PUBLIC FORUM DEBATE
September-October 2020

John F. Schunk, Editor

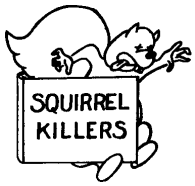
"Resolved: The United States federal government should enact the Medicare-For-All Act of 2019."

PRO

P01. U.S. HEALTHCARE IS INTERNATIONALLY INFERIOR
P02. MILLIONS LACK ADEQUATE HEALTH INSURANCE
P03. MEDICAL COSTS GENERATE DEBT AND BANKRUPTCY
P04. MILLIONS DELAY OR GO WITHOUT MEDICAL CARE
P05. EMPLOYER-BASED INSURANCE IS FATALLY FLAWED
P06. OBAMACARE IS TOTALLY INADEQUATE
P07. MEDICARE FOR ALL PRIORITIZES HEALTH OVER PROFITS
P08. MEDICARE FOR ALL SOLVES HEALTH & ECONOMIC HARMS
P09. MEDICARE FOR ALL LOWERS COSTS
P10. OTHER COUNTRIES DEMONSTRATE EFFICACY
P11. MEDICARE FOR ALL DOES NOT CURTAIL FREEDOM

CON

C01. U.S. HEALTHCARE IS NOT INTERNATIONALLY INFERIOR
C02. HARMS OF BEING UNINSURED ARE EXAGGERATED
C03. PRIVATE HEALTH INSURANCE IS NOT FATALLY FLAWED
C04. OBAMACARE CAN BE EXPANDED
C05. SINGLE-PAYER CAN'T WORK IN THE U.S.
C06. MEDICARE FOR ALL WOULD DECREASE QUALITY OF CARE
C07. MEDICARE FOR ALL WILL INCREASE COSTS
C08. MEDICARE FOR ALL DEVASTATES THE ECONOMY
C09. OTHER COUNTRIES ARE NOT MODELS FOR SUCCESS
C10. DELAYS IN CARE CAUSE DEATH AND SUFFERING
C11. MEDICARE FOR ALL DESTROYS INDIVIDUAL FREEDOM



S-K PUBLICATIONS
PO Box 8173
Wichita KS 67208-0173
PH 316-685-3201
FAX 316-260-4976
debate@squirrelkillers.com
http://www.squirrelkillers.com

SK/P01. U.S. HEALTHCARE IS INTERNATIONALLY INFERIOR

1. U.S. SPENDS MORE PER CAPITA THAN OTHER INDUSTRIAL NATIONS

SK/P01.01) Scott W. Atlas [Hoover Institution, Stanford U.], U.S. House of Representatives Hearings, GOVERNMENT DOCUMENTS & PUBLICATIONS, December 10, 2019, pNA, NexisUni. One undeniable fact is that the US already spends significantly more on health care than any other nation by OECD health spending data, whether calculated on a per capita basis or as a percent of GDP. That was true in 2008, prior to the ACA, and it remains true today.

SK/P01.02) Kalena Thomhave, THE PROGRESSIVE, February-March 2020, p. 26+, Gale Academic OneFile. We know that the United States spends more on health care per person than any other country in the world, even though it does not have the best health care outcomes.

2. U.S. SUFFERS WORSE HEALTH CARE OUTCOMES

SK/P01.03) Pramila Jayapal & Debbie Dingell [U.S. House of Representatives], IMPACT NEWS SERVICE, February 28, 2020, pNA, NexisUni. We are the only industrialized nation in the world that doesn't guarantee all its citizens health care. We spend twice as much per person and have worse outcomes, including low life expectancy and high infant mortality rates--and our broken system disproportionally effects minorities and low-income working families.

SK/P01.04) William C. Hsiao [Professor of Economics Emeritus, Harvard U.], FOREIGN AFFAIRS, January-February 2020, p. 96+, Gale Academic OneFile. In 2017, Americans spent an average of $10,224 per person on health care, according to a Kaiser Family Foundation study. The equivalent figure across similarly wealthy countries that year was just $5,280. Yet despite spending almost twice as much as Australians, Canadians, Japanese, and many Europeans, Americans suffer from lower life expectancy, higher infant mortality rates, and a higher prevalence of heart disease, lung disease, and sexually transmitted infections.

SK/P01.05) Matt Stevens, THE NEW YORK TIMES, June 27, 2020, pNA, NexisUni. Senator Bernie Sanders of Vermont and other 2020 candidates often note that the United States spends twice as much on health care as other comparable nations but gets less value in return. The context: Government data shows that the United States spent about $10,740 per person on health care in 2017. Other comparable nations spent about $5,280 the same year, according to the Kaiser Family Foundation. One 2017 study found that despite spending far more than other high-income countries, the American health care system ranked last in overall performance when compared with several nations, including Australia, Canada and the United Kingdom.

SK/P02. MILLIONS LACK ADEQUATE HEALTH INSURANCE

1. MILLIONS OF AMERICANS ARE UNINSURED

SK/P02.01) Pramila Jayapal & Debbie Dingell [U.S. House of Representatives], IMPACT NEWS SERVICE, February 28, 2020, pNA, NexisUni. Our current system is broken. More than 27 million people are uninsured, and even those with coverage face increasing prescription drug costs, outrageous out-of-pocket expenses, as well as the fear of losing coverage because of losing a job or getting sick.

2. MILLIONS HAVE LOST INSURANCE DUE TO COVID PANDEMIC

SK/P02.02) Sheryl Gay Stolberg, THE NEW YORK TIMES, July 14, 2020, pNA, NexisUni. The coronavirus pandemic stripped an estimated 5.4 million American workers of their health insurance between February and May, a stretch in which more adults became uninsured because of job losses than have ever lost coverage in a single year, according to a new analysis. The study, to be announced Tuesday by the nonpartisan consumer advocacy group Families USA, found that the estimated increase in uninsured workers from February to May was nearly 40 percent higher than the highest previous increase, which occurred during the recession of 2008 and 2009, when 3.9 million adults lost insurance.

SK/P02.03) Talya Meyers [Direct Relief], STATES NEWS SERVICE, July 27, 2020, pNA, NexisUni. According to a report that Families USA released on July 13, 5.4 million American workers and, presumably, many of their family members have lost insurance between February and May of this year, thanks to pandemic-related job loss. That number, according to the report, is 39% higher than the largest annual increase ever recorded in a matter of three short months. (The highest previous annual increase occurred during the Great Recession, when 3.9 million adults of working age became uninsured over the course of one year.)

3. MILLIONS MORE WILL LOSE INSURANCE BY THE END OF THE YEAR

SK/P02.04) Sheryl Gay Stolberg, THE NEW YORK TIMES, July 14, 2020, pNA, NexisUni. The nonpartisan Kaiser Family Foundation has estimated that 27 million Americans have lost coverage in the pandemic; that study took into account family members of the insured. Another analysis, published Monday by the Urban Institute and the Robert Wood Johnson Foundation, projected that by the end of 2020, 10.1 million people will no longer have employer-sponsored health insurance or coverage that was tied to a job they lost because of the pandemic.

4. EVEN MORE MILLIONS ARE UNDERINSURED

SK/P02.05) William C. Hsiao [Professor of Economics Emeritus, Harvard U.], FOREIGN AFFAIRS, January-February 2020, p. 96+, Gale Academic OneFile. Today, however, 28 million Americans remain uninsured, and 44 million are underinsured, meaning they spend more than ten percent of their incomes on out-of-pocket health-care expenses. This has a profound effect on American society.

SK/P03. MEDICAL COSTS GENERATE DEBT AND BANKRUPTCY

1. COVID PANDEMIC IS INCREASING MEDICAL DEBT AND BANKRUPTCY

SK/P03.01) Susan Harley [Managing Director, Public Citizen's Congress Watch division], STATES NEWS SERVICE, August 6, 2020, pNA, NexisUni. The coronavirus pandemic has laid bare the cracks in our broken health care system and far too many Americans are falling through them meaning untreated illness and medical debt or bankruptcy.

SK/P03.02) Eagan Kemp [Health Care Policy Advocate, Public Citizen], STATES NEWS SERVICE, March 26, 2020, pNA, NexisUni. Today, the U.S. Department of Labor announced that a record 3.28 million Americans filed for unemployment last week, largely in response to COVID-19, also called the novel coronavirus. In the U.S., losing your job also means that you and your family lose your health insurance. The dramatic increase in unemployment couldn't have happened at a worse time given that hundreds of millions of Americans may contract COVID-19, with many requiring extensive medical treatment. Doing so without insurance means facing medical debt and bankruptcy, if you can afford care at all.

2. MEDICAL DEBT ALSO BURDENS THE UNDERINSURED

SK/P03.03) Margot Sanger-Katz & Sydney Ember, THE NEW YORK TIMES, September 22, 2019, p. A19, NexisUni. Medical debt affects Americans who lack health insurance, of course. But it is also increasingly affecting people who have insurance with holes, like high deductibles or limited networks of doctors whose care is paid for. Around 16 percent of adults with credit reports have at least one medical debt, according to a study published last year in the journal Health Affairs.

3. MEDICAL COSTS ARE LEADING CAUSE OF BANKRUPTCIES

SK/P03.04) Lisa Marshall [U. of Colorado], STATES NEWS SERVICE, April 30, 2020, pNA, NexisUni. Bankruptcy, which impacts approximately 1 million families each year, tends to be most common among lower-middle-income people or those who earn enough money to qualify for debt to purchase things like cars and homes. When these individuals lose their health insurance, often due to divorce or loss of a job, an unexpected medical emergency can swiftly throw them into a financial crisis in which they can't pay those debts. Many people who file bankruptcy cite medical bills as a factor.

SK/P03.05) Talya Meyers [Direct Relief], STATES NEWS SERVICE, July 27, 2020, pNA, NexisUni. According to Benjamin Ukert, a professor of health policy and management at Texas A and M University, financial well-being also increases when a person has health insurance. Credit scores are higher; it's less likely that the person will declare bankruptcy. By some estimates, more than half of bankruptcies include medical debt.

SK/P04. MILLIONS DELAY OR GO WITHOUT MEDICAL CARE

1. LOSS OF INSURANCE DENIES ACCESS TO AFFORDABLE CARE

SK/P04.01) Henry J. Kaiser Family Foundation, STATES NEWS SERVICE, June 25, 2020, pNA, NexisUni. The COVID-19 crisis highlights the implications for the uninsured in states that have not expanded. That is partly due to increased health risks, but also because some people who lose income, jobs and potentially employer-sponsored health insurance amid the pandemic may lack an affordable coverage option that protects against catastrophic health costs and facilitates access to care.

2. MEDICAL COSTS LEAD AMERICANS TO DELAY CARE

SK/P04.02) Austin Frakt & Aaron E Carroll, THE NEW YORK TIMES, August 13, 2019, p. A12, NexisUni. "Cost sharing penalizes the sick and poor, who forgo vital as well as unneeded care, and suffer grave financial harms," Dr. Woolhandler [professor, Hunter College] said. "Experience in some nations proves that cost sharing is not necessary to control costs." On the contrary, she argued, collecting co-payments and deductibles just adds a costly, administrative burden. A downside of cost sharing is that it "can lead to patients and families delaying necessary care or skimping on prevention," Ms. Bradley [president of Vassar College] said.

3. HUNDREDS OF THOUSANDS GO WITHOUT NEEDED CARE

SK/P04.03) Jon Tester [U.S. Senator], TARGETED NEWS SERVICE, March 19, 2020, pNA, NexisUni. A quarter of a million Americans go without medical care for fear of the cost.

SK/P04.04) Margot Sanger-Katz & Sydney Ember, THE NEW YORK TIMES, September 22, 2019, p. A19, NexisUni. A survey of people with medical debts conducted by The New York Times and the Kaiser Family Foundation in 2016 found that 44 percent of adults under 65 who had problems paying medical bills said those bills had a "major effect" on their lives. Fear of medical debts causes some people to avoid needed medical care.

SK/P04.05) Talya Meyers [Direct Relief], STATES NEWS SERVICE, July 27, 2020, pNA, NexisUni. In addition, people who lose insurance may stop adhering to treatment regimens, or trying to stretch medications and other resources, said Caitlin Donovan, senior director for the National Patient Advocate Foundation, an advocacy organization focusing on the insurance and financial side of health care. Essentially, she said, losing insurance means that medications become instantly unaffordable at precisely the moment when people don't have an income. "They either stop adhering entirely because they don't want to put their families in dire financial straits or they start modifying, so you see people cutting their pills," she said.

4. LACK OF ADEQUATE CARE CAUSES PREMATURE DEATH

SK/P04.06) William C. Hsiao [Professor of Economics Emeritus, Harvard U.], FOREIGN AFFAIRS, January-February 2020, p. 96+, Gale Academic OneFile. The news media often focus on the more than half a million household bankruptcies that medical bills induce every year, but other substantial harms are less well recognized. The uninsured and the underinsured delay or even forgo treatment when they are ill, and their children often do not receive critical immunizations. This contributes to a pernicious form of inequality: on average, the top quarter of American earners live ten years longer than those in the bottom quarter.

SK/P04.07 Kalena Thomhave, THE PROGRESSIVE, February-March 2020, p. 26+, Gale Academic OneFile. Pharmaceutical companies, armed with patents, wield great power over prescription drug pricing and accessibility, and thus over our very lives. Families must often try raising money for their own medical care, through GoFundMe and similar crowdfunding platforms. Stories of people unable to receive medicine or a procedure due to cost are common; some of those people die.

5. EFFECTS ARE ESPECIALLY DEADLY IN A PANDEMIC

SK/P04.08) Sheryl Gay Stolberg, THE NEW YORK TIMES, July 14, 2020, pNA, NexisUni. Democrats and health care advocacy groups argue that the importance of insurance coverage extends beyond personal well-being because the uninsured tend to avoid going to the doctor, and that exposes others to an infectious disease outbreak like Covid-19.

SK/P04.09) Talya Meyers [Direct Relief], STATES NEWS SERVICE, July 27, 2020, pNA, NexisUni. "The bottom line is really clear: It is bad for you not to have health insurance," Dorn [Director, National Center for Coverage Innovation at Families USA] said. He explained that uninsured people are four times more likely to delay getting care, which can be disastrous for long-term health conditions like cancer and diabetes. During Covid-19, there's an added risk: that people with Covid-19 symptoms will postpone or avoid seeking care, increasing the risk to themselves and those around them, Dorn added.

SK/P05. EMPLOYER-BASED INSURANCE IS FATALLY FLAWED

1. U.S. IS ONLY INDUSTRIAL NATION TO TIE INSURANCE TO JOBS

SK/P05.01) Eagan Kemp [Health Care Policy Advocate, Public Citizen], STATES NEWS SERVICE, March 26, 2020, pNA, NexisUni. Among comparably wealthy countries, the U.S. is the only one that binds access to health care with employment status. It's a key reason that nearly 30 million Americans are uninsured. The time has come to break this cruel connection and instead guarantee health care for everyone in the U.S., regardless of employment status or ability to pay. This crisis has shown in myriad ways that we need Medicare for All.

2. MILLIONS HAVE LOST INSURANCE DUE TO LOSS OF JOBS

SK/P05.02) Edward J. Markey [U.S. Senator], STATES NEWS SERVICE, May 15, 2020, pNA, NexisUni. “Over 36 million people just lost their jobs, and in many cases their health care coverage as well, in the middle of a pandemic," said Alex Lawson, Executive Director of Social Security Works. "Even many people who still have insurance have co-pays and deductibles that can drive them into bankruptcy. People in their '50s and early '60s, who are likely to have more severe cases of COVID-19 but aren't yet eligible for Medicare, are in the greatest financial as well as medical danger. This is why we support the Emergency Health Care Guarantee Act to immediately cancel out of pocket costs for health care for everyone in this country during the public health emergency."

SK/P05.03) Talya Meyers [Direct Relief], STATES NEWS SERVICE, July 27, 2020, pNA, NexisUni. Not everyone will be able to get new insurance. For one thing, some such as undocumented workers won't be eligible. And some, Dorn [Director, National Center for Coverage Innovation at Families USA] said, will be distressed, overwhelmed, and even traumatized by a job loss. "Many people in those situations do not have the bandwidth needed to learn about America's complicated health system," he said. In addition, health insurance isn't always the first priority, said Nicole Lamoureux, president and CEO of the National Association for Free and Charitable Clinics. "A person who has lost their job is worried about their expenses...is mostly looking for how they're going to get unemployment in that case," she said.

SK/P05.04) Marilyn Albert [National Union of Healthcare Workers], STATES NEWS SERVICE, April 30, 2020, pNA, NexisUni. Some economists predict 40 to 50 million people will lose their jobs as a result of the pandemic, losing their healthcare also. This makes the biggest anti-Medicare for All talking point that everybody loves their employer-paid insurance now practically useless to our opponents. People are convinced that we need universal health care not related to employment.

3. COBRA FAILS TO FILL THE GAP

SK/P05.05) Talya Meyers [Direct Relief], STATES NEWS SERVICE, July 27, 2020, pNA, NexisUni. Some employees are eligible for COBRA, a health insurance program that will allow them to continue to receive the benefits they received as an employee provided they pay the entire premium themselves. "For many people, that will be cost-prohibitive," Donovan [Senior Director, National Patient Advocate Foundation] said.

SK/P05.06) Edward J. Markey [U.S. Senator], STATES NEWS SERVICE, May 15, 2020, pNA, NexisUni. Sanders [U.S. Senator] has previously argued that proposals to expand COBRA benefits with taxpayer subsidies would provide private insurance corporations with hundreds of billions of dollars in windfall profits, but do nothing to cover those who had already lacked employer-provided insurance, or those who continue to be deterred from seeking medical assistance due to high deductibles, which require roughly $1,800 on average in annual out-of-pocket spending before private insurance coverage kicks in.

SK/P05.07) Edward J. Markey [U.S. Senator], STATES NEWS SERVICE, May 15, 2020, pNA, NexisUni. New polling reveals overwhelming enthusiasm for [Senator] Sanders' proposal. According to Data for Progress, 73 percent of American voters support Medicare covering all out-of-pocket health expenses during this emergency, including 58 percent of Republicans. In comparison, 55 percent backed a separate proposal to cover the cost of insurance premiums through COBRA, a federal program that allows those who have lost their jobs to temporarily retain their former employers' health insurance coverage. When presented with evidence that Sanders' emergency Medicare proposal is significantly less expensive despite covering millions more people, 61 percent preferred Sanders' approach versus 14 percent who backed COBRA subsidies.

4. U.S. MUST SEVER THE TIE BETWEEN EMPLOYMENT AND INSURANCE

SK/P05.08) Austin Frakt & Aaron E Carroll, THE NEW YORK TIMES, August 13, 2019, p. A12, NexisUni. Other experts said it was time for employer-based coverage to go. A profusion of coverage options "generates complexity that drives up administrative costs," said Dr. Steffie Woolhandler, a physician and a professor at Hunter College. "We should transition away from employer-based private coverage," Ms. Meara [health economist and professor, Dartmouth] said. "Employer-based coverage should be ended," Dr. Angell [senior lecturer, Harvard Medical School] said.

SK/P06. OBAMACARE IS TOTALLY INADEQUATE

1. PRIVATE HEALTH INSURANCE PREMIUMS ARE SKYROCKETING

SK/P06.01) Marilyn Albert [National Union of Healthcare Workers], STATES NEWS SERVICE, April 30, 2020, pNA, NexisUni. Another predictor of the private insurance based health system collapse is that private insurance premiums may increase by up to 40 percent after the pandemic.

2. AFFORDABLE CARE ACT (OBAMACARE) IS TOO UNAFFORDABLE

SK/P06.02) Talya Meyers [Direct Relief], STATES NEWS SERVICE, July 27, 2020, pNA, NexisUni. And then, finally, there's the individual marketplace, which, through the Affordable Care Act, allows people to select an insurance plan. Thanks to tax credits, the premiums will be subsidized for some. But oftentimes, Donovan [Senior Director, National Patient Advocate Foundation] said, it's the cost of premiums not deductibles or copays that drives people's decisions about a health insurance plan. "Often they're picking a bad plan, because they're choosing the lowest monthly premium," she said.

SK/P06.03) Sheryl Gay Stolberg, THE NEW YORK TIMES, July 14, 2020, pNA, NexisUni. Four of every five people who have lost employer-provided health insurance during the coronavirus pandemic are eligible for free coverage through expanded Medicaid programs or government-subsidized private insurance through the Obama-era health law, according to the Kaiser Family Foundation. But experts say that insuring the recently unemployed is a difficult challenge. Many people cannot afford premiums for coverage through either the health care law or the program known as COBRA, for the Consolidated Omnibus Budget Reconciliation Act. Others might not know they are eligible for Medicaid.

3. AFFORDABLE CARE ACT LEAVES MILLIONS UNINSURED

SK/P06.04) Kalena Thomhave, THE PROGRESSIVE, February-March 2020, p. 26+, Gale Academic OneFile. The Affordable Care Act passed during the Obama Administration was meant to be universal. And yet, in 2018, nearly twenty-eight million nonelderly adults were still living without health insurance, with approximately half citing cost as the reason. And "access" sometimes means getting stuck with thousands of dollars in deductibles, premiums, and out-of-pocket costs.

SK/P06.05) William C. Hsiao [Professor of Economics Emeritus, Harvard U.], FOREIGN AFFAIRS, January-February 2020, p. 96+, Gale Academic OneFile. Meanwhile, huge numbers of Americans remain uninsured or underinsured. The 2010 Affordable Care Act (ACA) attempted to address such problems but has proved insufficient for many reasons--including the Trump administration's efforts to hollow out the legislation.

4. PUBLIC OPTION WOULD BE AN INADEQUATE REMEDY

SK/P06.06) Public Citizen, STATES NEWS SERVICE, October 24, 2019, pNA, NexisUni. A public option would: Leave millions uninsured or underinsured and subject to unnecessary out-of-pocket costs, including copays and deductibles; Leave more than 100 million Americans at the whim of private for-profit insurance corporations, so they would be under constant fear of disruption when their employer changes plans or they lose or change jobs; Force employers to continue to struggle with whether they can afford to provide insurance to their employees; and Enable for-profit insurers to cherry-pick healthier Americans, threatening the financial solvency of the public programs.

SK/P06.07) RAND Corporation, STATES NEWS SERVICE, May 28, 2020, pNA, NexisUni. Offering a government-sponsored health plan with publicly determined payment rates to people who buy their own insurance could lower the cost of premiums, but on its own it is unlikely to substantially increase the overall number of people with coverage, according to a new RAND Corporation study. Modeling four scenarios for adding a public option for individual coverage available nationwide, researchers found that premiums for public plans could be 10% to 27% lower than private insurance plans because of lower provider payment rates in the public option. A public option had much less impact on boosting the number of people with insurance. Under three of the scenarios, the number of uninsured people fell 3% to 8%, while the number of uninsured declined marginally under a fourth scenario studied.

SK/P06.08) RAND Corporation, STATES NEWS SERVICE, May 28, 2020, pNA, NexisUni. The analysis also found that lower-income people are less likely to benefit from the public option because of the tax credit structure of the federal Affordable Care Act. Since higher-income people pay the full cost of insurance on the individual market, they could receive substantial savings under a public option, said Jodi Liu, the study's lead author and a policy researcher at RAND, a nonprofit research organization. But policymakers should consider how the design of a public option could decrease the tax credits lower-income enrollees receive under the ACA.

SK/P07. MEDICARE FOR ALL PRIORITIZES HEALTH OVER PROFITS

1. HEALTHCARE IS A BASIC HUMAN RIGHT

SK/P07.01) Edward J. Markey [U.S. Senator], STATES NEWS SERVICE, May 15, 2020, pNA, NexisUni. "Health care is a right, not a privilege," said Gillibrand [U.S. Senator]. "The COVID-19 pandemic has made clear that every individual needs access to affordable health care, and the Health Care Emergency Guarantee Act would cover everyone's out-of-pocket- health care expenses during this emergency, regardless of insurance status. I am proud to partner with Senator Sanders and my colleagues to introduce this important legislation because we need to guarantee treatment and care to every individual American in order to safely reopen our economy."

SK/P07.02) Edward J. Markey [U.S. Senator], STATES NEWS SERVICE, May 15, 2020, pNA, NexisUni. "During this public health crisis, we must make sure that everyone in America is able to receive all of the medical care they need, regardless of their income, immigration status or insurance coverage. No one in this country should be afraid to go to the doctor because of the cost--especially during a pandemic. The American people deserve an emergency health care response that is simple, straightforward, comprehensive, and cost-effective," said Sanders [U.S. Senator]. "We should empower Medicare to pay all of the medical bills of the uninsured and the under-insured--including prescription drugs--for the duration of the coronavirus pandemic. When so many people in this country are struggling economically and terrified at the thought of becoming sick, the federal government has a responsibility to take the burden of health care costs off of the backs of the American people."

SK/P07.03) Austin Frakt & Aaron E Carroll, THE NEW YORK TIMES, August 13, 2019, p. A12, NexisUni. "Universality is essential," said Harold Pollack, a professor of social service administration at the University of Chicago. "At bottom, this is a moral issue." "Any decent society provides universal health care," said Dr. Marcia Angell, a senior lecturer at Harvard Medical School.

2. UNIVERSAL COVERAGE IS THE ONLY WAY TO FIGHT A PANDEMIC

SK/P07.04) Edward J. Markey [U.S. Senator], STATES NEWS SERVICE, May 15, 2020, pNA, NexisUni. "No family should go bankrupt because they had the misfortune of getting sick--especially as our nation continues to grapple with a dangerous pandemic," said Merkley [U.S. Senator]. "In a pandemic, every one of us is better off if someone who's sick can go to the doctor and get care as soon as they need it. The time is now for Congress to eliminate out-of-pocket health costs for essential care and halt the collection of medical debts, to help everyone get the care they need and to help our country get through this pandemic."

SK/P07.05) Edward J. Markey [U.S. Senator], STATES NEWS SERVICE, May 15, 2020, pNA, NexisUni. "The only way to remove the threat of COVID-19 is to keep everyone healthy and act without delay to contain the spread," said Sara Nelson, International President of the Association of Flight Attendants-CWA , whose union endorsed the legislation. "When any individual has to weigh paying our bills or paying for medical attention, we are all less safe because public health takes a back seat to personal financial concerns. We need care for everyone, and even those of us with union negotiated healthcare coverage shouldn't have to worry about copays, deductibles, or prescription costs. Our physical, mental, and financial health depends on full care for all."

3. PROFIT MOTIVE IS U.S. HEALTHCARE FATAL FLAW

SK/P07.06) William C. Hsiao [Professor of Economics Emeritus, Harvard U.], FOREIGN AFFAIRS, January-February 2020, p. 96+, Gale Academic OneFile. The root of these problems is that as the United States became a prosperous, industrialized society in the early twentieth century, it chose to treat health care as a commercial product rather than as a social good, such as education. As a result, whereas government-mandated universal schooling had become the norm by the 1920s, health care still remains primarily a private-sector activity driven by the profit motive.

SK/P07.07) Debbie Dingell [U.S. House of Representatives], STATES NEWS SERVICE, October 4, 2019, pNA, NexisUni. "Medicare Advantage" has a history of overbilling taxpayers and lining the pockets of private insurance companies through restrictive provider networks. This program has proven risky for seniors in poor or declining health as it includes plans that deny seniors access to care, often leaving them no choice but to drop their plans. These same for-profit insurance companies have even maintained lists of "unprofitable patients" and target seniors who are healthier to increase their profit margins.

4. MEDICARE FOR ALL REMOVES THE PROFIT MOTIVE

SK/P07.08) Debbie Dingell [U.S. House of Representatives], STATES NEWS SERVICE, October 4, 2019, pNA, NexisUni. “Our Medicare for All bill would remove the for profit motive in our healthcare system, include much-needed benefits like long term care for seniors and expand it so that seniors and other consumers can afford their health care without worrying about unaffordable premiums, co-pays, and deductibles."

SK/P08. MEDICARE FOR ALL SOLVES HEALTH & ECONOMIC HARMS

1. MEDICARE FOR ALL ACT OF 2019 PROVIDES COMPREHENSIVE CARE

SK/P08.01) Ken Perez [vice president of healthcare policy, Omnicell, Inc.], HEALTHCARE FINANCIAL MANAGEMENT, August 2019, p. 14+, Gale Academic OneFile. On Feb. 27, Rep. Pramila Jayapal (D-Wash.) introduced the Medicare for All Act of 2019 in the House. The bill was touted as an improved version of prior bills proposed in the Senate by Sen. Bernie Sanders (I-Vt.) in 2013 and 2017. Not to be outdone, on April 10, Sanders and 14 of his Democratic colleagues in the Senate introduced a bill with the same title as the Jayapal bill. In general, the Medicare for All bills would create a federally administered single-payer healthcare program that would provide comprehensive coverage for all Americans, across the entire healthcare continuum. All physicians would be effectively in-network, and there would be no deductibles, copayments or cost-sharing requirements of any kind.

SK/P08.02) Margot Sanger-Katz, THE NEW YORK TIMES, February 25, 2020, pNA, NexisUni. Mr. Sanders's proposal would set up a brand-new government health insurance system, with many more benefits than Medicare. Everyone in the United States would get health insurance from this new, generous government system. Existing private health insurance plans would be eliminated. So would insurance premiums, deductibles and co-payments. Medicare for all insurance would cover many services that most health plans omit now, including dental care, eyeglasses, hearing aids and home-based long-term care for people with disabilities. It would also make major changes to how health care is financed in the United States. Now, we pay for health care through federal taxes and state taxes, as well as premiums and cash when we go to the doctor or the pharmacy counter. Under Medicare for all, federal taxes would pay for the entire system.

SK/P08.03) Kalena Thomhave, THE PROGRESSIVE, February-March 2020, p. 26+, Gale Academic OneFile. Medicare for All is illustrative of what a single-payer system could look like. The phrase is refreshingly simple--people understand that Medicare is government-provided insurance. But Medicare for All doesn't actually mean Medicare in its current, complex form. All it means is that the government is the single provider of health insurance (hence "single-payer"). So yes, think Medicare, but in a form that is both better and cheaper, as copays and deductibles would be eliminated.

SK/P08.04) Kalena Thomhave, THE PROGRESSIVE, February-March 2020, p. 26+, Gale Academic OneFile. Under the gold-standard system of Medicare for All, everybody--citizens and immigrants alike--would have access to basic health services and other essential services, like comprehensive mental health care, abortion care, drug rehabilitation, and dental care. With these bases covered, a Medicare for All system could finally focus on prevention. And additional investment would ensure that people can access doctors, dentists, eye doctors, and mental health providers, in both rural and urban communities.

2. MEDICARE FOR ALL ACT OF 2019 WILL IMPROVE CARE FOR SENIORS

SK/P08.05) Debbie Dingell [U.S. House of Representatives], STATES NEWS SERVICE, October 4, 2019, pNA, NexisUni. The Medicare For All Act of 2019: Gives seniors the benefits they need. For too long, Medicare has not provided seniors with access to the benefits they need, such as dental, vision, hearing, and long-term care. Medicare for All covers all of these benefits with no premiums, co-pays or out-of-network deductibles. Allows seniors to have more choices without worrying about whether a provider is in-network. Covers home and community-based long term care for seniors, people with disabilities, and those with terminal illnesses, allowing these Americans to live with dignity with loved ones in their own homes.

SK/P08.06) Marilyn Albert [National Union of Healthcare Workers], STATES NEWS SERVICE, April 30, 2020, pNA, NexisUni. Long-term care will be a major benefit under Medicare for All, placed under public financing and control. Life care for our elders can be transformed under Medicare for All to being safe and enjoyable.

3. MEDICARE FOR ALL WILL DROP NUMBER OF UNINSURED TO ZERO

SK/P08.07) U. of Pennsylvania's Wharton School, TARGETED NEWS SERVICE, January 21, 2020, pNA, NexisUni. Penn Wharton Budget Model (PWBM) has produced the first integrated analysis of the Medicare for All Act of 2019, capturing health and demographic effects, interactions with other government programs, and macroeconomic changes. PWBM projects: Under current law, the percent of the population without medical insurance will grow from around 10 percent today to over 27 percent by 2060. Under Sanders' Medicare for All, the uninsured rate would essentially fall to zero by design.

4. MEDICARE FOR ALL WILL END MEDICAL DEBT AND BANKRUPTCY

SK/P08.08) Public Citizen, STATES NEWS SERVICE, October 24, 2019, pNA, NexisUni. However, Medicare for All would: Provide access to home and community-based care for all who need it; End medical debt and medical bankruptcies; Reduce administrative waste by $500 billion per year; End price gouging by pharmaceutical companies; and Put an end to corporations profiting off the sick.

5. MEDICARE FOR ALL WILL DECREASE DEATH AND SUFFERING

SK/P08.09) U. of Pennsylvania's Wharton School, TARGETED NEWS SERVICE, January 21, 2020, pNA, NexisUni. Sanders' Medicare for All would improve population health by 2060, reduce the share of the population that is seriously ill from 15 percent to 13 percent, increase life expectancy by two years, grow the population three percent, and increase worker productivity.

SK/P09. MEDICARE FOR ALL LOWERS COSTS

1. STUDIES PROVE MEDICARE FOR ALL WILL LOWER COSTS

SK/P09.01) Pramila Jayapal & Debbie Dingell [U.S. House of Representatives], IMPACT NEWS SERVICE, February 28, 2020, pNA, NexisUni. Medicare for All will save lives by ensuring health care is a right, and not a privilege by ensuring every person has access to quality health care. Medicare for All promises to streamline our fragmented health care system, and expand and improve coverage for every American. Study after study finds that it will lower overall health care costs.

SK/P09.02) Pramila Jayapal & Debbie Dingell [U.S. House of Representatives], IMPACT NEWS SERVICE, February 28, 2020, pNA, NexisUni. In a recent analysis of 22 academic studies on health care financing published in the Public Library of Science (PLOS), researchers at the University of California found that there is near consensus that universal, single-payer health care plans would reduce overall costs; 19 of 22 estimated immediate health care cost savings in year one, and all found long-term health care cost savings. Another recent study published in the Lancet found that Medicare for All would save more than $450 billion and save almost 69,000 lives every year.

SK/P09.03) Ken Perez [vice president of healthcare policy, Omnicell, Inc.], HEALTHCARE FINANCIAL MANAGEMENT, August 2019, p. 14+, Gale Academic OneFile. Citing the lower per- capita costs of healthcare in other industrialized countries that have single-payer systems, Sanders [U.S. Senator] contends that national health expenditures (NHE), which totaled $3.5 trillion in 2017, would actually amount to $6 trillion less over 10 years under his plan compared with the current system. Currently, the federal government's spending on healthcare amounts to roughly one-third of NHE, about $1.1 trillion, funding Medicare, Medicaid, the Children's Health Insurance Program, health insurance subsidies and related spending, and veterans' medical care.

SK/P09.04) Linda Qiu, THE NEW YORK TIMES, November 10, 2019, p. A16, NexisUni. On the flip side, the University of Massachusetts study projected that national health expenditures would be $5.1 trillion lower over 10 years under Medicare for all. Mr. Friedman estimated $5.5 trillion to $12.5 trillion in savings.

2. MOST AMERICANS WOULD SPEND LESS ON HEALTHCARE

SK/P09.05) Public Citizen, STATES NEWS SERVICE, October 24, 2019, pNA, NexisUni. About two-thirds of Medicare for All funding would come from taking public spending streams for health care programs and funneling them to Medicare for All. Some additional taxes would be needed to pay for Medicare for All, but most Americans would spend LESS on health care than they do right now.

SK/P09.06) William C. Hsiao [Professor of Economics Emeritus, Harvard U.], FOREIGN AFFAIRS, January-February 2020, p. 96+, Gale Academic OneFile. Would Americans have to pay more for health care under a single-payer system similar to those in Canada and Taiwan? A definitive study published in 2018 by a team of researchers led by the economist Robert Pollin has determined that they would not. In fact, Americans would see a net reduction in overall health expenditures. According to the report, the United States could save more than $250 billion each year by establishing a single-payer system.

3. HOSPITALS CAN AFFORD TO LOWER PRICES

SK/P09.07) Reed Abelson, THE NEW YORK TIMES, April 21, 2019, pNA, NexisUni. Proponents of overhauling the nation's health care argue that hospitals are charging too much and could lower their prices without sacrificing the quality of their care.

4. MEDICARE FOR ALL WILL BOOST ECONOMIC GROWTH

SK/P09.08) U. of Pennsylvania's Wharton School, TARGETED NEWS SERVICE, January 21, 2020, pNA, NexisUni. Without expanding benefits to include long-term care or dental--but still eliminating most deductibles while covering all workers--GDP increases by 12 percent with premium financing. These results indicate that Medicare for All can be designed in a way that boosts economic growth.

SK/P10. OTHER COUNTRIES DEMONSTRATE EFFICACY

1. ALL OTHER INDUSTRIAL NATIONS ACHIEVE UNIVERSAL COVERAGE

SK/P10.01) Austin Frakt & Aaron E Carroll, THE NEW YORK TIMES, August 13, 2019, p. A12, NexisUni. Universal coverage is found in every developed country except the United States, where 10 percent to 14 percent (depending on the survey) of the population is uninsured, down from a high of about 18 percent before the Affordable Care Act's coverage expansion.

SK/P10.02) Jessica Mendoza, THE CHRISTIAN SCIENCE MONITOR, April 14, 2020, pNA, NexisUni. The social-distancing policies of the COVID-19 era have led to millions of people losing their jobs - and their employer-based health insurance - at a time when access to health care is more essential than ever. The crisis has reinvigorated the debate around universal health coverage. Supporters of former presidential candidate Sen. Bernie Sanders see the situation as proof positive of the validity of his signature policy, "Medicare For All." They note that while universal coverage hasn't slowed the spread of the disease in countries that offer the policy, it has helped make sure their citizens aren't also slapped with huge medical bills after testing and treatment for coronavirus.

2. CANADA PROVIES A MODEL FOR THE UNITED STATES

SK/P10.03) Caitlyn Kelly, THE AMERICAN PROSPECT, January-February 2020, p. 28+, Gale Academic OneFile. Canadian health care is publicly funded and privately delivered, approximately the same vision that single-payer enthusiasts have for the American system. It even shares the same name as our largest government-run insurance provider: Medicare. But contrary to persistent American partisan mythmaking, no government officials sit in doctors' offices or haunt hospital hallways with a checklist of all the services they'll question and deny. They don't dictate hands-on care. Canadians face little government interference or oversight of their health care, although, for historical reasons, their doctors retain much more power than patients.

SK/P10.04) Caitlyn Kelly, THE AMERICAN PROSPECT, January-February 2020, p. 28+, Gale Academic OneFile. As Americans' life expectancy is dropping and maternal mortality is ranked shockingly high among other wealthy nations, Canadian health outcomes fare better; Canadian women live two more years than their American counterparts, men three.

SK/P10.05) Caitlyn Kelly, THE AMERICAN PROSPECT, January-February 2020, p. 28+, Gale Academic OneFile. "Canada makes you wait because everybody's included," says Dr. Tom Noseworthy, a professor of health policy and management at the University of Calgary, and a former hospital CEO, ICU specialist, and rural GP. "But every nation rations its health care. No one can get everything, everywhere, all the time. One system is explicit in its rationing, Canada, where we howl at our wait times--and the other is implicit, because Americans can only get it if they can afford it."

SK/P11. MEDICARE FOR ALL DOES NOT CURTAIL FREEDOM

1. MEDICARE FOR ALL ALLOWS FOR CHOICE OF PROVIDERS

SK/P11.01) Marilyn Albert [National Union of Healthcare Workers], STATES NEWS SERVICE, April 30, 2020, pNA, NexisUni. What has been sorely lacking in the United States planning, cooperation, and coordination are fundamental to a single payer system. Everyone could choose their providers freely, with hospitals competing only on the basis of the quality of their care. Although most hospitals would still be privately owned under our current Medicare for All proposals, decisions about opening and closing hospitals would be made by the publicly accountable governing structures on a national, state, and regional basis, not by hospitals or their owners themselves.

2. PROGRESSIVE INCOME TAX IS FAIREST WAY TO FINANCE PROGRAM

SK/P11.02) William C. Hsiao [Professor of Economics Emeritus, Harvard U.], FOREIGN AFFAIRS, January-February 2020, p. 96+, Gale Academic OneFile. The U.S. federal government could fund universal coverage through a payroll tax on both employers and employees; the poor and the near poor would receive subsidies to offset the tax burden. A better method, however, would be taxes on income and wealth, which would be more progressive and therefore fairer. Moreover, payroll taxation is less effective than in the past because in contemporary economies formal employment has become less common as companies increasingly hire independent contractors rather than staffers. It's for these reasons that Taiwan and Germany gradually shifted away from payroll taxes to fund their systems and adopted ear-marked income taxes instead.

3. MOST AMERICANS FAVOR MEDICARE FOR ALL

SK/P11.03) Ken Perez [vice president of healthcare policy, Omnicell, Inc.], HEALTHCARE FINANCIAL MANAGEMENT, August 2019, p. 14+, Gale Academic OneFile. Many Americans support the idea of Medicare for All. According to polls conducted by the Kaiser Family Foundation, public backing in 2019 for a single-payer system averaged 56% from January through April. Similarly, a survey of 2,000 U.S. registered voters conducted from April 30 through May 5 by RealClear Opinion Research found 55% in support of Medicare for All.

SK/P11.04) Marilyn Albert [National Union of Healthcare Workers], STATES NEWS SERVICE, April 30, 2020, pNA, NexisUni. There is good news in two new polls. The first, done by Politico the last week of March, shows that from February to March, somewhat early in the pandemic in the U.S. support for Medicare for All rose by 9 points. And that is following months of massive attacks on Medicare for All during Bernie Sanders' primary campaign. The second poll, released by Hill-Harris on approximately April 24th, showed that 88 percent of Democrats favor Medicare for All.

4. VETERANS ADMINISTRATION IS A SUCCESSFUL SOCIALISTIC MODEL

SK/P11.05) David H. Freedman, NEWSWEEK, March 27, 2020, pNA, Gale Academic OneFile. What goes largely unappreciated in this debate is that the U.S. government already owns and runs one of the most successful health care operations in the world. It's taken on the care of millions of some of America's most challenging patients, including residents of isolated rural communities and older patients who need long-term care. It does so while eliminating many of the racial disparities that haunt American health care. It trains most of America's doctors. It is a leader in telehealth, electronic health care records, precision medicine and many other important, forward-looking technologies. It earns quality-of-care ratings that most hospitals would envy. It keeps costs generally below average and charges most patients little or nothing. The system is the Veterans Health Administration--commonly referred to as the VA, after the broader agency that runs it, the U.S. Department of Veterans Affairs--along with the Walter Reed National Military Medical Center, operated by the Defense Department. Walter Reed serves about a million active-duty military personnel, military retirees and others.

SK/P11.06) David H. Freedman, NEWSWEEK, March 27, 2020, pNA, Gale Academic OneFile. The VA is, in fact, more of a socialist enterprise than anything Bernie Sanders has proposed. His Medicare for All would be an insurance program--patients would use private doctors, hospitals and clinics, who would then be reimbursed by Uncle Sam. (Much like Medicare, except Sanders' plan would pay the costs of health care received by nearly all Americans.) The VA, by contrast, directly employs 11,000 doctors and owns its 1,200 hospitals.

SK/P11.07) David H. Freedman, NEWSWEEK, March 27, 2020, pNA, Gale Academic OneFile. As a public institution, the VA has been subject to many in-depth, independent studies that show how well it stacks up against both private and public health care systems in the U.S. Quality of care, these studies show, is high in VA hospitals and clinics. In 2018, researchers at Dartmouth College's Institute for Health Policy and Clinical Practice concluded that VA hospitals "outperform private hospitals in most health care markets throughout the country" when it comes to quality of care. The study's lead author, Dartmouth Institute Professor and physician William Weeks, added at the time that "the VA generally provides truly excellent care." The Rand Corporation, a respected think tank, came to the same conclusion in 2018.

SK/P11.08) David H. Freedman, NEWSWEEK, March 27, 2020, pNA, Gale Academic OneFile. Studies have shown that the VA's wait times for care turn out to be shorter on average than those in the private sector for all types of treatments, with the one exception of elective orthopedic procedures such as knee surgery, where delays usually pose little risk to the patient. According to that 2019 VFW survey, 84 percent of vets said they were able to get care "in a timely manner."

SK/C01. U.S. HEALTHCARE IS NOT INTERNATIONALLY INFERIOR

1. W.H.O. RANKINGS ARE FATALLY FLAWED

SK/C01.01) Scott W. Atlas [Hoover Institution, Stanford U.], U.S. House of Representatives Hearings, GOVERNMENT DOCUMENTS & PUBLICATIONS, December 10, 2019, pNA, NexisUni. A decade prior to passage of the ACA, the ambitious World Health Report 2000 by the World Health Organization (WHO) ranked health care systems of 191 nations. Its most notorious finding - the relatively low US ranking as 37th in "overall performance" as defined by the WHO - has been repeatedly asserted as objective evidence of the overall failure of America's health care by many policymakers and advocacy groups, especially in light of the higher expenditures for health care in the US. Contrary to naively drawn inferences from that study, the WHO study methods and conclusions were heavily criticized in a body of peer-reviewed literature by academic international experts who examined the report in detail.

SK/C01.02) Scott W. Atlas [Hoover Institution, Stanford U.], U.S. House of Representatives Hearings, GOVERNMENT DOCUMENTS & PUBLICATIONS, December 10, 2019, pNA, NexisUni. Why would the WHO rankings have been deemed severely flawed by health policy experts? First, almost two-third of the WHO rankings were based on equality, rather than quality. For instance, a system with C-quality but equal performance for everyone would be ranked higher than a system with A-quality excellence for some and C-quality performance for others. Other fundamental flaws in the WHO methodology have also been detailed throughout the published literature. Serious problems have undermined legitimacy of the comparative rankings in the report, including: 1) highly subjective inputs, many of which do not closely reflect health care access or quality; 2) arbitrary assumptions about relative importance of inputs based on ideological bias; 3) when data was missing from dozens of countries, it was filled in simply based on assumptions of the study authors; and 4) substantial measurement errors with comparisons lacking statistical significance were ignored and misleading rankings were still put forth. Even the 37th place overall ranking had already been adjusted downward due to the high expenditures in the US, rather than based on quality per se.

2. INTERNATIONAL COMPARISONS ARE METHODOLOGICALLY INVALID

SK/C01.03) John Merline [Editor, Issues & Insights], inFOCUS, Winter 2020, p. 36+, Gale Academic OneFile. Sanders, along with every other Democrat pushing "Medicare for All" and its variants, constantly bleats about how the US spends far more on health care but gets worse results than countries such as Canada or the UK. But the quality measures--infant mortality and longevity--are notoriously unreliable for international comparisons. Infant mortality rates depend on how countries measure them, and longevity has more to do with things like obesity, crime, and drug abuse than health care.

SK/C01.04) Scott W. Atlas [Hoover Institution, Stanford U.], U.S. House of Representatives Hearings, GOVERNMENT DOCUMENTS & PUBLICATIONS, December 10, 2019, pNA, NexisUni. Beyond the widely discredited WHO Report, single-payer advocates often point to America's consistently low ranking in two statistics: life expectancy and infant mortality rate. But expert studies have proven these two statistics to be grossly flawed in ways that do not reflect health care system quality and also misleadingly rank the US lower than peer nations.

SK/C01.05) Scott W. Atlas [Hoover Institution, Stanford U.], U.S. House of Representatives Hearings, GOVERNMENT DOCUMENTS & PUBLICATIONS, December 10, 2019, pNA, NexisUni. Consider America's rate of infant mortality--death within the first year after birth--calculated to be 5.9 per 1,000 live births in the latest statistics, 32nd among 35 developed countries, according to the OECD. First, basic terminology and definitions vary country-to-country, generating false comparisons. The US strictly adheres to the World Health Organization (WHO) definition of live birth ("irrespective of the duration of the pregnancy. . . breathes or shows any other evidence of life"), counting all births, even extremely premature infants who have the least chance of survival. This isn't necessarily true for European nations. The WHO noted "(it is) common practice in several countries (e.g. Belgium, France, Spain) to register as live births only those infants who survived for a specified period beyond birth", and infants who did not survive were completely ignored for registration purposes. A British study of Belgium, Denmark, Finland, France, Germany, Greece, Netherlands, Norway, Portugal, Spain, Sweden, and UK found that terminology alone caused up to 40% variation and 17% false reductions in infant mortality.

SK/C02. HARMS OF BEING UNINSURED ARE EXAGGERATED

1. IMPACT OF MEDICAL DEBT IS EXAGGERATED

SK/C02.01) Margot Sanger-Katz & Sydney Ember, THE NEW YORK TIMES, September 22, 2019, p. A19, NexisUni. Studies suggest that medical debts can be less damaging to people's credit than other kinds of debt, in part because the credit reporting agencies treat people's ability to pay medical bills as less predictive of creditworthiness than, say, their ability to pay credit card bills or car payments. And, despite the news media's focus on particularly large medical bills, the typical bill in collections is less than $600, according to the Health Affairs article.

2. EXTENT OF MEDICAL BANKRUPTCIES IS OVERSTATED

SK/C02.02) Margot Sanger-Katz & Sydney Ember, THE NEW YORK TIMES, September 22, 2019, p. A19, NexisUni. The Sanders campaign circulated statistics suggesting that more than 500,000 Americans declare bankruptcy each year because of medical bills. That number, derived from a survey of bankrupt individuals, overstates the impact of medical bills on bankruptcy. The study itself noted that health problems can cause bankruptcies in two ways, through direct medical bills and through lost income due to illness itself. The 500,000 figure includes both groups.

3. LACK OF INSURANCE DOES NOT INCREASE BANKRUPTCIES

SK/C02.03) Lisa Marshall [U. of Colorado], STATES NEWS SERVICE, April 30, 2020, pNA, NexisUni. The researchers they [Tim Wadsworth, associate professor of sociology at U. of Colorado, Boulder & Michael D. Sousa, associate professor at University of Denver’s Sturm College of Law] found no evidence that people without insurance are more likely to file bankruptcy than people with full coverage. In contrast, prior to the implementation of the law, people with intermittent coverage were twice as likely to file for bankruptcy as the fully insured. "We found that it is not lack of insurance that is predictive of bankruptcy, but rather going on and off of it," said Sousa, who is also a PhD candidate in the CU Boulder Department of Sociology. After the passage of the ACA, however, that added risk disappeared.

4. BANKRUPTCIES HAVE PLUMMETED

SK/C02.04) Lisa Marshall [U. of Colorado], STATES NEWS SERVICE, April 30, 2020, pNA, NexisUni. On March 23, 2010, President Barack Obama signed the Affordable Care Act (ACA) into law with a stated goal of addressing the "crushing cost of health care...a cost that now causes a bankruptcy in America every 30 seconds." A decade later, the law, otherwise known as Obamacare, appears to be accomplishing that goal, leading not only to millions more insured individuals but also to a sharp decline in bankruptcy risk among those with on-and-off coverage, new University of Colorado Boulder and University of Denver research suggests. "The big picture finding is that the ACA is doing what it is supposed to be doing, providing more people with health coverage and buffering them from crushing debt that can play out in financial ruin," said co-author Tim Wadsworth, an associate professor of sociology at CU Boulder.

SK/C03. PRIVATE HEALTH INSURANCE IS NOT FATALLY FLAWED

1. BARRIERS TO COMPETITION ARE BEING DISMANTLED

SK/C03.01) Scott W. Atlas [Sr. Fellow, Hoover Institution, Stanford U.], THE NEW YORK TIMES, March 9, 2020, pNA, NexisUni. 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.

2. INSURANCE COMPANIES ARE RESPONDING TO COVID PANDEMIC

SK/C03.02) Reed Abelson, THE NEW YORK TIMES, August 5, 2020, pNA, NexisUni. Insurers say that they are using their financial strength to help customers as well as hospitals and doctors. "From the very beginning, health insurance providers have focused on being part of the solution," said Matt Eyles, the chief executive of America's Health Insurance Plans, a trade group. As examples, he cited waiving co-payments for testing and treatment for coronavirus and paying for telemedicine visits, some of which the government has mandated be covered. The companies also say they are spending billions of dollars on efforts that range from giving small businesses a break on their monthly premiums to paying physicians in advance to help keep practices afloat.

SK/C03.03) Reed Abelson, THE NEW YORK TIMES, August 5, 2020, pNA, NexisUni. On conference calls with Wall Street analysts, executives were quick to point out steps they have taken to assuage the worries of Americans overwhelmed by the virus outbreaks. "We took action to commit $2.5 billion in financial assistance to ease the burden of Covid-19 among our members, employer customers, care providers and nonprofit partners," said Gail K. Boudreaux, the chief executive of Anthem. She listed several initiatives, including giving customers a premium credit and donations to a food charity.

3. UNINSURED CAN QUALIFY FOR MEDICAID

SK/C03.04) Talya Meyers [Direct Relief], STATES NEWS SERVICE, July 27, 2020, pNA, NexisUni. For those who lose their jobs, Medicaid the nationwide public-insurance program designed for those with limited income and resources is often the first stop. "If you lose your insurance, you should go to the Medicaid program and apply for coverage right away," Dorn [Director, National Center for Coverage Innovation at Families USA] said. "A lot of people are eligible who don't think they're eligible."

4. MEDICAID COULD BE EXPANDED

SK/C03.05) Henry J. Kaiser Family Foundation, STATES NEWS SERVICE, June 25, 2020, pNA, NexisUni. About 4.7 million uninsured adults could gain eligibility for Medicaid by 2021 if the 14 remaining non-expansion states were to expand Medicaid under the Affordable Care Act, a new KFF analysis finds. That figure includes an estimated 2.8 million adults who already were uninsured prior to the coronavirus pandemic and would fall in the "coverage gap" meaning they have incomes too high to qualify for Medicaid but too low for ACA marketplace subsidies as well as 1.9 million more people who are at risk of losing health insurance due to job loss during the pandemic and otherwise would end up in the coverage gap.

SK/C04. OBAMACARE CAN BE EXPANDED

1. MILLIONS ARE INSURED DUE TO AFFORDABLE CARE ACT

SK/C04.01) Lisa Marshall [U. of Colorado], STATES NEWS SERVICE, April 30, 2020, pNA, NexisUni. Not surprisingly, they [Tim Wadsworth, associate professor of sociology at U. of Colorado, Boulder & Michael D. Sousa, associate professor at University of Denver's Sturm College of Law] found that more people were insured after the ACA was enacted. The percentage of fully insured individuals rose from 72% to 80%, while those with no coverage dipped from a high of 12.6% to 7.4%. On-and-off coverage declined from 17% to 13%. In all, about 20 million Americans gained access to health insurance as a result of the ACA.

SK/C04.02) North Carolina Democratic Party, STATES NEWS SERVICE, June 24, 2020, pNA, NexisUni. Currently more than 4 million people in the Tar Heel State now have coverage for pre-existing conditions through the ACA and over 1 million seniors have had drug costs lowered because of it. The law has also helped more than 500,000 North Carolinians purchase affordable insurance.

2. EXPANDING OBAMACARE IS PREFERABLE TO MEDICARE FOR ALL

SK/C04.03) Sheryl Gay Stolberg, THE NEW YORK TIMES, July 14, 2020, pNA, NexisUni. The studies come in the thick of the campaign season, when health care — and in particular the future of the Affordable Care Act, popularly known as Obamacare — will be a major issue. Democrats and their presumptive presidential nominee, Joseph R. Biden Jr., want to expand the law.

SK/C04.04) Reed Abelson, THE NEW YORK TIMES, August 5, 2020, pNA, NexisUni. Even if former Vice President Joseph R. Biden Jr., the Democratic presidential candidate, wins in November, he would probably be unlikely to push for anything close to Medicare for all. Mr. Biden favors revamping Obamacare and offering a public option, a government-run alternative to private insurance.

3. PUBLIC OPTION CAN BE INCLUDED

SK/C04.05) RAND Corporation, STATES NEWS SERVICE, May 28, 2020, pNA, NexisUni. State and federal lawmakers have expressed interest in creating a public health insurance option, broadly defined as an insurance plan for individuals under age 65 that provides access to publicly determined payment rates. Four different bills that would create a federal public option were introduced in Congress in 2019 and several Democratic presidential candidates (including presumptive nominee Joe Biden) included public options in their health reform platforms.

4. MULTIPLE-PAYER SYSTEM IS PREFERABLE TO SINGLE-PAYER

SK/C04.06) William C. Hsiao [Professor of Economics Emeritus, Harvard U.], FOREIGN AFFAIRS, January-February 2020, p. 96+, Gale Academic OneFile. Although Americans have begun to take a more favorable view of single-payer systems in recent years, it's far from clear that the idea has enough popular support to clear such hurdles. Perhaps a more practical approach would be for the United States to follow Germany's lead and to undertake reforms that would allow for multiple insurers but create a uniform system of payments and electronic records to help control waste and fraud. Such a system would also let insurers collectively bargain with major pharmaceutical companies for reasonable drug prices. These measures alone could save somewhere between $200 billion and $300 billion each year--savings that, along with modest tax increases, could be used to expand existing public coverage for the uninsured.

SK/C05. SINGLE-PAYER CAN'T WORK IN THE U.S.

1. MEDICARE MISMANAGEMENT PROVES FEDERAL INCAPABILITY

SK/C05.01) Jay Bhattacharya [Professor of Medicine, Stanford U.] & Jonathan Ketchum [Professor of Business, Arizona State U.], USA TODAY, May 2020, p. 49+, Gale Academic OneFile. First, he [Michael Cannon, Cato Institute's director of Health Policy Studies] argues that no country as vast as the U.S. limits the availability of private insurance, centrally controls health prices and provision, and provides health insurance coverage to its entire population. Second, he contends that it is farfetched to expect large savings from replacing private insurance and Medicaid with federally managed public insurance given the government's long track record of failure at managing Medicare.

2. EVEN VERMONT COULD NOT MAKE MEDICARE FOR ALL WORK

SK/C05.02) Austin Frakt & Aaron E Carroll, THE NEW YORK TIMES, August 13, 2019, p. A12, NexisUni. Paul Starr, a professor of sociology and public affairs at Princeton, favors tax financing, but a look at the numbers convinced him that it was not realistic. If taxes were to replace all private premiums as well as out-of-pocket spending (as in some single-payer plans), the government would have to nearly double what it now collects in personal income tax. "There's no precedent in American history for a tax increase of that magnitude," he said. "It's not going to happen." Mr. McDonough [Harvard professor who helped write the Affordable Care Act] reminded us that when Vermont considered a tax-financed single payer system, sticker shock killed it. The required tax increase "was recognized by then-governor and single-payer champion Peter Shumlin as political suicide."

SK/C05.03) Ken Perez [vice president of healthcare policy, Omnicell, Inc.], HEALTHCARE FINANCIAL MANAGEMENT, August 2019, p. 14+, Gale Academic OneFile. Shedding light on the potential tax implications of a single-care program, in 2014, Vermont's then-Gov. Peter Shumlin, a Democrat who had famously championed a single-payer system, abandoned his drive after concluding that 11.5% payroll assessments on businesses and sliding-scale premiums of up to 9.5% of individuals' income "might hurt our economy."

SK/C05.04) Jay Bhattacharya [Professor of Medicine, Stanford U.] & Jonathan Ketchum [Professor of Business, Arizona State U.], USA TODAY, May 2020, p. 49+, Gale Academic OneFile. After all, even small Vermont's single-payer experiment failed to launch under the weight of its costs.

SK/C06. MEDICARE FOR ALL WOULD DECREASE QUALITY OF CARE

1. MEDICARE FOR ALL IS NOT A SIMPLE MEDICARE EXPANSION

SK/C06.01) Margot Sanger-Katz, THE NEW YORK TIMES, February 26, 2019, pNA, NexisUni. The basic idea of "Medicare for all" is that all Americans should get access to the popular, government-run program. But a new bill toward this goal, the first introduced in the current Congress, would also drastically reshape Medicare itself. The bill, from Representative Pramila Jayapal of Washington and more than 100 Democratic House co-sponsors, would greatly expand Medicare and eliminate the current structure of premiums, co-payments and deductibles.

SK/C06.02) Margot Sanger-Katz, THE NEW YORK TIMES, February 26, 2019, pNA, NexisUni. It would be wrong to think of the Jayapal bill as simply expanding the current Medicare program to cover more people and more benefits. It also would make major changes to the way doctors and hospitals are paid. This would change not just how Americans get their insurance, but it could also reshape the health care system in ways that are difficult to predict.

SK/C06.03) Margot Sanger-Katz, THE NEW YORK TIMES, February 26, 2019, pNA, NexisUni. Currently, Medicare (as well as most private insurance) pays most doctors and hospitals for each service performed. There's one fee for a standard checkup, and another for appendicitis surgery, for example. Medicare determines prices for those various services, and medical providers are paid for performing them. Then those doctors and hospitals are largely free to allocate the money they make as they see fit. For-profit hospitals may return some of the dollars to their investors. Nonprofit hospitals might use them to buy new gadgets or upgrade to private rooms — or provide charity care for people without insurance. The Jayapal bill would upend that system. Instead of paying hospitals per treatment, Medicare would try to come up with an appropriate lump sum payment for every hospital and nursing home in the country — what the bill calls a "global budget" payment.

2. IT WILL SERIOUSLY UNDERMINE CURRENT MEDICARE FOR SENIORS

SK/C06.04) Scott W. Atlas [Sr. Fellow, Hoover Institution, Stanford U.], THE NEW YORK TIMES, March 9, 2020, pNA, NexisUni. It may seem counterintuitive, but single-payer health care proposals like Medicare for All could very well destroy Medicare as we know it and jeopardize medical care for seniors. It's not just because single-payer systems like those in Britain and Canada hold down costs by limiting the availability of doctors and treatments, even for the most serious life-threatening diseases like cancer, brain tumors and heart disease. And it's not just because single-payer systems restrict access to the newest drugs for cancer and other serious diseases, sometimes for years, compared with the United States system. Or that single-payer systems have shown to have worse outcomes than the United States system for many common diseases like cancer, high blood pressure, stroke, heart disease and diabetes. Or that tens of thousands of citizens in single-payer countries have died because of wait times for nonemergency treatment.

SK/C06.05) Scott W. Atlas [Sr. Fellow, Hoover Institution, Stanford U.], THE NEW YORK TIMES, March 9, 2020, pNA, NexisUni. 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.

SK/C06.06) Scott W. Atlas [Sr. Fellow, Hoover Institution, Stanford U.], THE NEW YORK TIMES, March 9, 2020, pNA, NexisUni. 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.

SK/C06.07) White House, STATES NEWS SERVICE, October 3, 2019, pNA, NexisUni. The proposed Medicare for All Act of 2019, as introduced in the Senate (Medicare for All) would destroy our current Medicare program, which enables our Nation's seniors and other vulnerable Americans to receive affordable, high-quality care from providers of their choice.

3. MEDICARE FOR ALL WILL BANKRUPT MANY HOSPITALS

SK/C06.08) Reed Abelson, THE NEW YORK TIMES, April 21, 2019, pNA, NexisUni. If Medicare for all abolished private insurance and reduced rates to Medicare levels — at least 40 percent lower, by one estimate — there would most likely be significant changes throughout the health care industry, which makes up 18 percent of the nation's economy and is one of the nation's largest employers. Some hospitals, especially struggling rural centers, would close virtually overnight, according to policy experts. Others, they say, would try to offset the steep cuts by laying off hundreds of thousands of workers and abandoning lower-paying services like mental health.

SK/C06.09) Rich Daly, HEALTHCARE FINANCIAL MANAGEMENT, September 2019, p. 16, Gale Academic OneFile. Although a slice of hospitals might financially benefit from a single-payer model based on Medicare rates, 90% would face cuts totaling $200 billion each year, according to a July 16 Crowe analysis of its transaction database for more than 1,000 hospitals.

SK/C06.10) Reed Abelson, THE NEW YORK TIMES, April 21, 2019, pNA, NexisUni. The nation's major health insurers are sounding the alarms, and pointing to the potential impact on hospitals and doctors. David Wichmann, the chief executive of UnitedHealth Group, the giant insurer, told investors that these proposals would "destabilize the nation's health system and limit the ability of clinicians to practice medicine at their best." Hospitals could lose as much as $151 billion in annual revenues, a 16 percent decline, under Medicare for all, according to Dr. Kevin Schulman, a professor of medicine at Stanford University and one of the authors of a recent article in JAMA looking at the possible effects on hospitals.

SK/C06.11) Reed Abelson, THE NEW YORK TIMES, April 21, 2019, pNA, NexisUni. Big hospital systems haggle constantly with Medicare over what they are paid, and often battle the government over charges of overbilling. On average, the government program pays hospitals about 87 cents for every dollar of their costs, compared with private insurers that pay $1.45.

4. MEDICAL SERVICES WILL BE DENIED

SK/C06.12) Scott W. Atlas [Hoover Institution, Stanford U.], U.S. House of Representatives Hearings, GOVERNMENT DOCUMENTS & PUBLICATIONS, December 10, 2019, pNA, NexisUni. On the other hand, nationalized single-payer systems spend less on health care than the US. But disregarded by those advocating single-payer care is the fact that governments regulate costs in single-payer systems by overtly restricting its use. Single-payer systems universally hold down health care costs by limiting availability of doctors, treatments, medications, and technology, through its power over patients and doctors as the only direct payer.

SK/C06.13) USA TODAY, January 2020, p. 30+, Gale Academic OneFile. Still, in traditional Medicare, you get worry-free treatment, right? Not exactly. Government controls constantly are tightening. The ironically named Protecting Access to Medicare Act of 2014 provides that clinicians must refer to "appropriate use criteria" (AUC) when ordering advanced imaging like CT scans or MRIs. We supposedly are in a "testing period," during which payment will not be denied. However, physicians already are receiving notices from their hospital that they now must use AUC when ordering outpatient studies.

5. QUALITY OF CARE WOULD INEVITABLY DECLINE

SK/C06.14) Scott W. Atlas [Sr. Fellow, Hoover Institution, Stanford U.], THE NEW YORK TIMES, March 9, 2020, pNA, NexisUni. 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.

SK/C06.15) Jay Bhattacharya [Professor of Medicine, Stanford U.] & Jonathan Ketchum [Professor of Business, Arizona State U.], USA TODAY, May 2020, p. 49+, Gale Academic OneFile. There also are palpable costs to individuals. Rather than paying through patient cost sharing, which is banned under Sanders' plan, people would pay in the form of fewer services and lower intensity of treatment per encounter. These costs are direct consequences of the proposed slashes in providers' payments and the need for draconian supply rationing to limit overuse in the absence of patient cost sharing. As documented in Japan and Canada, these policies result in more delays, more visits to resolve health problems, and lower productivity.

SK/C06.16) Ken Perez [vice president of healthcare policy, Omnicell, Inc.], HEALTHCARE FINANCIAL MANAGEMENT, August 2019, p. 14+, Gale Academic OneFile. On May 22, Congressional Budget Office deputy director Mark Hadley testified at a House Budget Committee hearing on Medicare for All. Although Hadley declined to provide a cost estimate for the legislation, he noted that the changes required to implement a single-payer system "could significantly affect the overall U.S. economy" and be "potentially disruptive," and he cautioned that "the amount of care supplied and the quality of that care might diminish."

SK/C07. MEDICARE FOR ALL WILL INCREASE COSTS

1. MEDICARE HAS PRODUCED RUNAWAY HEALTHCARE COSTS

SK/C07.01) USA TODAY, January 2020, p. 30+, Gale Academic OneFile. After a huge percentage of the population got "covered" by the government, did things get better? People did get more treatment. Great advances in medical technology occurred--likely unrelated to Medicare. However, toxic, unrelenting cost-price inflation began abruptly after 1965 for the first time in 90 years, leading to massive government interventions to put a lid on them. Administrative demands burgeoned--there now are at least 10 times as many administrators as doctors. Then government eroded the value of people's savings by inflating the dollar. If you had put $10 in a mattress in 1965, it would be worth $1.24 today.

2. MEDICARE FOR ALL WOULD COST TRILLIONS

SK/C07.02) Scott W. Atlas [Hoover Institution, Stanford U.], U.S. House of Representatives Hearings, GOVERNMENT DOCUMENTS & PUBLICATIONS, December 10, 2019, pNA, NexisUni. The current Senate bill to establish single-payer health insurance in the US by Senator Bernie Sanders, "Medicare for All Act, or M4A", has been estimated to cost over $32 trillion in its first decade. Doubling all currently projected federal individual and corporate income tax collections would be insufficient to finance the added federal costs of the plan.

3. MEDICARE FOR ALL COST WOULD DWARF CURRENT SYSTEM COST

SK/C07.03) Ken Perez [vice president of healthcare policy, Omnicell, Inc.], HEALTHCARE FINANCIAL MANAGEMENT, August 2019, p. 14+, Gale Academic OneFile. Unquestionably, under a single-payer system, the federal government's expenditures for healthcare would increase significantly. Sanders [U.S. Senator] posits that $16.2 trillion would be the implied expected increase in federal expenditures over a 10-year period under his plan. However, several analyses have concluded that federal expenditures would rise by significantly more than Sanders projected, and NHE would be higher under Medicare for All than under the present multi-payer system.

SK/C07.04) Ken Perez [vice president of healthcare policy, Omnicell, Inc.], HEALTHCARE FINANCIAL MANAGEMENT, August 2019, p. 14+, Gale Academic OneFile. The Urban Institute, a left-center think tank, has concluded that federal expenditures would increase by about $32 trillion over 10 years (2017-2036)--roughly twice what Sanders projected--and NHE would, in fact, increase, not decrease, by $6.6 trillion over the same 10-year period. Notably, the Urban Institute's projection incorporates "provider supply constraints faced by current Medicaid enrollees," which means not all increased demand for healthcare would be met under the program.

SK/C07.05) Linda Qiu, THE NEW YORK TIMES, November 10, 2019, p. A16, NexisUni. The Urban Institute found that total health spending would reach $52 trillion from 2020 to 2029 under existing law versus $59 trillion under Medicare for all. The RAND Corporation estimated the status quo costing $3.8 trillion versus $3.9 trillion for single-payer in 2019.

4. COSTS WOULD INCREASE FOR MOST AMERICANS

SK/C07.06) Peter Suderman [features editor], REASON, February 2020, p. 12, Gale Academic OneFile. Warren [U.S. Senator] has argued that total costs for middle-class families would go down under her plan, but there are reasons to doubt this, including an analysis from Emory University health care economist Kenneth Thorpe finding that under Medicare for All, more than 70 percent of people who currently have private insurance would see costs increase. A separate analysis from the liberal Urban Institute projects that single-payer plans would raise national health care spending by $7 trillion over a decade, contrary to Warren's estimates.

5. OPTIMISTIC FORECASTS MAKE UNPREDICTABLE ASSUMPTIONS

SK/C07.07) Linda Qiu, THE NEW YORK TIMES, November 10, 2019, p. A16, NexisUni. Apart from examining different time frames, such diverging estimates result from the unpredictable nature of projecting how Medicare for all would work in practice. How much fees paid to doctors and hospitals, prescription drugs prices and administrative costs could be reduced -- and how many more people would become insured and use health care services -- will all affect a single-payer system's bottom line.

SK/C08. MEDICARE FOR ALL DEVASTATES THE ECONOMY

1. TAXING THE WEALTHY CAN'T FINANCE MEDICARE FOR ALL

SK/C08.01) Alex Hendrie [Americans for Tax Reform], STATES NEWS SERVICE, August 14, 2020, pNA, NexisUni. Regardless, taxes on "the rich" will not come close to paying for Medicare for All. For instance, a "wealth tax," a financial transactions tax, a 10 percent surtax on "the wealthy," a 70 percent top rate, and doubling the tax rate on capital gains would pay for roughly 20 percent of the cost of Medicare for All according to the best-case scenario estimates by the left.

2. MIDDLE-CLASS TAX INCREASES ARE UNAVOIDABLE

SK/C08.02) Alex Hendrie [Americans for Tax Reform], STATES NEWS SERVICE, August 14, 2020, pNA, NexisUni. Medicare for All will require $32 trillion in higher taxes over the next decade, according to a report by the Urban Institute and the Commonwealth Fund.

SK/C08.03) Alex Hendrie [Americans for Tax Reform], STATES NEWS SERVICE, August 14, 2020, pNA, NexisUni. There is no way to come close to paying for Medicare for All without dramatic tax increases on the middle class. The proposal released by Bernie Sanders contains $14 trillion in tax hikes, roughly 40% of the total cost of Medicare for All. It is also important to note that a significant portion of Sanders' $14 trillion tax increase relies on eliminating healthcare options for American families ($4.2 trillion) and a 7 percent tax on employers large and small ($3.5 trillion).

SK/C08.04) Peter Suderman [features editor], REASON, February 2020, p. 12, Gale Academic OneFile. Warren [U.S. Senator] claims "we don't need to raise taxes on the middle class by one penny to finance Medicare for All." Instead, she refers to this as an "employer Medicare contribution" under which companies "would send payments to the federal government for Medicare." But there is a commonly accepted term for requiring companies to send payments to the federal government in order to finance government programs. That word is tax. Her plan is thus a nearly $9 trillion tax on employers, charged on a per-worker basis, with exceptions for small businesses. That would inevitably end up affecting employees' compensation. It is hard to see this as anything other than a massive middle-class tax hike.

3. MEDICARE FOR ALL WOULD TRIGGER MASSIVE JOB LOSS

SK/C08.05) Ken Perez [vice president of healthcare policy, Omnicell, Inc.], HEALTHCARE FINANCIAL MANAGEMENT, February 2020, p. 22+, Gale Academic OneFile. In explicitly abolishing private health insurance, the Warren plan has been described as an "existential threat" to the health insurance industry. America's Health Insurance Plans (AHIP), the insurers' trade association, estimates that the jobs of 1.5 million workers in the industry would be jeopardized.

4. MEDICARE FOR ALL WOULD EXPLODE FEDERAL DEFICITS

SK/C08.06) Peter Suderman [features editor], REASON, February 2020, p. 12, Gale Academic OneFile. Other outside experts, meanwhile, have suggested that [Senator] Warren's plan will cost more than she anticipates and raise less revenue. In an analysis of the fiscal effects of Warren's plan, Avik Roy, president of the Foundation for Research on Equal Opportunity, estimates that she would end up increasing deficits by about $15 trillion over a decade. That's because Warren doesn't account for the likely economic ripple effects her plan would almost certainly cause; instead, she assumes that even with an array of new taxes and fees on businesses and wealthy individuals, economic growth would continue without change. Corporate tax rates would go from 21 percent to 35 percent, which, as Roy notes, "would have a meaningful [negative] effect on employment and economic growth, especially in the manufacturing sector and other capital-intensive industries." This allows her to claim far more tax revenue than is realistic.

5. DEFICIT FINANCING WOULD DEVASTATE ECONOMIC GROWTH

SK/C08.07) U. of Pennsylvania’s Wharton School, TARGETED NEWS SERVICE, January 21, 2020, pNA, NexisUni. Taken literally, Sanders' Medicare for All Act lacks a financing mechanism, which by long-standing Congressional Budget Office and PWBM convention implies deficit financing. Under deficit financing, the plan would reduce GDP by 24 percent by 2060, despite large efficiency gains from lower overhead and reimbursement costs.

SK/C09. OTHER COUNTRIES ARE NOT MODELS FOR SUCCESS

1. OTHER COUNTRIES DON'T ABOLISH PRIVATE INSURANCE

SK/C09.01) Margot Sanger-Katz, THE NEW YORK TIMES, February 25, 2020, pNA, NexisUni. Nearly every peer country has universal health insurance coverage. But Mr. Sanders proposes a plan with the government providing insurance to everyone directly, and with people responsible for almost no out-of-pocket costs. It comes the closest to the Canadian system, also called Medicare. But in Canada, Medicare does not cover prescription drugs or dental care, for example. In most European countries, there is a mix of private and public sources of insurance.

SK/C09.02) Austin Frakt & Aaron E Carroll, THE NEW YORK TIMES, August 13, 2019, p. A12, NexisUni. One advantage is that private coverage can offer benefits that public plans like Medicare don't. Many other countries, even those with universal public coverage like Canada and Britain, also allow employers to offer additional coverage. "Americans like choice, and flexibility," said Elizabeth Bradley, a public health scholar and president of Vassar College.

2. HEALTHCARE IS NOT REALLY FREE

SK/C09.03) Scott W. Atlas [Hoover Institution, Stanford U.], U.S. House of Representatives Hearings, GOVERNMENT DOCUMENTS & PUBLICATIONS, December 10, 2019, pNA, NexisUni. Today, England's NHS Constitution explicitly states "You have the right to receive NHS services free of charge" ... despite taxing citizens about $125 billion per year, roughly equivalent to $160 billion dollars per year. Canada's "free" health care costs the average family about $13,311 per year for government health insurance; families among the top 10% of income earners in Canada will pay $39,486.. Note that Canada's "free" health care actually costs billions of dollars in 2019 to individuals in foregone wages and to the overall economy.

3. SINGLE-PAYER COUNTRIES LIMIT ACCESS TO CARE

SK/C09.04) Marilyn M. Singleton [President, Association of American Physicians and Surgeons], USA TODAY, May 2019, p. 22+, Gale Academic OneFile. Our Western counterparts with single payer have discovered that offering fewer benefits is the simplest way to control costs. The "Complete Lives System"--the brainchild of ObamaCare architect Ezekiel Emanuel--includes worrisome determinants of who should receive care. The system prioritizes adolescents and persons with "instrumental value," i.e., individuals with "future usefulness."

4. LIFE EXPECTANCY DOES NOT INCREASE

SK/C09.05) Jay Bhattacharya [Professor of Medicine, Stanford U.] & Jonathan Ketchum [Professor of Business, Arizona State U.], USA TODAY, May 2020, p. 49+, Gale Academic OneFile. As countries expand their governments' involvement in health care, they do not benefit from longer life expectancy on average, nor do they achieve any greater equality in life expectancy within the country.

5. QUALITY OF CARE ACTUALLY DECLINES

SK/C09.06) Scott W. Atlas [Hoover Institution, Stanford U.], U.S. House of Representatives Hearings, GOVERNMENT DOCUMENTS & PUBLICATIONS, December 10, 2019, pNA, NexisUni. Single-payer systems in countries with decades of experience have proven to be inferior to the US system in virtually every important objective measure of access to care and quality.

SK/C09.07) John Merline [Editor, Issues & Insights], inFOCUS, Winter 2020, p. 36+, Gale Academic OneFile. Canada and the UK are plagued with chronic shortages of doctors and nurses, shortages of hospital beds, shortages of the latest diagnostic tools. The result is treatment delays and outright denials. This grim reality plays out daily in the newspapers of the two countries, stories that Sanders, Sen. Elizabeth Warren and other single-payer advocates pretend don't exist.

SK/C10. DELAYS IN CARE CAUSE DEATH AND SUFFERING

1. LONG WAITS ARE THE NORM IN ENGLAND

SK/C10.01) Scott W. Atlas [Hoover Institution, Stanford U.], U.S. House of Representatives Hearings, GOVERNMENT DOCUMENTS & PUBLICATIONS, December 10, 2019, pNA, NexisUni. In those countries with the longest experience of single-payer health care, published data demonstrates massive waiting lists and delays that are unheard of in the United States. In England alone, according to government statistics, a record-setting 4.2 million patients are on NHS waiting lists as of 2018; 95,252 have been waiting more than six months for treatment; and more than 3,400 patients are waiting more than one full year as of July, 2018 ... all after already receiving initial diagnosis and referral. As of late 2016, the NHS average waiting time exceeded 100 days for hip or knee replacements, hernia repair, and tonsillectomies.

2. LONG WAITS ARE THE NORM IN CANADA

SK/C10.02) Caitlyn Kelly, THE AMERICAN PROSPECT, January-February 2020, p. 28+, Gale Academic OneFile. "The Canadian system is characterized by waiting," says Andre Picard, health reporter since 1987 for The Globe and Mail, Canada's national newspaper. "We wait to see a GP, wait for a referral to a specialist, for elective surgery, for home care and longer for long-term care. There is little to no accountability and little incentive for solving these problems."

SK/C10.03) Scott W. Atlas [Hoover Institution, Stanford U.], U.S. House of Representatives Hearings, GOVERNMENT DOCUMENTS & PUBLICATIONS, December 10, 2019, pNA, NexisUni. In Canada's single-payer system, the 2017 median wait from GP appointment to the specialist appointment was 10.2 weeks; when added to the median wait of 10.9 weeks from specialist to first treatment, the median wait after seeing a doctor to start treatment was 21 weeks, or about 5 months. An average wait for a Canadian cardiology patient was 6.4 weeks for the cardiologist appointment after seeing the GP, and another 5.3 weeks to start treatment; that means 11.7 weeks after GP appointment to first treatment. The average Canadian woman waits 13.2 weeks after seeing the GP to see the gynecologist and another 9.3 weeks to first treatment, or 22.5 weeks total from GP visit to treatment.

3. WAITS ARE MUCH HIGHER IN CANADA AND UK THAN IN THE U.S.

SK/C10.04) Scott W. Atlas [Hoover Institution, Stanford U.], U.S. House of Representatives Hearings, GOVERNMENT DOCUMENTS & PUBLICATIONS, December 10, 2019, pNA, NexisUni. These long waits are common for single-payer systems, but they stand in stark contrast to US health care. Aside from organ transplants, "waiting lists are not a feature in the United States," as stated by the OECD and verified by numerous studies. For instance, Ayanian and Quinn noted that "in contrast to England, most United States patients face little or no wait for elective cardiac care".

SK/C10.05) John Merline [Editor, Issues & Insights], inFOCUS, Winter 2020, p. 36+, Gale Academic OneFile. A 1995 study published in the Journal of the American College of Cardiology found that no patients needing an urgent coronary angiography test--used to reveal artery blockages--received one within 24 hours in Canada or the UK, whereas 65 percent did in the United States Nearly two-thirds of Canadians and 94 percent of Brits had to wait more than three days. The same study found that while 80 percent of urgent coronary bypass operations occurred within 24 hours in the US, only 24 percent did in Canada and 10 percent in the UK.

SK/C10.06) John Merline [Editor, Issues & Insights], inFOCUS, Winter 2020, p. 36+, Gale Academic OneFile. Tens of thousands of Canadians come across the border each year and pay out of pocket for health care they can't get in a timely fashion from their country's version of "Medicare for All."

4. LONG WAIT TIMES CAUSE UNNECESSARY DEATH AND SUFFERING

SK/C10.07) Scott W. Atlas [Hoover Institution, Stanford U.], U.S. House of Representatives Hearings, GOVERNMENT DOCUMENTS & PUBLICATIONS, December 10, 2019, pNA, NexisUni. The truth is that single-payer systems, including in the UK, Canada, Sweden, and other European and Nordic countries, impose shockingly long waiting times for doctor appointments, diagnostic procedures, drugs and surgery that are virtually never found in the US, specifically as a means of rationing care. And that failure to deliver timely medical care has serious consequences, including pain, suffering, and death; worse medical outcomes; permanent disability; lack of patient choices about their own health care; and tremendous costs.

SK/C10.08) John Merline [Editor, Issues & Insights], inFOCUS, Winter 2020, p. 36+, Gale Academic OneFile. The British regularly see headlines such as "Heath patients die on waiting lists," and "Patients are dying waiting for heart surgery." In Wales, 152 patients died waiting for heart surgery in two hospitals over five years. Last year, the NHS reported that wait times for bypass surgery doubled in Wales to 79 days. A 2003 analysis found that the death rate for patients with congestive heart failure was three times higher in British hospitals than those in the United States.

5. DELAYS IN CARE KILL THOUSANDS IN CANADA

SK/C10.09) Scott W. Atlas [Hoover Institution, Stanford U.], U.S. House of Representatives Hearings, GOVERNMENT DOCUMENTS & PUBLICATIONS, December 10, 2019, pNA, NexisUni. Indeed, the Supreme Court of Canada in the 2005 Chaoulli v Quebec decision was famously quoted to state "access to a waiting list is not access to health care", as it noted that patients in Canada die as a result of waiting lists for their single-payer health care.

SK/C10.10) Scott W. Atlas [Hoover Institution, Stanford U.], U.S. House of Representatives Hearings, GOVERNMENT DOCUMENTS & PUBLICATIONS, December 10, 2019, pNA, NexisUni. In single-payer systems, patients are dying or left unable to perform important daily living tasks while waiting months, even after their doctors recommended urgent treatment. Long waiting lists for care of Canadian women between 1993 and 2009 resulted in between 25,456 and 63,090 additional deaths, underscoring the point of Canada's Supreme Court statement in 2005.

SK/C10.11) John Merline [Editor, Issues & Insights], inFOCUS, Winter 2020, p. 36+, Gale Academic OneFile. A dozen cardiac patients died in Quebec in just the first four months of this year while waiting for surgery. Why the delay? According to the head of the province's cardiac surgeons association, it's largely because "of a shortage of operating room nurses and perfusionists--the technicians who operate the heart-lung machine during the surgery" as well as a lack of hospital beds. Overall wait times for specialist care of any kind has more than doubled in Canada since the 1990s, according to the Fraser Institute, which has been tracking this.

SK/C11. MEDICARE FOR ALL DESTROYS INDIVIDUAL FREEDOM

1. MEDICARE FOR ALL ELIMINATES MANY HEALTHCARE CHOICES

SK/C11.01) White House, STATES NEWS SERVICE, October 3, 2019, pNA, NexisUni. Medicare for All would not only hurt America's seniors, it would also eliminate health choices for all Americans. Instead of picking the health insurance that best meets their needs, Americans would generally be subject to a single, Government-run system. Private insurance for traditional health services, upon which millions of Americans depend, would be prohibited. States would be hindered from offering the types of insurance that work best for their citizens. The Secretary of Health and Human Services (Secretary) would have the authority to control and approve health expenditures; such a system could create, among other problems, delays for patients in receiving needed care. To pay for this system, the Federal Government would compel Americans to pay more in taxes. No one neither seniors nor any American would have the same options to choose their health coverage as they do now.

SK/C11.02) Jay Bhattacharya [Professor of Medicine, Stanford U.] & Jonathan Ketchum [Professor of Business, Arizona State U.], USA TODAY, May 2020, p. 49+, Gale Academic OneFile. Finally, he [Michael Cannon, Cato Institute's director of Health Policy Studies] notes that formally acknowledging health care as a right would limit access, worsen quality, and strip away Americans' rights to seek their own care or coverage outside the monopolist Medicare-for-All system.

SK/C11.03) Jay Bhattacharya [Professor of Medicine, Stanford U.] & Jonathan Ketchum [Professor of Business, Arizona State U.], USA TODAY, May 2020, p. 49+, Gale Academic OneFile. More than one-third of Americans age 65+ have opted out of traditional Medicare and into these private plans, including those with chronic conditions such as diabetes, schizophrenia, and lupus, for whom tailored Special Needs Plans are available. Similar dynamics play out in private markets, Medicaid, and many systems around the world. Under Sanders' proposal, those plans are illegal. There would be no customization of coverage, no ability to exclude providers, and no possibility for us to vote with our feet and seek care and coverage from models that bring us more value.

SK/C11.04) Jay Bhattacharya [Professor of Medicine, Stanford U.] & Jonathan Ketchum [Professor of Business, Arizona State U.], USA TODAY, May 2020, p. 49+, Gale Academic OneFile. Cannon's [Cato Institute] third point is a grim prophecy. Imposing one-size-fits-all coverage, shifting all pricing decisions and costs to the Federal government, and prohibiting any outside option will harm Americans' finances and freedoms with nothing to show for it in terms of health.

2. MEDICARE FOR ALL DESTROYS MARKET MECHANISM GUARDRAILS

SK/C11.05) Jay Bhattacharya [Professor of Medicine, Stanford U.] & Jonathan Ketchum [Professor of Business, Arizona State U.], USA TODAY, May 2020, p. 49+, Gale Academic OneFile. Under a market system, the prices negotiated with providers result from supply and demand. These prices act as powerful signals to providers about which markets to enter, which services to provide, how many hours to work, whether specialty training programs are worth the extra years, and which potential technologies risk capital and time researching and developing. Market prices also steer buyers, for example, by reducing demand where prices are high due to limited supply. While these mechanisms are imperfect, they embed safety valves and self-correction. They not only protect and benefit those in the private market, but serve as guardrails for Medicare's price-setting decisions. Under Sanders' proposed system, these guardrails of supply and demand are stripped away and replaced by unilateral decisions made by the government monopsonist.

3. PUBLIC OPINION DOES NOT REALLY FAVOR MEDICARE FOR ALL

SK/C11.06) Ken Perez [vice president of healthcare policy, Omnicell, Inc.], HEALTHCARE FINANCIAL MANAGEMENT, August 2019, p. 14+, Gale Academic OneFile. However, a January Kaiser Family Foundation Health Tracking Poll found that 60% would oppose Medicare-for-All legislation if it would require most Americans to pay more in taxes. Perhaps even more concerning--because it indicates a lack of understanding of the fundamentals of the Medicare-for-All concept--60% would oppose such legislation if it would threaten the current Medicare program and 58% would oppose it if it would eliminate private health insurance companies.

SK/C11.07) Margot Sanger-Katz, THE NEW YORK TIMES, February 25, 2020, pNA, NexisUni. Public opinion surveys also show that many voters who say they like Medicare for all don’t know much about the details, and some change their minds after learning about certain features, like the loss of private insurance or possible tax increases.

4. GOVERNMENT CONTROL IS TAKEN TO AN UNACCEPTABLE LEVEL

SK/C11.08) Jay Bhattacharya [Professor of Medicine, Stanford U.] & Jonathan Ketchum [Professor of Business, Arizona State U.], USA TODAY, May 2020, p. 49+, Gale Academic OneFile. With the entire U.S. health care system financed through the Federal government, the government has a controlling interest in any of our choices that might affect our health-care spending. Even under our current system, the externalities of health-care costs are used as a rationale for various government interventions, such as motorcycle helmet laws and the Patient Protection and Affordable Care Act's experiments to "bend the cost curve."

SK/C11.09) Margot Sanger-Katz, THE NEW YORK TIMES, February 25, 2020, pNA, NexisUni. Under Medicare for all, doctors and hospitals would remain in private hands. But because the government insurance would effectively be their only source of income, the government would have much more control over the medical system. Nearly every estimate of the cost of Medicare for all assumes that the public system would pay doctors and hospitals less than they currently earn from private insurers. That could mean substantial pay cuts for certain health care providers who see a lot of privately insured patients.

SK/C11.10) Jay Bhattacharya [Professor of Medicine, Stanford U.] & Jonathan Ketchum [Professor of Business, Arizona State U.], USA TODAY, May 2020, p. 49+, Gale Academic OneFile. Rightly or wrongly, the current pandemic's health-care utilization externalities have been used by governments across the U.S. to justify making it illegal to work or to leave our homes in many circumstances, even to surf in the ocean. Applying C.S. Lewis' insights, the government's power of the purse under Medicare for All gives justification for a system of "omnipotent moral busybodies...who torment us for our own good...without end.... To be 'cured' against one's will and cured of states which we may not regard as disease is to be put on a level of...domestic animals."