulate, leverage, or negotiate lower prices with drug makers. Simpler and more trustworthy methods of paying doctors, hospitals, and other caregivers help to hold down administrative waste.

C. Causes of failure to cover everyone and ensure access

By very different methods, the world's other rich democracies cover all people. Why has the U.S. failed to do so?

Why have U.S. incremental coverage improvements been so incomplete, in contrast to their successful conclusion in all other rich democracies? And why have U.S. incremental improvements stalled and then gone into reverse?

Political, financial, administrative, and caregiver barriers block many Americans from obtaining needed health care. Suppression of access is accepted or even embraced as a feature, not as a bug. Some Americans are not eligible for insurance. Others can't afford their share of premiums or OOPs. Others can't find doctors willing to accept their insurance. Still others are unable to surmount administrative difficulties associated with signing up for coverage or with prior authorization.³²¹⁸

It is useful to distinguish the underlying causes of the American failure to assure financial coverage and access to care for all from the mechanisms that impede or suppress access.

Mechanisms that impede access to care include lack of insurance, uninsurance, high OOPs, shortages and maldistribution of caregivers, fragmentation of coverage and caregiver networks, narrow and changing networks of caregivers, Medicaid's reliance on managed care contractors, and administrative barriers like prior approval demands and retroactive denial of coverage.

The main underlying causes of poor access are connected to one another in important ways.

- ✓ The first cause is weak and uneven political commitment to health care for all.
- ✓ The second is ineffective action to address high costs of U.S. health care—stemming from
 - ignoring the connection between cost control and affordable health care for all,
 - payer fragmentation,
 - powerful caregivers' addiction to more money for business-as-usual,
 - unwillingness to shrink the 4 types of waste, and, therefore
 - reliance on suppression of access to slow the rate of rise in cost.
- ✓ The third is health care anarchy resulting from reliance on both unattainable free market competition and incompetent, reactive government regulation.
- ✓ The fourth is inattention to caregiver configuration.

These causes warrant closer scrutiny.

1. 14 Causes

First, U.S. health care became extraordinarily expensive before everyone was covered. No one planned that. It happened because of inattention to cost, weak and fragmented payers, the low public share of revenue to finance health care, powerful caregivers demanding higher revenue, adoption of putative cost controls that either worked badly or actually boosted spending, weak

7. Assuring Medical security and Health care for all

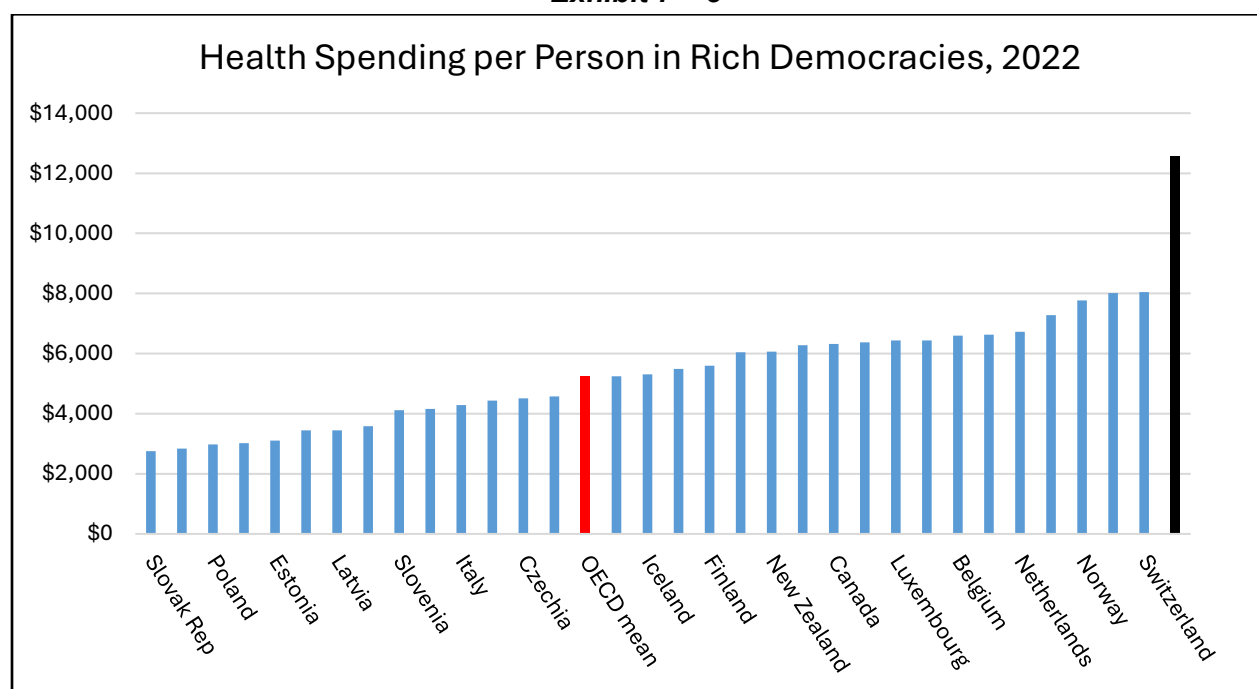
primary care and fragmented services, and reluctance to address the causes of the 4 types of waste.

Politically and financially, high costs deter coverage expansions. Corlette and Monahan considered them the main barrier to solidly protecting all Americans.³²¹⁹ The experience of other rich democracies indicates that effective controls are both more politically feasible and more economically essential when everyone is covered. This and other explanations for feeble U.S. cost controls are taken up in chapter 8.

Exhibit 7 – 8 displays health spending per person in rich democracies in 2022. The spending is adjusted to reflect purchasing power of each nation's currency. The U.S. level is 2.4 times the mean of the other rich democracies. And it is 1.56 times as great as spending in Germany or Switzerland, the two nations closest to U.S. spending levels.

Second is suppression of access. Since some Americans have not been well-protected financially, leaving them uninsured or under-insured—or even cutting their coverage—looks like a practical and politically feasible and even attractive method of containing cost. The various mechanisms by which Americans are under-insured make little sense otherwise.

Exhibit 7 – 8



Source: OECD, *Stat*, <https://stats.oecd.org/Index.aspx?DataSetCode=SHA>, accessed 13 June 2024.

Third, political pressure for covering all Americans has been weak. One reason is the relatively low rate of unionization.³²²⁰ Unions in other rich democracies have been strong proponents of health coverage for all. Their share of employed people has declined in almost all rich

7. Assuring Medical security and Health care for all

democracies. The drops in the U.S. are important because unionization has fallen from levels that were already very low.

Just as important, U.S. unions have typically treated health care coverage as a benefit for their members, one subject to collective bargaining with employers, not a legal right to be sought politically for all people. Ability to win health insurance was an important tool used by union organizers. Once won, unions generally favored non-profit Blue Cross and Blue Shield plans over profit-making health insurance companies.³²²¹ Union support helped BC and BS plans grow in the years following the Second World War.

A second reason for weak political pressure to cover all Americans has been relatively low fear of socialism or communism or of social instability.

A third was the early success of private health insurance in covering a substantial share of Americans.

Health care coverage began in the U.S. with small private mutual aid societies organized by groups of immigrants or by fraternal organizations. It continued with state workers' compensation plans that paid for doctor and hospital care for job-related injuries and, rarely, illnesses. The federal government's workers' compensation law was enacted in 1908 to cover its civilian employees.³²²² In 1911, Wisconsin became the first state to require workers' compensation, followed by 36 others by 1920.³²²³

Blue Cross plans were created in all states beginning in the 1930s. State and regional hospital associations initiated BC to generate a regular flow of revenue in response to the high unemployment and low wages during the Depression that impaired families' capacities to pay for needed hospital care. Employers and employees contributed small monthly amounts to pre-pay hospital costs. Soon, state medical societies launched their own Blue Shield non-profit pre-payment plans. Initially, these covered only services of specialists like surgeons.

BC and BS were created, first, to protect caregivers' revenues, and second, to protect ability of patients to afford to obtain treatment. Initially, BC and BS plans covered all hospitals and doctors, paying their charges. Patients enjoyed free choice of caregiver.

During the Second World War, the federal government imposed wage and price controls. But health insurance coverage was not considered part of wages, so employers in war industries that needed to compete for more workers began to offer health insurance coverage to entice them.

Morrissey reported that the share of Americans with private health insurance of any type rose from 9 percent in 1940 to 22 percent in 1945 and to 51 percent in 1950. It reached 73 percent in 1965.³²²⁴ The robust U.S. economy during the quarter-century following the Second World War helped to sustain that growth.

Early BC and BS plans were community rated. They charged the same premiums to young and old, healthy and sick. Patients paid the same premium, regardless of income. Fixed dollar premiums are inherently regressive, meaning they consume a bigger percentage a lower-income person's earnings. Community rating is somewhat less regressive than the traditional insurance industry practice of experience rating.

7. Assuring Medical security and Health care for all

Blue Cross's community rating invited private for-profit insurance companies to offer health insurance. They did so by assigning a premium commensurate with risk (and profit) for each employer's workers. This is how insurance works. Community rating, by contrast, is often called "social insurance," but it can be sustained only by government or other external compulsion. It isn't what the insurance industry calls "insurance."

By experience rating, for-profit insurers could charge a lower premium for younger and healthier bank workers than for older and more-likely-to-be-injured miners or factory workers. People were sorted—individually or by employer groups—into boxes that were themselves as homogeneous as possible. A premium was set for each box. Risk was shared only among people inside each box, not across boxes. Experience rating drove out community rating except in rare places like Rochester, New York, where Kodak and other then-dominant employers demanded that the regional BC plan continue community rating into the 1990s.

Elsewhere, experience rating prevailed. Younger and healthier groups and individuals paid lower premiums; those older and sicker paid higher ones. Employers with older workers paid higher premiums and were, therefore, burdened with higher costs of production, putting them at a competitive disadvantage.

And larger and more powerful employers could often leverage lower premiums for their workers. This resulted in higher premiums for smaller employers. By contrast, persisting community rating in Rochester meant that Kodak or Xerox could win lower costs of health insurance only by pressing hospitals to avoid duplication and waste, and by encouraging leaner professional practices by physicians. It is probably no accident that Rochester physicians learned to deliver more affordable health care.

Insurance coverage offered by smaller employers is less adequate, on average; OOPs are typically higher. Four factors help to explain both small businesses' higher rates of uninsured workers and also their opposition to employer mandates to buy health insurance or pay an added tax—play-or-pay—as a method of boosting insurance coverage.

- ✓ Weak leverage on premium was one reason workers employed by smaller firms were more likely to lack health insurance.³²²⁵
- ✓ Separately, smaller businesses were more heavily burdened by health care costs because they typically hired more workers per million dollars of revenue. They were more labor-intensive. Further, average worker incomes were lower, impairing affordability of insurance.
- ✓ Additionally, their profit margins were, on average, lower than those of larger employers—partly because they typically operated in more price-competitive sectors of the economy.
- ✓ Finally, smaller businesses were much less able to self-insure, to bear risk, so they were forced to rely on insurance companies to do so. This meant smaller businesses were obliged to comply with state coverage mandates (since ERISA pre-emption does not apply to state-regulated insurance).

One state's experience manifests the consequences for premiums. In Massachusetts, 2026 average premiums for individual and small group coverage rose by 11.5 percent—and by an added 10.4 percent for 2027.³²²⁶

A substantial share of Americans lacking health insurance are workers employed by small businesses and members of their families. Nationally, the share of businesses with fewer than 50 employees offering health insurance fell from almost one-half in 2000 to less than one-third in 2023.³²²⁷ Some had hoped that the ACA would help insure employees of small businesses

7. Assuring Medical security and Health care for all

and their dependents. That happened to a degree. But some advocates for small businesses criticized the ACA for making health insurance costlier for small businesses because of its robust set of 10 essential benefits and other requirements.

For a few decades after the Second World War, low health care costs and rising real incomes meant that health insurance coverage through the job was reasonably affordable for large shares of Americans. Just before Medicare was legislated, slightly more than one-half of elders had some level of insurance coverage for hospital care (though very few had any coverage for doctors' care).³²²⁸

Insurance does not work in health care. The U.S. is the only rich democracy whose health care financing is still shaped by traditional insurance principles. (Other nations may have what they call “national health insurance” but that’s a legacy term that no longer corresponds to how money is raised or to how caregivers are paid.) Although this was largely accidental, its results have been unfortunate for patients, for caregivers, and for all of us who pay for care.

Health insurance through the job typically required patients to pay substantial OOPs. This was for the same reason that deductibles and co-insurance have always been prominent features of private insurance for ships, homes, and most other things. Their aim is to deter insured parties from making insurance claims. Insurance aimed to make policy-holders less worse off. Chapter 4 explained the central role of OOPs in attempting to shoehorn health care realities to fit the theories of competitive free markets.

It is worth noting that traditional insurance—experience rated and with substantial OOPs—is only one vehicle for providing a measure financing health care for people who need it. For three reasons, it is far from the best vehicle.

First, premium financing is inherently regressive: it constitutes a bigger share of the incomes of lower-income people.

Second, experience rating for maritime insurance means that owners of older and badly-maintained ships captained by incompetent sailors pay higher premiums. Experience rating for health care means that older or sicker patients (and their employers) pay higher premiums. This is often unaffordable in itself. And it compounds the inherent regressivity of payment by fixed premium.

Third, using health care is not like insuring your ship or home. Risk of losing your ship or home is low, rare, and unpredictable. Insurance will cover a share of your loss.

But only a share—with traditional insurance, you are always supposed to be better off financially if you do not suffer a loss and therefore need to file a claim.

Risk of needing health care is high, frequent, and predictable. This is very different you're your ship sinking. When people need care, they need a way to pay for it.

Paying lots of small claims means high administrative cost. Also, we want people to use health care when they need it, so using high OOPs to deter patients from obtaining care is unwise.

Importantly, even if we take good care of ourselves, diet, exercise, and sobriety don't confer immortality. Prevention ultimately fails. When we are ill or injured, the cost of care is decided

7. Assuring Medical security and Health care for all

mainly by physicians as they diagnose and treat us. So we should ask **them** to weigh benefits and costs of care—within a budget of some sort—and to spend our vast but inevitably finite dollars as carefully as possible.

Insurance does none of this. And when it tries to interfere, via vehicles like prior authorization, it lacks knowledge to act carefully and also imposes high administrative burdens.

During the 1950s and 1960s, experience rating of private health insurance premiums, coupled with rising health care costs, raised cost of private health insurance for elders. That boosted political support for federal health insurance for seniors. In July of 1965, Johnson pushed through the Medicare statute. Heavy Democratic majorities in both houses of Congress made this possible.

Overcoming sustained and fierce resistance from doctors' organizations, Congress enacted mandatory hospital insurance as Medicare Part A and voluntary but heavily subsidized physician insurance.³²²⁹ Medicare covered hospital care, doctors' services, and very brief post-acute rehabilitation and surgical wound care. Retail outpatient meds and long-term care were excluded.

Perceiving a lesson in Medicare's passage, many reformers or advocates for health care for all believed then—and still—that spending more money will be essential to covering all people—owing to weak political support for either containing cost or for more carefully spending the huge sums that are already available inside U.S. health care. In 1965, though, health spending was only 5.6 percent of GDP, less than one-third of its share in the mid-2020s.

To build hospital support, the Medicare statute incorporated Blue Cross's open-ended cost reimbursement. To try to neutralize doctors' opposition, the law incorporated something close to most Blue Shield plans' generous payment of doctors' charges. Neither method contained any effective cost controls. Despite fierce opposition from organized medicine, Medicare boosted doctors' incomes very substantially.

A 1965 companion law, Medicaid, considerably expanded the vendor medical payments formerly made by state-federal welfare programs. Those covered people who were both poor and fell into one of 4 categories: permanently and totally disabled, blind, elderly, or in families with children under age 18. Many Republicans opposed Medicare and Medicaid but voted for their final passage because they saw that Medicare, in particular, was politically popular.

In 1972, younger disabled Americans were made eligible for Medicare along with people with end-stage renal disease.

The next 3 decades saw little progress in cutting the number of uninsured people.

In 2003, Congress enacted the Medicare Modernization Act to add a Part D prescription drug plan. Drug makers supported it because it would boost the numbers of prescriptions they would sell without curtailing their prices. Drug makers insisted that the bill be stripped any effective restrictions on what they could charge. Even so, the law passed the House by only 1 vote.

In 2010, the ACA added children under age 26 to parents' private health insurance, greatly expanded Medicaid—at state option—to all with incomes under 138 percent of the federal poverty level, and offered sliding scale subsidies to buy private insurance by people between

7. Assuring Medical security and Health care for all

the poverty level and 4 times the FPL who could not obtain coverage from employers that was deemed affordable.

No Republican in either house of Congress voted for the ACA. In 2017-2018, Trump sought to repeal the ACA and failed in the Senate by only 1 vote. Biden increased subsidies to purchase insurance but these expired during Trump's second presidency at the end of 2025.

ACA problems. Unfortunately, after the ACA passed Congress, Obama forfeited opportunities to boost public support for the new law by failing to speak widely about its coverage improvements. His silence made it easier for opponents to define the law politically by castigating its compulsion to buy individual coverage or pay a fine, and by false charges of creating "death panels."

Worse, the federal exchange that was supposed to make it easy to enroll in subsidized coverage was incompetently designed; so were many of the state-run exchanges. This is more than surprising since the ACA passed Congress in March and April of 2010 but the exchanges began enrolling patients only on 1 October 2013 for coverage starting 1 January 2014.

Also, the ACA's subsidized coverage was complex. The 4 metal levels of coverage made it harder for Americans to choose which plan to enroll in. The ACA did not require simple standardized benefits at each of the 4 tiers but relied instead on a confusing (and misleading) standard of "actuarial equivalence." This made it harder for Americans to gauge the value of individual plans and compare across plans.

The complexity of choosing a plan led many Americans to rely on brokers to choose plans—something unnecessary in the world's other rich democracies. Worse, some brokers accepted bribes from insurers to steer patients, and other brokers even enrolled people not eligible for subsidized coverage in exchange for corrupt payments from insurers or their agents. The job of choosing a plan has remained daunting.³²³⁰

A June 2026 report from Nelson and colleagues at DHHS's planning office concluded that Trump policies cut 2.9 million ACA enrollees "who had previously been improperly receiving subsidies they did not qualify for." They believed that an added 2.6 million enrollees remained covered improperly—including 1 million lacking Social Security numbers.³²³¹

Separate from problems of bribery and illegal enrollments, reliance on brokers to choose among health plans is expensive.

Meyers and colleagues calculated the cost of payments to brokers for MA plans at \$10.1 billion for 2022, up 159 percent from \$3.9 billion in 2014.³²³² That's an average compound rate of rise of some 13 percent yearly. Extrapolating that to 2026 would make for broker payments of \$17 billion in 2026.

This accords with estimates from Congress's Joint Economic Committee, which reported in June of 2026 that payments to MA plan brokers accounted for most of the \$25 billion then spent yearly on MA, ACA, and Part D plans.³²³³ This problem is compounded by broker steering of Medicare patients to MA plans with higher over-payments owing to coding intensity.

Capturing the \$25 billion in waste will be one meaningful source of emergency financing for U.S. health care when the crisis demands reform. Since the payments to brokers are made by ACA plans (or MA plans), the \$25 billion can be withheld from

7. Assuring Medical security and Health care for all

Paying for expanded health care coverage has clearly become more partisan. One reason is the rising national debt and associated substantial yearly federal deficits—even during good economic times.

A second is the rising cost of health care, which makes covering more people more and more costly. A third has been Trump's choice to use the 2025 budget bill to make his 2017 tax cuts permanent, and the consequent choice to cut Medicaid deeply to partially offset the revenue lost through those tax cuts.

As discussed earlier in this chapter, nominal increases in the share of Americans with plastic insurance cards have been accompanied by cost control techniques—some organizational, some administrative, and some political and financial—that substantially increase the share of Americans who are under-insured and suffer suppression of actual access to care and use of care. An important reason for adopting those techniques is the political failure to adopt effective cost controls that don't rely on under-insurance.

As noted in Exhibit 8 – 4, health care costs were only 4.3 percent of GDP in 1950 and 7.0 percent in 1970 but 19.7 percent by 2020. (The last was exceptionally high owing to Covid—the share stabilized in the 17 to 18 percent range for a few years subsequently, but is predicted to reach 20 percent again by 2032.³²³⁴)

Rising income inequality. At the same time, Americans' incomes were becoming markedly less equal. Income inequality rose by 20 percent from 1980 to 2016.³²³⁵

One reason was the drop in better-paying manufacturing jobs as manufacturing shifted to Mexico, Canada, and Asia. Many such jobs were held by union workers. Union membership consequently declined, as did the political power of unions—generally a force for greater income equality.

A second was the greater share of GDP going to capital in the form of corporate profits, not to labor in the form of wages and salaries. Ip reports that corporate profits' share of GDP rose from about 7 percent in 1980 to about 11 percent in 2025. At the same time, wages' and salaries' share of GDP fell from about 59 percent to about 51 percent.³²³⁶ Stoller discusses reasons for widespread citizen dissatisfaction during years of ostensible prosperity.³²³⁷

Therefore, absent effective action to recycle health care waste, protecting all Americans against rising health care costs requires taking ever more money from people who have more money to pay for health care for people who have less money. Shifting that money requires political action, which faces resistance. In time, this resistance will help Americans choose reform to address the looming health care crisis.

A report from Horowitz and others found that middle-income Americans' share of total income fell from 62 percent in 1970 to 43 percent in 2018, while upper-income Americans' share went from 29 to 48 percent. See Exhibit 7 – 9.

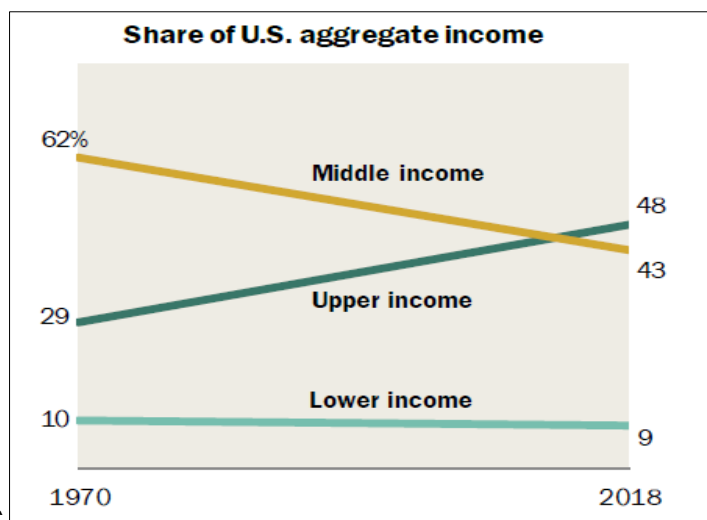
A different measure, the ratio of income at the 90th percentile of earners to income at the 10th percentile shows similar results. In 1960, that ratio was 9.1. But in 2018, it was 12.6, a rise of almost two-fifths.³²³⁸

7. Assuring Medical security and Health care for all

In 2022, the lowest one-fifth of households garnered 3.5 percent of U.S. income, down 2.1 percentage points from 5.6 percent in 1977—a decline of 38 percent.

In 2022, the top one-fifth of households garnered 50.7 percent of U.S. income, up 8.6 percentage points from 42.1 percent in 1967—a rise of 20 percent.³²³⁹

Exhibit 7 – 9



Source: Pew Research Center analysis of Current Population Survey, Annual Social and Economic Supplements (PUMS). In Juliana Menasce Horowitz, Ruth Igielnik, and Rakesh Kochhar, “Trends in Income and Wealth Inequality,” in Pew Research Center, *Most Americans Say There Is Too Much Economic Inequality in the U.S., but Fewer than Half Call It a Top Priority*, 9 January 2020, <https://www.pewresearch.org/social-trends/2020/01/09/trends-in-income-and-wealth-inequality/>.

A report from Owyang and Shell summarized trends in U.S. Gini coefficients over time. A Gini coefficient of 0 means perfect equality—all have the same income. A coefficient of 1 means perfect inequality—one person receives all of the nation’s income. As shown in Exhibit 7 – 10, Gini coefficients for households (the more inclusive measure) rose from 0.39 – 0.40 in 1967 – 1969 to 0.47 – 0.48 in 2011 – 2013.³²⁴⁰

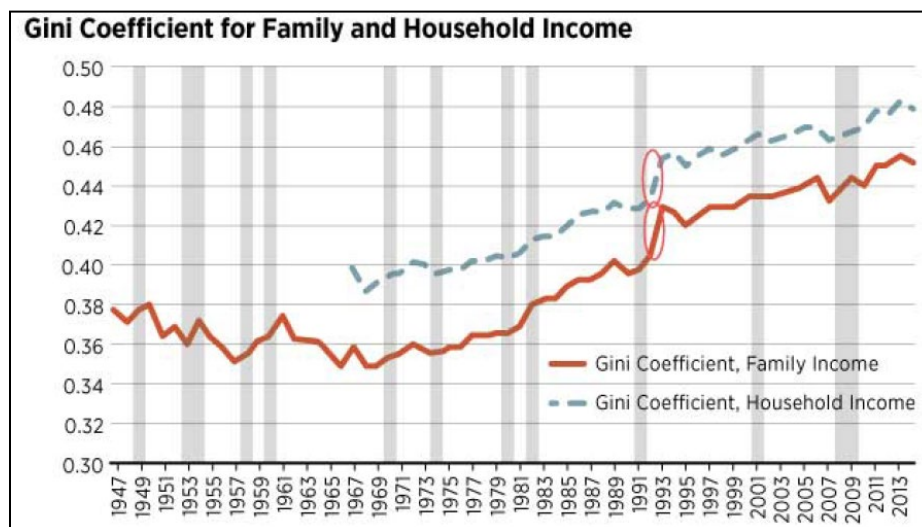
Gramm and Early, though, assert that income equality across the three lowest quintiles has grown substantially in the half-century between 1967 and 2017—after all government transfer payments are included. They write that the Census Bureau’s analyses exclude two-thirds of federal, state, and local transfer payments and ignore households’ tax payments.³²⁴¹

But that would be considerably offset by rising health insurance premiums—both the share paid by workers and the share paid by employers.

As discussed earlier, financing private health insurance coverage through traditional insurance premiums is typical in the U.S. It is very rare in other rich democracies. About one-half of Americans are covered through group or individual insurance. Only a few employers choose to modulate premiums so they rise with incomes. Vanderbilt University is one exception.³²⁴²

7. Assuring Medical security and Health care for all

Exhibit 7 – 10



Source: Michael T. Owyang and Hannah Shell, "Measuring Trends in Income Inequality," Federal Reserve Bank of St. Louis, 30 March 2016, <https://www.stlouisfed.org/publications/regional-economist/april-2016/measuring-trends-in-income-inequality>.

Since workers are typically asked to pay about one-quarter of the premium for individual coverage and about one-third of the premium to cover two or more people, lower-income workers find it harder to accept employers' offer of health insurance. (Further, the employer's payment for health insurance essentially reduces workers' paychecks as much as the employee's own share.) Wharam and Rosenthal urged federal action to reward employers that set workers' premiums in some proportion to their incomes.³²⁴³

Further, about 50 million on Medicare pay Part B and Part D premiums that don't vary with income. One exception is the 12 million dual eligibles, a substantial share of whom have their Medicare premiums paid by Medicaid. A second exception is the roughly 4 million high-income citizens who make extra premium payments called income-related monthly adjusted amounts (IRMAA).

This means that the great majority of working, elderly, and disabled Americans pay a dollar premium that does not vary with income. That means the same dollar premium is a much higher share of a low-income worker's or retiree's pay than of a high-income person's pay. This is the definition of regressive financing.

Hager and colleagues reported that, unsurprisingly, health insurance premium growth exceeded rises in workers' dollar compensation, squeezing all workers. On average, compensation of Black and Hispanic workers was constrained by rising premiums more than was compensation of White workers.³²⁴⁴

And more than one-fourth of workers must pay \$12,000 or more per year as their share of premium. The 50 million workers at small firms are particularly vulnerable because their average earnings are only 70 percent of those who work at larger firms.

7. Assuring Medical security and Health care for all

After paying premiums, average deductibles are \$3,900 for family coverage. Subsequent co-insurance payments can be very costly.³²⁴⁵ Both OOPs are even more regressive than premiums. That's because people who use lots of health care—and who therefore pay higher OOPs—are more likely to suffer reduced earnings owing to illness or disability.

Income and access. Importantly, almost one-third of lower-income workers with health insurance through the job—those with incomes under double the federal poverty level of \$54,640 for a family of three in 2026—reported difficulties in paying for medical care. Only one-eighth of workers with higher incomes reported the same. And the lower-income workers were much more likely to rate the overall performance of their health insurance as fair or poor. They found doctors, hospitals, and other caregivers substantially less available and also of lower quality. They also were much likelier to report delays in obtaining treatment, difficulty in obtaining the treatments their doctors recommended, and a decline in their health. And they were twice as likely to report trouble finding health insurance that met their needs.³²⁴⁶

If the employer offers insurance, the worker and family are not eligible for ACA-subsidized coverage unless the employer's offer is deemed unaffordable under ACA policy. That insurance is defined as unaffordable if the worker/family premium cost exceeds 8.39 percent of household income.³²⁴⁷

Fourth, racial, regional, religious, and ethnic frictions have impaired national or social solidarity in the U.S., undermining the view that we need to take care of one another. It is no accident that, of the 10 states refusing to expand Medicaid under the ACA, 7 are among the 11 former Confederate states. The average Black population shares of those 7 states in 2020 was 28 percent, double the U.S. total of 14 percent.

The U.S. hasn't yet decided to durably and simply protect all citizens against the costs of health care. Altman writes that a slim majority of Americans who lean Republican view Medicaid as a welfare program. This aligns with that failure of 10 states to expand Medicaid under the ACA, with Republican interest in work requirements for some Medicaid recipients,³²⁴⁸ and even with proposals to block-grant Medicaid spending or time-limit Medicaid eligibility. Nationally, though, three-fifths of Americans view Medicaid as health insurance, not as welfare.³²⁴⁹

Fifth, incomes of doctors, dentists, hospitals, drug makers, and most other caregivers have typically risen to high and generally secure levels without covering all Americans. Financially unthreatened by social, economic, and health care disintegration—powerful problems facing doctors and hospitals in much of Western Europe in the wake of the Second World War—U.S. caregivers never sought mandated financial protection for all people. Most American caregivers garnered enough revenue without it. Exceptions included lower-skilled and lower-paid workers in hospitals, nursing homes, home health care, and mental health care.

Nonetheless, many well-paid caregivers chose to deprecate the enormous sums bestowed on them by Medicare and Medicaid. Initially, some hospitals criticized Medicare's failure to pay their charges instead of their costs. Today, the American Hospital Association continues to criticize Medicare for under-payment.³²⁵⁰ Stensland and colleagues found, though, that hospitals lost money on Medicare owing to their own higher costs (not to Medicare's inadequate payments). And hospitals incurring those higher costs tended to have lots of high-paying

7. Assuring Medical security and Health care for all

commercially-insured patients—who generated higher revenues, which enabled hospitals to incur those higher costs.³²⁵¹

Moreover, Medicaid's history of paying low prices to caregivers—and the mistaken fear that even Medicare would pay inadequately—helped to further discourage most caregivers from embracing universal coverage. They didn't trust public programs to pay them adequately. And they feared regulated prices and constrained revenue would follow universal coverage.

Also, as shown in chapter 2, despite our high health care spending, the U.S. has many more people per doctor and fewer doctor visits per citizen than the typical rich democracy. And also a substantially lower rate of hospital admissions.

These may, in part, result from suppressed use of care owing to uninsurance and under-insurance. But associated long waiting times for care and difficulty finding a doctor, in many parts of the U.S., can deter some doctors from supporting health care for all. Doctors may suppose they are more than busy enough, even in the absence of health care for all. But their problem probably stem from shortages and maldistributions of doctors, not from excessive patient demand for care. Interestingly, doctors' average incomes are highest in the state with the lowest doctor-to-population ratio—Mississippi.

No one in the U.S. is accountable for training and paying the numbers and types of doctors Americans need, and retaining or securing them where they are needed.

As discussed in chapter 11, organized medicine in the U.S. has sometimes worked to hold down the number of doctors trained in the U.S. Length of training and associated tuition costs could have added to that suppression. High numbers of uninsured and under-insured Americans has held down purchasing power for doctors' services. The low supply of dentists, whose services are less likely to be insured, supports this view.

Sixth, in the U.S. the various public and private payers have been unwilling and unable to form a united front to negotiate with caregivers over prices and duties. Payers here are fragmented by political disagreements and by anti-trust laws. They vary considerably in the care they cover, the prices they pay, and the rules they make. Insurance companies seek opportunities to skim healthy people and shift the burden of paying the fixed costs of ER or inpatient care to other payers.

Even before many of the non-profit Blue Cross and Blue Shield plans converted to for-profit ownership, they had learned to survive by imitating the behavior of the for-profit health insurance companies—by experience rating employer groups and individual Americans, and by leveraging their often-dominant share of patients to pay lower prices to doctors and hospitals. The American Medical Association has complained frequently about this.³²⁵² A combination of for-profit BCBS plans, formerly called Anthem and now called Elevance, labels itself the nation's largest health insurer.³²⁵³

Large price differentials invite caregivers to discriminate when deciding which patients to serve and how to serve them. This disadvantages Medicaid patients in most states. Outside the U.S., all patients' care is typically paid at the same price, precluding price discrimination by caregivers. The one-tenth share of Germans enrolled in higher-paying private insurance is a rare exception.

7. Assuring Medical security and Health care for all

Similarly, no individual payer or combination of payers has the legal duty or the moral obligation or the real-world capacity to protect all Americans against costs of health care. No one is accountable.

In other nations, caregivers typically have no reason to prefer certain patients because they generate higher revenue. In the U.S., private insurers pay substantially higher prices than Medicare, and Medicaid is a notoriously low payer for most services, though adequacy varies considerably from state to state. Nominal financial coverage does not, therefore, consistently translate into actual access to care.

States set their Medicaid plans' payment rates. Most pay physicians and dentists at levels are well below Medicare rates for comparable care. This is a cause of unequal financial access. Substantial shares of primary care doctors, psychiatrists, dentists, and other caregivers simply do not accept Medicaid.³²⁵⁴ Unsurprisingly, MACPAC has found that states with higher Medicaid prices see more doctors accepting new Medicaid patients.³²⁵⁵

Medicaid was politically unpopular in many states, particularly those unsympathetic toward lower-income people or Black Americans. This has held true even though the federal share of Medicaid costs rises as the incomes of a state's residents falls. High-income states like California or New York must match federal support for traditional Medicaid, but low-income states like Mississippi or Arkansas garner about \$3 in federal Medicaid support for each dollar in state money they expend. And, states that refused to expand Medicaid under the ACA have foregone many billions of dollars in federal support, sums that would have covered 90 percent of the cost of expansion.

Hospitals (and nursing homes and other organized caregivers) in many states have been willing to accept special taxation on the understanding that the revenue raised would be added to existing state tax money and spent on care to Medicaid patients. All but one state imposes these taxes. In a recent year, they yielded \$38 billion in 2018, fully one-sixth of all state revenue paying for Medicaid.³²⁵⁶

Many in Congress saw this as a gimmick to extract more dollars from Washington. States' leveraging of special tax revenue to boost federal financial matches has been a source of contention for decades. Trump's 2025 budget will substantially slice states' use of these special taxes. This will oblige the states that employed them aggressively to either substitute state general tax revenue or cut Medicaid spending by lowering prices paid caregivers, trimming optional services, or covering fewer people. Trump's cut will therefore financially undermine Medicaid's financial and political foundations in a number of states.

A special tax might be imposed on all hospitals in a state, but the hospitals paying higher taxes often did not benefit from higher revenues—because they did not serve a very high proportion of Medicaid patients. Many states therefore allow redistribution of added revenues from hospitals that received much but paid little in special taxes toward hospitals that received little added revenues but paid much in taxes. The federal government seeks to block that redistribution away from hospitals serving higher shares of Medicaid patients.^{3257 3258}

Adequate Medicaid prices. While federal law requires states to set Medicaid prices for doctors, hospitals, nursing homes, and other caregivers at levels high enough to ensure access, the federal government has been unwilling to enforce that requirement.

7. Assuring Medical security and Health care for all

Until 1980, the secretary of DHHS had the duty to assure that state Medicaid prices were sufficient to win access to care for Medicaid patients. In 1980, at the behest of a number of state governments, the Boren Amendment transferred that job to the individual states. The Amendment notionally obliged states to set Medicaid rates that were “reasonable and adequate” to cover the costs of efficient delivery of care.³²⁵⁹

Beset by court decisions that forced some states to spend more on Medicaid than they wished, states won repeal of the Boren Amendment in 1997.³²⁶⁰ States hoped that repeal would insulate them from future lawsuits over adequacy of Medicaid rates. States expected that returning legal responsibility for ensuring adequate rates to the secretary of DHHS was expected to deny caregivers or patient advocacy groups the right to sue the secretary.

Harkins warned that repeal could leave the states vulnerable to being forced to pay higher Medicaid prices if caregivers or advocates successfully sued the secretary of DHHS.³²⁶¹

Unfortunately, in 2015, the Supreme Court ruled 5-4 in *Armstrong v. Exceptional Child Center, Inc.* that caregivers have no right of private action to sue state Medicaid programs to pay higher prices for their services.³²⁶² Obama and most states supported the ruling. Perkins decried it, noting that the Supremacy Clause had long allowed federal court suits against state actions or laws that violate federal statutes.³²⁶³

Instead, caregivers would have to rely on the hypothetical expertise of DHHS to investigate and remedy state Medicaid prices that are so low that they become barriers to accessing services. Writing the majority opinion in *Armstrong*, Scalia claimed that the federal law was so vague that courts could not competently rule on litigation. Only DHHS has the expertise, he wrote. Further, as Scalia wrote, the federal government’s sole tool would be to withhold federal Medicaid matching funds when states’ prices for caregivers were too low. That is a blunt instrument, one that federal officials would be reluctant to employ. It is not surprising, consequently, that the federal government lacks the stomach to fight with states about adequacy of their Medicaid prices.

State reliance on outside operators to manage care—and its cost—for Medicaid patients allows state governments to diffuse accountability adequate payment and shift responsibility for actions that damage access. As discussed earlier, one such action has been high rates of denial of prescriptions for sole source brand name drugs.

As discussed in chapter 3’s review of theft in health care, most state governments have contracted out high shares of their Medicaid patients to profit-making companies. In 2010, fewer than one-half of Medicaid patients were enrolled in full-risk managed care plans. In 2023, that share rose to nearly three-quarters. In 2010, less than one-quarter of Medicaid dollars went to full-risk managed care plans. That share rose to almost three-fifths in 2023.³²⁶⁴ In dollars, 2023 payments to full-risk Medicaid managed care plans totaled some \$560 billion. Equity, effectiveness, and efficiency of this spending is hard to evaluate; so is patient access to appropriate care.

A highly visible sign of this appears in the 2026 report to Congress from the Medicaid and CHIP Payment and Access Commission (MACPAC). The report devoted an entire chapter to compiling and reporting evidence on managed care plans’ compliance with federal and state laws and regulations, accountability actions, and sanctions. The Commission is clearly concerned about the adequacy of state oversight of Medicaid managed care plans. The Commission recommended:³²⁶⁵

7. Assuring Medical security and Health care for all

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to provide guidance on how to consistently report the types of accountability actions, such as liquidated damages, informal interventions, and other accountability actions taken in response to plan noncompliance, in the sanction section of the Managed Care Program Annual Report pursuant to 42 CFR 438.66(e)(2)(viii). 3.2

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to develop a publicly available database on managed care plan performance that links federally mandated reported data together to facilitate analysis. CMS should also issue guidance and toolkits to help states effectively use these data to assess past performance, improve beneficiary experience, and oversee managed care plans.

MACPAC's recommendation calls attention to the federal government's weak monitoring of states' Medicaid managed care contracts or their effects on access.

Still, even if the DHHS secretary were to implement this regulation, what practical good would the resulting rise in transparency do? How would it help patients in Medicaid managed care plans?

Transparency is no substitute for payment rates adequate to summon forth sufficient numbers of doctors and dentists to care for Medicaid patients. And it is no substitute for extruding for-profit managed care from Medicaid.

Similarly, the federal government declined to prevent a number of states from rapidly “unwinding” Medicaid eligibility in 2023-2024 in ways that mostly disenrolled Americans for purely technical administrative reasons. Chapter 1 described millions of Americans' loss of Medicaid coverage in 2023 and 2024 owing to state failure to follow legally required procedures. And to the federal government's fecklessness.

Failure to legally mandate thorough and steady coverage for all undermines access. Changing coverage and caregivers requires paperwork, identifying and coordinating new caregivers, and building new relationships. It is easy to make mistakes in each area.

One simple cause of the failure to cover all Americans is the complexity of applying for coverage. Applying for Medicaid or ACA subsidized individual insurance in Massachusetts requires completing a form that can run to 23 pages. Applying for coverage in Ontario requires completing a half-page form, shown earlier.

Ofri described how easy it was to enroll in the wrong health insurance plan, resulting in temporary denial of health insurance coverage to her spouse and children.³²⁶⁶ She recounts the bureaucratic hurdles to jump and the time required to fix the resulting problems. Ofri works as a primary care doctor.

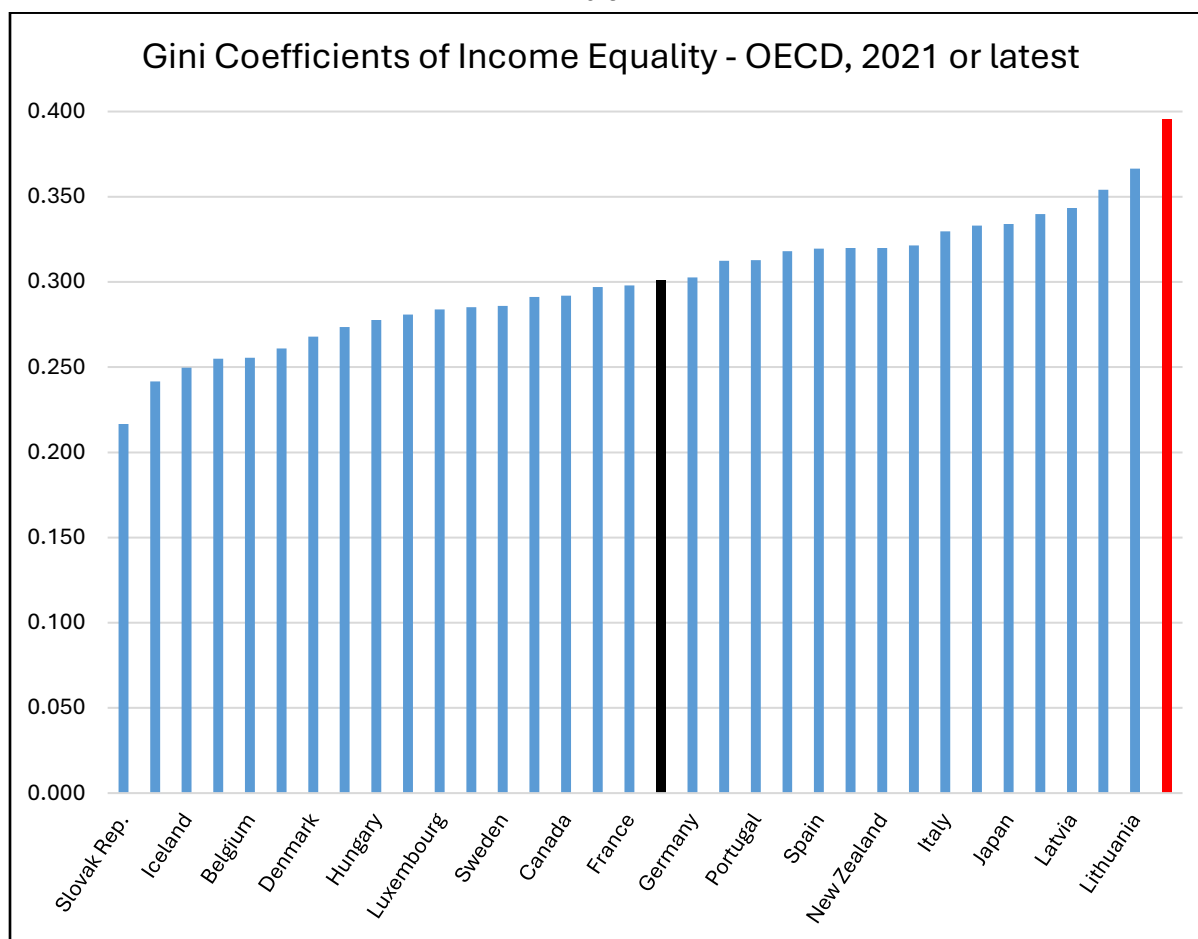
Seventh, Americans' attitudes toward government are more skeptical and even suspicious than are citizens of most rich democracies. In 2022, by one OECD report, Americans' trust in government was 5th-lowest across 33 rich democracies at 31 percent—compared to a median of 41 percent.³²⁶⁷ Other studies have somewhat different rankings.

7. Assuring Medical security and Health care for all

Eighth, U.S. income distributions have become the least equal across the OECD's rich democracies, as shown in Exhibit 7 – 11. Again, a Gini coefficient of 0 means perfect equality—all have the same income. A coefficient of 1 means perfect inequality—one person receives all of the nation's income. The OECD rich-democracy mean in 2021 was 0.30 and the U.S.A. coefficient was almost 0.40. This indicates that U.S. income inequality was one-third above the OECD mean.

High income-inequality means that covering all people requires shifting substantial sums from people who have it to people who do not. This inequality, compounded by high U.S. health costs, makes it harder—both politically and financially—to cover everyone. Doing so requires higher taxation.

Exhibit 7 – 11



Source: OECD, "Key Indicators on the Distribution of Household Disposable Income and Poverty, 2007, 2019, and 2021," 20 December 2023, <https://www.oecd.org/social/soc/IDD-Key-Indicators.xlsx>.

Ninth, as Vladeck noted, public action to redistribute income is handicapped, by design, by U.S. political institutions that have fragmented power since 1789.³²⁶⁸ This reflects the mistrust of government even by those who designed constitutional government here.

7. Assuring Medical security and Health care for all

Tenth, high U.S. health costs make it very expensive to both cover uninsured people and win medical security for all by addressing the many sources of under-insurance. That compounds the political difficulty of shifting money stemming from racial/regional/religious divisions, from mistrust of government, and from very uneven income distribution.

Eleventh, inadequate financial coverage is, in many ways, a direct result of the failure to contain costs by the effective methods employed in the world's other rich democracies. That failure leaves U.S. patients and payers flabbergasted, flapping, and foundering.

Payers often respond in ways that cut access. Leaving people uninsured is one. A second is increasing under-insurance by forcing people to pay high OOPs when sick or incentivizing managed care operators to cut care. A third is tolerating short supplies of caregivers who might serve under-insured people. A fourth is tolerating and even encouraging formation of transient and narrow networks of caregivers. Fifth is boosting uncertainty about whether care will be paid through administrative denials—both before and after care is given.

Twelfth, redistributing purchasing power would be essential to fully cover people who are currently uninsured or under-insured. Only government can do that.

It is far easier, politically, to redistribute purchasing power if health care costs are under control. In the U.S., government's inability or unwillingness to contain cost opened the door to high reliance on putative competitive free markets to do that job—one that markets cannot perform effectively or safely.

Pushing on that door were the many U.S. health economists with free market orientations. To contain cost, they urged use of devices like narrow networks of caregivers, higher OOPs, HSAs, and competing HMOs or MA plans or Medicaid managed care. When these proved ineffective and inequitable, free market advocates blamed government. Glaser notes that economists in other rich democracies are typically asked to do technical work. Examples include analyzing how to do what a government wishes, or to estimate costs of alternative cost control policies or various service expansions. Economists are not asked to advise on what to do. U.S. health economists seem emboldened and empowered to address both what and how.³²⁶⁹

Thirteenth, fewer doctors and hospitals are available in the areas where higher shares of low-income or Black or Latine or other citizens live—people who are vulnerable to deprivation of needed care. These include citizens of many rural districts and also cities.

As Radley and Schoen wrote, “there are staggeringly wide gaps in people’s ability to gain access to care in different communities around the country.”³²⁷⁰ Since the care Americans get depends heavily on the caregivers we’ve got,³²⁷¹ chapter 11 considers how to make vital primary care generously available to all of us. Chapter 12 takes up hospital configuration. Both primary and hospital care are essential to winning more equitable and affordable health care for all. More adequate and better balanced configurations of primary care and hospital care are essential foundations for medical security. On these solid foundations can be erected clear communication, strong relationships, and durable trust between patients and caregivers.

7. Assuring Medical security and Health care for all

And **fourteenth**, fragmented coverage, care delivery and payment impair health security and cost control.

Fragmenting groups of Americans by payer, by price, and by caregiver manifests weak commitment to equity. Four types of coverage—MA, Medicaid managed care, ACA, and private through insurance through the job—typically rely on distinct narrow networks of caregivers. Some doctors and hospitals contract to participate in numbers of different narrow networks, but each has its own rules, payment methods, and prices. Most of the payers or other organizations that create the narrow networks operate for-profit. They make more money, other things equal, when patients get less care or lower-priced care.

In 1986, Rosenblatt reviewed changes in Medicaid and argued that for-profit managed care organizations needed to integrate “the patient-centered ideal into increasingly private and cost-conscious administration of medical care to the poor.”³²⁷² More broadly, Dallek noted Reinhardt’s regretful insistence that Americans need to accept 3 classes of care. She also cited Thurow’s worry that the U.S. was headed for a “segregated three-tiered health care system.”³²⁷³

2. Out-of-pocket payments and moral hazard

Even as more greater shares of Americans gained some health insurance coverage, it remains shallow. Indeed, as more people are covered, boosting spending, efforts to contain spending rely more heavily on various indirect methods of suppressing use of health care. These indirect methods include higher OOPs and facility fees, narrow and shifting networks of caregivers, low availability of caregivers in many rural and urban areas, bureaucratic impediments like prior authorization or retroactive denials of payment. These indirect methods of suppressing use of care look attractive to those who can’t identify politically acceptable methods of cost control.

Blue Cross and Blue Shield plans included deductibles, co-insurance, and co-payments that were intended to hold down costs covered by health insurance. Commercial health insurance plans adopted them even more enthusiastically. All are embedded in the insurance mind-set—one of holding down premiums, discouraging false claims, combatting adverse selection, and countering moral hazard. OOPs have impeded financial access for lower-income or chronically ill people.³²⁷⁴ They have been one of the most durable forms of under-insurance and financial rationing of health care.³²⁷⁵

Indeed, Gladwell cites Nyman’s belief that Pauly’s assertion that good insurance makes for moral hazard has been the “single most influential article in the health economics literature.” Moral hazard is the belief that good insurance coverage encourages or allows some people to either act in ways that recklessly disregard their health and safety, or indulge their craving for unnecessary health care. This is a misapplication of insurance principles to human life. Theory trumps good health care coverage.

An 18th century maritime insurance company would not wish to financially incentivize a ship-owner to sink his vessel. So the ship could be insured for perhaps only 80 percent of its market value—of how much it could be sold for. And the same for its cargo. The insurer would inspect the cargo to confirm that it was the merchandise listed on the manifest and on the insurance policy, not ballast. And would inspect the ship’s hull, rigging, and sails to make sure they were

7. Assuring Medical security and Health care for all

in good condition. And that the captain was competent and not prone to drinking and running ships into rocks.

When Americans are forced to pay high OOPs, they use less care. That cuts spending on health care. It allows employers to lower their premium payments. And it allows Congress to rely less heavily on payroll or income taxes to finance Medicare.

Some argue that OOPs boost spending by delaying care so problems that could have been treated cheaply come to require expensive care. This assertion is appealing, but it is hard to prove. It assumes that prevention and early detection save money, and also that patients actually are willing and able to obtain the costlier care they might need later.

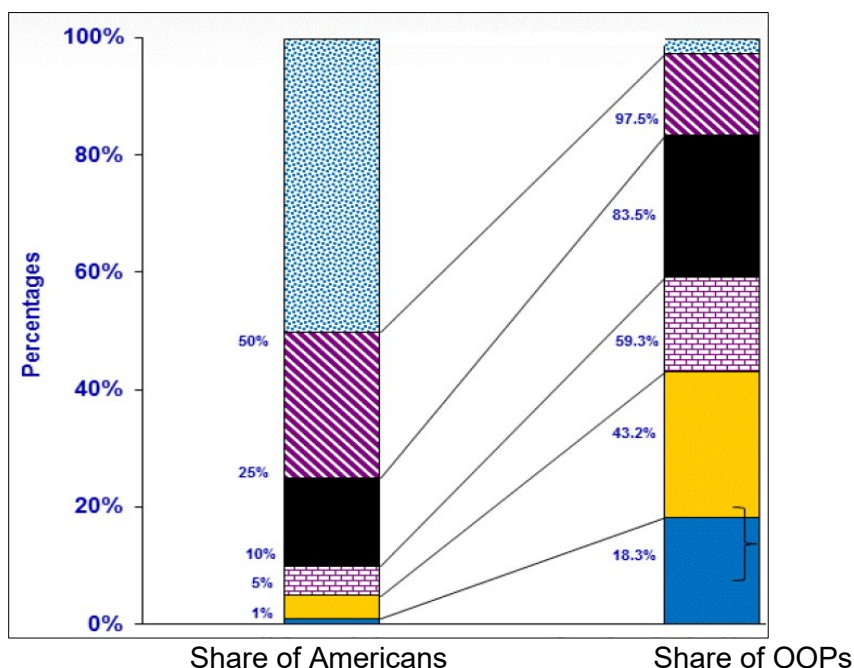
It is more realistic to argue that OOPs discriminate and that they ask the wrong people to make decisions about seeking care, and to do so for the wrong reasons. High OOPs are regressive and disproportionately cut use of care by low-income people.

They are a tax on using care. And they fall heavily on people with chronic illness and disability who need and use more health care. Chapter 8 discusses the very uneven use of health care—and resulting high costs.

OOPs fall with unfair and insupportable weight on those Americans who receive more health care. And they follow mostly from doctors' treatment decisions, not from patients' choices or exposure to moral hazard.

Small shares of Americans incur most of the OOP costs. As shown in Exhibit 7 – 12, 10 percent of non-elderly Americans incurred almost three-fifths of all OOPs. And 25 percent of Americans incurred five-sixths of all OOPs.³²⁷⁶

Exhibit 7 – 12
Small Shares of Non-elderly Americans Incurred High Shares of OOP Costs, 2011



7. Assuring Medical security and Health care for all

Source: Stephen B. Cohen and Namrata Uberoi, "Differentials in the Concentration in the Level of Out-of-pocket Health Expenditures across Population Subgroups in the U.S., 2011, Medical Expenditure Panel Survey, Statistical Brief No. 423, Figure 1, September 2013, https://meps.ahrq.gov/data_files/publications/st423/stat423.shtml.

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OOPs are one of the keystones in the arch of folly that sustains faith in relying on competitive free markets in health care. Without substantial OOPs, patients are imagined to be unwilling to use care carefully. With substantial OOPs, patients are imagined to be impelled to use information about price and quality to shop carefully.

As discussed in chapter 4, OOPs have been touted by theorists as a way to motivate people, when ill or injured, to think carefully about whether they need care and, if so, to shop for care by price and quality. OOPs overcome the dreaded moral hazard thought to be associated with generous insurance coverage—the risk that people would neglect their health because they have full insurance coverage or that they would opt for more care than needed because they paid little OOP.

But, as shown in chapter 4, data on price are bad, often irrelevant, and hard to use. Data on quality are much worse. And even if good data on both could be created, they would not help patients answer the question that matters most: what care do I need to diagnose and treat my problem?

Even smart, decent, and reform-minded researchers can be trapped in the fantasy world of OOPs. One group has asserted the value of switching from yearly deductibles and out-of-pocket maximum payments to monthly caps on OOPs (which they choose to call “cost-sharing” but that might be called regressive taxes on illness and injury). Monthly OOP caps would probably be better than yearly ones. But, apparently seeking a middle ground, they assert that these monthly caps “would reduce both overuse and underuse of care, by making care more accessible while maintaining the salience of costs every month.”³²⁷⁷

This posits an equivalence between the real risks of overuse and underuse. And it supposes that patients should or must continue to think about cost of OOPs. But. While it is usually better to light a candle than curse the darkness, some candles can consume oxygen vital to life.

Other well-intentioned people seek to make OOPs more fair, in some sense. Horny and colleagues propose to make OOPs more predictable by establishing fixed payments for various procedures. For example, they note, OOPs for patients receiving pacemaker implants rise substantially if treatment for pneumothorax becomes necessary. They therefore propose setting each patient’s OOP to include an actuarially calculated payment reflecting the average added expected OOP burden associated with pneumothorax.³²⁷⁸

But making the world safer for OOPs, however more predictable or more fair, in some theoretical sense, does not diminish OOPs’ overall toxicity. They remain unfair barriers to access; they punish poor people and people who need costly care.

Many economists and others addicted to free market thinking in health care support high OOPs as a matter of principle.

7. Assuring Medical security and Health care for all

In parallel, caregivers try to obtain revenues they desire but that payers won't give them. So they bill patients, instead. The two most prominent examples of these OOPs are surprise bills and facility fees.

Both efforts upset patients and both have generated legislative reactions. They should be seen as military theaters in the continuous low-intensity financial warfare between caregivers and payers.

Surprise bills. MA plans, Medicaid managed care plans, ACA plans, and commercial insurers make wide use of narrow networks of doctors and hospitals. Since health insurance has few intrinsic, built-in cost controls, narrow networks are one of the few theoretical tools available to payers to hold down their spending. They are not very effective, but insurers still cling to them.³²⁷⁹

Consequently, for decades, many patients wandered out of network owing to emergencies, incompetently prepared or outdated directories of in-network caregivers, lack of knowledge or understanding of the distinction between in- and out-of-network caregivers, or even trickery by caregivers or insurers.³²⁸⁰

Rubenstein describes the case of an infant who needed heart surgery. His parents made sure the surgeon was in-network. But a second surgeon, not in-network, assisted during an 8-hour operation and billed for \$15,000. The parent's insurer paid 10 percent of that bill and left the family to pay the remaining \$13,500. An executive working for the insurer said it was "'important for members to understand this aspect of their health plan.'" ³²⁸¹ That's both condescending and ugly.

After decades of patient anger at surprise bills, many of them very large and outrageous, some 31 states enacted laws designed to protect patients in various ways. Congress enacted a federal No Surprises Act in December of 2020 and Trump signed it.

For most patients, in emergencies and some other circumstances, the NSA caps out-of-network OOPs at the levels set for in-network care. Doctors, hospitals, and other caregivers can then request arbitration to set the payment from the various payers. This process is complicated. But caregivers with time and money to go through it have been able to win fairly high payments from those payers.³²⁸² And sometimes absurdly high payments.³²⁸³

That's because the NSA did not set a simple set of prices (such as those actually paid by Medicare) for out-of-network care, nor did it set out a simple process for resolving disputes. Congress was unwilling to make clear choices that would anger either caregivers or payers. Court decisions came down on the side of caregivers seeking higher prices for out-of-network services. One predictable result is higher payments to caregivers and higher premiums for citizens, taxpayers, and employers.³²⁸⁴ Another will be greater willingness by patients to obtain care from out-of-network doctors and hospitals.

Facility fees. When patients see doctors in hospital-owned offices, hospitals often impose facility fees. Payers sometimes cover these. But when payers don't cover the fees, they fall on patients. Then, they constitute a new form of OOP, one not contemplated by employers or insurers when they designed health insurance plans. Facility fees reinforce OOPs in discouraging people with less money from using health care.

7. Assuring Medical security and Health care for all

Ofri describes unexpected facility fees as a type of surprise bill, one that is unaffordable for many of the patients ambushed by such bills.³²⁸⁵

Facility fees may have cost Medicare \$6 billion in added payments to hospitals in 2023.³²⁸⁶ The national total for facility fees paid by public or private payers is not known. Nor is the national total paid by patients.

Schwartz and colleagues found that facility fees for evaluation and management services during ER visits rose 4 times as fast as did professional fees between 2004 and 2021.³²⁸⁷ The E+M services are about one-half of ER bills.

Hospitals claim they impose the fees to more fairly recover fixed costs of operation. They assert that the fees are added to bills for doctor visits when a hospital-employed or –contracted doctors gives care in a hospital-owned building.

It might seem, in principle (or in theory), that the fees do not generate added revenue. Some hospitals might make such a claim. That would be true if they do no more than reallocate certain indirect fixed and variable costs proportionately to all sites of patient care. In this view, fees are more visible today because more hospitals have acquired more physician practices and are imposing facility fees on more patient visits. If that is so, the hospitals' total revenue should not change when facility fees are imposed on outpatient care. That's because fixed and variable costs associated with inpatient care should fall by a sum equal to the rise in outpatient facility fees. But there's no evidence that happens. Hospitals negotiate prices with private payers in light of bargaining power, not evidence on cost. Medicare pays for inpatient admissions by the DRG. What is the evidence that imposing facility fees for outpatient visits have affected DRG payments?

The added outpatient facility fees almost certainly boost revenue substantially.

This is borne out by hospital claims that they need more money. Hospitals insist they need the revenue generated by facility fees because, they say, Medicare and Medicaid under-pay them and private insurers increasingly squeeze them. Hospitals point to the need to maintain costly emergency rooms and other services.³²⁸⁸

About a dozen states have sought to address facility fees, sometimes symbolically and sometimes seriously. Indiana requires reporting. Colorado prohibits some large hospitals from charging fees for preventive services. Connecticut bans fees for a wide range of outpatient services at many different sites.^{3289 3290 3291}

3. Complex, confusing, and unfair financing

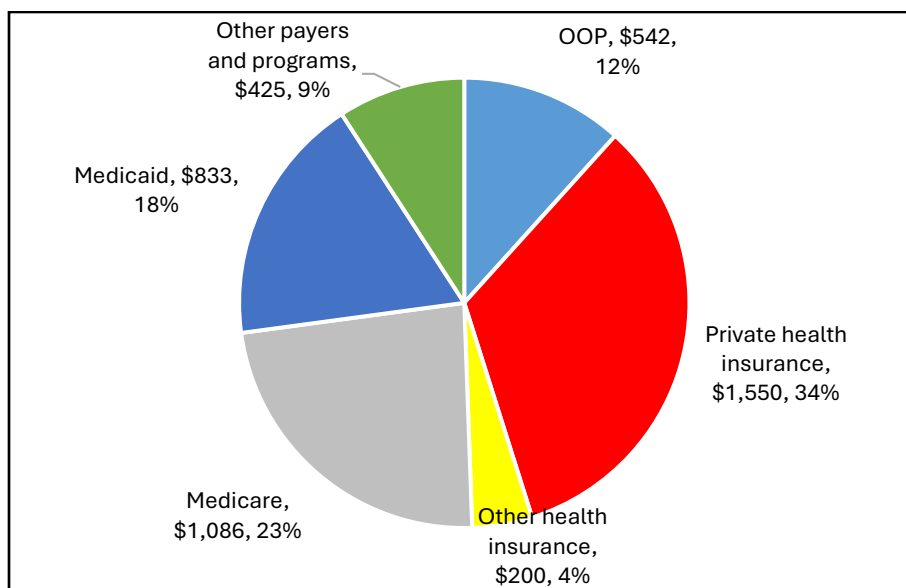
Sources of revenue by payer

A traditional approach categorizes sources of revenue administratively or legally. Which private or public entities write the checks to various caregivers? Exhibit 7 – 13 displays the main conventional sources of revenue for health care in 2024.

7. Assuring Medical security and Health care for all

Exhibit 7 – 13

Conventional Categories – Sources of Revenue to Pay for Health Services, \$ Billion and Percent, 2024



Source: Jacqueline A. Fiore, Andrew J. Madison, John A. Poisal, and others, “National Health Expenditure Projections, 2023-32: Payer Trends Diverge as Pandemic-related Policies Fade,” *Health Affairs*, Vol. 43, No. 7 (July 2024), pp. 1-12, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00469>.

Notes: Other health insurance is CHIP, DoD, and VHA.

Other third party payers and programs include federal and state workers' compensation for health costs, federal vocational rehabilitation health costs, federal-state-local governments' direct spending on hospitals, Substance Abuse and Mental Health Services Administration, Indian Health Service, general assistance health costs, school health, maternal and child health programs, medical spending by property and casualty insurance companies, employers' work site health services, private philanthropy, and non-patient revenue from hospital or nursing home gift shops, cafeterias, or parking garages. These are detailed in a methods paper from the CMS Office of the Actuary.³²⁹²

Exhibit 7 – 13 displays the immediate sources of revenue to pay for care, not the ultimate or under-lying sources. For example, health insurance for local, state, and federal workers is tax-financed government spending. But it shows up under private health insurance in Exhibit 7 – 13. That's because all these workers are covered through the various private health insurance companies that government workers choose. Government pays the premiums but private insurance companies write the checks.

Additionally, employers' and employees' private health insurance through the job is financed, in part, by federal subsidies—by exempting those premiums from individual or corporate income tax returns. The CBO has projected that, over the decade from 2026 to 2036, these subsidies would amount to \$7.2 trillion—just over one-fifth of federal support for health coverage. Medicare accounted for almost one-half and Medicaid/CHIP one-quarter.³²⁹³

7. Assuring Medical security and Health care for all

Sources of revenue from Americans

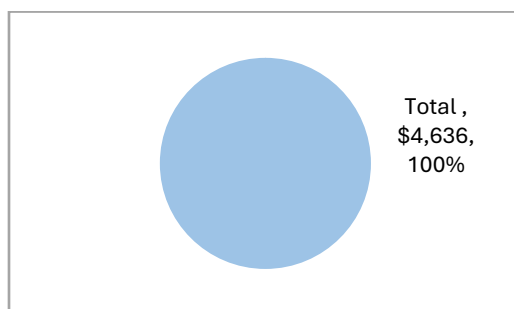
In a second view, all money is paid by the individuals who live and work in the United States. Here, the distinctions about sources of revenue (about who it is who nominally writes the checks to caregivers) are formalistic: How much money comes out of individual Americans' various pockets—the private insurance pocket, the taxes pocket, the charitable pocket, or the out-of-pocket pocket?³²⁹⁴

This view is helpful because it underlines the reality that 340 million Americans finance health care. Employers don't use their own money to pay for health insurance. (An auto maker or a cell phone company or a plumbing and heating company doesn't print money, we hope.) They use money they earn by selling goods and services. Similarly, governments impose taxes, ultimately, on all of us.

This makes trade-offs clear. If hospital, doctor, drug, or other health care costs rise, employers pay higher private health insurance premiums, boost employee shares of premiums, or shift costs directly to employees who use care by hiking OOPs. Or they cut employment via automation or other methods.³²⁹⁵ Employee health insurance constitutes a tax on jobs.

Exhibit 7 – 14 displays the share of health care dollars originating from all of us in 2024.

Exhibit 7 – 14
Share of Health Care Dollars Originating from Individual Americans in 2024, \$ Billion



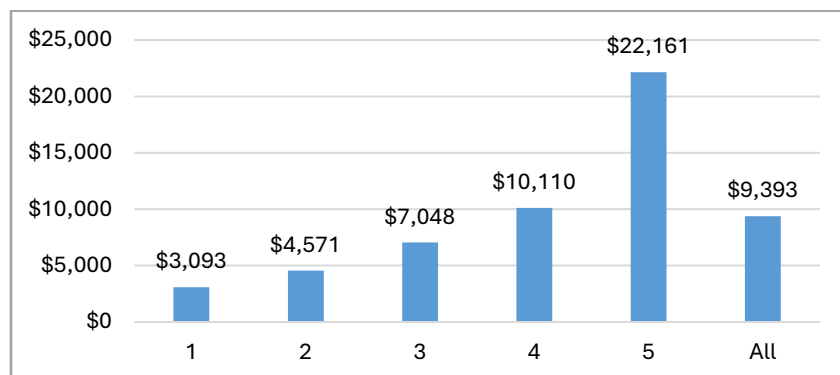
In a third view, payments for health care can be compared across income groups. Relying on data from Carman and colleagues, Exhibit 7 – 15 shows per capita dollar payments for health care by household income quintile in 2015.³²⁹⁶ The lowest one-fifth of households paid a little over \$3,000 and the highest paid about 7 times as much, a little over \$22,000.

Exhibit 7 – 16 now compares dollars paid with care used, per capita, across the income quintiles. Care used declines more rapidly with income at first and then levels off. Payment per person rises more and more quickly with income.

7. Assuring Medical security and Health care for all

Exhibit 7 – 15

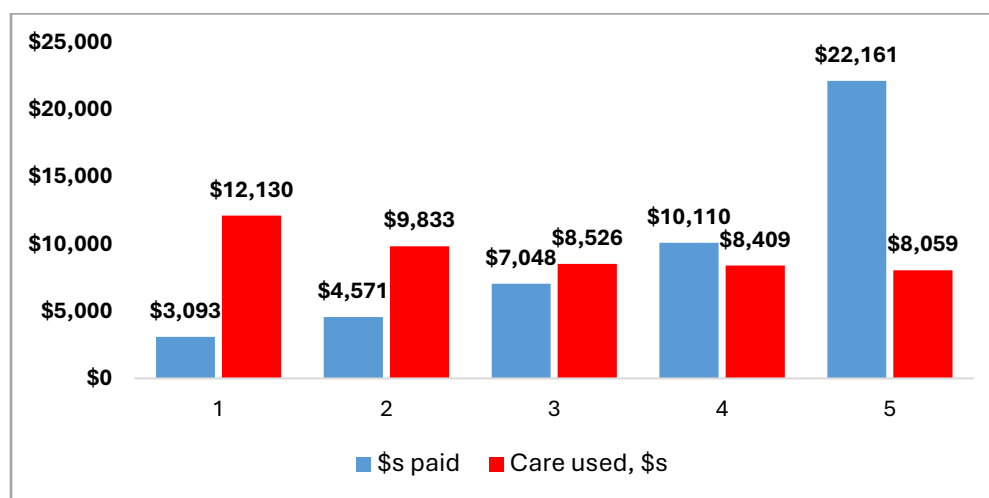
Per capita dollar payments for health care by household income quintile, U.S., 2015



Source: Katherine Grace Carman, Jodi Liu, and Chapin White, "Accounting for the Burden And Redistribution of Health Care Costs," *Health Services Research*, Vol. 55, No. 2 (April 2020), pp. 224-231, <https://doi.org/10.1111/1475-6773.13258>.

Exhibit 7 – 16

Dollars paid for health care versus care used, income quintiles, 2015

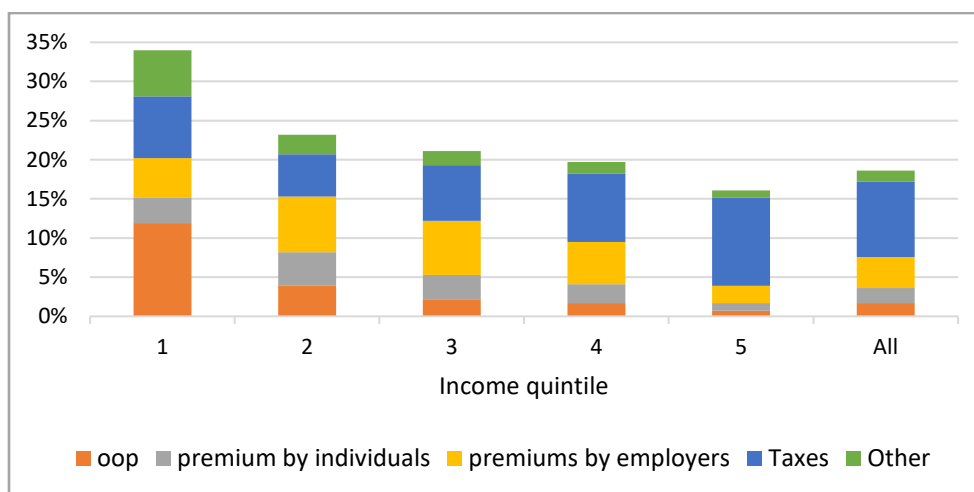


Sources of money to pay for health care change substantially by income quintile. As shown in Exhibit 7 – 17, OOPs are most important for lower-income households but trivial shares for higher-income households. Shares of income paid by taxes generally rise with income. Premium payments absorb higher shares in the middle income quintiles.

7. Assuring Medical security and Health care for all

Exhibit 7 – 17

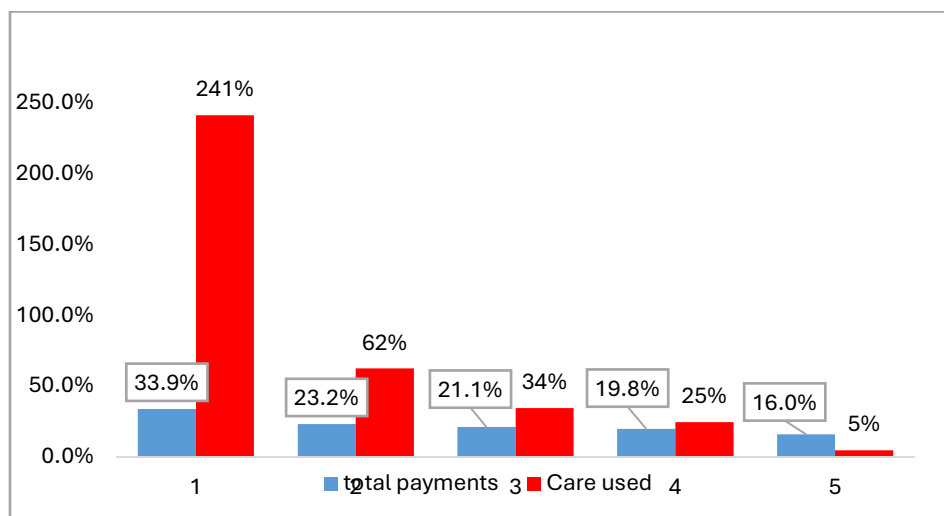
Shares of Income to Finance Health Care by Source and Quintile, 2015



Finally, Exhibit 7 – 18 contrasts care cost and payment, per capita, as shares of income. Americans in the lowest income quintile receive roughly 8 times as much care as they pay for, measured as shares of income. Only in the top quintile does payment exceed care received as a share of income.

Exhibit 7 – 18

Care Cost and Payment, per Capita, as Percentages of Income, by Income Quintiles, 2015



Together, these data present a mixed picture. Financing is clearly regressive: lower-income people pay higher percentages of their incomes for health care than do higher-income people. At the same time, lower-income people receive much more care than they pay for—both in dollars (Exhibit 7 – 16), and as percentages of income (Exhibit 7 – 18). Purchasing power for

7. Assuring Medical security and Health care for all

health care is being redistributed, but apparently not beyond the capacity of higher-income people to afford to pay for other Americans.

All this reflects today's world of substantial uninsurance and under-insurance. Without containing costs, improving financial coverage would require boosting taxes on Americans in the upper income quintiles. They might resist—especially if they also face higher taxes to meet other needs—like housing, transportation, environment, defense, or cutting the federal deficit.

Spending by income, adjusted for age and self-reported health status

Cliff and Meille offered a different evaluation of *adjusted* spending on care by income quintiles from 2005 to 2023.³²⁹⁷ *They calculated predicted spending, adjusted for age, self-reported health status, and number of reported conditions.* Those can be viewed as predictors of need for care. So, in that sense, they compared need-adjusted spending in real (inflation-adjusted) 2023 dollars.

They found that predicted adjusted spending rose with income. Over time, they saw a trend toward convergence of predicted adjusted spending by income from the time of implementing the ACA in 2014 until 2017. After 2018, though, predicted adjusted spending rose for the highest-income quintile, was flat for quintiles 2-4, and fell for the lowest quintile. The MEPS survey on which this analysis rested was re-designed between 2107 and 2018.

For 2023, they predicted average adjusted spending at under \$6,000 per person for the lowest quintile and above \$10,000 per person for the highest income quintile.

4. Complex subsidies for different groups of Americans

The exhibits just presented describe use of care and payment for care by different groups of Americans. Various groups of people enjoy varying levels of subsidies to help make their medical care affordable. These uncoordinated subsidies arose incrementally.³²⁹⁸ They are difficult to change or re-arrange.

For Medicare patients, most of the costs of Part A hospital care are paid by currently working people through a 2.9 percent assessment on all earned income. And about three-quarters of the premium costs of Part B coverage for doctors' care and Part D drug coverage is subsidized by federal general revenues. The remaining one-quarter is a regressive burden on Medicare patients.

For Medicaid patients, almost all costs are shared by federal and state governments. In high-income states, the federal share is one-half; in low-income states, it is three-quarters. Fully 90 percent of the cost of the ACA's Medicaid expansion is federally financed.

For people insured through the job, employer shares of premiums are not subject to federal corporate income tax. And the value of the employer shares of premiums is not taxable to workers. Similarly, employee shares of premium are typically paid with pre-tax dollars—and are not subject to individual income tax, Medicare tax, or Social Security tax. Both employer and employee shares are regressive, as is the federal tax subsidy for families.

7. Assuring Medical security and Health care for all

Families with high-deductible health plans can contribute up to \$8,300 tax-free to their health savings account each year, and people who are not in such plans can contribute \$3,200 tax-free to flexible savings accounts.

Existing subsidies are, effectively, locked in politically. Money dedicated to each subsidy is not available to subsidize other people. Unless done carefully, modifying any of these subsidies would be hard, politically, because each change would create winners and losers.^{3299 3300} Those who fear losses always speak louder than those who hope for gains.

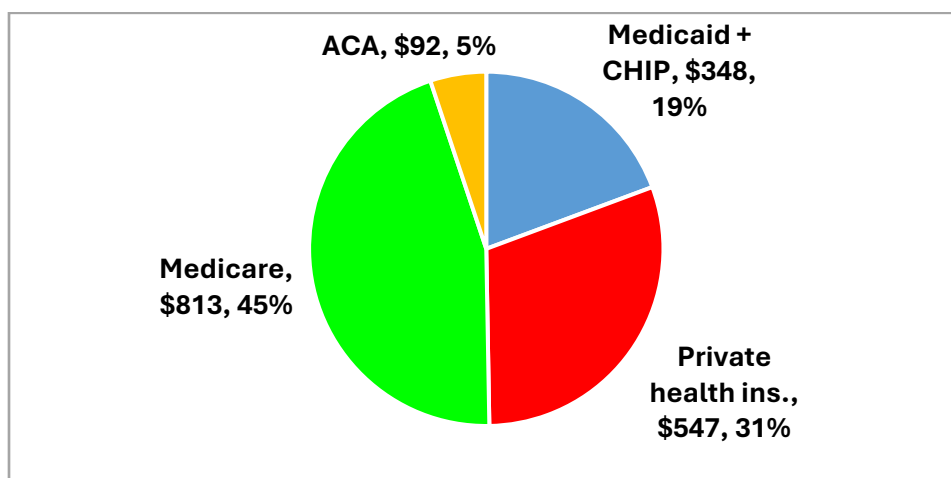
In 2023, combined federal spending on Medicare, Medicaid, ACA, other programs plus subsidies (tax spending) for private health insurance totaled some \$1.8 trillion, about 7.0 percent of GDP.³³⁰¹ They were projected to rise to 8.3 percent in 2033.

As shown in Exhibit 7 – 19, cost of Medicare Part A's inpatient hospital care plus payment of three-quarters of the cost of Part B and Part D premiums absorbed almost one-half of this money.

Non-taxation of private health insurance premiums accounted for three-tenths. Except for a short time in 1953 and 1954, employers have been exempt from paying corporate income tax or FICA tax on their shares of employees' health insurance premiums (or other non-cash benefits). In 1978, Congress added section 125 to the Internal Revenue Code. It allowed employers to establish "cafeteria" benefit plans; these enabled employees to exclude their own shares of health insurance premiums from income and FICA taxation.³³⁰²

Federal Medicaid payments to states absorbed one-fifth of the federal subsidies. ACA subsidies took only 5 percent, a share that roughly doubled since 2021 owing to higher subsidies enacted by Congress in 2021 and 2022. The American Rescue Plan Act hiked subsidies for 2021 and 2022; the Inflation Reduction Act extended them for three years, through 2025. They expired at the end of that year.

Exhibit 7 – 19
Distribution of Federal Health Care Subsidies across 4 Programs,
\$ Billion and Percentage, 2023



7. Assuring Medical security and Health care for all

The number of uninsured Americans probably bottomed out in 2024, for now, and is rising fairly substantially in 2026. The large number of under-insured Americans face financial barriers to care, often high ones. Under-insured Americans' access to care is constrained by lack of primary caregivers, shortages of specialists, closings of hospital services and entire hospitals, narrow networks, and bureaucratic barriers like prior authorization.

At the same time, very high spending levels increasingly preclude expanding coverage by simply spending more. Various private and public mechanisms cover different services and pay caregivers different prices for those services. Caregivers have become accustomed to addressing the challenge of generating adequate revenue in a complex and evolving financial environment.

Reforms that cap spending, pool dollars carefully, financially protect all Americans solidly, lower non-financial barriers to care, and re-work revenue sources will require careful thought and design, testing, re-design, and thoughtful implementation. Careful and proven techniques for squeezing waste while capturing the dollars saved will be essential to ensure financial security for patients, adequate revenue for the right configuration of caregivers, and politically popular and durable reforms.

Because political demand for reform will rise as health care slides into crisis for both patients and caregivers, the years of detailed design and testing work of the Red Team, described in chapter 1, will be indispensable to successful change.

D. Paths to health care for all

This section begins with an overview of 6 aspects of reform. It then considers possible incremental improvements that deepen or broaden financial coverage. Next comes a comparison of single payer and all payer methods of financing health care for all. This includes a short discussion of the different sources of revenue to finance crisis responses and then to durably pay for health care for all Americans. The section concludes with a short discussion of the integration of health care for all with both cost control and methods of paying and organizing the right numbers and type of caregivers in the right places.

Overview of 6 considerations

1. One option is to keep spending more to cover everyone. Vladeck wrote in 2003 that the U.S. was a rich nation and could afford to spend more to win health coverage for all. He believed then that it is impossible to expand access and reform health care at once. Each job is just too big—practically and politically.³³⁰³

Political support for cost control has proven weak. Cutting cost is usually understood to mean cutting caregiver revenue. Caregivers' anticipated sharp pain politically trumps theoretical gains to payers. One reason is that, as discussed in chapter 8, cost control proposals have rarely targeted waste.

Three laws manifest cost controls' weak political support. Enacting the 2006 chapter 58 Massachusetts universal health care law inspired the design of the 2010 federal ACA. It was politically impossible for either law to attempt to slow health care spending growth. Affected caregivers would have blocked passage of access expansions. The 2003 enactment of the Medicare Part D prescription drug benefit demonstrated the same rule.

Still, in Mead's view, cost control needs to precede expanding financial coverage—and will build political support for such expansions:³³⁰⁴

In the long run, affordability is access, and attacking the factors that inflate the cost of health care in the U.S. will do more good for more people than trying to subsidize an ever-growing share of the population as health care costs continue to escalate.

Moreover, stabilizing health care costs for the middle class could be more politically savvy for reformers. If the money currently being sucked out of middle class families' budgets by escalating health care costs...were in their pockets instead, they would likely be more willing to make sacrifices to help expand access for the poor.

Politics is not just about building technocratic systems of income redistribution and social nudgings. If Americans come to believe that intellectual and politics no longer see the prosperity of the American middle class as Job One, they will grow to mistrust government, tune out wonkish discourse, and rely on their own base instincts—as indeed we are seeing now with the rise of Donald Trump.

Unfortunately, that dynamic doesn't change today's politics of cost control.

Many reformers or advocates for health care for all believed in 1965—and believe today—that spending more money will be essential to covering all people—owing to weak political support for containing cost and for more carefully spending the huge sums that are already available inside U.S. health care. In 1965, though, health spending was only 5.6 percent of GDP, less than one-third of its share in the mid-2020s.

7. Assuring Medical security and Health care for all

A related argument is that the ACA *did not appear to accelerate* growth in health spending, demonstrating that the nation can afford to spend more to boost coverage.³³⁰⁵

More interesting is Fein's 1975 assertion that then-current health spending, a little over \$100 billion and 7.7 percent of GDP, was sufficient to finance health care for all Americans.³³⁰⁶

Against this, the 2023-2024 recertifications of Medicaid eligibility improperly pushed millions of eligible enrollees out of coverage. Trump's 2025 budget scheduled deep Medicaid cuts. And he allowed the enhanced subsidies for ACA coverage to lapse. One motive was spending cuts to partially offset legislation extending Trump's 2017 tax cuts. A second was the view that some people didn't deserve health insurance coverage through Medicaid. A third was long-standing friction between federal and state governments over methods of financing state shares of Medicaid.

As discussed in chapter 1, these cuts in financial coverage are some of the strong winds and rain squalls that precede the hurricane bearing down on U.S. health care.

2. Keep the ethical or moral element in mind. Good health care for all is the right thing. Keep in mind the ethical goal of financially protecting all people and including it in all reform efforts.

It follows from this that people with similar medical problems should be offered similar treatments. This does not always happen.

Each nation faces urban – rural differences in care. Rural districts generally have fewer doctors per 1,000 citizens and weaker access to primary, specialist, and emergency care. The Germans have separate and costlier financing for higher-income citizens, about 10 percent of people. They wait shorter times to see a doctor and enjoy longer visits. A similar share of Britons buy private health insurance and pay to see doctors privately, avoiding long waits for an appointment. Even in Canada, where it's illegal to buy private insurance for services covered by Medicare, Ontario's capitated family health teams are more likely to be found in higher-income districts.

The U.S. tolerates a greater degree of discrimination by income and race/ethnicity than do other rich democracies. Rates of use of care, quality of care, and health outcomes differ substantially.³³⁰⁷ One of the main reasons is that different payers cover different groups of people, and these pay very different prices for the same care.

A number of well-intentioned observers considered health care inequity in the U.S. to be inevitable because they viewed equity as financially unaffordable or politically impossible. Reinhardt described 3 classes of care.³³⁰⁸ Thurow also feared that U.S. health care was drifting ineluctably toward 3 tiers. One group would be covered by government; another by employers, and third by self-paying higher income Americans.³³⁰⁹

One two-tier proposal might cut inequality somewhat. It would protect all Americans—not badly, but not thoroughly.³³¹⁰ It urges tax-financed health coverage for all Americans. That would include primary and preventive care, care for critically ill patients, ER care, services of specialist physicians, and inpatient care. What would be excluded? Dental care, infertility treatments, long-term care, vision care, physical therapy, and other services. Some meds would be

7. Assuring Medical security and Health care for all

covered but probably not others. This approach resembles policies in effect in Canada, Israel, the Czech Republic, and some other nations.

Access to U.S. health care is decidedly unequal today. The U.S. has probably gotten to this place without containing cost.

A strong ethical case can be made for equitable access to care and use of care.

Moreover, it is unequal care that has proven financially unaffordable and, therefore, politically unsustainable.

3. The pragmatic case for equity is even stronger than the ethical case. It has 4 components.

First, no rich democracy has succeeded in containing health care costs without covering all people. To afford to cover everyone, cost must be contained. So coverage becomes the ally of cost containment, not its enemy. It's inequity that's been proven to be unaffordable. Equity is a key component of health care that's affordable and effective. Health care anarchy's reign must be ended to make good care affordable for all people.

Second, efforts to contain cost of U.S. health care—without covering all people equally—have simply failed. As discussed earlier in this chapter, those efforts certainly have suppressed access to care and use of care disproportionately for people with less income, with Medicaid coverage, or with fewer nearby caregivers. But they have done nothing to make U.S. health care more efficient, more affordable, or more effective.

Instead, they have invited peculiar adaptations. Doctors and hospitals merge to win higher prices from commercial insurers. Hospitals lobby Congress for special subsidies like the 340B program. Medicare and Medicaid push faith-based capitated managed care plans that promise to save money while protecting care. (They don't.) MA plans upcode patients to secure unwarranted boosts in capitation payments. Hospitals and doctors upcode patients to win higher payments.

Third, U.S. cost control efforts have failed in part because they have not addressed either of the 2 causes of anarchy—market failure and government incompetence. And in part because those efforts have themselves engendered higher levels of clinical waste, administrative waste, price increases, and theft. Each of the 4 types of waste is today baked in to U.S. health care. Not one can be addressed effectively without deep reforms that attack the causes of each type.

Under conditions of market failure and government incompetence, anarchy in health care means no one is accountable for anything that happens outside the building where they work.

Fourth, unequal financial coverage corrupts clinical judgment. Patients get more care if they are covered by payers that pay higher prices. Similarly, profitable treatments are performed more often. Financial thinking corrodes doctors' professionalism, ethics, and altruistic attitudes.

In the real world, caregivers have budgets, so money and clinical time are fungible.

In the real world, the only ethically sound reason to deny care to one patient is to conserve or liberate the dollars and time that would have been expended on that care—so they are available to serve patients whose needs are greater or whose care would be more effective. In the real

7. Assuring Medical security and Health care for all

world, everyone knows that dollars and time, while vast, are finite. So waste kills. No one goes without care—or gets low-value care—to enable doctors, hospitals, insurance companies, or investors to make more money.

When all people are covered well, doctors are able to deliver care in accord with evidence on what works and which patients need it. Professionalism and pride in doing a good job leave no room for financial incentives (bribes). Doctors don't sell their judgment or their self-esteem.

In these ways, care for all combines with a cap on available revenue to weed out low-value care, to cut administrative waste stemming from payer – caregiver mistrust, hold down prices, and slash theft.

And, in these ways, health care becomes self-regulating. Anarchy is dethroned. Clinical and financial accountability thrive because substitutes for failed markets and incompetent government have been crafted and tested. They work well enough.

Evidence-based standards for clinical decisions, broadly endorsed by physicians, can promote equity of care. These systemic protections can be supplemented by individualized action. Guyah and colleagues described the workings of a health care equity consult service. This offers internal expertise and information to address possible diagnosis and treatment inequity associated with race, ethnicity, language, and similar sources.³³¹¹

4. Contain cost while covering everyone. No rich democracy has ever attained either aim alone; all have relied on both together. Unfortunately, the very cost controls that are both somewhat effective and politically acceptable today rely substantially on suppressing use to care. *Today, high OOPs, narrow networks, Medicaid managed care and low Medicaid prices for physicians and other caregivers, prior authorization requirements, retroactive denials and other devices to suppress access to care and use of care are deemed by many to be essential to holding down cost. It will be impossible to remove these suppressors—these barriers to care—until effective alternative cost controls are in place.*

Those alternatives include full financial coverage for all Americans, caps on yearly health care spending, fixed budgets for hospitals and other organizations, financially neutral payments for doctors and dentists, strong efforts to improve the supply and configuration of caregivers, and to win lower prices for meds.

Some who have asserted that health care is compatible with cost control have relied on weak controls. These include electronic health records, primary prevention, and addressing social determinants of life. All these can be all valuable—but they don't address the sources of waste inside U.S. health care. So they don't make the dollars now wasted available to finance access, to improve caregiver configuration, or to level upward the quality and appropriateness of care.

5. While covering everyone and containing cost, close attention to reforming caregiver configuration and also methods of paying caregivers. And pay attention to leveling upward both appropriateness and quality of care. It is hard to do all of these together—but that must be attempted, since they have proven impossible to do individually.

Doing all 4 together in coordinated ways is essential—medically, financially, and politically. Addressing health care coverage for all, cost control, caregiver configuration and payment, and

7. Assuring Medical security and Health care for all

appropriateness and quality of care together is the only way to fix any of them. A solid foundation of good primary care, for example, helps to assure access and contain costs—while boosting appropriateness and quality of care. Capping total spending makes it essential to weed out waste. Paying caregivers in financially neutral ways is essential to build patient and political trust in health care—no one is giving or denying care to make money for themselves. The only motive to deny care is that it is not very valuable relative to its cost—so denial means reserving money and clinical time that will be needed to deliver effective and affordable care.

Reform efforts that fail to do this might try to shrink one problem but end up magnifying one or more other problems. Walsh writes that 13 of 14 Vermont hospitals were losing money in 2025, and that they might require \$3 billion in added subsidies of some sort over the next 5 years.³³¹² Where will that money come from? Why is so much needed? It's hard to imagine that \$3 billion would be needed to stabilize hospital care for so few people: Vermont has the second-lowest population in the nation. In 2024, three-fifths of Massachusetts hospitals lost money on operations. Scheetz describes a “death spiral” facing some hospitals in Pennsylvania.³³¹³ Clearly, though, if hospitals are simply paid more money, they become less affordable to governments and the citizens who pay taxes, employers and workers who finance premiums, or patients who pay OOP—or to all groups. Unless the higher revenues derive from money formerly wasted.

6. Winning health security for all Americans requires fixing health care itself. Health security means full financial coverage for all people, the right numbers and types of caregivers in the right places, paid in the right ways, and equitable delivery of appropriate and high-quality care. The U.S. can win health security for all Americans without fixing all of the other problems afflicting us—income distribution, housing, rebuilding manufacturing, employment, food, national and personal and neighborhood security, crime and criminal justice, environment/climate/energy, and the rest. Winning affordable medical security and health care cost control are essential to finding the money to address those other problems. Otherwise, health care will continue to sponge up the money needed to address any other problem.

That's because current health care spending is enough to finance health care for all. And because the health care crisis is soon likely to become visible, deep, dangerous, and oppressive to patients, caregivers, and payers.

Winning health security requires addressing a number of elements inside health care in a reasonably coordinated way. These include financially covering all people, containing costs, reforming methods of paying doctors and hospitals, configuring caregiving to match patients' needs, and leveling up the appropriateness and quality of care.

Reforming health care itself is central. For all the reasons discussed in chapter 2, health care problems can't be finessed by diverting energy and attention to housing, nutrition, education and job training, community and personal security, behavior changes, environmental action, and other social determinants of life (SDL). Those are all important. Very important. But too much money is locked up in health care today or mortgaged to health care tomorrow to afford wholesale investments to address SDLs now.

And, unfortunately, if we had the money, we would not know which of the SDLs to prioritize as strategic, or—for many—how to remedy them.

7. Assuring Medical security and Health care for all

Worse, talking about SDLs relieves pressure to reform health care and thereby enables business-as-usual to persist in health care. Fixing health care will liberate money and political will to address the SDLs. Health reform doesn't require higher spending. And, by winning victories for both competence and compassion, health care reform will show how it is possible to both contain cost and deliver more effective care for all. Better for everyone.

Improving housing, job training, transportation, and most SDLs will benefit all Americans. Building more housing, for example, makes buying or renting more affordable for all. But addressing SDLs would not save money on health care. We should prevent all the health problems that are preventable. But we should not expect that will save money now spent on health care.

Besides, it is wrong to subject prevention or addressing SDLs to a double standard. We don't spend money on health care to save money. We have very different aims in mind. Similarly, we should invest in preventing health problems because they are preventable—and because doing so will give us more good years of life. The aim is not to save money.

Nor can the need to fix health care be finessed by candle-lighting or feel-good incremental activities like buying up medical debt or publicizing bad behavior of hospitals.

Instead, affordable equitable coverage and access to needed health care require deeper reform in health care financing and delivery. These reforms include:

- ✓ All insurance cards look the same and pay the same prices, leaving caregivers with no financial reason to discriminate among patients.
- ✓ Financing equal financial coverage without increasing spending on health care. This requires addressing clinical waste, administrative waste, high prices, and theft. Money saved by cutting waste would be used to finance equal coverage.
- ✓ Trustworthy cost control also rests on reforming methods of paying hospitals, doctors, drug makers, and other caregivers—on putting our money in caregivers' hands and budgets under circumstances that allow us to trust them to take care of all of us as well as possible.
- ✓ Equitable access, cost control, and delivery of appropriate and equitable care also rest on reconfiguring doctors, hospitals, and other caregivers so that the right numbers and types of caregivers are in the right locations.
- ✓ That makes it essential to assure all needed caregivers enough revenue to finance efficient delivery of needed care. Most Americans think that health care cost control means lowering their premium plus OOP payments. Most payers think cost control means slowing the rate of growth in their own payments to caregivers. But, ***at heart, cost control means slowing the rate of increase in caregivers' own outlays***—their expenditures on nurses, meds, paperwork, and everything else. That requires addressing the waste pervading health care.

Walsh noted three ominous trends in Vermont—rising premiums, erosion of insurer reserves, and hospital operating losses. He then asserted that affordability for patients and solvency for caregivers must co-exist.³³¹⁴

7. Assuring Medical security and Health care for all

But winning both affordability and solvency is impossible without containing caregivers' own costs. This underlines the central importance of containing costs of care in tandem with fully covering all Americans. It is easy to tout well-intentioned measures that aim to make care more affordable—measures like buying up medical debt or begging hospitals to deliver more free care. It is valuable to propose setting premiums in proportion to income because that is a more fair way to raise money. But none of these slow spending. Only going after waste will make it possible to cover all Americans, protect all needed caregivers' revenues, and contain total costs of care at the same time.

- ✓ Nominal out-of-pockets, at most. Moral hazard is a sick joke played on sick Americans by ideology-obsessed U.S. health economists. OOPS are much more oppressive to sicker, older, and poorer people – who are much likelier to be deterred from using care.

Essien and colleagues found that higher OOPs deter appropriate adherence to using prescribed drugs, such as those for diabetes or heart failure.³³¹⁵ They go out on a limb and conclude that “Improving adherence to guideline-based therapies may require interventions that reduce out-of-pocket prescription costs.”

- ✓ Ceasing to rely on persuading, leveraging, or requiring non-profit hospitals or other caregivers to devote greater resources to care of uninsured patients through such mechanisms as charity care or community service requirements, demanding community needs assessments and reporting (in IRS-990 forms), seeking hospital free care commensurate in value with savings from tax-exemption, and the like.³³¹⁶

Current U.S. reform proposals fall into two main groups. One is incremental improvements that broaden or deepen financial coverage. The second is farther-reaching single payer or all-payer proposals. Both groups are now discussed.

Subsequently, chapter 7 concludes by summarizing sources of revenue to finance health care for all, methods of cost control, doctor configuration and payment, hospital configuration and payment, and appropriateness and quality of care.

1. Incremental improvements in financial coverage and use of care

Incremental improvements all rely on new money. This is the traditional method of boosting coverage in the U.S. It has been the political path of least resistance.

Continuing to rely on new money is a bad idea for two reasons. The first is that the weaknesses in the U.S. economy, competing demands for higher spending, and the enormous current costs of health care will make it hard to find still more money.

The second is that expanding protections against high health care costs has been accompanied by rising reliance on the very care suppressors discussed earlier in this chapter. These care suppressors—barriers to care—have been deliberately put in place in hopes of containing cost. These have not been effective but their many subtle and low-visibility advocates cling to them because no effective cost control tools are politically viable today.

7. Assuring Medical security and Health care for all

Nonetheless, it is useful to discuss ways to remove the incremental care suppressors because understanding how to do that will help guide more serious efforts to win affordable health care for all.

There are three types of incremental improvements.

First are the simple, appealing, but ineffective proposals to boost financial coverage and use of care: lowering medical debt and trying to persuade caregivers to more freely serve uninsured and under-insured people. These band-aids have been crafted by well-intentioned people anxious to reduce the amount of suffering in the world.

Second is a set of more serious incremental improvements to broaden coverage. Most rely on higher public spending. These start with simpler enrollment and more sustained, durable coverage. They continue with lowering the age of Medicare eligibility to 60 or 55. Or raising Medicaid's income eligibility from 138 percent of the federal poverty level to 150 percent—or improving how the FPL itself is calculated. Boosting ACA subsidies and making the higher subsidies permanent would raise ACA enrollments. So would raising the income for eligibility for a zero-premium ACA plan from 150 percent of FPL to 175 or 200 percent. A public option has been touted as a way to win lower caregiver prices, allowing the public option plan to offer lower premiums to Americans.

Third is deepening coverage to make needed care more affordable and accessible to Americans. Steps forward include lowering OOPS—including facility fees paid by patients—for all people and capping them in line with income and family size. These cuts would mean lower revenue for caregivers unless they were offset by higher public or private insurance payments. Expanded benefits could include dental, vision, and hearing care. Raising Medicaid prices to Medicare levels would boost the share of caregivers willing to see Medicaid patients. All of these would increase health care spending.

a. Simple, appealing, but ineffective

Two groups of well-intentioned and simple policies seek to improve access to care. Some aim to drain poisonous pockets of patient medical debt. Others are directed at practices of hospitals—and sometimes other caregivers—that cause medical debt. These practices include high prices for uninsured patients, failure to provide free care to low-income uninsured patients, and punitive collections practices.

The contention over drug makers' co-pay assistance plans and over the 340B drug discount program are examples of distracting big fights about two very different but equally weak methods of promoting access to care.

The fights over medical debt and hospital provision of uncompensated care

Efforts to improve access in these ways are appealing and simple because they appear to directly address real problems.³³¹⁷ But they have not been—and are not likely to be—very effective. Gupta and colleagues, for example, note that:

7. Assuring Medical security and Health care for all

Many insured working-age Americans face unexpected medical bills and coverage denials for doctor-recommended care. Challenging coverage denials and medical bills often works, but significant numbers of people are unaware of their right to do so.³³¹⁸

This may be true. But it is also true that it is not realistic to ask individuals to take the time and to suffer the frustration of working through voicemails, e-mails, forms, and bureaucratic impediments to lodge appeals or complaints. It is not reasonable to ask ordinary humans to demand justice or other reasonable responses from mechanisms deliberately established or tolerated in order to suppress use of care.

Kona and colleagues found that hospitals' financial aid programs often exclude patients who'd benefit from free or lower-cost care. Procedures to apply were complicated. They also found that many states' laws failed to protect patients from collection agents and legal action. They called for stronger state statutes on eligibility for free care, simpler administration, and tougher oversight of hospital actions.³³¹⁹

In the face of human suffering, reasons for these proposals are understandable. They are likely to enjoy political support in some states. But how much difference will they make in vulnerable patients' access to affordable medical care? Sadly, many hospitals are not willing or able to shoulder greater free care burdens. Especially as some hospitals face constrained revenue but have reason to expect greater numbers of uninsured patients. Also, steady state government regulatory enforcement against such hospitals is unlikely to be attempted or successful.

Lowering existing medical debt

Levey warned that caregivers should not ignore patient anger about medical debt.³³²⁰ It is at once a serious and pervasive problem in itself, and a symptom of weak financial coverage. By one measure, 15 percent of U.S. households owed medical debt of \$250 or more in 2021. Total medical debt was about \$220 billion.³³²¹ And this sum represents only obligations written off as bad debt—money caregivers deem uncollectable. It excludes money owed to hospitals, doctors, dentists, and other caregivers that is slowly being paid off. Caregivers carry that debt as accounts receivable.

Separately, Levey noted passage of laws to forestall accumulation of new debt, pay off old debt, and constrain aggressive debt collection in a growing number of states, both Democratic and Republican.³³²²

Confronting the debt problem has broad—though far from unanimous—political appeal. Paying off massive accumulated debt at low cost looks like a high-payoff investment. But some research has raised questions about its efficacy in promoting access. If these questions are serious, the anger, energy, organization, and money focused on debt relief may be out of proportion to its strategic value in boosting access.

In the real world, tiny investments rarely pay huge dividends. Splashy purchases of lots of debt for little money—often only a penny on the dollar—and often much less—simply show that the hospitals, other caregivers, or speculators that have bought up debt rarely expected to be paid anything. That's why a non-profit can buy up, say, \$50 million in accumulated debt for only \$500,000. Also, if a hospital values debt at its charges, that debt is radically inflated to start with, since hospital charges are today close to 4 times average cost of care—and 5 to 10 times

7. Assuring Medical security and Health care for all

the incremental cost of care. The last is the hospital's added actual cost—added outlays—associated with serving a patient.

By contrast, hospitals, doctors, and others holding debt that patients are slowly paying off typically carry those sums as accounts receivable. This money is rarely part of the debt extinguished by charities or public programs.

And focusing attention on a sideshow can dissipate attention to the main event. Today, since interest in the main event in access—full financial coverage and practical access—is low, wiping out old debt and preventing new debt will do some good to many worried Americans—and little harm to the cause of full access.

Paying off medical debt costs money that low-income people very often lack. Worry about debt casts a pall over many people's lives. Indebted people are often deterred from seeking care the next time a medical emergency strikes. After patients are unburdened by old debt, they may be more willing to seek new medical care and more able to obtain it. But that is likely to mean renewed debt.

Some organizations have been buying up hospital patients' medical debt. RIP Medical Debt (now named Undue Medical Debt) is probably the best-known. Founded in 2014 by two former debt collectors, it buys medical debt at an average of about 1 percent of stated value. It aids people under 4 times the federal poverty level and also those whose debt exceeds 5 percent of yearly income.³³²³ It often partners with decentralized local campaigns like that of a small church in North Carolina that raised \$15,000 to buy and then forgive \$3.3 million in debt owed by 3,355 local families.³³²⁴

Surprisingly, Charlotte, N.C.'s two large hospital conglomerates have refused to sell their debt. They assert that they have their own policies and subsidies and that, in the words of a reporter, "working with RIP would undermine efforts to get people to sign up for Medicaid."³³²⁵ Unfortunately, one of the two, Atrium—formerly a public hospital—filed 2,500 suits against patients in 5.5 recent years. It also "pushes patients who can't afford medical bills into loans from private equity-backed lender AccessOne that can come with interest rates as high as 13%...."³³²⁶

North Carolina accepted the 2010 ACA's Medicaid expansion, effective 1 December 2023. About 350,000 citizens would be newly-insured and the state and its caregivers would gain about \$5.1 billion in federal money.³³²⁷

But would selling debt to RIP really slow Medicaid enrollments in North Carolina or elsewhere? The hospitals could have worked with RIP to include information on how to sign up for Medicaid in letters to patients announcing debt forgiveness.

Subsequently, the State of North Carolina has moved in a different direction—by promising to boost Medicaid prices paid to hospitals that write off medical debt.³³²⁸ Koller called the state's effort "confronting the bully."³³²⁹

In Columbus, Ohio, by contrast, hospitals and city government work together. The city approved a \$500,000 contract with four local hospitals to wipe out \$335 million in medical debt incurred by city residents between 2015 and 2020. The money covered cost of address verification, notification of patients, and income verification. Only families earning between 2

7. Assuring Medical security and Health care for all

and 4 times the federal poverty level were eligible. Those earning less were excluded because they should not have been billed in the first place.³³³⁰

In 2022, Cook County spent \$12 million to buy \$1 billion in medical debt. Arizona is spending \$30 million in Covid relief dollars to do so for people earning less than 4 times the FPL or whose debt exceeds 5 percent of income.³³³¹ Both partner with RIP/Undue Medical Debt.

New York City is spending \$18 million to retire \$2 billion in medical debt under the same rules as Cook County employed.³³³²

Los Angeles County supervisors voted in June 2024 to begin buying up \$2.9 billion in debt afflicting some 800,000 residents. A first installment commits \$5 million to purchase \$500 million in debt burdening 150,000 people. The county would work with Undue Medical Debt.³³³³ The local hospital association opposed the debt relief plan, objecting to its data collection requirements and preferring to rely on individual hospitals' own free care and reduced-priced services.³³³⁴

In August of 2024, New Jersey worked with Undue Medical Debt to relieve 50,000 citizens of \$100 million in debt.³³³⁵

The Ochsner system negotiated in the summer of 2024 to wipe out \$366 million in debt for almost 200,000 patients throughout the South. This aimed to build on an earlier deal that saw the city of New Orleans use \$1.3 million in American Rescue Plan money to retire \$59 million in debt for 66,000 citizens of New Orleans.³³³⁶

Why is it possible to buy up so much debt with so little money? Because those holding it don't expect to be paid anything. If they don't expect to be paid, why don't they simply expunge the debt without payment? Probably, in part, because of the administrative cost of discharging the debt and notifying relevant parties.

And probably, in part, because many hospitals and other caregivers hope that the threat of debt will encourage some people to pay and others to refrain from seeking care that will burden them with unaffordable debt. In this last view, care suppression means lower cost and blacker bottom lines for hospitals.

Also, some caregivers still hope to harvest non-trivial sums from some patients. The Atrium – AccessOne arrangement in Charlotte is one mechanism.

This is one example of the increasing complexity of medical debt, a complexity that makes it harder to assess and buy that debt. Ordinary medical debt has long been money owed directly to hospitals, doctors, and other caregivers. But many people pay for care using ordinary credit cards or special medical credit cards. Issued by banks and other entities, these evade debt protection laws. And debt purchase programs may not be able identify these sums and buy them. Doctors' offices increasingly offer special credit cards. The cards often promise deferred interest or low short-term rates, but impose rates even higher than ordinary credit cards over time.³³³⁷

The immediate aim of buying up debt and retiring it is to relieve families from paying costs they can't afford. The complementary aim is to allow medically indigent Americans to seek and obtain care subsequently. That is made possible by coupling debt purchase with steps to encourage hospitals to make free care or low-priced care more available to low-income

7. Assuring Medical security and Health care for all

uninsured and under-insured Americans, and to discourage aggressive collection efforts by caregivers.

Together, proponents hope that these two steps will mean more care for people who previously could not afford it. They hope that the reduced worry about yesterday's debt, coupled with reduced chance of incurring unaffordable new debt tomorrow, will lead patients to obtain needed medical care. Purchasing old debt and persuading caregivers to minimize new debt are intended to lower barriers to needed care.

But the apparatus of debt and associated court appearances, garnisheeing of wages, liens, and jail time and fines for those who don't appear in court are intended by caregivers to instill fear, encourage repayment of debt, and discourage patients from using care they can't afford and thereby taking on new debt. That fear is debt's main function today.

Arguments against investing in debt relief—or against prioritizing such investments—take several forms. First, benefits to Americans may be small. The Southern California Hospital Association cited a 2024 study by Kluender and others in its letter to the LA County Commission opposing debt purchase. Noting high levels of debt—“[t]wo in five Americans have medical debt, nearly half of whom owe at least \$2,500”—that study conducted randomized tests of debt relief. They found “a moderate but statistically significant reduction in payment of existing medical bills.” But they found, on average, no effect on health, credit access, use of care, or financial distress.³³³⁸

Second, some hospitals—like those in Charlotte—apparently believe they will be better off financially if debt is not bought.

Third, others—such as the *Wall Street Journal's* editorial board—asserted that the Consumer Financial Protection Bureau's proposal to remove medical debt from credit reports is part of a scheme to “[h]elp people with low credit scores qualify for mortgages and loans they can't afford.”³³³⁹ The editorial board asked whether the Biden administration “believe[s] in having to repay any debt.” “Medical debt,” it wrote, “affected the credit scores of roughly 15 million Americans as of last June [of 2023], averaging about \$3,100—far from a terrible burden.” They suppose.

The editorial board asserts that avoiding debt is the purpose of health insurance, that “[v]ery few Americans with insurance rack up enormous medical debt”, that “[p]atients often prioritize other loan payments so cars aren't repossessed or homes foreclosed”, that a “credit-report blemish is the only tool healthcare providers have to encourage payment”, that “providers are usually willing to reduce or extend payments for those who can't afford care”, and that “[r]emoving a credit notice for not paying medical bills will result in more unpaid bills.... It will also reduce the incentive to buy health insurance....”

The board further assert: “Providers will raise prices charged to insurers to compensate for unpaid bills, which will push up premiums. Providers also say they'll demand more upfront payments for care, which could reduce access for low-income patients. This is simple economics.”

Interestingly, in 2022, the *Journal* reported favorably on the decision by the three main credit reporting companies to strip two-thirds of medical debt from their own reports, “erasing a black mark that makes it harder for millions of Americans to borrow.”³³⁴⁰

7. Assuring Medical security and Health care for all

In these views, seeking care that results in debt is a choice, that \$3,100 is not a heavy burden, and that caregivers have freedom to set prices—and that they set prices to cover costs. It is unlikely that these views match objective financial or health care realities.

The editorial board articulated a broad set of opinions held by many—though probably not most—hospital managers, trustees, and owners, and by a number of doctors and other caregivers.

In this view, debt has been assumed by choice, and repaying it is seen as an affordable option. And also as a personal or even moral obligation. Possibly, removing medical debt from credit reports, as was urged by the governor of Massachusetts as part of an affordability agenda,³³⁴¹ could have the effect of regularizing or encapsulating a symptom of debt instead of uprooting debt by addressing its causes.

The governor of Arizona articulated a different view of the dangers posed by medical debt:

Like many Arizona families, I have experienced the stress and burden of financial ups and downs. As Governor, I take seriously my duty to protect vulnerable Arizonans from falling into medical debt, and make healthcare more affordable”.... Hard-working, middle class Arizonans should not be forced to have those difficult kitchen table conversations because of medical debt from conditions they cannot control. Arizonans deserve a break, and they deserve a government that fights for them, helping ensure that medical debt is not going to torpedo their lives.³³⁴²

Medical debt is only one symptom of uninsurance or under-insurance. These debates about debt—and the high attention it has received—manifest Americans’ willingness to create a problem with many symptoms, debate cosmetic ways to address one of the symptoms, devise remedies with high publicity value but much less practical value, and thereby continue to fail to address the main powerful causes of the problem.

Debt is a distraction. Buying it up and retiring it does nothing to address the causes of uninsurance and under-insurance.

A deeply dumb idea. Abelson reported on a Trump administration proposal to allow ACA patients suffering high medical debt because they were forced to pay high OOPs to borrow from their ACA health insurance company. This idea stemmed from the rise in OOPs caused by the lapsing of the supplementary federal ACA subsidies at the end of 2025—and from the subsequent shift of many families to high-deductible/high co-insurance bronze plans.³³⁴³

This proposal parallels earlier ones advanced for certain drug. In the face of high prices for hepatitis-C meds, some cancer meds, and others, some individuals suggested that patients borrow large sums to pay for treatments. In some versions, the loans would be forgiven if the med failed to help the patient.³³⁴⁴

The debates over the origins, roles, and possible resolutions of medical debt add up to one variation on the sad argument over whether health care should be rationed by ability to pay. This is made clear in the chronic skirmishing over methods of slowing the accumulation of new medical debt.

7. Assuring Medical security and Health care for all

Slowing accumulation of new medical debt

This might be done by lowering the numbers of uninsured or under-insured Americans, by lowering the prices they pay, or by cajoling caregivers to serve uninsured or under-insured Americans at no charge. The second and third tactics are discussed here.

News reports—of garnisheeing wages, placing liens on homes or cars, jailing debtors who don't appear in court, embedding collection agents in ERs, and denying medical care until patients pay existing debt—could increase pressure to insure more Americans and to improve insurance coverage. They sometimes portray debtors sympathetically but also discuss many hospitals' difficulty in finding the money to serve patients unable to pay. Some citizens might conclude that improving coverage is the only feasible remedy. But attempts to improve coverage are slowed or blocked by the cost, political, and other barriers detailed earlier in this chapter. This leads many access advocates to put pressure on hospitals.

For many years, the American Hospital Association and individual hospitals wrongly claimed that Medicare rules required them to charge uninsured patients their full, posted charges and prevented hospitals from offering their lowest prices to uninsured patients.³³⁴⁵ And that hospitals were obliged legally to aggressively seek to collect unpaid sums from uninsured or under-insured patients. But Pres. Bush's secretary of health and human services bluntly criticized hospitals' assertions in 2004. He said hospitals were free to offer deeply discounted prices to uninsured or under-insured Americans. And that hospitals were not obliged to chase patients for unpaid bills.^{3346 3347}

Boost equity and efficiency of deciding who's eligible for free care. Presumptive eligibility for hospital free care would be one mechanism for effectuating a decision to give more such care. It means quickly designating low-income or other patients to be eligible for free care automatically.³³⁴⁸ This would cut through most hospitals' badly-publicized policies and bureaucratic mazes, and thereby make it easier for people in need to get help. A version of this approach is one element of the July 2024 medical debt plan proposed by North Carolina's governor, discussed shortly.

Further, Goodman and Chalmers were concerned that hospitals could farm out to consultants the job of determining patient eligibility. And that consultants would use AI and predictive analytics in ways that minimized eligibility for financial aid from hospitals.³³⁴⁹

Hospitals might create confusing free care policies because they don't feel patients deserve free care, or because they are themselves confused about the actual cost of free care.

Focus on real cost of bad debt to hospitals. Hospitals that don't wish to serve uninsured patients wave charges as an inflammatory flag.

In Los Angeles, a hospital group sought to justify doing so by claiming hospitals would have to "spend more than an average \$1,350 for a homeless person to spend the night".³³⁵⁰ To call that spending—about \$2,200 in 2026 dollars—is to say it is an actual outlay, a cost the hospital would not incur if the patient did not remain in the hospital. But the real incremental cost of meals, meds, and nursing time would be trivial.

7. Assuring Medical security and Health care for all

It's likely that the underlying problem was that the hospital did not wish to earn a reputation as a homeless shelter—need for which, in Los Angeles, was and is enormous.

Other hospitals—especially those in regions with many uninsured or under-insured patients—aggressively sought to collect on accounts receivable in order to discourage those patients from using the hospital.

But wealthy hospitals and those unlikely to face heavy needs for free care might see things differently. They would be more likely to help eligible patients obtain free care if they had a clearer picture of their own cost of giving such care. Hospitals sometimes highlight their charges at their actual costs—even though charges average almost 4 times average cost of hospital care. And the average may greatly exceed the real incremental cost of care—the added expenditures required to serve an uninsured or under-insured patient.

This means that hospitals located near many uninsured or under-insured patients are more likely to restrict their free care obligations, while hospitals with few such patients nearby would be more accommodating. This mismatch is understandable but unacceptable. It is one reason states like Maryland and Massachusetts sought to impose uniform percentage assessments on hospital revenue to finance uncompensated care, as discussed in chapters 9 and 12.

Removing medical debt from credit reports. Levey listed efforts undertaken by the Consumer Financial Protection Bureau to penalize debt collectors, warn caregivers and lenders, and bemoan the burden of health care costs on patients. It was preparing regulations to forbid inclusion of medical debt in citizens' credit reports.³³⁵¹ Some states have made similar efforts.³³⁵²

No one imagines that does anything about the debt itself. While it is always better to light a candle than curse the darkness, the light from the CFPB's candle will be visible to few humans. How many patients facing high medical debt worry about their credit ratings? How many will seek medical care more freely—knowing it will add to their medical debt—just because that debt doesn't lower their credit score?

Efforts to remove medical debt from credit reports testifies to the inherent weakness of regulatory efforts to protect access to care or make it more affordable.

Shaming hospitals. Hospitals have been criticized for behaviors that many—probably most—Americans judge to be heartless or, at least, uncaring. Discharging homeless patients to the street is one such behavior. As just mentioned, hospitals sometimes trumpet grossly inflated costs of retaining patients to justify shameful behavior.

Non-profit hospitals controlled by several religious bodies have faced allegations of low levels of charity care.^{3353 3354} Some of these have been entirely legitimate but others may have been organized by conservative groups aiming to discredit non-profit hospitals generally, and to boost for-profit operators.^{3355 3356}

Jenkins and Ho wrote that hospitals' yearly surpluses and accumulated net assets (wealth) grew from 2012 to 2019, but that charity care did not.³³⁵⁷ Hatton, writing for the American Hospital Association, criticized the Jenkins and Ho study, claiming that it exaggerated Medicare

7. Assuring Medical security and Health care for all

payments for bad debt, that it mentioned but did not account for the drop in the number of uninsured Americans during the years studied, and that its focus on charity care led it to ignore “the full spectrum of community benefits” hospitals might offer.³³⁵⁸

Hospitals have also been shamed for denying admission or ER care to patients facing medical emergencies or to women in labor. These instances resulted the Emergency Medical Treatment and Active Labor Act (EMTALA), which obliged hospitals to treat and stabilize patients regardless of ability to pay. Hospitals could bill for care but could not refuse to treat.

Hospitals in Minnesota were criticized widely for employing Accretive Health to embed debt collectors in ERs and trying to obtain payment before treatment.³³⁵⁹ Swanson, the attorney-general, sued Accretive for abusive collection practices and also for violating patient privacy. Accretive consented to paying a \$2.5 million fine and ceasing to do business in the state for 6 years.³³⁶⁰

A newspaper in St. Louis editorialized about the gap between the high dollar value hospitals’ tax exemption and the low—and falling—dollar value of their uncompensated care.³³⁶¹

The Lown Institute has been systematic in applauding hospitals it deems socially responsible and shaming those failing.^{3362 3363}

Defining and publicizing hospital obligations. Well-intentioned people seek ways to manifest those intentions. Recognizing that most hospitals are operated not-for-profit, advocates press hospitals to exert themselves more strenuously on behalf of uninsured or under-insured patients. This takes several forms.

First, the Hill-Burton uncompensated care and community service obligations provided legal paths by which advocates have sought to press hospitals to serve low-income patients and extend free care to many of them.

The federal Hill-Burton program financed one-third of the cost of eligible hospital capital projects from 1946 to 1971. In return, recipients “agreed to provide a reasonable volume of services to people unable to pay and to make their services available to all persons residing in the facility’s area.”^{3364 3365} Hospitals were to provide uncompensated care equal to at least a minimum share of revenue or a share of the value of the Hill-Burton grant, measured in the most current CPI-adjusted dollars.

Enforcement of these minimum shares was never strong or consistent. Hospitals were obliged to establish procedures by which patients could apply for free care. Hospitals have been criticized for failing to inform eligible patients that free or cut-price care was available. In one study, 70 percent of ER patients reported they had not been notified of these potential benefits.³³⁶⁶ Persuading hospitals to remedy this failure has been an uphill fight. Many hospitals complied but many did not. Advocates in some states tried to oblige hospitals to adopt formal procedures to apply for aid, in conformance with Hill-Burton requirements, and publicize availability of free care. The free care obligations have generally expired.

Almond and colleagues studied changes in non-profit Florida hospital behavior after their free care obligations ended. They found, first, that the hospitals had previously given free care to less risky maternity patients. Second, after expiration, the non-profit “hospitals quickly reduced

7. Assuring Medical security and Health care for all

their charity caseloads, shifting maternity patients to public hospitals...[suggesting], perhaps surprisingly, that requiring private providers to serve the uninsured can be effective.”³³⁶⁷

Hill-Burton imposed perpetual community service obligations on all grant recipients.³³⁶⁸ These have never expired legally but often have not been adhered to by hospitals or enforced by the United States. All facilities built with Hill-Burton grants must be made available to all people living or working in a hospital's service area. No person may be barred for any reason other than lack of medical need for available care—but a person unable to pay may be denied non-emergency care unless eligible for uncompensated care.

Hospitals sometimes establish rules for which patients are eligible for free or discounted care but fail to follow those rules. Mathews and colleagues reported on hospital practice that often make “aid hard to get. Hospitals put up obstacles, delay checking eligibility, and sometimes press for payments that aren't refunded even if a patient eventually gets qualified for assistance.”³³⁶⁹

The ACA required non-profit hospitals to set rules defining who was eligible for free or reduced-price care but allowed each hospital to set its own rules. No aspect of this requirement has been seriously enforced. The ACA did not set a floor under hospital obligations so this approach has been almost devoid of practical effect.

That has exemplified governments' failure to act effectively to protect Americans who are vulnerable to deprivation of needed health care.

It is reasonable to expect advocates and their lawyers to seek ways to persuade or force hospitals to offer more free care or to price their care in ways that reflect its actual incremental cost and therefore minimize resulting medical debt.

And to buy up and write off old medical debt.

All these efforts win headlines but have done little to advance practical access for vulnerable Americans.

Doctors, too. Hospital efforts are essential to realize the promise of uncompensated care benefits or community service obligations. But they are not enough. Even if a hospital is willing and financially able to serve more uninsured or under-insured patients, its doctors might not be. And doctors deliver or order the overwhelming share of care given in hospitals. Smaller and mid-size hospitals typically have few salaried doctors. Those paid fee-for-service may be reluctant to serve patients unable to pay ordinary fees. Larger teaching hospitals have salaried residents who can be persuaded to deliver care to uninsured or under-insured patients. The willingness of medical school faculty and other attendings to deliver or supervise that care varies considerably.

Satisfying the Hill-Burton community service obligation requires hospitals to arrange for doctors to admit and treat patients if they lack a physician or if their physician lacks admitting privileges. It has proven difficult to enforce this provision.

7. Assuring Medical security and Health care for all

Pennsylvania sought through legislation to require hospitals to condition doctors' admitting privileges on their willingness to serve uninsured or under-insured patients, but this effort lacked political and legal traction.

Kane reported on AMA surveys of physicians and found a rise in the share provided free or cut-price care from 1988 to 1994, followed by a drop in 1999. In 1999, doctors giving such care said they averaged about 9 hours weekly, about one-seventh of their clinical time, split about equally between free care and cut-price care.³³⁷⁰

Kane attributed the 1988-1994 rise to passage of the Emergency Treatment and Active Labor Act (EMTALA) in 1987. That law required examination of each ER patient to assess whether they face a medical emergency. The share of emergency medicine physicians providing free or cut-price care rose from under one-half in 1988 to over three-fifths in 1994. Her finding parallels that of Almond's and colleagues' regarding the efficacy of public policy in influencing caregiver behavior in Florida.

Cunningham and May found that the share of doctors reporting they provided *any* free or cut-price care fell from 75 percent in 1997 to 68 percent in 2005.³³⁷¹ Data on more recent provision of such care are lacking. But there is little reason for optimism.

Governments press hospitals to show charity commensurate with tax exemption. Second, advocates have pressed governments to induce non-profit hospitals to offer more tangible financial help to uninsured or under-insured people. Help could include lowering prices, offering more free care, making it easier to apply for it, and documenting specific benefits in exchange for non-profit status and tax exemption.

In 2007, Rhode Island state government negotiated charity care arrangements with the state's hospitals, all of which were then non-profit. Hospitals agreed to offer free care to all uninsured people whose incomes fell below 200 percent of the federal poverty level.³³⁷²

More consequentially, Maryland's all-payer hospital budgeting arrangements were actually sparked by the challenges of fair payment for uncompensated care. In the 1960s and early 1970s, it became clear that Maryland hospitals differed substantially in the shares of their patients who were uninsured or underinsured. Hospitals with much resulting uncompensated care could have generated revenue to pay for that care by raising their prices charged privately insured patients. But the resulting higher prices would have made those hospitals unattractive to privately-insured patients. Especially if they had few privately insured patients—that would have obliged them to set very high prices on those patients in order to generate revenue to cover uncompensated care costs.

The state's gradual movement toward all-payer price regulation was designed, among other things, to oblige each payer to pay its fair share of *statewide* uncompensated care costs. A statewide fixed percentage add-on to each hospital's commercial insurance prices was instituted. That money was distributed to hospitals in proportion to their actual uncompensated care burdens, thereby neutralizing any competitive price disadvantage for hospitals serving higher proportions of uninsured patients.³³⁷³

The Massachusetts Uncompensated Care Pool had a similar aim—to raise money to pay for hospitals' very different uncompensated costs in a fair manner. Lacking the foundation of a durable all-payer arrangement like Maryland's, where all payers pay very similar prices for the

7. Assuring Medical security and Health care for all

same care, Massachusetts imposed a standard assessment on each hospital's revenue and distributed that money to hospitals in proportion to their uncompensated care burdens. Private third party payers now directly provide a share of the revenue; hospitals no longer shoulder the entire burden.³³⁷⁴

Apart from these organized public requirements, few efforts have succeeded in compelling hospitals to justify their tax exemption. Most have involved process and words, not outcomes and dollars. Rarely are hospitals obliged to provide specified amounts of actual uncompensated care. Instead, hospitals have been allowed to claim health education activities, screening for high blood sugar or high blood pressure, and other activities as community benefits. Many of these are, at least in part, exercises in marketing or public relations.

To start, what is the value of tax exemption to non-profit hospitals? Godwin and colleagues estimated it at \$28 billion in 2020. A little over one-half was owing to federal exemptions. These were savings on federal corporate income taxes (about \$10 billion), higher charitable contributions (about \$2.5 billion), and lower interest rates on bonds (about \$1.5 billion). Of the remaining half, about \$6 billion was saved on state and local sales tax, about \$5 billion on local property taxes, and about \$3 billion on state corporate income taxes.³³⁷⁵

So all three levels of government should want to win value for the tax revenue they forego by refraining from taxing non-profit hospitals.

In 1956, the IRS ruled that hospitals providing charity care were exempt from federal taxation of corporate surpluses. Actual provision of charity care was rarely monitored.

In 1969, the IRS replaced the charity care duty with one of community benefits. This too was rarely monitored.

In 2009, the IRS added a form H to the IRS 990 form that non-profits must file each year. The 2010 ACA obliged hospitals to conduct "community health needs assessments" every three years. They must seek input from community residents. The CHNA and the strategy for implementing programs to address identified needs must be included in schedule H. But, as Atkeson and Higgins write, "there is no requirement that community benefit spending is tied to the CHNA or the implementation strategy."³³⁷⁶

While this failure of federal linkage is embarrassing, it is probably not accidental. Worse, it comports closely with the pattern of government incapacity to micromanage caregiver behavior in health care generally.

State governments vary considerably in their policies and attitudes toward tax exemption and hospital behavior. Some state governments—a minority—have exempted their non-profit hospitals from state sales taxes.³³⁷⁷

Some states require non-profit hospitals to submit annual reports on the benefits they provide to their communities. In 1996, the attorney-general in Massachusetts obliged hospitals and HMOs to report yearly on their community benefits.³³⁷⁸ The most current reporting guide is 42 pages. But this, like the federal Schedule H requirement, does not ask hospitals to quantify their benefits to uninsured or under-insured Americans. It is not at all clear that reporting has changed actual hospital behavior or improved health care for vulnerable citizens. Legalistic requirements elicit legalistic responses. Worse, state and federal attention to unquantified

7. Assuring Medical security and Health care for all

community benefits give the appearance of meaningful action while inviting hospitals to submit lengthy documents signifying little of value. More political performance.

Utah is one exception. It requires that a non-profit hospital “establish that its total gift to the community exceeds on an annual basis its property tax liability for that year.” ³³⁷⁹

Valuing—and pricing—uncompensated care at hospitals’ own incremental cost. Atkeson and Higgins compiled a variety of methods states do use or could use to hold hospitals more accountable for delivering benefits in exchange for tax exemption.

This highlights the importance of the method of quantifying those benefits.

Atkeson and Higgins noted that hospitals reporting uncompensated care on Schedule H are permitted by the IRS to value that care at the hospital’s own charges. Since charges average about 4 times hospitals’ average cost, reporting charges absurdly over-values hospitals’ actual burden of caring.

Hospitals have long reported uncompensated care in charges. One possible reason is that they believe that their charges legitimately measure the value of their services. Another, possibly, is opportunity cost. A hospital might creatively imagine that if it did not serve an uninsured patient in the ER, OR, or inpatient bed, it could instead substitute a patient who would pay full charges. Yet another is that charges are sometimes used to apportion a hospital’s various costs across its payers since they are directly proportional to volumes of care. A fourth reason is that they would like to inflate the value of their good deeds.

In the spirit of valuing uncompensated care at charges, hospitals sometimes report as uncompensated care the sums by which they suppose they are under-paid by state Medicaid programs. And even, sometimes, the gap between actual Medicare payments and charges. I noted these practices when commenting on a New Hampshire hospital’s certificate of need application decades ago. ³³⁸⁰

To be fair, hospitals are not the only parties conflating charges with cost. *A Wall Street Journal* reporter did this some years ago. ³³⁸¹

Incremental cost (variable or marginal cost) is probably the most fair measure of a hospital’s actual added burden of caring for small numbers of uninsured or under-insured patients. Small numbers might be 1 to 5 percent of all patients. Incremental cost is the added outlay associated with giving uncompensated care. This assumes, reasonably, that a hospital aims to cover its fixed costs (buildings, equipment, and other costs that do not change with volume of care) on its paying patients—95 to 99 percent of the total. So actual added costs of meds, food, imaging studies, nursing, OR time, and the like are the only new financial burdens associated with care for uninsured or under-insured patients. ³³⁸²

Incremental cost might well be the price hospitals should charge their uninsured or under-insured patients. Doing so, in turn, would probably boost volumes of care to those patients.

This pricing method would substantially cut medical debt per patient. It would be markedly easier for uninsured or under-insured patients to pay prices aligned with incremental cost of their care. Effects of this pricing on total medical debt is unclear, but it is unlikely that volumes

7. Assuring Medical security and Health care for all

and costs of uncompensated care would rise only as much as would incremental revenue. So a hospital's operating margin would not change.

North Carolina began implementing its medical debt relief plan in the summer of 2024. All 99 eligible hospitals have signed on. Provisions include immediate and complete debt forgiveness—for debts incurred back to 2014—for Medicaid patients and for others with incomes up to 350 percent of FPL. Certain patients would qualify automatically for free care. Others would receive discounted care. (When price is cut, though, it is not clear from what level—charges, average cost, or some other measure.) Additionally, hospitals would enroll those eligible for free or cut-priced care in advance. They would neither sell medical debt nor report it to credit rating companies. Payment plans run for no more than 3 years and monthly payments are capped at 5 percent of income. Interest on debt is capped at 3 percent.^{3383 3384 3385}

The state says that, in return, hospitals would receive \$500 million in added Medicaid payments in 2024 and \$3.3 billion in added payments in 2025.

This came at a time of rising demands on state government to pay for health care. The state treasurer, the official in charge of the health insurance plan for state workers, dependents, and retirees, warned that the plan might not be able to pay its bills in 2026 unless it receives more money from state government. The plan puts some of the blame for that difficulty on high Covid-related costs and rising prices for new meds.³³⁸⁶

Enforcing contractual limits on OOPs and bans on balance billing. It would also be helpful for health insurance companies to better enforce their contracts with hospitals. A few years apart, one of my sons was twice seen by a specialist at a well-known Boston hospital. The medical care was good but the financial care was not.

As required, we paid our co-payment and the insurer paid the rest of its negotiated total agreed price to the hospital. But the hospital then repeatedly billed me for the “balance due.” The hospital thereby sought payment of the difference between its arbitrarily set (and substantial) charge and the total price to be paid that it had negotiated with the insurance company. This practice violated its contract with the insurance company. It also has the aroma of consumer fraud.

I told the hospital it had no right to bill for that balance but it persisted. It replied by threatening to report my failure to pay to the various credit reporting agencies and to turn the bill over to collections. I invited them to do that but mentioned my plan to refer the matter to the Massachusetts attorney-general's consumer protection bureau. The threats and demands for payment ceased. Unfortunately, all this recurred after a second doctor visit.

Because this happened twice, several years apart, I concluded that the hospital's fraudulent balance billing was a chronic practice. I wondered how much money this hospital and others collected in violation of their contracts with insurers. All these higher OOPs constitute a regressive financial burden.

After the second episode, I presented the facts of this case to the attorney-general's office but don't know what may have transpired.

7. Assuring Medical security and Health care for all

Insurance company explanation of benefits (EOB) forms seek to identify patients' OOP obligations to caregivers. But they do not explicitly warn patients against paying additional sums. Hospital or others seeking to collect money can frighten or intimidate Americans into paying money they do not owe. Reducing OOPs to small, standard sums would provide greater security and clarity.

Removing tax exemption. Some advocates and local governments have sought to strip non-profit hospitals of city or county property tax exemption when they gave little uncompensated care. In 2002, Provena Covenant Hospital lost its exemption and was obliged to pay property taxes to Champaign County, Illinois after a county board recommended that loss to the state Department of Revenue. Provena was found to devote less than 1 percent of revenue to charitable purposes. After 8 years of administrative and court proceedings, the Illinois supreme court upheld the loss of exemption.³³⁸⁷ Carle Foundation Hospital in nearby Urbana also lost its exemption because it failed the test of paying for "its property tax exemption with certain services of an equivalent value."³³⁸⁸

Serbaroli describes the loss of property tax exemption in 2022 by three Tower Health hospitals in Pennsylvania owing to excessive management fees paid by the hospitals to their notionally non-profit holding company.³³⁸⁹ He notes the changes that have led to higher public scrutiny of non-profit hospitals: their efforts to maximize revenue from third party payers, their growing competitiveness, and also their widely-criticized efforts to deny free care and bill uninsured patients at high prices.

Instead of trying to confront individual non-profit hospitals with losing their tax exemption, Reinhardt proposed simply ending all federal, state, and local income, sales, and property tax-exemptions entirely. They would be replaced by credits to offset taxes. Hospitals would earn those credits by actually serving uninsured or under-insured people. Those credits would be priced at Medicare levels, close to average cost.³³⁹⁰ Rosenthal has suggested taxing large medical centers instead of continuing to pursue futile efforts to extract benefits commensurate with their tax exemption.³³⁹¹

Cutting old medical debt and forestalling new debt have been pursued by well-motivated actors anxious to smooth the path to medical care for uninsured and under-insured Americans. But the results have rarely been commensurate with reformers' efforts.

There are several reasons. Some hospitals are run by people who are not sympathetic to the notion that people without money should be able to obtain health care more easily. Others are run by people who are sympathetic but fear their own non-profit hospital could not afford to shoulder the added cost of care. As noted in chapters 1 and 12, hospitals differ widely in their profitability today. Some fear financial distress or closing. Distressed hospitals are more likely to be located in areas where more low-income, uninsured, or under-insured patients reside. And many of those hospitals lack enough doctors who are willing and able to serve patients in need.

Many Americans are outraged by the accumulation of medical debt burdens, the efforts hospitals make to collect old debts or block care, and the gap between the dollar value of most hospitals' tax exemptions and the cost of the uncompensated care they actually deliver. When hospitals or *Wall Street Journal* editorial writers oppose debt relief in principle or because they claim it deters people from securing insurance, they may be sincere. Or they may be quietly

7. Assuring Medical security and Health care for all

respecting debt's invidious roles as a barrier to care and as a tool to suppress use and cost of health care.

Uninsurance or under-insurance generate medical debt. Full financial coverage is the right way to cure the problem. Other agendas, however well-motivated, address symptoms and not causes.

The persistence and even growth of under-insurance at the same that the number of uninsured people has been cut testifies to the pervasive reliance on suppressing use of care in hopes of holding down health care costs nationally.

It's important to recognize that costs rise rapidly even in the face of those efforts to suppress use. As mentioned earlier, no rich democracy has ever contained health care costs without covering all people—or the reverse.

The fight over drug makers' co-pay assistance plans

Patients who can't afford high OOPs imposed when they are prescribed high-price meds often fight with drug makers and with their insurers. And their insurers certainly fight with the drug makers themselves.

As discussed in chapter 15, U.S. prescription drug prices are the highest in the world. Rising prices on old drugs and high prices on new drugs have resulted in higher premiums for private insurance plans and for Medicare parts B and D, and also in higher costs for state Medicaid programs.

Insurers seek to lower their costs by forcing patients to pay high sums OOP. These include higher dollar co-payments, higher co-insurance percentages of the price of drugs, and even separate yearly OOP maximum payments for meds alone—distinct from ordinary maximum OOP payments for in-network physician, hospital, and other non-med costs.

Drug makers have often responded to insurers' high OOPs by offering what they call co-pay assistance plans. These are intended to immunize the patient from high OOPs for high-price chronic use meds, thereby boosting drug makers' volumes of sales and profits on these high-price drugs. The co-pay assistance plans do so by offering a voucher or coupon card to patients. Patients use the voucher or card to cover the cost of OOPs for some months—often, up to the limit of the patient's yearly cap on OOPs. Drug makers then hope that insurer will subsequently pay the drug maker its high price for the remaining months of the year.

Many insurers have responded by accepting the voucher or coupon card as payment from the drug maker but, at the same time, by ceasing to recognize the voucher or coupon card as part of the patient's OOP burden. Insurers call these actions “co-pay accumulators.”

Chang described the case of a patient plagued by their insurer's response. The patient suffered from a serious and painful chronic medical problem and benefitted greatly from a high-price med.³³⁹² The patient's former insurers in several states had accepted a coupon card as payment for all but \$3,000 of the patient's yearly OOP requirement for 16 years. The patient's new insurer decided to keep the card and demand that the patient pay his full co-pay—some \$10,600 yearly.

7. Assuring Medical security and Health care for all

Medicare and Medicaid prohibit application of vouchers or coupon cards toward a patient's OOP costs. That prohibition stems from federal anti-kickback laws that view drug maker gifts as illegal financial incentives (bribes) that can skew patient choices. The IRS has applied the same rule to high-deductible health plans associated with HSAs. But patients covered by commercial insurance can legally take advantage of the drug makers' voucher or coupon.

Some 26 states have outlawed insurers' pocketing the drug makers' vouchers or coupons via co-pay accumulators. Unsurprisingly, drug makers and some patient advocacy groups have fought in court with insurers about the legality of accumulators and about the federal government's occasional interventions for or against insurers.³³⁹³

As with medical debt and hospital uncompensated care, fights over vouchers, coupons, and accumulators are only symptoms. They have several salient causes. The first is inadequate insurance coverage. That results from attempts by insurers--and by the employers who pay the premiums that finance the insurers—to hold down their obligations to pay for care by erecting financial walls between patients and the meds their doctors have prescribed. As discussed in chapter 4, patients are trained to fly as kame-kaze pilots in a futile cost control war.

The second cause is the high prices drug makers have imposed on Americans.

Third, those high prices are caused by public and private payers' failure to negotiate or regulate lower prices.

Fourth, that stems from payer fragmentation, market failure, and government incompetence.

And fifth, although most meds are safe and effective, drug makers' claims of safety and, especially, efficacy of new and high-priced drugs have sometimes not been carefully scrutinized by FDA regulators. This liberates drug makers to aggressively market high-price meds to often-uninformed doctors in order to boost volume of use.

Rarely do payers and physicians think about using meds carefully in light of their cost, efficacy, and safety. No one imagines that a finite budget exists to pay for meds, one that must be marshaled carefully to do as much good for patients as possible.

As long as public and political attention focus on fights about the symptom—high OOPs—the causes won't be addressed. The problems of high-priced meds and their often inappropriately high volumes of use are taken in chapter 15.

The fight over section 340B discounts

The section 340B program was discussed in chapter 1. It requires drug makers to sell meds to large numbers of hospitals, community health centers, and other caregivers at discounted prices. Those caregivers are allowed to charge full prices when dispensing the meds.

Initially, eligible caregivers served vulnerable patients but eligibility has been broadened considerably. This diffusion of eligibility led critics to question the efficiency of the program in helping vulnerable Americans and in supporting the caregivers serving them.

7. Assuring Medical security and Health care for all

Drug makers have resented lost profits.³³⁹⁴ Both payers and drug makers attacked the program.

In 2017 and again in 2026, Trump sought to cut the prices paid by Medicare Part B for discounted drugs acquired by caregivers under 340B. These were mainly meds administered in hospital outpatient clinics, typically chemotherapy.

In 2026, Lilly and other drug makers began demanding that hospitals and other caregivers submit individual claims for discounted drugs administered to individual patients. Hospitals typically refused, declaring that the drug makers' demands imposed unreasonable and costly administrative burdens. Lilly began denying 340B discounts to caregivers failing to submit individual claims. In July, Tampa General sued Lilly, claiming its denial of 340B discounts was illegal under Florida law.

This political and legal sparring testifies to several failures: Failure to identify needed hospitals and other caregivers; failure to learn those caregivers' costs of efficiently delivering needed care; failure to assure that those caregivers garner revenues sufficient to cover those legitimate costs; obliging drug makers to forgo profits to subsidize targeted hospitals and other caregivers; political pressure from caregivers to broaden eligibility for the subsidies; and failure to establish reasonable prices for prescription drugs nationally.

The 340B controversy is a symptom of these failures. Fighting over 340B does nothing to address the causes of the controversy. Yet this fight will occupy considerable amounts of energy and time of caregivers, politicians, drug makers, lawyers, and judges.

340B is one of the sideshows at the U.S. health care circus—distracting attention from the main event—ensuring that all Americans get needed care affordably.

b. Broader coverage

Although a number of steps might be taken to broaden insurance coverage, at this writing (summer of 2026), there is little reason for short-term optimism.

This catalog of reforms to broaden coverage might inform future reform efforts. And it also suggests a few possible cautions and concerns.

Medicaid

Many access advocates focus on Medicaid and urge broadening and simplifying Medicaid coverage. Williams and colleagues have prepared a useful summary of Medicaid financing and coverage provisions in 2026.³³⁹⁵

Medicaid expansions. The largest step would be to expand Medicaid in the 10 states that have not yet done so. Reasons for opposing expansion include lingering political animosity toward Obama or the federal government, persisting racial divisions, and a view that health care

7. Assuring Medical security and Health care for all

is to be earned or bought—that it is not a right of citizenship. Interestingly, one recent account simply did not mention race.³³⁹⁶

Early in 2024, Chang and Miller reported that a number of southern legislative leaders had decided to push their states to expand Medicaid under ACA provisions.³³⁹⁷

In the spring of 2024, a bill to expand Medicaid, conditional on a work requirement, passed both legislative houses in Mississippi but died in conference committee.³³⁹⁸

Six months later, Sommers and colleagues published a smart and trenchant analysis of that state's choices: do nothing and suffer poor health outcomes and hospital financial distress and closings; expand Medicaid with a work requirement; and expand Medicaid under ordinary ACA provisions. They noted the stark failure of Georgia's 2023 Medicaid expansion contingent on work requirement: only 1 percent of those eligible enrolled and 92 percent of spending went to administering the program. Calling insistence on a work requirement "ideological", Sommers and colleagues asserted that benefits of ordinary expansion would help the state's economy, its hospitals, and its uninsured low-income citizens.³³⁹⁹

But that was in 2024. Ten states' refusals to expand Medicaid probably constitute the most unreasonable and medically and financially destructive behavior in U.S. health care today. The breadth and duration of the persistence of this refusal remains hard to understand. So does the insistence on conditioning expansion on impractical, hard and costly to administer, and grossly inefficient work requirements.

Subsequently, the \$910 billion in Medicaid cuts over a decade required by the 2025 federal budget law—including caps on states' use of special taxes to help pay their shares of Medicaid costs—will make it harder for any of the 10 to expand Medicaid and for any of the other 40 states to sustain covered services or pay caregivers adequate prices.

*Beals and colleagues reviewed state Medicaid policy actions between 2018 and 2022. Many sought to expand access to care and equity. They found Trump's efforts to cut Medicaid raise "concerns about states' capacity to continue such efforts."*³⁴⁰⁰

That's a mild assessment. From the viewpoint of 2026, it is difficult to imagine a road by which access advocates can return to improving Medicaid coverage or financing. It's therefore important to think harder about alternatives.

Even more important, inter-state disagreements about Medicaid expansion under the ACA highlight great differences in both political attitudes and other important inter-state variations. Those include differences in real incomes (dollar incomes controlling for cost of living), inequality, economic conditions and prospects, unemployment, population mix and change, competence of state government both generally and in health care, caregiver adequacy and configuration and finances, and willingness and ability of health care stakeholders to work together.

A nation of 340 million is unlikely to see agreement across the states in the gravity of the predicted health care crisis, whether public intervention is desirable, whether federal or state action is preferable, and much more. The work of the Red Team, discussed in chapter 1, will need to carefully consider inter-state differences.

7. Assuring Medical security and Health care for all

Still, it's useful to inventory recent efforts and proposals to make Medicaid better and fairer. Why? Because they offer lessons or tools for thorough reform—and these will be identified.

Covering more people by simplifying enrollment. Some people are uninsured even though they are eligible—and even though signing up for coverage would cost them nothing. Residents of Medicaid expansion states are covered if their incomes fall below 138 percent of the federal poverty level.

The 2022 Inflation Reduction Act eliminated premiums for ACA subsidized coverage for people with incomes below 150 percent of the FPL. Even so, Americans with incomes below 150 percent of the FPL comprise just over two-fifths of all those uninsured.

Holahan and colleagues gauged that one-half of the 26 million Americans uninsured in 2026 were eligible for Medicaid or for subsidized ACA coverage but have not enrolled. They therefore urged automatically enrolling Americans in Medicaid if they are already covered by SNAP, unemployment insurance, or other programs, or if they have filed tax returns.³⁴⁰¹ Automatically enrolling everyone under 150 percent of the FPL in Medicaid or ACA plans would insure some 4.3 million currently uninsured people. Another 1.8 million would be deemed to be covered when they seek care.

Holahan and colleagues estimated the yearly cost of these reforms to the federal government at about \$30 billion, with states shouldering an added \$8 billion or so. But caregivers' own cost of uncompensated care would drop by about one-third, were enrollment and coverage regularized. Unless those savings were recouped by payers, though, they would fall to caregivers' bottom lines.

Maryland has begun using tax returns and applications for unemployment insurance to enroll citizens in Medicaid and in ACA-subsidized coverage.³⁴⁰²

Automatic enrollment could largely address the problem that has arisen in Medicaid “unwinding”—the disenrollment of millions of people for administrative reasons.

Lesson: Federal or state efforts to assure medical security and health care for all could incorporate a number of automatic enrollment tools. Single payer approaches would probably entail issuing new cards to all people—or all residing legally in the U.S. All-payer approaches would nominally retain the separate Medicare, Medicaid, private insurance and other cards held by insured people, and then add a new card for everyone else. All cards would steadily offer identical benefits.

Unfortunately, many states have aggressively sought to disenroll people, perhaps to save money, perhaps for political reasons, and perhaps owing to stunted empathy with people on Medicaid. In December of 2022, 25 governors wrote Biden to push for a speedy end to the public health emergency (PHE) declaration that continuously enrolled Americans in their states' Medicaid programs. The governors complained about higher costs of “hundreds of millions of dollars.”³⁴⁰³

Biden acceded to the governors' request. It is likely that the states whose governors pushed to end the PHE were numbered among the states that disenrolled higher shares of their Medicaid patients for administrative reasons rather than actual loss of eligibility.

7. Assuring Medical security and Health care for all

In states that want to cover more people, automatic enrollment would be a useful and efficient mechanism. But it is only that—a mechanism, one of many. Worse, it is only a more efficient way to make the U.S.'s fragmented methods of covering people work a little better. It does not move the U.S. any closer to the clear, simple, and lifelong methods of coverage that operates in all other rich democracies.

Make Medicaid coverage more durable for children and adults. The threat of Medicaid's massive "unwinding" of coverage in 2023-2024, after the end of Covid's public health emergency, prompted efforts to conserve and regularize Medicaid coverage. Galewitz described Oregon's first-in-the-nation program allowing children to remain on Medicaid from birth to age 6. At least 3 other states are pursuing this arrangement.³⁴⁰⁴ Collins and Haynes proposed Congressional action to permit states to sustain Medicaid coverage for adults.³⁴⁰⁵ Musumeci pointed to the return of churn in 2023-2024, noting that almost three-fourths of those disenrolled from Medicaid lost coverage owing to errors like failing to respond to requests to reapply, not actual ineligibility.³⁴⁰⁶

Lesson: In some rich democracies, individuals are protected perpetually against health care costs through the source under which they first enroll. That mechanism would be compatible with all-payer reforms since Americans would retain the same variety of health coverage cards that exist today.

Raise the income cut-off for Medicaid eligibility from 138 percent of FPL to 150 percent. This change would have some positive and some negative effects on access to care. But it is difficult to measure the change in number of people insured—or how well they are protected against under-insurance.

The change would keep more people eligible for Medicaid as their income rose. It would thereby reduce transfers to zero-premium ACA plans. Those transfers could cause patients to lose connections to valued caregivers as they switched from Medicaid to ACA individual coverage. Even though people with incomes below 150 percent of the FPL in ACA plans are eligible for zero-premium plans, they will still face much higher OOPs than they would in Medicaid.

Greater shares of caregivers might accept ACA coverage than Medicaid. Patients would avoid Medicaid managed care, which could constrict access. On the other hand, ACA plans deny an average of 17 to 20 percent of claims for in-network care, which could discourage some caregivers from serving patients in ACA plans.

States would face somewhat higher total costs because they would be paying for greater numbers of Medicaid patients. Still, states pay no more than 10 percent of the costs of Medicaid expansion, so their added burdens could be small. Most states do not have great numbers of citizens whose incomes are between 138 percent of FPL and 150 percent.

The federal government would probably face somewhat lower total costs, although this would depend partly on the average federal payment to subsidize the average number of people in the 138-to-150 percent of FPL gap now covered by ACA plans, versus the average federal payment to cover their costs if they shifted to Medicaid. And on the number of people who'd switch from ACA plans to Medicaid.

7. Assuring Medical security and Health care for all

Lesson: Shifting patients from one form of coverage to another can worsen access, disrupt patient – caregiver relationships, and make both delivery of care administration of coverage even more complicated. Transitions to either single payer or all-payer coverage should minimize these shifts and should reassure both patients and caregivers that continuity of care will not be disrupted.

Realities plaguing Medicaid expansions. One simple and persisting reality is that expanding Medicaid to cover more people means higher health care spending. Another such reality is that Medicaid's prices are so low that many doctors and hospitals don't serve Medicaid patients. Nominal expansion of coverage, therefore, doesn't translate into equivalent improvements in actual use of needed health care.

Lesson: Nominal insurance coverage alone—stapling a card to an American's clothing—is better than being uninsured. But more must be done.

Medicare

Simplification of Medicare options. Just as simplifying Medicaid enrollment would make it easier for eligible Americans to win insurance coverage, so would simplifying Medicare's choices and stability.

Mathews reported that 1.5 million Americans were obliged to obtain new MA plans for 2025 because an insurer has dropped their plan; 3.5 million were obliged to find new prescription drug coverage.³⁴⁰⁷ It is difficult to weigh the total premium plus OOP cost of different MA and drug plans. It is even harder to measure value of different plans since value depends on adequate caregiver networks, ease of obtaining authorization for needed care, scope of coverage, caregiver competence, and more. No other nation obliges its citizens to make such important decisions—or to make them so difficult. Indeed, freedom of choice of caregiver is the norm elsewhere.

Worse, Medicare's Part D drug benefit was designed to be complicated—to make it hard to judge which plan best covered one's drugs, with which prior authorization and step therapies, and changing formularies, at what yearly premium and expected OOPs, and with which pharmacies in-network.

Why was Part D designed to make it harder to identify the best plan? To make adverse selection harder, to make it harder for Americans to identify the plan best-suited to their needs—and thereby boost Americans' uncertainty—and insurers' ability to offer profitable plans.

Prescription drug costs are the most stable and predictable health care costs from year to year. This invites adverse selection—allowing patients to choose the plan that best covers their meds. But insurance requires randomness, unpredictability. This is the reason many insurance experts long opposed a stand-alone drug benefit as open to adverse selection and gaming.

Lesson: Provide solid coverage for all people, minimizing need to shop, choose, and change plans.

7. Assuring Medical security and Health care for all

Monitor special payments to MA plans. In 2024, Medicare provided some \$67 billion in “rebates” to MA plans. These were intended to reduce premiums or finance supplemental benefits such as dental and vision care and hearing aids, which traditional Medicare does not cover. Unfortunately, low-income MA enrollees more often reported unmet needs for these three benefits owing to high costs, reported Gupta and colleagues.³⁴⁰⁸ They urged public monitoring of the supplemental benefits’ equity and access. It is hard to understand how that could be done, in practice.

Lesson: Simplify payments. Protect people and pay caregivers in financially neutral ways that enhance trust and liberate caregivers to deliver valuable services. Avoid special arrangements.

One simple method would be to invite and oblige each person to enroll in one of a small number of non-profit HMO-like entities. All would offer the same benefits. Each HMO’s revenue would depend on its share of patients, adjusted for risk, in a given region. Revenue would derive from the single payer or all-payer entity.

A second method would be to cover all people via payments to caregivers. Primary care doctors would be paid by salary, capitation, fee-for-time, and fee-for-service. Specialists would be paid mainly by salary. The source of that salary would be the budget of the hospital that employed the doctors. Hospitals would have fixed budgets that were set in light of the people of the region, the patients actually served, and identified unmet needs.

Expand coverage by lowering the age for Medicare eligibility to 60, 55, or below. In the years after the failure of his 1993-1994 campaign to boost insurance coverage, Clinton advocated allowing some 3 million uninsured Americans aged 55 to 64 to buy into Medicare by paying moderate yearly premiums.^{3409 3410}

Clinton’s proposal was distinct from efforts to deepen Medicare coverage by adding hearing, vision, long-term care, and other benefits—and by capping OOPs. Those efforts are discussed shortly.

It was also distinct from the Medicare coverage extended to under-65’s in 1972, when recipients of Social Security Disability Income recipients were made eligible for Medicare after receiving SSDI cash benefits for two years. Almost 10 million Medicare enrollees—about one-seventh of all people covered by Medicare—are under age 65.

Current proposals to lower age of eligibility appear to do more to shift costs from employers to taxpayers than they do to add to the number of insured Americans.

A 2022 study by the Congressional Budget Office and the Joint Committee on Taxation (JCT) estimated that lowering the age of Medicare eligibility to 60 would lower the number of uninsured Americans by only 400,000 people. That’s because most of those newly covered by Medicare already are protected by Medicaid, group health insurance through their job, or ACA-subsidized individual coverage.³⁴¹¹

Effects of the lower eligibility age on employer-sponsored health insurance are much more dramatic. Rae and colleagues estimated that lowering the age of Medicare eligibility to 60 would cut employer health plans’ costs by as much as 15 percent. Lowering to age 55 would cut costs by as much as 30 percent. Lowering to age 50 would cut costs by as much as 43

7. Assuring Medical security and Health care for all

percent. These drops could be that high because older workers use much more health care than younger workers.³⁴¹²

These estimates assume that all people in given age groups switched from employer-sponsored insurance to Medicare. In practice, though, it is likely that many such people would choose to retain their private coverage and would not switch to Medicare.

Still, federal government costs would rise substantially and employer costs would fall correspondingly. Since Medicare typically pays lower prices to caregivers than private insurance, total health care spending would fall. Unless, that is, hospitals, doctors, and other caregivers succeeded in their inevitable demands to be made financially whole by obtaining a boost in Medicare's own prices.

The federal government might provide for claw-backs from employers whose workers shifted from private insurance to Medicare. Employers might pay sums equal to employer shares of premiums for, say, 5 years. The dollars could be capped in the nominal dollars of the year preceding the switch. Even so, this would markedly trim the size of tax increases required to pay for greater numbers of Medicare enrollees.

Lesson: If Congress had to find the money to pay for more Medicare patients, it might engage more seriously with ways to cut health care waste, better configure caregivers, and make other strategic decisions.

Lesson: Consolidating coverage through single payer plans like Medicare for All will require moving the dollars—the sources of revenue—to match movement of patients from one form of coverage to another.

Restore and make permanent the 2021 and 2022 increases in subsidies for ACA plans.

CBO and JCT estimated the net cost doing so at \$33 billion per year between 2025 and 2034. That net cost is the difference between added dollar outlays and partially offsetting rises in federal tax revenue (owing to higher federal income tax payment on earned income—stemming from loss of tax-advantaged health insurance premium payments).³⁴¹³

Swindle and Giovannelli found state efforts to supplement federal subsidies to be useful but could not be remotely adequate to insulate those harmed by the subsidies' expiration at the end of 2025.³⁴¹⁴ Reverting to the 2010 levels of subsidies predictably deprived millions of coverage and oblige many more millions to pay higher premiums, OOPs, or both.

Lesson: Renewed battles over subsidized ACA coverage may be unprofitable. The high OOPs, the complex mechanisms, the high rates of denial of payment for in-network care, and the corrupt actions of many brokers and insurers have worked to delegitimize the mechanisms of the 4 metal tiers, actuarial equivalence, and the rest.

Still, if all Americans were to be covered via patient choice among non-profit HMOs offering identical benefits at identical patient cost, then enrollment via the marketplaces might be familiar and convenient.

Offer public options to expand coverage and contain cost

7. Assuring Medical security and Health care for all

In the fall of 2024, Glied expressed optimism that the U.S. is already almost in an “era of universal coverage.” She called for taking three steps upward from the “near-universal multitiered system now in place.” One was to allow inequalities to persist but to assure a publicly financed or subsidized “minimum publicly acceptable scope of benefits and cost-sharing” for all.³⁴¹⁵

That minimum has proven difficult to define and pay for in practice. The gap between health care’s floor—the level below which we don’t allow anyone to fall—and its ceiling—the best we deliver to some—remains wide.

Second, Glied urged making it easier for Americans to shift easily from one form of coverage to another. This is, actually, very rarely necessary in other rich democracies. Their citizens generally retain one form of coverage for all their lives. And shifting is likely to remain hard in the U.S. owing to substantial differences in costs and covered benefits, to loss of connection with trusted caregivers, to bureaucratic enrollment complexities, and—more fundamentally—to competing payers’ and brokers’ and contractors’ desires to minimize costs of care and maximize revenues.

Finally, Glied appeared to call for phasing out accountable caregivers like community health centers and urban public hospitals that have had missions to serve patients who are vulnerable to deprivation of needed medical services. Her motives are doubtless benign. She apparently believed that these dedicated caregivers are no longer needed in an era of universal coverage. But that ignores different caregivers’ numbers and locations and histories. And many caregivers’ persisting preferences to serve higher-paying commercially-insured patients. Or, often, patients’ own current preferences.³⁴¹⁶ It is dangerous to close or repurpose some caregivers without assuring that better alternatives are actually available and acceptable. These matters are taken up in chapters 11 and 12.

Hacker proposed a public option called “Medicare Plus” in 2001 to cover uninsured Americans. He saw this as a politically feasible and practical middle ground between single payer and reliance on subsidized purchase of private insurance.³⁴¹⁷

The failure of the many proposals labeled as a “public option” to win more than marginal implementation says much about current prospects for incremental reforms to boost coverage and contain cost. Understanding the debates over the evolving public options—and their fates—requires attention to the very different versions of the proposals.

Public option no. 1, Medicare Plus, was the massive plan proposed in 2001 by Hacker. It would have covered virtually all previously uninsured Americans plus others. It would have enrolled non-working uninsured Americans, Medicaid patients, and a substantial share of working but uninsured citizens and their families. These might be enough to leverage low prices from hospitals, doctors, drug makers, and other caregivers.

Public option no. 2 surfaced during the debate over the ACA. It would have been one choice offered Americans seeking subsidized individual health insurance through the exchanges or marketplaces. This version was expected to cover perhaps 10 million people but have no visible effect on the number of uninsured Americans or on total spending on health care.

Public option no. 3 was discussed briefly during Biden’s 2020 campaign as one response to the Covid plague. According to the party’s platform, “Low-income Americans will be automatically

7. Assuring Medical security and Health care for all

enrolled in the public option at zero cost to them, though they may choose to opt out at any time.” Rosenthal reported that Biden did not use the “public option” phrase post-inauguration.³⁴¹⁸

Aims, design, and possible benefits of public option no. 1. Hacker aimed to build on Medicare by mandating that each uninsured and unemployed individual obtain health insurance through a new public option. This would be combined with a play-or-pay mandate for employers, one that would oblige employers to provide health insurance or pay a tax. The millions of workers lacking employer-sponsored health insurance would be covered along with their dependents. And these constituted the great majority of uninsured Americans. It also promised to wean Americans voluntarily from job-based insurance but its means of doing that were unclear.³⁴¹⁹

This public option would draw patients from employers that enrolled workers. Employers would pay a percentage of workers’ earnings. State governments would pay to enroll their Medicaid and CHIP patients. Other uninsured Americans would be obliged to pay premiums set on a sliding scale with income. All legal residents lacking qualified private insurance coverage would be eligible. Public subsidies would cover the gap between premiums paid and cost of care. Hacker’s proposal did not include clear, grounded estimates of premium revenue, needed subsidies, and total costs of care.

Hacker portrayed his original public option as a way to avoid the sort of direct threat to private insurance companies that the Clintons’ 1993 plan posed. And as a way to simplify what he portrayed as a complex mix of public coverages.

He supposed that the Medicare Plus plan would enroll so many people that it would enjoy great bargaining power to negotiate lower prices paid hospitals, doctors, and drug makers. It would therefore not need to rely on narrow networks of caregivers to win lower prices.

Benefits would include services covered by Medicare, including prescription drugs. OOPs would be higher than in most employer-sponsored insurance but, unlike Medicare, yearly OOPs would be capped.

Hacker enunciated 3 principles that guided his approach:

1. Affordable, guaranteed coverage offering a defined package of benefits should be available to all Americans, regardless of whether their employers sponsor it.
2. Such coverage should be designed to uphold social insurance precepts, spreading risks broadly through an inclusive plan that is available to all and within the financial reach of the less wealthy and the less healthy.
3. Basic insurance coverage should be expected of all Americans as long as all have access to an affordable plan.

These principles rested, he wrote, on 5 judgments about political and administrative constraints on reform:

1. Universal health insurance will most likely be achieved through a series of large-scale but nonetheless partial steps that will need to be calibrated over time to the responses of other actors and institutions with influence over the breadth and depth of health coverage.

7. Assuring Medical security and Health care for all

2. Any proposal that is perceived as taking away or significantly raising the cost of existing private coverage, imposing huge new costs on employers or individuals, or significantly reducing the benefits of public programs, is unlikely to be enacted.
3. A successful plan must be seen as beneficial and potentially available to all Americans, not as a form of organized charity through which the many aid the few.
4. Targeting coverage narrowly on the uninsured will likely be self-defeating, reinforcing the current confused welter of programs and leaving unprotected many Americans who are uninsured, insufficiently insured, at risk of becoming uninsured, or under serious financial pressure because of the cost of coverage.
5. Any plan should be simple to understand and to enroll in, based on popularly understood and time-tested institutions, relatively straightforward to finance and administer, and subject to democratic control.

The public option no. 1 is a clever idea, one with substantial strengths and weaknesses. During the debates that preceded passage of the ACA in 2010 public option no. 1 received some initial attention, partly because, as Pear reported, candidate Obama had said “he would ‘establish a new public insurance program’ alongside private health care plans.”³⁴²⁰ Pear also wrote that this attracted some initial interest but that this died owing to a combination of “an ineffectual White House strategy, the president’s failure to argue passionately for the ‘public option’ and all-out opposition by the insurance industry and much of the health care industry.”

Consequently, it was only the vastly weaker public option no. 2 that received much attention as one small, proposed element of the ACA exchanges/marketplaces. Even that was never enacted.

Biden mentioned new and strong public option no. 3 during his 2020 presidential campaign. This public option would have been a part of Medicare, relying on Medicare pricing. It would thereby get low prices by regulation, obviating getting big enough to leverage lower prices from caregivers through negotiation. Medicaid patients would no longer be included. But it would be available to all covered via ACA marketplaces.

Over the years, discussions of public options have sometimes been confused by failures to distinguish among the three.

Unsurprisingly, public option no. 1 was criticized from the left because it was not single payer, from the center as impractical, and from the right because it would mean greater government roles in health care that would deprive insurers of customers and caregivers of revenue.

One weakness of public option no. 1 stems from a chicken – egg problem. State- or region-level public option plans would need to enroll many Americans before they could leverage lower prices from hospitals, doctors, or drug makers. But they probably would need to offer lower premiums before they could attract many enrollees. The two can’t be done together—but they must in order for the public option to offer competitive premiums.

Second, if the public option did succeed in wresting lower prices from caregivers, how would caregivers recoup the substantial revenue they lost? By embracing U.S. price-leveraging games, the public option does nothing to enhance payers’ and caregivers’ accountability to one another—or to patients.

7. Assuring Medical security and Health care for all

A third reason is political. The public option was designed to be politically attractive. But that attraction, while perhaps broad, remained shallow.

Support for the public option. While preferring single payer in 2009, Reich decided to support some form of a public option as a politically feasible way to expand coverage. He noted its support in the House but that some moderate Senate Democrats had been persuaded it was merely a “Trojan Horse” for single payer.³⁴²¹

Opposition from the left. Single payer advocates have been the most consistent opponents of the public option from the left. Sullivan decried what he called the “bait and switch” tactics of public option promoters in 2009. He noted that Hacker’s original 2001 plan supposed that 50 – 70 percent of non-elders would be covered by the public option, allowing it to obtain low prices from caregivers and expand coverage. But the public option considered in 2009 was a shadow of that proposal—and would do little to boost coverage or constrain spending.³⁴²² McCanne asserted in 2010 that adding a greatly watered-down public option to the ACA’s marketplaces, discussed shortly, was essentially a waste of time.³⁴²³

Hacker addressed two criticisms offered by critics he called progressive. One is that less costly patients would gravitate to private alternatives, putting the public option at a disadvantage. Hacker sought to rebut this objection by claiming the public option would negotiate lower prices and offer wider choice of caregivers. Sadly, though, the wider choice of caregivers would reinforce the public option’s appeal to the very patients who need more care and therefore value that wider choice.

Hacker then offered a somewhat strange observation—that “opponents of the public option would not be against it unless they thought it would be effective and expand over time.”³⁴²⁴ Flipping that would suggest that these opponents would favor the plan if they thought it would fail.

The second criticism Hacker pointed to is that the public option touted briefly by Biden is a “pale imitation” of Medicare for All. Rejoining, Hacker noted that single payer would require much greater tax increases than the public option because single payer would shift many more workers and dependents from private insurance coverage.

Hacker then went on to point to the need to strengthen Medicare in order to reassure those it covers and to inspire trust in a public option that resembles Medicare. Greater strength would include capping Medicare’s OOPs and adding currently services currently omitted. ACA plans would need better protection from OOPs, denials of payment, and narrow caregiver networks.

To keep the ground firm enough to support a future public option, Hacker registered concerns about public options that were actually regulated private plans, and about letting states operate separate public option plans.

Opposition from the center. Starr worried that the public option would attract older and sicker Americans, and that risk adjustment of revenue would not adequately compensate for the resulting higher costs of care. And if the public option were to enroll as many as 100 million Americans, and thereby leverage lower hospital and doctor and drug prices, the resulting financial crisis would discredit reform.³⁴²⁵

Reinhardt decried the focus on the public option in 2009 during the early debates over health care reform. He said that, by trumpeting one mechanism, it displaced attention to “the real

7. Assuring Medical security and Health care for all

issue before us...helping the millions of currently uninsured low-income American families gain access to adequate and reliable health insurance.”³⁴²⁶

Reinhardt noted that the world’s other rich democracies have health insurance that is “easy to understand, reliable,” and life-long coverage. Their citizens are not bankrupted by medical bills. He asserted that, while single payer is one option, many nations have achieved affordable health care for all without either single payer or a public option. Instead, they require that all people be covered and that the insurers through which that coverage is financed be heavily regulated. And they do so without a public option.

Opposition from the right. Conservative opponents of the public option may have been somewhat less vocal than those from the progressive side, but they may actually have been more effective. The Heritage Foundation led a group that called the public option “the No. 1 deal killer for health care reform.”³⁴²⁷ Butler, a Heritage vice-president, condemned the public option as inherently unfair because he anticipated the federal government would skew rules to favor the public option over the private insurance companies with which it would compete.³⁴²⁸

Hacker has been less visible in addressing conservative critics. Some of these feared loss of revenue to hospitals, doctors, and other caregivers. Others anticipated disruption of private insurance and its ultimate expulsion from health care.

Sheils and Haught estimated effects on hospital and doctor revenue of a public option that displaced almost all private insurance. They thought hospitals would lose \$36 billion or 4.6 percent of revenue yearly, and doctors would lose \$33 billion or 6.8 percent of revenue.³⁴²⁹ These recurring revenue subtractions would upset caregivers.

As noted in chapter 3—and as will be discussed further in chapter 8, cutting revenue is certainly one way to contain the total costs caregivers can incur. But it is probably not medically safe or politically feasible.

Dobson and others noted that insuring previously uninsured Americans would boost volumes of care. These higher volumes raise revenue faster than they raise costs (since a substantial share of health care costs are fixed). Therefore, higher volumes boost hospitals’ and doctors’ surpluses, other things equal.

But Dobson and others also wrote that a public option’s cuts in prices paid caregivers would lower hospital revenues, perhaps leading them to raise prices on privately insured patients.³⁴³⁰ (But that assumes that hospitals had previously been leaving money on the table by not seeking as much revenue as possible when bargaining with private insurers.) Their view assumes that hospitals have aim only to gain targeted revenues, not as much revenue as they can.

Dobson and others noted that their work was completed under contract with America’s Health Insurance Plans (AHIP); they wrote that the “Opinions expressed are those of the authors, not the project sponsor or the affiliated company.”

CBO prepared an analysis of a low-keyed 2010 proposal to add a public option to the offerings of ACA marketplace exchanges. This bill would have set payment rates to hospitals at Medicare levels and payments to doctors slightly above Medicare’s. CBO estimated that premiums in the public plan would be 5 – 7 percent lower than those of private insurers via the exchanges. CBO also estimated that about one-third of exchange enrollees would choose the public option if it existed. But the public option was expected to boost the number insured

7. Assuring Medical security and Health care for all

through the exchanges by three-quarters of a million people; it was expected to cut the number with private health insurance through the job by the same number.³⁴³¹

Interestingly, a 2009 survey of doctors by Keyhani and Federman found that some 72 percent favored either single payer (10 percent) or a combination public and private options (63 percent) to expand coverage. Support for expanding coverage was consistent across primary care doctors, medical specialists, and surgical specialists.³⁴³²

Lessons from 2 decades of discussion of the public option. Designed to be politically attractive and financially feasible, the public option proposal has not been widely implemented. Versions enacted in several states have been so constricted that they could do little either to contain cost by constraining caregiver revenue or to cover many people. Nor have they done much to advance political awareness of causes of health care problems or remedies to them.

Still, after so much talk and attention, can nothing be learned? Perhaps the main lesson is that the twin challenges of covering all Americans well and containing costs can't be finessed by clever mechanisms. They need to be confronted head-on. When popular and political demands for action on both simply erupt.

Auto-enrollment

Holahan and colleagues proposed auto-enrollment of Americans under 1.5 times the Federal Poverty Level. Writing in 2024, they noted that one-half of the estimated 26 million uninsured Americans were then eligible for Medicaid or ACA subsidized coverage. They estimated that some 4.3 million uninsured people could be identified electronically via income tax filings, SNAP coverage, unemployment insurance, or Social Security records. An added 1.8 million could also be identified through prior contact with a caregiver. Thus, almost one-quarter of uninsured Americans could be protected against health care costs. Holahan and others estimated that federal spending would rise by \$30 billion and state spending by almost \$8 billion. Caregivers' estimated actual spending on previously uninsured people would fall by one-third.³⁴³³

Because auto-enrollment boosts federal and state spending, its use would rest on financial capacity and political willingness to boost spending to cover the people identified. Still, it is a smart and convenient way to identify eligible low-income people. It could be a tool that single payer or all-payer arrangements could employ.

c. Deeper coverage

Deeper coverage would entail better protections for all Americans. One policy would be to set all Americans' insurance premiums, OOPs, or both in proportion to income. A second would be to slash premiums or OOPs to merely nominal levels. And payers, not patients, would pay all facility fees. This could be done for Medicare, private insurance through the job, and subsidized ACA plans. A third would be to extend solid coverage for dental care, vision care, and hearing care for all Americans. A fourth would be to bring Medicaid's prices for physicians and hospitals up to Medicare levels.

7. Assuring Medical security and Health care for all

Set premiums for health insurance through the job in proportion to income. Something like this is done in those rich democracies that raise a substantial share of money to pay for health care via assessments on earned income. In Germany in 2024, for example, health insurance premiums equaled 14.6 percent of gross earned income—on incomes up to 62,100 euros yearly. This makes the premium (or tax) proportional to earned income up to 62,100 euros, and then regressive. It becomes somewhat more regressive because it excludes interest, dividends, capital gains, and other unearned income. Still, the income cap is two-fifths above median German earned income of 43,740 euros in 2024. This makes German health care financing close to proportional and only slightly regressive. By contrast, as discussed earlier, the great share of U.S. health insurance coverage through the job is financed in an entirely regressive manner—as a fixed dollar payment per worker or family.

Abelson reported that one-seventh of large U.S. companies asked better-paid workers to pay higher health insurance premiums.³⁴³⁴ But Andrews reported a year later that only about one-tenth of U.S. companies did so.³⁴³⁵ The two estimates probably were made by different methods or criteria. And sometimes, when premiums do vary by income, they don't vary by much.

ACA premiums are an exception. The individual/family share is assessed in a highly progressive manner. As individual or family size-adjusted income rises, premiums paid by the individual/family rise as a share of income.

It is important to note the great value of the extra help offered by the enhanced premium subsidies that were in effect from March of 2021 until December 2025. Loss of those subsidies explains both the precipitous drop in total ACA enrollment that began early in 2026 and also the high rate of shift from silver to bronze plans. The latter have low or no premiums but much higher OOPs.

Exhibit 7 – 20 displays the 2026 national average family costs of premiums for a silver plan—calculated with and without the enhanced tax credit subsidy that expired at the end of 2025.³⁴³⁶ Family costs are shown for 2 adults and 2 children, with total incomes of \$50,000, \$75,000, and \$100,000 yearly.

Exhibit 7 – 20

ACA Silver Plan Premiums and Subsidies – 2026 Actual and 2026 with Enhanced Subsidies

Family income of \$50,000	2026 with enhanced subsidy	2026 – actual lower subsidy
Family premium/month/year	\$9/month and \$110/year	\$186/month and \$2,230/year
Percent of income	0.22 %	4.46 %
Financial subsidy	\$2,150/mo and \$25,796/year	\$1,973/mo and \$23,676/year
Subsidy share of premium	100 %	91 %
Family income of \$75,000		
Family premium/month/year	\$208/month and \$2,498/year	\$489/month and \$5,865/year
Percent of income	3.3 %	7.8 %
Financial subsidy	\$1,961/mo and \$23,409/year	\$1,670/mo and \$20,041/year
Subsidy share of premium	90 %	77 %

7. Assuring Medical security and Health care for all

Family income of \$100,000		
Family premium/month/year	\$523/month and \$6,280/year	\$830/month and \$9,960/year
Percent of income	6.3 %	10.0 %
Financial subsidy	\$1,636/mo and \$19,626/year	\$1,329/mo and \$15,946/year
Subsidy share of premium	76 %	62 %

Source: “Interactive ACA Premium Subsidy Calculator for 2026, with and without expired enhanced subsidies,” KFF, accessed 25 July 2025, <https://www.kff.org/interactive/calculator-aca-enhanced-premium-tax-credit>

In addition to conditioning families’ shares of premiums on income, ACA silver plans provide for lower OOPs for enrollees whose incomes fall below 2.5 times the federal poverty level. But the great share of other Americans who are covered through their employer, have no such protections. As discussed elsewhere, a few employers do charge higher-income workers a higher percentage of total premium costs. But protections against high OOPs are invisible.

Walsh has proposed a “composite cost threshold.” By this, he means that family premium shares plus OOPs should not exceed 10 percent of yearly income.³⁴³⁷

Unless an employer offset higher premiums with higher wages or salaries, it might place itself at a disadvantage when competing for talented workers of the types who’d pay higher premiums if they were considerably varied by income. This speaks to the need for care when making substantial changes in methods of raising money to pay for health care.

The ACA originally included a “Cadillac Tax” on high health insurance premiums. In part, this was sold politically as a way to discourage companies from offering good health insurance coverage—so good it was imagined it would expose workers to moral hazard and reckless use of care. One financial company had been paying \$40,000 yearly for executives’ health insurance, a practice that became the face of the Cadillac Tax.³⁴³⁸ It was also sold as a way to tax some people with good insurance to help generate money to finance the ACA’s Medicaid expansions and subsidized individual coverage.³⁴³⁹

Gabel and colleagues found that the bulk of the variation in premiums could not be explained statistically.³⁴⁴⁰ Luxurious benefits did not seem to be a common cause of high premiums. Employers with older workers or companies located in states with high health care costs faced higher premiums. This undermined political support for the tax. Eskow called the Cadillac tax one that “even its defenders can’t love.”³⁴⁴¹ Due to take effect in 2018, the tax was briefly deferred and, then, repealed in 2019.

Cap Traditional Medicare’s Yearly OOPs. Wyden proposed capping OOPs for people enrolled in traditional Medicare at \$5,000 per year.³⁴⁴² This would project many Medicare patients from unaffordable debt and worry. Only about 43 percent of enrollees in traditional Medicare currently have Medicare supplement plans. These do cap OOPs but premiums are unaffordable for many. Capping traditional Medicare OOPs would make it easier and financially safer for patients disenchanted by the MA plans to switch to traditional Medicare. (MA plans’

7. Assuring Medical security and Health care for all

OOPs have been capped at \$9,250 per person, but most MA plans set substantially lower caps.)

It is worth noting that OOPs for Medicare Part D plans were capped at \$2,000 per person yearly at the start of 2026. Observers warned that some combinations of tighter formularies, more rigid step therapies, and higher premiums were likely. But traditional Medicare's Part A for hospital inpatient care and Part B for physician and other outpatient services were unlikely to follow this route. That's because their benefits are set by law. And Part B premiums are standardized nationally, so patients frustrated by rising premiums could not select a cheaper plan. Their recourse would be anger at their representatives and senators.

Capping OOPs for traditional Medicare at \$5,000 yearly might cost some \$50 billion per year. A short term source of financing would be to slash today's high payments to MA plans—payments that substantially exceed what MA patients would cost if they were covered by traditional Medicare.

Growing shares of MA patients have enjoyed zero OOPs for in-network primary care visits. Jiang and colleagues found that the share of MA enrollees with zero OOP for such visits grew from 46 percent in 2019 to 78 percent in 2025.³⁴⁴³

A long term alternative source of financing would be to squeeze out waste from U.S. health care. In 2026, national health expenditures reach \$6 trillion. If one-half (\$3 trillion) of that sum is wasted, the \$50 billion cost of capping traditional Medicare OOPs at \$5,000 per year would be one-sixtieth (1.67 percent) of yearly waste. It is best to see this as one desirable result of thorough-going reforms in assuring access, containing cost, paying caregivers, configuring caregivers, and boosting quality and appropriateness of care.

These are discussed briefly in later in this chapter under the heading of covering everyone equally and well, and more fully in chapter 8 (cost control), chapter 9 (paying caregivers), chapter 10 (organization and delivery of care, chapters 11-14 (primary care, hospital configuration, long-term care, and mental health care), chapter 15 (paying for meds), and chapter 16 (boosting quality and appropriateness of health care).

Reinsurance. Drake and Anderson argued that people receiving ACA-subsidized individual insurance have suffered some losses in coverage owing to reinsurance activities for higher-income people covered by unsubsidized individual insurance. The ACA capped its enrollees' premium cost (though not total premium cost, which was federally-subsidized on a sliding scale with income).³⁴⁴⁴

Drake and Anderson assert that, with federal approval, some 17 states began to allow reinsurance to pay high-cost claims for care of patients with individual insurance, lowering their premiums. But reductions in premiums lowered the cost of the benchmark second-most-costly subsidized silver plans—which had the effect of boosting subsidized individuals' premium costs if they chose silver plans more costly than the benchmark plan in their region.

This highlights the complexity and inter-relatedness of current U.S. methods of covering people, and also the difficulty of predicting the effects of reforms aiming to modulate problems.

7. Assuring Medical security and Health care for all

Expand benefits to include dental, vision, and hearing care

Dental care. In 2024, dental care absorbed 3.6 percent of U.S. health care spending. Applying that share to 2026 expected national health care expenditures of \$6 trillion—and allowing for the relatively slow growth in dental care spending—yields approximately \$210 billion.

Unfortunately, high shares of Americans are under-insured or entirely uninsured for dental care. At the same time, the nation's 200,000 dentists are fully occupied in serving those able and willing to pay for care.

Winning good dental care for all Americans will require more money and more caregiving capacity. The two must be coordinated.

One step forward would be to train more dentists. Dental school lasts for 4 years. Specialists train for 2-6 added years. About 80 percent of dentists are general practitioners. This share has dropped very slightly. The number of dentists per 100,000 Americans rose from 57.3 in 2001 to 61.1 in 2017 but fell to 59.5 in 2024. Retirements owing to Covid appear to be responsible for the drop. Dentists are, on average, younger than physicians.

A parallel step would be to expand use of dental therapists. Dental therapists would work as part of a team with dentists, taking responsibility for diagnosing, excavating, and filling cavities and also extractions. This would free dentists to devote more of their time to more difficult care.

Dental therapist training lasts for 3 years. They are licensed to perform varying tasks in 14 states. Training thousands of dental therapists yearly could greatly expand access to good dental care fairly rapidly and at lower cost than relying only on training more dentists.

Increased numbers of dentists, dental therapists, and dental hygienists might require a steady rise in spending equal to a one-third increase, or some \$70 billion or so in 2026 dollars.

Vision care. Solid data on current use of routine vision care—eye exams, eyeglasses, and contact lenses—are elusive. Wilson and colleagues reviewed data available in 2012 and found a 100 percent variation in estimated numbers of visits to optometrists and ophthalmologists.³⁴⁴⁵ Data on spending for routine vision care are not as reliable as might be hoped. The incremental cost of good eye care for Americans who now lack it are even more uncertain. It would be valuable to obtain reasonable estimates as a foundation for financing and delivering care equitably.

Hearing care. U.S. spending on hearing aids is about \$5 billion yearly. These are sold after testing by an audiologist. Many people pay excessive prices. Others in need rely on rapidly improving over-the-counter retail hearing aids.

Some 30 million U.S. adults could benefit from wearing hearing aids.³⁴⁴⁶ Only about one-fifth of Americans suffering hearing loss actually use hearing aids. It would cost \$12.5 billion yearly to finance public coverage of reasonably-priced hearing aids with 3-year warranties—at a price of \$1,500 per pair (or \$500 per pair per year), for all 25 million people in need of hearing aids but not currently using them. The added cost of testing by audiologists would need to be included.

7. Assuring Medical security and Health care for all

Boost Medicaid's prices paid doctors, hospitals, and other caregivers

One choice would be to raise Medicaid prices to Medicare's levels. How much would it cost nationally to do so?

Zuckerman and colleagues found that prices paid by Medicaid programs for physician services averaged 72 percent of Medicare's in 2019.^{3447 3448} That ratio varied enormously by state, physician specialty, and specific type of physician care.

A MACPAC study found that ordinary Medicaid payments to hospitals were 78 percent of Medicare's in FY 2015.³⁴⁴⁹ But Medicaid payments averaged 6 percent above those of Medicare once lump sum and other supplemental payments were included. These special revenues comprised one-half of all Medicaid payments to hospitals. But because hospitals, themselves, finance much of those payments through special taxes, the actual net payments by Medicaid to hospitals are assumed here to be equal to those by Medicare. Wide inter-state and inter-hospital variations in the ratio of Medicaid-to-Medicare prices were common.

A GAO study found that Medicare's average net price in 2010 for a sample of high-use, high-price prescription drugs was 2.15 times as great as Medicaid's. Here, the Medicare net price included patient OOPs.³⁴⁵⁰ This translates into a conversion factor of 0.47 to raise Medicaid prices to those of Medicare ($1 / 2.15 = 0.47$). It's reasonable to assert, though, that Medicaid's prices are fair and that Medicare has been over-paying radically. Table 7 – XX displays the total rise in Medicaid spending with and without higher drug prices.

A MACPAC study found that Medicaid prices in 2019 were about 86 percent of nursing home costs. Additionally, nursing homes received some \$3.4 billion in supplementary Medicaid payments. Comparisons with Medicare prices are not available—perhaps because the great share of Medicaid residents live in nursing homes for long times while all Medicare patients' stays are short because Medicare finances brief post-hospital nursing home services for patients requiring wound care or cardiac or other rehab and the like. It is probably reasonable to apply the 0.86 factor to home health care and other residential services as well as nursing homes.

If these factors are applied to 2024 projected Medicaid spending on physicians, hospitals, meds, and LTC, Medicaid spending would rise from \$738 billion to \$881 billion. This would be an increase of \$143 billion (almost one-fifth) to reflect prices paid by Medicare. This is a crude estimate, but probably a reasonable one.

Raising Medicaid prices paid to caregivers would not boost the number of people covered. But it would elevate many caregivers' willingness to serve Medicaid patients. Improved access stemming from the higher prices would raise volumes of care, so Medicaid spending might rise by substantially more than the one-fifth projected from the price rise alone. That may well be a cost of relying on incremental financing improvements to combat under-insurance owing to low Medicaid prices.

All of the studies comparing Medicaid and Medicare prices point to very large inter- and intra-state differences in the gaps between those two sets of prices. This would complicate the job of administering the elevation of Medicaid prices to Medicare levels.

7. Assuring Medical security and Health care for all

That is not the only complication. In a reasonable world, hiking Medicaid prices to Medicare levels would (and should) be cost-neutral—because the hike should be offset by drops in private insurance prices. But coordinating such drops would be complicated by the inter- and intra-state differences in Medicaid payments today. (Further, private insurance prices are established by interplay of caregivers and payers, not by meaningful regulations.) And also by shares of Medicaid and private insurance spending by sector. This is most dramatic in LTC, which relies heavily on Medicaid and hardly at all on private insurance.

Exhibit 7 – 21

Rise in 2024 Medicaid Spending if Medicaid Paid Medicare Prices, \$ Billion

	2024 Projected Medicaid Spending	Factor	If Paid Medicare Prices	Rise in Medicaid Spending	Percent rise
Doctors	\$110	0.72	\$153	\$43	
Hospitals	\$259	1.00	\$259	\$0	
Meds	\$47	0.47	\$100	\$54	
LTC	\$285	0.86	\$332	\$46	
Sum of above	\$701		\$844	\$143	
Other	\$38		\$38	\$0	
Total Medicaid PHCE	\$738		\$881	\$143	19.4%
Total Medicaid PCHE, minus Rx	\$738		\$781	\$43	5.8%

Sources: Author's calculations from projected 2024 Medicaid personal health care expenditures in Office of the Actuary, Centers for Medicare and Medicaid Services, NHE Projections, <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected>.

Factors are explained in the text.

Those prices could be applied to Medicaid managed care operators also. Herring and others described 2024 changes in Medicaid regs that allow states to elect to oblige Medicaid managed care plans to pay prices up to those of commercial insurers. About three-fourths of Medicaid patients are controlled by such plans.³⁴⁵¹

States will vary in their willingness to force managed care plans to boost prices paid to caregivers. The great inter-state range in shares of Medicaid patients disenrolled for administrative reasons in 2023-2024 testifies to that variation. And even willing states will not be able to finance their shares of the higher payments they might compel the managed care plans to make. Unless the federal government offered substantially higher federal matching funds to finance most of the added costs to states. The high federal deficit makes Congressional action unlikely.

California has for decades sought to stretch its dollars to cover a high share of the state's people—two-fifths in 2023—but this has meant particularly low rates of pay to caregivers.

7. Assuring Medical security and Health care for all

Effects on hospitals serving high shares of Medi-Cal patients were discussed in Chapter 1. Low prices have led many doctors and other clinicians to refuse to serve Medi-Cal patients.

In 2023, the state promised to use revenue from a tax on managed care plans to raise Medi-Cal payments, particularly for primary care, obstetrics, and mental health services. It hoped in a few years to hike rates to 85 percent of Medicare levels.³⁴⁵² But this may be only a hope. Even though rhetorical support for Medicaid is high in California, Newsom asked in 2024 to shift \$6.7 billion raised by the managed care tax from boosting Medi-Cal payments to helping to cover the state's \$45 billion deficit.³⁴⁵³

Medi-Cal is a costly and complex program. Its expected budget for FY2024 was \$151 billion. About \$90 billion was federal matching funds; \$36 billion came from the state's general fund, and \$24 billion from other non-federal funds. Paying higher prices to caregivers would require generating more money from all three sources. The document describing how Medi-Cal money is apportioned across counties runs to 1,243 pages.³⁴⁵⁴

CalOptima is California's Medi-Cal contractor for Orange County, the state third-most-populous, with 3.1 million residents. In 2023, about 940,000 (30 percent) were on Medi-Cal. In June of 2024, CalOptima's board approved \$526 million in higher payments to caregivers over 2.5 years, or \$210 million yearly. That seems like a lot of money, but it is only about a 5 percent sustained rise in prices.³⁴⁵⁵

Medicaid's prices affect both access to care and its quality. This is particularly true for the very young and very old. Medicaid's low payment rates to doctors are particularly dangerous to our children, just over one-half of whom are covered by Medicaid or CHIP.³⁴⁵⁶ Carroll ties high reliance on Medicaid to pediatricians' low incomes, and suggests this helps explain the drop in shares of residencies filled in general pediatrics and pediatrics specialties.³⁴⁵⁷ Jordan and colleagues called for raising Medicaid's prices to at least Medicare's level.³⁴⁵⁸ This topic will be taken up further in chapter 11.

Similarly, Medicaid sets prices for three-fifths of all U.S. nursing home patients.³⁴⁵⁹ Its low prices depress access to nursing homes, their staffing levels, and the quality of their care. Ways to address these problems are considered in chapter 13.

Covering more people under Medicaid would boost pressure for Medicaid to pay adequate prices for care.

Securing health care coverage is the U.S. has long been unnecessarily complex, confusing, adversarial, time-consuming to apply for, and costly to administer. Frequent recertification of Medicaid coverage is a good example. At minimum, wrote Buettgens, Congress should permit all states to allow 12 months' continuous eligibility for Medicaid.³⁴⁶⁰ (That option was available for children beginning in 2024.) More reasonably, citizens could be grandparented into Medicaid—such that, once eligible, they remain so until they obtain Medicare or employer health insurance.

These changes would boost the share of patients covered by Medicaid. That provision would induce hospitals and doctors to lobby states to hike their Medicaid prices. States would resist and beg for federal rescue.

7. Assuring Medical security and Health care for all

One compromise might be a federal take-over of Medicaid accompanied by a claw-back of state dollars paid for the program in, say, 2025. This was a feature of the 2003 law creating Medicare Part D. The claw-back might be capped in 2025 nominal dollars, reducing its burden on states each year. Immediately, this approach would most benefit those states with low Medicaid spending. But over time, the high-spending states propel them to design effective ways to contain cost while protecting all citizens. Alternatively, this federal take-over with claw-back could be one element of a transition to all-payer coverage.

Ban narrow networks of caregivers for Medicaid, subsidized ACA plans, and private insurance

In almost all rich democracies, patients enjoy freedom of choice of doctors, hospitals, and other caregivers. Freedom of choice frightens insurers and managed care plans because it removes one of the few tools they believe they can wield to hold down their spending. But it would heighten continuity of medical care for patients. Whose interests are more important?

Moreover, narrow networks do little to hold down the cost of health care. Much more effective methods and techniques are available. These are discussed in chapters 8 and 9.

Slash total patient OOPs and require payers to fully cover facility fees

OOPs and facility fees are the most regressive way to raise money to pay caregivers. Their burdens on patients suppress use of care. Alone, these two reforms would boost access but would either cut caregivers' incomes or oblige payers to raise more money via taxes or premiums. They would therefore be difficult to implement alone but could be part of a thorough deal between payers and caregivers.

Lessons from the passage and implementation of the ACA

Why did the ACA pass? The ACA expanded coverage in 3 main ways. Its Medicaid expansions went beyond the traditional categorical coverage to protect all people below 138 percent of the federal poverty level (FPL).

Its subsidized individual mandate offered protection to working people whose employers didn't offer coverage or whose premiums were unaffordable, or to self-employed Americans. This sought to address job-lock—retaining a job for its health insurance coverage when a better job is available. And it aimed to liberate Americans to start their own businesses without losing health insurance.

Its extension of private health insurance to children up to age 26 was popular with those children, their parents, and potential employers.

Despite the value of these three expansions, debates about their cost and about the federal government's role in paying for health care coverage slowed Congressional action. Obama's ACA seemed to be dead in the water early in 2010.

7. Assuring Medical security and Health care for all

Accidents then played a prominent role in reviving the legislation. Some were wholesale and involved large-scale matters of policy and money. And then came two reports from California that frightened and infuriated a number of Americans.

One was a proposal by for-profit Anthem-California Blue Cross to raise yearly health insurance premiums by up to 39 percent. That request outraged many citizens after Obama publicized it widely. As it happened, the insurer made several serious mistakes in calculating its request—all of them supporting the high rise in revenue. A skilled actuary discredited these. Anthem withdrew its request and subsequently made a much smaller one.³⁴⁶¹ Rarely do events like this powerfully capture the public's imagination.

The other described outrageous insurance company rescissions of payment for seemingly necessary medical services. These were retroactive denials of payments for care patients had already received. The ACA would have barred such practices.³⁴⁶² The publicity and public outcry over high premiums and rescissions were judged by some, at that time, to help revive the ACA politically.³⁴⁶³

Why did the ACA lack effective cost controls? The law's formal title is the Patient Protection and Affordable Care Act. But its affordability refers to attempting to make insurance coverage more affordable for more people via federal subsidies, not to making health care for all Americans durably affordable for the nation.

That's because expanding coverage exhausted the available political oxygen. The ACA passed by very narrow margins in both houses of Congress. Had it contained effective cost controls, those caregivers or insurers whose costs (revenues) would be controlled would have worked against passage, killing the law.

Instead, the ACA contained fantasy cost controls.

Cadillac tax. One was the so-called Cadillac tax on high-premium insurance policies. This was a 40 percent tax on health insurance premiums exceeding \$29,000 yearly for family coverage. Scheduled to take effect in 2018, its premise was that high premiums were unjustified because they paid for excessively generous benefits. Writing in 2016, Furman and Fiedler believed they were designed "to target the least-efficient plans."³⁴⁶⁴ This stems from the mind-set that more solid financial coverage encourages morally hazardous over-use of health care.

Lemieux and Moutray argued that economists like Furman, Summers, and Mankiw "love" the Cadillac tax but no one else did.³⁴⁶⁵

Gable and colleagues had offered evidence in 2010 that health insurance benefit design—generosity—explained only 4 percent of premium variation. Medical costs in a region helped to explain premiums, they found, but most variation in premiums couldn't be explained.³⁴⁶⁶

Late in 2019, Congress repealed the Cadillac tax entirely, after having earlier postponed its implementation. Underlining the law's unpopularity, the House vote for repeal was 419 – 6.³⁴⁶⁷

ACOs. A second fantasy cost control was reliance on accountable care organizations (ACOs). The ACO was designed to mitigate the widespread public dislike of HMOs that locked Americans into one network of care controlled mainly by for-profit owners who stood to make more money when patients got less costly care. ACOs enrolled Medicare patients virtually—in

7. Assuring Medical security and Health care for all

line with the main source of their primary care. Patients did not know they were enrolled so faced no barriers to seeking care out-of-network. ACO owners (varying mixes of physicians, hospitals, insurers, and others) shared savings if their quality scores were sufficiently high. Savings were calculated by subtracting actual costs of care for ACOs' attributed members with hypothetically calculated budgets. And ACOs were at risk financially for a share of deficits.

Unfortunately, as discussed in chapter 1, ACOs saved little money—perhaps none, after accounting for governmental and ACO administrative costs and the financial gains distributed. Some ACO proponents argued that they could indeed save money if ACO patients faced financial penalties or administrative barriers to seeking care outside the ACO to which they were attributed (which they never agreed to join).

Care suppression in the ACA

The ACA featured considerable choice of plans, confusion, high OOPs, and denials of payment for in-network services. These worked in various ways to suppress use of care.

Complexity and confusion. The ACA's coverage provisions were so confusing that the federal web site for enrolling eligible Americans was dysfunctional for months. The same was true for many of the state exchanges or "marketplaces." This is surprising since federal and state governments had from April of 2010 until October of 2013 to figure out how to enroll people. A combination of complex ACA rules, inexperience, and weak management were probable causes.

Unlike traditional Medicare, ACA subsidized coverage was not one simple public program. Instead, private insurers marketed inconsistent plans with 4 levels of actuarial values. The ACA was designed to offer various levels of coverage, bronze, silver, gold, and platinum. These ranged from actuarial values of 60 to 90 percent. These choices were created to diffuse potential resentment toward the ACA's individual mandate to buy insurance coverage by allowing many people to choose low-premium plans—and even no-premium plans.

Unfortunately, the ACA required substantial OOPs from many patients. The 70 percent actuarial value of a silver plan is only an average across all people. It is the sum of health spending covered by insurance for all people in a plan, divided by the sum of all health spending by those people. Owing to high deductibles, co-insurance, and high yearly ceilings on total OOPs per family, the share covered rises as people reach their high annual out-of-pocket maximums.

But most people will pay substantially more than 30 percent out-of-pocket. Polyakova and colleagues modeled effects of silver plans on families not eligible for extra cost-sharing reductions. They found that family spending would have to have been \$19,500 for their plan to cover 70 percent of their medical costs. They concluded that "for the vast majority of enrollees, the proportion of expenditures covered by a plan would have been much lower than is actuarial value."³⁴⁶⁸ This is exacerbated by many insurers' high rates of denial of payment for in-network claims, as discussed in chapter 1.

Were patients in marketplace plans aware of these two problems, they would have grounds for resentment that their financial coverage was far less solid than promised. Insubstantial coverage stemmed from the ACA's lack of cost controls in combination with Obama's demand that its 10-year cost be held down.

7. Assuring Medical security and Health care for all

Also unlike traditional Medicare, ACA plans did not offer standard premiums or consistent coverage. Instead, each plan had to promise to assure the proper actuarial value but could have its own deductibles, co-insurance, and co-pay. It could also develop its own prior authorization rules and decisions about when to deny payment. Each plan had its own network of caregivers.

Starting in 2014, the federal government paid special “cost-sharing reduction” subsidies to insurers for people in silver plans whose incomes were between 1 and 2.5 times the federal poverty level (FPL). They reduced average deductibles from \$4,902 to \$87 for those with incomes of 1.0 to 1.5 times FPL, and to \$682 for those with incomes from 1.5 to 2.0 times FPL. This pertained to both plans with one single deductible and to plans with separate doctor/hospital and meds deductibles.

In 2016, these direct subsidies were ruled illegal in the absence of congressional appropriation. Trump acquiesced in that ruling in 2017. Instead, ACA insurers were allowed and obligated to raise premiums. The federal subsidies to ACA silver plans were raised because the ACA set the family share of premiums as percentage of income, not as a percentage of premiums.³⁴⁶⁹

Nonetheless, for lower-income ACA enrollees, the silver plans offered substantially greater overall value—more solid financial protection. But their premiums were higher than those for bronze plans. These higher premiums deterred some enrollees from choosing silver plans.

Added complexity derived from ACA provisions designed to exclude workers and families already covered by health insurance through an employer that the law deemed affordable.

Still more complexity stemmed from challenges in sustaining continuity of care when patients moved among Medicaid, subsidized ACA coverage, and coverage through an employer. Narrow networks of caregivers meant that patients often had to change doctors or hospitals when changing coverage.

All these complications and choices among 4 metal tiers and numerous insurance offers—with different networks of caregivers, different (and unpredictable) practices of prior authorization and retroactive denial of payment, and different profiles of premiums and OOPs—led many ACA enrollees to rely on brokers to choose a plan. But—as discussed in chapter 3—the brokers, paid by insurers, did not always have the enrollees’ best interests at heart.

Choosing among plans can be confusing. For example, an appreciable number of people who qualify for very-low-premium or no-premium silver plans with 94 percent actuarial value instead elect bronze plans that offer only 60 percent actuarial value. Evidence is clear that these citizens should be switched automatically to silver plans unless they actively choose to opt out of the silver plan. Providing information and reminders is far less effective in realizing placement in the best plan.³⁴⁷⁰

It is possible to greatly simplify choices. The ACA created a structure for states to test ways to improve access, the section 1332 waiver program. Most waivers, though, were used by states simply to shift some high-cost claims to a reinsurance pool. Colorado is an exception. Its waiver requires insurers selling individual and small-group insurance to offer standardized plans at the three lowest metal levels for ACA insurance. This simplifies patient shopping.³⁴⁷¹

7. Assuring Medical security and Health care for all

Narrow networks and denials of payment for in-network care. A number of ACA insurers created narrow networks of doctors and hospitals. They did so in order to pay those caregivers lower prices. The resulting networks were sometimes too small to provide speedy appointments. Long travel times to caregivers exacerbated access problems.

Rae and colleagues reported in 2024 that only two-fifths of physicians located near ACA enrollees were in the average network. A quarter or fewer of doctors were in plans enrolling 23 percent of ACA members.³⁴⁷²

As discussed in chapter 1, ACA plans denied almost one-fifth of claims for in-network care year after year.³⁴⁷³ In 2024, they denied 19 percent of in-network claims and 37 percent of out-of-network claims. Denials varied greatly across insurers and across states. These high rates made some in-network caregivers gun shy about serving those plans' enrollees.

Political pitfalls

Public opinion surveys reported that the share of Americans holding favorable opinions of the ACA varied over time. Americans viewed the ACA favorably shortly after passage, but moderately negative views prevailed for much of 2010 and 2011. Views turned much more sharply negative in 2014 as enrollment problems persisted. But the share of those favoring the law grew steadily from 2016 to 2025, peaking at two-thirds favorable near the end of 2025. That number fell somewhat as the expiration of the enhanced premium subsidies approached.³⁴⁷⁴

Definition. Shortly after the ACA passed in March-April 2010, Obama fell silent. A persuasive speaker, he declined to rally political support for the Democrats' accomplishments in crafting and passing the ACA. Covering children up to age 26 on parents' private health insurance, substantial Medicaid expansions, and subsidized coverage should have made the ACA popular.

But Obama's silence allowed the Republicans to define the law politically. They were anxious to do this, having united against the ACA. Not one Republican voted for the law in either house of Congress. (Republicans had opposed Social Security in 1935 and Medicare in 1965, but many ultimately voted to pass each once the laws' political popularity became clear.) Republicans decried the mandate to buy insurance. And they manufactured the claim that the ACA required "death panels" to deny care—when all the ACA did was authorize Medicare to pay for an optional patient visit scheduled to discuss the patient's own preferences for treatment.

This may have helped Republicans to victory in the 2010 mid-term election. Paradoxically, after their victory in passing the ACA, Democrats' defeat in 2010 was almost as great as it was in 1994, after the Clintons' failure to expand health care coverage. In 2010, Republicans gained 60 House seats, surpassing their gain of 52 in 1994. They gained slightly fewer Senate seats, though.

A lesson here is that a politically contentious health care reform law deserves strong and visible and enthusiastic support from its proponents.

That support is much easier to mobilize when a new reform law quickly confers visible and valuable benefits. Timing is vital.

7. Assuring Medical security and Health care for all

Simplicity. So is clarity. As discussed earlier, it is very difficult to choose among the dozens of subsidized ACA insurance options available in each region. One approach would be to standardize covered benefits and OOPs so Americans could shop by price. This would be even easier if all plans provided for patient freedom to choose doctors, hospitals, and other caregivers.

Biden ordered elimination of the family glitch that denied ACA subsidies that Obama had unreasonably created. That made eligibility simpler and fairer. It is an example of steps that might be taken incrementally to improve insurance coverage and financing.^{3475 3476}

Still, Biden allowed insurance brokers to replace state marketplaces, and also restored financing for groups helping individuals obtain insurance.³⁴⁷⁷ These are no substitutes for simplifying enrollment and ensuring continuity of care both financial coverage and access to trusted caregivers.

Timing. To hold down the Congressional Budget Office's rating of the apparent cost of the law to the federal government, the ACA's main provisions to expand access—broader Medicaid eligibility and subsidized insurance purchase—were deferred for 3.5 years after passage. This gave time for opponents to define the law by trumpeting real or imaginary problems well before most benefits took hold.

This mirrored the mistake of the 1988 Massachusetts law mandating that employers provide health insurance or pay a tax. Hospitals won immediate and substantial rate increases they had demanded in exchange for supporting the law while the employer mandate was deferred for 4 years. The hospitals promptly abandoned political support for the law.³⁴⁷⁸

Chapter 1 posited a deep crisis in U.S. health care resulting from international, economic, political, and social challenges outside health care in combination with deep dysfunction and perceived waste inside health care. That crisis was made manifest by a freeze in federal health care spending late in the 2020s.

The crisis will mean political opportunity for reforming health care. Responding to this opportunity will require stabilizing both financial coverage of Americans and the caregivers who deliver needed medical services.

These two immediate responses will require money. That will have to be quickly and efficiently harvested from dollars now wasted. Sources of that money will be discussed shortly.

Stabilizing coverage and caregivers must be done in ways that build political capital through successful action. Responses that fail or are perceived to have failed will dissipate that capital.

Subsequent responses will require deeper reforms to financially protect all Americans, contain cost, configure caregivers to deliver needed services, and upgrade appropriateness and quality of care.

Why wasn't the ACA repealed in 2017? How was it badly weakened subsequently?

Republicans began trying to repeal the ACA in 2011 when the House voted to do so. The Senate, with a small Democratic majority, refused to do so.³⁴⁷⁹ In 2017, Trump sought to simply

7. Assuring Medical security and Health care for all

repeal the ACA. Republican majorities in both House and Senate seemed to make this possible. They prevailed in the House. And yet, the Senate defeated repeal by narrow margins five times.^{3480 3481} On several occasions, change in one senator's vote would have repealed the law.

A 2023 retrospective analyzed reasons Republicans abandoned repeal. Growing shares of Americans were nervous about both private insurance and competition in health care, and sought government action to help cover people. Covid helped to shift public opinion in this direction. The share of citizens who viewed the ACA favorably rose from one-half to three-fifths to two-thirds.^{3482 3483}

Those conclusions were premature. When Trump returned to office in 2025, he chose four indirect attacks on the ACA's Medicaid and subsidized insurance coverage. They all succeeded. Two weakened Medicaid coverage. Trump's 2025 budget added a work requirement for Medicaid. Equally important, it reduced states' abilities to rely on special taxes on caregivers to match federal Medicaid dollars. By one estimate, these would cut federal support for state Medicaid programs by almost a quarter trillion dollars over a decade.³⁴⁸⁴ This was one element of the 2025 budget's estimated cut in Medicaid of almost a trillion dollars over a decade.

Two other attacks weakened ACA coverage. At Trump's behest, Congress refused to extend Biden's enhanced subsidies to buy ACA coverage, so they lapsed at the end of 2025. As discussed earlier, this led millions to drop health insurance coverage and other millions to shift into low-value bronze policies. Early in 2026, Trump announced his aim to push people covered by the ACA individual mandate to buy low-premium and low-value catastrophic insurance.

The last was a natural extension of efforts to shoehorn health care realities to fit free market theories via high OOPs and weakened insurance coverage, as discussed in chapter 4. The Democrats' embrace of the Cadillac Tax can be seen as their own agreement with the argument against good insurance coverage.

Trump's promotion of junk insurance is one aspect of this approach. The ACA had set tight limits on duration and renewals of short-term policies that violated coverage requirements of ACA plans. Trump eased those limits considerably in 2018. This made coverage available to more people—especially those who could not afford ACA plans' premiums. But these citizens got what they paid for—or less, if those short-term plans had flimsy benefits and low care shares (percent of premium paying for medical services).

Ding and Glied found that very few Americans signed up for short-term policies after Trump's liberalization.³⁴⁸⁵ So very few are likely to have lost them when Biden restored the ACA's initial rules.

In 2023, Biden moved to restore the ACA's tight limits on junk insurance.^{3486 3487} But Americans could still sign up for these plans for up to three years. Some experts have urged state action to prohibit sales of short-term plans during ACA open enrollments, prohibit rescissions of payment or retroactively deny coverage, and set higher standards for coverage—like mandated coverage of pre-existing conditions and of the ACA's 10 essential benefits.³⁴⁸⁸

Making solid health care coverage affordable for all Americans is the best and simplest way to make the short-term plans less attractive. The ACA's enhanced subsidies were a step in that direction. But restoring them may be financially and politically challenging.

7. Assuring Medical security and Health care for all

Motives for cutting federal financing of coverage. Five factors might mix to motivate coverage cuts.

First, Trump sought cuts in federal health care spending to help offset the costs of making permanent his 2017 federal income tax cuts.

Second, the Medicaid work requirement manifested a belief that health insurance was not a right but should be earned.

Third, flimsy coverage makes sense to people who think good coverage exposes patients to moral hazard.

Fourth is an economic worry that public dollars are or will be inadequate to finance business-as-usual in health care—combined with a political worry that safe and effective cost controls are unattainable.

Fifth is simple stunted empathy.

In 2026, many Democrats imagined that they would be able to restore Medicaid cuts and enhanced ACA subsidies once Trump leaves office in 2029. These would be elements of their hope to make health care more affordable for more Americans. They might be able to find the money to pay for these through higher taxes or higher federal debt.

For the reasons asserted in chapter 1, there's little reason for optimism that a return to more money to finance business-as-usual in U.S. health care will be durably affordable.

1 price

Instituting single prices for each type of care is one deep reform to promote equitable access.

As discussed in chapter 4, single prices are one result of a competitive free market. Many small buyers and sellers in a market interact to set price and quantity sold for each good or service.

In health care, single prices can only be attained through public action because nothing close to a competitive free market exists today or can be brought into being.

This is not a matter of theoretical interest. It is both practical and important.

If one price prevails for each service, caregivers have no reason to discriminate by payer in order to maximize revenue. And payer mix ceases to distort caregiver revenue or profitability.

Considerable evidence demonstrates that Medicaid pays the lowest prices for physician care in almost all states. Medicare pays higher prices to physicians. And private insurers pay the highest prices for both physician and hospital care.

Priselac, CEO of a large teaching hospital, has written that “Politically determined, administratively set government payment levels cannot be expected to match the cost of caring for government-funded patients.”³⁴⁸⁹

7. Assuring Medical security and Health care for all

But decades of Maryland's experience with all-payer rate setting and total cost of care budgeting have shown otherwise. Maryland must by law set all payers' payments to hospitals at a level sufficient to allow each needed and efficient hospitals sufficient revenue to deliver good patient care. And it has done so.

Raising money in fair ways that help contain cost.

Money to pay for U.S. health care is raised by very different methods. Some are visible and others are hidden. Some are progressive and others are regressive.

Fairness. Just over one-half of federal general revenues are generated by personal income taxation. (Social Security and Medicare Part A taxes generated an added one-third. Corporate income taxes, excise taxes, and tariffs accounted for the rest.)³⁴⁹⁰

The federal income tax is fairly progressive overall, applying higher tax rates to most forms of higher incomes. Federal general revenues finance the federal share of Medicaid and also the federal subsidies of Medicare Part B and Part D premiums. That share is three-quarters of premium for all but high-income people. Medicare Part A is financed by a 2.9 percent tax on all earned income. Interest, dividend, capital gain, rent, business, and other unearned income is excluded. That makes the Medicare Part A tax regressive.

Almost one-half of Americans paid no federal income taxes but most of those paid Medicare taxes. About one-quarter of Americans paid neither.³⁴⁹¹

One-quarter of tax-payers paid almost 90 percent of federal income taxes in 2022.³⁴⁹²

The overall fairness of state government taxation is much harder to measure because sources of state revenue are varied.

State governments' general revenue finances the great share of state Medicaid payments. Special taxes on caregivers supplement state general revenue. Trump's 2025 budget imposed lower ceilings on those special taxes. States raise money in very different ways. Many rely heavily on state income taxes while others depend on state sales taxes. Many use both. Alaska and New Hampshire have neither. State income taxes vary: some are proportional while others are progressive. State sales taxes are strongly regressive.

Almost all private health insurance is financed by fixed premiums per worker, married couple, or family with children. These are heavily regressive because the fixed dollar premium is a much larger share of a lower-income person's pay. Workers who earn less are less likely to accept health insurance coverage through the job. Workers of smaller employers generally face either higher premiums for typical coverage or lower premiums for less adequate coverage (often in the form of higher OOPs).

To modulate the inherent regressivity of fixed-premium financing of traditional health insurance, Vanderbilt University imposed an added premium on higher-earning employees.³⁴⁹³

In a somewhat similar vein, Congress imposed higher premiums for Medicare Part B and part D on higher-income people in the 2003 Medicare Modernization Act. The 2010 ACA increased those Income-related Monthly Adjustment Amounts (IRMAA) substantially. These can be

7. Assuring Medical security and Health care for all

viewed as a partial effort to make coverage more affordable for some by obliging others to pay more.

Proponents see IRMAA as promoting equity because it reduces the federal subsidy to Part B and Part D Medicare premiums from the 75 percent of total premium level that was uniform for all, regardless of income, before the 2003 MMA, to subsidies as low as 15 percent. Opponents worry that doing so will make Medicare less attractive to higher-income Americans, or that it might reduce the solidarity associated with the program. In most rich democracies, tax money is raised progressively but benefits like health care coverage tend to be uniform. IRMAA is imposed in large jumps as income rises, which makes it a highly progressive tax—and also highly visible tax.³⁴⁹⁴

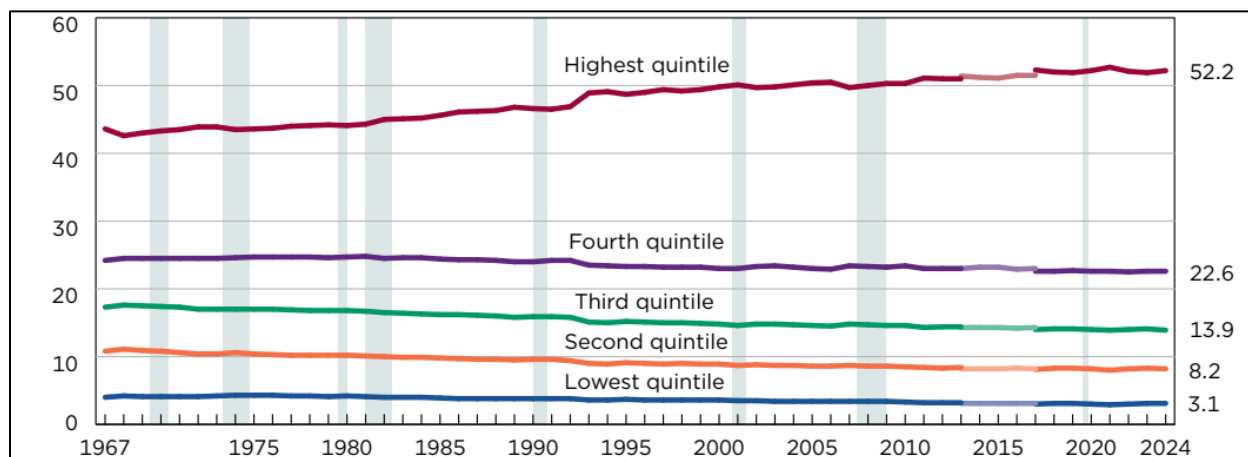
High and rising income inequality in the U.S. may make it harder to raise enough money to finance health care for all in fair ways.

Finding money to pay for health care

As discussed earlier in this chapter, U.S. income distributions are skewed. The top 20 percent of households garnered 52 percent of income in 2024, up from about 44 percent in 1967. The four lower quintiles all lost income share over these years. Figure 7 – 22 displays these data. By a different measure, the ratio of income at the 90th percentile to income at the 10th percentile rose from about 9.0 in 1967 to 12.6 in 2024.³⁴⁹⁵

The meanings of these data are clear. Only substantial income redistribution will finance health care for all Americans. Unless richer, younger, and healthier Americans pay for more health care than they use, poorer, older, and sicker Americans will not be able to afford to get the care they need. The costlier health care becomes, the more redistribution will be required, and the more politically challenging that may become.

Figure 7 – 22
Shares of U.S. Incomes by Quintile, 1967 – 2024



Source: Melissa Kollar and Zach Scherer, *Income in the United States: 2024*, Current Population Reports, figure 3, P60-286, September 2025, <https://www2.census.gov/library/publications/2025/demo/p60-286.pdf>.

7. Assuring Medical security and Health care for all

Visibility and source of pressure to contain health care costs. Greater visibility of the methods of raising money to pay for health care means greater pressure to restrain increases in cost. In most rich democracies, a larger share of the money to pay for health care is raised more visibly than in the U.S. That makes for stronger political pressure to contain cost of health care. Politicians who must raise taxes to finance more costly health care are more likely to lose elections. Workers who face a higher payment to industry sickness funds can see that take-home pay is reduced, euro-for-euro.

Federal income taxes are visible but almost one-half of Americans don't pay them. So the threat of higher federal income taxes exerts little pressure to contain cost. Moreover, in FY 2025, federal spending was about \$7.01 trillion but federal revenue was only about \$5.23 trillion. The resulting federal deficit was \$1.78 trillion. That was 5.9 percent of GDP—but it was a surprisingly high 25.4 percent of federal spending.³⁴⁹⁶

This means that federal spending has become unmoored from federal revenue, so higher health care spending (and other spending) hasn't required higher taxes.

So far. Chapter 1 posited that this can't and won't persist. If the dollar gradually loses status as the world's main reserve currency, foreigners will become less willing to park money in federal debt instruments. As the accumulated U.S. national debt rises as a share of GDP, and as interest payments rise as a share of federal spending, the Treasury will have to pay higher interest rates on new debt.

Suppose that, during a health care access and caregiver crisis, the federal government froze state Medicaid spending and also employers' payments for insurance through the job. Suppose, further, that the federal government enacted several new taxes. One would impose a 1 percent gross receipts tax on all employers—but existing but frozen employer payments for health care would be a non-refundable credit against the new tax. This would mean that only employers not providing health insurance would be subject to the tax. The tax would rise by 0.5 percent yearly until it equaled the average share of gross receipts that employers providing health insurance devoted to paying their frozen health care premiums.

Suppose that, similarly, a new federal personal income tax were introduced to finance all increases in nominal (not inflation-adjusted) health care spending. The tax would be reasonably progressive but all Americans would pay at least a small share of the tax. To offset a part of it, revenue from the Medicare 2.9 percent payroll tax would be frozen in nominal dollars.

The aim would be that all increases in nominal dollar health care spending would be financed by the new federal personal income tax. This would powerfully deter spending increases and would propel citizens, taxpayers, patients, and caregivers to focus on squeezing out waste in order to improve access to care and sustain needed caregivers.

Struggling to salvage business-as-usual for traditional insurance

Some writers propose ways that they believe will salvage or stabilize roles for traditional private health insurance to cover some Americans.

7. Assuring Medical security and Health care for all

Lower premiums for skimpier coverage. Trump has pushed various forms of skimpier coverage. As discussed early in chapter 1 and also earlier in this chapter, he has favored low-premium short-term insurance that fails to satisfy ACA requirements. By refusing to extend enhanced ACA subsidies, he has pushed many Americans out of silver plans and into low-premium and high-OOP bronze plans. At the same time, higher-than-expected shares of people dropping ACA coverage remained entirely uninsured.³⁴⁹⁷

Dublois noted Vermont's highest-in-the-nation premiums for silver plans and lauded efforts by Vermont's governor to lower premiums for ACA insurance by allowing some returns to experience rating by age and tobacco use.³⁴⁹⁸ He was correct that Vermont's ACA premiums are high—actually double the U.S. average.³⁴⁹⁹ But these plans, at their 2025 peaks, covered small shares of Vermonters (5.1 percent) and 7.2 percent of all Americans.³⁵⁰⁰ More meaningfully, Vermont commercial health insurance premiums for family coverage in 2023 were only 4 percent above the U.S. average and certainly in line with nearby northeastern states.³⁵⁰¹

Level-funded plans. Talento and colleagues believe that greater use of level-funded insurance plans could provide better choice and save money for small- and medium-size businesses. Level-funded plans are nominally self-insured so are exempted by ERISA from state regulation. They offer stop-less coverage, which caps employers' liability—or, at least, makes it more predictable.³⁵⁰²

Talento and colleagues seems to rest this approach, first, on a belief that private health insurance can usefully innovate to disrupt insider deals and undisclosed conflicts of interest between large insurers that administer most self-insured plans and the PBMs, stop-loss carriers, and navigation vendors with which they contract. And second, on employer flexibility in benefit design and in navigating workers to designated doctors or hospitals.

Corlette, though, points to dangers. The level-funded plans are exempt from state laws setting “reserve requirements, mandated benefits, premium taxes, as well as state and federal consumer protection regulations.” And they do not need to comply with ACA prohibitions against experience rating. So they could be attractive to employers with younger and healthier workers. She points to three risks associated with level-funded plans. ERISA makes the employer the plan fiduciary, liable also for breach of fiduciary duty by a claims administrator. Lower premiums for some employers could mean higher premiums for others, leading to an underwriting death-spiral for the latter. Some states have prohibited both sale of stop-loss coverage to firms below a certain size and also stop-loss coverage with “attachment points” so low that the employer is really buying something very close to a fully-insured (not self-insured) plan, but evading state insurance regulation.³⁵⁰³

Talento identifies herself as CEO of a firm advising employers. She seems strongly interested in promoting level-funded plans. She seems not to acknowledge or respond to the dangers in expanding level-funded plans and expanding self-funded insurance that Corlette pointed to in Congressional testimony about three months earlier. She seems to promise a free lunch of better and cheaper health insurance.

Adjusting benchmark ACO budgets for patients' medical and social needs. Adjustments in payments to Medicare accountable care organizations have aimed to boost equity of care of patients who have been under-served or are vulnerable to high costs of care. A new ACO

7. Assuring Medical security and Health care for all

option sets higher benchmark budgets for patients who are expected to be more costly for medical or social reasons. The ACO REACH program (Realizing Equity, Access, and Community Health), initiated in January 2023, obliged participating ACOs to state ways they would seek to improve equity of care and collect data on social drivers of health. Equity improvements were to be rewarded financially. And ACOs serving patients whose care would be predictably more costly—for medical or social reasons—would receive higher benchmark budgets.³⁵⁰⁴ REACH ACOs electing to be paid by capitation would receive higher monthly payments.³⁵⁰⁵

This is the Health Equity Benchmark Adjustment (HEBA). ACOs with more dual eligibles would receive higher benchmarks. Lower-income patients are predictably costlier. Greater social needs in a patient's region are measured by the Area Deprivation Index (ADI), a composite ranking of state- or nation-level data on income, education, housing quality, and employment. For 2023, the HEBA boosts benchmark budgets by \$30 per person monthly for patients in the predictably most costly decile. Patients in the five less costly deciles would see a cut of \$6 monthly in benchmark budgets.

These approaches may suggest ways to pay caregivers more fairly—to risk-adjust more accurately—than many current methods, such as those employed by MA plans to game Medicare's risk adjustments. But no approach will work if those controlling the data are motivated to cheat.

2. Single payer and all-payer paths to covering everyone equally and well

Responding to the access and caregiver crises

Chapter 1 asserted that by the mid-2020s it has been politically and financially impossible to find more money to pay for solid health care for all. The numbers of uninsured and under-insured Americans is rising again. Or to find the money to pay hospitals, doctors, drug makers, nursing home owners, and other caregivers enough to cover the ever-rising cost of business-as-usual.

The second half of the 2020s will see less care for fewer Americans at greater cost. At the bottom of the next deep recession, we will face the twin crises of widespread loss of coverage and wholesale caregiver bankruptcies.

Business-as-usual in U.S. health care is unaffordable. In different ways and to different degrees, both political parties recognize this. Biden allowed disenrollment of millions of Medicaid recipients in 2023-2024 because he did not want to fight with state governments. Trump and Republican Congressional majorities pushed through the 2025 budget's deep cut in federal Medicaid dollars. They allowed higher ACA subsidies to lapse at the end of 2025, and tolerated the consequent loss of ACA coverage for millions that followed. They push flimsier insurance coverage to paper over their unwillingness to win affordable coverage for all. Beguiled by free market fantasies, many Republicans cheer when coverage is stripped away or thinned out.³⁵⁰⁶

After the 2028 election, a hypothetical Democratic president and Congressional majorities will struggle to find the money to add back what Trump subtracted. They would have to boost taxes

7. Assuring Medical security and Health care for all

or borrowing or both. Recall that one-quarter of the FY2025 federal budget was financed with borrowed money. (While also finding money to redeem their many other electoral promises.) Restoring the pre-Trump status quo would be a hollow victory. And an expensive one.

It is more than possible that health care's incessant demands for more money for business-as-usual—combined with a deep recession, growing federal deficits, the dollar's weakening as the world's reserve currency, and resulting soaring interest payments—will prevent a new Congress and president from succeeding even in restoring the pre-Trump status quo in health care.

Sadly, such a restoration would do little to address the widespread suppression of access documented in this chapter.

It would do nothing to address the waste in U.S. health care documented in chapter 3.

It would do nothing to contain health care costs.

It would do nothing to increase the supply of primary caregivers, to sustain needed hospitals, to make meds more affordable, to remedy shortages of long-term care and mental health care, or to boost quality and appropriateness of care.

It would do nothing to organize and deliver effective, appropriate, and high-quality health care for all Americans.

It would do nothing to liberate the added dollars now sponged up by health care to address housing, job training, re-industrialization, personal/ neighborhood/national security, environmental problems, and all the other challenges our nation faces.

While restoration might delay the arrival of the health care crises at the bottom of the next deep recession, it will do nothing to mitigate their severity. Millions will lose coverage and dozens of millions will suffer deeper under-insurance that suppresses access. Many vital hospitals, doctors, dentists, nurses, nursing homes, and other caregivers will face unemployment or bankruptcy.

Those twin crises of access and caregiver bankruptcy will impel action to protect both patients and the caregivers.

Support for far-reaching reforms will grow as the crises of health care access and caregiver survival/availability become more severe. And as costs remain unaffordable.

Two main reforms will be available to address access, caregiver survival, and cost: single payer/Medicare for All or a European-style all-payer arrangement that merges the various streams of money to offer the same benefits to all Americans and the same rates of pay to all caregivers.³⁵⁰⁷

Chapter 1 described the origins of a Congressional freeze in federal health care spending. That freeze would threaten both patients' access to care and caregivers' bankruptcy. This crisis could be a political opportunity to reform health care. But crisis makes people fearful and impatient.

Realizing that opportunity will require presenting a credible way to quickly protect patients and caregivers with the constrained revenue available.

7. Assuring Medical security and Health care for all

Either single payer or all-payer could serve as a platform that promises both care for all Americans and quick stabilization of needed caregivers. But either platform, by itself, would be too weak to match its promises. To be judged credible, either would need to do 2 things.

First, since revenue to pay for health care would be capped—and also, by past standards, considered inadequate—reform would be judged credible only if it offered ways to speedily mobilize specific, identifiable savings won by cutting clinical waste, administrative waste, high prices, and theft.

Second, credibility would rest on presenting evidence that the proposed reforms would work. This short-term stabilization would identify ways to squeeze out and recycle waste to protect both patients and caregivers during the crisis sparked by the federal health spending freeze. That would require both advance drafting of required legislation and advance testing of financing and care delivery mechanisms to cover patients and sustain caregivers. If successful, that short-term victory would build political support for durable reform.

Those deeper, complementary reforms will be essential to make high-quality health care for all Americans affordable for decades to come.

Single payer or all-payer?

I suspect that, on balance, all-payer approaches will be more likely to succeed. What constitutes success? Enabling legislation, support from voters and caregivers, successful relief of patients and caregivers early in the crisis, and success in squeezing out health care fat and recycling it as clinical bone and muscle. This preference for all-payer rests on six assessments.

First, single payer reforms would require expending enormous amounts of political and logistical energy in passing new taxes to replace some \$2.1 trillion in private insurance and OOP revenue now (in 2026) financing about one-third of U.S. health care.

All-payer reforms focus mainly on changing how health care dollars are spent, while single payer reforms initially focus mainly on how the money is raised.

Second, the large and necessarily ponderous financing reforms necessary to establish a single payer are not well-suited to address the first phase of reform—immediate relief for patients losing coverage and care, and for caregivers facing bankruptcy and service disruption.

Third, all-payer reforms will offer a measure of comfort in perilous times by retaining familiar forms of coverage. Medicare, Medicaid, and private insurance will persist on the surface while their revenue streams are channeled into a single reservoir and while benefits and covered services are merged and upgraded. OOPs will shrink.

Fourth, while all-payer reforms have to devote energy to maintaining private insurance payments and diverting them into a merged financial reservoir, this should be much easier politically than winning single payer's \$2.1 trillion in new taxes.

7. Assuring Medical security and Health care for all

All-payer plans should cap and freeze private insurance premiums per worker or per employer as of the year Congress freezes federal health spending. So this will provide immediate—and growing—financial relief to most employers and workers. If added revenue is found to be required to finance reform, it would come from a new tax on employers not providing health insurance. The tax might begin at 1 percent of earned income. Employers' and employees' frozen (grandparented) private insurance premiums would count as non-refundable credits against the new tax—so they'd be effectively exempt from the new tax.

Fifth, while single payer relies on administrative savings and lower drug prices to help finance health care for all, it does less to address clinical waste and theft. The thrust of single payer is toward administrative waste.

All-payer reforms could not succeed without also addressing clinical waste and theft. To do so, they must pay caregivers in financially neutral ways that help to make health care self-regulating. The only reason to give care is that it's needed and effective. The only reasons to deny care are that it is not needed, effective, or worth the money—such that giving this care would preclude giving more valuable or better care to that patient or another patient.

Sixth, I think that neither single payer nor all-payer is **the** remedy. Rather, either is a foundation—a platform—on which to build solid coverage for all Americans solidly, cost containment, the right configurations of caregivers, paying caregivers in financially neutral ways, and liberating waste. Overall, all-payer reforms would probably be a more solid platform.

More details on reasons to prefer all-payer financing are presented shortly. Of course, I might be wrong. Single payer advocates have strong arguments.

5 Ways to build broader and deeper care on single payer or all-payer platforms

It is short-sighted to view either single payer or all-payer as more than a platform. Either will be necessary to cover all Americans affordably. But neither, alone, will suffice to win durable medical security for all. Or to survive their critics and prevail politically.

Five interdependent elements will need to rest on the platform.

First is to assure all Americans financial access to health care. Single payer or all-payer platforms can support plumbing that could pipe and distribute money to back financial access. But neither, alone, assures us that enough money will flow.

Still, a strong commitment to financing medical security is essential to assembling the other elements of reform. One reason is that no nation has been willing and able to contain cost without covering all citizens well. Or to contain cost without covering everyone well.

Another reason is covering everyone well is essential to sustain or build needed caregiving capacity. Appropriate caregiving capacity, in turn, is essential to realizing the care promised by assuring full financing of needed health care for all. And to containing cost in ways that are both medically sound and politically sound.

Some of us are uninsured and our numbers are growing. Many more of us are under-insured. Both stem from high costs for those who now obtain care, coupled with political unwillingness to protect all people. Mechanisms that suppress access include high premiums, high OOPs,

7. Assuring Medical security and Health care for all

uncovered services, narrow networks, unavailable caregivers, administrative barriers like prior authorization and retroactive payment denial, and the like.

Second is capping spending while financing care for all. The crisis will cap spending. But how to care for everyone with capped revenue? Squeezing out waste becomes the only way to balance the books—to cover all of us well, with the finite but vast dollars still available.

Reform will come in 2 phases. Phase 1 is rescue. Here, a minimum of \$250 billion will be needed quickly to stabilize both financial coverage for Americans and caregivers' finances. This quarter-trillion dollars must be drawn from current health care spending—from the low-hanging fruit of the tree of waste. Low-hanging fruit has 3 characteristics. It is ripe with unambiguous waste. Taking and moving it will therefore face much political support and little political criticism. And it can be excised quickly and efficiently—the money can be captured without loss and then put to good purposes.

Phase 2 is reform. Here, costs are controlled durably. Money is raised in fair and efficient ways. All people are covered solidly and fairly. Costs are contained. Sufficient caregivers are trained and deliver care where needed. They are paid by financially neutral methods.

A high share of the dollars formerly wasted on low-value/high cost clinical services, on futile or destructive administrative practices, on high-priced drugs and people, and on theft now finance health care for all and sustain all needed caregivers.

Third is to identify, stabilize, and obtain the right numbers and types of caregivers in the right places. This means several things. One is training more doctors, dentists, nurses, and other professionals. The U.S. is near the bottom in physicians per thousand citizens, and also in training new doctors. We have only about one-half the dentists we need.

Another is enticing a higher share of physicians to work in primary care. As discussed in chapter 11, sufficient primary care is the critical path to affordable health care for all—to containing cost, assuring access, and promoting appropriate and high-quality care for all. The critical path is the aspect of reform that takes the longest time to complete. This makes it essential to make rapid progress immediately. To accomplish that while securing enough procedure-performing physicians and other specialists will require substantial increases in the numbers of seats in medical and osteopathic schools, as also discussed in chapter 11.

Well-configured hospitals are as important as well-configured doctors. That means having the right numbers and kinds of both caregivers offering the right services in the right places. Physicians and hospitals are not alternatives; they are symbiotic. Many hospitals close when they lack physicians to admit patients and give care. Many physicians retire or relocate when the hospital that supports their patients goes out of business.

It's vital to learn which hospitals, with what services and inpatient and emergency room capacities, are needed in various locations. And also, how much revenue each needed hospital requires to efficiently deliver needed acute care.

A final area is addressing need for dental care, long-term care, mental health services, and the institutional and human caregivers required to deliver those services.

7. Assuring Medical security and Health care for all

Fourth is to deploy finite revenue to needed caregivers in ways that respect care for all. These methods, discussed in chapter 9, must be financially neutral. Without either a competitive free market or competent government action in health care, U.S. health care has long suffered financial and clinical anarchy. Relying on doctors' financially neutral professionalism and non-profit hospitals' and other caregiving organizations' fiduciary duty is the only path out of anarchy. Financially neutral payments mean that doctors' incomes don't depend on giving more or less care. And that hospitals and other institutional caregivers have budgets they must expend each year. Hospitals' trustees and CEOs much work with doctors to ensure that finite hospital budgets are marshaled to finance as much high-value care to patients as possible.

Fifth is to recognize that payment methods alone are insufficient. It's essential also to organize and deliver care for all Americans in trustworthy and affordable ways. The key is that caregivers act as fiduciaries.

This rests heavily on building durable and trusting relationships between primary care doctors and patients. Patient who trust their doctor are much more likely to accept provisions for squeezing out clinical waste—particularly no-value or high-cost/low-value care. These relationships also help to immunize patients against medical myths and misinformation.³⁵⁰⁸

Doctors' patient-by-patient decisions about diagnosis and treatment spend almost 90 cents on each health care dollar. Paying doctors by financially neutral methods liberates them to act professionally to balance the books in health care—to do as much clinical good as possible for all people with the finite dollars available.

Trustworthy and affordable care also rests on buying out for-profit caregivers and payers. As discussed in chapter 4, a competitive free market's drive for profit makes for efficiency, cost-cutting, innovation, and producing what sovereign consumers want. Failure of health care to satisfy any of the 7 requirements for a competitive free market means that profit-seeking doesn't engender these good things. So health care profits are not legitimate. Nor are profit-seeking businesses.

Instead, organized caregivers and payers must act as fiduciaries—holding in trust the dollars they control—to do as much clinical good as possible. This means a finite budget for each organized caregiver. If each is operated not-for-profit, each must be governed by trustees who are dedicated to efficiently delivering effective care equitably. Where will knowledgeable and dedicated trustees be found? Each hospital, nursing home, and other caregiving organization must be run day-to-day by managers who are similarly dedicated.

Sound organization and efficient delivery of effective and equitable care rest, in part, on integration across primary care, specialist physician care, emergency care, diagnostic labs and imaging, inpatient acute care, long-term care, mental health care, and pharmaceuticals. Various nations have sought to organize and deliver care in very different ways. Chapter 10 discusses choices for reforming organization and delivery of health care in the U.S.

7. Assuring Medical security and Health care for all

Building trust is central to creating and sustaining reforms to cover all of us

One view. Dzau and colleagues have written about trust in science, medicine, and public health.³⁵⁰⁹ Citing National Academy of Medicine work, they identify 5 arenas for trust: community trust, trust in science, trust in information, trust in technology, and trust in health care. They list 6 sources of greater trust: representation and voice, high-quality information, respect and inclusion, ethical safeguards, institutional accountability, and workforce well-being. And 6 sources of mistrust: historical harm and structural inequity, infodemics and unreliable information, stigma and social judgment, fast pace of innovation, “ivory tower” and opaque institutions, and workforce conditions and moral injury.

A different view. This is all very intelligent. But how much of it is relevant to building individual patients’ trust in their own health care? Will patients trust decisions by doctors and other caregivers regarding whether and how to diagnose and treat various medical problems?

I think that trust is mainly personal—that it rests mainly on relationships between humans. In health care, having a durable relation with a knowledgeable, sympathetic, competent, and trustworthy primary caregiver is essential. So are strong relations with important specialist physicians and also dentists.

I believe that good primary care is the single strongest foundation of trust in health care. It entails first contact care to offer a ready route to access to needed services, coordinated care that helps a patient navigate complexities of health care, continuity of care over time, and comprehensive care. Good primary care is the human source of reliable information about diagnosis and treatment.

Good primary care is the sun that exerts the gravitational pull that holds together the planets of a solar system. Integration of health services can’t rely on an EHR alone.

Trust also depends on the patient’s care from institutions and the people who work for them—in hospitals, nursing homes, home health agencies, and other organized caregivers.

Also important is confidence that the sources of unfairness are extirpated. Gone. Those include rationing by ability to pay, by race/ethnicity/gender, by geography and caregiver availability, and by other invidious criteria.

Building trust in health care’s fairness rests in part on solid financing of each patient’s care. This means no more than nominal OOPs. And it requires ready access to the right caregivers. That depends on appropriate caregiver configuration. And also on removing administrative barriers to care like prior authorization of care by a payer.

In the background, it means that a patient is confident that their doctor, dentist, other professional caregiver, hospital, or other institutional caregiver is not financially motivated to give unneeded care or without needed care. Each is financially neutral.

All this means a solid foundation for trust in health care’s equity, effectiveness, and efficiency. Inevitably scarce health care money and caregiver time are being marshaled as well as possible. No powerful financial incentives are pushing excessive care for some patients, withholding effective care from other patients, or bestowing unjustifiable and unjust profits on a few businesses.

7. Assuring Medical security and Health care for all

Clinical and financial anarchy no longer prevail because health care is governed by an alternative to market failure and government ineptitude. Health care has substituted financial coverage for all, capped spending, built appropriate caregiver configuration, crafted financially neutral methods of payment, re-organized care, and liberated fiduciary duty to marshal vast but finite dollars to do as much clinical good as possible.

Single payer/Medicare for All

Single payer reforms could serve as the platform for assuring that all Americans have solid financial protections against health care costs. They could dismantle the financial and non-financial forces that suppress access. The crisis will freeze federal dollars; the single payer plan could continue to cap spending to contain costs to make care affordable for all. Squeezing out waste becomes the only way to balance the books—to cover all of us well, with the finite but vast dollars still available. Single payer could help to sustain or build the caregiving capacity that is essential to realizing the care promise extended by assuring full financing.

All people would be financially protected. Costs would be controlled; that would be done mainly by capping revenues. Administrative costs would plummet—largely because doctors and hospitals would cease to be paid mainly for patient visits, procedures, or admissions. Doctors would be paid mainly by salary or capitation; some fee-for-service payment would probably persist. Hospitals would have fixed yearly budgets. Prices paid to drug makers would be cut.

Single payer advocates urge one national tax-financed method of covering all Americans. Private health insurance would be eliminated, at least for service covered by the single payer, and out of pocket costs would be slashed to nominal levels. Typically, hospitals would remain under current owners. Some proposals would eliminate for-profit ownership of hospitals and other institutional caregivers.

This would offer simplicity of coverage and equity of financing. It would create, in effect, one national risk pool.³⁵¹⁰ Experience rating of premiums by health or age would cease entirely.

Liu and colleagues found, unsurprisingly, that single payer markedly increased progressivity of financing. (By contrast, rate setting only slightly boosted higher-income families' payments to finance Medicare and Medicaid. And spending targets barely slowed growth in health costs shouldered by all income groups.)³⁵¹¹

Single payer would also substantially boost federal income and other taxes. In past years, the appearance of this toxic fiscal shock has generated considerable political resistance.

Oberlander's 2016 assessment of single payer's "virtues and vices" concluded that opposition by many caregivers, by all private insurance companies, by those who mistrust government competence or oppose higher taxes would preclude Congressional enactment.³⁵¹²

Mai-Duc's report on single payer's place in the 2026 race for governor of California captured this. She described the salience of the issue and the decision of many gubernatorial candidates to support single payer. But she also identified obstacles to passing and implementing it.³⁵¹³

7. Assuring Medical security and Health care for all

Those persist. Only a crisis will lower the barriers enough to allow passage.

That will be difficult. As will be seen shortly, Sanders's Medicare for All bill would phase in coverage gradually. It is not, therefore, well-suited to respond to crisis of families' loss of insurance coverage and caregivers' high risk of bankruptcy.

Evidence supporting single payer

Almost all studies of single payer have concluded that it would, if enacted and implemented, save money, cover all Americans, and improve health outcomes. Savings could be returned to all of us who now pay for care or used to expand covered benefits.

This might be thought in part to reflect the sympathies of most of those who study single payer. But the politically neutral Congressional Budget Office's findings offer reassurance. So does the near unanimity of the findings.

Some studies looked at the nation and others at individual states.

In 2026, Pandey and colleagues asserted that single payer would save over \$1 trillion and over 100,000 lives yearly in the U.S.³⁵¹⁴

A 2020 CBO analysis projected that single payer would cover essentially all Americans and would probably also cut total health care spending.³⁵¹⁵

Also in 2020, Cai and colleagues reviewed 22 single payer plans evaluated over 3 decades. They found that 19 expected median savings of 3.5 percent in the first year. All expected long-term savings. Size of savings depended most on cuts in administrative costs; reduced prices of meds also contributed to savings. The size of expected increases in use, resulting from better coverage, affected savings.³⁵¹⁶

A number of investigators assessed state implementation of single payer.

In 2026, Cote-L'Heureux and Friedman examined effects of single payer for Massachusetts. They expected savings of 42 percent from cuts in administration, drug prices, and theft. About one-half of the savings would be used to improve coverage and benefits, leaving net savings of one-fifth of yearly spending.³⁵¹⁷ A 2000 report on a single payer plan for Massachusetts by Brand and colleagues came to generally similar conclusions.³⁵¹⁸

In 2018, Liu and colleagues performed a detailed assessment of a single payer plan for New York State. They found greatly expanded coverage and initially small savings that grew over time.³⁵¹⁹

Hsaio and others prepared a report for the state of Vermont in 2011, one that helped lead to passage of the state's single payer legislation. Hsaio and colleagues expected single payer would cut health care spending in the state by 25 percent after full implementation. Hsaio was no novice or theoretician, having led the effort to design and implement Taiwan's successful transition to single payer care in 1995.³⁵²⁰ Two other studies forecasted savings of about 1.5 percent over 3 to 5 years.

7. Assuring Medical security and Health care for all

Why has the evidence been persuasive?

Given the strength and consistency of these findings, why don't we have single payer today?

One reason is that many Americans are reasonably happy with their health care.

A **second** is political opposition from health insurance companies that would lose the overwhelming share of their revenue and reason to exist, and from doctors, hospitals, and other caregivers that fear both loss of revenue and uncertainty.^{3521 3522}

A **third** is the stark opposition to raising taxes—by some \$2.1 trillion in the money of 2026.

A **fourth** is that political support for broad and deep health care reform in the U.S. would be greatest during a deep economic recession and the possible resulting health care financing crisis stemming from a freeze on federal health care spending. But that would be the worst time to raise taxes by \$2.1 trillion.

A **fifth** is the asymmetry of pain and gain. Many would win but their hopes of doing better under single payer are speculative and—usually—unknown. Many fear they would lose and their fears of doing worse under single payer are concrete and deep.

A **sixth** is that the early years of single payer reform would probably have to be devoted with enacting the tax increases to replace private insurance through the job. And also replace the OOPs that make care unaffordable for many Americans. It is hard to see how coverage would improve during those years. We'd see political fights but not better access

A **seventh**, related to the sixth, is that single payer is not currently designed to respond to patient access and caregiver bankruptcy crises. This book posits that reform will need to come in 2 phases. Phase 1 is rescue. Here, a minimum of \$250 billion will be needed quickly to stabilize both financial coverage for Americans and caregivers' finances. Therefore, this quarter-trillion dollars must be drawn from current health care spending—from the low-hanging fruit of the tree of waste.

An **eighth** concerns the reasons single payer was enacted in the U.K. and Canada—and the challenges in adapting the single payer response to probable future U.S. realities. The U.K. enacted the single payer National Health Service for 2 reasons. It had promised, early in the Second World War, to assure universal coverage. And traditional financing for health care was simply inadequate. The NHS provided public funds when no other sources were sufficient. The NHS meant increased revenue for health care.

Similarly, Canadian single payer originated in Saskatchewan just after the Second World War because Blue Cross-style private insurance was inadequate to finance hospital care. Single payer, again, meant not only public money for health care—it meant more money in total.

Enacting single payer to save money is very different from enacting single payer to add money.

7. Assuring Medical security and Health care for all

All this means that U.S. single payer proposals and legislation do not appear to anticipate the possible or probable source of political pressure for reform: the coverage and caregiver financial crises described in chapter 1. So they don't yet call for assembling substantial emergency financing by squeezing currently wasted dollars.

Single payer contemplates what this chapter calls phase 2 of reform. It builds on the success of phase 1's relief.

In phase 2, costs are controlled durably. Administrative waste is cut because money is raised in fair and efficient ways and because caregivers are paid by simple methods. All people are covered solidly and fairly. Costs are contained.

Sufficient caregivers are trained and deliver care where needed. They are paid by financially neutral methods. This entails deploying finite revenue to needed caregivers in financially neutral ways that respect care for all. Relying on doctors' financially neutral professionalism and non-profit hospitals' and other caregiving organizations' fiduciary duty is the only path out of anarchy.

Payment methods alone are insufficient. It's essential also to organize and deliver care for all Americans in trustworthy and affordable ways. This rests heavily on building durable and trusting relationships between primary care doctors and patients. Patient who trust their doctor are much more likely to accept provisions for squeezing out clinical waste—particularly no-value or high-cost/low-value care. These relationships also help to immunize patients against medical myths and misinformation.³⁵²³

Sanders's Medicare for All ³⁵²⁴

All Americans would be covered equally. Coverage would be married to cost control. Both would be phased in over several years.

This outline summary is drawn from the "Medicare for All Act," S. 1506, 119th Congress, introduced 29 April 2025.

a. Eligibility

- ✓ All residents will be covered through automatic enrollment.
- ✓ Americans become eligible during a 4-year phase in, with those over 65 or under 18 eligible in the first year, followed by those under 55 in the second year, and so on.

b. Protecting and expanding financial coverage

- ✓ During a 4-year transition, patient exposure to OOPs is gradually reduced.
- ✓ After 4 years, patients face no OOPs except for certain drugs, subject to a cap of \$200 yearly, and with people under 2.5 times the FPL subject to no OOPs.
- ✓ Similarly, balance billing is prohibited.
- ✓ Private health insurance may cover only services that supplement (not duplicate) coverage under this law.
- ✓ Medical underwriting is outlawed for any residual Medicare supplement policies.
- ✓ Patients have complete freedom of choice of caregivers; narrow networks are prohibited.
- ✓ A separate office of health equity would seek to coordinate all DHHS programs to help vulnerable patients.

7. Assuring Medical security and Health care for all

c. Covered services

- ✓ All services that are medically necessary or appropriate to maintain health or to diagnose, treat, and stabilize a health problem.
- ✓ These include hospital services, prescription drugs, primary care and other physician services, in-home and community LTC, mental health, dental, vision care, rehab, and emergency services—including transportation.
- ✓ Medicaid would continue to pay for nursing home care and similar institutional care, and would be obliged to maintain at least 2024 levels of spending, updated yearly for inflation.

d. Caregiver configuration

- ✓ An office of primary care is created under the office of health equity. It would coordinate resources and make recommendations.
- ✓ Generally, the Medicare for All bill ignores assessments of which hospitals, doctors, and other caregivers are needed, revenue they require to efficiently deliver needed care, methods of payment, and related matters.

e. Sources of revenue

A Medicare for All trust fund is created. It receives

- ✓ federal money now spent on Medicare, less premium payments for parts B and D.
- ✓ federal money is now spent on the federal employees' health benefit program.
- ✓ federal money now spent on Medicaid, less costs of nursing home and similar institutional care (since that care remains under a residual federal – state Medicaid program).
- ✓ Although most single-payer plans have required states to pay their former shares of most Medicaid costs into the single trust fund, such a clawback arrangement does not appear to be included the 2025 Sanders bill
- ✓ Medicare for All would cover health costs previously borne by state workers' comp programs; those programs will reimburse the Medicare for All trust fund for such costs paid by Medicare for All.
- ✓ After the first year, these sums would rise by the CPI for all urban consumers, less savings associated with efficiencies won by Medicare for All, adjusted by factors "determined to be appropriate by the Secretary."
- ✓ New revenue under sections 801 and 902 of the 2025 bill, but these are not clearly specified.

In 2019, as Sanders prepared to run for president, he introduced a Medicare for All bill and, separately, identified possible sources of revenue that would be raised over a decade to replace private insurance and OOP payments that would be ended. The sources presented here translate the decade of expected revenue into yearly figures to make them more imageable. It is not clear that these revenue sources would be sufficient to do that. Possible replacement revenue sources per year included ³⁵²⁵

- ✓ A payroll tax, paid by employers, of 7.5 percent. Small firms would be buffered by exempting the first \$2 million of payroll from the tax. Predicted to raise **\$390 billion yearly**.
- ✓ A 4 percent addition to personal income tax rates. Predicted to raise **\$350 billion**.
- ✓ Savings by ending exemption of employer-paid premiums from taxes on business profits. Predicted to raise **\$420 billion**.

7. Assuring Medical security and Health care for all

- ✓ Raise more tax revenue from higher-income Americans by raising marginal income tax rates; taxing capital gains as ordinary income; and restricting tax deductions for higher-income people. Predicted to raise **\$180 billion**.
- ✓ Make the estate tax more progressive. Predicted to raise **\$25 billion**.
- ✓ Impose a wealth tax on the top 0.1 percent of Americans, those with net worth exceeding \$21 million. Predicted to raise **\$130 billion**.
- ✓ Capture payroll tax income from owners of S-corporations. Predicted to raise **\$25 billion**.
- ✓ Impose one-time tax on business profits held offshore. Predicted to raise **\$77 billion**.
- ✓ Impose a 0.07 percent tax on liabilities of large banks. Predicted to raise **\$12 billion**.
- ✓ Repeal LIFO inventory accounting. Predicted to raise **\$11 billion**.

These 10 items sum to about \$1,620 billion yearly.

To this replacement revenue should be added expected savings associated with single payer financing. Sanders supposed that his single payer plan would save up to \$500 billion yearly in administrative costs.

He also expected that drug price negotiations would save \$130 billion yearly.

These 2 cuts in existing waste sum to \$630 billion yearly.

Together, the expected yearly added revenue and cuts in cost yield a grand total of \$2,250 billion (\$2.25 trillion) in yearly replacement revenue and averted costs.

Unfortunately, Sanders's 2019 revenue estimates for a decade did not overtly specify whether any adjustment was made for inflation or to increases in the underlying income streams and wealth subject to taxation. Since he expressed added revenue over a decade, it may be reasonable to assume that yearly rises in the sums subject to the various assessments were indeed taken into account.

Shortly, the \$2.25 trillion figure will be matched against revenue lost by ending private insurance, by virtually eliminating OOPs, and other provisions.

f. Methods of cost control

- ✓ Institutional caregivers are prohibited from establishing financial incentives or disincentives for doctors or other professionals. Fraud and abuse protections now applying to state Medicaid programs would be applied to all Medicare for All services.
- ✓ The Secretary of DHHS will “establish” a yearly national health budget for Medicare for All. It will include separate budgets for operations, capital, special projects, quality assessment, health professional education, administration (including operating the regional offices), reserves, and prevention/public health.
- ✓ Institutional and professional caregivers would be paid from the operating budget. It must be sufficient to allow “for every participating provider in the Medicare for All Program to meet the needs of their respective patient populations.”
- ✓ Within regions, each institutional caregiver would receive a quarterly fixed global budget to pay for all care for patients under Medicare for All.
- ✓ The other budgets must also be adequate to pay for relevant functions.
- ✓ Capital budgets would pay for construction, rehab, and major equipment.
- ✓ Special projects budgets would finance construction, staffing, and major equipment in rural or other underserved areas—all to address health disparities.
- ✓ Reserving budgets would finance care during rare epidemics, disasters, and large shifts in patient volumes.

7. Assuring Medical security and Health care for all

g. Methods of paying hospitals

- ✓ Only participating caregivers can be paid.
- ✓ The Secretary will establish regional offices to administer the program.
- ✓ Regional directors submit yearly assessments of needs in their region; they recommend changes in paying caregivers.
- ✓ Hospitals and other institutional caregivers would receive quarterly fixed global budgets to pay for all care of patients covered by Medicare for All.
- ✓ Budgets would be negotiated between hospitals and regional directors.
- ✓ Negotiations would have to take into account a hospital's
 - recent volumes of various types of care,
 - actual spending for each type of care,
 - comparisons of actual spending with those of other hospitals in the region,
 - expected changes in volumes and types of care to be given,
 - workers' wages,
 - numbers of RNs needed to assure safe staffing ratios,
 - optimal staffing levels for doctors and other caregivers,
 - increased access to physicians,
 - efforts to decrease health care disparities,
 - increased numbers of high-cost patients,
 - innovative programs,
 - location in a vulnerable or high-minority area, or
 - other factors deemed appropriate by the secretary.
- ✓ Moreover, hospitals could appeal for higher budgets to cover costs of natural disasters, epidemics, unexpected major repairs or purchases, large and unexpected increases in drug or device prices, unanticipated increases in the number of high-cost patients treated, or increases in labor costs.
- ✓ These complex elements may seem reasonable, but they invite both complex and lengthy negotiations, and also gaming.
- ✓ Further, the negotiated budget should consider how much a hospital would be expected to be paid under Medicare's decades-old prospective payment methods for inpatient care, ambulatory services, and other services.

It is not clear whether negotiating these budgets would be mainly top-down or bottom-up. That is, would they be imposed by the new single payer entity's regional representatives or would they be sums requested by hospitals?

How would fair payment methods be established? This is hard today since vital objective evidence is lacking: Which of the nation's 5,000 hospitals are needed to deliver various types and volumes of needed medical services? What is the valid cost of efficient delivery of needed hospital care? How would hospital-adjacent services like ambulatory surgical centers be paid?

h. Methods of paying doctors

- ✓ When doctors working at hospitals are paid by salary, the sums to pay those salaries would be included in the hospitals' global budgets.
- ✓ Solo doctors and those in group practices not paid salaries would be covered by a national fee schedule.
- ✓ The Secretary would establish that fee schedule in light of
 - Fees paid currently to doctors by Medicare's RBRVS
 - Caregivers' expertise

7. Assuring Medical security and Health care for all

- Value of services
- New analyses of the relative values of doctors' services
- Regional physician practice review boards would assure fair reimbursements to doctors

i. Paying for meds and devices

- ✓ The Secretary will negotiate prices for meds and devices yearly
- ✓ The Secretary will create a prescription drug formulary to encourage best practices and discourage use of excessively costly meds when better meds are available
- ✓ The formulary will promote use of generics

j. Paying for capital

- ✓ Caregivers apply to regional directors to obtain capital grants from the Secretary.
- ✓ Priority goes to projects to address capacity to care for people vulnerable to deprivation of needed services.
- ✓ Operating budgets can't be used to finance capital projects without permission of the regional director.
- ✓ Money designated to finance capital projects may not be used to finance operating costs.
- ✓ Special projects grants could pay for capital at hospitals or doctor groups that add capacity to serve vulnerable patients.

k. Protections for quality and appropriateness

- ✓ If a practice guideline is approved by the Secretary, services are covered if they are in accord with such guideline.
- ✓ Regional directors establish quality assurance mechanisms to cut both under- and over-use of care.

l. Implementation and administration

- ✓ Full implementation and enrollment of all Americans would take 4 years.
- ✓ Enrollment of under-18-year-olds and those already eligible for Medicare begins 1 year after passage.

m. Special provisions

- ✓ VA, Tricare, and IHS programs would remain intact.
- ✓ A beneficiary ombuds would receive complaints and grievances.
- ✓ For 5 years, at least 1 percent of total spending would go to help administrative workers displaced by Medicare for All.
- ✓ Payments to caregivers may not be calculated to cover marketing and may not be used for marketing.
- ✓ Payments to caregivers may not be calculated to cover profits or surpluses, or used to increase profits or surpluses.

Assessing Sanders's Medicare for All single payer

Proponents of single payer assert it to be the simplest, most direct, and most effective way to cut administrative waste in U.S. health care and to win lower prices for prescription drugs.

7. Assuring Medical security and Health care for all

Cai and colleagues reviewed economic analyses of federal and state single payer plans and concluded they would save money by cutting costs of administration and meds.³⁵²⁶ Sanders's 2019 statement took those 2 types of savings into account.

Single payer plans have been criticized for various reasons.

A **first** concern, and perhaps the most important, from this book's viewpoint, is the mis-match between the inevitably slow pace of single payer phase-ins and the emergencies and crises that this book posits will generate pressure for reform. Sanders's Medicare for All is not yet crafted to respond quickly to the needs of patients losing coverage and hospitals going broke.

Moreover, political opposition to enacting very large and very visible new taxes to replace private insurance and OOP revenue could cripple single payer reforms and discredit their proponents. Hunter and Kendall describe how opposition to new state taxes in Vermont, Colorado, and Massachusetts helped to stymie single payer proposals.³⁵²⁷

Could this be done in the future? Probably. But that would need to be one aspect of detailed planning for reform. And that would mean addressing the agenda set out for the Red Team in chapter 1.

A **second** and similar question is whether the DHHS regional offices would have the expertise and information to administer key aspects of Medicare for All. Would the regional offices know how to establish fair hospital budgets? Could they assess which hospitals were needed or what volumes or types of services they should provide. Could they gauge the capacity of hospitals—and their doctors—to deliver types of volumes of care commensurate with both need and budget?

This could also be done. It would require detailed design, pilot implementation, evaluation, and re-design.

A **third** set of questions concerns the winners and losers of the revenue sweepstakes. How would different employers, workers, and other parties be affected by the end of private insurance, the near-end of OOPs, the apparent end of state financing of Medicaid services (excepting nursing home care), and especially the 10 new revenues sources?³⁵²⁸

Reinhardt reminds us that:

An old adage has it that "the only good tax is an old tax." The idea is that all economic agents in society have fully adjusted to an old tax, however inefficient, and that changing it may unfairly create winners and losers.³⁵²⁹

And also dislocations. ***This concern may badly damage the prospects for implementing single payer/Medicare for All reforms.*** U.S. health care differs greatly from that of the U.K. in 1946 or of Canada in 1968. It is much more costly and a much greater share of the economy. The consequent adjustments to great financial winners and losers and to rapid changes in the flows of vast sums are therefore much greater than those in the U.K. or Canada.

And political challenges. Here, those challenges are attributable partly to the frightening novelty of big new taxes. On average, the anger and unhappiness of those who pay more

7. Assuring Medical security and Health care for all

will be far greater than the happiness and relief of the employers and workers who are unburdened by health insurance premiums, or the patients who are relieved of OOPs.

This is only one manifestation of the asymmetry of pain and gain discussed in chapter 1 under the heading of the Red Team's work.

A **fourth** is that the 1946 U.K. NHS added money to health care that had been radically under-financed. Similarly, single payer hospital care began in Saskatchewan in 1947 because hospitals lacked adequate financing. This book posits that political demands for reform will be triggered by crises stemming from freezes in enormous revenues. New revenue won't be available to grease the skids of reform

A **fifth** pertains to possible winners and losers among caregivers. Hospitals that forfeit revenue when new formulas are established to set their budgets will be upset; hospitals that gain revenue will soon take it for granted that they deserve to be better off.

The same for physicians. That's why Glaser long argued that raising primary care doctors' incomes can't be financed by cutting surgeons' incomes.³⁵³⁰ The budget neutrality requirement governing Medicare Part B payments to doctors under RBRVS preclude Glaser's approach. As discussed in chapter 11, that requirement helps considerably to explain the failure to make progress in assuring primary care for all Americans.

A **sixth** Medicare for All concern involves profit-making. If payments to for-profit caregivers may not be calculated to cover profits, would owners of for-profit organizations object that this constitutes a taking of property without compensation? If owners of for-profit caregivers are to be bought out with compensation, what mechanism would be used to raise the money and negotiate the terms of compensation?

As discussed in chapter 10, buying out for-profit caregiving and insuring is not cheap but is affordable. And also essential. As discussed in chapter 4, market failure means that pursuit of profit in health care is both dysfunctional and illegitimate. That's because it does not advance innovation, productivity, cost containment, or satisfaction of human wants or needs.

A **seventh** concerns how much revenue is lost and how much of that loss is offset by new revenue or savings.

Sanders's Medicare for All proposal would end private insurance for care covered by his new program. It would eliminate all but the smallest OOPs. His 2019 list of new revenue identified revenue to replace what was lost.

These 10 items sum to about \$1,620 billion yearly.

It is useful to convert the \$1.62 trillion in 2019 dollars into its 2026 equivalent. The GDP deflator is a useful measure. Dividing 1.62 trillion by the GDP price deflator for July 2019 and multiplying the result by the price deflator for April 2026 gives us almost **\$2.1** trillion in 2026 dollars.

To this replacement revenue should be added expected savings associated with single payer financing. Sanders supposed that his single payer plan would save up to \$500 billion yearly in administrative costs. Conservatively, let's call that \$250 billion yearly.

He also expected that drug price negotiations would save \$130 billion yearly.

7. Assuring Medical security and Health care for all

These 2 cuts in existing waste sum to \$630 billion yearly.

Together, the expected yearly added revenue and cuts in cost yield a grand total of \$2,250 billion (\$2.25 trillion) in yearly replacement revenue and averted costs.

Unfortunately, Sanders's 2019 revenue estimates for a decade did not overtly specify whether any adjustment was made for inflation or to increases in the underlying income streams and wealth subject to taxation. Since he expressed added revenue over a decade, it may be reasonable to assume, for now, that yearly rises in the sums subject to the various assessments were indeed taken into account.

How does the \$2.25 trillion in yearly replacement revenue plus savings match up against revenue lost by eliminating private insurance premiums, Medicare Part B premiums, Medicare Part D premiums, OOPs, and state Medicaid revenue (other than payments for nursing home and other institutional long-term care)?

As shown in Exhibit 7 – 23, lost revenue would be roughly \$2,756 billion, or about one-half trillion dollars (22.5 percent) more than expected replacement revenue plus savings in 2026.

Exhibit 7 – 23

2026 Revenue Lost under Medicare for All

	\$ thousands	notes	source
OOPs	\$597,380		1
Private health insurance premiums	\$1,798,114		1
less FEHB premiums	-\$75,000	2025+\$5B	2
Medicare Part B premiums	\$150,000	2023+\$5B/year	3
Medicare Part D premiums	\$25,000	2023+\$2B/year	3
State Medicaid non-LTC	\$261,000	author's estimate	
Total dollars to replace	\$2,756,494		

Sources

1. Office of the Actuary, Center for Medicare and Medicaid Services, "Projected National Health Expenditures," September 2025, <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected>.

2. Government Accountability Office, "Federal Employees Health Benefits Program: OPM Should Take Timely Action to Mitigate Persistent Fraud Risks," GAO-25-106885, 17 July 2025, <https://www.gao.gov/products/gao-25-106885>.

3. Center for Medicare and Medicaid Services, "CMS Program Statistics - Medicare Premiums," accessed 30 July 2026, <https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-premium-reports/cms-program-statistics-medicare-premiums>.

But what if we now suppose that Sanders's 2019 estimates of replacement revenue to be garnered over a decade was intended to be measured in 2019 dollars?

Using the GDP deflator to convert the 2019 nominal dollar estimates into their 2026 constant dollar equivalents—to adjust for inflation—yields \$2.87 trillion, or a little more than \$100 billion greater than projected lost revenue.

7. Assuring Medical security and Health care for all

In this case, new lost revenue is slightly over-balanced by the combination of replacement revenue and cuts in cost.

But if—as this book posits—the political conditions for effective, broad, and deep health care reform will arise during international/social/economic and health care crises, will Congress have the political and financial stomach to enact new taxes amounting to \$2.1 trillion yearly amidst the crises?

If so, how long would it take before the revenue began to flow? As with driving a stick shift car, will those administering the new law know enough to work the accelerator and clutch to shift gears smoothly?

And to negotiate, regulate, and coordinate the flows of revenue to hospitals, doctors, and other caregivers? In the early years of crisis and reform, will the replacement money and savings on administration flow fast enough to stave off wholesale caregiver bankruptcies or large-scale denials of needed patient care?

Finally, will political support for Medicare for All be broad, deep, and durable enough to pass the law and implement it reasonably smoothly? Support for Medicare for All would be stronger if caregivers' fear of bankruptcy or loss of income is greater, if patients' fear of inability to obtain or pay for care is greater, if business-as-usual is discredited, if free market thinking retreats from health care, and—particularly—if Medicare for All proponents have designed and tested acceptable ways to pay caregivers, to organize and deliver care, and to assure adequate capacity of needed caregivers throughout the nation.

State action. In parallel with national proposals, many single payer proponents have sought action in several states. States have long differed substantially in their political willingness, financial capacity, and economic foundation for financial coverage for all people. Scott has highlighted differences in states' shares of uninsured citizens,³⁵³¹ a topic discussed earlier in this chapter.

Vermont, Colorado, and Massachusetts pursued single payer plans. All were stymied, in large part, by the political resistance to enacting very large new state taxes to replace private insurance revenue.³⁵³² This points to one of the most important strengths of all-payer reforms.

Vermont. Vermont's strong interest in health reform testifies to several challenges. A single payer bill was enacted and signed in 2011. Hsiao and others had prepared a report for the state of Vermont that helped lead to passage of that legislation. Hsiao and colleagues expected single payer would cut health care spending in the state by 25 percent after full implementation. Hsiao was no novice or theoretician, having led the effort to design and implement Taiwan's successful transition to single payer care in 1995.³⁵³³ Two other studies forecasted savings of about 1.5 percent over 3 to 5 years.

In December of 2014, Shumlin ended 4 years of effort to implement the single payer legislation. Why? A number of possible explanations have been offered. One was the state's incompetent roll-out of its own ACA exchange in 2014. That weakened public confidence in the state's capacity to manage single payer financing.

7. Assuring Medical security and Health care for all

A second was attacks from various quarters—from libertarians and free market believers who disdained government efforts, from insurance companies, and from some hospitals and doctors that feared reduced revenue. Wallack, who directed the effort for several years, believed that hospitals budgets should shrink owing to better primary care, prevention, and chronic care case management.³⁵³⁴ Hospitals may have believed otherwise; in any case, it is hard to take away revenue to which caregivers have become accustomed.

A third was worry about the size and visibility of a new 11.5 percent payroll tax plus income tax increases to substitute for private insurance premiums and OOPs.

McDonough highlights a fourth reason for failure: political considerations. Shumlin barely won re-election in 2014 against a Republican opponent who denounced single payer. That year, a public opinion survey showed a balance between single payer supporters and opponents. Both of these may have stemmed, in part, to weak efforts by state government to provide the public with information on the benefits and mechanics of single payer. And the state legislature seemed unlikely to approve the new taxes required to replace private insurance premiums and OOPs.³⁵³⁵

As discussed in chapter 1, frustrations in designing and implementing reform in Vermont—where politicians, caregivers, and voters were sympathetic to the concept of single payer but doubtful about the state's competence and the very visible new taxes—point to the need to craft carefully and in depth, and to test robustly.³⁵³⁶ The Vermont experience shows that undertaking large, complex changes at a fraught time demanded careful analysis, considerable skill, mobilization and cooperation of key participants, smart public relations, co-optation or pacification of malcontents, patience, reassurance, and experience. It also shows that the asymmetry of pain and gain means a very steep uphill fight to enact and implement single payer.

California. For decades, California advocates have advanced various single payer plans. Despite many promises, progress has been close to zero. In 2013, though, the legislature enacted SB770, which created paths to seeking federal waivers that would consolidate Medicare and Medicaid spending and unify financing. It proved impossible to follow that path.

California's state effort had the advantage of simplicity, since its borders are sparsely populated, leaving little need for provisions to pay for care for Californians in other states, or for other states' people in California.

California health spending patterns and sources of coverage generally match those of the nation as a whole. CMS reports that 2020 California personal health spending per person was 1 percent above the U.S. average, barely changed from 1990, when it was equal to the U.S. average.³⁵³⁷ And California's shares of spending financed by private health insurance, Medicare, and Medicaid are very similar to that of the nation as a whole, as shown in Exhibit 7 – 24.

An important concern, though, is that the cost of living in California is fairly high—relative to median income, leaving less money to pay for health care.

Moreover, income inequality in California was 4th-greatest—after New York, Connecticut, and Massachusetts. This may affect political willingness to publicly finance health care spending.³⁵³⁸

7. Assuring Medical security and Health care for all

Exhibit 7 – 24 **Personal Health Care Expenditures in 2020, California and U.S., by Source**

Source	2020 spending, \$M		% of 2020 spending	
	California	U.S.	California	U.S.
Private health insurance	\$124,608	\$1,000,234	31%	30%
Medicare	\$86,833	\$754,521	21%	22%
Medicaid	\$87,062	\$786,914	21%	23%
Total, all sources	\$405,451	\$3,357,832	100%	100%
Sum of PHI, Mcare, Mcaid	\$298,503	\$2,541,669		
Three sources/total	74%	76%		

Politically, Californians vote Democratic at high rates. Biden won 63.5 percent of the state's votes in 2020, his 4th-highest share in the nation (just below Maryland, Massachusetts, and Hawaii).³⁵³⁹

Total personal health spending from all sources in 2020 was 13.2 percent of California's gross state product, 2.5 percentage points below the nation's 15.7 percent.³⁵⁴⁰

California's median age of 36.7 is just below the U.S. median of 38.1, making it the 7th-youngest state. That would tend to hold down health care costs somewhat.

More worrying California's 2023 cost of living is 3rd-highest, fully 36.4 percent above the national average.³⁵⁴¹ This is only partly offset by the state's 5th-highest median household income, 14 percent above the national average.³⁵⁴²

All-payer – practical and incremental

In light of single payer's political difficulties, an all-payer approach will probably be a more feasible path to covering all Americans equally and well while controlling costs. Single payer relies on diverting most existing streams of money into one reservoir, called the Health Security Trust Fund. And it requires much smaller tax increases than single payer.

It is noteworthy that more rich democracies rely on all-payer financing to cover all citizens than on purely tax-financed single payer.³⁵⁴³

The version of all-payer reform sketched here does incorporate elements of single payer proposals. Although it retains Medicare, Medicaid, and private insurance as ways of raising money, it channels them into one financial pool and administers them jointly to cover Americans and pay caregivers. Moreover, it freezes tax-financed programs and private insurance premiums, and gradually shifts financing toward taxation.

7. Assuring Medical security and Health care for all

All-payer financing could probably move more quickly than single payer to collect and cap existing health care revenues, to cover all people, to negotiate payments to caregivers, and to improve caregiver configuration.

By leaving in place the structure and the appearance of private health insurance, it sharply reduces the immediate need to hike taxes to replace insurance premiums paid by employers and employees. Private insurance, Medicare, and Medicaid cards would be retained initially but benefits would be equalized behind the scenes. So would prices paid to caregivers. OOPs would be phased out. The revenues they now generate for caregivers would be replaced by a combination of recycled waste and new tax revenue.

In these ways, all-payer financing reforms could serve as the platform for assuring that all Americans have solid financial protections against health care costs. These reforms would dismantle the financial and non-financial forces that suppress access.

The crisis will freeze federal dollars; the all-payer plan could continue to cap spending to contain costs to make care affordable for all. Squeezing out waste becomes the only way to balance the books—to cover all of us well, with the finite but vast dollars still available. All-payer financing could help to sustain or build the caregiving capacity that is essential to realizing the care promise extended by assuring full financing.

All-payer financing does not focus on immediately substituting tax dollars for premium dollars. Instead, it aims to restructure arrangements between payers and caregivers in ways that financially cover all Americans solidly while squeezing out waste and recycling it. Financial consolidation is a means toward deeper and broader ends.

Like single payer, all-payer reforms aim to slash administrative waste by crafting financially neutral payment methods that put money in the hands of caregivers in ways that promote trust that those caregivers will spend it well. All-payer reforms do parallel single payer proposals to cut drug prices. But all-payer reforms also pay great attention to squeezing out clinical waste and theft.

→ All-payer reforms initially emphasize changing how health care dollars are spent, while single payer reforms initially emphasize changing how the money is raised.

Both aim to address financing and care delivery, but single payer's daunting job of quickly replacing private \$2.1 trillion in private insurance premiums plus OOPs will absorb enormous political and implementation energy.

The transition to all-payer coverage and financing

All-payer financing shifts U.S. health care. It moves from a world where no one is accountable for anything that happens outside the building where they work to a world where the all-payer authority is accountable for specified key outcomes. And where physicians, hospitals, and other caregivers have both capacity and motivation to spend carefully to serve all of us.

(This is different from shifting from a world where no one is accountable for anything to a world where the all-payer authority is accountable for everything.)

7. Assuring Medical security and Health care for all

Shortly after Congress freezes federal health spending on Medicare, Medicaid, ACA, and other coverage, Congress moves to create a public – private all-payer Health Security Authority (HSA) partnership.

States may choose to operate their own HSAs. If they do not, the federal HSA will operate on behalf of their citizens and caregivers.

The Red Team described in chapter 1 had taken several years to design and test the transition to all-payer coverage and financing—politically, financially, and legally. That was built on efforts by Axelrod and others to develop the New York State UNY-Care proposal—described by Beauchamp and Rouse in 1990³⁵⁴⁴—and on subsequent work.

1. Coverage. Once the all-payer plan is enacted, each person covered from any given source of payment retains that coverage for life. Once covered, no one can be deprived of that coverage for any reason.

Since benefits under each plan converge in a few years—along with prices paid for individual services—source of coverage quickly ceases to matter.

When revenue allows, groups of uninsured Americans are identified and then automatically enrolled.³⁵⁴⁵ Within 5 years, it is expected that all Americans will be covered.

2. Financial convergence. In its first year, the HSA is made the recipient of all Medicare, Medicaid, private health insurance, and other designated revenues. Those streams of money are pooled in a single reservoir, the Health Security Trust Fund. The HSA becomes the sole organized buyer of health care services. Americans remain able to use their own money to pay for services from caregivers not covered by the Health Security Trust Fund.

Medicare and Medicaid dollars flow by amending those two programs' enabling statutes. Individuals covered by those programs retain their coverage perpetually. Initially, the HSA continues to pay Medicare prices for Medicare patients. Gradually, Medicaid prices are raised to Medicare levels. And those Medicare prices are set to cover full costs of efficient care across all patients.

Total Medicare OOPs are frozen in the dollars of the year when Congress freezes federal health care spending. They are initially capped at that year's average total OOPs paid by Medicare patients. This applies to the Part A hospital deductible, Part B deductible and 20 percent co-insurance, and the Part D cap on total OOPs. The cap is lowered by 10 percentage points yearly for a decade. Medicare OOPs are thereby eliminated at the end of that decade.

Separately, Part B and Part D premiums are frozen in the nominal dollars of the year of the Congressional freeze on federal health care spending. The IRMAA payments are frozen in nominal dollars as well.

State spending on Medicaid is frozen in the nominal dollars (unadjusted for inflation) of the year when Congress freezes federal health care spending. States continue to pay that much money each year into the Health Security Trust Fund. Their Medicaid burden falls each year as both a share of state budgets and as a share of U.S. health care spending.

7. Assuring Medical security and Health care for all

The private insurance dollars continue to flow, but now must align with 6 main provisions of a new federal law. First, the new law freezes employer and employee health insurance premiums paid to individual insurance companies in the nominal dollars of the current year. This means that employers' health care costs fall each year as a share of employers' revenues and as a share of health care spending. This reduces the regressivity of health care financing.

As was done for Medicare patients, a cap is placed on privately insured individual and family OOPs. It is set at the average OOP medical payment prevailing in each state. Separate prescription drug OOPs would be prohibited by law in the all-payer statute, and would be ignored in calculating the average OOP. The cap would be reduced by 10 percentage points each year for a decade until all but nominal OOPs are eliminated.

Second, the new law requires the insurance companies to immediately pay those premium dollars to the Health Security Trust Fund.

Third, the HSA relies solely on the Health Security Trust Fund to pay hospitals, physicians, dentists, nursing homes, drug makers, and other caregivers.

Fourth, it initially does so in accord with previously negotiated contracts.

Fifth, shortly, it converts to paying at Medicare prices plus designated excess payments.

Sixth, over time, as Medicare prices rise, the excess payments become unnecessary. All payers are now paying the same price for the same care.

Employers immediately begin paying a new 1 percent payroll tax. Existing employer and employee health insurance premiums are non-refundable credits against the tax. So only employers of uninsured workers are hit by the new tax. It is raised by 1 percentage point yearly until it equals the average percentage of employees' incomes, paid by employers and employees together, in each state where employees work.

Because low-income workers are disproportionately uninsured, the new equal-percentage tax will impose a lower financial burden on employees and employers than did traditional health insurance through the job. Again, the freeze on employer-employee premiums will mean that the burden of the new tax, in real (constant) inflation-adjusted dollars will fall over time.

In each state, OOPs for workers and families covered through the job are initially capped at the appropriate mean OOP for those privately insured in that state. As with Medicare OOPs, the cap is cut by 10 percent yearly for 10 years until OOPs are eliminated.

3. Budgets, salaries, and other payment mechanisms. Over time, per-admission or per-visit payments to hospitals cease. They are converted into 24 semi-monthly payments each year. These that provide revenues for all needed services, subject to efficiency standards. Hospitals now have fixed yearly budgets. Budgets reflect revenue required to efficiently and equitably deliver effective health services. They are, inevitably, constrained by the sums available to finance care.

Those budgets are increased over time to enable hospitals to pay salaries to the physicians who work there. Those added payments are designed so that needed hospitals are able to pay

7. Assuring Medical security and Health care for all

enough to attract and retain the physicians required to deliver inpatient, emergency, and other hospital-based care. Over time, all ambulatory surgery centers come under hospital licenses and are financed from hospital budgets.

Physicians' practices are increasingly owned or controlled by hospitals, large physician groups, insurers, and private investors. Physicians' professional autonomy is assailed by owners, by payers' prior authorization requirements, and by fear of malpractice suits.

Most physicians working in hospitals will find it attractive to be able to practice professionally, to cooperate with colleagues, and to marshal hospitals' large (though finite) budgets without payer interference, and with little fear of being sued. Hospitals would pay salaries substantial enough to leave physicians financially happy, able and willing to focus on doing as much as possible for patients.

Physicians in ambulatory practices might be paid in various ways. In primary care, a mix of capitation, fee-for-service, and fee-for-time

4. Benefits coalesce. Over several years, all payers' benefits are standardized upward. With all payers offering the same benefits and paying caregivers the same prices (or the same levels of contributions toward budgets), the individual insurance cards are gradually replaced by new Health Security Cards.

Mechanisms that suppress care are dismantled. First, all Americans enjoy solid financial coverage for the care they need.

Second, OOPs are gradually phased out as waste is recycled. Nominal OOPs persist, mainly to satisfy those who fear costs will otherwise explode, until the waste of time and money associated with collecting the OOPs obviously outweighs any deterrence of unnecessary care.

Third, a result of the payment reforms is that narrow networks of doctors and hospitals cease to exist. All patients have free choice of caregivers. Out-of-network care and surprise bills disappear.

Fourth, similarly, prior authorization and retroactive payment denials vanish. "Outsourcing the 'no'" ceases to have any meaning. Caregivers are financially neutral and have finite dollars and time to spend. They are clinically and financially accountable. There's good reason to trust most to spend both well.

Fifth, adequate caregiver configuration is gradually secured, both human—primary care physicians, other doctors, dentists, nurses, and others, and institutional—hospitals' inpatient and emergency care, nursing homes, home health agencies, and others. This means the right numbers and types of caregivers in the right places.

5. Financial neutrality. Hospitals' budgets must be entirely expended each year. All hospitals are operated under either non-profit or public ownership. As discussed in chapter 10, for-profit owners are bought out and compensated for their equity. Hospital trustees must act as fiduciaries to protect the health of patients; the well-being of physicians, nurses, other caregivers, and other workers; and the survival of the organization itself. Trustees may not do business with the hospital they serve.

7. Assuring Medical security and Health care for all

Hospital managers work with their physicians to conserve dollars and clinical time so that all high-value/low-cost care is provided to all in need before patients receive low-value/high-cost care.

6. Cutting all 4 types of waste, capturing and recycling the money saved, and securing adequate revenue. With health care spending capped, all Americans covered solidly, and caregivers paid by financially neutral methods, doctors and other caregivers will be motivated to deliver high-value/low cost care before low-value/high-cost care. When in-hospital clinical waste is cut, the money and time saved remain in the hospital's budget, ready to deliver effective care.

With hospitals and their doctors ceasing to bill Medicare, Medicaid, or commercial insurers for individual admissions or visits, administrative waste associated with claims processing plummets. So does waste associated with mistrust between payers and caregivers. Hospitals have budgets and their doctors have salaries. So caregivers don't need to upcode services to generate higher revenue, and payers don't need to downcode to hold down their costs. Money previously wasted on administration by payers remains in payer revenue that's consolidated in the Health Security Trust Fund. Money previously wasted on administration by caregivers remains in their budgets or income streams.

High prices for meds and devices plague U.S. patients and payers. The Health Security Trust Fund negotiates prices of drugs under patent with their manufacturers on behalf of all Americans. Slashing drug prices leaves money available in the Health Security Trust Fund to cover Americans solidly and pay caregivers fairly.

In the past, some of the revenue generated by doctors', hospitals', and other caregivers' higher prices had to be devoted to covering administrative costs—mainly coding, billing, appealing, obtaining prior authorization, and other burdens. With those costs slashed, institutional caregivers can recycle that formerly wasted revenue to pay for needed clinical services. Physicians in private practice can retain some of the money saved by cutting their own billing costs, and some of that money can revert to the Health Security Trust Fund.

Some of the money previously stolen by insurers, brokers, caregivers, investors, and others remains inside caregivers' budgets, available to pay for needed care. Other money remains in payers' hands and is channeled into the Health Security Trust Fund. With dollars clearly finite, theft visibly kills Americans. More numerous DoJ prosecutors quickly evaluate privately-filed False Claims Act suits, allowing the federal government to recover more money. Thieves are deterred by a greater chance of getting caught and by prosecutions that put them in jail instead of allowing them to settle by paying fines and pleading "no-contest."

7. Caregiving reforms. Since primary care is central to improving access, containing cost, and also assuring more appropriate care, each state government is asked to identify areas where primary care physicians are in short supply and, in cooperation with a state or national HSA, to steadily raise primary care doctors' incomes until sufficient numbers are in practice. Each state's target should be 1 FTE PC physician per 1,000 citizens.

Initially, non-physician primary caregivers will have to be utilized extensively. That may prove desirable. But adequate numbers of smart and experienced primary care physicians will be

7. Assuring Medical security and Health care for all

essential to coordinate care of other doctors and ensure continuity of integrated patient care that respects patient preferences and is guided by evidence on what care works and which patients need it.

Need for specialist physicians, dentists, nurses, and other professional caregivers should be assessed similarly.

One effective way to obtain needed health care professionals are to draft them and compel them to serve where needed. The other is to pay them enough to attract and retain the right numbers of needed caregivers in the right places. The second path is recommended. Unionization of health care professionals will facilitate structured negotiations. But the arguments over what constitutes fair and adequate pay will occasion political and health care delivery crises from time to time.

It will be much easier to resolve these if the over-riding shared concern of caregivers and the HSAs becomes equitable, effective, efficient, and affordable health care for all. The over-riding aim of paying caregivers should be to offer sufficient incomes and comfortable payment methods—such that thoughts about their own incomes fade into the background, liberating them to be financially neutral and to work hard to marshal available money and clinical time to patients' best advantage.

Each state government is also asked to learn the need for acute inpatient hospital care and also ER capacity in various locations. This, too, would be done in cooperation with a state or national HSA. What volumes of which services should be available in different places? How much revenue is required to finance efficient delivery of needed care?

The same should be done for long-term care and mental health services.

8. Political support and opposition.

Support for all-payer reforms will depend on several factors. The first is the perceived gravity of the immediate health care crises for patients and caregivers sparked by Congress's freeze in federal payments for Medicare, Medicaid, ACA subsidies, and other coverage.

The second is the breadth and depth of understanding that business-as-usual in U.S. health care is either dead forever or dead but cryogenically preserved indefinitely. Is it widely recognized that the weakness of the economy, the burden of current federal deficits and accumulated debt, and competing demands from defense/housing/job training/reindustrialization and other sectors require controlling health care costs? Is it also widely recognized that no rich democracy has been able to control health care costs without covering all citizens?

The third concerns the level of preparedness to address the patient and caregiver crises that follow the federal freeze. Did the Red Team have enough time and insight to develop and test its immediate responses to the crises? (Shortly, these are discussed under the heading of "Phase 1 rescue responses.") And did it have enough time and insight to develop and test the elements of its subsequent all-payer reforms?

The fourth concerns the level of support for recycling wasted health care dollars to deliver needed care to all Americans without increasing spending. Will the customary asymmetry of

7. Assuring Medical security and Health care for all

pain and gain prevail, blocking recycling reforms? Or will the great number of Americans with much to gain from reform prevail over the much smaller numbers who'd lose money or jobs?

It is useful to consider the supporters and opponents of reforms.

Supporters. Supporters will recognize that all-payer reforms mean repudiating the free market mythology and also the government regulatory mythology. Instead, publicly-established structures will liberate doctors and others to marshal finite but vast dollars to take care of all us as well as possible. Shrinking waste will finance expanded care.

The big wholesale public and professional decisions for coverage, cost control, caregiver payment, caregiver configuration and payment, and professional standards for appropriateness, quality, and equity will be foundations on which doctors and others can safely make billions of smart retail decisions to diagnose and treat all of us.

A first group of supporters would be those helped by immediate relief and rescue. At the bottom of the next deep recession, a freeze in federal payments for Medicare, Medicaid, ACA subsidies, and other health programs would cause crises in patient coverage and caregiver finances. Patients and caregivers would be grateful for speedy and effective rescues. But would that gratitude translate into support for continuing and deeper reform? That would depend partly on the speed and success of the rescues themselves. And on the clarity of the rescuers' message that short-term relief, while vital, is unsustainable for more than, say, a year—in the absence of deeper continuing reforms.

The phase 1 rescue's success will rest heavily on the ability to very quickly mobilize hundreds of billions of dollars of wasted health care spending and make it available to protect patients and caregivers. That will need to be done efficiently and without visible theft. Sources of that money and methods of securing and spending it are described shortly.

A second group of supporters will be, employers and workers paying health insurance premiums. They will applaud the all-payer program's freeze in those premiums in nominal dollars. So will Medicare enrollees whose Part B and Part D premiums were similarly frozen in nominal dollars.

Employers will no longer be forced to fight with workers over increases in premiums or trade-offs between premiums and OOPs. The weight of premiums on employers' profits or workers' take-home pay will gradually lessen. This will be particularly important and visible to workers in Southern states, where workers' share of premiums are the highest proportion of median income.³⁵⁴⁶ A smaller gain for employers will be ceasing to obtain bids for health insurance and ceasing to counsel workers on their insurance choices.

Third, similarly, state governments will applaud the freeze in their payments for Medicaid. The freeze will be particularly valuable to states expending high shares of states' own tax revenues on Medicaid. And also to states forced by the 2025 federal budget law to curtail special taxes on caregivers to finance state spending on Medicaid.

As large employers, state and local governments expend very substantial sums on health insurance coverage for their workers. All will welcome the freeze in private insurance company premiums.

7. Assuring Medical security and Health care for all

Fourth, most advocates for health care for all Americans will support all-payer reforms. Some strict single payer advocates may sit on their hands for a short time, though.

Fifth, most doctors, nurses, health care unions, and most other health care workers will recognize that the more-money-for-business-as-usual formula is no longer realistic. They will probably support all-payer reforms that finance good care for all Americans. And that, at the same time, free them from the dictates of insurance company bureaucracies and payment methods. Some doctors will fear the resulting freedom because it will require that doctors, themselves, set standards for diagnosing and treating medical problems—and for identifying, re-educating, or extruding dangerous doctors. As discussed in chapters 10 and 17, liberating doctors from fear of malpractice suits will be a valuable adjunct to setting diagnostic, therapeutic, and professional standards.

Sixth, most non-profit and public hospitals' trustees and managers will welcome assurances for adequate revenue for all needed hospitals.

Seventh, most citizens, voters, and patients will value all-payer payments' promises of solid coverage, cuts in OOPs, recycling waste, and health care cost control. It will be important to begin quickly to redeem these promises.

Opponents. First, insurance companies will fiercely oppose all-payer reform because it eliminates most of their functions. They will continue to collect premiums from employers. This will be an important task. If a substantial share of employers fail to sustain premium payment, monitoring and enforcement activities will be vital to sustaining the payment of capped private insurance premiums to the Health Security Trust Fund.

Insurers will pay the sums they collect to the Health Security Trust Fund each month. Insurers will have no further role in setting them. Because premiums will be frozen in nominal dollars, their value will decline steadily over time. Hospitals, doctors, and other caregivers will be paid from the Health Security Trust Fund. Insurers will therefore have no say in authorizing care or denying payment for care given. They won't suspect caregivers of upcoding patients or waste time trying to downcode them. Insurers will cease maintaining narrow networks of doctors and hospitals, formularies for meds, quality measures, and related functions. After a short transition, insurers will cease managing MA plans or Medicaid managed care plans. This means that insurers will no longer waste time by pursuing profits by making their enrollees look as sick as possible in order to harvest undeserved capitation payments.

Those who work for private employers and governments to obtain bids for premiums, counsel workers on insurance choices, and the like will oppose all-payer reform because need for their work will cease.

Second, the same is true for insurance brokers who help small businesses secure coverage, and who advise both Medicare patients on choices among MA plans and ACA patients on subsidized coverage plans. The allegations of broker misconduct discussed in chapter 3 point to a source of broker opposition to all-payer: the loss of substantial income.

Third, drug makers have much more reason to fear income loss. Their U.S. prices for brand name drugs are far out-of-line with those in other rich democracies. As discussed in chapter 15, even after federal negotiations with drug makers on the prices of 10 drugs highest in Medicare Part D spending, those prices remained 275 percent of the rich democracy average. An all-

7. Assuring Medical security and Health care for all

payer reform to cover all Americans and contain costs can't tolerate high drug prices. Drug makers can be expected to finance heavy fear-mongering ads about ceased innovation and unavailable meds.

Fourth, PBMs would have no role in all-payer health care. Instead, drug costs would be controlled by the techniques used with reasonable success in other rich democracies: assessment of clinical value and tough negotiations on price, including the option of renouncing use of a med that wasn't worth the money. PBMs' complicated practices have been criticized as ineffective in saving money, cumbersome for physicians, opaque for their clients, and sometimes illegitimate in their failure to protect clients' interests while benefiting drug makers.

Fifth, some non-profit hospitals. CEOs and trustees of large and powerful non-profit medical centers and systems of care may fear loss of their financial leverage, role as innovators, or prestige. Against that, weakened NIH research financing might previously have undermined these hospitals' capacities to innovate and restricted revenue might have threatened their finances, so many medical centers and systems might favor reform or remain neutral.

Sixth, the for-profit caregiving sector. For-profit hospital chains with profitable payer mixes or dominant market power are likely to fear and oppose reforms that diminish their revenue, reduce their stock prices, and lead to extrusion of for-profit caregiving itself.

Given the absence of anything close to a free market in health care—for reasons detailed in chapter 4, chapter 10 proposes to buy up the equity in for-profit caregivers by issuing special 20- or 30-year bonds

For-profit hospitals have become dominant caregivers in a number of states or regions of states. They often bind doctors to themselves through ownership of corporate stock. These considerations may argue for pursuing all-payer health reform selectively in states where the patient coverage and caregiver crises are deeper, and where political support for reform is stronger.

The same applies to investor- or doctor-owned ambulatory surgery centers.

In long-term care, for-profit nursing homes, home health agencies, and hospices dominate services in many parts of the nation.

Seventh, some doctors will oppose all-payer reforms for various reasons. Those include comfort with existing arrangements despite the crisis, fear that reforms will reduce doctors' incomes, and fear of reduced doctor autonomy owing to fixed hospital budgets will force doctors to learn to diagnose and treat patients more frugally, or to greater bureaucratization of care. And also fear that frugality will trigger greater numbers of malpractice suits.

Eighth, free market economists who have strayed into health care will oppose ending OOPs, ceasing to disseminate information about different caregivers' prices, and the rest of the efforts to shoehorn health care realities to fit markets' theories.

Ninth, some patients will fear losing extra MA benefits. Others will be panicked by drug companies' threats that pharma innovation will cease.

7. Assuring Medical security and Health care for all

The gravity of the crises of coverage and caregiver survival that result from the freeze on federal health care spending—during a time of deep economic recession and enormous international and domestic demands on federal and state governments—will galvanize demands for health care reform.

If the work of the Red Team, described in chapter 1, is far enough along, it will have identified of steps to first rescue patients and caregivers, and second to design and implement all-payer reforms that durably squeeze out waste to cover all Americans well while containing health care costs.

Unless the first (rescue) phase is widely agreed to be successful, the second will be halted. U.S. health care will then be stuck in a crisis, unable to go back to business-as-usual and unable to move toward reform. Its plight will resemble that of a sailing ship that tries to tack to avoid a rocky shore but lacks enough momentum and ends up “in irons.” That means the ship is pointing straight into the wind and is unable to maneuver. It is stuck.³⁵⁴⁷

Phase 1 – rescue

Health care reform will come in 2 phases. Phase 1 is rescue.

Suppose that the bottom of the next deep recession—around 2029—is accompanied by a deficit and national debt financing crisis, international pressures, deep domestic disagreements, and the freeze on federal health care financing.

Suppose further that this will mean that the number of uninsured Americans approaches 50 million. That would be one-seventh of projected 2030 population of 352 million. But it would be almost one-quarter of the projected 18-65 population.³⁵⁴⁸ (The great majority of uninsured people have been in that age range.)

At the same time, some 10 percent of the nation’s roughly 5,000 surviving hospitals face serious financial threats of bankruptcy or of curtailing all but essential services.

Suppose, further, that best guesses are that a total of about \$250 billion (in 2026 dollars), or a little over 4 percent of 2026 national health expenditures of \$6 trillion, will be needed each year to finance vital care to uninsured people and to keep each needed hospital and service operating.

Since federal health spending is frozen and since it is unreasonable, in the weak economy of 2030, to boost private health insurance premiums or patient OOPs, the \$250 billion must be drawn from current health care spending—from the low-hanging fruit of the tree of waste.

It will require separate efforts to quickly harvest each of the 8 types of waste identified in Exhibit 7 – 25. The Red Team will prepare statutory language, administrative procedures, and legal and political arguments to support amassing the \$250-plus billion as quickly and efficiently as possible.

7. Assuring Medical security and Health care for all

From what sources might this money be obtained? Exhibit 7 – 25 summarizes these.

Exhibit 7 – 25

Sources of \$259 Billion in Excised Waste to Respond to Coverage and Caregiver Crises, 2026 Dollars

Sources of Excised Waste	\$ billions	Notes
Payments to MA, ACA, and Part D insurance brokers	\$25	1
Employer payments to health benefits consultants	\$5	2
Facility fees for Medicare patients	\$6	3
End MA quality bonuses	\$13	4
Recoup higher payments to MA plans owing to upcoding, selection, other factors	\$50	5
Aggressive anti-theft action, recoveries that cut theft by 20 percent	\$60	6
Cut 2026 brand name drug prices by 15 percent	\$97	7
Cease to oblige hospitals to shoulder burden of value-based program reporting	\$3	8
Total	\$259	

Notes

1. Joint Economic Committee, “Right Plans or Wrong Incentives?” 22 June 2026, <https://www.jec.senate.gov/public/index.cfm/republicans/2026/6/jec-issues-brief-finding-insurance-broker-costs-rising-rapidly-especially-in-medicare-advantage-plans>.
2. Author’s estimate.
3. Melanie Evans, “Hospitals Are Adding Billions in ‘Facility Fees’ for Routine Care,” *Wall Street Journal*, 25 March 2024, <https://www.wsj.com/health/healthcare/hidden-hospital-fees-cost-patients-hundreds-of-dollars-0024cd95>.
4. Jeannie Fuglesten Biniek, Nancy Ochieng, and Meredith Freed, “Medicare Will Spend More Than \$13 Billion on the Medicare Advantage Quality Bonus Program in 2026,” KFF, 1 July 2026, <https://www.kff.org/medicare/medicare-will-spend-more-than-13-billion-on-the-medicare-advantage-quality-bonus-program-in-2026/>.
5. Author’s estimate from Medicare Payment Advisory Commission, *Report to Congress*, Chapter 12, “The Medicare Advantage Program, Status Report,” March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf; and from Steven M. Lieberman and Paul B. Ginsburg, “MedPAC Findings Versus the Insurance Industry: Is MA Paid More Than Traditional Medicare?” *Health Affairs Forefront*, 7 April 2026, <https://www.healthaffairs.org/content/forefront/medpac-findings-versus-insurance-industry-ma-paid-more-than-traditional-medicare>.
8. Added administrative cost to hospitals of mandatory “value-based” programs. These were Hospital Value-based Purchasing, Hospital Readmissions Reduction, and Hospital-acquired Conditions Reduction. Also added cost of a non-mandatory Comprehensive Care for Joint Replacement program. Zehui Zhou, Jason D. Buxbaum, and Andrew M. Ryan, “Mandatory Value-based Payment Programs and Hospital Administrative Costs,” *JAMA Health Forum*, Vol. 7, No. 8 (7 August 2026), <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2852212>.

The Red Team would also develop the political arguments for squeezing out each of the 8 types of waste in order to protect citizens and hospitals. To move quickly, emergency language would be

7. Assuring Medical security and Health care for all

attached to legislation. Given the severity of the health care crises, those harmed by the harvesting of wasted dollars might choose to accept the loss of revenue.

Steps to sustain political support could include publicizing help given to patients vulnerable to deprivation of needed care, to hospitals and other professional caregivers, and to hospitals. Those hostile to this effort to rescue care for patients and to support caregivers' finances might try to publicize any suffering or death owing to lack of care or delayed care and attribute it to the rescue effort's shortcomings. The rescue program, therefore, should publicize realistic aims and expectations, and to avoid seeming to over-promise.

Initially, about \$150 billion might go to protecting individuals. Much of this money would finance physician care, labs and imaging services, and meds. The remaining roughly \$100 billion would go to stabilizing needed hospitals and services. The focus of the money would probably be on emergency room and inpatient care.

Were the rescue program launched in 2029 or 2030, the sums involved would be larger, but so would be the costs of protecting Americans and stabilizing hospitals.

To retain the public's confidence in the rescue program, the wasted money squeezed out and captured will need to be spent quickly, efficiently, equitably, and without theft. Deterring theft will require legal obligations to report perceived theft and tough consequences for thieves. A standard of a year in jail for each \$100,000 stolen might help to deter theft.

Phase 2 – reform

Phase 2 is reform. Here, costs are controlled durably. Money is raised in fair and efficient ways. All people are covered solidly and fairly. Costs are contained. Gradually, sufficient physicians, NPs, PAs, dentists, dental therapists, and other professional caregivers are trained and deliver care where needed. They are paid by financially neutral methods. This entails deploying finite revenue to needed caregivers in ways that respect care for all.

Relying on doctors' financially neutral professionalism and non-profit hospitals' and other caregiving organizations' fiduciary duty is an important stretch in the only path out of anarchy. Payment methods alone are insufficient. It's essential also to organize and deliver care for all Americans in trustworthy and affordable ways. This rests heavily on building durable and trusting relationships between primary care doctors and patients. Patient who trust their doctor are much more likely to accept provisions for squeezing out clinical waste—particularly no-value or high-cost/low-value care. These relationships also help to immunize patients against medical myths and misinformation.³⁵⁴⁹

All people would be financially protected. Costs would be controlled; that would be done mainly by capping revenues and putting them in the hands of caregivers to marshal the money to win as much valuable care as possible, and as equitably as possible. Administrative costs would fall—mainly because doctors and hospitals would cease to be paid mainly for patient visits, procedures, or admissions. Instead, they would marshal scarce dollars that rest in their own budgets. Insurance companies would not have the power to say “yes” or “no” to caregiving and spending. Physicians, supported by operations managers and financial managers, would have

7. Assuring Medical security and Health care for all

that power. Doctors would be paid mainly by salary or capitation; some fee-for-service payment would probably persist. Hospitals would have fixed yearly budgets. Prices paid to drug makers would be cut.

This means that in phase 2—unlike phase 1—specific sources of waste probably do not need to be specified. Hospitals, doctors, dentists, and other caregivers work to diagnose and treat all patients.

It is important to note that the actual costs of covering currently uninsured patients well may not be as great as some have understandably feared. Hadley and Holahan estimated that cost at 3 to 6 percent of health care spending in 2001.³⁵⁵⁰ In that year, though, some 41 million people, one-seventh of Americans, lacked health insurance for the entire year. That's well above the current share, though that share is rising.

Taking their 3 percent low estimate to reflect the percentage of Americans likely to be uninsured in the next few years, and applying that to 2026 spending of \$6 trillion, we could estimate the incremental cost of covering uninsured people at \$180 billion yearly. This would, though, be financed not by higher spending, but by recycling dollars currently wasted. It would be only 6 percent of dollars currently wasted.

All-payer coverage and financing methods generally share several characteristics. All were developed, tested, and refined by the Red Team over several years.

First, all citizens and legal residents are protected against costs of health care. The Health Security Trust Fund finances all care. Patients would retain the insurance card they held when reform was enacted. As newly eligible people enroll, they would probably be issued a new type of card from the Fund. In time, the Health Security Trust Fund might well issue its own cards to all Americans. Administrative costs of determining eligibility disappear.

Second, the Fund pays for all patients' needed care. Decisions about how to diagnose and treat patients are made by physicians in consultation with patients. Primary care and other physicians reassure patients that care is guided by evidence and also, whenever possible, by patient preferences. Reassurance includes explaining caregiver financial neutrality, the policy of treating all patients with similar problems in similar ways, advancing equity.

The value of good primary care and of trusting relations between patients and primary care physicians can't be over-stated. As discussed in chapter 11, primary care is the critical path to reform. It is essential to assuring first-contact access to care, coordination, continuity, and comprehensive care. It means better access, lower cost, and more appropriate care. The work of the Red Team would identify ways to quickly add primary care capacity and also to prioritize patients who'd most benefit from it.

Gradually, standard lists of services, diagnostic methods, and treatment protocols are developed by caregivers to guide decisions. These are mainly developed by groups of physicians in light of evidence on efficacy and cost. Leonhardt's description of Brent James's work illustrates one way to do this.³⁵⁵¹

Patients would have equal access to those services in light of their medical needs. Costs of payers' outside prior authorization and retroactive denial of payment disappear. Caregivers deliver the services their budgets allow. And those budgets are very substantial indeed, since

7. Assuring Medical security and Health care for all

administrative costs have been slashed, as have high prices for meds. Theft has been cut in half.

Strong motives propel work to slash clinical waste, administrative waste, high prices, and theft: the savings remain in health care. Money and clinical time saved is available to cover everyone, expand covered services, and cut OOPs.

Effective care is covered. Still, remorseless pathology always outstrips available budgets and time. Americans remain allowed to spend their own money to pay for care not covered by the Health Security Trust Fund and not available from caregivers paid by the Fund.

Third, a cap on yearly OOPs is initially set in current (nominal) dollars of the year reform begins. It is not increased in line with inflation or health care cost increases. The real burden of OOPs drops steadily. Further, the cap is steadily lowered as savings through waste reduction allow.

Fourth, the Health Security Trust Fund establishes and negotiates financially neutral methods of paying caregivers. These are described in chapter 9. They include fixed yearly budgets for each needed hospital. These are set in light of populations served, needed types and volumes of services, and a case mix adjustment. Building on decades of work in Maryland, the Red Team tested and refined fair budgeting methods. These are subject to continuing improvement.

Gradually, doctors who work in hospitals are paid salaries from hospitals' budgets. Doctors working outside hospitals, dentists, and other caregivers are paid consistent incomes by consistent rules. Capitation rates, salaries, fees-for-time, and fees-for services are typically negotiated between the Health Security Trust Fund and groups of caregivers working outside hospitals.

Since doctors won't be drafted, they must be paid. Payments to physicians are set in line with a "market-clearing price" for the types and numbers of physicians needed and sought in a state or region. To take an extreme example: Mississippi has the nation's lowest physician-to-population ratio and also the highest average physician income. This means that attracting more physicians to fill currently unmet needs for care will require a combination of recruiting local citizens to be trained as physicians, individuals who'll return to family, friends, and familiar life-style—and also some measure of higher payments.

Government sometimes participates as a payer, as a party to negotiations. But more often, it referees the negotiations. Drug prices are held down to average levels prevailing across rich democracies; this is done sometimes by regulation and sometimes by negotiation. Negotiators are strengthened by the right to refuse to pay for a high-price drug. Ability to walk away has been central to lowering drug prices in Australia, Norway, Israel, and other nations.

Fifth, patients are generally free to choose their caregivers. The one possible constraint, discussed in chapter 10, is that some caregivers may choose to organize themselves into vertically integrated non-profit entities that include a spectrum of physicians, hospitals, and other caregivers. These would enroll patients and would be capitated by the Health Security Trust Fund in line with objective and valid measures of risk.

Sixth, total revenues available to pay caregivers are generally capped by the flows of dollars into the Health Security Trust Fund. Powerful political and financial pressures work to contain costs. One of the strongest is the requirement that most annual increases in spending are financed by visible tax increases.

7. Assuring Medical security and Health care for all

Employers that had not previously provided health insurance to all workers and families would be subject to a payroll tax. It would start at 1 percent of payroll and rise by 1 percentage point yearly until it reached 5 percent of payroll. In time, this would be the share of payroll paid by those employers that had previously insured workers and families. That's because those premiums would be frozen in the current dollars of the year reform was enacted.

Sixth, governments typically devote attention to the main large wholesale challenges: covering everyone, containing costs, securing an appropriate configuration of caregivers, and raising the floor under acceptable standards of appropriateness and quality of patient care.

Strengths and weaknesses of all-payer financing and coverage

In the U.S. today, money to pay for health care is often raised in unfair ways. Some employers pay more than others. Some employees have better coverage than others. Private insurers pay higher prices to caregivers than Medicare, and Medicare pays high prices to most caregivers than Medicaid.

All-payer methods have several main strengths. The first is that they sustain the great share of the existing sources of revenue. This radically shrinks the size of new taxes required to cover all Americans. Although newly capped, Medicare and Medicaid payments continue to flow. Private insurance premiums won't rise, but they will also continue to flow. These are payments to which all parties have become accustomed. Again, the only good tax is an old tax.

Greatly reducing the requirement for new taxes means many fewer immediate winners and losers. As discussed earlier, the anger and resentment expressed by those who are hurt by change generally greatly outweigh the gratitude of those who are helped by change.

Even more important, greatly reducing new taxation means that reformers will not need to spend years fighting to enact and defend \$2.5 trillion in those new taxes at the bottom of the next recession. That liberates reformers to move quickly to focus their attention to addressing access, cost, caregiver payment, and caregiver configuration. And that, in turn, means more rapid action to squeeze out waste and recycle it.

A second strength is that any unfairness plaguing existing sources of revenue can be gradually reduced by overlaying them with new and fair ways to raise money to pay for care.

A third strength is that imbalances in revenues raised per patient or prices paid for care can be remedied by pooling revenue in one reservoir and by shifting to single prices for each type of care. That reservoir, the Health Security Trust Fund, could be used to cover all Americans equally, to pay hospitals, physicians, dentists, other caregivers, and drug makers.

Since revenue will be pooled, all patients' care would be paid from the Health Security Trust Fund at the same price, and by the same method. This will make for equity of care. So will extension of covered benefits to all patients. OOPs would shrink as quickly as possible.

The main difference between this approach and single payer is that employers would continue to pay for workers and dependents. Those payments per employee would be frozen, though, at nominal dollar levels of the year reform legislation was passed. They would not rise with

7. Assuring Medical security and Health care for all

inflation or any other factors. Each year, therefore, their burden on employers would drop measurably.

Incremental spending on health care would be financed only by tax dollars. This builds in the single most powerful source of resistance to higher health care spending: politicians' fear of losing their jobs in response to tax increases. Just as important, it makes for a gradual transition to equal coverage and cost control.

To sustain some continuity amid changes, Medicare, Medicaid, and private insurance coverage would remain nominally in effect. Families and individuals would retain their insurance cards. Each year, though, the care paid under all forms of coverage would move toward convergence at a high level such that, in perhaps five years, all people would be covered identically for all the care that works—excepting care that's low in efficacy and very high in cost. Prices paid by all forms of coverage would also converge. OOPs would drop steadily to nominal levels.

In effect, all citizens would belong to one shared risk pool.³⁵⁵² Inevitably, the average younger and healthier and higher-income person would pay for more care than they received. But, in time, they would pay for less care than they received as they became older, sicker, and lower in income. Some people view this as intergenerational solidarity; others see it as a way to pay for lifetime medical security.

A fourth strength is that all-payer reforms could be implemented in individual states. In 1990, Beauchamp and Rouse described one all-payer proposal, New York State's UNY-Care.³⁵⁵³ A state would need to obtain federal waivers to authorize Medicare and Medicaid participation. The ACA's section 1132 waivers would permit a state to conduct all-payer reforms.³⁵⁵⁴

3. Health care for all - With eyes on controlling cost, paying caregivers, configuring them well, and boosting quality and appropriateness of care

Financial coverage for all Americans is the beginning of the job of winning health security for all. It is not possible to win and sustain durable financial coverage for all Americans—and health security for all—without containing cost. Containing cost, in turn, depends heavily on paying caregivers in financially neutral ways. Good care for all also requires organizing care sensibly, configuring caregivers well, and boosting both quality and appropriateness of care.

Cost control

As noted earlier, no rich democracy has been able to afford to cover all people well without containing cost. This is not surprising. The reverse is somewhat surprising: No rich democracy has been able to contain cost without covering all people well.

Chapter 8 analyzes ineffective and effective ways to contain cost of health care.

7. Assuring Medical security and Health care for all

Paying caregivers

Chapter 9 then takes up methods of paying doctors and hospitals. It discusses use of financial incentives to change behavior, and also financially neutral methods of payment.

Organization and delivery of care

Chapter 10 considers alternative methods of organizing and giving care.

First, competition's failure in health care renders profit-making illegitimate. This chapter discusses methods and costs of compensating owners' equity and converting for-profits to non-profit control. But if hospitals and other institutional caregivers are operated not-for-profit, who will control and guide them, setting clinical and financial priorities? Challenges in identifying competent and motivated trustees and executives are reviewed.

Second is the question of full freedom of choice of caregiver versus choice among competing non-profit HMOs.

Third is the related question of the desirability of vertical and horizontal integration of caregivers. Should hospitals or other entities be allowed to own doctors' practices?

Physician configuration and payment

As shown in chapter 11, the U.S. has one of the lowest ratios of physicians to population across rich democracies. Only South Korea and Japan have fewer physicians. Moreover, the U.S. is fifth-lowest in rate of training new physicians in proportion to population. Only Israel, Canada, South Korea, and Japan are lower. The U.S. trains 8.6 physicians per 100,000 citizens, only three-fifths of the OECD average of rate of 14.5 physicians per 100,000 citizens.³⁵⁵⁵

Primary physician shortages endanger access, boost cost, and undermined quality and appropriateness of care. It will be impossible, though, to train and retain adequate numbers of primary care physicians unless the total number of medical and osteopathic school seats is increased very rapidly and very substantially.

Chapter 11 asserts that strong primary care for all is one of the most important foundations for translating financial coverage into actual access to good health care. Because the U.S. suffers a deep shortage of primary care, and because it takes so long to train new primary caregivers, primary care is designated in chapter 11 to be the critical path to health reform. In the short run, this will require integration of greater numbers of NPs, PAs, and experienced RNs into primary care practices.

At the same time, strong primary care liberates specialists to do their own jobs. Primary care and specialist care are allies, not antagonists.³⁵⁵⁶

Three methods could boost the supply of primary care physicians. Doctors might be subjected to a draft, one that obliges them to serve as primary care physicians in under-served areas for, say, 5 years before obtaining specialist training. Some 70 nations—such as Mexico, Bolivia, Thailand,

7. Assuring Medical security and Health care for all

Philippines, China—legally require service of this sort.³⁵⁵⁷ Doctors often find these unpopular. Many nations find them difficult to enforce.

A second method is to hike incomes until the number of physicians willing to work in primary care matches need. Although no competitive free market works in health care, money still talks loudly. Incomes would need to be higher in locations doctors found less attractive.

A third method is to improve the conditions under which primary care doctors practice. Reasonable steps discussed in chapter 11 include marked cuts in panel size, cuts in administrative burdens, and adequate professional supports. Cutting panel size to an average of 1,000 patients per FTE primary care physician would allow longer visits to build trusting relationships, understand patient problems and preferences, follow patients into the hospital, and coordinate specialists' care.

Cutting administrative burdens is possible if physicians are paid in ways that promote trust between doctor and payer. This entails removing financial incentives to give more care or less care—incentives that magnify mistrust. Institutional supports include shifting residency training after PGY 1 into primary care practices that provide years of supervised care and learning, and building multi-physician rural practices—many based at surviving rural hospitals—to ensure that primary care doctors are not on call 168 hours weekly.

Hospital configuration and payment

If all needed hospitals are to be paid by fixed yearly budgets, it's essential to learn which hospitals—offering which types of volumes of services—and at which locations—are needed. Only 1 state has a list of needed hospitals. Others refuse to investigate this question.

Chapter 12 takes up the evolution of hospital services in the U.S. and their current configuration. What should be the future role of inpatient and emergency care? To what degree are hospitals essential to supporting needed physician services in each region? How to support care that is needed today while leaving room for bottom-up innovation in the types of care hospitals have offered?

Appropriateness and quality of care

Today, financial coverage is very uneven. So is availability of primary care and hospital care.

How will reforms assure much greater equity in appropriateness and quality of care? The 2 are often conflated. They should be considered separately. Appropriate care is the objectively correct care—assuring provision of the care that is needed to diagnose and treat a problem, and avoiding excessive care. It is effective care, given efficiently. High-quality care is competent, professional, caring, and proficient.

7. Assuring Medical security and Health care for all

One-half of all doctors know more about which care is more appropriate for which patients. One-half deliver higher-quality care. Both are inevitable. The challenge is to shift the distribution in a positive direction, such that the medians for appropriateness and quality improve steadily.

Chapter 16 examines which methods of covering all people well, containing cost, paying caregivers, organizing and delivering care, and assuring desirable configurations of primary care and hospitals will best promote appropriate and high-quality care in equitable ways.

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