SILVER BULLET BRIEFS

SEPTEMBER & OCTOBER 2020

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

TABLE OF CONTENTS

WHY SBB?

As debaters and coaches, we have always hunted for the "silver bullet" that will slay our debate monsters: the perfect meta-analysis, the unbeatable narrative, or the argument that is so inherently true that there is no response. We learned that the elusive silver bullet was as much a myth as the monsters that it was designed to slay, but the aspiration of finding it pushed us to gain a deeper understanding of every topic. Thus, we created Silver Bullet Briefs with two goals in mind:

First, debate provides an invaluable opportunity to learn, and we hope to advance that opportunity. Debate teaches competitors not only to research and prepare, but to think on their feet and consider solutions to real-world problems. It teaches young people the significance of viewpoint diversity and gives them an awareness of real-world issues. Most importantly, it leaves competitors with the power and confidence to advocate for themselves – to argue for the things in which they believe. Silver Bullet is an extension of debate. We believe that true success does not come from the evidence that a debater reads. Instead, it stems from the knowledge that a debater can reap from that evidence, and the story that they can tell using it. SBB is not meant to provide an endless stream of redundant evidence, but to give debaters a deeper understanding of each topic and the real-world issue behind it.

Second, we hope to level the playing field. Debate is an unequal activity. Gender minorities are less likely to win rounds and participate in the activity in the first place. The same is true for black and Hispanic debaters, as racial stereotypes and implicit biases limit their success. The structure of the activity has also made debate increasingly inaccessible. Tournament entry fees, travel and hotel expenses, private coaches, summer camps, and even tournament attire are only available to those with the means to afford them. While the advent of online competition has alleviated some of these problems, it has created others. Competition now requires stable internet connection and access to a personal computer. All of these factors have made debate inaccessible for many.

Doing our part: We created Silver Bullet Briefs as a way to increase accessibility to debate. Therefore, while SBB intends to sell debate briefs to those who can afford them, we will provide our briefs at a reduced cost to those who cannot, **AND** we will donate **100%** of the profits from the sale of these briefs to organizations that increase equity and access within the debate community, such as the National Association of Urban Debate Leagues.

Let's make a difference together.

ABOUT US

Maggie Mills competed in Public Forum debate for Chagrin Falls High School for all four years of high school. Maggie served as President and Vice President of Chagrin Falls High School's Speech and Debate team. Throughout her four-year career, she and her partner, Sasha, qualified for the Ohio state speech and debate tournament four times and for the Tournament of Champions three times. During her senior year, Maggie and Sasha won the Ohio state tournament without dropping a ballot. In June, the team won the 2020 NSDA national championship. Maggie plans to study Economics and Political Science as a member of the University of Chicago's class of 2024.

Sasha Haines competed in Public Forum Debate for Chagrin Falls High School for four years and was a co-captain of the team during her junior and senior year. Sasha often competed nationally, reaching elimination rounds at numerous national tournaments including the Sunvitational, the Season Opener at UK, UPenn, and Stanford. Throughout her career, Sasha qualified three times to the Gold division of the Tournament of Champions, was the Ohio State Champion and won the 2020 NSDA Nationals. Sasha plans to study Public Affairs and Philosophy, Politics, and Economics at The Ohio State University.

Albi Manfredi did Public Forum Debate for five years at Lake Mary Prep in Orlando, Florida. Throughout his time as a competitor, he amassed a total of 17 bids to the Tournament of Champions, semi-finaled at the Yale Invitational and the Tournament of Champions, was the Florida State Runner-Up, and championed the Blue Key Round Robin, the Crestian Tradition, and the Sunvitational. Individually, he achieved top speaker at the Blake Tournament, Emory's Barkley Forum, and Florida States. He finished his career placing 5th at NSDA Nationals. As a first year out, Albi has been a successful coach, most recently helping Sasha and Maggie win the prestigious NSDA national tournament. Albi is a sophomore at the University of Pennsylvania studying Chemical and Biomolecular Engineering and Legal Studies.

Ana Kevorkian competed in Public Forum debate for Chagrin Falls High School for 3 years. During her senior year, she served as Secretary of the school's Speech and Debate team, handling tournament registration and results reporting. She also founded the Ohio chapter of Beyond Resolved and served as the organization's first Director of Research and the Director of the Clothing Drive Initiative. In high school, she was a National Merit Scholar, National AP Scholar, AP Capstone Diploma recipient, and graduated Cum Laude. Ana will be a first-year at Tufts University in the fall, studying History and Civic Studies.

Richard Haber has been the Coach of Public Forum Debate at Chagrin Falls High School for 8 seasons. He first became involved as a debate coach when his daughter Victoria began competing as a freshman in High School. Leveraging his 30 years as a trial lawyer, he continued to coach even after Victoria graduated because he believed in the value of the activity. As an accomplished trial lawyer, Richard has been honored as an Ohio Super Lawyer® from 2004 to the present; as one of the top 100 lawyers in the state of Ohio from 2010 to 2017; and has been named from 2010 to the present in The Best Lawyers in America ® published by Best Lawyers in conjunction with U.S. News Media Group. As a debate coach, Richard has coached two teams to state championships in the last 3 years; qualified three teams to NSDA Nationals, coached teams to four Tournament of Championship qualifications in the last three years and along with Albi Manfredi coached Maggie and Sasha to the 2020 National Speech and Debate Association Public Forum Championship. Richard is a devout advocate of traditional public forum debate and helped found Silver Bullet Briefs to promote this style of debate.

Grace Lee competed in Public Forum debate for Chagrin Falls High School for 4 years. She was a National Merit Scholar Finalist, an AP National Scholar, and graduated with the AP Capstone Diploma. She will be a first year at the University of Rochester in the fall, studying Microbiology and Health Policy.

TOPIC ANALYSIS

History and Context

The history of healthcare in the United States dates back to the early twentieth century. Prior to the Great Depression, the market for healthcare did not exist because commercial insurance companies did not have a proper way to overcome adverse selection, where only the sick would get coverage, rendering the industry unprofitable. However, the medical industry steadily began adopting new regulations, such as the accreditation of hospitals and the rise of the American Medical Association (AMA). Concurrently, price and wage controls enacted during World War II limited high-paying salaries, so employers began investing in healthcare and other benefits in order to attract employees. As a result, the market for health insurance increased dramatically, up to 140 million in 1950.

As the healthcare system that we know today began to take shape, policymakers initiated an all-too-familiar cycle of healthcare expansion and decline. President Franklin Delano Roosevelt once pushed for healthcare as a human right in his 1944 Economic Bill of Rights, but it was dismissed in Congress as being a 'communist plot.' Two decades later, Congress created Medicare and Medicaid, the former being designed to cover the elderly, and the latter being a healthcare plan for low-income individuals. The 1970s saw the creation of HMOs (health maintenance organizations), the growth of which was largely encouraged by federal legislation. HMOs essentially provide a federally certified middleman to organize the healthcare plans of insured Americans. The 1980s and 1990s witnessed some Medicare expansion, such as the hospital reimbursement system and direct price negotiations with pharmaceutical companies. At the same time, healthcare cost inflation soared as new treatments became more and more expensive for patients, physicians, and the federal government.

The largest breakthrough in healthcare since the 1960s occurred in 2010 with the adoption of the Affordable Care Act (ACA). The ACA increased health insurance coverage for the uninsured and sought to reform the health insurance market. For example, the ACA outlawed discrimination based on disability because many insurers denied coverage to those with preexisting conditions. The ACA also allowed people with limited finances to get coverage when it was previously unaffordable. The ACA also included an "individual mandate," which taxed anyone who refused healthcare under the ACA and had no private health insurance of their own. After hefty battles in the court system, however, several core facets of the ACA were ruled unconstitutional, such as the mandate that states expand Medicaid. Other segments like the tax penalty were later eliminated by the Trump administration. Even so, more than 20 million Americans gained access to affordable health insurance through the ACA, and

countless more benefited from the expansion of Medicaid. All in all, it is estimated that 19,000 lives have been saved as a result of the ACA.

How does health insurance function today? Before getting into the logistics of how the private and public healthcare systems work, it should be noted that there are several parts of the current Medicare program. Part A deals with hospital insurance, covering costs if patients are placed in a hospital, and under some circumstances, if placed in a nursing facility or hospice care. Part B is medical insurance that covers the cost of seeing doctors and specialists. Part D negotiates drug prices and covers the cost of pharmaceuticals. There is a part C as well, known as Medicare Advantage, through which policy-holders pay one premium to get access to parts of Part A, B, and D in one plan. Currently, all Americans over the age of 65 are automatically enrolled in Medicare; if a person has a private insurance plan, it becomes supplemental to the Medicare plan because it only pays about 80% of any medical bill. This is not to be confused with Medicaid, which, as stated earlier, is a plan for low-income Americans, specifically anyone within 138% of the poverty line.

Medicare and Medicaid, like any health insurance plan, require policy-holders to pay premiums, co-pays, and deductibles that cover some medical expenses. A premium can be thought of as an insurance membership fee. Premiums are paid once a month to insurance companies (or in the case of Medicare, to the government), and the insurance provider combines all of the premium payments that they receive into one pool of money that is then used to cover expenses and reimbursements. A copayment, or co-pay, is a fixed amount that a healthcare beneficiary pays out-of-pocket for medical services. Co-pays are paid on a per-use basis in addition to the monthly premium. For instance, when a patient picks up prescription medication at a pharmacy, they may be required to pay a certain percentage of the cost on their own (a co-pay); the insurance company would then cover the remaining cost. Finally, a deductible is a sum money that beneficiaries pay to the healthcare provider (i.e. a hospital) before coverage kicks in. If a patient with a $500 deductible is rushed to the hospital, before the insurance company will cover any fees, the patient must pay the first $500 worth of hospital expenses out-of-pocket. The insurer will then cover any costs incurred after that deductible has been paid. This section only touches on the vast complexity of the US healthcare system, so if your head is spinning after reading all of this, imagine how Americans feel trying to receive coverage to make ends meet on top of an already chaotic health emergency.

Analysis of the Resolution

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

This resolution can be divided into three key parts. First is the actor: the U.S. federal government. Since the resolution specifies "the U.S. federal government" and not merely "the United States," we know that the enactment of this bill will be nationwide and will not differ on a state-by-state basis. This may seem obvious, but a wide-sweeping policy such as this would be a departure from the U.S.'s current healthcare system. Under the current system, different states have implemented vastly different healthcare bills. This is even true for the implementation of federal bills; even though states are required to execute federal law, individual states can tailor the implementation of federal bills to meet their specific needs. For example, while all states in the U.S. are required to provide Medicaid (health insurance for low-income Americans), only 38 states and D.C. have opted to expand Medicaid, meaning that low-income Americans living in California will get better Medicaid coverage than similarly situated people living in Georgia (Kaiser Family Foundation). The same is true of healthcare laws passed by individual states. One prominent example of this is abortion law; in 2019, Georgia, Kentucky, Louisiana, Missouri, Mississippi and Ohio all passed "heartbeat bills" that prohibit abortion after a heartbeat is detected, which usually occurs around the sixth week of pregnancy (Lai). A handful of other states, however, have very few restrictions on abortion. However, under this resolution, we can assume that implementation of the Medicare for All (M4A) bill will be uniform across all 50 states and D.C.

The second key part of the resolution is the verbiage used: "should enact." Most PF resolutions use "should" rather than "ought," which is used more regularly in Lincoln Douglass. While "ought" usually implies some kind of moral imperative, "should," is more cut-and-dry. The resolution will either make things better or worse, based on whatever framing or weighing that you choose to implement. Are lives the most important thing in the round? Is the health of the economy more important? Is the developing world more important than the developed world? Right away, you should be thinking about how you want to weigh your arguments at the end of the round. Why is what you're saying important?

The third part of the resolution is the actual Medicare for All Bill of 2019. This is where things get a bit dicey. Previous policy-based resolutions have generally been very clear as to which specific bill or law is being examined. For instance, the 2018 September-October topic focused on the United Nations Convention on the Law of the Sea. There's only one UNCLOS, so there was never any confusion regarding which

law teams were debating. M4A, however, is a different story. While the resolution specifies "The Medicare for All Bill of 2019," it does not specify *which* M4A bill debaters should examine. In 2019, there were two separate M4A bills proposed, one was House bill H.R. 1384, proposed by Representative Pramila Jayapal. The other was Senate bill S. 1129, proposed by Senator Bernie Sanders.

Both bills promise to do a few things. First and foremost, both bills would pay for "basically all medical care for all citizens" (Luthra). Patients would not be responsible for the cost-sharing of medical expenses, which means there would be no premium payments on insurance. M4A would cover preventative care, vision and dental care, prescription medication, and most other medical procedures. Both bills also have comprehensive coverage of reproductive care. Currently, a bill called the Hyde Amendment prohibits federal funds from being used on abortions, meaning that Medicaid patients cannot access abortion via Medicaid coverage (Astor). Both M4A bills, if passed, would effectively override the Hyde Amendment by providing abortion coverage. Lastly, both bills would forbid private insurers from competing with the federal government, which basically means that private health insurance would cease to exist.

While the bills are similar in that they both provide a single, national health insurance program for all U.S. residents, there are a few differences to note. The transition to M4A under the Sanders bill would take 4 years; under the Jayapal plan, the transition would be completed in 2 years. Unlike the Sanders bill, the Jayapal bill would also cover long-term care for elderly and disabled patients or for those suffering from chronic disease. This is important as long-term care can be prohibitively expensive (the Affordable Care Act previously included a provision for long-term care, but the provision was eventually eliminated because of its high cost). The Sanders bill, on the other hand, would continue to have long-term care administered on a state-by-state basis under Medicaid. The Jayapal bill would also allow for the "competitive licensing" of patents if pharmaceutical companies refuse to lower prices. Under this provision, the government would be able to revoke a pharma company's drug patent in order to allow for generic competition, and, ultimately, cheaper alternatives (Luthra). Lastly, the Jayapal bill would provide global budgets for hospitals and other medical providers. While the actual logistics of global budgeting are vague, the Jayapal bill promises "a lump sum" to help cover operating expenses and other costs, which might act as a lifeline for struggling rural hospitals.

For more information on each bill, consider reading the Sanders[1] and Jayapal[2] bills in full, or check out this handy chart[3] that outlines the key differences between the two.

Now that you know about the two bills, the question remains, which one should you use? Since the resolution doesn't specify one way or the other, there may not be an answer to that question. Certain stock arguments like "increasing access" are the same regardless of which bill you decide to utilize. Other, more niche arguments, however, will change based on the nuances of each bill. Because of Bernie Sanders' 2020 bid to be the Democratic presidential candidate, M4A was a hotly debated topic, and Sanders' bill was in the spotlight. For that reason, most judges and observers will probably associate M4A with the Sanders bill. Even so, Jayapal's bill is still a "Medicare for All Act of 2019," and debaters should be prepared to utilize both bills. Adopting a framework that only one of the two is legitimate would probably be viewed as abusive (and untrue), so instead, learn as much as possible about both and be prepared to defend your use of each.

Why are we debating this resolution now?

There are roughly 29 million uninsured Americans, and an additional 85 million are underinsured. In the richest country in the world, in terms of GDP, that is a staggering number. Over the course of the last few decades, the cost of insurance has increased faster than both wages and inflation, leaving many people without access to affordable coverage. Politicians on both sides of the aisle agree that healthcare needs to become more accessible, as estimates predict that anywhere from 27,000 to 44,000 people die every year due to lack of health insurance.

The current COVID-19 crisis has only exacerbated existing problems as more people have required medical attention, and millions of Americans have lost health insurance after being laid off or furloughed. Uninsured Americans may also have difficulty finding affordable COVID testing. This vast inequality with regards to COVID-19 is merely a symptom of the greater disease of unequal access to healthcare.

In 2018, the United States spent 17.7% of its GDP on healthcare, amounting to roughly 3.6 trillion dollars. The UK, which provides nationalized healthcare to every resident, spent half that. By nearly every conceivable metric, our current healthcare

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[1] S.S. 1129 (Sanders bill) https://www.congress.gov/bill/116th-congress/senate-bill/1129/text

[2] H.R. 1384 (Jayapal bill) https://www.congress.gov/bill/116th-congress/house-bill/1384/text#toc-H355CF24040E1488282DAB38C6BD561A7

[3] "Comparison Chart: House and Senate Medicare for All Acts." *Health Over Profit.* http://healthoverprofit.org/comparison-chart/

system is unequal, wasteful, and insufficient. The focus of this resolution is whether or not M4A itself is the best way to solve for these inequities.

Argument Rundown

At the end of the day, nearly every round on this topic will likely boil down to access versus quality of care. Students who debated the November 2018 Price Controls topic will be *extremely* familiar with this framing. On the affirmative, teams will likely end up weighing millions of Americans gaining insurance over wait times going up by a few weeks or having shortages of drugs or doctors. On the negative, teams will likely say that care worsening for everyone is worse than some people not having access to high quality care in the status quo.

Within the broader framework of access, there are many arguments that affirmative teams can run. These include, but are not limited to, general arguments about increasing access, alleviating medical bills, fighting structural violence, helping hospitals, and more. It is important for teams to understand that while these arguments have great variation when it comes to specific evidence and warrants, their overarching narrative is the same: access to healthcare is unequal in the status quo and needs to be fixed. The arguments differ in *where* they attribute the inequality: location, income, or minority status.

Within the framework of quality of care, there are several arguments that negative teams can run, including: rural hospitals, wait times, drug/doctor shortages, and pharmaceutical innovation. Teams, once again, would do well to understand that these arguments all fall under the narrative that eliminating competition in our healthcare system would ultimately hinder quality. Having this in mind will not only assist teams in crafting their negative cases, but also benefit affirmative teams attempting to craft effective rebuttals.

On either side, teams can run economic impacts that are unrelated to the primary structure of access vs. quality addressed above. Economic arguments are more often more nebulous, vague, hard-to-prove, and seemingly less important than arguments dealing directly with human life. Therefore, these arguments will likely be less popular at tournaments. However, when crafted well, this genre of argument can be incredibly effective. Understanding the far-reaching economic implications of Medicare for All will help teams both perceptually and technically dominate in round.

PRO ARGUMENTS

ACCESS INCREASES

What's the argument?

One of the most promising aspects of a Medicare For All bill would be increased access to healthcare for millions of Americans. Currently, there are over 27 million Americans without health insurance (Arevalo). In a 2018 National Health Interview Survey, 45 percent of the uninsured cited cost as the main reason for their lack of insurance, with another 53 percent attributing it to either job loss or change in employment, loss of Medicaid, an employer not offering healthcare, or being ineligible for coverage (Tolbert et al). Universal healthcare under Medicare for All would thus increase healthcare access with respect to the insurance coverage of prescription medication, medical procedures, preventative care, neonatal care, mental health care, and substance abuse treatment.

Prescription Medication

Medicare Part D lowers prescription drug costs for its beneficiaries (Litchenberg and Sun). In the first year the plan was rolled out, Litchenberg and Sun estimated Medicare Part D reduced user costs amongst the elderly by 18.4 percent, increased their use of prescription drugs by about 12.8 percent, and increased total U.S. usage by 4.5 percent.

Medical Procedures

In 2019, 33 percent of American households reported delaying care due to cost (Saad). Additionally, income inequality manifests in the realm of healthcare, as low-income Americans are 23 percent more likely to fail to receive treatment for a serious medical condition than high-income Americans (Saad). However, it is notable that this gap narrowed to an average of 11 points in the first few years after the implementation of the Affordable Care Act (Saad). This means that lowering healthcare costs and increasing access to medical procedures under Medicare for All would allow more of those in need to seek medical treatment.

Preventative Care

In the United States, a lack of access to preventative care has consistently been identified as a major contributor to high healthcare costs, as illnesses that

go untreated in their early stages later become more severe and expensive to treat. However, Sutphen asserts that Medicare for All would cover all necessary medical services, including primary care and illness prevention. In fact, "Medicare for All emphasizes access to primary preventive care to mitigate chronic diseases through early diagnosis and treatment" with the goal of transforming healthcare into a "front-ended" system based on prevention (Sutphen).

Neonatal Care

The United States has an extremely high death rate for newborns. According to Fox, the U.S. has the highest first-day death rate in the industrialized world. An estimated 11,300 newborn babies die each year in the United States on the day they are born, 50 percent more first-day deaths than all other industrialized countries combined (Fox). However, a Save the Children report asserts that most of these newborn deaths could be prevented with "fairly cheap interventions" (Fox). Thus, bettering access to healthcare facilities and procedures under a Medicare for All plan would improve the deliverance of neonatal care in the United States.

Mental Health Care

Private insurers are skimping on mental health care coverage. In 2015, behavioral care was four to six times more likely to be provided out of network than medical or surgical care, and the share of individual plans offering any reimbursement for such care has declined from 58 percent in 2015 to 29 percent in 2018 (Freedman). As a result, mental health care is out of reach for many. However, a universal Medicare for All plan would cover all medical care. In Rep. Pramila Jayapal's bill, for example, that includes mental health care.

Substance Abuse Treatment

In 2016, an estimated 21 million Americans aged 12 or older needed substance abuse treatment (Ahrsnbrak et al). In that same year, however, only 3.8 million, or 1.4 percent, received any treatment (Ahrsnbrak et al). Financial limitations are a significant barrier preventing people from receiving treatment for substance abuse. According to the National Comorbidity Survey, 15 percent of those who did not seek treatment did so because of financial barriers such as lack of insurance and concerns about cost. Additionally, nearly 17 percent had left treatment early due to costs and lack of insurance coverage. Medicare for All would grant individuals universal coverage for these treatments, as Medicare

Parts A and B currently pay for substance abuse and alcoholism treatments in both inpatient and outpatient settings (Center for Medicare Advocacy).

Why does the argument matter?

Most directly, increased access to healthcare saves lives, but you can also get more specific impacts with respect to each of the aforementioned aspects of healthcare.

Prescription Medication

Increased access to prescription medication decreases drug nonadherence. Drug non-adherence results in worsened health outcomes and increased hospital costs through ER visits and potentially avoidable medical procedures. Currently, health insurance plans such as Medicare Part D increase access to prescription medication by decreasing or eliminating the copayments for these medications. A Medicare for All Plan would eliminate copayments (Kliff and Scott). Litchenberg and Sun report an inverse relationship between copayments and prescription adherence, meaning as copayments increase, adherence decreases. They estimate that if the health plans included in the study had reduced patients' copayments on cholesterol-lowering medications from $10 to $0, the inpatient hospital spending of these health plans would have declined by $839 million through costs saved by adherence to prescription medication (Litchenberg and Sun).

Medical Procedures

Increased access to medical procedures saves lives. Americans without health insurance and access to care have higher mortality rates than those with access. Wilper et al estimates that almost 45,000 annual deaths among Americans aged 18-64 are associated with a lack of health insurance.

Preventative Care

Increased access to preventative care also saves lives. Maciosek concludes that investing in preventive services for the general population could produce more than 2 million additional years of life for American citizens. Maciosek also finds that increasing preventative care could save the healthcare system 21.9 billion dollars.

Neonatal Care

Increased access to neonatal care decreases infant mortality. The World Health Organization finds that women who receive continuity of care provided by professionals are 24 percent less likely to experience preterm birth and 16 percent less likely to lose their newborn.

Mental Health Care

Increased access to mental healthcare decreases suicide rates. Scahill finds a statistically significant decrease in the odds of suicide among youth who had a greater frequency of mental health visits.

Increased access to mental health care also decreases homelessness. 1 in 5 homeless Americans have a mental illness, and 1 in 3 of those experiencing chronic homelessness also deal with a mental disability (Schultheis). This is important as mental health disabilities often cause symptoms that interfere with a person's daily life and activities, such as maintaining steady employment. Increased access to mental health care means more people can be equipped with the tools necessary to rise up out of poverty.

Finally, increased access to mental health care decreases incarceration. The Treatment Advocacy finds that at least 1 in 5 jail and prison inmates suffer from disordered thinking caused by severe mental illness. They conclude that reducing incarceration driven by untreated mental illness will reduce inmate populations significantly.

Substance Abuse Treatment

Increased access to substance abuse treatment decreases overdoses. In 2018, there were 67,367 drug overdose deaths in the United States (Hedegaard et al). Increasing access to substance abuse treatment will serve as a preventative measure to overdose. Similarly, access to hospitals and effective, inexpensive, and safe medications such as Naloxone, which is used to resuscitate opioid overdose victims, will decrease overdose deaths. Increased access to substance abuse treatment also decreases incarceration. A review of recidivism in 15 states found that one-quarter of individuals released returned to prison within 3 years for technical violations that included, among other things, testing positive for drug use (Chandler et al).

Main Players

Uninsured Americans, those with chronic disease or preexisting conditions, expectant mothers, those who require expensive drugs or treatments

Strategy Considerations

This argument is strong because it is the most intuitive consequence of Medicare for All. It's pretty straightforward and easy to understand. With the current state of healthcare deliverance in the United States, affirmative teams can also run off of a risk-of-solvency narrative in which they frame Medicare for All as the only hope of the sweeping healthcare reform we so desperately need. In the negation's world, the same percentages of Americans remain uninsured and unable to access the care they need. In the affirmative world, there is at least a chance of increased access to healthcare.

However, this argument is disadvantageous in that negating teams can easily attack its certainty and magnitude through arguments on economic harms and decreased quality of care. This argument will need a lot of frontlining as well as clear, well fleshed-out links to hold up in round.

Evidence for Access Increases

General access increases evidence

Millions of Americans lack *insurance*

Tony Arevalo. "How Many Americans Are Uninsured." Policy Advice. April 21, 2020.
https://policyadvice.net/health-insurance/insights/how-many-americans-are-uninsured/
A series of highly-relevant statistics concerning the healthcare industry are published every year in November, by the US Census Bureau. Here are several statistics meant to better explain the situation of Americans that are uninsured: **Data from the US Census Bureau indicates that a total of 27.5 million Americans had no health insurance during 2018.** Seeing how no major health policies have been implemented by the Federal Government, statistical predictions indicate that the numbers are likely to be even higher by the time the Census Bureau publishes the stats for 2019 in September next year. Consequently, the US uninsured rate will likely grow. **The rate of uninsured US citizens increase from 25.6 million in 2016, to 27.5 million in 2017**. Based on this data, numerous researchers are trying to figure out the main factors which led to this abrupt decrease in insurance rates in the US. We will briefly discuss some of the main factors, later on, to facilitate a better understanding of why so many people are now going without health insurance. This aspect must be discussed, since uninsured individuals are at higher risk of medical complications, alongside debt accumulation.

M4A bills eliminate cost-sharing

Sarah Kliff and Dylan Scott. "We read 9 Democratic plans for expanding health care. Here's how they work." *Vox.* June 21, 2019. https://www.vox.com/2018/12/13/18103087/medicare-for-all-explained-single-payer-health-care-sanders-jayapal
Medicare-for-all (Senate and House) Both Medicare-for-all bills would eliminate cost sharing completely. This means no monthly premiums, no copayments for going to the doctor, and no deductible to meet before coverage kicks in. The only place where enrollees might pay out of pocket is under the Sanders plan, which does give the government discretion to allow some charges for prescription drugs — but even that would be capped at $200 per year. This is very similar to how the Canadian health care system works but is actually quite different from European countries. Most countries across the Atlantic actually do require patients to pay something for going to the doctor. In France, for example, patients are expected to pay 30 percent of the cost of their doctor visit — and in the Netherlands, copayments range from $10 to $30.

M4A could save 63,000 lives

Alison Galvani, Alyssa Parpia, Eric Foster, Burton Singer, and Meagan Fitzpatrick. "Improving the prognosis of health care in the USA". *The Lancet*. February 15, 2020.
https://www.thelancet.com/action/showPdf?pii=S0140-6736%2819%2933019-3
Although health care *expenditure per capita is higher in the USA than in any other country, more than 37 million Americans do not have health insurance, and 41 million more have inadequate access to care. Efforts are ongoing to repeal the Affordable Care Act which would exacerbate health-care inequities. By contrast, **a universal system,** such as that proposed in the Medicare for All Act,* **has the potential to transform the availability and efficiency of American health care services.** *Taking into account both the costs of coverage expansion and the savings that would be achieved through the Medicare for All Act, we calculate that a single payer, universal health care system is likely to lead to a 13% savings in national health-care expenditure, equivalent to more than US$450 billion annually (based on the value of the US$ in 2017). The entire system could be funded with less financial outlay than is incurred by employers and households paying for health-care premiums combined with existing government allocations.* **This shift to**

single-payer health care would provide the greatest relief to lower-income households. Furthermore, we estimate that ensuring health-care access for all Americans would save more than 68,000 lives and 1.73 million life-years every year compared with the status quo.

Americans without insurance 40% more likely to die

David Cecere, "New study finds 45,000 deaths annually linked to lack of health coverage." *The Harvard Gazette*. September 17, 2009. https://news.harvard.edu/gazette/story/2009/09/new-study-finds-45000-deaths-annually-linked-to-lack-of-health-coverage/

Nearly 45,000 annual deaths are associated with lack of health insurance, according to a new study published online today by the American Journal of Public Health. That figure is about two and a half times higher than an estimate from the Institute of Medicine (IOM) in 2002. The study, conducted at Harvard Medical School and Cambridge Health Alliance, found that **uninsured, working-age Americans have a 40 percent higher risk of death than their privately insured counterparts, up from a 25 percent excess death rate found in 1993**. "The uninsured have a higher risk of death when compared to the privately insured, even after taking into account socioeconomics, health behaviors, and baseline health," said lead author Andrew Wilper, M.D., who currently teaches at the University of Washington School of Medicine. "We doctors have many new ways to prevent deaths from hypertension, diabetes, and heart disease – but only if patients can get into our offices and afford their medications."

M4A could help homeless Americans specifically

"Medicare for All and the HCH Community." *National Health Care for the Homeless Council.* May 2019. https://nhchc.org/wp-content/uploads/2019/08/medicare-for-all-and-the-hch-community.pdf

"Medicare For All" as the best approach: **We support universal access** to a national health plan financed through a single entity **and believe** the existing **Medicare** program **is the best vehicle to achieve that goal.** To accomplish this, the current Medicare program must expand covered services and increase reimbursements to make a holistic system of care. This statement outlines how a single-payer, "Medicare-For-All" approach would benefit the HCH Community.

Access to drugs increases and non-adherence decreases

Existing Medicare programs cut cost and increase adherence

Litchenberg and Sun. "The Impact Of Medicare Part D On Prescription Drug Use By The Elderly." *Health Affairs*. November/December 2007. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.26.6.1735

A simple way to assess the impact of Medicare Part D is to compute the difference in the 2005–2006 growth rates of key variables for the elderly versus the nonelderly. These calculations are shown in Exhibit 4 . [15] The mean amount paid by nonelderly patients per day of therapy declined 0.4 percent, while the mean amount paid by elderly patients declined 18.8 percent. The number of days of therapy for the nonelderly increased 6.8 percent, while the number of days of therapy for the elderly increased 19.5 percent. **This suggests that Medicare Part D reduced user cost among the elderly by 18.4 percent and increased utilization among them by about 12.7 percent.** The ratio of the latter to the former is 0.70—virtually the same as the estimate of the demand elasticity reported above. Because of the increase in utilization, Medicare Part D reduced the total amount

paid by patients by only 5.6 percent. It increased the amount paid by third parties by 22.3 percent. Medicare Part D seems to have had a negligible impact on the overall price of prescription drugs (expenditure per day of therapy); the elderly and nonelderly growth rates differ by just 0.3 percent.

Cost is the main cause of drug nonadherence

Bresnick, "Cost is a Primary Driver of Medication Non-Adherence Rates." *Health IT Analytics: Xtelligent Healthcare Media.* September 11, 2017.
https://healthitanalytics.com/news/cost-is-a-primary-driver-of-medication-non-adherence-rates#:~:text=September%2011%2C%202017%20%2D%20The%20high,for%20population%20health%20management%20initiatives.

The high cost of prescription drugs is what drives 67 percent of patients into medication non-adherence, according to the latest Truven Health Analytics-NPR Health Poll, contributing to a multi-billion-dollar issue that is of particular concern for population health management initiatives. Ninety-four percent of patients with incomes under $25,000 per year stated that they did not fill or pick up their prescriptions due to the expenses involved, and more than 12 percent said that costs had led them to stop taking a medication before a provider recommended ending the treatment. Despite the fact that cost is a major factor in adherence, just 16 percent of low-income individuals had used drug company rebates or coupons to help reduce the prices of their medications. That number rises to 36 percent of individuals with incomes over $100,000 per year, indicating something of a disconnect between those who may be most in need of financial aid for maintaining adherence to treatment recommendations and those who are actually taking advantage of available options.

Drug nonadherence kills 125,000 Americans per year

Bosworth et al, "Medication Adherence: A Call for Action." *National Institute of Health.* September 2011.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3947508/#:~:text=Estimates%20are%20that%20approximately%20125%2C000,are%20due%20to%20poor%20adherence.

Medications are the primary tools used to prevent and effectively manage chronic illness; however, despite their importance and known benefit, appropriate medication use remains a challenge for both patients and providers. Patients frequently do not adhere to essential medications, resulting in poor clinical outcomes, increased cost of care, and deleterious consequences for workforce productivity and overall public health. [1] Half of the 3.2 billion annual prescriptions dispensed in the United States are not taken as prescribed. [2] Numerous studies have shown that patients with chronic conditions adhere only to 50-60% of medications as prescribed despite evidence that medical therapy prevents death and improves quality of life. [3-8] **Estimates are that approximately 125,000 deaths per year in the United States are due to medication non-adherence [9] and between 33 and 69 percent of medication-related hospital admissions in the U.S. are due to poor adherence**.[2] While some of the relationship between poor adherence and poor outcome is due to confounding factors, [10] the lost opportunity for effective therapies to improve health is staggering. For example, cardiovascular medications alone are estimated to be responsible for half of the 50% reduction in mortality from coronary heart disease over the past 20 years. [11] Yet actual achievement of these cardiovascular benefits is lost due to high rates of non-adherence in real-world settings. In fact, the true rate of non-adherence may be higher as patients with a history of non-adherence are likely underrepresented in trials outcomes research.

Access to preventative care and medical procedures

Most people uninsured because of cost

Tolbert, Jennifer et al. "Key Facts About the Uninsured Population." *KFF.* December 13, 2019. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

Cost still poses a major barrier to coverage for the uninsured. In 2018, **45% of uninsured nonelderly adults said they were uninsured because the cost is too high, making it the most common reason cited for being uninsured** (Figure 6). Access to health coverage changes as a person's situation changes. In 2018, 21% of uninsured nonelderly adults said they were uninsured because the person who carried the health coverage in their family lost their job or changed employers (Figure 6). More than one in ten were uninsured because they lost Medicaid due to a new job/increase in income or the plan stopping after pregnancy (13%) and one in ten were uninsured because of a marital status change, the death of a spouse or parent, or loss of eligibility due to age or leaving school.11" "Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.25, 26, 27, 28 **One in five (21%) nonelderly adults without coverage said that they went without needed care in the past year because of cost compared to 4% of adults with private coverage and 7% of adults with public coverage.** Part of the reason for poor access among the uninsured is that many (52%) do not have a regular place to go when they are sick or need medical advice (Figure 8).

Treatment delayed b/c of cost, inequality gap at 23%

Saad, Lydia. "More Americans Delaying Medical Treatment Due to Cost." *Gallup*. December 9, 2019, https://news.gallup.com/poll/269138/americans-delaying-medical-treatment-due-cost.aspx.

"A record 25% of Americans say they or a family member put off treatment for a serious medical condition in the past year because of the cost, up from 19% a year ago and the highest in Gallup's trend. Another 8% said they or a family member put off treatment for a less serious condition, bringing the **total percentage of households delaying care due to costs to 33%**, tying the high from 2014.Gallup first asked this question in 1991, at which time 22% reported that they or a family member delayed care for any kind of condition, including 11% for a serious condition. The figures were similar in the next update in 2001, and Gallup has since asked this question annually as part of its Health and Healthcare poll. This year's survey was conducted Nov. 1-14. Americans' reports of family members delaying any sort of medical treatment for cost reasons were lower in the early to mid-2000s when closer to a quarter reported the problem. Since 2006, the rate has averaged 30%. The pattern is similar for the subset of Americans postponing medical treatment for a serious condition. The rate rose from 12% in 2001 to an average of 19% since 2006. However, the current 25% is the highest yet, exceeding the prior high-point of 22% recorded in 2014. Income Gap Widens for Cost-Related Delays for Serious Conditions Reports of delaying treatment for a serious condition jumped 13 percentage points in the past year to 36% among adults in households earning less than $40,000 per year while it was essentially flat (up a non statistically significant three points) among those in middle-income and higher-income households. **As a result of the spike in lower-income households this year, the gap between the top and bottom income groups for failure to seek treatment for a serious medical condition widened to 23 percentage points in 2019**. The income gap had averaged 17 points in the early years of Barack Obama's presidency, but **narrowed to an average 11 points in the first few years after implementation of the ACA, from 2015 to 2018**.

M4A would cover preventative care

Richard Sutphen. "Guest Column: Medicare for All will Reduce Cost, Improve Quality" *Jacksonville.com*. November 11, 2018. https://www.jacksonville.com/opinion/20181111/guest-column-medicare-for-all-will-reduce-cost-improve-quality

Medicare for All is a simple one-plan, single payer system. It **would cover all medically necessary services, including primary care and prevention,** long-term care, mental health, substance abuse, dental care, vision care, hearing services and much less costly prescription drugs. Other features include: complete portability; no premiums, co-pays, deductibles or co-insurance; no major medical bills or bankruptcies. Individuals will be able to choose their preferred medical providers as they currently do under Medicare. Under our current system, we have the most expensive health care in the world that produces health outcomes that rank last among comparable nations, especially in infant mortality and life expectancy. **We pay twice as much for medical services** and pharmaceuticals and nearly three times more for administrative costs than other countries. We spend nearly half of our health care costs on the 5 percent of the population with chronic diseases. The absence of universal health care and **the lack of access to primary preventive care have been** consistently **identified as major contributors** to these high costs. **Medicare for All emphasizes access to primary preventive care** to mitigate chronic diseases through early diagnosis and treatment. A goal is **to transform health care into a "front-ended" system based on prevention** rather than the expensive, reactive, acute care based creature we have today. This kind of change should be a focal point on how to make the biggest impact on high costs.

Preventative care saves lives

Michael Maciosek. "Greater use of preventive care services in US health care could save lives at little or no cost". *Health Affairs*. September 2010. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2008.0701?ck=nck

In contrast, our calculated additional cost of increasing use of these services from current levels to 90 percent is less than the additional savings, resulting in a small negative net cost—or savings. The additional cost of increasing use to 90 percent is $18.3 billion, or 1.0 percent of U.S. personal health care spending in 2006. **The savings resulting from increasing use rates is $21.9 billion, and the net cost is −$3.7 billion**, or −0.2 percent of U.S. personal health care spending in 2006. These cost savings from incremental improvements in use are the result of gaps in the current use of services that have the potential to save money. Three services contributed more than $1 billion each to the net additional medical savings: tobacco cessation screening and assistance; discussing daily aspirin use; and alcohol screening with brief counseling. These **three services** plus colorectal cancer screening **each would have contributed more 100,000 years of life in 2006 had screening been increased to 90 percent.** Large changes in any single service do not alter the results. For example, doubling the cost of the service that adds the most to the 2006 additional cost of preventive care—colorectal cancer screening—would increase our estimates of total and net costs by only 0.25 percent of U.S. personal health care spending. Similarly, doubling the savings of the service that would produce the most additional savings—smoking cessation advice and assistance—would increase our estimates of savings and decrease our estimate of net costs by only 0.4 percent of U.S. personal health care spending. These findings with respect to increasing use from current rates to 90 percent suggest that investing in **an evidence-based package of preventive services** for the general population **could produce more than two million additional years of life each year they are delivered.** What's more, the increased costs of doing so would be recouped. Put differently, **more than two million people would have been alive during 2006**—or 780 people in a city of 100,000—if preventive care **had been widely delivered in prior years**, all without an increase in net cost.

Access to neonatal care

The U.S. is one of the worst places in the world for newborns

Maggie Fox. "More US babies die on their first day than in 68 other countries, report shows." *NBC*. April 30, 2013. https://www.nbcnews.com/healthmain/more-us-babies-die-their-first-day-68-other-countries-6C9700437

The U.S. is a worse place for newborns than 68 other countries, including Egypt, Turkey and Peru, according to a report released Tuesday by Save the Children. A million babies die every year globally on the same day they were born, including **more than 11,000 American newborns,** the report estimates. Most of them could be saved with fairly cheap interventions, the group says. "The birth of a child should be a time of wonder and celebration. But for millions of mothers and babies in developing countries, it is a dance with death," the report reads. "A baby's first day is the most dangerous day of life—in the United States and countries rich and poor," it adds. **"The United States has the highest first-day death rate in the industrialized world. An estimated 11,300 newborn babies die each year in the United States on the day they are born. This is 50 percent more first-day deaths than all other industrialized countries combined."** Globally, most babies who die at birth die because they were born too early – 35 percent of all newborns who die were pre-term, Save the Children finds. Another 23 percent die because of complications at birth, such as a failure to draw breath right away. Another 23 percent die from severe infections and 9 percent die because of birth defects.

Chen, Alice et al. "Why Is Infant Mortality Higher in the United States Than in Europe?" *American Economic Journal: Economic Policy*. 2016 May. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4856058/

"Our estimates suggest that **decreasing postneonatal mortality in the US to the level in Austria would lower US death rates by around 1 death per 1000.** Applying a standard value of a statistical life of US$7 million, this suggests it would be worth spending up to $7000 per infant to achieve this gain. **If policies were able to focus on individuals of lower socioeconomic status – given our estimates that advantaged groups do as well in the US as elsewhere – even higher levels of spending per mother targeted would be justified**."

Access to healthcare decreases maternal deaths

Laurie Zephyrin, Akeiisa Coleman, Rachel Nuzum, and Yaphet Getachew. "Increasing Postpartum Medicaid coverage could reduce maternal deaths and improve outcomes." *The Commonwealth Fund*. November 21, 2019. https://www.commonwealthfund.org/blog/2019/increasing-postpartum-medicaid-coverage

It is particularly encouraging that policymakers are recognizing the importance of two key aspects of this challenging crisis — the outsize potential of Medicaid to address maternal mortality and morbidity and **the critical role continuous health insurance coverage plays in keeping women healthy during and after pregnancy.** Postdelivery — the first 100 days after birth, often referred to as the fourth trimester — is an especially critical time for women to have access to health care because it is when most complications occur. Unfortunately, many women lack consistent insurance coverage. Before states had the option to expand Medicaid to adults with income up to 138 percent of the poverty level (about $23,000 for a family of two), roughly half of women experienced a gap in coverage within six months of giving birth — making continuous care difficult if not impossible. Medicaid eligibility levels for pregnant women vary across states — from 138 percent of poverty to 380 percent (about $62,000 for a family of two) — and coverage ends 60 days after birth. While research shows higher uninsured rates for postpartum women in nonexpansion states, which have lower eligibility levels for parents, women in expansion states may also experience a gap in coverage. When coverage lapses or people lose

and regain coverage over a relatively short span of time – a phenomenon known as churning – the disruption can lead to delays in identifying pressing health challenges. These disruptions are deeply troubling given what we know about the postpartum period. Moms who struggle with new or chronic conditions, such as depression or high blood pressure, are left unsupported and may not be able to seek help. **Gaps in health insurance coverage** during this critical time, the fourth trimester through the first year, **can prevent health care providers from identifying and treating complications that occur after the birth, contributing to rising maternal morbidity and mortality rates.** Comprehensive care and continuous coverage during the postpartum period are essential, especially for women with chronic medical or mental health conditions. Medicaid is well positioned to provide this kind of coverage and care. It has broad reach – it covered around 42 percent of births in the United States in 2018. And it is making a difference: **in Medicaid expansion states, maternal mortality dropped by 1.6 deaths per 100,000 women.**

Focusing on low-income individuals reduces post-neonatal mortality

Chen, Alice et al. "Why Is Infant Mortality Higher in the United States Than in Europe?" *American Economic Journal: Economic Policy.* May 2016. doi:10.1257/pol.20140224 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4856058/

"Our estimates suggest **that decreasing postneonatal mortality in the US to the level in Austria would lower US death rates by around 1 death per 1000.** Applying a standard value of a statistical life of US$7 million, this suggests it would be worth spending up to $7000 per infant to achieve this gain. If policies were able to **focus on individuals of lower socioeconomic status** – given our estimates that advantaged groups do as well in the US as elsewhere – even higher levels of spending per mother targeted would be justified."

Access to mental health care

Many insurance plans don't include mental health care; M4A does

Andrew Freedman. "Rich Kids Like Me Get Great Mental Health Care. With Medicare for All, Others Can, Too." *USA Today*. March 7, 2019. https://www.usatoday.com/story/opinion/voices/2019/03/07/medicare-for-all-mental-health-pramila-jayapal-column/3079559002/

Making matters worse is that **insurers are skimping on mental health benefits**. A recent study found that in 2015, **behavioral care was four to six times more likely to be provided out of network than medical or surgical care**. And that's if you even get out-of-network benefits to begin with. **The share of** individual **plans offering** any **reimbursement for such care has declined** from 58 percent in 2015 **to 29 percent last year**. The result is quality mental health care out of reach of all but a wealthy, fortunate few. Take me, for example. For years, I've gone to a psychiatrist who has helped me manage my anxiety disorder with quality therapy and personalized, informed prescriptions for medication. Psychiatrists are much more effective in prescribing anti-depressants than general practitioners, who often don't have the expertise needed to carefully adjust dosage to avoid damaging side effects. But with average costs for therapy sessions in places like New York exceeding $200 an hour (with initial consults sometimes being hundreds more), that's not a viable option for most people. More specialized treatment is even more expensive. When my insomnia and anxiety got so bad I considered harming myself, my psychiatrist referred me to a cognitive behavioral therapist who has made worlds of difference for me. But he also charges $385 per 45-minute session. Part of what makes mental health care so expensive is that it is an ongoing process. Yes, I'm in much better shape now than I have been in the past thanks to great mental health providers – my anxiety doesn't keep me awake in bed all night, and self-harm is no longer an acute idea – but dropping out of treatment at the first sign of improvement can lead to problems down the line. As my therapist put it, it's like why a healthy lifestyle of good eating and regular exercise is far better than doing a crash diet: It's about consistent healthy habits, not rushing to hit a certain metric. But when seeing a therapist just once can be a major expense, or impossible for the 55 million Americans with

no emergency savings, months or years of treatment is absolutely out of reach. There's a simple, effective solution to this affordability crisis: Medicare for All. As laid out by Rep. Pramila Jayapal, D-Wash., in a bill she introduced in Congress last month, a nationwide, government-funded, universal Medicare for All plan would cover all medical care, free at point of service. Crucially, that includes mental health care. What this means is **anyone would be able to see mental health providers** like psychologists and psychiatrists **without paying a dime**: no premium, no copay, no deductible. **A proposal like Jayapal's would transform Americans' access to quality mental health care**. Not only would it provide access to those who flatly cannot afford it now, it would also take away the lengthy paperwork and complicated appeal processes that patients with insurance must jump through to get even a cent of their treatment covered.

Mental health treatment decreases suicide rates

Eileen Scahill. "Study finds more mental health visits decrease risk of suicide among youths". *Ohio State University.* March 23, 2020. https://news.osu.edu/study-finds-more-mental-health-visits-decrease-risk-of-suicide-among-youths/

A multistate study of Medicaid enrollees led by researchers at The Ohio State University Wexner Medical Center found that suicide risk was highest among youth with epilepsy, depression, schizophrenia, substance use and bipolar disorder. In addition, **the odds of suicide decreased among those who had more mental health visits within** the **30 days** before the date of suicide. Researchers compared the clinical profiles and mental health service patterns of children and adolescents who had died by suicide to see how they differed from the general population. The findings are published today (March 23) in JAMA Pediatrics. "To the best of our knowledge, no studies have examined the clinical profiles and health and mental health service utilization patterns prior to suicide for children and adolescents within the Medicaid population," said lead researcher Cynthia Fontanella, an associate professor in the department of psychiatry and behavioral health at Ohio State Wexner Medical Center. "Understanding how health care utilization patterns of suicidal decedents differ from the general population is critical to target suicide prevention efforts." This population-based case-control study merged mortality data with U.S. Medicaid data from 16 states spanning all regions of the country and accounting for 65% of the total child Medicaid population. The study looked at **910 youths** aged 10-18 years **who died by suicide** between Jan. 1, 2009, and Dec. 31, 2013, **compared to a control group of 6,346 youths that was matched based on gender, race, ethnicity, Medicaid eligibility category, state and age.** For both groups, researchers examined health and behavioral health visits in the six-month period prior to the date of suicide. Associations between visits, clinical characteristics and suicide were examined. Clinical characteristics included psychiatric diagnoses (attention deficit hyperactivity disorder, conduct disorders, depression, bipolar disorder and other mood disorders, anxiety disorders, schizophrenia/psychosis, substance use and other mental health disorders) and chronic medical conditions (diabetes, seizure disorders, cerebral palsy, asthma or cancer). "Our study found that 41% of youth who died by suicide had at least one mental health diagnosis in the six months prior to death, a finding similar to those of previous studies on adults," Fontanella said. "Our findings suggest that youths with psychiatric disorders, particularly mood disorders, schizophrenia and substance use, should be routinely assessed for suicide risk and receive high-intensity, evidence-based treatments for suicidality, such as cognitive behavioral therapy."

*homelessness / poverty

Mental health issues increase risk of homelessness

Heidi Schultheis. "Lack of Housing and Mental Health Disabilities Exacerbate One Another." *Center for American Progress*. November 20, 2018. https://www.americanprogress.org/issues/poverty/news/2018/11/20/461294/lack-housing-mental-health-disabilities-exacerbate-one-another/

People with mental health disabilities often fall victim to harmful misrepresentation and discrimination, including having their diagnoses and symptoms used to publicly mock and insult others. Similarly, homelessness is widely misunderstood, and people who experience homelessness are frequently exploited, objectified, and violently victimized. Given the misperceptions about both of these groups—and especially about people at the intersection of the two—it is critical to understand the connection between mental health disabilities and homelessness and the role that policy plays in that connection.* People with mental health disabilities are vastly overrepresented in the population of people who experience homelessness. **Of the more than 550,000 people in America who experienced homelessness on a given night in 2017, 1 in 5 had a mental illness. The**

proportion of people experiencing chronic homelessness with mental health disabilities was even higher—nearly 1 in 3. Despite this fact, the reality is that most people with mental illness fortunately do not experience homelessness: While about 20 percent of all adults in the United States have a mental illness, less than two-tenths of 1 percent of people in the country experienced homelessness on a given night in 2017. While all individuals and diagnoses are unique, **mental health disabilities often cause a variety of symptoms that substantially interfere with a person's daily life and activities, including maintaining steady employment or paying rent and utilities on a regular basis. Symptoms such as illogical thinking and withdrawal, along with the intense stigma surrounding mental illness, can also make it difficult for someone with a mental health disability to seek treatment.** Furthermore, the extreme stress, anxiety, isolation, and sleep loss that come with homelessness worsen mental and physical health problems, demonstrating the vicious cycle between homelessness and mental illness. But it does not have to be this way.

Treating mental illness will decrease incarceration rates

"Focus on Mental Illness to Reduce Mass Incarceration." *Treatment Advocacy Center.* https://www.treatmentadvocacycenter.org/component/content/article/2883

The Treatment Advocacy Center urges lawmakers to focus on reducing the jail and prison population that suffers with severe mental illness and makes six recommendations: Make the reduction of mentally ill inmates in US jails and prisons a national priority. At least 1 in 5 jail and prison inmates – and as many as half in some institutions - suffers from disordered thinking caused by severe mental illness. **Reducing incarceration driven by untreated mental illness will reduce inmate populations significantly.** Foster adoption of assisted outpatient treatment (AOT) laws for people with severe mental illness who struggle with voluntary adherence to treatment. AOT provides court-ordered treatment in the community and has been shown to significantly reduce crime and violence among its target population. Implement evidence-based practices to divert individuals from the criminal justice system to the mental health system. **Fewer than half the US population lives in jurisdictions where the most basic methods of diversion are practiced.** Restore public psychiatric hospital beds. By 2010 (the latest year for which data is available), only 14.1 public hospital beds remained for every 100,000 US residents – the lowest total since 1850, when construction of state psychiatric hospitals began. A minimum of 50 beds per 100,000 people is a consensus target for ensuring minimally adequate availability of inpatient care. Promote understanding and use of civil commitment laws by funding educational programs for judges, law enforcement, school officials and others in a position to use them. Court-ordered treatment options exist to safeguard those with the most severe mental illness, their families and their communities. As long as these laws remain unfamiliar, misunderstood or overlooked, the public will remain needlessly at risk.

Only 1.4 percent of those who need substance abuse treatment in the U.S. actually receive it.

Ahrnsbrak et al. "Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health." *U.S. Department of Health and Human Services*. September 2017. https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm#adults

"In 2016, an estimated **21.0 million people aged 12 or older needed substance use treatment**. This translates to about 1 in 13 people needing treatment. Among young adults aged 18 to 25, however, about 1 in 7 people needed treatment. For NSDUH, people are defined as needing substance use treatment if they had an SUD in the past year or if they received substance use treatment at a specialty facility in the past year.[2] In 2016, **1.4 percent of people aged 12 or older (3.8 million people) received any substance use treatment in the past year, and 0.8 percent (2.2 million)**

received substance use treatment at a specialty facility. Only about 1 in 10 people aged 12 or older who needed substance use treatment received treatment at a specialty facility in the past year (10.6 percent)."

Financial limitations are a significant barrier preventing people from receiving treatment

"What are Barriers to Accessing Addiction Treatment?" *American Addiction Centers*. July 29, 2020. https://americanaddictioncenters.org/rehab-guide/treatment-barriers

"Financial limitations are one of the major barriers that prevent people from receiving treatment. Insurance can help cover the cost of substance abuse treatment, but many people remain uninsured due to:11 The high cost of insurance. The loss of a job. Losing Medicaid. Lack of insurance through an employer. Change in family status. Believing that they don't need coverage. In 2016**, 27.6 million people ages 0–64 did not have health insurance.** About 44% of these people were white, 33% were Hispanic, 15% were black, 5% were Asian/Native Hawaiian or Pacific Islander, and 3% were of another race, and three-quarters of them were in a household with one or more full-time workers.11 The National Comorbidity Survey-Replication, a nationally representative survey of more than 9,000 people, asked why people with mental health and substance abuse disorders did not seek treatment. About **15% of the respondents cited financial barriers such as lack of insurance and concerns about cost. Almost 17% said they left treatment early due to treatment costs and their insurance not paying for further treatment**.12 Socioeconomic status may also play a role in whether someone can access and complete treatment. It has already been established as a risk factor that can prevent people from entering treatment, and one study found that blacks and Hispanics were less likely to complete addiction treatment largely due to differences in socioeconomic status—particularly higher unemployment and unstable housing among these groups.13"

M4A would grant universal coverage of substance abuse treatment.

"Medicare Coverage of Mental Health and Substance Abuse Services." *Center for Medicare Advocacy*. *medicare-coverage-of-mental-health-services*

"**Medicare will pay for treatment of alcoholism and substance use disorders in both inpatient and outpatient settings.** Medicare Part A pays for inpatient substance abuse treatment; individuals will pay the same co-pays as for any other type of inpatient hospitalization. Likewise, Medicare Part B will pay for outpatient substance abuse treatment services from a clinic or hospital outpatient department."

Treating substance abuse will decrease incarceration rates.

Chandler, Redonna et al. "Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety." *JAMA*. Janurary 14, 2009. doi: 10.1001/jama.2008.976, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2681083/.

"The inadequacy of incarceration by itself in addressing drug abuse or addiction is evident in the statistics. A review of recidivism in 15 states found that **one-quarter of individuals released returned to prison within 3 years for technical violations that included, among other things, testing positive for drug use**.9 Illicit drugs are used in jails and prisons despite their highly structured, controlled environments,10 but even enforced abstinence can mislead criminal justice professionals as well as addicted persons to underestimate the vulnerability to relapse postincarceration. On release from prison or jail, addicted persons will experience challenges to their sobriety through multiple stressors that increase their risk of relapsing to drug use. These include the stigma associated with being labeled an ex-offender, the need for housing and legitimate employment, stresses in re-unifying with family, and multiple requirements for criminal justice supervision.11,12 Returning to neighborhoods associated with preincarceration drug use places the addicted individual in an environment rich in drug cues. As discussed below, these conditioned cues

automatically activate the reward/motivational neurocircuitry and can trigger an intense desire to consume drugs (craving).13 The molecular and neurobiological adaptations resulting from chronic drug use persist for months after drug discontinuation,14 and evidence exists that compulsive seeking of drugs when addicted individuals are reexposed to drug cues progressively increases after drug withdrawal.15 This could explain why many drug-addicted individuals rapidly return to drug use following long periods of abstinence during incarceration and highlights the need for ongoing treatment following release.

Treating substance abuse will decrease overdoses

Hedegaard, Holly et al. "Drug Overdose Deaths in the United States, 1999-2018." *CDC, National Center for Health Statistics Data Brief No. 356*. January 2020. https://www.cdc.gov/nchs/products/databriefs/db356.htm#ref1

"**In 2018, there were 67,367 drug overdose deaths in the United States,** a 4.1% decline from 2017 (70,237 deaths). The age-adjusted rate of drug overdose deaths in 2018 (20.7 per 100,000) was 4.6% lower than in 2017 (21.7). For 14 states and the District of Columbia, the drug overdose death rate was lower in 2018 than in 2017. **The rate of drug overdose deaths involving synthetic opioids other than methadone (drugs such as fentanyl, fentanyl analogs, and tramadol) increased by 10%, from 9.0 in 2017 to 9.9 in 2018. From 2012 through 2018, the rate of drug overdose deaths involving cocaine more than tripled (from 1.4 to 4.5) and the rate for deaths involving psychostimulants with abuse potential (drugs such as methamphetamine) increased nearly 5-fold (from 0.8 to 3.9). Deaths from drug overdose continue to contribute to mortality in the United States** (1–5). This report uses the most recent data from the National Vital Statistics System (NVSS) to update trends in drug overdose deaths for all drugs and for specific drugs and drug types, and to identify changes in rates by state from 2017 to 2018."

PREVENTING STRUCTURAL VIOLENCE

What's the argument?

Structural Violence, or "social arrangements that put individuals and populations in harm's way," is instilled within the very fabric of our political and economic systems (Farmer). Health care within the US significantly exacerbates structural violence. Through high prices that disproportionately impact minorities to racism that exists within the system, a lack of access to life saving treatments only serves to worsen some of the biggest problems plaguing the US. However, Medicare for All offers a solution by leveling the playing field and providing care to those who desperately need it.

Racism Within the Health Care System

The US healthcare system was built on a premise of "systematic segregation and discrimination of patients based on race and ethnicity" (The American Academy of Family Physicians). In both the past and the present, minority groups, specifically Black Americans, experience immense difficulties when it comes to receiving beneficial and fair health care. In fact, Black Americans experience a mortality rate at 1.6 times higher than their white counterparts (Williams). While Medicare for All does not solve for one of the largest barriers to equality, implicit biases, it does reduce medical debt. In Baltimore, for example, medical debt impacted 32 percent of people of color, whereas only 19 percent of white residents experienced difficulties in affordability. Nationally, nearly one out of three Black Americans between the ages of 18 to 64 have overdue medical bills (A. Philip Randolph Institute). The implications on Black individuals are dire. A Black person dies prematurely every 7 minutes, and more than 200 Black people a day could be saved if the health system were equal (Williams). Along with providing millions of people access to critical treatment and therefore saving countless lives, the implementation of Medicare for All is predicted to reduce poverty rates of Black Americans by 4.9 percent and for Hispanics by 6.1 percent.

Reproductive care/Abortion

The issue of abortion is one of the most controversial issues in the United States. When running this argument, please make sure it is something you strongly believe in and will advocate for even if it means losing based on a judge's opinion. That being said, let's dive into the argument. States are increasingly becoming more restrictive on abortion legislation. Laws have begun to challenge the monumental Roe v. Wade case

of 1973, which protects a woman's liberty to choose to have an abortion without excessive government restriction. There are roughly 30 anti-abortion laws that have been passed thus far, and states have begun passing some of the most prohibitive legislation in decades, meaning restrictions will only continue to increase (Tavernise). One of the most prominent anti-abortion bills in existence is the Hyde Amendment. This federal bill bars the use of federal funds to pay for abortion, except for in extreme circumstances, like if pregnancy is a threat to the mother's life or if the child was conceived through rape or incest. In application, the Hyde Amendment means that women on Medicaid cannot get abortion through their Medicaid coverage.

Medicare for All offers a solution. The M4A bill would nullify the Hyde Amendment, mandating "comprehensive reproductive care," which would include abortion (Cicerchia). The impact would be large: "approximately one-fourth of women who would have Medicaid-funded abortions instead give birth when this funding is unavailable". This amounts to roughly 60,000 prevented abortions annually (Astor). For that reason, the Hyde Amendment disproportionately impacts low-income women and women of color, as they are more likely to lack access to funding than white women. While terminating dangerous pregnancies or saving the lives of mothers could serve as an impact, decreasing poverty will be the most popular. Women possessing an income below the federal poverty line experience unintended pregnancy at rates five times higher than women within an income at or above the poverty line. Problematically, a survey asking women how they would pay for an emergency abortion found 47% of respondents would have to borrow money, sell something, forgo utility payments or not come up with the money at all (Boonstra). As a result, woman who are denied an abortion are more likely to fall into or remain in poverty 4 years after the denial (Foster).

Undocumented Immigrants

Another hot button political issue touched on by Medicare for All is immigration. In the current healthcare system, undocumented immigrants face large barriers when trying to access care. They are often ineligible for government funded insurance and subsidized private plans (Phillip). As such, it is no surprise that the uninsured rate for undocumented immigrants is nearly five times higher than for that of regular citizens (Kent). Sanders' intention with the bill is to provide access for everyone, which is why the bill uses the language "US resident" instead of "US citizen" (Wolf). However, especially in conservative states, this could be manipulated to trap undocumented residents in the system and possibly oust their immigration status. Creating a registry that includes citizenship status could also risk deportation for families.

Why does the argument matter?

Structural violence is an issue that affects every aspect of society and does traumatic and irreversible psychological and developmental damage. The healthcare system itself systematically harms minority populations. For example, Black Americans have a mortality rate that is 1.9 times that of white Americans. The Hyde Amendment prevents low-income women from accessing reproductive care simply because they are low-income, thus furthering the cycle of poverty. Undocumented immigrants have an uninsured rate 5 times that of citizens. Making our structures more equitable ought to be one of the primary goals of society at large, and a policy like Medicare for All that does so could have a large, positive impact.

Main Players

People of color, women, undocumented immigrants

Strategy Considerations

Structural violence arguments play an essential role in this activity to bring awareness to policymaking from a perspective that is almost always ignored in the media and on Capitol Hill. They strategically work best when they become a form of advocacy but are a pitfall if teams run them just to win. Please do not exploit human suffering to win a ballot. These impacts are inherently arbitrary and less tangible or quantifiable than stock arguments; however, if run with the proper framework, they can be an incredibly strong path to the ballot. Strategically, the argument moves away from a cost-benefit analysis; there is now an a priori moral imperative to correct the injustices within the system before considering anything else. It is very compelling because of how urgent and inherent it is. It is likely that no other policy will correct the system, so this is the only shred of hope for this situation to improve.

Evidence for Preventing Structural Violence

The definition of structural violence

Paul E Farmer, Bruce Nizeye [...], and Salmaan Keshavjee. "Structural Violence and Clinical Medicine." *PLOS Medicine*. October 2006. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1621099/#__ffn_sectitle

The term "structural violence" is **one way of describing social arrangements that put individuals and populations in harm's way (see Box 1) [16]. The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people** (typically, not those responsible for perpetuating such inequalities). With few exceptions, clinicians are not trained to understand such social forces, nor are we trained to alter them. Yet it has long been clear that many medical and public health interventions will fail if we are unable to understand the social determinants of disease [17,18].

Decreases racism in healthcare system

The healthcare system continues to implement racist practices

The American Academy of Family Physicians. "Institutional Racism in the Healthcare System." July 2019. https://www.aafp.org/about/policies/all/institutional-racism.html

The AAFP also recognizes **the impact of racism within the U.S. health care delivery system, which has historically engaged in the systematic segregation and discrimination of patients based on race and ethnicity, the effects of which persist to this day. Hospitals and clinics, which were once designated for racial and ethnic minorities, continue to experience significant financial constraints and are often under-resourced and improperly staffed. These issues result in inequities in access to and quality of health care and are major contributors to racial and ethnic health disparities**. While segregation and discrimination based on race and ethnicity is no longer legal today, some organizations continue to discriminate based on insurance status, which also disproportionately impacts non-white populations.

Mortality rates are higher for Black people due to healthcare inequalities

David R. Williams. Toni D. Rucker. "Understanding and Addressing Racial Disparities in Health Care." *Healthcare Financing Review*. 2000. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194634/pdf/hcfr-21-4-075.pdf

It is a national embarrassment that there are large and persisting racial differences in health. National data reveal, for exam- ple, that **black persons had an overall mortality rate that was 1.6 times higher than white persons in 1995—identical to the black/white mortality ratio in 1950 (Williams, 1999). Moreover, for multiple causes of death (heart disease, cancer, diabetes, and cirrhosis of the liver) the racial discrepancy was larger in 1995 than in 1950.** These inequities fly in the face of cherished American principles given the public's commitment to principles of equal treatment in society. As a society, we need to make it a national priority to build on the cultural support for egalitarian principles and develop strategies to eradicate racial inequities in medical care.

Inability to pay for healthcare further fuels the problem

Deborah Burger. "Medicare for All Will Boost the Fight for Racial Justice in Health Care." *Common Dreams*. December 17, 2019. https://www.commondreams.org/views/2019/12/17/medicare-all-will-boost-fight-racial-justice-health-care

The growing crisis of medical debt is another example. Since 2009, prestigious Johns Hopkins Hospital has filed more than 2,400 medical debt lawsuits in Maryland courts. The impact is especially severe **in Baltimore where 32 percent of people of color endure medical debt, compared to just 19 percent of white residents. The largest zip code targeted by Hopkins medical debt lawsuits is 90 percent African American.** Transformation of our health care system to a more humane model based on health care as a human right, not profits and ability to pay would sharply reduce systemic and institutional racial disparities, while we must concurrently address individual practitioner biases that are reinforced by the multiple ways our society perpetuates racism. Medicare for All would eliminate the cost barrier that disproportionately affects communities of color with higher rates of no insurance or underinsurance. It would abolish premiums, deductibles, and co-pays for such basics as emergency and hospital care, doctor's offices, and health needs not covered by traditional insurance, including dental, vision, hearing, mental health, and home and community based long-term care. In a hearing December 11 in the Energy and Commerce Health Subcommittee, National Nurses United President Jean Ross, RN explained how the House Medicare for All bill, HR would specifically provide funding for services in underfunded low income urban and rural areas with medically underserved patients, including many people affected by racial disparities in health. That could be a huge boon in the predominantly African American east District of Columbia community where the only remaining hospital is about to close. "With Medicare for all, and continuing the fight for racial justice, we can make real progress and a major impact on health care injustice." And in Chicago's largely African American South Side neighborhoods, home to only two of 12 Chicago hospitals that meet the American College of Surgeons guidelines on cancer care, as noted by a New England Journal of Medicine report. Not coincidentally, **Black women in Chicago were almost 40 percent less likely than white women to have the recommended breast cancer screening, and more likely to have their cancer diagnosis missed.** Even allegedly neutral technology can reinforce racism. **Another study documented that algorithms used by health systems, insurers, and practitioners to allocate extra medical care for patients with complex medical needs under-estimate health needs of the sickest Black patients.** The algorithm calls for extra care based on what people spend for medical care. But it too fails to account for lack of insurance, where people live, access to transportation, childcare costs, and other socio-economic factors that disproportionately affect Black patients and what they can spend to get needed care. Some racial disparities are clearly life threatening, such as the lack of trauma centers and best breast cancer screening facilities, and the well documented pregnancy-related mortality rates that are three to four times greater for African American women. Under Canada's health care system, similar to Medicare for all, overall treatment and survival rates for acute and chronic health conditions are 13 percent higher, and 36 percent higher in high poverty neighborhoods than in the U.S. Breast cancer survival rates for low income Canadians under age 65 are 14 percent higher than their U.S. counterparts. With Medicare for all, and continuing the fight for racial justice, we can make real progress and a major impact on health care injustice. Dr. King's vision of a beloved community based on justice, equality, dignity and good will for all requires no less.

Black and minority individuals are disproportionately uninsured/cannot afford care, M4A removes this barrier

A. Phillip Randolph Institute et al. "Medicare for All is a Racial Justice Issue." *The Center for Popular Democracy*. July 10, 2019. https://populardemocracy.org/news-and-publications/medicare-all-racial-justice-issue

Despite many gains, **30 million people in the United States lack health insurance, and tens of millions of households have health insurance but cannot afford to receive the medical care they need. One in five working-age Americans report having problems paying their medical bills despite having health insurance, driven by pocketbook-busting premiums, copays and deductibles.[1]** Universal health care is also a racial justice necessity because communities of color, in particular, suffer from a lack of access to affordable health insurance. People of color make up 42% of the nonelderly U.S. population, yet account for over half of the total nonelderly uninsured population. Latinx and Black people have significantly higher uninsured rates (19% and 11%, respectively) compared to

white people.[2] Medical debt remains a glaring issue for Black Americans. **Nearly one in three Black Americans aged 18 to 64 has past-due medical bills.[3] Black uninsured populations face burdensome out-of-pocket medical expenses when seeking care, which often means they are forced to delay preventative care and get treated as a last resort – the most expensive form of treatment.[4]** Latinx patients are the most uninsured population in the United States today. Latinx individuals already comprise much of the workforce that is unable to get health coverage through their job. Lawmakers have curtailed the Affordable Care Act's health enrollment program, which has severely challenged the ability of outreach workers to reach Latinx patients for new coverage. Undocumented Latinx patients suffer further as they are ineligible for government-funded insurance and subsidized private health plans. Despite the fact that undocumented adults pay taxes[5], they are ineligible to receive Medicaid health benefits and financial subsidies to buy health plans from the federal-state health insurance marketplaces. Disturbingly, racial bias mars the entirety of American health care. In particular, Black maternal and prenatal health access remains in crisis levels. In the state of New York between 2013 and 2015, 54 **Black women died for every 100,000 births -- nearly four times the rate of white women.[6]**

200 Black people could be saved each day

David R. Williams. "Why Discrimination is a Health Issue." *Robert wood Johnson Foundation*. October 24, 2017. https://www.rwjf.org/en/blog/2017/10/discrimination-is-a-health-issue.html

Indeed, half of maternal deaths in our country are preventable.[7] While there are many reasons why Black mothers and mothers-to-be experience poor treatment and care, a lack of quality health access is a significant factor. Forty-one years after graduating from Yale University, Clyde Murphy—a renowned civil-rights attorney—died of a blood clot in his lungs. Soon afterward, his African-American classmates Ron Norwood and Jeff Palmer each succumbed to cancer. In fact, more than 10 percent of African-Americans in the Yale class of 1970 had died—a mortality rate more than three times higher than that of their white classmates. That's stunning. But it's true: African-Americans live sicker and die sooner than whites in America. Heart disease is the number one cause of death in the United States and middle-aged black males and females have death rates that are about twice as high as their white counterparts. Elevated death rates are also evident for cancer, stroke, diabetes, kidney disease, maternal death—the list goes on. In fact, **every 7 minutes, a black person dies prematurely. That's more than 200 black people a day who would not die if the health of blacks and whites were equal.** And, as the Yale example shows, even higher levels of education—which can lead to higher incomes and the ability to live in healthier neighborhoods and to access high-quality health care—can't protect African-Americans from the disparities leading to higher mortality rates.

Access to care in conjunction with not having to pay for insurance would decrease poverty

Karina Wagnerman. "Research Update: Medicaid pulls Americans out of Poverty, Update Edition." *Georgetown University Health Policy Institute*. March 2018. https://ccf.georgetown.edu/2018/03/08/research-update-medicaid-pulls-americans-out-of-poverty-updated-edition/

Medicaid is among the most effective antipoverty programs. Medicaid reduced the health inclusive poverty measure by 3.8 percentage points. This is comparable to the combined effect of all social insurance programs and greater than the effects of non-health means tested benefits and refundable tax credits. Medicaid had a larger effect on child poverty than all non-health means tested benefits combined. It is estimated to reduce child poverty by 5.3 percentage points. Medicaid is particularly important for people of color**. It reduced the poverty rates of Hispanics by 6.1 percentage points and African Americans by 4.9 percentage points (in households with no disability recipients).** Health insurance benefits are important to families who receive them. Medicaid reduced poverty among its beneficiaries by 17.1 percentage points. This is higher than other types of insurance: ESI reduced poverty by 5 percentage points for those it covered and premium subsidies reduced poverty by 6.6 percentage points for those it covered.

Access to reproductive care / abortion

M4A covers abortion care

Jodi Jacobson. "'Medicare for All' Bill could be single greatest advancement in reproductive health care in a century." *Rewire News*. September 13, 2017. https://rewire.news/article/2017/09/13/medicare-bill-single-greatest-advancement-reproductive-health-care-century/

By unapologetically covering comprehensive reproductive health care (yes, including abortion) for everyone, **the Sanders bill would also spur perhaps the greatest expansion in access to reproductive health care in this country in the last century.** In its draft form, the bill clearly sends the message to all individuals in the United States: You deserve health care. You have a right to health care. The legislation, which currently has 15 Senate Democratic co-sponsors, galvanizes a much-delayed and oft-belittled public conversation about universal access to care that goes well beyond where the Affordable Care Act (ACA), as important as that is, can take us. The ACA, or Obamacare—originally passed in 2010 and until then also considered by many pundits and lack-of-visionaries as "a liberal pipe dream"—dramatically reduced the number of uninsured people in the United States, from just under 50 million in 2010 to roughly 28 million in 2016. Millions remain uninsured due in part to the continued reliance by the ACA on private insurance companies, but even more so as a consequence of vociferous Republican opposition to reducing the costs of premiums, expanding Medicaid for low-income populations, and including an essential benefits package. Under our current system, medical care tends to concentrate in larger urban areas, so geography also plays a large role: Some 60 million U.S. people in America live in areas without sufficient access to primary health-care providers. Sanders' approach seeks to eliminate these gaps. That means the hourly worker at Walmart would have the same access to basic health care as the Equifax executive pulling down $14 million per year. Moreover, the bill is transformative in other ways. While the ACA includes many reproductive health services in its own essential benefits package, the Obama administration caved to so-called conservative and religious ideologues in carving out exceptions for the birth control benefit, which guarantees patients access to contraception without a co-pay. These exceptions were later used in court by opponents of contraception to further weaken the benefit. Further, the administration acceded to demands of far-right legislators in accepting amendments to the ACA that grossly limited access to abortion care and helped spur the elimination of private insurance coverage of abortion at the state and national level, coverage that the vast majority of women with private insurance already had. In addition, the administration used executive power through HHS to expand application of the Hyde Amendment, which bans federal funding from being used for most abortion care. **Sanders' bill** explicitly **places reproductive health care** where it belongs: **as part of primary preventive care accessible to anyone who needs it.** It also explicitly prohibits application of the Hyde Amendment to the Trust Fund set up to pay for health services. In short: **abortion care is covered.** And the bill was "written to cover abortion, explicitly," said a Sanders staffer. By proactively stating the aim of eliminating the Hyde Amendment, Sanders will hopefully force ostensibly pro-evidence Democrats to actually understand and become comfortable discussing the public health, medical, and human rights aspects of reproductive health care, including contraception and abortion care. This is an area in which, for all their "pro-choiceiness," Democrats have historically fallen far short. The bill also ensures that the HHS secretary, charged with overseeing the fund, can't discriminate against reproductive health-care providers.

States make abortion access increasingly more difficult to obtain

Sabrina Tavernise. "'The Time is Now': States are Rushing to Restrict Abortion, or to Protect It." *The New York Times*. May 15, 2019. https://www.nytimes.com/2019/05/15/us/abortion-laws-2019.html

In April, Indiana placed a near-total ban on the most common type of second-trimester abortion in the state. Days later, Ohio passed a bill banning abortion in the very early weeks of pregnancy after a fetal heartbeat is detected. Now on Wednesday, Gov. Kay Ivey of Alabama signed a bill effectively banning the procedure altogether, and lawmakers in two more states — Louisiana and Missouri — moved ahead with bills similar to Ohio's. **States across the country are passing some of the most restrictive abortion legislation in decades**, deepening the growing divide between liberal and conservative states and setting up momentous court battles that could profoundly reshape abortion access in America. "This has been the most active legislative year in recent memory," said Steven Aden, general counsel of Americans United for Life, an anti-abortion group. The national race to pass new legislation began last fall, after President Trump chose Brett M. Kavanaugh to replace Justice Anthony M. Kennedy on the Supreme Court, adding what some predicted would be a fifth vote to uphold new limits on abortion. Red states rushed to

pass more restrictions and blue states to pass protections. Now, as state legislative sessions draw to a close in many places**, experts count about 30 abortion laws that have passed so far.** That is not necessarily more than in past years, said Elizabeth Nash, a legal expert at the Guttmacher Institute, which supports abortion rights. What's different is **the laws themselves,** which **have gone further than ever to frontally challenge Roe v. Wade**, the Supreme Court's 1973 ruling that established federal protections for abortion. And more are coming. On Wednesday, a committee of the Louisiana House in Baton Rouge advanced a fetal heartbeat bill as abortion rights activists demonstrated outside the chamber. And early Thursday, the Missouri Senate passed a fetal heartbeat billthat includes an exception for medical emergencies, but not for pregnancies caused by rape or incest. "This is a very serious situation," Ms. Nash said. "We are really facing a point at which the courts may make a shift on abortion rights."

The Hyde Amendment severely limits a woman's right to an abortion

Maggie Astor. "What is the Hyde Amendment? A look at its impact as Biden reverses his stance." *The New York Times*. June 7, 2019. https://www.nytimes.com/2019/06/07/us/politics/what-is-the-hyde-amendment.html

It is hard to put an exact number on how many abortions the Hyde Amendment prevents, but supporters and opponents agree that it is substantial. According to a 2009 literature review by the Guttmacher Institute, which supports abortion rights, **"approximately one-fourth of women who would have Medicaid-funded abortions instead give birth when this funding is unavailable."** In a 2016 report, the Charlotte Lozier Institute, which opposes abortion, cited studies showing **a 13 percent increase in births among Medicaid recipients after the amendment was enacted, and estimated that it prevented more than 60,000 abortions per year.** Because Medicaid is primarily a program for low-income Americans, **the amendment mostly affects low-income women. People of color are also disproportionately likely to rely on Medicaid**. What's the rationale for it? For opponents of abortion, the Hyde Amendment is an obvious corollary: If abortion is wrong, then so is government funding for it. Anti-abortion activists began pursuing the amendment soon after the Roe v. Wade ruling in 1973.

Medicare for all would nullify the Hyde Amendment, granting all women the right to an abortion

Lillian Cicerchia. "What Medicare for All means for Abortion Rights." *Jacobin.* January 18, 2019. https://jacobinmag.com/2019/01/medicare-for-all-abortion-hyde-trap-laws-reproductive-justice

Sanders introduced the Medicare for All Act in the United States Senate. Medicare for All is what many refer to as single-payer, where citizens pay for publicly funded health insurance through taxes rather than paying for private insurance. In the midst of Democratic Party backtracking on abortion rights, the bill came as a breath of fresh air to the reproductive justice movement. **Sanders's Medicare for All bill mandates "comprehensive reproductive care," including abortion. Mandated equal access to abortion care in federal legislation would mean nullifying the Hyde Amendment, which is the legislation that gets passed yearly preventing Medicaid programs from providing federal funds for abortions except in dire circumstances. There would then be no basis for Hyde's annual passage, since preventing federally mandated abortion access is the reason Hyde exists.** Defeating Hyde means abandoning the defensive, legalistic way of interpreting reproductive justice solely through the lens of privacy, which mainstream nonprofits and reproductive rights advocates have clung to under Roe v Wade. Roe is the Supreme Court decision that legalized abortion on the basis of the Fourteenth Amendment's due process clause. It affirmed that the state cannot interfere in a person's decision to terminate a pregnancy without

due process of law. Fundamentally, Roe affirms a pregnant person's right to privacy. It does not, however, affirm the state's responsibility to ensure abortion access. Sanders's approach means, instead, creating a class-wide basis for deepening reproductive justice. B**y tying abortion access into a health system that addresses all of women's needs, it affirms a more expansive sense of reproductive justice: both the right to reproduce and the right not to in a safe and healthy environment**. And the promise of fully funded health care for all takes the edge off the GOP's specter of "taxpayer-funded abortions" used to pass Hyde every year. With Medicare for all, the Right's zero-sum logic about who does and doesn't deserve "scarce" healthcare resources loses its relevance.

Medicare also increases access to maternal care and health screenings

Jessica Washington. "Bernie Sanders said Medicare for All would Protect Abortion. Here's Why." *Mother Jones*. June 28, 2019. https://www.motherjones.com/politics/2019/06/bernie-sanders-said-medicare-for-all-would-protect-abortion-heres-why/

Essentially, there are two mechanisms. First, Sanders' **Medicare for All bill promises free "comprehensive reproductive, maternity, and newborn care." Although the bill does not explicitly state this, Sanders' team confirmed that this provision would cover abortions. The bill would also repeal the Hyde Amendment,** a measure attached to yearly spending bills that currently bans federal funding for abortion coverage. While some states allow their own Medicaid dollars to go toward abortions, 35 states and the District of Columbia do not allow any Medicaid funding to cover abortions. In other words, in most of the country Medicaid recipients and other people on federal health insurance programs are forced to pay out of pocket for abortions, which can range from $75 to $3,000. Sanders' bill states: "Restrictions Shall not apply. —Any other provision of law in effect on the date of enactment of this Act restricting the use of Federal funds for any reproductive health service shall not apply to monies in the Trust Fund."

Decrease number of women pushed into poverty due to a lack of choice

Heather D. Boonstra. "Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters." *Guttmacher Institute*. July 14, 2016. https://www.guttmacher.org/gpr/2016/07/abortion-lives-women-struggling-financially-why-insurance-coverage-matters

But not all women are sharing equally in this progress. Although the rate of unintended pregnancy among low-income women declined between 2008 and 2011, major disparities remain. In 2011, **the unintended pregnancy rate among women with an income below the federal poverty level ($18,530 for a family of three that year5) was more than five times that among women with an income at or above 200% of poverty** (112 vs. 20 per 1,000 women aged 15–44).6 And because of this high rate of unintended pregnancy, **women who are struggling financially experience high levels of abortion.** Indeed, over the last few decades, **abortion has become increasingly concentrated among the poor. In 2014, 49% of abortion patients had a family income below the federal poverty level—up from 27% in 2000.7,8 An additional 26% of abortion patients in 2014 had an income that was 100–199% of the poverty threshold. In other words, 75% of abortions in 2014 were among low-income patients.** The reasons women give for having an abortion underscore their understanding of the economic impact unplanned childbearing would have on themselves and their families. Most abortion patients say that they cannot afford a child or another child, and most say that having a baby would interfere with their work, school or ability to care for their other children.9 Most women also cite concern for or responsibility to other individuals as a factor in their decision to have an abortion. These concerns make particular sense

when one considers that **six in 10 women who have an abortion are already a parent**.7 Unfortunately, for a pregnant woman who is already struggling to get by, the cost of an abortion may be more than she can afford on her own. The average amount paid for an abortion at 10 weeks' gestation was $480 in 2011–2012.10 The University of California, San Francisco Turnaway Study—a five-year longitudinal study of roughly 1,000 women seeking abortion care at 30 facilities across the United States—found that **for more than half of women who received an abortion, their out-of-pocket costs (for the procedure, as well as for travel and hotel, if needed) were equivalent to more than one-third of their monthly personal income**.11 Other studies show that many Americans do not have adequate savings to cover a financial emergency of any kind. In 2013, the Federal Reserve Board conducted a nationally representative household survey designed to "monitor the financial and economic status of American consumers."12 **The survey asked respondents how they would pay for a $400 emergency, and 47% said either that they would cover it by borrowing or selling something, or that they would not be able to come up with the money.** The number of women potentially affected by the Hyde Amendment is substantial. Of women aged 15–44 enrolled in Medicaid, 60% live in the 35 states and the District of Columbia that do not cover abortion, except in limited circumstances.17 **This amounts to roughly seven million women of reproductive age, including 3.4 million who are living below the federal poverty level.** The Hyde Amendment falls particularly hard on women of color. Because of social and economic inequality linked to racism and discrimination, **women of color are disproportionately likely to be insured by the Medicaid program: Thirty percent of black women and 24% of Hispanic women aged 15–44 are enrolled in Medicaid, compared with 14% of white women** (see graphic).17 A number of studies conducted over the last four decades have assessed the impact of the Hyde Amendment.18 **To afford an abortion, many low-income women without coverage for the procedure delay or forgo paying utility bills or rent, or buying food for themselves and their children**;19others rely on family members for financial help, receive financial assistance from clinics or sell their personal belongings.7,19 Moreover, women who have decided to have an abortion can get caught in a cruel cycle, in which the delays associated with raising the funds to pay for the abortion can lead to additional costs and delays. Abortion in the second trimester can cost 2–3 times as much as abortion in the first trimester.10Because of the time and effort needed to scrape together the funds, many low-income women have to postpone their abortion: Fifty-four percent of women in the Turnaway study sample reported that having to raise money for an abortion delayed their obtaining care.11 In addition, the risk of complications from abortion—although exceedingly small at any point—increases with gestational age.20 Although most low-income women who want an abortion manage to obtain one, some do not, and the result is an unplanned and often unwanted birth. A number of studies published over the course of decades have examined how many women are forced to forgo their right to abortion and bear children they did not intend. A 2009 literature review published by the Guttmacher Institute identified studies from five states that compared the ratio of abortions to births before and after coverage ended.18 The review concludes that among women with Medicaid coverage subject to the Hyde Amendment who seek an abortion, one in four are unable to obtain one because of lack of abortion coverage. The Turnaway study examined the reasons for not obtaining an abortion after being denied one because of provider gestational limits. **Among those who considered having an abortion elsewhere, but never obtained one, 85% reported that the reason for not obtaining an abortion was the cost of the procedure and travel**.21 The study also found that when a woman who is already struggling to get by is denied an abortion, she is especially likely to fall into poverty.22 Women denied an abortion who subsequently had a child (or another child) were more likely than women who received an abortion to be unemployed, receiving public assistance and living below the federal poverty level one year after their clinic visit—despite the fact that there were no economic differences between the women a year earlier.

Example of increased rates of poverty and unemployment amongst women without access to abortion

Foster et al. "Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States." *AJPH*. February 7, 2018. https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304247

Methods. Women who presented for abortion just before or after the gestational age limit of 30 abortion facilities across the United States between 2008 and 2010 were recruited and followed for 5 years via semiannual telephone interviews. Using mixed effects models, we evaluated socioeconomic outcomes for 813 women by receipt or denial of abortion care. Results. In analyses that adjusted for the few baseline differences, women denied abortions who gave birth had higher odds of poverty 6 months after denial (adjusted odds ratio [AOR] = 3.77; P < .001) than did women who received abortions**; women denied abortions were also more likely to be in poverty for 4 years after denial of abortion. Six months after denial of abortion, women were less likely to be employed full time (AOR = 0.37; P = .001) and were more likely to receive public assistance (AOR = 6.26; P < .001) than were women who obtained abortions, differences that remained significant for 4 years.** Conclusions. Women denied an abortion were more likely than were women who received an abortion to experience economic hardship and insecurity lasting years. Laws that restrict access to abortion may result in worsened economic outcomes for women. Since 2011, hundreds of state-level restrictions on abortion have been implemented in the United States. Little is known about the socioeconomic consequences for women and families if women are not able to obtain a wanted abortion. When women are asked why they want to end a pregnancy, the most common reasons are financial—in particular, not having enough money to raise a child or support another child.1–3 Yet no research has evaluated the economic consequences for US women of being unable to terminate an unwanted pregnancy and carrying the pregnancy to term. The lack of evidence about the socioeconomic consequences of barriers to abortion services is largely the result of methodological challenges related to study design and the identification of appropriate comparison groups.4–6 Given that preexisting economic difficulties contribute to a woman's decision to terminate a pregnancy, studies that compare socioeconomic outcomes of women who receive abortion services to women who do not choose to terminate a pregnancy may not identify the effects of abortion, but instead may reflect the characteristics that lead women either to seek abortions or carry a pregnancy to term, such as poverty, lack of education, and younger age.7,8 We aimed to examine the effects of receiving versus being denied a wanted abortion on women's socioeconomic well-being by following a group of women who all sought abortions, some of whom were denied services.

Access for Undocumented Immigrants

Undocumented immigrants experience great difficulties in accessing care in the US

A. Phillip Randolph Institute et al. "Medicare for All is a Racial Justice Issue." *The Center for Popular Democracy*. July 10, 2019. https://populardemocracy.org/news-and-publications/medicare-all-racial-justice-issue

Medical debt remains a glaring issue for Black Americans. Nearly one in three Black Americans aged 18 to 64 has past-due medical bills.[3] Black uninsured populations face burdensome out- of-pocket medical expenses when seeking care, which often means they are forced to delay preventative care and get treated as a last resort – the most expensive form of treatment.[4] Latinx patients are the most uninsured population in the United States today. Latinx individuals already comprise much of the workforce that is unable to get health coverage through their job. Lawmakers have curtailed the Affordable Care Act's health enrollment program, which has severely challenged the ability of outreach workers to reach Latinx patients for new coverage. **Undocumented Latinx patients suffer further as they are ineligible for government-funded insurance and subsidized private health plans. Despite the fact that undocumented adults pay taxes [5], they are ineligible to receive Medicaid health benefits and financial subsidies to buy health plans from the federal-state health insurance marketplaces.** Disturbingly, racial bias mars the entirety of American health care. In particular, Black maternal and prenatal health access remains in crisis levels. In the state of New York between 2013 and 2015, 54 Black women died for every 100,000 births -- nearly four times the rate of white women.[6] Indeed, half of maternal deaths in our country are

preventable.[7] While there are many reasons why Black mothers and mothers-to-be experience poor treatment and care, a lack of quality health access is a significant factor.

Uninsured rates among noncitizens are significantly higher and impact millions of people

Jessica Kent. "Noncitizens, Lawful Immigrants Much More Likely to be Uninsured." *Health Payer Intelligence.* February 27, 2019. https://healthpayerintelligence.com/news/noncitizens-lawful-immigrants-much-more-likely-to-be-uninsured

Non-US citizens, including immigrants lawfully present in the country, are significantly more likely than citizens to be uninsured, according to new data from the Kaiser Family Foundation (KFF). The uninsured rate for adult undocumented immigrants is nearly five times higher than that of citizens. Additionally, adult lawfully present immigrants are more than twice as likely as citizens to be uninsured, revealing that eligibility restrictions and enrollment barriers are limiting access to adequate health coverage. In 2017, **there were 22 million noncitizens living in the US,** KFF noted, which accounted for about seven percent of the total population. Of these noncitizens, about six in ten were lawfully present immigrants, or individuals authorized to live in the US either temporarily or permanently. The remaining 40 percent were undocumented immigrants. KFF pointed out that despite the high rates of citizens who don't have insurance, noncitizens are far more likely to go without coverage.

M4A would provide access for undocumented immigrants

Zachary B. Wolf, Tami Luhby, Curt Merrill. "Here's what Bernie Sanders' 'Medicare for All' proposal actually says." *CNN*. March 2, 2020. https://www.cnn.com/interactive/2020/03/politics/medicare-for-all-annotated/

SEC. 102. UNIVERSAL ENTITLEMENT. (a) IN GENERAL.—Every individual who is a resident of the United States is entitled to benefits for health care services under this Act. The Secretary shall promulgate a rule that provides criteria for determining residency for eligibility purposes under this Act. (b) TREATMENT OF OTHER INDIVIDUALS.—The Secretary— (1) may make eligible for benefits for health care services under this Act other individuals not described in subsection (a) and regulate their eligibility to ensure that every person in the United States has access to health care; and (2) shall promulgate a rule, consistent with Federal immigration laws, to prevent an individual from traveling to the United States for the sole purpose of obtaining health care services provided under this Act**. In Sanders' proposal, everyone who is a US resident, including undocumented immigrants, gets coverage.** That would be a likely point of contention with this plan. There is a prohibition on traveling to the US for free medical care. SEC. 103. FREEDOM OF CHOICE. Any individual entitled to benefits under this Act may obtain health services from any institution, agency, or individual qualified to participate under this Act. Medicare for All is meant to be an extremely egalitarian proposal in which everyone has access to any provider. That's certainly not the current system in the US, in which there are extreme differences based on the quality of a patient's insurance and wealth.

ALLEVIATING COSTLY BILLS

What's the argument?

In conjunction with increasing access, reducing the price of healthcare is one of the most obvious arguments on the topic. Currently, 44 million Americans live without health insurance and therefore lack vital care (PBS). The average household spends $5,000 per person on coverage, a 101% increase from the cost 34 years ago in 1984, and the cost will only continue to rise (Leonhardt). The price of care has pushed 11.2 million people into poverty, which will only worsen as time progresses (Weissman). However, the Act guarantees free access to healthcare to all US residents.

Why does the argument matter?

Insurance and the cost of medical bills serves as one of the largest contributors to poverty within the United States. In conjunction with the 11.2 million, 4 million Americans live in deep poverty as a result of high costs (Newkirk). Thus, the implementation of Medicare for All would remove a large perpetrator of financial distress. Indeed, 95% of households would save money as a result of M4A (PNHP). The argument is rather easy to weigh as the probability that Americans will experience a reduction in medical expenses is extremely high. Moreover, the magnitude of the argument proves large as the implementation of M4A would reduce the overall poverty gap by 22 percent (Bruenig). One could dive even deeper and explore the impacts of reducing income inequality, as medical expenses greatly contribute to inequality within the US (Newkirk).

Main Players

Low or middle-income Americans

Strategy Considerations

While this argument is rather stock, it inherently is a true argument and therefore is very believable in the eyes of a judge. Medicare for All exists to provide more affordable care to those individuals who currently do not have access. Teams running this argument on the affirmative almost certainly will win this argument on probability for that reason. However, preparing frontlines to taxation and debt arguments is critical. The way in which the government funds the program will dictate how much

money Americans actually save. Thus, teams should be equipped to respond in order to protect the feasibility of their argument. Once the affirmative side wins the links to the argument, impacting should become rather easy. The drastic impact of decreased poverty associated with M4A means teams could impact turn their opponents' case or could solve back for the problems the team in negation proposes. This argument has a short link chain, large impact, and can easily be weighed, making it rather strategic to run.

Evidence for Alleviating Costly Bills

Healthcare costs continue to increase

Number of uninsured Americans

Arevalo. "How Many Americans Are Uninsured." *Policy Advice.* April 21, 2020. https://policyadvice.net/health-insurance/insights/how-many-americans-are-uninsured/

A series of highly-relevant statistics concerning the healthcare industry are published every year in November, by the US Census Bureau. Here are several statistics meant to better explain the situation of Americans that are uninsured: **Data from the US Census Bureau indicates that a total of 27.5 million Americans had no health insurance during 2018.** Seeing how no major health policies have been implemented by the Federal Government, statistical predictions indicate that the numbers are likely to be even higher by the time the Census Bureau publishes the stats for 2019 in September next year. Consequently, the US uninsured rate will likely grow. **The rate of uninsured US citizens increase from 25.6 million in 2016, to 27.5 million in 2017.** Based on this data, numerous researchers are trying to figure out the main factors which led to this abrupt decrease in insurance rates in the US. We will briefly discuss some of the main factors, later on, to facilitate a better understanding of why so many people are now going without health insurance. This aspect must be discussed, since uninsured individuals are at higher risk of medical complications, alongside debt accumulation.

The cost of healthcare continues to increase

Megan Leonhardt. "Americans now spend twice as much on health care as they did in the 1980s." *CNBC.* October 9, 2019. https://www.cnbc.com/2019/10/09/americans-spend-twice-as-much-on-health-care-today-as-in-the-1980s.html

The average American household spent almost $5,000 per person on health care last year. That's a **101% increase from the roughly $2,500 per person that Americans spent about 34 years ago in 1984**, according to an analysis of the Bureau of Labor Statistics Consumer Expenditures Survey by data company Clever. To make accurate comparisons, Clever adjusted all dollar amounts for inflation. It's perhaps not surprising that health care expenses have risen over the past three decades. But the main driver of the increase is not drug costs or medical services. In fact, the costs related to medical services have decreased by about a third since the 1980s. **The biggest reason for the increase is insurance costs, which have grown by 740% since 1984,** Clever calculates. The average American paid about $3,400 for insurance alone in 2018. It's worth noting that Clever's analysis looks at the average cost of health care across all Americans, no matter how they get their coverage. But over half of Americans rely on their employer for health insurance, so typically employees do not pay the full cost. Individuals who rely on employer-based insurance benefits are paying an average of $1,242 in out-of-pocket costs, according to Kaiser Family Foundation's annual employer benefits survey. Overall, **the average premium for a single American is about $7,188 for 2019, with employers carrying a significantly larger portion of the overall expense.** Employer-based insurance for families costs about $20,576 this year, about a 5% increase from last year. Yet **families are still on the hook for an average of $6,015 in out-of-pocket expenses, which is about a 71% increase over the past 10 years.** These increases in insurance premiums have actually outpaced wages, which grew by about 3.4% over the past year and 26% over the past decade, according to Kaiser. Experts agree that **wages are not keeping pace with the rising costs of health care.**

M4A would help low-income Americans and businesses

The cost of healthcare pushes people into poverty faster than the government can get the impoverished out

Jordan Weissman. "Medical Expenses Still Drive an Outrageous Number of Americans into Poverty" *Slate.* September 13, 2016. https://slate.com/business/2016/09/medical-expenses-still-drive-more-than-11-million-americans-into-poverty.html

Based on an analysis of its so-called Supplemental Poverty Measure, **the Census Bureau reports that 11.2 million individuals were pushed below the poverty line last year thanks to out-of-pocket medical spending, including insurance premiums, prescription drug costs, and doctor's office co-pays**. Overall, those expenses drove up the supplemental poverty rate by 3.5 percentage points, little changed from most recent years. Economists widely consider the Supplemental Poverty Measure, or SPM, to be an improved, modern alternative to the official poverty line. There are a few reasons why. First, the official poverty figure we're used to hearing about is pretty anachronistic—it was set at three times the cost of food in 1963, and has mostly just been updated for inflation since. It also only counts cash income, so in-kind government benefits like food stamps that play an essential role in the safety net aren't counted. The SPM, in contrast, is based on the the average spending on essentials for contemporary lower-income families and is adjusted to reflect how housing costs differ across the country. Most crucially, it also counts a family's total financial resources, totaling up income after taxes and government transfers, while subtracting work and medical expenses. Currently, about 45.6 million Americans, or 14.32 percent, are in poverty as measured by the SPM (that's slightly higher than the official rate). Again, the bureau notes that were it not for medical out-of-pocket expenses (MOOP, on the graph below), **"11.2 million fewer people would have been classified as poor." That means medical expenses are driving more people into poverty than refundable tax credits or food stamps are pulling out of it.** It's discouraging that these numbers haven't noticeably improved in the wake of Obamacare's Medicaid expansion, which was designed to extend health insurance to more of the poor and near-poor, and went into effect in 2014 (yes, as my graph shows, the percentage in poverty due to medical bills fell that year, but the spike in 2013 looks sort of aberrant). After all, research has shown that, as you might expect, families that enroll in the program tend to experience less financial hardship due to health care bills. If the expansion were to succeed at anything, you'd think it'd be reducing medical poverty. Of course, part of the problem is likely that many states have refused to expand eligibility, and those holdouts have higher overall uninsured rates among the borderline poor at risk of being knocked into statistical impoverishment by an unexpected doctor's bill. If states like Texas and Florida ever embrace the expansion—I know, big if—we might one day see fewer Americans going broke because they got sick.

The expense of health care disproportionately impacts lower income citizens, further exacerbating income inequality within the US

VANN R. NEWKIRK II. "The American Health-Care System Increases Income Inequality" *The Atlantic.* January 19, 2018. https://www.theatlantic.com/politics/archive/2018/01/health-care-income-inequality-premiums-deductibles-costs/550997/

A new study in the forthcoming March issue of the American Journal of Public Health Sheds light on just how all that "skin in the game" affects the material conditions of patients. The research—by Andrea Christopher at the Boise Veterans Affairs Medical Center, David Himmelstein and Steffie Woolhandler at the City University of New York at Hunter College, and Danny McCormick at Harvard Medical School—indicates that **household spending on health care is a significant contributor to income inequality in the United States**. It also indicates that **medical expenses push millions of Americans below the federal poverty line, including 7 million people who make more than 150 percent of the poverty level. Four million of those Americans are pushed into the ranks of extreme poverty.** That health-care costs in the country are expensive—often, prohibitively so—is well known. As Vox's Sarah Kliff notes, the first reason why is the exorbitantly high cost of care, which doesn't always correspond with measurable increases in quality or demand. Even for routine procedures or precautionary visits, hospital bills can run over $400, an expense that almost half of American households can't meet

without dipping into credit. Additionally, billing is famously opaque, incoherent, and fragmented, creating major barriers to informed care decisions and often resulting in bills going into collections.

Medicare for All would save families and businesses billions, if not trillions

PNHP. "'Medicare for All' would cover everyone, save billions in first year." *HealthCare Now.* 2013. https://www.healthcare-now.org/blog/medicare-for-all-would-cover-everyone-save-billions-in-first-year/

Economist says Canadian-style, single-payer health plan would reap huge savings from reduced paperwork and from negotiated drug prices, enough to pay for quality coverage for all – at less cost to families and businesses

Upgrading the nation's Medicare program and expanding it to cover people of all ages would yield more than a half-trillion dollars in efficiency savings in its first year of operation, enough to pay for high-quality, comprehensive health benefits for all residents of the United States at a lower cost to most individuals, families and businesses. That's the chief finding of a new fiscal study by Gerald Friedman, a professor of economics at the University of Massachusetts, Amherst. There would even be money left over to help pay down the national debt, he said. Friedman says his analysis shows that a nonprofit single-payer system based on the principles of the Expanded and Improved Medicare for All Act, H.R. 676, introduced by Rep. John Conyers Jr., D-Mich., and co-sponsored by 45 other lawmakers, would save an estimated $592 billion in 2014. That would be more than enough to **cover all 44 million people the government estimates will be uninsured in that year and to upgrade benefits for everyone else.** "No other plan can achieve this magnitude of savings on health care," Friedman said. His findings were released this morning [Wednesday, July 31] at a congressional briefing in the Cannon House Office Building hosted by Public Citizen and Physicians for a National Health Program, followed by a 1 p.m. news conference with Rep. Conyers, Sen. Bernie Sanders (I-Vt.) and others in observance of Medicare's 48th anniversary at the House Triangle near the Capitol steps. A copy of Friedman's full report, with tables and charts, is available here. Friedman said the savings would come from slashing the administrative waste associated with today's private health insurance industry ($476 billion) and using the new, public system's bargaining muscle to negotiate pharmaceutical drug prices down to European levels ($116 billion). "These savings would be more than enough to fund $343 billion in improvements to our health system, including the achievement of truly universal coverage, improved benefits, and the elimination of premiums, co-payments and deductibles, which are major barriers to people seeking care," he said. Friedman said the savings would also fund $51 billion in transition costs such as retraining displaced workers from the insurance industry and phasing out investor-owned, for-profit delivery systems. Over the next decade, the system's savings from reduced health inflation ("bending the cost curve"), thanks to cost-control methods such as negotiated fees, lump-sum payments to hospitals, and capital planning, would amount to an estimated $1.8 trillion. "Paradoxically, by expanding Medicare to everyone we'd end up saving billions of dollars annually," he said. "We'd be safeguarding Medicare's fiscal integrity while enhancing the nation's health for the long term." Friedman said the plan would be funded by maintaining current federal revenues for health care and imposing new, modest tax increases on very high income earners. It would also be funded by a small increase in payroll taxes on employers, who would no longer pay health insurance premiums, and a new, very small tax on stock and bond transactions. **"Such a financing scheme would vastly simplify how the nation pays for care, restore free choice of physician, guarantee all necessary medical care, improve patient health and, because it would be financed by a program of progressive taxation, result in 95 percent of all U.S. households saving money," Friedman said.** Friedman's findings are consistent with other research showing large savings from a single-payer plan. Single-payer fiscal studies by other economists, such as Kenneth E. Thorpe (2005), have arrived at similar conclusions, as have studies conducted by the Congressional Budget Office and the General Accountability Office in the early 1990s. Other studies have documented the administrative efficiency and other benefits of Canada's single-payer system in comparison with the current U.S. system. Friedman's research was commissioned by Physicians for a National Health Program, a nonprofit research and educational organization of more than 18,000 doctors nationwide, which wanted to find out how much a single-payer system would cost today and how it could be financed.

Using a system that reduces costs would allow for net savings for the majority of Americans, and access for those who have no source of health care

Robert Pollin, James Heintz, Peter Arno, Jeannette Wicks-Lim, and Michael Ash. "Economic Analysis of Medicare for All." *Political Economy Research Institute.* November 2018. https://www.peri.umass.edu/publication/item/download/805_a63d4bc441beeaea71a1792c4ea3fee0

Establishing the Universal Right to Decent Health Care
Under Medicare for All, all residents of the United States will have the opportunity to re-ceive decent health care as a basic right. This will result through establishing a health insur-ance system that covers all residents in a manner comparable to the coverage now provided for residents 65 years old and older under the existing Medicare program. All health care consumers will also have the right to receive care from the providers of their choice. Increased Demand for Health Care Services under Medicare for All At present, **roughly 9 percent of U.S. residents are uninsured and 26 percent are underin- sured—i.e. they are unable to adequately access needed health care because of prohibitively high costs**. The demand for health care services by these population cohorts will rise sig-nificantly under Medicare for All. Medicare for All will also provide stable access to decent coverage for those currently receiving adequate insurance coverage but who may face dif-ficulties at later points. As a high-end estimate, we conclude that overall demand for health care services in the U.S. will rise by about 12 percent through Medicare for All.
Cost Saving Potential under Medicare for All Medicare for All has the potential to achieve major cost savings in its operations relative to the existing U.S. health care system. We estimate that, through implementation of Medicare for All, **overall U.S. health care costs could fall by about 19 percent relative to the existing sys-tem. The most significant sources of cost saving will be in the areas of: 1) administration (9.0 percent savings in total system costs); 2) pharmaceutical pricing (5.9 percent savings in system costs); and 3) establishing uniform Medicare rates for hospitals, physicians, and clinics (2.8 percent savings in system costs**). An additional, more modest source of cost savings, at least in the initial years under Medicare for All, would be to reduce the high levels of waste and fraud that currently prevail in service provision. As a low-end figure, we assume that achiev-able cost savings in these areas would be about 1.5 percent of total system costs in the first year of full operations. We also assume that further gains in waste reduction and fraud control are achievable in later years, at a rate of about 1 percent per year for roughly a decade.
ECONOMIC ANALYSIS OF MEDICARE FOR ALL / PERI 2018 1 ... 3.75 percent sales tax on non-necessities. Revenue generated = $196 billion. This includes exemptions for spending on necessities in four areas: food and beverages consumed at home; housing and utilities; education and non-profits. **We also include a 3.75 percent income tax credit for families currently insured through Medicaid.** ¡ Net worth tax of 0.38 percent. Revenue generated = $193 billion. We propose that the first $1 million in net worth are exempted from this net worth tax. The tax would therefore apply to only the wealthiest 12 percent of U.S. households.¡ Taxing long-term capital gains as ordinary income. Revenue generated = $69 billion. Budgetary Impacts on Businesses and Households Under the transitional program featuring the 8 percent premium reductions for covered em-ployees, businesses that have been providing coverage for their employees will see their health care costs fall by between about 8 – 13 percent, after accounting for administrative savings as well as their premium reductions. For families, our results show that Medicare for All can promote both lower average costs and greater equity in financing health care. For example, we find that for middle-income fami-lies, **the net costs of health care will fall sharply under Medicare for All, by between 2.6 and 14.0 percent of income.** By contrast, with high-income families, health care costs will rise, but still only to an average of 3.7 percent of income for those in the top 20 percent income group-ing and to 4.7 percent of income for the top 5 percent income group. The Transition into Medicare for All The transition out of the existing U.S. health care system into Medicare for All will entail formidable challenges. There will be three major sets of issues to tackle: 1) the overall admin-istrative transition; 2) the impact of the transition on both the incomes of physicians and on the capacity of physicians and other providers to meet the increased demand for health care services; and 3) the displacement of workers now employed in both the private health insur-ance and health services industries. We provide detailed assessments of the range of issues at hand and advance proposals for managing the transition in ways that are workable and cost- effective. This includes addressing the impacts on health care providers, health care consumers, and health insurance industry workers respectively.

Poverty rates would be cut by 22%

Matt Bruenig. "Medicare for All Would Cut Poverty by Over 20 Percent." *Jacobin.* September 13, 2019. https://jacobinmag.com/2019/09/medicare-for-all-poverty-out-of-pocket-expenses

Medicare for All doesn't just provide everyone with the care they need, free of charge. It's also a potent anti-poverty program, **reducing poverty by over 20 percent and increasing poor people's incomes by 29 percent.**

The Census released its annual income, poverty, and health insurance statistics earlier this week. The summary reports hows that **8 million of the nation's 42.5 million poor people would not be poor if they did not have to pay medical out-of-pocket (MOOP) expenses like deductibles, co-pays, coinsurance, and self-payments**. Medicare for All (M4A) virtually eliminates these kinds of payments, meaning that these 8 million people (18.8 percent of all poor people) would find themselves lifted over the poverty threshold if M4A were enacted. This head-count poverty measure actually understates how significant MOOP expenses are to poverty in this country. According to this same data, in 2018, the total poverty gap stood at $175.8 billion. This figure is derived by calculating how far each poor family's income is below the poverty line and then adding those calculations together to get an aggregate amount. **MOOP expenses make up $38.2 billion of that total gap, meaning that Medicare for All would cut poverty by about 22 percent.** Coincidentally, MOOP expenses also chew up about 22 percent of the income of poor people. That's right: more than 1 in 5 dollars received by the nation's poor goes toward out-of-pocket medical expenses. For families with incomes above 400 percent of the poverty line, the same figure is only 4.6 percent. What this means is that, by eliminating medical out-of-pocket expenses, **Medicare for All would reduce head-count poverty by 19 percent, reduce the overall poverty gap by 22 percent, and increase poor people's incomes by 29 percent.** Indeed, M4A's elimination of MOOP expenses would contribute more to the incomes of the poor than the earned income tax credit currently does. This makes M4A one of the most potent anti-poverty programs proposed thus far in the current presidential race.

HELPING HOSPITALS

What's the argument?

Hospitals, especially rural hospitals, are struggling under the current healthcare system in the US. Many opponents of Medicare for All argue that the policy would hurt hospitals and cause closures because of lower compensation for medical services, but this argument posits that components of Medicare for All would actually be better than the current system for hospitals.

One key component of this is global budgeting. Currently, hospitals are paid on a fee-for-service basis, whether by insurance companies or the government under Medicare or Medicaid. This system leads to significant administrative costs, burdening struggling hospitals (Gaffney). Under M4A, hospitals no longer have to file claims to hundreds of different insurance companies. This would decrease hospitals' administrative load by 65 percent, leading to nurses and doctors having around 12 additional hours per week to treat patients (Pollin). Some estimates indicate savings of around $600 billion per year under this reformed system (Archer), while other, more conservative estimates still indicate $150 billion in savings (Khan). Moreover, the House M4A bill includes a provision called "global budgeting," which would provide a lump sum to hospitals to help cover overhead costs, a possible lifesaver for struggling rural hospitals.

Furthermore, uncompensated care disappears under Medicare for All. Currently, if an uninsured person seeks care at a hospital, the hospital receives no compensation for that care. This creates a massive financial burden, especially at hospitals serving highly uninsured populations like rural hospitals. In fact, over 80% of rural hospital closures were in states that rejected Medicaid expansion, leading to fewer people being insured (Stankiewicz). Covering all of these people under Medicare for All would end uncompensated care and remove a significant financial burden placed upon hospitals.

Medicare for all also increases demand for healthcare, benefitting hospitals. Currently, millions of Americans forgo necessary medical care due to cost. In a world with universal, single-payer healthcare, this is a phenomenon of the past. This would lead to a drastic influx of demand for hospitals, quantified at around $300 billion annually (Bivens). Additionally, Medicare for All includes provisions for increasing reimbursement rates to "ensure adequate funding" and "be a lifeline for many hospitals" (Kemp). In fact, Medicare rates are about 20% higher than Medicaid rates, meaning hospitals serving largely Medicaid-covered or uninsured populations would benefit greatly.

Why does the argument matter?

Improving hospital efficiency allows for an increased quality of care, benefitting every patient that steps foot in the hospital. Additionally, though, this argument provides a narrative as to how hospitals continue to thrive in a M4A-world despite it appearing, at face value, that they would be worse off. This is critical as rural hospital closures increase inpatient mortality by 8.7%, while also increasing mortality in nearby urban hospitals by 7.6% due to overburdening of resources. Studies also show that this increased mortality disproportionately impacts Medicaid patients and racial minorities (Gujral). More broadly, global budgeting and reducing financial burdens on hospitals improves quality of care for all patients, as seen when the policy was implemented in the state of Maryland (Global Health Payment).

Main Players

Hospital administrators, uninsured and underinsured patients

Strategy Considerations

This argument, when framed correctly, performs well due to its clear clash with typical negative framing. It serves as a strong bolster to arguments regarding an increase in access to medical care because it preemptively undermines analysis regarding shortages or closures. This prevents common turns negative teams will attempt on access arguments, allowing the affirmative to maintain much of their offense.

There are a few flaws to this argument, though. First, it is counterintuitive. Many judges will inherently tend to buy into a narrative of hospitals being worse off under Medicare for All, due to the current nationally-accepted argument that Medicare will pay hospitals less than private insurance. Second, specifically regarding global budgeting, it can create a messy round. Global budgeting is a provision in HR1384, Rep. Pramila Jayapal's version of the Medicare for All Act of 2019. The resolution does not specify which bill the round should focus on, but many teams will likely focus on Senator Sanders' S1129 because it is more well-known. Thus, some teams may be unfamiliar with the concept of global budgeting or may challenge your ability to use that clause under the constraints of the resolution. While you may benefit from the element of surprise when it comes to the ballot, this could cause a messy and unproductive round.

Evidence for Helping Hospitals

Eliminating uncompensated care

Uncompensated care puts a burden on hospitals

Mike Stankiewicz. "Rural Hospitals Would Be Better Off Under Medicare for All." *Public Citizen.* January 9, 2020. https://www.citizen.org/news/rural-hospitals-would-be-better-off-under-medicare-for-all/

America's rural hospitals are financially struggling, facing low admission rates and under the frequent threat of closure. The current health care system has failed rural health care providers. Under Medicare for All, rural hospitals would experience much stronger financial stability and would be better able to serve the needs of America's rural population. Since 2005, more than 160 **rural hospitals** in the U.S. **have closed**, and nearly a quarter are at risk of closing, mostly **due to financial challenges under our for-profit health insurance system.** Around 51% of rural hospitals and about 45% of all hospitals serve a disproportionate share of patients who lack adequate coverage, and those **hospitals are forced to take on the cost of** that **uncompensated care**. Each year, these uncompensated costs continue to increase and place a heavier **financial burden on these hospitals**. **Under Medicare for All**, no patient would show up to the emergency room without insurance, and, as a result, **the incidence of uncompensated care would disappear.** Indeed, government-backed health insurance – Medicare and Medicaid – already serves as a financial lifeline for many rural hospitals. The U.S. Government Accountability Office found that between 2013 and 2017, **83% of rural hospital closures occurred in states that rejected Medicaid expansion**. A Health Affairs research article found similar results.

Global Budgeting

Global budgeting reduces administrative costs

Adam Gaffney. "The Hospital Under Medicare for All". *Jacobin Magazine.* May 2019. https://www.jacobinmag.com/2019/05/medicare-for-all-hospital-financing-costs

Among other issues, the waste would be colossal: large bureaucracies would be needed to issue and process the bills, and the paperwork would suck up large amounts of teachers' time, taking them away from, say, teaching. That's exactly what plays out in hospitals. At one large academic medical center, **25 percent of all payments to the hospital** for an ER visit **were consumed** simply **by the cost of processing the bill**. Overall, approximately **one-quarter of American hospitals' total revenues is consumed by administrative and billing expenses.** In contrast, Canadian and Scottish hospitals receive global lump sum budgets, similar to public schools, which allows them to eschew "per patient" billing altogether, and spend only 12 percent of revenue on administration. **Single payer**, in other words, **could cut US hospitals' administrative spending by half**, an enormous saving since hospital spending accounts for about one-third of our $3.5 trillion health bill. This has two implications. Because hospitals' wasteful administrative costs are baked into prices, **single payer would allow us to reduce payments** to providers **without shrinking** the **resources** they have available to take care of patients. More likely, as demand for care rises once everyone is covered and financial barriers to care like co-pays and deductibles are eliminated, **hospitals could increase the amount of care they provide within their existing budgets.** Single-payer financing, in other words, can cover the cost of true health care universalism in the short run. And in the long run, it provides a second critical tool to control hospital cost growth.

Diane Archer. "22 Studies Agree: 'Medicare for All' Saves Money." *The Hill*. February 24, 2020. https://thehill.com/blogs/congress-blog/healthcare/484301-22-studies-agree-medicare-for-all-saves-money

Medicare for All is far less costly than our current system largely because it reduces administrative costs. With one public plan negotiating rates with health care providers, billing becomes quite simple. We do away with three-quarters of the estimated $812 billion the U.S. now spends on health care administration. **Administrative costs are so high because thousands of insurance companies individually negotiate benefit rules and rates with thousands of hospitals and doctors. On top of that, they rely on different billing procedures — and this puts a costly burden on providers. Administrative savings from Medicare for All would be about $600 billion a year.** Savings on prescription drugs would be between $200 billion and $300 billion a year, if we paid about the same price as other wealthy countries pay for their drugs. A Medicare for All system would save still more with implementation of global health care spending budgets. Even more savings are possible in a Medicare for All system because, like every other wealthy country, we would have a uniform electronic health records system. Such a system generates additional savings because system problems would be easier to detect and correct. A uniform claims data system helps reduce health care spending for fraudulent services. In 2018, total U.S. health care costs were $3.6 trillion, representing 17.7 percent of GDP.

Global budgeting worked in Maryland

Global Health Payment, LLC. "Toward Hospital Global Budgeting: State Considerations." *State Health and Value Strategies.* May 2018. https://www.shvs.org/wp-content/uploads/2018/05/SHVS_-Global-Hospital-Budgets_FINAL.pdf

This issue brief provides an overview of hospital global budgeting, which represents a middle-ground approach between the narrow bundling of services and global capitation that transfers higher levels of financial risk to a hospital. **Global budgets** can provide strong financial incentives for cost control, including incentives for a hospital to collaborate and align incentives with non-hospital providers, and **promote high-quality care**. If structured appropriately, global budgets can also ensure some degree of financial stability for hospitals, particularly for facilities in rural areas. An experiment with **global budgeting in Maryland** since 2014 **has enabled the state to** meet hospital savings goals and **hit key quality benchmarks ahead of schedule**.[1] This experiment and earlier global budget models implemented in upstate New York in the 1980s, show that hospital global budgets can be a promising tool for cost control and improved care.[2] One significant overall policy advantage to global budgets is their potential to encourage hospital investments in population health initiatives. Global budgets can also support the efforts of ACOs and other primary care-based initiatives that are designed to promote the population health goals of the Centers for Medicare & Medicaid Services (CMS) "Triple Aim" of lower cost, better patient experience and improved health status. First, **global budgets encourage** hospitals to implement **strategies that improve the overall health of patients** in their communities. A global budget hospital that invests in community-based initiatives that emphasize care coordination, expanded access to and follow-up by primary care providers, and early intervention for chronically ill patients, will tend to realize reduced costs (i.e., healthier people make less use of hospital care). Hospital global budgets can also encourage investments in resources that address social determinants of health and social supports, such as improved access to housing and food, if the hospital believes such investments will support both its social mission and financial interests. Yet under a fixed budget the hospital will still maintain its historical revenue. The resulting surpluses can be reinvested in further efforts to improve population health. This model of improved population health and continuous reinvestment in population health initiatives works best for hospitals that serve well-defined communities (or reference populations).[6] Second, hospital global budgets can reverse the incentives of the current FFS payment system. Those volume incentives create hospital reluctance to support efforts of ACOs to reduce unnecessary care. As noted, hospitals with high fixed costs find volume reductions (which are a key to meaningful population-based cost control) unattractive from a financial perspective. Payment model researchers have observed that reductions in unnecessary hospitalizations, readmissions or shifting of care to less costly ambulatory settings represent lost hospital revenue and thus result in reduced profitability.[7],[8] The use of hospital global budgets replace the current FFS incentives that place hospitals at risk financially for volume reductions, with incentives that are consistent with the goals of the ACO program to reduce unnecessary hospital volumes and costs.

David Dayen. "The Best Part of Medicare for All That You Haven't Heard About" *The American Prospect.* March 7, 2019. https://prospect.org/health/best-part-medicare-heard/

Global budgeting is one way to fix this problem. It's used in Australia, Belgium, Canada, Finland, France, Germany, the Netherlands, Sweden, Switzerland, and the United Kingdom. T**he Jayapal version would not only set a global budget for each hospital, but restrict how that money is spent—bonuses for employees, marketing, or political donations would be disallowed**. There would be a separate fund for capital expenses like new equipment, and an emergency fund if hospitals need to treat an epidemic. **But in general, hospitals would need to stay under the global budget to turn a profit.** They would have a number of ways to achieve this. Reducing readmissions, for one, would limit the care provided. **Eliminating excessive or unnecessary treatments could help. Best practices would become an important priority. Procurement of supplies and medical devices and drugs would have to be mindful of cost efficiencies, instead of the pay-to-play clown show we currently have, which artificially increases prices.** And, perish the thought, salaries for hospital administrators might have to go down. The state implemented a global budget for acute-care hospitals in 2014, which limits growth in per capita health-care spending on a year-by-year basis. Studies of the program found that total hospital expenditures in Maryland dropped and readmissions fell. Because the program was applicable to hospital services rather than all providers, and because hospitals continued to bill per admission, the benefits were somewhat limited. Nonetheless, global budgeting in this small example did show promise. **Hospitals in Maryland generally supported global budgeting, but you could expect the provider community to resist any major cuts to their pay and lobby to boost the global budget number. Of course, this will be the major fight around Medicare for All more generally—hospitals and doctors don't want to end the gravy train where they can charge what they want with virtual impunity.** At least Jayapal's bill takes that fight on directly.

Global budgeting would save rural hospitals $150 billion

Christopher Cai. James Khan. "Medicare for All Would Improve Hospital Financing." *Health Affairs.* December 9, 2019. https://www.healthaffairs.org/do/10.1377/hblog20191205.239679/full/

Our current financing system incentivizes hospitals to engage in other wasteful behaviors. To handle bills from multiple payers, hospitals have created massive administrative apparatuses for billing: Currently, administrative costs consume 25.3 percent of total US hospital expenditures, roughly double that of Scotland or Canada, which operate under single-payer global budget systems. Hospitals have attempted to become more profitable primarily by increasing prices, investing in technology, or taking fewer publicly insured patients, rather than becoming more efficient or cutting expenses. Roughly a quarter of US health care spending is wasteful, with inefficient administration the greatest contributor, but no incremental interventions have been proven to substantially reduce administrative inefficiency**. Global budgeting would address these inefficiencies by streamlining payment, leading to $150 billion in annual savings.** Hospitals deserve an appropriate amount of funds to meet the growing needs of their communities. But the current system is geared to maximizing profits rather than serving the public health. In San Francisco, for example, a dozen hospital systems compete for privately insured obstetric patients, yet nearly half of rural nearby counties lack an obstetrics service altogether. **Since 2010, 160 rural hospitals across the nation have closed, and the rate is accelerating. Some rural hospital closures are driven by low volume, and in such cases, closure of inpatient services might be reasonable. However, many jeopardized rural hospitals serve a high volume of patients, yet still face financial challenges because fewer rural patients have the private insurance that brings high payment rates.**

Closures Increase Mortality

Mortality increases 8.7% with each rural closure

Kritee Gujral. "Rural hospital closures increase mortality". *Vox EU*. June 10, 2020. https://voxeu.org/article/rural-hospital-closures-increase-mortality

The difference-in-difference estimation shows that **rural closures increase inpatient mortality by 8.7%**, while urban closures have no measurable impact. This suggests that when no distinction is made between rural or urban closures, the null effect of urban closures have the potential to dominate and mask the significant and detrimental impact of rural closures.

Our subgroup analyses indicate that **Medicaid patients and racial minorities are relatively worse affected by rural closures** (11.3% and 12.6%, respectively), which supports the hypothesis that closures disproportionately affect vulnerable populations. We find evidence of spillover effects: **rural closures also increase mortality for patients that reside in urban ZIP codes, by 7.6%**. Results are thus not driven by rural ZIP codes alone and rural closures have negative implications for neighbouring urban ZIP codes, likely **due to overburdening of shared resources in the area.**

Increased demand

M4A would increase demand for healthcare by $300 billion

Josh Bivens. "Medicare for All would boost wages, expand workers' options, and likely create jobs." *Economic Policy Institute*. March 5, 2020. https://www.epi.org/press/medicare-for-all-would-boost-wages-expand-workers-options-and-likely-create-jobs/#:~:text=News%20from%20EPI%20Medicare%20for,options%2C%20and%20likely%20create%20jobs&text=For%20example%2C%20expanded%20access%20to,full%2Dtime%20health%20care%20workers.

A new report from EPI research director Josh Bivens finds that **Medicare for All would bolster the labor market, strengthen economic security for millions of U.S. households, and would likely boost the number of jobs in the U.S**. labor market. Opponents of a single-payer health care system have quoted an analysis of the economic effects of Medicare for All that includes the projection that up to 1.8 million jobs in the health insurance and billing administration sector could be eliminated if the policy were implemented. Bivens notes that this number has been stripped of all context that is included in the original study, and is often misleadingly presented as the predicted net employment effect of Medicare for All. But while **Medicare for All** would indeed lead to lower demand for labor in the health insurance and billing administration sector, it would boost demand for other types of jobs overall. For example, expanded access to health care **could increase demand for health services by up to $300 billion annually**, which would translate into an increased demand for 2.3 million full-time health care workers. Increased reimbursement rates for hospitals reliant on Medicaid

Increased reimbursement rates for hospitals reliant on Medicaid

M4A acts as a lifeline for struggling hospitals

Eagan Kemp. "Medicare for All Might Change Payment Rate". *Wall Street Journal*. August 20, 2019. https://www.wsj.com/articles/medicare-for-all-might-change-payment-rate-11566332306

Your editorial "Bernie's Medicare for All Bailout" (Aug. 15) is wrong about hospital reimbursement under Medicare for All and the real reasons for recent hospital closures. Nowhere in the House or Senate Medicare for All bills does it state that Medicare for All would reimburse hospitals at current Medicare rates. The Senate bill states that payment would be established in a manner consistent with current processes. In the House bill, the government would directly negotiate budgets with hospitals to ensure adequate funding. It serves nobody's interest for hospitals to go out of business under Medicare for All. Medicare for All would mean guaranteed universal coverage.

With people finally being able to access care, hospitals would remain open and **rates would increase where necessary** to ensure that is the case. A recent study found that hospital closures were due to states refusing to expand Medicaid (even though Medicaid has even lower reimbursement rates than Medicare). A previous study found that hospitals were more likely to stay open in states that expanded Medicaid. If hospitals around the country are staying open because of Medicaid expansion, they would do much better under **Medicare for All**, as it **would ensure adequate funding** and end uncompensated care, a huge challenge for hospitals. **Medicare for All would be a lifeline for many hospitals** and could mean the reopening (or opening) of hospitals in underserved parts of the country. Under Medicare for All, everyone in the U.S. would have guaranteed access to health care, regardless of where they live.

M4A helps hospitals that serve majority uninsured & Medicaid patients

Shira Tarlo. "Would Medicare for All really force hospitals to shutter? The devil is in the details." *Salon*. July 28, 2019. https://www.salon.com/2019/07/28/would-medicare-for-all-really-force-hospitals-to-shutter-the-devil-is-in-the-details/

Khullar said changes to reimbursement rates depend on the payer mix and cost structure of individual hospitals**. For rural hospitals who serve high levels of uninsured and Medicaid patients, Medicare rates could actually result in a big pay bump,** since **Medicare rates are about 20% higher than Medicaid** and there would be no more uncompensated care. On the other hand, hospitals in urban areas, especially those that currently serve higher percentages of privately insured patients, would probably take a financial hit.

Doctors have to spend less time on administrative tasks

Pollin et al, "Economic Analysis of Medicare for All." *Political Economy Research Institute at the University of Massachusetts Amherst*. November 2018. https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all

Increasing treatment by nursing staff and physician assistants. As noted above, **at present, nursing staff devote 19 hours per week per physician on BIR. This administrative load should also decline, on average, by 65 percent. As such, nurses, along with physicians, will have about 12 more hours per week available for treating patients.** Indeed, if physicians' practices do not rely more on nurses for treatment under Medicare for All, the alternative will be some job losses for nurses, due to the decline in their administrative responsibilities

(we address this potential for job losses below). This situation would then reinforce a long-term pattern that has already been projected within the existing U.S. health care system, in which, at least through 2025, the supply of nurse practitioners and physician assistants is growing significantly faster than demand.157 Nurse practitioners and physician assistants are both trained and licensed to diagnose and treat common illnesses and injuries, manage chronic illnesses, prescribe medications, and provide counseling. As an example of the type of increased treatment load that nurses and physician assistants could provide, since 2000, a growing number of U.S. states have granted nurse practitioners greater autonomy in prescribing medicines to patients. Recent research has found that this increased autonomy for nurse practitioners has not led to any decline in patient outcomes.

Closures increase mortality

Closures increases mortality 8.7%

Kritee Gujral. "Rural hospital closures increase mortality." *Vox EU*. June 10, 2020. https://voxeu.org/article/rural-hospital-closures-increase-mortality

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HELPING THE ECONOMY

What's the argument?

Medicare for All advocates argue that the bill is just as much of an economic stimulus policy as it is an extension of healthcare policy. There are several different areas where a universal healthcare system could alleviate economic burdens to create potential areas for consumption and stimulus. First, within the healthcare system itself, private insurance companies produce enormous amounts of administrative waste as hospitals and healthcare providers must file claims to hundreds of different insurance providers; centralizing the process could save around $600 billion per year amount of savings (Archer). This capital can be reallocated to improve treatments, increase doctor salaries, and create an overall healthier populace and healthier economy. Additionally, because the healthcare system would encompass every American, there would likely be a demand increase for healthcare workers. Analysts estimate that M4A could create between 2.3 and 17 million new healthcare jobs (Bivens). If critics say that M4A destroys jobs in private insurance, this increase in demand would more than make up for those displaced workers.

Outside of the healthcare industry, universal healthcare has the potential to reinvigorate a workforce whose wages and benefits have been stagnant since the 1980s. In the current healthcare system, most workers receive their insurance from their employers, which has negative consequences for labor mobility as working Americans stay locked into one job for fear of losing healthcare benefits. This results in employees being trapped in unfulfilling jobs or ones below their skill-levels. Economists call this "job lock". With Medicare for All, employment decisions can be based solely on the work environment, wages, and other important factors (Bivens). Some experts project that universal healthcare coverage would boost the probability that workers are in good jobs by 20%. (Schmitt and Jones).

Medicare for All also helps employers by alleviating the enormous expense that healthcare puts on employers across the country. The average company spends up to $15,000 per employee on health insurance per year; freeing up that money can go a long way towards improving wages, innovation, and productivity, all of which add to the GDP (Miller 2018). This benefits small businesses especially, as healthcare costs serve as a huge barrier to expansion when it comes to taking on more employees. Because of the omission of healthcare barriers, countries with single-payer systems like Spain France and Germany have far higher shares of self-employment and small businesses (Bivens 2020).

Why does the argument matter?

The health of the economy can make or break people's quality of life. Revolutionizing healthcare burdens and boosting business enterprise means more jobs and more productivity. Small businesses account for 50% of gross job creation and 60% of all productivity (Decker 2014). Productivity itself electrifies all aspects of the economy and benefits every household. A 1% increase in productivity increases long-run earnings by 1.5% and employment by 4% (Hornbeck 2018). Even better, workers in the bottom income percentiles see substantially greater earnings when there is small business growth, since they are the ones who benefit the most from receiving new jobs and living wages.

Main Players

Private insurance companies, US-based companies, small businesses, healthcare workers, all working Americans.

Strategy Considerations

This argument is a little tricky because of its complex economic warrants and its very hypothetical impact. Even if examples from single-payer countries can be brought into the fold, projecting that impact onto the United States is going to take some serious analysis and persuasion. However, if executed correctly, this argument has a large scope domestically because it affects every single worker and industry. It may also be smart to couple this argument with the current recession caused by COVID-19. The impact can be magnified if teams can apply worker mobility and business growth to economic recovery. This strategy could drastically increase the argument's scope and magnitude, making it very easy to weigh in the second-half of the debate.

Evidence for Helping the Economy

Job Creation

Increased demand for healthcare create 2.3 million new jobs with the same skills

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

Pollin et al. (2018) estimate that expanded access to health care could increase demand for health services by up to $300 billion annually. Given the current level of health spending and employment, this would translate into increased demand for 2.3 million full-time-equivalent workers in providing healthcare.17 Obviously all of the workers displaced from the health insurance and billing administration sectors could not necessarily transition into these jobs seamlessly, but well over 10% of workers in the health insurance sector, for example, are actually in health care occupations (e.g., they are doctors or nurses).18 **Further, several M4A plans have provisions to pay for long-term care services.** Reinhard et al. (2019) have estimated that in 2018, Americans provided roughly 34 billion hours in unpaid long-term care. **If this care was divided up among full-time paid workers, it would require 17 million new positions.** Of course, not all of this currently unpaid care would be converted into paid positions in the job market. But if even 10% of unpaid care translated into new jobs, it would create enough new demand for workers to essentially offset the displacement of workers in the health insurance and billing administration sectors.

Helping small businesses

Universal healthcare in other countries helps businesses

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

Despite policymakers' frequent claims that they seek to support small businesses in the U.S. economy, the United States has a notably small share of small-business employment relative to our rich country peers. In 2018, for example, the U.S. was dead-last among the members of the Organisation for Economic Co-operation and Development (OECD) in its share of self-employment, at just 6.3% of employment.

Countries that are frequently portrayed in U.S. business reporting as being choked by regulation—like Spain, France, and Germany—have far higher shares of self-employment, at 16.0%, 11.7%, and 9.9%, respectively (OECD 2020). Besides a low share of self-employment, the U.S. also had significantly lower shares of overall employment in small businesses, across nearly all industrial sectors. The latest OECD data show that the U.S. share of employment in enterprises with fewer than 50 employees is lower than in any other country except for Russia (OECD 2018, Figure 7). In an earlier overview of trends in employment by firm size, Schmitt and Lane (2009) highlight how health care policy plays two key roles in potentially explaining cross-country trends. **First, because health care is nearly universally provided in other rich countries, workers choosing to start their own businesses in those countries do not face a cost confronting would-be entrepreneurs in the U.S.: the loss of ESI. Second, small businesses in the U.S. are at a distinct disadvantage in recruiting employees because the cost of providing health care coverage is significantly higher for small companies.11**

Employers spend about $15k per employee on healthcare each year

Stephen Miller. "For 2019, Employers Adjust Health Benefits as Costs Near $15,000 per Employee." *Society for Human Resource Management*. August 13, 2018. https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/employers-adjust-health-benefits-for-2019.aspx#:~:text=The%20total%20cost%20of%20health,up%20from%20%2414%2C099%20this%20year

With the cost of employer-sponsored health care benefits expected to approach $15,000 per employee next year, large U.S. employers continue to make changes, new research reveals. Many want to hold down cost increases and are steering employees toward cost-effective service providers, such as telehealth options and high-value in-plan provider networks, according to the nonprofit National Business Group on Health (NBGH) survey 2019 Large Employers' Health Care Strategy and Plan Design. The survey was conducted from May to June with 170 large employers as they finalized their 2019 health plan choices; more than 60 percent of respondents belong to the Fortune 500. ig employers project that their total cost of providing medical and pharmacy benefits will rise 5 percent for the sixth consecutive year in 2019. If they weren't making benefit changes, their costs would rise 6 percent, the survey showed. **The total cost of health care, including premiums and out-of-pocket costs for employees and dependents, is estimated to average $14,800 per employee in 2019, up from $14,099 this year.** Large employers will cover roughly 70 percent of those costs, leaving $4,400 on average for employees to pick up in premium contributions and out-of-pocket expenses.

Increased labor mobility

The current healthcare system creates job lock

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

Medicare for All could decrease inefficient "job lock" and boost small business creation and voluntary self-employment. Making health insurance universal and delinked from employment widens the range of economic options for workers and leads to better matches between workers' skills and interests and their jobs. The boost to small business creation and self-employment would be particularly useful, as the United States is a laggard in both relative to advanced economy peers. **Substantial evidence indicates that our current system of employer-sponsored insurance (ESI) creates significant "job lock"—a condition in which workers who don't want to lose their current ESI stay in their current jobs rather than make transitions that would better meet their needs**. In a comprehensive review of this literature, Baker (2015) finds: The likely range of a job-lock effect is a reduction in turnover—the rate at which people leave jobs—of 15–25 percent among workers with EPHI [employer-provided health insurance, or ESI]. With normal turnover for prime-age workers (people ages 25–54) in the range of 15–20 percent per year, this job-lock effect implies a reduction in annual turnover of around 4 percentage points among prime-age workers with [employer-provided health insurance, or ESI]. **Making employment decisions based on access to ESI rather than on other criteria—such as work–life balance, cash wages, and commuting distance—can lead to employment "matches" that are less productive and that decrease overall worker welfare** relative to job choices that are not constrained by the availability of health insurance. Medicare for All could increase job quality substantially by making all jobs "good" jobs in terms of health insurance coverage and by increasing the potential for higher wages. While the definition of a "good job" is always going to be a bit imprecise, the vast majority of U.S. workers would say that a good job is one that pays decent wages and that also provides the health insurance coverage and retirement income benefits that most of today's workers can only reliably access through employment. Nearly half of jobs fail this test on account of health care coverage alone: In 2016, 46.9% of workers held jobs in which their employer made no

contributions to the workers' health care; for workers in the middle fifth of the wage distribution, 42.9% held jobs in which the employer made no contribution to their health care (EPI 2017). By making health coverage universal and delinking from employment, M4A would make it far easier for employers to offer good jobs in this regard, as every job would now be accompanied by guaranteed health care coverage. Further, as noted above, wages and salaries would have substantial room to grow if health care costs were taken off of the backs of employers. Schmitt and Jones (2013) estimate the share of good jobs—jobs that clear a specified wage floor8 and provide health and retirement coverage—in overall employment each year between 1979 and 2011. They then look at various policy changes that would boost this share. They find **that providing universal health coverage would boost the probability that any given job in the economy is a good job by almost 20%—and that's even before any potential boost to the share of jobs that are good jobs coming from cash wage increases provided as employers shed health care costs**.9 The boost to job quality from making health coverage universal would be even greater for women workers, as women are currently less likely to receive employer-sponsored health insurance benefits from their own employers.10

Small businesses account for most job creation

Ryan Decker. "The Role of Entrepreneurship in US Job Creation and Economic Dynamism." *Journal of Economic Perspectives*. Summer 2014.
https://pubs.aeaweb.org/doi/pdfplus/10.1257/jep.28.3.3

The United States has long been viewed as having among the world's most entrepreneurial, dynamic, and flexible economies. It is often argued that this dynamism and flexibility has enabled the US economy to adapt to changing economic circumstances and recover from recessions in a robust manner. While the evidence provides broad support for this view, the outcomes of entrepreneurship are more heterogeneous than commonly appreciated and appear to be evolving in ways that could raise concern. Evidence along a number of dimensions and a variety of sources points to a US economy that is becoming less dynamic. Of particular interest are declining business startup rates and the resulting diminished role for dynamic young businesses in the economy. We begin by describing how the concept of entrepreneurship is reflected in existing data on firm age and size. The recent addition of firm age to official statistics represents a dramatic improvement in the information available to entrepreneurship researchers. We then turn to a discussion of the role of startup firms in job creation. **Business startups account for about 20 percent of US gross (total) job creation while high-growth businesses (which are disproportionately young) account for almost 50 percent of gross job creation. Startups and young businesses are small, the underlying reason many commentators described small businesses as the engine of US job growth prior to availability of data by firm age (for summaries, see Haltiwanger, Jarmin, and Miranda 2013; Haltiwanger 2012). The contribution of startups and young businesses to job creation involves rich dynamics. Most business startups exit within their first ten years, and most surviving young businesses do not grow but remain small.** However, a small fraction of young firms exhibit very high growth and contribute substantially to job creation. These high-growth firms make up for nearly all the job losses associated with shrinking and exiting firms within their cohort. The implication is that each entering cohort of startups makes a long-lasting contribution to net job creation. **The contribution of startups and young firms to job creation is part of an overall rapid pace of reallocation of productive resources across firms in the US economy. Young firms exhibit rich post-entry dynamics: specifically, low-productivity young firms contract and exit, while high-productivity young firms rapidly expand.** In addition, young firms appear to play a critical role in innovative activity that also contributes to productivity growth (including within-firm productivity growth). Revenue-based measures of productivity may be a reasonable approximation for measures that adjust for price dispersion across producers. When Foster, Haltiwanger, and Syverson (2008) compare the revenue-based measures of total factor productivity with total factor productivity measured in physical quantities for a sample of manufacturing industries, they find that the correlation between these two measures of productivity is .75, which suggests that broad findings in the literature based on measures of revenue productivity would hold up reasonably well with measures of productivity based on quantities.5 The industries for which physical quantity data are available in the US economy are limited, so there is some question as to the wider applicability of these findings across the whole economy. However, evidence for Colombia (where establishment-level price indices are available for all manufacturing establishments) suggests these patterns are robust for a much wider range of industries (Eslava, Haltiwanger, Kugler, and Kugler 2004, 2013). To be clear, productivity growth in an economy is not only a

matter of moreproductive entering firms replacing less-productive exiting firms. A common finding in the literature about productivity growth in manufacturing is that about 60 percent of industry-level productivity growth happens within existing establishments and the rest comes from reallocation of productive resources resulting from entry, exit, and the expansion and contraction of existing establishments. For example, Foster, Haltiwanger, and Syverson (2008) find that entrants and young establishments have slightly higher total factor productivity (measured in quantity terms) than more mature incumbents, but the entrants have substantially higher productivity than exiting establishments. **In their data, 35 percent of industry-level productivity growth is accounted for by net entry. However, their study looks over a five-year time period, and thus some of the 60 percent of productivity growth happening within existing establishments occurs in young firms. Foster, Haltiwanger, and Krizan (2001, 2006) provide evidence of such selection and learning dynamics and show that within-plant productivity growth is mor e**

Increased employment and earnings help the lowest income bracket

Richard Hornbeck. "Who benefits from productivity growth? Direct and Indirect Effects of Local Growth on Wages, Rents, and Inequality." *National Burueau of Economic Research*. *Booth School of Business University of Chicago*. May 2018.
https://www.nber.org/papers/w24661

In the first part of the paper, we focus on estimating direct effects of local TFP shocks on cities directly hit by the shock. We use four instrumental variables to isolate exogenous changes in local productivity. We begin with a baseline "shift-share" instrumental variable, which reflects industry-specific TFP changes nationwide that have differential effects on cities due to differences in their initial industry concentration. Second, we construct an alternative instrument based on technological innovation, as measured by patenting activity within technology classes, which affects cities differently due to initial differences across cities in the presence of each technology class. A third instrument is based on changes in exposure to export markets, since trade exposure has been associated with patenting and investment in R&D (Autor et al., 2017a; Bloom, Draca and Van Reenen, 2016). We also use a fourth instrument, based on changes in stock prices by industry, to isolate variation in productivity growth that is unexpected. The instruments use different sources of empirical variation and are in large part uncorrelated with each other. The cities that are predicted to have larger TFP changes by one of our instruments are often different from the cities that are predicted to have larger TFP changes by the other instruments. The alternative instruments yield similar estimates, however, and over-identification tests fail to reject that the estimates are statistically indistinguishable. The fact that the instruments yield similar estimates, while being based on different assumptions and different sources of variation, lends some credibility to our empirical estimates. We find that local productivity growth increases the earnings of local workers. **A 1% increase in city-level TFP from 1980 to 1990 is associated with an average long-run increase of 1.45% in annual earnings from 1980 to 2000. Local employment increases by 4.16%, driven largely by in-migration from other cities. As a consequence of in-migration, demand for housing increases.** We find that a 1% increase in city-level TFP is associated with a 1.47% increase in housing rents and a 2.46% increase in home values. Who benefits from local productivity growth then depends in large part on residents' position in the housing market. For workers who rent their home, much of the increase in earnings is offset by increases in the local cost of living. **We calculate impacts on worker "purchasing power," which reflects earnings adjusted for cost of living, and find that a 1% increase in local TFP increases renters' purchasing power by 0.62% in the long-run. For workers who bought their home prior to changes in local productivity, the gains are much larger: a 1% increase in local TFP increases their purchasing power by 1.11% to 1.60%, depending on how we account 2 for home equity gains. Who benefits from local productivity growth also depends substantially on workers' level of education.** We estimate greater impacts on both nominal earnings and purchasing power for high school graduates than for college graduates. This finding is important because it means that local productivity growth compresses local inequality. **Correspondingly, we estimate that increases in nominal earnings and purchasing power are substantially greater for workers at the 10th percentile and 50th percentile of the income distribution than for workers at the 90th percentile of the income distribution.**

Lowering the cost of healthcare

M4A saves $600 billion in administrative costs

Diane Archer. "22 studies agree: 'Medicare for All' saves money." *The Hill.* February 24, 2020. https://thehill.com/blogs/congress-blog/healthcare/484301-22-studies-agree-medicare-for-all-saves-money

Medicare for All is far less costly than our current system largely because it reduces administrative costs. With one public plan negotiating rates with health care providers, billing becomes quite simple. We do away with three-quarters of the estimated $812 billion the U.S. now spends on health care administration. Administrative costs are so high because thousands of insurance companies individually negotiate benefit rules and rates with thousands of hospitals and doctors. On top of that, they rely on different billing procedures – and this puts a costly burden on providers. **Administrative savings from Medicare for All would be about $600 billion a year. Savings on prescription drugs would be between $200 billion and $300 billion a year, if we paid about the same price as other wealthy countries pay for their drugs. A Medicare for All system would save still more with implementation of global health care spending budgets.** Even more savings are possible in a Medicare for All system because, like every other wealthy country, we would have a uniform electronic health records system. Such a system generates additional savings because system problems would be easier to detect and correct. A uniform claims data system helps reduce health care spending for fraudulent services. In 2018, total **U.S. health care costs were $3.6 trillion, representing 17.7 percent of GDP.**

M4A reduces healthcare spending 10%

Pollin, Robert et al. "Economic Analysis of Medicare for All." *University of Massachusetts Amherst.* November 30, 2018. https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all.

"This study by PERI researchers Robert Pollin, James Heintz, Peter Arno, Jeannette Wicks-Lim and Michael Ash presents a comprehensive analysis of the prospects for a Medicare for All health care system in the United States. The most fundamental goals of Medicare for All are to significantly improve health care outcomes for everyone living in the United States while also establishing effective cost controls throughout the health care system. These two purposes are both achievable. As of 2017, the U.S. was spending about $3.24 trillion on personal health care—about 17 percent of total U.S. GDP. Meanwhile, 9 percent of U.S. residents have no insurance and 26 percent are underinsured—they are unable to access needed care because of prohibitively high costs. Other high-income countries spend an average of about 40 percent less per person and produce better health outcomes. **Medicare for All could reduce total health care spending in the U.S. by nearly 10 percent, to $2.93 trillion, while creating stable access to good care for all U.S. residents.**"

The UK spends half of what we do on their healthcare system

Reality Check Team. "Reality Check: Does UK spend half as much on health as US?" *BBC News.* February 6, 2018. https://www.bbc.com/news/uk-42950587

If you look at every penny spent on health by anyone in the country, then **the UK spends about half as much on health as the US does**. But if you compare the amount spent on the NHS with the amount spent by the US government on public healthcare, the difference is much smaller.

CON ARGUMENTS

PHARMACEUTICAL INNOVATION DECREASES

What's the argument?

One of the most prominent aspects of Medicare for All is that the bill allows for direct price negotiations between the government and pharmaceutical companies in order to lower the price of prescription drugs (Medicare for All Act of 2019). Rep. Pramila Jayapal's M4A bill outlines that if a company refuses to lower prices, the government can issue "competitive licenses" which allow other companies to make cheaper, generic versions of the drug (Lawson). Under M4A, the government would negotiate the price of every drug on the market, which economists have predicted would decrease drug prices by as much as a third (Katz et al). The Congressional Budget Office predicted that a similar price-negotiations bill, H.R. 3, would cut prices 55% (Rapfogel et al). In other developed countries with single payer systems, price controls decrease pharmaceutical prices by an average of 20% (Sood et al).

While decreased drug prices would help to lessen the cost of M4A, lower prices come with a score of negative ramifications. The development of pharmaceuticals is a time consuming and risky process. Each new drug sent to testing has an average success rate of 2%, meaning that the vast majority of compounds that pharmaceutical companies put through testing ultimately will not make it to consumers (Fleming). Similarly, putting even successful drugs through testing and production is an incredibly costly process. In fact, the cost of new drug development often ranges from $1.2 billion to $2.6 billion (US Dept. of Health and Human Services). In order to incentivize companies and shareholders to invest in such a costly and risky process, there must be a high return on investment (ROI), one that outweighs the investment's riskiness. When pharmaceutical companies make more money, the likelihood that they invest in new, expensive drugs increases. In fact, the more money that a pharma company makes, the more that company will spend on the research and development (R&D) of new drugs (Frank).

If M4A substantially cuts drug prices, the amount of investment into new drugs will likely decline as ROI decreases (Abbott). Historically, this effect has been seen in other developed nations with price controls. Most of these countries buy their drugs from the U.S. because pharma innovation in the U.S. is considerably stronger; over the course of the last few decades, the US has been responsible for about 57% of all new drugs (Lyman).

Why does the argument matter?

Decreased innovation comes with a few major consequences. First, as fewer innovative treatments enter the pipeline, long-run life expectancy decreases. One study from the RAND corporation estimates that decreased R&D could eventually decrease life expectancy 0.7% (Lakdawalla et al). Second, R&D aids the development of life-saving vaccines or orphan drugs, which are drugs that treat rare diseases (Dubois). Third, decreased drug prices may hurt the developing world. The current system allows pharma companies to profit off of drug sales in the US, which then allows companies to charge cheaper prices elsewhere, a process called "differential pricing" (Yadav et al). This differential pricing provides access to medicine to as much as 90% of a developing country's population (Yadav et al).

Main Players

Pharmaceutical companies, patients with rare diseases or complex illnesses, and patients in the developing world.

Strategy Considerations

This argument, like most, has some strengths and weaknesses. It works very well in technical rounds because of its enormous international impact. This makes it easy to outweigh on scope but it also can be used to link into accessibility arguments as a prerequisite. After all, access to treatment becomes irrelevant if the cure to a disease has not been created. Furthermore, improved prescription drugs can serve as preventative care, lowering the cost of healthcare long term as complex diseases become treatable. However, running high-magnitude impacts like this normally comes with a reduced probability. There is no guarantee that cures will be created meaningfully and in a short enough time frame to matter, and many counter-arguments exist, such as the idea that meaningful innovation isn't taking place in the status quo. Additionally, this argument takes the debate away from the resolution by focusing on a very narrow part of the topic. It misses the big picture, which might make late-round strategy difficult when arguing against pro cases with broader and more probable impacts.

Evidence for Innovation Decreases

M4A cuts drug prices

M4A allows for price negotiations

S.1129 - Medicare for All Act of 2019. https://www.congress.gov/bill/116th-congress/senate-bill/1129/text

SEC. 614. PAYMENTS FOR PRESCRIPTION DRUGS AND APPROVED DEVICES AND EQUIPMENT. (a) **Negotiated Prices.**—The prices to be paid for covered pharmaceuticals, medical supplies, and medically necessary assistive equipment **shall be negotiated annually by the Secretary.** (b) Prescription Drug Formulary.— (1) IN GENERAL.—The Secretary shall establish a prescription drug formulary system, which shall encourage best-practices in prescribing and discourage the use of ineffective, dangerous, or excessively costly medications when better alternatives are available. (2) PROMOTION OF USE OF GENERICS.—The formulary under this subsection shall promote the use of generic medications to the greatest extent possible. (3) FORMULARY UPDATES AND PETITION RIGHTS.—The formulary under this subsection shall be updated frequently and clinicians and patients may petition the Secretary to add new pharmaceuticals or to remove ineffective or dangerous medications from the formulary. (4) USE OF OFF-FORMULARY MEDICATIONS.—The Secretary shall promulgate rules regarding the use of off-formulary medications which allow for patient access but do not compromise the formulary.

If manufacturers can't decide on a price, the gov't can create competitive licenses (specific to Rep. Jayapal's bill)

Lawson "Medicare For All will drastically lower prescription drug prices by taking on Pharma's greed." *Salon.* March 3, 2019. https://www.salon.com/2019/03/03/medicare-for-all-will-drastically-lower-prescription-drug-prices-by-taking-on-pharmas-greed_partner/

The Medicare for All Act includes a key provision, modeled after the Medicare Negotiation and Competitive Licensing Act, which would lower drug prices for all Americans by allowing the government to negotiate lower drug prices with corporations. And **if a corporation refused to lower the price and threatened patients' access to the medication, generic competition would be allowed using a competitive license.** Yale law professor Amy Kapczynski and Harvard professor Aaron Kesslheim demonstrated that this authority exists and is used across the government. It is simply a matter of applying the same authority to generic pharmaceutical competition. The Department of Defense has used the same authority to purchase "generic" versions of night vision lenses and lead-free bullets, and the Department of the Treasury has used the authority to purchase "generic" software.

Negotiations could cut prices by as much as one-third

Katz et al, "Would 'Medicare for All' Save Billions or Cost Billions?" *New York Times.* October 16, 2019.
https://www.nytimes.com/interactive/2019/04/10/upshot/medicare-for-all-bernie-sanders-cost-estimates.html

A Medicare for all system would have more leverage with the drug industry because it could bargain for the whole country's drug supply at once. But politics would still be a constraint. A system willing to pay for fewer drugs could probably get bigger discounts than one that wanted to preserve the current set of choices. That would mean, though, that some patients would be denied the medications they want.

All of our economists thought a Medicare for all system could negotiate lower prices than the current ones. But they differed in their assessments of how cutthroat a negotiator Medicare would be. **Mr. Friedman thought Medicare for all could reduce drug spending by nearly a third. The Urban team said the savings would be at least 20 percent**. The other researchers imagined more modest reductions.

Price negotiations bill H.R. 3 would cut prices 55%

Rapfogel, "House Bill Could Lower Patients' Prescription Drug Spending by Thousands of Dollars." *Center for American Progress.* December 9, 2019. https://www.americanprogress.org/issues/healthcare/news/2019/12/09/478380/house-bill-lower-patients-prescription-drug-spending-thousands-dollars/

Under the process laid out in the bill, **the secretary of health and human services would negotiate as many as 250 drugs each year. The negotiation process would prioritize drugs with the greatest savings potential—those that rank highest by spending, have no generic or biosimilar competitor, and have a large pricing gap between the United States and peer nations.** Manufacturers of drugs subject to negotiation **would agree to a price no higher than 120 percent of the average price in other industrialized countries. The Congressional Budget Office (CBO) has estimated that H.R. 3 negotiations would result in an average discount of nearly 55 percent on current Medicare Part D net prices for the first group of drugs to undergo negotiations and a discount of 40 to 50 percent for drugs negotiated in subsequent years.** The bill would also bring down prices for new drugs, which could be among the most expensive in coming years. For example, Trikafta, a newly approved drug for cystic fibrosis, represents a big advance for treating the disease yet carries a list price of $311,503 per year. When international comparison data were unavailable, the **H.R. 3 negotiation process would cap drug prices at 85 percent of the U.S. average manufacturer price**.

Lower prices harm R&D

Only 2% of drugs make it through testing

Fleming, "Pharma's Innovation Crisis, Part 1: Why The Experts Can't Fix It." *Forbes.* September 6, 2018. https://www.forbes.com/sites/stanfleming/2018/09/06/why-experts-cant-fix-pharmas-innovation-crisis-part-1-and-what-to-do-about-it-part-2/#33e2a9a116fe

The data are alarming—an industry that destroys investor value faces a dim future. Yet, when Dr. Stott proceeds from data to diagnosis and then to prescription, he fails to come up with a credible action plan. His study may be mathematically accurate, but his conclusions are based on faulty assumptions. As a result, they are misleading. He diagnoses the problem as a failure of technology and so looks for a science-based solution to the innovation crisis. What he finds provides no way out of the dilemma. Failing productivity seems like a strange problem in an industry that generates more cash than it can deploy, enjoys unlimited demand and wields monopolistic pricing power. But pharma is not a "normal" business. Each new drug, each clinical trial is an experiment. Development is inherently unpredictable, **as reflected in a success rate of 2%** (8% approval rate X 25% commercial success rate for small-molecule therapeutics), far worse than that offered by that notorious destroyer of value, Las Vegas.

Drugs cost up to $2.6 billion to produce

U.S. Department of Health and Human Services, "Prescription Drugs: Innovation, Spending, and Patient Access." December 7, 2016.
https://delauro.house.gov/sites/delauro.house.gov/files/Prescription-Drugs-Innovation-Spending-and-Patient-Access-12-07-16.pdf

Between 2006 and 2015, the Food and Drug Administration approved an average of 29 novel drugs a year, with 45 approvals in 2015 alone [3]. **Published estimates of the cost of new drug development range from $1.2 billion to $2.6 billion** [7-10] and are highly sensitive to assumptions about pre-clinical and clinical development time, cost of capital, the likelihood of reaching approval following the start of clinical testing, and costs of preclinical development and clinical trials conducted among humans. Published estimates of the cost of new drug development are also highly sensitive to the incorporation of recent increases in Orphan drug approvals, which tend to have smaller trial sizes, higher success rates, and tax advantages for the sponsor. Between 2010 and 2015, Orphan drugs increased from 29 percent to 47 percent of new drug approvals. Applying updated information yields mean and median development costs for Orphan drugs of $1.0 billion and $0.8 billion, respectively, less than half the mean and median estimates of drug development costs of $2.6 billion and $1.9 billion published by DiMasi et al. (2016) [7].

Pharma companies spend more on R&D if they make more money

Frank & Ginsberg, "Pharmaceutical Industry Profits And Research And Development." *Health Affairs.* November 1, 2017.
https://www.healthaffairs.org/do/10.1377/hblog20190302.150578/full/

Reviews of the literature on the impact of market size differences on innovation suggest two broad conclusions. First, **increases in market size and potential profits have a strong positive impact on innovative activity, whether it is measured by clinical trial activity, R&D spending, or number of new drugs launched.** The second conclusion is less unanimous but represents the weight of the evidence: innovation increases less than proportionately with market size. Together, these conclusions are consistent with a couple of interpretations. One is that the science required to produce new drugs in 2017 is harder than it was a decade or two previously and so the "low hanging fruit" has been picked. A second interpretation, mentioned earlier, is that differentiated competition drives excessive entry and duplication of R&D effort, resulting in overinvestment in certain clinical areas. Both forces can be at work.

US pharma companies produce 57% of the world's new drugs

Lyman, "Which Countries Excel in Creating New Drugs? It's Complicated." *Xconomy.* September 2, 2014.
https://xconomy.com/seattle/2014/09/02/which-countries-excel-in-creating-new-drugs-its-complicated/

Let's dive in a little deeper. Consider the data in the table below (from the Milken Institute report, The Global Biomedical Industry: Preserving U.S. Leadership). The table purports to show how the number of drugs produced within certain countries has changed over time. The take home message: drug discovery efforts have moved in large part from Europe and Japan to the U.S. over the past 30 years. But these numbers are difficult to interpret due to the frequent acquisition of both companies and products during this time period. The percentage of all NCE's (New Chemical Entities) that originated from U.S.-based companies rose from about 31 percent in the '70s and '80s to 42 percent in the '90s to **57 percent in the 2000s**.

Price controls decrease life expectancy

Lakdawalla, "U.S. Pharmaceutical Policy In A Global Marketplace." *RAND Corporation.* December 16, 2008.
https://www.rand.org/content/dam/rand/pubs/reprints/2009/RAND_RP1380.pdf

Exhibit 1 illustrates **the impact of introducing U.S. price controls on the longevity of cohorts ages 55–59**, using our baseline parameter values. It shows that the introduction of price controls **would reduce life expectancy** by two-tenths of a year for Americans ages 55–59 alive in 2010 and by one-tenth for Europeans ages 55–59 alive in the same year. In percentage terms, these correspond to **0.8 percent and 0.7 percent declines from the status quo**. The longevity effects are larger for the older cohorts, because the effects of price controls take time to set in. The early cohorts are not exposed to innovation reductions for a number of years. This dampens the impact on their life expectancy. By 2060, Americans and Europeans in this age group lose almost 0.7 years of life expectancy as a result of U.S. price-control implementation. These represent reductions of approximately 2.8 percent.

If the US implements price controls similar to those in other countries, pharma Revenues drop 20%

Sood et al, "The Effect Of Regulation On Pharmaceutical Revenues: Experience in Nineteen Countries." *Rand Corporation.* December 16, 2008.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3829766/

In this paper we analyzed trends in pharmaceutical regulation and their impact on revenues. Several important patterns emerge from our analysis. First, we found that a majority of regulations greatly reduce pharmaceutical revenues, with direct price controls having the biggest impact on revenues. Sec- ond, we found that most countries that adopted new regulations already had some regulations in place for controlling costs. We found that such incremental regula- tion has a smaller impact on further controlling revenues. However, the results also suggest that introducing new regulations such as price controls in a largely unregulated market, such as the United States, could greatly reduce pharmaceutical revenues. For example, **if the United States implemented price controls and negotiations similar to those found in other developed countries, then U.S. revenues would fall by as much as 20.3 percent.** Finally, the results also show that the impact of regulations on revenues increases over time. Whether governments should regulate pharmaceutical markets is a contentious and much-debated policy question. Our results show that introducing price controls and other regulations in largely unregulated markets will greatly reduce costs today. However, it is important to note that revenue reductions will affect fu- ture innovation.19 These innovation effects ultimately could hurt consumers. So the real question is: what is the net impact of regulations on the welfare of current and future generations? Such estimates, beyond the scope of this paper, are discussed in a companion paper.20 Effect of regulations on revenues. Exhibit 4 presents the results of our re- gression analysis. Model 1 is the most general one and presents the impact of six broad categories of policies: profit controls, budgets (either global budgets or bud- gets at the physician level), direct price controls (of any kind), reference pricing (of any kind), economic evaluations, and number of policies for promoting generic use. The results from this specification show that three out of the six aggregate regulation groups reduce revenues significantly. Direct price controls have the largest im- pact on revenues, followed by economic evaluations and budgets. **In particular, direct price controls reduce revenues by 16.8 percent; economic evaluations and budgets have a much smaller impact of around 6 percent. Finally, reference pricing, profit controls, and policies for encouraging generic use did not have a statistically significant impact on revenues.**

A price reduction by 40% will lead to 60% fewer R&D projects undertaken

Thomas Abbott, "The Cost of US Pharmaceutical Price Regulation: A Financial Simulation Model of R&D Decisions." *National Bureau of Economic Research*. 2007.
https://www.nber.org/papers/w11114.pdf

Previous empirical studies that have examined the links between pharmaceutical price controls, profits, cash flows, and investment in research and development (R&D) have been largely based on retrospective statistical analyses of firm- and/or industry-level data. These studies, which have contributed numerous insights and findings to the literature, relied upon ad hoc reduced-form model specifications. In the current paper we take a very different approach: a prospective micro-simulation approach. Using Monte Carlo techniques we model how future price controls in the US will impact early-stage product development decisions in the pharmaceutical industry. This is done within the context of a net present value (NPV) framework that appropriately reflects the uncertainty associated with R&D project technical success, development costs, and future revenues. **Using partial-information estimators calibrated with the most contemporary clinical and economic data available, we demonstrate how pharmaceutical price controls will significantly diminish the incentives to undertake early-stage R&D investment. For example, we estimate that cutting prices by 40–50% in the US will lead to between 30 and 60% fewer R&D projects being undertaken (in early-stage development).** Given the recent legislative efforts to control prescription drug prices in the US and the likelihood that price controls will prevail as a result, it is important to better understand the firm response to such a regulatory change.

A 1% increase in revenue leads to 2.75% increase in number of marketed vaccines

Pierre Dubois. "Market Size and Pharmaceutical Innovation." *Toulouse School of Economics*. March 2014.
https://pdfs.semanticscholar.org/4a3d/1d55a7a9840b55119f17439972490ef76195.pdf

As we do here, AL rely for identification on changes in the variables that exogenously affect market size. Some papers in the literature instead estimate directly the impact of policy changes. The paper by Amy Finkelstein (2004) is an example of this approach focused specifically on the vaccine market. She exploits two kinds of policy change in the United States. One is when there are changes in the official recommendations as to who should be vaccinated, as such changes can dramatically affect market size. A second type of policy change she exploits is the introduction of liability protection for vaccine makers in the United States. This should have increased the profitability of vaccine markets and stimulated more investment. **Using three policy experiments of this type she finds that a 1% increase in revenue leads to a 2.75% increase in the number of marketed vaccines.** We cannot directly compare her elasticity to ours because there are significant differences between vaccine and drug innovation and approval costs.

High prices and innovation in the U.S. help the developing world

Pharma Innovation in Vaccines saved 500 million children preventing 7 million deaths since 2000

Bourree Lam, "Vaccines Are Profitable, So What?" *The Atlantic.* 2015. https://www.theatlantic.com/business/archive/2015/02/vaccines-are-profitable-so-what/385214/

But then a couple things happened to turn the vaccine market around in recent years. **Global demand, particularly in developing countries, shot up. Since 2000, the Gavi Alliance has provided vaccination for 500 million children in poor countries, preventing an estimated 7 million deaths.** GlaxoSmithKline reported that 80 percent of the vaccine doses they manufactured in 2013 went to developing countries. Additionally, vaccines that could turn a profit in high-income countries—constituting **82 percent of global vaccine sales** in terms of value, according to the World Health Organization—hit the market.

Differential pricing helps low income individuals access drugs

Prashant Yadav, "Differential pricing for Pharmaceuticals." *MIT. UK Department International Development.* August 2010. https://www.academia.edu/35901185/Differential_Pricing_for_Pharmaceuticals_Review_of_current_knowledge_new_findings_and_ideas_for_action

Recent trends, however, are prompting the pharmaceutical industry to pay more attention to differential pricing, such as economic and demographic growth in some low and middle-income markets, which has increased the potential market size of many low and middle income countries; greater recognition by the pharmaceutical manufacturers and their investors of the social responsibilities; stronger global advocacy for access to medicines, and growing competition from generic manufacturers in emerging markets. **Differential pricing allows pharmaceutical companies to signal that their pricing policies are socially responsible and consistent with their obligations to society and not just geared towards maximizing profits. In addition, differential pricing on select drugs opens opportunities to serve low and middle-income markets and creates economies of scope for pharmaceutical companies.In the case of vaccines, most now have a three-tiered pricing structure with fully loaded market prices charged in rich countries,** low prices in countries belonging to the Global Alliance for Vaccines and Immunization (GAVI), and intermediate prices in middle-income countries. However, the practice of charging higher prices in middle-income countries than in the poorest countries has been contentious. Firms argue that middle-income countries, especially upper- middle-income countries such as Brazil, have substantially greater capacity to pay for vaccines than do GAVI countries. Middle-income countries argue that their populations include many poor people and the prices they pay should be not too far from what the least-developed countries are paying. **Many low and middle-income markets could not be served earlier due to lack of overall affordability and demand across an overall drug portfolio. Differential pricing on select drugs opens opportunities to serve these markets and creates economies of scope for pharmaceutical companies. Sales of high volume low priced drugs help**

pharmaceutical companies learn about the distribution and regulatory infrastructure in these countries. This also helps build better influence and leverage over the stakeholders in this segment. Economic and demographic growth in low and middle-income markets and a change in the disease burden from communicable to non-communicable diseases have increased the potential market size of many low and middle-income countries. Differential pricing can provide opportunities to tap these new consumers and help build relationships that will continue to last when these consumers reach higher levels of income/ability to pay. Dumoulin (2001) examines the pricing of essential innovative medicines by comparing a single global price with differential prices based on country income. Using a simulation model, the author calculated the pharmaceutical manufacturer's profit and the affordability of drugs to the population. The analysis shows that **differential pricing maximizes both indicators and increases access by a factor of roughly 4–7 times**. The simulation model also shows that for countries with the same average GDP per capita, the country in which wealth is most concentrated will face a higher price under price discrimination because in such markets companies would rationally price for the rich market rather than the numerically larger (in terms of people) lower income market.

TECHNOLOGICAL INNOVATION DECREASES

What's the argument?

This argument is similar to the pharmaceutical innovation argument in that it relies on the idea that as reimbursement rates go down under M4A, companies and hospitals will be less likely to invest in expensive technologies. Currently, the United States is responsible for the majority of medical innovation (Whitman & Raad). The main reason that the U.S. excels in such innovation is because there is a high demand for medical technology. Americans tend to receive and pay for more new treatments than patients in other, similarly situated countries, which provides an incentive for companies and hospitals to invest in innovative (and expensive) treatments (Whitman & Raad). Profits decrease under M4A because reimbursement rates are lower than those of private insurance, which in turn eliminates the profit motive that encourages technological investment in the first place. Because M4A is a non-competitive form of insurance, it will survive regardless of outcomes, which means that even if Medicare funds treatments, it "lacks the mechanisms… to decide which are effective" (Rich). Moreover, if hospitals lose money under M4A, they have less funding to spend on "new, lifesaving technologies" (Fisher). This has been true in other single-payer countries; for example, the city of Pittsburgh has more MRI machines than all of Canada (Tse).

Why does the argument matter?

Advancements in medical technology is critical in treating complex diseases like cancer. Even though the U.S. suffers from higher mortality rates from things like obesity than other developed nations, the U.S.'s cancer survival rates are the highest in the world because of its technological advantage (Rich). Because a single-payer system would likely decrease medical innovation in the U.S., it is estimated that $10 trillion in hidden costs would be added to the already bloated healthcare system as it becomes more expensive to treat various illnesses (Conover). Moreover, the U.S. currently subsidizes medical innovation for the rest of the world, so decreased medical innovation in the U.S. would produce a ripple effect that potentially impacts everyone on earth (Whitman & Raad).

Main Players

Hospitals, patients with complex illnesses, medical technology companies

Strategy Considerations

This argument can be persuasive because there is a lot of precedent from other countries that can serve as support. Especially as chronic disease becomes more common, cutting-edge treatment becomes increasingly necessary and important. Because chronic disease and cancer are leading causes of death not just in the U.S. but in other developed nations, the fight against these illnesses has incredibly wide-reaching impacts on mortality and quality of life.

However, teams will have to be prepared to weigh this argument against standard pro arguments like "access increases" that have more tangible and quantifiable impacts. This argument is also vaguer than, for example, the argument that pharma innovation specifically decreases. A lot of dominos must fall in order to prove that innovation will go down: hospitals must lose money, profits must decrease, and these things must not be overridden by increased demand as access increases. A lot of different variables play into life expectancy and illness survival rates, so teams interested in running this argument will need a strong case that clearly lays out the facts and their importance.

Evidence for Technological Innovation Decreases

M4A eliminates profits which incentivize innovation

Rich, "Medicare for All Means Innovation for None." *Reason Foundation*. April 16, 2019. https://reason.org/commentary/medicare-for-all-means-innovation-for-none/

Payroll taxes allow Medicare to survive regardless of outcomes and make superior alternatives unaffordable for seniors. Heart disease and cancer treatment have seen improvements, but that progress was mostly targeted at other age groups that largely participate in market-based private health insurance. Of the 10 types of cancer most common among young adults, almost all now have survival rates near or better than 90 percent. Leukemia is an outlier in this group, as it has a survival rate of only 60 percent. But about 85 percent of young children diagnosed with the most common form of leukemia will survive – it's the elderly that keep the survival rate low. A National Institutes of Health study published in 1993 concluded that "The lack of significant improvement in median survival in the last 40 years for those older than 60 years of age stands in stark contrast to the remarkable improvement for younger patients. Acute leukemia in older patients demands new and probably different therapeutic strategies." Medicare has yet to address this disparity, which is typical for conditions that affect older people. In contrast, outcomes related to treatments for seniors that overlap age groups have seen major improvements. For example, breast cancer survival increased from 64.9 percent in 1975 to 82.8 percent by 2002, but half of women who are diagnosed are under the age of 62, when most patients still privately fund their health and incentivize innovation. Testicular cancer also saw a 95 percent death rate in 1975 become a 95 percent cure rate by 2010, but testicular cancer is also the most common cancer for males between the ages of 15 and 35. **Public health care has little incentive to introduce new technologies and prolong life. Rich countries like the United Kingdom and Canada provide universal health care but have lower cancer survival rates than America.** That's why many more American seniors today have health insurance than in 1965, yet their health outcomes are still often terrible. And more funding isn't enough – **Medicare already indiscriminately funds treatments, but lacks the mechanisms and competition to decide which are effective.** This might be why up to 20 percent of Medicare claims are fraud and waste.

Healthcare's hidden costs increase as innovation decreases

Conover, "The #4 Reason Elizabeth Warren's Medicare-for-All Single-Payer Plan Is A Singularly Bad Idea." *Forbes*. November 30, 2019. https://www.forbes.com/sites/theapothecary/2019/11/30/the-4-reason-elizabeth-warrens-medicare-for-all-single-payer-plan-is-a-singularly-bad-idea/#578354e81bd6

So while the figures have more inherent uncertainty in them than in the first three parts of this series, I can say with some confidence that **the grand total hidden cost associated with reduced innovation in the single-payer approach** proposed by Senator Warren likely would amount to at least $2.6 trillion in the first decade but more probably **would end up in the range of $9 or $10 trillion**. And for readers who view themselves as global citizens, the adverse effects would increase by anywhere from $4 to $16 trillion were the effects on those living in EU countries taken into account. For those keeping score, we now know that Senator Warren's ill-conceived Medicare-for-All plan would produce literally trillions of dollars hidden costs during its first decade: $3.5 trillion to $14.3 trillion in deadweight losses due to higher federal taxes; An additional $4.6 to $7.7 trillion worth of waste in a U.S. health system that already has seemed helpless to avert $1 trillion annually in existing waste. An additional $2.6 to $15.2 trillion in rationing costs related to restrictions on the availability of technology and waiting time losses related to physician and hospital services. Social losses associated with reduced innovation amounting to at least $2.6 trillion and more likely $9 or $10 trillion; when costs to EU patients are included, these costs more than double.

Less money = less investment in innovative technologies within hospitals

Fisher, "Medicare for All: Definition and Pros and Cons." *Smart Asset*, August 23, 2019. https://smartasset.com/insurance/medicare-for-all-definition-and-pros-and-cons

People may not be as careful with their health if they do not have a financial incentive to do so.

Governments have to limit health care spending to keep costs down. **Doctors might have less incentive to provide quality care if they aren't well paid. They may spend less time per patient in order to keep costs down. They also have less funding for new life-saving technologies.**

Since the government focuses on providing basic and emergency health care, most universal healthcare systems report long wait times for elective procedures. The government may also limit services with a low probability of success, and may not cover drugs for rare conditions.

The U.S. invests in more treatments than other countries

Whitman and Raad, "Bending the Productivity Curve: Why America Leads the World in Medical Innovation." *CATO Institute*, November 18, 2009. https://www.cato.org/sites/cato.org/files/pubs/pdf/pa654.pdf

In three of the four general categories of innovation examined in this paper – basic science, diagnostics, and therapeutics – the United States has contributed more than any other country, and in some cases, more than all other countries combined. In the last category, business models, we lack the data to say whether the United States has been more or less innovative than other nations; innovation in this area appears weak across nations. In general, **Americans tend to receive more new treatments and pay more for them** – a fact that is usually regarded as a fault of the American system. That interpretation, if not entirely wrong, is at least incomplete. **Rapid adoption and extensive use of new treatments and technologies create an incentive to develop those techniques in the first place. When the United States subsidizes medical innovation, the whole world benefits.** That is a virtue of the American system that is not reflected in comparative life expectancy and mortality statistics.

Precedent: Pittsburgh has more MRI machines than Canada

Tse, "MRI Scans: Waiting for Public Health Care vs. Paying for a Private MRI Clinic." *BCLiving*. November 23, 2010. https://www.bcliving.ca/mri-scans-waiting-for-public-health-care-vs-paying-for-a-private-mri-clinic#:~:text=Canada%20has%20one%20of%20the,machines%20than%20all%20of%20Canada.

Canada has one of the lowest rates of MRI scanning machines per capita in the developed world, with six MRI scanners per million people, compared to 40.1 in Japan, 14.4 in Switzerland and 26.6 in the United States. **Pittsburgh alone has more MRI machines than all of Canada.** "We seem to think that MRI scanning is some newfangled test, where it's the basis for medicine in the rest of the globe," said Dr. Peter Innes, president of medical staff and chief of family medicine for the South Island for the Vancouver Island Health Authority. MRI scans have become an essential diagnostic imaging tool, revealing problems that aren't detectable by other more common tests such as x-rays and ultrasounds

HARMING RURAL HOSPITALS

What's the argument?

Rural hospitals are a critical piece of the American healthcare system, even though they are often overlooked and underfunded. Roughly 60 million Americans depend on rural hospitals for care, but because these hospitals serve small populations that are often low-income, many hover at the brink of closure (Ellison). In fact, 5% of all rural hospitals have closed since 2010 alone, and of the hospitals still in operation, 21% are at risk of closure (Mosley & Debehnke). Some argue that Medicare for All increases the number of people with health insurance, so in poor, rural areas, hospitals might see an influx in patients. Unfortunately, the more likely outcome for rural hospitals is lost revenue and, eventually, closure. The main reason for this is that Medicare reimbursement rates, or the amount of money that Medicare pays hospitals per procedure, is lower than the actual cost of care. Private insurance reimburses hospitals at a rate higher than the cost of care, meaning that hospitals make a profit off of privately-insured patients. Current Medicare rates are about 40% lower than those of private insurers. For Medicare procedures, hospitals received only 87 cents for each dollar that they spent treating patients, meaning that hospitals lose money on Medicare procedures. For this reason, Medicare for All is expected to cost the U.S. hospital industry $800 billion in its first 10 years of implementation (Koenig et al). This is especially problematic as hospitals across the country are already losing hundreds of billions of dollars as profitable elective procedures are pushed to the wayside during COVID-19 (AHA). While larger, urban hospitals may be able to balance out this loss by providing more expensive elective treatments or experimental procedures, rural hospitals would only be pushed further into debt. Because M4A eliminates private insurance, rural hospital revenues would drop by up to 14%, leaving 55% of rural hospitals at risk of closure (Goldsmith & Leibach).

Why does the argument matter?

Rural hospitals are critical for a few reasons. First, they serve about a fifth of the U.S. population. This is a large impact in its own right, but it is magnified by the fact that rural Americans are more likely to be poor or suffer from health problems in the first place (Definitive Healthcare). Second, if a rural hospital closes, patients nearby have nowhere else to go, often for hundreds of miles. If a hospital closes in a city,

patients can move to a new hospital a few blocks away; there is no such alternative in rural areas. Because of the stated reasons, rural hospital closures have a major impact on the mortality of those living nearby: one closure increases inpatient mortality by 8.7% (Gujral & Basu).

Main Players

Rural hospitals, private insurers, rural Americans

Strategy Considerations

If written well, this argument is persuasive and clear. Because rural Americans are arguably some of the most vulnerable members of the U.S. population, it is possible to weigh the argument well against impacts with large scopes but less severity. The argument also serves as a prerequisite to most pro arguments. For example, most pro teams will argue some form of "access increases" contention, but if there is no hospital for a hundred miles, it doesn't matter if patients have *access* to care because they can't *receive* that care in the first place.

There are, however, some responses to the argument. First is global budgeting. See the "Helping Hospitals" section for more details, but global budgeting might provide enough additional revenue to prevent rural hospitals from closing, which would solve back for the 21% of rural hospitals currently on the brink of closure. Another counterargument is that since many rural Americans are low-income, many rely on Medicaid for healthcare coverage. Medicaid reimburses at rates lower than Medicare, so M4A might increase the amount of revenue rural hospitals are bringing in. Both of these counter arguments have some issues when it comes to certainty and specificity, but if you are considering running rural hospitals on the con, be aware of their existence.

Evidence for Harming Rural Hospitals

Rural hospitals are already losing money

Rural hospitals are already closing

Ellison, "Rural hospital closures hit record high in 2019 – here's why." *Becker's Hospital Review*. December 5, 2019. https://www.beckershospitalreview.com/finance/rural-hospital-closures-hit-record-high-in-2019-here-s-why.html

About 60 million people – nearly one in five Americans – live in rural areas and depend on their local hospitals for care. This year, 18 of those hospitals have closed, making 2019 a record year for rural hospital closures. Across the U.S., **119 rural hospitals have closed since 2010,** according to the Cecil G. Sheps Center for Health Services Research. Of the 31 states that have seen at least one rural hospital close since 2010, Texas leads with 20 rural hospital closures. It's followed by Tennessee, which has seen 13 hospitals close.

Rural hospitals are at risk of closure

Mosley and Debehnke, "Rural Hospital Sustainability: New analysis shows worsening situation for rural hospitals, residents." *Guidehouse.* February 22, 2019. https://guidehouse.com/insights/healthcare/2019/rural-hospital-sustainability

Rural hospitals are essential to the health of communities nationwide. Beyond providing care, they're also economic engines, often the largest employer and a driver of additional businesses and jobs to communities. But **since 2010, 5% of rural hospitals have shut down**, and the economic effects are immediate – a study found that when a community loses its hospital, per capita income falls 4% and the unemployment rate rises 1.6%. A new Guidehouse analysis shows that this trend is likely to accelerate. According to the analysis: **21% of rural hospitals nationwide are at a high risk of closing unless their financial situations improve. Of these hospitals, 64% are considered highly essential to their communities based on an analysis of trauma status, service to vulnerable populations, geographic isolation, and economic impact.** The situation is poised to worsen with an economic downturn looming, given that the country is in its longest period of economic expansion ever.

Rural hospitals lose more money under M4A

Medicare reimbursement rates lower

Blahouse, "How Much Would Medicare for All Cut Doctor and Hospital Reimbursements?" *Economics21.* October 10, 2018. https://economics21.org/m4a-reimbursements-blahous

On July 31, I published a study with the Mercatus Center at George Mason University estimating the added costs to the federal government of establishing a national single-payer healthcare system. That study presented a lower-bound estimate of **$32.6 trillion in added federal costs over the first 10 years of full implementation,** with the caveats that this estimate reflected several extremely favorable assumptions, and that actual costs were likely to be substantially higher. Among those favorable assumptions was that lawmakers would uphold Senator Bernie Sanders' Medicare for All (M4A) bill's specification that **healthcare provider payments would be cut down to Medicare rates, which currently average about**

40% lower than the rates paid by private health insurance, and well below providers' reported costs of providing services. Although my study as published was explicit about the nature and distribution of these cuts, some of the subsequent public discussion exhibited substantial confusion as to whose payments would be cut and by how much. This article seeks to clarify these issues. Medicare pays healthcare providers **at rates generally much lower than private insurance does.** These Medicare payment rate schedules are set by law, and they differ for different categories of providers. This article will focus on two especially important categories: hospitals and physicians. These categories are exceptionally important to the calculations, first because they represent large categories of national health spending, and second because private health insurance currently finances a significant share of spending within them. These factors together mean that the effects of cutting payments down to Medicare rates would be especially concentrated on hospitals and physicians.

Hospitals lose money on Medicare services

Goldsmith and Bajner, "5 Ways U.S. Hospitals Can Handle Financial Losses from Medicare Patients." *Harvard Business Review*. November 15, 2017. https://hbr.org/2017/11/5-ways-u-s-hospitals-can-respond-to-medicares-mounting-costs#:~:text=While%20the%20average%20hospital%20profit,money%20on%20their%20Medicare%20business.&text=By%202030%2C%20there%20will%20be,55%20million%20today.

The losses of U.S. hospitals from treating Medicare patients escalated sharply in 2012, when Congress included Medicare in its budget sequester, and they have remained high since. About **three-fourths of short-term acute-care hospitals lost money treating Medicare patients in 2016**, according to the Medicare Payment Advisory Commission (MedPAC), an independent agency established to advise the U.S. Congress on issues affecting the Medicare program. As can be seen from the exhibit "U.S. Hospitals' Medicare Losses Dwarf Medicaid Losses," hospitals have been losing nearly three times as much caring for Medicare patients as they have caring for their Medicaid patients, traditionally the worst paid-for insured-patient group. **While the average hospital profit margin on Medicare patients has been relatively steady at negative 10%, it is closer to negative 18% for the three-quarters of hospitals that lost money on their Medicare business.** As aging baby boomers continue to join the program, Medicare enrollment will rise at 3% a year until the end of the decade in 2029, and 2.4% a year in the decade after. By 2030, there will be 81.5 million Medicare beneficiaries vs. 55 million today. The fact that Medicare is the largest single federal domestic program means that further cuts in Medicare payment are a virtual certainty when, not if, the federal budget deficit is driven higher by recessions. What this means for hospitals is crystal clear: Unless their losses from treating Medicare patients can be contained, their financial future is in jeopardy!

American Hospital Association, "AMERICAN HOSPITAL ASSOCIATION UNDERPAYMENT BY MEDICARE AND MEDICAID FACT SHEET." January 2019. https://www.aha.org/system/files/2019-01/underpayment-by-medicare-medicaid-fact-sheet-jan-2019.pdf

In the aggregate, both Medicare and Medicaid payments fell below costs in 2017: Combined underpayments were $76.8 billion in 2017. This includes a shortfall of $53.9. billion for Medicare and $22.9 billion for Medicaid. **For Medicare, hospitals received payment of only 87 cents for every dollar spent by hospitals caring for Medicare patients in 2017.** For Medicaid, hospitals received payment of only 87 cents for every dollar spent by hospitals caring for Medicaid patients in 2017. In 2017, 66 percent of hospitals received Medicare payments less than cost, while 62 percent of hospitals received Medicaid payments less than cost.

Private insurance pays more than Medicare

Lopez et al, "How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature." *Kaiser Family Foundation,* April 15, 2020. https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/

Prior to the outbreak, national and state-level policymakers were already debating several proposals that would build on Medicare's payment structure – including Medicare-for-All and various public option proposals – to establish standardized rates for hospitals, physicians, and other health care providers. While supporters point to potential coverage gains and reductions in national health spending, critics contend that bringing private insurer payments closer to Medicare rates could threaten providers' financial viability. Once the U.S. overcomes the immediate public health emergency, attention will likely return to underlying questions regarding provider payments, as well as their impact on health expenditures and out-of-pocket costs. To inform both discussions, **this issue brief reviews the findings of 19 recent studies comparing Medicare and private health insurance payment rates for hospital care and physician services.** Key Findings **Private insurers paid nearly double Medicare rates for all hospital services (199% of Medicare rates, on average), ranging from 141% to 259% of Medicare rates across the reviewed studies.** The difference between private and Medicare rates was greater for outpatient than inpatient hospital services, which averaged 264% and 189% of Medicare rates overall, respectively. For physician services, private insurance paid 143% of Medicare rates, on average, ranging from 118% to 179% of Medicare rates across studies. Across all studies, **payments from private insurers are much higher than Medicare payments for both hospital and physician services, although the magnitude of the difference varies** (ES Figure 1). Differences across studies may be due to a number of factors, including the representativeness of hospitals, physicians, and insurers used in the analysis, the data collection period, and the characteristics of the markets examined by each study, with some studies focusing on highly consolidated health care markets where providers have stronger negotiating leverage over insurers. (For study descriptions, see the Appendix Table).

M4A would cost hospitals nearly $800 billion in 10 years

Koenig et al, "The Impact of Medicare-X Choice on Coverage, Healthcare Use, and Hospitals." *American Hospital Association*. March 12, 2019. https://www.aha.org/system/files/2019-03/the-impact-of-medicare-X-choice-final-report-2019.pdf

Key Findings: We used a micro-simulation model to estimate the effects of the Medicare-X Choice Act1 on health insurance coverage and healthcare spending. Medicare-X Choice would make a public health insurance plan fully available on the health exchanges beginning in 2024 and reimburse providers using Medicare rates. We project public plan enrollment of 40.7 million in 2024, with approximately 90 percent of enrollees coming from individuals currently insured on the non-group market or through employer-sponsored insurance (ESI). Of the 29.0 million currently uninsured, Medicare-X Choice would result in 5.5 million gaining coverage. By comparison, additional support of the Affordable Care Act would result in 9.1 million uninsured persons gaining coverage. **Nationally, healthcare spending would be reduced by $1.2 trillion (7%) over the 10-year period from 2024 to 2033, with spending for hospital services being cut by $774 billion -accounting for almost two-thirds of the total spending reduction.** The Medicare-X Choice reductions in healthcare spending and increases in coverage would be financed through reductions in provider payments, given that Medicare rates are significantly less than payments by commercial payers. Medicare-X Choice would compound financial stresses already faced by the nation's hospitals, potentially impacting access to care and provider quality. MedPAC estimates **Medicare hospital margins will be -11 percent in 2018.** Moreover, the Congressional Budget Office has projected that between 40 and 50 percent of hospitals could have negative margins by 2025 under current law. While Medicare-X Choice would increase insurance coverage, the gains are modest relative to what could likely be achieved through strengthening existing components of the Affordable Care Act.

M4A would put 55% of rural hospitals at risk of closure

Goldsmith and Leibach, "THE POTENTIAL IMPACT OF A MEDICARE PUBLIC OPTION ON U.S. RURAL HOSPITALS AND COMMUNITIES: A SCENARIO ANALYSIS." *American Healthcare.* August 2019.
https://americashealthcarefuture.org/wp-content/uploads/2019/10/Navigant-Rural-Public-Option-FINAL-8.19.pdf

A new analysis of U.S. rural hospitals has found that **offering a government insurance program reimbursing at Medicare rates as a public option on the health insurance exchanges created by the Affordable Care Act (ACA) could place as many as 55%. of rural hospitals, or 1,037 hospitals across 46 states, at high risk of closure.** The rural hospitals at high risk represent more than 63,000 staffed beds and 420,000 employees, according to the analysis by Navigant Consulting, Inc. Even those rural hospitals not at high risk of closure and the communities they serve face an increased threat. The availability of a public option could negatively impact access to and quality of care through rural hospitals' potential elimination of services and reduction of clinical and. administrative staff, as well as damage the economic foundation of the communities these hospitals serve. The analysis incorporated three scenarios in which the availability of a Medicare public insurance option would induce a shift of patients from higher-paying commercial plans, driving down rural hospital net revenue and negatively impacting the communities they serve. Key results and. implications from the study include: 1. Revenue loss to rural hospitals is projected to be 2.3% under a Medicare public option if only the uninsured and current individual market participants shift to the public option, placing an estimated 28% of rural hospitals at high risk of closure (Scenario 1). 2. If employers shift between 25% and 50% of their covered workers from commercial coverage to a Medicare public option, **hospital revenues are projected to drop between 8% and 14% and cause an estimated 51% to 55% of rural hospitals to face high risk of closure, with an additional 39% to 41% facing moderate risk** (Scenarios 2 & 3). 3. To keep hospitals whole from the financial consequences of any of these scenarios, Medicare **would have to increase hospital payment levels for a public option between 40% and 60% above present Medicare rates**, costing between $4 billion and $25 billion annually (depending on the severity of the employer shift)

COVID-19 exacerbates existing strain on hospitals as lucrative elective procedures are postponed

"Hospitals and Health Systems Face Unprecedented Financial Pressures Due to COVID-19." *American Hospital Association.* May 2020.
https://www.aha.org/system/files/media/file/2020/05/aha-covid19-financial-impact-0520-FINAL.pdf

This report attempts to quantify these effects over the short-term, which are limited to the impacts over a four month period from March 1, 2020 to June 30, 2020. Based on these analyses, **the AHA estimates a total four month financial impact of $202.6 billion in losses for America's hospitals and health systems, or an average of $50.7 billion per month.** Although the federal government moved quickly to provide relief, more help is needed. Critics have argued that hospitals were well funded prior to the COVID-19 public health emergency, however, the reality is that many hospitals were already facing financial pressures. Experts have raised concerns about low payment rates from government payers, which in part led the Congressional Budget Office to project that between 40% and 50% of hospitals could have negative margins by 2025 prior to the pandemic.2,3,4 Congress created a provider relief fund to support health care providers during the pandemic, but this fund is intended to stabilize providers in order to keep their doors open, rather than fully restore compensation to pre-COVID-19 levels. Further, these funds are being distributed to all health care providers with only a portion of these funds going directly to hospitals.

Closures increase mortality

Rural hospitals serve 57 million Americans; these Americans are most likely to suffer from poverty and poor healthcare

Definitive Healthcare, "Rural America's Healthcare Crisis: The Significance of Critical-Access and Safety Net Hospitals." September 2019. https://blog.definitivehc.com/critical-access-safety-net

It isn't difficult to find a rural region in the United States—**over 70 percent of the country is categorized as a non-metropolitan area. But only between 15 and 20 percent of the U.S. population, approximately 42 to 57 million people,** live in a rural county. Sprawling acres of land and low population density make it difficult for many rural communities to attract businesses and therefore more people, either as residents or tourists. This reluctance by big businesses to build or relocate to rural areas is one of many factors in the cycle of falling employment rates, rising poverty rates, and a lack of opportunity that drives younger residents to urban and metropolitan areas. Because of these and other factors, rural populations are more likely to live under the federal poverty line, face homelessness or housing insecurity, suffer from preventable and chronic illness, and lack health insurance coverage. **People living in rural areas are particularly susceptible to treatable illnesses like diabetes or depression. Rural populations are also older on average than urban populations and are more likely to suffer from illnesses associated with age, tobacco use, and cancer. Opioid-related deaths are also 45 percent higher in rural regions than in urban regions. Despite the high level of need for more than 40 million people living in rural America, they have less access to quality medical care than those living in metropolitan areas.**

Rural hospital closures increase mortality by 8.7%

Gujral and Basu, "Impact of Rural and Urban Hospital Closures on Inpatient Mortality." *National Bureau of Economic Research.* August 2019 (Revised June 2020). https://www.nber.org/papers/w26182.pdf

In this section, we present the main results estimating the impact of closures. As can be seen by the marginal effects presented in Table 2, when no distinction is made between HSAs affected due to rural closures vs. due to urban closures, there is no statistically significant impact of hospital closure on inpatient mortality, i.e. there is no discernible general impact of closures on inpatient mortality. In contrast, when examining the impacts of rural and urban closures differentially, it can be seen that **rural hospital closures have a statistically significant impact; they increase inpatient mortality by 0.78% points (an increase of 8.7%)** whereas urban closures have no measurable impact on inpatient mortality. These differential impacts are consistent with our hypotheses that rural closures are likely to have larger adverse patient-level impacts than urban closures. These results offer one possible explanation for a lack of published evidence on adverse patient-level impact of hospital closures. That is, combining rural and urban closures as one treatment group can mask harmful impact of certain types of closures.

INCREASED WAIT TIMES

What's the argument?

One of the most common arguments against a single payer system like Medicare for All is increased wait times – and for good reason. In Canada, which has a healthcare system comparable to what ours would likely be under Medicare for All, wait times are notoriously long. For specialty treatment, patients can wait up to 20 weeks, while only 43% of Canadians agree that they saw a doctor or nurse on the same or next day as when they needed care (Stark, Jacobs). More broadly, studies show that financial incentives and fee-for-service models, like those seen in our current privatized healthcare system, increase physician productivity and decrease wait times (Siciliani and Hurst).

This argument has three primary warrants. First, demand increases significantly under Medicare for All. The millions of Americans who currently forgo care due to cost would now be able to obtain medical treatment. While this is a good thing in terms of access, the sudden influx could overburden hospitals and increase wait times as demand outpaces supply (LaPointe). Second, there are fewer doctors under Medicare for All (see "Doctor and Drug Shortages" for more details). A study done by FTI consulting found that Medicare for All would cause a loss of 44,693 doctors, or a loss of .13 doctors per 1,000 people ("Medicare for All and the Future of America's Healthcare Workforce"). Keeping with the laws of supply and demand, this would cause longer wait times and worse quality of care. Third, there would be fewer hospitals under Medicare for All (see "Harming Hospitals"). Hospitals could stand to lose up to 14% of their revenue, risking the closure of 55% of rural hospitals (Luthi). This, once again, worsens care and increases wait times.

Why does the argument matter?

Wait times is one of the most commonly made arguments against a single payer system because it impacts all members of the population. Currently, 91% of Americans are insured (Berchik). Under Medicare for All, this would go to 100%, but we could hypothetically see wait times increase by weeks for all Americans, including the vast majority who have access to care in the status quo. Additionally, increased wait times can be weighed over increased access, considering that a 1 week increase in wait times can cause an increase in 3 deaths per 100,000 people (Barua).

Main Players

Patients, doctors, hospital administrators, people in need of surgery or commonly demanded procedures

Strategy Considerations

This will likely be one of the most popular neg arguments on this topic, due to its straightforward nature. Most judges that you encounter will easily understand and relate to this argument as it is often brough up in the national conversation about single payer healthcare. This puts you at an automatic advantage, because even the most unbiased judges are more likely to vote for arguments that they already understand.

However, the argument is not without flaws. Namely, the evidence is largely based on other countries that might be difficult to compare to the United States. For example, if the U.S. were to adopt M4A, we would be transitioning from a private system to a single payer system, whereas notable other single-payer countries like the UK and Canada modernized under single-payer.

While the argument may sound persuasive, it will likely be very difficult for teams to outweigh millions of Americans getting access to healthcare with a small chance that wait times *might* increase and *might* cause death.

Evidence for Wait Times Increasing

Single-payer systems have long wait times

Canadian wait times are very long

Roger Stark. "Single payer means longer waits for care". *Washington Examiner*. February 11, 2019. https://www.washingtonexaminer.com/opinion/op-eds/single-payer-means-long-waits-for-care

The median time for specialty treatment after a patient was referred by a primary care doctor in 2018 **was 20 weeks**. Saskatchewan had the lowest wait at 15 weeks; the high was New Brunswick at 45 weeks, which is nearly a year. On average, patients waited nine weeks to see a specialist, then waited an additional 11 weeks to receive treatment. **Only 12 percent of delays** in treatment **were at the patient's request**.

Christopher Jacobs. "Yes, Socialized Medicine will Lead to Waits for Care." *The Federalist*. December 18, 2019. https://thefederalist.com/2019/12/18/yes-socialized-medicine-will-lead-to-waits-for-care/

Patients who reported they saw a doctor or nurse on the same or next day the last time they needed care: Canada ranked in a tie for last, with 43% agreeing. (The United States had 51% who agreed.) Doctors who reported that patients often experience difficulty getting specialized tests like CT or MRI scans: Canada ranked third from last, with 40% agreeing. (The United States had 29% who agreed.) Patients who reported they waited two months or longer for a specialist appointment: Canada ranked last, with 30% agreeing. (The United States had only 6% who agreed.) Patients who reported they waited four months or longer for elective surgery: Canada ranked last, with 18% agreeing. (The United States had only 4% who agreed.) As I discuss in my book, Canada's health system suffers from myriad access problems, based on other metrics from Commonwealth Fund studies that CAP chose not to mention in their paper: The second-lowest percentage of patients (**34%**) who **said it was easy to receive after-hours care** without going to the emergency room; The lowest percentage of patients (**59%**) who **said they often or always receive an answer the same day when calling the doctor**'s office about a medical issue; The highest percentage of patients (41%) using the emergency room; and The highest percentage of patients (**29%**) **waiting four or more hours in the emergency room**. With results like that, little wonder that the liberals at CAP didn't want to highlight what single-payer health care would do to our health system.

Financial Incentives Increase Medical Productivity

Luigi Siciliani and Jeremy Hurst. "Explaining Waiting Times Variations for Elective Surgery across OECD Countries." *OECD*. October 7, 2003. https://www.oecd.org/els/health-systems/17256025.pdf

These data have been used to investigate associations between waiting times and several potential determinants such as capacity, expenditure, need and financial incentives for hospitals and specialists. The results include evidence of a clear negative association between waiting times and capacity, measured either in terms of number of beds or number of practising physicians. Analogously, a higher level of health spending is systematically associated with lower waiting times. On the other hand, a higher proportion of elderly in the total population is not a major predictor of waiting times across different countries. The evidence also suggests that **financial incentives** for hospitals and doctors may **influence waiting times**. **Fee-for-service systems induce specialists to**

increase productivity, a finding in line with other studies, and may also discourage the formation of visible queues because of competitive pressures and the incentive to disguise demand, especially if there are no gatekeepers and surgeons assume primary care responsibilities for patients. Meanwhile, activity-based funding appears to encourage hospitals to increase activity compared with fixed budgets.

Increased demand = longer wait times

A single-payer system could exacerbate the doctor shortage

Jacqueline LaPointe. "CBO: Single-Payer System to Impact Provider Pay, Physician Shortage." *Revcycle Intelligence*. May 2, 2019. https://revcycleintelligence.com/news/cbo-single-payer-system-to-impact-provider-pay-physician-shortage#:~:text=%E2%80%9CAn%20expansion%20of%20insurance%20coverage,the%20available%20supply%20of%20care.&text=If%20the%20number%20of%20providers,and%20reduced%20access%20to%20care.

In a new report, the Congressional Budget Office (CBO) says **establishing a single-payer healthcare system** would involve substantial changes to coverage, provider payment rates, and financing methods, which **could overburden provider organizations and lead to a physician shortage.** The long-awaited report states that establishing a single-payer system would substantially increase government spending on healthcare. But the report did not specify by how much. Industry stakeholders on both sides of the single-payer debate have been waiting on the CBO to provide an official cost estimate for implementing a single-payer healthcare system, like Medicare for All. A cost estimate will impact how much tax revenue the government will need to establish and support a single-payer healthcare system. Highly-cited cost estimates for a single-payer or Medicare-for-All system range from $13.8 trillion to $36 trillion depending on who is doing the estimating, according to the Committee for a Responsible Federal Budget.
Pinning down an accurate cost estimate is difficult. An accurate cost estimate depends on policy details, such as how the system would alter the sources and extent of coverage, provider payment rates, and methods of financing. "The amount of those additional resources would depend on the system's design and on the choice of whether or not to increase budget deficits," the CBO states in reference to the potential cost of implementation. "Total national healthcare spending under a single-payer system might be higher or lower than under the current system depending on the key features of the new system, such as the services covered, the provider payment rates, and patient cost-sharing requirements." While the report did not meet cost estimate expectations, the CBO did express other concerns in the report.

Specifically, the CBO raised concerns that **a single-payer healthcare system could exacerbate the existing physician shortage problem if provider payments do not adequately cover increases in demand.** "An expansion of insurance coverage under **a single-payer system would increase the demand for care and put pressure on the available supply** of care. People who are currently uninsured would receive coverage, and some people who are currently insured could receive additional benefits under the single-payer system, depending on its design," the report states.

Fewer doctors = longer wait times

Fewer people will become doctors because there is less money in the profession

"Medicare for All and the Future of America's Healthcare Workforce". *FTI Consulting*. January 2020. https://www.fticonsulting.com/~/media/Files/us-files/insights/reports/2020/jan/medicare-future-americas-health-care-workforce.pdf?mod=article_inline

FTI Consulting examined the impact of Medicare for All on the supply of physicians, finding a **significant increase in the projected shortage of** both specialists and primary care **physicians** in future years **as a result of** rate setting and subsequent **reductions in provider income**. American physicians enter the workforce with an average **student debt** load of nearly $200,000,12 a factor that **may drive graduates away from specialties with particularly low Medicare reimbursements, such as primary care**, under the current system. For experienced physicians, declining Medicare reimbursements can play a role in the decision to retire early.13 FTI's analysis demonstrates these factors would be amplified under Medicare for All, discouraging the next generation from entering the practice of medicine and prompting a greater number of older physicians to retire early. On average, Medicare reimbursements for physicians were about 75% of private insurance reimbursements for the same service in 201714 and are expected to fall to approximately 63% by 2025.15 Because Medicare for All's most significant effect would be to replace private coverage, total reimbursements paid to physicians would also fall absent changes to the law. FTI estimates that, **under Medicare for All, the U.S. could expect a loss of more than 0.13 physicians per 1,000 people** once the policy is fully implemented. The current ratio in the United States is 2.46 physicians per 1,000, **which translates to a nationwide loss of 44,693 physicians by 2050**, compared to the projected number of physicians under current law. In 2019, the AAMC projected a gap of between 46,900 and 121,900 physicians by 2032. Using those projections, and combining with the expected loss of physicians, we estimate that **the physician shortfall will be between 90,353 and 236,053 by 2050** even before the reduction has taken full effect.17

Fewer hospitals = longer wait times

Hospital revenue would decrease under a single-payer system

Susannah Luthi. "Rural Hospitals Take Spotlight in Coverage Expansion Debate". *Modern Healthcare*. August 7, 2019. https://www.modernhealthcare.com/payment/rural-hospitals-take-spotlight-coverage-expansion-debate

Opponents of the public option have funded an analysis that warns more rural hospitals may close if Americans leave commercial plans for Medicare. With the focus on rural hospitals, the Partnership for America's Health Care Future brings a sensitive issue for politicians into its fight against a Medicare buy-in. The policy has gone mainstream among Democratic presidential candidates and many Democratic lawmakers. **Rural hospitals could lose between 2.3% and 14% of their revenue if** the U.S. opens up Medicare to people under 65, the consulting firm Navigant projected in its estimate. The analysis assumed **just 22% of the remaining 30 million uninsured Americans would choose a Medicare plan**. The study based its projections of financial losses primarily on people leaving the commercial market where payment rates are significantly higher than Medicare. The estimate assumed Medicaid wouldn't lose anyone to Medicare, and plotted out various scenarios where up to half of the commercial market would shift to Medicare. The analysis was commissioned by the Partnership for America's Health Care Future, a coalition of hospitals, insurers and pharmaceutical companies fighting public option and single-payer proposals. In their most drastic scenario of commercial insurance losses, co-authors Jeff Goldsmith and Jeff Leibach predict **more than 55% of rural hospitals could**

risk closure, up from 21% who risk closure today according to their previous studies. Leibach said the analysis was tailored to individual hospitals, accounting for hospitals that wouldn't see cuts since they don't have many commercially insured patients.

Longer wait times cause death

Deaths among females increase with long wait times

Bacchus Barua, Nadeem Esmail, and Taylor Jackson. "The Effect of Wait Times on Mortality in Canada". *Fraser Institute*. May 2014. https://www.fraserinstitute.org/sites/default/files/effect-of-wait-times-on-mortality-in-canada.pdf

As discussed above, our primary analysis focuses on all-cause mortality. Estimates for the fixed-effects regressions on this variable are shown in table 1. The results indicate a significant and positive relationship between the wait time to receive medically necessary elective treatment after referral by a general practitioner and all-cause female mortality. Specifically, **a one week increase in the wait** from referral by a general practitioner to receipt of treatment **is associated with an increase of approximately three female deaths per 100,000 population**. A significant relationship was not noted for male mortality. The results also indicate that **an increase in the proportion of primary care doctors** (as a percentage of all doctors) **is associated with a decrease in mortality rates** for both males and females. Finally, the percentage of females over 65 is weakly associated with increases in mortality rates. A secondary investigation examines potentially avoidable mortality. Estimates for the fixed effects regressions on this variable are shown in table 2. The examination of avoidable mortality requires a modified analysis as our measure of wait times, capturing delays across 12 major medical specialties (including medically necessary elective procedures), may be too broad to be appropriately compared with this narrower measure of mortality. A recent analysis by the Canadian Institute of Health Information (CIHI, 2012b) concludes that the primary reason for changes in the rates of avoidable mortality between 1979 and 2008 is "reductions in deaths related to circulatory diseases such as heart disease, which decreased by 72%". Using this information, we choose to restrict our variable representing wait times for medically necessary elective care across 12 specialties to only the wait time for cardiovascular surgery. Additionally, Prince Edward Island was dropped from the model due to a lack of data on cardiovascular wait times from the province. The results indicate **a significant and positive (but small) relationship between the wait time** to receive medically necessary cardiovascular surgery after referral from a general practitioner **and avoidable female mortality**. Specifically, a one-week increase in the wait from referral by a GP to receipt of elective cardiovascular surgery is associated with an increase of approximately 0.18 female deaths per 100,000 population. A weakly significant, positive relationship is also noted for the variable representing the percentage of the population between 0 and 75 years old that is over 65. On the other hand, increases in real GDP per capita and the relative proportion of primary-care doctors are associated with decreases in female mortality. The F-test indicates that the coefficients representing the impact of all included variables on male mortality are not significantly different from 0. However, and in contrast to all the other examined models, a weak and positive relationship is noted for the proportion of family doctors (as a percentage of all doctors). On the other hand, a significant negative relationship is identified for this variable in our model examining female mortality.

DRUG & DOCTOR SHORTAGES

What's the argument?

Many opponents of Medicare for All argue that a decrease in price will trigger a decrease in the supply of critical components of a functioning healthcare system, namely drugs and doctors. This argument is supported by the basic laws of supply and demand: the higher the price of a good, the more of that good companies are willing to supply. If drug prices are lower, pharmaceutical companies have less of an incentive to produce high quantities of medication; if doctor salaries are lower, fewer people will become doctors.

Empirically, Medicare has already caused 267 drug shortages due to lower profit margins. Since Medicare pays pharmaceutical companies less for drugs than private insurers, the system drives manufacturers and investors to other patented markets (Sullivan). In other words, the price controls inherent to Medicare create lower profit margins for drug companies, which has caused them to exit the industry, causing shortages.

Additionally, Medicare causes doctors to work more hours with less pay (Pipes). This lower financial incentive causes the quality of care provided by these doctors to decrease as they spend less time per patient in order to keep costs down (Fisher). Ultimately, this means that the United States could lose nearly 45,000 doctors under Medicare for All (FTI Consulting).

Both of these problems cause an increase in mortality. Drug shortages increased hospitals' mortality rates by 4% (Vail). Additionally, the presence of every additional 10 primary care physicians per 100,000 people increased life expectancy by 51.5 days, and decreased mortality rates by 1.4% (Rapaport). Inversely, a decrease in the number of primary care physicians would likely decrease life expectancy and increase mortality.

Why does the argument matter?

Shortages, if widespread enough, could negate any of the positive effects stemming from increased access to care. If drugs and doctors become physically inaccessible, it no longer matters that they're accessible in terms of cost. Additionally, this means that medical outcomes become worse for those that currently have insurance, and don't change for those that do not have insurance: ultimately, a net negative outcome.

Main Players

Doctors, pharmaceutical companies

Strategy Considerations

This argument relies heavily on the negative team painting a "doomsday" scenario for the judge. In order for teams to adequately use this argument to counteract access arguments on the affirmative, they must prove that shortages would become so widespread that they would mean medical outcomes don't get better for the millions of Americans who are currently uninsured. That being said, teams who are successfully able to turn the access arguments on pro will have a clear path to victory, as nearly all affirmative arguments link back to access.

Evidence for Drug & Doctor Shortages

Lower prices under M4A could cause drug shortages

Low prices cause companies to exit the market

Thomas Sullivan. "Increasing Generic Drug Shortages Linked to Government Price Controls." Policy Med Magazine. May 6, 2018. https://www.policymed.com/2012/03/increasing-generic-drug-shortages-linked-to-government-price-controls.html

Unfortunately, as the author noted, "These shortages were not rare episodes. **Last year, a record of 267 drug shortages were reported, up from 58 in 2004. Even more tragically, most 2011 shortages remain unresolved."** The article explained some of the causes of these shortages. First, the number of suppliers of generic drugs has dwindled. There were 26 U.S. vaccine makers in 1967; today there are only six. Supply disruptions are common, including the possibility that a facility completely shuts down for a protracted time because of quality or safety problems. Second, unlike in most consumer goods industries, many pharmaceutical manufacturers have failed to invest in the technology and quality control improvements that would reduce the risks of partial or complete facility shutdowns—and this despite the FDA's regularly issued current guidelines for good manufacturing practices (cGMPs). **Behind both problems are the government's tight price controls for generic drugs, especially when purchased by Medicare and Medicaid. Low prices induce drug makers to exit various markets, or at least to reallocate their manufacturing capacity toward more profitable, patented pharmaceuticals. Low prices also tend to eliminate the rationale for investments in better manufacturing technologies and processes, as shown in a 2009 study conducted by the author and published in the Journal of Management Science. Government price controls on generic drugs limit the manufacturers' margin to 6% in many cases. Consequently, the author argued that one "way to resolve the shortage of critical drugs is to relax or eliminate government price controls**, and to increase the FDA's review and inspection capacities. In the latter case the generic drug industry is willing to foot most or all of the bill."

Drug shortages cost hospitals money

C. Lee Ventola. "The Drug Shortage Crisis in the United States Causes, Impact, and Management Strategies." US National Library of Medicine. November 2011. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3278171/

Drug shortages have had a profound and widespread impact on the quality of healthcare in the U.S. and have created significant obstacles. One way in which drug product shortages adversely affect hospital or health system finances is by raising the cost of delivering patient care, largely through increased drug acquisition and personnel expenditures.2 After surveying 311 pharmacy experts from 228 hospitals in late 2010, **Premier Healthcare Alliance estimated that drug shortages cost hospitals at least $200 million annually because of the need to purchase more expensive therapeutic substitutes.**3,8 This cost estimate does not include the indirect costs associated with drug shortages, such as the additional labor required.8 **The annual labor costs of drug shortages have been estimated to be an additional $216 million.3**

Drug shortages cause death

Drug shortages increase mortality

Emily Vail. "Association Between US Norepinephrine Shortage and Mortality Among Patients with Septic Shock." *American Medical Association.* March 21, 2017. doi:10.1001/jama.2017.2841. https://jamanetwork.com/journals/jama/fullarticle/2612912

Drug shortages are an increasing problem with poten- tial effects on patients and health care delivery costs.1,2 In the United States, the issue has received consider- able attention from federal legislators, media, and physician and pharmacist advocacy groups. However, the effects of drug shortages on patient outcomes or on alternative prescribing practices are poorly described.3-6 In addition, there is no na- tional reporting system that captures hospital-level data on drug shortages or their effect on patients. In February 2011, the US Food and Drug Administration (FDA) announced a severe nationwide shortage of norepi- nephrine caused by production interruptions at 3 drug manufacturers that persisted until February 2012.7 Because norepinephrine is recommended as the first-line vasopressor for treatment of hypotension due to septic shock,8 the hypothesis was that admission to a hospital affected by the norepinephrine shortage would be associated with increased mortality in patients with septic shock. This question was addressed using a large, nationally representative database of hospitalized patients in the United States to assess the associations between the norepinephrine shortage, use of alternative vasopressors, and mortality among patients with septic shock. Among 27835 patients(medianage,69 years[interquartilerange,57-79years]; 47.0% women) with septic shock in 26 hospitals that demonstrated at least 1 quarter of norepinephrine shortage in 2011, norepinephrine use among cohort patients declined from 77.0% (95% CI, 76.2%-77.8%) of patients before the shortage to a low of 55.7% (95% CI, 52.0%-58.4%) in the second quarter of 2011; phenylephrine was the most frequently used alternative vasopressor during this time (baseline, 36.2% [95% CI, 35.3%-37.1%]; maximum, 54.4% [95% CI, 51.8%-57.2%]).

Compared with hospital admission with septic shock during quarters of normal use, hospital admission during quarters of shortage was associated with an increased rate of in-hospital mortality (9283 of 25 874 patients [35.9%] vs 777 of 1961 patients [39.6%], respectively; absolute **risk increase = 3.7%** [95% CI, 1.5%-6.0%]; adjusted odds ratio = 1.15 [95% CI, 1.01-1.30]; P = .03).

Lower reimbursement rates for M4A creates doctor shortages

Doctors have to work longer hours for less pay

Pipes "Sally Pipes in WSJ: Medicare for All Could Mean Doctors for None." *Wall Street Journal.* February 12, 2020. https://www.pacificresearch.org/medicare-for-all-could-mean-doctors-for-none/

Professional groups representing doctors are buying into Democratic plans to remake health care—and thereby acting against the interests of their members. The American College of Physicians, the second-largest organization of U.S. doctors, recently came out in support of either a public option or single payer. At the American Medical Association's annual meeting last year, some 47% of delegates voted to reverse the organization's opposition to single payer. A new organization styling itself Physicians for a National Health Program has attracted some 20,000 members. Some doctors evidently believe Medicare for All would deliver better health care for Americans. Some no doubt think more insurance would mean more patients. **But it would also force physicians to work longer hours for less pay. A single-payer program would pay doctors at rates similar to Medicare reimbursement levels, already at least 25% less than private insurance pays, according to estimates by Charles Blahous of the Mercatus Center. Under the current legislative drafts of Medicare for All, government rates over the first decade would be 40% lower than those paid by private insurers**. That amounts to **an enormous pay cut for doctors.** U.S. physicians earned on average $313,000 in 2019, according to Medscape's international physician compensation report. The average physician in the U.K. earned only $138,000. The Commonwealth Fund reports that American general practitioners earned a little more than $218,000 on average in 2016,

compared with $146,000 in Canada and $134,000 in the U.K. **Drastic pay cuts would inevitably drive physicians to give up the practice.** Patients can't afford an exodus of doctors. **Nearly 80 million people live in areas with too few primary-care professionals,** the Kaiser Family Foundation reports. Even under current policies, the country may face **a shortage of as many as 120,000 doctors in a decade,** according to the Association of American Medical Colleges. The prospect of lower pay and stressful work **would also discourage young people from entering the profession.** Medical school is expensive; the median graduate takes on $200,000 in debt. It's time-consuming, too. The typical doctor spends four years in medical school, followed by three to seven years in residency and fellowship. Lucrative jobs in finance, technology and law require far less preparation time.

Doctors have less incentive to do good work if they're paid less

Fisher, "Medicare for All: Definition and Pros and Cons." *Smart Asset.* August 23, 2019. https://smartasset.com/insurance/medicare-for-all-definition-and-pros-and-cons

People may not be as careful with their health if they do not have a financial incentive to do so.

Governments have to limit health care spending to keep costs down. **Doctors might have less incentive to provide quality care if they aren't well paid. They may spend less time per patient in order to keep costs down. They also have less funding for new life-saving technologies.** Since the government focuses on providing basic and emergency health care, most universal healthcare systems report long wait times for elective procedures. The government may also limit services with a low probability of success, and may not cover drugs for rare conditions.

M4A would cause a shortage of 44k physicians by 2050

"MEDICARE FOR ALL AND THE FUTURE OF AMERICA'S HEALTH CARE WORKFORCE." *FTI Consulting Group*. January 2020. https://www.fticonsulting.com/~/media/Files/us-files/insights/reports/2020/jan/medicare-future-americas-health-care-workforce.pdf

On average, **Medicare reimbursements for physicians were about 75% of private insurance reimbursements for the same service** in 2017 and are expected to fall to approximately 63% by 2025.15 Because Medicare for All's most significant effect would be to replace private coverage, total reimbursements paid to physicians would also fall absent changes to the law. FTI estimates that, **under Medicare for All, the U.S. could expect a loss of more than 0.13 physicians per 1,000 people once the policy is fully implemented. The current ratio in the United States is 2.46 physicians per 1,000, which translates to a nationwide loss of 44,693 physicians by 2050**, compared to the projected number of physicians under current law.

Doctor shortages cause death

Primary care doctors decrease mortality

Rapaport, "Supply of primary care doctors linked with mortality rates." *Reuters.* February 18, 2020.
https://www.reuters.com/article/us-health-primary-care/supply-of-primary-care-doctors-linked-with-mortality-rates-idUSKCN1Q71NC

Overall in the U.S., the total number of primary care physicians rose from 196,014 in 2005 to 204,419 in 2015, the study found. But because of disproportionate losses of providers in rural areas, the average number of primary care physicians for every 100,000 people in the population declined from 46.6 to 41.1 during the same period. **Each 10 additional primary care physician per 100,000 people was associated with a 51.5 day increase in life expectancy, the study also found. Every 10 extra primary care doctors was also tied to declines of up to 1.4 percent in mortality rates from common causes like cancer, heart disease and respiratory disorders.**

"Greater supply of primary care physicians appeared to increase the chances that a person would be treated for cardiovascular disease risk factors like high blood pressure or high cholesterol, or caught early for major cancers like breast cancer or colon cancer," said lead study author Dr. Sanjay Basu of Stanford University in California.

ECONOMIC HARMS

What's the argument?

Opponents of Medicare for All often posit that M4A would lead to economic disaster for the US. The program itself would cost trillions of dollars a year in government spending. Moreover, it would dismantle the private, competitive healthcare sector in existence today.

The first reason that M4A would damage the economy is job loss. Currently, millions of people work in the private insurance sector, and eliminating private health insurance would cause an estimated loss of 1.8 million jobs (Pradhan). This will only exacerbate the existing job crisis imposed by COVID-19, because of which 40 million have lost their jobs (Morath).

In addition to job loss, Medicare for All would necessitate a significant amount of deficit spending. A midrange estimate for the cost of M4A is $30 trillion for the first ten years, an amount which could not be financed solely by increased taxes on high earners. Debt places a massive drag on the economy by crowding out public investments and increasing inflation (Committee for a Responsible Federal Budget; Peter G. Peterson Foundation). In fact, the amount of deficit spending necessary to fund M4A could reduce GDP by 5.9% (Committee for a Responsible Federal Budget). Debt also inhibits one of the government's most vital recession recovery tools, stimulus spending (Amadeo; Associated Press; Hilsenrath).

If the U.S. doesn't deficit spend, taxes would have to increase dramatically, which would also put a drag on the economy by limiting the flow of capital (Committee for a Responsible Federal Budget). Thus, regardless of the specific funding mechanisms, Medicare for All would likely hinder economic growth.

Why does the argument matter?

An economic downturn resulting from Medicare for All would impact every single American, not just the uninsured, and not even just those who interact with the healthcare system. Additionally, an economic downturn could have a spiraling effect, as higher taxes slow the economy, resulting in less tax revenue for the government, resulting in them having to raise tax margins in order to fund expensive programs like Medicare for All. If the strain that M4A puts on the economy becomes too great, then the long-term detriments to income, productivity, and GDP will outweigh any short-term monetary gain as Americans spend less on healthcare.

Main Players

The U.S. government, taxpayers, businesses, unemployed or low-income Americans

Strategy Considerations

Teams running economic harms on the neg will likely have the greatest scope, as the argument impacts every single American (and potentially creates a ripple effect around the globe). Whether someone is currently uninsured, sick, a healthcare worker, or none of the above, they will be impacted by an impending recession or economic slow-down. This allows negative teams to outweigh relatively easily on that front.

However, it is generally difficult for teams to weigh economic impacts against lives saved impacts. Would you rather lose 100,000 Americans or lose 1% of GDP? Most judges will tend to buy an affirmative team's framing and vote for lives saved. Thus, it is critical for teams to terminalize their impacts, fleshing out a scenario where economic harms reach a threshold where they cost a greater number of lives or push a greater number into poverty than what we are seeing in the status quo.

Evidence for Economic Harms

Lost insurance jobs

M4A would eliminate insurance jobs

Pradhan, "Medicare for All's jobs problem." *Politico.* November 25, 2019. https://www.politico.com/news/agenda/2019/11/25/medicare-for-all-jobs-067781

Initial research from University of Massachusetts economists who have consulted with multiple 2020 campaigns has estimated that **1.8 million health care jobs nationwide would no longer be needed if Medicare for All became law, upending health insurance companies and thousands of middle class workers whose jobs largely deal with them, including insurance brokers, medical billing workers and other administrative employees.** One widely cited study published in the New England Journal of Medicine estimated that administration accounted for nearly a third of the U.S.' health care expenses. Even if a bigger government expansion into health care left doctors, nurses, and other medical professionals' jobs intact, it would still cause a restructuring of a sprawling system that employs millions of middle-class Americans.

40 million jobs already lost to COVID

Morath, "How Many U.S. Workers Have Lost Jobs During Coronavirus Pandemic? There Are Several Ways to Count." *Wall Street Journal.* June 3, 2020. https://www.wsj.com/articles/how-many-u-s-workers-have-lost-jobs-during-coronavirus-pandemic-there-are-several-ways-to-count-11591176601

Friday's U.S. jobs report from the Labor Department is expected to show U.S. employers shed nearly 30 million positions from payrolls this spring as a result of the coronavirus pandemic and related shutdowns—but that is just one of several varying estimates of job destruction. Other data suggest **layoffs might have topped 40 million**, while another count shows only about 20 million are tapping unemployment benefits. No matter the measure, **job loss triggered by the pandemic is historically high and likely to leave a lasting mark on the U.S. economy**.

Deficit spending

If funded with debt, M4A would hurt the economy

Committee for a Responsible Federal Budget, "Choices for Financing Medicare for All." March 17, 2020. http://www.crfb.org/papers/choices-financing-medicare-all#:~:text=Medicare%20for%20All%20is%20likely,design%20choices%20and%20policy%20details.

Medicare for All is likely to increase federal costs by between $25 trillion and $35 trillion over ten years, depending both on estimating assumptions and on important design choices and policy details. **To finance $30 trillion – a rough midpoint – policymakers would likely adopt a combination of approaches that are equivalent to a 32 percent payroll tax, 25 percent income surtax, 42 percent value-added tax (VAT), a $7,500 per capita mandatory public premium, doubling all income tax rates, reducing non-health**

spending by 80 percent, or increasing debt 105 percent of GDP. Taxes on high earners and corporations alone could not finance Medicare for All. Each financing option would have different economic effects. An analysis from Penn Wharton Budget Model finds that payroll tax financing Medicare for All would reduce GDP by 7.3 percent in 2030, **deficit financing it would reduce GDP by 5.9 percent**, and premium financing would reduce GDP by 2.3 percent. Those options would reduce hours worked by 12, 10, and 7 percent, respectively – the equivalent of 17 million, 14 million, and 10 million jobs. Most financing options would be more progressive than new spending but have different distributional implications within and between income groups. Doubling income tax rates would be the most progressive, followed by an income tax surtax, followed by a payroll tax or a VAT. A mandatory public premium could be modestly regressive relative to the additional spending. Significant increases in tax rates from these options could lift the top rate to near or above the revenue-maximizing level, leaving little capacity to raise future revenue for other important purposes. Financing Medicare for All with a combination of policies – the most likely outcome – could balance these consequences but not necessarily reduce them.

The Coronavirus has sent the US into recession

Horsley, "It's Official: U.S. Economy Is In A Recession." *NPR*. June 8, 2020. https://www.npr.org/sections/coronavirus-live-updates/2020/06/08/872336272/its-official-scorekeepers-say-u-s-economy-is-in-a-recession

It may seem obvious, with double-digit unemployment and plunging economic output. But if there was any remaining doubt that **the U.S. is in a recession**, it's now been removed by the official scorekeepers at the National Bureau of Economic Research. The bureau's Business Cycle Dating Committee — the fat lady of economic opera — said the expansion peaked in February after a record 128 months, and **we've been sliding into a pandemic-driven recession since.** In making the announcement, the committee pointed to the **"unprecedented magnitude of the decline in employment and production, and its broad reach across the entire economy.**"

Debt spending necessary to lift US out of Coronavirus recession

The Associated Press for CNBC, "U.S. budget deficit hits all-time high of $864 billion in June." *CNBC*. July 13, 2020. https://www.cnbc.com/2020/07/13/us-budget-deficit-hits-all-time-high-of-864-billion-in-june.html

The federal government incurred the biggest monthly budget deficit in history in June as spending on programs to combat the coronavirus recession exploded while millions of job losses cut into tax revenues. The Treasury Department reported Monday that the deficit hit $864 billion last month, an amount of red ink that surpasses most annual deficits in the nation's history and is above the previous monthly deficit record of $738 billion in April. That amount was also tied to the trillions of dollars **Congress has provided to cushion the impact of the widespread shutdowns** that occurred in an effort to limit the spread of the viral pandemic. For the first nine months of this budget year, which began Oct. 1, the deficit totals $2.74 trillion, also a record for that period. That puts the country well on the way to hitting the $3.7 trillion deficit for the whole year that has been forecast by the Congressional Budget Office. That total **would surpass the previous annual record of $1.4 trillion set in 2009 when the government was spending heavily to lift the country out of the recession caused by the 2008 financial crisis**.

Stimulus spending critical during 2008 recession

Amadeo, "Obama's Stimulus Package and How Well It Worked." *The Balance.* May 28, 2020. https://www.thebalance.com/what-was-obama-s-stimulus-package-3305625

President Barack Obama outlined the economic stimulus package during his 2008 campaign. Congress approved the American Recovery and Reinvestment Act (ARRA) in February 2009.1 The Congressional Budget Office estimated **it would add $787 billion in budget deficits by 2019. The economic stimulus package ended the Great Recession by spurring consumer spending.** Most importantly, it instilled the confidence needed to boost economic growth. It also aimed to restore trust in the financial services industry. It limited bonuses for senior executives in companies that received the Troubled Asset Relief Program (TARP) funds.

Sources of US debt drying up

Leong, "Foreign buyers find U.S. Treasuries less appealing." *Reuters.* November 26, 2019. https://www.reuters.com/article/us-usa-bonds-foreign-graphic/foreign-buyers-find-u-s-treasuries-less-appealing-idUSKCN1NV27V

Some overseas investors appear to be taking a pass on U.S. debt securities just as the administration of President Donald Trump embarks on a record sale of Treasury bills, notes and bonds to pay for its big tax cuts and spending increases. **Top foreign holders of Treasuries like China and Japan have shrunk their portfolios of U.S. government bonds this year, and a recent barometer of participation in Treasury auctions suggests overseas buyers have not been showing up in force**, according to Treasury Department data. Some auctions since late October had **the weakest foreign participation rates in nearly a decade**, a Reuters analysis of U.S. Treasury sales shows. At the same time, auction sizes are rising fast, with bond issuance this quarter projected to set a record of $83 billion after deducting maturing debt. "We do worry about where demand for Treasuries is going to come from, given the ongoing significant increase in supply," said Torsten Slok, chief international economist at Deutsche Bank. That concern will be on sovereign debt investors' minds this week with the Treasury scheduled to auction $129 billion in notes with maturities ranging from two to seven years beginning on Monday. **Foreign investors** - both private funds and official entities such as central banks - **have been lynchpin participants in the $15.3 trillion U.S. Treasury market for years.** And while overall foreign holdings have remained steady at roughly $6.2 trillion, **their participation has not grown materially in several years. The Treasury market, meanwhile, has mushroomed in size,** leaving foreigners to account for just 40.5 percent of the market as of September versus nearly 50 percent in January 2013.

High debt hurts economic recovery

Hilsenrath, "Coronavirus Crisis Legacy: Mountains of Debt." *The Wall Street Journal*. April 9, 2020. https://www.wsj.com/articles/coronavirus-crisis-legacy-mountains-of-debt-11586447687

The full impact of the coronavirus pandemic may take years to play out. But one outcome is already clear: **Government, businesses and some households will be loaded with mountains of additional debt.**

The federal government budget deficit is on track to reach a record $3.6 trillion in the fiscal year ending Sept. 30, and $2.4 trillion the year after that, according to Goldman Sachs estimates. Businesses are drawing down bank credit lines and tapping bond markets. Preliminary signs are emerging that some households are turning to credit for funds, too. The debt surge is set to shape how governments and the private sector function long after the virus is tamed. Among other things, **it could be a weight on the expansion that follows**.

…

Past crises and buildups in U.S. government debt led to changes in the tax code and sharp fluctuations in inflation. In the private sector, debt loads could become a dividing line between firms that fail and those that emerge more dominant in their industries. Because states generally run balanced budgets to avoid large debt, they are likely to dip into rainy day funds in the weeks ahead and could turn quickly to cost cutting to keep their budgets in line in a downturn, squeezing the economy. Moody's Analytics sees $90 billion to $125 billion of such cuts or tax increases coming and says the hits will be unevenly spread around the country. New York, Michigan, West Virginia, Louisiana, Missouri, Wyoming and North Dakota are especially vulnerable, it said.

Debt is a drag on the economy

US debt crowds out important investments

"The Fiscal & Economic Impact." *Peter G. Peterson Foundation*. https://www.pgpf.org/the-fiscal-and-economic-challenge/fiscal-and-economic-impact

As the federal debt mounts, the government will spend more of its budget on interest costs, increasingly crowding out public investments. Over the next 10 years, the Congressional Budget Office (CBO) estimates that interest costs will total $5.9 trillion under current law. Currently, the U.S. spends more than $1 billion per day on interest payments. **As more federal resources are diverted to interest payments, there will be less available to invest in areas that are important for economic growth.** Although interest rates are currently low, we can't expect that situation to last forever. As interest rates rise, the federal government's borrowing costs will increase markedly. Within 30 years, CBO projects that interest costs could be more than twice what the federal government has historically spent on R&D, non-defense infrastructure, and education combined. Reduced Private Investment. **Federal borrowing competes for funds in the nation's capital markets, thereby raising interest rates and crowding out new investment in business equipment and structures.** Entrepreneurs face a higher cost of capital, potentially stifling innovation and slowing the advancement of new breakthroughs that could improve our lives. At some point, investors might begin to doubt the government's ability to repay debt and could demand even higher interest rates – further raising the cost of borrowing for businesses and households. Over time, lower confidence and reduced investment would slow the growth of productivity and wages of American workers.

US debt decreases GDP and income

"As Policymakers Consider Changes, CBO Warns: Fiscal Outlook Remains Unsustainable." *Peter G. Peterson Foundation*. https://www.pgpf.org/analysis/2017/03/as-policymakers-consider-changes-cbo-warns-fiscal-outlook-remains-unsustainable

As Washington lawmakers pursue significant policy reforms, **the non-partisan Congressional Budget Office (CBO) warns that the national debt remains on an unsustainable path. Under current law, federal debt is now projected to reach 150 percent of gross domestic product (GDP) within 30 years – by far an all-time high.** Unless policymakers act, **CBO concludes that rising debt could jeopardize long-term economic growth, crowd out critical investments, reduce policymakers' flexibility to respond to unforeseen events, and raise the risk of a fiscal crisis**.

Based on this unsustainable outlook, the dangerous path of federal debt remains a critical issue for the budget and the economy. Changes to spending and tax policies are necessary to put our long-term debt on a sustainable path. In the new report, CBO finds that:
Federal debt is already at its highest level since 1950 and is projected to climb to 150 percent of GDP under current law by 2047.
Rising debt is a result of a structural imbalance between revenues and spending: under current law, spending growth, which is fueled primarily by the aging of the population and growing healthcare costs, significantly outpaces the projected growth in revenues.
As the debt grows and interest rates rise, interest costs are projected to increase rapidly. By 2028, interest will become the third largest category of the budget, behind only Social Security and Medicare. Rising debt will harm our economy and slow the growth of productivity

and wages. **On our current path, the annual average income loss for a 4-person family would be $16,000 by 2047.**

M4A would increase debt-to-GDP ratio

Committee for a Responsible Federal Budget, "Choices for Financing Medicare for All." April 17, 2020. http://www.crfb.org/papers/choices-financing-medicare-all#:~:text=Policymakers%20have%20a%20number%20of,cost%20of%20Medicare%20for%20All.&text=Medicare%20for%20All%20could%20also,by%20105%20percent%20of%20GDP

[One way to finance the Medicare for All is to] **More than double the national debt to 203 percent of the economy.** Federal debt held by the public currently totals about $17 trillion, or 80 percent of GDP. Under current law, debt is projected to reach 98 percent of GDP by 2030. Assuming no changes in projected interest rates or economic growth, deficit-financing Medicare for All over the next decade would require nearly $34 trillion of new borrowing including interest, which is the equivalent of **105 percent of GDP by 2030**. As a result, **debt would rise to 203 percent of GDP, more than double its currently projected level. This would put debt in 2030 at almost five times its historic average of 42 percent and nearly twice the historic record of 106 percent** (set after World War II). Under different cost assumptions, debt could rise by as little as 89 percent of GDP and as much as 124 percent of GDP. Debt would continue to grow rapidly beyond 2030.

Increased debt-to-GDP ratio increases inflation

"HIGHER NATIONAL DEBT MEANS HIGHER INTEREST RATES FOR THE FEDERAL GOVERNMENT." *Peter G. Peterson Foundation*. May 6, 2019. https://www.pgpf.org/blog/2019/05/higher-national-debt-means-higher-interest-rates-for-the-federal-government#:~:text=Higher%20National%20Debt%20Means%20Higher%20Interest%20Rates%20for%20the%20Federal%20Government,-The%20amount%20spent&text=CBO's%20research%20found%20that%20over,03%20percentage%20points.

CBO's research found that **over the long-term, an increase in the debt-to-GDP ratio of 1 percentage point is associated with an increase in inflation-adjusted 10-year interest rates of .02 to .03 percentage points.** The debt-to-GDP ratio is currently projected to rise by about 14 percentage points over the next 10 years. Therefore, CBO's findings suggest that by 2029, interest rates on 10-year Treasury Notes could be roughly 0.3 to 0.4 percentage points higher than they would be in the absence of a debt increase.

High rates of inflation bad for the economy

Dorfman, "Inflation Is Still Bad For The Economy." *Forbes*. August 19, 2016. https://www.forbes.com/sites/jeffreydorfman/2016/08/19/inflation-is-still-bad-for-the-economy/#3fb256b14340

While these direct gains and losses balance out for the most part, they do impose future costs on the economy. Borrowers who see inflation as more variable will charge higher rates on future loans (above the amount justified by higher inflation) to cover the greater risk that their inflation expectations will be wrong. **That means higher credit costs for everyone, which is a real and non-trivial cost of inflation.** Most importantly, **higher inflation is bad for capital investment, meaning lower accumulation of productive capital which leads to slower economic growth for decades into the future.** Businesses are less interested in building factories using today's dollars if the products made have to be sold in the future in exchange for dollars that are worth less thanks to inflation. A smaller capital stock means lower labor productivity, which means slower wage growth.

Increased taxes

M4A would require an expansion of taxes

Sanger-Katz, "The Basic of 'Medicare for All'". *New York Times*. 25 February 2020. https://www.nytimes.com/2020/02/25/upshot/medicare-for-all-basics-bernie-sanders.html

Economists have produced various estimates. It's probably most helpful to think about the range. Give or take, they said the **Medicare for all system would cost around the same as the current system — government, employer and individual spending combined.** But even the most conservative spending estimate would involve a huge shift of health care dollars from individuals and businesses to the federal government. **Medicare for all would be an enormous expansion of government spending, and would almost certainly require large tax increases.**

M4A taxes would harm the economy

"Choices for Financing Medicare for All." *Committee for a Responsible Federal Budget*. March 17, 2020. http://www.crfb.org/papers/choices-financing-medicare-all#:~:text=Medicare%20for%20All%20is%20likely,design%20choices%20and%20policy%20details

Medicare for All is likely to increase federal costs by between $25 trillion and $35 trillion over ten years, depending both on estimating assumptions and on important design choices and policy details.

To finance $30 trillion – a rough midpoint – policymakers would likely adopt a combination of approaches that are equivalent to a 32 percent payroll tax, 25 percent income surtax, 42 percent value-added tax (VAT), a $7,500 per capita mandatory public premium, doubling all income tax rates, reducing non-health spending by 80 percent, or increasing debt 105 percent of GDP. Taxes on high earners and corporations alone could not finance Medicare for All. Each financing option would have different economic effects. An analysis from Penn Wharton Budget Model finds **that payroll tax financing Medicare for All would reduce GDP by 7.3 percent in 2030,** deficit financing it would reduce GDP by 5.9 percent, and premium financing would reduce GDP by 2.3 percent. Those options would reduce hours worked by 12, 10, and 7 percent, respectively – the equivalent of 17 million, 14 million, and 10 million jobs. Most financing options would be more progressive than new spending but have different distributional implications within and between income groups. Doubling income tax rates

would be the most progressive, followed by an income tax surtax, followed by a payroll tax or a VAT. A mandatory public premium could be modestly regressive relative to the additional spending. Significant increases in tax rates from these options could lift the top rate to near or above the revenue-maximizing level, leaving little capacity to raise future revenue for other important purposes. Financing Medicare for All with a combination of policies – the most likely outcome – could balance these consequences but not necessarily reduce them.

A2 PRO

A2 ACCESS INCREASES

A2 Access to Drugs Increases

Only 17% of drug nonadherence is due to cost

Luga and Maguire, "Adherence and health care costs." *National Institute of Health.* February 20, 2014. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3934668/

Among patients, **forgetting is the most frequently reported reason for nonadherence.**60,61 In a survey of 10,000 patients, the most common reported reason for missing medications was forgetfulness (24%), followed by perceived side effects (20%), **high drug costs (17%)**, and perception that a prescribed medication would have little effect on their disease (14%).62 In another survey of 14,464 Medicare beneficiaries, patients who did not fill at least one prescription reported the following reasons: "thought it would cost too much" (55.5%), "medicine not covered by insurance" (20.2%), "didn't think medicine was necessary for the condition" (18.0%), and "was afraid of medicine reactions/contraindications" (11.8%).63 More sophisticated patient assessment tools can elucidate psychological determinants such as self-reported medication self-efficacy, beliefs about medications and motivation that may impact adherence

M4A price cuts would cause drug shortages

Thomas Sullivan. "Increasing Generic Drug Shortages Linked to Government Price Controls." *Policy Med Magazine.* May 6, 2018. https://www.policymed.com/2012/03/increasing-generic-drug-shortages-linked-to-government-price-controls.html

Unfortunately, as the author noted, "These shortages were not rare episodes. **Last year, a record of 267 drug shortages were reported, up from 58 in 2004. Even more tragically, most 2011 shortages remain unresolved."** The article explained some of the causes of these shortages. First, the number of suppliers of generic drugs has dwindled. There were 26 U.S. vaccine makers in 1967; today there are only six. Supply disruptions are common, including the possibility that a facility completely shuts down for a protracted time because of quality or safety problems. Second, unlike in most consumer goods industries, many pharmaceutical manufacturers have failed to invest in the technology and quality control improvements that would reduce the risks of partial or complete facility shutdowns—and this despite the FDA's regularly issued current guidelines for good manufacturing practices (cGMPs). **Behind both problems are the government's tight price controls for generic drugs, especially when purchased by Medicare and Medicaid. Low prices induce drug makers to exit various markets, or at least to reallocate their manufacturing capacity toward more profitable, patented pharmaceuticals. Low prices also tend to eliminate the rationale for investments in better manufacturing technologies and processes, as shown in a 2009 study conducted by the author and published in the Journal of Management Science. Government price controls on generic drugs limit the manufacturers' margin to 6% in many cases. Consequently, the author argued that one "way to resolve the shortage of critical drugs is to relax or eliminate government price controls**, and to increase the FDA's review and inspection capacities. In the latter case the generic drug industry is willing to foot most or all of the bill."

During shortages, hospital mortality increases by 4%

Emily Vail. "Association Between US Norepinephrine Shortage and Mortality Among Patients with Septic Shock." *American Medical Association.* March 21, 2017. doi:10.1001/jama.2017.2841 https://jamanetwork.com/journals/jama/fullarticle/2612912

Drug shortages are an increasing problem with poten- tial effects on patients and health care delivery costs.1,2 In the United States, the issue has received consider- able attention from federal legislators, media, and physician and pharmacist advocacy groups. However, the effects of drug shortages on patient outcomes or on alternative prescribing practices are poorly described.3-6 In addition, there is no na- tional reporting system that captures hospital-level data on drug shortages or their effect on patients. In February 2011, the US Food and Drug Administration (FDA) announced a severe nationwide shortage of norepi- nephrine caused by production interruptions at 3 drug manufacturers that persisted until February 2012.7 Because norepinephrine is recommended as the first-line vasopressor for treatment of hypotension due to septic shock,8 the hypothesis was that admission to a hospital affected by the norepinephrine shortage would be associated with increased mortality in patients with septic shock. This question was addressed using a large, nationally representative database of hospitalized patients in the United States to assess the associations between the norepinephrine shortage, use of alternative vasopressors, and mortality among patients with septic shock. Among 27835 patients(medianage,69 years[interquartilerange,57-79years]; 47.0% women) with septic shock in 26 hospitals that demonstrated at least 1 quarter of norepinephrine shortage in 2011, norepinephrine use among cohort patients declined from 77.0% (95% CI, 76.2%-77.8%) of patients before the shortage to a low of 55.7% (95% CI, 52.0%-58.4%) in the second quarter of 2011; phenylephrine was the most frequently used alternative vasopressor during this time (baseline, 36.2% [95% CI, 35.3%-37.1%]; maximum, 54.4% [95% CI, 51.8%-57.2%]).

Compared with hospital admission with septic shock during quarters of normal use, hospital admission during quarters of shortage was associated with an increased rate of in-hospital mortality (9283 of 25 874 patients [35.9%] vs 777 of 1961 patients [39.6%], respectively; absolute risk increase = 3.7% [95% CI, 1.5%-6.0%]; adjusted odds ratio = 1.15 [95% CI, 1.01-1.30]; P = .03).

A2 Access to Preventative Care

Even insured Americans don't get preventative care

Barone, "NEARLY HALF OF INSURED U.S. ADULTS DON'T KNOW THEY SHOULD HAVE AN ANNUAL CHECK-UP." *Cigna*. December 9, 2015. https://www.cigna.com/newsroom/news-releases/2015/nearly-half-of-insured-us-adults-dont-know-they-should-have-an-annual-check-up

In a new survey of insured adults conducted by Cigna, **45 percent of Americans say they don't know that they should have an annual check-up - and half are unaware that if they have insurance, there is no cost for the annual check-up.** In fact, most Americans are more in tune with when their pets need to have their shots than when they should go for their own check-up. "Annual check-ups are critical to our personal health. They provide us with an opportunity to check on our most important health numbers such as Body Mass Index (BMI), cholesterol and blood pressure, allowing us to gauge our overall well-being," according to Isaac Martinez, M.D., utilization management medical director at Cigna. "However, many Americans forget they need an annual check-up and many of those who know, don't go. That's why we want people to 'know, go, and take control' when it comes to their health. The U.S. Centers for Disease Control and Prevention (CDC) reports that Americans use preventive services at only about half the recommended rate, despite insurance covering 100 percent of these costs.*"

Cost and lack of insurance cause a minority of treatment avoidance

Taber et al, "Why do People Avoid Medical Care? A Qualitative Study Using National Data." *Society of General Internal Medicine*. November 12, 2014. doi: 10.1007/s11606-014-3089-1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4351276/

Main Measures Participants first indicated their level of agreement with three specific reasons for avoiding medical care; these data are reported elsewhere. We report responses to a follow-up question in which participants identified other reasons they avoid seeking medical care. Reasons were coded using a general inductive approach. Key Results Three main categories of reasons for avoiding medical care were identified. First**, over one-third of participants (33.3% of 1,369) reported unfavorable evaluations of seeking medical care, such as factors related to physicians, health care organizations, and affective concerns. Second, a subset of participants reported low perceived need to seek medical care (12.2%), often because they expected their illness or symptoms to improve over time (4.0%). Third, many participants reported traditional barriers to medical care (58.4%), such as high cost (24.1%), no health insurance (8.3%), and time constraints (15.6%).** We developed a conceptual model of medical care avoidance based on these results. Conclusions Reasons for avoiding medical care were nuanced and highly varied. Understanding why people do not make it through the clinic door is critical to extending the reach and effectiveness of patient care, and these data point to new directions for research and strategies to reduce avoidance.

A2 Access to Neonatal Care

Neonatal care is a high cost service, meaning hospitals that provide more of it will suffer disproportionately

Glen Kazahaya. "'Medicare for All' isn't equitable for all hospitals", HFMA. February 1 2020. https://www.hfma.org/topics/hfm/2020/february/-medicare-for-all--isn-t-equitable-for-all-hospitals.html

Because of the disproportionate share of costs consumed for outliers compared with normal non-outlier DRGs, **losses would be the highest for hospitals that provide more high-cost, high-acuity and high-risk outlier services** (e.g., high-risk cardiac procedures, higher acuity surgeries and services delivered in **neonatal intensive care units**). Conversely, local and smaller community hospitals that may lack the resources or the ability to deliver such services would have lower outlier risks and typically lower costs under a Medicare-for-All payment system. In short, the high cost and utilization of outliers drastically increases the overall costs and presents unfair benchmark comparisons between high-outlier and low-outlier hospitals. Without major changes to the outlier payment methodology, AMCs and larger tertiary hospitals would tend to suffer in a Medicare DRG-based payment system. Thus, to achieve reasonable comparisons between these hospitals and the lower-cost, lower-acuity community hospitals, outlier discharges should be excluded from all benchmark key indicator comparisons. If any future single-payer health plan doesn't provide adequate stop-loss insurance to cover the full costs of outliers, **hospitals delivering high-risk outlier services will be forced to reconsider whether they can continue providing these services**. If the existing Medicare outlier-payment methodologies were not modified, these hospitals could continue to incur major, disproportionately high and unsustainable losses. And if it were to become unaffordable for them to continue providing high-outlier services such as NICU, transplants and major cardiac procedures, **the nation could face serious access problems for patients requiring such services**. The chart below provides an executive summary of the major key indicators for ABC Hospital. The numbers demonstrate the potential one-year impact on this model hospital if all discharges were paid at 100% of Medicare rates.

U.S. has a shortage of neonatal doctors; doctor shortages b/c of M4A would make this issue worse (see "drug & doctor shortages" argument)

Nina Martin, "A Larger Role for Midwives Could Improve Deficient U.S. Care for Mothers and Babies." *ProPublica*. February 22, 2018. https://www.propublica.org/article/midwives-study-maternal-neonatal-care

All of those countries have much lower rates of maternal and infant mortality than the U.S. Here, severe maternal complications have more than doubled in the past 20 years. **Shortages of maternity care have reached critical levels: Nearly half of U.S. counties don't have a single practicing obstetrician-gynecologist, and in rural areas, the number of hospitals offering obstetric services has fallen more than 16 percent since 2004**. Nevertheless, thanks in part to opposition from doctors and hospitals, midwives are far less prevalent in the U.S. than in other affluent countries, attending around 10 percent of births, and the extent to which they can legally participate in patient care varies widely from one state to the next.

A2 Access to Reproductive Care

Many states have passed early abortion bans that won't change under M4A

Gordon & Hurt, "Early Abortion Bans: Which States Have Passed Them?" *NPR*. June 5, 2019. https://www.npr.org/sections/health-shots/2019/06/05/729753903/early-abortion-bans-which-states-have-passed-them

This year has brought an unprecedented wave of new state laws that only allow abortions to be performed early in pregnancy – if at all. Most of the new laws – known as early abortion bans – explicitly outlaw abortion when performed after a certain point early in the pregnancy. The laws vary, with some forbidding abortion after six weeks of pregnancy, and some after eight weeks. Alabama's law is the most extreme: It aims to outlaw abortion at any point, except if the woman's health is at serious risk. **So far in 2019, nine U.S. states have passed laws of this type, and more states are considering similar legislation**. None of the laws passed this year are actually in effect, either because they have a future enactment date or because judges have put them on hold in response to lawsuits, or both. These new bans are a direct challenge to the precedent set by the 1973 Supreme Court ruling *Roe v. Wade*, which affirmed that a woman has a right to seek an abortion up until the point that the fetus could be "viable" outside of the uterus. Viability must be determined on an individual basis but is generally between 24 and 28 weeks of pregnancy.

Half of women already live in states that have policies "hostile" towards abortion

Berg, "How 20-Week Abortion Bans Are Spreading Across the U.S. (in 1 GIF)." *Planned Parenthood*. February 13, 2015. https://www.plannedparenthoodaction.org/blog/how-20-week-abortion-bans-are-spreading-across-us-one-gif

Politicians in these 12 states have already banned abortions after 20 weeks: Alabama Arkansas Indiana Kansas Louisiana Mississippi North Carolina North Dakota (*has a 6-week ban on the books already, although it is not in effect.*) Nebraska Oklahoma Texas West Virginia 20-week abortion bans are being challenged in the courts of these states: Georgia These states are currently considering 20-week abortion bans: Ohio Oregon South Carolina Wisconsin **The 20-week bans advancing in**

states across the country come on top of the more than 335 provisions aimed at restricting access to abortion that were introduced in state legislatures in 2014. **That means more than half (57%) of women of reproductive age are now living in a state that is either hostile or very hostile to abortion rights, according to the Guttmacher Institute**.

A2 Access to Preventative Care

Patients don't seek care for mental illness because of stigma, not cost

Heath, Sarah. "Understanding Stigma as a Mental Healthcare Barrier." *Patient Care Access News*. June 8, 2017. https://patientengagementhit.com/news/understanding-stigma-as-a-mental-healthcare-barrier?utm_content=b1281c3eaa9e820f79ecee0fe1311937&utm_campaign=MHD%25206%252F8%252F17&utm_source=Robly.com&utm_medi

Data from the Substance Abuse and Mental Health Services Administration (SAMHSA) shows that in 2014, **only 2.5 million of the 21.2 million individuals struggling with mental illness accessed treatment**. The agency, as well as other public health officials, strongly contend that **stigma is a fundamental barrier to care.** In the following primer, *PatientEngagementHIT.com* reviews how stigma affects access to mental and behavioral healthcare treatments and some of the current efforts to overcome those obstacles. The exact number of patients who cannot or do not access mental healthcare due to stigma is difficult to pinpoint. Patients who do not access mental healthcare fly under the radar and are underreported, making it difficult for researchers to provide an accurate picture of patients facing stigma obstacles. Therefore, measurements about stigma barriers to mental healthcare vary from study to study. That said, most research concludes that perceived stigma is a considerable barrier to mental healthcare. In a 2014 study published in *Psychological Science in the Public Interest*, lead researcher Patrick Corrigan of the Illinois Institute of Technology reported that about 40 percent of the 60 million patients suffering from mental illness go without treatment.
Other researchers confirm that perceived stigma is a significant barrier for patients seeking mental healthcare. Other barriers include lack of knowledge about mental healthcare, inability to recognize symptoms in one's self, and inability to identify adequate healthcare resources for mental health symptoms.

A2 PREVENTING STRUCTURAL VIOLENCE

Structural violence in healthcare is not due to cost, it is due to implicit bias in healthcare systems/professionals

Chloe Fitzgerald and Samia Hurst. "Implicit bias in healthcare professionals: a systematic review." *BMC Medical Ethics.* March 1, 2017. https://bmcmedethics.biomedcentral.com/articles/10.1186/s12910-017-0179-8

Thirty five articles found evidence of implicit bias in healthcare professionals; all the **studies** that investigated correlations **found a significant positive relationship between level of implicit bias and lower quality of care**. The evidence indicates that healthcare professionals exhibit the same levels of implicit bias as the wider population. The interactions between multiple patient characteristics and between healthcare professional and patient characteristics reveal the complexity of the phenomenon of implicit bias and its influence on clinician-patient interaction. The most convincing studies from our review are those that combine the IAT and a method measuring the quality of treatment in the actual world. Correlational evidence indicates that **biases are likely to influence diagnosis and treatment decisions and levels of care** in some circumstances and need to be further investigated. Our review also indicates that there may sometimes be a gap between the norm of impartiality and the extent to which it is embraced by healthcare professionals for some of the tested characteristics.

Hospital closures disproportionately harm racial minorities

Annalisa Merelli. "When rural hospitals close, minorities pay the biggest price." *Quartz*. June 10, 2020. https://qz.com/1866565/when-rural-hospitals-close-minorities-pay-the-price/

This affects rural communities across the country, but researchers from the University of North Carolina at Chapel Hill who track rural hospital closures around the country found **critical-access hospitals are at higher risk of closure in communities that have a higher percentage of non-white people, and especially Black people.** Specifically, **rural hospitals that are more financially secure serve communities that are overwhelmingly white, with populations that are only 0.9% Black, and 8.1% overall non-white. Hospitals are at risk of closure, however, serve 2.5% Black and 18.1% non-white populations.** Many of these states are in the south, where rural communities are more likely to be non-white than in the midwest, for example.

A2 ALLEVIATING COSTLY BILLS

Many Americans would end up paying more in taxes under M4A

Committee for a Responsible Federal Budget, "Choices for Financing Medicare for All." 3/17/2020. http://www.crfb.org/papers/choices-financing-medicare-all#:~:text=Medicare%20for%20All%20is%20likely,design%20choices%20and%20policy%20details.

Medicare for All is likely to increase federal costs by between $25 trillion and $35 trillion over ten years, depending both on estimating assumptions and on important design choices and policy details. **To finance $30 trillion – a rough midpoint – policymakers would likely adopt a combination of approaches that are equivalent to a 32 percent payroll tax, 25 percent income surtax, 42 percent value-added tax (VAT), a $7,500 per capita mandatory public premium, doubling all income tax rates, reducing non-health spending by 80 percent, or increasing debt 105 percent of GDP. Taxes on high earners and corporations alone could not finance Medicare for All.** Each financing option would have different economic effects. An analysis from Penn Wharton Budget Model finds **that payroll tax financing Medicare for All would reduce GDP by 7.3 percent in 2030,** deficit financing it would reduce GDP by 5.9 percent, and premium financing would reduce GDP by 2.3 percent. Those options would reduce hours worked by 12, 10, and 7 percent, respectively – the equivalent of 17 million, 14 million, and 10 million jobs. Most financing options would be more progressive than new spending but have different distributional implications within and between income groups. Doubling income tax rates would be the most progressive, followed by an income tax surtax, followed by a payroll tax or a VAT.

Deficit spending decreases GDP, which leads to 17 million jobs lost

Committee for a Responsible Federal Budget, "Choices for Financing Medicare for All." March 17, 2020. http://www.crfb.org/papers/choices-financing-medicare-all#:~:text=Medicare%20for%20All%20is%20likely,design%20choices%20and%20policy%20details.

Medicare for All is likely to increase federal costs by between $25 trillion and $35 trillion over ten years, depending both on estimating assumptions and on important design choices and policy details. **To finance $30 trillion – a rough midpoint – policymakers would likely adopt a combination of approaches that are equivalent to a 32 percent payroll tax, 25 percent income surtax, 42 percent value-added tax (VAT), a $7,500 per capita mandatory public premium, doubling all income tax rates, reducing non-health spending by 80 percent, or increasing debt 105 percent of GDP. Taxes on high earners and corporations alone could not finance Medicare for All.** Each financing option would have different economic effects. An analysis from Penn Wharton Budget Model finds that payroll tax financing Medicare for All would reduce GDP by 7.3 percent in 2030, **deficit financing it would reduce GDP by 5.9 percent**, and premium financing would reduce GDP by 2.3 percent**. Those options would reduce hours worked by 12, 10, and 7 percent, respectively – the equivalent of 17 million, 14 million, and 10 million jobs.** Most financing options would be more progressive than new spending but have different distributional implications within and between income groups.

A2 HELPING HOSPITALS

Global budgeting hurts hospitals

Berenson, Robert A et al. "Global Budgets for Hospitals." *Urban Institute*, April 2016, https://www.urban.org/sites/default/files/2016/05/03/05_global_budgets_for_hospitals.pdf

Global budgets do not promote competition among hospitals or reward hospitals for growth in market share, unless they include a mechanism to adjust a hospital's budget for shifts in volume due to desirable changes in referral patterns. (In Maryland, this mechanism is referred to as a market-shift adjustment.) **Without specific performance incentives and assessments, hospitals under global budgeting can operate within their budgets by limiting spending, even if the spending reduction approach might negatively affect access and quality.** In Europe, some hospitals have responded to global budgets by producing queues for elective services. **The common, historical-basis approach to budget setting reinforces existing resource flows, which may not accurately reflect need or market value. Payers may base allowances for annual budget increases on factors unrelated to health, such as the growth in inflation or GDP, or on budgetary constraints outside of the health care sector, thereby eroding the global budget's purchasing power.** A normative approach presumes the global budget is based on highly granular and accurate data, which may be more aspirational than real in many situations. Too much divergence from historical spending may cause real financial hardship for affected hospitals, which can compromise quality and access to care.

M4A pays hospitals less than private insurance

Blahouse, "How Much Would Medicare for All Cut Doctor and Hospital Reimbursements?" *E21.* October 10, 2018. https://economics21.org/m4a-reimbursements-blahous

On July 31, I published a study with the Mercatus Center at George Mason University estimating the added costs to the federal government of establishing a national single-payer healthcare system. That study presented a lower-bound estimate of **$32.6 trillion in added federal costs over the first 10 years of full implementation,** with the caveats that this estimate reflected several extremely favorable assumptions, and that actual costs were likely to be substantially higher. Among those favorable assumptions was that lawmakers would uphold Senator Bernie Sanders' Medicare for All (M4A) bill's specification that **healthcare provider payments would be cut down to Medicare rates, which currently average about 40% lower than the rates paid by private health insurance, and well below providers' reported costs of providing services.** Although my study as published was explicit about the nature and distribution of these cuts, some of the subsequent public discussion exhibited substantial confusion as to whose payments would be cut and by how much. This article seeks to clarify these issues. Medicare pays healthcare providers **at rates generally much lower than private insurance does.** These Medicare payment rate schedules are set by law, and they differ for different categories of providers. This article will focus on two especially important categories: hospitals and physicians. These categories are exceptionally important to the calculations, first because they represent large categories of national health spending, and second because private health insurance currently finances a significant share of spending within them. These factors together mean that the effects of cutting payments down to Medicare rates would be especially concentrated on hospitals and physicians.

American Hospital Association, January 2019, "AMERICAN HOSPITAL ASSOCIATION UNDERPAYMENT BY MEDICARE AND MEDICAID FACT SHEET." https://www.aha.org/system/files/2019-01/underpayment-by-medicare-medicaid-fact-sheet-jan-2019.pdf

In the aggregate, both Medicare and Medicaid payments fell below costs in 2017: Combined underpayments were $76.8 billion in 2017. This includes a shortfall of $53.9 billion for Medicare and $22.9 billion for Medicaid. **For Medicare, hospitals received payment of only 87 cents for every dollar spent by hospitals caring for Medicare patients in 2017.** For Medicaid, hospitals received payment of only 87 cents for every dollar spent by hospitals caring for Medicaid patients in 2017. In 2017, 66 percent of hospitals received Medicare payments less than cost, while 62 percent of hospitals received Medicaid payments less than cost.

COVID-19 exacerbates existing strain on hospitals as lucrative elective procedures are postponed

"Hospitals and Health Systems Face Unprecedented Financial Pressures Due to COVID-19." *American Hospital Association (AHA)*. May 2020. https://www.aha.org/system/files/media/file/2020/05/aha-covid19-financial-impact-0520-FINAL.pdf

This report attempts to quantify these effects over the short-term, which are limited to the impacts over a four month period from March 1, 2020 to June 30, 2020. Based on these analyses, **the AHA estimates a total four month financial impact of $202.6 billion in losses for America's hospitals and health systems, or an average of $50.7 billion per month.** Although the federal government moved quickly to provide relief, more help is needed. Critics have argued that hospitals were well funded prior to the COVID-19 public health emergency, however, the reality is that many hospitals were already facing financial pressures. Experts have raised concerns about low payment rates from government payers, which in part led the Congressional Budget Office to project that between 40% and 50% of hospitals could have negative margins by 2025 prior to the pandemic.2,3,4 Congress created a provider relief fund to support health care providers during the pandemic, but this fund is intended to stabilize providers in order to keep their doors open, rather than fully restore compensation to pre-COVID-19 levels. Further, these funds are being distributed to all health care providers with only a portion of these funds going directly to hospitals.

A2 HELPING THE ECONOMY

Eliminating private insurance destroys 1.8 million health care jobs

Pradhan. "Medicare for All's jobs problem." *Politico.* November 25, 2019. https://www.politico.com/news/agenda/2019/11/25/medicare-for-all-jobs-067781

Initial research from University of Massachusetts economists who have consulted with multiple 2020 campaigns has estimated that **1.8 million health care jobs nationwide would no longer be needed if Medicare for All became law, upending health insurance companies and thousands of middle class workers whose jobs largely deal with them, including insurance brokers, medical billing workers and other administrative employees.** One widely cited study published in the New England Journal of Medicine estimated that administration accounted for nearly a third of the U.S.' health care expenses. Even if a bigger government expansion into health care left doctors, nurses, and other medical professionals' jobs intact, it would still cause a restructuring of a sprawling system that employs millions of middle-class Americans.

People outside the healthcare industry are hurt since pension plans, mutual funds, and retirement accounts hold health insurance stocks

Sally C. Pipes. "Medicare for All Would Wipe Out Jobs, Pensions, and 401(k)s." *Pacific Research Institute.* July 3, 2019. https://www.pacificresearch.org/medicare-for-all-would-wipe-out-jobs-pensions-and-401ks/

Then there are the hundreds of thousands of people employed by private health insurers whom Medicare for All makes no bones about throwing out of work. Health insurers employ more than half a million people directly, according to the Insurance Information Institute. The industry also supports hundreds of thousands of brokers and third-party administrators. These jobs pay well – an average salary of $70,000. Medicare for All would destroy almost all of them. At least Medicare for All's supporters acknowledge as much. Congresswoman Pramila Jayapal, who has sponsored Medicare for All legislation in the House, recently said, "There's about a million people we think will be displaced if Medicare for All happens." **Even those with no apparent connection to the private health insurance industry would be collateral damage. Many pension plans, mutual funds, and retirement accounts hold health insurance company stocks. CalPERS, the giant California public pension system, owns 2.8 million shares of UnitedHealth Group and more than 1 million shares of Anthem.** The current value of those two holdings exceeds $900 million. The New York State Common Retirement Fund – the third-largest pension plan in the nation – owns more than 1 million shares of Cigna, worth more than $150 million. "You're fired" used to be confined to reality TV. **If Medicare for All comes about, that line may become a grim reality for millions of Americans.**

M4A would likely be financed w/ increased taxes, which would reduce GDP 7.3%

"Choices for Financing Medicare for All." *Committee for a Responsible Federal Budget.* March 17, 2020. http://www.crfb.org/papers/choices-financing-medicare-all#:~:text=Medicare%20for%20All%20is%20likely,design%20choices%20and%20policy%20details.

Medicare for All is likely to increase federal costs by between $25 trillion and $35 trillion over ten years, depending both on estimating assumptions and on important design choices and policy details. **To finance $30 trillion – a rough midpoint – policymakers would likely adopt a combination of approaches that are equivalent to a 32 percent payroll tax, 25 percent income surtax, 42 percent value-added tax (VAT), a $7,500 per capita mandatory public premium, doubling all income tax rates, reducing non-health spending by 80 percent, or increasing debt 105 percent of GDP. Taxes on high earners and corporations alone could not finance Medicare for All.** Each financing option would have different economic effects. An analysis from Penn Wharton Budget Model finds **that payroll tax financing Medicare for All would reduce GDP by 7.3 percent in 2030,** deficit financing it would reduce GDP by 5.9 percent, and premium financing would reduce GDP by 2.3 percent. Those options would reduce hours worked by 12, 10, and 7 percent, respectively – the equivalent of 17 million, 14 million, and 10 million jobs. Most financing options would be more progressive than new spending but have different distributional implications within and between income groups. Doubling income tax rates would be the most progressive, followed by an income tax surtax, followed by a payroll tax or a VAT. A mandatory public premium could be modestly regressive relative to the additional spending.

A2 CON

A2 PHARMACEUTICAL INNOVATION DECREASES

Only 8% of pharmaceutical revenue is spent on innovation

"The R&D smokescreen: The Prioritization of Marketing & Sales in the Pharmaceutical Industry." *Institute for Health and Socioeconomic Policy.* October 20, 2016. https://nurses.3cdn.net/e74ab9a3e937fe5646_afm6bh0u9.pdf

We've often heard the stories of high drug prices in the U.S. causing many individuals to go into severe debt or forcing people to cut their pills in half to get by. One common excuse the pharmaceutical industry uses to justify their exorbitant drug prices is that this money is needed to cover high Research & Development (R&D) expenses.1 Sadly, there is little truth to this statement. The industry claims that it costs about $2.6 billion to release a new drug. 2 The industry standard now is to invest more in Marketing & Sales (M&S) than in R&D. So, what are the actual intentions of these drug companies? Is it to help find cures to help the general public or is it to reap insanely high profits at the sake of the public good? Sadly, the industry has made a conscious choice to put profits over public health. In the past 20 years, the top 50 drug companies have made over $1.6 trillion in profits. The Tufts Center for the Study of Drug Development that produces this and similar studies is funded by pharmaceutical companies primarily for the purpose of promoting these misleading and inflated claims. As we will see, the $2.6 billion figure is just a smokescreen that is intended to make us believe that the industry is investing huge amounts in the development of innovative and new drugs. 3 The pharmaceutical industry appears to have found that the return-on-investment in R&D doesn't meet the short-term expectations of shareholders. As a result, they have created smokescreens around their funding of R&D and, instead, funneled massive amounts of resources into M&S to persua Marketing & Sales (M&S) expenses far exceed that of Research & Development (R&D) expenses in the pharmaceutical industry In 2015, out of the top 100 pharmaceutical companies by sales, 64 spent twice as much on M&S than on R&D, 58 spent three times, 43 spent five times as much and 27 spent 10 times the amount. **Drug companies have not invested in R&D due to low return-on-investment Out of the top 100 pharmaceutical companies in 2015, 89 spent more on M&S than on R&D. In 2015, the top 100 pharmaceutical companies, on average, spent 8.32% of their revenues on R&D.**

The government is the main investor in drug innovation, not the private sector, so price controls would not matter.

Ekaterina Cleary. "Contribution of NIH funding to new drug approvals 2010-2016." *John Hopkins School of Medicine.* December 27, 2017. https://doi.org/10.1073/pnas.1715368115

This report shows that NIH funding contributed to published research associated with every one of the 210 new drugs approved by the Food and Drug Administration from 2010–2016. Collectively, this research involved >200,000 years of grant funding totaling more than $100 billion. The analysis shows that >90% of this funding represents basic research related to the biological targets for drug action rather than the drugs themselves. The role of NIH funding thus complements industry research and development, which focuses predominantly on applied research. This work underscores the breath and significance of public investment in the development of new therapeutics and the risk that reduced research funding would slow the pipeline for treating morbid disease. This work examines the contribution of NIH funding to published research associated with 210 new molecular entities (NMEs) approved by the Food and Drug Administration from 2010–2016. We identified >2 million publications in PubMed related to the 210 NMEs (n = 131,092) or their 151 known biological targets (n = 1,966,281). Of these, >600,000 (29%) were associated with NIH-funded projects in RePORTER. This funding included >200,000 fiscal years of NIH project support (1985–2016) and project costs >$100 billion (2000–2016), representing ~20% of the NIH budget over this period. NIH funding contributed to every one of the NMEs approved from 2010–2016 and was focused primarily on the drug targets rather than on the NMEs themselves. There were 84 first-in- class products approved in this interval, associated with >$64 billion of NIH-funded projects. The percentage of fiscal years of project funding identified through target searches, but not drug searches,

was greater for NMEs discovered through targeted screening than through phenotypic methods (95% versus 82%). For targeted NMEs, funding related to targets preceded funding related to the NMEs, consistent with the expectation that basic research provides validated targets for targeted screening. This analysis, which captures basic research on biological targets as well as applied research on NMEs, suggests that the NIH contribution to research associated with new drug approvals is greater than previously appreciated and highlights the risk of reducing federal funding for basic biomedical research.

Mariana Mazzucato. "How taxpayers prop up Big Pharma, and how to cap that." *LA Times.* October 27, 2015. http://www.latimes.com/opinion/op-ed/la-oe-1027-mazzucato-big-pharma-prices-20151027-story.html

Since the 1930s, the National Institutes of Health has invested close to $900 billion in the basic and applied research that formed both the pharmaceutical and biotechnology sectors, with private companies only getting seriously into the biotech game in the 1980s. Big Pharma, while of course contributing to innovation, has increasingly decommitted itself from the high-risk side of research and development, often letting small biotech companies and the NIH do most of the hard work. **Indeed, roughly 75% of so-called new molecular entities with priority rating (the most innovative drugs) trace their existence to NIH funding, while companies spend more on "me too" drugs (slight variations of existing ones.) But if Big Pharma is not committed to research, what is it doing?** First, it is well known that Big Pharma spends more on marketing than on R&D. Less well known is how much it also spends on making its shareholders rich. Pharmaceutical companies, which have become increasingly "financialized," distribute profits to shareholders through dividends and share buybacks designed to boost stock prices and executive pay.

Innovation is failing right now: 90% of new drugs have no clinical significance.

Donald Light, "PHARMACEUTICAL R&D What do we get for all that money?" *British Medical Journal*. August 11, 2012. https://www.bmj.com/bmj/section-pdf/187604?path=/bmj/345/7869/Analysis.full.pdf

The preponderance of drugs without significant therapeutic gains dates all the way back to the "golden age" of innovation. Out of 218 drugs approved by the FDA from 1978 to 1989, only 34 (15.6%) were judged as important therapeutic gains.12 Covering a roughly similar time period (1974-94), the industry's Barral report on all internationally marketed new drugs concluded that only 11% were therapeutically and pharmacologically innovative.13 **Since the mid-1990s, independent reviews have also concluded that about 85-90% of all new drugs provide few or no clinical advantages for patients.1419.** This small, steady increase in clinically superior drugs contrasts with the FDA granting "priority" review status to 44% of all new drugs from 2000 to 2010.20 The percentage of drugs with a priority designation began to increase in 1992 when companies started funding the FDA's approval process. Other regulatory agencies have classified far fewer of the same medicines as needing accelerated reviews.21 Post-market evaluations during the same period are much less generous in assigning significant therapeutic advances to medications.18 21 This is the real innovation crisis: pharmaceutical research and development turns out mostly minor variations on existing drugs, and most new drugs are not superior on clinical measures. Although a steady stream of significantly superior new drugs enlarges the medicine chest from which millions benefit, medicines have also produced an epidemic of serious adverse reactions that have added to national healthcare costs.22

M4A incentivizes real innovation by removing the mechanisms that allow for monopolization and "evergreening"

Srivats Narayanan. "Medicare for All and Evergreening". *Medium*. August 15, 2019. https://medium.com/@srivats.narayanan/medicare-for-all-and-evergreening-cb84c930e0ea

Medicare for All would prevent evergreening. National healthcare financing would align how much the government pays a drug company with how much patients benefit from the company's drugs. **If a new drug had more clinical benefits than an older version, the government would pay more for it**. If a new drug produced the same results as an older version, the government wouldn't pay more for the new drug. So, **Medicare for All would encourage pharmaceutical companies to pursue truly innovative drugs because such drugs would be more profitable. The policy would incentivize companies to invest in R&D for more useful drugs,** instead of just producing redundant and expensive medications. A national healthcare plan would prioritize "patient and community needs" and match up pharmaceutical companies' interests with actually improving public health. Evergreening has become the name of the game for the pharmaceutical industry. A major solution to the evergreening problem is Medicare for All. A single-payer system like **Medicare for All would sharply curtail evergreening, since drug companies wouldn't be able to profit from it.** Medicare for All would usher in a new era of medical innovation.

A2 TECHNOLOGICAL INNOVATION DECREASES

Hospitals don't lose money because uncompensated care decreases (no need to cut innovative tech)

Mike Stankiewicz. "Rural Hospitals Would Be Better Off Under Medicare for All". *Public Citizen.* January 9, 2020. https://www.citizen.org/news/rural-hospitals-would-be-better-off-under-medicare-for-all/

America's rural hospitals are financially struggling, facing low admission rates and under the frequent threat of closure. The current health care system has failed rural health care providers. Under Medicare for All, rural hospitals would experience much stronger financial stability and would be better able to serve the needs of America's rural population. Since 2005, more than 160 **rural hospitals** in the U.S. **have closed**, and nearly a quarter are at risk of closing, mostly **due to financial challenges under our for-profit health insurance system.** Around 51% of rural hospitals and about 45% of all hospitals serve a disproportionate share of patients who lack adequate coverage, and those **hospitals are forced to take on the cost of** that **uncompensated care**. Each year, these uncompensated costs continue to increase and place a heavier **financial burden on these hospitals**. **Under Medicare for All**, no patient would show up to the emergency room without insurance, and, as a result, **the incidence of uncompensated care would disappear.** Indeed, government-backed health insurance – Medicare and Medicaid – already serves as a financial lifeline for many rural hospitals. The U.S. Government Accountability Office found that between 2013 and 2017, **83% of rural hospital closures occurred in states that rejected Medicaid expansion**. A Health Affairs research article found similar results.

Hospitals making more from global budgeting

Adam Gaffney. "The Hospital Under Medicare for All". *Jacobin Magazine.* May 2019. https://www.jacobinmag.com/2019/05/medicare-for-all-hospital-financing-costs

Among other issues, the waste would be colossal: large bureaucracies would be needed to issue and process the bills, and the paperwork would suck up large amounts of teachers' time, taking them away from, say, teaching. That's exactly what plays out in hospitals. At one large academic medical center, **25 percent of all payments to the hospital** for an ER visit **were consumed** simply **by the cost of processing the bill**. Overall, approximately **one-quarter of American hospitals' total revenues is consumed by administrative and billing expenses.** In contrast, Canadian and Scottish hospitals receive global lump sum budgets, similar to public schools, which allows them to eschew "per patient" billing altogether, and spend only 12 percent of revenue on administration. **Single payer**, in other words, **could cut US hospitals' administrative spending by half**, an enormous saving since hospital spending accounts for about one-third of our $3.5 trillion health bill. This has two implications. Because hospitals' wasteful administrative costs are baked into prices, **single payer would allow us to reduce payments** to providers **without shrinking** the **resources** they have available to take care of patients. More likely, as demand for care rises once everyone is covered and financial barriers to care like co-pays and deductibles are eliminated, **hospitals could increase the amount of care they provide within their existing budgets.** Single-payer financing, in other words, can cover the cost of true health care universalism in the short run. And in the long run, it provides a second critical tool to control hospital cost growth.

M4A would increase the demand for healthcare, meaning that healthcare providers make more money by volume

Bivens, "Fundamental health reform like 'Medicare for All' would help the labor market." *Economic Policy Institute.* March 5, 2020. https://www.epi.org/publication/medicare-for-all-would-help-the-labor-market/

While it may seem counterintuitive, **fundamental health reform like M4A is almost guaranteed to substantially *expand* employment in the health care sector overall, even taking reduced billing administration employment into account.** Often people hear that fundamental reform is aimed at cost containment and then imagine that part of this cost containment will take the form of fewer jobs providing health care, but this is not necessarily the case. As noted before, the U.S. is an outlier in terms of how much it *spends* on health care, but its health care workforce as a share of the total workforce is not out of line with shares in other countries. For example, in 2017 the health care workforce in the U.S. was equal to 13.4% of the overall workforce, while the share averaged 12.9% in the 20 other richest OECD countries.15 Additionally, seven of these other countries had health care workforce shares equal to or higher than the U.S.'s 13.4%.16 Pollin et al. (2018) estimate that **expanded access to health care could increase demand for health services by up to $300 billion annually.** Given the current level of health spending and employment, this would translate into increased demand for 2.3 million full-time-equivalent workers in providing healthcare.17 Obviously all of the workers displaced from the health insurance and billing administration sectors could not necessarily transition into these jobs seamlessly, but well over 10% of workers in the health insurance sector, for example, are actually in health care occupations (e.g., they are doctors or nurses).18 Further, several M4A plans have provisions to pay for long-term care services. Reinhard et al. (2019) have estimated that in 2018, Americans provided roughly 34 billion hours in unpaid long-term care. If this care was divided up among full-time paid workers, it would require 17 million new positions. Of course, not all of this currently unpaid care would be converted into paid positions in the job market. But if even 10% of unpaid care translated into new jobs, it would create enough new demand for workers to essentially offset the displacement of workers in the health insurance and billing administration sectors.

A2 HARMING RURAL HOSPITALS

Hospitals wouldn't suffer that much under Medicare for All

Salvador Rizzo. "Would Medicare-for-all mean hospitals for none?" *Washington Post*. July 3, 2019. https://www.washingtonpost.com/politics/2019/07/03/would-medicare-for-all-mean-hospitals-none/

The Sanders bill is vague on whether hospitals would be paid at Medicare rates and **seems to leave those decisions to federal health officials, so it's not a given that hospitals would be asked to operate at 13 percent below their cost.** Larry Levitt, executive vice president for health policy at the Kaiser Family Foundation, gave us this assessment: While the Sanders bill is not specific about how much hospitals would get paid under Medicare-for-all, it's a reasonable assumption that government-set prices would be less than what they get today from private insurers. However, with universal coverage, hospitals would no longer have uncompensated care. It's also quite possible that without deductibles and copays, the number of hospital admissions and outpatient visits could rise, boosting hospital revenues. **The net effect on revenues would vary substantially** from hospital to hospital. Hospitals in high-income suburban areas with lots of privately-insured patients might lose, while hospitals in low-income communities with lots of uninsured patients could win. It's very likely that hospitals would face heightened cost pressure under Medicare-for-all, but **it's hard to envision an outcome where all or even many hospitals would actually shut their doors.**

Hospital closures don't worsen health outcomes

Karen Joynt, Paula Chatterjee, E. John Orav, and Ashish Jha. "Hospital closures had no measurable impact on local hospitalization rates or mortality rates, 2003-11." *Health Affairs*. May 2015. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.1352

The Affordable Care Act (ACA) set in motion payment changes that could put pressure on hospital finances and lead some hospitals to close. Understanding the impact of closures on patient care and outcomes is critically important. We identified 195 hospital closures in the United States between 2003 and 2011. **We found no significant difference between the change in annual mortality rates for patients living in hospital service areas (HSAs) that experienced one or more closures and the change in rates in matched HSAs without a closure (5.5 percent to 5.2 percent versus 5.4 percent to 5.4 percent, respectively). Nor was there a significant difference in the change in all-cause mortality rates following hospitalization (9.1 percent to 8.2 percent in HSAs with a closure versus 9.0 percent to 8.4 percent in those without a closure).** HSAs with a closure had a drop in readmission rates compared to controls (19.4 percent to 18.2 percent versus 18.8 percent to 18.3 percent). Overall, we found **no evidence that hospital closures were associated with worse outcomes for patients living in those communities.** These findings may offer reassurance to policy makers and clinical leaders concerned about the potential acceleration of hospital closures as a result of health care reform.

Hospitals that are currently struggling would be better off under Medicare for All

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

In congressional testimony, Dr. Jessica Banthin, Deputy Assistant Director for Health, Retirement, and Long-Term Analysis at the Congressional Budget Office, explains that enacting single-payer **Medicare for All could keep rural hospitals afloat**. Everyone would have good coverage. And, hospitals would be compensated at Medicare rates, or better, for the care that they deliver. Other health care reform proposals that allow people the option to buy into Medicare, such as a "public option" or "Medicare buy-in," would not ensure rural residents access to care. A new study published in the Lancet by Yale Professor Alison Galvani et al. finds that these proposals would drive health care costs higher. Health care would continue to be unaffordable for much of rural America. Thousands of rural Americans would continue to die unnecessarily each year. Right now, our **for-profit health care** system leaves millions of rural residents uninsured or underinsured and unable to get the care they need. It **is not designed to serve rural communities**. Mountains of research show that rural Americans with low incomes and chronic conditions often cannot afford needed care or coverage. Not surprisingly, the 46 million rural residents – one in six Americans—have far poorer health outcomes and lower life expectancies than Americans living in urban areas. Because rural hospitals are not reimbursed for much of the care they deliver, many of them cannot generate the revenue needed to serve their communities. **Nearly four in 10 rural hospitals are unprofitable**. Low patient numbers contribute to the problem. Hospitals are cutting services and closing. Rural Americans sometimes must travel 30 miles to the nearest hospital. Public health insurance helps rural hospitals to a limited extent. Rural hospitals are stronger in states that have expanded Medicaid under the Affordable Care Act. **The uninsured rate in those states for people with incomes under 138 percent of the federal poverty level has dropped from 35 percent to 16 percent.** Medicaid provides necessary revenue to hospitals in those states. But 14 states have not expanded Medicaid, and the Supreme Court ruled that Congress cannot require states to expand Medicaid. Moreover, if the Trump administration is successful at repealing the Affordable Care Act, which covers the cost of Medicaid expansion, uninsured rates will rise significantly and hundreds more rural hospitals will be at risk. Rural Americans living in the South and in states that have not expanded Medicaid have witnessed the highest number of hospital closures. In states that have not expanded Medicaid, rural hospitals must serve more uninsured patients and deliver a significant amount of uncompensated care. Nearly one in three people with incomes under 138 percent of the federal poverty level are uninsured. Residents of Texas, Tennessee, Oklahoma and Georgia—none of which expanded Medicaid—are among those at greatest risk of losing access to hospital care. Over the last 10 years, Texas saw 20 rural hospitals close and Tennessee saw 12 hospitals close. Oklahoma and Georgia each saw seven hospitals close. Beyond struggling to meet their health care needs, rural patients are often burdened with sky-high medical debt. Many are low-wage workers, with little hope of paying off their hospital and medical bills. Rural hospitals and doctors have taken to suing patients for the cost of their care. Thousands of rural Americans are jailed or threatened with jail each year when they don't show up in court for unpaid medical bills. With **Medicare for All**, Congress **would ensure the viability of rural hospitals**. Rural hospitals would be properly compensated for the care they deliver, strengthening their balance sheets.

A2 INCREASED WAIT TIMES

Wait Times Don't Increase That Much

Thomas Waldrop. "The Truth on Wait Times in Universal Coverage Systems." *Center for American Progress,* October 18, 2019, https://www.americanprogress.org/issues/healthcare/reports/2019/10/18/475908/truth-wait-times-universal-coverage-systems/

However, the data—both from other nations with universal coverage and from historic expansions of coverage within the United States—show that this is not the case. **Patients in peer nations generally have similar or shorter wait times than patients in the United States** for a variety of services, refuting the argument that universal coverage would necessarily result in longer wait times in the future. This issue brief provides an overview of the factors that affect wait times, outlines evidence that suggests **universal coverage need not increase wait times** in the long run, and discusses policy solutions to mitigate any impact on wait times in the short run. Discussions of wait times often ignore the fundamental reality that, **for many patients, wait times are already long**. Where a patient lives has a significant effect on their wait time, largely due to provider concentration in more urban areas compared with more rural ones. For example, a 2017 analysis of hospital wait times found that mid-size metropolitan areas—cities such as Hartford, Connecticut—had 32.8 percent longer wait times than large metropolitan areas such as Washington, D.C.3 A recent article in the Journal of the American Medical Association further supports this idea.4 The study found that wait times at private-sector hospitals ranged from 16.5 days in New York City to 57.33 days in Boston, Massachusetts. The same study compared wait times between a similar set of private and U.S. Department of Veterans Affairs (VA) hospitals and found that VA hospitals had "significantly shorter" wait times than private hospitals, in part because wait times at VA hospitals have improved in recent years—now averaging 20 days—while wait times at private hospitals have stagnated at around 41 days.5 Insurance status also affects wait times. Generally, privately insured patients have shorter wait times than publicly insured patients, though the magnitude of this difference varies. A 2018 study by the Leonard Davis Institute of Health Economics in Philadelphia found that **Medicaid beneficiaries' wait times** for new primary care physician (PCP) appointments **were**, on average, **only two days longer than those for privately insured patients**.6 Meanwhile, an examination of the impact of Medicaid expansion in Michigan found that **wait times** for PCP appointments **were approximately one day longer on average, both before and after expansion.**7 A similar study of 10 states found that privately insured patients were almost universally more likely than publicly insured patients to have wait times of less than one week for a new PCP appointment and were less likely to have a wait time of more than 30 days—which represented the 50th and 90th percentiles, respectively.8 **This difference in wait times is largely attributable to differences in payment rates between payers, not any inherent advantage to private insurers.** Many coverage expansion proposals address this issue of differing payment rates: Both the House and Senate versions of Medicare for All establish the federal government as the only payer, and the Center for American Progress' Medicare Extra proposal indirectly lowers the rates that private insurers pay by limiting out-of-network providers to receiving no more than what the federal government pays.9 All of these studies, however, focus on insured patients. Newly released data from the U.S. Census Bureau estimate that the uninsured rate is approximately 8.5 percent, which amounts to more than 27 million people.10 Since discussions of wait times fail to consider these individuals, they paint a far rosier picture than the reality. Uninsured people are much more likely to postpone seeking care or skip needed care due to cost.11 And while specific data on wait times for uninsured patients are missing from the discussion, what is known is that being uninsured is associated with worse access to care and that, for some uninsured patients, their wait times are essentially infinite. Expansions of coverage in the United States, while not resulting in universal coverage, show that passing any of the **universal coverage** proposals currently being discussed in Congress **would not significantly increase wait times**. For example, in 2006, Massachusetts passed significant health reform legislation—similar to the Affordable Care Act—that expanded Medicaid eligibility and encouraged health insurance enrollment through an individual mandate.18 The law was extremely effective at its goals: Massachusetts continues to have the lowest uninsured rate in the country, currently estimated at 2.8 percent.19 While wait times did increase in the short term following the implementation of the Massachusetts law, researchers have found no evidence that this increase had any negative impact on preventable hospitalizations.20 Other, more recent research has examined primary care appointment wait times in 2012 and 2016, finding that while most states saw decreases in wait times of less than a week and increases in those of more than 30 days, Massachusetts saw the opposite.21 For both privately insured patients and Medicaid beneficiaries in the state, wait times improved during this period.22 This suggests that the impact of health coverage expansions diminishes over time as provider supply rises to meet the new demand. Policymakers can therefore be reassured that patients will not have worse health outcomes as a result of expanded coverage and that policies can be included in any expansion to help mitigate the effect in the short term and accelerate

provider supply increases. Transition can mitigate any impact on wait times The idea of increasing wait times for insured patients is unappealing; however, it is not a necessary component of any proposal to expand coverage. There are a variety of policy tools that can be used to help ensure that provider supply meets, as quickly as possible, the new demand for health care associated with coverage expansions. Two of the best ways to achieve this are by expanding the scopes of practices for nonphysician providers and by adjusting payment rates to better incentivize primary care providers.

People in single-payer countries are more likely to be able to see a doctor on the same or next day

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

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

A2 DRUG & DOCTOR SHORTAGES

UK shortages have nothing to do with single payer

M Taylor. "Why is there a shortage of doctors in the UK?" *Bristol Royal Infirmary*. https://publishing.rcseng.ac.uk/doi/pdfplus/10.1308/rcsbull.2020.78

The reasons **for the current medical staffing crisis are** multiple. **Reductions in the number of medical school places** in the past decade have been short-sighted and are only now being addressed. It will take over a decade for the new increases in medical school places to take effect upon the staffing crisis. It is **only with a well thought out recruitment and retention plan that the numbers of doctors will increase** and patient safety will improve.

M4A would increase the job security of physicians by increasing demand for health services by up to $300 billion annually.

Josh Bivens. "Medicare for All would boost wages, expand workers' options, and likely create jobs." *Economic Policy Institute*. March 5, 2020. https://www.epi.org/press/medicare-for-all-would-boost-wages-expand-workers-options-and-likely-create-jobs/#:~:text=News%20from%20EPI%20Medicare%20for,options%2C%20and%20likely%20create%20jobs&text=For%20example%2C%20expanded%20access%20to,full%2Dtime%20health%20care%20workers.

A new report from EPI research director Josh Bivens finds that **Medicare for All would bolster the labor market, strengthen economic security for millions of U.S. households, and would likely boost the number of jobs in the U.S**. labor market. Opponents of a single-payer health care system have quoted an analysis of the economic effects of Medicare for All that includes the projection that up to 1.8 million jobs in the health insurance and billing administration sector could be eliminated if the policy were implemented. Bivens notes that this number has been stripped of all context that is included in the original study, and is often misleadingly presented as the predicted net employment effect of Medicare for All. But while **Medicare for All** would indeed lead to lower demand for labor in the health insurance and billing administration sector, it would boost demand for other types of jobs overall. For example, expanded access to health care **could increase demand for health services by up to $300 billion annually**, which would translate into an increased demand for 2.3 million full-time health care workers.

Doctor burnout caused by paperwork

Englehard, "The new healthcare crisis? Doctor burnout, thanks to paperwork." *The Hill*. February 1, 2017. https://thehill.com/blogs/pundits-blog/healthcare/317233-doctors-are-increasingly-burnt-out-thanks-to-paperwork

Physician burnout has increased by 25 percent in just four years. A recently released survey by Medscape asked over 14,000 physicians from over 30 specialties about "burnout," a condition defined as a loss of enthusiasm for work, feelings of cynicism and a low sense of personal accomplishment. In the 2017 Medscape report, 51 percent of all physicians reported experiencing

burnout, up from 40 percent in 2013. **The main causes reported were "too many bureaucratic tasks"** and "spending too many hours at work." These two factors ranked highest among both male and female physicians and were consistent with the findings in the preceding two surveys from Medscape. To be sure, the additional documentation required by the growing number of productivity and quality measures directed at physicians from public and private payers has taken its toll. A study last year in the journal Health Affairs found that **physicians and their staff spent over 15 hours per week complying with quality reporting requirements at an annual cost of over $15 billion.** Another recent study funded by the American Medical Association (AMA) and reported in the Annals of Internal Medicine found that for every hour a physician spends with patients, an additional two hours are consumed completing administrative tasks related to the visit.

M4A decreases amount of time spent on paperwork and billing

Philips, "Medicare for All and the Myth of the 40% Physician Pay Cut." *Common Dreams*. September 11, 2018.
https://pnhp.org/news/medicare-for-all-and-the-myth-of-the-40-physician-pay-cut/

Smaller practices spend an average of $83,000 per year on claims, coverage and billing. **Doctors personally spend nine hours each week on billing and admin**; that's time we're not seeing patients. It's no surprise that doctors today report unprecedented levels of exhaustion and burnout. Then there's the issue of malpractice insurance, which takes a big bite out of doctors' income. Future medical costs are a large part of malpractice settlements, but are removed from the settlement equation under Medicare for All. Lower potential settlements means lower premiums for doctors. **Dealing with one single payer—Medicare—would mean drastically fewer hours of uncompensated administrative time, fewer office staff, and lower overhead.** It's a tremendous amount of time and money that Mercatus fails to include in their analysis.

Less admin costs means that hospitals don't have to cut salaries

Archer, "22 Studies Agree: 'Medicare for All' Saves Money." *The Hill*. 24 February 2020.
https://thehill.com/blogs/congress-blog/healthcare/484301-22-studies-agree-medicare-for-all-saves-money

Medicare for All is far less costly than our current system largely because it reduces administrative costs. With one public plan negotiating rates with health care providers, billing becomes quite simple. We do away with three-quarters of the estimated $812 billion the U.S. now spends on health care administration. **Administrative costs are so high because thousands of insurance companies individually negotiate benefit rules and rates with thousands of hospitals and doctors. On top of that, they rely on different billing procedures – and this puts a costly burden on providers. Administrative savings from Medicare for All would be about $600 billion a year. Savings on prescription drugs** would be between $200 billion and $300 billion a year, if we paid about the same price as other wealthy countries pay for their drugs. A Medicare for All system would save still more with implementation of **global health care spending budgets**. Even more savings are possible in a Medicare for All system because, like every other wealthy country, we would have a uniform electronic health records system. Such a system generates additional savings because system problems would be easier to detect and correct. A uniform claims data system helps reduce health care spending for fraudulent services. In 2018, **total U.S. health care costs were $3.6 trillion**, representing 17.7 percent of GDP.

A2 ECONOMIC HARMS

Increasing investment in job creation

Robert Pollin. "Economic Analysis of Medicare for All." *Political Economy Research Institute.* November 2018. https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all

As a matter of accounting, **job creation** in any economy **depends on** 1) the level of production (**GDP**) in the economy; **and** 2) **the proportion of overall production costs that are spent on hiring people into jobs**. For a given level of production, employment will rise when the economy's productive activities are more labor-intensive—i.e. a higher share of overall production is devoted to hiring workers as opposed to spending relatively more on, among other things, purchasing machines, buildings, land, and energy supplies. **Medicare for All will support relatively higher levels of spending on job creation**. As we have seen, net health care costs will fall for small- and medium-sized businesses. The operations of these businesses tend to be more labor-intensive than those for larger-scale businesses. Medicare for All will therefore encourage small- and medium-sized businesses to expand their operations and increase hiring.

Helping small businesses

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

Despite policymakers' frequent claims that they seek to support small businesses in the U.S. economy, the United States has a notably small share of small-business employment relative to our rich country peers. In 2018, for example, the U.S. was dead-last among the members of the Organisation for Economic Co-operation and Development (OECD) in its share of self-employment, at just 6.3% of employment. **Countries that are frequently portrayed in U.S. business reporting as being choked by regulation—like Spain, France, and Germany—have far higher shares of self-employment, at 16.0%, 11.7%, and 9.9%, respectively** (OECD 2020). Besides a low share of self-employment, the U.S. also had significantly lower shares of overall employment in small businesses, across nearly all industrial sectors. The latest OECD data show that the U.S. share of employment in enterprises with fewer than 50 employees is lower than in any other country except for Russia (OECD 2018, Figure 7). In an earlier overview of trends in employment by firm size, Schmitt and Lane (2009) highlight how health care policy plays two key roles in potentially explaining cross-country trends. **First, because health care is nearly universally provided in other rich countries, workers choosing to start their own businesses in those countries do not face a cost confronting would-be entrepreneurs in the U.S.: the loss of ESI. Second, small businesses in the U.S. are at a distinct disadvantage in recruiting employees because the cost of providing health care coverage is significantly higher for small companies.11**

INDICTS TO PRO EVIDENCE

A2 GALVANI ET AL

The Lancet, M4A costs $540 billion less per year and would save 68,000 lives per year[4]

There are a few major problems with this study.

First, let's look at the finding that U.S. healthcare spending would decrease $540 billion per year. The study calculates that much of the saved costs would be from avoided hospitalizations and emergency room visits, which they calculate based on the assumption that access to preventative care will decrease hospitalization in the first place. However, this has not been the case in states that have expanded Medicaid and Medicare, as hospitalizations and emergency room visits did not disappear due to increased access (Luthra[5]). The study also assumes that hospitals would save over $219 billion in administrative costs, since dealing with one insurer is easier than filing claims to hundreds of different insurers. While that may be true to some extent, other administrative costs, like expensive electronic health records, would not go away (Luthra). Finally, the study also underestimates the number of people who would take advantage of M4A coverage. While the Lancet study takes into account increased usage by uninsured and underinsured Americans, it does not "account for people who already have decent or adequate insurance and who would still be moving to a richer benefit," meaning that the study might overlook large amounts of potential spending (Luthra).

Second, on the lives saved claim. This figure is based on a 2009 paper but does not acknowledge any studies done after 2009. In short, the findings are based on cherry-picked evidence (Luthra).

One other important thing to note: the lead author of this study was an unpaid adviser to the Sanders staff during the drafting of the 2019 M4A bill. This could have provided an incentive for the author to cherry pick numbers in order to produce a conclusion favorable to the Sanders campaign.

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[4]Galvani et al, "Improving the prognosis of health care in the USA." *The Lancet*. February 15, 2020. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)33019-3/fulltext

[5] Shefali Luthra, "Sanders Embraces New Study That Lowers 'Medicare For All's' Cost, But Skepticism Abounds." *Kaiser Family Foundation*. February 26, 2020. https://khn.org/news/bernie-sanders-embraces-a-new-study-that-lowers-medicare-for-alls-price-tag-but-skepticism-abounds/

A2 LEVY

The Journal of Health and Economics, A 20% decrease in the price of drugs increases access by 23%[6]

There are a few key problems with this evidence.

Firstly, it is a mathematical theoretical modeling tool based on healthcare data from the European Union. Teams can point out the difference between the healthcare systems of the European Union and the one proposed for the United States under M4A. For example, in the United Kingdom, hospitals and doctors are government-owned, so not only is the government the only health insurer, but it is the only healthcare provider; this cohesion simplifies the logistical aspects of the healthcare system.

Secondly, the evidence also says that a 20% decrease in the price of drugs would drastically reduce the revenues of pharmaceutical companies. Using this part of the study, a con team can turn the study to their side by arguing that reduced revenues end up with cuts to things like R&D. It is incredibly persuasive to support your own arguments with your opponents' evidence.

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[6] Levy, Moshe & Rizansky Nir, Adi. "The utility of health and wealth." *Journal of Health Economics.* March 2012. https://doi.org/10.1016/j.jhealeco.2012.02.003 https://www.sciencedirect.com/science/article/abs/pii/S0167629612000100

A2 LIN

MIT, a 17% increase in pharmaceutical market share increases research and development by 40%[7]

This evidence is often construed to say that increasing access to new treatments in turn increases pharmaceutical revenues and spending on R&D. For the most part, this is used as a response to the con argument that decreased pharmaceutical prices would decrease pharmaceutical revenues, which would lead companies to slash R&D funding. However, the way that this evidence is used in round does not actually reflect the authors' conclusion. The term "market size" as used in the paper does not refer to the idea that the market size will increase as healthcare becomes affordable. The authors define a "new market" as a new medical treatment for a disease that previously had no remedy. Rather than focusing on making a drug more accessible, the study focuses on how research and development targets emerging diseases. Even if the evidence were to be about market affordability, it would be reverse-causal. Essentially, the study does not conclude that increased market size from better access leads to more research and development. Instead, it concludes that as companies spend more on R&D, they develop treatments for diseases that were previously untreatable. Market size then increases as the number of treatable diseases increases. Companies can then profit off of this larger market. In short, increased market size does not lead to increased R&D spending; increased R&D spending increases market size. Because of this reverse-causal relationship, the evidence cannot be used to argue that increased access to pharmaceuticals increases R&D spending.

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[7] Daron Acemoglu and Joshua Linn. "Market Size in Innovation: Theory and Evidence from the Pharmaceutical Industry." Fellows of Harvard College and Massachusetts Institute of Technology. *The Quarterly Journal of Economics.* 2004. https://economics.mit.edu/files/4464

A2 HIMMILSTON ET AL

American Journal of Medicine, 62% of all bankruptcies are the result of medical expenses[8]

This study has a couple of issues. First, the scope of its application is limited by its data sample, as the study only looks at data from 2007. Thus, it is very easy to postdate the study or outweigh it by presenting a more holistic analysis that looks data from several years rather than just one. The second problem lies in how the authors determined what qualifies as a "medical bankruptcy". Essentially, the authors found a random sample of about 2000 people who had filed for bankruptcy and then researched the extent to which medical expenses contributed to bankruptcy. However, the authors classified a bankruptcy as a medical one if any amount of the debt was medical. This means that in many of these cases, medical expenses may not have been the main contributor to debt. Many debtors had credit card debt, mortgage payments, student loans, and other financial burdens besides medical bills. Thus, the impact of medical expenses is severely overestimated.

[8] David Himmilston, Deborah Thorne, Elizabeth Warren, Steffie Woolhandler. "Medical Bankruptcy in the United States, 2007: Results of a National Study" *American Journal of Medicine.* 2009. https://www.amjmed.com/article/S0002-9343%2809%2900404-5/pdf

INDICTS TO CON EVIDENCE

A2 GOLDSMITH & LEIBACH

Navigant, rural hospitals' revenue decreases by 14% w/ M4A[9]

Many negative teams use this analysis as the crux of their shortages argument. It argues that Medicare does not pay hospitals as much which will force closures especially in rural areas. However, this study was commissioned by pharmaceutical companies who have a vested interest in stopping the Medicare for All bill from passing, as M4A would limit the profits that pharmaceutical companies make. Thus, the study itself was contrived to come to a certain conclusion, one that casts a negative light on M4A. In short, it's not credible. It is important to use this in conjunction with counter evidence arguing that hospitals either don't lose money or make more money under M4A. That way, in addition to casting doubt on your opponents' facts, you can turn the argument to your side with better evidence.

[9] Goldsmith and Leibach, Navigant, August 2019, "THE POTENTIAL IMPACT OF A MEDICARE PUBLIC OPTION ON U.S. RURAL HOSPITALS AND COMMUNITIES: A SCENARIO ANALYSIS." https://americashealthcarefuture.org/wp-content/uploads/2019/10/Navigant-Rural-Public-Option-FINAL-8.19.pdf

A2 ABBOTT

National Bureau of Economic Research, a 40% reduction in prices lowers R&D projects 60%[10]

This evidence is often the crux of the con argument that pharmaceutical innovation decreases, given that it directly quantifies the link between price reductions and drug development. Responding to this evidence can be crucial in taking the argument down. Firstly, the study assumes that the government is not going to subsidize research and development, which would be wholly inaccurate in a single-payer system. The government already subsidizes the majority of new research and development through the National Institute of Health. The author even concedes that it would be a good idea for the government to subsidize R&D, and that R&D investment will continue if the government does so. Secondly, the study assumes that any lost revenue would be balanced out by cutting R&D budgets. This is also nonsensical because new, innovative products are what make pharmaceutical companies the most money. It's much more likely that pharma companies would recoup costs by reallocating money spent on things like marketing and administration.

[10] Thomas Abbot and John Vernon. "The cost of US pharmaceutical price regulation: a financial simulation model of R&D decisions." *National Bureau of Economic Research.* 17 August 2007. https://www.nber.org/papers/w11114.pdf

A2 SHEPHERD

National Bureau of Economic Research, new drug developments save 11,200 life-years per year[11]

The Shepherd analysis is often used as the final impact card for the innovation argument. Unfortunately, the numbers are very, very flawed. Shepherd bases the 11,200 number on a different analysis conducted in 1998. That analysis calculated the 11,200 lives based on the increase in life expectancy since 1940 and attributes all of the gains in life expectancy to new drug procurements. This relationship is not proven in any way to be a causal one. Life expectancy has increased since the 1940s, but that increase is not solely due to new pharmaceutical drugs. At best, a portion of that is from new drugs, but certainly not all of it. Bringing this point up in round drastically reduces the impact potential of your opponent's argument and can help in weighing the magnitudes of your impacts against theirs.

[11] Joanna Shepherd. "A 'social contract' for the drug industry." *Truth on the Market Blog.* September 11, 2016. https://truthonthemarket.com/2016/09/11/a-social-contract-for-the-drug-industry/

A2 The Hill

Wait times in Europe caused 600,000 deaths[12]

This evidence is the perfect example of a biased source using numbers that sound too good to be true. While the Hill is neither a left nor right leaning media source, this article is an opinion piece, which means that readers should consider its information with a grain of salt. The 600,000 deaths number essentially comes from the media equivalent of "debater math". The author explains that colon cancer kills roughly 600,000 people every year in Europe, and that wait times for colon cancer treatment are long. The line most likely to be seen in round comes later when the author asserts that those 600,000 deaths could be avoided if there were no price regulations on pharmaceuticals, because it is the price controls that create wait times. This is definitionally a logical fallacy. No one knows how many of these colon cancer deaths were treatable, how many could be prevented early on, or how many were caused by wait times. Colon cancer is fairly lethal in other developed countries as well, meaning the claim that all 600,000 deaths could be avoided is not only an exaggeration, but is an untruthful statement.

[12] Andrew Spiegel. "The tragic toll of drug price controls." *The Hill*. May 5, 2017. https://thehill.com/blogs/pundits-blog/healthcare/332145-the-tragic-toll-of-drug-price-controls