

THE CONSTITUTION, CORONAVIRUS, AND CARE: HOW THE ACA TRILOGY AND THE COVID-19 PANDEMIC CREATED NEW BASES FOR MEDICARE-FOR-ALL

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American healthcare is expensive. Despite decades of attempts to make care affordable, many people in the United States remain uninsured or otherwise experience high out-of-pocket costs. H.R. 1976, the Medicare for All Act of 2021, provides a solution where the federal government directly covers medical care for all residents. Medicare for All is popular, sensible, and humane, especially in the wake of the COVID-19 pandemic. But if the Act were to pass, it would face a similar fate to that of the Affordable Care Act just over a decade ago—endless litigation, some of which might land before the Supreme Court.

This Note assesses Medicare for All's future in light of the Supreme Court's Affordable Care Act holdings and the COVID-19 pandemic. Part I summarizes the history of healthcare reform, the status of healthcare in the United States, and the contents of the Affordable Care Act and H.R. 1976. Part II analyzes how the Medicare for All Act might be evaluated based on the Supreme Court's relevant holdings in the Affordable Care Act cases. Finally, Part III assesses how the COVID-19 pandemic heightened the need for Medicare for All through the lens of the health justice framework. This Note concludes that Medicare for All makes sense both legally and ethically, though advocates for the proposal will need to be prepared for challenges should the law come to pass.

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INTRODUCTION

Health reform is a hot-button political issue that will not go away. Both national health expenditures and individual out-of-pocket costs have increased steadily over the last several decades,¹ outpacing changes in the gross domestic product² and wages.³ By 2028, approximately one in five dollars spent in the United States will be spent on healthcare.⁴

As these figures suggest, the history of efforts to make healthcare affordable in America is largely a tale of false starts. The most ambitious attempts to do so arrived in 1965 and 2010, with the creation of Medicare and Medicaid and the enactment of the Patient Protection and Affordable Care Act (“ACA”), respectively. But these laws employ means testing and preserve a major role for profit-seeking private insurers, leaving large gaps in who has coverage and even

1. Nisha Kurani et al., *How Has U.S. Spending on Healthcare Changed Over Time?*, PETERSON-KFF HEALTH SYS. TRACKER (Feb. 25, 2022), <https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/> [https://perma.cc/S7K6-Y9GA]; Katherine Wilson, *2021 Edition—Health Care Costs 101: U.S. Spending Growth Outpaces Economy*, CAL. HEALTH CARE FOUND. (June 28, 2021), <https://www.chcf.org/publication/2021-edition-health-care-costs-101/> [https://perma.cc/XP8L-BNEY].

2. *National Health Expenditure Projections 2019-2028: Forecast Summary*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/files/document/nhe-projections-2019-2028-forecast-summary.pdf> [https://perma.cc/C8D6-DPPA] (last visited Mar. 16, 2022).

3. *Real Earnings Summary*, U.S. BUREAU LAB. STATS. (Mar. 10, 2022), <https://www.bls.gov/news.release/realer.nr0.htm> [https://perma.cc/6R2A-2954].

4. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 2.

larger gaps in who has quality coverage. In some respects, they have also been weakened over time.⁵

The best solution to America's healthcare troubles is a national single-payer system, where the federal government directly covers medical care for all people. It would make healthcare more affordable, simplify our currently Byzantine healthcare system, and establish universal coverage.⁶ Single-payer's favorability has grown in recent years; a majority of Americans now support it.⁷

The need for single-payer healthcare has become particularly acute amid the COVID-19 pandemic. Between January 22 and August 31, 2020, 44% of COVID infections and 32% of COVID deaths were linked to gaps in insurance coverage.⁸ The fewer people with coverage in a given county, the worse the outcomes, with a 70% increase in COVID cases and a 48% increase in COVID deaths for every 10% increase in the uninsured rate during the same period.⁹

However, since the early twentieth century, single-payer advocates have faced staunch opposition from big business and business-friendly politicians. Even during the pandemic, this opposition has shown no signs of slowing. Indeed, trillions of dollars are at stake. But so are many lives. Amid this tragedy, the time is right to push more forcefully for a single-payer program. Health justice advocates should anticipate a strong reaction, including legal battles, just like the challenges that the ACA advocates encountered.

This Note assesses the future of Medicare for All ("MFA") based on the two major U.S. healthcare events of the last decade: the enactment of the ACA and the COVID-19 pandemic. Part I describes the historical push for a national health program, the controversy surrounding the ACA, and key parts of the MFA legislation. Part II presents potential constitutional challenges to MFA based on the Supreme Court's ACA jurisprudence—as well as ways that MFA supporters could

5. See *infra* Part II. Additionally, Medicare has been largely privatized; 42% of Medicare beneficiaries are enrolled in a privately administered plan as of 2021. *Medicare Advantage in 2021: Enrollment Update and Key Trends*, KAISER FAM. FOUND., <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/> [https://perma.cc/YR5F-ERSA] (last visited Apr. 25, 2021).

6. John Holahan & Michael Karpman, *What Explains Support or Opposition to Medicare for All?*, URB. INST. HEALTH REFORM MONITORING SURV. 1, 13 (Aug. 2019), https://www.urban.org/sites/default/files/publication/100752/what_explains_support_or_opposition_to_medicare_for_all_final_v2.pdf [https://perma.cc/3QAH-DRZK] (finding approximately 90% or more for those benefits among supporters). See also Lucile Bruce, *Speaking Out for "Medicare for All,"* YALE SCH. MED. (Oct. 19, 2021), <https://medicine.yale.edu/news-article/speaking-out-for-medicare-for-all/> [https://perma.cc/DT58-UPLT].

7. *Universal Health Care*, JUST. PARTY (2022), <https://www.justiceparty.us/universal-health-care.html> [https://perma.cc/U6E6-8QNZ] ("A 2021 poll reflects that 55% of voters support 'Medicare for All'").

8. *The Catastrophic Cost of Uninsurance: COVID-19 Cases and Deaths Closely Tied to America's Health Coverage Gaps* FAMILIES USA 1, 5 (Mar. 2021), https://familiesusa.org/wp-content/uploads/2021/03/2021-37_Loss-of-Lives_Report_AnalysisStyleB_Final.pdf [https://perma.cc/9VDT-XLBJ].

9. *Id.*

counter those arguments and otherwise provide a legal defense for the law. Part III evaluates MFA from health justice and policy perspectives through the lens of COVID-19. This Note concludes that (1) MFA can withstand a constitutional challenge based on the Court's decisions in the ACA cases, and (2) the pandemic exposed the urgent need for MFA.

A. *On Terminology*

Certain terms are often used—and misused—in health reform discussions. It is important to distinguish between them to ensure that each concept is communicated clearly. “Universal healthcare” means everybody in a jurisdiction, typically a nation, has coverage.¹⁰ In theory, universal healthcare could be achieved through a public system, a private system, or a combination of the two. A “single-payer system” is one where a sole entity provides payment.¹¹ Fee-for-service Medicare is a single-payer system in the United States, even though only certain groups can receive Medicare coverage. Single-payer systems can provide universal coverage—such would be the case with MFA. This Note uses MFA instead of “single-payer” because the analysis will rely on the specific bill with the same name.

It is also important not to conflate MFA with other types of health reform proposals. These proposals include a public option (at the state or federal level), Medicare buy-in, Medicaid buy-in, lowering the Medicare eligibility age, and building on the reforms of the ACA (e.g., by expanding eligibility for tax credits or subsidies). These all have their own varied implications, and sometimes different ideas exist within each proposal type (e.g., lowering the Medicare age to 60¹² vs. lowering it to 50¹³). Those discussions generally exceed the scope of this Note, but the bottom line is that none would provide coverage as comprehensive or widespread as MFA.¹⁴

Finally, this Note occasionally refers to the “underinsured” population. People who are underinsured have private health insurance, but that insurance covers so little of their care that they still face high medical expenses relative to their income.¹⁵ Although the federal government has not defined this term and it lacks a

10. E.g., Simon F. Haeder, *Universal Coverage, Single-Payer, 'Medicare for All': What Does It All Mean for You?*, CONVERSATION (Jan. 7, 2020), <https://theconversation.com/universal-coverage-single-payer-medicare-for-all-what-does-it-all-mean-for-you-128518> [<https://perma.cc/9VDT-XLBJ>].

11. *Id.*

12. Improving Medicare Coverage Act, H.R. 5165, 117th Cong. (2021).

13. Medicare at 50 Act, S. 1279, 117th Cong. (2021).

14. See, e.g., Ezra Tanen, *Will the Public Option Provide Universal Access to Affordable Health Insurance?*, GEO. J. ON POVERTY L. & POL'Y BLOG (Nov. 3, 2020), <https://www.law.georgetown.edu/poverty-journal/blog/will-the-public-option-provide-universal-access-to-affordable-health-insurance/> [<https://perma.cc/L2S8-BB3T>].

15. See Jenny Gold, *The 'Underinsurance' Problem Explained*, KAISER HEALTH NEWS (Sept. 28, 2009), <https://khn.org/news/underinsured-explainer/> [<https://perma.cc/NUC5-QK33>]; Joseph Burns, *Being 'Underinsured' Another Measure of Health Coverage*, ASS'N OF HEALTH CARE JOURNALISTS (Nov. 6, 2017), <https://healthjournalism.org/blog/2017/11/being-underinsured-another-measure-of-health-coverage/> [<https://perma.cc/Y85J-APFB>].

single, formal definition, some studies define this population as adults who spend more than 10% of their incomes on out-of-pocket medical expenses.¹⁶

I. THE HISTORICAL AND LEGISLATIVE BACKGROUND OF MEDICARE FOR ALL

A. *The Long History of American Healthcare Reform, in Brief*

Universal healthcare advocacy began in the early twentieth century when the Socialist Party endorsed “sickness insurance” in its campaign for worker protections in 1901.¹⁷ In 1906, a group of economists founded the American Association for Labor Legislation (“AALL”).¹⁸ The AALL’s initial goal was to research labor conditions, but it soon began advocating for a national health insurance program—as well as laws related to child labor, occupational health and safety, and workers’ compensation—distributing 13,000 copies of a draft national health program bill to state legislatures by 1915.¹⁹ The healthcare issue gained a new level of prominence in 1912 when Theodore Roosevelt’s Progressive Party pledged “to work unceasingly” for the “protection of home life against the hazards of sickness . . . through the adoption of a system of social insurance.”²⁰

But by the end of the decade, the movement had slowed. Some labor unions, including the American Federation of Labor, opposed the measure, arguing it would thwart collective bargaining.²¹ Insurance companies fought the AALL bill because it would cover funeral expenses—for them, a profitable business.²² Finally, the American Medical Association (“AMA”) began to shift from supporting a national health program to opposing it. In 1920, the AMA’s delegates voted to oppose “any plan embodying the system of compulsory contributory insurance against illness, or any other plan of compulsory insurance which provides for

16. Gold, *supra* note 15; Sara R. Collins, Herman K. Bhupal & Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA*, COMMONWEALTH FUND (Feb. 7, 2019), <https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca> [https://perma.cc/C4RC-RE2Y].

17. See JANE C. BANASZAK-HOLL, SANDRA R. LEVITSKY & MAYER N. ZALD, *SOCIAL MOVEMENTS AND THE TRANSFORMATION OF AMERICAN HEALTH CARE* 40 (2010).

18. JAAP KOOIJMAN, . . . AND THE PURSUIT OF NATIONAL HEALTH: THE INCREMENTAL STRATEGY TOWARD NATIONAL HEALTH INSURANCE IN THE UNITED STATES OF AMERICA 25 (1999).

19. *American Association for Labor Legislation, 1905-1943*, PROQUEST, <https://web.archive.org/web/20150912045830/http://www.proquest.com/products-services/American-Association-for-Labor-Legislation-38.html> [https://perma.cc/W75C-2LX9] (last visited Dec. 4, 2021).

20. *The American Presidency Project, Progressive Party Platform of 1912*, U.C. SANTA BARBARA, <https://www.presidency.ucsb.edu/documents/progressive-party-platform-1912> [https://perma.cc/3HPZ-8TZ6] (last visited Dec. 4, 2021).

21. KOOIJMAN, *supra* note 18, at 24.

22. *Id.*

medical service to be rendered to contributors or their dependents, provided, controlled, or regulated by any state or the Federal government.”²³

In 1927, a group of economists, physicians, and public health specialists formed the Committee on the Costs of Medical Care (“CCMC”), which studied “the ills in the present economic organization of medicine.”²⁴ The CCMC considered recommending a national healthcare program in its early reports but ultimately decided against it.²⁵ During the early years of the Great Depression, the CCMC concluded that many Americans needed more medical care than they could afford, but it called for a voluntary health insurance system and did not indicate the extent to which the government should be involved.²⁶ At this time, the CCMC split in three. An anti-national-health-insurance faction teamed up with the AMA, which described the idea as “socialism and communism—inciting to revolution” in 1929.²⁷ Meanwhile, other CCMC members said the recommendation did not go far enough and proposed an insurance-based national health system.

Although the election of Franklin Delano Roosevelt as President delighted national health insurance advocates, Roosevelt’s administration ultimately took a different course of action. After launching the New Deal in 1933, it turned its attention to “social insurance” in early 1934. The Committee on Economic Security (“CES”) was formed to advise the President on what would soon become the Social Security program; the Social Security Act passed in 1935.²⁸ Initially split on whether to move forward with national health insurance, CES leadership chose to shelve the proposal after the AMA protested even the most modest, incremental ideas, which the AMA’s president claimed “smacked of socialism and communism and might incite revolution.”²⁹ But CES reasoned that it could revisit the idea later.³⁰

In 1945, six months after FDR’s death, President Truman proposed a national health program to Congress.³¹ It included national health insurance, as well as protection against lost income due to sickness and disability, appropriations for

23. *Rationality & Welfare: Public Discussion of Poverty and Social Insurance in the United States 1875-1935*, SOC. SEC. ADMIN. HISTORIAN’S OFF., <https://www.ssa.gov/history/reports/schlabach4.html> [https://perma.cc/J5DF-4QZ3] (last visited Dec. 4, 2021).

24. KOOLJMAN, *supra* note 18, at 33.

25. *Id.* at 34.

26. *Id.* at 35.

27. Theron Schlabach, *Rationality & Welfare: Public Discussion of Poverty and Social Insurance in the United States 1875-1935*, Research Notes & Special Studies by the Historian’s Office, SOC. SEC. ADMIN., <https://www.ssa.gov/history/reports/schlabach4.html> [https://perma.cc/W46P-NGVP] (last visited Sept. 9, 2022).

28. KOOLJMAN, *supra* note 18, at 49-50; COMM. ON ECON. SEC., SECURITY (1934), <https://www-origin.ssa.gov/history/reports/ces/cesvol9security.html> [https://perma.cc/VWL6-235G].

29. JILL QUADAGNO, ONE NATION, UNINSURED: WHY THE U.S. HAS NO NATIONAL HEALTH INSURANCE 7 (2005); KOOLJMAN, *supra* note 18, at 59–60.

30. KOOLJMAN, *supra* note 18, at 59–60.

31. *Id.* at 102.

hospital construction, and an expansion of public health.³² Truman later made national health insurance a key component of his 1948 reelection campaign.³³ In response, the AMA hired Campaigns, Inc.—the first political consulting and advertising firm in the United States—to fight back against Truman’s proposal.³⁴ Its propaganda appeared in 65,000 waiting rooms across the country.³⁵

But the AMA was not alone in its opposition: groups from the Farm Bureau to the American Bar Association to the American Legion opposed it as well. Truman’s health secretary, Oscar Ewing, worked with Congress to produce a bill that would only provide coverage for adults ages 65 and older³⁶ (at the suggestion of William Randolph Hearst, interestingly).³⁷ However, the legislation went nowhere. Meanwhile, the private health insurance market grew, lessening the public’s perception that national health insurance was necessary.³⁸

By the next presidential election, in 1952, more than 9,000 industry organizations had publicly voiced opposition to the idea.³⁹ These groups, plus Republicans and conservative Democrats in Congress, also benefitted from the mid-century Red Scare and the burgeoning Cold War. Meanwhile, labor unions remained split.⁴⁰ Some continued to support the measure, while others opposed it, especially those that gained medical coverage through hard-fought collective bargaining.⁴¹ Healthcare advocates eventually changed course, focusing instead on expanding care through research, medical education, and hospital construction.⁴²

The more left-leaning side of the Democratic Party later turned back to healthcare, thanks in part to Senator—and soon, President—John F. Kennedy. In 1960, Kennedy sponsored an amendment to the Social Security Act that served as a precursor to Medicare.⁴³ In some ways, the argument he made while introducing the bill sounds like something one might hear today:

Few people deny the urgency of the need for this medical care. But there are some who prefer to rely upon voluntary health insurance policies. Unfortunately, voluntary health insurance has not and cannot do the job I agree that we must maintain the highest

32. Harry S. Truman, Special Message to the Congress Recommending a Comprehensive Health Program (Nov. 19, 1945), <https://www.trumanlibrary.gov/library/public-papers/192/special-message-congress-recommending-comprehensive-health-program> [<https://perma.cc/SCW8-F2JU>].

33. KOIJMAN, *supra* note 18, at 103.

34. *Id.* at 109; *See also* Jill Lepore, *The Lie Factory*, *NEW YORKER* (Sept. 17, 2012).

35. KOIJMAN, *supra* note 18, at 109.

36. *Id.* at 121.

37. *Id.* at 119.

38. *Id.* at 129.

39. *Id.* at 112.

40. *Id.*

41. *Id.* at 107.

42. *Id.* at 116.

43. John F. Kennedy, Speech in the Senate on Medical Care of Our Older Citizens (Jan. 26, 1960), <https://www.jfklibrary.org/archives/other-resources/john-f-kennedy-speeches/washington-dc-19600126> [<https://perma.cc/S6NM-P9CY>].

standards of family responsibility and personal thrift. But I am concerned about the futility of imposing on any person or any family an unwarranted, unpredictable, and often unmanageable burden that could easily be borne by an insurance arrangement – insurance that is spread over the working lifetime of each individual.⁴⁴

But while Kennedy nodded toward the need for a national health program, his proposal—like others in recent years, including Ewing’s—remained narrowly focused. Kennedy attempted to move forward with a health program for the elderly during his presidency. Despite increased public support, Democrats in Congress were divided on how to approach the issue, and Kennedy realized the program “would not be a political reality in the near future.”⁴⁵ After an unsuccessful speech on the issue in 1962, the Medicare bill failed by two votes in the Senate.

Still, the Medicare proposal remained popular among the American public, and this became especially clear after Johnson’s reelection in 1964. Unsurprisingly, the AMA opposed the Johnson Administration’s initial proposal, as did congressional Republicans.⁴⁶ The AMA proposed a program that would cover inpatient hospital care only. Representative John Byrnes, a Republican from Wisconsin, then introduced legislation that would create opt-in coverage for older adults for physician services.⁴⁷ Ultimately, the two were both incorporated into the Medicare program. To this day, Part A covers hospital services, and Part B covers outpatient physician services.⁴⁸ The 1965 legislation also created Medicaid, the jointly federal- and state-run program that covers care for people with disabilities and those below a certain income level. Private companies began administering Medicare benefits in the 1970s, but this comprised only a small portion of the program until the 2000s. What is now known as Medicare Advantage began to expand significantly with the Medicare Modernization Act in 2003. The same Act created Medicare Part D, the prescription drug benefit, which is also administered by private insurers.⁴⁹ Part D went into effect in 2006.⁵⁰

44. *Id.*

45. KOIJMAN, *supra* note 18, at 149–51.

46. See Bob Rosenblatt, *With Deft Legislative Move, Mills Clears Way for House Approval of Major New Health Plan*, NAT’L ACAD. SOC. INS. (Mar. 6, 1965), <https://www.nasi.org/discussion/covered-with-deft-legislative-move-mills-clears-way-for-house-approval-of-major-new-health-plan/> [https://perma.cc/A84X-YBRX].

47. KOIJMAN, *supra* note 18, at 165.

48. See Paul Starr, *The Health-Care Legacy of the Great Society*, in *RESHAPING THE FEDERAL GOVERNMENT: THE POLICY AND MANAGEMENT LEGACIES OF THE JOHNSON YEARS* (Norman J. Glickman et al. eds., 2014), https://www.princeton.edu/~starr/articles/articles14/Starr_LBJ_HC_Legacy_1-2014.pdf [https://perma.cc/E4CL-MP5Q].

49. *History*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/About-CMS/Agency-Information/History> [https://perma.cc/K5C4-ZJU8] (last visited Mar. 16, 2022).

50. *Id.*

In the meantime, other proposals to expand care—such as the 1992–1993 Clinton initiative⁵¹—were considered highly controversial and overly complex, and they did not succeed. Health programs also experienced funding cuts in the second half of the twentieth century.⁵²

The underlying theme of this history is capital’s tireless effort to limit the government’s provision of health insurance. It is a theme that continued into the next major shift in the history of U.S. healthcare: the debate over, and eventually enactment of, the ACA during President Obama’s first two years in office.

B. The Affordable Care Act

Signed into law on March 23, 2010, the ACA⁵³ was touted as a path toward universal health coverage without a national insurance system. Instead of directly providing health insurance to the entire population, it attempted to use market mechanisms—“carrots and sticks”—to increase coverage. The carrot was the law’s cost-sharing subsidies and premium tax credits, which were allocated based on household income and plan type. The stick was the “individual mandate”—the requirement for all citizens and legal residents to possess health coverage or pay a penalty.⁵⁴ People who did not qualify for a public healthcare program or receive insurance through an employer were to enroll in a private plan on the newly established “Exchanges.”⁵⁵ Generally, insurance companies could no longer deny prospective enrollees coverage based on existing conditions.⁵⁶ However, they could still charge higher premiums based on age,⁵⁷ tobacco use,⁵⁸ and geographic location.⁵⁹

The ACA also initially required states to expand Medicaid. Specifically, states were required to cover individual adults with incomes up to 138% of the Federal Poverty Level.⁶⁰ If a state refused to do so, the federal government would no longer provide that state any Medicaid funding.⁶¹

Some provisions sought to lower the uninsured rate in other ways, such as by allowing young adults to stay on a parent’s plan until age 26. Other sections were

51. *Health Care Reform Initiative*, CLINTON DIGIT. LIBR., <https://clinton.presidentiallibraries.us/health-reform-initiative> [https://perma.cc/ZE9A-JZEM] (last visited Mar. 16, 2022).

52. For example, the Reagan administration reduced the federal Medicaid budget by 18%. Olivia Campbell, *Here’s What Happened When Reagan Went After Healthcare Programs. It’s Not Good.*, TIMELINE (Sept. 13, 2017), <https://timeline.com/reagan-trump-healthcare-cuts-8cf64aa242eb> [https://perma.cc/98NC-ENQZ].

53. Patient Protection and Affordable Care Act, Pub. L. No. 111–48, 124 Stat. 119 (2010).

54. 26 U.S.C. § 5000A (2022).

55. 42 U.S.C. § 18031 (2022).

56. 42 U.S.C. § 18032 (2022).

57. 42 U.S.C. § 300gg(a)(1)(A)(iii) (2022).

58. 42 U.S.C. § 300gg(a)(1)(A)(iv) (2022).

59. 42 U.S.C. § 300gg(a)(1)(A)(ii) (2022).

60. 42 U.S.C. § 1902(k)(1), § 1903(i)(26) (2022).

61. 42 U.S.C. § 1396c (2010).

intended to improve the quality of care—for instance, by requiring plans to cover certain services,⁶² or by establishing programs to measure service quality.⁶³

The ACA is, by at least one measure, the most controversial federal law of the last 100 years.⁶⁴ Voters considered healthcare a major issue in 2008, especially amid the recession.⁶⁵ Litigation ensued “[n]ot five minutes after” President Obama signed the ACA, when Virginia’s attorney general, followed by TV cameras, walked to the federal courthouse in Richmond to file the first suit against it.⁶⁶ Since then, it has been litigated more than 2,000 times.⁶⁷

Meanwhile, Republicans in Congress have attempted to repeal the law more than 70 times.⁶⁸ The ACA’s timing coincided with the rise of the Tea Party, which protested—including at healthcare town halls⁶⁹—against what it considered government overreach amid the federal response to the 2008 financial crisis. The movement’s figures became some of the law’s most vociferous opponents. Congressional Tea Party Caucus founder Representative Michele Bachmann, for example, said the ACA “literally kills people.”⁷⁰ Misinformation about care rationing became commonplace, exemplified by vice presidential candidate Sarah Palin’s famous statement on “death panels.”⁷¹ Senator Rand Paul insinuated that the

62. 42 U.S.C. § 18022 (2022).

63. 42 U.S.C. § 1315a (2022).

64. Derek Thompson, *The Most Controversial Laws of the Last 100 Years (The Stimulus and Obamacare Are 1 and 2)*, THE ATLANTIC (Sept. 23, 2013) <https://www.theatlantic.com/politics/archive/2013/09/the-most-controversial-laws-of-the-last-100-years-the-stimulus-and-obamacare-are-1-and-2/279899/> [<https://perma.cc/TLY4-PWYM>].

65. *Issues and the 2008 Election*, PEW RSCH. CTR. (Aug. 21, 2008), <https://www.pewresearch.org/politics/2008/08/21/section-3-issues-and-the-2008-election/> [<https://perma.cc/2EF7-Z4X6>]. 73% of voters said healthcare was “very important” to their vote, following only the economy at 87% and energy at 77%. George Lowery, *Economists: 9 Million Lost Health Insurance in Recession*, CORNELL CHRONICLE (Dec. 7, 2011), <https://news.cornell.edu/stories/2011/12/economists-9-million-lost-health-insurance-recession> [<https://perma.cc/7JQK-FLM8>] (finding that about 9.3 million adults lost health insurance due to a job loss between 2007 and 2009).

66. DANIEL BÉLAND, PHILIP ROCCO, & ALEX WADDAN, *OBAMACARE WARS* 1 (2016) (citing the Washington Post).

67. Abbe R. Gluck, Mark Regan & Erica Turret, *The Affordable Care Act’s Litigation Decade*, 108 GEO. L.J. 1471, 1473 (2020).

68. Chris Riotta, *GOP Aims to Kill Obamacare Yet Again After Failing 70 Times*, NEWSWEEK (Sept. 9, 2017, 6:53 PM), <https://www.newsweek.com/gop-health-care-bill-repeal-and-replace-70-failed-attempts-643832> [<https://perma.cc/2EF7-Z4X6>].

69. See, e.g., NELLA VAN DYKE & DAVID S. MEYER, *UNDERSTANDING THE TEA PARTY MOVEMENT* (1st ed. 2014).

70. Aaron Blake, *Bachmann: Obamacare ‘Literally Kills’ People*, WASH. POST (Mar. 21, 2013), <https://www.washingtonpost.com/news/post-politics/wp/2013/03/21/bachmann-obamacare-literally-kills-people/> [<https://perma.cc/FHX9-J9A6>].

71. Politico Pro Health Staff, *25 Unforgettable Obamacare Quotes*, POLITICO (Jul. 16, 2013, 1:11 PM) <https://www.politico.com/gallery/2013/07/25-unforgettable-obamacare-quotes-001595?slide=1> [<https://perma.cc/J3YR-NERT>]. Palin’s original quote was “The

IRS would evaluate medical records.⁷² In addition to the more outlandish claims, many prominent Republicans asserted that the law was simply too expansive and expensive.

C. Why Healthcare Reform Still Matters

Despite slight improvements every few decades, the uninsurance, underinsurance, and cost problems of the U.S. healthcare system have never been resolved. According to the Census Bureau, 8.6% of people⁷³ did not have health insurance at any point in 2020.⁷⁴ Perhaps even more shockingly, 43.4% of adults were underinsured, meaning:

- their out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 10% or more of household income; or
- their out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 5% or more of household income for individuals living under 200% of the federal poverty level (\$25,520 for an individual or \$52,400 for a family of four in 2020); or
- their deductible constitutes 5% or more of household income.⁷⁵

Contemporary efforts to make healthcare affordable, including the ACA, have been largely ineffective. As the above statistics illustrate, health insurance remains unaffordable and unreliable. Since 2000, Americans have consistently named costs or access as the “most urgent health problem facing this country” (with

America I know and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama’s ‘death panel’ so his bureaucrats can decide, based on a subjective judgment of their ‘level of productivity in society,’ whether they are worthy of health care.”

72. Politico Pro Health Staff, *25 Unforgettable Obamacare Quotes*, POLITICO (Jul. 16, 2013, 1:11 PM) <https://www.politico.com/gallery/2013/07/25-unforgettable-obamacare-quotes-001595?slide=22> [<https://perma.cc/JJA3-KVAT>].

73. *Infra* note 74, at 2. This sample includes the “civilian noninstitutional population” ages 15 and older in the 50 states and D.C. *Current Population Survey: 2021 Annual Social and Economic (ASEC) Supplement*, U.S. CENSUS BUREAU at 2-1 (2021) <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf> [<https://perma.cc/9V4B-F8NP>]. The institutionalized population “consists primarily of the population in correctional institutions and nursing homes.” *Id.* at G-1. Civilians include “members of the Armed Forces living off post or living with their families on post, as long as at least one civilian adult lives in the same household.” *Id.* at 1-1.

74. Katherine Keisler-Starkey & Lisa N. Bunch, *Health Insurance Coverage in the United States: 2020*, U.S. CENSUS BUREAU (2021), <https://www.census.gov/content/dam/Census/library/publications/2021/demo/p60-274.pdf> [<https://perma.cc/AH58-599R>].

75. Sara R. Collins, Munira Z. Gunja & Gabriella N. Aboulaflia, *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability*, COMMONWEALTH FUND (Aug. 19, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial> [<https://perma.cc/UNM3-46WR>].

the sole exception of 2020, when viruses were the top concern).⁷⁶ The public perceives costs of and access to healthcare as bigger issues than cancer, obesity, mental illness, or substance abuse.⁷⁷ Nearly everyone has an opinion on the total cost of care, and an overwhelming majority has been dissatisfied with it.⁷⁸ A substantial majority has said the healthcare system has “major problems” or is in “crisis;” almost no one has said it has no problems.⁷⁹

D. H.R. 1976: Medicare for All

A single-payer system, commonly referred to as Medicare for All, would eliminate many problems in the healthcare system. This proposal gained steam with Senator Bernie Sanders’s presidential candidacy in 2016. Sanders introduced the Medicare for All Act (or nearly identical legislation with a different name) in the Senate in 2011,⁸⁰ 2013,⁸¹ 2017,⁸² and 2019,⁸³ taking over the Senate version of the legislation from Ted Kennedy after Kennedy’s passing in 2009.⁸⁴ While a single-payer bill has not been introduced in the Senate since the start of the 117th session, Representative Pramila Jayapal has introduced an equivalent bill in the House: H.R. 1976, which was also titled the Medicare for All Act.⁸⁵

H.R. 1976 includes 11 titles, which are broken down into a total of 44 sections. At 131 pages,⁸⁶ it is significantly shorter than the Affordable Care Act, which was criticized at the time it was passed for exceeding 900 pages.⁸⁷ Despite being equally significant, if not more of a systematic overhaul, this difference reflects how much simpler the healthcare system would be with MFA in place.

I	Establishment of the Medicare for All Program; Universal Coverage; Enrollment
II	Comprehensive Benefits, Including Preventive Benefits and Benefits for Long-Term Care
III	Provider Participation
IV	Administration

76. *In Depth: Topics A to Z—Healthcare System*, GALLUP, <https://news.gallup.com/poll/4708/Healthcare-System.aspx> [https://perma.cc/CK6D-KC4S] (last visited Sept. 24, 2021).

77. *Id.* Of course, conditions such as these cannot be treated if care is prohibitively expensive.

78. *Id.*

79. *Id.*

80. American Health Security Act of 2011, S. 915, 112th Cong. (2011).

81. American Health Security Act of 2013, S. 1782, 113th Cong. (2013).

82. Medicare for All Act of 2017, S. 1804, 115th Cong. (2015).

83. Medicare for All Act of 2019, S. 1129, 116th Cong. (2019).

84. *See, e.g.*, Medicare for All Act, S. 1218, 110th Cong. (2007).

85. Medicare for All Act of 2021, H.R. 1976, 117th Cong. (2021).

86. *Id.*

87. Patient Protection and Affordable Care Act, Pub. L. No. 111–48, 124 Stat. 119; *see, e.g.*, Peter Roff, *Pelosi: Pass Health Reform So You Can Find Out What’s In It*, U.S. NEWS & WORLD REP. (Mar. 9, 2010), <https://www.usnews.com/opinion/blogs/peter-roff/2010/03/09/pelosi-pass-health-reform-so-you-can-find-out-whats-in-it>.

V	Quality Assessment
VI	Health Budget; Payments; Cost Containment Measures
VII	Universal Medicare Trust Fund
VIII	Conforming Amendments to the Employee Retirement Income Security Act of 1974
IX	Additional Conforming Amendments
X	Transition
XI	Miscellaneous

The MFA program would cover “medically necessary or appropriate” services for “maintenance . . . diagnosis, treatment, or rehabilitation” across 15 categories:

1. Inpatient and outpatient hospital care,
2. Ambulatory services,
3. Primary and preventive care,
4. Prescription drugs and medical devices,
5. Mental health and substance use services, including inpatient care,
6. Laboratory and diagnostic services,
7. Reproductive, maternity, and newborn care,
8. Dental, vision, and audiology care,
9. Rehabilitative and habilitative services and devices,
10. Emergency services and transportation,
11. Early and periodic screening, diagnostic, and treatment services,
12. Transportation to appointments for individuals with disabilities, older adults with functional limitations, and low-income people,
13. Long-term services and supports (“LTSS”),
14. Hospice, and
15. Services provided by a licensed marriage, family, or mental health therapist or counselor.⁸⁸

All U.S. residents would qualify for this coverage.⁸⁹ The text does not define “resident.” Instead, it directs the Secretary of Health and Human Services (“HHS”) to do so via regulation.⁹⁰ The Act also says the Secretary may decide to cover additional populations “to ensure that every person in the United States has access to health care.”⁹¹ However, “the Secretary shall ensure that individuals are

88. H.R. 1976 § 201(a)(1)–(15).

89. H.R. 1976 § 102(a).

90. *Id.*

91. H.R. 1976 § 102(b).

not allowed to travel to the United States for the sole purpose of obtaining health care . . . under this Act.”⁹²

There would be no cost-sharing of any sort.⁹³ The Act would not require private health insurance companies to shut down, but it would become unlawful for health insurers to sell plans that duplicate the program’s benefits.⁹⁴ Similarly, employers would no longer be allowed to provide health insurance to employees that duplicates MFA coverage.⁹⁵ While this part of the Act does not define “duplicate” benefits, another part⁹⁶ provides that “no employee benefit plan may provide benefits that duplicate payment for any items or services” covered under the MFA program. If “duplicate” means the same thing in these sections, then presumably a private plan could not sell, for example, a plan that covers only half of what MFA covers. In practice, this provision would substantially reduce the business of private health insurers.

H.R. 1976 also contains provisions related to provider participation,⁹⁷ quality standards,⁹⁸ budgeting,⁹⁹ conforming amendments for existing forms of coverage,¹⁰⁰ and program administration.¹⁰¹ Providers who participate in the program could not bill or contract with eligible individuals for covered services; non-participating providers could bill anyone, eligible or ineligible, for any service, covered or not.¹⁰² In the rare event that an individual does not qualify for the program (e.g., by not meeting HHS’s definition of “resident”), participating providers could bill that person for covered services.¹⁰³ The program’s funding would be determined based on a budget created by the Secretary annually.¹⁰⁴ Funding for existing health programs would be funneled to MFA through a new “Universal Medicare Trust Fund.”¹⁰⁵ One year after the Act’s enactment date, a year-long transition program would begin.¹⁰⁶ MFA-eligible individuals under age 18 or over age 55 could enroll, and others could enroll through the “Medicare Transition Buy-In” on the Exchanges.¹⁰⁷ Providers who accept assignment under Medicare currently would participate in the transition.¹⁰⁸ The MFA program would fully go into effect two years after enactment.¹⁰⁹ Entities within HHS (specifically, the Center for Clinical

92. *Id.*

93. H.R. 1976 § 202.

94. H.R. 1976 § 107(a).

95. H.R. 1976 § 107(b).

96. H.R. 1976 § 522.

97. H.R. 1976 § 301-303.

98. H.R. 1976 § 501-502.

99. H.R. 1976 § 601.

100. H.R. 1976 § 901-903; *see also* § 1001-1002 (on the transition); § 1012 (on continuity of care).

101. H.R. 1976 §§ 401-405.

102. H.R. 1976 §§ 301-303.

103. H.R. 1976 § 303(b)(6).

104. H.R. 1976 § 601(a)(1).

105. H.R. 1976 § 701.

106. H.R. 1976 § 1001.

107. H.R. 1976 § 1002.

108. H.R. 1976 § 1002(d)(3).

109. H.R. 1976 § 1001.

Standards and Quality under CMS and the Agency for Healthcare Research and Quality) would establish quality standards and report to Congress on numerous health disparities.¹¹⁰

E. How Medicare for All Differs from the ACA

The single-payer approach of MFA fundamentally differs from the ACA. The ACA not only preserved a role for private insurers but also attempted to encourage private insurance enrollment through subsidies and tax credits. These initiatives compounded the ACA's overall complexity. It is easier to understand "everyone gets free care"—the MFA approach—than to navigate a web of means tests.¹¹¹ Moreover, private insurance itself was already confusing: a survey by the largest health insurer in the country, United Healthcare, found that only 9% of respondents understood four fundamental terms: "premium," "deductible," "out-of-pocket maximum," and "co-insurance."¹¹² On top of that, it is often impossible for the privately insured to predict out-of-pocket costs due to the lack of price transparency and various layers of middlemen.¹¹³ Prior authorization requirements cause another dimension of confusion and lead to delays in care.¹¹⁴ These and other administrative burdens waste money and time, both for patients and providers. Administrative expenses have accounted for 15% to 25% of annual national health expenditures for more than two decades.¹¹⁵ Although MFA opponents decry its potential costs, many of these expenses would no longer be necessary. The MFA system would also save the government billions of dollars by not lining executives' pockets.¹¹⁶

110. H.R. 1976 §§ 501–502.

111. See Pete Wilmoth, *Many Americans Are Confused About the Affordable Care Act*, RAND BLOG (Mar. 26, 2014), <https://www.rand.org/blog/2014/03/many-americans-are-confused-about-the-affordable-care.html> [<https://perma.cc/CJ2U-6U77>].

112. Les Masterson, *UnitedHealth Survey: Most Americans Don't Understand Basic Health Plan Terms*, HEALTHCARE DIVE (Oct. 10, 2017), <https://www.healthcaredive.com/news/unitedhealth-survey-most-americans-dont-understand-basic-health-plan-term/506895/> [<https://perma.cc/9NG5-WK5A>].

113. Joshua Cohen, *U.S. Healthcare Markets Lack Transparency; Stakeholders Want to Keep It That Way*, FORBES (Dec. 7, 2020), <https://www.forbes.com/sites/joshuacohen/2020/12/07/us-healthcare-markets-lack-transparency-stakeholders-want-to-keep-it-that-way/>.

114. Ani Turner, George Miller & Samantha Clark, *Impacts of Prior Authorization on Health Care Costs and Quality*, ALTARUM (Nov. 2019), <https://www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf> [<https://perma.cc/RNJ9-WXYF>].

115. Michael Chernew & Harrison Mintz, *Administrative Expenses in the U.S. Healthcare System: Why So High?*, 326 J. AM. MED. ASS'N. 1679 (Oct. 20, 2021), <https://jamanetwork.com/journals/jama/fullarticle/2785479> [<https://perma.cc/8DU7-3XQY>].

116. Beth Mole, *Health Care CEOs Raked in \$3.2 Billion as Pandemic Raged*, ARS TECHNICA (June 15, 2021), <https://arstechnica.com/science/2021/06/health-care-ceos-raked-in-cash-as-pandemic-raged-taking-home-3-2-billion/> [<https://perma.cc/4QJR-L75N>].

II. POTENTIAL CONSTITUTIONAL CHALLENGES TO MEDICARE FOR ALL AND CORRESPONDING DEFENSES

Given the amount of previous litigation and staunch backlash to any sort of healthcare reform, MFA is bound to face constitutional challenges. Throughout the twentieth century, many different groups with a financial stake in a privately run healthcare system successfully defeated multiple proposals for a national healthcare system. More recently, they have relentlessly fought the ACA—which is seen as a more moderate proposal. Perhaps most concerning, all sectors of the healthcare industry—hospitals, pharmaceutical companies, and pharmacy benefit managers, as well as insurers—are already actively fighting MFA together,¹¹⁷ even though it will not pass in Congress anytime soon. Amid this fierce opposition, MFA advocates should prepare well in advance of the law’s potential enactment for legal challenges based on the Supreme Court’s ACA decisions.

In what Justice Alito deemed “our epic Affordable Care Act trilogy,”¹¹⁸ the Supreme Court has heard three cases on the ACA: *National Federation of Independent Business v. Sebelius* (hereinafter *NFIB*),¹¹⁹ *King v. Burwell*,¹²⁰ and *California v. Texas*.¹²¹ The plaintiffs in *NFIB*—26 states, as well as the small-business association—argued that the law was unconstitutional because Congress lacked the power to require all Americans to own insurance and condition Medicaid funding to states on adopting the expansion.¹²² *King v. Burwell* involved tax credit eligibility for people purchasing insurance on certain exchanges.¹²³ Finally, in *California v. Texas*, multiple states argued that the law was unconstitutional after Congress lowered the individual mandate penalty to \$0.¹²⁴ The Court did not decide on the merits; instead, it decided the challenging states lacked standing.¹²⁵

117. P’SHP FOR AM.’S HEALTH CARE FUTURE, <https://americashealthcarefuture.org/> [<https://perma.cc/CB4V-Q3B3>] (last visited Mar. 16, 2022).

118. *California v. Texas*, 141 S. Ct. 2104, 2123 (2021).

119. *Nat’l Fed’n Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012).

120. *King v. Burwell*, 576 U.S. 473 (2015).

121. 141 S. Ct. 2104 (2021).

122. *Nat’l Fed’n*, 567 U.S. at 530–31 (“Today we resolve constitutional challenges to two provisions of the Patient Protection and Affordable Care Act of 2010: the individual mandate, which requires individuals to purchase a health insurance policy providing a minimum level of coverage; and the Medicaid expansion, which gives funds to the States on the condition that they provide specified health care to all citizens whose income falls below a certain threshold.”).

123. *King*, 576 U.S. at 478 (“This case is about whether the Act’s interlocking reforms apply equally in each State no matter who establishes the State’s Exchange. Specifically, the question presented is whether the Act’s tax credits are available in States that have a Federal Exchange.”).

124. 141 S. Ct. at 2112 (“Texas and 17 other States . . . claim that without the penalty the Act’s minimum essential coverage requirement is unconstitutional. Specifically, they say neither the Commerce Clause nor the Tax Clause (nor any other enumerated power) grants Congress the power to enact it.”).

125. *Id.* (“We do not reach these questions of the Act’s validity, however, for Texas and the other plaintiffs in this suit lack the standing necessary to raise them.”).

While *NFIB* and *California v. Texas* can be instructive, *King v. Burwell* is probably not applicable because it involved a specific aspect of the ACA that would no longer exist under MFA. This section assesses whether and how the Court's conclusions in these two cases would apply to MFA.

A. *The Commerce Clause*

The Commerce Clause ruling in *NFIB* is, at first glance, a boon to single-payer advocates, due to fundamental differences in how the ACA and MFA provide coverage. The ACA's individual mandate required most adults to maintain "minimum essential coverage" or pay a penalty.¹²⁶ The law defined minimum essential coverage as government-sponsored coverage (e.g., Medicare or Medicaid), an individual market plan, or an eligible employer-sponsored plan.¹²⁷ In *NFIB*, the plurality held that the individual mandate was impermissible under the Commerce Clause because Congress cannot require people to participate in an economic activity.¹²⁸ This, Chief Justice Roberts wrote, "would open a new and potentially vast domain to congressional authority," which countered the Framers' vision for a federal government of limited and enumerated powers.¹²⁹ To the plurality, the nature of the insurance market could not outweigh these concerns. It did not matter that the mandate was created specifically to bring those who did not buy insurance— younger, healthier people—into the risk pool, in order to lower premiums. Rather, "commercial inactivity rather than activity is [the uninsured population's] defining feature."¹³⁰

Unlike the individual mandate, MFA would not force anyone to make a purchase. In fact, nobody would even be coerced to accept MFA coverage; the Act only discusses eligibility criteria.¹³¹ Thus, it is difficult to imagine the program being overturned on those grounds. However, this expansiveness is exactly why MFA would almost certainly, however creatively, be challenged. To those who seek to preserve, uphold, and expand private insurance—including the Republican Party writ large,¹³² and the Democratic Party less directly¹³³—MFA is a threat.

126. 26 U.S.C. § 5000A(a) (2022). The law exempted low-income people and members of Indian tribes from the penalty. § 5000A(e). It also exempted incarcerated individuals, undocumented people, and individuals with a certified religious exemption from the mandate. § 5000A(d)(2).

127. 26 U.S.C. § 5000A(f) (2022).

128. See *Nat'l Fed'n*, 567 U.S. at 552.

129. *Id.* at 552, 555.

130. *Id.* at 556.

131. H.R. 1976 § 102–03, 117th Cong. (2021).

132. See *Rules & Resolutions 36-37* (2020), REPUBLICAN NAT'L COMM., https://prod-cdn-static.gop.com/docs/Resolution_Platform.pdf [https://perma.cc/FCA9-QV25].

133. While the Democrats' 2020 platform "welcomes advocates . . . who support a Medicare for All approach," it does not endorse MFA. Rather, it explicitly aims to maintain the current system. The platform endorses a public option because "private insurers need real competition." It also would "build upon" the ACA, which has funneled a substantial amount of money toward insurer profits, as well as Medicaid, which has been largely privatized. *Party Platform: Achieving Universal, Affordable, Quality Health Care* (2020), DEMOCRATIC NAT'L

This is not to say the Commerce Clause holding would be unhelpful to single-payer opponents. Inherent in this part of the decision is the notion that not only must Congress's authority be limited, but that it is naturally limited.¹³⁴ Moreover, the mandate would “draw within its regulatory scope those who otherwise would be outside of it”—a scheme that, even if necessary, would not be proper.¹³⁵ MFA would, of course, constitute a major expansion of government authority, effectively making almost the entire health insurance industry public. And while the program would not mandate enrollment, there would only be one source of general health coverage.

But some who typically favor small government have been able to look past this. Perhaps most significantly, Georgetown professor Randy Barnett—who represented NFIB in the landmark case—has long acknowledged that “if Medicare is constitutional then Medicare-for-everyone is constitutional.”¹³⁶ Former Louisiana Attorney General Buddy Caldwell, who represented his state in the case, similarly said single-payer would be “a whole lot better” than regulating private insurance.¹³⁷ Explaining his opposition to the ACA, Caldwell said insurance companies are “the absolute worst people to handle [healthcare]” because regulations are inconsistent among states and it is difficult for claimants to receive coverage.¹³⁸ Others have observed that access to medical care is “necessary to individual freedom, opportunity, and self-responsibility,”¹³⁹ and many have pointed out that single-payer would be more cost-effective than the disjointed, largely private system that the United States currently has.¹⁴⁰ As a result, while MFA would represent a major expansion of government authority, there are potential political workarounds that may also appeal to more right-leaning members of the Court.

COMM., <https://democrats.org/where-we-stand/party-platform/achieving-universal-affordable-quality-health-care/> [https://perma.cc/RM39-RNPB]; Mike Stankiewicz, *White House Report: Health Insurers See Profits Boom Under ACA, Even as Premiums Rise*, FIERCE HEALTHCARE (Mar. 22, 2018, 12:57 PM), <https://www.fiercehealthcare.com/payer/white-house-report-health-insurers-see-profit-boom-under-aca/> [https://perma.cc/2TX5-QYFB]; Louise Norris, *The ACA's Cost-Sharing Subsidies*, HEALTHINSURANCE.ORG, <https://www.healthinsurance.org/obamacare/the-acas-cost-sharing-subsidies/> [https://perma.cc/E4LX-QDEE] (last visited Oct. 28, 2021); *Share of Medicaid Population Covered Under Different Delivery Systems*, KAISER FAM. FOUND., <https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/> [https://perma.cc/6SRJ-GQYE] (last visited Oct. 28, 2021).

134. *Nat'l Fed'n*, 567 U.S. at 554–55.

135. *Id.* at 560.

136. Adam Liptak, *Common Ground for Legal Adversaries on Health Care*, N.Y. TIMES (Sept. 29, 2011), <https://www.nytimes.com/2011/09/30/us/health-care-adversaries-have-common-ground.html> [https://perma.cc/TG3A-TT7A].

137. *GOP Attorney General Suing Over ACA Supports Single Payer*, PHYSICIANS FOR NAT'L HEALTH PROGRAM (Mar. 30, 2012), <https://pnhp.org/news/gop-attorney-general-suing-over-aca-supports-single-payer/> (citing article by Scott Keyes in Think Progress).

138. *Id.*

139. Paul Menzel & Donald W. Light, *A Conservative Case for Universal Access to Health Care*, 36 HASTINGS CTR. REP. 36, 37 (2006).

140. See, e.g., *id.*; Chase Madar, *The Conservative Case for Universal Healthcare*, AM. CONSERVATIVE (July 25, 2017), <https://www.theamericanconservative.com/articles/the-conservative-case-for-universal-healthcare/> [https://perma.cc/SW9H-4WMW].

B. The Tenth Amendment and the Anti-Commandeering Doctrine

Because states regulate private health insurance currently, the federal government's takeover of the industry could be construed as a Tenth Amendment violation. The Tenth Amendment delegates all powers not granted to the federal government in the Constitution to the states.¹⁴¹ Since 1992, the Court has interpreted this in a way that prohibits the federal government from forcing states to enact particular policies or enforce federal law—a concept now known as the anti-commandeering doctrine.¹⁴²

Using the *NFIB* Medicaid expansion ruling, which held that conditioning all state Medicaid funding on accepting the expansion violated the Constitution, states could try to challenge MFA on the grounds that the federal government cannot eliminate the public health insurance programs on which they have come to rely. In *NFIB*, Chief Justice Roberts famously described the original Medicaid expansion as “a gun to the head.”¹⁴³ Requiring coverage for individual adults of all ages with income up to 133% of the federal poverty level “accomplishes a shift in kind, not merely degree,” he wrote.¹⁴⁴ The plurality concluded that Congress could not force states to accept the expansion by taking away all of their Medicaid funding if they refused to comply with it.¹⁴⁵ By contrast, H.R. 1976 provides that “[n]o individual is entitled to medical assistance under a State plan approved under title XIX of the [Social Security] Act for any item or service furnished” two years after the MFA Bill's enactment and “no payment shall be made to a State under section 1903(a).”¹⁴⁶ In other words, nobody could receive Medicaid coverage, and the federal government would not fund state Medicaid programs. Put simply, Medicaid would become moot.

The issue here largely is whether states would accept the elimination of the Medicaid programs that they administer. Unlike the Medicaid expansion, MFA would not compel states to provide coverage in a certain way or to a certain population. On the contrary, states would not have to do anything. It is easy to argue that states would benefit from MFA because the dollars that they currently put

141. U.S. CONST. amend. X.

142. *New York v. United States*, 505 U.S. 144, 175–76 (1992) (holding that a “federal action [that] would ‘commandeer’ state governments into the service of federal regulatory purposes . . . would . . . be inconsistent with the Constitution’s division of authority between federal and state governments,” as would “regulating pursuant to Congress’s direction . . .”).

143. *Nat’l Fed’n Indep. Bus. v. Sebelius*, 567 U.S. 519, 581 (2012).

144. *Id.* at 583.

145. *Id.* at 581–87.

146. H.R. 1976 § 901(a)(1)(A), (D), 117th Cong. (2021). Similarly, the proposal says, “Federal and State Exchanges established pursuant to title I of the Patient Protection and Affordable Care Act . . . shall terminate, and any other provision of law that relies upon participation in or enrollment through such an Exchange . . . shall cease to have force or effect.” *Id.* at § 902. However, the number of people participating in the Exchanges is far lower than those in Medicaid, and Medicaid comprises a far higher share of states’ budgets. See *Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/total-population/> [https://perma.cc/8Z4Y-6Z5B] (last visited Oct. 28, 2021).

toward Medicaid could be used for other purposes. The federal government is statutorily required to pay for at least 50% of each state's Medicaid spending,¹⁴⁷ and it covers 33% of Medicaid spending nationally, though some states' proportion is far higher.¹⁴⁸ In Wyoming, 43% of Medicaid dollars come from the state; Nebraska and Massachusetts also top 40%.¹⁴⁹ In terms of raw dollar amount, California (unsurprisingly) spends the most, followed by New York and Texas, putting forth \$36 billion, \$26 billion, and \$14 billion, respectively.¹⁵⁰ Even the state that spends the least, Wyoming, spends more than \$267 million per year—and again, this is a higher-than-average portion of its total Medicaid budget.¹⁵¹

States have reason to be concerned that these numbers will increase dramatically in the future. Because Medicare generally does not cover LTSS,¹⁵² Medicaid covers a greater share of LTSS than any other type of coverage or payment source.¹⁵³ Costs vary by location and type of care, but on average, it is thousands of dollars per month per patient—prohibitively expensive for most people to pay out of pocket.¹⁵⁴ Because of this, many older adults spend down their assets to qualify for Medicaid. As a result, state Medicaid expenditures are expected to increase. Meanwhile, states are scrambling to devise solutions that will help their elderly populations without stressing their budgets.¹⁵⁵ However, MFA would cover LTSS. States would not have to worry about the impending rise in costs, nor would they have to devise ways to work around them. Perhaps most importantly, older Americans would not need to put themselves into a less-than-ideal financial situation simply to obtain LTSS. States would benefit from this population being able to retain its assets. Older Americans would remain financially secure, not have to worry about whether they will have coverage, and stay active, as much as is feasible, in the local economy.

147. Robin Rudowitz et. al., *Medicaid Financing: The Basics*, KAISER FAM. FOUND. (May 7, 2021), <https://www.kff.org/report-section/medicaid-financing-the-basics-issue-brief/> [https://perma.cc/5BWG-GEKC].

148. See *Federal and State Share of Medicaid Spending*, KAISER FAM. FOUND., <https://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/> [https://perma.cc/5BWG-GEKC] (last visited Oct. 28, 2021).

149. *Id.*

150. *Id.*

151. *Id.*

152. *What Part A Covers*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicare.gov/what-medicare-covers/what-part-a-covers> [https://perma.cc/4QCS-9DUB] (last visited Apr. 24, 2022).

153. KRISTEN J. COLELLO, CONG. RSCH. SERV., IF10343, WHO PAYS FOR LONG-TERM SERVICES AND SUPPORTS? (June 15, 2022).

154. *Costs of Care*, ADMIN. FOR CMTY. LIVING, <https://acl.gov/lc/costs-and-who-pays/costs-of-care> [https://perma.cc/7PNN-A4UW] (last visited Apr. 22, 2022).

155. Teresa Wiltz, *Getting Older, Going Broke: Who's Going to Pay for Long-Term Care?*, PEW CHARITABLE TR.: STATELINE (July 25, 2019), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/07/25/getting-older-going-broke-whos-going-to-pay-for-long-term-care> [https://perma.cc/Y5DT-ZN94].

Granted, the increased Federal Medical Assistance Percentage for the expansion population was not enough to deter states from pursuing this case.¹⁵⁶ And under MFA, the states would not have a say in whether they get to keep Medicaid. But it is difficult to imagine how states could establish standing if they were to bring this case given the Court's three requirements:

- (1) The plaintiff must have suffered an “injury in fact”—a concrete, particularized, and actual or imminent violation of a legally protected interest;
- (2) The injury can be traced to the conduct in question; there must be a causal connection between the two;
- (3) A favorable decision will “likely” redress the injury. This potential cannot be merely “speculative.”¹⁵⁷

The third of the ACA trilogy cases, *California v. Texas*, is instructive here; it turned entirely on this test.¹⁵⁸ In that case, 18 states, led by Texas, challenged the law's constitutionality after Congress lowered the individual mandate penalty to \$0 in 2017, rendering it unenforceable. The states claimed pocketbook injuries from having to pay for (1) higher enrollment in state-run health programs, such as Medicaid and state employee coverage, and (2) additional administrative costs. They sought an injunction against the entire ACA, arguing that the penalty was not severable from the rest of the Act.

But the Court rejected these claims, holding 7–2 that the states “failed to show a concrete, particularized injury fairly traceable to the [federal government's] conduct in enforcing the specific statutory provision they attack as unconstitutional.”¹⁵⁹ They did not prove that the minimum coverage provision directly increased state health program enrollment, nor did they demonstrate a link between that part of the law and other sections that imposed other requirements for states. As Justice Breyer wrote for the majority, “[i]t would require far stronger evidence than the States have offered here to support their counterintuitive theory of standing, which rests on a ‘highly attenuated chain of possibilities.’”¹⁶⁰ Even Justice Thomas, who rejected the ACA's constitutionality in *NFIB*, agreed, writing in a

156. The states that challenged the ACA in *NFIB* and their Medicaid expenses as a percent of total budget were as follows: Florida (30.0%), Alabama (25.8%), Alaska (12.0%), Arizona (27.7%), Colorado (15.3%), Georgia (19.5%), Idaho (23.0%), Iowa (18.6%), Indiana (23.1%), Kansas (18.8%), Louisiana (23.7%), Maine (28.6%), Michigan (24.2%), Mississippi (22.9%), Nebraska (17.2%), Nevada (18.3%), North Dakota (13.7%), Ohio (21.3%), Pennsylvania (29.6%), South Carolina (22.6%), South Dakota (21.7%), Texas (24.6%), Utah (11.9%), Washington (23.0%), Wisconsin (17.1%), and Wyoming (7.3%). See *Medicaid Expenses As A Percent of State Budgets*, SHADAC, <http://statehealthcompare.shadac.org/map/103/medicaid-expenses-as-a-percent-of-state-budgets#a/3/140> [https://perma.cc/GN6G-86SL] (last visited July 16, 2022). The average for all 26 of these states is 20.8%.

157. *E.g.*, *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–61 (1992).

158. *California v. Texas*, 141 S. Ct. 2104, 2104 (2021).

159. *Id.* at 2120.

160. *Id.* at 2119.

concurrence that the states' case had "a fundamental problem . . . they have not identified any unlawful action that has injured them."¹⁶¹

If states were to challenge MFA, there would be even less of a concrete injury, much less a connection between an injury and the law. MFA would not increase state health program enrollment; rather, state health program enrollees would gradually enter the national health program. Further, as discussed above, states would no longer need to pay for those programs—neither the coverage itself nor the associated administrative costs.

C. The Taxing Power

While the individual mandate was not upheld on Commerce Clause grounds, it was upheld in *NFIB* as an acceptable use of Congress's taxing power.¹⁶² The Court upheld the mandate as a tax by reading the statute narrowly. The opinion relied on the long-held notion that when a statute can be read two ways, but one reading is unconstitutional, courts should adopt the meaning that is not.¹⁶³ The Court provided three additional justifications. First, the mandate's penalty preserved the choice not to purchase insurance.¹⁶⁴ Second, the mandate contained no scienter requirement.¹⁶⁵ Third, the IRS was statutorily required to enforce the penalty, consistent with other provisions of the Internal Revenue Code.¹⁶⁶ The Court also noted that Congress has long used taxes to encourage or discourage certain behaviors.¹⁶⁷

The potential for tax hikes is one fiscal conservative argument against MFA.¹⁶⁸ To be sure, this argument is easy to follow, especially when presented without other information about MFA or the healthcare system overall. However, this political persuasiveness does not translate into legal muster.

As far as taxes and penalties go, the ACA and MFA are almost incomparable. The individual mandate penalty was difficult to define, toeing the line between tax and penalty, at least until *NFIB*.¹⁶⁹ It functioned to allow people to opt out of coverage, rather than providing coverage. The MFA program would not be funded through a penalty, and nobody would pay individually to opt out. Instead, funding would be determined the same way as most other federal programs: the Secretary would develop a budget and submit it to the Office of Management and

161. *Id.* at 2121.

162. *Nat'l Fed'n Indep. Bus. v. Sebelius*, 567 U.S. 519, 561–75 (2012).

163. *Id.* at 562.

164. *Id.* at 566.

165. *Id.*

166. *Id.*

167. *Id.* at 572.

168. *See, e.g.*, U.S. S. REPUBLICAN POL'Y COMM., MEDICARE FOR ALL: HIGHER TAXES, FEWER CHOICES, LONGER LINES (Dec. 4, 2018), <https://www.rpc.senate.gov/policy-papers/medicare-for-all-higher-taxes-fewer-choices-longer-lines> [<https://perma.cc/MMK8-TMTJ>].

169. *See Nat'l Fed'n*, 567 U.S. at 564 ("It is of course true that the Act describes the payment as a 'penalty,' not a 'tax.' But . . . that label . . . does not determine whether the payment may be viewed as an exercise of Congress's taxing power.").

Budget for approval, who would submit it to the president, who would submit it to Congress.¹⁷⁰

As a result, any taxes required to fund the program are not included in the legislative text. While the Sanders campaign provided a “menu” of funding options that may serve as ideas, these are not legally objectionable as a component of the Act.¹⁷¹ Moreover, the taxing power generally has few limits. Direct taxes must be apportioned proportionally to states’ populations, indirect taxes must be levied uniformly, and state exports cannot be taxed.¹⁷² But there is no legal limit on how high federal income taxes can be.¹⁷³

As with any matter, it is difficult to predict how the Supreme Court would handle an MFA challenge. However, the current Court might respond favorably to these and similar arguments.

III. MEDICARE FOR ALL AND HEALTH JUSTICE IN THE COVID ERA

The ACA cases can be instructive for MFA advocates in a potential legal proceeding. But those cases were filed and, for the most part,¹⁷⁴ decided before the COVID-19 pandemic—a healthcare crisis unlike anything the United States had ever seen. The pandemic prompted a new and unique wave of discourse on the American healthcare system. Like the ACA trilogy, health justice advocates can use the pandemic’s lessons to advocate for necessary changes in the law.

This Section will discuss the specific ways that the pandemic illustrated the need for further reforms and the need to look beyond monetary costs.

A. *How the Pandemic Demonstrated the Need for Improvements*

The healthcare system’s failings once again took center stage when the COVID-19 pandemic began in the United States in 2020. Critiques emerged as early as March 2020, just days after state-level shutdowns began and the President

170. H.R. 1976 § 601(a), 117th Cong. (2021); *see also* BUDGET OF THE U.S. GOV’T, USA.GOV, <https://www.usa.gov/budget> [<https://perma.cc/9UVW-2TB5>] (last visited July 16, 2022). Note also that funding for current health programs would be redirected to the Universal Medicare Trust Fund. *See* H.R. 1976 § 701(b)(2).

171. *How Does Bernie Pay for His Major Plans?*, BERNIE SANDERS, <https://berniesanders.com/issues/how-does-bernie-pay-his-major-plans/> [<https://perma.cc/X2LH-MHAY>] (last visited Mar. 16, 2022).

172. *Art.I.S8.C1.1.1 Taxing Power*, CONST. ANNOTATED, https://constitution.congress.gov/browse/essay/artI-S8-C1-1-1/ALDE_00013387/ (last visited Mar. 16, 2022).

173. *See, e.g.*, ANDREW KOPPELMAN, THE TOUGH LUCK CONSTITUTION AND THE ASSAULT ON HEALTH CARE REFORM 99 (2013) (“The federal taxing power empowers the government to tax incomes at 100%.”).

174. The Supreme Court granted certiorari to the petitioners in *California v. Texas* on March 2, 2020—just days before the initial shutdown. While oral arguments took place that fall and the decision was released on June 17, 2021, all of the trial and appellate proceedings occurred pre-pandemic.

declared a national state of emergency.¹⁷⁵ Health policy analysts and epidemiologists pointed out that Americans would be reluctant to seek testing or treatment due to cost concerns, which would worsen the virus's spread.¹⁷⁶ Although the federal relief legislation prohibited cost-sharing for COVID-19 tests,¹⁷⁷ insurance companies found loopholes in the law and still billed some patients.¹⁷⁸ Further, the federal government and most states did not require insurers to waive treatment costs.¹⁷⁹ Instead, this option fell to insurers themselves.¹⁸⁰

H.R. 1976 was introduced on March 17, 2020, amid a series of stock market crashes¹⁸¹ and the largest spike in unemployment on record.¹⁸² As the Act's press release pointed out, nearly 100 million people in this country were uninsured or underinsured at that time due to, of all things, a pandemic.¹⁸³ Amid the devastation, there seemed to be a golden opportunity to make the healthcare system work better for ordinary people by assuaging cost concerns, ensuring continuity of care, and providing a sense of security in case of a catastrophic emergency. The pandemic laid bare all the problems with the healthcare system, including socioeconomic

175. CDC Museum COVID-19 Timeline, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/museum/timeline/covid19.html> [<https://perma.cc/L5YA-3RVB>] (last visited Dec. 4, 2021).

176. E.g., Dylan Scott, *Coronavirus Is Exposing All of the Weaknesses in the U.S. Health System*, VOX (Mar. 16, 2020, 7:30 AM), <https://www.vox.com/policy-and-politics/2020/3/16/21173766/coronavirus-covid-19-us-cases-health-care-system> [<https://perma.cc/Y8F9-2CCJ>].

177. Karyn Schwartz, et al., *Gaps in Cost Sharing Protections for COVID-19 Testing and Treatment Could Spark Public Concerns About COVID-19 Vaccine Costs*, KAISER FAM. FOUND. (Dec. 18, 2020), <https://www.kff.org/health-costs/issue-brief/gaps-in-cost-sharing-protections-for-covid-19-testing-and-treatment-could-spark-public-concerns-about-covid-19-vaccine-costs/> [<https://perma.cc/4X2T-DPR7>].

178. See Georgetown Center on Health Insurance Reforms, *Surprise Medical Bills and Coronavirus*, GEO. UNIV. SCH. PUB. POL'Y, <https://surprisemedicalbills.chir.georgetown.edu/surprise-medical-bills-and-coronavirus/> [<https://perma.cc/PHP3-NKRY>] (last visited Mar. 16, 2022).

179. *State Health Policy Actions During COVID-19 Public Health Emergency*, KAISER FAM. FOUND., <https://www.kff.org/report-section/state-covid-19-data-and-policy-actions-policy-actions/#policyactions> [<https://perma.cc/E7SS-FS6F>] (last visited Dec. 4, 2021).

180. *Most Private Insurers Are No Longer Waiving Cost-Sharing for COVID-19 Treatment*, KAISER FAM. FOUND., <https://www.kff.org/coronavirus-covid-19/issue-brief/most-private-insurers-are-no-longer-waiving-cost-sharing-for-covid-19-treatment/> [<https://perma.cc/NL2K-NJ3Q>] (last visited Dec. 4, 2021).

181. See, e.g., Matthew DiLallo, *The Biggest Stock Market Crashes in History*, MOTLEY FOOL (Sept. 3, 2021, 11:15 AM), <https://www.fool.com/investing/stock-market/basics/crashes/> [<https://perma.cc/Z97N-GKPE>].

182. *Unemployment Rate Rises to Record High 14.7 Percent in April 2020*, BUREAU OF LAB. STATS. ECON. DAILY (May 13, 2021), https://www.bls.gov/opub/ted/2020/unemployment-rate-rises-to-record-high-14-point-7-percent-in-april-2020.htm?view_full [<https://perma.cc/G7AF-7P9J>].

183. Press Release, *Jayapal Introduces Medicare for All Act of 2021 Alongside More Than Half of House Democratic Caucus After Millions Lose Health Care During a Pandemic*, OFF. OF CONGRESSWOMAN PRAMILA JAYAPAL (Mar. 17, 2021), <https://jayapal.house.gov/2021/03/17/medicare-for-all/> [<https://perma.cc/AD4J-4AN4>].

disparities. It seemed impossible to ignore them any longer or to continue pretending that the existing system worked for everyone. Still, nothing happened.¹⁸⁴ The Act did not budge. The window closed, but the problems remained. Public uncertainty and distrust festered.¹⁸⁵

Americans' lack of trust in the medical system may be reflected in the subsequent response to the COVID-19 vaccine. While some are quick to blame social media and misinformation for the vaccine's relatively low uptake, vaccine hesitancy may not actually be so black and white. According to a summer 2021 poll from the Kaiser Family Foundation ("KFF"), of those who have not yet received the COVID-19 vaccine, fairly small minorities believe that COVID-19 is overblown or distrust vaccines in general.¹⁸⁶ Far more are concerned about the vaccine's side effects or feel that it was not tested sufficiently.¹⁸⁷

The respondents' explanations provide an interesting and oft-overlooked perspective. For example, a Latina woman in California explained that she could not risk the side effects because she is "the rock of the family."¹⁸⁸ Another respondent, in North Carolina, expressed concerns about how the vaccine would interact with "every preexisting condition."¹⁸⁹ And a woman from Montana said "I've checked the CDC lists of ingredients and many are toxic . . . I believe it's mainly about making money."¹⁹⁰ Notably, all three of these respondents were neither Democrats nor Republicans, but independent voters.¹⁹¹

These responses call into question the idea that antivaccine sentiment is fueled purely by online misinformation and conspiracy theories, or that antivaxxers are all purely "tin-foil-hat" types. One study, conducted jointly between Northeastern, Harvard, Northwestern, and Rutgers, even found that the unvaccinated are less likely to trust social media than the vaccinated.¹⁹² Rather, the KFF results reflect a reasoned and understandable distrust of a medical system whose primary goal is maximizing profit. They also suggest that Americans are so

184. See *Actions Overview, H.R.1976 — 117th Congress (2021-2022)*, CONGRESS.GOV, <https://www.congress.gov/bill/117th-congress/house-bill/1976/all-actions> (last visited Feb. 2, 2022).

185. See NORC, *Surveys of Trust in the U.S. Health Care System*, UNIV. CHICAGO (2021), https://www.norc.org/PDFs/ABIM%20Foundation/20210518_ABIM_Foundation_Topline1_Public%20Survey.pdf [<https://perma.cc/X7XY-M9HC>].

186. Ashley Kirzinger, Grace Sparks & Mollyann Brodie, *KFF COVID-19 Vaccine Monitor: In Their Own Words, Six Months Later*, KAISER FAM. FOUND. (July 13, 2021), <https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-in-their-own-words-six-months-later/> [<https://perma.cc/KHJ5-FEGX>].

187. *Id.*

188. *Id.*

189. *Id.*

190. *Id.*

191. *Id.*

192. Peter Ramjug, *Why Aren't the Unvaccinated Getting Their Shots?*, NEWS@NORTHEASTERN (Sept. 16, 2021), <https://news.northeastern.edu/2021/09/16/why-are-people-not-getting-vaccinated/> [<https://perma.cc/H257-A4UP>].

accustomed to being charged egregious amounts of money for medical care that anything free is likely too good to be true.

Two-thirds of Americans do not trust insurance companies or pharmaceutical companies.¹⁹³ Is it shocking that some people do not trust industries whose primary goal is to profit from their medical care? Is it any surprise that a substantial minority of the population worries about getting sick when costs remain what they are? Of all the shifts that occurred in the spring of 2020, it is almost incomprehensible, at least from an ethical perspective, that Congress did not seize the opportunity to create a national health program. Instead, Congress passed a series of bills that each included piecemeal solutions to disparate parts of the healthcare system.¹⁹⁴

The pandemic's trajectory over the last two years in countries that have national healthcare systems with low patient costs may be instructive for the U.S. government, should it choose to prepare for a future pandemic.¹⁹⁵ Granted, many factors contributed to the severity of the COVID-19 crisis in the United States.¹⁹⁶ And a few countries that reacted similarly have also experienced high infection and mortality rates, even if they do have a single-payer system—for example, the United Kingdom.¹⁹⁷ But a country-level COVID-19 mortality rate correlates with existing prevalence of cardiac and respiratory disease,¹⁹⁸ access to care,¹⁹⁹ and income

193. See NORC, *supra* note 185.

194. See Families First Coronavirus Response Act, H.R. 6201, 116th Cong. (2020); Coronavirus Aid, Relief, and Economic Security Act, H.R. 748, 116th Cong. (2020); Paycheck Protection Program and Health Care Enhancement Act, H.R. 266, 116th Cong. (2020).

195. Epidemiologists had warned for years about the risk of a pandemic. See Robin Marantz Henig, *Experts Warned of a Pandemic Decades Ago. Why Weren't We Ready?*, NAT'L GEOGRAPHIC (Apr. 8, 2020), <https://www.nationalgeographic.com/science/article/experts-warned-pandemic-decades-ago-why-not-ready-for-coronavirus> [<https://perma.cc/F23K-P5PA>]. Now that this one has happened, it seems prudent to prepare for another one sometime in the future.

196. E.g., Satyaki Roy & Preetam Ghosh, *Factors Affecting COVID-19 Infected and Death Rates Inform Lockdown-Related Policymaking*, PLOS ONE (Oct. 23, 2020), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0241165> [<https://perma.cc/G5R6-648Y>] (finding a relationship between COVID infections and population density, airport traffic, and testing numbers); Lyudmyla Kompaniyets, et al., *Body Mass Index and Risk for COVID-19-Related Hospitalization, Intensive Care Unit Admission, Invasive Mechanical Ventilation, and Death — United States, March–December 2020*, 70 MORBIDITY & MORTALITY WKLY. REP. 355–61 (Mar. 12, 2021) (concluding that higher BMI corresponded to COVID case severity).

197. See *Mortality Analyses*, JOHNS HOPKINS UNIV. & MED.—CORONAVIRUS RESPONSE CTR., <https://coronavirus.jhu.edu/data/mortality> [<https://perma.cc/E6V6-SWJS>] (last visited Aug. 31, 2022).

198. See Gabriele Sorci, Bruno Faivre & Serge Morand, *Explaining Among-Country Variation in COVID-19 Case Fatality Rate*, 10 SCI. REPS. 18909 (2020).

199. See Arindam Banik et al., *Why Do COVID-19 Fatality Rates Differ Across Countries? An Explorative Cross-Country Study Based on Select Indicators*, 21 GLOB. BUS. REV. 607–25 (2020).

inequality.²⁰⁰ It is unsurprising that the U.S. COVID-19 fatality rate (316.98 per 100,000 individuals) far exceeds that of economically comparable (i.e., high-income) nations, such as France (237.56), Germany (177.05), Canada (115.20), Norway (72.92), or Japan (31.06).²⁰¹

At the end of the day, it is basic economics: When a product or service is expensive, fewer people can buy it. According to the Petersen-Kaiser health tracker, one in ten Americans avoided getting medical care in 2019 due to cost.²⁰² Among the uninsured, this figure shoots up to 37%.²⁰³ Contrary to arguments about “young invincibles,” those in poor health were more likely than those in good health to delay or go without care due to cost concerns.²⁰⁴ Additionally, Black and Latino individuals were more likely to forego care than whites.²⁰⁵ When people delay care, early-stage illnesses—including those associated with COVID-19 mortality—go undetected and worsen.²⁰⁶ At the same time, the chronically ill are most likely to avoid care because their conditions are expensive to treat.²⁰⁷ “Health insurance literacy” may be a reason why Americans, especially those with chronic illnesses, postpone care.²⁰⁸ But that would not be an issue with MFA. Nobody would struggle to make sense of premiums, deductibles,²⁰⁹ or coinsurance because the out-of-pocket cost would be \$0.²¹⁰ Nor would anyone have to run through preauthorization and decision-appeal mazes to obtain necessary coverage because every American would qualify.²¹¹

Although private plans were required to cover COVID-related care in full in the earlier stages of the pandemic, an overwhelming majority of private plans

200. See Rabail Chaudhry et al., *A Country Level Analysis Measuring the Impact of Government Actions, Country Preparedness and Socioeconomic Factors on COVID-19 Mortality and Related Health Outcomes*, 25 LANCET 100464 (2020).

201. *Mortality Analyses*, supra note 197.

202. Krutika Amin et al., *How Does Cost Affect Access to Care?*, PETERSON-KAISER HEALTH SYS. TRACKER (Jan. 5, 2021), https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/#item-costaccessstocare_4 [<https://perma.cc/AP92-8XF2>].

203. *Id.*

204. *Id.*

205. *Id.*

206. *Increasing Access Benefits Everyone: Health Consequences of Being Uninsured*, NAT'L IMMIGR. L. CTR. (Aug. 2017), <https://www.nilc.org/issues/health-care/health-consequences-of-being-uninsured/> [<https://perma.cc/77XP-BDHX>].

207. BRIAN W. WARD, NCHS DATA BRIEF NO. 275, BARRIERS TO HEALTH CARE FOR ADULTS WITH MULTIPLE CHRONIC CONDITIONS: UNITED STATES, 2012-2015 (2017).

208. See, e.g., Kyle T. Smith et al., *Access Is Necessary but Not Sufficient: Factors Influencing Delay and Avoidance of Health Care Services*, 3 MDM POL'Y & PRAC. 1 (2018).

209. See Chai Dingari, Adam Westbrook & Brendan Miller, *Why Is It So Expensive?*, N.Y. TIMES (Apr. 28, 2021), <https://www.nytimes.com/2021/04/28/opinion/healthcare-us.html> [<https://perma.cc/X99N-TLEJ>].

210. H.R. 1976 § 202(a)–(b), 117th Cong. (2021).

211. H.R. 1976 § 102(b), § 202(c).

have stopped covering COVID-19 treatment.²¹² More than 70% of privately insured COVID-19 patients who were hospitalized in 2020 incurred cost-sharing, as well as nearly half of those who had privately-run Medicare plans, according to a study from the University of Michigan.²¹³ As its lead author notes, insurers claim they should be able to charge patients for COVID-19 hospitalizations because vaccines are available—which ignores the fact that some people are ineligible for the vaccine or experience breakthrough infections.²¹⁴ Insurers’ reasoning also implies that unvaccinated people have some moral failing that makes them deserving of expensive medical bills. In addition to the reasons outlined above, some unvaccinated people have not been able to make time for their vaccination and its attendant recovery period due to work and family obligations, according to a Census survey.²¹⁵ Others have physical disabilities—which the Census defines as “difficulty seeing, hearing, remembering or walking or climbing stairs”—that complicate or limit their access.²¹⁶

To make matters worse, nearly all private health insurance plans stopped covering COVID-19 treatment by March 2022.²¹⁷ The Institute for Health Metrics and Evaluation, a health data research center at the University of Washington, predicts that even by November 2022, there will still be more than 13 million infections per day.²¹⁸ Then what happens? Do people with private insurance forego medical care for COVID-19 (on top of everything else they must skip because of costs)? Does the infection then spread in yet another wave? Or will the U.S. government continue to downplay, if not outright ignore, the pandemic for the sake

212. Jared Ortaliza et al., *Most Private Insurers Are No Longer Waiving Cost-Sharing for COVID-19 Treatment*, PETERSON-KAISER HEALTH SYS. TRACKER (Aug. 19, 2021), <https://www.healthsystemtracker.org/brief/most-private-insurers-are-no-longer-waiving-cost-sharing-for-covid-19-treatment/> [https://perma.cc/T4KY-3JVZ].

213. Kao-Ping Chua et al., *Assessment of Out-of-Pocket Spending for COVID-19 Hospitalizations in the US in 2020*, JAMA NETWORK OPEN 8 (Oct. 18, 2021).

214. Kara Gavin, *Patients Hospitalized for COVID-19 This Year Could Pay Thousands of Dollars, Study Suggests*, UNIV. MICH. HEALTH LAB (Oct. 18, 2021, 11:00 AM), <https://labblog.uofmhealth.org/industry-dx/patients-hospitalized-for-covid-could-pay-thousands-of-dollars-study-suggests> [https://perma.cc/Y8MT-XYKT].

215. Lindsay M. Monte, *Household Pulse Survey Shows Many Don't Trust COVID Vaccine, Worry About Side Effects*, U.S. CENSUS BUREAU: AM. COUNTS: STORIES BEHIND THE NUMBERS (Dec. 28, 2021), <https://www.census.gov/library/stories/2021/12/who-are-the-adults-not-vaccinated-against-covid.html> [https://perma.cc/RBN2-W5FQ]; Amy Harmon & Josh Holder, *They Haven't Gotten a Covid Vaccine Yet. But They Aren't 'Hesitant' Either*, N.Y. TIMES (Oct. 24, 2021) <https://www.nytimes.com/2021/05/12/us/covid-vaccines-vulnerable.html> [https://perma.cc/26HU-PG8S].

216. Monte, *supra* note 215.

217. Ortaliza et al., *supra* note 212.

218. *COVID-19 Projections*, INST. FOR HEALTH METRICS AND EVALUATION, <https://covid19.healthdata.org/global?view=infections-testing&tab=trend&test=infections> [https://perma.cc/3PHF-G7KT] (last visited June 19, 2022) (scroll down to “Daily infections and testing”).

of “getting back to normal”?²¹⁹ This tragedy has demonstrated the urgent need to overhaul our healthcare system.

B. Beyond Monetary Costs

The way the pandemic has unfolded is the result of devaluing life in favor of economic interests. Some of the most vocal commentators, who hold positions at medical schools and in the federal government, have also been the most eager to “reopen” (though, granted, the United States hasn’t really been locked down since April 2020).²²⁰ They acknowledge that some people will still get sick, but the economic benefit of “returning to normal” supposedly is so high that it outweighs the cost of allowing the virus to continue to spread.

This implies that the most at-risk populations—older people, people with disabilities, and people with compromised immune systems or other health conditions—would get ill anyway. Disability advocate Beatrice Adler-Bolton describes the idea as “deaths pulled from the future”:

. . . [It] is part of a much broader narrative that has been pervasive throughout the pandemic, which has resulted in the framing of deaths from Covid-19 as somehow preordained. The idea that any of the death and despair that vulnerable populations have seen throughout the duration of the pandemic is necessary has been manufactured

219. As of August 2022, the Biden Administration includes “Prevent[ing] Economic and Educational Shutdowns” as part of its four-pronged COVID response plan. In the description of this prong, the White House touted “historic job growth,” “exceed[ing] . . . pre-pandemic output,” and giving “schools, workers, and workplaces . . . resources and guidance to prevent shutdowns.” *National COVID-19 Preparedness Plan*, THE WHITE HOUSE, <https://www.whitehouse.gov/covidplan/#economy> [<https://perma.cc/79HR-TCR4>]. But “staying open” is not an inherently positive thing. “Staying open” has allowed continual spread, countless deaths, and an ongoing influx of long-COVID cases. This Administration has also failed to respond seriously to new variants, as exemplified by the January 2022 omicron surge. Weak “resources and guidance” also provide little to no help with disease prevention. *E.g.*, *Operational Guidance for K-12 Schools and Early Care and Education Programs to Support Safe In-Person Learning*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/k-12-childcare-guidance.html> [<https://perma.cc/9DPQ-UZ2D>] (eliminating recommendations to quarantine after exposure and to screen students routinely in K-12 schools, among other things). And amid these overlapping problems, “staying open” does nothing to promote healthcare access or affordability. Not unrelatedly, the health insurance lobby’s messaging on this matter has been scattered—and lately, scant, with only one COVID-related resource posted publicly on its website this year, and only a few posted in 2021. *See Resources*, AHIP, [https://www.ahip.org/resources?issue\[\]=175](https://www.ahip.org/resources?issue[]=175) [<https://perma.cc/MB48-FSVC>] (last visited August 31, 2022). It also speaks of the pandemic in the past tense. *E.g.*, *Public Health Tech Initiative*, AHIP, <https://www.ahip.org/resources/public-health-tech-initiative> [<https://perma.cc/X52H-ZJGW>] (last visited August 31, 2022) (“The COVID-19 pandemic was an unprecedented event . . .”).

220. *See* Joe Pompeo, “When Virologists Are in Demand, It’s a Sign of the Apocalypse”: Meet the Unlikely Breakout Stars Getting Us Through the Pandemic, VANITY FAIR (Aug. 30, 2021) <https://www.vanityfair.com/news/2021/08/meet-the-covid-commentariat-unlikely-breakout-stars-getting-us-through-the-pandemic> [<https://perma.cc/D295-QGQP>].

through frameworks of austerity. This results in deadly political inaction that threatens the survival of vulnerable people and will impact their health outcomes not just during the pandemic but for decades to come.²²¹

Still, to the “pro-normalcy” crowd, the benefits of keeping high-risk people healthy, even alive, would not outweigh the costs to everyone else of presuming the pandemic is over, returning to business as usual, and having fun.²²² (Never mind that anyone, even healthy, vaccinated people, can contract COVID-19 and then possibly suffer from its long-term effects.) Thus, nonpharmaceutical precautions—testing, screening, installing better air filters, physical distancing, limiting the size of gatherings, and perhaps most notably, masking—are simply not worth the money or the effort.²²³

Cost-benefit analysis is part and parcel of modern American policymaking (though history shows that it does not have to be this way).²²⁴ Perhaps no

221. Beatrice Adler-Bolton, “Deaths Pulled From the Future,” BLIND ARCHIVE (Jan. 3, 2022), <https://blindarchive.substack.com/p/deaths-pulled-from-the-future> [<https://perma.cc/85RD-S4WK>].

222. See, e.g., Michelle Holmes, *We Need to School Ourselves As To What Safe In-Person Education Looks Like*, BOSTON GLOBE, Feb. 3, 2022. Holmes correctly observes that the high-profile figures pushing to reopen schools, such as David Leonhardt, Emily Oster, and David Rubin, ignore the needs of children with disabilities and children living in multi-generational households, as well as the disproportionate potential for harm to non-white children. She also points out the ageism inherent in the idea that “only” older people die of COVID and ageist, ableist statements from Biden Administration officials, including CDC Director Rochelle Walensky.

223. E.g., Yascha Mounk, *Open Everything*, THE ATLANTIC, (Feb. 9, 2022), <https://www.theatlantic.com/ideas/archive/2022/02/end-coronavirus-restrictions/621627/> [<https://perma.cc/U3X5-3X54>] (“Worldwide spread of the coronavirus will likely continue to result in serious suffering for years to come. That’s tragic. But it is not a sufficient reason to permanently change our society in ways that make it less free, sociable, and joyous.”); Leana S. Wen, *The CDC’s New Mask Guidelines Finally Got It Right*, WASH. POST, Feb. 25, 2022, 6:37 PM, <https://www.washingtonpost.com/opinions/2022/02/25/cdc-mask-guidelines-covid-pandemic-got-it-right/> [<https://perma.cc/8XXL-XZB2>] (saying that “we need to live with covid-19 and remove restrictions while we can,” and even though “it is unfair that many will get to move on to reclaim normalcy while some cannot . . . there is a cost to keeping blanket restrictions in place.”); Ashish Jha, *We’ve Entered a New Phase of the Pandemic. It’s Time for New Metrics*, N.Y. TIMES, (Feb. 25, 2022), <https://www.nytimes.com/2022/02/25/opinion/cdc-covid-guidelines.html> [<https://perma.cc/YDA4-CUCE>] (stating that the February 2022 change in CDC’s masking guidelines “mark a turning point for how people, institutions and governments should respond to the coronavirus”).

224. Exec. Order No. 12,866; *A Death Panel History of 504, Part One*, DEATH PANEL, at 37:25-38:08 (Apr. 14, 2022), <https://soundcloud.com/deathpanel/a-death-panel-history-of-504-part-one-041422> (“The other thing that’s not addressed in [Section] 504 [of the Rehabilitation Act, which prohibits discrimination on the basis of disability] and not addressed in any amendments is cost. There’s no discussion of cost or how it’s going to be paid for. This was sort of the style of the time [in 1975]. They decide . . . we need to intentionally leave that out because if we put that in, it’s a sort of catch and it’s a cynical

government body encapsulates this as well as the Congressional Budget Office (“CBO”). The CBO uses unreleased (exempt from the Freedom of Information Act²²⁵) “models” to “score” legislation.²²⁶ It then writes reports that members of Congress consider when deciding whether to vote for or against the associated bill.²²⁷

On November 3, 2021, CBO director Phillip Swagel delivered a presentation about COVID-19’s effect on economic policy.²²⁸ After walking through the relief packages, employment statistics, and GDP projections, Swagel concluded with a list of other effects, including productivity, labor force participation, mortality and fertility, healthcare utilization and spending, interest rates, inflation, and potential output.²²⁹ The theme that connects these points is that people are not inherently deserving of protection in a pandemic, or financial security broadly, but worth only the value of their labor. There is no cut-and-dry way to measure fear, despair, or grief.

But this is standard for the CBO, which works at Congress’s direction. When it analyzed single-payer healthcare in December 2020—well into the pandemic—it focused overwhelmingly on monetary costs.²³⁰ In fact, it did not discuss potential benefits of single-payer healthcare given the disease toll at all. In sections of the report about outcomes and patient satisfaction, CBO was sure to minimize the benefits of eliminating barriers to care. For example, greater access supposedly would bring “congestion,” which would decrease patient satisfaction and worsen health outcomes.²³¹ This is like saying that the advent of public education led to overcrowded, low-quality schools. Of course, the flip side of improving access is restricting it further or keeping it where it is—cost anxiety and medical debt included. The analysis, put bluntly, says that care should remain only for the deserving—those with a certain income, plus the few with means-tested coverage.

obstruction to focus on costs, and any benefits would quantifiably above and beyond so outweigh any potential costs that it wouldn’t even merit comparing them, and this is taken into account in the drafting process.”).

225. E.g., Phil Rocco, *The Democrats’ Trick Handcuffs*, SICK NOTE (Sept. 29, 2021), <https://www.sicknote.co/p/phil-rocco-on-the-democrats-trick> [<https://perma.cc/H4UP-U5Y6>].

226. See, e.g., Pascal-Emmanuel Gobry, *Open Source the CBO!*, WEEK (Jan. 11, 2015), <https://theweek.com/articles/442973/open-source-cbo> [<https://perma.cc/825U-9TJJ>].

227. *Introduction to CBO*, CONG. BUDGET OFF., <https://www.cbo.gov/about/overview> [<https://perma.cc/J632-BPZ6>] (last visited Mar. 16, 2022).

228. Phillip Swagel, *CBO’s Budget and Economic Analysis During the Pandemic*, CONG. BUDGET OFF. (Nov. 3, 2021), <https://www.cbo.gov/publication/57523> [<https://perma.cc/DUQ8-AB3L>].

229. *Id.*

230. CBO’s Single-Payer Health Care Systems Team, *How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare’s Fee-for-Service Program, passim* (Cong. Budget Off., Working Paper No. 2020-08, Dec. 2020).

231. *Id.* at 157–60.

On the outcome side, CBO cited studies that found a mix of outcome changes with cost improvements.²³² But these were not a good yardstick. For instance, the famed Oregon Health Insurance Experiment analyzed ER utilization after Medicaid expansion. Because Medicaid, even post-ACA, is so different from MFA—if only because so much of it is now run by privately managed care organizations—it is not a one-to-one comparison. The CBO also cites the RAND Health Insurance Experiment, which is from 1984. Common sense and a simple chart of average out-of-pocket expenditures²³³ over time should be enough to discredit reliance on nearly 40-year-old studies.

The CBO makes it easy for Congress to forego policies that will generate material improvements in poor, working-class, and middle-class Americans' lives. It is Congress's crutch for when our legislators do not want to make sound policy decisions that serve the many instead of the few. For these reasons, CBO's score of H.R. 1976 should not be considered a reason to reject MFA, nor should other cost-benefit analyses that dismiss the policy's potential and that, perhaps not coincidentally, tend to receive a lot of publicity. The Act would further other more important goals that do not fit neatly into the usual cost-benefit analysis framework. You get what you pay for.

C. COVID, Health Justice, and Medicare for All

Broadly, health justice is the concept that law can be used to reduce disparities in health outcomes. One of the earliest law review articles on health justice, by Professor Lindsay Wiley, cited The Praxis Project's definition of the term: “. . . social change that transforms the current system of neglect, bias, and privilege into systems—policies, practices, institutions—that truly support health[y] communities for all.”²³⁴ Said differently, health justice is the pursuit of health equity in the context of “social determinants of health”—demographic, political, and environmental factors that create the conditions for good or bad health, such as income, geographic location, education level, and citizenship status.²³⁵ In contrast to current American policymaking, health justice does not prioritize cost-benefit analysis.

232. *Id.* at 162–64.

233. Rabah Kamal et al., *How Has U.S. Spending on Health Care Changed Over Time?*, PETERSON-KAISER HEALTH SYS. TRACKER (Dec. 23, 2020), <https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/> [<https://perma.cc/WF98-6GR5>] (“In dollar terms, out-of-pocket expenditures have grown steadily since 1970, averaging \$1,240 per capita in 2019, up from \$115 per capita in 1970 (\$603 in 2019 dollars).”).

234. Lindsay Wiley, *Health Law as Social Justice*, 24 CORNELL J.L. & PUB. POL'Y 47, 84–85 (2014).

235. *E.g.*, *Social Determinants of Health*, OFF. DISEASE PREVENTION & HEALTH PROMOTION, <https://health.gov/healthypeople/priority-areas/social-determinants-health> [<https://perma.cc/T4TT-MYY9>] (last visited Apr. 25, 2022); *Social Determinants of Health*, HEALTHYPEOPLE.GOV, <https://www.healthypeople.gov/node/3499/2020/topics-objectives/topic/social-determinants-health> [<https://perma.cc/GQD4-XEN2>] (last visited Apr. 25, 2022); *Determinants of Health*, WORLD HEALTH ORG. (Feb. 3, 2017), <https://www.who.int/news-room/questions-and-answers/item/determinants-of-health> [<https://perma.cc/JYT7-AQ3T>].

The health justice framework provides an additional basis for furthering MFA. In 2015, Professor Emily Benfer described four goals for achieving health justice: (1) developing primary prevention policies, (2) addressing laws that adversely affect health, (3) ending implicit and overt bias and discrimination, and (4) engaging with and helping to mobilize affected communities.²³⁶ While, as Wiley discussed, health justice goes far beyond delivery system reform,²³⁷ MFA could nevertheless further each of those four goals.

For goals (1) and (2), MFA would eliminate major barriers to care. The most obvious of these barriers is cost, though it would improve access in other ways too. People would have no questions about what services are covered, whether their providers are in-network, or whether they would have to seek preauthorization or attempt other therapies before using what works for them. People would not postpone care due to cost concerns, nor would they worry about exactly how much a service will cost. MFA would also eliminate the need to battle with an insurer for hours, days, or weeks attempting to get it covered later.

MFA would most improve care for the most marginalized groups—low-income people, nonwhite communities, immigrants, and non-English speakers—advancing goals (3) and (4). Black, Hispanic, and Indigenous Americans are more likely to be uninsured than white Americans. This is partially because a higher proportion are in jobs that do not offer insurance, but purchasing insurance separately is not feasible.²³⁸ Additionally, Black families spend about 20% of household income on health insurance premiums; the national average is 11%.²³⁹ Eliminating that financial burden would lessen the disparity in disposable income, leading to equities in terms of financial security. Despite misconceptions to the contrary, low-income people *do* face out-of-pocket medical expenses—and they chew up a substantial part of their income. An analysis of Census data found that MFA would reduce poverty by 22%.²⁴⁰ Consider also those who speak limited English, including many immigrants. As discussed above, common health insurance terminology is difficult even for native English speakers to understand.²⁴¹ Navigating paperwork, understanding what's covered, and finding in-network providers can be impossible—to say nothing of appealing unfavorable coverage

236. Emily Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice*, 65 AM. U.L. REV. 275, 335–349 (2015).

237. Wiley, *supra* note 234, at 88.

238. Samantha Artiga et al., *Health Coverage by Race and Ethnicity, 2010-2019*, KAISER FAM. FOUND. (Jul. 16, 2021), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity> [<https://perma.cc/VGM9-2RWE>].

239. Jamila Taylor, *Racism, Inequality, and Health Care for African Americans*, THE CENTURY FOUND. (Dec. 19, 2019), <https://tcf.org/content/report/racism-inequality-health-care-african-americans/?agreed=1>.

240. Matt Bruenig, *Medicare for All Would Cut Poverty by Over 20 Percent*, PEOPLE'S POL'Y PROJECT (Sept. 12, 2019), <https://www.peoplespolicyproject.org/2019/09/12/medicare-for-all-would-cut-poverty-by-over-20-percent/> [<https://perma.cc/W9JM-DSNN>].

241. Masterson, *supra* note 112.

decisions.²⁴² These considerations, and many others in the same vein, are especially important in the COVID era, given that the pandemic disproportionately hurt those with the most barriers to healthcare in the first place.

In sum, MFA would further the goals of health justice. The current healthcare system is not just deleterious to those with lower incomes, but other marginalized populations as well. Replacing it with MFA, which would provide truly equitable access to care by eliminating cost barriers, would provide a direct avenue to care for many of those who need care the most. This is crucial as the pandemic continues: MFA could play a key role in mitigating the pandemic's ongoing tragic effects.

CONCLUSION

Healthcare in America has never really been about care. Since the modern healthcare system's inception, its main goal has been to generate profits. Money speaks loudly in this country. This context is no exception. That is why, at every turn, those advocating to put "care" as the primary aim of healthcare have been largely shut down. Rationing care makes it scarce, which allows it to be expensive. Keeping the system complex makes people tired as they try to navigate it. Because the system is overly complicated, those in political and economic power escape accountability.

With the spread of COVID-19, the need for medical care became so acute and widespread that people could not ignore the healthcare system's structural infirmities. Hospitals overflowed. Supplies ran out. The fear of sickness and the fear of debt ran parallel to each other. Eventually, everybody knew someone who got COVID-19, and many people knew someone who did not make it. The already-weak system crumbled under a crushing weight.

The pandemic proved that single-payer healthcare is long overdue; more Americans understand this now than ever. The people who got sick and died because they could not afford medical care cannot be brought back, but single-payer healthcare can save countless lives in the future. Many Americans also realize that just as there was no good reason for so much devastation, there is no good reason that MFA should not come to be. Those who wish to advocate for a healthier, more just future should anticipate legal challenges, but they can use recent events in health law to make a strong, constitutionally sound case for MFA.

242. E.g., Ogbonnaya I. Omenka, *Understanding the Healthcare Experiences and Needs of African Immigrants in the United States: A Scoping Review*, 20:27 BMC PUB. HEALTH 8–9 (2020).