Premier Debate

September/October 2020

Expert PF Brief

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Introduction

Friends of Premier Debate,

This is Premier's first brief of the 2020-2021 season, and the topic is "**Resolved: The United States federal government should enact the Medicare-For-All Act of 2019."** We are so excited to help all of you kick off this season with some of the best cards on the topic!

This topic is a refreshing, policy-heavy topic. There are a variety of aspects of healthcare policy to explore, and successful teams will use the nuances and peripherals of the healthcare industry to craft unique contentions. All teams should also familiarize themselves with the core cost saving / spending debate, as it represents the biggest point of clash.

This brief provides **215 cards** that cover topic background, unique contentions for both sides, and blocks for both sides. It also includes a thorough **topic analysis** by Ben Goldberg. We're confident that these are some of the best resources out there!

Best practice for brief use is to use it as a guide for further research. Find the articles and citations and cut them for your own personal knowledge. You'll find even better cards that way. If you want to use the evidence in here in a pinch, you should at least re-tag and highlight the evidence yourself so you know exactly what it says and how you're going to use it. Remember, briefs can be a tremendous resource but you need to familiarize yourself with the underlying material first.

We're always looking for ways to make the briefs better, so please, let us know what you think! And, if you use these briefs please help us direct other debaters to premierdebate.com/briefs where we will continue uploading .doc versions of the briefs.

If you like what we're doing and these cards have been helpful to you, consider signing up for online coaching through Premier Debate. Our coaches were elite competitors in their own right and have now coached students to elimination rounds, earning TOC bids, and qualifying to state and national championships. See premierdebate.com/coaching for more details on how to apply!

Finally, we'd like to thank Ben Goldberg, Amy Santos, Peter Zhang, and Kevin Zeng for their help in assembling this brief. These are some of the best, round-ready cards you'll see on the topic, and we couldn't have done it without them.

Good luck everyone. See you 'round!

Bob Overing & John Scoggin

Directors | Premier Debate

Topic Analysis

by Ben Goldberg

Introduction

Welcome back to the competitive season! September-October is always a fun introduction back into the circuit, and this year is no exception. Regardless of whether or not you went to (or I guess zoom-ed into) debate camp over the summer, the two-month topic period (as well as quarantine) should give you plenty of time to research and experiment with argumentation. Even though a good chunk of debating will be online this year, many big tournaments will still be continuing on this topic, including UK, Yale, Grapevine, and Bronx. These are all great opportunities for rigorous competition, and all great opportunities to learn more about the topic. If you're a team that will be competing at multiple tournaments on this topic, you should use your first tournament or two to test out as many strategic angles as you feel comfortable with. Two months should give you plenty of time to craft the perfect nuanced argument. However, it will also give your opponents the chance to do the same, so be sure that you go to tournaments prepared to block out other cases and to frontline attacks on your own.

Now, before I get into discussing the arguments in depth, I'll go over the topic more generally term-by-term.

"The United States federal government"

This definition is pretty straightforward, and doesn't require much explanation. The actor implementing this policy will be the federal government; it is composed of the executive branch, the legislative branch, and the judicial branch. We are not looking at the policies of state governments, though it is possible that the resolution impacts state government in some way.

You probably have a decent idea of what the branches of the federal government do, but I'll review them briefly just in case. The **executive branch** is led by the President (currently Donald Trump), and it also includes the Vice President (Mike Pence), the Cabinet, and the bureaucratic departments that work for each cabinet official. It's main purpose is to implement and enforce any policies that are passed. The President also has the power to veto legislation passed by Congress.

The **legislative branch**, or Congress, is a bicameral legislature comprised of the House of Representatives and the Senate. The House of Representatives has 435 members (though the number is relatively fluid), and their members are apportioned among the fifty states according to the census population data. It is currently controlled by the Democratic Party. The Senate has 100 members, two members for each of the fifty states. It is currently controlled by the Republican Party. The purpose of Congress is to propose and pass legislation. To make a bill into law, it must gain majority approval from both houses of Congress. Critically, each house of Congress can vote on different versions of the same bill, which must then be reconciled in committees and negotiations. It must then either be signed into law by the president, or have a two-thirds majority support in both houses.

The **judicial branch** is the least likely to be referenced in this debate. It includes district courts, appeals courts, and the Supreme Court. Judges who serve on these courts are not elected, but are instead appointed for life by the President. It's goal is to interpret the constitutionality and legitimacy of

laws passed by the government. Something to be noted is that it often takes years before a case reaches the Supreme Court; the case often goes in circles between the District Courts and the Courts of Appeals for years until the Supreme Court decides whether it wants to step in. The Supreme Court is currently leaning conservative by a 5-4 majority, but several of its conservative members have shown their willingness to support more liberal policies. For example, John Roberts sided with the four liberal justices in defense of Obamacare a few years ago.

"The Medicare-for-All Act of 2019"

The next part of this topic that I will discuss is the Medicare-for-All Act of 2019, which will likely be abbreviated to "MFA" or "M4A" in many rounds. There are two versions of this bill, one from the House and one from the Senate. I hyperlinked each bill to the respective house of Congress, and I recommend anyone debating this topic read them both (though they are very similar). Even so, I believe that the bill most frequently discussed in this debate will be the Senate Bill, as it was written by Bernie Sanders and is the most widely known version.

Medicare is an entitlement program for seniors that reduces and sometimes eliminates their healthcare costs. It has four distinct parts to it.

1. **Part A** is Hospital Insurance. This includes inpatient care, skilled nursing, hospice, etc. It accounts for roughly 2/3 of program costs.
2. **Part B** is Supplemental Medical Insurance. It includes physicians, outpatient, lab services, and ambulatory care. It accounts for the other 1/3 of costs.
3. **Part C** combines Parts A and B, and is basically additional coverage provided by private insurance and approved by Medicare. You won't need to know this.
4. **Part D** is supplemental drug cost coverage. It is a voluntary prescription drug program offered by private health insurance companies to offset (but not fully cover) prescription drug costs.

None of this is cheap, by the way. Medicare currently comprises 14.1% of the annual federal budget. It is primarily funded through payroll taxes, but it isn't enough. Due to factors such as the sheer size of the Baby Boomer generation, coupled with increases in life expectancy, Medicare is set to be insolvent within a couple decades.

Medicare-for-all would be the same concept and policy, just expanded in terms of eligibility and benefits. Everyone would have access to affordable and high-quality healthcare coverage. It would also include negotiations with drug companies to lower the costs of pharmaceuticals. However, the program also stipulates that private healthcare coverage would be phased out and abolished. Medicare-for-all has wide support from the progressive wing of the Democratic Party, and its support is growing. Conservatives, on the other hand, despise the concept, and believe it to be an infeasible step towards communism (these are oversimplifications, arguments will be provided later in the analysis). People who are closer to the center tend to support the concept of universal healthcare, but not the idea of losing their private insurance.

In this debate, you will not be arguing about some theoretical Medicare-for-All, but a specific proposal for its implementation. As such, there are a few key facts you should know about the proposal.

1. **It has a proposed method of funding**. If you scroll to “Universal Medicare Trust Fund”, it explains that Medicare will be funded by a combination of taxes and the appropriation of funds from other programs. This includes the existing Medicare program, Medicaid, and other similar programs.
2. **It has a built-in transitional period**. Implementing a program as massive as Medicare-for-all would not happen overnight; it would occur more gradually. For example, every subsequent year after its implementation, it would lower its age of eligibility by ten years.

Background

So…the United States healthcare system is grossly inefficient and impractical. The US spends SIGNIFICANTLY more on healthcare than any other country, and this spending is only continuing to increase. As of now, most of this spending is used to treat just 10% of the population: the uninsured, who in turn raise costs for everyone else. This isn't to say that the quality of American care isn't good; in fact, it's excellent. However, millions simply lack access to this care, even when they desperately need it.

Healthcare costs are increasing right now for a few reasons, such as the rising costs of prescription drugs, the rise of chronic diseases due to behaviors such as obesity and smoking, and the existence of uninsured Americans. However, the largest current driver of healthcare costs is innovations in medical technology; the continuous addition of new medical equipment to hospitals means that private insurers and hospitals alike continue to jack up prices.

Some other healthcare policies currently on the books include Medicaid, which provides low-cost health insurance to the poor; and the Affordable Care Act, which provides a series of benefits aimed at expanding coverage and lowering costs. I doubt you'll need to know too much about this in particular, though.

The topic of healthcare is also still in flux. Due to coronavirus, the government has renewed its focus on public health. On July 24, Trump signed a series of executive orders aimed at lowering drug prices. One order aims to force insurance companies to pass along to consumers the rebates their agents negotiate with drugmakers. Other orders would allow drugs to be imported if they're produced in countries with regulatory systems deemed safe by the U.S., or reimported from foreign countries if they were produced here; permit low-income Americans to buy deeply discounted insulin and injectable epinephrine from federally supported health centers; and require certain drugs to sell for the same price in the U.S. as they sell for in other major developed nations. I will be the first to say I do not know much about the effects these programs will have, so you should definitely conduct strong research into this topic in particular.

With background and definitions out of the way, it's time to look at the key arguments for this topic…

Affirmative Arguments

Argument 1: Affordability

This argument is pretty straightforward, and it will likely be the crux of most affirmative cases that you see. As I previously alluded to, there are millions of Americans that, for financial reasons, cannot afford to splurge on health-related expenses. This argument can be taken in two different directions.

First, **free healthcare coverage**. When people cannot afford high or even average-quality health insurance, any trips to hospitals or doctors will be ridiculously costly. This leaves low income Americans with two options. Either (a) they go to the doctor when they are sick/injured, and lose out on money to spend on food or housing; or (b) they forgo medical assistance in order to afford these other essentials. Because of this dilemma, millions of Americans will opt not to seek medical attention during times of crisis, and may die from injury or illness. For the same reason, these same Americans will likely avoid regular checkups; as a result, they may not receive preventative care that could have successfully preempted injury or illness. Because these people are losing out on both critical and preventative care, they are far more likely to suffer and die.

Medicare-for-all reverses this trend. Americans would be able to visit doctors and hospitals without fear of bankrupting themselves and their families. As a result, they would be far more likely to seek care. This means two things:

1. People will go to the hospital when they are genuinely sick or injured, and are in desperate need of treatment
2. People are more likely to receive checkups and other preventative care, meaning that it is easier to detect and treat chronic illnesses like cancer or diabetes

Second, **lower drug costs.** Although Trump has passed efforts to lower the prices of prescription drugs, many remain skeptical. People think that the methods by which Trump is proposing to reduce prices are either not enough, or that they actually benefit the pharmaceutical companies.

This is critical, because the price of these drugs is often prohibitively high, therefore preventing low-income Americans from being able to afford them. Without these vital medications, millions are more likely to succumb to otherwise treatable illnesses.

Once again, Medicare-for-all would flip the script. Under Medicare-for-all, the government would negotiate down the prices of prescription drugs. This means that people would be able to afford life-saving drugs that they so desperately need.

For both of these warrants, the impacts would be saving lives and reducing out-of-pocket costs. There is tons of evidence out there to justify these claims, so it won't be difficult to construct a full argument about these points if you go looking.

Argument 2: Opioid Crisis

Tens of thousands of Americans die every year as a result of opioid overdose. This can come in the form of heroin, fentanyl, Oxycontin, what have you. This is only being compounded by the coronavirus pandemic, as addicts are being exposed to increased levels of stress due to isolation and unemployment. Medicare-for-all can address the opioid crisis in two ways.

Firstly, by **increasing access to treatment**. There are certain medications that are used to wean people off of addiction; methadone is a synthetic and non-addictive opioid that suppresses withdrawal symptoms and relieves cravings. It is proven to be extremely effective in combating opioid addiction and reducing the rate of overdoses. As a result, substance abuse clinics are being established across the country that can provide addicts with the methadone they need.

However, the current healthcare system tends to interfere with these policies. Many methadone clinics will jack up the prices of methadone treatment to inaccessible levels; others will not accept most forms of private insurance; others still will not accept Medicaid, a safety-net program providing healthcare to low income individuals. Because of this, millions do not have access to methadone that would allow them to combat their addiction.

The argument is that Medicare-for-all has the potential to flip the script for a few reasons. Firstly, Medicare already covers Methadone treatment in the status quo, meaning that an expansion of Medicare to the entire population would continue this coverage. Secondly, the Medicare-for-All Act of 2019 explicitly states that substance abuse programs and clinics will be created; these clinics often offer methadone treatment. Thirdly, with Medicare-for-all as the only form of insurance available, clinics would be unable to reject patients. All of this means that Medicare-for-all would increase access to methadone, lowering rates of both addiction and overdose.

Secondly, by **preventing over-prescription**. If the other warrant was about reducing the consequences of the opioid crisis, this one will address the underlying causes. The opioid crisis has several causes, but one of the most prominent is lobbying by Big Pharma. Corporations such as Pfizer provide direct financial incentives and gifts to doctors who prescribe more of their opioids. As a result, opioids are prescribed to many patients who do not need them, and they are prescribed for longer periods of time than are needed. This makes it more likely for patients to become addicts.

This also increases the likelihood of patients becoming heroin addicts (this part might not be necessary, but is good background info), because these patients struggling with addiction are often poor, and will not have the money to afford a steady stream of pills. As a result, many are lured to the black market to quench their addictions.

Fortunately, the House of Representatives version of the Medicare-for-all bill includes provisions that eliminate the ability of service providers to enter into purely financially-incentivized agreements with other providers. This means that Big Pharma's lobbying of doctors would necessarily come to an end, and a primary cause of the opioid crisis would be eradicated; tens of thousand of lives could be saved annually as a result.

I do not believe that the opioid crisis itself will be the center of every debate, but it will certainly come up from time to time. There are other methods of running it as an argument, but this is almost definitely the smartest.

Argument 3: Economics

This argument may not seem like it has as high of an impact as the others I have mentioned, but it is a legitimate argument nonetheless. In the status quo, employers spend a great deal of money on private healthcare benefits for their employees. This is separate from wages, but still encompasses a good deal of spending.

Under Medicare-for-all, private health insurance would be abolished, freeing up a significant amount of money for businesses to spend on a variety of other things.

Firstly, **wages**. You could argue that employers would redirect money from healthcare benefits directly into the pockets of their workers. While I doubt that all of the money would go into this, it is fairly easy to argue that workers might currently settle for lower wages than they would like in exchange for high quality healthcare. Therefore, when insurance is no longer an issue, workers and unions would demand at least slightly higher wages. With an increase in wages, the economy would grow and poverty would decrease.

Second, **back into the company**. Not all the money that businesses make go to its employees. Very often, a good chunk (if not the majority) of the money made will be reinvested in the company. This way, the company can do things like modernize its equipment or grow its market share. Doing these things will allow the businesses to grow, and encourage the economy to grow with it. This in turn means decreased unemployment and poverty.

Like I mentioned, this argument does not have as grand of an impact as the others, so I'm not sure if it's the smartest to run unless you can weigh it very well.

This is by no means a comprehensive list of arguments. There are certainly other arguments out there. However, these arguments (or variations of them) are going to appear relatively often, so you should be well versed in them before your first tournament.

Negative Arguments

Argument 1: Funding

Medicare-for-all is purported to be an extraordinarily expensive endeavor. Conservative estimates place it at costing from $28-32 trillion over the next decade. That is a massive sum of money, and it has to come from somewhere. The argument is that the ways in which the government acquires the money will be catastrophic to America and/or the world.

I believe that this will be among the most common negative arguments, though it is also one of the most misconstrued and misunderstood. The reason for this is that not many debaters will actually know what I mentioned when reviewing the basics of Medicare-for-all: there is already a proposed funding mechanism in the bill itself! As such, unless you are talking about the harms of taxation and/or cutting the explicitly mentioned social programs, you will need to show:

- Why it is that the proposed funding mechanism is not enough?
- Why your specific mechanism of funding will be the most likely option?

That being said, let's get into the arguments as to how the program would be financed.

Firstly, **taxation**. The Medicare-for-All Act does not specify which taxes will be implemented to fund the program. However, we can try to piece it together by looking at what Bernie Sanders and Elizabeth Warren have said about it. This includes having households and employers pay the government an income-based "premium", raising the capital gains tax, and raising the income tax. Proponents of Medicare-for-All will frequently argue that lower and middle-income individuals will still see their spending decrease on net, as they would save money that would otherwise be going to healthcare or medical bills. This makes it your burden to show why this taxation is simply too devastating for the American people, and why the net cost is a negative. You could also probably say that this cost would be especially prevalent now, when coronavirus has decimated low and middle-income households across America. With this, you can try to impact to increasing poverty throughout America.

Second, **debt**. Like I said, the Medicare-for-All Act of 2019 does not mention a plan for debt financing. As such, you will need evidence that the taxes and diversion of funding would not be enough (I have heard it, I know it exists). You will also need to show why debt financing is the next most likely alternative after the designated funding sources. For this, you can point out how the Democrats are constantly willing to debt finance in the name of entitlement programs, while Trump's policies have made the GOP increasingly willing to debt finance (Ex: Trump's tax cuts added trillions to the deficit, yet congressional Republicans overwhelmingly voted in favor of them). Meanwhile, nobody likes being taxed, so adding more taxes would be considered political suicide. Once you have established both of these things, you can explain why debt financing is bad.

If the government borrows from private markets, it crowds out private investment. It takes money that would have circulated through the economy, and takes it for its own purposes. The problem with this is that public investment, as opposed to private investment, is inherently economically inefficient; it

does not allow the free flow of the market. As a result, decreasing private investment by such a great margin could lead to a precipitous economic decline.

When the government increases its debt, the Federal Reserve responds by increasing the interest rates on bonds (government loans) to reassure investors; this increased investment causes the value of the dollar to increase. Unfortunately, this harms developing countries by making the US economy and the US currency seem like a better investment. As a result, investors will withdraw their capital from developing countries, plunging their economies into debt and recession.

I apologize if this argument is confusing. Some of it is based on cases I have heard/seen and cards I have read rather than an understanding of the economic concepts. I personally do not recommend running funding as an argument without doing extensive research, especially through the lens of debt. Nonetheless, many will be running similar arguments to this, so it is certainly worth delving into and learning about.

Argument 2: The Stock Market

This is an argument that carries much more truth to it than funding. In the status quo, companies and consumers alike spend trillions of dollars on healthcare. Insurance is the norm, and it is an integral part of the American market. Therefore, passing Medicare-for-All would mean that all health insurance agencies would be banned from competing with government coverage. Even worse, this would cause investor confident to plummet, leading almost all of its shareholders to sell their healthcare stocks. Precedent for this exists; during the Democratic primaries, healthcare stocks fell when Medicare-for-All began to emerge as a major talking point for the frontrunners.

The collapse of the healthcare sector is not all. The government wiping out an entire industry could set a dangerous precedent in the eyes of investors, and encourage mass selloffs across the market. Additionally, with healthcare being such a major expenditure of companies, its abolition could only compound this uncertainty. All of this has the potential to snowball into a massive economic downturn that would harm both the US and the rest of the world by proxy.

Some people may try to argue that “we are already in a recession, so this impact is not unique”. This is genuinely one of the worst responses you could give. The reasoning is simple: even though we are in an economic downturn, it could always get worse. Recessions wildly vary in degree; for example, we can agree that the Great Depression was worse than the Dot-Com Bubble. As bad as the economy is faring right now, outside factors could always add fuel to the fire.

I think that, even with the public option transition period, this is one of the easiest arguments to extend and defend. For weighing, however, you would need to show why the harms of worsening one recession right now would be worse than tens of thousands of deaths every single year.

Argument 3: Medicare Reimbursements

The point of health insurance is to reimburse doctors and hospitals for costs that clients incur as patients; that is to say, if I go to the hospital, my private insurance would cover much of the cost that I would have otherwise paid. What many people do not consider, however, is that Medicare reimburses at a far lower rate than private insurance. In fact, the Centers for Medicare and Medicaid Services find that the rate paid to hospitals for Medicare patients in 2022 will be 40% lower than that paid by private insurance. Additionally, payments to physicians would be 30% lower. This has a few consequences.

Firstly, **there would be a shortage of doctors.** The argument is that the medical field will become far less profitable in a world of Medicare-for-all. With less money from reimbursements, physicians will simply earn less money. This is especially problematic considering that a significant percentage of doctors already suffer from burnout in their profession. The likely outcome: many doctors will quit, and fewer people will be willing to enter into the medical field to replace the lost workers. A shortage of doctors is extremely problematic, as it will cause the doctors left behind to be stretched increasingly thin; they will have less time to spend on each patient, and it is very likely that patients would be forced to wait weeks or months for appointments. Therefore, even if everyone can pay for healthcare, fewer people are actually able to access the treatment they need. Some precedent exists: in the UK, the National Health Service (NHS) provides high quality care to everyone regardless of income, but is known for its notoriously long wait times.

Secondly, **there would be a shortage of hospitals.** On a similar note, hospitals would likely be forced to close as they lose funding. Millions of hospitals are already barely getting by, and are actually losing more money than they make; without private insurance, these struggling hospitals will be forced to close their doors forever. This will be especially problematic in rural America; hospitals in rural areas are already spread very thin, and patients must travel hours to find the nearest emergency room. When even these hospitals begin to close their doors, rural America will suffer. Millions of people will not receive the care they need, even if it is absolutely urgent.

For these reasons, even if Medicare-for-all increases the amount of insured Americans, it will decrease access to the healthcare they so desperately need.

Conclusion

Overall, I hope this analysis was helpful. This is a very broad topic with lots of room for argumentation on both sides, so don't feel constrained by the arguments I listed. Good luck in the months to come!

Ben Goldberg

Background

Time Frame

For children and seniors, the bill goes into effect in one year. For everyone else, it takes hold after two years.

Keith 19 Keith, Katie, Principal at Keith Policy Solutions, LLC. "Unpacking The House Medicare-For-All Bill." HealthAffairs. 3 March 2019. https://www.healthaffairs.org/do/10.1377/hblog20190302.150578/full/. [Premier]

The bill would establish the Medicare for All Program (M4A) which would go into effect **two years from enactment** (half of the four-year transition period in the Sanders bill). The bill would extend benefits to younger and older residents even more quickly: individuals under the age of 19 or 55 or older could enroll in M4A coverage one year after enactment of the bill.

Replaced Benefits

The M4A removes existing healthcare benefits.

Keith 19 Keith, Katie, Principal at Keith Policy Solutions, LLC. "Unpacking The House Medicare-For-All Bill." HealthAffairs. 3 March 2019. https://www.healthaffairs.org/do/10.1377/hblog20190302.150578/full/. [Premier]

Once the bill went into effect, most benefits would no longer be available under the traditional **Medicare** program, the **Medicaid** program, the Children's Health Insurance Program (**CHIP**), the **F**ederal **E**mployees **H**ealth **B**enefits **P**rogram, or the **TRICARE** program. The bill would **prohibit** the sale of **private** health insurance, **employer**-sponsored insurance, and **retiree** coverage if that coverage duplicates payment for any item or service covered under M4A. (Insurers and employers could still offer coverage of additional benefits that are not covered under M4A.) The Department of Veterans Affairs and the Indian Health Service would remain intact.

Many performance based programs would be eliminated.

Keith 19 Keith, Katie, Principal at Keith Policy Solutions, LLC. "Unpacking The House Medicare-For-All Bill." HealthAffairs. 3 March 2019. https://www.healthaffairs.org/do/10.1377/hblog20190302.150578/full/. [Premier]

The bill would also sunset the Affordable Care Act's (ACA's) marketplaces and eliminate the ACA's many pay-for-performance and value-based programs, most of which are implemented in the Medicare program. This includes eliminating the Center for Medicare and Medicaid Innovation (**CMMI**), **incentive payments** for quality reporting, **accountable care** organizations, **bundled** payments, hospital **readmissions programs**, and other value-based purchasing programs. The Sanders bill maintains CMMI and does not include a similar provision to eliminate these programs, at least some of which have been successful.

Drug Prices

Compulsory licensing is included in the bill.

Luthra 19 Luthra, Shefali, correspondent covering health care. "There's A New 'Medicare-For-All' Bill In The House. Why Does It Matter?" Keiser Health News. 27 February 2019. https://khn.org/news/theres-a-new-medicare-for-all-bill-in-the-house-why-does-it-matter/. [Premier]

The House bill also would take a swipe at high prices for prescription drugs by empowering the government to negotiate prices directly with manufacturers and to take away and reissue drug patents if such efforts faltered. This idea, known as "compulsory licensing," has appeared in drug-pricing bills, but not in other Medicare-for-all legislation.

Private Plans

Private plans and cash-charges are allowed but would be insignificant.

Luthra 19 Luthra, Shefali, correspondent covering health care. "There's A New 'Medicare-For-All' Bill In The House. Why Does It Matter?" Keiser Health News. 27 February 2019. https://khn.org/news/theres-a-new-medicare-for-all-bill-in-the-house-why-does-it-matter/. [Premier]

And the bill wades into one of the hottest Medicare-for-all controversies: the role of private health care. Notably, it permits it. Private plans can cover services not included in the single government health plan. Doctors can also refuse to participate in the program and charge patients cash for medical treatment instead.

"Whether there's someone out in Beverly Hills who sees the stars and doesn't partake — that would be possible," said Dr. Adam Gaffney, a doctor and president of Physicians for a National Health Program, a single-payer advocacy group that supports the legislation. "The way the whole program is structured is to really make it such that that's a very insignificant overall phenomenon."

Consumers can use a transitional plan.

Keith 19 Keith, Katie, Principal at Keith Policy Solutions, LLC. "Unpacking The House Medicare-For-All Bill." HealthAffairs. 3 March 2019. https://www.healthaffairs.org/do/10.1377/hblog20190302.150578/full/. [Premier]

Consumers could generally maintain their existing coverage **until** M4A went into effect. But the bill would also create a comprehensive transitional Medicare buy-in option for eligible individuals and a transitional public option. The transitional public option plan would be available to any U.S. resident through the ACA marketplaces and offer platinum-level coverage with the availability of premium tax credits and cost-sharing reductions.

Secretary

A lot of the bill is up to interpretation.

Luthra 19 Luthra, Shefali, correspondent covering health care. "There's A New 'Medicare-For-All' Bill In The House. Why Does It Matter?" Keiser Health News. 27 February 2019. https://khn.org/news/theres-a-new-medicare-for-all-bill-in-the-house-why-does-it-matter/. [Premier]

Still, the legislation leaves a lot of meaningful details open to interpretation.

Three big ones: what precisely would be **covered**, what doctors would be **paid** and how the program would be **financed**.

Generally, Medicare-for-all would provide "comprehensive benefits," accounting for health care needs as "medically necessary or appropriate." That means covering hospital and doctor visits, but also, for instance, mental health, maternity services, addiction treatment, pediatrics and medications.

Where it gets tricky is determining which specific services qualify as "necessary." Sometimes that's obvious — insulin for diabetics or a cast for a broken leg.

In other cases, it's not as clear. Examples include politically controversial treatments, like gender confirmation surgery. Many experts do say the procedure is an important option for people with gender dysphoria. But specific components of it are sometimes deemed cosmetic or unneeded — often by those skeptical of the treatment to begin with.

There are also reconstructive surgeries that provide medical value, but may be deemed cosmetic.

The Department of Health and Human Services would have significant discretion in interpreting what specific services are "medically necessary." That means political leanings or scientific debates could sway what's covered, even from administration to administration.

"Reasonable people could disagree on certain things," Gaffney acknowledged.

The legislation also spells out steps for determining how to pay doctors — a tricky issue, since doctors often complain that traditional Medicare pays them less than does private insurance. But the bill doesn't set up a reimbursement system.

Of course, there's the question of how the U.S. pays for the new program. Studies suggest Medicare-for-all would bring down national health care costs. Currently, though, much of that health spending is borne by the private sector. Under the Jayapal-Dingell bill, the money would have to come out of **taxpayer dollars.**

That would mean new taxes, and that's a subject that does not appear anywhere in the Jayapal-Dingell bill. (Jayapal has said she will put out a separate list of potential taxes that could finance her single-payer proposal. Sanders also used this strategy — a separate list of "pay-fors" — to make a case for his bill.)

The secretary of HHS has flexibility in design.

Keith 19 Keith, Katie, Principal at Keith Policy Solutions, LLC. "Unpacking The House Medicare-For-All Bill." HealthAffairs. 3 March 2019. https://www.healthaffairs.org/do/10.1377/hblog20190302.150578/full/. [Premier]

The M4A bill grants significant flexibility to the Secretary of Health and Human Services (HHS) to design major components of the program. The Secretary is, for instance, directed to develop policies, procedures, guidelines, and requirements related to eligibility, enrollment, long-term care eligibility, provider participation standards and qualifications, levels of funding, provider payment rates, planning for capital expenditures and health professional education, and regional planning mechanisms.

Trump's HHS secretary doesn't like Medicare for All.

Wiexel 18 Weixel, Nathaniel, Health Reporter at The Hill. "HHS chief dismisses 'Medicare for all' as 'too good to be true'." The Hill. 27 September 2018. https://thehill.com/policy/healthcare/408777-azar-dismisses-medicare-for-all-as-too-good-to-be-true. [Premier]

The Trump administration's top health official on Thursday dismissed "Medicare for all" as a promise that's too good to be true.

"When you drill down into the details, it's clear that Medicare for all is a misnomer. What's really being proposed is a single government system for every American that won't resemble Medicare at all," Health and Human Services Secretary Alex Azar said during a wide-ranging speech in Nashville, Tenn.

Azar said embracing Medicare for all would mean ignoring the mistakes of ObamaCare, which he called a failure.

"The main thrust of Medicare for all is giving you a new government plan and taking away your other choices," Azar said.

This was not the first time a top official at the Department of Health and Human Services has tried to discredit the idea of Medicare for all. Centers for Medicare and Medicaid Services Administrator Seema Verma in July called it socialized medicine that would put seniors at risk.

Coverage

M4A includes and expands on ACA health benefits.

Keith 19 Keith, Katie, Principal at Keith Policy Solutions, LLC. "Unpacking The House Medicare-For-All Bill." HealthAffairs. 3 March 2019. https://www.healthaffairs.org/do/10.1377/hblog20190302.150578/full/. [Premier]

The M4A benefit package is largely consistent with the **10** categories of essential health benefits (EHB) that are outlined in the ACA but includes additional benefit categories:

- hospital services (including inpatient and outpatient hospital care, emergency services, and inpatient prescription drugs);
- ambulatory patient services;
- primary and preventive services (including chronic disease management);
- prescription drugs, medical devices, and biologics;
- mental health and substance abuse treatment services (including inpatient care);
- laboratory and diagnostic services;
- comprehensive reproductive, maternity, and newborn care;
- pediatrics;
- oral health, audiology, and vision services;
- rehabilitative and habilitative services and devices;
- emergency services and transportation;
- early and periodic screening, diagnostic, and treatment services covered under Medicaid;
- transportation to receive health care services for persons with disabilities or low-income people (as determined by the Secretary); and
- long-term care services and support.

The final four bulleted services are additional categories of benefits in the M4A bill that are not explicitly included in the Sanders bill. Unlike EHBs under the ACA, HHS is not directed to define these benefits, a decision that HHS under the ACA ultimately pushed to state decisionmakers. The bill allows each state to provide additional benefits and extend coverage to additional individuals not eligible under M4A so long as the state covers the expense of doing so. HHS is directed to make national coverage determinations with respect to experimental services and drugs, and the bill extends the Medicare appeals process to these coverage decisions.

HHS would have to annually evaluate whether changes to the benefit package are needed to reflect the most current medical practice and research, consult with stakeholders, and make recommendations to Congress to improve or adjust the benefit package. In a difference from the Sanders bill, two House committees—Energy and Commerce and Ways and Means—would be required to hold hearings on these recommended benefit changes on at least an annual basis; the bill defines this as an exercise of rulemaking power by the House.

The bill further clarifies that items or services would be covered if they have been provided pursuant to a national practice guideline that has been recognized by HHS. Even when an item or service is not provided in accordance with a national practice guideline, it would be treated this way if the **provider** exercised professional judgment and acted in the patient's best interest consistent with their wishes. Providers would also be allowed to **override** practice guidelines or standards if the override is a medical necessity and appropriate, in the patient's best interest, and consistent with the individual's wishes. This override option was not included in the Sanders bill.

The bill provides coverage for long-term care.

Keith 19 Keith, Katie, Principal at Keith Policy Solutions, LLC. "Unpacking The House Medicare-For-All Bill." HealthAffairs. 3 March 2019. https://www.healthaffairs.org/do/10.1377/hblog20190302.150578/full/. [Premier]

In a significant difference with the Sanders bill, M4A would establish new federal benefits for **long-term care**. Individuals would be entitled to long-term services and supports to maintain their health or for care, services, diagnosis, treatment, or rehabilitation to address 1) a functional limitation in performing one or more activities of daily living or 2) a similar need in performing instrumental activities of daily living due to cognitive or other impairments. Many of these terms are defined in the legislation itself. (The Sanders bill would require state Medicaid programs to cover long-term care services defined as 13 categories of services such as nursing facility services and home health services.)

The Secretary is directed to issue rules on individual eligibility for long-term care as well as an assessment of the various long-term services and supports needed for those who are eligible. Beyond what must already be covered under Medicaid, the bill does not identify specific services to be covered and instead lays out principles that the Secretary would have to adhere to in defining these services and supports.

These principles include providing coverage of a broad spectrum of services and supports and coverage that maximizes autonomy and civic, social, and economic participation. The bill also directs the Secretary to prioritize **home** and **community-based** services over institutionalization regardless of disability, service need, or age. In developing regulations, the Secretary would have to consult with an advisory commission that includes people with disabilities, those who represent people with disabilities, providers of long-term care (including family caregivers and unions), **disability right**s organizations, and **academic researchers.**

The new bill covers long-term care.

Luthra 19 Luthra, Shefali, correspondent covering health care. "There's A New 'Medicare-For-All' Bill In The House. Why Does It Matter?" Keiser Health News. 27 February 2019. https://khn.org/news/theres-a-new-medicare-for-all-bill-in-the-house-why-does-it-matter/. [Premier]

The biggest difference: This House vision of Medicare-for-all would also cover **long-term care**. That isn't part of the Sanders bill, and it is not covered by Medicare. But for people with disabilities and the elderly, it's a significant benefit — and one that can get very expensive to pay for out-of-pocket. (The Affordable Care Act included a long-term care provision that was eventually scrapped because of its high cost.)

Providers

Providers are required to be licensed, accountable, and inclusive.

Keith 19 Keith, Katie, Principal at Keith Policy Solutions, LLC. "Unpacking The House Medicare-For-All Bill." HealthAffairs. 3 March 2019. https://www.healthaffairs.org/do/10.1377/hblog20190302.150578/full/. [Premier]

To participate in M4A, a provider would have to be licensed or certified, meet federal and state requirements to provide health services, meet existing Medicare provider standards (unless waived by HHS), and meet any additional minimum provider standards developed by HHS. The bill includes a list of optional areas that HHS could address in developing new minimum provider standards, such as facility quality, staffing levels for physicians and nurses, personnel training and competence, continuity of service, and patient satisfaction. Providers that qualify to offer services through the Department of Veterans Affairs or the Indian Health Service would automatically qualify as M4A providers. In a difference with the Sanders bill, the M4A bill additionally prohibits participation of providers that do not provide items or services directly to individuals, such as Medicare Advantage Coordinated Care Plans.

As under the current Medicare program, providers would be required to file a participation agreement with HHS and meet existing federal requirements related to accepting Medicare funds. The M4A bill and the Sanders bill both apply existing Medicare fraud and abuse provisions to their programs, but the M4A bill additionally includes physician referrals. The M4A bill also includes additional **reporting requirements**, such as requiring institutional providers to provide additional data on a quarterly basis and all providers to disclose coding and classification systems used in global budget negotiations.

The M4A bill includes new whistleblower and **conflict of interest** standards. Board members, executives, or administrators of providers are prohibited under the bill from receiving compensation from an entity that provides it with health care items or services. There would be a new "duty of ethics" on providers, including institutional providers, to advocate for and act in the exclusive interest of patients under their care. Providers could not have financial interests or relationships that impair their ability to provide appropriate care. The Secretary would be required to develop reporting rules and prohibit additional conflicts of interest. New whistleblower provisions would **prohibit retaliation** against individuals that notify HHS of a violation of M4A, refuse to act illegally, or testify or assist in proceedings regarding a violation of M4A.

The bill includes a broad nondiscrimination provision that mimics the protections outlined in Section 1557 of the ACA, which prohibits individuals from being excluded from, denied benefits, or subject to discrimination by health providers, programs, and activities. The bill explicitly defines sex discrimination, which has been the subject of ongoing litigation under Section 1557, to include sex stereotyping and discrimination based on gender identity, sexual orientation, and pregnancy and related medical conditions, including termination of pregnancy. The bill requires the establishment of an administrative adjudication process to address discrimination claims and authorizes a private right of action.

There are a few differences from the Sanders bill in the nondiscrimination section. First, the M4A bill includes more protected classes than the Sanders bill by additionally prohibiting health care discrimination based on marital status, citizenship status, primary language use, genetic conditions, previous or existing medical conditions, and religion. Second, nothing in the M4A bill, the legislation says, should be taken to invalidate or otherwise limit a person's rights under federal civil rights laws nor does the bill preempt or supersede

state nondiscrimination laws. Third, a person could bring an administrative claim and a lawsuit at the same time.

Funding

Medicare would divert the funding towards other programs, places restrictions on provider payments,

Keith 19 Keith, Katie, Principal at Keith Policy Solutions, LLC. "Unpacking The House Medicare-For-All Bill." HealthAffairs. 3 March 2019. https://www.healthaffairs.org/do/10.1377/hblog20190302.150578/full/. [Premier]

Funding for M4A would be provided through the **Universal Medicare Trust Fund**, which would receive appropriations that would have otherwise been used to fund Medicare, Medicaid, the Federal Employees Health Benefit Program, the TRICARE program, the maternal and child health program, vocational rehabilitation programs, programs for drug abuse and mental health services, programs providing general hospital or medical assistance, and any other federal programs identified by HHS and the Treasury that provide for the payment of health services.

The bill directs HHS to establish an annual national health budget beginning with the year prior to the date on which benefits first become available. The M4A national health budget would include total expenditures for operations, capital improvements, special projects, quality assessment activities, health professional education, administrative costs, prevention and public health activities, and a reserve fund for epidemics, natural disasters, and health emergencies.

The M4A bill includes more detail (and limitations) on what expenses would be included under the operating budget, capital expenditures budget, special projects budget, and health professional education expenditures. These payments could not, for instance, be used for marketing, profit or net revenue, or incentive payments or bonuses. Providers could not divert operating expenditures for capital expenditures or profit, and the Secretary would have to prioritize funding for capital expenditures to improve service in medically underserved areas or address health disparities. In a curious provision, the Secretary is explicitly prohibited from using quality metrics or standards when developing payment methodologies, programs, or other adjustments for provider payments.

Recognizing that M4A would be disruptive to the health insurance workforce, the bill allows up to one percent of the national health budget to be allocated to programs that **assist health insurance-related workers** who may experience displacement. This budget allowance is authorized for the first five years that M4A is in place. In differences with the Sanders bill, this assistance would also be available to those who perform related functions within health care institutions or organizations, and the assistance would have to include wage replacement, retirement benefits, job training, and education benefits.

Workers compensation carriers would have to reimburse M4A for the cost of services if the M4A provides consumers with coverage for work-related injuries and illnesses.

Affirmative

Aff Framing

Squo = Unsustainble

The American healthcare system is unacceptable in the status quo.

Deysh 20 Igor Deysh, Staff writer at Salon. "Multiple studies show Medicare for All would be cheaper than public option pushed by moderates." Salon. 22 February 2020. https://www.salon.com/2020/02/22/multiple-studies-show-medicare-for-all-would-be-cheaper-than-public-option-pushed-by-moderates/. [Premier]

While critics have claimed that the proposal would lead to "rationing" of health care, a recent Federal Reserve survey found that roughly a **quarter** of "adults skipped necessary medical care in 2018 because they were unable to afford the cost." Millions of Americans have been forced to ration their insulin or avoid calling an ambulance in emergencies due to sky-high costs, including those who have insurance.

Critics also argue that wait times for care are longer in countries with single-payer systems, but a 2017 survey found that wait times have already **increased** in the United States by **30%** since 2014 under the current system.

Critics have claimed that Medicare for All would lead to people abusing the free health care system. But a study published in the Journal of General Internal Medicine in November showed that use did not generally increase in countries that moved to single-payer systems.

All these studies make various assumptions about costs and figures associated with what a single-payer system would look like in America.

"Experts answer those questions differently, which is reflected in their final cost estimates. And though we can't predict the future, we do have plenty of data on what's happening in the American health-care system right now," wrote Washington Post data journalist Christopher Ingraham. "Relative to people in other wealthy nations, Americans are less likely to be in good health and more likely to die of preventable causes. Our babies and mothers are more likely to die after child birth, and our lives are shorter overall."

Healthcare costs occupy an unsustainable portion of national GDP.

Kotlikoff 19 Laurence Kotlikoff, Professor of economics at Boston University, a fellow of the American Academy of Arts and Sciences, a research associate of the National Bureau of Economic Research, a fellow of the Econometric Society, and president of Economic Security Planning. "Actually, 'Medicare for All' is the only affordable option." The Hill, 8 November 2019, https://thehill.com/opinion/healthcare/469562-actually-medicare-for-all-is-the-only-affordable-option. [Premier]

Paying attention to **total** national health care spending, not whether it's called public or private, is what's important.

Under our current Balkanized, four-part (employer-provided, Medicare, Medicaid and ObamaCare) health care system, total national health care spending has grown to a gargantuan **18 percent** of GDP. Yet our health care system still leaves almost 30 million Americans uninsured and almost 60 million underinsured.

Other high-income countries, including Germany, France, Switzerland, Sweden, Japan and Canada, spend less than 12 percent of their GDP on health care, while providing uniform high-level health care to all. Thanks to the

staggering, one-in-four number of Americans who are uninsured and underinsured, our country has pitiful health care outcomes. This includes the lowest life expectancy and the highest infant mortality of any high-income country.

If the cost of the current health care system wasn't bad enough, the Congressional Budget Office (CBO) projects a 4 percentage-point of GDP rise in federal health care spending by mid-century. If private health care spending rises at the same rate, which has been the rule, we're looking at spending **one quarter of GDP** on health care by 2050 and still leaving a quarter of the population in the proverbial health care ditch.

Keeping this system going or Balkanizing it even further, as South Bend, Indiana, Mayor Pete Buttigieg proposes, is a prescription for economic doom. If our country is perpetually spending a quarter of GDP on health care and other leading economies are spending half that share, they, not we, will be able to **afford** all manner of investments in **education**, **infrastructure**, **basic research**, and the like, that are critical to long-term growth.

As it is, the part of our national health care spending that's called public has left the federal government with a **massive fiscal gap.** The fiscal gap, which puts all future obligations, official and unofficial, on the books is the present value difference between projected outlays and projected receipts.

I've calculated the U.S. fiscal gap using projections through mid-century from the CBO as well as extrapolations beyond 2050 of their projections. Brace yourself. Uncle Sam's fiscal gap is now $239 trillion, i.e., 10 years of GDP. Eliminating our current fiscal gap requires either a 50 percent immediate and permanent hike in all federal taxes or a 33 percent immediate and permanent cut in all federal outlays apart from debt service. The longer we wait, the larger the requisite tax hike or spending cut.

Access

Link – Coverage

Current healthcare is excessively expensive because of overhead and profits.

Angell 19 Marcia Angell, former editor in chief of The New England Journal of Medicine and faculty of Global Health and Social Medicine at Harvard Medical School. "We overpay for broken health care. Medicare for All would be much better and cost less." USA Today. 2 August 2019. https://www.usatoday.com/story/opinion/2019/08/02/bernie-sanders-medicare-for-all-better-care-lower-cost-column/1889567001/. [Premier]

Now, our patchwork system for those under age 65 treats health care as a commodity sold to those who can afford it or whose insurance companies will cover it. Some patients receive excessive care, and some none at all. This market-based system costs more than **twice as much** as the average in other advanced countries, while the outcomes are generally worse. Overhead costs are among the highest in the world. Private insurance companies, for example, spend about 12% to 18% of their revenue on overhead; Medicare spends less than 2%.

Prices in the health care system **consistently rise faster** than the background inflation rate because they can. Witness the big drug companies, which charge whatever the market will bear even as their profits soar. The same is true of many for-profit providers and health facilities, such as outpatient imaging centers. As prices go up, payers reduce benefit packages and increase out-of-pocket costs to try to lessen the impact. I believe an important part of Medicare for All should be to move to a largely nonprofit-provider system to curb the incentive to raise prices.

The next time you hear someone say Medicare for All sounds good but wonder how we could possibly pay for it, the answer is that we're already paying more than enough to cover it. But too little of that money is going for actual health care and way too much for profits and overhead. And the current system is **unsustainable.** Not only can we afford Medicare for All, we **can't afford anything else.**

High costs are responsible for lack of coverage. Families go bankrupts because of medical bills.

Berkeley 19 Berkeley Political Review. "Medicare for All: Resolving the Affordability Crisis Obamacare Didn't." 14 November 2019. https://bpr.berkeley.edu/2019/11/14/medicare-for-all-resolving-the-affordability-crisis-obamacare-didnt/. [Premier]

However, the Affordable Care Act fails miserably in honoring the "affordable" part of its name. Of the **27 million** still uninsured, **45 percent** cite cost as their reason for not getting coverage. Healthcare in the United States remains the most expensive in the world because profit-driven insurance companies charge absurdly high prices. The United States spends over $3.5 trillion on healthcare, or almost $11,000 per person, whereas other wealthy countries spend about **half as much** – and return **better health outcomes**. For such a steep price for healthcare, it would not be too much of Americans to expect quality medical services. Yet, Americans have worse health outcomes and higher infant mortality rates than is expected for a major country, much less the richest country in the world.

Where United States healthcare spending is on par with other countries, however, is in its government-funded healthcare systems — Medicare and Medicaid, programs that often offer the lowest prices for healthcare compared to private insurance companies. The government can negotiate prices down significantly for people using public health insurance because public insurances cover a wider amount of people than the hundreds of insurance companies that have to share the remaining population. So if hospitals refuse to accept the negotiations made by the government for Medicare and Medicaid patients, they lose out on a lot of business.

Yet private insurance companies are still allowed to exist under Obamacare. And while Obamacare provides discounts to offset insurance costs for people at or four times the federal poverty level, it is definitely not making the cost of healthcare any more affordable. In 2016, insurance premiums for families increased 20 percent since 2011 and 58 percent since 2006. The high cost of healthcare has resulted in about **half a million families** filing for bankruptcy each year — that's a whopping two-thirds of all bankruptcies.

M4A would increase access and choice by capping costs.

Berkeley 19 Berkeley Political Review. "Medicare for All: Resolving the Affordability Crisis Obamacare Didn't." 14 November 2019. https://bpr.berkeley.edu/2019/11/14/medicare-for-all-resolving-the-affordability-crisis-obamacare-didnt/. [Premier]

Cue Medicare for All, a government-run universal healthcare plan penned by Senator Sanders. Compared to Obamacare, this plan would assure everyone coverage; like Medicare and Medicaid, the government would be the ultimate price negotiator. In its purest, unadulterated form — Sanders's original bill — the government alone covers the cost of all necessary healthcare, hence the commonly used term "single-payer" to describe the plan. Medicare for All would do away with private, profit-driven insurance companies, putting an end to out-of-pocket payments, such as deductibles and copays. Ending private insurers also ends "out-of-network" healthcare professionals, **increasing accessibility** and **choice**, as people will be able to see any doctor they choose.

In terms of prescription drugs, Sanders proposes limiting an individual's payments to $200 annually. Under a single-payer system, pharmaceutical companies will no longer be able to put profits before people by charging high prices for necessary medication. Take insulin, for example, a life-saving drug for diabetics that costs a few dollars to make. Several pharmaceutical manufacturers have marked up the drug more than 5,000 percent, which has left people resorting to rationing their insulin, a sometimes deadly course of action. In the past three years alone, rationing insulin has cost 10 people their lives. Under Medicare for All, no one will have to desperately choose between life or debt.

M4A expands access to 30 million people.

Angell 19 Marcia Angell, former editor in chief of The New England Journal of Medicine and faculty of Global Health and Social Medicine at Harvard Medical School. "We overpay for broken health care. Medicare for All would be much better and cost less." USA Today. 2 August 2019. https://www.usatoday.com/story/opinion/2019/08/02/bernie-sanders-medicare-for-all-better-care-lower-cost-column/1889567001/. [Premier]

Most important, Medicare for All would **cover everyone.** Obamacare has certainly benefited millions of people. But it has left **30 million people** still uninsured, and by continuing to rely on the private insurance industry, it has not contained costs or controlled the inflation of costs.

Bernie's plan is not some wild, disruptive idea. Medicare has been in effect for senior citizens for a half-century, and it is the most popular part of our system. Many 64-year-olds can hardly wait to be 65 so they are eligible. Bernie's plan would simply extend Medicare to all age groups. Moreover, Medicare for All would not be a "government-run" system or "socialized medicine," as opponents often argue. It is merely government-financed. The delivery of care by providers would remain private, as it is now for senior citizens. Patients would have free choice of providers, without being confined to networks by insurance companies, and they would not lose their insurance because of job loss.

Many defenders of the current system argue that we should not force people to give up their private insurance, which polls suggest many of them like. But I've never personally met anyone who actually likes their private insurance, because it almost always entails micromanagement and onerous out-of-pocket costs. It's just better than nothing, and they don't want to lose what they have without being confident of a better replacement. Medicare for All is that better replacement.

Bernie's plan would improve on Medicare by broadening the benefit package to encompass all health services (including dental, eye and hearing care) and eliminating all out-of-pocket costs. He calls for a four-year transition, beginning with dropping the Medicare eligibility age from 65 to 55, and covering all children. This is different from a "public option," which would allow private insurance companies to skim off the healthier, more profitable customers while leaving the sickest to the public system. Instead, in the first year, everyone 55 and older would automatically be in Medicare.

Link – Cost Saving

Medicare for all would be net cheaper than the status quo after factoring in administrative savings.

Deysh 20 Igor Deysh, Staff writer at Salon. "Multiple studies show Medicare for All would be cheaper than public option pushed by moderates." Salon. 22 February 2020. https://www.salon.com/2020/02/22/multiple-studies-show-medicare-for-all-would-be-cheaper-than-public-option-pushed-by-moderates/. [Premier]

Biden has repeatedly demanded to know how Sanders plans to pay for the proposal. Sanders has repeatedly said it would be paid for by tax increases that would cost far less than the premiums, deductibles, copayments and other costs that Americans already pay. The United States spends more than $10,000 per year for every man, woman and child's health care, far more than any other nation.

Biden is right that Sanders' plan would add trillions to the federal budget. A widely-shared study funded by a think tank backed by the Koch brothers estimated that the plan would cost $32 trillion over the next decade. But the Department of Health and Human Services estimates that the country would spend more than $34 trillion under the **current** profit-driven system.

Two new studies further showed that the Medicare for All plan is not only cheaper than the status quo but also **costs less** than the public option moderates have claimed is more fiscally sound.

A study published in The Lancet this month by researchers at Yale University, the University of Florida and the University of Maryland estimated that Medicare for All would **save $450 billion** per year — about $2,400 in annual savings per family — and would prevent more than **68,000** unnecessary deaths each year.

"Our study is actually **conservative** because it doesn't factor in the lives saved among underinsured Americans—which includes anyone who nominally has insurance but has postponed or foregone care because they couldn't afford the copays and deductibles," Yale researcher Alison Galvani told Newsweek.

Medicare for All would allow the government to negotiate prices for care, as most Western nations with single-payer systems already do, and reduce overhead costs.

Every study finds that we would save money from administration and drugs.

Archer 20 Diane Archer, Senior adviser at Social Security Works."22 studies agree: 'Medicare for All' saves money." The Hill, 24 February 2020, https://thehill.com/blogs/congress-blog/healthcare/484301-22-studies-agree-medicare-for-all-saves-money. [Premier]

Christopher Cai and colleagues at three University of California campuses examined 22 studies on the projected cost impact for single-payer health insurance in the United States and reported their findings in a recent paper in PLOS Medicine. **Every single study** predicted that it would yield net savings over several years. In fact, it's the only way to rein in health care spending significantly in the U.S.

All of the studies, **regardless of ideological orientation**, showed that long-term cost savings were likely. Even the Mercatus Center, a right-wing think tank, recently found about $2 trillion in net savings over 10 years from a single-payer Medicare for All system. Most importantly, everyone in America would have **high-quality** health care coverage.

Medicare for All is far less costly than our current system largely because it **reduces administrative costs.** With one public plan negotiating rates with health care providers, billing becomes quite simple. We do away with three-quarters of the estimated $**812 billion** the U.S. now spends on health care administration.

Administrative costs are so high because thousands of insurance companies individually negotiate benefit rules and rates with thousands of hospitals and doctors. On top of that, they rely on different billing procedures — and this puts a costly burden on providers.

Administrative savings from Medicare for All would be about $600 billion a year. Savings on prescription drugs would be between $200 billion and $300 billion a year, if we paid about the same price as other wealthy countries pay for their drugs. A Medicare for All system would save still more with implementation of **global health care spending budgets.**

With uniform EHR systems, we can detect fraud and save even more.

Archer 20 Diane Archer, Senior adviser at Social Security Works."22 studies agree: 'Medicare for All' saves money." The Hill, 24 February 2020, https://thehill.com/blogs/congress-blog/healthcare/484301-22-studies-agree-medicare-for-all-saves-money. [Premier]

Even more savings are possible in a Medicare for All system because, like every other wealthy country, we would have a uniform electronic health records system. Such a system generates additional savings because system problems would be easier to detect and correct. A uniform claims data system helps reduce health care spending for fraudulent services. In 2018, total U.S. health care costs were $3.6 trillion, representing 17.7 percent of GDP.

Savings are in part a function of the benefits Medicare for All covers. The Mercatus report and others projected savings, **even with** the elimination of deductibles and out-of-pocket costs. Under both Sen. Bernie Sanders's (I-Vt.) Medicare for All bill and Rep. Pramila Jayapal's (D-Wash.) Medicare for All bill, patients would not pay deductibles or coinsurance when they receive medical care. Their bills also provide for vision, hearing and dental care, as well as long-term services and supports, such as home care and nursing home care.

Even if other countries still have private insurance, those insurers are subject to much more regulation.

Archer 20 Diane Archer, Senior adviser at Social Security Works."22 studies agree: 'Medicare for All' saves money." The Hill, 24 February 2020, https://thehill.com/blogs/congress-blog/healthcare/484301-22-studies-agree-medicare-for-all-saves-money. [Premier]

No matter **how you design** a single-payer public health insurance system, it would have lower overall health care costs, so long as for-profit private health insurers no longer exist to drive up health care costs. Yes, it's true that some other wealthy countries rely on "private insurers" to provide benefits and spend far less than we do on care. But, these insurers **do not operate in any way like health insurers in the U.S.**

Other wealthy countries dictate virtually every element of the health insurance people receive, including what's covered, what's paid, and people's out-of-pocket costs — all identical for everyone. The insurers operate

like claims processors or bill payers. They follow the coverage and payment rules set by the government, nothing like the private health insurers in the U.S. which revel in product diversity (read: complexity and confusion).

Canada and numerous studies prove that M4A would save immensely.

Deysh 20 Igor Deysh, Staff writer at Salon. "Multiple studies show Medicare for All would be cheaper than public option pushed by moderates." Salon. 22 February 2020. https://www.salon.com/2020/02/22/multiple-studies-show-medicare-for-all-would-be-cheaper-than-public-option-pushed-by-moderates/. [Premier]

Another study published in the Annals of Internal Medicine by researchers at Harvard University, Hunter College and the University of Ottawa similarly estimated that switching to a single-payer system like Medicare for All could **save up to $600 billion** per year on administrative costs alone.

The study found that the average American pays **$2,597 per year** on **administrative costs** — overhead for insurers and hospitals, salaries, huge executive compensation packages and growing profits — while Canadians pay $551 per year.

Though Canada had costs similar to the United States and worse health outcomes before it adopted its single-payer system in 1962, Canada now has better health outcomes than the United States and only spends 17% of its health care spending on administrative costs, compared to 34% in the U.S.

"Americans spend twice as much per person as Canadians on health care. But instead of buying better care, that extra spending buys us sky-high profits and useless paperwork," lead author Dr. David Himmelstein, who teaches at Harvard and Hunter College, said in a statement. "Before their single-payer reform, Canadians died younger than Americans, and their infant mortality rate was higher than ours. Now Canadians live three years longer and their infant mortality rate is 22% lower than ours. Under Medicare for All, Americans could cut out the red tape and afford a Rolls Royce version of Canada's system."

Himmelstein told Time that the savings in administrative costs alone would be enough to **eliminate** "all copayments and deductibles" and still "have money left over."

But while Medicare for All would reduce these costs by eliminating private profit-seeking insurers, the public option alternative would add costs while leaving the bloated administrative costs in place.

"Medicare for All could save more than $600 billion each year on bureaucracy, and repurpose that money to cover America's 30 million uninsured and eliminate copayments and deductibles for everyone," said researcher Dr. Steffie Woolhandler, who also teaches at Harvard and Hunter. "Reforms like a public option that leave private insurers in place can't deliver big administrative savings. As a result, public option reform would cost much more and cover much less than Medicare for All."

Other studies have led to similar conclusions. A **review of 22 single-payer studies** published in PLOS Medicine found that 19 of them "predicted net savings ... in the first year of program operation and 20 ... predicted savings over several years; anticipated growth rates would result in long-term net savings for all plans."

Current funding is funneled to corporations and investors.

Arno and Caper 20 Peter S. Arno, Economist and senior fellow and director of health policy research at the Political Economy Research Institute at the University of Massachusetts–Amherst and a senior fellow at the National Academy of Social Insurance, and Philip Caper, Physician and founding member of

the National Academy of Social Insurance and currently serves on the Board of Maine AllCare. "Medicare For All: The Social Transformation Of US Health Care." health Affairs, 25 March 2020, https://www.healthaffairs.org/do/10.1377/hblog20200319.920962/full/. [Premier]

The other major objection to a universal single-payer program is cost. Yet, public financing for health care is not a matter of raising new money for health care but of reducing total health care outlays and distributing payments more equitably and efficiently. Nearly **every credible study** concludes that a single-payer universal framework, with all its increased benefits, would be **less costly** than the status quo, more effective in **restraining future cost** increases, and more popular with the public—as 50 years of experience with Medicare has demonstrated.

The status quo generates hundreds of billions of dollars in surplus and profits to private stakeholders, who need only spend a small portion (millions of dollars) to influence legislators, manipulate public opinion, distort the facts, and obfuscate the issues with multiple competing reform efforts.

M4A empowers the government to fix the fiscal gap.

Kotlikoff 19 Laurence Kotlikoff, Professor of economics at Boston University, a fellow of the American Academy of Arts and Sciences, a research associate of the National Bureau of Economic Research, a fellow of the Econometric Society, and president of Economic Security Planning. "Actually, 'Medicare for All' is the only affordable option." The Hill, 8 November 2019, https://thehill.com/opinion/healthcare/469562-actually-medicare-for-all-is-the-only-affordable-option. [Premier]

According to the Urban Institute, MFA would raise the national health care spending share of GDP by 13 percent were it implemented immediately. Sen. Warren disagrees. She says her MFA plan would slightly lower the share. The Mercatus Center seems to agree with the senator. The **big question**, though, is whether MFA would **stabilize** the health care spending share at its current 18 percent or slightly higher value. If it does, then the fiscal gap will be dramatically reduced. Why? Two reasons.

First, Warren just released her plan for new taxes to collect the extra money needed to cover the health care spending that will be done under MFA by Uncle Sam rather than by ourselves and our employers. This means that the switch to public from private payment won't, if we take Warren's estimates as correct, increase the fiscal gap.

Second, if national health care spending is kept at 18 percent of GDP, we won't experience what the CBO projects will happen under the current system — a 4 percentage points of GDP increase in federal health care expenditures for which there is no proposed additional tax funding.

In short, the introduction of MFA, with its extra outlays covered by extra taxes and total federal health care outlays fixed permanently at today's 18 percent share of GDP would make a **huge dent** – probably 40 percent – in our fiscal gap.

Controlling total national health care spending is essential to getting back onto a path fiscal solvency. And MFA is the only system that can make that happen because it's the only system that gives Uncle Sam direct control of national health care spending.

Stated differently, MFA affords us the ability to **set a national health care expenditure budget** and makes it easy to check if we're sticking to it. Consequently, Warren and Sanders ought to add to their plans three simple stipulations, which should silence their fiscal detractors.

We will spend trillions of dollars either way.

Berwick 19 Donald M. Berwick, President emeritus and senior fellow at the Institute for Healthcare Improvement, lecturer and former faculty member at the Harvard Medical School, and former administrator of the Centers for Medicare and Medicaid Services in the Obama administration. "Stop fearmongering about 'Medicare for All.' Most families would pay less for better care." USA Today. 22 October 2019. https://www.usatoday.com/story/opinion/2019/10/22/medicare-all-simplicity-savings-better-health-care-column/4055597002. [Premier]

Faced with these facts, opponents of Medicare for All too often revert to myths instead. The first myth is that Medicare for All will necessarily increase health care spending. That's wrong. The fact is that, without a change, Americans will spend over **$45 trillion** on health care in the next 10 years. Under Medicare for All, total health care spending would likely be far lower. The cost would depend on many implementation decisions that Vermont Sen. Bernie Sanders' bill, for example, leaves open for thoughtful exploration, careful choice and adjustments over time: payment rates to hospitals and doctors, content of the benefit package, details of price negotiations with drug companies, design of simplified administration and more.

The costs are largely under our control; they will depend on how we design the new system. If we made wise choices, I regard it as nearly certain that Medicare for All would **save trillions of dollars** over the decade compared with our projected health care spending.

Only single payer cuts through admin costs and provides incentives – they are cascading now and destroy the ACA

Dave 17 Dhaval Dave, Stanton Research Professor in the Department of Economics at Bentley University and a Research Associate at the National Bureau of Economic Research, Ph.D. in Economics from the Graduate Center of the City University of New York. "Health Care: Multi-Payer or Single-Payer?" *Eastern Economic Journal*, Vol. 43, pgs. 180-182. [Premier]

With the U.S. spending more on health care than any other developed nation and yet achieving lower levels of health (ranking 28th, in terms of life expectancy at birth, among the 35 OECD countries, for instance), it is evident that **our health care system is ailing**. David Collander's thought-provoking article ''Reforming the Affordable Care Act'' (ACA) rightfully diagnoses what ails U.S. health care, underscoring the central problems related to cost and accessibility. The issue that David points to is that accessibility and health care costs are **strongly intertwined** – the high cost of medical care **raises insurance premiums** making it difficult for many to afford coverage and obtain access to quality care. While I agree with this assessment, David overlooks the reverse feedback (from the uninsured or under-insured to higher costs) and downplays the importance of the ''insurance problem.'' Certainly, as health care costs rise, more people – many younger, and for the moment in good health – **opt to live without insurance**, which raises rates for everyone else. However, there is evidence that **uninsured individuals end up costing the health care system more**, not just from the standpoint of administrative expenses or because of their lower bargaining ability as David notes, but because they lack a routine source of care. For instance, those who were previously uninsured received fewer basic clinical services when uninsured and, upon gaining Medicare coverage, cost the program an additional $1,000 annually per

person when compared to those who were consistently covered.1 These increased costs were mainly due to delayed care and preventable hospitalizations. **Lack of insurance**, which leads to such fragmented care, is thus at least partly responsible for the inefficient care; when we look at life expectancy at age 65, the age at which Medicare provides virtually universal care in the U.S., health disparities between the U.S. and other developed nations substantially narrow.

The primary aim of the ACA has been to improve accessibility, and it does so by reforming the non-group insurance market. To the extent that almost 20 million individuals have newly gained coverage as a result of it, this would lead to a more efficient allocation of resources between preventive and curative care and reduce costs over time. Nevertheless, almost 30 million individuals still lack coverage. And, for political reasons **the ACA was not able to fully take on cost control**, instead including a variety of promising proposals which may or may not be successful in bending the cost curve. I agree with David that holding down health care costs is key to addressing the accessibility problem as well, but **the $3 trillion question** is how.

The U.S. system currently is a hybrid between a single-payer and a multi-payer system, and David proposes the fair health care pricing and health insurance pricing laws to move the system in the direction of a true multi-payer system. Both are laudable and based on sound economic principles, the first being motivated by efficiency gains from blocking the use of bargaining/monopsony power and the second motivated by efficiency gains from experience-rated health care premiums. However, in undercutting a movement in the reverse direction toward a single-**payer model**, which could be facilitated, for instance, by reinstating the ''public option'' into the ACA to create a government-run health insurance agency that would compete with other private companies on the insurance exchanges, David's proposal may leave substantial cost savings on the table or even exacerbate some inefficiencies. A relatively **large degree of administrative cost** pervades our system precisely due to the existence of multiple payers. The average U.S. physician spends 43 minutes daily interacting with insurance plans and hires staff to support billing functions.2 As much as $361 billion annually (14% of total health care costs) is spent on health care administration, though this figure masks considerable heterogeneity across private plan administration and Medicare administration.3 The U.S. version of the single-payer model, Medicare, spends only about 2% of its operating expenditure on administrative costs, compared to about **17% of revenues** for the private insurance industry. While the fair health care pricing law may reallocate overhead, in maintaining the current multiplicity of policies and payers and related bureaucracy however, it would not substantially reduce the level of the overhead.

David addresses the very important issue of how to draw young and healthy individuals into the insurance market, which has been a challenge facing the insurance exchanges under the ACA. Experience-rated insurance premiums, which reflect an individual's health status and the actuarial cost of covering that individual, would indeed be an efficient form of pricing and lower premiums for the young and healthy (in contrast to community-rated premiums which are more or less independent of health status). However, this **would price many individuals out of the market** – for instance, those with chronic conditions or preexisting conditions – and thus require subsidies which would be in direct proportion to one's health status or risk. (Currently, under the ACA, subsidies are related only to income and not to health status.) Linking subsidies to health and risk would not moderate the incentives for **ex ante moral hazard** – the notion that insurance may increase unhealthy behaviors if the health costs of such behaviors are not reflected in the pricing, as would be the case if unhealthy individuals are receiving the larger subsidies. Granted that these incentives are also strong under community rating, the point relates to the tradeoff between moderating these incentives and pricing high-risk individuals out of the market, in turn **reducing accessibility for groups with the strongest need**. Furthermore, insurance pricing differentials between the individual, small group and large group markets prior to the ACA, in states which allowed experience-rated premiums, reflected not just differences in risk levels, but also differences in monopsony power, pooling, scale economies, and administration costs, which would **continue to exist** under the fair insurance pricing law as proposed.

David concludes with the essential point that the reforms he outlines (and those brought about by the ACA) are not sufficient. Cost control in the health care system ultimately has to address **how we deliver care and the embedded payment incentives**, which currently are mostly based on quantity and volume rather than quality and performance. I am not sure however that a multi-payer system would be most amenable to new models of organizing and reimbursing medical providers. On the contrary, such reforms are intrinsically **more likely under a single-payer system**. As Jon Gruber notes, cutting health care costs in

the U.S. would mean cutting incomes for the medical sector, which is never politically easy and would be even more difficult under a multi-payer system.

If we had to design a health care system from scratch, our current hybrid model would likely not have been the outcome. The question then is whether to adopt reforms that move this model toward a true multi-payer system or a single-payer system (for instance, by incorporating a public option into the ACA and adopting payment reforms). While it is difficult to point to such frictionless multi-payer systems currently in existence for evidence, there are single-payer systems (including Medicare in the U.S.) which we can look to for **favorable evidence regarding accessibility and cost**.

Impact – Growth

Industry skyrockets health care costs---only the federal government solves.

Holland 13 Joshua Holland, former senior digital producer for BillMoyers.com, writer for The Nation. "Rip-Off: How Private-Sector Health Costs Are Killing the American Dream." Bill Moyers. 1 November 2013. billmoyers.com/2013/11/01/rip-off-how-private-sector-health-costs-are-killing-the-american-dream. [Premier]

The federal government doesn't have a deficit problem. Its fiscal issues are entirely related to the bloated cost of American health care. **If we paid the same amount for health care per person as people do in other wealthy countries with longer average life expectancies, we'd have a balanced budget now and surpluses projected for the future**. But those are just numbers on a spreadsheet. Fran and Randy Malott understand those costs more viscerally. The Whittier, Calif., couple aren't living the American dream right now. They haven't for a while. They were slammed when Wall Street's house of cards came tumbling down, and now they're feeling the squeeze of the Great American Rip-off. Fran lost her job as a customer service representative in 2009, at the height of the Great Recession. "A lot of companies are getting rid of customer service these days," explains Randy. He lost his job managing a temp agency a year or so later. The Malotts are two of what Paul Krugman called "the forgotten millions" – the long-term unemployed who face unique barriers to reentering the workforce, including discrimination by potential employers just because they've been out of work for an extended period. "And our age doesn't help either," says Randy. He's 59 and she's 60. "There was unemployment for a while," Randy says, "and now we're getting by on savings." He tells Moyers & Company, "we live pretty frugally," but the $1,600 a month they're forking over for health insurance represents about half their total spending. The Malotts are a healthy couple, yet they're watching their life savings drain away, in large part due to their health insurance company. The $140,000 the Malotts had socked away for retirement is now down to around $45,000. "We've got quite a ways to go before Social Security and Medicare kick in," says Randy. The Malotts are in a tough spot, like a lot of people who find themselves in similar circumstances. Studies have shown that long-term unemployment causes stress and illness. In the rest of the world's highly developed countries, the Malotts' health care would be covered by their government – the risk of long-term unemployment would be spread across an entire society – which means they'd have one less serious stressor, and around $45,000 more in the bank than they do today. When Competition Drives Up Costs The US system is a stark testament to the fact that, at least when it comes to health care, **more competition doesn't lead to lower prices or better outcomes**. **Three facts are indisputable**. First, the $8,500 we spent per person on health care in 2011 was around $5,000 more than the average among developed countries in the Organization for Economic Cooperation and Development (OECD) — and almost $3,000 more than the average in Switzerland, which was the next highest spender. Second, **multiple studies have found that we have significantly poorer health outcomes than most developed countries** (see here, and here) – by some measures, we rank dead last. And it's not just because we have higher rates of poverty and inequality — a study conducted by the **N**ational **R**esearch **C**ouncil and the Institute for Medicine accounted for those factors and found that, as Grace Rubenstein summarized for The Atlantic, "even white, well-off Americans live sicker and die sooner than similarly situated people elsewhere." (American men are also becoming shorter relative to men in other highly developed countries – the average height of a population is a proxy for the quality of prenatal health care and nutrition.) Finally, we rely much more heavily on the private sector to finance our health care than any other wealthy country. Every developed state finances health care through a mix of private and public spending, but the balance between private and public health care in the US looks different from the rest of the wealthy world. Across the OECD countries, governments pick up 72 percent of the tab for health care, but our government finances just under 48 percent – only the Chilean government covers a smaller share (XL). (In the eight social democracies with the highest tax burdens in the OECD — Denmark, Sweden, Norway, Belgium, Italy, France, Austria and Finland — 79 percent of health costs are financed through the public sector.) There are several reasons why **our outsized reliance on the private sector ends up costing us so dearly**. The first is a simple matter of scale. In 2009, at the height of the debate over Obamacare, economist Josh Bivens wrote that "**health care is an area where the more costs are loaded up on the federal government, the more efficiently care tends to be delivered overall.**" This is a big reason why costs in America's public health care programs, with their purchasing clout, have grown more slowly than they have in the private sector. **When a single-payer system covers a vast pool of people,** it has

more bargaining power to negotiate with providers. It **needs significantly less administrative overhead** to figure out who will pay which bill (**a question which is regularly litigated**). A 2003 study published in the New England Journal of Medicine found that three out of every 10 health care dollars spent in the US goes to administrative costs rather than care. And **in health care, competition often drives costs up rather than down**. According to Adam Linker, a policy analyst with the Health Access coalition, Medicare costs are highest where there are the most treatment facilities competing for patients. He writes:

> More competition drives up the cost of care because when several hospitals are competing for patients and doctors they feel more pressure to build more beds, provide more amenities, and purchase the latest expensive gadgets. Instead of focusing on patient preference and improving care, hospitals are in an arms race to gain market share. **That makes** health **care more expensive for everyone**.

A 2011 study by the Robert Woods Foundation found that new medical technologies are the number one driver of US health care costs. When it comes to purchasing the latest gadgets, our providers are close to the top of the heap: In 2009, only Japan had more MRI machines and CT scanners per million people than the U.S. And we use them, too, getting twice as many MRIs and CT scans per person as the OECD average. Health Care as a Commodity All of these differences in how we pay for health care may pale next to a more fundamental one: We view health care as a commodity and allow providers to set prices as high as the market will bear. The problem with that is that health care is a market in which we often don't have enough information to shop and choose, and because most of us have a good chunk of our costs picked up by a third party – an insurance company – the market often ends up bearing ludicrously high costs. It may sound obvious, but the biggest reason we spend so much on health care is not only because insurance companies take out profits and overhead — it's that health care costs us more than citizens of other wealthy countries. Everything from pharmaceuticals to surgical procedures to tests costs us more than citizens of other rich countries (the linked study found only a single exception: cataract surgeries cost more in Switzerland). Even a basic checkup is more expensive here than in other highly developed states. A big reason for that is that government cost controls – both soft and hard – are common in the rest of the world. Pharmaceuticals provide a good example. We paid $947 per person for prescription drugs in 2009, on average, which was almost double the $487 per person in the OECD as a whole, but we don't take twice as many pills. We just let big pharma charge whatever it can get away with. Some other countries only approve drugs at a price that's in line with what those medications cost in other countries. Many countries evaluate new drugs not only on safety and efficacy, but also on whether they provide better value than existing medications. The U.K. has a board that sets the amount that its National Health Service will pay for a drug and limits how much profit drug companies can make from the British public. As Jonathan Wolff, a professor at the University College London described it:

> Each year pharmaceutical companies have to open their books to the [National Health Service] accountants and if the profits they make are above a certain level then there is a 'clawback'. Furthermore, the agreements have to be renewed every few years and each time price cuts are negotiated as part of the contract. Hence although it appears that drug companies can charge what they want, in practice there are both price controls and profit controls, enforced by the government.

US big pharma, like other providers, argues that it needs to charge high prices to pay for innovative new research. **But a** 2006 **study by the C**ongressional **B**udget **O**ffice found that the pharmaceutical industry already benefited greatly from government-sponsored research: Much of the $25 billion the federal government spent on basic scientific research accrued to an industry that itself spent $39 billion on research and development. And, as economist Dean Baker has argued, **there are other, more efficient ways to finance drug research**, but they would also require more, not less, involvement by the government. Shackled by Private Health Care Our sky-high health care costs place a huge burden on American families. Medical bills are the leading cause of bankruptcies in this country, ahead of credit card debt and unwieldy mortgages. Rising costs for health benefits are a big reason for flat wages: What employers pay in total compensation, including health benefits, has grown a lot faster than wages in recent years.

High costs deck the economy and undermine health which is a larger internal link to growth.

HSPH 12 Harvard T.H. Chan School of Public Health. "How the next U.S. president can stack the deck in favor of people's health and wealth in 2013." Fall 2012. https://www.hsph.harvard.edu/news/magazine/public-health-economy-election/. [Premier]

With the November 2012 elections on the horizon, Americans surveyed in national polls consistently rank the economy as their number one concern. Public health professionals can have a big impact on this ballot-box issue. More than 17 percent of the U.S. Gross Domestic Product is spent on health care—in many cases, for conditions that could be prevented or better managed with public health interventions. Yet only 3 percent of the government's health budget is spent on public health measures. A 2012 study in Health Affairs notes that since 1960, U.S. health care spending has grown five times faster than GDP. Why do these numbers matter? First, a **healthier workforce is a more productive workforce**. According to an April 2012 report from the Institute of Medicine (IOM), **the indirect costs associated with preventable chronic diseases**—costs related to worker productivity as well as the resulting fiscal drag on the nation's economic output—may **exceed $1 trillion per year.** A 2007 study from the Milken Institute found that when unhealthy workers show up on the job, as many must to survive financially, the effects of their lower productivity on the nation's economic health are immense: in dollar value, **several times greater than the business losses accrued when employees take actual sick days**. Avoidable illness also diverts the economic productivity of parents and other caregivers. Second, **the costs of health care are built into the price of every American-built product and service**. And the per capita cost of health care in the U.S. is higher than in any nation in the world. **If the U.S. can reduce the costs of health care over the long term**—by preventing diseases that require costly medical procedures to treat and by making our existing health systems more efficient—**the costs of American products can become more competitive in a global marketplace**. Today, U.S. per capita health expenditures are more than twice the average of other countries in the Organization of Economic Cooperation and Development. The IOM estimates that cutting the prevalence of adult obesity by 50 percent—roughly the same reduction across the population as was achieved through public health's multipronged attack on smoking in the late 20th century—could cut annual U.S. medical care expenditures by $58 billion. Put simply, effective public health measures, including those aimed at improving health systems, have the potential to be **economic engines**. But **these engines have been chronically underfunded and have received too little attention from lawmakers** and voters. Michael Blanding, a Boston-based journalist and author, asked seven Harvard School of Public Health experts from widely ranging fields, to assess public health's vital but often overlooked role in the American economy. Here's what they told him.

Impact – Recession

Healthcare costs are ballooning and devastate competitiveness.

Douglass 17 Michael Douglass, Deputy Managing Editor @ The Motley Fool, an economic forecaster. "Warren Buffett: Health care is a "tape worm" for the U.S." CBS. 8 May 2017. https://www.cbsnews.com/news/berkshire-hathaway-annual-meeting-warren-buffet. [Premier]

In fact, Buffett claimed at Berkshire Hathaway's (BRK-A, BRK-B) annual shareholders meeting that other corporate leaders who complain about **tax rates** know the **real issue is health care**. He even went so far as to call medical costs "the **tapeworm of American economic competitiveness**." That's a bold statement, but the research backs him up. According to Buffett and his business partner Charlie Munger, health care spending in the U.S. (and around the world) was around **5 percent of GDP** in the 1960s but **ramped up faster in the U.S.**, with health care spending here now totaling around **17 percent of annual GDP** versus low double digits worldwide. This means, according to Buffett, "[other countries] have gained a five- or **six-point advantage** over us" in health care spending today. They were a little off in the particulars, but on the overall issue, they're spot-on. According to the Centers for Medicare & Medicaid Services, health care spending grew from **5 percent** of GDP in 1960 to **17.8 percent** in 2015. And according to the World Bank, the U.S. spent 17.1 percent of GDP on health care in 2014, while the overall worldwide average was 9.9 percent. That's a lot of extra cost here in the U.S. -- **over a trillion dollars in incremental health care spending** due to that extra 7 percent of GDP we're spending compared to the rest of the world. American businesses, which provided insurance for 49 percent of the American population in 2015 according to the Kaiser Family Foundation, are **suffering** from this rapid growth. According to the National Federation of Independent Business's (NFIB) 2016 survey of small-business priorities and problems, the cost of health insurance is **"the most severe"** problem facing American small businesses today, and 52 percent of small-business owners identified it as a **"critical" issue**. And like the growth in health care costs, this has been a long-standing issue: NFIB noted that health care costs have been the most severe issue cited by small businesses for the **past 30 years running.** Buffett and Munger are good at quickly identifying a problem and its components. Right after Buffett cited the "five- or six-point advantage" other countries had in health care spending over U.S. companies, Munger bluntly noted: "That's because of **socialized medicine."** Later, Munger further explained that costs "put our manufacturers at a **big disadvantage to other people where the government pays."** Keep in mind, these two have made a career out of identifying companies with competitive advantages and buying them before other investors catch on. The European experience **confirms their accuracy**. For example, drug prices are substantially lower in the European Union than in the U.S., largely as a result of single-payer systems that **aggressively negotiate** on price before they allow drugs to be sold to their citizens. Pharma companies risk **rejection** of their drugs if they fail to offer sufficiently generous discounts, and the difference in drug prices is **obvious**. The traditional American fee-for-service model, wherein hospitals were paid for every test and procedure they provide instead of whether they actually help patients get better, is also a major culprit. The profit incentives in such a private system can have structural inefficiencies based on the competing priorities of insurers, hospitals, pharma companies, patients and the government. Buffett and Munger have identified health care as the **biggest issue facing American businesses**. If they're correct, the U.S. has a **tremendous economic opportunity**.

Rising health care costs cut into disposable income and wages, slowing down economic growth

Howrigon 16 Ron Howrigon, President and CEO of Fulcrum Strategies, Masters in Economics from North Carolina State University. *Flatlining: How Healthcare Could Kill the US Economy*. Greenbranch Publishing, pages 17-20. 30 December 2016. [Premier]

Now it's time to look at the impact of healthcare costs on the employers in this country and how it affects their **ability to compete in a global economy**. Economists agree, market places are becoming ever more global in nature, less restricted by geography every year. More US. companies are competing globally for the goods and services they produce. This reality has increased the utilization of outsourcing, overseas production, and off-shore service industries—largely due to the lower cost of doing business in other countries compared to the United States. How many times have you heard a friend or neighbor complain about a product being made in another country, or calling a customer service line only to have it answered by someone who is obviously outside the United States? Unfortunately, it makes financial sense for many US. firms to move production or services out of this country. How much of those lower operating costs can be attributed to the cost of healthcare in America? What impact does the rising cost of healthcare have on employers and labor that remain in this country?

Let's begin by looking at healthcare spending per capita and as a percentage of GDP by country. Today the United States spends almost 20% of its GDP on healthcare. That's twice as much as most other industrialized nations. That kind of spending puts a **significant strain on the US. economy**.

In 1970, the United States spent about the same per capita on healthcare as Canada and most of Europe. By 1985, our healthcare inflation had moved us into first place when it comes to per-capita spending. Today the US. spends more than twice as much per capita on healthcare as do other similar industrialized nations. It's easy to see from this information the increased pressure that trend puts on US. businesses. The longer this trend continues, the more pressure and incentive there will be on US. businesses to transfer part, or all, of their **operations and production overseas**.

The disadvantage carried by US. companies is significant. For example, let's once again look at the auto industry. General Motors pays over 50% more for healthcare per worker hour than does Toyota. GM estimates that healthcare costs add over $1,500 to the cost of each car they produce. With GM paying more than 50% more for healthcare than Toyota, almost $1,000 is added to the price of a Chevy that isn't there for a Toyota or a Honda. The base Chevy Malibu lists at $22,500 while the base Toyota Camry has a sticker price that is $23,070, only $570 more than the Chevy. However, if GM paid the same for healthcare as Toyota, the Malibu would hold a $1,570 price advantage over to the Camry. How many more people might choose the Chevrolet over the Toyota at that price point?

A study by the National Bureau of Economic Research examined the impact of rising healthcare costs on the labor market. The study concluded that every 10% increase in healthcare costs decreased the number of paid work hours by 1% —and your **chances of being employed by 1.6%.** This clearly shows the direct correlation of rising healthcare costs to both **under- and unemployment**. Further, the study concluded that increases in healthcare costs are increasingly being borne by our labor forces in the form of **wage reductions**. For every 10% increase in healthcare costs, real wages are reduced by 2.3% as employers attempt to offset healthcare increases that, in many cases, cannot be transferred to product price in an increasingly competitive global economy.

Diving deeper into the numbers shows that low-wage, hourly workers are impacted the most by rising healthcare costs. Employers have minimum wage limitations for these workers, so **reductions** in payroll have to be realized with layoffs or hiring freezes. Many of the businesses in question are small, exempting them from penalties if they decide to drop healthcare coverage entirely.

Arguably, people who fall into this segment of the labor force are the least likely to be able to purchase health insurance on their own, even with the new federal subsidies in the health exchanges. As such, if they're laid off, or their employer suddenly decides to drop their insurance due to the rising costs of providing coverage, **these Americans are most likely to go without it**.

If we take all of these factors into consideration, it's plain to see the negative impact of rising healthcare costs on our economy. It puts pressure on employers to shift production or service overseas, which **increases unemployment**. It puts pressure on employers to reduce wages to remain competitive, which decreases disposable income in this country and **slows economic growth**. Finally, it puts pressure on small employers to reduce or eliminate the healthcare coverage they offer their employees to offset rising costs that can't be pushed to the market through higher pricing.

All of this illustrates the fact that healthcare, as a market segment, is **enormous**. It impacts almost every other segment of our economy. The increase in healthcare costs has had a dramatic impact on government spending, taxes, employers and their employees, and the American family. If we draw these individual pressures and impacts together and look at their impacts in total, several truths stand out from the dire landscape we've revealed:

Truth: The cost of healthcare has been inflating at an unsustainable rate for the last several decades.

Truth: Healthcare costs cannot be allowed to continue to inflate at rates faster than CPI-U.

Truth: If left unchecked, healthcare inflation will result in a **market adjustment that could send the US. economy into a tailspin**, the likes of which we haven't seen since the Great Depression.

Collapse causes a total economic meltdown---dwarfs housing and auto collapses.

Howrigon 17 Ron Howrigon is president and CEO, Fulcrum Strategies and the author of Flatlining: How Healthcare Could Kill the U.S. Economy. "How health care could crash the U.S. economy." KevinMD. 19 January 2017. www.kevinmd.com/blog/2017/01/health-care-crash-u-s-economy.html. [Premier]

In recent history, **the U.S. economy has experienced the near catastrophic failure of two major market segments**. The first was the **auto** industry **and** the second was the **housing** industry. While each of these reached their breaking point for different reasons, **they both required a significant government bailout to keep them from completely melting down**. What is also true about both of those market failures is that, looking back, **it's easy to see the warning signs. What happens if health care is the next industry to suffer a major failure and collapse? It's safe to say that a health care meltdown would make both the automotive and housing industries' experiences seem minor in comparison.** While that may be hard to believe, it becomes clear if you look at the numbers. The **auto** industry **contributes around 3.5 percent of this country's GDP and employs 1.7 million people**. This industry was deemed "too big to fail" which is the rationale the U.S. government used to finance its bail out. From 2009 through 2014, the federal government invested around $80 billion in the U.S. auto industry to keep it from collapsing. **Health care is five times larger than the auto industry in terms of its percentage of GDP, and is ten times larger than the auto industry in terms of the number of people it employs.** The **construction** industry (which includes all construction, not just housing) **contributes about 6 percent of our country's GDP and employs 6.1 million people**. Again, the **health care market dwarfs this industry**. It's three times larger in terms of GDP production and, with 18 million people employed in the health care sector, it's three times larger than construction in this area, too. **These comparisons give you an idea of just how significant a portion health care comprises of the U.S. economy. It also begins to help us understand the impact it would have on the economy if health care melted down like the auto and housing industries did.** So, let's continue the comparison and use our experience with the auto and housing industries to suggest to what order of magnitude the impact a failure in the health care market would cause our economy. The bailout in the auto industry cost the federal government $80 billion over five years. Imagine a similar failure in health care that prompted the federal government to propose a similar bailout program**. Let's imagine the government felt the need to inject cash into hospital systems and doctors' offices to keep them afloat like they did with General Motors. Since health care is five times the size of the auto industry, a**

similar bailout could easily cost in excess of $400 billion. That's about the same amount of money the federal government spends on welfare programs. To pay for a bailout of the health care industry, we'd have to eliminate all welfare programs in this country. Can you imagine the impact it would have on the economy if there were suddenly none of the assistance programs so many have come to rely upon? When the housing market crashed, it caused the loss of about 3 million jobs from its peak employment level of 7.4 million in 1996. Again, if we transfer that experience to the health care market, we come up with a truly frightening scenario. **If health care lost 40 percent of its jobs** like housing did, **it would mean 7.2 million jobs lost**. That's more than four times the number of people who are employed by the entire auto industry — an industry that was considered too big to be allowed to fail. The loss of 7.2 million jobs would increase the unemployment rate by 5 percent. That means we could easily top the all-time high unemployment rate for our country. OK, now it's time to take a deep breath. I'm not convinced that health care is fated to unavoidable failure and economic catastrophe. That's a worst-case scenario. The problem is that **at even a fraction the severity of the auto or housing industry crises we've already faced, a health care collapse would still be devastating**. Health care can't be allowed to continue its current inflationary trending. I believe we are on the verge of some major changes in health care, and that how they're implemented will determine their impact on the overall economic picture in this country and around the world. Continued failure to recognize the truth about health care will only cause the resulting market corrections to be worse than they need to be. I don't want to diminish the pain and anguish that many people caught up in the housing crash experienced. I think an argument can be made, though, that if the **health care market crashes and millions of people end up with no health care, the resulting fallout could be could be much worse than even the housing crisis.**

Health sector debt is the most likely spark for an economic crisis – it poses the biggest system risk for a recession

Richter 17 Wolf Richter, CEO of Wolf Street Corp. and the editor-in-chief at Wolf Street, BA and MBA in Texas and an MA in Oklahoma. "Health-Care Industry Debt Turns into 'Systemic Recession Risk.'" *Wolf Street*. 27 March 2017. http://wolfstreet.com/2017/03/27/health-care-industry-debt-turns-into-systemic-recession-risk/. [Premier]

Sector booms and busts have historically been driven by **speculation and over-borrowing**, often triggering regional or even national **recessions**. Textbook examples include the 2014 Energy and 2008 Financial sector collapse. In both of these instances, fallacies such as perpetual $100+ oil and ever rising home prices drove rampant speculation, overinvestment, and unsustainable debt buildup.

So warns John Burns Real Estate Consulting, in a new paper, "Industries at Risk and Implications for Housing."

This time, three sectors stand out where "a similar pattern of unsustainable growth has driven rapid expansion" since the end of the Great Recession: technology, automotive (whose current travails I keep dissecting), and health care.

But **health care poses the biggest "systemic recession risk"** to the US economy, according to the report. After employment in the sector has soared 113% since 1990, it accounts for 16% of private sector jobs, up from 10% in 1990.

[T]thus a correction to the industry will likely cause a **slowdown for the national economy**. Several large housing markets have an even bigger concentration of jobs tied to the Health Care industry and will be disproportionately hit by a Health Care slowdown, including: Philadelphia, Boston, New York, and Nashville.

As so many times, it has to do with debt. Health-care sector debt has soared **308% since 2009**, the depth of the Great Recession which elegantly bypassed the sector. Over the same period, GDP has grown 30%, and overall jobs have grown only 18%. Thus health-care sector debt has grown 10 times faster than GDP and 17 times faster than private-sector jobs, "exceeding multiples of prior finance and energy sector boom-and-bust cycles."

Hospitals and other health-care facilities, funded by this "debt binge," have sprouted like mushrooms. Due to their "large multiplier effect on local economies" as doctors, nurses, and other employees live and spend money in the area, "municipalities have been eager to invest in health care facilities because of the assumed jobs/tax dollars." This overenthusiasm and over-investment has "accelerated the industry's growth."

It occurred during a period of industry consolidation via, you guessed it, a debt-fueled wave of Mergers & Acquisitions. This chart shows the annual number of announced deals (green) and the number of hospitals (blue) involved:

M&A activity has also consolidated the pharmaceutical sector, **health insurers**, and the like, which further lowered competition and helped contribute to surging prices that have become **"unsustainable" for consumers**.

Medical costs for a family of four in an employer-sponsored PPO plan soared 190% since 2002, from $9,000 to $26,000, according to the Milliman Medical Index, which includes health care costs and employee and employer contributions but not plan administrative expenses or profit:

The medical needs of the aging boomers support growth, "but not at the breakneck pace seen in recent years," the report explains. The population aged 65+ has grown 41% since 2000 and will likely grow another 29% through 2025. Medical spending increases with age, and folks aged 65+ account for about 40% of total personal health spending.

But these "demographic tailwinds do not justify skyrocketing debt growth," the report points out. The health care sector's debt per 65+ person has **soared** from less than $1,000 in 2000 to over $13,000 in 2016, a stunning rise of 1,376%:

The unsustainability of this debt binge is **showing up in the higher yield** that investors are demanding in order to hold health-care **junk-rated bonds** – a sign investors see higher industry risks. Hence, borrowing costs are rising.

The chart below shows the difference in yield between junk-rated health care bonds and all junk-rated bonds (between the Effective Yield of the BofA Merrill Lynch High Yield Health Care Sector Index and the BofA High Yield Index).

A negative spread, which dominated for much of the period of the chart, means that investors saw the sector as less risky than the overall junk-bond market. But that changed in 2015, and John Burns Real Estate Consulting anticipates that the sector's corporate borrowing costs will continue to "trend higher":

And now there are "early signs" the industry is cutting back, "after years of rapid expansion and renewed political pressure." The report cites some examples, including these:

"Community Health Systems Retrenches. Hospital operator forced to sell some hospitals after long buying spree" – Wall Street Journal, October 2016. "After years of acquiring hospitals and increasing debt [current debt to equity of 10x], one of the largest hospital operators announced it would be selling several of its 158 hospitals in order to pay down debt."

"High price tags for medicines are about to come under renewed pressure" – The Economist, December 2016. "The president-elect, the pharma industry's preferred candidate, has promised to bring prices down."

"MD Anderson cutting staff by 1,000 workers via layoff, retirement," Houston Chronicle, January 2017. "MD Anderson Cancer Center, Houston's second-largest employer, is eliminating about 1,000 jobs as the elite medical institution continues to wrestle with losses that exceeded $100 million last quarter."

So the report: "Speculative investing – often fueled by debt – has preceded 11 of the last 12 recessions; we believe **debt will spark the next downturn**." And the number one candidate for that spark is the phenomenally over-indebted **health care sector**.

Impact – Marginalized

M4A disproportionately helps women, trans people, and other marginalized groups.

Yurcaba Jo Yurcaba. "What Medicare For All Would Cost Women, LGBTQ People, According To Experts." Bustle. 28 October 2019. https://www.bustle.com/p/what-medicare-for-all-would-cost-women-lgbtq-people-according-to-experts-19261749. [Premier]

Advocates point out that **the current conversation about paying for Medicare excludes who exactly will be paying less: women, people of color, lower-income people, LGBTQ people, and other marginalized groups**. Sarah Coombs, senior health policy analyst for the National Partnership for Women & Families, which advocates for gender equality through policy and public education, tells Bustle that universal health care like Medicare for All would be particularly important for women. "Women spend a disproportionate amount of their economic resources on health care," she says. "So, expanding universal coverage is really essential to women's health and economic security." Medicaid, the government health insurance program for low-income people, is the largest single payer of pregnancy-related services in the United States, funding 43% of all births in 2016, according to the Kaiser Family Foundation. But Coombs points out that Medicaid coverage expires in most states 60 days after a pregnant person has given birth, despite the current maternal mortality crisis in the U.S. "We're seeing that women are facing mortality and severe maternal morbidity up to a year postpartum, so it's essential to keep that coverage up to a year," Coombs says. Universal health care like Medicare for All would allow anyone to have insurance regardless of reproductive status or income, meaning that new parents wouldn't lose access to life-saving postpartum care. Gillian Branstetter, media relations manager for the National Center for Transgender Equality, tells Bustle that easier access to health care would help transgender people in a number of ways. Trans people are more likely to live in poverty due to employment and housing discrimination, among other factors. And poverty, in addition to making it harder to afford care, can create and exacerbate health problems. "When you're living in poverty, you're also more likely to face a variety of health issues ranging from psychological distress to substance abuse, to HIV, to a sedentary lifestyle, to diabetes," Branstetter says. Trans people more often living in poverty means they're more likely to experience those health problems, "which means we are even more likely or even more desperately in need of a health care system that is affordable," she says.

Innovation

Link – Incentive

Single payer changes incentive structures – that resolves overwhelming fraud that undermines innovation

Sage 17 William Sage, James R. Dougherty Chair for Faculty Excellence, School of Law, and Professor of Surgery and Perioperative Care, Dell Medical School, The University of Texas at Austin. "Fracking Health Care: The Need to Safely De-Medicalize America and Recover Trapped Value for Its People." U of Texas Law, Public Law Research Paper. 31 May 2017. [Premier]

The incoherence of health care products and services compared to other commercial contexts – and the fact that the incoherence has all but gone unnoticed – shows how pervasive law-driven market distortions have become. In advanced industries serving consumers, products are almost universally delivered fully assembled, generally with a warranty for performance as expected. By contrast, the health care system trades in physician-led process steps that can be assigned a billing code and "reimbursed," along with isolated inputs to professional processes. Health insurance "benefit packages" are loose assemblages of these process steps and inputs, grouped in ways that obscure the purposes that might be served by offering them in combination and disclaiming any responsibility for combining them effectively. **Products or services assembled to meet consumers' intuitive needs are rare**, and warranty-style accountability for failing consumer expectations is even rarer.67 Even Medicare's new "bundled payment" initiatives tend to proxy assembly rather than actually demanding it – **kind of like paying for all the things that experts say should go into making a television set but not simply buying a television** set.68 Most perniciously, accreted regulation and professional self-regulation have distorted innovation itself**, which is the engine of change** over the longer term. Although process innovation has finally begun in earnest, the last several decades of medical innovation have mainly involved reimbursable technologies that fit existing, **flawed methods of production and therefore that have tended to increase costs without dramatically improving health outcomes**.69 As Lewis Thomas noted long ago, "definitive technologies" that prevent or cheaply cure disease are few and far between.70 Moreover, medical innovations have almost always been conceptualized as extensions of the physician's economically capacious if now merely metaphorical "black bag" – reinforcing professional intermediation in the receipt of health care rather than freeing the public from it. A new technology not attached to a physician (or to a technician for whom a physician or health facility catering to physicians can bill) **will likely go unused in the current regulatory and payment environment**. Basic science investment by government remains strong, but the "translational science" that has come into vogue to compete with it for funding tends to center on care delivery in academic health centers, which are hardly exemplars of efficiency or accountability. "Precision medicine" may eventually link molecular characteristics to personalized treatment protocols, **but in the short term seems more likely to bolster regressive arguments for costly, customized production models**.71 Even health information technology (HIT) has struggled, despite generous federal support to promote supply (the Bush approach) and incentivize demand (the Obama approach). 72 Real advances in HIT have been stymied by traditions of collecting health care information primarily **to get paid and not to improve production processes**, a paucity of users (other than large hospitals) who are willing to expend their own capital on HIT, and an aging generation of physician and hospital leaders who – like the matriarchs of Midwest farm families who wanted a "horseless carriage" rather than an automobile – understand HIT more as paperless medical records than as an integrated production management system.

Link – Free Riders

The aff solves free-riding which makes Europe more innovative

Thomas 06 Mark Thoma**,** Professor of Economics @ Department of Economics @ University of Oregon. "Single-Payer Health Care and Medical Innovation." *Economist's View*. 5 October 2006. http://economistsview.typepad.com/economistsview/2006/10/singlepayer_hea.html. [Premier]

First, the main argument is that switching to a single-payer system would **stifle innovation**. But I'm **not convinced** the case has been made that it is the **difference in health care systems** that has caused the agglomeration of research facilities in the U.S. **Even if the U.S. were** a **single-payer** system, drug companies, etc. would **still do research** and it is likely that **much of it would be** carried out **in the U.S.** just as it is now. In addition, as noted in the article, much of the research that is done here is funded directly or indirectly **by the government**. Second, given that European countries can **free ride** on this research, comparing the amount spent in the two countries **may not accurately reflect European willingness to fund** health care **research** since the two figures may not be independent. If the U.S. spent less, **European countries might** be induced to **spend more**. Third, Tyler says "The American government could use its size ... to bargain down health care prices... In the short run, this would save money but in the longer run it would cost lives." I understand less spending would cost lives, but I'm not sure I see why driving prices down **toward marginal cost** is necessarily **inefficient from the free market perspective** taken in the article, particularly if **drug companies,** etc. **have market power**. Fourth, the Veteran's Administration hospitals are **far ahead of private sector hospitals** in implementing information technology **undermining** the claim that private sector providers are **more innovative**. With 20 cents of every dollar insurance companies spend devoted to **avoiding paying claims** and with all the other **waste and inefficiencies** in the current system, but with only **2 cents** needed for overhead in the **VA system**, the VA can **use the reclaimed resources** to **improve health care** rather than to avoid paying the bills. Finally, here's Paul Krugman on the need to control cost escalation arising from the pressures from the powerful "medical-industrial complex" to adopt increasingly expensive drug therapies and procedures: [T]o get health reform right, we'll have to overcome wrongheaded ideas as well as powerful special interests. For decades we've been lectured on the evils of big government and the glories of the private sector. Yet health reform is a job for the public sector, which already pays most of the bills directly or indirectly and sooner or later will have to make key decisions about medical treatment. ... Consider what happens when a new drug or other therapy becomes available. Let's assume that the new therapy is more effective ... than existing therapies ... but that the advantage isn't overwhelming. On the other hand, it's a lot more expensive than current treatments. Who decides whether patients receive the new therapy? We've traditionally relied on doctors to make such decisions. But the rise of medical technology ... makes ... medicine ... in which doctors call for every procedure that might be of medical benefit, increasingly expensive. Moreover, the high-technology nature of modern medical spending has given rise to a powerful **medical-industrial complex** that seeks to influence doctors' decisions. ...[D]rug companies in particular spend more marketing their products to doctors than they do **developing those products** ... They **wouldn't do that** if doctors were **immune to persuasion**. So if costs are to be controlled, someone has to act as a **referee on doctors' medical decisions.** During the 1990's it seemed, briefly, as if private H.M.O.'s could play that role. But then there was a public backlash. It turns out that even in America, with its faith in the free market, people don't trust for-profit corporations to make decisions about their health.

Link – NHI

Big pharma trades off with NIH innovation which would develop more, better drugs cheaper without them

Snapp 17 Shaun Snapp, MS Business Logistics from Penn State, Managing Editor & Consultant at Brightwork Research & Analysis. "The Inefficiency of the Pharmaceutical Industry." *SCM Focus*. 26 April 2017. http://www.scmfocus.com/criticalthinking/2017/04/inefficiency-pharmaceutical-industry. [Premier]

NIH vs. Pharmaceutical Companies There are **two research paths** in the pharmaceutical industry. One is the NIH, which spends roughly $30 billion per year on basic research. The other is pharmaceutical companies which mostly perform and run clinical trials, but also perform research in assaying chemicals found by NIH supported university research. This comes to roughly $25 billion per year. Pharmaceutical revenues are roughly $325 billion per year (according to Reuters). Most the costs that the pharmaceutical companies incur are "marketing" related costs (over-paying doctors for clinical trials in order to get them to prescribe drugs, buying off top university research professors, patenting and re-patenting drugs, paying for pharmaceutical reps for distributing company propaganda, lobbying in congress, television advertising etc..). As can be seen, some of these marketing costs are not really marketing costs as much as **bribes**. The Current System Under a system where the NIH took over final drug development and clinical trials patents could be removed from the drug business altogether. The productivity of drug companies is atrocious. For the $325 billion in yearly expenditures (to which we must add the $30 billion of the NIH budget bringing it to $355 billion), US drug companies produce roughly 7 innovative drugs, and most of these are very narrow drugs which do not cure ailments but extend the life of late-stage terminal diseases. 78% of drugs are simply extending the life of old drugs which could come off of patent or copying another drug that already exists. This is according to (Marcia Angell as well as Dr. Jerry Avorn – two of the top experts in the field) Secondly the cost of clinical trials is greatly increased by the fact that a good portion of the payment to doctors is, in fact, a payoff to prescribe drugs (for those that are already approved), and in 78% of the cases, the drugs they are performing a trial on are not new chemical compounds. For this reason, we estimate that pharmaceutical companies only do actually $2.5 billion in research on new drugs. (and a number of these drug tests are falsified) However, they claim $325 billion in drug revenues. Even if all of their research was beneficial and non-corrupt (which we estimate less than $2.5 billion of it is) it still would not entitle the industry to $325 billion off of it. Handing it All Over to the NIH If the NIH took over clinical trials, it could do so at a cost of only $32.75 billion dollars (their current budget + the actual contribution of pharmaceutical company research). These unpatented discoveries could then be released to the generic manufacturers. This new system would mean no advertising, no pharmaceutical reps (doctors can read journals for their medical information, or if they don't have time (and most of them don't) they can go to Consumer Reports Health.com which provides a quick rundown of the benefits of drugs in an easy to read and digest format). This would allow the doctor to begin working for the patient rather than the pharmaceutical industry when prescribing drugs. It would also allow the doctor to be looking for other factors related to health problems rather than taking a narrow-minded drug approach because that is where their bread is buttered. Generic drug companies have low-profit margins and low costs of doing business. It cost less than ½ again as much to provide generic companies with a good profit for manufacturing and distributing the drugs because it is a very simple operation with high economies of scale. This would mean the total drug cost to Americans would not be more than $32.75 billion x 1.4 = $45 billion. This would reduce US health care costs by roughly $280 billion per year. In fact, there would be so much only left over that we could even increase the NIH budget by another $10 to $20 billion creating somewhat of a renaissance in medical research and providing more employment in the industry. This would require that most the old drugs, which should come off patent because they have been artificially extended through the abuse of patent law, need to fall into the public domain. It also means that the major pharmaceutical companies essentially go away and become small generic manufacturers with no ability to influence health care policy. For all the calculations see the image below. How Easy Would It Be? What is amazing is how **easy** this policy change would be (practically, not politically). The NIH can easily run clinical trials and do it far better than pharmaceutical companies.

Pharmaceutical companies should not be running clinical trials, or even paying for clinical trials at all. Universities used to perform more clinical trials, but big pharma has increasingly begun to use private practice doctors or trial mills that they completely control. They then receive the studies, and compile them and then send only the ones the like to the FDA, where they have already positioned executives from their company into the top roles through political appointment. Better Quality Drugs Another issue that could be changed with an NIH takeover is better drugs could be developed. We could even decide as a society to give another 5 to 10 billion to the NIH, there would be **so much excess** created by removing the pharmaceutical companies, which could lead to even more useful drugs and more money for the actual workers, medical researchers. Because of greed and narrow self-interest, big pharma is **pushing mostly the wrong drugs** to clinical trials. Right now drugs that are not very socially beneficial are developed because they are the most profitable. The major category being lifestyle drugs. Pharmaceutical companies don't develop drugs that support that overall objective of the health care system, but rather develop drugs that are very profitable. By having the NIH take over drug development, social goals in public health can begin to come to the **forefront**. Indirect Cost Benefits The indirect cost reductions would be enormous. Pharmaceuticals are a force that **corrupts everything it touches**. In addition to developing the wrong drugs, and re-patenting old drugs that are not improvements, they have a big place at the health care policy table that they do not deserve. They sit there for one reason, the **corrupting influence of their money**. Because this plan would essentially break the pharmaceutical monopoly, relegating them to nothing more than generic drug manufacturers, it would actually change how health care is practiced in the US. The indirect cost savings fall into the following categories: The major pharmaceutical companies would wither away as lobbyists in Washington and would lose their ability to corrupt medical schools and motivate the profession to look for pharmaceutical solutions to every problem. Over prescriptions, which is currently a **huge problem** would be **greatly reduced** because pharmaceuticals would tend to be prescribed only if they actually benefited the patient. The medical industry could begin to refocus on health and prevention. Many people currently employed in non-value added activities (pharmaceutical marketing and influence peddling activities) could be **redirected to beneficial pursuits**. Many clinical trials that are currently run need not be run. This would greatly reduce the load of pharmaceuticals on trial subjects, which they are, in the majority of cases, being misled into thinking that they are doing something beneficial for themselves and for society. (the very fact that clinical trial recipients are taking placebos when the exact drug was tested years ago is a loss for the system in terms of health efficiency.) The indirect benefits are difficult if not impossible to quantify. However, indirect benefits being ½ of the direct benefits could be easily justified. This would bring the benefits to $280 billion x 1.5 or $480 billion, or ½ trillion. Health care costs are growing in an **unsustainable fashion**, this could be **critical change** which in addition to reducing costs would more likely than not lead to better health for the country's population.

NIH needs a boost in funding - they've been super effective.

Atkinson 19 R Atkinson. "Healthy Funding: The Critical Role of Investing in NIH to Boost Health and Lower Costs." 25 March 2019. https://itif.org/publications/2019/03/25/healthy-funding-critical-role-investing-nih-boost-health-and-lower-costs.

The federal government, principally through the National Institutes of Health (NIH), funds scientific research related to biology and human health that sets the stage for applied research and development (R&D) activity by industry, ultimately leading to the commercialization of new medicines and treatments. New drugs not only improve the quality and length of lives but reduce the costs to society from illness. In order to accelerate biomedical innovation, Congress doubled NIH founding around the turn of the millennium. The results are paying off with basic and translational research, including discoveries of the genetic basis of disease and development of related diagnostics and therapies. For example, cancer therapies are being tailored not just to a patient's genome but to the genome of that patient's tumors. Other discoveries include sickle cell genomic therapy,1 immunotherapy for breast cancer,2 a universal flu vaccine, the TAILORx genetic screening breast cancer trial,3 and discoveries for

the treatment of Alzheimer's.4 NIH funding overall plays an important role, not only in biomedical innovation, but in enabling a competitive U.S. life sciences industry, and the millions of good paying jobs associated with it. In fact, while overall manufacturing jobs have declined in the last two decades, the number of biopharmaceutical industry jobs has grown. As such, increasing NIH funding is important not only to improving the health of Americans, but in reducing health care costs and spurring global life sciences competitiveness. Boosting NIH funding has long been a nonpartisan issue. For example, at a 2015 forum, former Republican House Speaker Newt Gingrich and Senator Elizabeth Warren (D-MA) both called for significant increases in NIH funding.5 And there is currently strong bipartisan support in Congress, with senators Roy Blunt (R-MO) and Patty Murray (D-WA) and representatives Rosa DeLauro (D-CT) and Tom Cole (R-OK) leading the charge for increases in NIH funding. Moreover, Americans are extremely optimistic and interested in biomedical breakthroughs. A recent survey conducted on behalf of the USA Today Network and the Charles C. Koch Institute asked Americans to name three areas of technological change they were most excited about for the future. Medical innovation, including pharmaceutical breakthroughs, ranked number 1, by an equal proportion (61 percent) of Democrats and Republicans, and an even higher share (66 percent) of rural Americans.6 However, even with recent increases, NIH funding as a share of GDP in 2019 is still 12 percent below that of 2003. Getting NIH funding to that 2003 level will require Congress to appropriate an additional $7.4 billion in FY 2020.7 As such, Congress should increase the NIH budget by around $8 billion annually over the next two years, and then maintain regular steady increases—ideally 2 to 3 percentage points faster than the nominal rate of GDP growth.

Link – Pharma Bad

Squo pharma's business model is busted---hurts innovation, plan solves it

Lazonick et al. 17 William Lazonick, Professor of Economics, University of Massachusetts Lowell; Visiting Professor, University of Ljubljana; Professeur Associé, Institut MinesTélécom; and President, The Academic-Industry Research Network (theAIRnet); Matt Hopkins, Ken Jacobson, Mustafa Erdem Sakinç, and Öner Tulum are researchers at theAIRnet. Jacobson is also theAIRnet communications director. Sakinç has just completed a PhD in economics at the University of Bordeaux. Tulum is a PhD student at the University of Ljubljana. "US Pharma's Business Model: Why It Is Broken, and How It Can Be Fixed." 22 May 2017. http://www.isigrowth.eu/wp-content/uploads/2017/06/working_paper_2017_13.pdf. [Premier]

1. Drug-Price Gouging to "Maximize Shareholder Value" The news in September 2015 that pharmaceutical company Turing, led by a 32- year-old hedge-fund manager, had raised the price of a 62-year-old drug from $13.50 to $750.00 focused public attention on price gouging in an industry in which the pursuit of wealth has trumped the improvement of health (Pollack 2015). The day after Democratic presidential candidate Hillary Clinton tweeted that this "price gouging" was "outrageous," the NASDAQ Biotechnology Index plunged by 4.7%, or $15 billion in market capitalization, in a few hours of trading. This reaction demonstrated the importance of the stock market to the fortunes that individuals can reap when pharmaceutical companies can keep drug prices high (Langreth and Armstrong 2015). The industry trade group Pharmaceutical Researchers and Manufacturers of America (PhRMA) was quick to disown Turing, tweeting that its actions did not "represent the values of PhRMA member companies" (Cha 2015). Yet price gouging in the US pharmaceutical drug industry goes back more than three decades. In 1985 US Representative Henry Waxman, chair of the House Subcommittee on Health and the Environment, accused the pharmaceutical industry of "gouging the American public" with "outrageous" price increases, driven by "greed on a massive scale" (Horowitz 1985). Despite many Congressional inquiries since the 1980s, including the case of Gilead Sciences' extortionate pricing of the Hepatitis-C drug Sovaldi since 2014 (United States Senate Committee on Finance 2015), the US government does not regulate drug prices. UK Prescription Price Regulation Scheme data for 1996 through 2008 show that, while drug prices in other advanced nations were close to the UK's regulated prices, those in the United States were between 74% and 152% higher (UK Department of Health 1996-2008, 2015; see also Kantarjian and Rajkumar 2015). Médecins Sans Frontières (MSF) has produced abundant evidence that US drug prices are by far the highest in the world (Médecins Sans Frontières 2015). The US pharmaceutical industry's invariable response to demands for price regulation has been that it will kill innovation. US drug companies claim that they need higher prices than those that prevail elsewhere so that the extra profits can be used to augment R&D spending. The result, they contend, is more drug innovation that benefits the United States and indeed the whole world (see for example Kravitz 1985, Horowitz 1987, Pollack 1988, Rovner 1992, Leary 1995, Mossinghoff 1999, Levin 2001, Nordrum 2015). It is a compelling argument, **until one looks at how major US pharmaceutical companies actually use the profits** that high drug prices generate. In the name of "maximizing shareholder value" (MSV), pharmaceutical companies allocate profits from high drug prices to massive repurchases, or buybacks, of their own corporate stock for the **sole purpose of giving manipulative boosts to their stock prices**. Incentivizing these buybacks is stock-based compensation that rewards senior executives for stock-price performance (Lazonick 2014b, Lazonick 2014c, Lazonick 2015b, Hopkins and Lazonick 2016). Like no other sector, the pharmaceutical industry puts a spotlight on how the political economy of science is a matter of life and death. In this chapter, we invoke "the theory of innovative enterprise" to explain how and why high drug prices restrict access to medicines and undermine medical innovation. An innovative enterprise seeks to develop a high-quality product that it can sell to the largest possible market at the most affordable price (Lazonick 2015c). **In sharp contrast**, the MSV-obsessed companies that dominate the US drug industry have become monopolies that **restrict output** and **raise price**. **2. Buyback Boosts to Stock Prices** US pharmaceutical companies claim that high drug prices fund investments in innovation. Yet the 19 drug companies in the S&P 500 Index in February 2015 and publicly listed from 2005 through 2014 distributed **97%** of their profits to shareholders over the decade, 47% as buybacks and 50% as dividends (see Table 1). The total of $226 billion spent on buybacks was equivalent to **51%** of their combined R&D expenditures. That $226 billion could have been returned to households in the form of lower drug prices without infringing on R&D spending, while providing ample dividends to shareholders.

Or it could have been allocated to the development of drugs for high-priority access areas that are otherwise underfunded and underserved. In the United States, massive distributions of cash to shareholders are not unique to pharmaceutical companies. From 2005 through 2014, 459 companies in the S&P 500 Index expended $3.8 trillion on buybacks, representing 53% of net income, on top of paying $2.6 trillion in dividends equaling 36% of net income. They held much of the remaining profits abroad, sheltered from US taxation (Rubin 2015). Many of America's largest corporations, Pfizer and Merck among them, routinely distribute more than 100% of profits to shareholders, generating the extra cash by reducing reserves, selling off assets, taking on debt, or laying off employees (Lazonick et al. 2015). Over the decade 2005-2014, Johnson & Johnson, Pfizer, and Merck, the three largest pharma companies, spent an annual average of $3.9 billion, $6.1 billion, and $2.6 billion, respectively, on buybacks, while Amgen, the largest independent biopharma company, spent $3.5 billion per year. The profits that a company retains after distributions to shareholders are the **financial foundation** for investment in innovation. These retained earnings can fund investment in plant and equipment, research and development, and, of **critical importance** to innovation, training and retaining employees (Lazonick 2015b). Dividends are the traditional, and legitimate, way for a publicly listed corporation to provide income to shareholders. They receive dividends for holding shares. In contrast, by creating demand for the company's stock that boosts its price, buybacks reward existing shareholders for selling their shares. The most prominent sharesellers are corporate executives, investment bankers, and hedge-fund managers who can time their stock sales to take advantage of buyback activity done as open-market repurchases. Buybacks also automatically increase earnings per share (EPS) by decreasing the number of shares outstanding. Since EPS has become a major metric by which stock-market traders evaluate a company's performance, buybacks tend to increase demand for a company's stock, thus creating opportunities for stock-market traders to sell their shares at a gain, even in the absence of increased corporate revenues or profits (Lazonick 2015a). **3. Pumping Up Executive Pay** Why do companies buy back their own shares? In "Profits Without Prosperity: Stock Buybacks Manipulate the Market and Leave Most Americans Worse Off," Lazonick argues that the only logical explanation is that stock-based compensation gives senior executives personal incentives to do buybacks to boost stock prices (Lazonick 2014b). There are two main types of stock-based pay: stock options, for which the realized gains depend on the difference between the stock price on the date the option to buy the shares is exercised and the date the option was granted; and stock awards, for which the realized gains depend on the market price of the stock on the date that the award vests (Hopkins and Lazonick 2016). By using stock buybacks to boost stock prices, executives can augment the gains that they realize from exercising options or the vesting of awards. As shown in Table 2, from 2006 through 2014, the average annual total compensation of the 500 highestpaid US executives (not including billion-dollar-plus outliers) ranged from $14.7 million in 2009 to $33.2 million in 2014, with realized gains from the combination of exercising options and vesting of awards constituting from 66% to 84% of the average annual total pay (Hopkins and Lazonick 2016).1 Stock-based pay incentivizes executives to take actions that increase the company's stock price and rewards them for doing so. Buybacks serve these purposes. Pharma executives are well represented among the 500 highest-paid executives at US corporations. In the most recent years, as their numbers among the top500 have increased, the average total compensation of the drug executives has soared, with the proportion of their pay derived from exercising stock options substantially higher than the average for the top500 as a whole in 2013 and 2014. Table 3 shows that biopharma companies launched in the late 1980s and early 1990s account for the explosion in pharma executive pay. Table 4 identifies the six highest-paid pharma executives for each year from 2006 through 2014. Note the prominence, especially in 2012-2014, of executives from four of the companies in Table 3: Gilead Sciences (14 of the 54 cells), Celgene (7), Regeneron (7), and Alexion (3), and also note the extent to which their pay is stock based.2 Gilead Sciences CEO John C. Martin appears on this top6 list in all nine years, three times in first place, four times in second, and twice in third. 4. Gilead's Greed With 12-week treatments for Hepatitis-C Virus (HCV) costing $84,000 for Sovaldi and $94,500 for Harvoni, Gilead Sciences exemplifies the price-gouging drug company. Prior to 2014 Gilead had two blockbuster drugs, with Truvada, launched in 2004, reaching $3.2 billion in sales in 2012, and Atripla, launched in 2006, generating a high of $3.6 billion in 2013. In their first full years on the market, Sovaldi had sales of $10.3 billion in 2014 and Harvoni $13.9 billion in 2015. As a result, Gilead's revenues and profits exploded in these two years (see Table 5). Once Gilead moved into sustained profitability in 2007, it had very high profit margins (NI/REV%), but these margins soared with its most recent blockbusters, as have sales per employee (REV/EMP$m). Pre-Sovaldi/Harvoni, Gilead was already doing substantial buybacks, but these reached massive levels in 2014 and 2015. The result, as the Sovaldi/Harvoni pricing strategy intended, was an exploding stock price from June 2012 (see Figure 1), about six months after its $11.2 billion acquisition of Pharmasset, which had substantially developed sofosbuvir (Sovaldi). An 18-month Congressional inquiry by US Senators Ron Wyden (D-OR) and Charles Grassley (R-IA) probed the rationale for Gilead's Sovaldi pricing strategy, and, in a report issued on December 1, 2015, concluded that "a key consideration in Gilead's decision-making process to determine the ultimate price of Sovaldi was setting the price such that it would not only maximize revenue, but also prepare the market for Harvoni and its even higher price" (The Staffs of Senators 2015). But the WydenGrassley report made no attempt to probe the influence and impact of Gilead's pricing strategy on its stock price and executives' pay. In our view, the objective of Gilead's executives in setting high prices was not to maximize revenues but rather to "maximize shareholder value" so that soaring stock prices would translate into enormous executive-pay packages.3 The greed of Gilead's top executives, sanctioned by MSV ideology, is preventing millions of people with HCV in the United States and abroad from accessing Sovaldi/Harvoni at an affordable cost.4 What is needed is a business model that shares the gains from innovative medicines with households as taxpayers who fund the government agencies that provide intellectual and financial support to the drug companies, workers whose skills and efforts have developed the drugs, and consumers who have illnesses waiting to be

cured or relieved. In contrast, the MSV business model concentrates the gains from innovative medicines in the hands of senior corporate executives who pad their paychecks by doing billions of dollars of stock buybacks to manipulate the company's stock price. In the process, for millions who cannot afford access to innovative medicines, the life sciences become death sciences. In a hard-hitting article entitled "Gilead's greed that kills," economist Jeffrey Sachs (2015) makes this case: Gilead Sciences is an American pharmaceutical company driven by unquenchable greed. The company is causing hundreds of thousands of Americans with Hepatitis C to suffer unnecessarily and many of them to die as the result of its monopolistic practices, while public health programs face bankruptcy. Gilead CEO John C. Martin took home a reported $19 million last year in compensation – the spoils of untrammeled greed. A glance at Table 4 above reveals, however, that Martin's actual compensation in 2014 was $192.8 million. As Hopkins and Lazonick (2016) explain, the "reported $19 million" that Sachs cites is an estimated "fair value" accounting measure of executive compensation that, as can be seen, vastly understates actual compensation. For the decade 2005-2014, the "fair value" measure of Martin's pay totaled $141.5 million but his actual pay, reported to the US Internal Revenue Service, was $717.4 million, of which 95% was stock based. In 2014 the actual pay packages of the other four Gilead executives named on the company's proxy statement were: John F. Milligan $89.5 million (97% stock based); Gregg H. Alton $52.6 million (97%); Norbert W. Bischofberger $50.7 million (96%); and Robin L. Washington $26.6 million (93%). In 2015 the compensation of Martin was $232.0 million (98%), Milligan $103.4 million (97%), Bischofberger $95.5 million (98%), Alton $33.6 million (94%), and Washington $22.0 million (91%). In the first six months of 2016, even with Gilead's stock price in decline, Martin, who stepped down as CEO in March but remains at the company as executive chairman, "earned" $55.1 million from stock-based compensation. In the first quarter of 2016 Gilead did $8.0 billion in buybacks, thus helping to "create value" for its senior executives as sharesellers. In the second quarter of 2016 Gilead scaled back its buybacks to $1 billion.5 In an interview in December 2013, Alton, Gilead vice-president of corporate and medical affairs, defended the price of Sovaldi by saying: "Really you need to look at the big picture. Those who are bold and go out and innovate like this and take that risk, there needs to be more of a reward on that. Otherwise it would be very difficult for people to make that investment" (The Staffs of Senators 2015, p. 108).But whose risks are being rewarded? Over its entire corporate history, Gilead has secured a total of $376 million from public share issues, all between 1991, when it did its IPO, and 1996. Especially since Gilead only began paying dividends in 2015, it is probable that virtually all of those shareholders have long since sold their shares to secure capital gains. Current shareholders are just stock-market traders who have bought outstanding shares. So why are Gilead's senior executives so intent on "creating value" for shareholders who have contributed nothing to the development of Gilead's products? The executive-pay numbers provide the answer. Gilead is not an innovative company. Among the ten drugs that have generated 97% of Gilead's revenues since 1999, only two contain ingredients fully developed by Gilead researchers. Gilead gained control over the remaining ingredients, including sofosbuvir, the key component of Sovaldi and Harvoni, through acquisitions of companies that had brought the drugs to the later stages of development or had already put them on the market. And the history of the design and development of the drugs that Gilead sells reveals seminal research that was done with government funding from the National Institutes of Health (NIH). Indeed, the NIH's 2016 budget of $32.3 billion is, in real terms, triple NIH's annual spending in the mid-1980s (National Institutes of Health 2016). Yet even three decades ago, before companies like Celgene, Gilead, Cephalon, Regeneron, Vertex, and Alexion had been founded, NIH funding was critical to drug innovation. At a meeting with French President François Mitterrand in Silicon Valley in 1984, documented in a Washington Post report (Henderson and Schrage 1984), venture capitalist Thomas Perkins, whose firm brought Genentech from startup in 1976 to IPO in 1980, "extolled the virtues of the risk-taking investors who finance the entrepreneurs." The Post article goes on to say: Perkins was cut off by Stanford University Professor Paul Berg, who won a Nobel Prize for work in genetic engineering. "Where were you guys in the '50s and '60s when all the funding had to be done in the basic science? Most of the discoveries that fueled [the industry] were created back then....I cannot imagine that if there had not been an NIH funding research, that there would have been a biotechnology industry," Berg said. As these things go, Berg himself would be appointed to Gilead's board in 1998, and as a company director from 2004 to 2011 regularly exercised his stock options, netting an average of $2.9 million per year.6 But the **acute problem** of access to medicines goes far beyond the actions of individuals or even companies. The Gilead problem is an American problem, and given the **centrality** of US pharmaceutical research, the American problem is a **global problem**. The key cause of high drug prices, restricted access to medicines, and **stifled innovation**, we submit, is a **social disease** called "maximizing shareholder value." Armed with "the theory of innovative enterprise," policy-makers can take steps to eradicate the MSV disease (Lazonick 2014a). **5. The Theory of Innovative Enterprise and the Flaws in MSV** MSV is a profit-driven ideology that results in high drug prices, restricted access to existing medicines, and **stifled pharmaceutical innovation**. If widespread access to critical medicines at affordable prices is the goal, MSV needs to be replaced by a product-driven norm of corporate governance. Underpinning this product-driven norm is "the theory of innovative enterprise" (Lazonick 2012b; Lazonick 2016b).7 The theory of innovative enterprise provides an analytical framework for understanding how a business enterprise can generate a product that is higher quality (in medicines, more effective and safer) and lower cost (more accessible and affordable) than products previously available. The innovation process that can generate these outcomes is: • **Uncertain**: When investments in transforming technologies and accessing markets are made, the product and financial outcomes cannot be known. Hence the need for strategy. • **Collective**: To generate higher-quality, lower-cost products, the enterprise must integrate the skills and efforts of large numbers of people with different responsibilities and capabilities into the learning processes that are the essence of innovation. Hence the need for organization. • **Cumulative**: Collective learning today enables collective learning tomorrow, and these organizational learning processes must be sustained over time until, through the sale of innovative products,

financial returns can be generated. Hence the need for finance. The theory of innovative enterprise identifies three social conditions – strategic control, organizational integration, and financial commitment – that can enable the firm to manage the uncertain, collective, and cumulative character of the innovation process. • **Strategic control**: For innovation to occur in the face of technological, market, and competitive uncertainties, executives who control corporate resource allocation must have the abilities and incentives to make strategic investments in innovation. Their abilities depend on their knowledge of how strategic investments in new capabilities can enhance the enterprise's existing capabilities. Their incentives depend on alignment of their personal interests with the company's purpose of generating innovative products. • **Organizational integration**: The implementation of an innovative strategy requires integration of people working in a complex division of labor into the collective and cumulative learning processes that are the essence of innovation. Work satisfaction, promotion, remuneration, and benefits are important instruments in a reward system that motivates and empowers employees to engage in collective learning over a sustained period of time. • **Financial commitment**: For collective learning to cumulate over time, the sustained commitment of "patient capital" must keep the learning organization intact. For a startup company, venture capital can provide financial commitment. For a going concern, retained earnings (leveraged if need be by debt issues) are the foundation of financial commitment. The theory of innovative enterprise explains how, in the United States during the twentieth century, a "retain-and-reinvest" allocation regime enabled a relatively small number of business enterprises in a wide range of industries to grow to employ tens, or even hundreds, of thousands and attain dominant product-market shares.8 Companies retained corporate profits and reinvested them in productive capabilities, including first and foremost collective and cumulative learning. Companies integrated personnel into learning processes through career employment. Into the 1980s, and in some cases beyond, the norm of a career-with-one-company prevailed at major US corporations. A steady stream of dividend income and the prospect of higher future stock prices based on innovative products gave shareholders an interest in "retain-and-reinvest." From the 1960s, however, a changing business environment encouraged executives of established US corporations to shift corporate resource allocation from "retainand reinvest" to "downsize-and-distribute" (Lazonick 1992, Lazonick and O'Sullivan 2000, Lazonick 2009, Lazonick 2015b).9 By the 1980s, even in good times, companies began to downsize their labor forces and distribute more profits to shareholders. Justifying this dramatic transformation in corporate resource allocation was a new ideology that taught that, for the sake of economic efficiency, companies should "maximize shareholder value" (Lazonick and O'Sullivan 2000; Lazonick 2014a). The MSV argument is that, of all participants in the corporation, only shareholders make productive contributions without a guaranteed return (Jensen 1986). All other participants such as creditors, workers, suppliers, and distributors allegedly receive a market-determined price for the goods or services they render to the corporation, and hence take no risk of whether the company makes or loses money. On this assumption, only shareholders, as the sole risk-takers, have an economically justifiable claim to profits. A **fundamental flaw** in MSV lies in the erroneous assumption that shareholders are the only corporate participants who bear risk. Taxpayers through government agencies and workers through the firms that employ them make risky investments in productive capabilities on a regular basis. Households, as taxpayers and workers, may have legitimate economic claims on the distribution of profits. The National Institutes of Health (NIH), which from 1938 through 2015 spent $958 billion in 2015 dollars on life-sciences research, is a prime example of how taxpayers invest without a guaranteed return (National Institutes of Health 2016). Drug companies benefit from the knowledge that the NIH generates. As risk bearers, taxpayers fund investments in the knowledge base – as well as physical infrastructure such as roads – required by business, and hence have tax claims on corporate profits. But because profits may not be forthcoming and tax rates can be changed, the returns to taxpayers' investments are not guaranteed. Through the application of skill and effort, workers regularly make productive contributions to the company's future products, and hence prospective profits. Their rewards take the forms of continued employment and career advancement, and hence workers invest in collective and cumulative learning without guaranteed returns. "Retain-and-reinvest" rewards innovative workers. But profits from innovation may not materialize, and even when they do, "downsize-and distribute" may deny these workers shares of profits that, as risk-bearers, they should have received. As risk bearers, therefore, taxpayers whose money supports business enterprises and workers whose efforts generate productivity improvements have claims on corporate profits if and when they occur. MSV ignores the risk-reward relation for these two types of economic actors in the operation and performance of business corporations. Another basic flaw in MSV is that the public shareholders whom it holds up as the only risk bearers typically **do not invest in the value-creating capabilities** of the company. Rather, as savers or speculators, they buy outstanding shares on the stock market for the sake of dividends and stock-price increases. Public shareholders generally make no productive contributions to the enterprise. Indeed, from 2006 through 2015, net equity issues in the United States were over four trillion dollars in the negative; US stock markets fund public shareholders rather than vice versa.10 The proponents of MSV (see Jensen 1986; Jensen and Murphy 1990) advocate that, through stock-based pay, senior executives should be incentivized to "disgorge" corporate earnings as buybacks and dividends to the corporate participants who matter least – just the opposite of the financial commitment needed for innovation. These distributions to shareholders generally **come at the expense** of the stable and remunerative career opportunities that integrate employees into processes of collective and cumulative learning. As for

strategic control, a senior executive who sees MSV as the key to corporate success has lost not only the incentive but probably also the ability to allocate corporate resources to potentially innovative investments. In sum, MSV **undermines investments in innovation** that, if successful, can yield products that are higher quality and lower cost than previously available. Major US pharmaceutical companies have the **MSV disease**, as evidenced by not only massive stock buybacks and exploding executive pay (Lazonick et al. 2014, Hopkins and Lazonick 2016) but also a "**productivity crisis**" in drug discovery (Pisano 2006, Cockburn 2007, Munos 2009, Lazonick and Tulum 2011, Pammolli et al. 2011, Khanna 2012, DeRuiter and Holston 2012). Companies such as Merck and Pfizer have spent the last two decades living off patented blockbuster drugs, with very little to replace them in the pipeline (Phillips 2014, McGrath 2014a, McGrath 2014b). **In the name of MSV, they have been profit-driven. For a company to be an innovative enterprise, however, it needs to be product-driven**.

Link – Rent Seeking

Rent seeking destroys the industry & undermines innovation – only single payer stops catastrophic collapse.

Deaton 17 Angus Deaton, Dwight D. Eisenhower Professor of International Affairs and Professor of Economics and International Affairs at the Woodrow Wilson School of Public and International Affairs (WWS) and the Department of Economics at Princeton, awarded the 2015 Nobel Prize in Economic Sciences, Ph.D. from the University of Cambridge. "Speech at the National Association for Business Economics: Economic Inequality." 7 March 2017. https://www.c-span.org/video/?424924-5/national-association-business-economics-economic-inequality&start=2051. [Premier]

What is not ok is for rent seekers to get rich by lobbying or persuading governments to give them special favors. **Much of the health care industry today**. Excluding the people who are dying. The problem with such rent seeking is not only does it not generating new product it is **slowing down economic growth** because all of that talent is devoted to stealing things instead of making things. Economists argue that that is the virus that would **ultimately undermine capitalism**. Let me go back to my favorite topic, opioids. I wonder book called dreamland said that many of those addicted get prescriptions paid for by medicaid. In a recent commentary piece, this wonderful phrase he said -- this means that dependence on government has come to take on an entirely new meaning. Medicaid is making people dependent on drugs. There's another part of this story, who really benefits? Follow the money. Following the Los Angeles times who did a long investigative journalism into this, pharmaceutical earned $31 billion from oxycontin. Oxycontin has so far killed 200,000 people. Medicaid is giving the money and 2000 people -- 200,000 people are incidental casualties. **The prime example of rent seeking**. It seems to me that it is so impossible to exclude government from health-care. Such a system is exquisitely **designed to give opportunities for rent seeking**. One of the lowest life expectancies from the richest countries in the world. It is very good for rent seeking. I do not believe in socialized health care and **would advocate a single payment system** because of the health care system because it will get the monster that we have created out of the economy and **allow the rest of capitalism to flourish** without the awful things that health care is doing to us. I just want to say very quickly the recipe on the left would be redistributed through taxes. It grabs the successful effort to nurse one with the rent seekers create -- I think the key is to find a way of tackling rent seeking crony capitalism and illegal and illegal -- build a fairer society **without compromising innovation or entrepreneurship**. Thank you very much indeed. [applause] >>

Growth

Link – Costs

Single-payer spurs economic growth – it increases employment and lowers health care costs

Malloy et al. 16 Liam C. Malloy, assistant professor of economics at the University of Rhode Island, Ph.D. in Economics from the University of Maryland, Shanna Pearson-Merkowitz, associate professor of political science at the University of Rhode Island, Ph.D. in Political Science from the University of Maryland, Irwin L. Morris, Professor and Chair of the Department of Government and Politics at the University of Maryland, College Park, Ph.D. in Political Science from UNC-Chapel Hill. "State-Sponsored Health Insurance and State Economic and Employment Growth." *Politics & Policy*, Volume 44, Issue 5. October 2016. pgs. 945–975. [Premier]

This study employed two datasets—one on health insurance coverage in the contiguous 48 U.S. states and one for countries in the OECD—to model the effect of expanding health insurance on state and country economic and employment growth over the last two decades. We draw three main conclusions from our results. First, in the United States, **government health insurance** (e.g., Medicaid, Medicare, and Military) of the working age population is associated with **faster GDP per capita growth**. Second, health insurance coverage in general, but **especially** Medicaid coverage in the United States sample, and **public coverage** in the OECD sample, is associated with **faster employment growth**. Finally, in the United States, per-enrollee Medicaid spending is associated with slower GDP and employment growth. However, public health-care spending in the OECD sample (and total Medicaid spending as a percent of state GDP) is associated with faster growth although the direction of causality is unclear. Taken as a whole our results suggest that when the government takes steps to insure a larger share of the working age population through **government provided health insurance**, it is **beneficial to economic growth**.

However, our results also suggest that a **single-payer** public health-care system is likely to be the **most beneficial for economic growth** in that the government can maximize health insurance coverage and **use its monopsony power** as the only major buyer of health services to control costs. Single-payer systems have the benefit of covering the entire population (and therefore the entire working age population) and allow governments to set the rate for procedures, prescriptions, and other health-care expenditures. This suggests that regardless of how the ACA specifically affects the economy, if the goal of health insurance regulators and reformers is to **increase economic growth**, they should reconsider a universal coverage public system. However, even as the ACA stands now, where many states have significantly expanded Medicaid to previously uncovered working age populations, our results do suggest that this should be beneficial to those states' economies.

Insurance costs are a neg drag on growth – it's wasteful spending

Papavlassopulos et al. 16 Nikolas Papavlassopuos, P.h.D in Financial Economics and Professor @ St. Thomas Aquinas College David Keppler, and Don Johnson, "On the Benefits and Costs of Healthcare and the Financing of a Single Payer System." Social Science Today, Volume 3, No. 1. September 2016. [Premier]

Some may argue that healthcare costs represent nothing more than income to others. Thus, their overall effect on population health should be a zero sum game. This might be the case under conditions of perfect income equality and efficient mechanisms in the delivery of healthcare. But in reality **this argument is fallacious on several grounds**. As we know from economic theory, given that some part of healthcare is delivered by non-competitive markets, as a rule, **there exists excess profit or economic rent**. Excess profits and economic rent is possible by curtailing production (a kind of artificial scarcity) and thus income. And, any reduction in income, as we have shown before, leads to lower net benefits BN. Moreover, the motive for profit superseding the motive for industry, allows

for significant misallocation of resources, redundancies and inefficiencies, as they have actually been cited by studies (Institute of Medicine [US] Roundtable on Evidence-Based Medicine, 2010). This translates to l**ower labor productivity**, lower income, and thus lower net benefits. And finally, if economic rent is paid by lower incomes to higher incomes (as is usually the case), the loss in life expectancy and health outcomes for the lower incomes will be larger than the gain for the higher ones (see equation [5]). Thus, **the result will be a net loss in health benefits for the population.** Therefore, high health care costs are a negative sum game for population health. From equation [5] we can also see that rising healthcare costs, in addition to reducing health and life expectancy overall, exacerbate any existing disparities in health outcomes. The negative impact from a rise in costs c is larger the lower is the income, because for $y1 < y2$, $f'(y1-c) > f'(y2-c)$. This finding may very well explain - or being a contributing factor17- the "puzzling" rising inequality in health outcomes and life expectancy in the U.S. Note that the opposite is also true. A reduction in cost c improves the health outcomes for all income levels y and reduces existing disparities.

Link – Jobs

M4A would increase healthcare jobs by increasing demand.

Bivens 20 Josh Bivens, Director of Research. "Fundamental health reform like 'Medicare for All' would help the labor market." Economic Policy Institute. 5 March 2020. https://www.epi.org/publication/medicare-for-all-would-help-the-labor-market. [Premier]

While it may seem counterintuitive, fundamental health reform like M4A is almost guaranteed to substantially expand employment in the health care sector overall, even taking reduced billing administration employment into account. Often people hear that fundamental reform is aimed at cost containment and then imagine that part of this cost containment will take the form of fewer jobs providing health care, but this is not necessarily the case. As noted before, the U.S. is an outlier in terms of how much it spends on health care, but its health care workforce as a share of the total workforce is not out of line with shares in other countries. For example, in 2017 the health care workforce in the U.S. was equal to 13.4% of the overall workforce, while the share averaged 12.9% in the 20 other richest OECD countries.15 Additionally, seven of these other countries had health care workforce shares equal to or higher than the U.S.'s 13.4%.16

Pollin et al. (2018) estimate that expanded access to health care could **increase demand** for health services by up to $300 billion annually. Given the current level of health spending and employment, this would translate into increased demand for 2.3 million full-time-equivalent workers in providing healthcare.17 Obviously all of the workers displaced from the health insurance and billing administration sectors could not necessarily transition into these jobs seamlessly, but well over 10% of workers in the health insurance sector, for example, are actually in health care occupations (e.g., they are doctors or nurses).18

Further, several M4A plans have provisions to pay for long-term care services. Reinhard et al. (2019) have estimated that in 2018, Americans provided roughly 34 billion hours in unpaid long-term care. If this care was divided up among full-time paid workers, it would require **17 million** new positions. Of course, not all of this currently unpaid care would be converted into paid positions in the job market. But if even 10% of unpaid care translated into new jobs, it would create enough new demand for workers to essentially offset the displacement of workers in the health insurance and billing administration sectors.

Even if some healthcare administrators lose jobs, overall layoffs wouldn't be affected much and they would be able to find new jobs.

Bivens 20 Josh Bivens, Director of Research. "Fundamental health reform like 'Medicare for All' would help the labor market." Economic Policy Institute. 5 March 2020. https://www.epi.org/publication/medicare-for-all-would-help-the-labor-market. [Premier]

It is true that one source of cost savings from the introduction of M4A is the reduced demand for insurance and billing administration. In turn, this reduced demand would shift employment out of these sectors. This could certainly cause challenges and economic distress for the workers within these sectors who are directly affected. But for some perspective, it is worth noting that 21.5 million workers were laid off in 2018 (BLS 2020b). If the 1.8 million workers that Pollin et al. (2018) identify as potentially being displaced by M4A were forced to transition over the four-year phase-in commonly identified with M4A plans, this would increase the national rate of layoffs by about **2%.** It is also worth noting that even within just the finance and insurance sectors, there have been 1.7 million layoffs in the past four years (BLS 2020b). And yet it's safe to say that very few people even in the business press have made any note of this. This is not a shock: Our economy

generates a huge amount of **job churn** every year. This churn is the hallmark of growth in productivity—getting more economic output with fewer inputs. While productivity growth can indeed put downward pressure on jobs in the sector experiencing it directly, Autor and Salomons (2018) demonstrate that productivity gains within a given sector strongly boost job growth in other sectors, as the savings to households and businesses stemming from enhanced productivity increase purchasing power that supports demand for these other sectors' outputs.

If workers in the insurance or billing administration sectors were particularly hard-pressed for reemployment prospects because of geographic isolation or low average levels of educational credentials, their displacement might pose particular concern to policymakers. But employment in the health insurance and billing administration sectors is not particularly geographically concentrated,[14] and Pollin et al. (2018) show that 56.5% of workers in these sectors have a four-year college degree or more education, a far greater share than the overall labor force (in 2018, 37.6% of workers had a four-year degree or more education, according to EPI 2020b).

Link – Businesses

Single payer halts price hikes, decreases the burden businesses have to bear, and distribute those costs more than the ACA quadruple tax.

Sterret et al. 14 Dave Sterrett, Principal at the Health Care Policy Group where he provides government affairs and public relations consulting to healthcare clients; Ashley Bender is a third year law student at American University Washington College of Law. In May 2012, she graduated from Northwestern University with a degree in Political Science, Spanish, and Global Health; David Palmer is a third year law student at American University Washington College of Law and is on American University Law Review. "A Business Case for Universal Healthcare: Improving Economic Growth and Reducing Unemployment by Providing Access for All." Health Law and Policy Brief, Volume 8 Issue 2, Article 3. digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?article=1132&context=hlp. [Premier]

Although many Americans believe as an article of faith that the **U**nited **S**tates enjoys the strongest, most entrepreneurial, most resilient economy in the history of the world, recent empirical assessments comparing the economies of the United States and other countries have not been so charitable.42 Meanwhile, most of the countries that rate higher than the United States, even by the scorecard published by the conservative Heritage Foundation, offer universal healthcare through government-directed systems.43 In fact, most other developed countries in the world have universal access to care through government-directed systems, which partially explains why all of the countries that outrank the United States in various economic indices have such systems.44 Despite conservatives' reflexive view that a government-directed healthcare system would be a pox on the economy, there are many common sense reasons that **such systems foster economic growth**. Aside from enabling greater job mobility, as discussed in Part I of this report, a government-directed system would diminish the burden on businesses by (1) slowing (or, potentially, reversing) increases to health costs, (2) decreasing businesses' obligations to bear the burden of those costs, and (3) distributing the costs that remain on businesses' shoulders more equitably. A. The United States Trails Many of Its Competitors by Various Economic Measures As discussed above, the United States fares worse than many countries with universal healthcare systems by various measures, including some maintained by conservative organizations. For example, the Heritage Foundation/Wall Street Journal Index of Economic Freedom ranks countries based on ten benchmarks under the four broad headings of Rule of Law, Limited Government, Regulatory Efficiency, and Open Markets.45 The United States ranks twelfth in this index.46 Ten of the eleven countries outranking the United States have government-directed universal care systems. [See Table 1]. On another list, the Organisation for Economic Co-operation and Development (OECD) ranks its members on what it terms the "employer enterprise birth rate," which it defines as the rate at which new enterprises with at least one employee are formed.47 The United States ranked last or second-to-last in this category in every year from 2008 to 2011, the most recent year for which United States data are available.48 In fairness, these years mostly coincided with the worst recession in the United States since the Great Depression. But those seeking to find solace in pre-recession data will be disappointed. The United States ranked twenty-one out of twenty-six countries included in the OECD's rankings for 2006.49 [See Table 2] Patents are indicative of business innovation and economic performance.50 The OECD also ranks its members on the rate of patents issued by start-ups younger than five years old in relation to each country's GDP.51 Here, the United States ranks nine out of twenty- two countries, another indicator that the United States is not as strong at innovation as several other countries.52 [See Table 3]. B. How the Employer-Funded United States Healthcare System Harms Businesses United States businesses that furnish healthcare benefits are shouldering costs that go well beyond their own employees' needs. A health insurance premium paid by a business in the United States has been characterized as a triple tax (and in reality might conceivably be called a **quadruple tax**).53 **First**, as might be expected, part of the payments cover insurance for their employees (and often their employees' families), but that is just a portion of what business' healthcare premiums cover.54 **Secondly**, the payments indirectly subsidize Medicaid and, possibly, Medicare.55 This is because hospitals pad their bills to private insurance companies to compensate for lower Medicaid and Medicare reimbursements.56 This phenomenon is known as "cost shifting."57 **Third**, the amounts hospitals bill private insurance companies is also increased to help hospitals recoup losses for services rendered to uninsured patients who are unable to pay their bills.58 A **fourth** "tax" wrapped up in hospitals' insurance payments is a subset of the first item listed above—money that pays for benefits to employees or their families. Employers that provide healthcare benefits are often covering costs for other

businesses that avoid doing so. For example, in 2004, seventy-one percent of PepsiCo's hourly employees were covered on someone else's healthcare.59 This suggests that PepsiCo was foisting costs onto other businesses that would be its responsibility if it were to pay its fair share.60 **These costs hurt** those **businesses** doing the right thing. Companies in the United States that must pay large amounts to private insurance companies to cover their employees with healthcare are at **a competitive disadvantage** against companies in countries with single-payer healthcare or other universal healthcare systems. This is illustrated in cases in which different divisions of the same company operate in different countries.61 In 2002, Ford Motor Co., General Motors, and DaimlerChrysler signed a joint letter entreating the Canadian government to take steps to preserve the Canadian National Health System.62 In it, they specifically cited the fact that labor costs in Canada are lower than in the Unites States in part because businesses do not have to pay for their employees' health insurance.63 Savings for Canadian divisions amounted to as much as "several dollars per hour of labor worked."64 This savings is a "significant factor in maintaining and attracting new auto investment to Canada."65 Although this letter was written in 2002, it is important to note that the cost of employersponsored health insurance in the United States has escalated greatly since then. Between 2000 and 2011, the cost of the average annual employer-sponsored premiums in the United States **doubled**.66 In fact, General Motors estimated as recently as 2012 that the rising healthcare costs it faces in the United States add "between $1,500 and $2,000 to the sticker price of every automobile it makes."67 Len Nichols, Director of the Health Policy Program at the New American Foundation, estimates that United States manufacturing companies spend almost **three times** as much on healthcare per worker per hour as foreign companies do.68 C. Why a Universal Care System Would Lessen Burdens on Businesses No universal care systems, including pure single-payer systems, are a free lunch for businesses. In one way or another, often through a payroll tax, businesses end up providing at least some of the money to finance the system.69 There are several reasons to believe that a universal care system would mitigate this impact on businesses. Primarily, such a system would cause future costs to be lower, or at least stem the trend of cost-increases far exceeding inflation.70 Secondly, businesses' overall share of healthcare bills would likely be lower.71 Finally, a universal care system would distribute costs far more equitably among businesses.72 1. Future Overall Healthcare Costs Would be Lower Across the Board There are two primary reasons that future costs in a government-directed, universal care system would be lower than they would be if we remained on our current trajectory: such a system would result in **reduced administrative costs** and would **lower costs for procedures and prescriptions**.73 A 2003 study published in the New England Journal of Medicine concluded that administrative costs account for thirty-one percent of healthcare spending in the United States compared to just 16.7 percent in Canada, which has a single-payer system.74 United States healthcare costs in 2011 were about $2.7 trillion.75 If the United States were able to shave 14.3 percent off of its healthcare bill, it would save approximately $415 billion a year.76 Additionally, governments that coordinate their countries' healthcare delivery are able to **negotiate lower rates** for procedures and prescription drugs.77 The example below compares costs for medical procedures and prescriptions in the United States with those in France, which the World Health Organization in 2000 ranked as having the best healthcare services in the world.78 [See Table 4]. It is doubtful that costs for procedures and drugs would be cut to the levels in France if the United States were to adopt a government-directed, universal care system as that would require reducing drug and provider reimbursement rates in Medicare, which is extremely difficult politically. A more likely scenario is that the rate of increase of payments to providers in the United States would be slowed or temporarily stopped.79 A window of insight into the potential cost savings that could be realized by converting to a universal care system can be gleaned by comparing the rate of increase in perpatient private insurance costs versus per-patient Medicare costs. Although some singlepayer purists disagree with this characterization, Medicare is essentially a single-payer system for people sixty-five years of age and older. Advocates for single-payer systems often express their proposed policy as Medicare for All or Improved Medicare for All.80 Private insurance costs outpaced Medicare over the four decades concluding in 2010.81 The discrepancy was particularly pronounced for the most recent decade. [See Table 5]. Critics of the hypotheses that a universal Medicare system would generate cost savings argue that hospitals simply charge private sector insurers more to compensate for insufficient payments from Medicare.82 But many dispute this "cost shifting" theory. Anecdotally, as noted above, Medicare payments have been sufficiently large to fund vast expansions of medical infrastructure.83 Meanwhile, hospitals spend money on advertising to compete for Medicare patients, which defies common sense because this would never happen if Medicare were not at least covering providers' costs.84 A study published in 2011 by Austin Frakt of the Veterans Affairs Administration concluded that cost-shifting is a factor in determining medical providers' pricing but only one of many factors.85 "Policymakers should take hospital and insurance industry claims of inevitable, large scale cost shifting with a grain of salt," Frakt wrote.86 "Though a modest degree of costs shifting may result from changes in public payment policy, it is just one of many possible effects. Moreover, changes in the balance of market power between hospitals and healthcare plans also have a significant impact on private prices."87 2. Businesses' Overall Share of Costs Would Be Lower Nearly every European country has a more regulated healthcare system than the United States, and most have provisions in place to ensure virtual universal coverage of their residents. A 2010 survey of financing systems published by Kaiser Permanente and a series of reports by the World Health Organization indicate that European systems are funded by an array of sources, often including general taxes and payroll taxes in which employers and employees pay equal shares, as well as individual user fees.88 If a universal healthcare system were implemented in the United States, chances are that the burden would be lifted at least to some extent from employers and thus reduce the overall costs.89 Residents would probably be required to pay some additional taxes that would be dedicated to healthcare, but their contribution would likely be mitigated because they would no longer have to pay private health insurance premiums.90 3. Healthcare Costs Would be Distributed More Equitably In a

Universal Care System To the extent that a single-payer or other government-directed universal care system would be funded with payments from businesses, those payments would likely be made according to a formula to ensure equity.91 This type of system would protect businesses in low-margin industries that currently seek to provide their employees with access to healthcare because it would ensure that those businesses' competitors are not gaining an advantage by dodging the cost. Thus, businesses would pay more in healthcare fees on behalf of employees whom they pay more and less on behalf of lower-paid employees. CONCLUSION If the United States were to implement a system to ensure universal care, American companies would no longer face a disadvantage in competing with businesses from countries, such as Canada, that provide national healthcare systems. Additionally, healthcare would cease to be a large factor guiding individuals' career decisions. A national, universal care system would level the playing field among domestic businesses, and eradicate the free-rider problem. For all of the above reasons, economic **growth would** likely **improve**, which would yield additional self-perpetuating benefits. There is an argument that the taxes to finance such a system would constrain business. This claim is seriously undercut by examples from around the world. For instance, Hong Kong, viewed by many as a "beacon of capitalism," has universal healthcare. So does Denmark, which has higher levels of entrepreneurship than the United States.92 What is becoming increasingly clear now is that the current employer-sponsored healthcare system in the United States does hurt business.

Link – Job Lock

Employer-based insurance forces job lock, which limits employment dynamics and undermines innovation – universal public health care enables entrepreneurship and significantly increases GDP

Sterret et al. 14 Dave Sterrett, Principal at the Health Care Policy Group where he provides government affairs and public relations consulting to healthcare clients; Ashley Bender is a third year law student at American University Washington College of Law. In May 2012, she graduated from Northwestern University with a degree in Political Science, Spanish, and Global Health; David Palmer is a third year law student at American University Washington College of Law and is on American University Law Review. "A Business Case for Universal Healthcare: Improving Economic Growth and Reducing Unemployment by Providing Access for All." Health Law and Policy Brief, Volume 8 Issue 2, Article 3. digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?article=1132&context=hlp. [Premier]

Fifty-five percent of all Americans, and more than sixty-eight percent of working-age Americans—those ages eighteen to sixty-five—**rely on employer-based insurance** for access to healthcare.20 Although the United States has health insurance programs for the very poor (Medicaid) and those sixty-five and older (Medicare), there is no reliable, reasonably affordable means for Americans who lack access to government programs or employer-based insurance to obtain access to healthcare. Some would argue that the health insurance exchanges being created under the ACA will meet this need, but costs to obtain insurance through the new exchanges, especially for older people, will likely put this solution out of reach for many.21

Our employer-reliant system has caused health insurance to become an **overriding consideration in Americans' career decisions**.22 This phenomenon has resulted in **lower "employment dynamics,"** which are "the rate at which workers and businesses exchange jobs."23 An employee's unwillingness to change jobs for fear of losing health insurance benefits is known as "job lock."24 Job lock inhibits workers from gravitating to the jobs most suited to them or **pursuing entrepreneurial endeavors**. Likewise, it frustrates employers' ability to find and hire the best potential employees.25 Studies have found that **job lock reduces mobility by 22.5 percent**,26 makes employees sixty percent less likely to leave their jobs,27 and decreases the rate of self-employment by two-to-four percent.28

A system that provides **universal access to health coverage**, on the other hand, is "far more likely to **promote entrepreneurship** than one in which would-be innovators remain tied to corporate cubicles for fear of losing their family's access to affordable healthcare," wrote Jonathan Gruber, who was one of the chief architects of the healthcare reform law passed in Massachusetts in 2005 and whose work greatly influenced the structure of the ACA.29 It is estimated that 1.6 million small business workers suffer from job lock and that **providing universal healthcare coverage would bring that number close to zero**.30 In addition, instituting a system to ensure universal coverage would add 1.5 million entrepreneurs,31 which would significantly increase our gross domestic product (GDP), according to a study by the Kauffman Foundation.32

The Kauffman Foundation study goes further to explain how eliminating job lock benefits the economy on a micro-level. Through the process of new and expanding businesses replacing the market share of established companies and the ongoing efforts of businesses and workers seeking their most productive matches, entrepreneurs create new products, which allows employees to accomplish more tasks in less time and ultimately creates more jobs.33 This increased activity is associated with higher economic growth.34 By enabling workers to do the type of work that they do best and enjoy the most, eliminating job lock increases the GDP.

B. 'Job Lock' Drives Up Unemployment, Reducing the Number of Potential Customers for Businesses

A 2009 study by researchers at the Rand Corporation shows a link between the healthcare system in the United States and **unemployment** levels.35 The study examined the effects of "excess healthcare costs," which the study defined as the difference

between the inflation rate for healthcare services and the increase of the GDP of the United States.36 For example, if the rate of medical inflation were five percent and the rate of GDP growth were three percent, "excess healthcare costs" would be calculated as equaling two percent.

By looking at the experience of close to seventy million workers in thirty-eight industries over nineteen years, the researchers measured the impact of rates of growth of healthcare costs in certain industries and extrapolated that data across the United States economy.37 The average excess healthcare costs over the period in which the Rand study was conducted (1986-2005) were 2.2 percent.38 Meanwhile, the Rand study found that an excess healthcare cost of just 0.2 percent—one-tenth the actual experience for the period—would exact a toll of 120,803 lost jobs.39 Taken together, Rand study findings yield the conclusion that excess healthcare costs led to the **loss of more than a million jobs** over a twenty-year period.40 This means that businesses were left with about a million fewer employed potential customers.41

Instituting a system that provides care to all Americans would **end the problem** of nonportable healthcare benefits, freeing the United States economy from a long-standing burden and **create jobs**.

The current employer-centric healthcare system destroys U.S. competitiveness via job-lock, bankruptcies, and corporate burdens—the plan boosts competitiveness and alleviates debt burdens by centralizing bargaining power

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Much of the controversy over our nation's healthcare policy is rooted in a widely perceived tradeoff between improving access to care or nurturing the economy. Some conservative economists argue that a government-directed program to provide healthcare to all Americans would reduce economic growth, possibly even leading to a decrease in access to healthcare itself.4 Conversely, others argue that treating healthcare as a fundamental human right might willingly sacrifice some economic growth in exchange for the security and social value of ensuring that everyone has access to affordable healthcare.5 **This report will show that the perceived tradeoff between prosperity and universal access to care is a false choice**. A survey of other countries' healthcare systems compared with their relative levels of economic vitality suggests that providing universal care is **more likely to foster economic growth than inhibit it.** The need to reform the United States healthcare system is beyond dispute. We spend more than two-and-one-half times more per capita ($8,508) than the average amount spent ($3,322) by the thirty-four countries in the Organization for Economic Cooperation and Development ("OECD").6 However, life expectancy, which is arguably the most important healthcare indicator, is almost one-and-one-half years lower in the United States (78.7 years) than the OECD average (80.1).7 Despite the extraordinary spending in the United States, about forty-eight million Americans lack health insurance, diminishing their access to necessary care and jeopardizing their financial security.8 **Medical bills are the greatest cause of bankruptcy in the United States**.9 Furthermore, a 2010 study published in the New England Journal of Medicine ranked the United States just thirty-seventh in the world on an index of global health systems.10 This report does not expound further on these generally accepted findings about the shortcomings of the United States system. Instead, the aim of this report is to debunk the perception that instituting a government-directed—or, colloquially, "single payer"— system to provide universal access to care would be harmful to the United States economy. This report will illustrate that the United States economy is currently hampered in numerous ways by having an inefficient, inequitable healthcare system.11 The research on which we relied was completed before the full implementation of the Patient Protection and Affordable

Care Act (ACA). However, we expect that even if the law works as intended, it will not resolve the problems that we raise because the law largely preserves our employment-based healthcare system.12 In Part I, we discuss specific harms to the economy inflicted by our system's reliance on employers to provide healthcare benefits.13 Part II examines how the United States economy compares through the lens of several indices, including some published by conservatives.14 These comparisons illustrate that most countries with more vibrant economies than the United States have government directed, universal healthcare systems.15 I. THE NEGATIVE EFFECTS OF NON-PORTABLE HEALTH INSURANCE ON ECONOMIC GROWTH AND UNEMPLOYMENT **A. 'Job Lock' Reduces Economic Growth** Unlike people who live in other industrialized countries, most Americans rely on employer-sponsored health insurance for access to medical services.16 Our system is a historical accident that resulted from World War II economic controls.17 To dodge government-imposed wage controls, businesses began offering health insurance and other fringe benefits to attract workers.18 The federal government made this system permanent in 1943 by making employer-sponsored healthcare a tax-free benefit.19 Fifty-five percent of all Americans, and more than sixty-eight percent of working-age Americans—those ages eighteen to sixty-five—rely on employer-based insurance for access to healthcare.20 Although the United States has health insurance programs for the very poor (Medicaid) and those sixty-five and older (Medicare), there is no reliable, reasonably affordable means for Americans who lack access to government programs or employer-based insurance to obtain access to healthcare. Some would argue that the health insurance exchanges being created under the ACA will meet this need, but costs to obtain insurance through the new exchanges, especially for older people, will likely put this solution out of reach for many.21 Our employer-reliant system has caused health insurance to become an overriding consideration in Americans' career decisions.22 This phenomenon has resulted in lower "employment dynamics," which are "the rate at which workers and businesses exchange jobs."23 An employee's unwillingness to change jobs for fear of losing health insurance benefits is known as "job lock."24 Job lock inhibits workers from gravitating to the jobs most suited to them or pursuing entrepreneurial endeavors. Likewise, it frustrates employers' ability to find and hire the best potential employees.25 Studies have found that job lock reduces mobility by 22.5 percent,26 makes employees sixty percent less likely to leave their jobs,27 and decreases the rate of self-employment by two-to-four percent.28 A system that provides universal access to health coverage, on the other hand, is "far more likely to promote entrepreneurship than one in which would-be innovators remain tied to corporate cubicles for fear of losing their family's access to affordable healthcare," wrote Jonathan Gruber, who was one of the chief architects of the healthcare reform law passed in Massachusetts in 2005 and whose work greatly influenced the structure of the ACA.29 It is estimated that 1.6 million small business workers suffer from job lock and that providing universal healthcare coverage would bring that number close to zero.30 In addition, instituting a system to ensure universal coverage would add 1.5 million entrepreneurs,31 which would significantly increase our gross domestic product (GDP), according to a study by the Kauffman Foundation.32 The Kauffman Foundation study goes further to explain how eliminating job lock benefits the economy on a micro-level. Through the process of new and expanding businesses replacing the market share of established companies and the ongoing efforts of businesses and workers seeking their most productive matches, entrepreneurs create new products, which allows employees to accomplish more tasks in less time and ultimately creates more jobs.33 This increased activity is associated with higher economic growth.34 By enabling workers to do the type of work that they do best and enjoy the most, eliminating job lock increases the GDP. **B. 'Job Lock' Drives Up Unemployment, Reducing the Number of Potential Customers for Businesses** A 2009 study by researchers at the Rand Corporation shows a link between the healthcare system in the United States and unemployment levels.35 The study examined the effects of "excess healthcare costs," which the study defined as the difference between the inflation rate for healthcare services and the increase of the GDP of the United States.36 For example, if the rate of medical inflation were five percent and the rate of GDP growth were three percent, "excess healthcare costs" would be calculated as equaling two percent. 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IMPLEMENTING A UNIVERSAL CARE SYSTEM WOULD IMPROVE AMERICAN COMPETITIVENESS INTERNATIONALLY** Although many Americans believe as an article of faith that the United States enjoys the strongest, most entrepreneurial, most resilient economy in the history of the world, recent empirical assessments comparing the economies of the United States and other countries have not been so charitable.42 Meanwhile, most of the countries that rate higher than the United States, even by the scorecard published by the conservative Heritage Foundation, offer universal healthcare through government-directed

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Primarily, such a system would cause future costs to be lower, or at least stem the trend of cost-increases far exceeding inflation.70 Secondly, businesses' overall share of healthcare bills would likely be lower.71 Finally, a universal care system would distribute costs far more equitably among businesses.72 1. Future Overall Healthcare

Costs Would be Lower Across the Board There are two primary reasons that future costs in a government-directed, universal care system would be lower than they would be if we remained on our current trajectory: such a system would result in reduced administrative costs and would lower costs for procedures and prescriptions.73 A 2003 study published in the New England Journal of Medicine concluded that administrative costs account for thirty-one percent of healthcare spending in the United States compared to just 16.7 percent in Canada, which has a single-payer system.74 United States healthcare costs in 2011 were about $2.7 trillion.75 If the United States were able to shave 14.3 percent off of its healthcare bill, it would save approximately $415 billion a year.76 Additionally, governments that coordinate their countries' healthcare delivery are able to negotiate lower rates for procedures and prescription drugs.77 The example below compares costs for medical procedures and prescriptions in the United States with those in France, which the World Health Organization in 2000 ranked as having the best healthcare services in the world.78 [See Table 4]. It is doubtful that costs for procedures and drugs would be cut to the levels in France if the United States were to adopt a government-directed, universal care system as that would require reducing drug and provider reimbursement rates in Medicare, which is extremely difficult politically. A more likely scenario is that the rate of increase of payments to providers in the United States would be slowed or temporarily stopped.79 A window of insight into the potential cost savings that could be realized by converting to a universal care system can be gleaned by comparing the rate of increase in perpatient private insurance costs versus per-patient Medicare costs. Although some singlepayer purists disagree with this characterization, Medicare is essentially a single-payer system for people sixty-five years of age and older. Advocates for single-payer systems often express their proposed policy as Medicare for All or Improved Medicare for All.80 Private insurance costs outpaced Medicare over the four decades concluding in 2010.81 The discrepancy was particularly pronounced for the most recent decade. [See Table 5]. Critics of the hypotheses that a universal Medicare system would generate cost savings argue that hospitals simply charge private sector insurers more to compensate for insufficient payments from Medicare.82 But many dispute this "cost shifting" theory. Anecdotally, as noted above, Medicare payments have been sufficiently large to fund vast expansions of medical infrastructure.83 Meanwhile, hospitals spend money on advertising to compete for Medicare patients, which defies common sense because this would never happen if Medicare were not at least covering providers' costs.84 A study published in 2011 by Austin Frakt of the Veterans Affairs Administration concluded that cost-shifting is a factor in determining medical providers' pricing but only one of many factors.85 "Policymakers should take hospital and insurance industry claims of inevitable, large scale cost shifting with a grain of salt," Frakt wrote.86 "Though a modest degree of costs shifting may result from changes in public payment policy, it is just one of many possible effects. Moreover, changes in the balance of market power between hospitals and healthcare plans also have a significant impact on private prices."87 2. Businesses' Overall Share of Costs Would Be Lower Nearly every European country has a more regulated healthcare system than the United States, and most have provisions in place to ensure virtual universal coverage of their residents. A 2010 survey of financing systems published by Kaiser Permanente and a series of reports by the World Health Organization indicate that European systems are funded by an array of sources, often including general taxes and payroll taxes in which employers and employees pay equal shares, as well as individual user fees.88 If a universal healthcare system were implemented in the United States, chances are that the burden would be lifted at least to some extent from employers and thus reduce the overall costs.89 Residents would probably be required to pay some additional taxes that would be dedicated to healthcare, but their contribution would likely be mitigated because they would no longer have to pay private health insurance premiums.90 3. Healthcare Costs Would be Distributed More Equitably In a Universal Care System To the extent that a single-payer or other government-directed universal care system would be funded with payments from businesses, those payments would likely be made according to a formula to ensure equity.91 This type of system would protect businesses in low-margin industries that currently seek to provide their employees with access to healthcare because it would ensure that those businesses' competitors are not gaining an advantage by dodging the cost. Thus, businesses would pay more in healthcare fees on behalf of employees whom they pay more and less on behalf of lower-paid employees. CONCLUSION If the United States were to implement a system to ensure universal care, American companies would no longer face a disadvantage in competing with businesses from countries, such as Canada, that provide national healthcare systems. Additionally, healthcare would cease to be a large factor guiding individuals' career decisions. A national, universal care system would level the playing field among domestic businesses, and eradicate the free-rider problem. For all of the above reasons, **economic growth would likely improve**, which would yield additional self-perpetuating benefits. There is an argument that the taxes to finance such a system would constrain business. This claim is seriously undercut by examples from around the world. For instance, Hong Kong, viewed by many as a "beacon of capitalism," has universal healthcare. So does Denmark, which has higher levels of entrepreneurship than the United States.92 What is becoming increasingly clear now is that the current employer-sponsored healthcare system in the United States does hurt business.

Data

Link

Multiple payers are impeding big data rollout because of profit motives and lack of standards. Single payer harmonizes them.

Frolick et al. 17 Ph.D. Professor/Endowed Chair, Management Information Systems, Thilini Ariyachandra is an Associate Professor of Management Information Systems in the Williams College of Business at Xavier University in Cincinnati, Ohio, USA, and Sadath Hussain, Xavier University. "Patient Healthcare Smart Card System: A Unified Medical Record for Access and Analytics." *Journal of Information Systems Applied Research*, 10(1). April 2017. [Premier]

The overall integration of patient health records is the main success factor of UMRAA. However, there is a need for the healthcare system stakeholders to realize that it is important to either have a **single payer system** or a federal mandated multi payer system for the proposed plan to be adopted and implemented **nationwide**. Besides the factors that were discusses earlier, the main factor that stops different healthcare organizational silos from adopting something like this is that **they fear losing patients to their competitors**. This paper has highlighted this fundamental deterrent that needs to be addressed in order to have buy-in from the payers and providers of healthcare. If not there may be a need to make it a federal mandate, just as it was done in the case of the "Affordable Care ACT." Smart Card Alliance which is a non-profit organization whose purpose is to develop an understanding and explain the use of smart card technology is trying to bring awareness and therefore stays connected to industry leaders through educational programs, marketing research, and open forums (Alliance 2015). They have also been trying to ease the industries fear that revolves around the security and privacy issues that come with it. However, Smart Card Alliance fails to understand that in US, it is going to be **very difficult** to implement such a system due to a **multiple payers** (Hussey & Anderson 2003), in spite of all the benefits that have been discussed already in this paper. There are healthcare smart cards in the US that are currently being proposed for nationwide implementation. **However**, the players proposing such smart card implementation are failing to take into account the **biggest barrier** to nationwide system implementation: **the multi payer system**. The US healthcare system is comprised of multiple payers. Medicare is the single largest payer in the US and the rest are multiple private insurers. Therefore, the US healthcare has been mostly working in silos up until the affordable care act (ACA) came into play. 9. CONCLUSION The use of heterogeneous patient information system in various health care facilities can make it a challenge to report and analyse patient data. The data integrity and completeness can be challenging for the employers, clinicians, and researchers. The UMRAA card distributed information system approach can combine and integrate the pertinent patient data in all the healthcare facilities to support quality of health care, reporting, treatment and management. Besides the innumerable benefits of this system, there are challenges to overcome. These challenges come in the shape of privacy, security, and costs associated with the initiation, implementation, and maintenance of this system. Smart cards are not new to the healthcare industry. Current health smart card is in use in many parts of Europe as well as here in the US such as the one that was implemented by the Mount Sinai health system in New York. Most of these health smart cards are used of reimbursement feasibility. In addition to making reimbursement easy, there are a few that are more geared towards improving the care of patients as well as improving quality and reducing cost. There are **endless possibilities** and benefits that could come along with this program, such as **globalization of healthcare** and **uniformity in the quality of services** offered to the patients. An UMRAA system has the potential to reduce malpractices, delayed decision making, etc. which usually occur as a result of healthcare providers not having enough information. Other future possibilities in health care with UMRAA would be with the use of **analytics**. Analytics **for research purposes** using the data derived from the widespread use of UMRAA card would potentially lead to **better** health care **process reengineering**.

Single payer is key – it integrates data systems across levels and centralizes reporting

Ford and Spicer 12 Morgan A. Ford, Committee on Review Data Systems for Monitoring HIV Care, and Carol Mason Spicer, Institute of Medicine. "The Role of Health Information Technology and Data

System Integration in the Collection of HIV Care Data." 2012. https://www.ncbi.nlm.nih.gov/books/NBK201373/. [Premier]

MODELS AND BEST PRACTICES IN DATA SYSTEM INTEGRATION The committee was asked to identify models and best practices in data system integration to improve interoperability of data systems and core indicators. In health care, "interoperability" is generally defined as "the ability of different IT systems and software applications to communicate, exchange data accurately, effectively, and consistently, and to use the information" (HHS, 2008). **Interoperability is not fully possible in the United States at this time (ONC, 2011a).** For the most part, the various sources of care and care coverage have their own health IT systems with their own digital language. **Systems also vary in their complexity, length, and technical vocabulary and are run using different information architectures, protocols, and software programs (Edwards et al., 2010).** As PLWHA move through the health care system, each provider's health IT system captures a portion of the patient information, and care data cannot easily be tracked across these systems. Methods of **data system integration can help to address challenges of interoperability**. Some examples of data system integration involve direct information exchange across settings, which simply makes information available between systems. The Indiana Network for Patient Care has been an operational statewide health information exchange for more than 10 years, linking hospitals, public health departments, and state Medicaid data to deliver clinical data to care settings throughout Indiana and has served as a model of HIE across the nation. New York State in 2006 began a significant investment in health data integration with the Healthcare Efficiency and Affordability Law for New Yorkers (HEAL-NY) capital grant program (Kern et al., 2009). Initially this program distributed $53 million to 26 RHIOs across the state, each of which pursued a specific implementation of health IT and exchange. Although most of the recipients focused more heavily on health IT adoption, among the RHIOs were prominent examples that facilitated direct information exchange, such as the Bronx RHIO, Brooklyn Health Information eXchange (BHIX), Long Island Patient Information eXchange (LIPIX), and the New York Clinical Information eXchange (NYCLIX). Other information exchange initiatives have also been developed in other states. Other examples go beyond just data integration to actually monitor patient populations. The Academic Model Providing Access to Healthcare (AMPATH) medical record system is used specifically to monitor HIV patients and was implemented to support HIV care in sub-Saharan Africa (Tierney et al., 2007). AMPATH includes standard EHR components, as well as data entry capabilities for clinical observations relevant to HIV care. From the system, data can be extracted and reported to national AIDS programs or funding agencies. The data in structured form can also support research queries. The New York City Department of Health and Mental Hygiene's (NYC DOHMH's) Primary Care Information Project (PCIP) promoted EHR adoption in clinics and doctors' private offices, with technology supporting both CDS and electronic reporting of required health measures to public health organizations. Data exchange focused more on reporting than on access across providers, which created an information-supported centralized data model at the DOHMH (Mostashari et al., 2009). This allowed the use of the PCIP infrastructure for the NYC DOHMH in population monitoring. Integrated delivery networks with extensive information systems, such as Kaiser Permanente, Geisinger, and Intermountain Healthcare, have created patient monitoring systems by gathering data from multiple sites of care. Common examples are the various diabetes or chronic disease registries, which can be used to both monitor patient status with accepted guidelines and prompt care providers to bring patients back into care. **National research registries have also exchanged health information— but to support research rather than to direct patient care**. The National Registry for Myocardial Infarction collects health information for patients in multiple institutions to monitor the effectiveness of various treatments and patient outcomes. Other examples include the Surveillance, Epidemiology and End Results (SEER) program, a source for cancer statistics in the United States, and the National Program of Cancer Registries. Various lessons learned throughout these examples might be applied to a strategy of data monitoring for HIV care. Most of these examples are focused on HIE, and integration is done through the clinicians only on individual cases. Data integration does exist for patient monitoring, but usually this is done within delivery networks where systems are already integrated and/or incentives can better justify data integration. These examples are relevant to PLWHA in these systems, but most PLWHA receive care outside of integrated delivery networks. AMPATH was applied directly to HIV/AIDS care, but that was in an environment where the disease prevalence was sufficiently high to promote monitoring systems. Lessons learned from AMPATH are thus best applied to settings where the prevalence of HIV/AIDS in the patient population is high enough to standardize the integration of data, such as specialty HIV/AIDS clinics. The PCIP project was interesting in that it centered data exchange with the public health organization. **Data reporting was facilitated, and data integration could occur within a centralized system**. Since public health reporting is ubiquitous among sites where PLWHA receive care, this is the most relevant example for patients outside of integrated delivery networks and specialty clinics. A final lesson is learned from research registries. Many registries require manual abstraction of data from patient records at the institutions providing data. Where this information is available electronically, registry reporting can be more efficient, but only when the data are collected consistently. Indicators of care are more efficient when they can be based on data that are collected consistently and are available electronically. As noted in the ONC's Federal Information Technology Strategic Plan for 2011–2015, future stages of meaningful use for EHRs may become more rigorous—for example, by requiring that providers not only adopt health IT but use it to exchange health information (ONC, 2011a). If implemented as planned, these changes could help to lay the groundwork for increased data system interoperability and to simplify the assessment of the state of HIV care at the national level. **The federal government is currently developing a standards and interoperability framework (S & I Framework) to broaden interoperability across different organizations and federal agencies**.10 To support health IT adoption and information exchange for public health and populations with unique needs, ONC is working with CDC, CMS, the National Institutes of Health (NIH), the Food and Drug Administration (FDA), the Assistant Secretary for Preparedness and

Response (ASPR), and the Health Resources and Services Administration (HRSA) to ensure that meaningful use of certified EHRs supports the needs of public health agencies. In particular, these **agencies are working to ensure that EHRs include capabilities to submit electronic syndromic surveillance data, immunization registries, and electronic lab reporting** (as based on current stage 1 meaningful use criteria). **This may help set the stage for two-way communication between providers and public health agencies** (ONC, 2011a). Data System Linkage One means of data system integration is data linkage. Data linkage refers to the bringing together of information from one or more disparate data sources for the same individual, family, event, or place, removing the need to extract data from several sources. Data linkage has been used frequently for medical and population health research (Brook et al., 2008; Herzog et al., 2007; Jutte et al., 2011; Karmel and Rosman, 2008). Rather than initiating new data collection efforts, linkage allows researchers to make better use of data that are already collected for other purposes (e.g., claims or registry data) (Jutte et al., 2011). Data linkage can improve the cost-effectiveness of data collection, can reduce the amount of time needed for data collection in research, and has the potential to improve the quality of the data collected—for example, through the detection of duplications that otherwise may not have been identified (Herzog et al., 2007; Holman et al., 2008). Methods for record linkage are described elsewhere in the research literature (see Fellegi and Sunter, 1969; Herzog et al., 2007). In general, linkage is achieved using individual identifiers to reliably identify an individual across two or more data systems (Jutte et al., 2011; Tromp et al., 2011).11 Identifiers may include Social Security numbers, names, dates of birth, zip codes, and other information. The use of a unique individual identifier (e.g., Social Security number, patient medical record number) across data sources can help to overcome problems of inaccuracies in identification of matches across systems based on other types of identifiers. However, in the United States, unique identifiers are not applied ubiquitously across the various sources of care and care coverage for PLWHA. Some of the best examples of successful data linkage while maintaining patient privacy and confidentiality come from the international realm (Jutte et al., 2011). **For the most part, countries that have demonstrated successful data linkages for most of their residents have single-payer health care systems that do not face the same administrative and legal barriers to sharing of health information encountered within the U.S. health care system (see Chapter 4).** In Sweden, the MigMed2 database was developed by linking data from several national registers, including those containing population, death, hospital discharge, multigenerational (i.e., identities of the biological and adopted parents), and immigration data. The national 10-digit civic registration identification number that each person uses for her or his lifetime are used to link individual-level data across registers. Prior to inclusion in the database, the identification numbers are replaced with serial numbers to ensure anonymity. MigMed2 has been used for research in a number of areas including, but not limited to, prostate cancer mortality and patterns of breast cancer survival within families (Hemminki et al., 2008; Ji et al., 2010; Li et al., 2011). Population Data BC (British Columbia), formerly the British Columbia Linked Health Database, contains data on nearly every person in British Columbia and links individual-level health care utilization, population demographics and vital statistics, cancer registry, and occupational and early childhood information for use in research. Population Data BC uses identifiers (e.g., names, birth dates) to link data, but it does not store data in a linked format, and data are reported only at an aggregate level to protect confidentiality. This resource has been used by researchers to identify determinants of health for the entire population of BC as well as for health disparities research (Population Data BC, 2012). Other international examples of successful record linkage for population-based research include the Scottish Record Linkage System, the Oxford Record linkage Study, and the Western Australia Data Linkage System (Holman et al., 2008; Jutte et al., 2011). **In keeping with the fragmented nature of the U.S. health care system, a number of successful examples of data linkage in the United States have occurred more locally.** One example involving PLWHA is the HIV/AIDS Cancer Match Study, which uses anonymized data collected by state and regional HIV/AIDS and cancer registries to study cancer in PLWHA. The study data are pulled from computerized linkages between databases that are maintained by study sites in 13 states and the District of Columbia (NCI, 2012). Data from the linked registries have helped to identify cancers that occur more often among PLWHA; describe changes in cancer burden among PLWHA over time; and identify predictors of cancer outcomes for PLWHA (Shiels et al., 2010, 2011a,b; Simard et al., 2011). The results from the study provide important information on the impact of HIV on cancer risk and trends in morbidity and mortality to the National Cancer Institute and other policy makers (NCI, 2012). Data linkage has been used in several HIV-related research studies carried out in the United States to improve the completeness of data for surveillance and for monitoring HIV care. A study of linkage of HIV/AIDS surveillance data in the District of Columbia Department of Health with death registries showed that the linkage improved the accuracy of estimation of the prevalence of individuals living with HIV/AIDS (CDC, 2008). In the LaPHIE study described earlier in this chapter, state public health surveillance data was linked to real-time EMR data to successfully identify PLWHA who had fallen out of care (Herwehe et al., 2011).

Impact – Innovation

Single-payer enables deep and broad data with standardized assessment and data sharing – that enables better clinical research and international collaboration on medical treatment and research

Stuss et al 15 Donald T. Stuss, PhD in Psychology from Ottawa University, Professor, Graduate Dept. of Rehabilitation Science, Faculty of Medicine, University of Toronto, University Professor, Department of Psychology, Faculty of Arts and Science; Department of Medicine (Neurology), Faculty of Medicine; Centre for Studies of Aging, University of Toronto, Shiva Amiri, CEO at BioSymetrics Inc., Ph.D. in Computational Biochemistry from Oxford, Martin Rossor, NIHR National Director for Dementia Research, Professor of Clinical Neurology, University College London, Richard Johnson, CEO, Global Helix LLC, Juris Doctor degree from the Yale Law School where he was Editor of the Yale Law Journal, he received his M.S. from MIT where he was a National Science Foundation National Fellow, Zaven Khachaturian, President of the Campaign to Prevent Alzheimer's Disease by 2020, PhD Case-Western Reserve. "How we can work together on research and health big data: Strategies to ensure value and success." Chapter 5 in *Dementia Research and Care Can Big Data Help?: Can Big Data Help?*, pgs. 61-74. [Premier]

The value lies in the creation of a system, **integrating all partners** from the very beginning of research to catalyse, facilitate, and maximise scientific, health care and policy, and commercialisation efforts. The **standardisation of assessments** and the **sharing of data** have many positive outcomes. Assessment standardisation in all of the clinical centres involved in the research means **consistency of clinical evaluation** at the research level across regional and national boundaries and an increase in the number of individuals involved in research activities. The **sample size increase has obvious benefits for research power**, and the study of mechanisms of disorders across diseases.

With a greater number of individuals involved, and careful standardised characterisation, the potential exists for good data and high quality **clinical trial platforms**. There is an increased opportunity to observe the variability and heterogeneity of disease expression (Georgiades ct al., 2013; Stuss and Binns, 2008), and develop well- characterised sub-groups. A direct and completely linked corollary is **improved diagnosis and treatment**. This should be attractive to improve clinical trials and commercialisation of neuroscience research, in both neurotechnology and neurotherapeutics, i.e., the potential benefit of targeted pharmacological and behavioural treatments. In essence, there is a real opportunity for product development based on a "personalised medicine" approach. And this will only be enhanced if the full data sets from all past clinical trials are shared (Eichler et al., 2013).

Equally important is the need to link both research "**deep data**" and an individual's and population "broad data" (defined as the data in the health system - often the greatest breadth of data is in **single payer arrangements** — of the patient's medications, usage of the health system, changes in personal health over time, the existence of co-morbidities, and the associated cost of this usage) about AD and dementia with the vast amounts of data generated during clinical trials. It is important to take advantage of the new policies adopted by many biopharmaceutical companies, social philanthropists, and government funders to increasingly share clinical data. This provides a unique opportunity for health policy and health service delivery research. The OECD should identify and catalogue these new policies and trends across different regulatory jurisdictions. For example, the US National Academies recently released a new report proposing guiding principles for responsible sharing of clinical trial data (National Research Council, 2014).

As indicated in the 2014 OECD report on harnessing big data, "big data is, however, not just a quantitative change, it is a conceptual and methodological change" (OECD, 2014). The goal then, to truly maximise the value of big data, is to establish a system where basic science flourishes because of patient characterisation and removing boundaries around diseases are removed to facilitate **studies of mechanisms of disorders**; where the informatics platform and **data sharing** within and across diseases provide an opportunity not only for hypothesis driven research, but for chance finding, data mining, and the creation of new hypotheses; where discovery and treatment are more closely linked; where industry works closely with researchers to implement their discoveries into new products; where the new products for improved patient health has an economic benefit through the creation of new companies and jobs; where the creativity of the researchers and the needs of individuals with disorders fuel new research questions and ideas; where the network of patient advocacy groups and health charities, as well as knowledge exchange with primary health care givers push early and rapid uptake of new diagnoses and new treatments; and where collaborative linkages and partnerships are created to harness the value of these approaches. There are technical challenges of bringing together datasets even within jurisdictions, let alone beyond national borders, and harmonising these linkages internationally is the biggest challenge (Khachaturian, 2013). But they are not insurmountable, and the outcomes appear to be well worth the effort (Cukier and Mayer-Shocnbcrger, 2013). **There is a value to the international scientific community**. with economic impacts of shared R&D resource/structure, to facilitate **international collaborative research**.

Impact – Blockchain

Disjointed records prevent blockchain adoption.

Krawiec et al. 16 "Blockchain: Opportunities for Health Care," White Paper Prepared for Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services, August 2016. https://www2.deloitte.com/content/dam/Deloitte/us/Documents/public-sector/us-blockchain-opportunities-for-health-care.pdf. [Premier]

The current state of health care records is **disjointed and stovepiped** due to a lack of common architectures and standards that would allow the safe transfer of sensitive information among stakeholders in the system. Health care providers track and update a patient's common clinical data set each time a medical service is provided. This information includes standard data, such as the patient's gender and date of birth, as well as unique information pursuant to the specific service provided, such as the procedure performed, care plan, and other notes. Traditionally, this information is tracked in a database within a singular organization or within a defined network of health care stakeholders. This flow of information originating from the patient through the health care organization each time a service is performed does not need to stop at the individual organizational level. Instead, health care organizations could take one more step and direct a standardized set of information present in each patient interaction to a nationwide blockchain transaction layer. The surface information on this transaction layer would contain information that is not Protected Health Information (PHI) or Personally Identifiable Information (PII); rather, select and non-personally identifiable demographics and services rendered information could enable health care organizations and research institutions access to an expansive and data-rich information set. Information stored on the blockchain could be universally available to a specific individual through the blockchain private key mechanisms, enabling patients to share their information with health care organizations much more seamlessly. This deployment of a transaction layer on the blockchain can help accomplish ONC HIT's interoperability goals while creating a trustless, and collaborative ecosystem of information sharing to enable new insights to improve the efficiency of the nation's health care system and health of its citizens.

Blockchain is key to pandemic prevention and response.

Banafa 20 Ahmed Banafa. "Blockchain Technology and COVID-19." OpenMind. 22 June 2020. https://www.bbvaopenmind.com/en/technology/digital-world/blockchain-technology-and-covid-19/. [Premier]

A blockchain is an essential tool for establishing an efficient and transparent healthcare business model based on higher degrees of accuracy and trust because technology is a tamper-proof public ledger. Blockchain will surely not prevent the emergence of new viruses itself, but what it can do is create the first line of rapid protection through a network of connected devices whose primary goal is to remain alert about disease outbreaks. Therefore, the use of blockchain-enabled platforms can help prevent these pandemics by enabling early detection of epidemics, fast-tracking drug trials, and impact management of outbreaks and treatment. But before we explore in details the possible ways of using Blockchain to help in fighting this invisible enemy, we need to understand some of the challenges defining this deadly virus. MAJOR CHALLENGES OF COVID-19 One major issue is how prepared the world's health systems are to respond to this outbreak. Tracking a huge population of infectious patients to stop epidemics Another is the immediate requirement for developing better diagnostics, vaccines, and targeted therapeutics. Misinformation and conspiracy theories spread through social media platforms. Various limitations while accessing the tools when required. No adequate measures to adopt in a crisis situation. [4][7] CAN BLOCKCHAIN HELP IN PREVENTING PANDEMICS? With Blockchain we can share any transaction / information, real time, between relevant parties present as nodes in the chain, in a secure and immutable fashion. In this case, had there been a blockchain where WHO, Health Ministry of each country and may be even relevant nodal hospitals of each country, were connected, sharing real time information, about any new communicable disease, then the world might have woken up much

earlier. We might have seen travel restrictions given sooner, quarantining policies set sooner and social distancing implemented faster. And may be fewer countries would have got impacted. What every country is doing now fighting this pandemic, would have been restricted to fewer countries and in a much smaller scale. The usage of a Blockchain to share the information early on, might have saved the world a **lot of pain.** The world had not seen anything like COVID-19 pandemic before in the recent history. Today we need to take a hard look at the reporting infrastructure available for communicable diseases, both technology and regulations and improve upon that, such that we do not need to face another pandemic like this in the future. [9] Blockchain Applications in fighting COVID-19 Tracking Infectious Disease Outbreaks Blockchain can be used for tracking public health data surveillance, particularly for infectious disease outbreaks such as COVID-19. With increased blockchain transparency, it will result in more accurate reporting and efficient responses. Blockchain can help develop treatments swiftly as they would allow for rapid processing of data, thus enabling early detection of symptoms before they spread to the level of epidemics. Additionally, this will enable government agencies to keep track of the virus activity, of patients, suspected new cases, and more. [9] Donations Tracking As trust is one of the major issues in donations, Blockchain has a solution for this issue. There has been a concern that the millions of dollars being donated for the public are not being put to use where needed. With the help of blockchain capabilities, donors can see where funds are most urgently required and can track their donations until they are provided with a verification that their contributions have been received to the victims. Blockchain would enable transparency for the general public to understand how their donations have been used and its progress. [9] Crisis Management Blockchain could also manage crisis situation. It could instantly alert the public about the Coronavirus by global institutes like the World Health Organization (WHO) using smart contracts concept. Not only it can alert, but Blockchain could also enable to provide governments with recommendations about how to contain the virus. It could offer a secure platform where all the concerning authorities such as governments, medical professionals, media, health organizations, media, and others can update each other about the situation and prevent it from worsening further. [9] Securing Medical Supply Chains Blockchain has already proven its success stories as a supply chain management tool in various industries; similarly, Blockchain could also be beneficial in tracking and tracing medical supply chains. Blockchain-based platforms can be useful in reviewing, recording, and tracking of demand, supplies, and logistics of epidemic prevention materials. As supply chains involve multiple parties, the entire process of record and verification is tamper-proof by every party, while also allowing anyone to track the process. This technology could help streamline medical supply-chains, ensuring that doctors and patients have access to the tools whenever they need them, and restraining contaminated items from reaching stores. [9]

Impact – Disease

Interoperability and uniform data collection is necessary for effective disease response – otherwise oversight failures and coverage gaps undermine effectiveness

Richards et al. 17 Chesley L. Richards, MD, MPH (CDC Office of Public Health Scientific Services, Atlanta, GA), Michael F. Iademarco, MD, MPH (CDC Center for Surveillance, Epidemiology and Laboratory Services, Atlanta, GA), Delton Atkinson, MPH (CDC National Center for Health Statistics, Rockville, MD), Robert W. Pinner, MD (CDC National Center for Emerging and Zoonotic Diseases, Atlanta, GA), Paula Yoon, ScD, MPH (CDC Center for Surveillance, Epidemiology and Laboratory Services, Atlanta, GA), William R. Mac Kenzie, MD (CDC Center for Surveillance, Epidemiology and Laboratory Services, Atlanta, GA), Brian Lee, MPH (CDC Office of Public Health Scientific Services, Atlanta, GA), Judith R. Qualters, PhD (CDC National Center for Environmental Health, Atlanta, GA) and Thomas R. Frieden, MD, MPH (CDC, Office of the Director, Atlanta, GA). "Advances in Public Health Surveillance and Information Dissemination at the Centers for Disease Control and Prevention." Public Health Reports, vol. 132, no. 4. 13 June 2017. http://journals.sagepub.com/doi/full/10.1177/0033354917709542. [Premier]

Challenges and Opportunities Although the examples provided represent progress in enhanced data collection, data analysis, data visualization, and information dissemination, CDC and its partners continue to face major challenges and opportunities to improve public health surveillance. In the future, public health surveillance will depend increasingly on the secondary use of existing data and information found in rapidly evolving health care information systems, as well as nonhealth information systems with data on social determinants. The US Department of Health and Human Services (HHS) vision for the evolution of US health information technology is outlined in the Shared Nationwide Interoperability Roadmap.35,36 Three key areas of focus for CDC to improve public health surveillance and incorporate recommendations from the Roadmap include (1) implementing shared information technology services, (2) developing the surveillance workforce, and (3) harnessing electronic health records and health care information technology systems. Shared Information Technology Services **To promote public health data interoperability, particularly among CDC, state and local health agencies, and health care systems, CDC needs to foster and catalyze a standards-based, shared health information technology services environment. The use of information technology services and standards from health care, such as HL7 Clinical Document Architecture and Fast Healthcare Interoperability Resources, can promote data harmonization, improve cybersecurity, and more efficiently manage resources.**37,38 To accelerate progress, CDC is moving toward greater use of shared digital data services and an interoperable, integrated, cloud-based data platform. Although CDC has identified and begun developing an initial set of prioritized shared digital data services, substantial work remains to develop, deploy, support, and govern the use of shared information technology services both within CDC and with external partners.39 In addition to promoting data interoperability, shared information technology services have the potential to offer new tools for data analytics, data visualization, and information dissemination. Workforce Development In recognition of emerging trends in health care delivery, medical care payment, and patterns of morbidity and mortality, public health agencies are decreasing their roles as direct medical providers and pursuing a more prominent role that involves community health assessment, primary prevention, and health promotion.40 Increasingly, public health must address the social determinants of health; to do so, data are needed on housing, transportation, telecommunications, environment, weather, population density, and neighborhood sociodemographic characteristics. To best develop the information needed for rapid and cost-effective decision making, public health surveillance activities increasingly must complement the use of traditional health-based data sources with data on the social determinants of health. At the same time, the public health workforce must continue to adapt. For example, expertise in informatics is needed more broadly across the entire public health workforce, and literacy in multisectoral data, systems science, diplomacy, partnership building, and policy development is needed at every level.41–43 CDC currently has training programs in public health informatics and related disciplines, which will need to adapt to these emerging data and informatics needs. To extend the capabilities of CDC's internal information technology workforce, CDC has worked with HHS's Office of the Chief Technology Officer (IDEA Lab) Entrepreneur-in-Residence program to ask experts from outside the government to join CDC as term-limited employees focused on entrepreneurial approaches to complex problems. To date, CDC has embedded 5 entrepreneurs with specialty in modern software design, data science, and high-complexity data management. This program helps to fill immediate resource gaps in CDC while also developing and extending the skills of CDC staff members.44 Although it is an important first

step, it does not meet the growing information technology workforce needs at state and local health departments or represent a long-term, strategic approach to developing an information technology workforce at the federal level. CDC must look for more opportunities to leverage private-sector and entrepreneurial talent and complement the public-sector workforce. **Harnessing Data From Electronic Health Records** and Health Information Systems **Electronic case reporting (eCR) is the automated electronic generation and transmission of reports of potential cases of reportable conditions from the electronic health record to state and local public health authorities for review and action. eCR can allow state and local health departments to conduct real-time surveillance without burdening health care providers**. As part of fulfilling Medicare requirements for electronic health record implementation, clinicians will need to be able to send electronic case reports to state and local public health agencies by mid-2018.45 Building on the experiences and successes of previous ELR initiatives, CDC and key public health associations, such as the Council of State and Territorial Epidemiologists, Association of State and Territorial Health Officials, Association of Public Health Laboratories, and National Association of County and City Health Officials, have partnered to create tools and to propose a technical framework for eCR that will be interoperable and scalable nationally. The Robert Wood Johnson Foundation has convened leaders among electronic health record vendors, clinical provider systems, and public health to support eCR as an important step toward broader bidirectional information exchange between clinicians and health departments.45 Although initial planning for eCR started in 2016, true integration of eCR into workflows of clinicians and at public health agencies will be essential to realize its potential to support true bidirectional information exchange and improve public health action. **Initial work on eCR is focused on reportable infectious diseases, and this approach may offer opportunities for timelier and better quality data on chronic health conditions, environmental health hazards, and injuries**. Conclusion **Although the improvements described here in data collection, visualization, and dissemination are important for CDC, much work remains to be done**. Building on these efforts, CDC, working with state and local partners, will need to continue progress in improving interoperability, improving standards development and implementation, and reducing unnecessary duplication and inefficiency. **Ultimately, systems are needed that efficiently allow data to move from clinical encounters or primary data collection at a local level to public health departments**, and to be appropriately shared with CDC with minimal human effort, while also maintaining privacy and protecting confidentiality of individual data. These systems can make the best use of technology to reduce burden, particularly on data partners, and improve both the quality and timeliness of data collection, analyses, and dissemination. In addition to technology and workforce, a key component of developing these systems will be trust between data partners in local and state health departments and CDC. An important value in the efforts described here has been building trust, which will be key to sustaining and enhancing progress. Trust is key for sharing data but is even more important for how the data and subsequent analyses are shared with partners and the public. Consequently, **further advances in surveillance are intimately connected to both data collection** and dissemination.

Impact – Smart Cities

Centralizing data's key to mega cities

Frolick et al. 17 Ph.D. Professor/Endowed Chair, Management Information Systems, Thilini Ariyachandra is an Associate Professor of Management Information Systems in the Williams College of Business at Xavier University in Cincinnati, Ohio, USA, and Sadath Hussain, Xavier University. "Patient Healthcare Smart Card System: A Unified Medical Record for Access and Analytics." *Journal of Information Systems Applied Research*, 10(1). April 2017. [Premier]

***UMRAA=Unified Medical Record for Access and Analytics

The initiation and implementation of this program is indeed a herculean task, but the advantages **far outweigh the disadvantages**. All in all the UMRAA system is at the **center of providing the most efficient and standardized** patient **care** within the United States (Raghupathi & Raghupathi 2014). In addition to traditional analytics, **emerging and innovative applications** and **platforms** such as Big Data Analytics, Real-time Business Intelligence, Internet of Things and **Smart Cities** are frameworks that would **most benefit from the UMRAA program**. UMRAA has the potential to generate **data** from numerous patient care points of contact and **integrate it** with global healthcare communities. Various innovative platforms mentioned earlier may **stumble into** potential **pitfalls** without a **well-engineered data integration support system**. However, UMRAA program with its current robust design can act as a **promising instrument** for laying the **foundation** and widespread **realization future mass data-centric applications.**

That's key to innovation

Basulto 14 Dominic Basulto, Washington Post innovations contributor. "The future of innovation belongs to the mega-city." Washington Post. 28 October 2014. https://www.washingtonpost.com/news/innovations/wp/2014/10/28/the-future-of-innovation-belongs-to-the-mega-city/?utm_term=.42327edfad1c. [Premier]

By 2030, according to the UN, there will be 41 mega-cities around the world with populations of greater than 10 million people. Not only will these mega-cities control the lion's share of the world's global economic and financial resources, they **will also largely determine the future of innovation — and that could have a major impact on how we think about America's hub-and-spoke model of innovation.** If you think about how innovation works in America, a relatively small metropolitan area such as Austin or Seattle (both of which do not rank among America's 10 biggest cities by population) **can have a disproportionate impact** on the future of national innovation. That's a pattern repeated around the country, as even smaller metropolitan areas — places like Raleigh-Durham or Chattanooga — also play an important role in pushing forward U.S. innovation. Even freewheeling Silicon Valley has always been based on its density of ideas, not the density of its population. Yet, all the current trends suggest that this uniquely American system of innovation, in which innovation is so geographically diverse and spread out across so many hubs, is about to sustain a major challenge from the relentless pace of urbanization around the world. Just 40 years ago, there were only 3 mega-cities in the world: New York, Tokyo and Mexico City. Now there are 28, and there are plenty more waiting in the wings**. It's now become conventional wisdom that cities are the engines of growth, progress, jobs and prosperity. And the bigger the cities are, the bigger is that potential engine.** Viewed from this perspective, it's almost impossible to see any way that the United States can keep up with the growth of Asia's mega-cities **without making changes to its national model of innovation**. Take a look at the

projected map of global mega-cities created by Bloomberg – of the 41 mega-cities in the world by 2030, 24 will be in Asia. By way of comparison, North America will have only three mega-cities: New York, Los Angeles and Mexico City. South America will have five: Bogota, Lima, Sao Paulo, Rio and Buenos Aires. Even Africa — with Lagos, Luanda, Kinshasa and Johannesburg — will have more mega-cities than North America. You can already glimpse how the inexorable logic of the mega-city is going to play out. Take America's two mega-cities, New York and Los Angeles. A recurring theme in New York tech circles has been that New York City has finally caught up to Silicon Valley as America's new innovation leader, based largely on the remarkable confluence of so many industries – media, finance, fashion – being based in such a densely populated urban space. That's exactly the right environment for new technologies to take advantage of network effects. And Los Angeles seems to be experiencing a new tech boom these days, giving us a whole host of interesting new start-ups. Again, sheer population density is one of the factors at work. "Silicon Beach" is showing signs of being a rival to Silicon Valley these days. **As a recent paper from Kristin Ljungkvist of Uppsala University in Sweden points out, it's not only technological innovation where these mega-cities have the potential to play a huge role in future innovation. On just about any issue with a political angle to it — climate change, poverty, transnational crime, pandemics and counterterrorism – there's a good chance that mega-cities are going to be at the forefront of new innovation and creative thinking**. The specific example cited by Ljungkvist in her paper is New York City. In areas such as counterterrorism, New York City is already a national leader. In many ways, says Ljungkvist, New York is acting like its own city-state, with its own approach to climate change and its own counterterrorism policy. And all this policy innovation drives economic growth as part of a virtuous circle: "Local representatives, when they get involved in global issues such as climate change, do it primarily to ensure continued strong economic development for the metropolitan area." After all, as the UN argued in its 2013 report "World Urbanization Prospects," innovation is the single most important weapon these mega-cities have to deal with problems ranging from transportation to health care. In **short, to deal with the massive crush of higher population, mega-cities have to get smarter faster. They have a real need for all the innovations that can transform them into "greener, healthier, friendlier and more efficient metropolises**." Of course, not everyone is upbeat about the growing role of mega-cities. McKinsey has pointed out that some of the talk about mega-cities may be overhyped: "Contrary to common perception, mega-cities have not been driving global growth for the past 15 years." And other researchers have highlighted how mega-cities present their own unique socio-economic problems — everything from traffic congestion to slums — created by such dense population growth. Joel Kotkin, for example, sees mega-cities as "a tragic replaying of the worst aspects of the mass urbanization that occurred previously in the West." So what does all this mean for U.S. innovation? For one thing, tech innovators chasing new opportunities may choose to move to America's biggest cities in even greater numbers, further exacerbating demographic trends of population shifting away from suburbs to urban metropolises. Immigrants, who typically cluster in larger cities, may play an even greater role in guiding the future of American innovation. And larger cities not typically regarded as national innovation leaders but on the demographic cusp of becoming a mega-city – Dallas, Houston, Miami and Phoenix — may increasingly find their innovation prospects improved at the expense of regional hubs that have smaller or declining populations. With the rise of mega-cities, Washington policymakers and Wall Street investors may find it harder to sell the Silicon Valley story abroad. Remember when just about every city in the world was attempting to build its own version of Silicon Valley? If mega-cities in China, India and Nigeria take off as many suggest they will, then policymakers could be talking about implementing a "Chengdu" or an "Ahmadabad" or a "Lagos" model rather than a "Silicon Valley" model. That would imply not just a new language of innovation, but also a radically new way of thinking about America's role in global innovation. **When it comes to innovation, maybe size does matter.**

Reproductive Health

Link – Access

Feminist movements are fighting for Medicare for All – it is essential to reproductive freedom.

Brown 19 Jenny Brown, member of National Women's Liberation and a former editor at Labor Notes. "Medicare for All Is a Reproductive Rights Issue." Jacobin. 17 January 2019. https://www.jacobinmag.com/2019/01/medicare-for-all-abortion-hyde-amendment. [Premier]

Encouragingly, many individual NOW members are already active in the Medicare-for-All movement, and California NOW has signed onto the state's single-payer plan. Following persistent calls for its inclusion, Medicare for All will now be on the **Women's March agenda** (which will be released on January 19). And some smaller feminist groups (including my own, National Women's Liberation) are also involved in the fight for Medicare for All.

The stakes are high. Medicaid is under serious attack. The system is being bled by the private companies that manage its benefits and deny care to save money. States are getting the green light to tack on work requirements — just another way to knock people off the rolls. Meanwhile, thousands of women, both on and off Medicaid, give birth **against their will** because of the current system, while those who want to have kids **can't afford the health care to do so.**

We need to all be pulling together on things that are worth winning and that benefit everyone if we are to save the programs we have and reverse the general slide towards barbarism. We can't be content with Medicaid minus the Hyde Amendment. Even if Medicaid started covering abortions tomorrow and the states all agreed, plenty of women would still be **unable to afford them**. Means-tested programs like Medicaid divide the desperate who don't qualify against the even more desperate who do.

To truly achieve **reproductive freedom**, we should go for what we really want and need. And **that's Medicare for All.**

M4A solves coverage of reproductive health, resolves long term care, and cements reproductive rights.

Brown 19 Jenny Brown, member of National Women's Liberation and a former editor at Labor Notes. "Medicare for All Is a Reproductive Rights Issue." Jacobin. 17 January 2019. https://www.jacobinmag.com/2019/01/medicare-for-all-abortion-hyde-amendment. [Premier]

Second, and perhaps even more importantly, feminists and reproductive rights advocates should throw their efforts into the growing movement for **Medicare for** All — which, if we fight for it, could include **full abortion and birth control coverage** for everyone.

Winning Medicare for All would be a resounding victory for feminism. Because of job discrimination, women tend to have worse health coverage and often have to depend on a spouse for health care (especially if they leave the paid workforce to do unpaid care work). Guaranteeing health insurance to all would enhance women's economic independence because health care would no longer depend on employment or marital status.

The current for-profit system also relies heavily on the unpaid work of women caring for family members, who are discharged "quicker and sicker" by an insurance system that exists only to make shareholders money. Long-term care, such as is paid for by national health systems in other countries, here is provided by family members, mostly women, many ruining their own health in the process.

Finally, a Medicare-for-All system in which the federal government paid for abortion and birth control would likely be less vulnerable to legal challenges than Medicaid or the Affordable Care Act, because states would not be funding or administering it. While feminists would still need to win the argument for full abortion and birth control coverage, we'd be in a much better position to achieve our goals — especially if every feminist group is in there fighting for **reproductive rights.**

Link – Modeling

Domestic coverage expansion is key to global access---now is key.

GFW 17 Global Fund for Women is one of the world's leading foundations for gender equality, standing up for the human rights of women and girls. "Women's movements matter more than ever: A critical moment for global women's rights." 2017 .https://www.globalfundforwomen.org/womens-movements-a-critical-moment-for-global-womens-rights/#.WayA9siGNF8. [Premier]

A critical global moment for women's rights The transition of power in the U.S. comes at a critical time for women's rights around the world. Women all around the world are facing threats to their **fundamental rights**, ranging from abortion access and ending sexual violence to racial justice and environmental rights. **Global movements for reproductive health and rights**—including campaigns for access to contraceptives and safe and legal abortion—**are at a critical moment**. They are under threat in countless places, including in Latin America and the Caribbean where maternal mortality rates from unsafe abortions are highest, and facing powerful opposition from religious and cultural fundamentalists and others. Groups working with refugee women and girls also face a pivotal moment. The vast majority of Syrian refugee women and girls are hosted in Lebanon, Turkey, and Jordan, where women's groups are focused on providing core services including anti-violence training and healthcare while empowering refugee women with knowledge about their rights, leadership skills, and economic opportunities—and these women's groups are advocating for critical changes in national laws that restrict refugees' access to jobs, hospitals, and other basic rights citizens have. Concerns are escalating about how the policies of a new U.S. administration may impact their work. Feminist activists globally are increasingly facing fears for their safety. For example, in Egypt, Turkey, and several other countries, we've witnessed an escalating crackdown on feminist and human rights activism, including harassment against women human rights defenders and threats to journalists and academics. In many places—such as the Inter-American Commission on Human Rights and Court—U.S. influence is a critical factor in enforcing mechanisms for their protection. In countries from Sub-Saharan Africa to Asia and the Pacific, grassroots women are coming together to protect their land and water rights amid climate change and increased violence to improve their own farming and local food sources, and to increase their economic opportunities. Women are standing up against rollbacks to rights, resisting the rise of conservatism, blocking dangerous anti-women policies, and fearlessly defending women's rights amid conflicts and political and economic crises. Conservative leadership is on the rise in many countries around the world and women's groups are joining forces to share their strategies of resistance. Connecting the dots in threats to fundamental rights globally—and learning together "As far as women and other civil society organizations [in Africa] are concerned, **all progressive issues might suffer under a Trump Presidency**," says Bisi Adeleye-Fayemi, co-founder of African Women's Development Fund and Global Fund for Women Board Member. "Women's rights, sexual and reproductive rights, climate change, LGBTQ, Muslim people, refugees… are not likely to get the attention they deserve—they will probably ge t the wrong kind of attention." Indeed**, policy stances in the U.S. will have a direct impact on global communities and situations**. And **by and large, many of the key human rights issues that are coming into play in U.S. domestic policy including access to reproductive health and rights and ending violence against women, are issues that are under the spotlight in other places around the world. U.S. leadership could play a significant role—either in moving the needle positively on these critical issues, or in condoning or precipitating the rollback of hard-won gains.** When it comes to environmental rights, for instance, the new U.S. administration's denial of climate change could spell disaster—especially for indigenous and marginalized women. "Brazil has a key role in world climate and environment—the Amazon is called the lung of the world," said Jacqueline Pitanguy, a long-time women's rights and reproductive rights activist in Brazil and former Global Fund for Women Board Chair. "A U.S. denial of global warming and its lack of support to global accords and initiatives is a disaster." Pitanguy also sees analogies with the shifts taking place in other countries. "**Conservative, patriarchal, and intolerant leaders and ideologies might gain strength in different countries, challenging the women's human rights that are in place, bringing backlashes on laws and policies, or supporting regimes where women are treated as second-class citizens**," says Pitanguy.

Impact – Growth

Reproductive health is key to global sustainable development.

Starrs 15 Ann M Starrs, president and chief executive of the Guttmacher Institute, a chief authority on global sustainable development and gender inequality. "Sustainable development is only possible if women's health is prioritised." The Guardian. 21 January 2015. https://www.theguardian.com/global-development/poverty-matters/2015/jan/21/sustainable-development-is-only-possible-if-womens-health-is-prioritised. [Premier]

"Let the 21st century be the century of women." These were the words of the UN secretary general, Ban Ki-moon, when he launched his report on the post- 2015 development agenda. "The **empowerment and rights of girls and women must be at the heart of everything we do**," said Ban. Let's hope the member states were paying attention. In September, UN delegates will come together in New York to decide on the content of the sustainable development goals (SDGs), which will drive the global agenda on social, economic and environmental development for the next 15 years. Work thus far has resulted in 17 draft goals and 169 specific targets. The goals are broad and ambitious, but improving women's health is not mentioned specifically in any of them and is referenced in just two targets. Even a glance at the list of proposed goals makes clear that **universal access to contraception and other sexual and reproductive health services is vital to achieving many of them. How can we end poverty if women and couples cannot determine whether or when to have a child, or how many to have? How can we ensure equitable education for all if so many girls drop out of school due to unwanted pregnancy? How can we achieve gender equality if women's reproductive rights are not fulfilled?** The answer to all of these questions is the same: **we can't.** But these are the questions that must be asked in September as UN delegates and civil society groups negotiate a final version of the SDGs. For negotiations to take women's wellbeing into account effectively, they must start with the basic facts. While more women are practising modern contraception today than a decade ago, contraceptive use has barely kept pace with global population growth. New research from the Guttmacher Institute shows that a **shockingly high number** of women in developing regions still **do not receive the services they need to protect their health and that of their newborns:** 225 million women who want to avoid pregnancy are not using contraceptives and 43 million pregnant women face health risks by giving birth outside a health facility. In addition, while increased access to antiretroviral therapy has changed the course of the Aids epidemic globally, increasing life expectancy significantly, nearly half of women who need treatment for HIV do not receive it. The consequences are devastating: 74m unintended pregnancies, 28m unplanned births and 20m unsafe abortions each year. Some 290,000 women and 2.9 million newborns die each year, largely because of the lack of access to good-quality care during childbirth. In addition, 273,000 infants become infected with HIV during pregnancy and delivery or breastfeeding. **The rewards for providing these women and their newborns with the services they need are tremendous**: unintended pregnancies would drop by 52m; 200,000 fewer women and 2 million fewer newborns would die every year and new HIV infections in newborns would be virtually eliminated. **Fully satisfying women's need for modern contraception would also make healthcare investments more affordable overall**. For every additional dollar invested in contraception in developing regions, the cost of pregnancy-related care –including HIV care for women and newborns – is reduced by about $1.50 (about £1). Beyond these striking health gains, **there is a huge payoff in terms of other social and economic returns. Girls and young women are more likely to be able to stay at school, improving their future participation in the labour force and earning potential**. In turn, **household savings and assets receive a boost. Poverty is reduced, living conditions improve and communities are better off when women can fully participate and contribute. All these benefits have direct impacts on a wide variety of other development goals**. In the months ahead, government negotiators and civil society will grapple with many competing priorities as they try to reach a consensus on a new global development agenda. And, undoubtedly, socially conservative countries and activists who are hostile to sexual and reproductive health rights will lobby against addressing these issues in the final goals. But **these core principles must not be compromised or**

negotiated away. UN delegates need to pay attention to the evidence that clearly establishes how investing in sexual and reproductive health benefits women, their families, their communities and their nations. If they don't, **half of humanity will continue to lag behind and true sustainable development will be impossible to achieve.**

Excluding women from developing economies prevents sustainable growth.

Ortiz-Barroeta 14 Gabriel Ortiz-Barroeta, communications associate for World Learning, an international nonprofit organization that focuses on international development, education, and exchange programs. "Female Economic Exclusion and Inequality Leads to Underdevelopemnt." 15 May 2014. blogs.worldlearning.org/now/2014/05/15/female-economic-exclusion-and-inequality-leads-to-underdevelopment. [Premier]

A society's economic growth is stunted when women are excluded or not fully included in the economic system. People are always a country's most valuable resource. Countries that exclude women—half of their population—from participating in economic activities are tossing away half of their potential. This is because **their workforces are half the size they could be.** Apart from **decreasing a country's productivity and creativity in gross terms, women's economic exclusion undermines consumption-led growth**, as a **large segment of the population does not have purchasing power**. Consequently, **local business growth is** often **inhibited**. It is no coincidence that **economic growth is correlated to women's economic inclusion** (Arutyunova, 2012: 306). To put things into context, one study shows that East Asia experiences nearly 1.6 percent greater economic growth per year than the Middle East, which the researchers attribute to increased female inclusion in the workforce (Klasen & Lamanna, 2010: 110). Over time, this percentage of yearly growth adds up and **makes the difference between development and underdevelopment**. That is, **between breaking the cycle of poverty or not**. Even in countries where women participate in the workforce but do so **unequally**, **problems arise**. Japan—a developed economy—is the most recent example of this. Only 60 percent of women are in the workforce as compared to 80 percent of men. Most women in the workforce are young and work on entry-level positions. **Due to a lack of support of motherhood**, training and an appropriate legal framework, women in Japan have a tough time re-entering the workforce after giving birth. As result, only about a third of all mothers are part of the workforce and women comprise only 1.6 percent of all high-level executive positions. The **broad inclusion of women in mid- and high-level positions is a key element** of ambitious economic reforms the Japanese government is implementing in order **to grow the workforce and spare the county from a looming financial crisis**. Opinions on this matter vary, but some argue that had Japan fully included women into the economic system, financial troubles would not have deteriorated to current levels. Yet the most damage created by women's economic exclusion, or inequality, is its effect on future generations and the creation of human capital. In countries with female economic exclusion, household income is often dependent on only one earner. **As a result, households have less purchasing power and struggle to make ends meet**. This often translates into less opportunity for younger generations and thus stagnant upward social mobility (Arutyunova, 2012: 306). In cases where women are heads of households in these countries, poverty is an almost certain outcome. Even in countries where women participate unequally, for instance, by doing the same jobs as men but receiving lower wages, households suffer. Although no country is completely free from this, the degree of the gender pay gap varies significantly depending on the country. According to the OECD, for example, gender pay gap is much lower both New Zealand and Belgium than in the United States, and so is its impact. In particular, single-mother households are highly vulnerable to economic inequalities, as they have access to fewer resources. Younger generations from these households have a tough time developing their full capabilities. Thus, **a considerable amount of human capital**, **which is key to innovation** and creativity, **is wasted** (Klasen & Lamanna, 2010: 97). As the global economy grows ever-more competitive, **countries**

lacking human capital fall behind. Therefore, **the impact of gender inequality goes from one generation on to the next one, strengthening poverty and undermining sustainable development**.

That causes civil war escalation, organized crime, and international terrorism.

Galster 15 Kirk Galster is a global advisor at The Global Chamber, assisting corporations, members, and Executive Directors of the Global Chamber in establishing trade and global commercial integration. He also works for the University of Utah. "Poverty and Conflict: Can Economic Development Prevent Conflict?" 1 July 2015. nsuworks.nova.edu/cgi/viewcontent.cgi?article=1000&context=jics. [Premier]

Abstract War and widespread poverty plague the developing countries of the world in a devastatingly violent cycle. **This paper illustrates a correlation between economics and** the role it can play in **violence**. The author surveys three theoretical approaches to understanding conflict resolution and socioeconomic causal relationships of violence, summarizes empirical evidence of those causal relationships, explores these relationships in terrorism and civil war, and utilizes those theories and empirical data in an analytical case study of the Hashemite Kingdom of Jordan, including a correlation coefficient matrix and regression analysis with policy implications. The theoretical approaches surveyed include human security and development, the horizontal inequalities theory, and structural demographic theory. **The unique and peaceful approach of growing a developing nation's economy could be key to breaking the cycle of violent conflict in war-torn countries and avoiding such violence in countries on the verge of civil war**. Possibly the most unfortunate state of affairs of all is war. Armed conflicts around the world yield countless refugees, widows, orphans, and render many destitute. The costs of armed conflict in many ways are immeasurable, but action can and should be taken to prevent situations causing the outbreak of violence in addition to rebuilding and rendering aid in post-conflict occasions. Although socioeconomic issues are not the primary reason for conflict**, empirical evidence supports that there is a strong case for causal relationships between economic stability and violence**. A survey of three theoretical concepts, in addition to empirical evidence, examples of civil war and terrorism, policy choices, and an analysis of a case study of the Hashemite Kingdom of Jordan, may further develop understanding of the subject. Finally, the potential roles of nongovernment (both not-for-profit and for-profit entities) and government organizations in preventing conflict through economic development will be addressed. Three theoretical approaches to understanding links between conflict and socioeconomic standing are human security and development, horizontal inequalities and conflict, and structural demographic theory. Human security and development, as indicated by Krause and Jutersonke (2005), is based on the basic human need for security in economic stability as well as from both internal and external violence. The commonly held view in economics and development was that development was a precondition for security and increased development would reduce the incidence of conflict within and between states (Krause & Jutersonke, 2005). This was severely challenged, however, with the development that took place directly before the Rwandan genocide. In a crisis of scarcity, development assistance and relief are precious commodities which, if wrongly distributed, can reinforce social cleavages and consequently establish insecurity, instilling fear and provoking the environment of hostility, which results in conflict rather than alleviating it (Krause & Jutersonke, 2005). Thus, the security-development link has been reversed, and basic security is a precondition for political, social, and economic development or well-being. Major aid donors and international financial institutions demonstrate the history of this shift in the focus on "security sector reform." These kinds of efforts represent the change in thinking for post-conflict development institutions in program development for security and development efforts (Krause & Jutersonke, 2005). The UK has set up a Post Conflict Reconstruction Unit for the purpose of growing awareness to close the planning gap between security and development efforts. The World Bank also included a security dimension, taking the lead on demobilization and reintegration programs (Krause & Jutersonke, 2005). **The connection between peace building and the provision for individual security is vital. It encompasses more than fostering stability to prevent conflict, but building political, social, and economic institutions for the purposes of capacity building, good governance, inclusion, economic opportunity, and individual well-being**. Therefore, in order to incorporate the comprehensive understanding of peace, **the development component needs to be included in peace-building** programs (Krause & Jutersonke, 2005). The new, broader concept of security was first introduced in the UNDP Human Development Report to include seven different dimensions, which consisted of economic, food, health, environmental, personal community and political security. The overall goal for this report was to expand the general understanding of security, which was before defined primarily in terms of territory and external threats (Krause & Jutersonke, 2005). An example of a broader view of security beyond that of physical security, which typically leads to violence, is food security. Brinkman and Hendrix concluded: Food insecurity is both a cause and a consequence of violence, contributing to a vicious cycle or "conflict trap". Food security is critical for political stability. Food insecurity is linked to increased risk of democratic failure, protests and rioting, communal violence and civil conflict. Violent conflicts, in turn, create food insecurity, malnutrition and – in some instances – famine. Thus food insecurity can perpetuate conflict, although its effects depend on the context, with the strongest links evident in states that already have fragile markets and weak political institutions (Brinkman & Hendrix, 2011, p. 20). Food is a basic need for all of mankind. It is obvious that a lack of access to food can have adverse effects on society, especially when there are deeper social reasons for the absence of food security. The second theoretical approach to understanding conflict is the horizontal inequalities theory, which seeks to understand conflict and the mobilization of groups toward violence. These both demonstrate a powerful link between different types of horizontal inequities and conflict. Frances Stewart of the University of Oxford explored the importance of horizontal inequalities (HIs) and their relationship to conflict. Stewart concluded that there is a proven status quo that cultural, ethnic, religious, or racial differences alone cannot account for conflict in an unavoidable "clash of civilizations," and that they can, in fact, peacefully coexist. According to Stewart, the findings of Fearon and Laitin (1996) have estimated that from 1960 to 1979, of all the potential ethnic conflicts in Africa (defined as occurring where different ethnic groups live side by side) only 0.01% actually turned into violent conflict. The question Stewart's (2008) research raises is, what may be identifiable ways in which preventing conflict and the costs in terms of deaths, injuries, and economic social collapse from happening? If horizontal inequalities are inequalities which cause conflict, then policies should be engineered to reduce HIs and therefore reduce the likelihood of conflict. Horizontal inequalities are "inequalities in economic, social, or political dimensions of cultural status between culturally defined groups" (Stewart, 2008). Violent conflict within poor countries is typically found in seven out of ten of the poorest nations in the world. These countries are undergoing or have recently experienced some sort of civil war (Stewart, 2008). In return, violence becomes a major obstacle to development, reducing incomes and investment and undermining human development. Regression analysis suggests an average loss in gross domestic product (GDP) per capita of between 2.0% and 2.4% per annum among countries experiencing conflict. The cost of war is staggering. There was a suggested cumulative loss of half of the GDP in Iraq in the case of the war between Iraq and Iran, and infant deaths during the Uganda conflicts amounted to 2% of the population (Stewart, 2008). Mobilization for violence requires motivation. Organized group conflict may be a result of a variety of motivations. Individual mobilization motivation is commonly believed to primarily be the desire to gain economic advantage. However, there is neither exclusively nor primarily a matter of individual motivations included in group mobilization. What are most involved in group's mobilization are shared identities linked to goals to attack others in the name of the group. Young men may fight because they are unemployed, uneducated, or have few opportunities. Generally they fight out of loyalty to a group as opposed to personal convictions (Stewart, 2008). Bearing this in mind, it is apparent that HIs play an important role in mobilization of groups. Vertical inequalities (VIs) are inequalities among individuals in social classes whereas HIs are inequalities specific to groups of culturally defined individuals on the basis of religion, ethnicity, or salient factors, which bind groups of people together (i.e. political, socioeconomic, or social cleavages) (Stewart, 2008). In order for mobilization to occur, grievances at both the leadership and the mass level may be present. In many cases, political ambition may cause a multidimensional horizontal inequality due to a lack of representation of a given group's leadership because of their economic and social position in relation to other groups. Major grievances, whether political or social, may likely be causes of mobilization. This is due to them limiting access to education and employment, which are two primary means to elevate from poverty, and makes it an economic issue (Stewart, 2008). Stewart concludes: There are causal connections between different HIs. For example, inequalities in political power often lead to similar social and economic inequalities. A biased distribution of government jobs and provisions of infrastructure is common, with the group in power discriminating in its favour. For example, in Burundi in the 1990's, half of government investment went to the Bujumbura region and its vicinity, which is the home of the elite Tutsi group (Gaffney, 2000). In some countries, the president and his coterie have taken a massive share of state resources for their private use, such as the Duvaliers in Haiti and the Somoza family in Nicaragua (Lundahl, 2000; Pastor and Boyce, 2000). Moreover, there are connections between economic and social elements. Lack of access to education leads to poor economic opportunities, while low incomes tend to result in poor educational access and achievements in a vicious cycle of deprivation. There are also reinforcing cycles of privilege and deprivation because of the way that one type of capital requires others to be productive (Stewart, 2008, p.13). Therefore, economic status and garnering a political power base between social groups can be a motivator for mobilization. Horizontal inequalities may be created due to high levels of natural resources and power struggles over who gains from these resources. However, conflict may be less likely to break out if HIs exist and there is a growing economy or where a very strong state represses any conflict. Another reason could be political accommodation. Socioeconomic HIs generate a hostile environment for conflict to emerge as cultural status inequalities act to bind groups together for mobilization. Political HIs provide incentives for leaders to mobilize people for rebellion. Where severe HIs exist and abrupt changes in political or cultural events where cultural or religious values are threatened, there exists the possibility of a powerful trigger to conflict (Stewart, 2008). Finally, Stewart argues that out of four hypotheses, three were confirmed significant and the last deemed untestable. The

hypotheses include: conflict is more likely where there are significant political and/or economic HIs, political mobilization is especially likely where HIs are consistent, and cultural recognition or status inequalities are also provocative. The last, undetermined hypothesis is that political mobilization, and possibly conflict, is more likely to occur when HIs are widening. Due to lack of data over a period of time, this was determined untestable (Stewart, 2008). The final theory assessed is the structural demographic theory. It postulates that labor oversupply leads to falling living standards and elite overproduction. Those, in turn, cause a wave of prolonged and intense sociopolitical instability. Three empirically supported generalizations may impact outbursts of these violent cycles followed by periods of internal peace (Turchin, 2012). The generalizations include: the neoMalthusian principle, the principle of elite overproduction, and the structural demographic causes of political instability. The neo-Malthusian principle states that sustained population growth inevitably leads to falling living standards and is positively impacted by the switch from an agrarian to an industrial economy. Simplified in terms of supply and demand, it means the supply of labor exceeds its demand, and the price of labor then decreases causing living standards to decrease. Agrarian demand for labor is limited to resources for production (cultivatable land, ability to get supplies/livestock). Uncontrollable population growth inevitably leads to falling living standards. Modern economies have more dynamic demand for labor (Turchin, 2012). Elite overproduction refers to a situation when upward mobility overmatches downward mobility, and the process of declining living standards for lower class is mismatched with increasing consumption levels of elites. This creates a situation where there is an increase in inequality (Turchin, 2012). Inequality leads to a structural demographic issue where elites obtain the higher paying employment opportunities and the lower class is unable to obtain any employment thus creating a recipe for grievances and political instability. These theoretical concepts increase understanding of civil wars among impoverished countries. **Civil war in a low-income country typically lasts for nearly a decade with overwhelming non-combatant casualties**. Reasons for death include disease, forced migration, and the breakdown of health systems (Collier, Development and Conflict, 2004). War creates a gaping hole in the economy that takes many years to recover. Many of the costs of the war become apparent after it is over. **Damage** is rarely contained and **spreads to neighboring countries** and regions with more than half of the total economic cost falling on the shoulders neighboring countries (Collier, Development and Conflict, 2004). Other costs of civil war are significant as well. 95% of the world's hard drug production takes place in civil war environments where territory is outside the control of recognized governments (Collier, Development and Conflict, 2004). Paul Collier's research of civil wars in the world that broke out from the period of 1965- 99 indicated **factors that statistically make a country prone to conflict are low income, rate of growth, and economic structure**. A civil war is classified as an internal conflict with at least one thousand battle-related deaths. During this period, there were 73 civil wars globally, and in principle, Collier analyzed the pattern to determine why these wars occurred (Collier, Economic Causes of Civil Conflict and their Implications for Policy, 2006). Collier divided the period up into eight, five-year sub-periods and attempted to predict the occurrence of war during a sub-period by the characteristics at its start. Utilizing statistical logit and probit regressions, he drew conclusions about patterns of the factors involved in civil war. Due to a lack of data on some countries, knowing that a war took place, but not knowing enough of its other characteristics to include it in analysis, Collier reduced the sample to 47 civil wars. However, this was still sufficient to find some strong patterns (Collier, Economic Causes of Civil Conflict and their Implications for Policy, 2006). Low-income countries face a 14% risk of civil war, **but doubling the income of a country will halve the risk of conflict**. One percentage point of growth rate reduces the risk by around a percentage point, and reducing dependence upon natural resource exports powerfully reduces the risk of conflict (Collier, Development and Conflict, 2004). Causes that lead to increased risk of conflict and poor economic conditions are many. One such factor is poverty making it difficult for governments to gain popular allegiance. Rebellion becomes an attractive option with the prospect of the parties involved gaining power, weapons, and drugs (Collier, Development and Conflict, 2004). Generally, half of all civil wars are due to post-conflict relapse and results in common underlying characteristics such as low income, natural resource dependence, and the legacy of the conflict itself (Collier, Development and Conflict, 2004). Collier's analysis indicated that a major component of risk was whether or not the country had a substantial share of its income in Gross Domestic Product (GDP) generated from primary commodities. Dependence of 26% of GDP or more indicated serious danger of conflict. The risk in Collier's sample was 23%, whereas countries with no primary commodity in exports, but were otherwise the same, would have a risk of half of a percentage point (Collier, Economic Causes of Civil Conflict and their Implications for Policy, 2006). This, as well as economic opportunity, provide major implications for conflict. Conflict was found to be concentrated in countries with low education (Collier, Economic Causes of Civil Conflict and their Implications for Policy, 2006). On average, young males in secondary education in the sample consisted of 45%. Any country that had 55% of its youth in an education system would cut its risk from the 14% risk of civil war to 10%. Again, conflict was more likely in countries with rapid population growth. Each percentage point of growth raises the risk of conflict by around 2.5 points. Therefore, the most significant predictors of civil war were dependence on primary commodity exports, low average incomes, slow growth, and large diasporas (Collier, Economic Causes of Civil Conflict and their Implications for Policy, 2006). In periods of economic stagnation, countries where there are large numbers of disaffected youth, particularly males, may become more likely to be mobilized by rebel groups. Cincotta, Engelman, and Anastasion (2003) studied demographic structures and incidence of war in the 1990s and found that the outbreak of civil conflict was more than twice as likely in countries which the youth between the ages of 15-25 comprised more than 40% of the adult population compared to countries with lower proportions. Conditions in which young men feel frustrated with poor life prospects for income and employment may increase the likelihood that they become recruited for violent conflict (Fukuda-Parr, 2007). Regarding post-civil war reconstruction, a field experiment was conducted in northern Liberia where randomly assigned villages received international development assistance. Evidence demonstrates that new local-level institutions can alter patterns of social cooperation in a way that persists after the program concludes. Villages that were exposed to a community-driven reconstruction program exhibited higher subsequent levels of social cooperation than those in the control group (Fearon, Humphreys, & Weinstein, 2009). This suggests that the changes in community cohesion can take place over a short period of time and occur in response to outside intervention within the context of the given and unchanged macro-level political economic situation. Therefore, it is possible for post-conflict reconstruction efforts to have measurable impact on social cohesion (Fearon, Humphreys, & Weinstein, 2009). Post- civil war prescriptions can be effective if a holistic development approach is utilized. Three instruments to reduce post conflict relapse are political design and reform, economic recovery, and military provisions. Collier and Hoeffler (2004) find that the security benefits alone are around four times the cost of the aid and still substantially exceed the costs even at the adverse bounds of the confidence intervals of their estimates (Collier, Development and Conflict, 2004). Given the evidence supporting the connection between civil war and economic standing, it is necessary to focus on other specific forms of conflict in terms of analysis on potential economic causal relationships. Much research conducted on the relationship of terrorism and poverty would cast doubt that there is a strong correlation between terrorist operatives and their economic well-being. Generally, evidence supports that those recruited by terrorist organizations are highly educated, potentially in a higher income bracket, and have many reasons for getting involved. This does not, however, explain the phenomenon of why the origins international terrorist attacks are traced to impoverished countries. Terrorism is defined as "premeditated, politically motivated violence perpetrated against noncombatant targets by subnational groups or clandestine agents, usually intended to influence an audience," (Berrebi, 2007, p. 5). Its objective is maximizing media exposure to the act and, ultimately, to the terror group and/or to its "cause." Many academics and policy makers have maintained that terrorist activity is the result of ignorance or poverty. Research conducted on terrorism in Palestine indicated that 31% of Palestinians were considered poor whereas only 16% of those involved in terrorist activities were considered poor (Berrebi, 2007). Out of 208 observations where information about terrorist operatives' education was available, 96% have at least a high school education and 65% (135 observations) have some kind of higher education, compared to 51% and 15% respectively in the overall Palestinian population of same age, sex, and religion. Contrasted with the general population, operatives tend to be younger, which further accentuates the findings of differences in poverty and education (Berrebi, 2007). All estimates were statistically significant and indicated an inverse relation between poverty and education positively related between the likelihood someone was a Hamas or PIJ (Palestinian Islamic Jihad) operative (Berrebi, 2007). A possible explanation for this is that terrorist organizations prefer more educated individuals, but those individuals are more likely to participate in terrorist activity when the economic environment is not in favor of their opportunities (Berrebi, 2007). Interestingly, out of the information provided on education, which was little, over half indicated religious studies. The most likely explanation of the results pertaining to education may be related to the educational content (Berrebi, 2007). Demonstrably, terrorist operatives' likelihood of being recruited for terrorist activities is not linked to poverty statistically. **However, there does prove to be a correlation between instability and the likelihood of international terrorist events originating from those countries or regions which are unstable**. **If in fact civil war is correlated with poverty, and contributes to overall instability where international terrorist attacks are likely to originate, then poverty in that context may contribute to international terrorism.** The rationale of **the "escalation effect," which stresses that domestic political instability is the main reason for international terrorism, has demonstrated to be plausible**. The **econometric evidence** (total number of terror acts, total fatalities, and median fatalities) from a panel of more than 130 countries from 1968 to 2003 demonstrates that civil wars and guerrilla warfare are robustly associated with various aspects of international terrorism (Campos & Gassebner, 2009). Thus, **terrorists** appear to **exploit existing arenas of conflict.** The results **supporting the escalation effect** indicates that civil wars and guerilla warfare, as well as riots, all exhibit the expected positive relationship and are all **highly statistically significant**. **Transitioning from no civil war to an eruption of civil war would result in an increase in terror attacks by approximately 30%.** The magnitude of the effect of guerilla attacks is almost identical. Keeping all other factors equal, increasing the number of guerilla incidences by one results in roughly 30% more international terror events originating from that location (Campos & Gassebner, 2009). These results have proven to hold true in light of the attacks on 9/11, 2001, as well as the foiled "underwear bomber" on Christmas Day, 2009, attempted to board a flight in Detroit. Both cases originated from unstable countries with histories of civil war: Afghanistan, and Yemen, respectively. Umar Farouk Abdulmutallab (the underwear bomber) was believed to have been moved to Yemen by Al-Qaeda for training prior to the attempt (Temple-Raston, 2010). General consensus among scholars is that **fragile states are commonly impoverished, rendering the less capable to deal with and manage negative dynamics like civil war and drug, weapons, or human trafficking**. **Weak states are less able to protect themselves against insurgency or terrorist networks**, deploy peaceful political means to resolve conflict and prevent the onset of it, or resolve local disputes when they arise (Fukuda-Parr, 2007). Hence, such **insurgent**

networks are able to exist and use weak or unstable states as a platform to conduct international terrorism.

Aff Blocks

AT: Jobs

Inefficient health care jobs aren't stimulus---they drain resources from other priorities

Baicker and Chandra 12 Katherine Baicker, C. Boyden Gray Professor of Health Economics in the Department of Health Policy and Management at the Harvard T.H. Chan School of Public Health, Ph.D. in economics from Harvard, and Amitabh Chandra, Malcolm Wiener Professor of Social Policy and Director of Health Policy Research at the Harvard Kennedy School of Government. "The Health Care Jobs Fallacy." New England Journal of Medicine. 366: pgs. 2433-2435. 28 June 2012. http://www.nejm.org/doi/full/10.1056/NEJMp1204891#t=article. [Premier]

But this **focus on health care jobs is misguided**. The goal of improving health and economic well-being **does not go hand in hand** with rising employment in health care. It is tempting to think that rising health care employment is a boon, but if the same outcomes can be achieved with lower employment and fewer resources, that leaves extra money to **devote to other important** public and private **priorities** such as education, infrastructure, food, shelter, and retirement savings.

Consider an example involving two hospitals that serve the same number of patients: one employs 100 physicians, and the other 120 physicians. The leadership of the second hospital might claim that the additional employment is benefiting the local economy. But unless the employment of 20 extra physicians in the second hospital generates additional health improvements that are commensurate with the additional spending on physicians' salaries, **the higher employment is not socially beneficial**. Salaries for health care jobs are not manufactured out of thin air — they are produced by someone paying **higher taxes**, a patient **paying more for health care**, or an employee taking home lower wages because **higher health insurance premiums** are deducted from his or her paycheck. Additional health care jobs leave Americans with less money to devote to groceries, college tuition, and mortgage payments, and the U.S. government with less money to perform all other governmental functions — including paying teachers, scientists, and social workers. That trade-off can be justified if it goes along with improved health outcomes, but not if those jobs do not generate benefits that exceed those of alternative uses. (Of course, local politicians may still prefer the larger hospital to be in their district, as long as the people paying for it are not — but this is not a strategy that serves the greater good.) The challenge is that it's easy to count jobs but much, much harder to figure out who paid for them and whether those resources could have been put to better use.

The way we view rising employment in the health sector should therefore be governed by the health produced by those people and resources. Panel A of the figure illustrates the growing share of the workforce employed in the health care field.1 If we were confident that resources were flowing into health care solely because they were driving innovation, raising quality, and improving health and longevity, that would indeed be cause for celebration. There is, however, **mounting evidence** that our health care system could deliver better care without spending more and that there are tremendous opportunities for **improvements in productivity** — which suggests that the increase in resources devoted to health care has not generated commensurate value.

The graph in Panel B shows that the cost per year to produce a 1-year increase in life expectancy has risen dramatically over time,2,3 far exceeding conventional cost-effectiveness thresholds of $100,000 per life-year — findings that suggest that those resources could do more good if put to alternative uses. Although the specific numbers depend on the share of health gains attributed to health care spending itself,4 there is ample evidence that incremental health care spending is producing, at best, small gains in health, and these high prices for small gains are seen both for interventions at the start of life and for those after age 65.2,3 This misallocation is driven by features of our current health care system that **interfere with getting the most health for each dollar spent** — such as the fee-for-service payment structure, the lack of incentives for patients to select and providers to recommend more conservative care options, and the tax preference for first-dollar employment-based health insurance.5

Many reforms aim to reduce these inefficiencies, thereby **improving health** and potentially **slowing the growth of health care spending**. These reforms would focus spending by public programs such as Medicare on rewarding higher-value care and reducing the incentives to provide therapies with unproven benefits. The net effect of such policies on employment in the health care sector is unclear: on the one hand, they might reduce employment by improving efficiency and allowing us to get the same health outcomes with fewer health care workers. Such policies might also lead to a change in the mix of people employed within health care — such as increased numbers of nurse practitioners or reduced numbers of administrators. On the other hand, improving the productivity of the health care sector might increase the incentives to spend more on health care, thereby increasing the share of the economy devoted to health care **in the long run**.

Although such efforts would improve overall health and people would be better off on average, there would be losers as well as winners. Taxpayers and workers who would take home bigger paychecks (because of lower health insurance premiums) would be better off. The people who lost those jobs would be worse off (at least in the short run), and some of them might be lower-income workers. Although we may very well want to do more for the poor, continuing to subsidize an inefficient health care system through outdated payment policies and distorted insurance markets is a **singularly inefficient way to redistribute resources**. A far more effective way to help low-wage workers who are displaced would be through expanding antipoverty programs such as the Earned Income Tax Credit or other social insurance programs such as Medicaid and food assistance. Of course, such reforms must be implemented gradually to avoid harming patient care in the transition, and changes in public spending must take into account the current economic climate, but public spending produces the most stimulus when it goes to the most productive activity.

The bottom line is that employment in the health care sector should be neither a policy goal nor a metric of success. The key policy goals should be to achieve better health outcomes and increase overall economic productivity, so that we can all live healthier and wealthier lives. Our ability to ensure access to expensive but beneficial treatment is hampered whenever health care policy is evaluated on the basis of jobs. Treating the health care system like a (**wildly inefficient**) **jobs program** conflicts directly with the goal of ensuring that all Americans have access to care at an affordable price.

The insurance industry wouldn't implode – it'd transition to provide supplemental policies – prevents major job losses

Strauss 17 Matt Strauss, Owner of Strauss Insurance, Pennsylvania based employee benefits firm. "What would happen to health insurance companies if we switched to a single payer health care system?" Quora. 8 May 2017. https://www.quora.com/What-would-happen-to-health-insurance-companies-if-we-switched-to-a-single-payer-health-care-system. [Premier]

We already have a good example of what a single-payer system would look like in America, and it's called Medicare. So, **let's make** some **predictions** about what would happen to health insurance companies and their employees if Medicare was expanded to all citizens from birth. First, there are **about 500,000 people** who are employed by the health insurance industry. And, while it would be unrealistic to assume that none of these jobs would be lost, I **don't think it would be as catastrophic** as some predict. Let me explain. A lot of people assume that once you turn 65 and become eligible for Medicare, that you will no longer need private insurance. But this is simply not the case. While it is not mandatory, a great majority of people end up purchasing, what's called, a Medicare supplement plan from a private insurer. This "supplemental" policy covers out of pocket expenses that Medicare does not like: $1,316 hospital deductible (2017 standard Medicare hospital deductible) 20% coinsurance for doctor expenses $164.50/day copayment for a Skilled nursing facility stay So, if America moved to a **Medicare for All** system, **many health insurers** may simply **pivot** and offer **supplemental policies** to cover the **gaps** and **out of pocket expenses** that the National plan did not. Under this scenario, many of today's health insurance carriers could **remain in business** and keep, at least, a

portion of **their current staff**. And, since the government would be paying the majority of the claims, it may even **encourage more competitors** to enter the health insurance market, as the potential liabilities would be diminished.

AT: Spending

Replacing premiums with taxes is net beneficial for economic growth and brings taxes to standard rates with the rest of the world.

Seidman 15 Laurence Seidman, Professor of Economics, University of Delaware, Ph.D. in economics, University of California, Berkeley. "The Affordable Care Act versus Medicare for All." *Journal of Health Politics, Policy & Law*, Vol. 40, No. 4. August 2015. [Premier]

What is the effect of **replacing premiums with taxes?** Taxes vary with ability to pay, while premiums do not (Seidman 2009). **It would be better for the economy** and fairer to use a set of earmarked taxes that have moderate rates (Seidman 2013b). The set of taxes earmarked for Medicare for All might consist of the following: the Medicare payroll tax, a VAT, and a Medicare for All income tax surcharge on the 1040 income tax return. The Medicare payroll tax is currently 1.45 percent on the employer and 1.45 percent on the employee— a combined rate of 2.90 percent on all wage income. The VAT is used successfully by virtually every economically advanced country except the United States. Many US economists have recommended a US VAT (Seidman 2004, 2013b; Hines 2007). Several analysts have recommended that a VAT be enacted and earmarked for universal health (Morone 2002; Burman 2009). The VAT burden on low-income households would be offset by giving these households a refundable tax credit on their 1040 income tax return to compensate roughly for most of the burden they bear from the VAT (Seidman 2013b).

Today US medical costs are 18 percent of gross domestic product (GDP), while no other country exceeds 12 percent. Suppose Medicare for All aims to cut the huge 6 percentage point gap in half to 3 percent so that US medical costs are 15 percent of GDP. If Medicare for All succeeds in using its single-payer bargaining power (as explained below) to achieve its medical cost target of 15 percent of GDP, then **Medicare for All taxes would need to be 15 percent of GDP**. Government (federal and state) spending on Medicare, Medicaid, and other government health programs is currently about 7 percent of GDP (CBO 2012: 49, 55-57), so new earmarked taxes would need to be **roughly 8 percent of GDP**.

To put this 8 percent of GDP number in perspective, in 2007 (before the Great Recession caused a plunge in tax revenue) US taxes (federal, state, and local) were about 30 percent of GDP. Thus taxes would rise from 30 percent of GDP to **38 percent** (federal taxes would rise by 9.5 percent of GDP, while state taxes would fall by 1.5 percent of GDP due to the reduction in state Medicaid expenses), which would still leave US taxes as a percentage of GDP **slightly lower than the average of the** economically advanced member countries of the Organisation for Economic Cooperation and Development (**OECD**) (roughly 40 percent) and far below the Scandinavian countries (roughly 50 percent).

The aff boosts growth and makes care resilient in the face of downturns---the DA can't turn the aff

Liaropoulos and Goranitis 15 Lycourgos Liaropoulos, PhD in Economics @ MSU, Professor Emeritus @ the National and Kapodistrian University of Athens and Ilias Goranitis, PhD in Healthcare Management and Evaluation/Health Informatics @ the University of Athens, Research Fellow in Health Economics & Assistant Director of Teaching, Assistant Director of the MSc programmes Health Economics and Health Policy. "Health care financing and the sustainability of health systems." 15 September 2015, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4570753/. [Premier]

In addition, cyclical fluctuations are now **common events** rather than rare occurrences. **Health financing** may determine how pressures on health systems are weathered without loss of equity, quality and financial protection. Social Health Insurance has been found to have **negative labor market effects** **[21]** and to **hurt competitiveness** **[7]** due to higher labor costs. This is crucial in

monetary unions where devaluation during economic crises is not an option and competitiveness gains are the **only way for the economy to adjust to pre-crisis levels.** In addition, as unemployment increases, incomes decline and pressures on health budget and public infrastructure are **pushed to extremes**, evidence has indicated that **public health systems** financed through taxation can be **more responsive** to economic pressures and **more effective** in health expenditure consolidation **[22]. Although conclusive evidence is lacking, the experiences of Canada and Greece may be indicative.** Evidence from Canada, where health is financed mainly through taxation, suggests that patient satisfaction, hospital performance and health outcomes **were maintained despite the financial strain** [23]. Concerns that reliance on taxation may be associated with higher private payments, especially during economic downturns [22], or that corruption may inhibit administrative capacity to collect taxes [24], **may be put to rest** by the fact that during economic turmoil individuals **become more price-sensitive** and **administrative capacity tends to improve**. In Greece, Social Insurance historically covered approximately 40 % of health care cost. In the face of severe unemployment (27 %) caused by 25 % GDP contraction, reliance on employer-employee contributions **proved an inadequate funding base** for health care. Between 2009 and 2012,9 Social Insurance expenditure declined by 29.3 %, with the fairness of the system and quality of care severely affected [25, 26]. Greece is now a country where the need of re-orientation of health care financing is pressing [25, 27]. In conclusion, employment contributions as a source of health financing are **incompatible** with **universal coverage**, **quality of services**, and **rising life expectancy**. A move towards general taxation to meet health care needs can **boost economic growth** through **increased competitiveness**, and achieve major non-health objectives, like equity, financial protection, quality and responsiveness **even during economic downturns**. Health system sustainability, as a system objective, must turn to financing through progressive taxation of all types of income. "Uncomfortable" as this may appear, it is a reality **not to be overlooked**. Political concerns associated with economic imperatives as well as moral considerations may force changes in health services financing in both the developed and developing world. National health insurance financed through taxation should gain momentum in the quest for more sustainable and responsive health systems.

Healthcare already disproportionately harms middle class families.

Berwick 19 Donald M. Berwick, President emeritus and senior fellow at the Institute for Healthcare Improvement, lecturer and former faculty member at the Harvard Medical School, and former administrator of the Centers for Medicare and Medicaid Services in the Obama administration. "Stop fearmongering about 'Medicare for All.' Most families would pay less for better care." USA Today. 22 October 2019. https://www.usatoday.com/story/opinion/2019/10/22/medicare-all-simplicity-savings-better-health-care-column/4055597002. [Premier]

The second myth is that is Medicare for All must raise taxes on middle-class families. That **is misleading**. Medicare for All's cost to families, no matter how it is funded, should be compared with what those same American families will spend on health care if we do nothing. And as things stand now, the trajectory of their health care spending is looking increasingly painful. Sanders at last week's debate railed against "defending a system which is dysfunctional, which is cruel," one that leaves tens of millions of people uninsured or underinsured, and contributes to tens of thousands of deaths and bankruptcies each year.

Health care costs are **crushing the middle class**, taking more and more money straight from the wallets of workers and families. Small businesses simply cannot afford coverage anymore, and governments at all levels know that uncontrolled health care costs crowd out other priorities, like roads, schools and the social safety net. Every "Made in America" product has these sky-high costs built into its price. The average premium for a family of four in 2019 is a staggering $20,576 — a toll that is eating into their wages, while their out-of-pocket costs soar.

Since 2009, premiums have increased 54% and workers' contributions to premiums have increased 71%, but wages have risen only 26%.

Medical costs comparatively outweighs taxes

La Roche 17 Julia LaRoche, Yahoo Finance citing Warren Buffett. "Buffett: 'Medical costs are the tapeworm of American economic competitiveness'." Yahoo Finance. 6 May 2017. https://finance.yahoo.com/news/buffett-medical-costs-tapeworm-american-economic-competitiveness-220647855.html. [Premier]

Legendary investor Warren Buffett said that **rising health care costs**, not the tax system, is the number one problem that American businesses face. "If you go back to 1960, or thereabouts, corporate taxes were about 4% of GDP, I mean they bounced around some. And now, they're about 2% of GDP," Buffett said during Berkshire Hathaway's (BRK.A) (BRK.B) annual shareholders meeting. "At that time, health care was 5% of GDP, and now it's about 17% of GDP." In Buffett's view, this says a lot of what's playing a bigger role in **hindering business activity** in the economy. "When American business talks about taxes strangling our competitiveness, or that sort of thing, they're talking about something that as a percentage of GDP has gone down **from 4% to 2%,** while **medical costs**, which are borne to a great extent by business, have gone **from 5% to 17%,"** he said. "So, medical costs are the **tapeworm of American economic competitiveness**." He added that health care will be problem that society will face, regardless of what political party is in power. Republicans are pushing for a tax cut for people like Buffett In terms of the American Health Care Act, the Republicans' plan to repeal and replace the Affordable Care Act, Buffett said that the net effect if it should pass that it would be a big windfall for wealthier Americans. "The one thing I can tell you, if it goes through the White House … anybody with a $250,000 adjusted gross income and a lot of investment income, is going to have a huge tax cut," Buffett said. "When there's a tax cut, either the deficit goes up or they get the taxes from somebody else." Charlie Munger, Berkshire's vice chair, agreed with the medical care costs are going wild. He noted that sometimes there's "too much medicine" and "too much chemotherapy" for people who are "all but dead." Munger added that U.S. manufacturers are at a "big disadvantage" compared to countries where the government is paying the health care costs. "On this issue, both parties hate each other so much that neither one can think rationally, and I don't think that helps either," Munger said. Buffett agreed that it's going to be "very tough" for the political parties to take on this issue. "If you talk about about world competitiveness of American industry, it's the **single biggest variable** where we keep getting **more and more out of whack with the rest of the world**," Buffett said. "It's very tough for political parties to attack it, but it's basically a political subject."

AT: Physicians

Market systems don't compensate physicians because higher costs are spent on overhead---and, turn---single payer solves retention by reducing administrative hassles.

London 17 Cathleen London, physician based in Maine who developed a cost-effective alternative to the standard EpiPen in response to skyrocketing prices. "Why are fiscal conservatives opposed to single-payer healthcare?" The Hill. 6 May 2017. http://thehill.com/blogs/pundits-blog/healthcare/332226-why-are-fiscal-conservative-opposed-to-single-payer-healthcare. [Premier]

If we are to be truly fiscally conservative, then **single payer would be the only option that would be discussed**. Medicare has a **3 to 5 percent overhead**. There are **no multi-million dollar executive salaries**. There are **no stockholders**. There is **minimal money spent on advertising** and certainly **none spent on lobbying**. A simple glance at costs over the last few decades show very little rise in physician salaries but a giant leap in administrative overhead. Physicians have been overburdened with **unfunded mandates** and **reporting** and **meaningless administrative hassles** that take up the majority of our time and the joy out of medicine. Doctors go to medical school to learn to diagnose and treat disease. **Spending two-thirds of our time not on patient care has resulted in physicians retiring early**, switching careers and committing suicide.

Single payer will trim unneeded specialty positions and adequately compensate primary care. Primary care solves better and more cheaply.

Winakur 16 Jerald Winakur, practiced internal and geriatric medicine for 36 years and is an associate faculty member at the Center for Medical Humanities and Ethics at the University of Texas Health Science Center at San Antonio. "A Single-Payer System Can Save Primary Care," Caring For The Ages, Volume 17, Number 7. June 2016. http://www.caringfortheages.com/pb/assets/raw/Health%20Advance/journals/carage/JULY_2016.pdf. [Premier]

The problem with Medicare, of course, is the fee schedule itself. It vastly undervalues the work that doctors like me do. At the same time, it overvalues the work of my **sub-specialty colleagues**. The fee schedule favors technology over touch, performing procedures over spending time with patients. Of course, Medicare didn't pick numbers out of the air; the fee schedule has been unduly influenced by the **richer** and thus more powerful **doctor groups** that sit on the American Medical Association's resource update committee. This secretive and specialist-stacked assemblage advises Medicare on setting procedural fees. Ninety percent of such advice finds its way into the schedule, which is why an otolaryngologist makes more money to clean wax out of an ear than a geriatrician gets for evaluating an 85-year-old woman who comes into the office after having had a "little spell." I believe that a vibrant system of primary care is **essential for patient wellbeing**. Every one of us needs and deserves enough space for an unrushed visit and a thorough physical examination by someone who knows us and our unique circumstance and is available across time and sites of care to minister and to advocate. Patients who are under the watchful eye of a primary care physician receive **less expensive medical care** without **sacrificing the quality** of that care. Medicare may track every test I order, every consultant to whom I make a referral, every hospital admission I initiate. But Medicare has never known how many patients I saved from inappropriate testing and consultations, ED referrals, hospital stays, and LTC placements. And aside from the dollars saved, my patients have been spared many needless procedures and the associated morbidity these entail. Single-Payer Solution There is one simple way to accomplish this. A **single-payer plan** can **tinker with the fee schedule and fi nally make it financially remunerative for young doctors to once again pursue primary care**. Increase the routine doctor visit reimbursement codes signifi cantly — enough to allow

primary care physicians to actually spend **face-to-face time** with patients. The 7-minute visit is unsatisfactory to patients and demoralizing to doctors. Undoubtedly, **this is contributing to the greater than 50% burnout rate for primary physicians.** Changing to a single-payer system will not require an infusion of more dollars into the system. It will require a **rebalancing** of what a sane single-payer system pays for the thousands of over-compensated procedure codes that currently exist. Yes, my **specialty colleagues** will be unhappy with such a proposal. But unless they want to take over the 24/7 responsibility of caring for the soon-tobe 75 million seniors with their complex medical histories, polypharmacy, and fraught social needs, my specialist friends should **yield to the reality** that our current system of crumbling **primary care** cannot accomplish this task without major change.

AT: Industry

Industry collapse is inevitable.

Byrne 17 John Aidan Byrne, New York Post. "The health care industry is bound to collapse soon, experts say." April 30, 2017. nypost.com/2017/04/30/the-health-care-industry-is-bound-to-collapse-soon-experts-say/. [Premier]

The US health care sector may be incubating the next big Lehman-style disaster that could **tip the economy into a full-blown recession**, according to industry analysts. **Forget about the subprime mortgage collapse. The health care sector is nursing its own toxic mess**, with soaring debt, the analysts say. "As a nation, **we have to step up our game and get on top of it**; this is a huge issue," said Chris Oretis, a former Washington lobbyist who now works as executive vice president in the life insurance secondary markets at GWG Holdings. As industry spending and debt servicing rage out of control, health care is ranked as the No. 1 US "systemic recession risk" in a new report. The sums at stake are staggering: Spending in the sector accounted for $3.3 trillion in 2015, and is 18 percent of the US economy today. The industry generates 16 percent of private sector jobs nationwide, up from 10 percent in 1990. US health care spending is forecast to grow by an average 5.6 percent annually in the coming decade, according to a report by the Center for Medicare and Medicaid Services (CMS), a projection based on no changes out of Washington and in the Affordable Care Care through 2025. Meanwhile, national spending on health care is forecast to outpace US gross domestic product growth by 1.2 percent. CMS has estimated that spending will comprise 19.9 percent of GDP by 2025, up from 17.8 percent in 2015. "There's no question that **rising health care costs are hurting our overall economy,**" said New York-based financial adviser Michael Mondiello. "With consumer spending accounting for some 70 percent of economic activity, the more we spend on health care, the less we have to purchase other things like a vacation or to save for retirement." The **feeble economic growth elsewhere has failed to keep up with a gargantuan health care debt binge among both individuals and governments**, critics said. Then there's **the boom in mergers, in facility building and in manpower hiring that analysts say could be signs of a speculative bubble that could eventually burst**. "The bigger picture is with the health industry's ballooning debt and a government that lacks sufficient capital," said Mondiello. "This [bailout] bill will likely be passed on to consumers, putting us as a country deeper into debt," added Mondiello, a former CPA in the emerging business sector at Coopers & Lybrand.

Startups guarantee industry collapse—their only goal is ***market disruption***.

Munford 17 Monty Munford, 15 years' experience in the mobile, web and digital sectors. " The Insurance Industry Is Dead... Long Live the Insurance Industry." *Forbes*, March 31, 2017. https://www.forbes.com/sites/montymunford/2017/03/31/the-insurance-industry-is-dead-long-live-the-insurance-industry/#5987cdd4732a. [Premier]

The health insurance industry as we know it **is dead**. No matter how much the behemoths of the sector defend their current positions and attempt to catch up with the disruptors, **their hegemony is over**. Whether it's updating ancient or legacy systems, inherited technology from acquisitions or bolting IoT products on to insurance policies such as Fitbit or black boxes monitoring data in vehicles, **the end is nigh for these companies.** Everything has been tried. Crowdfunding, going 'mutual', easy-profit philanthropy, PR budgets that make the mind boggle, none of it is working. The so-called InsurTech industry in many ways resembles the FinTech revolution. A new ecosystem is forming and it's out with the old and in with the new… last year there was $1.7 billion of investment in the InsurTech sector. Startups such as Oscar and (home, not health, insurance company) Lemonade are entering unicorn territories and the momentum accelerates

every week. Banking is an obvious parallel, but so is the accountancy industry… they are being decimated by the new. So, is this a good thing? Will a zero-sum platform emerge that will undoubtedly benefit the consumer, but completely destroy a centuries-old industry? Is there any hope that the old and the new can work together and create the best of all possible worlds? Perhaps there is. In the UK, the Western Provident Association (WPA), (a not-for-profit insurer) is not one of the biggest players, but still has a significant chunk of the UK market; a $220 million UK-only health insurer. It has legacy issues like any of the other larger companies, but these size of insurance businesses can move fast, exploit global technology resources and create innovative technology such as DELOS and Precision Analytics, which underpin any innovation in insurance that can be reasonably anticipated. Medium-sized company meeting big data could be the confluence that really innovates the insurance business. Lazarus has walked from the tomb, but he has a different gait. This makes sense. Startups are devoid of one feature and that is experience in a traditional industry. **The mission is to disrupt and destroy, not collaborate and co-operate**. It seems there is a big trick being missed here. Clearly, the future of insurance will be in the hands of startups and there are currently spry and nimble players who can literally see into the future and hedge against/for it. Insurance has never been more than a more sophisticated form of gambling, and sometimes not sophisticated at all. It had to change, but it needs to change positively. Maybe we will all crowdfund our own insurance where we don't pay subscriptions all our lives, but when we need money for a life-saving operation, we will raise the funding from our friends and networks. Many people are doing that already. Maybe we will return to the early 20th Century model of 'savings clubs' that care for members - call it Old Skool crowdfunding, but the one certainty is that the future players will be wholly different from the ones we have now. In the UK, the people at Tech City in London's Canary Wharf are doing awesome things promoting London's FinTech industry, but have seen the gap in the market and are now creating a FinTech/InsurTech vertical because they may also be able to see the future… of insurance. Other luminaries in the UK such as Jonathan Swift, the Content Director at Insurance Post (the pre-eminent trade site for the sector) has created a Digital Insurance Collective (DIC) for the industry. Consequently, where there is regulation, there will be no charlatanism, but there will be growth. **The tolls are chiming for the insurance industry and the Grim Reaper is polishing his scythe.**

A buy-out is cheap and effective.

Diaz-Alvarez 13 Enrique Diaz-Alvarez, Finance in New York City. "The Backroom Deal That Could've Given Us Single-Payer." Jacobin. 9 December 2013. https://www.jacobinmag.com/2013/12/the-backroom-deal-that-couldve-led-to-single-payer. [Premier]

How much compensation? Well, in mid–2009, the total market capitalization of four out of the five top health insurers (the fifth is a nonprofit) amounted to about $60 billion. By then, the stock market had already rebounded nicely from the lows of the crisis, and the uncertainty over Obamacare had largely dissipated, so these were not particularly depressed valuations. Extrapolating this valuation to the rest of the health insurers would have a put a price tag of about $120 billion on the whole racket. This means that **buying out** the **entire health insurance industry** at an **enormous**ly generous **premium** of, say, 100 percent, would have cost the Treasury **$240 billion** – about **2 percent** of 2009 gross domestic product. And this figure is **highly inflated** – premiums for buying out well-established companies rarely exceed 50 percent and are usually closer to 20 percent. Also, I am valuing the dubious claims of non-profit policyholders on par with the more vigorously-enforced property rights of for-profit shareholders. Other than the big smiles on the faces of health insurer shareholders across the country, what would have been the US Treasury's **payoff** for writing a $240 billion check? Once again, the numbers are simple, and startling. US **private insurance**, whether for-profit or otherwise, may well be the most **wasteful bureaucracy in human history**, making the old Gosplan office look like a scrappy startup by comparison. Estimates of **pure administrative waste** range anywhere from 0.75 percent to **2.6 percent of total US economic output.** Extrapolating again from the biggest four for-profit insurers, in 2008, the industry as a whole claimed to spend 18.5 percent of the premiums it collected on things other than payments to providers. (The other 81.5 percent that is spent paying for actual care is known as "medical loss ratio". Keeping this ratio down is a health insurer CEO's top priority.) Medicare, by contrast, spends just **2 percent**. The difference amounts to $130 billion, to which we must add the compliance costs the private insurers impose on health care providers — $28 billion, according to Health Affairs. The costs incurred by consumers are difficult to measure, although very real to anyone who's spent an afternoon on the phone with a health insurance rep. So, to recap, **nationalization** of the health insurance industry in 2009 would have cost no more (and almost certainly a lot less) than $240 billion. The **savings in waste** resulting from replacing the health insurance racket with an extension of Medicare would have resulted in no less than **$158 billion a year**. That's an **annualized return on investment of 66 percent**. The entire operation would have **paid for itself in less**

than eighteen months, and after that, an **eternity of administrative efficiency for free**. And, of course, happy shareholders.

Market is unsustainable.

Archer 13. Diane Archer, Attorney and health care authority, is Special Counsel and Co-Director of the Health Care for All Project at the Institute for America's Future. "No Competition: The Price Of A Highly Concentrated Health Care Market." Health Affairs. March 6, 2013. healthaffairs.org/blog/2013/03/06/no-competition-the-price-of-a-highly-concentrated-health-care-market/. [Premier]

As health care costs swell, **the private insurance system** that covers most working Americans **is in crisis**. Americans are paying higher and higher premiums for increasingly threadbare coverage, and employers are getting out of the business of providing health care altogether. Rising costs cannot be attributed purely to improving technology or increasing operating costs for providers, because Medicare has controlled per capita spending more effectively than commercial insurers that provide employer-sponsored coverage. Rather, **commercial insurers cannot contain costs because the pricing mechanism for medical services is broken**. When it comes to health care, **competition simply isn't working. Prices in the private sector are out of control.** On average, private insurers pay 25 percent more than Medicare for physician services and 30 percent more for hospital care. What's more, both public and private sector payment rates for doctors in America are far and away the highest in the world, and research suggests that these high rates are among the principal reasons health care is so much more expensive in this country than elsewhere. These international gaps are much wider in the private sector. For instance, private payments for an office visit in the United States cost 70 percent more than those abroad, while public payments are 27 percent higher. And **prices aren't just high; they are rising**. Data on private insurers is notoriously hard to get, but the industry has chosen to release, on a very limited basis, information about rising health spending to the Health Care Cost Institute. The Institute's report revealed that the main reason spending is rising from year to year is increasing unit prices, or fees paid to hospitals, doctors and other providers. Looking at local markets illustrates how prices have become excessive. In Oregon, the cost of many medical services is rising at roughly 10 percent a year, more than three times faster than overall inflation. In California over the last decade, hospital revenues from a day of inpatient care have risen 78 percent for Medicare and 150 percent for private insurers. **Prices are rising on** both **a totally unsustainable trajectory** and a seemingly irrational one. Prices vary enormously from place to place (the cost of a colonoscopy can fluctuate by 400 percent within the state of New Jersey) and within and outside of provider networks (out-of-network charges can rise to 5,000 percent of the Medicare rate for a given procedure). These are not the hallmarks of a system that features efficient pricing. **Rather than being influenced by competition, health care prices are largely set by insurers and providers with monopoly power to maximize profits**. Big hospital chains and provider groups dominate most local markets and extract extremely high rates from dominant insurers, which are motivated by fear of losing market share if they fail to attract these providers to their networks. Research indicates that hospitals can change their business practices and control their costs effectively when faced with competitive pressure, but **health care markets have concentrated in the last few decades**. Providers simply haven't had to compete to offer high-value care. **Commercial health plans have little bargaining power when they negotiate prices with monopolistic providers**. In fact, even insurance industry lobbyists admit that private health plans cannot hold down the cost of health care. Insurers choose instead to adapt to this non-competitive environment. Sometimes they resort to collusion, as was the case with Partners Health, a massive provider group that entered into an ethically dubious arrangement with Massachusetts Blue Cross, as the Boston Globe reported in 2009. In that deal, Partners agreed to ensure that no other health insurer would pay lower rates than Blue Cross. While that scandal was an extreme example, the fact is that big insurers regularly negotiate most-favored nation clauses with providers, thereby agreeing to raise rates significantly while guaranteeing that providers will charge other insurers higher rates and passing the additional costs on to consumers and businesses. And why would they seek out innovative ways to absorb risk and deliver high-value care when the current system delivers big, reliable profits? In any case, most insurers face little competition, so there is little appetite for pushing rates downward. On both the left and the right, serious scholars

realize that **the system is failing to yield positive-sum competition**. Several years ago Michael Porter and Elizabeth Teisberg, conservative business professors who are fiercely opposed to public health insurance, wrote in the Harvard Business Review that every kind of competition now prevalent in the health care system drives up costs and the kinds of competition that might push costs down are absent. Meanwhile liberal scholars like Ted Marmor, Johnathan Oberlander and Joseph White have illustrated that Medicare controls costs much more effectively than private insurers, and these academics advocate the broad adoption of road-tested Medicare mechanisms for influencing prices. So what is to be done? The Patient Protection and Affordable Care Act ("ACA") will for the first time guarantee the overwhelming majority of Americans access to good coverage, a huge step forward. But it expands coverage mostly by relying on the dysfunctional private insurance market. There is no evidence that the newly created exchanges will exert any downward pressure on prices, given the experience of private plans to date. Congress needs to recognize that players in the private health care marketplace will continue to set excessive rates until they are stopped. These exorbitant rates are not only hurting working people, they are also driving up Medicare costs and imposing a massive burden on taxpayers and the federal government. Doctors and hospitals are conditioned to expect higher and higher rates and demand higher payments from public programs.

Private insurance collapse doesn't turn access—it magnifies inequity.

Geyman 15 John Geyman, Professor emeritus of family medicine at the University of Washington School of Medicine in Seattle, a member of the Institute of Medicine, and past president of Physicians for a National Health Program. "Why the Private Health Insurance Industry Has to Go." *PNHP*. April 10, 2015. www.pnhp.org/news/2015/april/why-the-private-health-insurance-industry-has-to-go. [Premier]

The private health insurance industry in the U.S. has had a long run since shifting to medical underwriting and a for-profit status in the early 1960s. **It finds itself increasingly dependent on the government as the costs and prices of health care have continued upward** since the 1980s. Its many perks from government include tax exemptions for employer-sponsored insurance (ESI), privatized Medicare and Medicaid programs, and longstanding over-payments to Medicare Advantage programs. The Affordable Care Act (ACA) has added to these perks since 2010 with subsidized premiums through the exchanges, a "risk corridor system" to protect insurers from losses, and allowing automatic self-renewal for 2015 plans.1 Incremental attempts to contain health care costs and reform the system since the 1990s have built upon our current multi-payer financing system. After five years' experience with the ACA, we now know that **insurers themselves are a major barrier** to achieving the kind of access to affordable care that our population so desperately needs. Here are some of the major reasons why private health insurers warrant no further bailout by government and taxpayers. 1. Continued discrimination against the sick. Despite the supposed consumer protections in the ACA, a 2014 letter from more than 300 patient advocacy groups to the Secretary of Health and Human Services described continuing ways that insurers still discriminate against the sick, including **benefit designs that limit access, high cost-sharing, restrictive drug formularies, inadequate provider networks, and deceptive marketing practices**.2 A recent study by Kaiser Family Foundation found that only one-third of households with incomes between 100 percent and 250 percent of poverty have enough liquid assets to pay their deductibles, while only about one-half can meet out-of-pocket limits.3 As other examples, Wellpoint developed an algorithm to search its database for patients with breast cancer with an intent to cancel their policies4, while many insurers place all drugs used to treat such complex diseases as cancer, multiple sclerosis and HIV in the highest drug formulary cost-sharing tiers, thereby reducing insurers' costs but making the drugs unaffordable for many patients.5

AT: Innovation

Every step of the contention is wrong – profits don't go to R&D, most R&D isn't actually innovative, most innovation occurs in non-profit centers, and innovation is useless if it's ultra-expensive – it can't solve or turn the case.

Kesselheim et al. 16 Aaron S. Kesselheim, Associate Professor of Medicine at Harvard Medical School and a faculty member in the Division of Pharmacoepidemiology and Pharmacoeconomics in the Department of Medicine at Brigham and Women's Hospital, M.D. and J.D. from University of Pennsylvania School of Medicine and Law School, MPH from Harvard School of Public Health, primary care physician at the Phyllis Jen Center for Primary Care at Brigham & Women's Hospital, Jerry Avorn, Professor of Medicine at Harvard Medical School and Chief of the Division of Pharmacoepidemiology and Pharmacoeconomics in the Department of Medicine at Brigham and Women's Hospital, M.D. from Harvard Medical School in 1974, and completed a residency in internal medicine at the Beth Israel Hospital in Boston, Ameet Sarpatwari, PhD in epidemiology at the University of Cambridge, Instructor in Medicine at Harvard Medical School, an Associate Epidemiologist at Brigham and Women's Hospital, and Assistant Director of the Program On Regulation, Therapeutics, And Law (PORTAL) within the Division of Pharmacoepidemiology and Pharmacoeconomics, JD at the University of Maryland as a John L. Thomas Leadership Scholar, Principal Investigator on a Greenwall Foundation Making a Difference in Real-World Bioethics Dilemmas grant and a Faculty Affiliate with the Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics at Harvard Law School and the Behavioral Insights Group at the Harvard Kennedy School. "The High Cost of Prescription Drugs in the United States: Origins and Prospects for Reform." *Journal of the American Medical Association*, Vol. 316, No. 8, pgs. 858–871. 23 August 2016. [Premier]

Justifications for High Drug Prices The pharmaceutical industry has maintained that high drug prices reflect the **research and development costs** a company incurred to develop the drug, are necessary to pay for future research costs to develop new drugs, or both. It is true that industry often makes expensive investments in drug development and commercialization, particularly through late-stage clinical trials, which can be costly.84 These assertions have been used to justify high prices on the grounds that if drug prices are constrained, the pipeline of new medications will be adversely affected. Some economic analyses favored by the pharmaceutical industry contend that it costs $2.6 billion to develop a new drug that makes it to market.85 However, the rigor of this widely cited number has been disputed.86,87 **A number of factors weigh against these rationales** for high drug prices. First, important innovation that leads to new drug products is often **performed in academic institutions** and supported by **investment from public sources** such as the National Institutes of Health. A recent analysis of the most transformative drugs of the last 25 years found that **more than half** of the 26 products or product classes identified had their origins in publicly funded research in such **nonprofit centers**.88 Other analyses have highlighted the importance of small companies, many **funded by venture capital**.89,90 These biotech startups frequently take early-stage drug development research that may have its origins in academic laboratories and continue it until the product and the company can be acquired by a large manufacturer, as occurred with sofosbuvir. Arguments in defense of maintaining high drug prices to protect the strength of the drug industry **misstate its vulnerability**. The biotechnology and pharmaceutical sectors have for years been among the very best-performing sectors in the US economy. The proportion of revenue of large pharmaceutical companies that is invested in **research and development** is just **10%** to 20% (Table 4); if only **innovative product development** is

considered, that proportion is **considerably lower**.91 The contention that high prescription drug spending in the United States is required to spur domestic innovation has not been borne out in **several analyses**.92 A more relevant policy opportunity would be to address the stringency of congressional funding for the National Institutes of Health, such that its budget has barely kept up with inflation for most of the last decade. Given the evidence of the central role played by publicly funded research in generating discoveries that lead to new therapeutic approaches, this is one obvious area of potential intervention to address concerns about threats to innovation in drug discovery. Thus, **there is little evidence of an association** between research and development costs and drug prices93; rather, prescription drugs are priced in the United States primarily on the basis of what the market will bear. This explanation also helps to account for several high-profile case studies, including high-priced new branded products94 and exorbitantly priced generic drugs described above.95 In preparation for recent hearings on this topic, the US House Committee on Oversight and Government Reform subpoenaed internal correspondence from Turing and Valeant Pharmaceuticals, which had sharply increased the prices of older drugs the companies had acquired. The investigation revealed, for example, that Turing received "no pushback from payors" when it increased "Chenodal price 5x... [Thiola] price 21x... [and Daraprim] price 43x."96 Similarly, Gilead spent $11 billion to purchase sofosbuvir from Pharmasset, a small biotechnology firm that developed the drug, based in part on federally funded research led by an investigator at Emory University.97 Gilead recouped almost all of this cost in the first year that sofosbuvir was on the market, recording sales of $10.3 billion in 2014.98 In December 2015, the US Senate Committee on Finance released a **detailed report** based on its access to internal company documents on Gilead's strategies to maximize the prices it could charge for both that drug and its planned successor, which the company also owned.99 In the current system for drug payment in the United States, few options exist to counter this approach. Companies should of course be rewarded fairly for the research innovations they make that help generate new drug products and for their costly trial work that facilitates the assessment and availability of new medications. But providing them with large incentives to do the opposite is counterproductive. Clinical Consequences of High Drug Prices The high cost of prescription drugs in the United States has **clinical as well as economic consequences**.100,101 Even though more Americans have drug coverage as a result of the Medicare drug benefit plan and the Patient Protection and Affordable Care Act, cost-containment strategies in recent years have **shifted** an increasing share of drug expenses **to patients**.102 Private insurers have increased deductibles103 and most co-payments, and added a new payment tier for certain specialty drugs in which patients must pay coinsurance—often between 20% and 33% of the total drug price—rather than a simple co-payment.104 Although such cost-shifting measures have helped "bend the cost curve" for employers and payers, **they can reduce use of effective medications**.105,106 Almost **a quarter of** 648 **respondents** to a 2015 poll reported that they or another family member did not fill a prescription in the last year because of cost.107 In other studies, patients who were prescribed a costly branded product rather than a more affordable generic alternative were found to adhere to their regimen less well than those receiving a similar generic drug12 and to have worse health outcomes.108 Nonadherence due to all causes has been estimated to contribute to $105 billion in avoidable health care costs annually.109 In some cases, manufacturers have attempted to circumvent higher co-payments by providing patients with coupons that reimburse their out-of-pocket expenses.110 Coupons can be useful for patients with no other option, but they leave the insurer obliged to pay the much larger amount of each prescription's costs, thereby increasing health care spending. This approach has become common for branded drugs that have comparable but much less expensive alternatives.111 Faced with fixed health care budgets, states with higher drug costs for their Medicaid programs have had to **reduce other services** or increase health care eligibility requirements.112 Several state Medicaid programs, for example, have imposed nonevidence-based policies to restrict sofosbuvir, including **denying coverage** to users of alcohol or other drugs.113,114

Single payer makes pharma coherent – free markets reward inefficiency and explode prices while undermining innovation – every step of the DA is wrong

Merelli 15 Annalisa Merelli, reporter at Quartz. "The way to fix outrageous drug pricing in the US is simply to do what all other rich countries do," *Quartz*. 25 September 2015. https://qz.com/509344/the-way-to-fix-outrageous-drug-pricing-in-the-us-is-simply-to-do-what-all-other-rich-countries-do/. [Premier]

When news broke that the price of Daraprim, a 62-year-old life-saving drug often prescribed to AIDS patient, had been raised from $13.50 a tablet to $750, outrage ensued. The steep rise was announced on Sept. 20 by Turing Pharmaceuticals, a startup that, according to the New York Times, acquired the rights to the medication in August, and immediately after increased its price by over 5,500%. Turing's CEO, former hedge fund manger Martin Shkreli, publicly defended his decision to raise the drug price saying that the new profit would be invested in further research and the drug's new cost was more in line with that of other life-saving drugs. But he eventually gave in and announced a price revision. While insults of all kinds have been thrown at "Pharma Bro," he is not the real villain but rather someone trying to do his job, which is to make a profit. **The villain is the system**. A privately funded healthcare system, as the one at work in the US, **sets all the conditions that allow Shkreli's actions**. What's more, they seem perfectly justifiable if viewed from the perspective of entrepreneurship. Health is arguably the most valuable of goods, and if you let the market determine its price without regulation, well, suppliers will always try and get the highest price they can. It's the market, stupid Americans pay far more than any other country for prescription drugs. In fact, **Americans overpay for every aspect of healthcare**: procedures and services are the most expensive in the world, because efficiency plays no role in rewarding the healthcare providers. As Dr. Stephen Ondra—who works as chief medical officer for customer-owned health insurance company Health Care Service Corporation—told Quartz, "right now **inefficiency is rewarded**, the more you do to get an outcome, the more you make." There is a common denominator behind all of this: the free, unregulated market. The US is an outlier among industrialized nation: it's the only rich country that does not offer a publicly funded health system, relying instead largely on private insurance. This affects the pricing of drugs in several ways that are independent from the actual regulations imposed on pharmaceutical companies. First, and perhaps most importantly, the power in setting the price for drugs is **skewed toward drug manufacturers**. Unlike countries where universal health coverage is in place, the negotiating is left to individual care providers rather than being in the hand of a large, publicly funded buyer that's able to negotiate since it purchases most (if not all) of the drugs. For those with health insurance, high drug **prices result in higher premiums, but it's hard to notice the price increases directly**. This means consumers lack awareness of the actual medication prices, and consequently, any pressure to keep them under control. Plus, the costs of bringing a drug into the US market are higher, partially because of marketing expenses. **The US is one of only two countries** (the other being New Zealand) **that allows direct-to-consumer advertisement** of prescription drugs, while elsewhere promotion is limited to medical professionals. This raises the already steep marketing bill of drugs manufacturers. As Robert Yates, former World Health Organization senior health economist told Quartz, "**the amount [pharmaceutical companies] spend on marketing is massively more than they do on research and development."** Finally, pharmaceutical companies can count on tens of billions of dollars in revenue, at higher margins than most other sectors (with the sole exception of software). So they make the most of the opportunity to advertise directly to the customer in the world's only rich market that's unregulated. With more advertising come more requests of specific brand names, which in turn can cause higher volumes of prescriptions, overmedication, and price hikes.

It's not that expensive to develop drugs---their studies are industry-funded

Goozner 17 Merrill Goozner, MS, editor emeritus citing/summarizing new study by Prasad, MD and MPH and Mailankody, MBBS in JAMA. "A Much-Needed Corrective on Drug Development Costs." Health Care Policy and Law. 11 September 2017. http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2653008. [Premier]

Contemporary pharmaceutical industry pricing practices are threatening to undermine the health care industry's and policymakers' efforts at cost control. Egregious as the price hikes are, the hedge fund managers who gained notoriety for exorbitant price increases on some generics are the least of the problem. The **2 biggest drivers** of high drug costs in recent years have been the steady increase in prices for existing on-patent drugs, which account for more

than 70% of all drug spending, and the 6-figure retail prices set for the latest generation of specialty and cancer therapeutics. To counter increasing public alarm over these high prices, industry leaders continue to assert that the substantial investment in researching and developing new products and the riskiness of that enterprise must justify charging Americans the highest prices in the world for medicines. To support the assertion, the industry's trade group relies on an **industry-funded study** first produced in 1979 by the Tufts University Center for the Study of Drug Development.1 The most recent iteration of the study, which was last updated in 2014, claims it takes more than 10 years and nearly $2.7 billion in capital to develop a single drug.2 In inflation-adjusted dollars, the study's estimate for developing a new drug has more than doubled in the past decade and is more than 10 times the original 1979 figure. Industry critics and journalists have repeatedly questioned the assumptions in the Tufts study. They argue its authors arbitrarily inflate the value placed on the cost of capital spent on research and development, which is a current expense and not an investment for accounting and tax purposes; fail to distinguish between new products that are truly innovative and those that merely replicate drugs already on the market; and ignore the fact that the industry consistently generates the highest profit margins among all US industries, which suggests the pricing power afforded by patent exclusivity **far outweighs** the inherent riskiness of pharmaceutical research and development. Critics also lament the Tufts study's lack of transparency because it relies on **industry-supplied data that the authors refuse to make public.** Over the years, none of the critiques have had much political impact. Most politicians from both political parties accept the Tufts study's basic premise because it provides them with a rationale for failing to enact countermeasures, which could include giving Medicare the right to negotiate prices, allowing drug importation or establishing reference pricing or value-based pricing schemes for new products.3 It took just one meeting with industry leaders for President Donald Trump, who had campaigned against high drug prices, to put the issue on the backburner. "Fifteen years, $2.5 billion to come up with a product where there's not even a safety problem. So it's crazy," he said.4 However, the issue of increasing drug prices continues, as do the repercussions. Total retail prescription drug spending increased by 4.8% in 2016, about the same pace as overall health spending, after increasing 12.4% in 2014 and 9.0% in 2015. The outlook for the next 5 years is for 4% to 7% annual growth as new specialty and rare disease drugs, which now account for 42.9% of all drug spending, come on line.5 Therefore, it is timely to revisit the issue of the cost of pharmaceutical research and development and its association with drug pricing. In this issue of JAMA Internal Medicine, Prasad and Mailankody6 report the results of their study of compiled research and development data from the Securities and Exchange Commission filings of start-up companies with a single approved product. By tracking the pharmaceutical companies' publicly reported investments, the authors found that the actual cost of developing a new drug is **approximately one-fourth** the Tufts study estimate. Their fresh perspective is powerful because the authors **chose not to challenge the core assumptions** of the Tufts study, specifically, including the cost of failed experiments, giving equal value to new products that mimic the therapeutic approach of previously approved drugs (so-called me-too drugs), and treating research and development expenses as an investment. Prasad and Mailankody **account for the cost of failure** because all the companies in their sample were developing multiple drugs at the time of their first approval. They do not discriminate based on the value of the newly approved medications (just half their sample of 10 drugs received a priority review from the US Food and Drug Administration, which is reserved for substantial breakthroughs). In addition, like the Tufts study authors, they increase the total estimated cost of developing a new drug by adjusting the value of expenditures made during the early stages of development for inflation and what those investments would have earned if placed in an alternative investment. To estimate this latter factor, Prasad and Mailankody used an expected rate of return (the cost of capital) that was 3.5 percentage points below the rate reported in the Tufts study. However, the latter's 10.5% rate may be unrealistic given the industry's very low tax rate, very low debt to equity ratio, and mean stock price volatility.7 In any case, using the higher Tufts study rate would raise their overall estimate of the cost to develop a new drug by only approximately 10%, which would not alter the markedly different outcomes of the 2 studies. The authors note as a weakness that their study looked only at cancer drugs, whose high cost may not translate to other disease states. However, the method works well with another new drug whose high price generated headlines in recent years: sofosbuvir (Sovaldi) for hepatitis C. Developed by an antiviral drug development start-up company called Pharmasset, the company's US Securities and Exchange Commission filings reveal it spent just $315 million on research during a dozen years (some of it from government grants) before selling the firm and its promising late-stage drug candidate (phase 2 trials had shown remarkable success in clearing the virus) to Gilead Sciences for $11 billion in 2011.8 The cost of the final trials plus a cost of capital would bring its total development costs into the same range as the Prasad and Mailankody cancer drug study. According to the US Securities and Exchange Commission filings, Gilead generated sales of sofosbuvir, either alone or as part of combination products, that were $2.6 billion alone in the first quarter of 2017 or more than 3 times its estimated cost of development.9 In addition, sofosbuvir has yet to make good on its promise of reducing the number of cases of hepatocellular carcinoma. Basing their study on

start-up drug development company costs has another major strength not noted by the authors. Approximately 70% of new sales by the traditional pharmaceutical industry now come from small companies they buy outright (such as Pharmasset) or forge partnerships with during the development process. That is up from just 30% in the 1990s.10 The Tufts study's focus on the research and development costs of large drug companies, which still spend a substantial portion of their research and development budgets on developing me-too drugs or marketing-oriented seeding trials,11 ignores the substantial shift in the source of important medical breakthroughs that has taken place during the past quarter century. The implications of the present study seem **clear**. Current pharmaceutical industry pricing policies are **unrelated to the cost of research and development**. **Policymakers can safely take steps to rein in drug prices without fear of jeopardizing innovation.**

No impact to pharma innovation---it's low AND doesn't solve anything

Belk 12 David Belk, Medical degree from the University of Southern California School of Medicine and is board certified in Internal Medicine. "The Pharmaceutical Industry." *True Cost of Healthcare*. 2012. http://truecostofhealthcare.org/the_pharmaceutical_industry. [Premier]

Another point about pharmaceutical research; the pharmaceutical industry paid the FDA about $712 million in 2013 for prescription drug user fees to "help" the FDA in the process of approving drugs for the sale and distribution in the US. That money paid to the FDA is also part of the research budget for the pharmaceutical companies. Going Back to This "Bargain" We Made Now that we've taken a closer look at how the money is spent after the pharmaceutical companies get it, let's go back to the bargain—the one where we in the US agreed to pay far more for the same drugs than anyone else in the world—and ask "how did we end up making this bargain, anyway?" In any market, an actual bargain can only occur when each party has the option to walk away. If you think the hamburger is too expensive in one store, you can shop in a different store. Or you decide to buy chicken instead. If the rancher can't make money selling you beef, he'll sell it to someone else. Or maybe he'll decide to raise chickens. Somewhere in there, the two of you agree what the product is worth, and that's what you pay. But can you really "bargain" when buying prescription drugs? Think about it, when a doctor writes a prescription that's the only drug you can legally buy. Your only other choice is to get no medication at all and remain sick. And, if the disease you have could kill you then the choice you have is literally "your money or your life". Most people won't choose to die in order to save money, even if it's most of their money. So, since the patient really can't just walk away she has no real ability to bargain at all. But then why does the rest of the world pay so much less than we do? The answer is that, while individual patients have practically no bargaining power when buying prescription drugs that's not at all true of governments. **Virtually every other government in the world finds that pharmaceutical companies would rather lower prices significantly than simply not to sell in a particular country**. So other governments bargain with the pharmaceutical companies on behalf of their citizens, and this type of bargaining significantly lowers the price of brand name medications in these countries. The one exception is the US government. As the single largest market for medications in the developed world, you can imagine our government is in the best possible position to bargain on our behalf. And, even though this strategy works for all the other governments, our government won't do it. US law prohibits our government from taking any active role in negotiating the prices charged by pharmaceutical companies. And for practical purposes, that fact is the reason that we pay more (much more) than anyone else in the world for drugs. That is the "bargain" we (or really our Congress) made. This has led to a rather unusual business for pharmacies in other Countries like Canada: they're able to sell prescription medications here in the US for far less than the price US pharmacies pay for these medications. In other words, pharmacies in other Countries buy drugs from the same suppliers and pharmaceutical companies that our pharmacies use, only at a fraction of the price our pharmacies pay. These international pharmacies can then sell them back to us online for a fraction of the price we would be charged here in the US for these same drugs. Now, this practice is technically illegal in the US and the FDA warns us that a lot of counterfeit and unsafe drugs are sold on the internet this way. That's actually true for anything you buy online (don't give your bank account number to a Nigerian prince either). But the fact is, there are legitimate online pharmacies that are able to sell brand name prescription medications here in the US for a fraction of the price our pharmacies pay for these medications. And this is only possible because ours is the only government in the world that chooses not to protect us from being gouged by the pharmaceutical companies. Why does our government opt out on this task? There are two reasons often given. First, there's the argument that the government shouldn't interfere because we have a "free market" for drugs. Americans have a great deal of faith in our market system, but in this case, our "free market" offers absolutely no freedom when purchasing prescription medications. As we discussed, you don't choose which medications you're prescribed; and people don't (often can't) shop around and compare the prices of brand name medications. In other words, it's a free market minus any evidence of freedom. What are we Really Getting in Return? But our discussion here largely concerns the second justification often given for giving up all control over drug prices. We're told that the high prices Americans pay for drugs are needed to generate the money needed to cure diseases. We've taken a long look at where the money goes. Briefly, lots of marketing, lots of profits, and "research" that's a combination of some new drug development, repeated attempts to get old drugs approved, more marketing and corporate takeovers. But even if most of the money we pay goes to marketing and profits, it's still reasonable to ask whether the pharmaceutical companies are delivering results. In other words, are they developing new drugs to cure diseases? That's where we'll go now. The Golden Age of the Pharmaceutical Industry Not too long ago many of the new pharmaceutical products were having a revolutionary impact on health care. Between 1970 and the mid 1990's dozens of new medications changed the way

we doctors practiced medicine. Peptic ulcer disease, a chronic painful stomach condition often requiring surgery and lengthy hospitalization, could suddenly be managed with no hospitalization using new classes of antacids, and then cured with a new course of oral antibiotics. New drugs treated malignant high blood pressure before it led to strokes, heart failure and kidney damage. Medications for heart disease and diabetes prolonged the lives of patients by years or even decades. New classes of oral antibiotics were more effective than the drugs that previously could only be administered in the hospital, and so patients with severe infections (pneumonia, diverticulitis, severe cellulitis) could now be sent home with pills. In 1993 Barbara Bradfield became the first woman ever to be cured of metastatic breast cancer. The treatment was Herceptin™, the first of another new class of medications called monoclonal antibodies. Soon, several other monoclonal antibodies were developed as targeted treatments for other types of cancer and severe rheumatological diseases. When the first of the protease inhibitors was introduced in 1995 it proved to be the key to arresting the AIDS epidemic that had been accelerating for more than a decade. AIDS, a plague that was unheard of prior to 1982, and an almost guaranteed death sentence, was killing tens of thousands of people each year in the US in 1995. These deaths were all but ended by the pharmaceutical companies by 1999. This was an era in which medical miracles were so common that doctors started taking them for granted. Because of what the pharmaceutical industry produced, many diseases that required lengthy hospitalization and/or major surgeries in the past can now be treated at home with a few pills. The golden age of the pharmaceutical industry lasted about two decades and produced many new medications that cured the previously incurable and treated the previously untreatable. Financial Risk and the End of an Era Almost two decades have passed since then. The protease inhibitors were among the last of the truly revolutionary classes of medications to come from the pharmaceutical industry. **Since then, almost all new medications have been variations of old medications with a slight improvement (if even that)** or a new indication. Few new classes of medications, almost no medical miracles, nothing that has significantly changed the way we practice medicine has come from the pharmaceutical industry since the late nineties. So how is it that an industry that gave us so many revolutionary, life saving wonder drugs in decades past is now reduced to peddling gimmicks and repeatedly recycling old ideas? The "golden age of the pharmaceutical industry" was drawing to a close as early as 1990 when the pharmaceutical companies began to tire of new ideas. New ideas are always expensive and risky. Even the most brilliant sounding ideas often go nowhere when tested clinically. This innovation fatigue had become so serious by the early 1990's that Herceptin, the monoclonal antibody that first cured metastatic breast cancer, almost didn't even get tested. In his book "The Emperor of All Maladies," Siddhartha Mukherjee describes the difficulty Genentech scientists had convincing their executives to fund the testing of Herceptin after it had already been developed in 1990: "… but Genentech was worried that pouring money into the development of another drug that failed would cripple the company's finances. Chastened by the experience of others–"allergic to cancer" as one Genentech researcher described it– Genentech pulled funding away from most of its cancer projects." (Page 418) Herceptin had already been developed, but Genentech executives didn't care. Testing to see if it worked risked wasting money and these executives were becoming very risk averse. Genentech executives weren't alone in their risk aversion either. From 1995-1997 Novartis executives tried equally hard to kill Gleevec– another miracle drug that suppresses a deadly form of leukemia indefinitely–because they feared that the trials needed to clear Gleevec would cost too much (Page 436). Fortunately, both Gleevec and Herceptin got the funding they needed and are now providing billions of dollars in revenue to the pharmaceutical companies that tried to kill them. They were among the last new ideas to get funding from the drug companies though. By the time Gleevec came on the market in 2000 the door had mostly shut on novel pharmaceutical research. By 1990 the pharmaceutical industry knew they already had a lot of very effective products that were making them lots of money each year. They had patents that were generating billions of dollars a year and would continue to do so for many years to come. They also knew they could probably find a number of new uses for the classes of medications they already had. **The most profitable course they saw at that point was to just coast; put no more funding into new foundational research and just keep pushing what was already working for them.** That's exactly what they did, and it worked! **The profits made by the pharmaceutical companies exploded over the last decade without them putting out any new products that were even remotely innovative.** But that strategy can only work for a little while. Two decades after they shut the door on actual innovation the revenue from the old ideas is starting to run dry. Figure 4: (From linked article above.) New medications released each successive year since 2001 by the pharmaceutical companies have been increasingly less popular. So, we in the US continue to overpay for brand name prescription medications, but the pharmaceutical industry has given us almost no new important therapies in more than 15 years. A somewhat unexpected result of this is that, total pharmaceutical revenue has been nearly flat since 2010. PharmaAnnualRevenue Figure 5: Total annual revenue for the twelve largest pharmaceutical companies since 2003. You can see from the above graph that the total revenue from the twelve largest pharmaceutical companies has barely increased at all since 2010. It has actually dropped slightly since 2011 despite a more than 50% increase in the cost of brand name prescription drugs in the US since 2012. What changed? A flood of Generic drugs came on the market. Because there really is a market for generic drugs, we don't pay any more for most generics than people in other countries. In 2003, most of the medications prescribed were still under patent. Today, the opposite is true. The effect is easy to see in the following graph, which shows the dramatic loss of revenue when the patent Bristol-Myers Squibb owned on Plavix expired. downloads Figure 6: Bristol-Myers Squibb lost their patent for Plavix in 2011 and, as you can see, that cost them over $6 billion a year in lost revenue from just the US. Profit Without Innovation The pharmaceutical companies haven't been taking all of these patent losses lying down. They've instituted a number of measures to help offset the amount they've been losing to lost patent protection: 1) They've fought very hard, and in every way they can, to delay the expiration of drug exclusivity whenever possible. This process is called "evergreening" a patent. For example, they can apply for a new indication for an old drug just prior to it's patent expiration. They can change the delivery system for, say, an inhaler. They can alter the recommended doses of a drug by a small amount– they have a lot of tricks for maintaining exclusivity and these tricks can often delay generic competition for several years. 2) In 2013 the pharmaceutical companies got the US Supreme Court to allow them to pay generic drug makers to delay the release of generic equivalents of medications for a time after the patent for a medication expires. 3) They've raised the prices of the few patented medications left in the US substantially in the last few years. The following table clearly shows this pattern: Table 3 shows the average (NADAC) price pharmacies paid for 15 medications. It shows the average cost for these medications in October 2012 compared to the average cost for the same medications in June 2016. In just 3 1/2 years most of the listed medications rose at least 60-90% in price. This rapid escalation in medication prices has managed to offset some of the losses to the pharmaceutical

companies but it hasn't significantly increased the total amount we in the US have paid for our drugs. That's an important point: The overall cost of pharmaceuticals in the US hasn't been going up and, in fact, outside of a few select medications, most drugs are now a lot cheaper. These techniques the pharmaceutical companies are using to cut their losses generally provide no new therapeutic benefit—they just renew their ability to demand very high prices (at least in the US). Conclusion: A Broken Promise from an Industry in Decline Starting in the 1970's the pharmaceutical industry churned out incredible treatments for diseases so rapidly that they seemed to have a factory for miracles. Many horrible diseases went from long-term suffering in the hospital to rapid cures at home. Prices were lower then, the economy was growing rapidly and few would argue against continuing to feed this golden goose. By allowing pharmaceutical companies to charge as much as they wanted for their medications, they would have the tools and the incentive to continue to create new and better medications. We've kept our part of that bargain for a long time without asking very many questions. But now we see that the miracle factories seem to have been boarded up for many many years—the industry executives seem to have decided they were just too risky to keep open when they already had so much money coming in. And now it's been a long time since we've seen much in the way of new therapies. We've kept sending the money, but what we've gotten back is mostly television commercials, paid physician promoters, and pretty young pharmaceutical representatives who take your doctor's time to try to convince him to prescribe expensive patented drugs instead of generics that work just as well. In short, **we've bought marketing. And corporate profits that are still among the highest of any industry. The "research" we've purchased has often gone not into finding better drugs, but into finding how to make the drugs look better. Or into extending their patent protection for reasons that don't make them better.** Some legitimate research still occurs, to be certain, **but it has much less impact in an industry that became risk-averse decades ago.** And strangely enough, in failing to uphold their part of the bargain to provide new and innovative therapies, the pharmaceutical companies have themselves started to suffer. Nine of the twelve companies whose financial records I examined have had flat or declining revenue for the last several years. That trend is likely to continue, and even get worse, in an industry that continues to live in the past. And what of the rest of us? We've blindly pumped trillions of dollars into an industry with an assumption that they'd continue to turn that money into medical miracles. It's plainly obvious that **industry decided nearly two decades ago they'd rather keep most of that money than continue to revolutionize health care.** Since the pharmaceutical companies haven't done much to keep their end of this bargain, isn't it time we stopped giving into their demands? Every other Country in the World figured them out years ago. When will we be ready to open our eyes and start doing the same?

Under Medicare for All, the NIH would maintain funding and remain the leading source of innovation.

Cohn 07 Jonathan Cohn, Senior national correspondent at the Huffington Post, former executive editor of The American Prospect and senior editor at The New Republic. "Does universal health care suppress innovation?" *Physicians for a National Health Program*. 12 November 2007. http://www.pnhp.org/news/2007/november/does_universal_healt.php. [Premier]

The single biggest source of medical research funding, not just in the United States but in the **entire world**, is the National Institutes of Health (NIH): Last year, it spent more than $28 billion on research, accounting for about **one-third** of the total dollars spent on medical research and development in this country (and half the money spent at universities). The majority of that money pays for the kind of basic research that might someday unlock cures for killer diseases like Alzheimer's, aids, and cancer. No other country has an institution that matches the NIH in scale. And that is probably the **primary explanation** for why so many of the intellectual breakthroughs in medical science happen here.

There's no reason why this has to change under universal health insurance. NIH has its own independent funding stream. And, during the late 1990s, thanks to bipartisan agreement between President Clinton and the Republican Congress, its funding actually increased substantially—giving a tremendous boost to research. **With or without** universal coverage, subsequent presidents and Congress could ramp up funding again—although, if they did so, they would be breaking with the present course. It so happens that, starting in 2003, President Bush and his congressional allies let NIH funding stagnate, even though the cost of medical research (like the cost of medicine overall) was increasing faster than inflation. The reason? They needed room in the budget for other priorities, like tax cuts for the wealthy. In this sense, the greatest threat to future

medical breakthroughs may not be universal health care but the people who are trying so hard to fight it.

That causes better innovation.

Fox 17 Andrea Fox, Editor of EfficientGov.com and Senior Editor at Praetorian Digital. "Are We Really Back to 'National Healthcare versus Medical Innovation?'" EfficientGov. 3 May 2017. https://efficientgov.com/blog/2017/05/03/national-healthcare-versus-medical-innovation. [Premier]

Editorial: The presumption that medical innovation is done best by private health companies means it's impossible for government to drive access to cutting-edge medicine. Late Night Host Jimmy Kimmel delivered an impassioned May 1 monologue that did not go unnoticed by lawmakers and supporters of the Affordable Care Act (ACA) also known as Obamacare. Kimmel talked openly about the experience of seeing his son born with a chronic heart condition that requires several surgeries, and the concern about him being denied affordable health insurance in the future under the latest ACA repeal and replace bill before Congress. "You know, before 2014, if you were born with congenital heart disease, like my son was, there's a good chance you'd never be able to get health insurance, because you had a pre-existing condition," said Kimmel. The reaction was swift with former President Barrack Obama, Hillary Clinton and scores of others commenting. There are many preexisting conditions that can put an adult in a situation where they cannot afford healthcare coverage. According to the Kaiser Foundation in December 2016, "We estimate that 27 percent of adult Americans under the age of 65 have health conditions that would likely leave them uninsurable if they applied for individual market coverage under pre-ACA underwriting practices that existed in nearly all states." Heart disease is a category of preexisting condition. Nick Mulvaney, director of the Office of Management and Budget, addressed Kimmel's plea as it went viral yesterday with FoxNews. Mulvaney defended the second healthcare bill saying the latest plan is about giving states authority over providing healthcare for their citizens. The point behind the state waiver program is that state governments know how to treat children like the Kimmel baby better than the federal government does," he said. That is a risk to the purses of people with preexisting conditions — and their Congressional representation — in all 50 states will have to take, if the new healthcare reform bill moves forward. But be that as it may, what is really surprising is that there are still arguments that **national healthcare kills medical innovation and research**, and this perspective is being **bandied about as if it were fact**. The National Review's Michelle Malkin, responded to Kimmel with: "Compassion without clear thinking is just a waste of Kleenex." She noted how children born with conditions cannot be refused care at the hospital, which is provisionally true, although coverage of that care under the Children's Health Insurance Protection plan could be eliminated if it's not replaced in new healthcare legislation. But Malkin insisted – **without example** – that costs driven up by a national health care system lead to **elimination of medical innovation**. "Moving toward a nationalized health system might play well with an emotion-driven late-night comedy audience. But sober observers know it would mean undermining America's superior access to cutting-edge diagnosis, innovative treatment, top specialists and surgeons, technology and drugs." If I'm picking up on her drift — because I am a thinking mom, too — all those 'drunk' on the belief that the United States can afford national healthcare are going to pull the rug out from under medical progress. But a decade ago, the New Republic covered this very argument. **Many disagree** with the logic that higher healthcare costs kill the promise of innovative medical research. But it's one thing to say that **u**niversal **c**overage could lead to **less innovation** or reduce the availability of high-tech care. **It is quite another to say that it will do those things**, which is the claim that opponents frequently make. That argument requires several **leaps of logic**, many of them **highly suspect.** The forces that produce innovation in medicine turn out to be a **great deal more complicated** than critics of universal coverage seem to grasp. Ultimately, whether innovation would continue to thrive under universal health care depends entirely on **what kind of system we create** and how well we run it. In fact, it's quite possible that **u**niversal **c**overage could lead to **better innovation**," wrote author Jonathan Cohn. He cited the **N**ational **I**nstitutes of **H**ealth as a key driver of medical innovation. Congress must agree with that because now — about 10 years later — they acted to **increase NIH funding** by $2 billion. **Despite** the fact that the proposed Trump budget called for a 20 percent **slash** to NIH. Don McCanne, MD's comment — whenever he may have made it in the last decade — sums it up best, "The fundamental flaw in the argument that optimal innovation is possible only in a privately financed health system is the presumption that the **quest for profit** – the high profits characteristic of Wall Street supported firms – is the **primary driving force behind innovation**." **Governments** — not just the private sector alone — **can** of course **spawn, nurture and drive innovation**. They can do things like: Find the key to a **sickle cell cure** (2009) Discover a genetic disorder causing **strokes** and vascular inflammation in children (2014) Target an antibody that **stops the AIDS HIV virus** from infecting a cell (2016)

M4A would be the best of both worlds – it frees up resources to focus on impactful innovations, whereas insurers respond to short-term needs and Wall Street.

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The ideal would be to come up with some way of achieving the **best of both worlds**—paying for innovation when it yields actual benefits, but without neglecting less glitzy, potentially more beneficial forms of health care. And that is precisely what the leading proposals for universal health care seek to do. All of them would establish **independent advisory boards**, staffed by leading medical experts, to help decide whether proposed new treatments actually provide clinical value.

Of course, the idea of involving the government in these decisions is anathema to many conservatives—since, they argue, the private sector is bound to make better decisions than a bunch of bureaucrats in Washington. But, while that's frequently true in economics, health care may be an exception. One feature of the U.S. insurance system is its relentless focus **on short-term good**. Private insurers have little incentive to pay for interventions that don't yield **immediate benefits**, because they are gaining and losing members all the time. As a result, money invested on patient health may very well help a competitor's bottom line. What's more, the for-profit insurance industry—like the pharmaceutical and device industries—**responds to Wall Street**, which cares more about quarterly filings than long-term financial health. So there's relatively little incentive to spend money on the kinds of innovations that yield long-term, diffuse benefits.

The government, by contrast, has plenty of incentive to prioritize these sorts of investments. And, in more centralized systems, it can do just that. Several European countries are way ahead of us when it comes to establishing electronic medical records.

Another virtue of more centralized health care is its ability to generate savings by reducing administrative waste. A universal coverage system that significantly streamlined billing (either by creating one common form or simply replacing basic insurance with one, Medicare-like program) and cut down on the need for so many insurance middle-men would leave more resources for actual medical care—and **real medical innovation.**

… the truth about universal health insurance: You don't have to choose between universal access and innovation. It's possible to have both— as long as you do it right.

Private insurance hurts the economy and prevents innovation.

Kirsch and Schakowsky 09 Richard Kirsch, Senior Fellow at the Roosevelt Institute and Jan Schakowsky, Illinois Rep. "The Private Health Insurance Industry is Killing the U.S. Economy." Huffington Post. 28 May 2009. www.huffingtonpost.com/richard-kirsch/the-private-health-insura_b_191770.html. [Premier]

Fifteen years ago the private health insurance industry told Congress and the nation that it could fix the health care mess if government got out of the way. The insurers said that they would control costs for American families and businesses and improve the quality of care. The American people, American business and the Congress aren't about to buy that line again. The result of leaving health care reform to the insurance industry is that health insurance premiums have gone up six times faster than wages in the past nine years. **Those dollars are buying skimpier health coverage** with high deductibles and caps on

benefits, **resulting in more and more insured people being forced into medical bankruptcy**. Businesses that are struggling to meet health care costs in a global economy and dropping coverage, so much so that now 1 out of 3Americans under the age of 65 has been uninsured at some time in the past two years. Health care eats up 16% of our economy, up from 11% when the nation decided to leave the private insurance in charge. The insurance industry and their defenders on the ideological right are resorting to the same name tired name calling that worked for them the past, "government-run" health care. It's a desperate attempt to fend off a sensible government role in making health care affordable to our families, businesses and nation. This time it won't work. The President and leadership in Congress — and the American — people support a two-pronged role for government. One, set rules so that the private insurance industry can't continue to put profits before our health. Two, offer a choice of private insurance or a public health insurance plan, so people aren't stuck only with private insurance. The fact is that if private insurers controlled health care inflation as well as Medicare has over the past decade, businesses and families would see much lower premiums than they do today. Between 1997 and 2006, per enrollee spending in private insurance grew 59% faster than spending in Medicare. And Medicare has the tougher job, because it cares for the most expensive population: the elderly and those with serious disabilities. One reason that private insurers have gotten away with skyrocketing premium increases is that they have a near monopoly across the nation. According to data from the American Medical Association, in virtually every metropolitan area in the country (96%) **the insurance market is dominated by so few insurers so as to be considered "highly-concentrated."** A public health insurance option coupled with a regulated private insurance market will break the stranglehold a handful of companies have on the insurance market. Most importantly, under these reforms consumers will be able to vote with their feet when their health care plan — public or private — doesn't work for them. In fact, the main argument that the industry and the right has with offering the choice of a public health insurance option is that too many Americans will choose it. If private insurers are really more efficient than government, they shouldn't have any trouble competing with a public health insurance plan. It's the height of irony that the defenders of free markets are opposed to competition. But when it comes to health care, which is a public good, public insurers really are more efficient. There is broad agreement that America's health care system does not deliver the value we need. Today, **private insurers have little incentive to develop sophisticated disease management programs,** since such programs may attract sicker patients into their plan. And **when care improvements are achieved, private plans have no incentive to share best practices with industry competitors**. A new public health insurance plan would create a mechanism for the development of innovative and transparent payment mechanisms, the expansion of quality incentives, and the adoption of evidence-based protocols. As the Veterans Health Administration and Medicare have proven capable of doing, **a new public** health insurance **program could lead the way in advancing electronic medical records, creating incentives for greater integration of delivery systems, and establishing improved measures of quality.**

Coordination means innovations gain marginal utility even if quantitatively reduced.

Mikkers and Ryan 15 Misja Mikkers & Padhraig Ryan, Dutch Healthcare Authorities "Optimisation of Healthcare Contracts: Tensions Between Standardisation and Innovation." International Journal of Health Policy and Management, vol. 5, no. 2. 17 October 2015. [Premier]

An important determinant of health system performance is **contracting**. Providers often **respond to financial incentives**, despite the ethical underpinnings of medicine, and payers can craft contracts to influence performance. Yet contracting is highly **imperfect** in both single-payer and multi-payer health systems. Arguably, in a **competitive**, multi-payer **environment**, contractual innovation may occur **more rapidly** than in a single-payer system. This innovation in contract design could enhance performance. However, contractual innovation often **fails to improve performance** as **payer incentives are misaligned with public policy objectives**. Numerous countries seek to improve healthcare contracts, but thus far no health system has demonstrably crafted the necessary blend of incentives to stimulate optimal contracting. Health systems can be conceptualised as a mesh of interlinked, interdependent markets. There are distinct markets for primary care services, hospital care, medical devices, pharmaceuticals, labour markets for healthcare human resources and positions, and markets for medical and nursing education. Each market involves supply and demand. Given this diverse array of market forces, Professor Goddard duly notes that the real issue is not whether competition should (or should not) exist in healthcare, but rather to identify the particular circumstances and forms in which competition can

exert beneficial effects. In a competitive market, the relationship between sellers and buyers typically takes the form of a contract. Healthcare contracts seek to specify the characteristics of service provision and the level of reimbursement. The contract is an instrument through which market participants seek to determine performance and value. A number of conditions are necessary for the stipulation and enforcement of contracts. These include the specification of anticipated performance or "deliverables," the identification of clear loci of responsibility, and the availability of penalties such as non-payment or non-renewal of the contracting relationship.1 Professor Goddard's editorial considers many key elements of competition,2 but we believe that comment is warranted on the interaction between competitive markets and contracting practice. As Professor Goddard notes, competition is not a binary phenomenon. In each developed country, governments play some role in healthcare financing and provision, while **even in state provision countries** (eg, National Health Service [NHS] in the United Kingdom) payment per patient exists and **some competition is present**. All systems must address problems relating to equity and performance, while a fundamental problem is development of improved instruments to observe quality and value. The design of contracts (either by the state or by competing insurers) is of fundamental importance in addressing these problems. Go to: Innovation in Contracts This paper shall consider contracts in the market for health services, in which a private insurer or public purchaser writes contracts with provider organisations or clinicians. The underlying principles apply to primary care and hospital services. Provider organisations often serve as an intermediary between purchasers and clinicians, when purchasers negotiate contracts at the organisational level and managers seek to improve performance of clinicians through contracts and other organisational change instruments. The three archetypal forms of contract for healthcare services are fee for service, capitation, and global budget, and various combinations of these have been implemented to offset associated perverse incentives.3 Empirical evidence consistently illustrates the impact of contracts on performance. Numerous studies illustrate that activity-based payment can increase throughput,4 while paying clinicians by salary tends to reduce the number of treated patients. The bulk of health spending relates to service provision, and contracts that encourage provision of care in a prudent manner may temper cost escalation. Furthermore, contracts that reward high quality care may, in principle, save lives and improve patients' quality of life.5 Innovation in contracts is evident in many health systems. In the English NHS, a monopsonistic purchaser system, authorities negotiated the Quality and Outcomes Framework with primary care providers in an effort to enhance clinical quality and value. In the United States, a major public policy objective is development of contracts that **discourage unnecessary care**, while **rewarding high quality care and value**. In the marketplace of Massachusetts, USA, the Blue Cross Blue Shield health insurance company sculpted the Alternative Quality Contract, a forerunner of "accountable care" contract mechanisms that are becoming more prevalent across the United States.6 In the Netherlands during 2010, the government approved the concept of bundled-payment on a national basis for the care of certain chronic conditions including diabetes. Services are specified according to recommendations in national clinical guidelines. Insurers contract with a care group that is responsible for managing care, in many cases involving sub-contracting of services to clinicians such as dietitians and ophthalmologists. In the case of diabetes, early evaluation suggests this bundled payment contract may have improved adherence to key care processes and boosted performance transparency, but this raises anti-trust concerns and may impinge on patients' freedom of choice, while researchers have found no effects on spending.7 As noted, health systems can be viewed as a mesh of interdependent markets. The structure and conduct of the insurance market has ramifications for the contracts written with providers. Arguably, innovative contract forms may evolve more rapidly in a pluralistic payer environment such as the Dutch or US systems. By contrast, in a **centralised, single-payer system,** the emergence of **new contract designs may be less dynamic**. In a single payer environment in which all providers are treated the same, a change for one provider impacts all providers. In a competitive payer environment individual contracting may be the norm, leading to variation in contract design. In turn, this may lead to learning about the optimal attributes of contracts, and ultimately to evolution and improvement[1].1 According to proponents of competition, better performance may emerge from pressure on purchasers to develop innovative contract mechanisms. But **competition can damage performance when purchasers lack incentives to encourage value in service provision**. The insurance market must be **astutely regulated**, to transmit the right incentives to the provider sector. Accordingly, contractual evolution **might not improve system performance**. In multi-payer systems where the effectiveness of risk equalisation is limited, such as in Ireland and Israel, insurers may **flourish** by **risk-selecting profitable patient subpopulations**, as noted by Professor Goddard, and this **dilutes incentives to craft improved contracts** for providers.8 Risk adjustment is also increasingly used in provider-payer contracts to adjust payment to reflect patients' risk profile. This is important when using capitation or global budget forms of contract, such as the Alternative Quality Contract.6 In a multi-payer system, beneficial waves of contractual innovation may be more likely when effective preconditions for competition between payers are in place, to compel payers to serve as prudent purchasers of care on behalf of enrolees. According to the "managed competition" framework, insurers can flourish by crafting effective contracts with care providers, in order to extract value from the provider market. If these preconditions are met, arguably innovation in contracts can occur more rapidly and effectively than in a single payer environment. Authorities in countries such as the Netherlands seek to transition to such an incentive framework, but to our knowledge, no country has demonstrably achieved such incentives.8 Go to: Standardisation of Contracts Despite the potential benefits of contractual innovation, in many circumstances it is appropriate to temper the degree to which payers can innovate. In the

United States, annual spending on healthcare administration is approximately $361 billion per year, twice the national spend on heart disease and three times the spend on cancer. Around half of this expenditure is considered unnecessary by the Institute of Medicine, and this waste is partly due to lack of standardisation in contracting. According to one study, US physicians spend an average of 43 minutes a day interacting with health plans about contractual issues such as the content of medical formularies and procedure authorisation. Moreover, physician offices must employ coders to process and monitor diverse reimbursement arrangements across different contracts. Provider credentialing systems are a part of many contracting systems, but these systems exhibit much redundancy as providers must furnish almost identical information to many organisations, and physicians and their staff typically spend a total of 23 hours working on credentialing related tasks annually. It may be possible to **significantly reduce administrative costs through standardisation**. The potential benefits of standardisation have been **demonstrated in multiple industries**. In the **retail sector**, Walmart forced suppliers to adhere to its computer standards in order to process transactions, and this led to widescale standardisation of retail information systems. Contract standardisation constrains the number of dimensions on which payers can innovate, and may temper the number of ways in which insurers compete. In the United States, a coordinated, national credentialing system may save almost $1 billion annually for providers. Furthermore, providers could save up to $2 billion annually from standardisation of electronic transmission of contract billing information and other administrative data. In a pluralistic payer environment, government agencies may be the only purchaser with sufficient power and scale to compel standardisation of contracts.9 The decision of whether to enforce standardisation for a contractual process or metric should be determined on a case by case basis. It may be appropriate to standardise basic administrative procedures (such as use of ICD-10, and recording of patient characteristics), but the freedom to redesign contracts in various ways may result in learning and evolution. To reach optimal contracting, this inherent tension between standardisation and innovation must be reconciled. Go to: Other Considerations An ideal contract in one setting may be inappropriate elsewhere, as contracts must be tailored for local circumstances and needs. For example, the introduction of universal healthcare coverage in Massachusetts was facilitated by an established and forceful regulatory culture, and by comparatively little consumer demand for the high-cost sharing, low-benefit insurance products that are increasingly prominent elsewhere in the United States. In other states, it has been more difficult to implement contracts modelled on the Massachusetts system.10 Nonetheless, a subset of contractual innovations in a pluralistic environment such as the United States might be of use in other settings. For example, the application of the “diagnosis-related group” classification system was pioneered in the United States, and this has been adapted for use in many other settings. The perverse incentives associated with multi-payer systems are well-documented, and a **fragmented payer market dilutes the influence of each payer on provider behaviour**.8 Moreover, contractual innovation is not confined to the private sector or to multiple payer systems. The Center for Medicare and Medicaid Innovation in the United States, for instance, is a public sector unit conducting trials in innovative contracting mechanisms.11

Private innovation resilient too

Resnick 17 Lindsay Resnick, healthcare marketer, strategist, connector, and maven. Will Healthcare Innovation Survive?" ReviveHealth. 24 February 2017. http://thinkrevivehealth.com/2017/02/will-healthcare-innovation-survive. [Premier]

The biggest question HIMSS attendees and others in the industry are asking: Will all this uncertainty slow down innovation and inhibit future investment in technology? While there’s an abundance of unknowns, sweeping health system change – whether financing, care delivery, or even political – isn’t around the corner. The machinery of big government, both legislative and regulatory, where much of this change takes place moves at a deliberate, if not glacial pace. And while political rhetoric and grandstanding will shape the headlines, “reform redux” or an overhaul of Medicare and Medicaid will be years in the making. Unfortunately, the daily deluge of political pomposity around healthcare has the average consumer confused and often times plain scared. Remember the “Day One” promise: On the first day of the Presidency I will repeal the Affordable Care Act (ACA) and replace it with…something better, or more specifically, something terrific. “Repeal and replace” has moved to “repeal and repair” and some say it’s more likely to be “repeal and rename”. In any case, pundits believe that a new healthcare program will stretch implementation over three to four years as components of the Affordable Care Act are phased-out or modified and new program components are phased-in. Realists across the country however, know that an ounce of bipartisanship would go a long way for all healthcare consumers – improve ACA through smart, targeted, legislated fixes and modifications. So back to that critical question: Will all this uncertainty slow down innovation and inhibit future investment in technology? NO! Given the current direction of the healthcare industry – increased coverage for millions of Americans, shift from volume to value-based healthcare, sophisticated technology to support both efficient care delivery and consumer decision-making, new convenience-driven remote and mobile health outlets – there’s a new baseline and more importantly, there’s **momentum**! **Entrepreneurs have always led the way in healthcare innovation, and they won’t let up anytime soon. It’s the innovators and risk-takers that are making breakthroughs in cancer,**

Alzheimer's and preventative treatments, and breaking down barriers with artificial intelligence and cognitive computing for diagnostic accuracy and precision medicine.

AT: Recruitment

The link is wrong – people don't enlist for healthcare reasons.

Volsky 08 Igor Volsky, Vice President at the Center for American Progress and the Deputy Director for the Center for American Progress Action Fund. "NYT Blogger: No Health Care For You! Because It Would Undermine Military Recruitment." Think Progress. 30 May 2008. https://thinkprogress.org/nyt-blogger-no-health-care-for-you-because-it-would-undermine-military-recruitment-102bc4cf8511/. [Premier]

In today's New York Times, blogger Floyd Norris suggests that universal health care reform would reduce military recruitment rates by undermining the military's generous health benefit incentive: A significant factor for many recruits, it turns out, is the military's generous health benefits for dependants…It seems a bit perverse that the incentives for a young person with children to join are greater than the incentives for his childless friend. But that is the way it is. All that could change if the push for some kind of national health insurance program were to be successful. The notion that Americans should be deprived of health insurance for national security purposes is both **perverse** and **illogical**. In fact, Norris' implication, which suggests that the government must maintain a disparity between civilian and military entitlements, **overstates** the financial benefit of enlisting and contradicts the needs of the military. Few Americans cash-in from their military service. "The Department of Defense estimates that its employees take a $**20,000-per-year pay-and-benefits hit** relative to civilians the same age throughout their careers." Moreover, according to Christopher Jehn, former U.S. assistant secretary of defense for force management and personnel, soldiers who are forced into service **weaken the military's capabilities**. Second, because service members are all volunteers, the military has far fewer discipline problems, greater experience (because of less turnover) and thus, more capability. Based on this experience, U.S. military leaders today are thoroughly convinced that a return to the draft could only weaken the armed forces. This is why, when students at the Naval Postgraduate School (mainly U.S. military officers), are asked whether they would like to return to the draft, there are few takers. As one put it, "Why would I want to be in charge of people who don't want to be there?" The burden of serving in the army should also be shared by all Americans, not just by the poor or the uninsured. Unfortunately, the underprivileged are already over-represented in the armed forces. While the Defense Department does not track how much recruits earn before they enlist, a study by the non partisan National Priorities Project "that compares home ZIP codes of new recruits to tax return data for those areas" found that "neighborhoods with low- to middle-median household incomes are over-represented," while areas "with high-median household incomes are under-represented." Americans who lack health insurance should not be forced to join the military in order to obtain it. If a government must deny its citizens benefits to entice recruits to war, perhaps that war is not worth fighting.

Military healthcare doesn't drive enlistment – it's worse than civilian care.

Johnson 16 Justin Johnson, senior analyst for defense budgeting policy in The Heritage Foundation's Center for National Defense. "It's Time to Improve Military Health Care." War on the Rocks. 17 February 2016. https://warontherocks.com/2016/02/its-time-to-improve-military-health-care. [Premier]

Unfortunately, this system is not currently accomplishing either of its two primary goals sufficiently. **Patient satisfaction** and quality of care are consistently lower than civilian benchmarks, and the military medical workforce is optimized for the patients they serve at home, not the patients they would serve in combat. A military health care system that better supports the operational mission and also provides better care for servicemembers and their families is possible. But this can only be done with structural reform.¶ Last January, the Military Compensation and Retirement Modernization Commission (MCRMC) released a series of recommendations in its final report. Unlike many Washington commissions, the MCRMC has already had a huge impact on policy — its retirement modernization proposal was largely implemented in the FY2016 National Defense Authorization Act. Part of what made that proposal successful was the commission's focus on providing a better system for servicemembers instead of cutting benefits or increasing fees in an attempt to balance the books. Impressively, the commission was able to develop a system that was more flexible for servicemembers and will also (in the long run) be more affordable.¶

TRICARE, the military's health care program, is ripe for the same kind of overhaul. Surveys of servicemembers and their families show that the system **trails the private sector significantly** in terms of customer satisfaction, the wait time for appointments, and the quality of care received. TRICARE data show that the time it takes to get appointments, particularly with specialists, takes longer than in the private sector. And on a range of specific procedures, health outcomes are worse in the military system. At the same time, the military health system is not designed well to support combat operations. The MCRMC has outlined a proposal that would address the quality of care both at home and in combat, but change is not easy and the Pentagon needs to provide leadership if real improvements are to be made.¶ Dissatisfaction with Health Care¶ A major MCRMC survey of active servicemembers found that 47 percent of respondents were dissatisfied or very dissatisfied with their health care provider choices, and 43 percent were dissatisfied with the quality of health care they experience. In other words, almost half of servicemembers are not satisfied with the health care they are receiving from the military. According to TRICARE's own surveys, the military health system consistently lags **five percent** or more **behind civilian benchmarks** in satisfaction measures including getting needed care and getting care quickly.¶ As you dive deeper into the numbers, it is clear that **younger servicemembers** are more frustrated with the current system than those with greater time in service. **More than half (51 percent) of junior enlisted** (E1–E4) and junior officers (O1–O3) say they are dissatisfied or very dissatisfied with their health care provider choices. Meanwhile, 46 percent of junior enlisted and 43 percent of junior officers are dissatisfied or very dissatisfied with the quality of their health care experience.

Compensation would be adjusted to maintain incentives to join

Thoma 08 Mark Thoma, Professor of Economics at the Department of Economics of the University of Oregon. "Universal Health Care and Military Retention." *Economists View*, 30 May 2008. http://economistsview.typepad.com/economistsview/2008/05/universal-healt.html. [Premier]

Continuing a discussion of this topic from not too long ago, the right way to do this is to state the the goals we are trying to reach, then build incentives into the polices that direct people toward those goals with as few negative consequences as possible. One possible goal is retention. If you want people to **stay** longer, **deferred compensation schemes** are a way to accomplish that goal. We need to decide how many people we want to stay for additional terms, and then set the compensation incentives accordingly (these can be tweaked as needed, e.g. you can have incentives for reenlistment at each decision point, or you can discourage reenlistment after some number of terms if there is some reason to do so). Yes, it may require that the government **pay people serving in the military more**, at least those who stay longer, but that is simply what it will cost to reach the goal, that's the price to command these resources. People who applaud the ability of markets to value resources should understand that. If it costs too much to induce sufficient reenlistment, i.e. if the costs of producing higher retention rates are greater than the benefits, then it's not a very good policy anyway. But if the goals are different, e.g. if the goal is to provide educational benefits to make up for lost opportunities in the private sector due to service in the military, the the policy will, of course, be different as well. When evaluating a proposed policy to, for example, increase educational benefits all of the consequences, including the effects on retention, should be examined. But this is part of a cost benefit calculation. If the educational benefit - the goal of the policy - exceeds the retention cost, then it's still worthwhile. And it may not be necessary to give up on the retention goal just because you offer educational benefits, one does not have to be traded against the other. It's possible - if you are willing to pay the cost - to offer both higher education benefits and higher deferred compensation so that both goals are attained. More help for education is available for those who choose to leave when their term ends, but since deferred compensation is higher for those who reenlist, just as many stay as before. Whether it's worth it to do this is matter of comparing the costs and benefits, but increasing education benefits does not have to lower retention rates. **If national health care is enacted and that lowers the incentive to enlist**, or to reenlist, then the compensation levels will have to be **adjusted** to compensate, but it doesn't have to **change retention rates or the ability to provide education benefits** after people leave the military if we are willing to pay what's needed to induce the desired behavior.

Turn – increases in military healthcare spending are wrecking the defense budget – plan solves costs

Roy 12 Avik Roy, co-founder and president of the Foundation for Research on Equal Opportunity. "A Real Domestic Threat: How Health-Care Spending Strains the U.S. Military." *Atlantic*, 12 March 2012. https://www.theatlantic.com/business/archive/2012/03/a-real-domestic-threat-how-health-care-spending-strains-the-us-military/254350/. [Premier]

Lots of people have views about U.S. military spending. Liberals and libertarians think we spend far too much on defense. On the other side, Mitt Romney speaks for many conservatives in arguing that we should spend more: "If you do not want America to be the strongest nation on Earth," says Romney, "I am not your President. You have that President today." But while we usually think of military spending in terms of foreign wars and joint strike fighters, we often neglect one of the biggest growth drivers of the U.S. defense budget: **health care**. "Health care costs are **eating the Defense Department alive**," said former Defense Secretary Robert Gates in 2011. Military spending consumes over half of all federal discretionary spending: $712 billion out of $1,277 billion in 2011 discretionary outlays. Defense analyst Todd Harrison calculates that military health spending is about **9.5 percent** of the base defense budget: $52.5 billion out of the $559 billion that the Defense Department requested for fiscal year 2012. On top of that, the Department of Veterans Affairs, which has a separate budget, seeks to spend $51 billion of its $132 billion 2012 budget request on health care. We spend $520 billion a year on Medicare, $450 billion a year on Medicaid, and $300 billion a year on the employer health insurance tax deduction. Still, **$100 billion in annual military health spending** is real money. And while defense spending as a percentage of GDP nears historic lows (about 4 percent today, compared to 6 percent in the 1980s), the military's health-care spending is increasing at rates **much faster than inflation**, just like health spending elsewhere.

Poor health outcomes kill military readiness

Weinstein et al. 17 James Weinstein, Amy Geller, Yamrot Negussie, and Alina Baciu, Editors at the National Academies of Sciences, Engineering, and Medicine. "Communities in Action: Pathways to Health Equity." Chapter 1. 2017. https://www.nap.edu/read/24624/chapter/1#ii. [Premier]

Political and Economic Impacts of Health Disparities In addition to the dollar cost of health care, because health inequities contribute to overall poor health for the nation, health inequity has consequences for the U.S. economy, national security, business workforce, and public finances. Consequences for the Next Generation American children rank behind their peers in most Organisation for Economic Co-operation and Development (OECD) nations in health status and on key determinants of health, and they experience growing disparities on multiple measures of child well-being (OECD, 2009; Seith and Isakson, 2011). Poverty, food insecurity, lack of stable housing, and lack of access to high-quality and developmentally optimal early childhood education are among the childhood factors that contribute to "chronic adult illnesses and to the intergenerational perpetuation of poverty and ill health found in many communities (e.g., obesity, diabetes, cardiovascular disease, poor educational outcomes, unemployment, poverty, early death)" (AAP, 2010, p. 839). Young children are most likely to live in poverty, and children from low-income and minority communities are most vulnerable (Burd-Sharps and Lewis, 2015). The nation's growing racial and ethnic diversity, coupled with the conditions that lead to serious early life disadvantage, have serious implications for health and health disparities in later life, leading to squandering human lives and their potential (OECD, 2009). Consequences for the Economy The economic effects of health inequity are the result of both **unsustainable and wasteful health care spending and diminished productivity** in the business sector. Health care spending accounted for 17.5 percent of gross domestic product (GDP) in 2014, and health disparities contribute to a significant amount of financial waste in the health care system. LaVeist and colleagues (2009) calculated that eliminating health disparities for minorities would have reduced indirect costs associated with **illness and premature death** by more than $1 trillion between 2003 and 2006. In 2009, the Urban Institute projected that from 2009 to 2018, racial disparities in health will cost U.S. health insurers approximately $337 billion in total (Waidmann, 2009). Disparities in access to health care and in the quality of care can be costly to individuals, health care providers, health insurers, and taxpayers. Obtaining care late in the course of disease (i.e., **delayed care**) and

inadequate health care coverage may increase the cost of care exponentially due to the exacerbation of complications, the need for more expensive care (e.g., emergency department services), and the need for more extensive care; furthermore, such treatment can increase longer-term reliance on the health care system for the management of unintended consequences on one hand and preventable chronic diseases on the other (IOM, 2009). Consequences for National Security For a nation that **prizes military readiness**, the effects of poor health status on entrance to military service and the readiness of the force matter. Military leaders reported that more than 75 percent of 17- to 24-year-olds—more than 26 million young adults—in the United States cannot qualify to serve in the armed forces because they have health problems ranging from obesity to dependencies on prescription and nonprescription drugs, are poorly educated, or are involved in crime (Christeson et al., 2009). According to more than 500 retired admirals, generals, and other senior military leaders, the health of our nation's youth represents a **serious national security concern** (Christeson et al., 2009, 2010). Individuals who are not healthy enough to participate in the workforce will not be afforded the same employment opportunities as their healthy counterparts. Rear Admiral Robert Besal (ret.) has asserted that young people who are physically unfit for "productive employment or military service represent a staggering loss of individual potential and collective strength for the nation as well" (Council for a Strong America, 2016).

AT: Rural Hospitals

Rural hospitals are already down but M4A would save them.

Archer 20 Diane Archer. 453 rural hospitals are failing — Medicare for All would save them." The Hill. 11 March 2020. https://thehill.com/blogs/congress-blog/healthcare/487026-453-rural-hospitals-are-failing-medicare-for-all-would-save. [Premier]

Our for-profit health care system isn't working for rural Americans. More than 120 rural hospitals have closed since 2010. According to a new report from Chartis Center for Rural Health, another 453—almost one in four—are at risk of failing. Corporate health insurers can't provide coverage to meet rural patients' needs, and it's endangering the bottom line of rural hospitals. Medicare for All would save them. In congressional testimony, Dr. Jessica Banthin, Deputy Assistant Director for Health, Retirement, and Long-Term Analysis at the Congressional Budget Office, explains that enacting single-payer Medicare for All could keep rural hospitals afloat. Everyone would have good coverage. And, hospitals would be compensated at Medicare rates, or better, for the care that they deliver. Right now, our for-profit health care system leaves millions of rural residents uninsured or underinsured and unable to get the care they need. It is not designed to serve rural communities. Mountains of research show that rural Americans with low incomes and chronic conditions often cannot afford needed care or coverage. Not surprisingly, the 46 million rural residents — one in six Americans—have far poorer health outcomes and lower life expectancies than Americans living in urban areas. Because rural hospitals are not reimbursed for much of the care they deliver, many of them cannot generate the revenue needed to serve their communities. Nearly four in 10 rural hospitals are unprofitable. Low patient numbers contribute to the problem. Hospitals are cutting services and closing. Rural Americans sometimes must travel 30 miles to the nearest hospital.

AT: Stock Market

This is an aff argument because it'll implode from unsustainable debt.

Richter 17 Wolf Richter, CEO of Wolf Street Corp. and the editor-in-chief at Wolf Street, BA and MBA in Texas and an MA in Oklahoma. "Health-Care Industry Debt Turns into 'Systemic Recession Risk.'" *Wolf Street*, 27 March 2017. http://wolfstreet.com/2017/03/27/health-care-industry-debt-turns-into-systemic-recession-risk/. [Premier]

Sector booms and busts have historically been driven by **speculation and over-borrowing**, often triggering regional or even national **recessions**. Textbook examples include the 2014 Energy and 2008 Financial sector collapse. In both of these instances, fallacies such as perpetual $100+ oil and ever rising home prices drove rampant speculation, overinvestment, and unsustainable debt buildup. So warns John Burns Real Estate Consulting, in a new paper, "Industries at Risk and Implications for Housing." This time, three sectors stand out where "a similar pattern of unsustainable growth has driven rapid expansion" since the end of the Great Recession: technology, automotive (whose current travails I keep dissecting), and health care. But **health care poses the biggest "systemic recession risk"** to the US economy, according to the report. After employment in the sector has soared 113% since 1990, it accounts for 16% of private sector jobs, up from 10% in 1990. [T]thus a correction to the industry will likely cause a **slowdown for the national economy**. Several large housing markets have an even bigger concentration of jobs tied to the Health Care industry and will be disproportionately hit by a Health Care slowdown, including: Philadelphia, Boston, New York, and Nashville. As so many times, it has to do with debt. Health-care sector debt has soared **308% since 2009**, the depth of the Great Recession which elegantly bypassed the sector. Over the same period, GDP has grown 30%, and overall jobs have grown only 18%. Thus health-care sector debt has grown 10 times faster than GDP and 17 times faster than private-sector jobs, "exceeding multiples of prior finance and energy sector boom-and-bust cycles." Hospitals and other health-care facilities, funded by this "debt binge," have sprouted like mushrooms. Due to their "large multiplier effect on local economies" as doctors, nurses, and other employees live and spend money in the area, "municipalities have been eager to invest in health care facilities because of the assumed jobs/tax dollars." This overenthusiasm and over-investment has "accelerated the industry's growth." It occurred during a period of industry consolidation via, you guessed it, a debt-fueled wave of Mergers & Acquisitions. This chart shows the annual number of announced deals (green) and the number of hospitals (blue) involved: M&A activity has also consolidated the pharmaceutical sector, **health insurers**, and the like, which further lowered competition and helped contribute to surging prices that have become **"unsustainable" for consumers**. Medical costs for a family of four in an employer-sponsored PPO plan soared 190% since 2002, from $9,000 to $26,000, according to the Milliman Medical Index, which includes health care costs and employee and employer contributions but not plan administrative expenses or profit: The medical needs of the aging boomers support growth, "but not at the breakneck pace seen in recent years," the report explains. The population aged 65+ has grown 41% since 2000 and will likely grow another 29% through 2025. Medical spending increases with age, and folks aged 65+ account for about 40% of total personal health spending. But these "demographic tailwinds do not justify skyrocketing debt growth," the report points out. The health care sector's debt per 65+ person has **soared** from less than $1,000 in 2000 to over $13,000 in 2016, a stunning rise of 1,376%: The unsustainability of this debt binge is **showing up in the higher yield** that investors are demanding in order to hold health-care **junk-rated bonds** – a sign investors see higher industry risks. Hence, borrowing costs are rising. The chart below shows the difference in yield between junk-rated health care bonds and all junk-rated bonds (between the Effective Yield of the BofA Merrill Lynch High Yield Health Care Sector Index and the BofA High Yield Index). A negative spread, which dominated for much of the period of the chart, means that investors saw the sector as less risky than the overall junk-bond market. But that changed in 2015, and John Burns Real Estate Consulting anticipates that the sector's corporate borrowing costs will continue to "trend higher": And now there are "early signs" the industry is cutting back, "after years of rapid expansion and renewed political pressure." The report cites some examples, including these: "Community Health Systems Retrenches. Hospital operator forced to sell some hospitals after long buying spree" – Wall Street Journal, October 2016. "After years of acquiring hospitals and increasing debt [current debt to equity of 10x], one of the largest hospital operators announced it would be selling several of its 158 hospitals in order to pay down debt." "High price tags for medicines are about to come under renewed pressure" – The Economist, December 2016. "The president-elect, the pharma industry's preferred candidate, has promised to bring prices down." "MD Anderson cutting staff by 1,000 workers via layoff, retirement," Houston Chronicle, January 2017. "MD Anderson Cancer Center, Houston's second-largest employer, is eliminating about 1,000 jobs as the elite medical institution continues to wrestle with losses that exceeded $100 million last quarter." So the report: "Speculative investing – often fueled by debt – has preceded 11 of the last 12 recessions; we believe **debt will spark the next downturn**." And the number one candidate for that spark is the phenomenally over-indebted **health care sector**.

Stocks only help rich people – wages are negatively correlated with stock trends

Styczynski 17 Michelle Styczynski, Research Advocate at the Consumer Federation of America. "The Stock Market Doesn't Matter." *Jacobin*. 26 August 2017. https://www.jacobinmag.com/2017/08/stock-market-boom-wages-inequality. [Premier]

For most of the twentieth century the stock market made **only small gains** compared to the golden era we are living in today. Since the 2008 financial crisis, markets have soared and, month after month, the major stock indexes have broken new records. In July, the NASDAQ and the S&P 500 broke new all-time highs, with the Dow Jones not far behind. The stock market has not just recovered from the financial crisis. It is making serious bank.

One of the stock market's most popular cheerleaders has been President Donald Trump. Since July, Trump has sent out eleven tweets championing the strength of the stock market. Two in particular seem to suggest that a rising stock market goes hand in hand with increased wages:

[Tweets omitted]

Former president Barack Obama was a bit more discerning when he compared the stock market to wages. However, he still used the stock market as a yardstick to measure the strength of the economy.

A few years after the financial crisis, when the stock market began to pick up, Obama said in his 2011 State of the Union Address: "Two years after the worst recession most of us have ever known, the stock market has come roaring back. Corporate profits are up. The economy is growing again."

Our political leaders seem to suggest a soaring stock market means great things for our country. But, **what does the stock market do** for average Americans? More specifically, what does it do for their wages?

[Chart omitted]

The figure above compares the average real wages of nonsupervisory workers and the real level of the S&P 500 from the early twentieth century to today. Both series are adjusted for inflation using the CPI (pre-1978) and CPI-U-RS (post-1978).

To begin, let's look at real wages measured in 2016 dollars. From 1920 to the early 1970s, real wages rise quickly and consistently. But in the mid-1970s **real wages begin to decline**. Then in the mid-1990s wages begin to slowly rise. The S&P, on the other hand, behaves quite differently. From the 1920s to the early 1970s it also moves upward, but slowly. Then the S&P rapidly shoots up just as wages begin to decline.

Let us study the figure in more detail. Before 1980, real wages grow at an average rate of two and one half cents ($0.025) per month. Then, after 1980 wages grow by only an average rate of 0.7 cents ($0.007) per month — a 71 percent drop in the average rate of growth. The S&P 500 follows a different pattern. Before 1980, the S&P grew at an average pace of 0.53 points per month. But, after 1980 the S&P begins to soar. The index increases by 4 points per month — a 660 percent rise in its growth rate.

Looking at this more abstractly, how does the real wage respond when the S&P increases by one point? Before 1980, when the S&P rises by one point, on average the real wage increases by three cents ($0.027). After 1980, when the S&P rises by one point, the real wage increases by only **one tenth of one cent** ($0.001).

This leads us to ask: are these two variables even correlated? When the S&P increases, does the real wage also increase? Correspondingly, when the S&P decreases, does the real wage decrease? From 1950 to 1975, they were largely positively correlated. But after 1975, the correlation **tended to be more negative than positive**. Meaning, when the S&P increases the **real wage tends to decrease**, and when the S&P decreases the real wage tends to increase. After 1975, on average, while one was moving up the other was moving down.

Political leaders seem to believe that what's good for the stock market is good for the larger economy. But the data show that since the 1980s, **when the stock market rises, wages barely move**.

Today, hourly wage earners — who constitute nearly 60 percent of the workforce — are only making slightly more on average than they did forty years ago. In fact, if the federal minimum wage kept pace with the average hourly wage and average productivity since the late 1960s, it would be over $18 per hour today.

Yet, political and business leaders still proceed as if the stock market is key to measuring the success of the economy. Perhaps the stock market tells us about the prospects of capital owners. But it certainly **doesn't tell us much** about the average worker.

Turn—single payer boosts hospital stocks.

Bukhari 16 Jeff Bukkhari, business journalist. "Here Are the Stocks to Buy if Bernie Sanders Becomes President." Fortune. 9 March 2016. http://fortune.com/2016/03/09/bernie-sanders-portfolio-stocks/. [Premier]

But depending how much you believe President Sanders, **hospital stocks could do well.** The Sanders campaign says his plan would dramatically cut medical costs by $6 trillion over 10 years. If that's the case all health care companies will fare poorly under Sanders. But it's not clear that Sanders can achieve the health savings he is promising. If that's so, his plan could increase coverage and health care usage, increasing coverage. If that's the case, **then hospital stocks could do well**. HCA Holdings (HCA, -0.01%) is the largest hospital operator in America, and could benefit.

AT: Competition

The current "choice" of insurance is merely a reflection of people losing insurance.

Arno and Caper 20 Peter S. Arno, Economist and senior fellow and director of health policy research at the Political Economy Research Institute at the University of Massachusetts–Amherst and a senior fellow at the National Academy of Social Insurance, and Philip Caper, Physician and founding member of the National Academy of Social Insurance and currently serves on the Board of Maine AllCare. "Medicare For All: The Social Transformation Of US Health Care." Health Affairs, 25 March 2020, https://www.healthaffairs.org/do/10.1377/hblog20200319.920962/full/. [Premier]

The various "option" reform proposals will not simplify our confusing health care system nor will they lead to universal coverage. None have **adequate means** to restrain health care costs. So why go down this road? Is it too difficult for the US to guarantee everyone access to affordable care when every other developed country in the world has done so?

The stated reason put forth in favor of these mixed option approaches is that Americans want "choice." But **choice of what?** We know with certainty from former insurance company executives such as Wendell Potter that the false "choice" meme polls well with the US public and was used to undermine the Clinton reform efforts more than 25 years ago. It is being widely used today to manipulate public opinion.

But choice in our current system is largely an illusion. In 2019, 67.8 million workers across the country separated from their job at some point during the year—either through layoffs, terminations, or switching jobs. This labor turnover data leaves little doubt that people with employer-sponsored insurance are losing their insurance constantly, as are their spouses and children. And even for those who stay at the same job, insurance coverage often changes. In 2019, more than half of all firms offering health benefits reported shopping for a new health plan and, among those, nearly 20 percent actually changed insurance carriers. Trading off choice of doctors or hospitals for **choice of insurance** companies is a bad bargain.

AT: Quality

American health care rations by cost, and single-payer reduces wait times. The Canada case is not instructive

Khazan 13 Olga Khazan, staff writer at the Atlantic. "Universal Healthcare Doesn't Mean Waiting Longer to See a Doctor." *The Atlantic*, 19 November 2013. https://www.theatlantic.com/health/archive/2013/11/universal-healthcare-doesnt-mean-waiting-longer-to-see-a-doctor/281614/. [Premier]

Opponents of healthcare reform have, historically, argued that we should be wary of imitating foreign healthcare systems because people in other countries have to **wait longer to see the doctor**. Cheaper, more universal care, the argument seems to be, comes with the tradeoff of slower care.

This is not necessarily true, according to new numbers from the Commonwealth Fund, a nonpartisan organization that studies industrialized healthcare systems around the world.

The organization surveyed between 1,000 and 5,400 people in 11 industrialized nations. The first thing they found is fairly well-known: American healthcare is mind-bogglingly expensive, as compared to that of other Western democracies:

Americans are far more likely to experience a "cost-related" access issue or to spend more than $1,000 out of pocket than citizens of other countries.

But what's less talked-about is that **we don't actually get better access to medical care** for our money. People in many countries that spend far less on healthcare than the U.S. are more likely to say they can usually get a **same-day or next-day appointment** when they need it, and to say they can get after-hours treatment without going to the ER. This is true for countries that have **single-payer systems**, like the U.K. (though not Canada), and for many Western European countries that have multi-payer systems like ours.

Negative

Neg Framing

No Analogs

Abolishing private insurance has no historical or international precedent.

Abelson and Sanger-Katz 19 Reed Abelson (Reporter for The New York Times) and Margot Sanger-Katz (Domestic correspondent for The New York Times). "Medicare for All Would Abolish Private Insurance. 'There's No Precedent in American History.'" The New York Times, 23 March 2019, https://www.nytimes.com/2019/03/23/health/private-health-insurance-medicare-for-all-bernie-sanders.html. [Premier]

But doing away with an entire industry would also be **profoundly disruptive**. The private health insurance business employs at least a half a million people, covers about 250 million Americans, and generates roughly a trillion dollars in revenues. Its companies' stocks are a staple of the mutual funds that make up millions of Americans' retirement savings.

Such a change would shake the entire health care system, which makes up a fifth of the United States economy, as hospitals, doctors, nursing homes and pharmaceutical companies would have to adapt to a new set of rules. Most Americans would have a new insurer — the federal government — and many would find the health insurance stocks in their retirement portfolios much less valuable.

"We're talking about changing flows of money on just a huge scale," said Paul Starr, a sociology professor at Princeton University and author of "The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry."

"There's **no precedent** in American history that compares to this," he said.

Economists have begun wrestling with basic questions about what this sort of change would mean and disagreeing over whether it would cost more or less than the country's current health care system.

No one has examined the **full economic impact** of such plans on jobs, wages, investors, doctors and hospitals — or the health insurance companies themselves. Such an undertaking would be difficult, given the vagueness of key parts of the proposals being discussed and the wide-ranging possible effects.

There are **few international analogues** to the Medicare for all proposals, but Canada, which provides similar doctor and hospital benefits for its residents, probably comes closest. Even there, people **buy private insurance** for benefits that are not covered by the government program, like prescription drugs and dental care.

Most other countries with single-payer systems allow a more expansive, competing role for private coverage. In Britain, for example, everyone is covered by a public system, but people can **pay extra** for insurance that gives them access to private doctors. Most countries in Europe don't have single-payer systems, but instead allow private insurance companies to compete under extremely tight regulations.

Starr 16 Paul Starr, Co-founder and co-editor of the The American Prospect and professor of sociology and public affairs at Princeton University. "The Larger Problems of the Sanders Single Payer Plan." Prospect. 29 February 2016. www.prospect.org/article/larger-problems-sanders-single-payer-plan. [Premier]

Sanders and his supporters **misrepresent** the experience of other countries. Many countries with universal coverage have **multiple insurance funds** and still have much lower costs than in the United States. Concentrating payment in a single payer-and making the national government that payer-is not the essential requirement for an improved health-care system. Canada, so often cited as the model of single-payer, organizes and finances health care at the provincial level. Other countries with multiple payers have **regulatory and bargaining arrangements** that keep costs under control.

Most of the European countries with national insurance systems introduced their programs long ago, when health care was a **small fraction** of their economy. They did not have to expropriate a highly developed private insurance system. The challenges are altogether different when health care represents more than one-sixth of the economy and private institutions are already in place serving the same functions as a federally financed and controlled system. Just as other countries generally built on their previous institutions, so can the United States.

Alternatives Solve

We can improve quality of care without increasing costs by requiring employer insurance, controlling drug costs, and streamlining administration.

Eichhorn and Hutchinson 19 Edward Eichhorn, Veteran medical products and services developer and founder of Medilink Consulting Group LLC, and Michael Hutchinson, Senior faculty at the Icahn School of Medicine at Mount Sinai in Manhattan. "Why Medicare-for-All Is Not Good for America." US News. 26 April 2019. https://www.usnews.com/news/healthcare-of-tomorrow/articles/2019-04-26/commentary-why-medicare-for-all-is-not-good-for-america. [Premier]

In our book, "Healing American Healthcare," we describe our Eichhorn-Hutchinson plan. There are six critical objectives that, if achieved, could **improve quality** while **reducing** the **cost** of healthcare by as much $1 trillion per year:

1. Provide universal health care by requiring all employers to provide health insurance for their employees. Establish and provide a national health care option, which we have named Allcare, which would provide the same minimum benefits of the Medicare program. We estimate that the cost of Allcare would be 30% below the average cost of employer-based health insurance today as established by the annual Kaiser Family Foundation Survey. Existing insurers would be invited to compete, and could develop Medicare Advantage-like plans to expand benefit offerings to people under the age of 65.

2. Control drug costs through the establishment of a national negotiating platform that would be shared with all health care systems to prevent and eliminate price gouging in the pharmaceutical industry and unreasonable hospital markups of drugs they administer to their patients. The goal is to reduce the per capita costs of our medications to match the per capita cost of other industrialized democracies. Nonprofit hospitals and nonprofit hospital systems that earn operating profits would be required to pay income tax at the corporate rate.

3. Reduce the complexity and bureaucracy of billing by having a national standard for the cost of care: a national chargemaster for all services provided for patients at any hospital or clinic or doctor's office anywhere in the US regardless of the provider's tax status as for-profit or nonprofit entities.

4. Eliminate hospital facility fees for outpatient testing and standardize all imaging and lab testing fees. While this would be a loss of revenue for hospitals, at the same time hospitals would gain by not having to provide indigent care, since everyone would be insured, and by shedding much of their bureaucratic overhead.

5. Use the health care data that is available to monitor costs, improve quality, and reduce waste, and recommend that Accountable Care Organizations be provided with this data as they work to control costs and improve patient outcomes.

6. Massively reduce the complexity of the Electronic Health Record, or EHR, and EHR-associated measures of efficiency and quality, which are burdensome, insulting and actually reduce efficiency and quality. The EHR is the number one cause of physician burnout – let's let doctors go back to being doctors.

We also believe that employers and individuals should have choice in selecting health insurance. Under our plan, employers could be self-insured, contract with private insurance companies or contract with Allcare. In each case they could have Gold, Silver or Bronze plans to expand physician networks for their employees. This layered plan would allow anyone to be insured at the level of basic Medicare, but by paying extra would gain access to larger pools of doctors. Individuals could also choose between Allcare and private insurance.

Our proposed plan reduces bureaucracy and medical waste, while improving quality and creating much-needed competition. Savings to corporations alone would be as much as $**174 billion** annually.

Today, 15 million Medicaid beneficiaries are employed. Under our plan, they and their families would receive health insurance through their employers. This would reduce the cost of the Medicaid program by 31%.

We believe that our plan provides an opportunity for legislative compromise. Both liberal and moderate Democrats want a universal health care system that covers all Americans. They would like a single-payer system like Medicare-for-All or a combination of public and private payers that would cover everyone. Historically Republicans would like to reduce the federal deficit, and it is likely that they feel a more urgent need to do so with the passage of the tax cut of 2018 that is projected to increase the deficit. Efforts to reduce the federal deficit will likely in part focus on expenditures for Medicare and Medicaid. They also want to give people more choice in health care. All of these goals could be accomplished with the adoption of the Eichhorn Hutchinson Health Care Plan.

Spending

Link

The bill would cost 32 trillion dollars. Proposed funding sources are insufficient and existing estimates don't factor in the cost of long-term care.

Moffitt 19 Robert E. Moffit, Senior Fellow, Health Policy Studies. "New "Medicare for All" Bill Would Kick 181 Million Off Private Insurance." Heritage Foundation. 11 April 2019. https://www.heritage.org/medicare/commentary/new-medicare-all-bill-would-kick-181-million-private-insurance. [Premier]

Curiously, the new Senate bill, like its predecessor, has no financing provisions. Instead, as with the last version, Sanders has offered a list of financing options that could be used to pay for this massive enterprise, including a 4% income-based premium, a 7.5% payroll tax, the elimination of all tax breaks for existing health insurance, and a series of taxes on wealthy citizens.

Independent analysts have concluded that such "options" would **fall far short** of covering the true costs of such a program, meaning that individuals and families would pay much higher taxes than the senator's revenue proposals anticipate. Both the liberal Urban Institute and the conservative Mercatus Center projected that the earlier version of the Sanders' plan would cost approximately **$32 trillion** over 10 years.

Those **earlier projections** are **obsolete**, because the senator has now added a costly long-term care program to the bill's mandatory benefits package.

M4A requires a 70% tax hike, is unpopular among voters, and would cause a physician shortage.

Eichhorn and Hutchinson 19 Edward Eichhorn, Veteran medical products and services developer and founder of Medilink Consulting Group LLC, and Michael Hutchinson, Senior faculty at the Icahn School of Medicine at Mount Sinai in Manhattan. "Why Medicare-for-All Is Not Good for America." US News. 26 April 2019. https://www.usnews.com/news/healthcare-of-tomorrow/articles/2019-04-26/commentary-why-medicare-for-all-is-not-good-for-america. [Premier]

There are many questions about how this approach to universal care would be funded. **No budget** has been provided, though estimates vary from an annual increase in cost of $3.2 trillion to an annual savings of $600 billion. Jayapal said it would likely require raising taxes on the wealthy, and Sanders suggested this could be up to **70%.** Another option could be taxing investment income at the same rate as stock sales.

Under the Medicare-for-All plan, private insurance would be eliminated and physicians who are in private practice would be paid on a fee-for-service basis through a national fee schedule, likely at the current Medicare rate or slightly lower. By eliminating the insurance industry, the plan would also eliminate one million jobs. The new fee schedule would be significantly lower than the current industry fee schedule, which means Medicare-for-All would likely lower physician incomes in a significant way, making a bad situation for physicians even worse.

There are three basic objections to Medicare-for-All. The first is that taxes would go up, so it would not receive bipartisan support. The second is that it's a vote loser. When Americans are polled, 70% say that they approve of

Medicare-for-All. However, when a follow-up question is asked, in which it is made clear that this means everybody would be required to have it, support drops to **38%.** The third and perhaps most important objection is that many experienced doctors would simply leave the profession, and this problem is not solved by retaining the commercial insurance corporations, since this is merely retaining a system that needs to change.

Physicians are the single most important service provider in any healthcare system, and we are facing a shortage. The Association of American Medical Colleges projects that this shortage will worsen, even without the negative influence of Medicare-for-All. And doctors face the highest burnout rate among all professions -- as many as 46% of doctors in the U.S. have suffered from burnout at some time in their careers, according to Dr. Dike Drummond in his article from Family Practice Management Journal.

Impact – Unsustainble

Even their cost estimates would be a political non-starter.

Starr 16 Paul Starr, Co-founder and co-editor of the The American Prospect and professor of sociology and public affairs at Princeton University. "The Larger Problems of the Sanders Single Payer Plan." Prospect. 29 February 2016. www.prospect.org/article/larger-problems-sanders-single-payer-plan. [Premier]

Even if we accept Friedman's **lowball estimates** of the cost, the Sanders plan would require staggering increases in federal taxes. Those increases raise two kinds of questions-about the feasibility of the taxes and about the opportunity costs of using so much tax revenue to substitute for private health expenditures.

Sanders calls for six different increases to fund single-payer. Two of the changes-a new payroll tax of 6.2 percent and a new income tax of 2.2 percent-would affect everyone. The other four increases fall primarily on high-income households (higher income tax rates, taxing capital gains as ordinary income, eliminating deductions, higher estate taxes). Both sets of tax increases create **serious political problems.**

As a result of the first set, the post-tax income of Medicaid beneficiaries (who now receive coverage for **free**) would fall 8.4 percent. Other low- and middle-income people, to be sure, would get coverage worth more than 8.4 percent of their income, but they might not think so. For households with incomes between $18,550 and $75,300, for example, marginal tax rates (payroll and income tax combined) would rise from 30.3 percent to 38.9 percent. That will be a **hard sell**. Whether people at that income level with employer-provided insurance would objectively be winners or losers under the Sanders plan depends on whether Friedman's or Thorpe's cost estimates are right. (Thorpe estimates that 70 percent of the privately insured come out losers.) But, subjectively, even many winners would see themselves as losers because they don't feel that their employer's health-insurance payments were their money to begin with. Perceptions bias calculations against a tax-financed alternative.

The tax increases affecting high-income households raise other problems. I am in favor of more progressive taxes, but there is **no peacetime precedent** in American history for increases of the magnitude Sanders is talking about. In his health care and other proposals, Sanders proposes raising the top marginal rate on earnings (income taxes and payroll tax combined) to **77 percent**-higher than in Sweden (67 percent), Denmark (55.6 percent), or any other European country. The capital-gains tax rate that Sanders is proposing (64.2 percent, not counting his financial transaction tax) would so high as to be **counterproductive**. At that level, the tax wouldn't **generate the expected revenue**. People would hold on to appreciated assets rather than sell them, and capital would be locked into present uses, depressing new investment.

Medicare spending is already unsustainable.

Atlas 20 Scott W. Atlas, Senior fellow at Stanford University's Hoover Institution. "The Dangers of Medicare for All." The New York Times. 9 March 2020. https://www.nytimes.com/2020/03/09/opinion/medicare-for-all-cost.html. [Premier]

We also must not ignore the fact that Medicare is already facing serious financial challenges. A projection in the 2019 Medicare trustees' report states that the Hospital Insurance Trust Fund, one of two Medicare funds, will be **depleted in 2026.** On top of that is the issue of funding the program. Just as the population of older people is greatly expanding, the taxpayer base financing the program is greatly.

Medicare now spends over $740 billion for more than 60 million enrollees, but taxpaying workers per beneficiary — will decline by half in 2030 from when Medicare began. Nearly four million Americans now reach age

65 every year. In 2050, the 65-and-over population is projected to have almost doubled from 2012. America's aging population means more heart disease, cancer, stroke and dementia — diseases that depend most on specialists, complex technology and innovative drugs for diagnosis and treatment. The current trajectory of the system is **unsustainable.**

Program isn't fiscally sustainable and hurts hospital budgets.

McArdle 17 Megan McArdle, Bloomberg View columnist. "Why Not Try 'Medicare for All'? Glad You Asked." Bloomberg. 7 June 2017. https://www.bloomberg.com/view/articles/2017-06-07/why-not-try-medicare-for-all-glad-you-asked. [Premier]

When arguing about national health care in this country, those favoring some sort of government-led system always come back to one argument. "But everyone loves Medicare," they say. "If Medicare's so great, **why not expand it to everyone?"** Indeed, Alan Grayson, a Democratic congressman from Florida, recently introduced a bill that would allow people of any age to buy into the program. And what's wrong with that? After all, if people buy in, it won't cost the government a dime, right? I'm so glad you asked. For one thing, as Obamacare has shown, "people will be paying for it, not the government, so what's the problem?" is not quite as simple as it sounded when you were saying it in front of a room of cheering supporters. For whom is it likely to be a good deal? Sick people. Medicare can adjust the buy-in premium to take account of this, but then next year, folks are going to be looking at the new higher premiums, and who is likely to opt in at that high price? The sickest folks in the insurance pool. Better adjust those premiums again … Yes, it's our old friend, adverse selection, which pops up **whenever you build an insurance market without underwriting**. Medicare is a government program, so it can't death spiral out of existence. **However**, **there will be considerable political pressure to set the premiums well below the expected actuarial expenditure on care for beneficiaries**. So **instead of a death spiral, you get a fiscal crisis** in Medicare. Yet here's a measure of how badly thought out this idea of expanded Medicare is: Adverse selection isn't even its biggest problem. A far bigger problem is what this might do to hospital budgets. Why? Because Medicare **doesn't** necessarily **pay enough to keep** those **hospitals running**. Deep in the weeds of health wonkdom, a long battle has been going on over whether -- and to what extent -- Medicare controls its costs by offloading them onto private insurers, a phenomenon called cost shifting. Conservatives often promote a somewhat simplistic version of this argument: Medicare pays too little, so hospitals have to charge insurers more to make up the lost reimbursements. As stated, this is probably wrong. The empirical evidence to support it is weak, and even just theoretically, this misunderstands how market actors behave. It treats costs as a budget problem: Companies have to cover certain costs, and if one customer pays less, another customer has to pay more. (Liberals often make this mistake in reverse when talking about drug prices, assuming that if the U.S. cracked down on pharmaceutical reimbursements, European governments would have to raise their reimbursements to make up for the lost cash, thereby ending their free riding on the new drugs produced from U.S.-derived profits.) In fact, economists generally assume that sellers are charging each buyer as much as they can. Having one customer refuse to pay so much doesn't make your other customers more willing to pay, so there's no reason to think that you'll be able to raise the price you charge them. However, **there remains an undeniable fact: Medicare pays significantly less than private insurers.** And this can't simply be explained by the fact that Medicare covers a huge number of people, because so do Aetna and Humana and Anthem and Blue Cross.

Impact – Economy

Taxes for single payer would destroy the economy.

Tanner 17 Michael Tanner is a senior fellow at the Cato Institute and the author of Going for Broke: Deficits, Debt, and the Entitlement Crisis. "Embracing the Hard Realities of Health-Care Reform." National Review. 7 June 2017. www.nationalreview.com/article/448350/health-care-reform-reality-check-single-payer-model-economically-ruinous. [Premier]

The **utopian fantasy** of a **single-payer** system is attractive to many voters, but **it would destroy the American economy.** It is an old joke among health-policy wonks that what the American people really want from health-care reform is unlimited care, from the doctor of their choice, with no wait, free of charge. For Republicans, trying to square this circle has led to panic, paralysis, and half-baked policy proposals such as the Obamacare-replacement bill that passed the House last month. For Democrats, it has led from simple disasters such as Obamacare itself to a position somewhere between fantasy and delusion. The latest effort to fix health care with fairy dust comes from California, whose Senate voted last week to establish a statewide single-payer system. As ambitious as the California legislation is, encompassing everything from routine checkups to dental and nursing-home care, its authors haven't yet figured out how it will be paid for. The plan includes no copays, premiums, or deductibles. Perhaps that's because the legislature's own estimates suggest it would cost at least $400 billion, more than the state's entire present-day budget. In fairness, legislators hope to recoup about half that amount from the federal government and the elimination of existing state and local health programs. But even so, the plan would necessitate a $200 billion tax hike. One suggestion being bandied about is a 15 percent state payroll tax. Ouch. The cost of California's plan is **right in line with that of other recent single-payer proposals**. For example, last fall, Colorado voters rejected a proposal to establish a single-payer system in that state that was projected to cost more than $64 billion per year by 2028. Voters apparently took note of the fact that, even after figuring in savings from existing programs, possible federal funding, and a new 10 percent payroll tax, the plan would have still run a $12 billion deficit within ten years. Similarly, last year Vermont was forced to abandon its efforts to set up a single-payer system after it couldn't find a way to pay for the plan's nearly $4 trillion price tag. The state had considered a number of financing mechanisms, including an 11.5 percent payroll tax and an income-tax hike (disguised as a premium) to 9.5 percent. On the national level, who could forget Bernie Sanders's proposed "Medicare for All" system, which would have cost $13.8 trillion over its first decade of operation? Bernie would have paid for his plan by increasing the top U.S. income-tax rate to an astounding 52 percent, raising everyone else's income taxes by 2.2 percentage points, and raising payroll taxes by 6.2 points. Of course, it is no surprise that Medicare for All would be so expensive, since our current Medicare program is running $58 trillion in the red going forward. It turns out that "free" health care isn't really free at all. How, though, could a single-payer system possibly cost so much? Aren't we constantly told that other countries spend far less than we do on health care? It is true that the U.S. spends nearly a third more on health care than the second-highest-spending developed country (Sweden), both in per capita dollars and as a percentage of GDP. But that reduction in spending can come with a price of its own**: The most effective way to hold down health-care costs is to limit the availability of care**. Some other developed countries ration care directly. Some spend less on facilities, technology, or physician incomes, leading to long waits for care. Such trade-offs are not inherently bad, and not all health care is of equal value, though that would seem to be a determination most appropriately made by patients rather than the government. But the fact remains that no health care system anywhere in the world provides everyone with unlimited care. Moreover, **foreign health-care systems rely heavily on the U.S. system to drive medical innovation and technology**. There's a reason why more than half of all new drugs are patented in the United States, and why 80 percent of non-pharmaceutical medical breakthroughs, from transplants to MRIs, were introduced first here. **If the U.S. were to reduce its investment in such innovation in order to bring costs into line with international norms**, would other countries pick up the slack, or would the next revolutionary cancer drug simply never be developed? In the end, there is still no free lunch. American **single-payer advocates** simply **ignore these trade-offs**. They know that their fellow citizens instinctively resist rationing imposed from outside, so they promise "unlimited" care for all, which is about as realistic as promising personal unicorns for all. In the process, they also ignore the fact that many of the systems they admire are neither single-payer nor free to patients. Above and beyond the **exorbitant taxes that must almost always be levied to fund their single-payer schemes,** many of these countries impose other costs on patients. There are frequently co-payments, deductibles, and other cost-sharing requirements. In fact, in countries such as Australia, Germany, Japan, the Netherlands, and Switzerland, consumers cover a greater portion of health-care spending out-of-pocket than do Americans. But **American single-payer proposals**

eliminate most or all such cost-sharing. Adopting a single-payer system would crush the American economy, lowering **wages, destroy**ing **jobs, and throw**ing **millions into poverty.** The Tax Foundation, for instance, estimated **that Sanders's plan would** have **reduce**d the U**.S. GDP by 9.5 percent and after-tax income for all Americans by an average of 12.8 percent** in the long run. That is, simply put, not going to happen. So Americans are likely to end up with a lot less health care and than they have been promised. Santa Claus will always be more popular than the Grinch. But the health-care debate needs a bit more Grinch and a lot less Santa Claus. Americans cannot have unlimited care, from the doctor of their choice, with no wait, for free. The politician that tells them as much **will not be popular**. But **he or she may save them from** something that will much more likely resemble **a nightmare** than a utopian dream.

Impact – Turns Access

Increases in taxes means Americans would overall be worse off.

Haislmaierm and Hall 19 Edmund Haislmaierm, Preston A. Wells, Jr. Senior Research Fellow, and Jamie Hall, Research Fellow, Quantitative Analysis. "How “Medicare for All” Harms Working Americans." Heritage Foundation. 19 November 2019, https://www.heritage.org/health-care-reform/report/how-medicare-all-harms-working-americans. [Premier]

Advocates of this idea suggest that Americans currently covered by private health plans would be financially better off, even after their taxes are raised to fund the proposed new government program. For example, Senator Bernie Sanders (I–VT) has said: “Are people going to pay more in taxes? Yes. But at the end of the day, the overwhelming majority of people are going to end up paying less for health care because they aren’t paying premiums, co-payments or deductibles.”2

That assertion is **incorrect.** Our analysis finds that in order to fund such a program, it would be necessary for the federal government to impose substantial, broad-based taxes equal to 21.2 percent of all wage and salary income. Those taxes would be in addition to the payroll taxes that most workers already pay for the existing Social Security and Medicare programs, bringing total payroll taxes to 36.5 percent for most workers.3 We also find that nearly **two-thirds** of American households (65.5 percent, comprising 73.5 percent of the population) would experience reductions in their disposable income, making them financially **worse off.** Those households would pay more in new taxes to fund the program than they would save as a result of the program eliminating their current spending on private health insurance and out-of-pocket medical expenses.

After accounting for both the tax increases and the reductions in private spending for health insurance and medical care, we find that average annual household disposable income would decline by $5,671 (or **11 percent**) under a new government-run health care program.

Among households with employer-sponsored health benefits, 87.2 percent would be worse off financially under a new government-run health care program, and their annual disposable income would be $10,554 lower, on average. That would occur despite those households receiving wage increases, as employers responded to the new program by converting the value of current tax-free, employer-provided health benefits into additional taxable cash income.4 The reason: Workers would pay much higher taxes to fund the cost of the new program because workers would need to (1) replace their own private spending, (2) replace non-workers’ private spending, and (3) pay for the additional spending that would result from the program stimulating increased use of medical care.

Impact – Other Programs

Independently, there is an opportunity cost to spending tax dollars.

Starr 16 Paul Starr, Co-founder and co-editor of the The American Prospect and professor of sociology and public affairs at Princeton University. "The Larger Problems of the Sanders Single Payer Plan." Prospect. 29 February 2016. www.prospect.org/article/larger-problems-sanders-single-payer-plan. [Premier]

We need more tax revenue, but we need to find it at more reasonable rates and with a wholly different approach (see my article, "How Gilded Ages End," Spring 2015, for a strategy that emphasizes attacking tax privileges). Moreover, we need that revenue to do things that **aren't being done** now-not to substitute for hundreds of billions of dollars in current private health spending. The Sanders health plan imposes an **enormous opportunity cost** from a progressive standpoint. All that tax money substituting for private premiums is money that isn't available for **other public purposes**. Once you get to 77 percent marginal income-tax rates, where do you go next if your cost estimates have been too low or for any of the many public purposes not served by Sanders's program?

Innovation

Link – Coverage

Coverage expansion tanks pharma.

Philipson 10 Philipson, Thomas J. Ph.D. and the Daniel Levin Professor of Public Policy at The University of Chicago and The Chairman of Project FDA of The Manhattan Institute. In 2003-04, he served as the Senior Economic Advisor to the Commissioner of the FDA. "We Can't Lose Our Global Leadership In Medical Innovation." Fox News. 23 April 2010. www.foxnews.com/opinion/2010/04/23/tomas-philipson-obamacare-health-care-europe-medical-innovation.html. [Premier]

As a European with dual U.S. citizenship, I'm skeptical about whether European social policies truly benefit those they are intended to help. And I'm deeply concerned that America's embrace of the European solidarity model will come at the expense of another, ultimately a more valuable brand of solidarity: solidarity with the young and with future generations, who depend on continued **medical innovations**. **If the U.S.**, in the name of funding a new **universal health care entitlement**, **abandons its global leadership in medical innovation**, we'll be **selling our future short.** European nations have set price controls or other restrictions on new drugs, diagnostics, and medical devices that limit patient access to those technologies – and limit profits for the companies that make them. Partly due to these government controls, Europe manages to spend significantly less than the U.S. does while still maintaining fairly advanced medical systems. Has Europe found some new way to have their cake and eat it too – enjoying both lower costs and high levels of innovation? In a word, no. Solidarity is cheap in Europe, but only because it is expensive in the U.S. **The United States generates the lion's share of global profits for medical innovators**, because so far U.S. policymakers have **rejected explicit price controls** on private markets. For example, **more than half the world's sales of drugs occur in the U.S.**, even though the U.S. represents only about one-fifth of the world economy. **Profits generated in the United States allow innovators across the world to fund the expensive R&D efforts that are critical for bringing innovative new medicines to market**. Countries like the United Kingdom, with just 3% of world drug sales, face very different incentives. In fact, it is in their self-interest to provide solidarity through government-controlled prices, because such a policy does not significantly affect the flow of new medicines into Britain. **As long as the U.S. underwrites world innovation, E.U. member countries can "free ride" on the new flow of treatments largely paid for by American free-market policies.** However**, if the U.S. were to start acting like a European country** – as seems likely in the wake of health care reform and the resulting fiscal pressures to come– **innovation would lessen world-wide, reducing the flow of new and valuable products both to Americans and Europeans**. **The U.S. faces real innovation tradeoffs in creating new health care entitlements**; European countries don't. Proponents of American reform may still claim that it merely aims to eliminate wasteful spending. However, the consensus in the research community is that **new technologies are the main source of cost-growth in the U.S.**, but they also generate far larger health benefits than increased spending. Waste does need to be eliminated, particularly in public programs, but it is not the primary factor driving health care inflation. Put differently, insurance plans offering 1980s technologies with the corresponding lower premiums would not survive today. Because of the economic value of innovation, by moving toward the European government-based model of care **the U.S. faces a choice** between two forms of solidarity. One is the most commonly articulated version of solidarity with those who currently cannot afford care: universal coverage. It's all about the present and the near term. The other version is solidarity towards the younger population and future generations, who will inevitably suffer from U.S.-based reforms that reduce medical innovation. It's about the long term. In effect, American solidarity with the less affluent today risks shortchanging the young tomorrow.

Link – Lower Cost

Driving prices down eliminates the investment motive for innovation.

McArdle 16 McArdle, Megan. Bloomberg View columnist who wrote for the Daily Beast, Newsweek, the Atlantic and the Economist and founded the blog Asymmetrical Information. "High Prices Today, Effective Drugs Tomorrow." Bloomberg News. 7 December 2016. https://www.bloomberg.com/view/articles/2016-12-07/high-prices-today-effective-drugs-tomorrow. [Premier]

A few days ago, Sarah Kliff of Vox published a sort of cartoon guide to pharmaceutical pricing, which I recommend. The basic arguments will probably be familiar to readers of this column, but her stick figures make an important point: When we talk about what to do about pharmaceutical prices, we have to think hard about the trade-offs we're willing to make. America pays higher prices for drugs because the government doesn't negotiate with insurers. The government doesn't negotiate with insurers in part because we have a powerful pharmaceutical industry that lobbies the government not to, but also in part because we're not willing to have the government say, "Nope, we've decided you can't sell your expensive treatment here," which is a major way that other governments get their bargaining power. Telling Americans they can't have stuff is really politically unpopular, so we mostly don't do that. Instead, we pay some of the highest prices in the world for prescription drugs. That sounds terrible! But it also has a benefit: Those **profits give drug companies the necessary incentive for innovation**. **This issue is often misunderstood on the left**, where the argument goes: "If we slashed their profits by 90 percent, they'd still be making money, so obviously they don't need such high profits in order to do research." This is a fundamental misunderstanding of how profits function in the pharmaceutical industry, where **funding research is not a budget problem; it's an investment problem.** A budget problem is deciding whether you want to buy steak or tofu. You're definitely going to eat; the question is only how much you're going to spend to do so. An investment problem is how you decide how much you want to gamble on future gains, instead of spending that money on something you'd like to consume right now. One major consideration is not just how much you'd like to invest, but where you'd like to invest it. And when you start looking at investment, you quickly start thinking about risk versus reward. You probably do this in your own financial life. You can buy a new flat panel television, which would definitely be nice. Or you could put that money in the bank, where it will earn you some nanofraction of a cent in interest and frequent e-mails from your bank urging you to "go green" and sign up for electronic statements. Or you could invest it in the stock market, where the potential returns are much higher but there's also a greater possibility that you will lose your investment. When you decide how much of your money to put in each place, you're making a trade-off between risks and potential rewards. Investors also do this when they're deciding which companies to invest in: a grocery store that offers razor-thin profit margins, but probably isn't going to see demand for its product vanish any time soon, or something like a tech startup, where you could make a lot of money or you could end up with some commemorative stock shares from Pets.com. Companies go through a version of the same process when they decide what internal projects get funded. **Pharmaceutical investment is a particularly risky move, because it requires a huge amount of money to research and develop a new drug**. And unlike most markets, there's a binary hurdle once you've finished developing the product: Either you get FDA approval, or you don't. **Most drug candidates don't pan out, and all that invested money is a complete write-off.** So consider the math of our two potential investments: groceries or pharmaceuticals. If you invest in groceries, you get, say, a 5 percent return on your money, all but guaranteed. That same investment in pharmaceutical research may get, a 100 percent return on your money if their new drug candidate succeeds, but there's a 90 percent chance of getting nothing. 1 If you just look at the profits, the biotech firm seems to be an obviously better option -- 100 percent returns! Once you add in risk, however, it doesn't look nearly as exciting; the expected value of your biotech investment is only 10 percent (because of the likelihood of a whiff), while the expected value of your grocery investment is 5 percent. The biotech firm still has a higher expected value, of course. Investments with highly variable returns need to pay a "risk premium" because people worry about losing everything, which is why stocks offer higher long-term returns than bonds and why pharmaceutical companies have higher profit margins than Wal-Mart. **America's high pharmaceutical prices are what compensates pharmaceutical firms for the risk of developing drugs. If we drive them lower, we'll get fewer new drugs.** That makes for a hard trade-off: Higher prices drive up the cost

of health care and mean that some folks may have trouble accessing the latest wonder drugs until they lose patent protection after a decade or so. There's certainly a conversation worth having about whether the innovations we're getting are worth the cost we're paying. At a time when we're getting exciting new treatments for intractable diseases like cancer and Hepatitis C, I'd say the answer is "yes"; others will have different answers. But as we're having this conversation, there's one thing we should keep in mind: the people who are missing from the discussion. Which is to say, the people, many of them unborn, who aren't sick yet but will be, and who could be helped or even cured by treatments that haven't yet been developed. **Pharmaceutical research is cumulative**. With the notable exception of antimicrobials, whose usefulness degrades over time because strains of bacteria and viruses and fungi develop drug resistance, **every new innovation goes into our disease-fighting arsenal and stays there to help every future patient**. After a few years of obscene profits, most of these innovations will be pretty cheap and widely available. **Every useful weapon we decide not to try to produce for that arsenal comes at a cost to future people's health.** This matters because there are a lot of future people -- more than there are current people. They don't get a voice in today's debates, but we should consider their interests when we talk about pharmaceutical pricing, as we do when we debate what to do about global warming or our entitlements crisis. We're certainly leaving future generations enough problems. Let's offer them some solutions as well.

Link – Drug Pricing

Price controls ruin innovation globally---turns and solves disease

Easton 18 Easton, Robert J. Co-chairman of Bionest Partners, a global medical business consultancy serving pharmaceutical, medical device, and diagnostic firms and their investors. "Price controls would stifle innovation in the pharmaceutical industry." Stat News. 22 January 2018. https://www.statnews.com/2018/01/22/price-controls-pharmaceutical-industry/. [Premier]

Consumer access to affordable and effective medicines is an important issue. As the cost of many drugs continues to rise, sometimes astronomically, some have suggested imposing price controls on the U.S. pharmaceutical industry. Doing that risks **crippling our only hope of curing the many serious diseases that still plague us.**

The global pharmaceutical industry is among the most profitable, driven by its ability to price to value, especially in the United States. High profits attract investors and generate money for research. The global pharmaceutical industry's investment in research and development is second, barely, to the computer and electronics industry and well beyond that of most other industries. For comparison, the top 10 pharmaceutical companies spend five times more on research and development as a percent of sales than do the top 18 U.S. chemical companies.

The pharma industry's efforts have been quite productive in attacking some of **the most vexing problems in medicine.** Cardiovascular mortality in the U.S. has declined more than 50 percent since the introduction of propranolol, the first beta blocker, in 1964. Many cancers, such as childhood leukemia, have almost been cured. AIDS is now a chronic disease, as the death rate has declined from near 100 percent to near 0 percent. Hepatitis C is now curable. Even metastatic melanoma, formerly a death sentence for 95 percent of its victims, is now curable for many. Lung cancer may be next. All these miracles have been brought through the clinic and into the market by commercial pharmaceutical companies.

Yet there remain **huge unmet needs** for new and better treatments for most **cancers**; all neurological problems, especially **Alzheimer's** disease; most autoimmune diseases; most major gastrointestinal disorders; macular degeneration; and diabetes — not to mention the global scourge of **drug-resistant** bacterial and viral infections. Advances in these areas will come if **money continues flowing** to pharmaceutical companies and their **primary sources of innovation**, biotechnology startups.

But if U.S. drug prices come under bureaucratic control, as they have in most of Europe and Japan, it will be a different story. Little pharmaceutical innovation occurs in price-control jurisdictions. The United States has always, by a large margin, **led the world** as a source of new drugs, and that lead has widened as Japan and Germany have imposed price controls over the past few decades. **All major international pharma**ceutical **companies, without exception**, have instituted R&D and commercial operations in the U.S. to **take advantage of its pricing environment.**

If price controls pressure the U.S. industry into a more conventional process industry model, like that of the chemical industry, pharmaceutical R&D budgets would be **slashed.** To achieve the chemical industry's rate of R&D spending, as would be required to achieve profitability competitive with the chemical industry, top pharmaceutical companies would have to reduce their R&D budgets by **80 percent** — almost $50 billion in total. This reduction in spending would take a few years to realize, but would be completely evident by 2023 or earlier.

An important corollary is that, if profitability and value creation opportunities for new drugs declined, the appetite of the venture community for risky, long-term biopharmaceutical investments would **shrink exponentially**. Price controls on drugs would have the surprising effect of accelerating the flow of investment into high technology, where

timelines to market are shorter, less regulated, and less risky. The venture capital community is flush with cash and anxious to invest where high returns can be achieved — ideally within a much shorter time than is typically possible in the realm of drug R&D.

As a society, if we force pharma into a chemical industry model, where there is no biotech equivalent and no venture investing, we will be trading better and sooner effective drugs for better and sooner virtual reality devices and self-driving cars.

Squeezing pharmaceutical R&D spending down to one-fifth of what it is today would also have an enormous impact on the problems that drug developers often choose to address. Orphan diseases would be deprioritized, as the returns under price controls would not warrant the investment. Complex diseases would also be deselected. While Alzheimer's disease and diabetes have huge patient populations, the extremely high cost of conducting the difficult research and the need for huge and complex clinical trials would **dissuade all but the largest companies** from pursuing those illnesses if the potential pricing upside was to be significantly constrained. Moreover, for difficult diseases like schizophrenia, where today's treatments are mostly inadequate, the flow of more effective new treatments would slow from a trickle to a rivulet, depriving those with these conditions from the possibility of relief.

Link – Startups

Status quo is a steady upward trend in biopharma innovation driven by strategic acquisitions – investment in startups is key

Richman et al. 17 Barak Richman, Professor of Law, Duke University Law School, Will Mitchell, Professor of Strategic Management, University of Toronto, Rotman School of Business, Elena Vidal, Assistant Professor of Management, Baruch College/CUNY, Zicklin School of Business, Kevin Schulman, Professor of Medicine, Duke University Medical Center. "Pharmaceutical M&A Activity: Effects on Prices, Innovation, and Competition." Loyola University Chicago Law Journal, Vol. 48, Issue 3. Spring 2017. pp. 787-819. https://scholarship.law.duke.edu/faculty_scholarship/3749/. [Premier]

III. M&A AND R&D—A CHANGING MARKET FOR DISCOVERY Perhaps even more important than the potential impact on prices, some observers and theorists suggest that M&A activity in the pharmaceutical sector might reduce innovative activity in the industry.33 Commentators not only worry that industry consolidation increases prices, but also that it reduces incentives to innovate.34 These commentators express concern that large pharmaceutical firms exhibited diminishing R&D productivity—producing fewer discoveries, generating less valuable discoveries, and creating discoveries that represent more incremental and duplicative innovations.35 In parallel, commentators suggest that the recent merger trend contributed to big pharma's diminishing innovation, in part because mergers are often followed by layoffs in R&D personnel, changes in management and research priorities, and reductions in total R&D spending.36 Our review of data measuring pharmaceutical innovation, however, **tells a different story**. First, even as merger activity in the United States increased over the past ten years, there has been a **steady upward trend** of FDA approvals of new molecular entities ("NMEs") and new biological products ("BLAs").37 Hence, the industry has been highly successful in bringing new products to the market. [Figure Omitted] In addition, the diversity of firms carrying out R&D in the industry grew strikingly. Figure 4 denotes the status of firms receiving approvals from the FDA since 1979, and it illustrates the growing importance of "bio and specialty firms" and of (to a lesser degree) Japanese companies as drug developers for the United States and other markets. Although established United States and European firms continue to be important sources of new products, a vast array of specialized firms, ranging from large biological companies such as Amgen and Biogen to a globally distributed set of smaller specialists, now lead the industry. This fragmentation of the development base reflects both the increasing complexity of science underlying pharmaceutical products and the growing global scope of R&D expertise. [Figure Omitted] This fragmentation and diversification of discovery reveals one significant reason why pharmaceutical M&A activity increased. While established pharma companies such as Pfizer, Merck, GlaxoSmithKline ("GSK"), Eli Lilly, and Novartis continue to develop new drugs in their own labs, they are becoming increasingly dependent on acquiring other firms to fuel their new product lines. **The locus of innovation is shifting** from inside large firms to smaller start-ups and to firms operating in nontraditional geographic markets and complementary product markets. As a result, the pharmaceutical industry appears to be in **significant structural transition**, and the surge of acquisitions reflects that transition. A number of forces are contributing to these industry changes. First, some medical researchers suggest that the frontier of discovery is moving away from small molecules—which has been the core of large pharma research—and toward biologics and delivery systems. One reason for this shift might be diminishing opportunities to discover new molecular innovations. Some academic physicians believe that the molecular space available for new discovery for small molecules is finite, and that current pharmacological technology is pressing against those upper limits.40 Meanwhile, the growth of research on biologics is **rapidly expanding**, and meaningful innovation is coming from research in biological interventions (some call this the "biological revolution," as biologicals constituted more than one third of approvals in 2015). Traditional large pharmaceutical firms do not have dominant expertise in this scientific area, and the shift away from small-compound interventions and toward alternatives means a corresponding shift of innovation away from established pharmaceutical firms. Thus, established firms must pursue strategic acquisitions to sustain sales and pursue market opportunities now available from biological discoveries. The growth of new sources of discovery creates both growing scientific breadth in the industry's underlying knowledge base and increasing market complexity, both domestically and globally.41 Another significant change in the market for innovation is the decline in costs and resources required to pursue meaningful innovation. The growing codification of scientific knowledge has increased the role of information technology ("IT") on research. Thus, information for basic research is much easier both to transmit and to obtain. As a result, startup biotech firms have been able to pursue meaningful innovations while remaining small. Consequently, competition for discovery of new pharmaceutical therapies is robust, and consolidation of big pharma companies **does not seem to threaten the competitiveness of this upstream market for innovation**. Yet while large and established pharmaceutical

companies no longer have the dominant presence in discovery they once did, they still maintain an important comparative advantage over smaller firms from their ownership of large-scale marketing networks in multiple countries. Small firms developing drugs typically do not have the marketing capabilities required to bring those new drugs to global and segmented markets on their own. This need for global reach has been accelerated by the growth of pharmaceutical sales in emerging markets. Where the major markets were once concentrated in North America, Western Europe, and Japan, multiple emerging markets in Asia, South America, and elsewhere are now key targets for global pharmaceutical firms.42 Indeed, China alone is now one of the top three pharmaceutical markets in the world, about level with Japan and markedly behind only the United States.43 To succeed, established pharmaceutical companies now require global reach, while smaller players seeking to expand often need to acquire regional development and/or commercialization targets. Figure 5 highlights the growing importance of a broader range of pharmaceutical markets, particularly in the Asia-Pacific region, and Figure 6 depicts the proportion of acquisition targets that were based in the United States, Western Europe, and Asia between 1991 and 2015. The share of targets in the United States and Europe declined from over 40 percent each in the early 1990s to about 20–25 percent by 2015, while the share of targets based in Asia (other than Japan) grew rapidly, approaching 40 percent in 2015. [Figures Omitted] Serving such a disparate global market requires both refinements to products to suit local demand and local presence for development, regulatory, and marketing activity. While some of the expansion can build on existing internal skills or alliances with local partners, creating a strong local base in multiple markets commonly requires purchasing firms that already have a relevant presence. For these reasons, many smaller firms with valuable discoveries opt to sell their innovative products, and often the entire company, to an established firm that wants to fill its pipeline.46 Such deals provide an **efficient way to leverage existing investments in marketing systems** at the established companies, and they explain much of the growth in M&A activity that occurred during the past two decades.47 Another comparative advantage established firms have over start-ups is their access to the **financing required to obtain FDA approval**, and especially to fund Phase-III human trials or large scale trials at earlier phases. For this reason, start-ups frequently sell their discoveries to large pharmaceutical firms prior to FDA approval and commercialization. Accordingly, large pharmaceutical firms are occupying a different role in drug development. Rather than primarily being creators of innovation— investing in R&D and managing a soup-to-nuts operation—these firms are increasingly functioning as purchasers of innovations and are adding value to the downstream regulatory and commercialization processes. Perhaps ironically, many of the megamergers **contributed to, rather than squelched, the competitiveness of this process**. Mergers often result in the departures of important executives, and many of those executives then form new ventures that aid in turning discoveries—often the discoveries they helped develop before departing to the large company— into commercialized products. One trend is to form small companies that purchase the rights to specific compounds, contract with firms to conduct the appropriate clinical trials to win FDA approval, and then sell to a large pharmaceutical company for distribution and marketing. Such ventures are called "virtual companies" because they conduct neither research nor clinical tests themselves, but manage the development-tocommercialization process through contracting agents. They signal a new disaggregation of the pharmaceutical industry that dilutes many concerns for industry concentration. One remaining question is whether small companies—whether startups engaged in R&D, virtual companies that rely on contracting services, or even mid-sized clinical trial companies that take ownership of discoveries—will find the capital to pay for substantial clinical trials. Even if the industry is moving toward further disaggregation, megamergers might harm competition if it means fewer parties are available to finance the development process. But the **emergence of venture capital ("VC")** in the health care sector helps mitigate any monopsony power that large pharmaceutical companies might have for new discoveries. Even though large pharmaceutical firms are increasingly relying on purchasing rather than producing innovation (it is likely that over 25 percent of total sales of the twenty largest pharmaceutical firms now come from in-licensed products), the **flow of VC into the health sector has increased significantly** in recent years, with health sector VC representing 31 percent of total VC investments in 2007. 48 [Figure Omitted] Although the number of VC investors declined during this recent economic downturn, VC will remain an important part of health care innovation in the years to come. Whether VC is a reliable source of funding for Phase III and other human trials, however, is an open question. Venture capitalists view FDA review and Medicare and insurance reimbursement policies as sources of significant risk that steer VC investments toward firms that do not focus exclusively on health care. Though venture capitalists looked into funding Phase-III trials, they achieved few successes to date. The role of VC is especially important because although the market for discovery is vibrant, it is also fragile, with up to 50 percent of listed firms at risk of going bankrupt in 2017 and many currently trading at less than cash value.49 If the finance and VC markets cannot adequately fund the innovation process, then large pharmaceutical firms with significant cash on hand and reliable sources of income from currently commercialized drugs will have an advantage in the market for purchasing discoveries. Although VC and third-party funding slowed with the current downturn, companies of all sizes are still able to attract sufficient funding to carry discoveries forward, and **the market should remain vibrant for players in addition to big pharma firms**. This suggests that recent **megamergers have not sufficiently concentrated either the market for discoveries to harm the rate of innovation**. Thus, there remains an adequate number of parties capable of shepherding discoveries through to commercialization. In short, we are witnessing a major structural change in the locus of biomedical research. The three trends discussed

herein—that innovation is increasingly occurring within start-ups, that large pharmaceutical companies are increasingly relying on in-licensed products, and that megamergers are potentially concentrating the market for buyers of innovation—will lead to major changes in drug discovery. Although it is unclear whether megamergers stifled innovation within this new industry paradigm, the data do not conclusively suggest that mergers have actually created harm.

Current prices undergird innovation – the aff's expanded coverage generates monopoly-leverage, ensuring price controls that spur investment flight

Grabowski and Manning 17 Henry, Professor Emeritus of Economics at Duke University specializing in the investigation of economics in the pharmaceutical industry, M.A. and Ph.D. from Princeton University, Richard, Ph.D. in Economics from the University of Chicago, former Assistant Professor of Economics at Brigham Young University, Partner at Bates White Economic Consulting. "Drug Prices And Medical Innovation: A Response To Yu, Helms, And Bach." Health Affairs Blog. 2 June 2017. http://healthaffairs.org/blog/2017/06/02/drug-prices-and-medical-innovation-a-response-to-yu-helms-and-bach/. //JBS [Premier]

In a recent Health Affairs Blog post, Nancy Yu, Zachary Helms, and Peter Bach note that prices for top-selling drugs are higher in the United States than in other countries. They conclude that "premium pricing [in the United States] exceeds what is needed to fund global R&D." They further suggest that "lowering the magnitude of the US premium" would have saved $40 billion for US prescription drug purchasers in 2015. Essentially, the authors imply that the US price premium could be significantly reduced without affecting research and development investments or having other adverse effects. **This is a strikingly bold and unfounded conclusion**. There is **no sound economic rationale** to suggest that price ratios across countries or revenue premiums in the United States should match current research and development spending. Hence, the fact that price differences and research and development spending levels fail this **arbitrary test does not offer a basis for sound policy making.** The issue of drug prices is always controversial, but in today's politically charged environment, it seems particularly important to carefully evaluate this post's methods and conclusions—and to do so through the lens of the economic principles that drive companies to search for new medicines and set prices for them. Thought leaders and policy makers would be well advised to approach this issue with a clear-eyed view of facts and underlying principles that govern economic behavior. The Authors Have A Fundamental Misunderstanding Of The Research And Development Investment Process The research and development investment process in pharmaceuticals is **long, costly, and risky**. Only a small proportion of new drug candidates that enter clinical trials (around 10 percent) become new drug introductions. It generally takes more than a decade for the maker of a new drug to perform the costly trials and gain Food and Drug Administration approval, and there is uncertainty concerning a drug's efficacy and safety at every stage of the process. **Economic models of investment behavior under uncertainty** indicate that spending will be driven by the expected future gains from these investments. If US policy makers were to enact regulations that drive prices down significantly, as Yu and her colleagues suggest, **many projects that now have positive expected returns would no longer be profitable**. Current prices would be lower but so would the expected level of future innovation. A recent analysis by Ernst R. Berndt and colleagues published in Health Affairs is instructive in this regard. The authors found that research and development investment in pharmaceuticals generally provides competitive returns historically commensurate with other risky investment activities, but there is high variability across products and over time. They also observed a downward trend in pharmaceutical industry returns for the most recent cohorts, a period when research and development investments have plateaued or even declined for many firms. Another failing of the Yu and colleagues analysis is that they analyze research and development investment in isolation from all other activities and expenses associated with new product development and commercialization. These include the **costs of production**, **management**, **distribution**, **and provision of information** about clinical trial results to physicians and payers. When these other expenses are included along with research and

development costs, taxes, and the need for risk-adjusted returns to investors, as in the Berndt and related studies, **there is no "excess premium"** beyond what is needed to maintain current research and development investment levels as implied by Yu and her colleagues. Drug Price Determinations In The United States And The Other Benchmark Countries The US Market-Based System Ultimately, market-based drug prices will reflect the value and benefits they provide to patients. Drug manufacturers conduct pharmacoeconomic studies to demonstrate the cost-effectiveness of their new drug introductions. In the United States, insurance companies and other agents that administer private employer plans and government insurance plans such as Medicare Part D evaluate these studies and negotiate prices and access conditions. They use various market-oriented instruments in this process, including formulary placements and copayment tiers, rebates, prior authorizations, and step therapy. In this market setting, a new medicine that solves health problems more effectively, or that solves a problem that previously could not be solved, will tend to command a higher price than its alternatives. This explains why new therapies, such as the recently launched hepatitis C drugs, are able to sell at a high price. The new hepatitis C drugs offer something important and valuable that existing therapies simply did not offer. The sellers of these drugs did not charge high prices because they had spent a lot on research and development; they were able to set high prices because the products generated remarkable new value to patients (and to the health care systems that would be less likely to have to pay for higher-cost medical interventions in the future). It is important, but often ignored, that there were multiple contestants in the race to bring these new drugs to market. As succeeding companies have introduced competing hepatitis C drugs, prices have fallen because customers have alternatives to which they can turn if the sellers do not negotiate lower prices (typically in the form of discounts and rebates). The **incentives of market-based prices drive invention, which in turn drives prices down**. In the case of the first hepatitis C drug, Sovaldi, for example, average rebates to Medicaid and the Department of Veterans Affairs, which receive best-price discounts, resulted in price reductions of more than 50 percent when competitive therapies entered the market. Monopoly Buyers Abroad Regulators abroad also evaluate pharmacoeconomic studies in negotiating prices. However, they are **essentially negotiating as monopoly buyers** in most instances. Their governments impose various additional mandatory regulatory measures such as price and quantity controls, international **reference pricing** schemes, and **expenditure caps** that do not exist in market settings. As with all buyers, the objective generally of national purchasers abroad is to obtain new drug products as close as they can to the seller's reservation price or marginal cost of supply, to minimize expected drug expenditures. The difference is that, when the negotiating regulator is the only customer, the ability of the seller to bargain or walk away is severely diminished because some returns are better than none. Refusing to sell medicines that stand to benefit patients in a country also presents reputational challenges for a company. For these reasons, regulators in other countries are able to employ mandatory constraints and controls that extract much lower prices than might be available in market settings. However, if all countries, including the United States, behaved in this manner, **manufacturers would be unable to cover the high fixed costs of research and development investment** and earn a return to sustain future innovation. This is the sense in which **price premiums in the United States provide most of the returns to sustain future innovation**. Correspondingly, US policy measures to lower prices toward these international values would adversely affect current research and development commitments, in contradiction to the conclusions of Yu and her colleagues. The authors' approach also suffers from **numerous biases and related methodological issues**. In particular, several economic studies demonstrate that the outcomes of the research and development process in pharmaceuticals and other innovative industries are highly skewed, with a few high societal value "blockbuster" products accounting for a large share of company sales and returns. By considering only the biggest successes in this process, the authors bias their analysis in favor of finding high US price premiums, particularly in view of the relatively unique market-based price setting process in this country. One would also expect higher market premiums in the United States based on higher incomes and a greater demand for health inputs. Market prices respond to customer incomes; prices are typically lower for customers with less buying power (subject to certain conditions). Thus, many goods and services cost less in countries where incomes are lower. Prescription drugs are no exception. Average US income levels are substantially higher than incomes in all but one of the countries (Ireland) in the Yu and colleagues analysis, so **even in a setting where regulators abroad did not regulate prices, one would expect prices to be higher in the United States on the basis of economic analysis**. This would suggest nothing about the appropriate allocation of the revenue contributions to research and development. The Particular Danger To Start-Ups If The United States Moves Toward International Prices It is also important to recognize that over the past several decades, **hundreds**

of start-ups have emerged in the biopharmaceutical industry, backed by venture capital firms and other early investors that are concentrated in the United States. A few of these start-up companies have evolved into significant entities based on the development of important new therapies, while many others have disappeared given the high failure rate of new drug candidates. A number of the companies on Yu, Helms, and Bach's list are relatively young companies that illustrate this phenomenon; for example, Amgen, Biogen, Celgene, Gilead Sciences, and Cephalon (now a division of Teva) were start-ups in the recent past. Obviously, a new start-up company has no revenues to use for research and development spending, so it **must entice investors** to support its research and development efforts. US policies designed to decrease prices toward those that prevail abroad would have **particularly adverse consequences for young start-ups that invest in uncertain early-stage research**. Venture capital firms do not restrict their activities to investments in new drugs and medical technologies, but also invest in web-based applications, new and improved energy sources, advanced scientific instruments, and many other competing opportunities. **If expected returns in start-up biopharmaceutical companies are reduced, early-stage investors will look elsewhere for returns.** Established companies also respond to these same pressures. If the return to pharmaceutical research and development is reduced, **they will be led to seek other investments by reducing pharmaceutical research and development spending** or will return money to shareholders (through higher dividends or share repurchases) so that the shareholders can invest their money elsewhere. In summary, the authors fail to address the **dynamic nature of research and development investments** and the **expected consequences for future global drug innovation** that would occur from downward pressures on US drug prices to levels prevalent abroad. Rather, the authors look at the geographic distribution of revenue from products already on the market and ask whether the domestic revenues from the US price premiums exceed global research and development investments. **This is a meaningless exercise** from the perspective of assessing policy issues relating to drug prices, research and development investments, and future global biopharmaceutical innovation.

Link – Perception

Perception of price controls alone decks innovation.

Santerre et al. 06 Rexford E. Santerre, John A. Vernon, and Carmelo Giaccotto are Professors of Finance in the Department of Finance's Center for Healthcare and Insurance Studies in the School of Business at the University of Connecticut. "The Impact of Indirect Government Controls on U.S. Drug Prices and R&D." Cato Journal, Vol. 26, No. 1. Winter 2006. https://www.questia.com/library/journal/1G1-145572325/the-impact-of-indirect-government-controls-on-u-s. [Premier]

The threat of more direct price controls **in the future** provides a second method by which government may influence both the level and rate of increase of drug prices. Threat considers that the actions taken by government **today** may provide **a signal** about the invasiveness of actions that the government **might take tomorrow**. For example, some prominent government representatives might voice the opinion that the government should adopt a more rigid drug-pricing policy unless the industry disciplines itself. Facing the increased prospect of direct controls and lowered expected profits, individual drug companies might moderate their price increases. As another example, state or federal politicians might attempt to **initiate** new laws to regulate drug prices. **Regardless of whether laws actually pass**, the drug industry might **perceive that more direct controls are inevitable** unless appropriate actions are immediately implemented. Several proposed laws in the past provide instances where threats of this kind may have worked. As one example, in response to persistently high pharmaceutical profits, Senator Kefauver introduced in 1961 a provision contained in Senate bill 1552 that would have limited pharmaceutical patents to three years of full exclusivity (Comanor 1986). After that period, patent holders would have been required to license their drugs to all approved companies at a prespecified royalty rate. The compulsory licensing provision, however, never passed the parent committee on the judiciary and was not included in the final 1962 drug amendment.3 As another example, in 1966, Senator Long introduced a bill stipulating that drugs purchased under **federall**y aided **programs** should be prescribed under the generic rather than the brand name of the drugs (Schwartzman 1976). While the proposal **only** applied to individuals covered by public drug insurance programs, **it was believed** that the approval of the bill would have caused **a national trend** in private plans as well. Similarly, in 1967, Senator Montoya introduced a bill providing for the reimbursement of the costs of qualified drugs only, which were defined as those drugs acceptable to a formulary committee. Drug reimbursement would have been made on the basis of the lowest drug cost, provided that the drug was of an acceptable quality to the formulary committee. Different aspects of these two bills were merged, modified, and then proposed over the next five years but never progressed beyond the House-Senate Conference Committee. Nevertheless, the **threat** that these proposed laws generated likely **affected the pricing behavior of drug companies** at that time.4

Link – Stats

Best evidence and simulations prove our link arguments.

RAND 08 Regulating Drug Prices. "U.S. Policy Alternatives in a Global Context." 2008. https://www.rand.org/pubs/research_briefs/RB9412.readonline.html. [Premier]

The Effect of Regulation on Pharmaceutical Revenues: Recent Experience in 19 Nations Research points to **an underlying link** between manufacturer revenues and the pace of pharmaceutical innovation: Though some have **challenged** this link, **evidence** suggests that lower profits delay the development and introduction of **new drugs**. Therefore, an important first step in understanding the impact of drug price regulation is examining how regulation affects revenues. To date, there has been little systematic study of this relationship across the full range of developed countries. To remedy this gap, the RAND team examined **the regulatory environment** from 1992 to 2004 and the impact of regulation on pharmaceutical revenues in 19 nations that are members of the Organisation for Economic Co-operation and Development. They also looked at the full array of **regulatory mechanisms**, ranging from **direct price controls** to policies for increasing the **use of generics,** and used **a microsimulation model** to estimate the effects of regulation on drug revenues. The main results showed that (1) drug price regulation increased during the period in question; (2) most regulations **significantly** reduced revenue, with direct price controls having the **greatest** effect; (3) the effect of regulation in a previously unregulated market was greater than the effect of added regulation in a regulated market; and (4) the revenue-reducing impact of regulation increased **over time.**

Impact – Access

Private plans offer crucial competition that drives down costs and improve benefits.

Atlas 20 Scott W. Atlas, Senior fellow at Stanford University's Hoover Institution. "The Dangers of Medicare for All." The New York Times. 9 March 2020. https://www.nytimes.com/2020/03/09/opinion/medicare-for-all-cost.html. [Premier]

But there is another paradigm. The Trump administration has begun breaking down barriers to competition in the health care market by improving transparency essential to value-seeking patients. It has also reduced the government's harmful overregulation of health care and insurance: barring "gag clauses" that prohibit pharmacists from revealing that a prescription drug may cost less than the insurance co-payment if bought with cash; and executive orders that require hospitals and doctors to post prices for procedures under Medicare and that facilitate tools to show patients their out-of-pocket costs have been introduced.

These moves, intended to remove the cloak of mystery around health care prices, are long overdue. The Trump administration has also increased private plan choices under Medicare, through Medicare Advantage, over the past few years. Nationwide, 3,148 private insurance plans now participate in Medicare Advantage, an increase of 15 percent over 2019 and the largest number of plans in the history of the program.

The average Medicare beneficiary can choose from 28 plans offered by seven firms in 2020. The continual increase in choices of coverage under Medicare Advantage to 28 in 2020 from 19 in 2016 reversed the trend of reduced choices under the Obama administration, when 33 plans offered in 2010 declined to 18 in 2015.

And while these private plans provide extra benefits not covered by traditional Medicare, according to the Centers for Medicare and Medicaid Services, **average premiums** for Advantage plans **dropped** this year by **23 percent** compared with 2018 — down to the lowest monthly premiums since 2007 — likely a result of competition among insurers, reversing the average premium costs seen from 2012 through 2015 under the Obama administration.

Voters must realize this. It is pure fantasy to believe that the access and quality Americans enjoy today would be maintained if private insurance — used by more than 217 million Americans — were abolished and everyone used Medicare for All.

Abolishing private insurance, whether by law or via the slower pathway via introducing a public option, will **eliminate the health care access** and **quality** that today's retirees enjoy. Instead, empowering older people to seek value with their money with more flexible coverage and larger, liberalized health savings accounts, stimulating competition among doctors and hospitals, and increasing the supply of medical care will generate what Americans most value and expect from health care — access, choice and quality.

Innovation is key to quality and affordability.

Kessler 04 Daniel P. Kessler, Stanford University, Hoover Institution, and the National Bureau of Economic Research.
"The Effects of Pharmaceutical Price Controls on the Cost and Quality of Medical Care: A Review of the Empirical Literature." http://plg-group.com/wp-content/uploads/2014/03/The-effect-of-pharmacetuical-price-controls-on-the-cost-and-.pdf. [Premier]

I. The two key effects of price regulation on the cost and quality of care The primary goal of drug price regulation is to reduce expenditures by cutting prices. This may affect the cost and quality of care, and thus patient well-being, through two channels. In each case, the effects of price regulation on well-being are theoretically ambiguous. First, regulation may affect cost and quality through its effects on R&D. Regulation-induced reductions in pharmaceutical expenditures mean **lower profits and lower cash** flows for pharmaceutical firms. Lower expected profits translate into a **reduced supply** of external capital, which translates into **reduced investment**. Holding profits constant, lower expected cash flows translate into a reduced supply of internal relative to external capital, which may independently reduce investment, to the extent that external capital markets are imperfect (Vernon 2004). Reduced investment in R&D, in turn, may translate into fewer or less innovative new products. As Danzon (1997, Chapter 5) points out, the implementation of most forms of price regulation tends to intensify this effect. Regulators whose aim is to reduce drug expenditures focus disproportionately on products with high prices and/or volumes, but these targets also tend to be the most innovative. Furthermore, "reference pricing" systems also tend to be **biased against innovative drugs**, to the extent that the unregulated price of drugs within a reference group is positively correlated with their innovativeness. 4 If reduced R&D investment leads to fewer or different types of drug discoveries, there are two possible effects for society. On one hand, reduced R&D may lead to less cost-effective care. In this case, the costs imposed by regulation-induced reductions in R&D, in the form of higher mortality, morbidity, and/or expenditures on other forms of health care, would exceed the savings in R&D expenditures. On the other hand, reduced R&D may lead to more cost-effective care, if the savings in R&D expenditures exceeded the associated costs. Second, regulation may affect cost and quality through prices and use of existing products. On one hand, lower regulated prices may lead to lower costs per use and therefore greater use, which may in turn lead to higher quality and lower overall costs of care. On the other hand, regulation may have unintended consequences for prices and use that mitigate or outweigh its intended benefits. Regulation may actually lead to **increases in the prices** of some products, which in turn may lead to **lower quality and higher costs of care**. In addition, lower regulated prices may **reduce access** to new drugs by leading firms to launch products later in regulated markets than they otherwise would, which would have similar adverse effects. As Danzon, Wang, and Wang (2003) explain, because low prices in one market may "spillover" to others, through parallel trade and external referencing, firms may prefer longer delay or non-launch to accepting a regulated price. Because the magnitudes of these competing effects of regulation on patients' well-being are theoretically indeterminate, the effects of pharmaceutical price regulation have been studied extensively and are the subject of important policy debates. In the following sections, I summarize existing empirical research on this topic. 5 II. The links between price regulation, market performance, and innovation An extensive empirical literature has examined the links in the pharmaceutical industry between regulation, market performance, R&D, and discovery of new drugs.1 Studies examining the link between regulation and market performance find that regulation reduces the incentives for R&D. Ellison and Mullin (2001) assess the effect of regulation on pharmaceutical firms' market values with event studies of the effects of the evolution of President Clinton's health care reform proposal. They identify a 52.3 percent decline in market-adjusted pharmaceutical stock prices over the January 1992- October 1993 period, much of which occurred as the Clinton plan implicitly endorsed price regulation. Vernon (2003) examines the relationship between price regulation and profit margins. Based on data on the world's 20 largest pharmaceutical firms from 1994-99, he finds a significant negative correlation between the proportion of a firm's sales subjected to price regulation, as measured by the proportion of sales from outside the US, and its pre-tax profit margins. In particular, he finds that a 10 percentage point increase in the proportion of sales from outside the US leads to a 2.7 to 3.5 percentage point decline (depending on specification) in profit margin. Vernon (2004) extends this analysis to show, in turn, that declines in a firm's profit margin from a high proportion of outside the-US sales lead to declines in its R&D. He then simulates how global pharmaceutical R&D would respond to a new regulatory regime in which pharmaceutical prices in the US were regulated as they are currently regulated, on average, outside the US. He concludes that this regime would lead to a **decline in industry R&D** of between 23.4 and 32.7 percent. 1 See Comanor (1986) for a review of older work. 6 In addition to reducing incentives for R&D through aggregate firm performance, regulation also reduces incentives for R&D by disproportionately affecting the prices of more innovative drugs (e.g., Danzon 1997, Chapter 5). Danzon and Chao (2000a) estimate the responsiveness of prices to two measures of innovativeness or therapeutic value -- the number of countries in which a molecule has been approved and molecule age. They classify countries as having more versus less stringent price regulation, based on the regulatory regime in effect in 1991-92. Based on IMS data on sales through retail pharmacies from 1991-92, they find that countries with more stringent price regulation have systematically lower prices for widely-approved molecules, holding constant molecule age; however, these countries also have systematically lower prices for older molecules, holding constant the number of countries in which the molecule has been approved. Danzon and Ketcham (2003) study the related question of the effects of more versus less stringent reference pricing systems on the prices of new drugs. They analyze data from Germany, the Netherlands, and New Zealand on the reference price and patient copayment at country-specific product launch date for all products with sales in the first half of 1998 in five major therapeutic categories (antiulcerants, hypoglycemics, antihyperlipidemics, antidepressants, and antihypertensives), for a total of 200 molecules. They find that the reference price of expensive versus inexpensive drugs in more stringent reference pricing systems is disproportionately lower than the analogous relative reference price in less stringent systems. Changes in incentives for R&D, in turn, have a significant effect on firms' R&D investment decisions. Based on data on 14 firms from 1959-91, Gambardella (1995, Chapter 6) finds a significant positive effect of a firm's past sales on R&D. Scherer 7 (2001) finds a significant contemporaneous correlation between aggregate pharmaceutical margins and industry-level R&D from 1962-96. Based on aggregate data for major US pharmaceutical companies from 1952-2001, Giacotto, Santerre, and Vernon (2003) find that increases in real drug prices lead to increases in industry R&D, holding all else constant. They conduct simulations that

indicate that the capitalized value of pharmaceutical R&D spending would have been about 30 percent lower if price regulation had limited the rate of growth of drug prices to the rate of overall price inflation, which would have resulted in 330 to 365 fewer new drugs discovered over that time period.

Grabowski and Vernon (2000) and Lichtenberg (2004c) use data on 11 firms from 1974-1994 and 55 firms from 1953-1996,2 respectively, to isolate the independent effects of expected future profits and cash flows on R&D. Grabowski and Vernon measure expected future profits by industry-level sales of new chemical entities (NCEs) divided by real R&D expenditures and by industry-level profit margins; Lichtenberg measures expected future profits by firm-level market values. These two studies find that R&D responds positively to both factors, but that the effects of expected future profits are greater than the effects of cash flows. Finally, R&D expenditures affect the rate of discovery of new drugs. Based on data on 28 firms from 1969-79, Jensen (1987) shows that R&D expenditures have a significant, positive effect on the number of NCEs discovered. In addition to affecting innovation through the level of R&D, regulation also affects innovation through the return to R&D. Gambardella, Orsenigo, and Pammolli (2000, Table 7) show that output 2 Not all firms in the analysis in Lichtenberg (2004c) report data for all years; the total number of firm/year observations in this analysis is 872. 3 growth responds less to pharmaceutical R&D investment in countries with price regulation than in the US. In a series of studies, DiMasi et al. (1991, 2003) quantify the "price" of innovation by estimating the expected costs of developing a new drug. Their most recent work analyzes confidential data from 10 pharmaceutical firms that account for 42 percent of the industry's total R&D expenditures. This research estimates the average-out-of-pocket cost per new compound discovered during the 1990s to be $403 million (2000 dollars); capitalizing out-of-pocket costs to the point of marketing approval at a discount rate of 11 percent yields a total pre-approval cost of $802 million (2000 dollars). By comparison, DiMasi et al. (1991) reports that the average-out-of-pocket cost per new compound for a random sample of 93 new compounds developed from 1970 to 1982 was $231 million (1987 dollars, capitalized to the point of marketing approval at a discount rate of 9 percent). A related set of empirical studies estimates the effects of intellectual property protection on pharmaceutical R&D. This work is relevant because weaker intellectual property protection decreases pharmaceutical firms' expected returns from innovation just as price regulation does (e.g., Kremer 2002). For this reason, empirical estimates of the effects of intellectual property protection on R&D are a good proxy for the effects of regulation. Pazderka (1998) investigates the impact of the strengthening of intellectual property rights in Canada on R&D in the Canadian pharmaceutical industry. After almost two decades of compulsory licensing of prescription drugs, Canada restored full patent protection in two steps taken in 1987 and 1992. Based on intervalidity 9 comparisons of R&D in Canada, comparisons of Canadian pharmaceutical R&D to OECD averages, and trends in Canada's share of foreign R&D by US pharmaceutical firm s, he finds relative increases in Canadian pharmaceutical R&D spending after 1987. Lanjouw and Cockburn (2001) find that stronger intellectual property protection in developing countries stimulates R&D on drugs that address those countries' health needs. Specifically, they find that increases in intellectual property protection in the 1980s in countries with a high incidence of malaria were accompanied by increases in research related to that disease. Hughes, Moore, and Snyder (2002) simulate the effects of the policy of eliminating all patent protection on prescription drugs, and find that society would lose $5 in benefits of innovation for every dollar gained due to easier access. 4. The link between pharmaceutical innovation and cost and quality of care Empirical evidence shows that both the discovery and use of pharmaceuticals – particularly new or novel compounds – lead to lower medical expenditures and improved health outcomes.5 Lichtenberg (2004b) estimates the effect of the stock of drugs available to treat a disease on the death rate from that disease. He matches data from three sources on the treatments and outcomes for 100 diseases from 1979-98: data from First DataBank's National Drug Data File on the list of all drugs appropriate for treatment of each disease; data from the FDA on the year in which every compound available in the year 1998 was approved as a NME; and data on mean age at death by cause of death from the Compressed Mortality File from the National Center for Health Statistics. He finds that increases in the stock of available compounds to treat a disease lead to significant 1 See Murphy and Topel (2003) for an analysis that quantifies the substantial potential gains to medical research more generally. 10 increases in the mean age at death and reduces the fraction of individuals dying before age 65 from a disease. Lichtenberg concludes this study with a comparison of the total costs and benefits of pharmaceutical knowledge accumulation. He estimates that the increase in the stock of priority-review drugs from 1979-98 (on average, 6.0 drugs per illness) led to an increase in the mean age at death of 0.39 years (4.7 months) – or about 10 percent of the total increase in mean age at death during the period. Based on a value-of-a-year of life of $150,000, the value of this knowledge is about $120 billion per year = 2,000,000 deaths per year * 0.39*150,000. Compared to the total estimated cost of $182 billion of all pharmaceutical expenditures on NME research and spread during the period, he estimates the rate-of-return on investment in pharmaceutical R&D to be 18 percent. The use of drugs, particularly of novel or new drugs, also affects the cost and quality of care. Based on aggregate cross-sectional data from the early 1960s, Miller and Finch (2002) find a significant association between a country's expenditures on pharmaceuticals and quality and length of life. Lichtenberg (1996) estimates the effects of the growth in quantity and novelty of drugs used to treat a disease on the change in the number of days a patient with that disease spends in the hospital. He measures quantity growth with the total number of prescriptions written for patients with each of 50 diseases in the 1980 and 1996 National Ambulatory Medical Care Survey (NAMCS)Drug Mentions files. He measures novelty with an index that is increasing in the dissimilarity of the distribution of compounds prescribed for patients with each disease in 1980 versus 1991. He finds that both growth in quantity and novelty of pharmaceutical use lead to declines in the number of inpatient bed-days. 11 Lichtenberg (2000, 2001, 2002, 2003c) extends this research in important ways. Lichtenberg (2001) estimates the effect of the measures of growth in quantity and novelty above on mortality growth from each disease (both in- and out-of-hospital mortality) and on measures of growth in service utilization other than inpatient hospital bed-days. In this work, he finds that growth in quantity and novelty lead to reduced mortality, but to increased expenditures on ambulatory care. Lichtenberg (2003c) replicates the mortality results in Lichtenberg (2000), but extends the period of analysis to include 1970-1980 as well as 1980-1990/2, and substitutes the quantity of recently-approved drugs for the earlier quantity and novelty measures. Lichtenberg (2001) makes a similar point with an analysis of data from the 1996 Medical Expenditure Panel Survey (MEPS) on 21,230 individuals and the 171,587 prescriptions they received. He estimates the effect of the age of each drug prescribed, as measured by the number of years since the drug's FDA approval, on individuals' subsequent medical spending, morbidity, and mortality, holding constant their other characteristics such as gender, age, education, race, income, insurance status, and medical condition. He finds that individuals consuming newer drugs had fewer hospital stays, lower nursing medical spending of all types, fewer days of work lost, and lower rates of mortality than individuals consuming older drugs. Lichtenberg (2001) replicates the spending results in Lichtenberg (2001) with newer MEPS data from 1996, 1997, and 1998 and several methodological advances. In this work, he finds that a reduction in the age of drugs utilized reduces non-drug expenditure 7.2 times as much as it increases drug expenditure. In particular, he estimates that reducing the mean age of drugs used to treat a condition from 15 years to 12.5 years increases prescription drug spending by $18, but reduces other medical spending by $129. Results from these cross-illness studies are supported by results from studies of patients with specific illnesses. A Lichtenberg (2003a), for example, shows that deaths from HIV in the US declined in response to the one-year-lagged-count of drugs approved by the FDA to treat HIV. Lichtenberg (2004a) assesses the contribution of pharmaceuticals to the increase in cancer survival rates using annual, cancer-site-level mortality rates for 1975-95. Controlling for site of cancer, year, incidence, stage distribution of diagnosed patients, age at diagnosis, and surgery and radiation treatment rates, he finds that cancers for which the stock of drugs increased most rapidly reported the greatest increases in survival rates. Frank et al. (1999) quantify the costs and benefits of treatment for depression with selective-serotonin reuptake inhibitors (SSRIs), a new class of drugs discovered in the 1980s. According to them, a standardized course of treatment with an SSRI costs $305 and yields a probability of being depression-free after 16 weeks of approximately 0.28, leading to a cost per depression-free case of $1,087 (= 305 / .2805). Because 15 percent of patients suffering from depression improve after 16 weeks with no intervention, this implies an incremental cost per depression-free case of $2,346 (= 305 / (0.28 - 0.15)). Although the benefits of freedom from depression are hard to quantify, based on standard assumptions, the benefits of SSRIs are more than worth the costs: every dollar spent on SSRIs generates a return of six to seven dollars.5 Frank et al. (2003) undertake a similar analysis of treatment for schizophrenia. They show that the dramatic increase in the use 4 See also Schulthiß (2002) for a series of disease-specific case studies of the determinants of pharmaceutical use in Europe. 5. See also Cutler (2004, Chapter 4) for an alternative analysis with similar conclusions. 13 of atypical antipsychotic drugs from 1994-95 to 1998-2000 (from 19% to 61% of individuals diagnosed with schizophrenia) was accompanied by a 22–25% decrease in the quality-adjusted cost of care. Gains of this magnitude are not limited to the use of new drugs: according to several studies catalogued in MEDTAP (2004), treatment of heart attack patients with statins and beta-blockers can create enormous improvements in the cost-effectiveness of care as well. iv. The link between price regulation, use of existing products, and cost and quality of care Empirical evidence on the link between regulation and access to and use of existing pharmaceuticals suggests that regulation reduces patients' well-being through this channel as well. This happens because the costs of price regulation, in the form of delayed access to drugs due to regulation-induced delays in new product launches, are unlikely to be outweighed by the benefits, in the form of increased use of drugs due to regulation-induced reductions in price. On one hand, price regulation leads to delays in new product launches. Kyle (2003) matches data on all drugs developed and launched in the 28 largest pharmaceutical markets from 1982-2000 with OECD health data by country and year. She categorizes compounds into therapeutic classes using Medline data on citations to compounds by type of illness. She reports three key findings. First, holding other factors constant, drug launches into price-controlled markets are delayed. Second, drugs discovered by firms headquartered in countries with price controls reach fewer markets and take longer to diffuse than drugs from firms in countries without price controls. 14 Third, firms are less likely to introduce a drug in additional markets after entering a market with price controls. Danzon, Wang, and Wang (2003) estimate the effect of country characteristics on the probability of launch for 65 NCEs that were launched in the UK or US between 1981 and 1998. They find that the probability of launch in one of 21 major pharmaceutical markets is positively related to expected price and volume, controlling for income per capita. They also find significant negative country-specific effects, holding all else constant, for countries that have stringent regulation and have been major parallel importers (i.e., exporters of legitimately produced drugs into other countries without manufacturing firms' authorization). Similarly, Danzon and Ketcham (2003) find that launch lags are longer in countries with more versus less stringent reference pricing systems. Launch delays, in turn, lead to reduced longevity. Lichtenberg (2003b) matches data from the World Health Organization on cause-specific mortality from 52 countries from 1982-2001 with information from the IMS Health Drug Launches database. He finds that launches of NCEs have a strong positive impact on the probability of survival, but that launches of drugs that are not NCEs do not. He concludes this study with calculations of the "mortality cost of launch delays (p. 19). Based on his estimates, increasing a country's launch delay by 5 years would reduce life expectancy by 15 weeks. On the other hand, the benefits from regulation-induced increases in price of pharmaceuticals are unlikely to outweigh these costs. Danzon (1997, Chapter 6) presents evidence that confirms that stringent price regulation reduces the price of originator 15 prescription drugs and increases the overall volume of pharmaceutical consumption. However, she also shows that much of this higher volume is accounted for by molecules not sold in the US – a rough indicator of these molecules' lower therapeutic value.6 Countries with the most stringent price regulation also have the lowest percentage among Danzon's study countries of sales of US-approved molecules. For example, in France, more than half of all sales of cardiovascular drugs in 1992 were of products that either could not meet FDA standards for safety and efficacy or would have sales insufficient to support launch in the US. The potential benefits of price regulation are further mitigated by the fact that regulation may actually lead to price increases of some compounds. For the special case of Category 1 (line extension) new products in Canada, Aris and Wen (1998) show that the controls imposed by the Patented Medicines Prices Review Board led to price increases in some existing products during the 1987-96 period. Based on analysis of the IMS data from Danzon and Chao (2000a), Danzon and Chao (2000b) show that competition from generic drugs lowers prices less in countries with stringent price regulation.7 They hypothesize that this is due to the fact that, in countries with stringent regulation, generic firms earn higher profits by becoming licensed co-marketers or introducing 'new' versions of compounds strategically to obtain higher regulated prices than they do by competing on the basis of price. How does government price regulation of pharmaceuticals affect the cost and quality of medical care? In theory, price regulation could improve patient well-being. Lower regulated prices could lead to lower costs per use and therefore greater use, which may in turn lead to higher quality and lower overall costs of care. But regulation may have a number of consequences that **mitigate or outweigh this effect**: **reduced R&D, delays** in the launch of new drugs even after they have already been discovered, and distortion of patients' and physicians' choices toward compounds with **lower therapeutic value**. Because the magnitudes of the costs and benefits of price regulation are theoretically indeterminate, its effects have been studied empirically and the subject of considerable debate. In this essay, I review existing empirical research on the effects of price regulation of pharmaceuticals. In summary, empirical research finds that price regulation has **adverse effects** on the cost and quality of care. The adverse effects of price regulation occur through two channels. First, price regulation depresses firms' market performance, thereby depressing R&D and the discovery of new drugs. Declines in the number and innovativeness of new drugs, in turn, lead to decreased longevity and higher expenditures on other forms of medical care. Second, price regulation delays drug launches, distorts consumers' choices toward less innovative drugs, and in some cases actually leads to increases in prices. These effects lead to decreased longevity as well.

A 90 day delay in developing new drugs results in 600,000 deaths annually.

Spiegel 17 Andrew Spiegel, Executive director of the Global Colon Cancer Association. "The tragic toll of drug price controls in America." The Hill. 6 May 2017. http://thehill.com/blogs/pundits-blog/healthcare/332205-the-tragic-toll-of-drug-price-controls-in-america. [Premier]

Colon cancer is one of the biggest killers in the developing world. The disease claims more than 600,000 lives every year. **Breakthrough treatments** can contain this disease and dramatically extend life. However, many colon cancer patients are currently denied access to these breakthrough treatments because of short-sighted government policies. In hopes of driving down drug costs, public authorities all over the world have installed price controls in the pharmaceutical market. This approach, though it generates some short-term savings, is ultimately counterproductive. Price controls **significantly restrict** patients' access to **life-saving medications**, condemning many to die from eminently treatable conditions. One of the most popular forms of drug price controls is "reference pricing." Officials group drugs into therapeutic classes, based on how the drugs attack disease. They then set a single price for each class. In fact, several forms of reference pricing do not distinguish between innovative new medications and older generic alternatives. So, for instance, a new, breakthrough medication gets priced exactly the same as an older, less effective drug that's been off-patent for years. By doing this, reference pricing fails to value the innovative nature of the next generation of treatments and cures. The Canadian province of British Columbia has incorporated reference pricing into its public health system. So have Italy, Spain, and Germany. Less developed economies have resorted to even more nefarious means. By issuing so-called "compulsory licenses," they have broken patent protections on innovative medicines. Compulsory licenses were designed to be used only in the event of a public health disaster, but some countries are now using them to drum up discounts for drugs without any plausible connection to an emergency. In Indonesia, compulsory licensing is an industrial policy tool. If a new treatment isn't manufactured locally, anyone can petition the government to break the patent on that product. And, of course, several major

economies have installed straight-up caps on drug prices. South Korea's public insurance system imposes some of the most stringent caps in the world, tightly controlling even generics. Newly introduced generics can't be sold for more than 60 percent of the price of the brand name upon which they're based. And that cap drops to 53 percent after a year. Likewise, India's National Pharmaceutical Price Authority aggressively controls product prices, dictating down the cost of diabetes drugs by 40 percent over the last year and cancer drugs by nearly 90 percent. And these controls are only going to get tighter. Just this February, the World Health Organization released a draft report criticizing industry pricing practices and sketching out a spreadsheet for governments to calculate a "fair price" for medicines. That's a barely disguised call for lower caps. The justification for these controls rests on a simple story: drug prices as a whole are spiraling skyward, preventing sick patients from affording needed medications. **That's pure fiction**. Drugs actually represent a relatively small slice of global medical spending. Just consider: over the next decade, spending on prescriptions will account for **less than 10 percent** of total healthcare spending growth in the OECD, the economic association encompassing the **U**nited **S**tates, Canada, and much of Europe. And the price control **process** significantly degrades patient well-being. Pharmaceutical firms have to undergo **a long, drawn-out negotiating process** every time they want to sell **a new medication** in a controlled market. All the while, sick people aren't getting the medicines they need. In America, which has a relatively free drug market, the average medicine is approved **90 days quicker** than in Europe and about a year quicker than in Canada. This **delay can be deadly, especially for colon cancer patients**. The drug industry has invented advanced drugs proven to beat back this disease, including specialty chemotherapy agents such as panitumumab and "angiogenesis inhibitors," which prevent colon cancer cells from growing by cutting off their blood supply. Obviously, these drugs can only help patients if regulators **approve** them. **Too often, that approval is slow to come**. And such delays are now common across **a wide variety of drug classes**, leading to serious carnage: some 600,000 European deaths could be avoided each year if the continent's healthcare systems simply offered "timely and effective medical treatments," according to the European Union's own data.

Aff balloons costs by eradicating competition.

Patton 15 Patton, Mike. Economy contributor to Forbes. “U.S. Health Care Costs Rise Faster Than Inflation.” Forbes Magazine. 29 June 2015. https://www.forbes.com/sites/mikepatton/2015/06/29/u-s-health-care-costs-rise-faster-than-inflation/#c644b936fa10 [Premier]

One of the promises of Obamacare was that it would reduce health care costs. Since its passage on March 23, 2010, has this promise been kept? In this article, we’ll examine this issue by looking at the annual rate of inflation for the Consumer Price Index, compared to the inflation rate for health care. What Causes Health Care Inflation? Generally speaking, prices rise when demand increases relative to supply. Health care is no different. However, there are other forces that influence the cost of health care. **One would be political decisions such as additional taxes and increased regulations can impact health care costs.** An increase in lawsuits which influence the cost of malpractice insurance for medical practitioners are another factor. For several years during the 2000s, health care costs were rising rapidly, causing concern among patients and insurance companies. According to the November 2013 issue of the Journal of the American Medical Association (JAMA), the primary reason for the rise in health care costs between 2000 and 2011 accounting for 91%, was an increase in the price of drugs, medical devices, and hospital care. Since medical devices were one of the primary contributors to the rise in health care inflation, should Congress have eliminated the 2.3% medical device tax contained in the Affordable Care Act? This tax will be passed on to consumers and insurance companies, causing the price of medical devices to rise further. Rising health care inflation prompts insurance companies to raise premiums. The following chart shows the percentage increase in overall inflation as measured by the consumer price index (all items) and health care inflation from 2005 through May 31, 2015. As you can see, health care inflation has outpaced the CPI in each year except 2008. Moreover, in 2007, 2009, 2010, 2014, and thus far in 2015, the difference is quite significant. It seems that **over-regulation, excessive taxation, and a few additional issues are the root of this problem**. What can be done to reduce health care costs? Health care, like any other industry, **needs competition** to push prices lower. Unfortunately, because each policy must cover the 10 essential health benefits, insurance companies have no latitude to create innovative, customized policies. It reminds me of the original Model-T Ford. You could buy a Model-T in any color you desired, as long as it was black. In my next article, we’ll examine the rising cost of health insurance premiums and compare this to personal income. If premiums increase at a faster rate than income, the consumer suffers. This is one article you won’t want to miss!

Outweighs cost savings potential.

Pope 17 Pope, Chris. Senior fellow at the Manhattan Institute. Served as director of policy research at West Health; health-policy fellow at the U.S. House Committee on Energy and Commerce; fellow at the Heritage Foundation; and research manager at the American Enterprise Institute. "The Single-Payer Mirage," National Review. 26 May 2017. http://www.nationalreview.com/article/447967/single-payer-no-solution. [Premier]

While it is not possible for the government to get more than it pays for, it is certainly possible for it to pay too much for what it gets. When policymakers set prices in the presence of a multitude of lobbyists scattering fears about diminished access to care, payments will frequently exceed the levels that competition would yield. Very few physicians are currently unwilling to accept Medicare patients, which suggests that the program's payment terms (fees, claims reviews, and tax implications) are highly attractive for providers relative to those offered by other payers. Indeed, as providers have a veto over every major Medicare-payment change, reforms tend only to inflate the advantages they enjoy. For laboratory services, where government intervention has not deliberately sought to inflate the prices that private insurers must pay providers, Medicare routinely pays 18 to 30 percent more for the exact same products. Single-payer advocates claim that eliminating private insurers reduces administrative costs. It does this only by letting fraud, waste, and abuse go unchecked. In 2016, 11 percent of claims associated with the single-payer part of Medicare were improperly paid, at a cost of $1,422 per beneficiary. Having a single payer doesn't remove tradeoffs from health care; it just places them out of patients' sight. When many countries established single-payer health care soon after World War II, very few of the expensive procedures that characterize modern health care existed, and so it was simple to cover everything. As costly new drugs and surgical procedures have been invented, in nations where care is available only through a single payer, these have frequently been left unavailable to patients, who often don't know what they're missing. In the United States, a vigorously competitive provider marketplace drives patient expectations to make this method of cost control unrealistic. As a result, it has proven impossible for even a very liberal state like Vermont to afford establishing a comprehensive single-payer entitlement. Equivalent plans for New York and California are likely to experience a similar fate.

Single payer lowers innovation, increases costs, and ruins quality.

Epstein 17 Epstein, Richard A. The Peter and Kirsten Bedford Senior Fellow at the Hoover Institution, the Laurence A. Tisch Professor of Law, New York University Law School, and a senior lecturer at the University of Chicago. "WHY A SINGLE PAYER HEALTH CARE SYSTEM IS A REALLY BAD IDEA." Newsweek. 18 July 2017. www.newsweek.com/why-single-payer-health-care-system-really-bad-idea-638334. [Premier]

But now that the results are in, there are all too many people who think that the cure for excessive government regulation is the complete takeover of the health care market, here in the form of a single-payer system under which the government provides the financing for all health care in the United States, effectively ending the private provision of these services. One notable effort to defend this position comes from the economist Robert Frank, who takes the heroic view that single-payer can provide the same level of health care at lower costs, making it a bargain for the public as a whole. Unfortunately, his analysis is riddled with errors. The program has thus far proved to be a nonstarter in the states—those laboratories of democracy. Places like California, Colorado, and Vermont have gagged at the huge prospective costs of putting that a single-payer system into place. To Frank, this common sense objection rests on the supposed fallacy that an increase in taxes always results in a loss of social welfare. In his view, the benefits of taxation can more than offset those rising taxes if those tax revenues can deliver superior levels of health care in exchange. But this is one big "if." To Frank, one of the two obvious sources of savings are the elimination of competitive advertisements, which he notes can run to 15 percent of total costs. Yet he links to an article that sends a very different message. It praises how additional advertisement can fuel needed revenue growth. Frank is also blind to the benefits of advertisement, which allow consumers to

learn of the full range of services of benefit to them. That increased demand can allow firms to spread their fixed costs over a larger customer base, thereby reducing average costs. Advertisements may not be needed for a national health plan, but only for the worst of all reasons. Legislative menus of mandated goods are so rigid and standardized that firms have **nothing new to sell**. But **this** in turn **reveals the weakness of a top heavy health care plan**, namely not developing a sensible innovation policy because of the inability to market its fruits. **It also leads to a systematic reduction in long-term capital investment, which translates into chronic shortages tomorrow.** Frank also insists that a single-payer system could reduce administrative costs to around two-percent of total budget, or about one-sixth the total for private insurers, including those that operate under the current mandates of the Affordable Care Act. But again, that gross figure is misleading for several reasons. The first is that there is no a priori way to decide just what fraction of health care expenditures should be spent on administration. One of the many design failures of the ACA was its artificial limitation on these expenditures. In a working market, firms try to equilibrate the margin, so that the last dollar spent on each category of expenses generates the same level of additional system benefit. It follows that Medicare and Medicaid may be faulted for spending too little on administrative expenses, hampering their ability to control fraud and making them less able to identify the best treatment protocols—or locate new facilities, train employees, counsel patients, or conduct any number of activities that a sensible business undertakes to improve its market position. **The failure of single-payer health care to innovate is** then **complicated by the impossible constraint whereby people do not have to pay for any of the health care they get.** Despite what Frank alleges, the huge uptick in the quantity of services demanded when participants get all care at zero-price threatens to overwhelm the system. Since single-payer does not ration health care by price, the care gets rationed of necessity in other ways. Thus, the **Canad**ian system relies on long-waiting times to curb demand. Unfortunately, the people at the head of the queue are not always those who have the greatest need for treatment. Even prices that cover a fraction of full costs can help to tamp down on the demand. But, sadly, **no one in a single-payer system has any idea** of **how** these **prices should be set.** Hence, **government's duty to take all comers at a zero price means it cannot re-price efficiently to respond to shifts in supply and demand as is routinely done in airlines, hotels, and leasing in ways that eliminate the queues from price controls.**

Impact – EU Econ

Cheap access to new drugs key to prevent European economic collapse.

Griffiths 13 Griffiths, Jane. Company Group Chairman Janssen Pharmaceutical Companies of Johnson & Johnson Europe, Middle East and Africa. "Investing in European health R&D, A pathway to sustained innovation and stronger economies" Janssen. https://www.quotidianosanita.it/allegati/allegato2141477.pdf. [Premier]

The collaborative research efforts of academia and the pharmaceutical industry in developing **new treatments** have resulted in the most spectacular **increase in life expectancy and quality of life** in the history of mankind. It has been estimated that around 40% of the increase in life expectancy in the last decades is because of the introduction of **innovative new drugs46**. Yet, for the first time in recent years, there is a **stagnation** in health R&D funding, both by public and by private organisations, as you can read in this report. This is extremely worrying if we consider that for the last decade the cost of conducting clinical research has increased by **10%** on average per year.88 It is even more worrying in the context of the **increasing burden of disease and an ageing population** in Europe, and the millions of people whose health **cannot be improved** without new therapeutic approaches. The development of new pharmaceuticals is **crucial** to meeting these challenges, and while pharmaceuticals in general only represent around 17% of healthcare budgets 27, their innovative value has a much greater impact, helping to **reduce overall treatment costs significantly** across many areas of care. Pharmaceutical R&D expenditure is typically generated from company revenue, rather than from public funding. At Janssen R&D investments represent 21% of our sales, and as our business grew, so did our R&D investments, reaching more than $5.3 billion last year. Pharmaceutical research is primarily encouraged by offering the appropriate price to innovative new drugs. Very few industries incur the same financial risks as the innovative pharmaceutical industry, and with on average only 4% to 6% of early development (phase I) compounds ever reaching the market, it is critical that a fair reward system is in place for those molecules that actually become medicines. Today, with effective treatments being available for many diseases, we are moving into an era of transformational innovation, trying to tackle diseases of very high complexity, where **breakthrough science** is needed to deliver value to patients. All this comes at a **price**, but the initial cost of innovation to society is small compared to the long term **economic benefits** of having new treatments. Europe as a whole has historically lagged behind the US in terms of investment in research and development (R&D) in healthcare and life sciences technologies. Since the start of the economic crisis in 2007/8, R&D investments in Europe – from both public and private sources – have been under **further pressure**. Janssen commissioned this study from Deloitte's European Center on Health Economics and Outcomes Research to draw together the relevant data and information into one document and to evaluate this issue in detail. The aim was to present a thorough analysis of the potential consequences of current trends and, based on the evidence, to explore possible scenarios for the future with relevant stakeholders. R&D investments in health have generated substantial and positive outcomes for us today. The most self-evident direct benefit of investing in health R&D is the subsequent **improvement in health outcomes and longevity**. There are numerous examples over recent decades of how new medical interventions have greatly improved population health and wellbeing. In addition, there are also several other benefits of health R&D, such as improving the efficiency of healthcare provision**, gains in productivity** as a result of the improved health status of the working age population, and the positive contributions of health R&D to **overall economic growth** and to the knowledge economy in Europe. Each of these benefits has been documented and demonstrated to be crucial by various commentators, academics, clinicians, health policy experts and patients alike.

Causes multiple scenarios for global war.

Wright 12 Wright, Thomas. fellow with the Managing Global Order at the Brookings Institution. "What if Europe Fails?" The Washington Quarterly. Summer 2012. http://csis.org/files/publication/twq12SummerWright.pdf. [Premier]

Yet, verbal warnings from nervous leaders and economists aside, there has been remarkably little analysis of what the end of European integration might mean for Europe and the rest of the world. This article does not predict that failure will occur it only seeks to explain the geopolitical implications if it does. The severity and trajectory of the crisis since 2008 suggest that failure is a **high-impact** event with a **non-trivial probability.** It may not occur, but it certainly merits serious analysis. Failure is widely seen as an imminent danger.¶ Would the failure of the Euro really mean the beginning of the end of democracy in Europe? Could the global economy survive without a vibrant European economy? What would European architecture look like after the end of European integration? What are the implications for the United States, China, and the Middle East? Since the international order has been primarily a Western construction, with Europe as a key pillar, would the disintegration of the European Union or the Eurozone have lasting and deleterious effects on world politics in the coming decade?¶ Thinking through and prioritizing the consequences of a failed Europe yield five of the utmost importance. First, the most immediate casualty of the failure of the European project would be the global economy. A disorderly collapse (as opposed to an orderly failure, which will be explained shortly) would probably trigger a new depression and could lead to the unraveling of economic integration as countries introduce protectionist measures to limit the contagion effects of a collapse. Bare survival would drag down Europe's economy and would generate increasing and dangerous levels of volatility in the international economic order.¶ Second, the geopolitical consequences of an economic crisis depend not just on the severity of the crisis but also the geopolitical climate in which it occurs. Europe's geopolitical climate is as healthy as can be reasonably expected. This would prevent a simple repeat of the 1930s in Europe, which has been one of the more alarming predictions from some observers, although certain new and fragile democracies in Europe might come under pressure.¶ Third, failure would cement Germany's rise as the leading country in Europe and as an indispensable hub in the European Union and Eurozone, if they continue to exist, but anti-Germanism would become a more potent force in politics on the European periphery.¶ Fourth, economic downturn as a result of disintegration would undermine political authority in those parts of the world where the legitimacy of governments is shallow, and it would exacerbate international tensions where the geopolitical climate is relatively malign. The places most at risk are the Middle East and China.¶ Fifth, disintegration would weaken Europe on the world stage–it would severely damage the transatlantic alliance, both by sapping its resources and by diverting Europe's attention to its internal crisis–and would, finally, undermine the multilateral order.¶ Taking these five implications in their totality, one thing is clear. Failure will badly damage Europe and the international order, but some types of failure–most notably a disorderly collapse–are worse than others. Currently, the pain is concentrated on the so-called European periphery (Greece, Portugal, Spain, Italy, and Ireland). Disorderly collapse would affect all European countries, as well as North America and East Asia. If a solution to the Eurocrisis is perceived as beyond reach, leaders of the major powers will shift their priorities to managing failure in order to contain its effects. This will be strenuously resisted on the periphery, which is already experiencing extremely high levels of pain and does not want to accept the permanence of the status quo. Consequently, their electorates will become more risk-acceptant and will pressure Germany and other core member states to accommodate them through financial transfers and assistance in exchange for not deliberately triggering a break-up. This bitter split will divide and largely define a failing Europe. Absent movement toward a solution, EU politics is about to take an ugly turn.

Impact – Bioterror

Key to stop bioterror.

Poupard 11 Poupard, James. He received a BA in natural science from Temple University, an MS in clinical microbiology from Thomas Jefferson Medical College, and he started his PhD studies in the history of science at Bryn Mawr College and completed his PhD studies at the University of Pennsylvania. He was supervisor of clinical microbiology at the Hospital of the University of Pennsylvania and microbiology director of Bryn Mawr Hospital and later became associate professor of microbiology, pathology, and medicine at the Medical College of Pennsylvania. Pharmaceutical Industry. *Encyclopedia of Bioterrorism Defense, 2nd Edition.* 2011. http://preview.keyanmi.com:28080/414000/7bbe114c82a24edfa414fdf2cc7b448a.pdf. [Premier]

INTRODUCTION The pharmaceutical and biotechnology industries play an important role in providing anti-infective drugs, vaccines, and biologicals (a category of pharmaceutical products consisting not of chemical agents like drugs and not of vaccines but rather of products such as immunomodulators, interferons, and monoclonal antibodies, which are often produced in facilities similar to vaccine production lines since they are usually derived from tissue cultures or, in some cases, from organisms like modified Escherichia coli but are not classic vaccines) **for use in responding to a bioterrorist attack. Research, development, and production programs initiated by the pharmaceutical industry will play a key role in providing new therapeutic agents for use against potential bioterrorist threats,** and **the industry will be an important element in determining future policies relating to bioterrorism defense.**

Extinction.

Myhrvold 13 Myhrvold, Nathan. He is the former Chief Technology Officer at Microsoft, MA and PhD from Princeton University. He held a postdoctoral fellowship at the University of Cambridge working under Stephen Hawking "Strategic Terrorism: a Call to Action." The Lawfare Research Paper Series. July 2013. http://www.lawfareblog.com/wp-content/uploads/2013/07/Strategic-Terrorism-Myhrvold-7-3-2013.pdf. [Premier]

¶ For the first time in human history, the curve of cost ¶ versus lethality has turned rapidly downward, falling ¶ many orders of magnitude in just a generation. Today, ¶ tremendously lethal technology is available on the cheap. ¶Anyone—even a stateless group—**can have** the deadliest weapons on earth. Several trends led to this inflection ¶ point. one is nuclear proliferation, which in recent years ¶ reached a tipping point at which access to nuclear weapons ¶ became impossible to control or limit in any absolute way. ¶ The collapse of the soviet Union scattered ex-soviet weapons across many poorly governed and policed states, and ¶ from there, the weapons may spread further into the hands ¶ of terrorists. At the same time, the set of ragtag countries ¶ that have developed homegrown nuclear devices is large ¶ and growing. The entrance to the nuclear-weapons club, ¶ once limited to a small number of sophisticated and stable ¶ countries, is now far more open.¶ It is only a matter of time before a nuclear bomb gets ¶ into the hands of a terrorist group, whether by theft or construction. A nuclear weapon smuggled into an American ¶ city could kill between 100,000 and 1,000,000 people, depending on the nature of the device, the location of ground ¶ zero, and the altitude of detonation. an optimist might say ¶ that it will take another decade for such a calamity to take ¶ place; a pessimist would point out that the plot may already ¶ be under way.¶ Chemical weapons, particularly nerve agents, are another new addition to the terrorist arsenal. Sarin, a frighteningly lethal poison discovered in 1938 and stockpiled ¶ (although never used) by the nazis, was produced and released in locations in the tokyo subway system in 1995 by ¶ aum shinrikyo, a Japanese religious cult. The attack injured ¶ nearly 3,800 people and killed 12. A botched distribution ¶ scheme in the tokyo subway spared many of the intended¶ victims; better dispersal technology would have resulted in ¶ a vastly higher death toll. ¶ Cult members had more morbid ambitions than a ¶ subway attack. They had gathered hundreds of tons of raw ¶ materials and had procured a Russian military helicopter ¶ to use in spraying the nerve agent over tokyo. Experts ¶ have estimated that aum shinrikyo had the ingredients to ¶ produce enough sarin to kill millions of people in

an all-out ¶ attack. The civil war in syria, whose military is known to ¶ possess stockpiles of sarin and other chemical weapons, ¶ raises the prospect that these munitions could fall into the ¶ hands of extremists.¶ Frightening as such possibilities are, nuclear bombs ¶ and chemical agents pale in lethality when compared with ¶ biological weapons. indeed the term "weapon" is not entirely adequate because biological agents include not only ¶ pathogens that are controllable (in the traditional sense) ¶ but also those that are not.¶ even more so than with nuclear weapons, the cost ¶ and technical difficulty of producing biological arms has ¶ dropped precipitously in recent decades with the boom in ¶ industrial molecular biology. A small team of people with ¶ the necessary technical training and some cheap equipment can create weapons far more terrible than any nuclear ¶ bomb. Indeed, even a single individual might do so.¶ Ether, these trends utterly undermine the ¶ lethality-versus-cost curve that existed throughout all of ¶ human history. Access to extremely lethal agents—even to ¶ those **that may exterminate the human race—** will be available to **nearly anybody**. Access to mass death has been democratized; it has spread from a small elite of superpower ¶ leaders to nearly anybody with modest resources. Even the ¶ leader of a ragtag, stateless group hiding in a cave—or in a ¶ Pakistani suburb—can potentially have "the button."

Impact – Biotech

Sustained investment and profits are uniquely key to biotech innovation – the plan's reduced prices wreck it

Stossel 16 Thomas Stossel, Professor emeritus at Harvard Medical School, M.D. from Harvard Medical School, Visiting scholar at the American Enterprise Institute. "Prescription Drug Pricing: Scam or Scapegoat?" American Enterprise Institute. February 2016, https://www.aei.org/wp-content/uploads/2016/02/Specialty-Drug-Pricing.pdf. //JBS [Premier]

Sustained investment, not lofty intentions, is the only antidote for the high drug development failure rate. The pharmaceutical business must provide sufficient returns to attract such investment. A confirmation of this reality is that former presidential candidate Bill Clinton's threat to impose drug price controls in 1992 caused a 52.3 percent drop in market-adjusted stock prices—an amount greater than the entire capitalization of the biotechnology industry at the time—as the S&P in general rose by 8.1 percent. Pharmaceutical company stocks did not recover until nearly a year later when the price control threats abated.39 The current presidential candidates' pronouncements about drug prices have spurred a similar investment flight.40 The Senate Finance Committee report concerning Gilead's hepatitis C drugs did not seem to recognize this reality: Gilead's own documents and correspondence show its pricing strategy was focused on maximizing revenue— even as the company's analysis showed a lower price would allow more patients to be treated.41 Gilead's careful analysis leading to the pricing of its drugs—minutely documented in the Senate report—was directed at ensuring the ability of the company to sustain its innovation activities. **The more profitable drug companies are, the more capability they may possess to take more shots at the elusive goal of successful drug development**.42 The fact that Gilead's pricing strategy resulted in fewer hepatitis C treatments in the short term was because of payers' prior-approval obstructionism—an outcome the company predicted. Furthermore, the pricing criticisms ignore that what any company charges for its drugs is **only one part of an extensive innovation system**. The drug pricing and profitability debates tend to blur the fact that the drug industry is incredibly diverse, ranging from merged behemoths to struggling startups. For example, the biotechnology industry currently consists of only seven highly profitable companies, and as a whole it barely breaks even.43 Vertex Pharmaceuticals, the company that sells the cystic fibrosis drug Kalydeco, has been profitable for one year of its 26-year existence.44 **Biotechnology investment has always been of particularly high risk**. Thanks to pent up demand from the resolution of the recent recession, investment in that sector has been relatively brisk, although the history of such investment reveals high volatility and long downturns.45 If, as is often claimed, the cutting edge of innovation resides in small companies desperately scratching for investment to stay technologies to or being purchased by larger companies to have their drugs actually achieve regulatory approval, **price controls would disproportionately harm these small innovators** and the patients their products might benefit.

Biotech innovation's key to resolve a laundry list of societal threats.

ICAF 10 Industrial College of the Armed Forces, National Defense University, Authors include many US military colonels and faculty of the National Defense University. "Biotechnology 2010." Spring 2010. http://es.ndu.edu/Portals/75/Documents/industry-study/reports/2010/icaf-is-report-biotechnology-2010.pdf. //JBZ [Premier]

Biotechnology has the potential to **solve some of the most complex problems of the 21st century**. As an industry, biotechnology is unparalleled in its potential to impact **global health**, **food and water security**, **energy security**, and the **environment**. This **innovation-based** industry is strategically significant because it impacts both **national security** and the **sustained growth** of the domestic economy. For the United States

to maintain its current competitive advantage in the industry, it must focus on policy and investments which strengthen the industry's **ability to rapidly innovate** and to transform innovative ideas into products and services for the global market. The purpose of this report is to conduct a strategic level examination of the biotechnology industry – an industry **vital to the nation's security and economic welfare**. The study includes over fifty activities spanning lectures by leading biotechnology experts and field visits to important government and corporate organizations. The industry study program includes travel to key domestic and international biotechnology centers such as Boston, Chicago, San Francisco, Taiwan, Singapore, Malaysia, and Japan. The study methodology uses critical thinking to analyze the structure, conduct and performance of the biotechnology industry and market sectors. This includes using the five forces of competition (new entrants, supplier power, buyer power, substitutes and the degree of rivalry) to assess the capacity and capability of U.S. biotechnology firms to deliver globally competitive products and services. Additionally, the methodology evaluates the biotechnology industry's performance in meeting national security interest and promoting economic growth.

AT: Monopolies

Pharma mergers boost innovation.

Ringel and Choy 17 Ringel, Michael S. and Choy, Michael K. Michael Ringel is a Boston-based senior partner of The Boston Consulting Group and global leader of its research and product development topic. Michael K. Choy is a New Jersey-based partner at BCG. "A new wave of pharma mergers could put innovative drugs in the pipeline." Stat News. 24 July 2017. https://www.statnews.com/2017/07/24/mergers-pharma-drug-development/ [Premier]

While big mergers could have many impacts — on employment at home and abroad, competition, and drug prices, to name a few — **one of the most important would be the effect on research and development productivity and innovation.** Analysts have tackled this topic before. Their work has been of mixed quality and, perhaps not surprisingly, has yielded mixed results. Pundits at the Institute for Competition Economics in Dusseldorf, Germany, for example, claimed last year in a Harvard Business Review article that previous drug company mergers had "substantially" reduced R&D and innovation, not only at the merging firms but at the merging firms' competitors as well. Another team, this one from Duke University, the University of Toronto, and Baruch College/CUNY, reached a different conclusion with its data-driven approach. The team's review of hundreds of mergers and acquisitions from 1985 to 2009, published in Loyola University Chicago Law Journal, indicated that the correlation between merger and acquisition activity and FDA approvals of new drugs is "moderately positive," both at an industry level and individual firm level. Who's right? Are those in need of new lifesaving drugs harmed by consolidation in the pharmaceutical industry, or are they helped? We believe that one of the main problems with much of the previous research in this area has been an over-reliance on anecdotal reporting rather than employing systematic data analysis. Even when such analysis has been done, researchers have sometimes focused on research and development spending or patent activity as benchmarks of success, as if these metrics are indicators of — or even synonymous with — actual product innovation. But they aren't necessarily the same. Spending is just an input, measured in dollars or some other currency. The same is true with patents. There is a long distance between the laboratory where new compounds are discovered and the corner drugstore where medicines are purchased. We sought to address this uncertainty by focusing on research and development productivity: the amount of innovation created as measured by the value of new FDA-approved compounds reaching the pharmacy, relative to input. After all, what matters to patients is the creation of quality medicines, not how much a company spends on research and development or the number of patent applications it files. To determine whether mega-mergers benefit patients, we looked at what happened to research and development productivity in all of the major mergers going back to 2001, including the last big wave in 2009 that brought together Merck & Co. and Schering-Plough, Pfizer and Wyeth, and Roche and Genentech. As expected, the results varied from year to year and company to company. But **our report** in Drug Discovery Today **showed that mergers generally appeared to drive productivity up — and did so significantly.** Why might this be so? While mergers undoubtedly bring disruption to research and development, **they also can be catalysts for addressing the fatal flaw of most research and development enterprises: the high cost of failure.** More than 90 percent of pharmaceutical industry spending on research and development goes into projects that never reach the market. **Any intervention that helps reduce this waste can be a real boon to productivity**. There are really only two ways to fix the industry's cost-of-failure problem: 1) start with better science, so you have fewer failures; and 2) employ better decision-making about when to stop projects so you can reallocate that capital to more-promising opportunities. **Mergers** can **help with both** of these dimensions. **They bring the best combined science of the merged organizations to bear on the difficult questions of which pathways, modalities, and molecules to pursue. Mergers also trigger reviews that drive the leadership of the new company to take a fresh look at research and development. These** reviews can **offer the leadership an opportunity to soberly and objectively reassess its scientific hypotheses in each disease area and reevaluate the combined research and development portfolio, eliminating those projects least likely to produce advances in treatment.** This spring cleaning can have a cathartic effect. The combination of the two factors — fresh science and a fresh look at the portfolio — can create **a renewed research and development enterprise better able to**

bring new medicines to patients. Our analysis doesn't suggest that all mergers are good. Even from the perspective of research and development productivity, some mergers in our study appeared to have depressed the flow of new medicines to patients by slowing down or stopping promising projects. And there are considerations beyond the scope of our analysis, such as jobs or drug prices, that may be equally valid inputs to views about mergers and acquisitions. **Overall**, however, the **evidence indicates that large mergers increase, not decrease, the productivity of pharmaceutical research and development** — good news for those in need of new therapies.

AT: Profits Aren't Used

Profits go to R&D.

Schneider 17 Schneider, John E, PhD. John E. Schneider is the CEO and founder of Avalon Health Economics. Dr. Schneider was one of the founding partners of the Health Economics Consulting Group, LLC (HECG), which formed in 2004. He has over 25 years of experience studying economic and organizational aspects of the health care industry. "The Value of Biopharmaceutical Innovation in the U.S." Avalon Health Economics. 22 February 2017. http://avalonecon.com/The-Value-of-Biopharmaceutical-Innovation-in-the-U.S.html [Premier]

There have been some **negative reports** recently regarding the pricing practices of some pharmaceutical companies. However, it is important to give at least **equal consideration** to the value derived from the **intensive level of research and development** undertaken by the biopharmaceutical industry in the U.S. The invention of new products and processes has been shown to be an important determinant of economic growth, especially for the firms and countries fostering the innovation. 1 Innovation in the biopharmaceutical industry in the U.S. has been shown to have positive effects on the economy, including direct and indirect employment effects, value-added effects, and efficiency effects associated with medicines that offer treatment substitutes for more expensive interventions. Over the past decade, the U.S. pharmaceutical industry increased its annual spending on research and development (R&D) from $38 billion in 2005 to $56 billion in 2015, an **increase of nearly 50 percent** (Figure 1). Over the same time period, after relatively flat development of new molecular entities (NMEs) and new therapeutic biologics (NTB) in the first half of the decade, the pace of discovery **accelerated** and by 2015, 45 new compounds were approved—more than double the number that were approved in 2005.2 This represents a **reversal of the trend** over the decade prior to 2005, where R&D expenditures rose rapidly while the number of NMEs declined.3. In terms of the scale of biopharmaceutical R&D, at $56 billion per year, annual R&D expenditures account for nearly **18%** of all U.S. domestic R&D expenditures (based on 2013 data).4 Moreover, the U.S. biopharmaceutical industry devotes nearly **11%** of net sales revenue to R&D, which is more than **four times** the national industry average.5 What is the value of the innovation efforts in the biopharmaceutical industry? There are three primary ways in which innovation in this industry creates value: (1) increases in **clinical value**, either by treating "undertreated" diseases or by increasing treatment effectiveness within a therapeutic space; (2) **lowering the costs** of treatment within a therapeutic area by substituting innovative drugs for more expensive existing treatments (i.e., "value-based" innovation); and (3) substantial and increasing firm-level and **economy-wide economic impact.** Clinical value is the **backbone** of biopharmaceutical innovation, and there many examples in which drugs have increased the overall effectiveness of treatment.6 In recent years, manufacturers have devoted increasing efforts to finding the drugs that can add clinical value and lower overall treatment costs, focusing on "value-based" products that are also more cost-effective than prevailing standards of care.7 Finally, R&D expenditures are associated with **above-average rates of return** to pharmaceutical makers, and have an unexpectedly large impact on the U.S. economy, with combined direct and indirect economic impact of more than $1.2 trillion and more than 3 million jobs.8

AT: Government R&D

Government pharma is insufficient.

Stone 17 Kathlyn Stone, medical and business writer covering clinical trials. "Biomedical Research is Essential For New Cures, But It's Costly." The Balance. https://www.thebalance.com/who-funds-biomedical-research-2663193.

In a Journal of the American Medical Association (**JAMA**) study published in January 2010, **the largest study** to date to attempt to quantify U.S. funding of biomedical research by the pharmaceutical industry, government, and private sources, researchers estimate that U.S. biomedical research currently stands at about over $100 billion annually.

The pharmaceutical industry is the largest contributor towards funding research, funding over 60 percent. The government contributes to about a third of the costs, with foundations, advocacy organizations and individual donors responsible for the remaining investments.

Basic research that supports drug discovery received a one-time boost through the American Recovery and Reinvestment Act (ARRA), the health care reform law, which became law in February 2009. About $310 million of the $10.4 billion allocated to the National Institutes of Health (NIH) was dedicated to advancing scientific discovery. Aside from that investment meant to spur the economy during a recession, the financial crisis almost guarantees that government support for drug research will remain **flat** for some time.

Only for basic research.

Moses et al. 15 Hamilton III, MD, David H. M. Matheson, JD, MBA; Sarah Cairns-Smith, PhD; et al Benjamin P. George, MD, MPH4; Chase Palisch, MPhi,; E. Ray Dorsey, MD, MBA. "The Anatomy of Medical Research: US and International Comparisons." JAMA. 2015;313(2):174-189. [Premier]

In 1994, the National Institutes of Health (NIH) budget totaled $17.6 billion and in 2004 reached a peak of $35.6 billion (Figure 3). Following a decade of remarkable public sponsorship of medical research with growth exceeding 7% per year in the1990s, **funding from the NIH declined** nearly 2% per year in real terms (Figure 3) after the mid-2000s. This decrease represents **a 13% decrease** in NIH purchasing power (after inflation adjustment) since 2004 (eFigure 2 in the Supplement), which may be more **severe** when considering NIH appropriations through 2013.5 Other sources of US investment were not immune to **slowed growth**. Funding from major sources of investment either **slowed** or **declined** over the past 10 years, with the exception of other federal support, which includes organizations such as the Agency for Healthcare Research and Quality (AHRQ). From 1994 to 2004, the medical device, biotechnology, and pharmaceutical industries had annual growth rates greater than 6% per year (Figure 3), with biotechnology demonstrating the largest increases. The share of US medical research funding **from industry** accounted for 46% in 1994 and grew to **58% in 2012**. Although **much** of the growth in medical research funding over the past 20 years can be **attributed to industry**, investment still slowed (medical device, 6.6% to 6.2% in 1994-2004 vs 2004-2012; biotechnology, 14.1% to 4.6% in 1994-2004 vs 2004-2012), or declined (pharmaceutical firms, 6.8% to −0.6% in 1994-2004 vs 2004-2012). Research Funding Biomedical Research The distribution of investments across the types of medical research changed from 2004 to 2011. Pharmaceutical companies shifted funding to late-phase clinical trials and away from discovery activity such as target identification and validation. The share of pharmaceutical industry funding (including that by US companies outside of the United States) spent on phase 3 trials increased by **36%** (5%/year growth rate) from 2004 to 2011 (Figure 4), and the share of investment in prehuman/preclinical activities decreased by 4% (2%/year average decline). This shift toward clinical research and development reflects the increasing costs, complexity, and length of clinical trials but may also reflect a deemphasis of early discovery efforts by the US pharmaceutical industry. While industry has shifted funding to clinical trials, the share of NIH contributions dedicated to basic science and clinical research was unchanged (eTable 2 in the Supplement), with the majority of funds still focused on **basic research**. These data may not accurately reflect the true division of NIH investment for basic

science vs disease-focused research, as a growing proportion of NIH expenditures is for projects having potential clinical application in many diseases or organ systems.7

That means pharma is key for development which is the warrant for why public sector innovation works.

Hogberg 7 David Hogberg, Senior policy analyst at The National Center for Public Policy Research in Washington, D.C. “Letting Medicare "Negotiate" Drug Prices: Myths vs. Reality.” National Center. https://www.nationalcenter.org/NPA550MedicareDrugPrices.html.

Myth: Medicare price controls will have no effect on pharmaceutical industry research and development, especially as most drug research is conducted by the **N**ational **I**nstitute of **H**ealth.

Reality: The **N**ational **I**nstitute of **H**ealth plays an important but **limited role** in drug research. Furthermore, price controls in OECD countries have already caused a decline in pharmaceutical industry research and development and, thus, the development of new drugs.

Jonathan Cohn provides a typical disparagement of the importance of pharmaceutical industry research and design (R&D):

...the most important basic medical and scientific research that leads to major medical breakthroughs usually takes place under government auspices - typically, through grants from the National Institutes of Health. In other words, taxpayers - not drug companies - are the ones financing the most important drug research today. So, even if the pharmaceutical industry did reduce its research and development investment because of declining revenues, what we'd lose probably wouldn't be the next cure for cancer - it would be the next treatment for seasonal allergies, and likely no better than the ones we have already.18

A systematic study conducted **by the** National Institute of Health (**NIH**) suggests that the NIH's role is not as large as Cohn suggests it is. The NIH funds a lot of **"basic research**," and the study noted, "technologies developed in basic research laboratories are **nascent**, requiring extensive **further development**."19 It is the **pharma**ceutical companies that **fund that further development**. The study also examined pharmaceuticals that had at least $500 million in sales in the U.S. Of the 47 drugs that met that standard, the NIH determined that it had involvement in only **four** of them. The other 43 included drugs for bacterial infections, diabetes, hypertension, high cholesterol and Hepatitis C - hardly mere "treatments for seasonal allergies."

Data Breaches

Link – Centralization

Single payer causes centralization---makes EHRs vulnerable to breaches.

Grams 11 Ralph Grams, Pathology and Medical Informatics, College of Medicine University of Florida. "In the World of Medical Alphabet Soup—Will A Workable EMR or EHR Please Stand Up?" Journal of Medical Systems, October 2012, Volume 36--5. https://link.springer.com/article/10.1007/s10916-011-9785-z. [Premier]

The physician views each patient as a unique entity that needs services customized for that case. The government and insurance industry sees healthcare as an assembly line where there is a uniform product and a uniform delivery and application process. They are focused on rationing care to minimize expenses and making the treatment decisions at a central point where statistics and cost benefits are calculated. **The closer we get to a single-payer system the more centralized will be the systems operation**. The single-payer system and the rationing of care are structurally linked and not easily separated. Under Obamacare, as you add a broader scope of patients to the pool of eligible clients, the demands increase to pick and choose winners and losers. Quality of life panels will need to be established to decide who is given the therapy to live and who gets cut off [2]. Do the aged take second place and the youth prevail? Do the handicapped get left in wheel chairs while the productive get bone marrow transplants? Under a single-payer system these types of discussions can be predicted with certainty. Under the Obama healthcare system, we are being forced into a single-payer system. That was the President's choice during the presidential election debate. He favors centralized control of all services, providers and hospitals. You can now see why this move to establish a uniform electronic medical record is so intense. This whole **single-payer system depends on herding the entire medical community into one corral** and keeping them penned. The obvious question is: How have they enticed physicians to participate? Answer: They are spending tax dollars to encourage doctors to automate their offices and install government-approved systems that will accomplish their ultimate goals. This "Trojan Horse" program will have a whole series of intended consequences that are all negative for the doctors. As they herd the health providers into this electronic pen, they are looking at every claim and every bill with legal and automated teeth to deny claims. Doctors will be asked to prove that the patient has improved and that they are better now than when they started. They are going to be grading the physician about their billing and performance so that patients can see a ranking of government based criteria [3]. Each patient will be structured into an approved treatment protocol and the doctor will be doing nothing more than following the government mandates for uniform patient care. The termination of care will be made at the national level and the local control of patient choice will disappear. In the rush to implement both Obamacare and this new EHR program, no provisions were made for malpractice reform. Was this a mistake or was it done to support the legal lobby that runs Congress and most of Washington. These attorneys have a huge cash flow to protect and there is no action being taken to make this any different than it is now. In fact, it could get much worse. These new EMRs and EHRs are often so poorly constructed that they are not even readable by an average physician. The progress notes they produce are filled with things that were not said or implied. The doctor is often hard pressed to defend his own documents. This is a huge hole in our systems and will result in lawsuits and more claims in the near future [4]. Now there are many people who think these are good and excellent options. They don't want to keep people alive who are not productive and are a burden on society. These people usually support population control and abortion. This is called the progressive socialist agenda and has been alive and well for decades. This philosophy has now been ingrafted into Washington and the nation is currently headed full speed in this direction. This is what was called "Change" in the last presidential election: "A new way of living and a new formula for social interaction." This new social "constitution" also implies a redistribution of wealth so that those who are poor get what belongs to the rich. They want to create an even playing field for all. This means that we are all entitled to: government healthcare, union representation, government jobs, government housing and government pensions. As you inspect this "new" social contract you will note that it directly copies the Constitution of the Soviet Union. This "new idea" is merely the reintroduction of Marxism dressed up as "Change". As we move down this progressive road to "change", let's look at several of the fruits of this new technology and its operation. EMRs (electronic medical records) and EHRs (electronic health records) are two code words that talk about the same condition. The goal is to move the entire medical record from clinics and hospitals onto a computer storage device so that everything about an individual is accessible at one location. These records include your billing information and all your personal and financial data. Sounds like a great idea, but there are some drawbacks: If all your data is located in one place, what happens if the data is copied or stolen and then sold to others for criminal purposes? You the patient are stuck with a terrible mess and your identity will be compromised and your credit and **finances** could be destroyed**.** Has this happened? Here are a partial list of groups that have lost or compromised electronic medical records in the last year along with their fines: Massachusetts General Hospital—$1 million dollars [5]; Cignet—$4.3 million dollars [6]; Triple-S in Puerto Rico lost 400,000+ medical records—the full fines are not known [7]; Keystone Mercy Health Plan compromised 280,000 medical records compromised—no fine assessed yet [8]; University of Tennessee breaches 8000 medical records—no fine assigned yet [9]; California has seven institutions that are being fined for lost or compromised records with a total so far of $540,000.00 [10]. These are just recently published data and there are many more problems to be anticipated as the volume of records increases and the scope of their exposure expands. As these records move into the government sector they will be used by many contractors and government employees who will be able to open new doors for hackers and Internet thieves. This new massive federal database will be a **huge target** for many who could use this data for their personal gain [11]. We can't even protect our State Department and government emails from being published on WikiLeaks! How will we ever keep this massive database secure?? A second concern with this new medical records initiative is the lack of proven benefit from this type of massive investment. A recent study from Stanford University and published in the Archives of Internal Medicine shows **minimal benefit** to patient care from the use of electronic health records [12]. The obvious question to ask is why are we spending so much money to force the medical community into this rigid structure if it does not improve patient care? The answer is very simple. The government is

not primarily interested in patient care but in controlling costs and controlling physician behavior. The only way to stop the spending is to stop the doctor from writing orders and have his orders disapproved. Here is this basic conflict again showing up in our government's actions. They are pulling the medical professional into a socialist system with tight governmental controls. As we move along this production line of government controls and mandates, we approach another acronym—MU. No, it is not the cry of a cat, but a new term called "meaningful use". The government has drafted a set of guidelines that all EHR and EMR providers must meet if they are going to get their clients money from the government. All systems must now be certified for MU. The guidelines have almost nothing to do with patient care and physician improvement, but deal with transmitting data in a uniform way so that federal computers can compare and "process" all this new data [13, 14]. **This is all about data mining** and trying to get something out of nothing. The hope is that if you get enough data you can set standards and guidelines for everyone and discover all kinds of new associations for medical use. Unfortunately, this is a totally misguided expectation. When you have a wide range of different systems using medical terminology that is difficult to grade, you will get a wide range of interpretations which are may not be related or controlled. The old adage is still true: garbage in will eventually get you garbage out. We leaned a long time ago that only tightly controlled studies with every variable defined and supervised could be used for clinical trials. Even these controlled studies have troubles and often need to be duplicated to be sure of the final results. To expect a large pile of medical records with minimal controls in place to result in meaningful end result is irrational exuberance. Analyzing demographic data is one thing, but trying to compare treatment results and patient outcomes will be impossible. Every patient is unique and has a unique response to a treatment plan and medications. Tightly controlled clinical studies are needed for these types of questions and not a national repository of random medical records.

Single payer centralizes records into a vulnerable pot of gold for hackers---the federal government is especially bad at security.

Sherrod 17 James Sherrod. "Cyber-Security In Government Healthcare." *Halsey News*. 31 October 2017, https://www.halseynews.com/2017/10/31/cyber-security-government-healthcare/. [Premier]

The debate over government healthcare typically revolves around money, and often devolves into both sides claiming the moral high ground by exploiting victims of their opponent. Although there have been many debates on **single-payer** healthcare, **one potential downfall that is overlooked is cyber-security.** What does going to the doctor have to do with cyber-security? Well, these days, quite a lot actually. Nearly every piece of information you share with your healthcare and insurance providers is stored electronically. Unfortunately, these electronic healthcare records have a **poor record for security**. In 2015 alone 100 million health care records were stolen. That was an 11,000% increase from the prior year. Why are your medical records being targeted? Simple. They are valuable and they are vulnerable. Your medical records are valuable because they contain every piece of personal and financial information a criminal could ever want. Electronic healthcare records are 100 to **1,000 times more valuable** on the black market than a credit card number. Beyond that, medical records may contain very personal information ideal for blackmailing an individual. Electronic healthcare records are vulnerable because they are part of **massive centralized databases**. **Due to their enormous size, these databases are very vulnerable to** internal **attacks**. **They are** also **highly rewarding to any** would-be **attacker**. **A single breech gains access to millions of records.** As healthcare becomes **more and more centralized, so do all of the healthcare records**. We have already seen this happen as healthcare providers and insurance companies consolidate electronic records into more centralized databases. So, what does the government have to do with this? Whether you call it socialized medicine or **single payer**, government based healthcare is the **ultimate centralization**. In order for the government to be responsible for the healthcare of every citizen, they must require access to the medical records of every citizen. What this boils down to is the medical records of the entire United States population becoming **one very large and very vulnerable pot of gold**. This is especially concerning given the United States government's **history of cyber security failures.**

Single payer would centralize records and make them vulnerable.

IHF 04 Institute for Health Freedom. "Can You Have True Health Privacy Under Nationalized Health Care?" 20 May 2004. www.forhealthfreedom.org/Publications/Privacy/NatPrivacy.html. [Premier]

Now some of the groups who previously supported federalizing health care and medical privacy are opposing the federal medical-privacy rule because they don't like how it applies to issues near and dear to them. And the problem with this rule—as bad as it is now—would only get worse with **national** health care, or a **single-payer** system. **Whoever pays the bill would have access to everyone's medical records**. Moreover, the government would determine what health-care services would and wouldn't be covered. It's time to face this important fact: **You can't have a truly confidential patient-doctor relationship if the government pays for your health care**.

Single payer would consolidate electronic health records.

Lobosky 12 Jefferey M. Lobosky, Associate Clinical Professor in the Department of Neurological Surgery at the University of California at San Francisco, Doctorate of Medicine from the University of California at Irvine. "It's Enough to Make You Sick: The Failure of American Health Care and a Prescription for the Cure" Rowman & Littlefield Publishers, 16 June 2012. [Premier]

In a **single-payer** system each American would have the **same insurance**, the **same card**, **the same benefits**, and the **same access**, all without the endless hassle many commercial insurers now impose upon their beneficiaries. With a **single-payer**, there would be a **single database** that would facilitate the sharing of **electronic medical records** to make certain that when a patient presents unconscious or incapacitated to an emergency room, his or her **past history**, current medication regiment, and advcanced directive **wishes** (provided by Obama's Death Panels, of course) are all **well known**. In addition, that same database could provide us with invaluable information as to the outcomes of the care we provide, helping to assure that treatment is evidence-based rather than profit-based.

Impact – Bioterror

Healthcare data vulnerability causes bioterrorism.

Davis 16 Jessica Davis, Healthcare IT News, citing Brenner, MIT Fellow and former senior counsel at the NSA. "Cyberattacks are going to get a lot worse, former NSA official says." *Healthcare IT News*. 5 December 2016. www.healthcareitnews.com/news/cyberattacks-are-going-get-lot-worse-former-nsa-official-says. [Premier]

The face of cybercrime is changing. Healthcare has gone from a declared mission of stealing personal data to much more disruptive issues. In fact, **healthcare has seen the largest jump in ransomware attacks than in any other industry**. When Joel **Brenner** opened the HIMSS Privacy & Security Forum in Boston Monday morning, the **M**assachusetts **I**nstitute of **T**echnology research fellow - who focuses on cybersecurity, privacy and intelligence policy - and former senior counsel at the **N**ational **S**ecurity **A**gency, didn't sugarcoat the state of healthcare security. The government isn't going to sort out that problem until we suffer some great losses, Brenner said. "**We're facing industrial espionage on an industrial scale**," Brenner explained. "If espionage is not the oldest business in the world, it's the second oldest." "You can steal a **terabyte of data remotely**; this has really changed who is conducting espionage," Brenner continued. "**There's a convergence of bioterrorism and cybersecurity** … **increasing the likelihood of a mass casualty event.**" And while healthcare may not top the list in terms of incidents or breaches, it is number one by percentage of incidents and the number of incidents by stolen assets. It's also number one in terms of 'losing stuff.' **Healthcare is very high in terms of the ratio of incidents to breaches. In** other words, the number of people trying to get in are succeeding more often than not.

Causes extinction---preparation is impossible.

Farmer 17 Ben Farmer, correspondent for the Telegraph. "Bioterrorism could kill more people than nuclear war, Bill Gates to warn world leaders." *Telegraph*, 17 February 2017. https://www.telegraph.co.uk/news/2017/02/17/biological-terrorism-could-kill-people-nuclear-attacks-bill. [Premier]

Bioterrorists could one day kill hundreds of millions of people in an attack **more deadly than nuclear war**, Bill Gates will warn world leaders. **Rapid advances** in genetic engineering have opened the door for small terrorism groups to tailor and easily turn biological viruses into weapons. A resulting disease pandemic is currently one of the most deadly threats faced by the world, he believes, yet governments are complacent about the scale of the risk. Speaking ahead of an address to the Munich Security Conference, the richest man in the world said that while governments are concerned with the proliferation of nuclear and chemical weapons, they are overlooking the threat of biological warfare. Mr Gates, whose charitable foundationis funding research into quickly spotting outbreaks and speeding up vaccine production, said the defence and security establishment "have not been following biology and I'm here to bring them a little bit of bad news". Mr Gates will today (Saturday) tell an audience of international leaders and senior officers that the world's next deadly pandemic "could originate on the computer screen of a terrorist". He told the Telegraph: "Natural epidemics can be extremely large. Intentionally caused epidemics, bioterrorism, would be the largest of all. "With nuclear weapons, you'd think you would probably stop after killing 100million. Smallpox won't stop. Because the population is naïve, and there are **no** real **preparations**. That, if it got out and spread, would be a larger number." He said **developments in genetic engineering** were proceeding at a **"mind-blowing rate".** Biological warfare ambitions once limited to a handful of nation states are now open to small groups with **limited resources and skills.** He said: "They make it much easier for a non-state person. It doesn't take much biology expertise nowadays to assemble a smallpox virus. Biology is making it way easier to create these things." The

increasingly **common** use of gene editing **tech**nology would make it **difficult to spot** any potential terrorist conspiracy.

Impact – Terror

Health data breaches are key terror revenue.

Rashid 15 Fahmida Y. Rashid is a senior writer at CSO, focused on the information security beat. Before joining CSO, she wrote about networking and security for various technology publications, including InfoWorld, eWeek, PC Magazine, Dark Reading, and CRN. She also spent years as an IT administrator, software developer, and data analyst. "Why hackers want your health care data most of all." *Info World*. 14 September 2015. https://www.infoworld.com/article/2983634/security/why-hackers-want-your-health-care-data-breaches-most-of-all.html. [Premier]

Health care breaches aren't typically discovered through black market sales the way retail breaches were last year, because **criminals monetize health care data in a different way** than they cash in on financial data. Most **forums selling health care data tend to be more specialized** than the carding forums where payment card information is sold. **Stolen health care data forums operate** more **like drug cartels**, where health records are **not sold outright, but rather used to buy and sell addictive prescriptions**, said Angel Grant, senior manager for antifraud solutions at RSA. "Health insurance credentials are especially valuable in today's economy because health care costs are causing people to seek free medical care with these credentials," Grant said. Many experts believe the **health care breaches are not the work of typical cyber crime gangs but of state-sponsored, well-funded groups.** The Community Health hack, the first big health care breach, is widely believed to be the work of a Chinese espionage group. While attribution is extremely difficult, **substantial "below the surface" noise links state-sponsored groups with other health care breaches,** said Eric Cowperthwaite, a vice president of advanced security and strategy at Core Security. He was "quietly warned about nation state interest in health care" back in 2012, when he was CISO of Providence Health & Services. It makes sense that governments would be interested in getting their hands on this data because it can be useful for building dossiers that reflect a deeper understanding of the target population. Medical and insurance records provide insights about where people live, what medical treatments they had, who their family members are, and who they work for. Moreover, if the health care data stolen from these breaches was ever combined with the data stolen from the Office of Personnel Management, "it would be the Holy Grail of electronic data on almost all people with government clearances," Cowperthwaite said.

Health data is super profitable for organized crime networks because of financial return and accuracy---vastly outweighs any alt cause.

Burgess 15 Christopher Burgess is an author and speaker on the topic of security strategy. "Data Breaches in Health Care Sector – Nation State Espionage Targeting?" *Clearance Jobs*. 20 March 2015. https://news.clearancejobs.com/2015/03/20/data-breaches-in-health-care-sector-nation-state-espionage-targeting/. [Premier]

MONETIZATION OF YOUR HEALTH RECORD DATA There is **no denying the black market value** of the **medical and personal identifying information** which may have been placed at risk as a result of these data breaches. Included in a report by Price Waterhouse Coopers on managing cyber risk, was a snippet from research conducted in 2013 by Dell Secureworks which noted, "A complete identity-theft kit containing comprehensive health insurance credentials can be worth hundreds of dollars or even **$1,000 each on the black marke**t, and health insurance credentials alone can fetch $20 each; stolen **payment cards, by comparison, typically are sold for $1** each." Doing the simple math, 90 million identities at just $100 each adds up to real money for the cyber criminal. YOUR HEALTH RECORD FOR MEDICAL IDENTITY THEFT The complete identity often times found in **medical records carry this high valuation by criminal elements largely due to the overall accuracy of the data**. While the medical diagnosis and treatments may have value to a criminal looking to engage in a bit of medical identity theft and fraud, the accuracy of the diagnosis and treatment is largely immaterial. **It's access to the health benefit and prescription which has value for the**

medical identity thief. YOUR HEALTH RECORD FOR FINANCIAL IDENTITY THEFT That same medical file will also contain your personal identifying information. In the United States, the crown jewel is the individual's Social Security Number (**SSN**), coupled with current address, phone numbers, insurance, alternative insurance, and credit card data used for the co-pay, it becomes clear why the **health care providers are prime targets**. The well-organized criminals conducting data breaches will immediately **monetize this information directly**, perhaps with a well orchestrated phishing campaign to **fill out any gaps in your identity**, or simply taking the name, address and SSN and file a bogus tax return. This happens with such frequency the Internal Revenue Service has a page specific to this issue, "Data Breach: Tax-Related Tax Information for Taxpayers," which provides guidance on what to do if you're a victim of identity theft which resulted in a false tax return being filed.

Data breaches are a key source of organized crime income.

Trend Micro 16 Trend Micro is the global leader in enterprise data security and cyber security solutions for businesses, data centers, cloud environments, networks, and endpoints. "Healthcare under Attack: What Happens to Stolen Medical Records?" Trend Micro. 30 June 2016. https://www.trendmicro.com/vinfo/us/security/news/cyber-attacks/healthcare-under-attack-stolen-medical-records. [Premier]

Healthcare remains a **key target** of ransomware, and information theft to spear phishing attacks, and it's not difficult to see why. Healthcare facilities store an extensive repository of information that, when stolen, **cannot be easily replaced** and can even go undetected by victims for a long time. As such, **cybercriminals consider the industry a lucrative source of personal**ly identifiable **information** (PII) and their accompanying financial records, which are easily monetized as **tradable** goods in **underground marketplaces**. In turn, individual malefactors and **organized syndicates** use these stolen data to commit fraud, identity and intellectual theft, espionage, blackmail, and extortion. The information can also be used to deliver malware to unsuspecting users through spam and phishing attacks. In fact, identity theft has been reported to be the most rampant in healthcare in 2015. In this case, **fraudsters** use a patient's stolen PII to access someone else's services or other resources, apply for loans or credit cards, open bank accounts, make online transactions, file tax returns to collect rebates, and conduct **other illegal activities** without the victim's consent and knowledge. **Cybercriminals leverage the financial value of data when monetizing the information they steal**. For instance, according to a survey of customers in 2015, health information and medical records are estimated at $82.90 apiece for U.S. consumers, while a Social Security number is worth $55.70. Payment details, physical location information, home address, marital status, as well as name and gender information are pegged at $45.10, $38.40, $17.90, $6.10 and $2.90, respectively. In online black markets, stolen data are sold in various prices depending on the type of information. In the Brazilian underground, a list of landline phone numbers may be priced between $317 and $1,931, while a set of email account credentials can be sold in Chinese darknet marketplaces for $163. Work and personal email addresses can be sold in the Russian online underworld for as much as $200. **Cybercriminals can use the data to** cause personal distress, damage an unknowing user's reputation, commit identity theft, expose private information to the public, and even **compromise corporate accounts and use them as gateway to breach an enterprise's network.**

Revenue from counterfeiting legitimate pharma supports WMD terror.

Finlay 11 Brian Finlay, MA in International Affairs at Carleton, is the president of the Stimson Center. "Counterfeit Drugs and National Security." 2011. https://www.stimson.org/sites/default/files/file-attachments/Full_-_Counterfeit_Drugs_and_National_Security_1.pdf.

The growing danger of counterfeit pharmaceuticals is well understood to pose a serious challenge to the health of North Americans (see Box 2), yet public health is not the only consequence of this sinister crime. Counterfeiters also work to evade legitimate

taxation and quality controls. They threaten to **destroy** corporate brands and undermine public confidence in health infrastructures. Perhaps most distressingly, growing evidence suggests that these crimes are increasingly linked to criminal syndicates whose activities range from petty crimes to **global terrorism**. In short, the lucrative nature of **counterfeiting** threatens to feed larger and even more insidious criminal and terrorist activities in the **U**nited **S**tates and around the world. These concerns go beyond the specious claims that terrorists may use the US drug supply to introduce poisons or biological agents to the homeland. Rather, these criminal entities are using the **funds** derived from counterfeiting indirectly to support their extremist and often violent activities around the globe. This trend is in keeping with a growing sophistication of terrorists and criminal networks that exploit the forces of globalization, such as a well-developed supply chain, in an effort to support their local, national, and even international operations. Examples in the sphere of proliferation of arms—both weapons of mass destruction and small arms—include individuals such as Viktor Bout and A.Q. Khan, who managed illicit international proliferation networks and shipping arms or materials to build them to the highest bidder worldwide. The increased focus on the counterfeit drugs industry by non-state actors is also a result, in part, of successful international efforts to cut off traditional sources of revenue to terrorist organizations. As noted, the sale of counterfeit pharmaceuticals is often perceived as a problem endemic to developing countries where consumers are likely to seek inexpensive medications. However, **given the fact that industrialized countries invest more in health programs** for their citizens, criminals are beginning to target **legitimate** (and **lucrative**) supply **distribution chains in developed nations** as well, including in North America and Europe. Counterfeit operations by European criminal organizations have been recently uncovered. For instance, Italian authorities discovered a clandestine facility for the production of counterfeit medication owned by Camorra, an organized criminal group based in Naples. A connection between Camorra and several Islamic terrorist groups has also been identified.20 Such **linkages** between **organized crime groups and terrorist organizations** are **especially disconcerting** since both parties may be involved in remittance exchanges. According to the American Council on Science and Health, there is documented evidence of groups including the Irish Republican Army, the Basque separatist group ETA, Chechen rebels and North African guerillas using drug counterfeiting as a source of funding.21 An Interpol report in 2004 also identified terrorist financing through counterfeiting pharmaceuticals by loyalist and Union terrorists in Northern Ireland, and local ethnicAlbanian extremists in Kosovo.22 In addition, the US Justice Department recently discovered a multi-national counterfeiting ring that smuggled counterfeit drugs into the United States and funneled its profits to the terrorist group Hezbollah. Finally, recent cases have linked al Qaeda to counterfeiting activities as well.23 According to documents seized from al Qaeda camps, Abu Sayyaf and Jemmah Islamiyah—**terrorist groups closely affiliated with al Qaeda—have turned to counterfeiting operations as a means to replace revenues lost as a result of counterterrorism efforts** instituted after September 11, 2001.24 How is Trafficking/Counterfeiting Conducted? According to the incident database of the Pharmaceutical Security Institute, countries in Asia report the largest share of counterfeits detected globally (See Figure 1). This is likely not only due to lax enforcement, but also to the scale of production of counterfeits emanating from China and countries of South and Southeast Asia. Other major producers include Nigeria, Russia, Mexico, Brazil and Latin America. Gray and substandard pharmaceutical product manufactures in the United States also pose a serious challenge to both public health and national security. Depending upon their point of origin, these products can pass through multiple links on the illicit supply chain prior to acquisition by the consumer (See Figure 2). While the lion's share of WHO-defined counterfeits appears to be produced overseas, a growing share of counterfeits, substandards, and gray pharmaceuticals are being packaged from within Western markets—including the United States and Canada. In turn, their **profits** can **support** all manner of **illegal activity, from** illicit drug and human trafficking to **weapons prolif**eration **to terrorism**.

Funding is the key barrier to nuclear terrorism.

Klein 12 Klein, John J., Senior Analyst at ANSER in Arlington, Virginia. "Deterring and Dissuading Nuclear Terrorism." *Journal of Strategic Security* 5, no. 1. 2012. [Premier]

The last aspect of dissuading nuclear terrorism involves aggressive efforts to intercept and minimize funding sources used by militant extremist groups. **Funding is critical to sustaining the activities of most terrorist organizations**. In the past, such funding has come through charities, illegal activities, and front companies. Persistent multinational fiscal interdiction efforts could significantly reduce the funding available to support any potential **nuclear** terrorism activities. These monetary interception efforts could include targeting transactions supporting terrorist organizations, whether conducted by states, nongovernmental organizations, or private entities. Economic efforts to thwart nuclear proliferation might focus on the potential suppliers of nuclear or radiological material.39 A sustained effort to eliminate or minimize funding sources used by terrorist organizations could help curtail future recruits for the organization's cause. This in turn might lead to a sense of futility within the

organization. Combined monetary efforts such as this could dissuade a terrorist organization's leaders from pursuing a path of direct confrontation through nuclear terrorism.

Financing is key to the effectiveness of every terror organization and tactic

Freeman 16 Michael Freedmam, Associate Professor Department of Defense Analysis Graduate School of Operational and Information Sciences. "Financing Terrorism: Case Studies." Routledge, p. 7-8. 2016. [Premier]

Although the costs of specific operations may be relatively inexpensive (and even more so for low level attacks), terrorist organizations require much larger budgets to function. Organizations **need** to devote resources to recruiting new members. If they are operating in failed or sympathetic states, they need funds to build training camps, and sometimes must provide food and housing for their members. Organizations must acquire the equipment necessary for conducting acts Of violence—guns, explosives, triggers, training simulators, as well as fake passports and other travel or identification documents—and communication devices such as phones and computers. They may need to bribe officials to turn a blind eye to their activities. Finally, many groups need funds to pay stipends to their "retired" veterans and the families of dead terrorists or suicide bombers. As a result of these expenses, terrorist groups have budgets that can range up to hundreds of millions of dollars per year, especially for the larger and more active groups. Although the following numbers are just estimates, they are indicative of the overall phenomenon: al-Qaeda's annual budget was estimated to be $30 millions until the 1990s, the Provisional IRA had a budget of up to $15 million per year;6 at its peak the 1 the PKK was thought to have an annual budget of $86 million" Hezbollah's budget is between $100 million and $200 million per year, and may range as high as $400 million* the FARC Colombia has an annual budget of somewhere between around $100 million and $1 billion the Afghan Taliban raises somewhere between $240 million and $360 million per year, 10 and all the different insurgent groups in Iraq collectively raised between $70 million and $200 million per year. Il As these figures demonstrate, the organizations that are responsible for terrorist attacks are **much more expensive** to operate than is indicated by the cost of any individual attack. Acquiring tens or even hundreds of millions of dollars requires that the organization must pay a certain degree of attention to its own financial portfolio.

Terrorism causes nuclear retaliation.

Roth and Bunn 17 Nickolas Roth, research associate at the Belfer Center's Project on Managing the Atom at Harvard University and research fellow at the Center for International and Security Studies at the University of Maryland; Matthew Bunn, professor of practice at the Harvard Kennedy School. "The effects of a single terrorist nuclear bomb." *Bulletin of the Atomic Scientists*. 28 September 2017. http://thebulletin.org/effects-single-terrorist-nuclear-bomb11150. [Premier]

The escalating threats between North Korea and the United States make it easy to forget the "nuclear nightmare," as former US Secretary of Defense William J. Perry put it, that could result even from the use of just a single terrorist nuclear bomb in the heart of a major city. At the risk of repeating the vast literature on the tragedies of Hiroshima and Nagasaki—and the substantial literature surrounding nuclear tests and simulations since then—we attempt to spell out here the likely consequences of the explosion of a **single terrorist nuclear bomb** on a major city, and its **subsequent ripple effects** on the rest of the planet. Depending on where and when it was detonated, the blast, fire, initial radiation, and long-term radioactive fallout from such a bomb could leave the heart of a major city a smoldering radioactive ruin, killing tens or **hundreds of thousands of people** and wounding hundreds of thousands more. Vast areas would have to be evacuated and might be uninhabitable for years. Economic, political, and social **aftershocks** would **ripple throughout the world**. A single terrorist nuclear bomb would change history. The country attacked—and the world—would never be the same. The idea of terrorists accomplishing such a thing is, unfortunately, not out of the question; it is far easier to make a crude, unsafe, unreliable nuclear explosive that might fit in the back of a truck than it is to make a safe, reliable weapon of known yield that can be delivered by missile or combat aircraft. **Numerous government studies** have concluded that **it is plausible** that a

sophisticated terrorist group could make a crude bomb if they got the needed nuclear material. And in the last quarter century, there have been some 20 seizures of **stolen**, weapons-usable nuclear **material**, and at least two terrorist groups have made significant efforts to acquire nuclear bombs. Terrorist use of an actual nuclear bomb is a low-probability event—but the immensity of the consequences means that even a small chance is enough to justify an intensive effort to reduce the risk. Fortunately, since the early 1990s, countries around the world have significantly reduced the danger—but it remains very real, and there is more to do to ensure this nightmare never becomes reality. Brighter than a thousand suns. Imagine a crude terrorist nuclear bomb—containing a chunk of highly enriched uranium just under the size of a regulation bowling ball, or a much smaller chunk of plutonium—suddenly detonating inside a delivery van parked in the heart of a major city. Such a terrorist bomb would release as much as 10 kilotons of explosive energy, or the equivalent of 10,000 tons of conventional explosives, a volume of explosives large enough to fill all the cars of a mile-long train. In a millionth of a second, all of that energy would be released inside that small ball of nuclear material, creating temperatures and pressures as high as those at the center of the sun. That furious energy would explode outward, releasing its energy in three main ways: a powerful blast wave; intense heat; and deadly radiation. The ball would expand almost instantly into a fireball the width of four football fields, incinerating essentially everything and everyone within. The heated fireball would rise, sucking in air from below and expanding above, creating the mushroom cloud that has become the symbol of the terror of the nuclear age. The ionized plasma in the fireball would create a localized electromagnetic pulse more powerful than lightning, shorting out communications and electronics nearby—though most would be destroyed by the bomb's other effects in any case. (Estimates of heat, blast, and radiation effects in this article are drawn primarily from Alex Wellerstein's "Nukemap," which itself comes from declassified US government data, such as the 660-page government textbook The Effects of Nuclear Weapons.) At the instant of its detonation, the bomb would also release an intense burst of gamma and neutron radiation which would be lethal for nearly everyone directly exposed within about two-thirds of a mile from the center of the blast. (Those who happened to be shielded by being inside, or having buildings between them and the bomb, would be partly protected—in some cases, reducing their doses by ten times or more.) The nuclear flash from the heat of the fireball would radiate in both visible light and the infrared; it would be "brighter than a thousand suns," in the words of the title of a book describing the development of nuclear weapons—adapting a phrase from the Hindu epic the Bhagavad-Gita. Anyone who looked directly at the blast would be blinded. The heat from the fireball would ignite fires and horribly burn everyone exposed outside at distances of nearly a mile away. (In the Nagasaki Atomic Bomb Museum, visitors gaze in horror at the bones of a human hand embedded in glass melted by the bomb.) No one has burned a city on that scale in the decades since World War II, so it is difficult to predict the full extent of the fire damage that would occur from the explosion of a nuclear bomb in one of today's cities. Modern glass, steel, and concrete buildings would presumably be less flammable than the wood-and-rice-paper housing of Hiroshima or Nagasaki in the 1940s—but many questions remain, including exactly how thousands of broken gas lines might contribute to fire damage (as they did in Dresden during World War II). On 9/11, the buildings of the World Trade Center proved to be much more vulnerable to fire damage than had been expected. Ultimately, even a crude terrorist nuclear bomb would carry the possibility that the countless fires touched off by the explosion would coalesce into a devastating firestorm, as occurred at Hiroshima. In a firestorm, the rising column of hot air from the massive fire sucks in the air from all around, creating hurricane-force winds; everything flammable and everything alive within the firestorm would be consumed. The fires and the dust from the blast would make it extremely difficult for either rescuers or survivors to see. The explosion would create a powerful blast wave rushing out in every direction. For more than a quarter-mile all around the blast, the pulse of pressure would be over 20 pounds per square inch above atmospheric pressure (known as "overpressure"), destroying or severely damaging even sturdy buildings. The combination of blast, heat, and radiation would kill virtually everyone in this zone. The blast would be accompanied by winds of many hundreds of miles per hour. The damage from the explosion would extend far beyond this inner zone of almost total death. Out to more than half a mile, the blast would be strong enough to collapse most residential buildings and create a serious danger that office buildings would topple over, killing those inside and those in the path of the rubble. (On the other hand, the office towers of a modern city would tend to block the blast wave in some areas, providing partial protection from the blast, as well as from the heat and radiation.) In that zone, almost anything made of wood would be destroyed: Roofs would cave in, windows would shatter, gas lines would rupture. Telephone poles, street lamps, and utility lines would be severely damaged. Many roads would be blocked by mountains of wreckage. In this zone, many people would be killed or injured in building collapses, or trapped under the rubble; many more would be burned, blinded, or injured by flying debris. In many cases, their charred skin would become ragged and fall off in sheets. The effects of the detonation would act in deadly synergy. The smashed materials of buildings broken by the blast would be far easier for the fires to ignite than intact structures. The effects of radiation would make it far more difficult for burned and injured people to recover. The combination of burns, radiation, and physical injuries would cause far more death and suffering than any one of them would alone. The silent killer. The bomb's immediate effects would be followed by a slow, lingering killer: radioactive fallout. A bomb detonated at ground level would dig a huge crater, hurling tons of earth and debris thousands of feet into the sky. Sucked into the rising fireball, these particles would mix with the radioactive remainders of the bomb, and over the next few hours or days, the debris would rain down for miles downwind. Depending on weather and wind patterns, the fallout could actually be deadlier and make a far larger area unusable than the blast itself. Acute radiation sickness from the initial radiation pulse and the fallout would likely affect tens of thousands of people. Depending on the dose, they might suffer from vomiting, watery diarrhea, fever, sores, loss of hair, and bone marrow depletion. Some would survive; some would die within days; some would take months to die. Cancer rates among the survivors would rise. Women would be more vulnerable than men—children and infants especially so. Much of the radiation from a nuclear blast is short-lived; radiation levels even a few days after the blast would be far below those in the first hours. For those not killed or terribly wounded by the initial explosion, the best advice would be to take shelter in a basement for at least several days. But many would be too terrified to stay. Thousands of panic-stricken people might receive deadly doses of radiation as they fled from their homes. Some of the radiation will be longer-lived; areas most severely affected would have to be abandoned for many years after the attack. The combination of radioactive fallout and the devastation of nearly all life-sustaining infrastructure over a vast area would mean that hundreds of thousands of people would have to evacuate. Ambulances to nowhere. The explosion would also destroy much of the city's ability to respond. Hospitals would be leveled, doctors and nurses killed and wounded, ambulances destroyed. (In Hiroshima, 42 of 45 hospitals were destroyed or severely damaged, and 270 of 300 doctors were killed.) Resources that survived outside the zone of destruction would be utterly overwhelmed. Hospitals have no ability to cope with tens or hundreds of thousands of terribly burned and injured people all at once; the United States, for example, has 1,760 burn beds in hospitals nationwide, of which a third are available on any given day. And the problem would not be limited to hospitals; firefighters, for example, would have little ability to cope with thousands of fires raging out of control at once. Fire stations and equipment would be destroyed in the affected area, and firemen killed, along with police and other emergency responders. Some of the first responders may become casualties themselves, from radioactive fallout, fire, and collapsing buildings. Over much of the affected area, communications would be destroyed, by both the physical effects and the electromagnetic pulse from the explosion. Better preparation for such a disaster could save thousands of lives—but ultimately, there is no way any city can genuinely be prepared for a catastrophe on such a historic scale, occurring in a flash, with zero warning. Rescue and recovery attempts would be impeded by the destruction of most of the needed personnel and equipment, and by fire, debris, radiation, fear, lack of communications, and the immense scale of the disaster. The US military and the national guard could provide critically important capabilities—but federal plans assume that "no significant federal response" would be available for 24-to-72 hours. Many of those burned and injured would wait in vain for help, food, or water, perhaps for days. The scale of death and suffering. How many would die in such an event, and how many would be terribly wounded, would depend on where and when the bomb was detonated, what the weather conditions were at the time, how successful the response was in helping the wounded survivors, and more. Many estimates of casualties are based on census data, which reflect where people sleep at night; if the attack occurred in the middle of a workday, the numbers of people crowded into the office towers at the heart of many modern cities would be far higher. The daytime population of Manhattan, for example, is roughly twice its nighttime population; in Midtown on a typical workday, there are an estimated 980,000 people per square mile. A 10-kiloton weapon detonated there might well kill half a million people—not counting those who might die of radiation sickness from the fallout. (These effects were analyzed in great detail in the Rand Corporation's Considering the Effects of a Catastrophic Terrorist Attack and the British Medical Journal's "Nuclear terrorism.") On a typical day, the wind would blow the fallout north, seriously contaminating virtually all of Manhattan above Gramercy Park; people living as far away as Stamford, Connecticut would likely have to evacuate. Seriously injured survivors would greatly outnumber the dead, their suffering magnified by the complete inadequacy of available help. The psychological and social effects—overwhelming sadness, depression, post-traumatic stress disorder, myriad forms of anxiety—would be profound and long-lasting. The scenario we have been describing is a groundburst. An airburst—such as might occur, for example, if terrorists put their bomb in a small aircraft they had purchased or rented—would extend the blast and fire effects over a wider area, killing and injuring even larger numbers of people immediately. But an airburst would not have the same lingering effects from fallout as a groundburst, because the rock and dirt would not be sucked up into the fireball and contaminated. The 10-kiloton blast we have been discussing is likely toward the high end of what terrorists could plausibly achieve with a crude, improvised bomb, but even a 1-kiloton blast would be a catastrophic event, having a deadly radius between one-third and one-half that of a 10-kiloton blast. These hundreds of thousands of people would not be mere statistics, but countless individual stories of loss—parents, children, entire families; all religions; rich and poor alike—killed or horribly mutilated. Human suffering and tragedy on this scale does not have to be imagined; it can be remembered through the stories of the survivors of the US atomic bombings of Hiroshima and Nagasaki, the only times in history when nuclear weapons have been used intentionally against human beings. The pain and suffering caused by those bombings are almost beyond human comprehension; the eloquent testimony of the Hibakusha—the survivors who passed through the atomic fire—should stand as an eternal reminder of the need to prevent nuclear weapons from ever being used in anger again. Global economic disaster. The economic impact of such an attack would be enormous. The effects would reverberate for so far and so long that they are difficult to estimate in all their complexity. Hundreds of thousands of people would be too injured or sick to work for weeks or months. Hundreds of thousands more would evacuate to locations far from their jobs. Many places of employment would have to be abandoned because of the radioactive fallout. Insurance companies would reel under the losses; but at the same time, many insurance policies exclude the effects of nuclear attacks—an item insurers considered beyond their ability to cover—so the owners of thousands of buildings would not have the insurance payments needed to cover the cost of fixing them, thousands of companies would go bankrupt, and banks would be left holding an immense number of mortgages that would never be repaid. Consumer and investor confidence would likely be dramatically affected, as worried people slowed their spending. Enormous new homeland security and military investments would be very likely. If the bomb had come in a shipping container, the targeted country—and possibly others—might stop all containers from entering until it could devise a system for ensuring they could never again be used for such a purpose, throwing a wrench into the gears of global trade for an extended period. (And this might well occur even if a shipping container had not been the means of delivery.) Even the far smaller 9/11 attacks are estimated to have caused economic aftershocks costing almost $1 trillion even excluding the multi-trillion-dollar costs of the wars that ensued. The cost of a terrorist nuclear attack in a major city would likely be many times higher. The most severe effects would be local, but the effects of trade disruptions, reduced economic activity, and more would reverberate around the world. Consequently, while some countries may feel that nuclear terrorism is only a concern for the countries most likely to be targeted—such as the United States—in reality it is a threat to everyone, everywhere. In 2005, then-UN Secretary-General Kofi Annan warned that these global effects would push "tens of millions of people into dire poverty," creating "a second death toll throughout the developing world." One recent estimate suggested that a nuclear attack in an urban area would cause a global recession, cutting global Gross Domestic Product by some two percent, and pushing an additional 30 million people in the developing world into extreme poverty. Desperate dilemmas. In short, an act of nuclear terrorism could rip the heart out of a major city, and cause ripple effects throughout the world. The government of the country attacked would face desperate decisions: How to help the city attacked? How to prevent further attacks? How to respond or retaliate? Terrorists—either those who committed the attack or others—would probably claim they had more bombs already hidden in other cities (whether they did or not), and threaten to detonate them unless their demands were met. The fear that this might be true could lead people to flee major cities in a large-scale, uncontrolled evacuation. There is very little ability to support the population of major cities in the surrounding countryside. The potential for widespread havoc and economic chaos is very real. If the detonation took place in the capital of the nation attacked, much of the government might be destroyed. A bomb in Washington, D.C., for example, might kill the President, the Vice President, and many of the members of Congress and the Supreme Court. (Having some plausible national leader survive is a key reason why one cabinet member is always elsewhere on the night of the State of the Union address.) Elaborate, classified plans for "continuity of government" have already been drawn up in a number of countries, but the potential for chaos and confusion—if almost all of a country's top leaders were killed—would still be enormous. Who, for example, could address the public on what the government would do, and what the public should do, to respond? Could anyone honestly assure the public there would be no further attacks? If they did, who would believe them? In the United States, given the practical impossibility of passing major legislation with Congress in ruins and most of its members dead or seriously injured, some have argued for passing legislation in advance giving the government emergency powers to act—and creating procedures, for example, for legitimately replacing most of the House of Representatives. But to date, no such legislative preparations have been made. In what would inevitably be a desperate effort to prevent further attacks, traditional standards of civil liberties might be **jettisoned**, at least for a time—particularly when people realized that the fuel for the bomb that had done such damage would easily have fit in a suitcase. Old rules limiting search and surveillance could be among the first to go. The government might well impose martial law as it sought to control the situation, hunt for the perpetrators, and find any additional weapons or nuclear materials they might have. Even the far smaller attacks of 9/11 saw the US government authorizing torture of prisoners and mass electronic surveillance. And what standards of international order and law would still hold sway? The country attacked might well **lash out militarily** at whatever countries it thought might bear a portion of responsibility. (A terrifying description of the kinds of discussions that might occur appeared in Brian Jenkins' book, Will Terrorists Go Nuclear?) With the nuclear threshold already crossed in this scenario—at least by terrorists—it is **conceivable** that some of the **resulting conflicts might escalate to nuclear use**. International politics could become more brutish and violent, with powerful states taking unilateral action, by force if necessary, in an effort to ensure their security. After 9/11, the United States led the invasions of two sovereign nations, in wars that have since cost hundreds of thousands of lives and trillions of dollars, while plunging a region into chaos. Would the reaction after a far more devastating nuclear attack be any less?

Impact – Turns Economy

Breaches turn every one of their internal links and will collapse the health care industry.

Berkoff 17 Leslie A. Berkoff is a Partner with Morrit Hock & Hamroff where she serves as Chair of the firm's Bankruptcy Practice Group. "Cybersecurity and health care: where the concern lies." *Benefits Pro*. 27 November 2017. www.benefitspro.com/2017/11/27/cybersecurity-and-health-care-where-the-concern-li?ref=rss&slreturn=1511801166&page_all=1. [Premier]

This past May, international headlines were made when one of **the** largest "**ransomware**" **attacks** on records aptly named "WannaCry," "WCry" or "Wanna Decryptor" was transmitted via email targeting vulnerabilities in computer systems. During this attack, cyber attackers took over computers, encrypted information, then demanded payment of $300 of Bitcoin per machine to unlock the devices. The attack impacted 74 countries and a wide variety of industries. It affected some of the world's largest institutions and government agencies, including the United Kingdom's National Health Service, where 16 hospitals were hit. **Since many of the European hospital systems are centralized, the result was crippling**. For some reason, perhaps **because the hospital systems in the United States are less centralized, U.S. hospitals were not significantly impacted by this attack.** These attacks impacted health systems in a variety of ways, resulting in the **inability of hospitals to provide health care** to the patients. Among other things, the attacks disabled the facilities and **inhibited the ability for doctors to access medical records**. Without access to medical records, hospitals could not access health insurance records to confirm coverage, and, more importantly, medical history could not be obtained, doctors could not prescribe new scripts or render services because they could not check for contraindications for adverse interactions or allergies. More minor complications resulted in the doctors' inability to update records or communicate with other doctors. There are **problems** that **extend beyond the immediate impact**. The hackers can use or sell the stolen information to falsely obtain medical procedures. Another potential harm is that individuals could potentially be blackmailed due to sensitive information contained in health records. Health care systems do not just contain medical records; they contain **S**ocial **S**ecurity **n**umbers, bank statements, financial history, driver's licenses and information on spouses and guarantors. Unscrupulous third parties can also use this information to **falsify prescriptions, sell the scripts on the black market, or obtain them for personal use.** The financial and operational risks from a cyberattack would be exacerbated in bankruptcy, although to date so far none have occurred post-petition. Moreover, the harms identified above could force an entity to contemplate or file for bankruptcy because of an influx of claims. WannaCry was the indirect result of a failure to perform certain simple upgrades and implement patches. Thus, **individuals who have had their privacy breached, or their personal data hacked, or utilized by third parties may have a basis to sue the medical facilities, or their officers or directors, for failing to take proper precautions**. Patient injury or death due to compromised devices, systems or technology could lead to a potential rise in **class actions** and claims against the facilities. In the bankruptcy case 21st Oncology Holdings, pending in the Southern District of New York, 17-22770 (RDD), a class action was filed on behalf of over two million current and former patients of the debtor who had their personal information compromised while undergoing cancer treatment at the facility. The claims assert that the loss was due to the company's failure to enforce sufficient security protocols and procedures and that the company did not discover the breach, but rather the FBI informed the company that the information was posted on the Dark Web. The validity of the claims is currently being litigated before the Bankruptcy Court, but the existence of these claims suggests they may have contributed to the bankruptcy filing. The **cost of these suits can be enormous**. **In the United States, HIPAA settlements totaled over $17 million from breaches of confidential information.** In June, Anthem, the largest U.S. health insurance company, settled a multi-district lawsuit after the personal information of 78.8 million people was stolen during a 2015 cyberattack for $115 million. The concomitant loss of public confidence and trust when these kinds of attacks occur often result in the loss of revenue from the public seeking alternative venues for treatment. Moreover, insurance companies may consider the failure to protect this data a basis to stop reimbursements. Loss of revenue may lead to loss of independent funding. Lenders to the facility may consider any or all of these to be a breach of an underlying loan covenant as a result of disruption of operations and loss of patient information. All of these events may stress an already financially stressed health care provider. Health care systems have an obligation to take reasonable care to protect private customer information. Focusing on these issues is also part of the responsibility of the officers and directors of a facility. Yet the cybersecurity protections do not seem to be in place. While health care providers are universally switching over to electronic data, the security of this information has not matched its growth. Financial services industries devote in excess of ten percent of their annual IT budgets to cybersecurity while the health care industry is less than 5 percent. Given that these facilities often have outdated IT systems and a wealth of confidential patient data, hospitals remain a particularly tempting target. As health care budgets

shrink, health care providers must focus on preparing and protecting against further attacks. While it may not be possible to replace all outdated equipment, some steps can be taken. One thing is clear, as these attacks continue to increase, the concomitant risk grows, leading a shaky industry to perhaps tip more into the insolvency zone.

Impact – Turns Costs

It causes huge losses and forces out-of-pocket payments---both balloon costs.

Experian 10 Experian plc is a consumer credit reporting agency. "The Potential Damages and Consequences of Medical Identity Theft and Healthcare Data Breaches." April 2010. https://www.experian.com/assets/data-breach/white-papers/consequences-medical-id-theft-healthcare.pdf. [Premier]

Conversely, this percentage of victims indicates there is a significant population of consumers who are victims… and are still not aware of it! This nascent form of identity theft can no longer be ignored. **A breach of personal health information** (PHI) **can have a significant negative impact on clients, customers and on the ongoing health of a business**. Impact to the Consumer: Unfortunately, by the time medical identity theft is discovered, the damage has been done. Forty percent of consumers say that they found out they were a victim of medical identity theft only when they received collection letters from creditors for expenses that thieves incurred in their name. As a result, the consequences of medical identity theft are frequently **severe**, stressful and expensive to resolve. According to a 2010 Ponemon survey, the average cost incurred in trying to resolve a medical identity theft incident is more than $**20,000**.3 Additionally, **55%** of survey respondents **had to make out-of-pocket payments to the health plan provider** or insurer to restore coverage and **32% experienced an increase in their health insurance premiums**. The effort to resolve the crime and restore an identity can also be extensive. Seventy four percent of those surveyed consumers say that the effort to resolve the crime and restore their identity was significant or very significant. In addition to the cost, consumers say the most immediate impact included mental anguish or embarrassment.3 Business Impact: The effects of a breach of PHI can be **devastating to a business, organization or institution** both financially and to their coveted customer relationships. According to Ponemon Institute research, **the average expense incurred for a company to address a medical data breach is $211 per record.** Additionally, the research indicates that **those companies that do not closely follow the new regulatory requirements established through the HITECH** Act can incur damages and **fines of up to $1.5M. Damages go beyond the associated costs and potential fines in managing a data breach**. The negative impact also manifests itself in losses to consumer **trust**, confidence and loyalty. As a matter of fact, over 70% of respondents surveyed trust healthcare providers such as hospitals, clinics and physicians to protect their PHI.4 Should this **trust be broken** the **impact on a healthcare provider's bottom line could be severe.** Fifty five percent of consumers responding to a Ponemon study strongly agree that the medical identity theft caused them to lose trust and confidence in health care organizations. Another 2009 study indicated that of those who were severely injured by a data breach, such as a breach of PHI, over 50% of them switched their business to a competitor.

Lost revenue and litigation costs are magnified because of record blending.

Hamilton 17 Edie Hamilton, oding and industry expertise at Verscend. "The true costs of medical identity theft." 11 January 2017. https://blog.verscend.com/the-true-costs-of-medical-identity-theft. [Premier]

$13,500. That is the average cost victims pay to resolve medical identity theft—when they can resolve it. Medical identity theft occurrences are becoming more common. Incidents increased 22 percent from 2014 to 2015, impacting more than 2.3 million people in the United States, per the Ponemon Institute's Fifth Annual Study on Medical Identity Theft. The impact of medical identity theft can be measured in both financial terms and how it hurts the patient-provider relationship. One common complaint voiced in the Ponemon study was that the provider or insurer did not inform the patient about the theft. Instead, the victims learned about it on their own from an error in their bill or a collection letter. Clearly, this is not just a patient issue. **The costs to providers and facilities can range from lost revenue to a costly and litigious review of all entries in a medical record.** Think about **how time consuming and complicated it is to unravel a single medical record** blended with encounters from two or more different patients.

Impact – Tax Fraud

Undermines effective care distribution and cause tax fraud.

Weisbaum 16 Herb Weisbaum, NBC Correspondent. "Cyber Attacks and Negligence Lead to Rise in Medical Data Breaches." NBC. 17 May 2016. https://www.nbcnews.com/tech/tech-news/cyber-attacks-negligence-lead-rise-medical-data-breaches-n575471. [Premier]

Human cost of medical breaches Medical identity theft is extraordinarily harmful to people, **much worse than** the **breach of credit or bank account numbers**. When those are stolen, you can close the account and move on with your life. The damage that can result from stolen medical records can be significantly worse and harder to spot, and can last a lifetime. That's because your medical file is a treasure trove of sensitive personal information that an identity thief can use in various ways. "Your **medical records are the keys to the kingdom**," said Eva Velasquez, president and CEO of the non-profit Identity Theft Resource Center. "The information in that file includes [your] Social Security number, often payment information, where you're going for medical care and where you're getting your prescriptions." An identity thief can use this information to get medical treatment, medical equipment or prescription drugs in your name. That can result in bogus information being added to your medical file — and you may never spot it. All of a sudden your **blood type changes** or it looks like **you had a surgery** that you didn't have. The consequences of that, experts say, **can be life-threatening**. In fact, the Ponemon study found that fifty-eight percent of healthcare organization and 67 percent of their business associates don't have a process in place to correct these errors in a victim's medical records. And because **medical records** contain so much personally identifying information, they **can be used to commit other types of fraud.** "The thief can do all sorts of things to **monetize** that **stolen information**," Velasquez told NBC News. "We believe these **medical breaches have led to the explosion of IRS and state identity tax fraud**."

Tax evasion collapses the economy.

UEA 16 University of East Anglia. "Tax evasion impacts country credit ratings and lending costs says new study." https://www.sciencedaily.com/releases/2016/01/160119213202.htm. [Premier]

High levels of tax evasion are linked to higher interest rates and can be a predictor of a country's credit risk, according to a new study led by the University of East Anglia (UEA). Researchers investigated the controversial role of the 'informal' or 'shadow' sector -- activities that are not officially registered but do make an economic contribution -- in the economies of 64 countries in the run-up to the current Eurozone crisis. For the first time they focused on the impact the informal sector, which is directly linked to tax evasion, has on sovereign debt markets. They found that it has significant adverse effects on country credit ratings and lending costs. These **results do not change with respect to the stage of economic development of a country.** Countries such as Switzerland, the United States, Luxemburg, Austria and Japan that had the smallest levels of informal economic activity -- averaging between 8% and 11% of Gross Domestic Product (GDP) -- faced low lending costs, under about 4%. In countries such as Panama, Peru, Uruguay, Honduras and Sri Lanka, where around half of the economy was untaxed, country lending costs were much higher and ranged between 7% and 10%. In comparison, the United Kingdom's informal sector averaged at 12.4% of GDP, while its interest rate was 4.5%. There was a wide variation in the level of the informal economy, even within developed countries. Those with the largest informal sector among member countries of the Organisation for Economic Co-operation and Development (OECD) studied were Greece (26.86%), Italy (26.96%), Portugal (23.12%) and Spain (22.38%), all of which had around a quarter of economic activity untaxed and faced severe problems during the recent Eurozone debt crisis. Publishing their findings today in the European Journal of Operational Research, the authors suggest that trying to reduce the amount of tax evasion in financially challenged countries is **likely to help in relaxing credit risks and cutting lending costs**. The study is particularly important given that previous research has not been able to show clearly if the informal economy has an overall positive or negative influence on economic activity and growth. The research was led by Raphael Markellos, professor of finance at UEA's Norwich Business School, working with Dr Dimitris Psychoyios from the University of Piraeus in Greece, and Prof Friedrich Schneider, a leading authority on shadow economies and tax evasion at Johannes Kepler University, Austria. They analysed country-specific financial data and other variables, such as inflation and unemployment rates, GDP, tax revenue and public debt, for the years 2003-2007. In addition to the implications for government debt, the study also highlights that countries with a higher **shadow economy** face adverse general conditions with respect to balance of payments, deficit,

inflation, unemployment, tax revenues, and Research & Development spend, as well as competitiveness, economic freedom, corruption and human development, for example in relation to life expectancy and education. Prof Markellos said: "Given the ongoing sovereign debt crisis in Europe, any new findings about the drivers of country credit ratings and costs of debt are particularly valuable. Tax evasion harms the ability of a country to raise cheap debt in the international financial markets. This in turn can have **damaging effects across the economy**, including **public** spend and **services**, corporate investments, jobs, price levels, availability and cost of mortgages and consumer debt. **"In modern economies, everything is strongly related to the creditworthiness of the country you live in. If someone is not paying taxes, they are not only free-riding on public services but they are ultimately hurting the credit score of others."**

Impact – Turns Coverage

Even basic hacks or malfunctions will shut down the system because of reliance on a centralized database.

Raposo 15 Vera Lucia Raposo, Faculty of Law at Macao University and Coimbra University. "Electronic health records: Is it a risk worth taking in healthcare delivery?" 2015. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4677576/. [Premier]

Despite the many advantages, let's not forget also **the EHR's risks** – known as e-iatrogenesis [5] – many of them the opposite of the referred potentialities [2], [6], [7], [8], [9], [10], [11], [12]. Although technology in its current state is very reliable, it is still **not without dangers**, from computer bugs to **cyber-attacks that** can **leave the system inoperative** or cause functional errors, some with serious consequences. The mere **loss of a password** is enough to involve problems in system operation, since it prevents the use of the EHR and its information, eventually **precluding the provision of** adequate medical **care**. **Even when the system is operating 'normally'** (i.e., **with no** virus or **cyber attacks**), it may lead to some **errors caused by the software design** itself. E.g., we have the case of a patient, whose treatment for cancer was delayed for several years, because, instead of referring the doctor to the last exam performed, the system referred to an older normal exam which did not present any abnormal results. Hoffman and Podgurski [2] relate different episodes of medical injuries caused by computer errors, such as when the EHR software of the **V**eterans **A**ffairs led to the administration of potentially dangerous medicine's doses. Actually, the **majority of patient's injuries** caused during the use of EHRs come from **wrongful** ordering and **administering of drugs** or **peroneus diagnosis** originated by the **lack of the necessary info**rmation **by the EHR** to make the proper diagnosis. Those mistakes are, in a way, to be expected. In fact, the EHR has become so complete and complex that the technology underneath is, likewise, quite complex. **A small flaw can throw it all away, by messing with the records of many patients** (**adding, dealing, or misplacing data**). Another difficulty to be considered relates with the possible **simultaneous** existence of two medical records for the same patient, a computerized one and another in paper format, a frequent situation in the beginning of the EHR implementation, so that a patient will have a record on paper referring to past events, and another one in electronic form for future events. However, this duality weakens many of the advantages aimed by the EHR in terms of efficiency and error prevention and may even **cause confusions and malfunctions**. In Johnson v. Hillcrest Health Center, Inc. – 70 P.3d 811 (Okla. 2003) [13] – the doctor sent the patient home twice alleging that his condition was not serious, but the patient ended up dying in another hospital of heart attack because his heart condition was not diagnosed in due time. In court, the claimant, Mrs. Johnson, wife of the deceased, alleged that the doctors and the hospital failed in storing the results of the exams, which were placed in the wrong chart, so that the doctor did not find them. However, the doctor could have traced them in the system, what he did not, since probably he was used to solely verify the paper chart. Though the doctor settled the case, the hospital did not, so, the court had the chance to analyse the behaviour of health institutions that allowed the parallel existence of a medical file in paper, and another one computerized. The court stated that, in this case, the applicable standard of care demanded the hospital to include all patient information not only in the computer, but also in the paper chart. On the other hand, **technology may exacerbate the error**. In effect, it is a well-known fact that many users of the EHR simply make **copy/paste** of past records of the patient, and even of records of other patients, **in order to satisfy the demanding information request made by the system**. But the simple fact of **copying** information from one record to another **multiplies mistakes**, because **an eventual error in one record turns into dozens of errors in dozens of records.**

Even if records aren't directly hacked, ransomware attacks will compromise the entire health system because operations would be centralized in fed single payer---UK proves. That removes any benefit compared to a market system.

Thomas 17 Cal Thomas, Washington Times, is one of the most widely syndicated political columnists in America. Based in Washington, he has been a columnist for 30 years. "The big hack attack and the NHS." 17 May 2017. https://www.washingtontimes.com/news/2017/may/17/single-payer-health-care-system-has-been-tried-bef/. [Premier]

GLASGOW, Scotland | The ransomware cyberattack that wormed its way into at least 74 countries recently exposed new vulnerabilities in the United Kingdom's National Health Service (**NHS**), as if it weren't vulnerable enough. Hospital systems in England and Scotland **were taken off-line**. Major operations were delayed, causing frustration and additional worry to patients who spoke to TV interviewers. Sky News technology correspondent Tom Cheshire asked why the affected NHS trusts were not up to date. The answer he received from an information technology source inside NHS was: "They patched nothing generally." Mr. Cheshire wrote: "Staff working to keep systems up to date were 'crushed' — by a **lack of organizational understanding** and money." After an investigation last year into cybersecurity in the NHS, "We found that some trusts spent no money whatsoever on cybersecurity. The white hat hackers we worked with found serious vulnerabilities just at first glances. Those failings have now been exposed. And **it's patients who** are **pay**ing **the price.**" Failure to protect its computers and patient records is one of many problems within the NHS. **These problems contain warnings for Americans pushing for single payer** health insurance, which could likely lead to health care **dispensed by the federal government**. Should that occur, Washington almost certainly will ration care based on a utilitarian view of the value of human life. Last week, the London Times reported a dim future for the NHS. According to "leaked estimates," (the White House isn't the only place affected by leaks), more than 5 million people could be stuck on waiting lists for treatment over the next two years. "The number of patients waiting more than four months for surgery," writes the Times, "could more than double to 800,000 by 2019." If that happens, **it will** likely **cause** even **more deaths that might have been prevented under a** different and **market-oriented health care system**.

AT: Can't Hack

There's no organizational security capability and records are a prime target of organized crime.

Weisbaum 15 Herb Weisbaum is an award-winning journalist who writes for NBC, citing the 2015 Study on Privacy and Security of Heathcare Data. "Health Industry Can't Protect Your Records from Hackers: Report." May 2015. https://www.nbcnews.com/tech/security/hey-alexa-how-secure-are-voice-activated-assistants-you-n824566. [Premier]

Your medical records are a **prime target** for hackers and identity thieves, **but the healthcare industry is not prepared to deal with** a surge in data **breaches**, security incidents and criminal attacks, according to a new report by the Ponemon Institute released on Thursday. "Organizations in the healthcare space are not **playing their 'A game'** in terms of security and data protection," said Larry Ponemon, founder and CEO of the Ponemon Institute. "There are some exceptions, but generally speaking, healthcare **providers either lack the resources, staff or the technical innovations** to meet the changing cyber-threat environment." The 2015 Study on Privacy and Security of Healthcare Data is based on information provided by healthcare organizations large and small, as well as related businesses that often deal with healthcare records. The report concluded that **no healthcare organization, regardless of size, is immune to a data breach**. And in fact, **half of all the organizations surveyed have "little or no confidence" in their ability** to detect every theft or loss of patient data. Other key findings: 91 percent of the healthcare organizations surveyed had one data breach during the past two years; 39 percent experienced two to five breaches and 40 percent had more than five Data breaches are costing the healthcare industry $6 billion a year Cases of medical identity theft have nearly doubled in the last five years, from 1.4 million adult victims to more than 2.3 million in 2014 "Consumers should be mad as heck that their personal medical information is being lost, stolen and exposed at a greater rate than ever," said Rick Kam, founder and president of ID Experts, which sponsored the study. Perhaps the most eye-opening finding in the report is the increase in criminal attacks -– up 125 percent since 2010. These breaches, resulting from a cyber attack or a malicious employee inside the company, are now the leading cause of medical data breaches. Until now, the primary way medical records became compromised was through carelessness –- maybe a lost or stolen computer -– what Ponemon calls "good people doing stupid things." And that still happens. But now, **organized criminal gangs from Eastern Europe, Russia, China and Iran are trying to steal** this **valuable information**. A medical health record is **extremely valuable.** Experts say it can sell for $60 to $70 on the black market, as compared to just 50-cents or a dollar for a stolen Social Security number.

AT: Regs Check

HITECH and HIPPA are useless against breaches.

Flaute 16 Andrea Flaute, Associate Member, University of Cincinnati Law Review. The Double Edged Sword: Electronic Health Records and Data Breaches." *UC Law Review*. 24 February 2016. https://uclawreview.org/2016/02/24/the-double-edged-sword-electronic-health-records-and-data-breaches/. [Premier]

HITECH has given healthcare providers a financial incentive to switch to EHR systems right now but has **not** provided a means to ensure those **systems stay up-to-date with** the latest **protections**. As technology constantly changes and the costs associated with frequently updating equipment and software quickly add up, it is understandable why some **providers cannot remain complaint with HIPAA and HITECH regulations**. But failure to remain compliant leaves patients vulnerable to a variety of **threats that have long-lasting implications**. EHR systems are a great resource, but data privacy risks need to be addressed, not by choice, but by law. Congress must craft a remedy to constrain the threats and illegal actions that are currently being taken against patients and their highly sensitive information.

Jobs

Link

ACA created an overreliance on insurance jobs---changing course now would collapse the economy.

Diamond 16 Diamond, Dan. A graduate of the University of Pennsylvania and has appeared to discuss health care, politics, and policy on NPR's "All Things Considered" and "1A," the NBC Nightly News, the BBC, CBS, MSNBC, the Dan Patrick Show, KQED's "Forum" and other programs. He was recently named a 2015-2016 fellow of the Association of Health Care Journalists. “Obamacare, the secret jobs program.” Politico. 13 July 2016. www.politico.com/agenda/story/2016/07/what-is-the-effect-of-obamacare-economy-000164 [Premier]

The resulting law — born **at the very moment the economy was bottoming out** — ultimately came down on the side of saving jobs. It conceded many cost controls in favor of softer measures. And in that respect the decision paid off: **The industry has gained nearly 2 million jobs since the ACA was signed into law** in March 2010. More people — 15.5 million — now work in health care than live in the state of Ohio. Employment in the **health insurance industry**, which had fallen since the recession, jumped nearly 9 percent from 2012 to 2013 as millions of Americans became newly insured. Based on job numbers, no sector is healthier than health care. But is that what the American economy needs? Experts say that many health care jobs are an explicit drag on growth, and the higher the cost of health care, the less money invested elsewhere. The rising cost of health care is a top-three issue for CEOs; it’s often cited as a reason for why U.S. manufacturers are less competitive with their overseas rivals. Today, the jobs-driven political tradeoff that prevented Obamacare's authors from making hard cuts to health care costs is still bedeviling policymakers. Despite a recent slowdown in spending growth, which the White House has repeatedly touted, health costs continue to rise every year — and they’re increasingly hard for legislators to address because scaling back will turn off a jobs engine. If Congress doesn’t figure out a way to confront the industry's unchecked spread, economists believe, the decisions made in 2009 will have costs that linger years and even decades into the future — leaving the next administration with the kind of success story it would prefer not to inherit. “OBAMACARE KILLS JOBS” is a Republican talking point so common it might as well be burned into a teleprompter. "It is the biggest job-killer in this country," Ted Cruz said at the final GOP primary debate — a position echoed by John Boehner, Mitch McConnell, Rick Scott and nearly every other Republican luminary. Donald Trump, in his 2011 book "Time to Get Tough: Make America Great Again!", put it more floridly: "Obamacare is a heat-seeking missile that will destroy jobs and small businesses." **That’s not how the law turned out**. The private sector has grown every single month since the ACA passed in March 2010, a number that Obama often touts when he defends his signature law. And many of those jobs are, literally, in health care. **More than 1 in 9 employed Americans now gets a paycheck directly from the health care industry, and that's not counting the millions more who work in associated fields, like tech companies that specialize in health care services or the consulting firms that gorge on the sector's inefficiency.** Health care leaders tell a simple story: That **their industry helped cure America's economy, post-recession**. It's already surpassed the manufacturing industry in terms of total jobs, and based on current hiring trends, health care will become the nation's largest industry by 2019, passing the entire retail sector. But there's another truth: All those new jobs are hiding a poison pill. Health care's fast growth is actually a drag on the rest of the nation's economy. As it grows, it's setting up an ever-bigger health care bill that employers, patients and taxpayers ultimately shoulder. **Many of those jobs are effectively waste**. "**For every doctor, there are now 16 FTEs that are non-doctors**," Kocher said. "**Nine of them are administrators** — and it's jumped from six" in the past few years. **That means that efforts to slow or even reverse health care costs would be massively disruptive to millions of middle-class workers by reducing jobs in one of the nation’s largest industries.** So **as it grows, health care becomes the sacred cow that lawmakers can't** — or won't — **cut.** To understand the **central role health care now plays in employment**, it helps to look at the recession, and how the sector appeared to **pull off a** minor **miracle during America's darkest economic cycle in decades**. **Even as the rest of the economy shed more than 9 million jobs** from January 2008 to February 2010, health care delivery firms like hospitals, physicians and home health agencies collectively gained more than 550,000 jobs. In fact, the health care sector added jobs every single month during the nation's historic downturn. On employment charts, it looks like a mistake — the only straight upward line as every other industry cratered. And the

sector just kept growing through the recovery, adding net jobs at a historic pace. Meanwhile, industries like manufacturing and retail have stayed flat or even shrunk since Obama took office.

Health insurance employs over 1.2 million.

Novack 08 Novack, Eric. MD and healthcare advocate. "Where will all the employees go? By Eric Novack." The Health Care Blog. 18 February 2008. thehealthcareblog.com/blog/2008/02/18/where-will-all-the-employees-go-by-eric-novack/ [Premier] ****2.5 million/4 = .625 + .6 million = 1.2 million**

A quick question: With calls for a substantial increase in government involvement in health care by so many—and, among the major justifications is the claim of high administrative overhead in the private sector relative to government—**what do the proposals plan to do with the hard working people currently working in the health insurance industry? The insurance workforce is** estimated at close to **2.5 million**. It would be not unreasonable to say that 25% of that is health care related. And **that does not even include the people working on health insurance related issues on the provider/ hospital end—a number that absolutely exceeds 600,000**. So, put another way: what do the reformers plan to do (a) for, (b) with, the potential displacement of over 1 million workers? Just asking, but could it be that the claimed efficiencies will not materialize and they will stay employed? Could it be that the costs of 'retraining' and financial support for these families will exceed the 'savings' claimed? Which group really will be displaced—will the size of the in-office, and in-hospital administrative workforce even be counted when looking at 'streamlined' administrative costs? Will many of the displaced workers simply end up working as government employees in a similar capacity? I would hope that supporters of the Obama plan, the Clinton plan, and the single-payer plan would weigh in here with real specifics—and not ad hominem attacks…Eric Novack

Aff puts hundreds of thousands out of work.

Small 16 Small, Leslie. A senior editor at FierceMarkets, where she oversees the content for a daily publication, FierceHealthPayer, a weekly publication, FierceHealthPayer: AntiFraud and the Hospital Impact blog. "Bernie Sanders' healthcare plan: The trouble with nixing private insurers." FierceHealthCare. 3 February 2016. www.fiercehealthcare.com/payer/bernie-sanders-healthcare-plan-trouble-nixing-private-insurers [Premier]

But how will a single-payer system affect the country's private insurers--and the impact they have on the economy? To find out, **F**ierce**H**ealth**P**ayer analyzed data from America's Health Plans (AHIP) on how insurers contribute to the economy and health coverage in each state. Here's a brief rundown of how AHIP's most recent data plays out nationally: **States collect $17.4 billion in premium taxes from health plans**. Health insurers provide a total of **515,234 direct jobs**, which is an average of 10,103 per state. Health insurers provide **842,105 indirect jobs**, which is an average of 16,512 per state. An average of 54.69 percent of residents across all 50 states and the District of Columbia are insured through private payers. The net savings Sanders expects from his plan will come from "reduced spending on administrative activities, in both private insurers and providers' offices, reduced spending on monopoly prices for pharmaceuticals and medical devices, and a slowdown in the growth of spending because of controls on administrative costs and drug prices," University of Massachusetts at Amherst economics professor Gerald Friedman writes in a memo assessing the plan. The Sanders campaign also has said that his plan would cost an additional $1.38 trillion per year and would be financed primarily by raising taxes on high-earners, employers and other entities. **Yet an analysis out Wednesday from the bipartisan Committee for a Responsible Budget finds that those proposed offsets would cover only 75 percent of the projected cost, adding up to a $3 trillion shortfall over 10 years**. For its part, **the health insurance industry's biggest trade group is, understandably, against eliminating private payers.** "**A competitive market is key to delivering on the promise of consumer choice, value and innovation**," America's Health Insurance Plans (AHIP) spokeswoman Courtney Jay wrote in an email to FierceHealthPayer.

"Health plans are working to deliver that value to consumers every day by **offering them a range of coverage choices and improving the way we pay for care. That needs to be the focus** moving forward."

The plan would cause waves of unemployment.

Kamper 17 Kamper, Dave. Dr. Kamper is a labor organizer in the Twin Cities. He received his Ph.D. in History from the University of Illinois at Urbana-Champaign in 2003. "Taking Single-Payer Seriously." Jacobin. 28 May 2017. https://jacobinmag.com/2017/05/single-payer-medicare-for-all-health-jobs [Premier]

The private health insurance industry is, as many have observed, one of the primary drivers of health care costs. We spend far more on health care than any other advanced capitalist country and end up with inferior health outcomes. The Affordable Care Act (ACA) kept that basic system in place. For all the talk of mandates and cost curves and exchanges, **Obamacare massively increased spending in the health care system. When more people get health insurance, more people use health care.** The Medicaid expansion and the subsidies for coverage on the individual market **funnel tens of billions of additional dollars into insurance companies** and health care providers every year. In 2014, the first year that the ACA was more or less in full force, net expenditures on health care rose 4.6 percent. In 2015, they jumped 5.6 percent. The same year, the federal government estimated that outlays would expand "1.2 percentage points faster than Gross Domestic Product" over the next decade. By 2025, it projected, health care would no longer make up one-sixth of the American economy. It would make up one-fifth. Much of this spending results in new jobs. From 2011 to 2016, overall job growth in the US sat at 8.3 percent, but the number of health care practitioners rose 15.8 percent. Nurse practitioner jobs increased 76 percent. Speech-language pathologist positions expanded by 29.6 percent. "Medical records and health information technicians" went up 58.6 percent. **In the health insurance industry, "insurance claims and policy processing clerks" went up 11 percent.** As long as the ACA fire hose keeps spraying money at the health care industry, jobs will balloon accordingly. If the water pressure drops, the consequences will be real and drastic, even if the overall result is more equitable and more affordable health care. Medicare for All wouldn't just scrap Obamacare — it would **uproot the entire industry**. It would be a huge efficiency savings. But it would also be **devastating** in the short term for **hundreds of thousands** of working people whose only crime was getting a job at an insurance company, and the **hundreds of thousands more who work as billing specialists** for clinics and hospitals (the number of medical assistants shot up 44 percent between 2011 and 2016). Yes, the CEO of United Health Group made $101 million in 2011. But few of the 230,000 other people working for the company saw money like that. Bernie Sanders's recently announced Medicare for All plan asserts that we "need a health care system that significantly reduces overhead, administrative costs, and complexity," and projects that his plan would save $6 trillion over ten years. Those trillions — currently being sucked up by a bloated, profit-hungry industry — could do amazing things. Infrastructure. Education. Housing. Insurance for all, in and of itself, would be remarkable. **But you don't save $6 trillion just by getting rid of the insurance industry.** The US has 35.5 MRI machines per million people. The UK, with its National Health Service, has 6.1. Single-payer Canada has 8.5. We don't need as many as we have. We can deliver complete patient care with many fewer machines. But **fewer machines means fewer manufacturing jobs, fewer technician jobs, less need for new construction for new facilities, and so on.** And MRIs are just one facet of a huge health care system that will see efficiencies across the board in a single-payer system. **The benefits of those efficiencies will be felt by all, the harms by few, but they will feel them hard.** The effects of these changes would be highly local. Some of the campuses of large health insurance companies employ thousands. **Shuttering them would be like shuttering a steel mill or auto factory — the shockwaves would reverberate through the whole community**. Like laid-off autoworkers, employees of insurance companies would be pushed onto the job market with a set of skills and experiences **unsuited to most other occupations**. The color of their collar wouldn't change that.

Literally shuts down an industry---supplemental coverage doesn't come close to enough to sustain it.

Alonso-Zaldivar 15 Alonso-Zaldivar, Ricardo. Correspondent for Health in the Associated Press with six videos in the C-SPAN Video Library. "What you should know about 'BernieCare' — Sanders' proposed health overhaul." PBS. 18 November 2015. www.pbs.org/newshour/rundown/what-you-should-know-about-berniecare-sanders-proposed-health-overhaul/ [Premier]

WHAT ABOUT INSURERS? Economic changes, new technologies, and globalization have disrupted many industries. People in the United States have learned to live with fast-paced change, even if they don't like it. But **rarely does the government shut down a major industry**. **That's basically what would happen to health insurance companies under Sanders' plan. Insurers would be relegated to selling supplemental coverage for services not covered under the single-payer plan. States could hire them to help administer coverage. But hundreds of thousands of jobs would disappear. Billions of dollars in shareholder equity would evaporate.**

Impact – Economy

The industry is key to the economy.

Scott et al 13 Scott, Greg. Thenational leader of Deloitte's health plan practice. He leads a multi-disciplinary team of more than 75 partners, principals, and managing directors who serve clients through consulting, risk advisory, financial advisory, audit, and tax services. He has more than 27 years of diverse industry experience as management consultant, insurance company executive, and government official. Also Paul Keckley, Bill Copeland. "The future of health care insurance: What's ahead?" Deloitte Insights. 24 July 2013. https://dupress.deloitte.com/dup-us-en/deloitte-review/issue-13/the-future-of-health-care-insurance-whats-ahead.html. [Premier]

Where is the industry now? Fast forward to the present, where **the US health insurance industry plays a ubiquitous role in the nation's economy** and in many American households. **More than 160 million Americans are covered by employer-sponsored insurance plans.**6 Another 17 million Americans purchase insurance for themselves in the private insurance market, and about 100 million are covered by government-sponsored insurance plans.7 Notably, in each of these categories, there are unique eligibility, enrollment, and premium requirements, and each is under intense regulatory scrutiny at the state and federal levels. It's a big industry comprising about 400 operators, including 154 with more than 100,000 enrollees, with enrollment split almost evenly between investor-owned plans and not-for-profit plans.8, 9 And **it is growing at home and abroad as individuals, governments, and companies seek to mitigate the financial risk of health cost while attracting/retaining employees**.

Insurance jobs have high wages which means cutting them causes downstream unemployment that magnifies the link---this card is about just one state.

Roy 17 Roy, Avik. Resident, The Foundation for Research on Equal Opportunity, Editor at Forbes. "The Price of Single Payer Health Care in New York." FreOpp. 2 March 2017. https://freopp.org/how-state-based-single-payer-initiatives-crush-economic-opportunity-604ac9ac17c9. [Premier]

Health insurance and health care administration. **The Act seeks to eliminate the private health insurance industry** in the State of New York. The Friedman report estimates that these changes will result in the loss of 150,000 jobs in the health insurance and health care administration sectors. As noted above, Friedman overstates by a factor of three the impact of the Act on administrative costs. As a result, a more realistic estimate of job loss in health care administration is 67,000. **Friedman**, however, **may be underestimating the number of individuals employed in the health insurance industry**. Friedman estimates that there are 26,000 people employed by health insurers in New York state; but in 2016, according to the New York Health Plan Association, the industry employed more than 52,000 individuals, paid $4.4 billion annually in health care taxes, and covered 10.9 million state residents**. Those jobs and taxes would be eliminated** by the Act. Financial services. **Financial services are the engine of the** New York state **economy**. According to the New York State Department of Labor, two key subsectors of the financial services industry — credit intermediation and securities — employed 350,000 state residents in 2014, representing more than 3.5 percent of the state's labor force. **Because financial services jobs often pay high wages, the industry represents a critical part of the** state's **revenue base**. The Office of the New York State Comptroller has estimated that the securities industry alone accounted for 19 percent of state tax collections in State Fiscal Year 2014, totaling $13.2 billion. Many New York-based financial institutions, such as hedge funds, private equity funds, and venture capital funds, are organized as pass-through partnerships in which income is taxed at the individual level. Today, the common sources of interest income — most notably U.S. Treasury and Savings bonds — are exempt from New York personal income taxes. In addition, bonds issued by the State of New York and its localities are exempt from New York personal income taxes. Dividends and capital gains are treated as ordinary income for state tax purposes; hence, in 2015, the state tax rate for dividends and capital gains was 6.65 percent for those earning more than $80,150; 6.85 percent for those earning more than $214,000; and 8.82 for those earning more than $1.07 million. The Friedman report estimates that the Act will raise state taxes on dividends, interest, and capital gains by $32.6 billion in 2019 alone. These funds would be raised, in Friedman's proposal, by a new, progressive tax on such gains starting at 9 percent for those with incomes above $25,000 per year, and topping out at 16 percent on those with incomes above

$200,000 per year. For an individual making $215,000 per year, the Friedman proposal would more than triple the state tax rate on capital gains and dividends, and tax for the first time many interest-bearing securities. Given the intensely competitive nature of the financial services industry, it would be conservative to estimate that 25 percent of securities firms and individuals, totaling 87,500 jobs and $3.7 billion in tax revenue, would relocate from the state by 2019 in order to protect themselves from the new tax. **The departure of these high-wage jobs could enact significant downstream effects on the** state **economy, leading to the loss of another 20,000 jobs in sectors such as retail and dining.** For example, in 2014, New York state lost 126,000 tax filers to other states, the largest number of any state that year. It would be conservative to estimate that between the departure of other high net worth households and slower economic growth, New York state could lose another $1 billion in tax revenue.

Impact – Turns Case

Unemployment decks the economy and turns case---overstretches entitlement budgets.

Simpson 17 Simpson, Stephen D., CFA. Freelance financial writer, investor, and consultant. He has worked as an equity analyst for both sell-side and buy-side investment companies in both equities and fixed income. Stephen's consulting work has focused primarily upon the healthcare sector, while he has also written extensively for publication on topics pertaining to investments, security analysis, and healthcare. "The Cost of Unemployment to the Economy." Investopedia. 5 May 2017. www.investopedia.com/financial-edge/0811/the-cost-of-unemployment-to-the-economy.aspx. [Premier]

Costs to the Country The economic costs of unemployment are probably more obvious when viewed through the lens of the national checkbook. Unemployment leads to higher payments from state and federal governments for **unemployment benefits** ($2.96 billion worth of benefits were paid out in February 2017), food assistance, and **Medicaid**. At the same time, **those governments are no longer collecting the same levels of income tax as before** - forcing the government to **borrow** money (which defers the costs and impacts of unemployment into the future) **or cut back on other spending** (perhaps **exacerbating the bad economic situation**). **Unemployment is** also **a dangerous state for the U.S. economy**. Over 70% of what the U.S. economy produces goes to personal consumption and unemployed workers. **Even those getting government support cannot spend at prior levels.** The production of those workers leaves the economy which reduces the GDP and moves the country away from the efficient allocation of its resources. For those who subscribe to Jean-Baptiste Say's theory that "products are paid for by products," that is a serious issue. It is also worth noting that companies pay a price for high unemployment as well. Unemployment benefits are financed largely by taxes assessed on businesses. When unemployment is high, states will often look to replenish their coffers by increasing their taxation on businesses - counter-intuitively **discouraging companies from hiring more workers**. Not only do companies face less demand for their products, it is also more expensive for them to **retain or hire workers**. The Bottom Line Governments rightly fret about the consequences of inflation, but unemployment is likewise a serious issue. Apart from the social unrest and disgruntlement that unemployment can produce in the electorate, **high unemployment can have a self-perpetuating negative impact on businesses and the economic health of the country**. Worse still, some of the worst effects of unemployment are both subtle and very long-lasting **- consumer and business confidence are key to economic recoveries and workers must feel confident in their future to invest in developing the skills (and building the savings) that the economy needs to grow in the future**. The costs of unemployment go far beyond the accumulated sums handed out as unemployment insurance benefits. (Preparation can help you land on your feet after getting the "old heave-ho." See Planning For Unemployment.)

AT: Cost Saving

Even if the industry is riddled with waste, shutting it down would cause massive job losses. Also turns the case by shrinking access.

Diamond 16 Diamond, Dan. A graduate of the University of Pennsylvania and has appeared to discuss health care, politics, and policy on NPR's "All Things Considered" and "1A," the NBC Nightly News, the BBC, CBS, MSNBC, the Dan Patrick Show, KQED's "Forum" and other programs. He was recently named a 2015-2016 fellow of the Association of Health Care Journalists. “Obamacare, the secret jobs program.” Politico. 13 July 2016. www.politico.com/agenda/story/2016/07/what-is-the-effect-of-obamacare-economy-000164. [Premier]

What it all means: **There aren’t easy answers if lawmakers want to shift spending priorities without killing jobs**. **A specialist in arcane health care billing codes or revenue cycle can't become a nurse or doctor overnight**. Democratic presidential candidate Bernie Sanders confronted this reality during his campaign. His proposed single-payer plan — which would have radically reshaped the health insurance industry by replacing it with Medicare-for-all — could have led to as many as 2 million Americans needing to find new work, according to an economic analysis. One retired health care worker plaintively asked Sanders at a CNN town hall earlier this year what would happen to them. "**There's hundreds of thousands of middle-class jobs in the health insurance industry all across this country that could be adversely affected,**" she said — prompting a **vague, implausible promise from Sanders** that all of those workers could be retrained. It would seem that one big target might be waste: It's no secret that America's health system is wildly inefficient, and could theoretically shed many jobs without having much of an impact on patients. Some estimates have suggested that America's unnecessary health care spending and care tops 30 percent. The United States was ranked 11th out of 11 nations on health care efficiency by the Commonwealth Fund, and peer countries like Switzerland spend one-third less on health care as a share of GDP and 50 percent more on social services — like disability benefits and supportive housing — that experts increasingly say are linked with good health. **Yet it's still hard to pry wasted money out of our system, if that money helps keep people employed**. "**Every dollar of health care spending is someone else’s health care income**," says Princeton economist Uwe Reinhardt. "**Even when it's fraud, waste or abuse**."

AT: Retraining Solves

Not even close to sufficient.

Rupe 16 Rupe, Susan. Managing editor for InsuranceNewsNet. She formerly served as communications director for an insurance agents' association and was an award-winning newspaper reporter and editor. "Public Option Would Hurt Consumers, Industry, Agent Advocates Say." Insurance News Net. 15 July 2016. https://insurancenewsnet.com/innarticle/agent-advocates-say-public-option-hurt-consumers-damage-industry. [Premier]

Would a public option go so far as to **eliminate health insurance agents altogether?** Boyle said **it depends on how the option is structured**. "**The devil is in the details,"** she said. "Look at the exchanges. When they were first proposed, the question was would the exchanges put agents out of business? Depending on how they're designed, absolutely they could." Boyle said she doesn't believe the public option will gain momentum, "but if it does, do we step in and ask if there is a role for the agent within that structure? **The need for access to professional advice even in a government-run plan is going to be necessary**. How is the government-run plan going to enroll individuals, how is it going to provide consumers with access to advice? **Even in that scenario, could there still be a role for the agent? Will it be a meaningful, fairly compensated role? Probably not."**

Industry

Link

Private insurance will remain solvent because of market flexibility---the aff would undermine that.

Freeman 18 Freeman, Gregory. A contributing writer for Media Health Leaders, citing Dr. Christina Dalton, a PhD professor of economics at Wake Forest, and a report from the Kaiser Family Foundation. "Health Insurers Rely on Group Coverage Profits to Offset Exchanges." Health Leaders Media. 1 January 2018. www.healthleadersmedia.com/health-plans/health-insurers-rely-group-coverage-profits-offset-exchanges. [Premier]

Despite all the talk about how the **A**ffordable **C**are **A**ct and recent revisions to the healthcare law have challenged health plans to remain profitable on the individual market, **insurers are reporting good financial results and are prospering**. That's because their **bread-and-butter business, group health insurance provided through employers**, is largely **unaffected by the turmoil in the individual market**. **More than half** of Americans have health insurance coverage paid for by their employers, in whole or in part, and another 40% are covered by Medicare or Medicaid, **leaving only** around **12%** to fend for **themselves in the individual market**, notes Christina Marsh **Dalton**, PhD, assistant professor of economics at Wake Forest University's School of Medicine in Winston-Salem, North Carolina. That means that even health plans struggling to profit in the individual market can **succeed** overall, Dalton says. "All the discussion in the news is about the individual market. This is the piece of the industry that wasn't working and was addressed most directly by the Affordable Care Act, and it's the piece that is undergoing so much change right now," Dalton says. "But for the rest of the country who get their insurance through their employers or Medicare or Medicaid, not a lot has changed for them. **That's a stable market and that's where insurers can still be successful**." **Stock prices for** some of the country's **health insurance companies outperformed the rest of the** stock **market in 2017**, **despite** how efforts to **repeal and replace** the Affordable Care Act created uncertainty for the industry. **A report from** the **Kaiser** Family Foundation, examining insurers' financial data from the third quarter of 2017, **found that insurers gained ground in their medical loss ratios**, which averaged 81% through the third quarter. They saw similar improvement in gross margins per member per month in the individual market segment, up to $79 per enrollee in the third quarter of 2017. That figure had been as low as $10 in 2015. "These **new data** from the first nine months of 2017 offer further evidence that the **individual market has been stabilizing** and **insurers are regaining profitability**, even as political and policy uncertainty and the **repeal of the individual mandate penalty** as part of tax reform legislation cloud expectations for 2018 and beyond," the Kaiser report says. "Third quarter financial data reflects insurer performance in 2017 through September, before the Administration ceased payments for cost-sharing subsidies effective October 12, 2017. The **loss of these payments during the fourth quarter of 2017 will diminish insurer profits, but nonetheless, insurers are likely to see better financial results** in 2017 **than** they did in **earlier years** of the ACA Marketplaces," the Kaiser report says. Industry remains stable and profitable Dalton expects the insurance industry to **remain stable and profitable** by relying on the group market. **No matter how unappealing the individual market becomes** to insurers, they have the **flexibility** to **quickly pull out** when it becomes clear they won't be able to make a profit, she says. **Any legislation that makes them less flexible** in that regard **could have a far-reaching impact on the** insurance **industry overall**, she says. "There is no precedent for forcing companies to offer a product, but of course it wasn't so long ago that we also had never seen the government forcing individuals to buy a product, and the individual mandate still went through," she says. In the individual market, uncertainty is still the primary motivator for health plan strategies in 2018, Dalton says. Some plans may respond to the uncertainty with more restraint and conservative approaches, she says. Losing the individual mandate in 2019 has many health plan leaders anticipating a significant reduction in membership and revenue, she says. "Executive orders are also creating uncertainty because health plans can't see those changes coming from very far off—orders like the one expanding association health plans, and the extension of short-term health plans," Dalton explains. "The Trump executive orders are leaning toward creating more diversity of plans, which, on some level, could increase demand. With more plans created, you may have more people signing up because they can find a plan that matches them." Critics have said the **expansion of association health plans** could further damage the individual market by siphoning off generally healthy people, leaving only the sickest and costliest consumers to buy insurance on the individual health exchanges. That could happen, Dalton says, but insurers also will be selling group health plans and could benefit from those as

well. "Those healthy people might not have been interested in buying those ACA-compliant plans because they were so expensive and they didn't think they needed all that coverage, and in 2019 they won't have any mandate forcing them to buy them," she says. "Now those healthy people might **have reason to buy a health plan rather than opt out,** so there is potential for more purchasing of insurance because insurers **can offer plans that healthy people would like more."**

Private insurance is systemically important---its role is increasing.

Cole et al 15 Cole, Cassandra. PhD from Florida State University, written with Enya He, Ph.D., FCII, and J. Bradley Karl, Ph.D. "Market Structure and the Profitability of the U.S. Health Insurance Marketplace: A State-Level Analysis." National Associaiton of Insurance Commissioners. 2015. www.naic.org/prod_serv/JIR-ZA-34-04-EL.pdf. [Premier]

Our research makes an important contribution to existing literature. Despite the existence of a number of studies examining the relation between market competition and industry profitability within the various sectors of the insurance industry, we are unaware of any studies that have performed a multivariate analysis of the concentration-performance relation in health insurance markets, at the state level, using health insurer financial data from the NAIC.5 Given the distinct differences in the characteristics of the U.S. health insurance and property-liability insurance markets and **the ever-increasing important role that the health insurance industry plays in the overall economy**, we believe our analysis of health insurance markets is an important and timely contribution to the existing literature relating to insurance markets in general and health insurance markets specifically

Removing the private insurance industry destroys the economy even with a buy out.

Caird 17 Caird, Lawrence. Worked in health care management and public affairs for the Veterans Administration for more than 28 years. "Medicare For All would likely be a huge failure." Register Guard. 20 September 2017. registerguard.com/rg/opinion/35974386-78/medicare-for-all-would-likely-be-a-huge-failure.html.csp. [Premier]

You say, "What about the profits?" Profits are paid to stockholders, many of whom are people investing for their retirement. The balance is invested in the economy. Insurance companies, unlike the government, have to have assets to cover unanticipated costs. How do you think 9/11 claims were paid? Insurance companies did not have that amount of cash on hand. They liquidated investments to get the cash. **The investments of health insurance companies, if they were put out of business by this law**, would probably be sold and the proceeds would be paid to stockholders. **But the industries and real estate they invest in would suffer the loss of capital**. Beside losing the right to sue for losses, we would probably also lose the Affordable Care Act in the process. It is hard to defend one program while advocating for another. It is impossible to estimate how much **the stock market would tumble.** Stock prices are based on the confidence of investors. If the government can wipe out an entire industry because it does not like the way it is being run, **hospital stocks, drug company stocks, medical supply stocks and medical equipment stocks would** probably **be affected**. **This could cause the stock market to crash**, somewhere **between what happened in 1929 and 2008**. **The losses** to American families in retirement funds **could** possibly **be in the trillions** of dollars.

Those shocks go global and trigger mass financial collapse---buyout and retraining don't solve because ending their capital investment causes decline.

Gelos and Valckx 16 Gelos, Gaston and Valckx, Nico. Gaston Gelos is a PhD in Economics @ Yale, Assistant Director and Division Chief of the Global Financial Stability Analysis Division in the Monetary and Capital Markets Department, formerly an Advisor at the IMF Institute, a Deputy Division Chief in the Western Hemisphere Department, and prior to that, the Fund's Resident Representative for Argentina and Uruguay. Nico Valckx is a PhD in Applied Financial Economics @ UFSIA, University of Antwerp, Senior Economist in the Monetary and Capital Markets Department of the IMF. "The insurance sector and systemic risk." Vox EU. 27 July 2016. http://voxeu.org/article/insurance-sector-and-systemic-risk. [Premier]

Insurance companies – life insurers, as well as providers of property, casualty, **health**, and financial coverage – perform **important economic functions** and are big players in financial markets. Traditionally, however, they were not considered to pose systemic risks. Insurers have **longer-term liabilities than banks**, a greater diversification of assets, and less extensive interconnections with the rest of the financial system. However, the near-collapse of AIG during the Global Crisis prompted a rethinking of the sector's systemic riskiness. A number of insurance firms were subsequently among the financial institutions designated as **globally systemically important**. Systemic risk analysis has typically focused on the risks of failure of individual institutions and their potential knock-on effects (the 'domino' view of systemic risk; see Acharya 2015). However, the contribution to **systemic risk** by insurers and other financial firms extends beyond this dimension. In the 'tsunami' or macroprudential view, **even solvent firms** may **propagate or amplify shocks** to the **rest of the financial system** and the real economy. Systemic risk may stem from **common exposures** of a few large firms or many small ones (Acharya 2015, IMF 2013). For example, insurance companies play a **critical role in corporate bond markets**, and if they are hit by a **large common shock**, a consequent cessation of funding could hurt other companies badly (Bank of England 2015). In principle, the insurance sector could therefore be a **significant contributor to systemic risk** even if no single insurance company were systemically important.

Impact – Industry

Integration means insurance industry decline collapses the entire health sector.

Zucchi 14 Zucchi, Kristina Zucchi. A freelance financial writer, investor, and consultant. For over a decade, she has worked as an equity analyst for buy-side investment companies and in the private equity sector. Kristina's consulting work has focused primarily on cyclical, industrial and healthcare companies, while she has also written extensively for publication on topics pertaining to investments and security analysis. "Investing in Health Insurance Companies." 15 September 2014. www.investopedia.com/articles/stocks/09/investing-in-health-insurance.asp?lgl=myfinance-layout-no-ads. [Premier]

The health insurance industry is a very large and integrated industry in the U.S. economy. Health insurers, sometimes called managed care companies, are often thought of as the **gate-keepers to American healthcare.** They tend to control what doctors can be seen and how often, how much you will pay, and what the doctors and hospitals will receive. As such, **these companies are** perhaps **the most important aspect of the American healthcare system today**.

The health of the economy depends on the industry---health care jobs are dominated by insurance employees.

Terhune 17 Terhune, Chad. Senior Correspondent, previously worked for the Los Angeles Times, where he spent four years covering the business of health care. He wrote about medical costs, the health-law rollout and superbug outbreaks tied to medical devices. Before the Times, he was an award-winning reporter for The Wall Street Journal and Businessweek. "In bid to revamp health care, Trump could hurt one of U.S.'s biggest job creators." CNN. 25 April 2017. money.cnn.com/2017/04/25/news/economy/health-care-jobs-trump-obamacare/index.html [Premier]

In many ways, **the health care industry has been a great friend to the U.S. economy. Its plentiful jobs helped lift the country out of the Great Recession and, partly due to the Affordable Care Act, it now employs one in nine Americans — up from one in 12 in 2000.** As President Donald Trump seeks to fulfill his campaign pledge to create millions more jobs, the industry would seem a promising place to turn. But the business mogul also campaigned to repeal Obamacare and lower health care costs — a potentially serious job killer. "The goal of increasing jobs in health care is incompatible with the goal of keeping health care affordable," said Harvard University economist Katherine Baicker, who sees advantages in trimming the industry's growth. "There's a lot of evidence we can get more bang for our buck in health care. We should be aiming for a health care system that operates more efficiently and effectively. That might mean better outcomes for patients and fewer jobs." But **the country has grown increasingly dependent on the health sector to power the economy. Thirty-five percent of the nation's job growth has come from health care since the recession hit in late 2007, the single biggest sector for job creation.** Hiring rose even more as coverage expanded in 2014 under the health law and new federal dollars flowed in. It gave hospitals, universities and companies even more reason to invest in new facilities and staff. Training programs sprang up to fill the growing job pool. Cities welcomed the development — and the revenue. Simply put, rising health spending has been good for some economically distressed parts of the country, many of which voted for Trump last year. In Morgantown, West Virginia, the West Virginia University health system just opened a 10-story medical tower and hired 2,000 employees last year. In Danville, Pennsylvania, the Geisinger Health System has added more than 2,200 workers since July and is trying to fill 2,000 more jobs across its 12 hospital campuses and a health plan. Out West, the UCHealth system in Colorado expanded its Fort Collins hospital and is building three hospitals in the state. In cities such as Pittsburgh, Cleveland and St. Louis, **health care has replaced dying industries like coal and heavy manufacturing as a primary source of new jobs.** "The industry

accounts for a lot of good middle-class jobs and, in many communities, it's the single-largest employer," said Sam Glick, a partner at the Oliver Wyman consulting firm in San Francisco. "One of the hardest decisions for the new Trump administration is how far do they push on health care costs at the expense of jobs in health care." House Republicans, with backing from Trump, took the first swipe. Their American Health Care Act sought to roll back the current health law's Medicaid expansion and cut federal subsidies for private health insurance. The GOP plan faltered in the House, but Republican lawmakers and the Trump administration are still trying to craft a replacement for Obamacare. Neither the ACA nor the latest Republican attempt at an overhaul tackle what some industry experts and economists see as a serious underlying reason for high health care costs: a system bloated by redundancy, inefficiency and a growing number of jobs far removed from patient care. Labor accounts for more than half of the $3.4 trillion spent on U.S. health care, and medical professionals from health aides to nurse practitioners are in high demand. But **the sheer complexity of the system also has spawned jobs for legions of data-entry clerks, revenue-cycle analysts and medical billing coders who must decipher arcane rules to mine money from human ills. For every physician, there are 16 other workers in U.S. health care. And half of those 16 are in administrative and other nonclinical roles**, said Bob Kocher, a former Obama administration official who worked on the Affordable Care Act. He's now a partner at the venture capital firm Venrock in Palo Alto, California. **"[W]hat's driving our health insurance premiums is that we are paying the wages of a whole bunch of people who aren't involved in the delivery of care**. Hospitals keep raising their rates to pay for all of this labor," Kocher said.

Impact – Lashout

Best data shows crashes cause depression.

Barro et al. 17 Barro, Robert J. PhD in Economics @ Harvard University, wrote with Paul M. Warburg, Professor of Economics @ Harvard University, senior fellow of the Hoover Institution of Stanford University, and a research associate of the National Bureau of Economic Research, and José F.Ursúa, PhD candidate in Economics @ Harvard University, "Stock-market crashes and depressions." *Research In Economics*, Volume 71, Issue 3. September 2017. https://www.nber.org/papers/w14760.pdf. [Premier]

5. Conclusions and future research The **long-term history** for **30 countries** indicates that stock-market crashes (cumulative real returns of –0.25 or worse) have **substantial predictive power** for **depressions** (cumulative macroeconomic declines by 10 percent or more). In a non-war environment, the realization of a stock-market return of –0.25 or worse implies that the probability of a minor depression (macroeconomic decline by 10 percent or more) is 22 percent, and the probability of a major depression (decline by 25 percent or more) is 3 percent. When the stock return is –0.40 or worse, the corresponding depression probabilities are 30 percent and 4 percent. The probabilities are **46 percent** and 8 percent, respectively, when a stock-market crash of –0.25 or worse in a non-war period is accompanied by a **currency or banking crisis** and occurs during a time of global economic turmoil. Given the stock-market crashes for the United States and other countries in 2008 (characterized as non-war, featuring a currency or banking crisis, and occurring during a global event), these last probabilities applied at the beginning of 2009. The **long-term data** also show that the **majority** (**67 percent**) of minor, non-war depressions are accompanied by stock-market crashes, whereas **most major**, non-war depressions (**83 percent**) are accompanied by these crashes. Therefore, in the **absence of a stock-market crash**, the occurrence of a depression is **highly unlikely**. The full history of **3037 annual observations** reveals **71 matched cases** of stock-market crashes and depressions, of which 41 percent are associated with war. The years contained in the 71 cases constitute 12 percent of the overall sample (because the average duration of a crisis was 4.9 years). The co-movement between stock returns and macroeconomic changes for the 71 cases may be sufficient to explain the observed equity premium of 7 percent, assuming that the coefficient of relative risk aversion is between 3.5 and 4. The required coefficient falls to 3.5 or less if we bring in the additional 19 percent of the sample that features a stock-market crash or depression but not both. A crucial aspect of this analysis is that the computed covariances allow for a flexible timing pattern between stock returns and macroeconomic changes. In future research, we plan to assess this flexible covariance approach in more detail. Part of this research involves the roles of missing data and wartime price controls, which can distort the covariances calculated from a rigid timing structure.

Stock market crashes cause major recessions.

Farmer 13 Farmer, Roger. Professor of Economics at UCLA, "The Stock Market Crash Really Did Cause the Great Recession." National Bureau of Economics Research Working Paper No. 19391. August 2013. https://www.nber.org/papers/w19391.pdf. [Premier]

Rosnick (2013) has argued that a univariate model provides a better prediction of the unemployment rate than Farmer's published model. I show here, that although the univariate model provides more accurate out-of-sample forecasts than the VECM, a bivariate model that includes information from the stock market outperforms both alternatives. My results establish that **the stock market contains significant information that helps to predict the future unemployment rate**. A big stock market crash, in the absence of central bank intervention, will be followed by a **major recession one to four quarters later**. Further, the connection between changes in the stock market and changes in the unemployment rate has remained **structurally stable for seventy years**.

Decline causes nuke war.

Mann 14 Man, Eric. He is a special agent with a United States federal agency, with significant domestic and international counterintelligence and counter-terrorism experience. Worked as a special assistant for a U.S. Senator and served as a presidential appointee for the U.S. Congress. He is currently responsible for an internal security and vulnerability assessment program. Bachelors @ University of South Carolina, Graduate degree in Homeland Security @ Georgetown. "AUSTERITY, ECONOMIC DECLINE, AND FINANCIAL WEAPONS OF WAR: A NEW PARADIGM FOR GLOBAL SECURITY." Johns Hopkins University. May 2014. https://jscholarship.library.jhu.edu/bitstream/handle/1774.2/37262/MANN-THESIS-2014.pdf. [Premier]

The conclusions reached in this thesis demonstrate how economic considerations **within states** can figure prominently into the calculus for future conflicts. The findings also suggest that **security issues with economic** or financial **underpinnings will transcend classical determinants of** war and **conflict**, and change the manner by which rival states engage in hostile acts toward one another. The research shows that security concerns emanating from economic uncertainty and the inherent vulnerabilities within global financial markets will present **new challenges for national security**, and provide developing states new **asymmetric options** for balancing against stronger states. The security areas, identified in the proceeding chapters, **are likely to mature into global security threats** in the immediate future. As the case study on South Korea suggest, the **overlapping security issues** associated with **economic decline** and **reduced military spending** by the **U**nited **S**tates will affect **allied confidence** in America's **security guarantees**. The study shows that this outcome could cause **regional instability** or realignments of strategic partnerships in the Asia-pacific region with ramifications for U.S. national security. **Rival states and non-state groups** may also **become emboldened to challenge America**'s status in the unipolar international system. The potential risks associated with stolen or **loose WMD**, resulting from poor security, can also pose a threat to U.S. national security. The case study on Pakistan, Syria and North Korea show how financial constraints affect weapons security making weapons vulnerable to theft, and how **financial factors** can **influence WMD prolif**eration by contributing to the motivating factors behind a trusted insider's decision to sell weapons technology. The inherent vulnerabilities within the global financial markets will provide terrorists' organizations and other non-state groups, who object to the current international system or distribution of power, with opportunities to disrupt global finance and perhaps weaken America's status. A more ominous threat originates from states intent on increasing diversification of foreign currency holdings, establishing alternatives to the dollar for international trade, or engaging financial warfare against the United States.

Impact – Global Economy

Health insurance industry is the backbone of the global economy.

BIW 16 Bio-ITWorld. Weekly Update newsletter and News Bulletins cover the application of informatics, IT and computer science in biomedical research and drug discovery. As the life sciences become an increasingly quantitative discipline, Bio-IT World provides topical news coverage and analysis of cutting-edge technologies to handle the data deluge in petascale computing and the tools to deliver individualized medicine. Citing Transparency Market Research is a Market Research Firm providing Current Market Trends And Forecast Reports. "Health Insurance Industry is one of the Cardinal Components of the Global Economy." Bio-ITWorld. 23 September 2016. http://www.bio-itworld.com/Press-Release/Health-Insurance-Industry-is-one-of-the-Cardinal-Components-of-the-Global-Economy/. [Premier]

ALBANY, NY, UNITED STATES - Sep 23, 2016 - The concept of health insurance, in general, is objectively simple wherein an individual or organization purchase services or plans to avoid their risk in event of un-avoidable health conditions. Health insurance provides financial security to the people in their health care needs. **The health insurance industry is one of the cardinal components of the global economy by virtue of the amount of revenue it collects, the extent of the global investment**, and most prominently the indispensable socio-economic role it plays by securing personal and business risk in the event of an unforeseen problems. **Transparency Market Research's report,** titled 'Health Insurance Market - Global Industry Analysis, Size, Share, Growth, Trends and Forecast 2015 – 2023', **examines the market through a microscopic lens to get a detailed understanding of various facets of the global health insurance market**. It also presents historical data pertaining to the healthcare insurance industry and correlates it with the forecast to help readers in building a framework of the market's trajectory. **The global health insurance market is growing by leaps and bounds, contributing significantly to the global economy**. Health insurance can be purchased individually or by companies for their employees to offer heath care coverage. In an individually purchased health insurance, the out-of-pocket spending is far more than group insurance purchases. The premium is higher in the individual market, as the buyer pays the full premium without any contribution from the employer. The most obvious benefit of health insurance is the financial security it provides to the patient in the event a health-related expense arises. **The remarkable growth of the health insurance market in the past few decades has made it the spinal cord of the global economy, as it collects mammoth amounts of revenue. The healthcare industry** also **plays a vital role in determining the global investments** and securing lives of many, thereby keeping the socio-economic structure balanced**. In 2014**, as the global economies stabilized, limping back to normalcy after an economic downturn, the disposable incomes and GDPs showed notable improvements. As the high income groups and middle class were equipped with more financial resources, both the groups were seen investing in healthcare insurance for safeguarding themselves against unforeseen problems. **This trend is expected to augment the global health insurance market in the coming years as well**. In the coming years**, insurance companies and investment firms will adopt digitalization of business process to reach out to a wider audience across all boundaries**. Furthermore, the impactful business and marketing strategies, transparency in operations, and simplification of products by insurance companies is also expected to win them new clientele. Some of **the important players** profiled in the global health insurance market are **UnitedHealth** Group Inc., **Allianz** SE, **Cigna** Corporation, **Express** Scripts Holding Company, AIA Insurance Group, Zurich Insurance Group Ltd., AXA, **Aetna**, Inc., International Medical Group, Aviva plc, and Apollo Munich Health Insurance. The research report offers an insight into the competitive landscape of the global health insurance market along with presenting details regarding companies' financial overview, research and development activities, investment outlook, and business and marketing strategies. The report also assesses the companies using a SWOT analysis and a Porter's five forces analysis to highlight the key elements impacting them.

US is key---largest market share.

MRO 15 Market Reports Online. Summarizing the comprehensive report "Global Health Insurance Market: Trends and Opportunities (2015-2019). “Research and Markets.” BusinessWire. 21 May 2015. https://www.businesswire.com/news/home/20150521005506/en/Research-Markets-Global-Health-Insurance-Market-Trends. [Premier]

The global health insurance industry has been growing consistently over the past couple of years. **The US is the largest market for health insurance products** while in the European Union it is the second largest segment of the insurance industry.

Decline causes global war.

Green & Schrage 09 Green, Michael and Schrage, Steven. Michael Green, Senior Advisor & Japan Chair @ The Center for Strategic and International Studies & Associate Professor @ The Walsh School of Foreign Service, Steven Schrage, CSIS Scholl Chair in International Business, Former Senior official with the U.S. Trade Representative's Office, State Department and Ways & Means Committee, “It's not just the economy.” Asian Times. 26 March 2009. http://www.atimes.com/atimes/Asian_Economy/KC26Dk01.html. [Premier]

Facing the worst economic crisis since the Great Depression, analysts at the World Bank and the US Central Intelligence Agency are just beginning to contemplate the ramifications for international stability if there is not a recovery in the next year. For the most part, the focus has been on fragile states such as some in Eastern Europe. However, the Great Depression taught us that a downward global economic spiral can even have jarring impacts on great powers. It is no mere coincidence that the last great global economic downturn was followed by the **most destructive war in human history.** In the 1930s, economic desperation helped fuel autocratic regimes and protectionism in a downward **economic-security death spiral that engulfed the world in conflict**. This spiral was aided by the preoccupation of the United States and other leading nations with economic troubles at home and insufficient attention to working with other powers to maintain stability abroad. Today's challenges are different, yet 1933's London Economic Conference, which failed to stop the drift toward deeper depression and world war, should be a cautionary tale for leaders heading to next month's London Group of 20 (G-20) meeting. There is no question the US must urgently act to address banking issues and to restart its economy. But the lessons of the past suggest that we will also have to keep an eye on those fragile threads in the international system that could begin to unravel if the financial crisis is not reversed early in the Barack Obama administration and realize that economics and security are intertwined in most of the critical challenges we face. A disillusioned rising power? Four areas in Asia merit particular attention, although so far the current financial crisis has not changed Asia's fundamental strategic picture. China is not replacing the US as regional hegemon, since the leadership in Beijing is too nervous about the political implications of the financial crisis at home to actually play a leading role in solving it internationally. Predictions that the US will be brought to its knees because China is the leading holder of US debt often miss key points. China's currency controls and full employment/export-oriented growth strategy give Beijing few choices other than buying US Treasury bills or harming its own economy. Rather tha..n creating new rules or institutions in international finance, or reorienting the Chinese economy to generate greater long-term consumer demand at home, Chinese leaders are desperately clinging to the status quo (though Beijing deserves credit for short-term efforts to stimulate economic growth). The greater danger with China is not an eclipsing of US leadership, but instead the kind of shift in strategic orientation that happened to Japan after the Great Depression. Japan was arguably not a revisionist power before 1932 and sought instead to converge with the global economy through open trade and adoption of the gold standard. The worldwide depression and protectionism of the 1930s devastated the newly exposed Japanese economy and contributed directly to militaristic and autarkic policies in Asia as the Japanese people reacted against what counted for globalization at the time. China today is similarly converging with the global economy, and many experts believe China needs at least 8% annual growth to sustain social stability. Realistic growth predictions for 2009 are closer to 5%. Veteran China hands were watching closely when millions of migrant workers returned to work after the Lunar New Year holiday last month to find factories closed and jobs gone. There were pockets of protests, but nationwide unrest seems unlikely this year, and Chinese leaders are working around the clock to ensure that it does not happen next year either. However, the economic slowdown has only just begun and nobody is certain how it will impact the social contract in China between the ruling communist party and the 1.3 billion Chinese who have come to see President Hu Jintao's call for "harmonious society" as inextricably linked to his promise of "peaceful development". If the Japanese example is any precedent, a sustained economic slowdown has the potential to open a dangerous path from economic nationalism to strategic revisionism in China too. Dangerous states It is noteworthy that North Korea, Myanmar and Iran have all intensified their defiance in the wake of the financial crisis, which has distracted the world's leading nations, limited their moral authority and sown potential discord. With Beijing worried about the potential impact of North Korean belligerence or instability on Chinese internal stability, and leaders in Japan and South Korea under siege in parliament because of the collapse of their stock markets, leaders in the North Korean capital of Pyongyang have grown increasingly boisterous about their country's claims to great power status as a nuclear weapons state. The junta in Myanmar has chosen this moment to arrest hundreds of political dissidents and thumb its nose at fellow members of the 10-country Association of Southeast Asian Nations. Iran continues its nuclear program while exploiting differences between the US, UK and France (or the P-3 group) and China and Russia - differences that could become more pronounced if economic friction with Beijing or Russia crowds out cooperation or if Western European governments grow nervous about sanctions as a tool of policy. It is possible that the economic downturn will make these dangerous states more pliable because of falling fuel prices (Iran) and greater need for foreign aid (North Korea and Myanmar), but that may depend on the extent that authoritarian leaders care about the well-being of their people or face internal political pressures linked to the economy. So far, there is little evidence to suggest either and much evidence to suggest these dangerous states see an opportunity to advance their asymmetrical advantages against the international system.

AT: Bailout

Trump won’t allow a bailout.

Kodjak 17 Kodjak, Alison. American journalist and currently works for the Associated Press as its Washington investigations editor. She previously reported for the AP from 1997 to 2000. "Trump Warns Against 'Bailouts' For Insurance Companies In Bipartisan Health Care Deal," NPR. 17 October 2017. https://www.npr.org/sections/health-shots/2017/10/17/558370338/senators-reach-deal-to-stabilize-aca-insurance-markets-for-two-years. [Premier]

Trump offered mixed opinions on the deal at first, though he encouraged the bipartisan effort. But on Wednesday morning, he tweeted that he **"cannot support" measures** that he sees as **bailouts of insurance companies**, which are the heart of the bill. Donald J. Trump ✓ @realDonaldTrump I am supportive of Lamar as a person & also of the process, but I can never support bailing out ins co's who have made a fortune w/ O'Care. 7:41 AM - Oct 18, 2017 12,901 12,901 Replies 13,067 13,067 Retweets 60,921 60,921 likes Twitter Ads info and privacy Sens. Lamar Alexander, R-Tenn., and Patty Murray, D-Wash., reached a tentative agreement to appropriate for the next two years subsidies to insurers to support discounts for low-income consumers required by law, restore money used to encourage people to sign up for Affordable Care Act health plans, and make it easier for states to design their own alternative health care systems. Halt In Subsidies For Health Insurers Expected To Drive Up Costs For Middle Class SHOTS - HEALTH NEWS Halt In Subsidies For Health Insurers Expected To Drive Up Costs For Middle Class Alexander said the idea is to stabilize the markets in the short term while Congress continues to debate long-term changes to the ACA, also known as Obamacare. Trump Pushes Obamacare To Detonation, Forges Path Away From GOP, Democrats ANALYSIS Trump Pushes Obamacare To Detonation, Forges Path Away From GOP, Democrats "Over the next two years, I think Americans won't have to worry about the possibility of being able to buy insurance in the counties where they live," he said in a conversation with reporters at the Capitol on Tuesday. He said that he spoke with Trump over the weekend and that the president said he supported the idea. Alexander also responded to Trump following his opposition on Wednesday morning, trying to reassure the president that his bill could achieve the president's goals. 18 Oct Sen. Lamar Alexander ✓ @SenAlexander Replying to @SenAlexander He and I absolutely agree that CSRs should benefit consumers and not insurance companies. Sen. Lamar Alexander ✓ @SenAlexander The Alexander-Murray agreement has strong language to do that, and I will work with the president to see if we can make it even stronger. 8:54 AM - Oct 18, 2017 34 34 Replies 24 24 Retweets 46 46 likes Twitter Ads info and privacy However, Senate Majority Leader Mitch McConnell, R-Ky., would not commit on Tuesday to bringing a bill up for a vote, as Murray and Alexander seek enough support to ensure it could pass. The bill would need 60 votes to get across the finish line and would require at least a dozen Republicans to take a difficult political step in voting to shore up parts of Obamacare. It has faced resistance from **conservatives** in the House, who have echoed **Trump's sentiment** that the payments represent "bailouts" to insurers.

AT: Cost Saving

Cost saving magnifies the link because of immediacy---they'd be a huge, overnight shock that wipes out the healthcare sector.

Studebaker 17 Studebaker, Benjamin Studebake. BA in Politics from University of Warwick and MA from UChicago, PhD candidate in Politics and International Studies at Cambridge. Research focuses on economic inequality and democratic theory. "Why Single Payer Works Better at the National Level than the State Level." 2 June 2017. https://benjaminstudebaker.com/2017/06/02/why-single-payer-works-better-at-the-national-level-than-the-state-level/ [Premier]

In theory, if the United States were to create a federal single payer system like Britain's and cut healthcare spending to 9% of GDP, it could save $1.4 trillion every year. That's more than $14 trillion in the first decade, without including inflation or economic growth, both of which would raise that figure. **The thing is, these cost savings are so immense that if we did this all at once we'd create tremendous disruption in the healthcare sector. In addition to wiping out the $800 billion health insurance industry and its 450,000+ jobs, we'd also cut some of the 12.4 million healthcare jobs and reduce compensation for the rest**. So in practice, a federal system might instead reduce healthcare costs gradually. Instead of forcing compensation down to European levels immediately, we might hold down the rate at which healthcare costs grow below the rates of growth and inflation until at some point, some years down the line, we'd achieve a competitive spending percentage and HER. This means that a federal single payer system might initially cost a trillion dollars more than is really necessary, as we slowly transition the healthcare system to a lower compensation, higher efficiency model.

Centralization

Link

Federal centralization ensures drastic cost increases and budget tradeoffs that are magnified by political control of appropriations.

Starr 16 Starr, Paul. Co-founder and co-editor of the The American Prospect and professor of sociology and public affairs at Princeton University. "The Larger Problems of the Sanders Single Payer Plan." Prospect. 29 February 2016. www.prospect.org/article/larger-problems-sanders-single-payer-plan. [Premier]

The single payer in Sanders's plan is the **federal government**. The plan effectively **removes any interest** in **controlling health costs** not only from patients and providers, but also from **employers** and **other levels of government**, including states. If the federal government is the only institution with a stake in controlling health costs, it **will have to do all of the controlling.**

Over the years, other universal-coverage proposals have generally retained some sharing of the costs by patients, employers, and state governments so as to give them an interest in monitoring and checking cost increases. This was the case under the 1993 Clinton health plan, and it is also true of the Affordable Care Act, which emphasizes the principle of "shared responsibility."

It is not clear from Sanders's proposal whether he is proposing an individual legal right to free health care-that is, an "entitlement" that would be automatic from year to year and not come under the discretionary part of the budget that Congress needs to approve annually. Moving all health expenditures-17.5 percent of the economy-onto federal taxpayers as an entitlement exposes the Treasury to **much greater risk** than the more limited federal expenditures for Medicare and Medicaid (the latter, of course, shared with the states). If health care isn't a federal legal entitlement and funds have to be decided on every year, health care would continually be up against **every other rival** for budgetary appropriations, including the military. Of course, Congress can modify entitlements, too, so either way it would ultimately decide not just total spending but many aspects of health care that are today one or two removes away from the political process.

Some of the defenders of the plan may point to Medicare and see nothing to worry about. But the existing Medicare program and Sanders's plan are very different. Medicare has patient cost-sharing and limits on the scope of coverage, which Sanders would do away with. (Sanders's term "Medicare for all" is a misnomer; Medicare as we know it would be abolished.) Once the federal government pays for all of health care for people of all ages and incomes, providers would no longer be in the position of making up their losses on Medicare and Medicaid patients by charging more to the privately insured. Everything would then depend on decisions in Washington about such questions as whether new treatments would be covered and what prices would be paid.

Sanders has not been forthright in acknowledging that concentration of payment implies concentration of power. No doubt Americans would love to have all their health care paid for. Whether they would like to centralize those decisions in the federal government is another matter.

Opposition will sabotage the bill.

Rocco et al. 14 Rocco, Philip. University of California, Berkeley, Charles and Louise Travers Department of Political Science. Go Bears! Also Daniel Beland and Alex Waddan. "Implementing health

care reform in the United States: Intergovernmental politics and the dilemmas of institutional design." Health Policy. 2014 January 22. https://pubmed.ncbi.nlm.nih.gov/24508181/ [Premier]

2. Why institutional design matters **Debates over public policy are rarely debates about substance alone**. Rather, **these battles frequently involve disputes over the institutional design of public policy** [9,21]. **Instead of asking what benefits health plans should be required to offer**, legislators debate about which level of government (or which combination of institutions) should be given the authority to make this decision. In part, this is the result of the buildup of the administrative state, where specialists have the expertise to make these kinds of decisions [10]. More importantly, politicians care about design because **different institutions create dramatically different preferences and capacities to implement policy**. This is especially so in a country with a strong federal tradition like the U.S., where states can vary significantly in terms of partisan control, administrative capacity and fiscal resources [11]. Though opponents of policy change may wish simply to shut down the reform process they still have real incentives to stay at the bargaining table. Especially when the enactment of reform is inevitable, **bargaining over the design of policy allows opponents leverage to craft administrative structures that permit them to extend conflict over the law and dampen public support for it in the longerterm.** In particular, opponents want to design laws with performance standards that make institutional failures more apparent to the public. They also want institutional veto points, which prevent well-insulated bureaucratic agents from enacting their preferences [9,12,13]. Ideally, **opponents may even be able to structure policies in a manner that leads to their future demise** [14].

Government health care ensures rampant fraud.

Roy 17 Roy, Avik. Resident, The Foundation for Research on Equal Opportunity, Editor at Forbes. "The Price of Single Payer Health Care in New York." FreOpp. 2 March 2017. https://freopp.org/how-state-based-single-payer-initiatives-crush-economic-opportunity-604ac9ac17c9 [Premier]

Government-sponsored insurers face higher rates of fraud. Friedman believes that the Act would reduce fraud, because a single payor could be more effective at combating fraud, thereby reducing total health spending by 2.5 percent. However, the empirical evidence strongly flows in the other direction. **The private sector is quite effective at preventing fraud; this is what insurers' administrative costs are directed towards**. On the other hand, according to official federal estimates, improper billing reached 10.5 percent of Medicare spending and 8.4 percent of Medicaid spending in 2009, with significant evidence that **fraud rates are as high as 30 percent** in some states. Hence, if non-ERISA private insurance were replaced with state-run coverage, we estimate **fraud would increase by 4.1 percent** of New York health spending.

Mismanagement and inadequate planning undermines solvency

Diamond 09 Diamond, Michael A. Family medicine doctor in Miami, Florida and is affiliated with multiple hospitals in the area. "Con: Single-Payer Health Care Why It's Not the Best Answer" ATS Journals. 2009. http://www.atsjournals.org/doi/full/10.1164/rccm.200906-0882ED [Premier]

Single-payer health insurance would also lead to rationing and long waiting times for medical services. The adverse consequences of waiting for health services in countries with single-payer insurance are well documented **(12**, 13). Access to a waiting list for health care does not equate with access to health care, which is one reason why patients from abroad often prefer to come to the U.S. for treatment. It is unlikely that Americans would welcome these changes.

The strongest argument against a single-payer system may well be the outcomes in states that have attempted to expand health care access through the use of government programs and mandates. TennCare was a widely touted managed-care Medicaid program adopted by Tennessee in 1994 that was characterized as the solution to providing health insurance to most uncovered residents while simultaneously controlling costs (14). TennCare's subsequent **collapse** has been attributed to **mismanagement and unrealistic fiscal planning**, a perhaps predictable consequence of government administration of health care (15). Massachusetts enacted legislation in 2006 that was intended to move that state to near-universal health care coverage. Indeed, by 2008 some 165,000 more residents were insured through a combination of employer mandates and government subsidized insurance, and overall, almost 93% of nonelderly adults had coverage by late 2007 (16). However, because inadequate (or no) provision was made to expand the provider workforce, many of these patients had no access to care (16), and costs have escalated so far beyond estimates that additional financial support is required (17).

Impact – Circumvention

Trump would limit single payer to catastrophic coverage

Koons 17 Koons, Robert C. Professor of Philosophy at University of Texas at Austin. "The single-payer plan Trump should embrace." The Philadelphia Inquirer. 5 June 2017. http://www.philly.com/philly/opinion/commentary/the-single-payer-plan-trump-should-embrace-20170601.html [Premier]

President Trump should embrace a new, **genuinely conservative** version of the **single-payer** system used throughout the developed world. By **building a new coalition of social conservatives with economic populists**, Trump could **permanently reshape the political landscape.**

The current strategy of Ryancare was doomed from the start. It required the successful threading of a needle from a distance of a thousand yards. Given the razor-thin margins of Republican majorities in both houses, the 60-vote cloture obstacle in the Senate, and the Byzantine restrictions on the "reconciliation" gambit for relying on 50 senators and the vice president, and given that no complicated, Rube Goldberg-like contraption will ever be able to satisfy both the libertarian Freedom Caucus in the House and Republican moderates in the Senate, no plan devised by conventional "conservatives" has any hope of passage. You cannot simultaneously provide cheap coverage for those with preexisting conditions, move toward a free market, and reduce federal spending. A prudent politician does not attempt the impossible.

We already spend more of the taxpayers' dollars per citizen on our failed health-care system than every country with a single-payer system (with the sole exception of Norway). Let that fact soak in: We could provide every citizen with coverage as good as anything available in Canada or Australia and still reduce government health-care spending. In fact, by simultaneously eliminating the huge tax advantages given to health care, we could lower marginal taxes and balance the budget.

How is such a magical solution possible? Because we now have the worst possible system of all, one in which massive federal spending drives up medical costs, while the lack of an elegant, single-payer system deprives tens of millions of the security of coverage and foists the huge burden of costly private insurance on our businesses and industries. With a single-payer system, the government could use its overwhelming position as the dominant buyer of health care to reduce costs dramatically, bringing both industry profits and physician and executive salaries back to sensible and sustainable levels.

Does this mean that Trump should endorse a Bernie Sanders-like single-payer system, similar to what has been proposed in California? **Absolutely not.**

Trump should propose a **conservative version**, one that offers protection **only for catastrophic illnesses**, whether new or preexisting. The system should have a **large**, income-adjusted **deductible** (10 percent of adjusted gross income), and it should **pay only for essential care** — care that significantly extends life or sensory or skeletal-muscular functioning.

Trumpcare should **explicitly exclude** all social engineering disguised as "health" care, including **abortion**, **contraception**, and **"gender-reassignment" surgery**. This would accomplish two things: It would keep Trumpcare cost-effective (at levels no greater than current government spending, including lost tax revenue), and it would attract **firm and enthusiastic support from America's religious groups, especially Catholics and evangelicals.** Finally, Trumpcare should respect the freedom of the individual states to add to the bare-bones coverage as they see fit, with an expected two-thirds federal and one-third state balance (as in Australia).

It's net worse than ACA

McManus 17 McManus, Doyle. Washington columnist for the Los Angeles Times. He has been a foreign correspondent in the Middle East, a White House correspondent and a presidential campaign reporter, and was the paper's Washington bureau chief from 1996 to 2008 "Column: Obama's enduring legacy: The concept of universal coverage". LA Times. 4 January 2017. http://www.latimes.com/opinion/op-ed/la-oe-mcmanus-obama-legacy-20170104-story.html [Premier]

After that, Republicans in the Senate and House will get to work on a new plan, drawing on conservative proposals drafted well before the election. The irony is that the drafts most likely to succeed share some basic features with Obamacare.

They agree on the basic goal of universal coverage — or, at least, universal access to affordable insurance. They agree on subsidies to make it possible for low- and middle-income families to afford insurance — in most cases, in the form of tax credits ("refundable" credits, so they would go even to people who don't pay taxes). Some Republican plans would even keep the state insurance exchanges that Obamacare set up — and in at least one case, the federal healthcare.gov exchange as well.

Naturally, there are big differences too, all of which make the GOP proposals **less generous** and **less universal** in coverage than Obamacare.

Most of the Republican alternatives would push many people into **bare-bones catastrophic insurance policies**, with **less coverage than Obamacare offers**. (They would pay less, but **get less**.) **They would cover fewer people too** — at least 4 million fewer, according to one forecast. And there's a controversial divergence on guaranteed coverage for people with preexisting conditions: The GOP plans provide it only for users who have maintained "continuous coverage" for some period of time.

Impact – Separation of Powers

The plan will be circumvented in implementation---statutory text is reinterpreted by the executive to fit political priorities---this ensures litigation and further court modification.

Adler 16 Adler, Jonathan. Johan Verheij Memorial Professor of Law and Director, Center for Business Law Regulation, Case Western Reserve University School of Law. "Of Kings to Come: The Future of Health Care Reform Still Remains in Federal Court." Journal of Employee Rights and Employment Policy. 2016. https://www.kentlaw.iit.edu/institutes-centers/institute-for-law-and-the-workplace/publications/employee-rights-employment-policy-journal/v20n1/jonathan-h-adler [Premier]

From the time of its enactment prominent ACA supporters acknowledged that the law, as written, had problems and would need to be fixed.46 **Absent a viable means of securing such reforms through the legislative process, administrative agencies have sought to make do, stretching the law's language where possible (and otherwise) to achieve desired policy goals.** These departures from the ACA's text may well represent sound policy choices. Yet **whatever their policy merits, they represent departures from the text Congress enacted and represent a form of ad hoc rulemaking and implementation that generates uncertainty and could fuel further litigation.** The House of Representatives lawsuit against HHS Secretary Sylvia Burwell, for instance, challenges the employer mandate delay and the allegedly unlawful payment of costsharing subsidies to insurers without congressionally authorized appropriations.' IV. JUDICIAL RECONSTRUCTION Just as ad hoc implementation of ACA provisions results in ACA implementation that departs from the plain text of what Congress enacted, **litigation may prompt courts to interpret the law in ways that do not conform to the legislatively enacted text**. In King v. Burwell, for example, the Chief Justice candidly admitted that the Court would read the ACA in a way that "depart[s] from what would otherwise be the most natural reading of the pertinent statutory phrase"48 so as to find that tax credits are available in exchanges established by the federal government, when the relevant statutory language only provided for tax credits in exchanges "established by the State." Whether or not the King majority was correct to read the ACA as it did, King was not the first time the Supreme Court departed from the "most natural reading" of the statutory language in the course of interpreting and evaluating the ACA.49 Chief Justice **Roberts did much the same thing in NFIB, departing from the statutory text to save the rest of the statutory structure**.o In evaluating the constitutional challenge to the individual mandate, Chief Justice Roberts's controlling opinion readily acknowledged that the relevant provision, as written, was a mandate of the sort that could only be justified as an exercise of Congress's commerce power. Yet a mandate imposed this way would be unconstitutional." To salvage this provision, Roberts concluded that the provision could be read as a "tax" - and could thus be upheld as a constitutional exercise of Congress's taxing power - even though this was not the most natural reading of the relevant text.52 Chief Justice **Roberts took even greater liberties with statutory text when it came to the Medicaid provisions**. Roberts agreed with a majority of his colleagues that threatening to withdraw all Medicaid funding from states that refused to implement the Medicaid expansion was unconstitutional.53 He concluded that leveraging longstanding state participation in the Medicaid program, and reliance upon significant federal support, was impermissibly coercive. Key to Chief Justice Roberts's analysis on this point was the idea that the Medicaid expansion was a "new" program separate from preexisting Medicaid.54 The Chief Justice may have been correct that the Medicaid expansion operates this way, particularly insofar as it presented a radically different approach to determining who should be eligible for such assistance, but there is no statutory basis for concluding that Medicaid expansion is a separate program. Once he concluded that the Medicaid expansion was unconstitutionally coercive, the Chief Justice did not invalidate the Medicaid expansion (let alone the ACA as a whole). Instead, he effectively rewrote the relevant ACA provisions, making the Medicaid expansion a separate and fully optional addition to the preexisting Medicaid program in every state. **This choice**, and the separation between old and new Medicaid, may well make sense, but it **has no grounding in the relevant statutory text.** Congress had constructed the Medicaid expansion as an extension of the existing program by simply including the expansion among the conditions imposed on receipt of all Medicaid funds. Post NFIB, however, the Medicaid

expansion is a separate and separable add-on. For good or ill, the ACA's Medicaid provisions post-NFIB operate quite differently than what Congress enacted. V. CONCLUSION ACA **litigation will continue so long as the ACA is on the books.** For some of the same reasons, ad hoc implementation of the ACA is likely to continue as well. A consequence of these phenomena is that the **ACA, as it is implemented and experienced, will be uncertain and at variance with the statutory language Congress enacted**. Future **elections may alter the ACA's prospects**, either **by producing political majorities** that seek to expand and fulfill the ACA's purposes or those **that seek to undo the ACA's architecture and replace it with something else**. Such efforts are unlikely to end the phenomena discussed in this article. Indeed, it is possible **they could provide even more fuel for the litigation flames.** Efforts to undo health care reform, much like the efforts to enact it, could encourage **resort to litigation**. In short, even post-King there is every reason to believe that **the future of health care reform remains in federal court.**

That undermines SOP.

Hamilton 12 Hamilton, Eric. J.D. Candidate, Stanford Law School. "POLITICIZING THE SUPREME COURT." Stanford Law Review Online 65--35. 30 August 2012. www.stanfordlawreview.org/wp-content/uploads/sites/3/2012/08/Hamilton-65-SLRO-35.pdf [Premier]

To state the obvious, Americans do not trust the federal government, and that includes the Supreme Court. Americans believe politics played "too great a role" in the recent health care cases by a greater than two-to-one margin.1 Only thirty-seven percent of Americans express more than some confidence in the Supreme Court.2 Academics continue to debate how much politics actually influences the Court, but Americans are excessively skeptical. They do not know that almost half of the cases this Term were decided unanimously, and the Justices' voting pattern split by the political party of the president to whom they owe their appointment in fewer than seven percent of cases.3 Why the mistrust? When the Court is front-page, above-the-fold news after the rare landmark decision or during infrequent U.S. Senate confirmation proceedings, **political rhetoric from the President and Congress drowns out the Court**. Public perceptions of the Court are shaped by politicians' arguments **"for" or "against"** the ruling or the nominee, which usually fall along partisan lines and sometimes are based on misleading premises that ignore the Court's special, nonpolitical responsibilities. The Framers of the Constitution designed a uniquely independent Supreme Court that would safeguard the Constitution. They feared that the political branches might be able to overwhelm the Court by turning the public against the Court and that the Constitution's strict boundaries on congressional power would give way. **As evidenced in the health care cases**, politicians across the ideological spectrum have played into some of the Framers' fears for the Constitution by politicizing the decision and **erasing the distinction between the Court's holding and the policy merits** of the heath care law. Paradoxically, many of the elected officials who proudly campaign under the battle cry of "saving our Constitution" endanger the Court and the Constitution with their bombast. Politicization of the Supreme Court causes the American public to lose faith in the Court, and **when public confidence in the Court is low, the political branches are well positioned to disrupt the constitutional balance of power between the judiciary and the political branches**. THE FRAMERS' SUPREME COURT It would have been unsurprising had the Constitutional Convention granted Congress the power to take a vote to change Supreme Court decisions. In fact, the antifederalists' chief argument against the judiciary was that it was too powerful without a congressional revisionary power on Court opinions.4 Many of the early state constitutions that were enacted between the Revolution and the ratification of the U.S. Constitution permitted the state executive and legislature to remove, override, or influence judges. Rhode Island judges were called before the legislature to testify when they invalidated legislative acts.5 The New Hampshire legislature vacated judicial proceedings, modified judgments, authorized appeals, and decided the merits of some disputes.6 Instead, the Framers created a Supreme Court that was independent from the political branches and insulated from public opinion. The Supreme Court would be the intermediary between the people and the legislature to ensure that Congress obeyed the Constitution. Congress could not be trusted to police itself for compliance with the Constitution's limited legislative powers. Courts would be "the bulwarks of a limited Constitution against legislative encroachments."7 Still, the Framers believed Congress would overshadow the Supreme Court. The Framers were so concerned about helping the Court repel attacks by the legislature that they considered boosting its power and inserting it into political issues. James Madison's draft of the Constitution included an additional check against congressional power, the Council of Revision.8 Instead of the presidential veto, the Council would have placed several Supreme Court Justices on a council with the President or asked the President and the Supreme Court to separately approve legislation before it became law. Justices would have had the power to oppose legislation on nonlegal, policy grounds.9 The Council is nowhere to be found in the Convention's final product, but delegates' arguments from the Council debates reveal a suspicion of Congress, fear for the Court's ability to defend itself, and concern for the Court's public reputation. Madison believed that even with the Council, Congress would be an "overmatch" for the Supreme Court and President and cited the experience of spurned state supreme courts. Experience in all the States had evinced a powerful tendency in the Legislature to absorb all power into its vortex. This was the real source of danger to the American Constitutions; & suggested the necessity of giving every defensive authority to the other departments that was consistent with republican principles.10 Delegates ultimately decided that politicizing the Court would undercut its legitimacy. Luther Martin, a delegate who later became Maryland's longestserving attorney general, offered the most prescient comment on the subject: "It is necessary that the Supreme Judiciary should have the confidence of the people. This will soon be lost, if they are employed in the task of remonstrating [against] popular measures of the Legislature."11 "It was making the Expositors of the Laws, the Legislators which ought never to be done," added Elbridge Gerry, a Massachusetts delegate.12 "SAVING THE CONSTITUTION FROM THE COURT" The Framers correctly connected loss of public confidence in the Court with judicial policymaking. Of course, the Constitution does not force judges to "remonstrate" against legislation, but experience proves Martin to be correct. Too often that becomes the public perception when Congress and the President politicize the Supreme Court. Chief Justice Roberts started and ended his health care opinion with the basics—the important distinction between whether the Affordable Care Act is good policy from whether it is a constitutional law. Within two hours, President Obama and Mitt Romney, both Harvard Law School graduates, looked into television cameras and told Americans the opposite. "Today, the Supreme Court also upheld the principle that people who can afford health insurance should take the responsibility to buy health insurance," said Obama.13 Romney criticized the majority for deciding not to "repeal Obamacare." "What the Court did not do on its last day in session, I will do on my first day if elected President," said Romney.14 Congress and the President have belittled the Court. President Obama told Americans at the 2010 State of the Union address that "the Supreme Court reversed a century of law" with its Citizens United decision and suggested that the Court opposed honest elections. The ensuing image was even more damaging. With 48 million Americans watching, the camera panned to a cadre of expressionless Supreme Court Justices sitting in the front row while lawmakers sitting next to them rose to their feet and applauded.15 Presidents Obama and Bush and members of Congress have derided the Court for its "unelected" nature, with President Obama publicly wondering before the health care decision whether "an unelected group of people would somehow overturn a duly constituted and passed law."16 **Judges lack clear defenses.** Judges would risk their credibility if they

shouted back at the President, did the Sunday morning talk show circuit, or held a press conference after a decision. Unlike speeches from members of Congress and the President, Supreme Court proceedings are difficult to follow without legal training. **The media coverage of the Supreme Court can be incomplete or inaccurate**. FOX News and CNN famously misunderstood Chief Justice Roberts' oral opinion and misreported the fate of the individual mandate. The publicly available audio recordings of oral arguments contribute little to public understanding of the Court. Even before the decision, the Republican Party doctored audio clips of Solicitor General Don Verrilli coughing and pausing during oral argument to suggest in an ad that the health care law was indefensible.17 **Politicization of the Court is dangerous** because **it primes the public for a power grab by the political branches. If the Court loses authority to check political power and make unpopular decisions, it cannot enforce the Constitution** with the same effectiveness. **Without enforcement of the Constitution, Congress is free to invade constitutional rights and exceed its lawful powers.** The Supreme Court came frighteningly close to losing some of its independence when the Court made politically significant decisions striking down parts of the New Deal, and President Franklin D. Roosevelt responded with the Court-packing plan. His arguments alleged misconduct by the Court. The Courts, however, have cast doubts on the ability of the elected Congress to protect us against catastrophe by meeting squarely our modern social and economic conditions. . . . The Court has been acting not as a judicial body, but as a policy-making body. . . . We have, therefore, reached the point as a nation where we must take action to save the Constitution from the Court and the Court from itself. We must find a way to take an appeal from the Supreme Court to the Constitution itself.18 Roosevelt's words from seventy-five years ago could be repeated today by Court opponents. In his recent presidential primary campaign, Newt Gingrich promised to employ the tactics of early state constitutions by ignoring disagreeable Court decisions and ordering Justices to testify to congressional committees.19 Proposals to invade the Court's independence ignore the Framers' fears for enforcement of the Constitution without the Supreme Court. Madison believed if the legislature and executive united behind a law and convinced the public that it was in their interest, the people could not properly judge its constitutionality, even if it was patently unconstitutional. The "passions" of the people on the particular issues would prevail over wellreasoned constitutional judgment.20 * * * **The health care law's closely watched journey through the three branches of government concluded in the Supreme Court, a rare opportunity in the sun for the Court.** What would have been a shining moment for the Constitution in a vacuum was instead validation of the Framers' apprehensions. Our Constitution is the oldest in the world because of Americans' enduring reverence for it. But when elected officials exploit Americans' patriotism to score political points, they jeopardize the Framers' **carefully constructed balance of power.** Instead, honest public discourse on the Constitution and the Court is the surest security for our government.

Trade Wars

Link – Drug Pricing

The plan causes aggressive drug pricing---stronger bargaining power causes global trade war

Lopez 17 Linette Lopez. "Now we really know how Trump looks at America's drug price problem." Business Insider. February 2017. http://www.businessinsider.com/what-trump-will-do-about-high-drug-prices-2017-2. [Premier]

Investors have **less to fear** with Trump's drug pricing talk than they thought because it's **just** that — **talk**.

We know that because Republicans in Congress **don't seem interested** in taking up the cause at all.

President Trump met with big pharma CEOs on Tuesday, and in what should've been a clear threat to the profits of the American drug industry, he told them "you have to get your prices down."

Trumpian populism should've been scary to investors too.

But it wasn't, because of two other big statements he made.

Trump promised a relaxation of FDA regulations for drug approval – a classic capitalist move — and suggested that trade should be the centerpiece of lowering drug pricing, railing against the "global price controls" implemented by other countries.

"Trade policies will prioritize that foreign companies pay their fair share," he said. "Right now it's very unfair what other countries are doing to us."

This is Trump's trademarked line of economic victimhood – the part that sounds good to populists right off the bat, makes capitalists queasy, and puts our country at **risk of** a **trade war**. It's becoming more and more clear that Trump sees making threats and starting fights with other countries as a form of fiscal policy.

And now it's **coming to the drug game**, a place where it definitely won't work.

Dude, you're not scaring anyone

After Trump's meeting with the pharma CEOs, the Nasdaq Biotechnology Index had its best day in weeks, gaining nearly 3%. The index has been on the decline since he began railing on the industry after his election, scaring investors away. Now, all of a sudden, **they're less worried.**

And they have every reason not to be. Less than 24 hours after their meeting, Congressional Republicans **basically put their fears to rest.**

Here's how: After Trump's meeting House Energy and Commerce Committee Chairman Greg Walden (R-Ore.) said that fixing this problem would be "high on our agenda."

Sounds good at first, until you read what he said afterward. Then his "high on our agenda" sounds more like Washington speak for, "we'll get around to it eventually."

Aside from the FDA deregulation, Walden suggested **no concrete legislation**. He also said nothing of **more drastic measures** both Democrats and Trump have proposed – like letting **Medicare and Medicaid negotiate prices.**

But worse than any of that, is the fact that Walden said that Trump can get results by "just by having a conversation" with pharma CEOs. Trump, he thinks, can scare some of the most powerful CEOs in the world with words.

This is Walden expressing his belief in Trump's "bully pulpit." The idea that Trump, like great American reformer President Theodore Roosevelt, has the power to convince the public – and other leaders in the US and around the world – to do as he says.

The problem with that comparison is that Roosevelt combined words with years of experience in politics (he made his career in political brawls in turn of the century New York City bars and wading through the cesspool of New York state government); an incredible intellect (he wrote his first book on naval history in college); and a incredible mind for the details of every issue.

More importantly, Roosevelt was willing to **back up what he said with real legislation.** His **bark had bite.**

All smiles

These CEOs **don't care** about Trump's bully pulpit. They walked into that meeting, smiled, nodded, talked about the jobs they were creating, heard that some deregulation was coming, and walked away smiling.

No other concrete policies for actually bringing down drug prices were actually discussed, and until that's on the table, they could lower prices 10% across the board just to make nice and it wouldn't mean much. As for calling for the FDA to approve more drugs to spur competition – that's really great and all, until you actually think of what these companies have been doing. They've been accused of fixing prices. Remember, that toward the end of the last year the Obama Justice Department went after around a dozen big pharmaceutical companies, including EpiPen-maker Mylan, for colluding to keep prices high. The makers of insulin were just accused of doing the same thing in a class action lawsuit. This practice is rampant in the industry and Capitol Hill is just starting to wrap its mind around it. Heather Bresch Mylan Mylan CEO Heather Bresch holds up an EpiPen while testifying on Capitol Hill in Washington, Wednesday, Sept. 21, 2016, before the House Oversight Committee hearing on EpiPen price increases.AP You know what else drug companies have been doing that they FDA can't fix? Paying their way into your healthcare plan. As we learned through our work looking into Valeant Pharmaceuticals, drug companies are more than willing to pay the companies that manage your healthcare plan to get on lists called formularies – formularies determine what drugs your insurance company will pay for. That means a higher priced drug with cheaper competition can find its way on a list where it really doesn't belong. It means drugs that should've been crushed by competition in a fair market don't actually die a natural death – they live on thanks to palms greased in the system. And that's the problem – our system. Not another country's, not the FDA's, the American pharmaceutical industry's system. Looking at it any other way ensures you apply the wrong solutions on the wrong problem. That's because the biggest problem with the industry is all its own, and it doesn't require regulation to fix either. It is the fact that our drug pricing system is incredibly opaque. Try telling a pharmacy benefit manager (the people who manage the lists) to publish a clear list of how it prices everything, what cut it's taking, and who is paying for it. Tell drug companies to do the same. Then watch them all have a panic attack. It's the opacity of the market that allows it to price things the way it does. Imagine yourself turning on the light in the bathroom at a remote campsite in the middle of the night. Imagine that light hasn't been turned on in about 10 years. Imagine what you would see. It would be like that.

Just bullying, no pulpit

Trump is **straddling the line** between a populist, who listens to the needs of the people, and a corporatist, who understands the needs of corporate moguls like himself. Drug pricing is one of those issues where you can **only really please one party or the other.**

And it's the kind of issue that could have **serious repercussions** if Trump tries to use bullying as a fiscal policy. That is to say, if he tries to bully other countries into **giving up their regulation on pricing and paying what Americans pay.** Those countries could feel the need to **retaliate** in kind.

Bullying is **not a real fiscal policy**, it is an **encroachment** on other countries' sovereignty and an **insult** to their national pride. It's not how you get things done, it's how you get humiliated in public when the President of Mexico refuses to have a meeting with you. It's is how **trade wars start.**

Price controls force rejection of trade---UK proves---it turns case, pharma imposes rations to control re-sale which ruins health care---we can win on this alone

Worstall 12, (Fellow at the Adam Smith Institute in London, a writer here and there on this and that and strangely, one of the global experts on the metal scandium, one of the rare earths. An odd thing to be but someone does have to be such and in this flavour of our universe I am. I have written for The Times, Daily Telegraph, Express, Independent, City AM, Wall Street Journal, Philadelphia Inquirer and online for the ASI, IEA, Social Affairs Unit, Spectator, The Guardian, The Register and Techcentralstation, You Can't Have Free Trade and Price Controls: Pharmaceutical Drugs Edition, https://www.forbes.com/sites/timworstall/2012/06/23/you-cant-have-free-trade-and-price-controls-pharmaceutical-drugs-edition/#24695f2a33d6)

This is a nice example of the fact that in economics there are no such things as solutions. There are only possible trade offs. In this case the **trade off** is between the **general desirability** of free trade and the perceived desirability of **fixing** pharmaceutical drugs prices. As the UK is finding out, you **can't have both at the same time:** Four in five NHS trusts in England and Wales say patients are suffering **"unacceptable" delays** for drugs to treat **life-threatening conditions** including cancer, Parkinson's disease, schizophrenia and organ failure. A survey of 60 NHS authorities found that the shortage was doing patients "**serious harm**", with some having to be admitted to hospital for emergency treatment after they were **unable to get** their **medicines**. Pharmaceutical companies began **rationing** drugs to the NHS four years ago after British wholesalers and pharmacies started **selling them abroad** to take advantage of

favourable exchange rates. The basic problem is twofold. Within the European Union we have absolute free trade. It is not possible to stop anyone selling goods across internal to the EU borders. The second point being that the National Health Service "**negotiates" with the pharma**ceutical providers prices which are **substantially below the open market prices** in the rest of Europe. The end result of this is that wholesalers and even retail pharmacies receive drugs at prices which mean that they can then be **profitably resold** to pharmacies in **other** EU **countries**. The **reaction** to this, from the drugs companies, was **obvious**: to **limit supplies** into Britain to the amount that they thought would or should be consumed in Britain. As we can see from the above this **hasn't changed matters**: because prices are **still below market clearing prices.** Thus some of **even this limited supply is being exported.** The lesson here is as at the top. There really are no solutions in economics. There are simply a series of trade offs. We can have this **free trade area or we can have price controls** on drugs. If we try to have both then we're going to have a **shortage of drugs** as they are exported. In one view this will mean that the government attempting to negotiate prices downwards kills citizens. Not quite what is desired but an inevitable outcome of trying to do those two things together.

That upends the global economy and trade---Trump is moderating now, but the plan reverses it

Sterland 17 Brary Sterland, Visiting Fellow leading a project looking at economic risk and resilience in Asia. "G-20 and trade: How worried should we be?" Brookings. 22 March 2017. https://www.brookings.edu/blog/up-front/2017/03/22/g-20-and-trade-how-worried-should-we-be/. [Premier]

The rhetorical shift **does not herald** an imminent **trade war** or even a permanent change in the G-20 consensus. The U.S domestic policy expression of the campaign pledges on trade is **just emerging.** While a decision has been made not to proceed with the Trans-Pacific Partnership, **broader trade policy** is subject to a **fierce debate** within the U.S. administration. Indeed, differences between the **administration** and **other influential players**, not least elements of the Republican dominated **Congress**, are **significant**. It **remains to be seen** whether a fundamental change in the U.S. approach to global trade will result.

In this context, it is important that the international community negotiates hard on these norms, to add what pressure it can to the domestic scales of debate. By all accounts the U.S. representatives in Baden Baden **heard loud and clear** the **strong view** of other countries (many of whom are **close** U.S. **allies**, and **all** of whom are **important partners**) on the positive contribution of trade to prosperity, and the dangers of protectionism. The direct engagement between players at G-20 meetings is vital, no matter the final negotiated outcome. This dynamic will be **critical** at the leaders meeting in Hamburg in July.

But it is also important that the other G-20 countries engage the U.S. in finding the best possible consensus language supporting trade and related international institutions and commitments. This will be both more important and harder in the G-20 summit in Hamburg in July, where there is more detailed trade language to negotiate. It is helpful in this context that the G-20 is at the same time focusing its attention on underlying concerns of citizens—the growth and distribution of economic opportunities ("inclusive and fair" growth in communique language). This is ultimately a more constructive way to address the range of policy issues associated with the structural changes being brought about by trade and technology.

For now, other elements of the G-20 consensus remain largely intact. The language on financial regulation and tax cooperation appears largely in line with the inherited G-20 agenda.

Indeed, the strong pre-existing language on currency and the need to address global imbalances, which was largely unchanged, will prove helpful to the task of engaging the new administration over time. These sentiments, at least at a high level, are consistent with the new administration's views—for example, that countries should not engage in devaluations to gain competitive advantage. This hopefully underpins the ongoing usefulness of such international fora. It also shows that tampering too much with hard-won consensus statements has downsides as well.

Perhaps the **strongest factor** that will **prevent** a **conversion of protectionist rhetoric into damaging action is the overall global economic context.** As the G-20 finance ministers and central bank governors note, the economic recovery seems **finally to be taking hold**, or "progressing" in the understated language of communiques. But global growth remains weaker than desirable and significant downside risks remain. They go on to reiterate their commitment to economic cooperation and, directly before the watered-down trade comment, undertake to reduce policy uncertainty to minimize negative spillovers between countries.

This general backdrop of strengthening recovery in the presence of remaining risks gives **extra ammunition** for those inside the U.S. arguing for caution against putting the anti-trade rhetoric into practice. The **last thing that the global economy** needs are the **unpredictable consequences** that could come with a shock to trade flows arising from unilateral trade actions.

The **most immediate goal then is to prevent a damaging conversion of anti-trade rhetoric into action** and constraining to the extent possible the erosion of important international norms around trade. This involves engaging the new U.S. administration on trade on all fronts, including through G-20 Leaders. And hopefully, over time, the U.S. may revert to its earlier principled support for the liberal global world order that it has **done more than any other country to create.**

Impact – Multilat

That causes great power war---trade drives multilateral solutions to disease and every impact

Linn 17 Johannes F. Linn , Distinguished Resident Fellow, Emerging Markets Forum. "Current and Future Threats to Multilateralism: Causes and Possible Remedies." Emerging Markets Forum. September 2017. http://www.emergingmarketsforum.org/wp-content/uploads/2017/09/Multilateralism-1.pdf. [Premier]

Introduction Multilateralism and the multilateral institutions face **serious threats**. This in turn threatens the **continuing progress** in **solving critical global** economic and social **challenges**: **slowing global** economic **growth** and **recurring** global **financial crises**; growing **inequality** and – despite significant improvements in living conditions worldwide in recent decades – persistent deprivation due to poverty, **hunger**, **conflict** and **fragility**, esp. in **Africa**; rising challenges to an open global trading regime; and the **pervasive risks of pandemics**, natural **disasters**, and **climate change**.1 If this statement sounds excessively gloomy, consider Mohamed El-Arian's opening paragraph for his op-ed in the Guardian on September 20, 2017: "Next month, when finance ministers and central bank governors from more than 180 countries gather in Washington, DC for the annual meetings of the International Monetary Fund and the World Bank, they will confront a **global economic order under increasing strain**. Having failed to deliver the inclusive economic prosperity of which it is capable, that order is subject to growing doubts – and mounting challenges. Barring a course correction, the risks that today's order will **yield to a world economic non-order will only intensify."** On the other side, David Bosco believes in the "durability of multilateralism" when he writes in the Journal of International Affairs that "we've been here before" and that "[President] Trump's challenge to the slow march of multilateralism may be even less consequential than de Gaulle's."2 This paper aims to assess the threats faced by multilateralism and multilateral institutions and to develop some ideas on how they might be addressed. Just to be clear, though, multilateralism is not just about the financing of investments. It is very importantly also about **developing and maintaining rules-based and fair global economic and social relations among countries** and peoples, about setting **widely accepted norms** and monitoring their adherence, about establishing networks to create, collect, and exchange knowledge and data, and about **resolving** potential **conflicts** among partners and competitors for global resources, markets, and influence. There are two countervailing trends over the last seven decades:3 After World War II (WWII) globalization and globalism took hold, reinforced after the fall of the Bamboo and Iron Curtains by the integration of China and the Former Soviet Block into the world economy. This was reflected in rapid **global connectivity** and economic **integration**, the **development of a rules-based international order** supported by the rise of the global and regional **multilateral institutions**, drastic **declines in extreme poverty** and increases in living standards across the world, and a **growing recognition** of continuing and new global challenges, and far-reaching agreement on the emerging global development and climate change agendas. The approval of the Agenda 2030, the Addis Agenda, and the Paris Agreement of COP21 in 2015 represented a high point in this trend towards a global agenda underpinned by multilateralist approaches. However, recent years also have shown **increasing stresses** in the multilateral system, which appear to have intensified since about 2014. In the geoeconomic and geopolitical arena, the dramatic shift of the economic balance from the G7 countries towards the emerging market economies has meant that what used to be a bipolar world (US-USSR, 1950-1990) and briefly a unipolar world (US, in the 1990s) is now rapidly becoming a multipolar world (China, Europe, India, Russia, US, and perhaps others).4 While in many ways a welcome development, and indeed a sign of the spectacular success of multilateralism over the last 70 years, the convergence in economic and political power has also been a contributing factor to the revival of East-West tension, perhaps even a "new" or "second cold war." 5 Historians have observed the historical preva - lence of the so-called "Thucydides Trap," where the "trap" refers to the supposedly **inevitable tension** between an **established power** and a **rising power, eventually leading to war** (as between Sparta and Athens in Ancient Greece). The potential for tensions and possibly conflict between today's established and rising powers, and especially between China and the US, is therefore seen by some astute observers as **serious**.

Impact – Currency

Sustained confidence is tied to perceptions of broad trade commitment---new protectionism in the next few days causes devaluation, dollar sell-off, and bond crisis

Wilson 18 Neil Wilson, Analyst at ETX Capital. "FX Weekly: Have the currency wars reignited?" ETX Capital . 26 January 2018. https://www.fxstreet.com/analysis/fx-weekly-have-the-currency-wars-reignited-201801261521. [Premier]

Cue the big man. With Trump in Davos he used an interview with CNBC to **repair** some of the **damage** done by Mnuchin by arguing – probably **correctly** – that his Treasury Secretary's comments were **taken out of context**. "The dollar is going to get strong and stronger and ultimately I want to see a strong dollar," he said. The USD leapt on the remarks before easing back close to the lows hit earlier on Thursday.

But does the US desire a weaker dollar? Trump may want to 'weaponise' the dollar to get other countries to accept his 'America First' trade policies and has previously said he didn't like the strong dollar – saying over the last year that it is 'too strong' and that 'lots of bad things happen with a strong dollar'. He should be careful what he wishes for – it can be tough to talk a currency back up, tougher than talking it down at any rate. We've been here before in the early Clinton administration era, when remarks about a weaker dollar resulted in a **broader sell-off in US assets.**

Whether the US does or doesn't seek a weaker dollar to promote exports and rebalance the deficit, the worry is that this kind of thing starts, albeit inadvertently, a **slow but steady stream** of countries seeking **competitive devaluations** of their own.

No wonder the ECB is concerned – but not that concerned by the current level of the euro it seems. If Mnuchin really did fire the first shot in a new round of currency wars, the Draghi **brought a plastic spoon to the pistol fight.** His presser resulted in a spike in EURUSD which even the Trump intervention has failed to quell.

Commenting on the recent euro **volatility**, he said that it is a source of **uncertainty** that requires monitoring with regards to the medium term outlook for price stability. However there was no explicit reference to the level, just the volatility. This is by and large what all central bankers say as they don't like wild swings in their currencies. If he had really wanted to take the euro down a peg or two he would have talked about the actual level more than just the volatility. This was taken as a fairly bullish signal, as was the assertion that the ECB has increased confidence that inflation will converge with target. Still the ECB does not appear to be moving especially quickly or any faster than markets currently expect. Keep an eye on inflation – if euro appreciation is deflationary then the ECB could be forced into an awkward spot. The pool of available bonds to purchase is running out. Nevertheless I think there could be some upgraded inflation projections in March that Draghi can use as his cue to exit the QE party.

Trade and protectionism

We **have to see Mnuchin's remarks in a wider context and** particularly **the Trump administration's attitude to trade.** We have seen the first tariffs imposed on South Korean washing machines and Chinese solar panels. There **could be many more** to come and we should **learn more over the coming days** whether protectionism leads to **more rifts between the US and Europe.** Ultimately this could feed into a weaker USD and a broader selloff in stocks and bonds.

Bond collapse destroys the economy---it's the biggest internal link

Amadeo 18 Armadeo, president of WorldMoneyWatch.com. "How Bonds Affect the U.S. Economy." The Balance. 2 January 2018. https://www.thebalance.com/how-do-bonds-affect-the-us-economy-3305601. [Premier]

Bonds affect the U.S. economy by determining interest rates. This affects the amount of liquidity. This determines how easy or difficult it is to buy things on credit, take out loans for cars, houses or education, and expand businesses. In other words, **bonds affect everything in the economy.** Here's how.

Treasury bonds impact the economy by providing extra spending money for the government and consumers.

This is because Treasury bonds are essentially a loan to the government that is usually purchased by domestic consumers.

For a variety of reasons, foreign governments purchase a large percentage of Treasury bonds. In effect, they are providing the U.S. government with a loan. This allows Congress to spend more, which stimulates the economy. It also increase the U.S. debt. The biggest owners of the U.S. debt are China, Japan, and the oil-exporting nations.

Treasury bonds also help the consumer. When there is a great demand for bonds, it lowers interest rates because. The U.S. government doesn't have to offer as much to attract buyers. Treasury notes affect interest rates for other bonds. Investors in Treasurys are also interested in the safety of other bonds. If Treasury rates are too low, other bonds look like better investments. If Treasury rates rise, other bonds must also increase their rates to attract investors.

Most important, bonds affect mortgage interest rates. Bond investors can choose among all the different types of bonds, as well as mortgages sold on the secondary market. They are constantly comparing the risk versus reward offered by interest rates. As a result, lower interest rates on bonds means lower interest rates on mortgages.

This allows homeowners to afford more expensive homes.

Mortgages are riskier than many other types of bonds because they are the longest duration, usually 15 or 30 years. Therefore, investors generally compare them to long-term Treasuries, such as 10-year Treasury notes or 30-year Treasury bonds.

Bond have so much power over the economy that political consultant James Carville once said, "I used to think if there was reincarnation, I wanted to come back as the **president** or the **pope** or a .400 baseball hitter. But now **I want to come back as the bond market. You can intimidate everybody."**

How to Use Bonds to Predict the Economy

Bonds' powerful relationship to the economy means you can also use them for forecasting. That's because bond yields tell you what investors think the economy will do. Normally, the yields on long-term notes are higher, because investors require more return in exchange for tying up their money for a longer time. In this case, the yield curve slopes up when looked at from left to right.

An inverted yield curve tells you that the economy is about to go into recession. That's when the yields on short-duration Treasury bills, like the one-month, six-month or one-year notes, are higher than the yields on long-term ones like 10-year or 30-year Treasury bonds.

That tells you that short-term investors demand a higher interest rate, and more return on their investment, than long-term investors. Why? Because they believe a recession will happen sooner rather than later.

Could the Bond Market Collapse?

The **boned market is more susceptible to volatility than is the stock market**. One reason is that bonds are still bought and sold the old-fashioned way. Dealers call their clients to offer individual bonds. This adds

to the cost of bond trading, especially for small investors. It can cost 50 to 100 times more for them to own bonds than stocks of the same company. That's because stocks, and most other investments, are traded electronically.

The stodginess of the bond market also increases its volatility. Investors cannot find the best prices quickly. They must call individual brokers.

Similarly, dealers cannot sell large quantities of bonds efficiently. They must make several phone calls to find enough buyers. This inefficiency means prices can bounce around wildly depending on if the dealer talks to a large buyer.

But this volatility does not mean the market is on the verge of a collapse. There are six reason why the why the bond market won't crash. But the most important is a look at history. Since 1980, the bond market has only had three years with a negative return. In all three of those years, (1994,1999, and 2013,) the stock market did very well. That makes sense, because bonds drop when the stock market rises. In none of those years did the bond market lose more than 3 percent. That wouldn't even register as a market correction in the stock market.

Antibiotics

Link

Prescription rates are decreasing now for people with commercial health insurance.

Goldstein 17 Amy Goldstein, Staff writer at The Washington Post for more than a quarter-century. "Fewer antibiotic prescriptions are being filled, a new analysis finds." Washington Post. 24 August 2017. https://www.washingtonpost.com/news/to-your-health/wp/2017/08/24/fewer-antibiotic-prescriptions-are-being-filled-a-new-analysis-finds/?utm_term=.49872b04cea4. [Premier]

The **use** of antibiotics among Americans **with commercial health insurance** has **decreased** during the past several years, **according to a new analysis** that nevertheless shows lingering variations for different ages and in different parts of the country. The study released on Thursday provides the latest evidence of how **doctors and patients have begun to heed warnings** that excessive antibiotic use breeds dangerous drug resistance and "superbug" bacteria. The analysis is based on **173 million insurance claims** from people under age 65 with Blue Cross Blue Shield coverage who filled prescriptions between 2010 and 2016. It is a sequel of sorts to research by the federal **C**enters for **D**isease **C**ontrol and Prevention, which **found a** smaller **decline and comparable age and geographic variations**. The CDC reported a 5 percent decrease overall between 2011 and 2014 in antibiotic prescriptions written in outpatient settings such as doctors' offices, clinics and hospital emergency rooms. The study by the Blue Cross Blue Shield Association found that **9 percent fewer antibiotics prescribed** in outpatient settings were filled in 2016, compared with 2010.

Chart Omitted

Efforts to make sure that doctors and patients rely on antibiotics only when necessary have **gained prominence in recent years**. A study last year by the CDC and the Pew Charitable Trusts was the first to try to quantify the overuse, concluding that nearly one-third of the antibiotics prescribed in outpatient settings were not needed. Many of these estimated 47 million unnecessary prescriptions were for colds or other respiratory illnesses that are caused by viruses and do not respond to antibiotics. The Blue Cross Blue Shield analysis of 31 million commercially insured customers a year found that the steepest decrease in filled prescriptions was for children — a drop of 16 percent, compared with 6 percent for adults. The prescriptions filled for infants fell the most — 22 percent. As with earlier research, the analysis also found wide geographic differences, with people in the South and Appalachia tending to fill prescriptions at rates significantly greater than those in New England and along the West Coast. The highest rates were in Mississippi, Alabama and Arkansas. However, between 2010 and 2016, the rates fell in all states except Delaware, Illinois and Nebraska. Among types of antibiotics, **the decrease was greatest among those that are broad-spectrum — covering a wide range of bacteria and most likely to lead to drug-resistance**. Still, the analysis found that about one in five of the filled prescriptions after outpatient visits were for conditions not considered treatable by such antibiotics. Trent Haywood, chief medical officer for the Blue Cross Blue Shield Association, said in a statement that the study suggests **public health efforts to reduce inappropriate use "appear to be achieving measurable results,"** particularly in misuse of broad-spectrum antibiotics. But, he said, "there are further improvements to be made."

Public insurance dramatically increases antibiotic use.

Laxminarayan 03 Ramanan Laxminarayan, Ph.D., M.P.H. "What Does Economics Have to Offer in the War Against Antimicrobial Resistance?" 2003. https://www.ncbi.nlm.nih.gov/books/NBK97140/. [Premier]

Price Measures The most reliable axiom in economics is that **as the price of any commodity goes up**, the **quantity** of that commodity that **people will consume declines**, all else being equal. Therefore, **if our objective is to reduce** the **use of antibiotics**, then **the most reliable way of doing so without second-guessing physicians' decision-making is by raising the cost of using antibiotics to the patient**. One solution might be to impose a tax on antibiotics. However, a tax may be undesirable for two reasons. First, a tax may not discourage

antibiotic use **if insurance coverage shields many patients from drug costs** and physicians are relatively insensitive to these costs. Second, the burden of a tax may be disproportionately borne by poorer patients who are less likely to have health insurance to cover the cost of antibiotic prescriptions. A logical alternative would be to mandate an increase in the extent of cost-sharing for antibiotics. This could be accomplished by increasing copayments for antibiotic prescriptions for certain conditions where a regulatory or scientific body believes that antibiotics are overprescribed (such as for the treatment of ear infections).5 Such a measure would not hurt the majority of economically disadvantaged patients who currently lack prescription drug coverage, but would effectively tax antibiotic use. Figure 4-1 shows how an increase in the cost-share borne by patients would decrease the quantity of antibiotics consumed from Q1 to Q2. Empirical evidence on the effect of cost-sharing on antibiotic use is limited but consistent. For instance, **a large randomized study** conducted in 1985 **showed that people who received free medical care used 85 percent more antibiotics than those required to pay for at least some portion of their medical care** (Foxman et al., 1987). However, the same study found that cost-sharing was likely to equally reduce both appropriate as well as inappropriate antibiotic use. To be sure, a price-based policy intervention is a blunt instrument, and may, in some instances, discourage the use of antibiotics even when their use is justified. However, targeted cost-sharing efforts aimed at certain diagnoses may be preferable to an across-the-board increase in mandatory cost-sharing for all antibiotics. Increased cost-sharing for antibiotics, or other methods of raising the cost of antibiotics to the patient **may not be popular. However, short of direct case-by-case oversight of antibiotic prescriptions, there are few other alternative strategies that can effectively lower antibiotic use.** Policy makers in the antibiotic resistance arena would do well to learn from the use of tobacco taxes in the United States. **The tremendous success of higher tobacco taxes on lowering smoking in this and other countries is self-evident**.

Impact – Resistance

ABR causes economic decline, supercharges healthcare costs, ends sustainable development, and causes food collapse.

WB 16 World Bank. "By 2050, drug-resistant infections could cause global economic damage on par with 2008 financial crisis." 20 September 2016. www.worldbank.org/en/news/press-release/2016/09/18/by-2050-drug-resistant-infections-could-cause-global-economic-damage-on-par-with-2008-financial-crisis. [Premier]

NEW YORK, September 19, 2016—**Drug-resistant infections have the potential to cause** a level of **economic damage** similar to—and **likely worse than**—that caused by the **2008** financial crisis, according to a new report by the World Bank Group entitled "Drug Resistant Infections: A Threat to Our Economic Future." The research shows that **a high-case scenario of antimicrobial resistance** (AMR)—where antibiotics and other antimicrobial dugs no longer treat infections the way they are supposed to—could cause low-income countries to lose more than 5% of their GDP and push up to 28 million people, mostly in developing countries, into poverty by 2050. And unlike the financial crisis of 2008, **there would be no prospects for a cyclical recovery** in the medium term, as **the costly impact of AMR would persist.** "**The scale and nature of this economic threat could wipe out hard-fought development gains and take us away from our goals of ending extreme poverty and boosting shared prosperity,"** said Jim Yong Kim, President of the World Bank Group. "The cost of inaction is unaffordable—especially for the poorest countries. We must urgently change course to avert this potential crisis." Key findings of the report are based on World Bank Group projections of the world economy in 2017-2050. They include: Impact on GDP: By 2050, **annual global GDP would fall by** 1.1% in the low-impact AMR scenario and **3.8% in the high-impact AMR scenario**. Low-income countries would lose more every year leading up to 2050, with the loss exceeding 5% of GDP in 2050 in the latter scenario. Impact on global poverty: There would be a **pronounced increase in extreme poverty** because of AMR. Of the additional 28.3 million people falling into extreme poverty in 2050 in the high-impact AMR scenario, the vast majority (26.2 million) would live in low-income countries. Currently, the world is broadly **on track to eliminate extreme poverty** (at $1.90/day) by 2030, reaching close to the target of less than 3% of people living in extreme poverty. AMR risks putting this target out of reach. Impact on world trade: In 2050, the volume of global real exports would shrink by 1.1% in the low-case scenario, and by 3.8% in the high-case scenario. Impact on healthcare costs: **Global increases in healthcare costs may range from $300 billion to more than $1 trillion per year by 2050.** Impact on livestock output: By 2050, the **decline in global livestock production** could range from a low of 2.6% to a high of 7.5% per year. Drug-resistant infections, in both humans and animals, are on the rise globally. If AMR spreads unchecked, many infectious diseases will again be untreatable, reversing a century of progress in public health. The United Nations has scheduled a day-long special session on AMR as part of the UN General Assembly in New York this week, only the fourth time that health is being highlighted in this way. "We now know that—unless addressed swiftly and seriously and on a sustained basis—**the growing global problem of antibiotic resistance will be disastrous for human and animal health, food production and global economies**. The fact that, left unchecked, it would penalize the poor more than anyone, makes clear why this needs to be addressed as a critical issue for development. As heads of state come together at the UN General Assembly high-level meeting on antimicrobial resistance this week, this should be front of mind," said Margaret Chan, Director-General of the World Health Organization (WHO). Several recent reports on AMR, including the most recent one by Lord Jim O'Neill's independent policy review, have called for an urgent focus on this issue and **highlighted the enormous global economic losses it can cause—it estimated about $100 trillion** in total by 2050. Lord Jim O'Neill, Chairman of the Review on Antimicrobial Resistance, said about today's World Bank Group report: "This report provides another timely reminder that rising **drug resistance is a** looming **threat to our prosperity and sustained economic development in all parts of the world**. As global leaders meet at the UN this week, I hope that this report will help to harden their resolve to take proper, collaborative action on the many challenges of AMR."

Resistance causes extinction.

Sample 14 Ian Sample, science correspondent. “Antibiotic-resistant diseases pose 'apocalyptic' threat, top expert says.” The Guardian. 23 January 2014. http://www.theguardian.com/society/2013/jan/23/antibiotic-resistant-diseases-apocalyptic-threat. [Premier]

HEALTH - Britain’s most senior medical adviser has warned MPs that the rise in drug-resistant diseases could trigger a **national emergency** comparable to a catastrophic terrorist attack, pandemic flu or major coastal flooding. Dame Sally Davies, the chief medical officer, said the threat from infections that are resistant to frontline antibiotics was **so serious** that the issue should be added to the government’s national risk register of civil emergencies. She described what she called an “**apocalyptic scenario**” where people going for simple operations in 20 years’ time die of routine infections “because we have run out of antibiotics.” The register was established in 2008 to advise the public and businesses on national emergencies that Britain could face in the next five years. The highest priority risks on the latest register include a deadly flu outbreak, catastrophic terrorist attacks, and major flooding on the scale of 1953, the last occasion on which a national emergency was declared in the UK. Speaking to MPs on the Commons science and technology committee, Davies said she would ask the Cabinet Office to add antibiotic resistance to the national risk register in the light of an annual report on infectious disease she will publish in March. Davies declined to elaborate on the report, but said its publication would coincide with a government strategy to promote more responsible use of antibiotics among doctors and the clinical professions. “We need to get our act together in this country,” she told the committee. She told the Guardian: “There are few public health issues of potentially greater importance for society than antibiotic resistance. It means we are at increasing risk of developing infections that cannot be treated – but resistance can be managed. “That is why we will be publishing a new cross-government strategy and action plan to tackle this issue in early spring.” The issue of drug resistance is as old as antibiotics themselves, and arises when drugs knock out susceptible infections, leaving hardier, resilient strains behind. The survivors then multiply, and over time can become unstoppable with frontline medicines. Some of the best known are so-called hospital superbugs such as MRSA that are at the root of outbreaks among patients. “In the past, most people haven’t worried because we’ve always had new antibiotics to turn to,” said Alan Johnson, consultant clinical scientist at the Health Protection Agency. “What has changed is that the development pipeline is running dry. We don’t have new antibiotics that we can rely on in the immediate future or in the longer term.” Changes in modern medicine have exacerbated the problem by making patients more susceptible to infections. For example, cancer treatments weaken the immune system, and the use of catheters increases the chances of bugs entering the bloodstream. “We are becoming increasingly reliant on antibiotics in a whole range of areas of medicine. If we don’t have new antibiotics to deal with the problems of resistance we see, we are going to be in serious trouble,” Johnson added. **The supply of new antibiotics has dried up** for several reasons, but a major one is that drugs companies see greater profits in medicines that treat chronic conditions, such as heart disease, which patients must take for years or even decades. “There is a broken market model for making new antibiotics,” Davies told the MPs. Davies has met senior officials at the World Health Organisation and her counterparts in other countries to develop a strategy to tackle antibiotic resistance globally. Drug resistance is emerging in diseases across the board. Davies said 80% of gonorrhea was now resistant to the frontline antibiotic tetracycline, and infections were rising in young and middle-aged people. Multi-drug resistant TB was also a major threat, she said. Another worrying trend is the rise in infections that are resistant to powerful antibiotics called carbapenems, which doctors rely on to tackle the most serious infections. Resistant bugs carry a gene variant that allows them to destroy the drug. What concerns some scientists is that the gene variant can spread freely between different kinds of bacteria, said Johnson. Bacteria resistant to carbapenems were first detected in the UK in 2003, when three cases were reported. The numbers remained low until 2007, but have since leapt to 333 in 2010, with 217 cases in the first six months of 2011, according to the latest figures from the HPA.

Impact – Microbiome

Overproduction of antibiotics causes microbiome collapse---extinction.

Garrett 16 Laurie Garrett , awarded the Pulitzer Prize for Explanatory Journalism. "**Antibiotic-Resistant Bacteria and the World's Peril**." Scientific American. 19 September 2016. https://blogs.scientificamerican.com/guest-blog/antibiotic-resistant-bacteria-and-the-world-s-peril/. [Premier]

Welcome to the Anthropocene, the era in which one species—human beings—so utterly dominates the planet that all of the driving forces of climate, oceans, geology, air and every other life form on Earth are controlled by the activities of humanity. Most of the damage is thoughtless. Humans don't decide to pollute, they just do so. People don't make a choice to lower the numbers of oxygen-producing trees on the planet, they just chop them down without thinking about it. Among the most dangerous of these thoughtless actions executed by our species is wild misuse of antibiotics. On September 21, the United Nations General Assembly is convening a special session to look at ways to curb use of precious medicinal drugs that are swiftly being outwitted by drug-resistant bacteria, making everything from a scraped knee to a bout of pneumonia far more dangerous and difficult to treat. But that focus, important as it is, remains limited to human use of chemicals and concern about their misuse to our species' health. Genuine governance and stewardship in the Anthropocene requires a far broader look at what our activities mean for the planet, writ large. At the most basic levels of life every single system on Earth is controlled, or influenced, by microbes—microscopic creatures ranging from nano-sized viruses to enormous colonies of bacteria; from populations of microbes in the depths of the oceans to the inside of the human gut. A human being is made up of about 30 trillion cells and 39 trillion microbes, most of which are indispensable to our mental and physical health. If all the viruses and parasites swarming inside and on the skin of a human being are tallied the microbe-to-cell ratio is about ten-to-one. The microbes—collectively known as the Human Microbiome—digest our food, help us do battle with invading pathogens, clean our skin and provide us fuel. **Life without microbes is no life at all.** Antibiotics kill bacteria, and as anybody who has been on a long course of the drugs to treat an ailment knows, the medicine is indiscriminate, knocking off not only invaders like the bugs that cause pneumonia and ear infections, but also those that prevent stomach aches and constipation in response to ingestion of food. Human overuse or misuse of antibiotics has bred the emergence of Superbugs that are not only resistant to the drugs, but may be able to surge in numbers within a person's gut, for example, leading to dangerous imbalances in bacterial populations that then cause diabetes, some types of heart disease, depression and an enormous range of common diseases. The Earth has its own microbiome, representing about a third of the weight of all biological material and life forms on the planet. And it is every bit as indispensable to the planet as your microbiome is to your personal health. Microbes living on the surface of the oceans, for example, aerosolize and end up in the atmosphere, where water droplets collect on their surfaces, forming clouds . Eliminating those microbes would directly affect rainfall. More oxygen that humans breathe is made by microbes than plants. And even the plants rely upon the microbiome of soil to transfer nutrients into their roots, allowing trees and forests to make more oxygen for humans to breathe. So it should be with some **considerable alarm** that we consider **the killing potential manmade antibiotics have for Earth's microbiome.**

Impact – Biodiversity

Antibiotics decimate aquatic ecosystems.

Keyles 16 Shayna Keyles, editor at Ulysses Press, citing data from The United States Geological Survey. "**Pharmaceutical Waste Damages Aquatic Ecosystems**." Got Science. 6 July 2016. http://www.gotscience.org/2016/07/pharmaceuticals-damage-aquatic-ecosystems/. [Premier]

Pharmaceutical Waste: Diving into the Stream of Chemicals From April 14, 2014, through June 13, 2014, the USGS team collected biweekly samples from 59 wadeable headwater streams in the Piedmont ecoregion, which comprises the following urban centers: Atlanta, Georgia; Raleigh-Durham, North Carolina; Charlotte, South Carolina; and the District of Columbia. Some headwater streams they sampled were closer to more urban environments, while others were closer to agricultural areas. The team discovered that the samples contained 108 human-use pharmaceutical and pharmaceutical-degradate compounds, and 68 of those compounds were ubiquitous in all of the sampled sites. **The presence of a compound was not significantly affected by location**: Samples from both urban and agricultural areas across all five states contained the same compounds. Some compounds showed up more than others. Metformin, a medication used to treat and control symptoms associated with type II diabetes and insulin resistance, was found in 89 percent of the samples. Compounds related to nicotine were found in 71 percent of samples, and caffeine was found in 49 percent of samples. Antihistamines, decongestants, and antibiotics were also common finds. How Does Effluent Affect the Ecosystem? Studies have already been done on the impacts of human-use pharmaceuticals on water habitats. The letter published by the USGS team, "Metformin and Other Pharmaceuticals Widespread in Wadeable Streams of the Southeastern United States," cites **at least fifteen of these studies, which document such impacts as changes in predator-prey relationships, antimicrobial activity, endocrine disruption, and antibiotic resistance selection.** Many of the previous studies have focused on the effects of individual pharmaceutical compounds on the ecosystem, but this current study notes that these streams are contaminated with numerous compounds, many of which probably went undetected in previous samples. Presently, research does not show how these compounds interact with each other and whether these interactions will have a more pronounced effect on the aquatic ecology. The **researchers suspect that the large amount of antibiotics will likely have profound effects on the microbial base of the food web, which can lead to region-wide disruption.** Antihistamines were another area of concern; aquatic invertebrate communities, specifically insects, use histamines as neurotransmitters. The stream samples showed significant amounts of fexofenadine, an antihistamine, which is known to impair flight response in aquatic insect species such as the damselfly. Metformin, labeled an environmentally recalcitrant compound, also poses a risk to these aquatic environments. Exposure to the drug has caused upregulation of vitellogenin mRNA and male intersex in the fathead minnow.

North American waterway diversity prevents extinction—it has unique taxonomic diversity.

Walsh et al. 09 Stephen J. Walsh, Ph.D., research biologists with the U.S. Geological Survey and co-chairs of the American Fisheries Society's Endangered Species Committee, Howard L. Jelks, M.Sc., and Noel M. Burkhead, M.Sc.. "The Decline of North American Freshwater Fishes." Action Bioscience. June 2009. http://www.actionbioscience.org/biodiversity/walsh.html#fullbio. [Premier]

North America has a **broad array** of freshwater ecosystems because of the continent's complex geography and geological history. Within a **multitude of habitats**—that include streams, large rivers, natural lakes, springs, and wetlands—rich assemblages of fishes reside, representing **diverse taxonomic groups** with unique ecological requirements. They face an unprecedented conservation crisis.1 In the last few decades, the proportion of inland fishes of North America, which are considered imperiled or extinct, increased from 20 to 40%.2 Although extinctions have occurred, many species and populations are declining in

range size and abundance. The fish biota of the continent as a whole remains diverse; however, we can take action to stem any further declines.

Fish biodiversity is prolific

Globally, fishes outnumber all other vertebrates combined and have the highest rate of discovery of new species.3 Fishes exhibit a remarkable diversity of morphological attributes and biological adaptations and occur in most aquatic habitats on Earth. Even in North America, where scientific knowledge of the fauna is advanced, new species are described every year. These discoveries are the combination of applied technologies, such as gene sequencing, which increase recognition of biodiversity at all levels, and the documentation of new, morphologically distinct forms and populations. Biological taxonomy is the discipline of classifying and naming organisms using an internationally accepted system or code. Because of the dynamic nature of fish taxonomy, and the extent of unexplored areas of the planet with potentially many undescribed species, statements or conclusions about numbers and percentages of species occurring in particular habitats or geographical regions are but rough approximations. Published information reveals the following: A conservative estimate is that as many as 32,500 extant (living) fish species may exist in the world.3 This number may eventually prove greater, however, with approximately 30,000 currently recognized as valid and over 300 new species described each year.4 Fresh water constitutes only about 1% of the Earth's surface area and less than 0.01% of its water by volume. Almost half of fishes are found in fresh waters. About 12,000 species, or approximately 43% of all currently named fishes, occur exclusively in fresh waters. A small number are diadromous, regularly living part of their lives in rivers, streams, or lakes, and part in the oceans. North America has the greatest taxonomic richness of freshwater fishes among temperate regions of the world,1 although it is greatly surpassed in number of species by less documented areas of the tropics—especially the biological hotspots of South America, Africa, and southeast Asia.5,6 Currently, there are approximately 1,200 recognized fish species that occur in inland waters of the continental United States, Canada, and Mexico. Collectively, the fish fauna (ichthyofauna) of North America's freshwater ecosystems has at least 435 imperiled species, another 72 species with distinct populations in trouble, and 36 species that are extinct from the wild.2 Worldwide, historical, and emerging trends in the conservation of fishes and fishery stocks portray continued or even accelerated population decreases; yet, there are reasons for optimism, as well as potential for recovery and protection of these declining resources given societal resolve.7 Threats to freshwater fishes and habitats Threats to freshwater ecosystems are so widespread that many endemic species—those naturally restricted to a single drainage or ecoregion—are imperiled simply because restricted geographic distribution makes them more vulnerable to human modification of landscapes. The most important documented threats to fishes in freshwater habitats include:1,7,8,9 Habitat loss for fish is a major concern. Destruction or modification of habitat resulting in reduced range size and/or loss of populations. Examples include dam construction, channelization, mining, clearing of natural forests for agriculture, urban development, and other intensive land-use practices. Water depletion. Some desert fishes have become extinct because of human exploitation of limited groundwater resources. Pollution from point and non-point source contaminants. Runoff from urban areas, and the compound effects of multiple pollutants, often reduces water quality to the point that only the most tolerant species remain in receiving water bodies. Erosion and sedimentation. Fine sediments can smother bottom substrates, to the detriment of many bottom-dwelling (benthic) species, whose prey and reproductive success are dependent on clean substrates and good water quality. Fishing has overexploited populations. Overexploitation for commercial, recreational, scientific, or educational purposes. Examples of fishes that have been overharvested include salmons, whitefishes, trouts, striped bass, and sturgeons. Disease or parasitism. For instance, whirling disease, a microscopic parasite introduced from Europe, has ravaged many wild and hatchery populations of trouts and salmons in the U.S. and Canada. Other anthropogenic factors—including introduction of non-native species—which may result in hybridization, competition, and predation. Numerous introductions of fishes and other aquatic organisms, both from outside of North America and intracontinental transplants, have had severe negative impacts on native species,including some that have caused extinction.10 Climate change. Regional variation in rainfall patterns, storm events, and droughts can affect habitats and potentially have negative consequences for rare species. Conservation status Land animals make better news than aquatic animals. Media coverage of conservation issues about the world's animals is often greatest for species that are particularly endearing to humans, such as mammals and birds, whereas perils to aquatic faunas, including fishes, are often much less publicized. This disparity is due, in part, to taxonomic bias in research and funding in the field of conservation biology.11 Based on published scientific literature, fishes, amphibians, reptiles, and invertebrates are greatly underrepresented in conservation studies relative to the proportion of species of each group known worldwide,11 and organisms in the freshwater and marine realms receive much less coverage than those in terrestrial environments.12 Among invertebrates, however, it is notable that mollusks and crustaceans, of which many species are aquatic, are generally better studied than the vast diversity of arthropods—especially insects, with the exception of butterflies and moths. Even within freshwater fishes, game, and commercial species often receive greater attention than non-game species. Fish funding and research is lacking. Major deficits in funding for faunal surveys, monitoring, basic research, and the general lack of public awareness about the conservation status of fishes across taxonomic groups and ecosystems is a significant problem. Given the myriad of threats to aquatic habitats throughout the world, the degree to which degradation of these habitats is accelerating; and the overall proportion of biodiversity represented, exceptional natural resources are at risk of being severely diminished or lost. In particular, freshwater habitats are some of the most threatened in the world.8,9,13 Moreover, aquatic systems are inextricably linked to terrestrial habitats, and pollutants and sediments from perturbed landscapes flow into lakes, streams, and rivers. New studies reveal fish are in peril. The Endangered Species Committee of the American Fisheries Society (AFS-ESC) has tracked the plight of imperiled fishes in North America for over 30 years, with the explicit aim of providing objective and unbiased status assessments independent of the influence of policy or regulatory considerations. Recently, the AFS-ESC—represented by 16 scientists from the United States, Canada, and Mexico, with the assistance of numerous colleagues— evaluated the conservation status of the entire continental fish fauna.2 In the latest assessment, approximately 40% of described North American freshwater and diadromous fish species are documented as imperiled or extinct, representing a substantial increase over previous assessments. Past conservation assessments by the AFS were limited to determining the status of distinct species and subspecies. Undescribed forms, or those not named in the scientific literature using classic Linnaean binomial nomenclature, were included where sufficient data were available to document taxonomic distinctiveness, as evidenced by unique morphological, genetic, or other attributes. In the most recent assessment, additional infraspecific taxa were included in the form of distinctive populations, or what are sometimes referred to in the scientific community as evolutionarily significant units (ESUs) or distinct population segments (DPSs, although this term has certain legal connotations under the Endangered Species Act within the U.S.).14 A taxon (taxa, plural) is a unit used in biological classification and is defined based on a natural relationship, formally recognized as one or more lineages (= clades) of descendants sharing a common ancestry. 700 freshwater fish taxa in N.A. are in peril. Seven hundred fish taxa are considered imperiled in North America's inland waters, currently, which represent 133 genera in 36 families (see Figure 1).2 The majority of taxa are named species (63%), followed by named subspecies (13%), populations (12%), undescribed species (7%), and undescribed subspecies (5%). Previous lists from 1979 and 1989 also had about 63% listed species and 37% infraspecific taxa. Of the total taxa currently listed, 280 taxa are endangered (E), i.e., in imminent (fewer than 50 years) danger of extinction, or extirpation (loss of populations) throughout most portions of a taxon's range. 190 are threatened (T), or in imminent danger of becoming endangered. 230 are vulnerable (V), that is, in imminent danger of becoming threatened, which is comparable to a designation of "Special Concern" by many agencies and conservation organizations. 61 are presumed extinct (X), meaning a taxon that has not been observed for over 50 years. Two subcategories are included: Possibly Extinct (Xp), a taxon suspected to be extinct, as evidenced by more than 20 but less than 50 years since living representatives were observed, and Extirpated in Nature (Xn), where all populations in natural habitats are presumed eliminated but surviving individuals are maintained in captivity. Figure 1 Chronological increase in the number of fish taxa imperiled in North American freshwater ecosystems, as assessed by the American Fisheries Society Endangered Species Committee.2 Assessments were conducted in 1979, 1989, and 2008. Delisted taxa are those that appeared on a previous list but were removed due to improved status, taxonomic invalidity, or extralimital distributions. The number of imperiled fishes represents a 92% increase over a nearly 20-year period dating to 1989. The list of imperiled taxa encompasses fishes that span a remarkable diversity of lineages, morphologies, life histories, and habitats. A taxonomic breakdown of the list and comparison to known, described species reveals disparities by family. Nearly one quarter of all imperiled taxa belong to the most species-rich family of North American freshwater fishes, the Cyprinidae, represented by the minnows and their allies. The Candy Darter is a vulnerable species found in the New River system of Virginia and West Virginia. Darters are a colorful, species-rich group of small-bodied fishes limited in distribution to North America; their greatest diversity is in uplands of central and eastern U.S. Photograph by N.M. Burkhead. Another 15% is represented by the second-most diverse family—the Percidae—that includes a large number of darters—small, colorful fishes that have their greatest diversity and abundance in clear-flowing streams of the central and eastern U.S. The Salmonidae—trouts, salmons, ciscoes, and their allies—comprise nearly 12% of all imperiled taxa, but are disproportionally represented in comparison to other families by large numbers of infraspecific taxa. Imperiled species include minnows and salmon. There are distinct geographic trends evident for imperiled North American fishes based on distributions within natural hydrologic units or ecoregions (defined by a combination of physical drainage features and faunal similarity, see Figure 2).12 Concentrations of at-risk fishes occur in the southeastern U.S., the mid-Pacific coast, the lower Rio Grande, and coastal and south-central inland regions of Mexico.1 Of particular note is the distribution of imperiled fishes in North America within ecoregions; 80% of all taxa are confined (endemic) to a single ecoregion, and another 10% are limited to two ecoregions. Much of the imperilment of the inland continental fish fauna is attributed to a combination of limited range sizes of many species and broad-scale habitat degradation. Figure 2 Numbers of imperiled freshwater and diadromous fishes by ecoregions, within North America, based on the most recent conservation assessment by the American Fisheries Society's Endangered Species Committee.2

Why be concerned about the decline?

Fish declines affect humans and other species. **Loss of biod**iversity **on** planet **Earth is** thought by some to be **the greatest impending** environmental **crisis** currently **facing humanity**.15 The decline of North American fish species and populations, as with elements of biodiversity throughout the world, directly or indirectly impacts other faunas, is detrimental to freshwater ecosystems in general, and **affects humankind** in a variety of ways. Freshwater fishes are **important sentinels** of **environmental conditions** and play a crucial role in the ecology and **sustainability of natural ecosystems**. The natural balance of both aquatic and terrestrial communities, including birds, mammals, reptiles, and other fishes, is **dependent** on fish populations that provide critical functions, such as cycling nutrients and serving as prey to a large variety of carnivores. The larvae of native freshwater mussels, called glochidia, require fish hosts in order to complete their life cycles. Some **migratory fishes**—such as shads, smelts, chars, and salmons—**serve as keystone species of entire ecosystems**. For instance, a variety of predators and scavengers feed on adults of migrating and spawning salmon, their eggs, fry, and their decaying carcasses. The nutrients that are transferred from the sea and incorporated into the food chain contribute to the health of forests adjacent to streams in which salmon spawn, thereby illustrating the linkage between terrestrial and aquatic habitats.7,16,17

Military Recruitment

Link

Expanded coverage would deck military recruitment – healthcare is a key incentive for attracting new recruits.

Norris 08 Floyd Norris, chief financial correspondent of The New York Times and The International Herald Tribune. "Health's Gain May Be Army's Loss" The New York Times. 30 May 2008. https://www.nytimes.com/2008/05/30/business/30norris.html/. [Premier]

If the Democrats win the election this year, and are able to enact a health care plan that extends adequate coverage to all Americans, the **loser could be the Army**. Getting enough people to enlist could become a major problem for the next president.

Senator John McCain, the presumptive Republican candidate, has already pointed out that Senator Barack Obama, the likely Democratic candidate, never served in the military. It remains to be seen how potent that will be as an issue, given the fact that the last four presidential elections have been won by the candidate with the less impressive military resume.

But there is something else that distinguishes Mr. Obama from all recent candidates for the presidency. He would be the first presidential nominee to come of age after the draft was abolished in the administration of Richard M. Nixon. He never had to decide how to deal with the draft, and legally was under no more pressure to enlist than he was to go to medical school or become a bus driver. Joining the military was a career option like any other.

And that has made it harder to put the Army together. Government polls show that the proportion of young people who think they might enlist is roughly half what it was in the late 1980s. The military has responded with more recruiters and higher cash **enlistment bonuses**, and has met its goals. **A significant factor for many recruits, it turns out, is the military's generous health benefits for dependants.**

Michael Massing, writing in the April 3 issue of The New York Review of Books, tells the story of one part-time college student from Brooklyn, who was holding down two jobs but still going into debt. "Meanwhile, he got married, his wife got pregnant, and he had no health care. From a brother in the military, he had learned of the Army's many benefits, and, visiting a recruiter, he heard about Tricare, the military's generous health plan." He enlisted.

It seems a bit perverse that the incentives for a young person with children to join are greater than the incentives for his childless friend. But that is the way it is. All that **could change** if the push for some kind of national health insurance program were to be successful.

It is true, of course, that Democrats have been talking about such things for generations. The failure of health care legislation during Bill Clinton's first two years in office left some viewing the issue as political dynamite — good for a campaign but fatal to anyone who tries to pass a specific program. It is quite unclear how the government would pay for a comprehensive program, and no candidates seem eager to discuss ways to hold down health care spending.

But if such a program were adopted, it seems likely that the military, and particularly the Army, would feel the immediate effect. To expand the Army, as all the candidates say they want to do, would require some **other incentive for** enlistment, particularly when the economy recovers.

Health care would undermine US Army enlistment---every person covered decreases militarism.

Cebula et al. 09 (Richard Cebula, Usha Nair-Reichert, and Kyle Taylor, Profs of Economics @ Armstrong Atlantic State Univ, Georgia Institute of Technology, and Armstrong Atlantic State Univ.

“Does a Lack of Health Insurance Elicit an Increase in the Rate of Voluntary Military Enlistment in the U.S.? The ”Military Health Care Magnet Hypothesis.” 1974-2007." 4 February 2009. https://webcache.googleusercontent.com/search?q=cache:aDaIiBDd4lUJ:https://mpra.ub.uni-muenchen.de/56719/1/MPRA_paper_56719.pdf+&cd=13&hl=en&ct=clnk&gl=us. [Premier]

Thus, it can be reasonably inferred that the U.S. Army enlistment rate is positively impacted by a stronger institutional and cultural presence of the military (Segal, Bachman, and O’Malley, 1999; Kleykamp, 2006; Cebula, Menon, and Menon, 2008). In addition, the greater the growth rate of real GDP, the lower the enlistment rate (Seeborg, 1999; Warner, Simon, and Payne, 2003; and Cebula, Menon, and Menon (2008). Furthermore, it can be inferred that wartime conditions and the associated greater expected risk of being seriously wounded or killed create a disincentive to enlist (Cebula, Menon, and Menon, 2008). Finally, the coefficient on the health insurance variable is **positive and highly statistically significant**, implying strong support for the “Military Health Care Magnet Hypothesis.” Clearly, these 2SLS findings are all consistent with the OLS findings. 5. Conclusion This study addresses the following question: “Does the unavailability of health insurance act as a incentive for persons to enlist in the military?” Within a cost-benefit framework, the present study endeavors to provide insight into this issue, referred to here as the “Military Health Care Magnet Hypothesis”. The OLS and 2SLS results provide substantial evidence that **the greater the percentage of the civilian population without health insurance, the greater the rate of enlistment in the U.S. Army**. Voluntary enlistment in the U.S. Army also is positively impacted by a greater presence of military veterans (which “promotes” enlistment). Furthermore, it is negatively impacted by a more rapidly growing economy (a proxy for higher opportunity costs) and military conflicts/wars (risk-averse behavior with military conflict being a risk factor that elevates the expected probability of being wounded or killed). Thus, the AVMF (all-voluntary military force) market appears to function as the free enterprise system would expect. Finally, it may be worthy of note that if the “Military Health Care Magnet Hypothesis” is valid, then it logically follows that if a system of de facto universal health care is in fact instituted in the U.S., there may be **unforeseen externalities** from a military recruitment perspective. In particular, implementation of universal health care would naturally result in a decline in the expected gross benefits of enlistment. This is because would-be enlistees will factor the same into their cost-benefit analysis of whether to enlist. Clearly, as the AVMF market factors the availability of universal health care outside the confines of the military into its marginal enlistment decision calculus, for many the expected net benefits (of enlisting) will decline sufficiently as to create a no-enlist decision. In turn, it follows that some form of additional incentives will be needed in order to induce sufficient recruitment/enlistment. We contribute to the debate on universal health care coverage by pointing out the possibility for an unintended consequence, namely a decline in military enlistment. Thus if **universal health care is instituted, it could increase the cost of military recruitment in the future.**

Impact – Readiness

Ground force readiness prevents global nuclear war.

Bonds 17 Timothy M. Bonds is vice president, Army Research Division, and director, RAND Arroyo Center. Bonds has served as a RAND vice president since 2011. Previously, he was deputy director of the Arroyo Center from 2003 to 2011, acting director from March 2009 to May 2010, and, from 1999 to 2003, director of the Aerospace Force Development Program within RAND Project AIR FORCE. Prior to joining RAND, Bonds spent nine years in the aerospace industry, where he led projects to develop high-speed vehicle and weapons concepts. He holds an M.S. in aero/astro engineering from the University of Illinois and an M.B.A. from Washington University, St. Louis. "Limiting Regret: Building the Army We Will Need--An Update." Testimony presented before the House Armed Services Committee, Subcommittee on Tactical Air and Land Forces on 1 March 2017. https://www.rand.org/content/dam/rand/pubs/testimonies/CT400/CT466/RAND_CT466.pdf. [Premier]

As the **Trump** Administration develops its defense policy and strategy, it needs to assess whether further growth in the nation's **ground force** size, capabilities, and posture may be needed.

To begin this assessment, we sought answers to four specific questions: • How is the Army being used now around the globe? • What has the United States committed itself to do? • What regret might the nation have if it does not meet those commitments? • How large a ground force could be needed to meet those commitments?

The final question assumes that the **ground force** would be employed **as part of** joint air, sea, land, space, and cyber operations as one component of national power, in addition to diplomatic, economic, and other measures.

The United States currently maintains forces **worldwide**, as shown on the above map. Specifically, as highlighted on in red, the Army has 68,000 soldiers on rotational deployments to the Baltics, Iraq, the Persian Gulf, Africa, Afghanistan, South Korea, and other places around the world.

These soldiers are deployed on a rotational basis, so it takes more than 68,000 troops to maintain a constant presence in a given theater. For the Army, forces could be deployed for nine months, followed by 18 months at home—a 1:2 deployment ratio. At a 1:2 deployment ratio, 204,000 troops are needed to keep 68,000 troops deployed in the field—68,000 conducting operations, 68,000 just back, and 68,000 more getting ready to go.

Also shown on the map in blue are the 40,000 troops the Army has assigned to US European Command and with the North Atlantic Treaty Organization (NATO); the 22,000 troops forward stationed in South Korea and Japan; and the 17,000 additional soldiers forward stationed in other parts of the world. Because these 79,000 soldiers are home-based in these regions, they are all postured to support contingencies. Finally, the Army has 31,000 soldiers in the United States, providing a variety of support for ongoing missions. (Many of these may be the 23,000 Army National Guard and Army Reserve soldiers on active duty in February 2017). At an end strength of 476,000 regular soldiers, the Army would also have 11,000 soldiers in the continental United States (CONUS) supporting the Global Response Force (GRF), along with other forces available for assigned missions.

Let me also mention the 151,000 soldiers conducting generating-force and strategic activities. At present, about 65,000 new soldiers are undergoing training or education; approximately 46,000 soldiers are organizing, training, and equipping the Army and building the capabilities that the United States will need in the future; and 40,000 soldiers are providing support for joint and national missions, including the 23,000 soldiers in Army Medical Command and the 8,000 soldiers in joint assignments, such as combatant commanders and other senior officials. Additional soldiers are assigned to theater commands, strategic intelligence, U.S. Cyber Command, and other activities that support the DoD.

Given the forces available, the question then is how such forces map against the commitments the United States has made. We list above several recent statements of intent by the Trump Administration. In this testimony, we will focus on three of our commitments that are particularly salient today: our commitment to defeat violent extremism, our commitment to defend our NATO allies, and our commitment to defend South Korea.

First, the national strategy commits the United States to combatting the persistent threat of terrorism. President Trump has specifically stated that "today, we deliver a message in one very unified voice: To these forces of death and destruction, America and its allies will defeat you." 4

However, our current force planning mainly considered efforts to continue to degrade al Qaeda. It turns out that the Middle East is in much worse shape than we assumed in our planned "rebalance" to the Pacific: The Taliban remains a threat to the government of Afghanistan, and the rise of ISIL—and its seizure of population centers—was not anticipated in our force planning.5

Therefore, the forces that have been deployed to these areas **further reduce** our **available capacity** for more **serious threats** to America's security. The next two commitments are related. Our nation has long been committed to assuring allies and deterring, defeating, and denying aggression in multiple theaters. Regarding NATO, in the same speech, President Trump stated that:

We will make a historic financial investment in the Armed Forces of the United States and show the entire world that America stands with those who stand in defense of freedom. We have your back every hour, every day, now and always.6

He has also commented on the fact that many of our NATO partners have not yet met their obligation to increase defense spending to 2 percent of GDP; stating that: That also means getting our allies to pay their fair share. It's been very unfair to us. We strongly support NATO. We only ask that all of the NATO members make their full and proper financial contributions to the NATO alliance, which many of them have not been doing. Many of them have not been even close, and they have to do that.

Our NATO allies have agreed to increase their spending in order to contribute their fair share to our collective security.7

Even if and as they do so, however, it will take some time for those increased investments to result in the needed forces in the field. In the meantime, the United States must decide whether it is willing to bridge this gap with our allies, increasing their share as time goes on.

However, the current force planning in the 2014 QDR does not provide sufficient ground capabilities for the United States to sustain a defense against Russian aggression. The QDR did not anticipate the Russian invasion of Ukraine and its potential implications for the NATO Baltic states. There are some references in the QDR to concerns about Russia's behavior, including: Russia's multidimensional defense modernization and actions that violate the sovereignty of its neighbors present risks. We will engage Russia to increase transparency and reduce the risk of military miscalculation.

Other than that, the QDR force-planning construct does not anticipate what President Obama later described as Russia's "brazen assault on the territorial integrity of Ukraine." Finally, this and previous administrations have long acknowledged the dangers that weapons of mass destruction (**WMD**) pose to the United States, its allies and friends, and their interests. In a phone call with acting South Korean President Hwang Kyo-Ahn, the White House reports that President Trump "reiterated our ironclad commitment to defend the ROK, including through the provision of extended deterrence, using the full range of military capabilities." The statement further reports, "The two leaders agreed to take steps to strengthen joint defense capabilities to defend against the North Korean threat."8

The QDR does address deterring a North Korean attack and countering WMDs to some degree. However, the scope and scale of needed capabilities are not fully addressed. In particular, the QDR does not anticipate the scope and scale of countering provocations that could escalate to a massive North Korean artillery barrage of South Korea. Similarly, the problem of "loose nukes" is described in terms of counterterror and special operations, but not in terms of securing the entire North Korean nuclear program, including an estimated 200 separate sites, from theft and proliferation.9

Given that our most recent defense plans have not completely anticipated current threats, let's examine the regrets that the nation might face if it does not meet the commitments we have made to meet those threats.

For our first example, what might happen if the United States does not continue its missions to defeat ISIL, al Qaeda, the Taliban, and other violent extremist groups around the world? One potential regret is enduring terror movements that continue to **destabilize** vulnerable nations and **whole regions**; harm captured peoples; exploit captured territory to train terrorists, raise funds, and attract new recruits; and export violence to the United States and its allies and friends.

It remains unknown whether currently deployed forces are sufficient to achieve U.S. objectives. In fact, the United States has steadily increased troop deployments to Iraq and Syria and extended the mission in Afghanistan. However, this analysis assumes that U.S. ground forces will remain engaged at their current levels against extremist groups in order to continue to degrade them. Therefore, we assume here that these troops could not be pulled away for other operations without ending this mission. It is also possible that countering violent extremists will require **more troops** if the mission changes—for example, if additional ground troops are committed to combat operations, such as those in Syria and Iraq. Total troop requirements would remain those shown earlier as the worldwide commitments.

For our second example, how might **Russia** take the same course in the **Baltics** that it has taken in Ukraine? Russian "**volunteers**" could enter and destabilize Estonia and Latvia, or worse, **conventional forces** could launch a surprise invasion and present a **fait accompli to NATO**. We estimate that against currently stationed forces, the Russians could reach the Baltic capitals in 36–60 hours. That would leave the President with **few** and **bad choices**. The President could negotiate for the Russians to leave and risk the **fracture of NATO** if negotiations and sanctions drag on for months or years, or the President could choose to launch a counteroffensive to retake NATO territory—against a **nuclear-armed Russia** that has threatened **first use** of **nuclear weapons** to defend its territory from conventional attack and

prevent its military from being destroyed. While the risk of war with Russia is small, and the **risks of escalation** to **nuclear conflict** are smaller still, **neither risk is zero**. Since the human and financial costs of both would be **catastrophic**, it is prudent to **hedge against them**.

Instead, NATO—and the United States—might place armored brigades in the Baltics. These armored brigades, along with other U.S. and NATO forces able to quickly deploy on warning, would be capable of denying Russia a quick victory. Such forces could be permanently stationed or rotationally deployed. These ground forces would be supported by air and sea power from the United States and its NATO allies. The European Reassurance Initiative and the four NATO battalion tactical groups deployed to Poland and the Baltics have made an important statement of alliance commitment and an initial "down payment" on the forces needed, but are not yet close to the amounts required to deny Russia a quick overrun of the Baltics.

If the Russians attacked under this scenario, the United States and NATO would send air, sea, and land reinforcements to deny a Russian victory. **Additional** U.S. and NATO **forces** would be needed to defeat Russian forces and reverse any Russian territorial gains.

We will now assess the numbers of ground forces needed for the missions described above. We will begin with continuing infrastructure tasks, including training new troops, supporting joint missions, and current overseas missions. Adding the forces supporting current missions, we have a demand for 434,000 soldiers to support infrastructure tasks and current missions. This includes the troops who are rotationally deployed; those forward-stationed in Europe, South Korea, and other places; and those supporting generating- and strategic-force operations (but who are not in the GRF or available for other missions). How large of an additional force would be required to deter and defeat aggression in the Baltics (shown here in orange)? For the deterrent force, we estimate that a total of three armored brigades would be needed on the ground in the Baltics on the day fighting started, along with the two U.S. brigades and supporting soldiers already in Europe, and two other U.S. Army and NATO rapid reaction brigades (the 82nd Airborne GRF and the NATO Very High Readiness Task Force) that can deploy to the Baltics on warning. In the future, our NATO allies should be able to provide one or more of the three armored brigades needed. However, in the near term, it is unlikely that any one of these nations would be able to sustain a deployed armored brigade. Therefore, we assume that the U.S. would need to deploy two more armored brigades and a fires brigade in addition to the forward stationed forces already in Europe and the armored and aviation brigades already deployed in a "heel to toe" fashion. In total, 36,000 additional soldiers would be needed over and above those already forward stationed or rotationally deployed to Europe. When deployed at a 1:2 rotation ratio, keeping 36,000 soldiers on the ground in the Baltics requires 108,000 soldiers to maintain a continuous presence. Including the 283,000 soldiers forward deployed in or rotating to Europe and other theaters, and the 151,000 soldiers engaged in infrastructure activities, a total of 542,000 soldiers would be required for these activities alone. This number exceeds the 476,000 soldiers now planned for the regular Army, forcing the DoD to reduce day-to-day operations, continuously deploy 66,000 National Guard or Army Reserve soldiers, grow the regular Army, or take some combination of these measures. Worse, this leaves no margin for higher demands if deterrence fails and war breaks out in Europe, Korea, or elsewhere in the world. In wartime, therefore, the DoD might be compelled to suspend troop rotations to maintain sufficient numbers of forces to meet contingency needs. From this point on in this testimony, we will discuss wartime demand, with troops deployed without rotation for the duration of a conflict. Such extended deployments for the duration of the conflict will impose extraordinary strain on troops and their families. (We should also note that some troop rotation will still be needed within theaters, so battle-worn units can pull back from the line for rest, refit, and replacement of casualties). If troop rotations to all theaters are suspended, including the deterrent force in the Baltics, troop demands will decline somewhat. The additional demand in the Baltics would decline to the 36,000 soldiers deployed at any one time; demand for the combination of other theaters would decline to 146,000, while the demand for infrastructure forces would remain steady at 151,000 soldiers. The total troops needed for these missions would decline to 334,000 soldiers when on a wartime footing. Additional troops would be needed if the Russians were not deterred and decided to invade. To expel the invading Russian forces, we estimate that an additional 85,000 U.S. troops, including six armored brigades and associated artillery, aviation, headquarters, and other supporting troops, would be needed to defeat a Russian invasion (shown in brown), along with eight brigades and a similar number of troops from our NATO allies. This raises the total U.S. troops needed to around 420,000 soldiers. This includes soldiers tasked to conduct infrastructure missions, continue current missions around the world, and deploy the U.S. contribution to the NATO deterrent and war-winning forces shown above. Once again, this assumes a wartime footing for all of these troops with no rotations of soldiers. We now turn to a third example—a war resulting from a provocation cycle that escalates to a North Korean attack on South Korea.

Current DoD force planning seems to focus on an invasion threat to South Korea from **North Korean** forces, as depicted on the map. But the threat is changing. A provocation cycle could escalate out of control and lead to an artillery **barrage of Seoul**, involving some of the 10,000 artillery pieces and multiple rocket launchers, firing from hardened positions that the DoD believes to be in range of South Korea.10 Or **North Korea** might collapse as a result of war or economic failure, leaving up to **200 nuclear**, chemical, and biological program **sites** unsecured (as represented by dots on the map above)..11

In **either event**, a **significant burden** would fall on **U.S. forces**. To counter North Korean artillery, U.S. ground forces would need to provide forces to evacuate U.S. noncombatants; engineering, logistics, and maneuver units to sustain South Korean and U.S. operations to clear artillery within range of Seoul; WMD-elimination task forces to secure chemical or nuclear munitions deployed with artillery units; and ground combat forces to protect each of these types of units.

South Korean forces would also be stretched to gain control over North Korean military forces, exert political control over territory captured, and deal with a massive humanitarian catastrophe—all at a time when the South Korean Army is decreasing in size by one-third from its peak.

For these reasons, countering an artillery barrage or **North Korean WMDs** would require **significant U.S. ground forces**.

Trust

Link

Single payer collapses trust.

Klein 17 Erza Klein, editor-at-large and founder of Vox. "Yes, Bernie Sanders's plan moves America closer to single-payer," Vox News. 15 September 2017. https://www.vox.com/policy-and-politics/2017/9/15/16304082/bernie-sanders-single-payer-medicare. [Premier]

Advocates of single-payer argue that a single-payer system would be better than America's health care system, and they're right. Single-payer could, in theory, achieve true universal coverage at significantly less cost. But then, a lot of possible systems could be better than our current system in theory. The problems lurk in the **transition from policy paper to reality**. For single-payer in particular, three problems stand out, and Sanders's plan solves none of them: First, Americans don't much trust the government, and they're **particularly risk-averse** when it comes to health care. The core feature of a single-payer system is, well, that there's only a single payer. So Sanders's plan makes it illegal for employers to offer benefits duplicative of his new program, and he folds all existing government insurance programs save for veterans care and the Indian Health Service into the new system. The upshot of that is Sanders's proposal will **cancel the existing insurance plans of** more than **250 million people**. It's a level of disruption that **no social reform in American history has dared** attempt. Sanders refuses to admit that this will actually be experienced as disruption. That's the context for his comment that "it's not a question of switching plans." His argument is that no one will have to switch providers, and that's all anyone really cares about. "You go to the same doctor. You go to any damn doctor you want to go to," he says. This fails on a few levels. First, you may well not be able to go to the same doctor. A reform of the size Sanders envisions will have **vast and unpredictable consequences** throughout the health system. At the simplest level, insuring 30 million more people, and freeing everyone else from financial constraints on care, will **sharply increase demand**, and overwhelmed doctors will change how they practice. On the other side, the core way this bill will save money is by using the government's pricing power to **pay doctors and hospitals less**, and that means **some will go out of business**, others will begin taking only richer patients who can pay out of pocket, and so on. But even if that weren't true, it's still the case that there will be a period of time — multiple years, in fact — between when people are told their insurance plans will be **canceled** and when they're moved onto the new system **run by a government many of them don't trust**. And this is happening in a bitterly divided country, where even a reform as comparatively mild as **Obamacare** led to widespread belief in "**death panels**" and armed IRS agents going door to door. Imagine this playing out on Fox News. Even now, about a third of Americans hold a negative view of Sanders — how will they react as Fox News covers President **Sanders's effort to take away their health insurance and replace it with socialism?**

The public is suspicious of government and would hate the transition from paying premiums which are hidden costs to taxes which are highly visible---that turns the case because it means single payer shreds the public support necessary for continued policy improvement.

Hacker 18 Jacob S. Hacker, Stanley Resor Professor of Political Science at Yale University. "The Road to Medicare for Everyone." The American Prospect. 3 January 2018. http://prospect.org/article/road-medicare-everyone. [Premier]

These are questions I've struggled with for a long time. As a health policy expert, I'm one of the many social scientists and historians who've sought to understand why the American framework of health insurance looks so different from the systems found in other nations. Why do

we spend roughly **twice as much per person** as any other nation while leaving tens of millions of people without insurance and many times more with inadequate protection—all with worse health outcomes?

The basic answer is simple: **Americans are distrustful of government**, and America's fragmented political institutions make transformative policies hard to enact, especially when they're opposed by powerful interest groups. Even at the height of the Great Depression, with overwhelming Democratic majorities in Congress, FDR decided not to include health insurance in the Social Security Act of 1935, because he feared the opposition of physicians would kill the whole bill.

FDR's decision turned out to be fateful. With America's entry into World War II, the nation's agenda shifted away from domestic affairs. Unions, corporations, and private insurers stepped into the breach—thanks in part to favorable tax laws and federal support for collective bargaining—and by the 1950s, the majority of working-age Americans got health benefits at work. By the time advocates of government insurance finally had another bite at the apple after LBJ's landslide election in 1964, they had strategically retreated to the goal of covering those left out of the employment-based system: the elderly and the poor. The result was Medicare and Medicaid—the biggest step toward universal health care until the passage of the Affordable Care Act.

The system was a mess, but it was also a minefield. You had a huge insurance industry, allied with a range of profitable sectors that benefited from its open checkbook, from drug manufacturers to medical device makers to highly paid specialists. You had excessive costs that government could finance only with hefty taxes. Most important, for every unfortunate American who fell through the cracks, you had eight or nine more who had benefits at work or through Medicare or Medicaid. To make matters worse, most of these eight or nine **had no idea how much their health benefits really cost**, because the expense was hidden in their pay packages or spread across all taxpayers.

It would be hard to design a **less welcoming context for single-payer**. Enacting a universal program meant taking on a lobbying juggernaut to **impose taxes on people generally suspicious of government**, most of whom were insulated from the true costs of their care. Our unique health-financing system was a reflection of our unique political hurdles. But increasingly it was the system itself that posed the biggest hurdle of all.

There's a lesson in this history: The struggle over health care has always been about **politics as much as policy**. The evidence that the American model is inferior is overwhelming, and many policies would make it better. The challenge is figuring out how to **overcome the political barriers** to pursuing those policies—not only to get them passed, but to **ensure that they foster the political conditions for continuing improvement**.

Impact – Vaccines

Vaccinations are increasing!

Kluger 16 Jeffery Kluger, editor at large, oversees TIME's science and technology reporting. He has written or co-written more than 40 cover stories for the magazine, "Vaccine Rates Are on the Rise in the U.S." Time Magazine. 29 July 2016. time.com/4430377/vaccines-good-news/ [Premier]

The anti-vaccine movement has always had two things working against it: science is patient and parents, armed with accurate information, make smart choices. That's a pretty powerful combination, especially when what's at stake is the health of children. Now, after years of falling vaccination rates and alarming outbreaks of measles, whooping cough and other vaccine-preventable illnesses, the trend lines at last appear to be changing.

In a study conducted by the medical news and information service Medscape, investigators surveyed 1,551 physicians, nurse practitioners and physicians' assistants in family practices across the U.S. to ask them about vaccine compliance among their patients and the reasons parents were giving for accepting or declining vaccines. The results were both encouraging and enlightening.

Broadly, the investigators report that 46% of parents said they were more accepting of vaccines overall, while only 12% were less accepting, and 42% say their view had not changed. Meanwhile, 44% of parents say they are more inclined to allow their children to be vaccinated according to the recommended schedule, 14% are less inclined and 42% have not changed their opinion.

Maintaining trust is key to vaccinations---it can reverse

Ward 17 Ward, Paul Russell, Professor at Flinders University, Head of Public Health. "Improving Access To, Use Of, and Outcomes from Public Health Programs: The Importance of Building and Maintaining Trust with Patients/Clients." Frontiers in Public Health, vol. 5. PubMed Central. 8 March 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5340761/. [Premier]

Trust in Childhood Immunizations Childhood immunization programs have been so effective in the elimination of infectious disease that they have become a victim of their own success (79), with some people now **questioning** the need for childhood immunizations due to their **perception** that certain diseases are **rare and therefore less concerning** (80). Public health practitioners thus have to **engage with, and promote the benefits of, vaccination** to groups who are increasingly **unlikely to have encountered** some of **the diseases** they are being asked to vaccinate their children against. The increasing debate in Western society regarding the real or perceived adverse events following vaccination has made some parents **"uneasy"** about the decision to vaccinate their children (81). This "unease" or "uncertainty" is called **"vaccine hesitancy"** (82), and approximately **20–30% of all parents** in some countries are **vaccine hesitant** (80, 83). The literature attempting to understand this phenomenon reveals **mistrust as a key factor**, but there lacks a rich theoretical exploration of the interaction between trust and vaccine hesitancy and specifically how trust in vaccines is eroded and maintained. There are a number of concerns that parents hold regarding vaccines, mostly centered on concerns about vaccine **safety** (84). The immunization process induces complex, emotional decisions in some parents who are faced with potentially difficult choices, such as attempting to balance the individual rights of their child with the broader health protection of the community (85). Other widely held concerns by vaccine hesitant parents are as follows: the perceived high number of vaccinations given to children; that health professionals may provide inadequate information; that health professionals are perceived to be unwilling to spend adequate time providing vaccine information; and that vaccines may be perceived to overload their child's immune system, vaccine components may be harmful, and

alternative medicines may suffice in place of vaccines (84). The final concern regarding vaccine hesitancy concerns trust. Not only do some parents distrust the medical system but anything recommended by government institutions (83). A core research question that resulted from the 2014 report by American Academy of Arts and Sciences, entitled "Public Trust in Vaccines: Defining a Research Agenda" was, "To what extent does vaccine hesitancy result from broader distrust in government and science" [(83) p. 10]. This question resonates with other recent literature which cites "trust" as critically important in the decision for parents to vaccinate (86–89). Trust in vaccines and vaccination is complex: it describes a continuum of trust from the funding of immunology research, to vaccine design and manufacture, through government decision making regarding which vaccinations to fund for immunization programs, to the point at which a vaccine is administered by the medical provider to the individual. The parental decision to vaccinate or not is both the beginning and the end point of the vaccine journey and if distrust is evident at any point in this journey then there is a potential for **vaccine rejection**. **Public trust in** vaccinations, and the **health professionals** who promote them, has been identified in the literature as **pivotal** in determining whether parents will decide to immunize their child (80, 90). Parental perceptions of insufficient, **biased**, poorly communicated **advice** from health-care providers is noted in the literature as **key to a lack of trust in vaccinations** (90) with the result that individuals may turn to the **internet** for advice, where they may compound their confusion with a multitude of **conflicting and unregulated material** so that it is difficult to discriminate between the evidence-based sources and those based on anecdote and misinformation (87, 91). Maintenance of institutional trust is **paramount** to immunization programs. For example, concerns regarding trust in institutions involved in vaccinations during the **2009 influenza H1N1 pandemic** led to increasing hesitancy to vaccinate, linked to conspiracy theories, and speculation that the pandemic response was influenced by commercial interests (79). This distrust was further promulgated in Australia when the 2010 seasonal influenza vaccine for children was withdrawn due to an observed increase in febrile convulsions, later found to be linked to one vaccine brand. Despite the resumption of the vaccine program with other vaccine brands, persistent mistrust, and confusion is linked to a decline in influenza vaccination coverage. It is also argued that institutional trust is being eroded by current social trends toward patient advocacy, empowerment, and patient choice, being at odds with the traditional approach to public health programs, which is increased further with virtually unlimited access to health information via sources, such as social media and the internet (79). Given the importance of understanding parental (dis)trust in childhood immunizations, I am currently part of a research team undertaking in-depth qualitative research to further develop our understanding. Our first paper from this study outlines the ways in which broad distrust in multinational pharmaceutical companies impacts some parents trust in childhood vaccinations and their decisions not to vaccinate their children (92). A number of parents perceived that pharmaceutical companies were motivated purely by profits and had the global power and reach to influence governments and research institutions and thus questioned whether they were indeed "working for the best interests of children", a key issue in trustworthiness. The immunizations were therefore imbued with distrust, not necessarily due to the ingredients of the vial, but the various institutions that have created and marketed it. Rebuilding trust in this example may require "distancing" the immunization from the pharmaceutical companies and being clearer on the independence of researchers (and the scientific system) and governments (and the political system) in making decisions on childhood immunization policy and practice. Conclusion Contemporary public health systems are located historically and culturally within a society whereby individuals question, research, interrogate, and seek alternatives to "traditional" approaches to health and illness. The push to modernity has meant that public health practitioners can **no longer just assume** that patients or the public will simply **"trust" them** because of their position in society or their extensive training. Therefore, trust needs to be **won and kept** because "trust **comes on foot and goes away** of **[on] horseback**" (93) (p. 389). In other words, once trust has been lost, it is very difficult to regain it. This is critically important because, as I have shown using numerous examples from different areas of public health, people who distrust public health services are **less likely to use them**, **less likely to follow advice** or recommendations, and more likely to have **poorer health outcomes**. Therefore, public health practitioners need to understand the **centrality of trust in their roles**. They need to understand the importance of engaging meaningfully and in a trustworthy fashion to build and maintain trust in those groups who are currently mistrusting and to maintain trust in all other groups.

Impact – Bioterror

Declining trust in government collapses bioterror response

Barbeschi 17 Barbeschi, Maurizio. Scientist for the World Health Organization. "A Global Catastrophic Biological Risk Is Not Just About Biology." Health Security Journal. 1 August 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5576194/. [Premier]

Given the multifactorial nature of a biological (catastrophic) hazard, the interventions that would help stop a situation from evolving into a catastrophe would be event specific. What would the impact of the same Nigeria Ebola case be if it happened in Paris, New York, or Rio or New Delhi, where you have different health systems, different media approaches, different anthropological behavior, a different baseline of vaccination, and so on? The media in New York may say, "We have a problem, everybody stay at home," and people will follow it. If in other parts of the world, you say, "Stay at home," the answer may be, "Mmmm, they're possibly going to steal my car. Why would they say to stay home?!"

So, in addition to vaccines, hospitals, plans, and countermeasures, **any intrinsic distrust** between the majority of people and the government can be **very influential** in a biological event. In that case, if you want to send a message, you talk to the footballer and say, "Look, tell the people to stay home," and they may listen to him. Even if I try to give you a vaccine, nowadays will you take it? What is the root of such mistrust? As far as interventions to prevent a biological catastrophe, we need research regarding the vaccine, but **also research regarding trust**—the "social" elements, if you will.

Impact – Pandemic Response

Trust is a key determination of behavior in pandemics – shared values are key.

Prati 11 Gabriele Parti, Department of Education, University of Bologna, "Compliance with recommendations for pandemic influenza" H1N1 2009: the role of trust and personal beliefs." Health Educ. Res. 26 October 2011. https://pubmed.ncbi.nlm.nih.gov/21613380/. [Premier]

Results showed that media trust and trust in the Ministry of Health were related to all recommended behaviors. The results for trust are in line with Tang and Wong's study [8] concerning SARS and Rubin et al. study [4] concerning pandemic influenza H1N1 2009. However, this study showed that participants who complied with recommended behaviors had higher trust in media and health ministry regardless of what they did concerning this risk. In other words, there have been participants who perceived that the media had exaggerated the risks and that health ministry is not doing a good job of dealing with this risk, still they complied with recommended behaviors because of their trust in media and health ministry. **These results may suggest that it is important to build trust and commitment in advance of a pandemic outbreak**. This is especially true during emerging health threats when people may be concerned about sensationalism and may feel distrust toward the government [23]. In contrast with a previous study [4], we found an effect of the Topo Gigio campaign, however, this effect was limited in line with another study of evaluation of a cold/flu self-care public education campaign [19, 24]. This limited evidence calls for renewed strategies that will significantly increase stated compliance with the official recommendations in a timely and massive scale. It should be noted that a recently published study showed that exposure to media reporting or advertising coverage was associated with recommended behaviors through the mediation of perceived knowledge about swine flu and perceived efficacy of hygiene strategies [25]. While these results suggest that media campaign may have an influence on stated compliance with the official recommendations, the results of the present study indicate that trust is an essential element of the communication strategy. According to Earle and Cvetkovitch's perspective, social trust may be increased by telling stories expressing salient values that are similar to the receivers [26, 27]. More specifically, according to this perspective, **people do not infer trustworthiness from direct evidence rather from value-bearing narratives**. **Thus, social trust depends on salient value similarity, in other words, the shared sense between the institution and the public of what are the important goals** and/or processes that should be followed in a specific situation. Affective reaction to risks such as worry was found to be as important in predicting recommended behaviors as cognitive dimensions of risk perception. Whereas several models of health behavior recognized as key determinants of protective or preventative behavior cognitive factors (e.g. risk perception) [14, 15], this study provides further evidence for the role of emotions [4, 8, 11, 15–17]. In line with the literature [4, 15], we found that people who believed that there is currently a high risk of catching influenza (likelihood of infection), that it is possible to control their risk of catching this illness (control) and that did not think that the media had exaggerated the risks of catching influenza tended to comply with recommended behaviors. These findings endorse the policy of providing the public with clear consistent information, which report the risks, focuses on the practical things that people can do to reduce their risk and emphasizes the efficacy of recommended behaviors. A challenge for public health authorities is to deliver a communication aimed at increasing the perceived likelihood of infection without exaggerating the risk.

Blocks

AT: Costs

Costs manageable now.

Slatter and Kuehner-Heber 17 Marlene Y Satter, Covered the financial industry since 1997, first for Investment Advisor magazine, and Katie Kuehner-Hebert, Award-winning Freelance Journalist and Ghost Writer. "Health care pricing slows as employers' cost rises." BenefitsPro. 18 July 2017. http://www.benefitspro.com/2017/07/18/health-care-pricing-slows-as-employers-cost-rises. [Premier]

As the expansion of health care coverage due to the Affordable Care Act is slowing, so, too, is health care spending, according to the Altarum Institute Center for Sustainable Health Spending's Health Sector Trend Report June 2017. "The 2016 decline in prescription drug spending and net cost of insurance is indicative of the **slowing expanded coverage from the ACA**," the authors write. "Spending on health care services dropped to 5.1 percent growth in Q1 2017, perhaps signaling that the **expected slowdown has finally begun."** Paul Hughes-Cromwick, Altarum's codirector of the Center for Sustainable Health Spending, says that prices across hospitals and in other health care sectors have only increased by 1.6 percent in May, compared with a year ago. That's the slowest rate of increase since June of 2016. And hospital prices were even slower to rise, at just 1.5 percent in May. Hughes-Cromwick says that an April rate of 1.8 percent has driven down the 12-month moving average for health care prices to 1.9 percent for the third straight month. Hospitals have been trying to get ahead of slowing prices by several years of cost-cutting, so that they can protect their margins against pricing pressures. Meanwhile, the health care services industry now accounts for more than 15 million jobs, about 10.8 percent of all U.S. jobs — **an all-time high**, according to the report. While hospitals account for 45 percent of health services spending, their share of health services jobs is only 33 percent. Physician practices account for 28 percent of spending, but only 17 percent of jobs. The remaining services, including nursing homes, home health, dentists, and other ambulatory services, account for more than half of all jobs, but only 27 percent of spending. In addition, with consumers shopping around and looking for better pricing and transparency for care, Hughes-Cromwick says, the **downward pressure on pricing will only continue**—particularly since ever more consumers have to fork over increasingly growing deductibles before their insurance kicks in.

Health care cost growth is slowing

Sanborn 17 Beth Jones. "Healthcare spending, price growth slows in 2017 but job growth spikes." *Healthcare Finacne News*. 30 August 2017. http://www.healthcarefinancenews.com/news/healthcare-spending-price-growth-slows-2017-job-growth-spikes. [Premier]

Healthcare spending growth slowed in 2016, and **the trend appears to be continuing**, according to the August 2017 Altarum Institute Center Health Sector Trend report. According to the report, spending grew by only 4.6 percent in 2016 and estimates based on new data have the downward trend continuing with growth for the first half of 2017 at 4.4 percent. Altarum said the estimates illustrate the impact of expanded coverage, and its subsequent leveling off, on healthcare utilization. Coverage expansion was concentrated in 2014 and 2015, leading to a jump in health services utilization. That peaked at at 5.1 percent in 2015. "Coverage leveled off in 2016 and, in response, the growth in health services utilization has been trending back toward pre-expanded coverage rates," Altarum said. Healthcare price growth has also dropped in 2017, from 2 percent in the first quarter to 1.6 percent in the second quarter. Though much higher than healthcare services, prescription drug price growth slowed to 3.6 percent in the second quarter 2017. However it is important to note that the impact of rebates are not reflected in these data, and that drug pricing controversies like the one surrounding Mylan's EpiPen were recently resolved and some generic alternatives have been made available at lower prices. Finally, health employment grew an average of 21,000 jobs per month during the first 5 months of 2017 then unexpectedly rebounded to 38,000 in June and July. The jump in June and July was a surprise, and was focused mainly in ambulatory settings. "Growth averaged 32,000 during 2015 and 2016, and the decline in monthly growth during the first 5 months of 2017 was expected

due to slower growth in health care utilization driven by the leveling off in expanded coverage," Altarum said. The American Hospital Association's February 2017 Cost of Caring report also illustrated the increased utilization in 2014 and 2015, due to expanded healthcare coverage and more intense utilization of services like chronic disease management. However, the report mentioned that statistics also suggested that hospitals are trying to hold costs down. For instance, hospital price growth in 2015, as measured by the Hospital Producer Price Index, was .9 percent, a 13-year low and a notable drop from the rate of 4.4 percent in 2006, the report said. Growth in Medicare spending for all hospital services, both inpatient and outpatient, is at a 17-year low, and inpatient spending dropped 1.9 percent in 2015. So it is possible that along with a leveling off of coverage and utilization, successful hospital attempts at stabilizing or reducing cost of care could be responsible for the lower spending. The slowing in hospital price growth in the Altarum report is also illustrative of these theories.

AT: Access

Increased usage and decreased reimbursed would deck quality of care.

Moffitt 19 Robert E. Moffit, Senior Fellow, Health Policy Studies. "New "Medicare for All" Bill Would Kick 181 Million Off Private Insurance." Heritage Foundation. 11 April 2019. https://www.heritage.org/medicare/commentary/new-medicare-all-bill-would-kick-181-million-private-insurance. [Premier]

If the Senate bill—or some version of it, such as the House Democratic bill—were to become law, ordinary Americans could surely expect three major consequences.

1. **Slower care.**

With a single government health program designed as an entitlement for 327 million Americans—providing services "free" at the point of service—**utilization** would explode. Americans would face long waiting lists, delays, and even denials of medical care. It would be unavoidable.

The experience of "single payer" countries, like Britain and Canada, shows that **waiting lists** for medical treatment are common, especially for hospitalization and specialized medical services.

2. Even **fewer doctors** available.

Today's doctor shortage, fueled by accelerated retirements and physician burnout, would surely worsen. Beyond imposing Medicare's huge regulatory regime and its paperwork burden on the entire nation, the Senate bill would impose Medicare payment rates (rates lower than private insurance) as the means to reduce reimbursement for all doctors, hospitals, and medical professionals. Former Medicare Trustee Charles Blahous estimates that this would translate into a stunning **40% decline** in medical reimbursement.

While leftist ideologues might vigorously applaud such a radical reduction in physician payment as a major source of health care "savings," the negative impact on patient **access** and **quality of care** would be incalculable.

Medicare vastly underpays providers for the cost of care.

Atlas 20 Scott W. Atlas, Senior fellow at Stanford University's Hoover Institution. "The Dangers of Medicare for All." The New York Times. 9 March 2020. https://www.nytimes.com/2020/03/09/opinion/medicare-for-all-cost.html. [Premier]

Beyond that, Medicare for All will radically change health care for retirees because the services they get from hospitals and doctors are in effect subsidized by higher payments from **privately insured** patients. According to a report by the Centers for Medicare and Medicaid Services, while private insurance often pays over **140 percent** of the cost of care, Medicare and Medicaid pay an estimated **60 percent** of what private insurance pays for inpatient services, and an estimated 60 percent to 80 percent for physician services. Most hospitals, skilled nursing facilities and in-home health care providers already lose money per Medicare patient. By 2040, under today's system, approximately half of hospitals, roughly two-thirds of skilled nursing facilities and over 80 percent of home health agencies would lose money overall.

The estimated $32 trillion cost of Medicare for All includes the immediate cuts of about 40 percent to hospitals and about 30 percent to doctors now treating patients under private insurance, with these cuts likely growing more severe over time. Will these cuts occur without **hurt**ing **timeliness** or **quality of care** for patients?

Retirees rely on supplemental private insurance.

Atlas 20 Scott W. Atlas, Senior fellow at Stanford University's Hoover Institution. "The Dangers of Medicare for All." The New York Times. 9 March 2020. https://www.nytimes.com/2020/03/09/opinion/medicare-for-all-cost.html. [Premier]

Here's another truth — abolishing private insurance would **harm** today's **retirees** on Medicare, because more than 70 percent of them use private insurance in addition to or instead of traditional Medicare. About 29 percent of those enrolled in traditional Medicare (A and B) buy "Medigap" plans, state-based private insurance that supplements non-drug Medicare benefits.

Twenty-two million other beneficiaries, 34 percent, enroll in alternative private Medicare Advantage health plans to replace traditional Medicare, a number doubling in the past decade. And millions of Medicare beneficiaries buy private prescription drug coverage in Part D.

Can't solve---cost is just one factor for avoiding care, tons of alt causes

Taber 14 Jennifer M. Taber, Ph.D Psychology, Bryan Leyva, B.A, and Alexander Persoskie, Ph.D, Psychology. "Why do People Avoid Medical Care? A Qualitative Study Using National Data." J Gen Intern Med, 30(3). March 2015. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4351276. [Premier]

Data were collected as part of the **2008 Health Information National Trends Survey, a cross-sectional national survey.** Participants Participant-generated reasons for avoiding medical care were provided by 1,369 participants (40% male; Mage=48.9; 75.1% non-Hispanic white, 7.4% non-Hispanic black, 8.5% Hispanic or Latino/a). Main Measures Participants first indicated their level of agreement with three specific reasons for avoiding medical care; these data are reported elsewhere. We report responses to a follow-up question in which participants identified other reasons they avoid seeking medical care. Reasons were coded using a general inductive approach. Three main categories of reasons for avoiding medical care were identified. First, over **one-third** of participants (33.3% of 1,369) reported unfavorable evaluations of seeking medical care, such as factors related to physicians, health care organizations, and affective concerns. Second, a subset of participants reported **low perceived need** to seek medical care (12.2%), often because **they expected** their **illness** or symptoms **to improve** over time (4.0%). Third, many participants reported traditional barriers to medical care (58.4%), such as high cost (24.1%), no health insurance (8.3%), and **time constraints** (15.6%). We developed a conceptual model of medical care avoidance based on these results. Conclusions Reasons for avoiding medical care were nuanced and highly varied. Understanding why people do not make it through the clinic door is critical to extending the reach and effectiveness of patient care, and these data point to new directions for research and strategies to reduce avoidance. People often avoid seeking medical care even when they suspect it may be necessary;1–4 nearly one-third of respondents in a recent national United States (U.S.) survey reported avoiding the doctor.5–7 Even individuals with major health problems4,8,9 or who are experiencing symptoms10–12 avoid seeking medical care. For example, in one study, 17% of patients diagnosed with rectal tumors reported that they waited a year or more to seek medical consultation after noticing symptoms, with some waiting up to five years.12Avoiding medical care may result in late detection of disease, reduced survival, and potentially preventable human suffering.1,8,13,14 In the present study, we sought to understand why people avoid seeking medical care. Avoidance of medical care has been defined as "keeping away from something [in a medical context] that is thought to cause mental or physical distress."8 Avoidance can also occur as a result of barriers, which can be defined as factors that limit access to or ease of obtaining quality health care (e.g., financial concerns, time constraints).1,15Avoidance of medical care can occur at any point on the disease continuum, including preventing and detecting asymptomatic disease, noticing symptoms and interpreting their significance, seeking care after determining a potential need, and complying with recommended treatment.1,2,16 Of note, the term "patient delay" has also been used to describe phenomena related to avoidance, but guidelines for research on early cancer diagnosis have suggested instead using the more informative terms "appraisal interval" (the time taken to interpret symptoms) and "help-seeking interval" (the time taken to seek care after determining a need).17 To date, research on avoidance of medical care has been limited in the extent to which it examines the broad spectrum of reasons for avoidance (but see 7), often focusing on specific factors such as barriers or psychological characteristics (e.g., lack of insurance, fear of a diagnosis).4–6,15,18–24 A conceptual review of reasons people avoid medical care identified only six qualitative or mixed-methods studies assessing participant-generated reasons, all of which used convenience samples with predominately white participants.1Moreover, five of the six studies reviewed assessed avoidance of specific procedures.1 The exception was a focus group study among a sample of Hispanics that explored reasons for avoiding medical visits in response to warning signs of heart disease, cancer, and diabetes.11 This qualitative study identified factors such as low trust in doctors, low perceived severity of symptoms, emotional factors (e.g., denial, avoiding worry, embarrassment), practical barriers, and prior negative experiences as contributing to avoidance.11 Given the significance and prevalence of medical care avoidance in the U.S.,1,5 there is a need for continued basic qualitative research that can uncover the reasons underlying this phenomenon. Simply put, why do people avoid medical visits that could save lives or reduce suffering, whether through early detection of disease or timely treatment? To help answer this question, the present study used data collected from a large national sample. The purpose of the study was to identify the reasons people avoid seeking medical care and to classify these reasons into conceptually distinct categories reflecting underlying factors contributing to avoidance. Ultimately, we sought to develop a model of medical care avoidance that can inform efforts to promote care-seeking, help providers reduce avoidance in their patient populations, and promote theoretical advancement in this area of research. Data Source **Data were obtained from the National Cancer Institute's 2008 Health Information National Trends Survey** (HINTS). This cross-sectional survey collects data from a nationally representative sample of civilian non-institutionalized adults aged 18 and over in order to assess trends and patterns in health communication. Data were collected from January through April 2008. Phone and mail surveys were administered to maximize response rates (24.2 and 31.0 %, respectively). The

survey was completed by 7,674 participants. Details of the study design have been published elsewhere.25–27 Measures Participants were first asked whether they "avoid visiting their doctor even when they suspect they should." Participants who responded "yes" (n=2,327) were then asked to what extent they endorsed three researcher-identified reasons for avoiding the doctor (i.e., feeling uncomfortable when their body is being examined, fear of having a serious illness, and because it makes them think of dying); results concerning these items have been published elsewhere.5,7,18,24 Next, participants were asked whether there were "any other reasons why you avoid seeing your doctor," and either wrote their response in a small box if completing a mail survey or stated their response to an interviewer, who summarized their response, if completing a phone survey. Responses were brief and typically consisted of a short phrase or sentence. Interpretable responses were provided by 1,369 participants (58.8% of those who reported avoidance in response to the initial question). Eight participants provided uninterpretable responses either because they failed to provide a reason (e.g., "don't know") or because it was impossible to determine the motivation (e.g., "ambivalence" or "family tradition"), with 164 participants listing more than one reason. Data Management and Analytic Approach An independent research company was contracted to preliminarily clean the participant-generated responses (n=1,377; see 7 for a report of these uncoded responses) by using short phrases to standardize responses (e.g., "Busy" and "I'm too busy to go to the doctor" were recoded into "Too busy"). A prior study reported the top five of these uncoded responses (i.e., preference for self-care or alternative care, dislike or distrust doctors, fear or dislike of medical treatments, time, and money) and predictors of these responses.7 For the present study, the three study authors analyzed these short phrases provided by the research company in conjunction with participants' raw responses using a general inductive data analysis approach, a method in which a theory or conceptual model is developed through an iterative process of coding, grouping codes into categories based on underlying concepts, and forming a model or generating hypotheses based on the data.28,29 Coding was conducted by discussion of each participant response among all three authors; in rare cases when two authors disagreed, the third author acted as arbiter. Through this process, the authors identified emergent codes and collapsed and re-conceptualized existing codes as necessary. After assigning codes, all authors participated in an iterative process of placing codes into sub- and superordinate categories. The goal of the coding and categorization was to identify conceptually distinct factors underlying reasons for avoiding medical care, and to organize these factors into a conceptual framework that could provide targets for intervention and stimulate further research on avoidance. Upon completing the coding and categorizing, we reviewed existing theory on care-seeking and avoidance to determine whether our data provided support for a pre-existing theory or whether we should develop a new theory and/or model. We provide quantitative counts of the number of respondents, listing each reason in order to convey the frequency of responses, and qualitatively describe themes to provide context and explanation. Among participants who indicated avoiding medical care, characteristics of those who provided qualitative responses (n=1,369) compared to those who did not (n=958) are shown in Table 1. Participants who provided responses were more likely to be white, female, younger, married, born in the U.S., to have completed the survey by phone, and to have higher income and education, but were less likely to have health insurance. Of the 1,369 participants who provided interpretable "other" responses, fewer than half (43.5%, n=595) endorsed at least one researcher-identified reason (answered "agree/strongly agree" versus "disagree/strongly disagree") for avoiding medical care. Approximately one-fourth reported avoiding medical care because of feeling uncomfortable (26.8%, n=369) or fearing a serious illness (26.4%, n=363), with substantially fewer reporting avoiding medical care because it made them think of dying (8.2%, n=113). From the analysis of participant-generated qualitative reasons for avoiding the doctor, we identified three overarching, conceptually distinct categories of reasons for avoiding medical care based on whether participants perceived seeking medical care to be necessary, available to them as a course of action, and favorable or beneficial. In the first category, "low perceived need to seek medical care," responses indicated a determination that seeking medical care was unnecessary. In the second category, "traditional barriers to medical care," responses indicated that seeking medical care was not an option because of a lack of resources. In the third category, "unfavorable evaluations of seeking medical care," people evaluated some aspect of the care-seeking process as negative. A fourth category, labeled "personality traits," was also identified as a reason for avoidance that did not fall into any of the three major categories. Each category and relevant subcategories are described in detail below and outlined in Fig. 1. Low Perceived Need to Seek Medical Care Many responses, coded as "low perceived need," indicated the belief that seeking medical care was unnecessary (n=167). The most common reasons were that medical problems would either "improve over time" or "improve on their own" (n=55; e.g., "Whatever the symptoms, time will make it better"; "I believe the body will heal itself in most cases"). Participants often indicated that this was contingent on the problem not being very serious (e.g., "What I have will pass. I only go if I think it is serious"), with many stating not being "sick enough" as a reason for avoiding medical care (n=40; e.g., "Don't go unless there is a real need"). Despite the question stem referring to avoiding the doctor "when you think you should go," many participants said they avoided medical care because they did not have health problems (n=40; e.g., "Not sick. If not broken don't fix"). A small subset of participants also reported avoiding medical care because they "try to take care of themselves" (n=13; e.g., by using over-the-counter medication), were either a doctor or worked in a health care setting (n=9), were afraid to be labeled a hypochondriac (n=5), or preferred to rely on spiritual healing (n=3) or to use natural remedies (n=2). Traditional Barriers to Medical Care The largest overarching category of reasons for avoidance of medical care may be best described as "traditional barriers to medical care" (n=800, 58.4%). In this category, we included responses indicating circumstances or obstacles limiting access to medical care. Participants reported having too little time or being **too busy** to seek medical care (n=214), that clinic hours were inconvenient (n=57; e.g., "Have to take time off from work"), that **transportation was difficult** (n=18) or the distance was too far (n=7), that they were too sick to travel to the doctor's office (n=6), or that an existing physical (n=5; e.g., multiple sclerosis) or mental health (e.g., depression, severe anxiety) problem prevented them from going. Financial reasons included concerns about overall cost (n=330), co-pays (n=35), and health insurance (n=151). Few reported not having a doctor (n=13), that their doctor was inaccessible (n=5; e.g., "I don't see him, I just see nurses, he is never there"), not having childcare (n=3), or language barriers (n=2). Unfavorable Evaluations of Seeking Medical Care Approximately one-third of participants (n=456, 33.3%) provided responses that demonstrated unfavorable evaluations of the process or outcomes of seeking medical care. Physician Factors The most frequently reported reasons for unfavorable evaluations were factors related to physicians (n=178). There were two major categories of physician factors: interpersonal concerns (n=98) and concerns about the quality of medical care (n=81). The most frequent interpersonal concerns involved communication concerns (n=34), including perceptions that doctors do not follow-up, that communication is difficult, disliking how doctors communicate (e.g., "Doctors often make you feel like you're stupid"), disliking the manner in which doctors provide advice or recommendations (e.g., "Tired of being chewed out for not following medical advice"), perceiving that doctors do not listen to patients (e.g., "They are impersonal—paying more attention to computers"; "My experience is one of not being heard/considered"), and perceiving that doctors do not take patients' concerns seriously. Other interpersonal reasons included general mistrust of doctors (e.g. "I just don't trust them"; n=25), believing that doctors do not care about patients (e.g., "I don't always feel that they truly care"; n=8), and perceiving that doctors are too busy (n=8). Participants also reported a broad dislike of doctors, without elaboration (n=21). The most frequent reason concerning the quality of medical care was that participants had **low confidence in doctors' expertise** (n=61), which included beliefs that doctors would not be able to diagnose patients (e.g., "Fear that they won't know what's wrong either"), that doctors would provide incorrect diagnoses (e.g., "They usually make the wrong diagnosis"), and that doctors simply "make things worse." This category also included more general statements about a lack of confidence in medical providers (e.g., "No confidence in today's medical field"). Participants also expressed concerns that doctors would prescribe unnecessary tests or medication (n=13), and several participants stated that "doctors care more about money than patients" (n=9). Organizational Factors Many reasons for unfavorable evaluations concerned aspects of the medical system (n=108), such as long **waiting times** (n=52) and **"hassle"** (n=51), which included the hassle of making timely appointments (e.g., "Usually can't see doctor at the time of a problem") or even making appointments at all (e.g., "Difficult to get appointment, office too busy"), as well as general hassle (e.g., "It's a big bother"). Several participants reported not wanting to be around sick people (n=6). Additional reasons are shown in Fig. 1. Affective Concerns Some participants reported that anticipated fear, embarrassment, or guilt kept them from seeking medical care (n=76). Responses concerning fear included the fear of receiving bad news (n=31) such as a medical diagnosis or a prognosis concerning an already diagnosed condition (e.g., "Afraid they might say my diabetes is worse"). Participants also reported fear of needles (n=7), pain (n=5), and specific procedures such as surgery or prostate exams (n=5), or simply reported "fear" (n=12). Relatedly, participants reported the specific emotion of embarrassment (n=15), including embarrassment about weight (n=4), health issues (n=2), or general feelings of discomfort (n=9). Finally, some participants reported feeling guilty about potentially disclosing engagement in unhealthy behavior (n=2).

AT: Savings

Cost-cutting means net-more waste, fraud, and abuse and is prohibitively expensive.

Ehrlich 17. Scott Ehrlich, COO of DTC Perspectives and the host of the upcoming health policy radio show "Debating Health. “Why Single-Payer Will Only Make Health Care More Expensive.” 31 July 2017. The Federalist. https://thefederalist.com/2017/07/31/single-payer-will-make-health-care-expensive/. [Premier]

So where else must those savings come from? The good old waste, fraud, and abuse category. Are government health organizations really the vehicle to stamp down waste, fraud, and abuse? After all, Medicaid pays out around 10 percent of its payments in waste, fraud, and abuse. So, somehow a government organization with no competitive incentive to save money that already allows a huge amount of waste in a program that covers about one-quarter of the country is somehow going to manage to cut waste, fraud, and abuse, not as a percent of payments but in the aggregate, when they have to manage four times the consumers? Somehow, I am a bit skeptical. So, can single-payer save us money? Sure. And going to free clinics for all your health care will save you money, going to food banks for all your grocery needs will save you money, and living in Section 8 housing will save you money. But most people, including those who would certainly benefit economically, do not use these services. Why? Because quality is not there. Choice is not there. Convenience is not there. This is the level of all of these that cost-effective single-payer would give us. If your child has a cold and a basic antibiotic will do, then single-payer could save you money (unless you inevitably have to wait at the doctor longer and miss more work, which may reduce or even eliminate the economic benefits). But if you have something more advanced and need to go beyond a general practitioner, then hope you survive your lengthy wait for an appointment. Specialists will be in short supply, necessarily, as my debate opponent suggested. New, improved, and experimental devices and treatments, developed largely by U.S. companies for the large and lucrative U.S. market, will dry up due to a lack of potential profits for developing such technologies, leading us to make do with mostly the options we have. And if you think at least you are sticking it to those evil wealthy, who now lose their medical advantages, think again. That same wealth that gives them access to the best doctors and treatments in this country will allow them to simply head to one of the multitude of other countries that will be happy to have their patronage and money. As I wrote in another article, health care, like any other product or service, can be cheap, abundant, or high quality. It can even be two of those things. But it can never be all three. That’s also true of single-payer health care. As states like California, New York, and Vermont have found out when they’ve journeyed down that road, high-quality single-payer is bankruptcy expensive. So there is little reason to believe similar quality single-payer health care would be cheaper when trying to deliver it to a larger populace. If we did want to save money on it, it would hardly be the utopia proponents are selling. I’m happy to look for a better way to deliver or pay for U.S. health care. But stop trying to convince me I can get great, readily available care in this country and save money. It isn’t true in any other product or service run in competitive markets by people trying to make money. It surely won’t work in a government monopoly. And it just makes those advocating for single-payer look ideological, dishonest, and poorly thought out.

Medicare administrative costs are more expensive – prefer our better private plan data and dollars-per-person spending.

Book 17 Robert Book, health economist and Senior Research Director at Health Systems Innovation Network LLC, Health Care and Economics Expert for the American Action Forum. "Medicare-For-All Would Increase, Not Save, Administrative Costs." Forbes. 20 September 2017.

https://www.forbes.com/sites/theapothecary/2017/09/20/medicare-for-all-would-increase-not-save-administrative-costs/#71b3626560ba. [Premier]

Dean Baker of the Center for Economic and Policy Research, the source of Sanders' "12 percent" number for private health plans, chimed in to say that some of Medicare's administrative costs shouldn't actually be counted as administrative costs, and made a thinly substantiated claim that private health plans' costs were closer to 20 percent. The actual figure (for 2014) from CMS regulatory filings for **private health plans** in the individual market (where one expects administrative costs to be particularly high) is **7 percent**. Based on those figures, I found that the ACA reduced private health plans' administrative costs, but **increased the government's cost** (mainly, running the exchanges) by more than private plans saved, thus increasing total administrative costs subtantially.

But as Kessler pointed out (full disclosure: Kessler cited both me and my colleague Avik Roy on this point), expressing administrative costs as a percentage of medical costs is measuring the **wrong thing.**

Medicare, by definition, covers people who are over age 65, or too disabled to work, or with end-stage renal disease. This population needs, on average, more health care per person than the rest of the population, in particular the population eligible for private health plans. In 2014, Medicare spent almost $11,000 per beneficiary paying for health care. By comparison, private health plans spent about $4,600 per covered person. This doesn't prove that private plans are chincy, or that they're more efficient – it's mainly the result of the fact that Medicare beneficiaries are, on average, sicker.

Most of the administrative costs of any health plan – private or government – consist of designing the plan and enrolling members. This **doesn't scale** with the health care needs of enrollees or spending required to provide their care. A small percentage – about 4 percent of administrative costs (not 4 percent of total costs, just of administrative costs) – is spent on claims processing, but this depends on the number of claims, not their dollar value.

As a result, expressing administrative costs as a percentage of total costs in inherently misleading – not just misleading in the sense of "biased," but misleading in the sense that it will lead one to an **incorrect understanding** of what is going on. Instead, administrative costs should be expressed as the number of **dollars per person** a plan spends on maintaining its enrolled population.

In a previous report, I found that Medicare's administrative costs amounted to about $509 per primary beneficiary, and private plan administrative costs were about $453 per beneficiary. That means, in effect, that private health plans' administrative costs were about **10 percent lower** than Medicare's. However, Medicare spends more on actual medical care (payments to hospitals, doctors, and other health care providers), so if you expressed administrative cost as a percentage of total costs (administrative plus medical), you'd get **6 percent for Medicare and 13 percent for private health plans** – a result that is exactly backwards.

To put it another way, if you wanted to require private plans to achieve Medicare's percentage of administrative costs when Medicare is spending $509 per person on administration, private plans would have to cut their administrative costs down to $209 per person, 59 percent lower than Medicare's – and that's just to tie, not to win!

If Sen. Sanders' "Medicare for All" plan were implemented, millions of under-65, non-disabled people would be enrolled in Medicare. The health status would not immediately change, nor would Medicare's administrative efficiency. That means, that, on average, administrative costs would increase by about $50 per person – perhaps **even more** in the

short term, since Medicare would have to expand capacity **rapidly to enroll millions** of people all at once.

Medicare currently has over 58 million beneficiaries. That means there are about 250 million Americans who are not Medicare beneficiaries. If they were all enrolled in Medicare, and Medicare's administrative costs remained constant, that would result in an **increase in total administrative costs of at least $12.5 billion per year** – not a savings of $500 billion, as Sanders claimed.

Administrative costs do not make up the gap and the government is not good at cutting redtape.

Haskins 19 Justin Haskins, executive editor and a research fellow at The Heartland Institute. "2020 Democrats' 'Medicare-for-all' plan would cause a massive doctor shortage." Fox News. 23 March 2019. https://www.foxnews.com/opinion/democrats-medicare-for-all-plan-would-cause-a-massive-doctor-shortage. [Premier]

This is, simply put, a lie. According to Blahous' analysis, the expected savings in 2022 for reduced administrative costs is about **one-fifth** of the amount lost because of lower reimbursement payments. Further, it's **extremely unlikely** that involving the federal government in nearly every health care-related transaction would reduce red tape, as anyone who has ever dealt with the federal government knows.

Democrats' "Medicare-for-all" plan would grant significant powers to federal bureaucrats to regulate, control and manipulate nearly every aspect of the health care system, and providers who agree to accept payments from the government must, as a condition of receiving payment, provide reports to government agents and comply with a laundry list of new regulatory mandates.

Furthermore, it would add millions of people to the health care market without increasing the number of physicians – all while reducing pay to the point that many practices will go out of business.

AT: Debt

Not nearly enough and no impact---their studies are garbage.

McArdle 17 Megan McArdle, Bloomberg View columnist. "The Myth of the Medical Bankruptcy." Bloomberg. 17 January 2017. https://www.bloomberg.com/view/articles/2017-01-17/the-myth-of-the-medical-bankruptcy. [Premier]

One of the predictions that was made, with great fanfare, when Obamacare passed, was that our nation's bankruptcy epidemic would finally come to an end. Last week, veteran liberal commentator Norm Ornstein declared that it had already come to pass. "Before Obamacare," he tweeted, "more bankruptcies from health bills than anything else. Now, hardly at all. Do we really want to go back to that?" Did medical bills single-handedly account for more bankruptcies than anything else? **No**. **This is an exaggerated half-remembering of a series of studies**, authored by (among others) Elizabeth Warren, that were themselves **exorbitant exaggerations**. I went into detail on the problems with the work seven years ago, but the highlight reel is that these authors have **an aggressive tendency** to employ any technique that **ratchets the count of "medical bankruptcy" upward**, while **not using similar techniques that would tend to ratchet up other categories** and diminish the number of bankruptcies counted as medical, and to **present their results in misleading ways** -- so as **to obscure**, for example, the fact that by their own accounting, **the number of medical bankruptcies actually fell by hundreds of thousands** between 2001 and 2007. Which is why their study tended to be presented in the media as "growing problem" rather than "shrinking threat." To be clear: I don't believe that medical bankruptcies fell by hundreds of thousands between 2001 and 2007. I think this conclusion further suggests just how problematic their methodology is. So does the fact that in 2011, two of Warren's co-authors issued a new study finding that medical bankruptcy hadn't fallen in Massachusetts after the passage of Romneycare. These two co-authors are the co-founders of Physicians for a National Health Care Program, an advocacy group that supports single-payer in America, and they have a noticeable tendency to find that -- quelle surprise -- America has enormous problems with medical bills that can be solved only by a single-**payer health-care system**. They have a lot of latitude to get that answer, because **it's surprisingly hard to know exactly which bankruptcies are medical**. Someone who bought **three new cars**, and also had a hernia, is **probably going to blame the hernia**. And we also have to look beyond the bills. The Warren studies tended to get reported, or remembered, as "medical bills cause more than half of all bankruptcies." That's not quite what they said. Bad health events do more than land you with big medical bills (which bills can often be settled for pennies on the dollar, because the collectors know they get nothing if you file). Getting really sick also cuts your income as you stop working. If you've got debt and no savings, that job loss is going to be catastrophic. Unfortunately, the incentives of both academic journals and the media mean that dubious research often gets more widely known than more carefully done studies, precisely because the **shoddy statistics and wild outliers suggest something new and interesting about the world**. If I tell you that more than half of all bankruptcies are caused by medical problems, you will be alarmed and wish to know more. If I show you more carefully done research suggesting that it is a real but comparatively modest problem, you will just be wondering what time "Game of Thrones" is on. So no**, it was never reasonable to think that medical bills**, all by themselves, **could explain more than a modest fraction of bankruptcies**. Nor is it reasonable to think that Obamacare single-handedly reduced those bankruptcies to nothing. For one thing, the methodology of Warren et al showed that having insurance had little effect on the medical bankruptcies; I think that this is yet another reason to distrust them, but if you're going to cite their results, you have to accept the inevitable corollary that Obamacare wasn't going to help much. For another, we have data on what's been happening with bankruptcies over the last 10 years. The number of bankruptcies right now is slightly higher than it was in 2007.[1] *****BEGINNING OF FOOTNOTE***** This includes business filings, but the difference is trivial, because **consumer bankruptcies make up the overwhelming majority of total bankruptcies**. *****END OF FOOTNOTE***** **This is emphatically not the result we would expect if medical bills had been causing a large plurality of bankruptcies** and Obamacare reduced those bankruptcies to practically nothing. I do think medical bills contribute to or cause a significant number of bankruptcies. I also think that Obamacare must have prevented some medical bankruptcies, though I couldn't say how many. Unfortunately, a lot of unrelated trends have whipsawed bankruptcy statistics around over the last decade. First the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 tightened up bankruptcy filing rules, so that a huge number of people rushed to file right before the rules changed, causing a spike in 2005 and an offsetting trough in 2006. Then, just as bankruptcy filings should have been reaching whatever their "natural" post-reform level was, we had the financial crisis. Then we had Obamacare. It's hard to tease out the effects of one change when so much is happening all at once. It seems likely to me -- indeed,

almost certain -- that without Obamacare, the number of bankruptcy filings in 2016 would have been higher than it actually was. I find it difficult to say whether the difference is closer to “major public policy problem” or “a series of unfortunate events.” But it is possible to say that medical bills did not cause a majority, or even a large plurality, of bankruptcies. And that another problem remains substantial: the number of people who fervently **believe something for which there is no good evidence**.

AT: Growth

High prices don't hurt the economy.

Graham 16 John R. Graham, Public-policy analyst, Director of the Health Technology Forum, and a Senior Fellow at the National Center for Policy Analysis. "The U.S. Health System Is Not An Economic Burden." *Forbes*. 20 April 2016. https://www.forbes.com/sites/theapothecary/2016/04/20/the-u-s-health-system-is-not-an-economic-burden/#177a6f862832. [Premier]

Health spending consumes a higher share of output in the United States than in other countries. In 2013, it accounted for 17% of Gross Domestic Product. The next highest country was France, where health spending accounted for 12% of GDP. Critics of U.S. healthcare claim this shows the system is too expensive and a burden on our economy, demanding even more government intervention. This conclusion is **misleading** and leads to **poor policy recommendations**, according to new research published by the National Center for Policy Analysis (U.S. Health Spending is Not A Burden on the Economy, NCPA Policy Report No. 383, April 2016). Discussing health spending in dollars, rather than proportion of GDP, the report notes Americans spent $9,086 per capita on healthcare in 2013, versus only $6,325 in Switzerland, the runner-up. (These dollar figures are adjusted for purchasing power parity, which adjusts the exchange rates of currencies for differences in cost of living). This big difference certainly invites us to question whether we are getting our money's worth. However, it is not clear that this spending is a burden on Americans, given our very high national income. After subtracting health spending from U.S. GDP, we still had $44,049 per capita to spend on all other goods and services we value. Only two countries, Norway and Switzerland, beat the United States on this measure. But compared to larger developed countries, Americans have higher income per capita after subtracting healthcare spending. For example, in the United Kingdom, GDP per capita after health spending was only $34,863 in 2013. So, even though Americans spent significantly more on healthcare than the British, the average American enjoyed $9,185 more GDP after health spending than his British peer; and just under $6,000 more than his Canadian neighbor. Britain socialized its health system shortly after World War II, completing the work by 1948. Canada's healthcare was more gradually socialized by provincial and federal governments during the period 1947 through 1966. Many **assert** these so-called single-payer systems relieved the burden of private payment from citizens and made the economy more productive.On the **contrary**: Since 1960, the U.S. economy has **outperformed** all comparable developed countries except Norway and Switzerland with respect to economic growth, after subtracting health spending. From 1960 through 2013, the share of U.S. GDP allocated to healthcare more than tripled. However, this had **no impact** on the ability of the U.S. economy to deliver high GDP per capita, outside healthcare. Adjusted for purchasing power parity, U.S. health spending increased $8,937, while GDP per capita increased $50,269, from 1950 through 2013. Thus, GDP per capita available for other goods and services, after spending on health care, increased $41,332, or $780 per year. Over these 53 years, only Norway and Switzerland increased their non-health GDP per capita more than the United States. Norway, which had become a petro-state due to revenue gushing from the North Sea oilfields, increased this amount by $57,981, which is $16,649 more than the United States, or $314 more in non-health spending per year per person. The report concludes the theory that health spending influences economic growth for better or worse is **too simple**. In fact, wages, prices and resources allocated to healthcare are a consequence of economic activity in other parts of the economy, as well as health policy. Further, whether the system is defined as "universal" or "single payer" may be less important than other characteristics in determining how the system performs. The report ranks 13 developed countries by the share of health spending that is controlled directly by patients out-of-pocket versus the share controlled by third-party bureaucracies, either private or public. With only 12% of health spending controlled by patients directly, the U.S. ranks ninth by this measure. Swiss patients directly control over one-quarter of their health spending. Even Canadians, who live under a tightly closed,

government monopoly, so-called “single-payer” system, control a somewhat higher share of their own health spending than Americans do. Because most other countries allow patients to control a higher share of health spending than the United States does, the report concludes this is likely another factor keeping health spending lower than in the United States.

AT: Bubble

No bubble---hype and they're unpredictable.

Housel 16 Morgan Housel, Partner at Collaborative Fund and a former columnist at The Motley Fool and The Wall Street Journal. "The Difference Between a Bubble and a Cycle." *Collaborative Fund*. 27 September 2016. http://www.collaborativefund.com/blog/the-difference-between-a-bubble-and-a-cycle/. [Premier]

According to various media sources we now have at least 14 bubbles:¶ A new real estate bubble.¶ A bond bubble.¶ A tech bubble.¶ A VC bubble.¶ A startup bubble.¶ A stock bubble.¶ A shale oil bubble.¶ **A healthcare bubble**.¶ A dollar bubble.¶ A college tuition bubble.¶ A Canadian housing bubble.¶ A central bank bubble.¶ A social media bubble.¶ A China bubble.¶ One economist recently gave up and just said "Everything's a bubble."¶ At a conference I attended a few years ago, Yale economist Robert Shiller said something amazing: The word "bubble" wasn't even in the economic lexicon 25 years ago. Not in textbooks, not in papers, not in schools. But now we have bubbles **everywhere**.¶ How did that happen?¶ The good news is, I don't think it did happen.¶ Markets have been rising and falling for centuries, but the term "bubble" is new. Since it's new, there's no official definition of what it is. Since there's no definition, anyone can classify anything they want as a bubble and no one can prove them wrong. What began as a serious topic among economists has become a **job-security loophole for pundits**.¶ Shiller, in his book Irrational Exuberance, tried to solve this problem.¶ He says spotting a bubble is like diagnosing a mental illness. "The American Psychiatric Association's diagnostic and statistical manual, which defines mental illness, consists of a checklist of symptoms" he once said.¶ He used this as a template to come up with his own checklist of bubble symptoms:¶ Rapidly increasing prices.¶ Popular stories that justify the bubble.¶ Popular stories about how much money people are making.¶ Envy and regret among those sitting out.¶ Cheerleading by the media.¶ It's so simple, and so smart.¶ But it's far from perfect. Just as someone in a bad mood isn't necessarily depressed, a lot of assets can give off the scent of a bubble without actually being one002E¶ My favorite example of this is Microsoft in the early 1990s.¶ Shares tripled from 1988 to early 1990. People were telling stories about how computers would change the world. Bill Gates was celebrated on magazine covers as one of the youngest billionaires of all time.¶ Then, after years of hype, shares fell 31% in the middle of 1990.¶ It checked every box of being a classic bubble, down to the crushing loss of losing a third of your money in a few months.¶ But Microsoft wasn't a bubble in 1990. It wasn't anything close. Even if you start from the peak, shares increased six-fold over the next five years, and 74-fold over the next ten years. It's only obvious in hindsight, but shares were massively undervalued at a time when they looked like a clear-cut bubble.¶ We see this so often.¶ Was Amazon a bubble in 1999? It checked all the boxes, but it wasn't. Shares are eight times higher today than they were back then. Same with Facebook in in 2012, and GM in 1960. Was China a bubble in 2007? It looked like it, and then its economy hit a wall. But then it came roaring back just as fast. So who knows? The number of bubbles we predicted with foresight is an order of magnitude larger than the number of bubbles we now acknowledge with hindsight.¶ In my experience, most of what people call a bubble turns out to be something **far less sinister**: A **regular cycle** of capitalism.¶ Cycles are one of the most fundamental and **normal** parts of how markets work. They look like this:¶ This cycle is self-reinforcing, because if assets didn't get expensive they'd offer big returns, and offering big returns attracts capital, which makes them expensive. That's why cycles are everywhere and we can never get rid of them.¶ To me a bubble is when this cycle breaks. I have my own definition: It's only a bubble if return prospects don't improve after prices fall. It's when an asset class offers you no hope of recovery, ever. This only happens when the entire premise of an investment goes up in smoke.¶ That was true of a lot of dot-com stocks, which weren't bargains after they fell 90% because there was still no tangible company backing them up. It was true of homes in the mid-2000s, because you stood no chance of enjoying a recovery if you were foreclosed on. It was true of Holland's 1600s tulip bubble, as the entire idea that tulips had any value went up in smoke.¶ But it wasn't true of stocks in 2007. Yes, the market fell 50%. But that made it so cheap – particularly compared to the alternative of bonds – that buyers instantly came rushing back in. Prices hit a new all-time high by 2013.¶ It wasn't true of the crash of 1987, when stocks fell 25% in one day, but were back at all-time highs within 18 months.¶ I don't even think it was true for stocks in 1929. Yes, shares fell almost 90% by 1932. But business wasn't broken, and valuations had never been cheaper after the crash. Adjusted for inflation and dividends, stocks were back at a new all-time high by 1936, seven years after the peak.¶ I wouldn't call those bubbles. Prices went down and then came back up in a few years. What did you expect them to do? Go up 1% a month forever? Ha! It never works that way, and it never will. What we experienced were cycles, albeit huge ones.¶ This is an important distinction to make, because whether something is a bubble or not impacts how you invest and respond to market changes.¶ Bubbles should be avoided, because you risk widespread permanent loss of capital. Cycles, by and large, shouldn't, because all they imply is that you have to be patient and humble to earn long-term returns, which is par for the course for successful investing.¶ If you find an asset whose price looks expensive and is probably going to fall, you likely haven't found a bubble. You've found capitalism. Excesses will correct, recover, and life will go on.¶ But that raises a question: If we know cycles are regular, why not try to get ahead of them by buying and selling before they turn?¶ Because regular does not mean predictable.¶ We can say, in hindsight, that you should have sold stocks in 1999 and repurchased them in 2002. We can say, in hindsight, that you should have gotten out of the market in 1929 and bought back in in 1932. But not one person in a million actually achieved this, which should make us question how feasible it is do it in the future. Look at the returns of macro hedge funds, which try to ride the ups and downs of cycles and bubbles. You would not wish them upon your worst enemy.¶ The investing world becomes a lot less scary when you

view most booms and busts as **cycles rather than bubbles**. Will things ebb and flow, sometimes by a lot? Well, yeah. That's what you signed up for as an investor. But is everything with a valuation above its historic average a civilization-shattering bubble? **Not by a long shot**.¶ Three years ago Robert Shiller won the Nobel Prize in economics for his work spotting bubbles. He shared the prize with Eugene Fama, who emphatically states that **bubbles can't be spotted**, and are only obvious with hindsight.